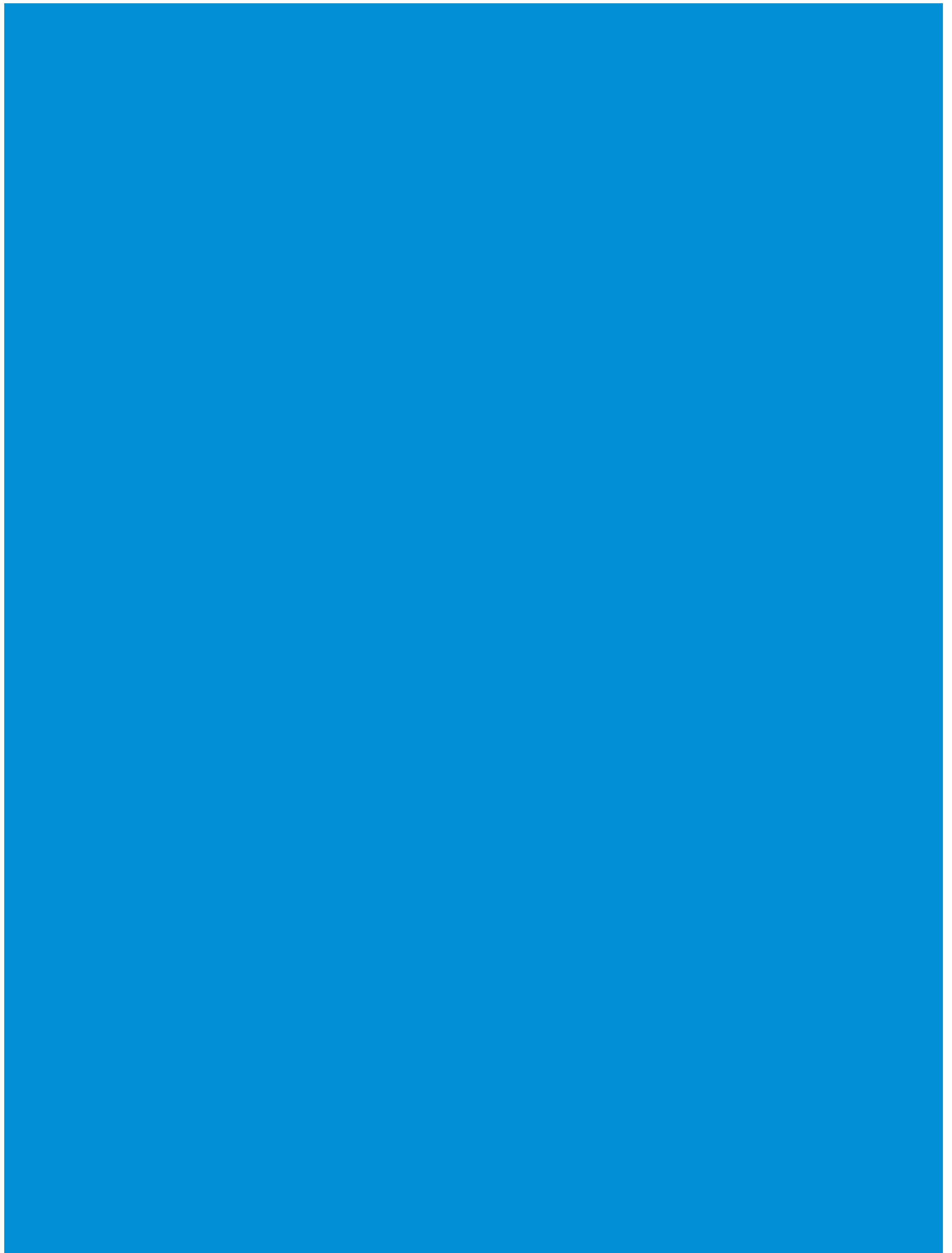
Myanmar National Strategic Plan & Operational Plan on HIV and AIDS

2011-2015

CONCISE VERSION



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Acronym

3DF	Three Diseases Fund
FXB	Francois-Xavier Bagnoud
AHRN	Asian Harm Reduction Network
AIDS	Acquired Immunodeficiency Syndrome
Alliance	International HIV/AIDS Alliance
AMI	Aide Médicale Internationale
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
ASEAN	Association of South-East Asian Nations
AZG	Artsen Zonder Grenzen (MSF Holland, MSF-H)
BSS	Behavioural Sentinel Survey
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CoC	Continuum of Care
DU	drug user
EC	European Commission
FBO	Faith Based Organization
FERD	Foreign Economic Relations Department
FSW	female sex worker
GAVI	Global Action for Vaccine Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General Practitioners
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
HSS	Health Sector Strengthening
INGO	International Non Governmental Organization
IOM	International Organization for Migration
MANA	Myanmar Anti Narcotics Association
MBCA	Myanmar Business Coalition on AIDS
M-CCM	Myanmar Country Coordinating Committee
MCWA	Maternal and Child Welfare Association
MdM	Médecins du Monde
MMA	Myanmar Medical Association
MNMA	Myanmar Nurse and Midwife Association
MoH	Ministry of Health
MPG	Myanmar Positive Group
MRCS	Myanmar Red Cross Society

MSF	Médecins Sans Frontières
MSF-CH	Médecins Sans Frontières - Switzerland
MSI	Marie Stopes International
MSM	men who have sex with men
MWAF	Myanmar Women's Affairs Federation
NAP	National AIDS Programme
NGO	Non Governmental Organization
NSP	National Strategic Plan
NSP I	National Strategic Plan I (2006-2010)
NSP II	National Strategic Plan II (2011-2015)
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PGK	Pyi Gyi Khin
PMCT	Prevention of Mother-to-Child Transmission
PPPH	Private Partnerships for Public Health
PSI	Population Services International
PWID	Person who injects drugs/ People who inject drugs
SHG	Self Help Group
STI	Sexually Transmitted Infections
TB	Tuberculosis
The Union	International Union against Tuberculosis and Lung Disease
TSG	Technical and Strategy Group
TWG	Technical Working Group
UMFCCI	Union Of Myanmar Federation of Chamber for Commerce and Industry
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
VCCT	Voluntary Confidential Counselling and Testing
VDRL	Venereal Disease Research Laboratory test , a blood test for syphilis
WFP	World Food Programme
WHO	World Health Organization

About the Concise Version

On 6 January 2011, the Ministry of Health endorsed the Myanmar National Strategic Plan on HIV and AIDS 2011-2015 along with the Operational Plan for the same period.

This document provides a summary of the full Myanmar National Strategic Plan on HIV and AIDS 2011-2015 and the Operational Plan. It is meant to provide policy makers, programme planners, implementers, community members, people living with HIV and the donor community with a quick reference to the main components of the Strategic Plan. However, those who wish to have full details and more information must refer to the full documents.

The Concise Version provides summary information of the HIV situation and epidemiology trends; objectives; guiding principles; strategic framework; roles and responsibilities and institutional arrangements; governing structures; priorities, interventions and key services; indicators; and summary budget.

The National Strategic Plan and Operational Plan 2011-2015

The NSP has a vision of achieving the HIV related MDG targets by 2015. It aims to cut the new infections by half of the estimated level of 2010. NSP II aims to reduce HIV transmission and HIV-related morbidity, mortality, disability and social and economic impact.

There are three strategic priorities: (1) Prevention of the transmission of HIV through unsafe sexual contacts and use of contaminated injecting equipment; (2) Comprehensive continuum of care for people living with HIV; and (3) Mitigation of the impact of HIV on people living with HIV and their families.

NSP II recognises the link between prevention, treatment and care, particularly for PMCT, VCCT, and for the sexual partners of people living with HIV. There are three cross-cutting interventions; (1) health systems strengthening - including the private health sector, structural interventions and community systems strengthening; (2) a favourable environment for reducing stigma and discrimination; and (3) strategic information, M&E and research.

NSP II is a living document: it lends itself to adjustments and revisions as further experience is gained, resources are mobilized and evidence of success and shortcomings is generated through monitoring, special studies and mid-term and end-of-term evaluations and regular national partnership forums.

The NSP II and the Operational Plan present an indicative budget envelope of US$ 343.6 million over five years, with a first two year budget of US$ 111.7 million.

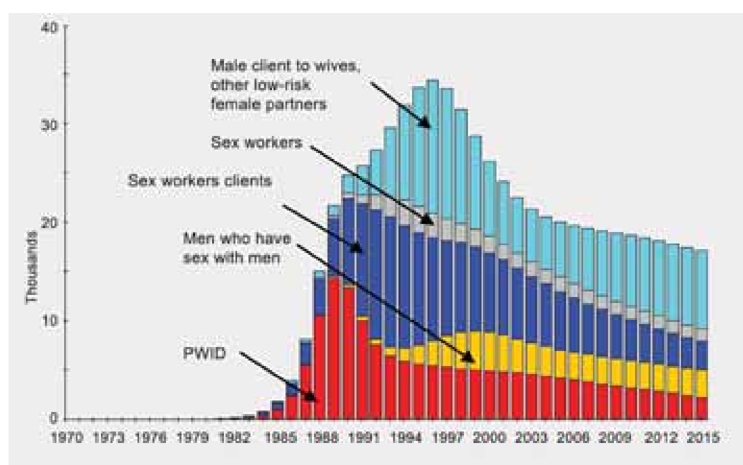
Epidemiology

The two-decade old HIV epidemic in Myanmar is largely concentrated among population sub groups with high risk behaviours. The majority of the AIDS cases are reported from large urban areas and from the northern and north-eastern parts of the country. While the overall HIV prevalence in Myanmar is estimated to be below 1%, there are sizeable key populations at higher risk (female sex workers and their clients, men who have sex with men, and people who inject drugs). These key populations are disproportionately affected by HIV. In 2009, the prevalence of HIV was estimated at 11.2% (range 9.2-13.6%; CI 95%) for female sex workers (FSW), at 34.6% (range 31.6-37.7%; CI 95%) for people who inject drugs (PWID) and at 22.3% (range 18.2-26.4%; CI 95%) for men who have sex with men (MSM)[1]. In selected sites, sexually transmitted infection (STI) rates are also high among key populations. Condom use in paid sex with female sex workers is reported to be high but unprotected sex among men who have sex with men and among people who inject drugs is common[2]. The large size of key populations at higher risk, the high prevalence of syphilis, and risk behaviours, population mobility, poverty, HIV associated stigma, and limited coverage of effective prevention programmes are some of the important determinants that make Myanmar highly vulnerable to HIV.

HIV incidence

Figure 1 shows trends in distribution of new HIV infections by sub-population groups. Like in other Asian countries, people who inject drugs (PWID) was the first group to be affected. HIV incidence in PWID peaked in the early 1990s. The HIV epidemic among people who inject drugs was followed by increase in cases among female sex workers (FSW) and their clients. Finally, following the infection of a large number of male clients of FSW, HIV incidence reached a peak in the so-called “low-risk” female population due to transmission from male clients of FSW.

Figure 1. Trends in the distribution of new HIV infections by population subgroups[3]

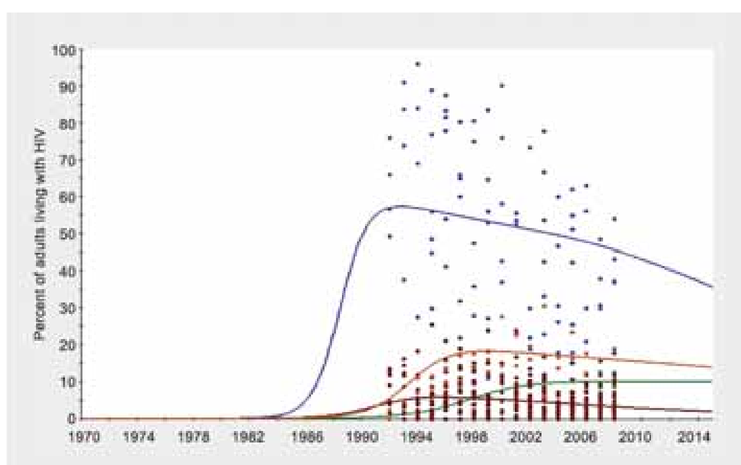


[1] National AIDS Programme, Report of the HIV Sentinel Sero-Surveillance Survey 2009, Myanmar
[2] National AIDS Programme, BSS 2008 – Injecting Drug Users and Female Sex Workers, Myanmar, 2009
[3] National AIDS Programme, HIV Estimates and Projections, Myanmar 2008-2015, Myanmar 2010 (To be updated)

Trends in HIV prevalence

Figure 2 shows HIV prevalence trends among PWID, FSW, their clients and MSM. Notably, HIV prevalence is decreasing among all high risk behaviour groups except MSM where a large degree of uncertainty persists due to the limited number of data points.

Figure 2. Trends in HIV prevalence among key populations at higher risk [4]

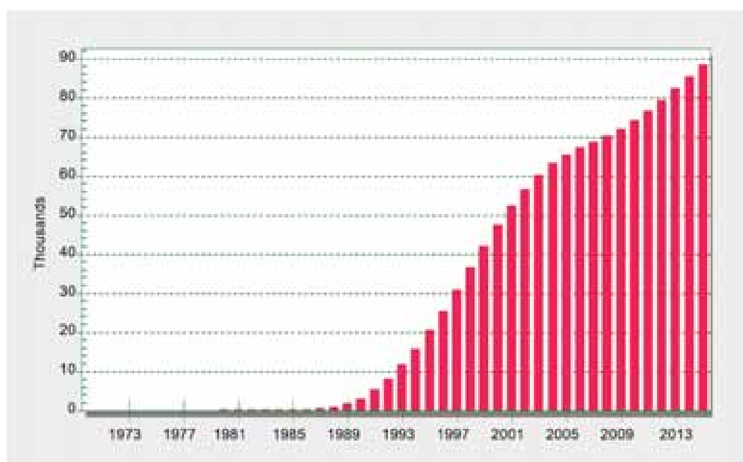


The majority of HIV infections in Myanmar have been in men, with the male to female ratio declining from 8 to 1 in 1993 to 1.9 to 1 in 2009. By 2015, it is projected that the male to female ratio will be 1.6:1. These women are largely the sexual partners of current and former FSW clients, PWID, and MSM. It is estimated that the number of pregnant women living with HIV was about 4,300 in 2009.

In Myanmar, ART is provided by the National AIDS Programme (NAP), international and local NGOs. As of the end of 2009, approximately 21,000 adults and children are on treatment. Estimates of the number of people needing ART in a given year are based on the NAP ART guideline recommendations from 2006. According to the national ART guidelines, patients with CD4 counts of less than 200 should receive ART and those with CD4 200-350 can be considered for treatment. Using a threshold of CD4 <200, approximately 74,000 adults needed ART in 2009. However, as more people needing treatment start to receive it, the need for ART will increase as more people will survive longer (Figure 3). When the national guidelines are revised to reflect the recommended change to start treatment at CD4 <350, then adult ART needs will increase accordingly.

[4] National AIDS Programme, HIV Estimates and Projections, Myanmar 2008-2015, Myanmar 2010

Figure 3. Number of adults with advanced HIV infection in need of antiretroviral[5] treatment



[5] National AIDS Programme, HIV Estimates and Projections, Myanmar 2008-2015, Myanmar 2010

The National Strategic Plan 2011-2015

Vision

The National Strategic Plan on HIV and AIDS will contribute to the overall efforts of Myanmar to achieve its Millennium Development Goals, hence improve the wellbeing of Myanmar people. Specifically, the NSP II has the vision to achieve a society that is free of new HIV infections and where all people regardless of gender, age or origin have access to treatment and support that enables them to live a fulfilling life.
Aim

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

Objectives

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

Targets

By 2015, the National Strategic Plan will have met the goals set in the MDGs and turned around the epidemic, if extraordinary commitment and efforts are made by all concerned stakeholders. Specifically, the following will have been achieved:

1. New HIV infections are cut by half of the estimated level of 2010, the reduction of new infections of females will be at least equal to overall reduction.
    - Less than 5,000 new infections will occur in 2015

2. 80% of people living with HIV, who are eligible, will receive life saving ARV treatment based on the current national treatment guideline and criteria (i.e. CD4 count <200/mm3) that are non-discriminatory with regard to gender, type of transmission, age, ethnicity and location.
    - 70,000 adults and children will be receiving ARV treatment in 2015

3. More than 80% of women living with HIV are receiving antiretroviral prophylaxis therapy to reduce the risk of mother-to-child transmission
    - 2,680 women will receive ARV prophylaxis in 2015

4. Much greater number of people living with HIV or affected by HIV receive support in line with the assessed needs

- 48,500 people will receive community home-based care in 2015
- 15,000 orphans and vulnerable children will receive some form of support in 2015

5. Intervention service coverage for key population at higher risks greatly improved
    - Consistent condom use by female sex workers will be over 80% in 2015
    - Consistent condom use by men who have sex with men will be higher than 70% in 2015
    - More than 80% of people who inject drugs will consistently avoid use of contaminated injection equipment

Guiding Principles

NSP II identifies the following guiding principles as essential to ensuring a more effective national response to the HIV epidemic. These principles build on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar. The guiding principles will underpin more effective national and local responses to the challenges of meeting the objectives of this strategic plan. They are described in more detail in Annex II of Part I of the NSP.

1. **The "Three Ones" principles** will be adhered to: One agreed AIDS Action Framework; one National AIDS Coordinating Authority; and one agreed country-level Monitoring and Evaluation System.

2. **Achieving Universal Access** and the **Millennium Development Goals on HIV/AIDS** (to halt and reverse the spread of the epidemic by 2015) as national commitment.

3. **Evidence-informed and results-oriented programming:** building on evidence, strategic information will guide decision and action with key populations at higher risk and vulnerability and with the greatest needs, with an emphasis on programme outcomes.

4. **The protection of human rights**, both of those vulnerable to infection and those already infected, which also produces positive public health results against HIV. In particular, it has also become increasingly clear that:

    - National and local responses will not produce intended results without the full engagement and participation of those affected by HIV, particularly people living with HIV;
    - The human rights of women, young people and children must be protected if they are to avoid infection and withstand the impact of HIV;
    - The human rights of marginalized groups (sex workers, people who use drugs, men who have sex with men, prisoners) must also be respected and fulfilled for the response to HIV to be effective;
    - Supportive frameworks of policy and law are essential to an effective HIV response.

5. **Cost effectiveness/cost efficiency/prioritisation** – the specifics of the Myanmar context, where AIDS work, like other health and development areas, is significantly under funded, it is important to ensure that resource allocation takes place with evidence and strategic information that points to interventions that are effective and cost-efficient.

6. **Scaling up:** programme access, reach and implementing capacity will be expanded at the maximum achievable pace. NSP II will ensure that scaling up comprises (a) expansion in the level of existing service to provide greater coverage both geographically and numerically; (b) expansion in the range of services based on needs of each target group; and (c) greater focus on quality of services and ensuring minimum standard of services.

7. **Partnership**: NSP II recognises the importance of partnership involving all of these actors – Government, international and national NGO, CBO and self help groups, professional associations, national and international entities, researchers, policy developers and the private sector will work together to engage the cooperation and collaboration of communities and the participation of the people most affected by the epidemic.

8. **Coordination**: mechanisms for effective and inclusive coordination will be strengthened, especially at national and township levels.

9. **Participation**: people living with HIV and affected populations; vulnerable people and local communities should participate in every aspect and at every stage of the programme. Participation empowers stakeholders to be better able to avoid HIV infection or to cope with HIV and its effects, and communities to be compassionate and caring towards those who live with or are affected by HIV. Participation is based on the recognition of people as people rather than as objects of interventions; people as creative and capable actors.

10. **Favourable policy and legal context**: compassion and understanding: the strategy will foster enabling environments conducive to an effective response to HIV.

11. **Gender** cuts across all interventions and implies an understanding of how social norms affect vulnerabilities of men and women and people of different sexual orientations differently and thus may require differential interventions. Gender equality is important in relation to HIV. Women and men experience different health risks, engage in different health seeking behaviour, and usually receive different responses from health services. As power is distributed unequally, women have less access to health information, care and services, and resources to protect their health.

12. **The GIPA Principle** – greater involvement of people living with HIV and AIDS in all aspects of the HIV response. People living with, or affected by HIV are involved in a wide variety of activities at all levels of the response to AIDS, from appearing on posters, and supporting and counselling others with HIV, to participating in major decision- and policy-making activities.

Strategic Framework

NSP II identifies three strategic priorities to address the most pressing needs of populations at higher risk of HIV infection:

Strategic priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and use of contaminated needles

Strategic priority II: Comprehensive Continuum of Care for people living with HIV

Strategic priority III: Mitigation of the impact of HIV on people living with HIV and their families

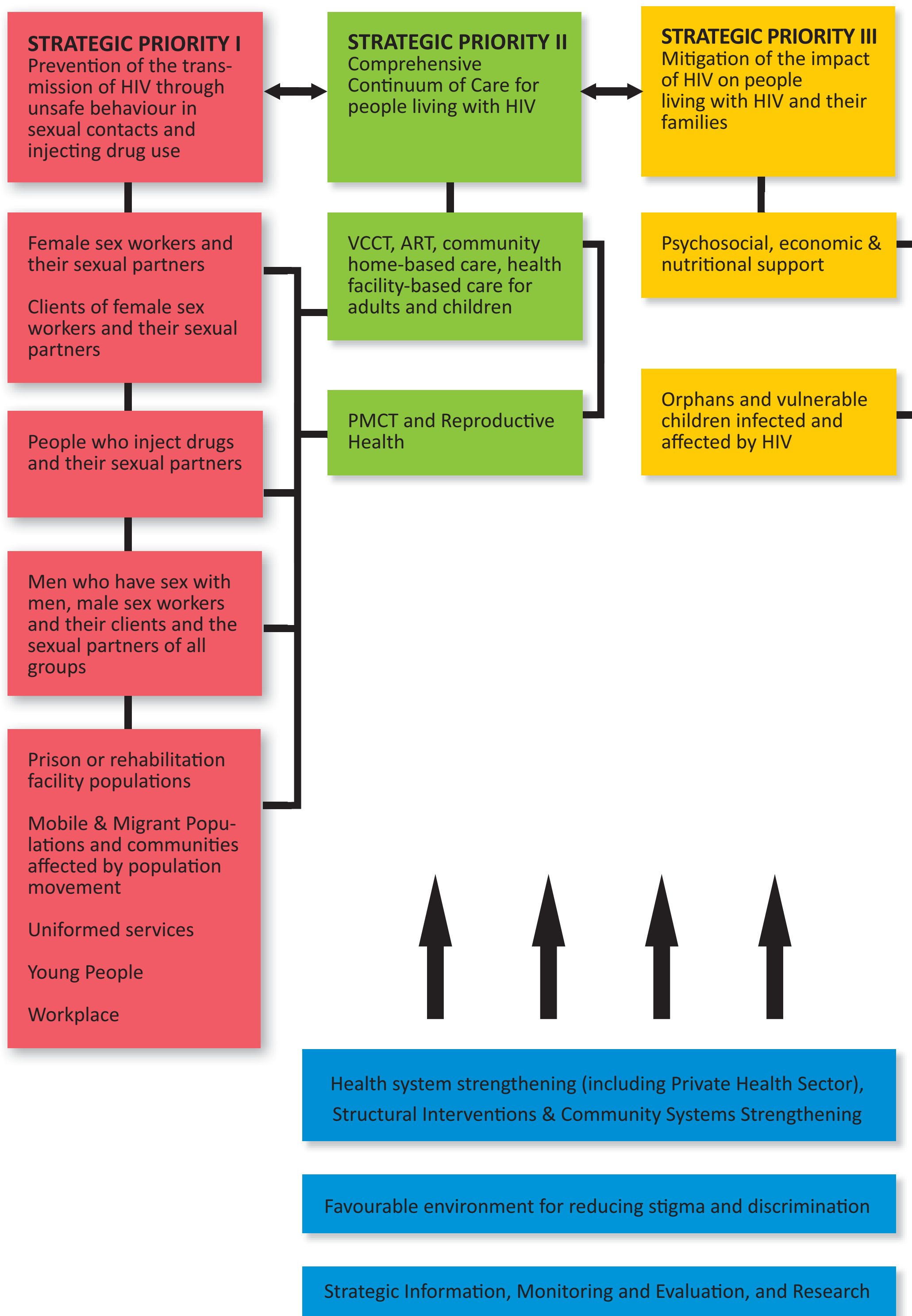
Cross cutting interventions for all three strategic priorities will include:

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

At the level of interventions, target populations, implementing partners and activities are identified for each of these strategic priorities.

In Part Two of NSP II, target populations, interventions for each of the three strategic priorities – including implementing partners, activity areas, and planned outputs and outcomes – are presented in a tabular form for each intervention area. Within each intervention area, specific activities will be planned, prioritized and costed covering five-year periods, however, targets for the first two years are captured in Part Two of the NSP II.

Figure 4. The National Strategic Framework



Summary of the Strategic Priorities, interventions and cross-cutting activities

The NSP II includes comprehensive packages of services within each intervention area. The detailed lists of services can be found in Part Two of the full NSP document. The Operational Plan includes costing that is based on these packages of services. The yearly targets and cost estimates are available in Annex 1 and Annex 2 of this document, while more details are to be found in the Operational Plan 2011-2015.

All interventions follow the guiding principles and apply the following approaches:

- Provision of services that are highly effective: flexible, tailored and targeted by location, age, gender and transmission behaviour
- Ensure better reach of relevant population groups
- Ensure linkage to treatment services including access to ART, screening for hepatitis B and C
- Promote meaningful involvement and empowerment of key population groups in programme design, development, implementation and evaluation
- Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible

Strategic Priority I:

Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use

In this new NSP, priority is given to scaling up essential prevention interventions, aiming to increase coverage and improve quality of interventions. For those programmes that are lagging behind, increased efforts to unblock programme impediments and to secure technical and financial support will be needed to accelerate progress in those areas. In addition, in the upcoming five years, based on epidemiological trends, increased focus will have to be given to sexual partners of key populations.

The priority key populations are those at most risk of acquiring HIV infection and identified with behaviours or situations that bring about higher than average prevalence of HIV (>5%) and who do not yet practise preventive behaviours consistently. These populations include the following:

- Female sex workers and their clients and the sexual partners of both
- Men who have high risk sex with men and their sexual partners
- People who inject drugs and their sexual partners
- Male sex workers and their clients and the sexual partners of both
- Sexual partners of people living with HIV
- Institutionalized populations (prison, detention and rehabilitation centres)
- Children born to HIV-infected parents.
- Mobile populations vulnerable to/with risk behaviour
- Young people vulnerable to/with risk behaviour
- Uniformed services personnel vulnerable to/with risk behaviour
- People in the workplace vulnerable to/with risk behaviour

Intervention 1: Female sex workers and their sexual partners; clients of female sex workers and their sexual partners

Definition of population
Sex worker: A person who sells sexual services in exchange for money to generate income or as work. Sex workers may be direct or indirect.

Clients of sex workers: A person who purchases (with money or in-kind) sexual services from a sex worker

Sexual partners: Spouse and any other sexual partner

Size estimate
Clients of female sex workers: 880,000 clients (BSS 2007)
Female sex workers: 60,000 female sex workers (range: 40,000-80,000)

Highlights of interventions

- Targeted Condom Promotion Programme strengthened. Access to resources – male and female condom provision, lubricants social marketing.
- Linkages including referrals to counselling, testing, treatment (antiretroviral therapy and STI) and care as well as to other existing services such as drop-in-centres providing primary health care and social services.
- Peer and outreach education programmes and partner disclosure targeting male groups identified as potential clients of sex work and their sexual partners.
- Sex worker support groups established and functioning.
- Recovery, re-integration and social services for women who want to leave sex work, including services tailored to the needs of under-age sex workers.

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement, Ministry of Home Affairs
INGO: AHRN, Alliance, AMI, AZG, CARE, FXB, IOM, Malteser, MDM, MSI, PSI, WVI
Local NGO/professional association: MANA, MNA, MMA, MRCS, PGK
Network/CBO/Self Help Group: Ma Hay Thi, Myitta Shin Pwint Phyo Toe Tet Yay, Twe Let Myar Shin Than Yar
UN: UNFPA, WHO

Partners to be mobilised
Ministry of Rail Transportation, Ministry of Transport, Ministry of Border Affairs, UNICEF
Private sector: Entertainment Facilities, Hotels and Motels, Transportation Workers' Association.

Intervention 2: Men who have sex with men and their sexual partners

Definition of population
Men who have sex with men: A public health term used to define male-to-male sexual behaviours and practices. This term is regardless of social or gender identity, motivation for engaging in sex, or identification with any particular "community".

Size estimate
Men who have sex with men including transgender persons: 240,000 MSM (range 183,600 to 264,000) data from 2008[6]

Highlights of interventions

- VCCT, STI services (including syndromic approach), treatment (including ART) care and support in men who have sex with men-friendly health services.
- Young men who have sex with men-friendly services established and improved – health as well as other social and support services.
- Men who have sex with men are better able to initiate their own prevention and care and support programmes (i.e. activities could be capacity building activities).
- Research and special studies to better understand the local context of men who have sex with men, their sub-groups and transgender and to improve prevention and care programmes.

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement
INGO: Alliance, AMI, AZG, CARE, FXB, IOM, MDM, MSI, PSI, Save the Children, WVI
Local NGO/professional association: MANA, MNA, MRCS, PGK
Network/CBO/Self Help Group: Light, The Help, HLHS, Mr. Lady, Mee Aim Shin Lay Myar, Khine Hnin See
UN: UNFPA, UNDP, UNAIDS

Partners to be mobilised
Ministry of Home Affairs (Police Force, Prison Department)

[6] Estimation Report 2009

Intervention 3: People who inject drugs, drug users and their sexual partners

Definition of population

Person who injects drugs (PWID): A person who has injected a non-medically-prescribed substance at least once in the past 12 months

Drug user: A person who has used a non-medically-prescribed substance at least once in the past 12 months

Size estimate

People who inject drugs: 75,000 PWID (range 60,000-90,000)

Highlights of interventions

- Drug dependency treatment, drug substitution treatment (methadone, opium tincture, buprenorphine), therapeutic communities and outpatient drug treatment programmes expanded.
- Voluntary confidential counselling and testing, STI services (including syndromic approach), treatment for opportunistic infections, tuberculosis, screening for hepatitis B and C, and ART are provided in settings that are friendly for drug users and youth vulnerable to drug use.
- Development of programmes to include family and caregiver in all aspects of recovery and support.
- Scale up successful community-based detoxification programmes under the supervision of Drug Dependency Treatment and Research Unit.
- Alternative vocational training for drug users, especially people living with HIV (socio economical reintegration), promoted through community programmes.
- Local support groups and networks of drug users and ex-drug users are established.

Partners

Government: MOH, NAP, DOH, and Drug Treatment Centres, Ministry of Home Affairs, Central Committee for Drug Abuse Control (CCDAC), Ministry of Social Welfare, Relief and Resettlement
INGO: AHRN, AZG, Burnet Institute, CARE, MDM, MSI, PSI
Local NGO/professional association: MANA
Network/CBO/Self Help Group: Swifts, Youth Empowerment, Oasis, Omega, Black Sheep Peer Support Group, MNDN
UN: UNODC, WHO

Partners to be mobilised

Ministry of Home Affairs (Police Force, Prison Department)

Intervention 4: Prison or rehabilitation facility population

Definition of population

Institutionalized populations include people in prison facilities, police lock-ups and other temporary custody, mental health institutions, rehabilitation centres, disability-related residential centres, juvenile detention centres and residential facilities for young people.

Size estimate

Prison population: 60,000 inmates

Highlights of interventions

- Voluntary confidential counselling and testing, STI services, support for behaviour change and harm reduction, appropriate resources including prevention commodities, are available within prison and rehabilitation facilities.
- Ensure treatment, care for Opportunistic Infections including TB, STI, ART, Post-Exposure Prophylaxis (for staff and inmates), Prevention of Mother-to-Child Transmission (and PMCT plus) and support for people living with HIV in prison and rehabilitation facilities and for the staff of these institutions.
- Provide methadone maintenance and drug treatment in prison and rehabilitation facilities.
- Arrange referrals on discharge so individuals can continue treatment (including Antiretroviral Therapy and treatment for Opportunistic Infections).
- Programmes and services in prison or rehabilitation facilities ensure confidentiality of prisoners having access to HIV-related services.

Partners

Government: NAP, Ministry of Social Welfare, Relief and Resettlement
INGO: AHRN, CARE, FXB, MDM
Local NGO/CBO/professional association: MANA
UN: UNODC

Partners to be mobilised

Ministry of Home Affairs (Police Force, Prison Department), CCDAC

Intervention 5: Mobile and migrant populations and communities affected by population movement

Definition of population

Migrant (internal and external): A person, or the family member of a person who has left his or her home place, seasonally or temporarily, to be engaged in a remunerated activity in another part of the country or in another country. Migrants who have left their home and resettled permanently in another part of the country or in another country are excluded from this definition.

Mobile person: A person who, regardless of the nature of his or her activity (professional, studies, business), makes frequent or periodic trips from one place to another requiring at least one overnight stay away from home, or moves from place to place.

Mobile population reached include seafarers, formal and informal workers, cross border migrants, truckers, railways workers, workers from inland water transport, traders, construction workers, workers in mining and agricultural sites.

Migration-impacted communities: A community that is impacted (positively or negatively) by mobility and/or migration either because it is the home place which migrants or mobile people leave and eventually come back to (source community), or because migrants or mobile people pass though it when they travel (transit community), or because it is the final destination for migrants, the place where they settle temporarily (destination community).

Highlights of interventions

- International or cross-border construction, infrastructure and natural-resource projects integrate prevention programmes.
- Prevention programmes (including for sexual partners) are integrated into infrastructure (large construction) projects wherever feasible.
- More community-based prevention and care, treatment and support programmes are implemented in identified mobility-affected communities in a coordinated and participatory fashion using migrant-friendly methods, linked to and supporting existing services wherever possible.
- Integration of HIV awareness raising, safe sex messaging and condom provision in humanitarian work in emergency settings.
- Increased interaction between existing and new potential source communities to share information, knowledge and experience.
- Improved analysis of migration patterns using common tools to facilitate regional sharing (common database, mapping at state level, collection instruments, and early warning systems) leads to improved programmes.

Partners
Government: NAP
INGO: AMI, AZG, CARE, FXB, Malteser, MSF-CH, PACT
Local NGO/CBO/professional association: MANA, MBCA, MRCS, PGK
UN: IOM, UNODC, UNHCR

Partners to be mobilised
Ministry of Home Affairs, Ministry of Foreign Affairs, Ministry of Social Welfare, Relief and Resettlement, Ministry of Rail Transportation, Ministry of Construction, Ministry of Transport, Ministry of Labour, Ministry of Border Affairs, Ministry of Immigration and Population

Intervention 6: Uniformed services personnel

Definition of population
Uniformed services personnel: The National Strategic Plan defines this group as including the military, police, prison staff, Bureau of Special Investigation, immigration, fire brigade, customs, other special forces in border areas and some civilians (e.g. working for the military in accounting and factories). Family members are included.

Highlights of interventions

- Behaviour Change Initiatives to promote health seeking behaviour and utilization of STI and VCCT health services (including mobile services) by uniformed personnel and their families.
- Clean injecting equipment and PEP supplies available, health staff trained in safe injection procedures and PEP procedures.
- Capacity building in voluntary and confidential counselling, HIV testing and referral networks for uniformed services health personnel.
- Review of policies related to HIV-positive uniformed service members, once ART is introduced and generalized.
- Coverage of proven prevention interventions for police should be scaled-up quickly.

Partners
Government: NAP, Ministry of Defence, Ministry of Home Affairs (Police Force, Prison Department), Ministry of Border Affair, Ministry of Immigration and Population
INGO: AMI, AZG, CARE, FXB, Malteser
Local NGO/CBO/professional association: MANA
UN: UNODC

Intervention 7: Young people

Definition of population

Young people (10 to 24 years old): early adolescents (10-14 years), late adolescents (15-19 years) and late youths (20-24 years). A distinction by age subgroups is necessary due to the different needs of these subgroups. Street children include those aged below 10.

Highlights of interventions

- In collaboration with public health and social services more non-government organizations, international non-government organizations and the private sector, are officially involved in provision of services for out-of-school young people.
- Quantitative research conducted to determine the extent and characteristics of anecdotal reports of unsafe sex and substance use behaviour among students, including university students, living in dormitories far from their families.
- Services are more available to street children, in collaboration with public health and social services more NGO, INGO, CBO, and the private sector are involved in provision of services.
- Referral networks created to link street children with families of origin or new families, young people support groups, local schools for re-entry to school, health services for screening and treatment for substance use, sexual reproductive health and others.
- High quality mass media campaign and behavioural change communication for HIV prevention among young people
- Forums for out-of school young people and street children to exchange knowledge and experiences on effective ways to change and support safe behaviours.
- Current level of young people participation in organizations and projects assessed, including organizational capacity and shifts in attitudes on the way that young people and adults view each other.
- Local organizations and community capacity enhanced to understand and protect rights and needs of street children for shelter, education, recreation, health and full development.
- Better collaboration between anti-trafficking programmes, especially of girls and street children.
- HIV prevention, care and impact mitigation programmes are more available to girls and street children.

Partners

Government: NAP, Ministry of Social Welfare Relief and Resettlement, Ministry of Education (for formal and non-formal education), State/Regional Ministry Departments; Township Level,
INGO: Alliance, Consortium, AZG, CARE, FXB, MDM, MSI, PSI, Save the Children, WVI
Local NGO/CBO/professional association: MANA, MRCS
UN: UNFPA, UNICEF, WHO,

Partners to be mobilised

Ministry of Information, Ministry of Home Affaires (Police Department)
Local NGO/CBO/professional association: Community leaders

Intervention 8: Workplace

Definition of population
Target population is employees of formal and informal workplaces and their families.

Highlights of interventions

- Business AIDS Networks further developed and then work to strengthen HIV prevention work in informal workplaces such as teashops and guest houses.
- Prevention, care and support are provided in workplaces (STI diagnosis and treatment, treatments for opportunistic infections, counselling, social support, leave, time off, zero tolerance to stigma and discrimination and insurance).
- Local support groups and networks established in large workplaces where there are many vulnerable people or many people living with HIV.
- National policies on HIV and AIDS in the workplace are developed and implemented.

Partners
Government: NAP and other relevant departments of Ministry of Health
INGO: AMI, AZG, CARE, FXB
Local NGO/professional association: MANA, MBCA, MNMA, MMA
Network/CBO/Self Help Group: MPG
UN: UNAIDS

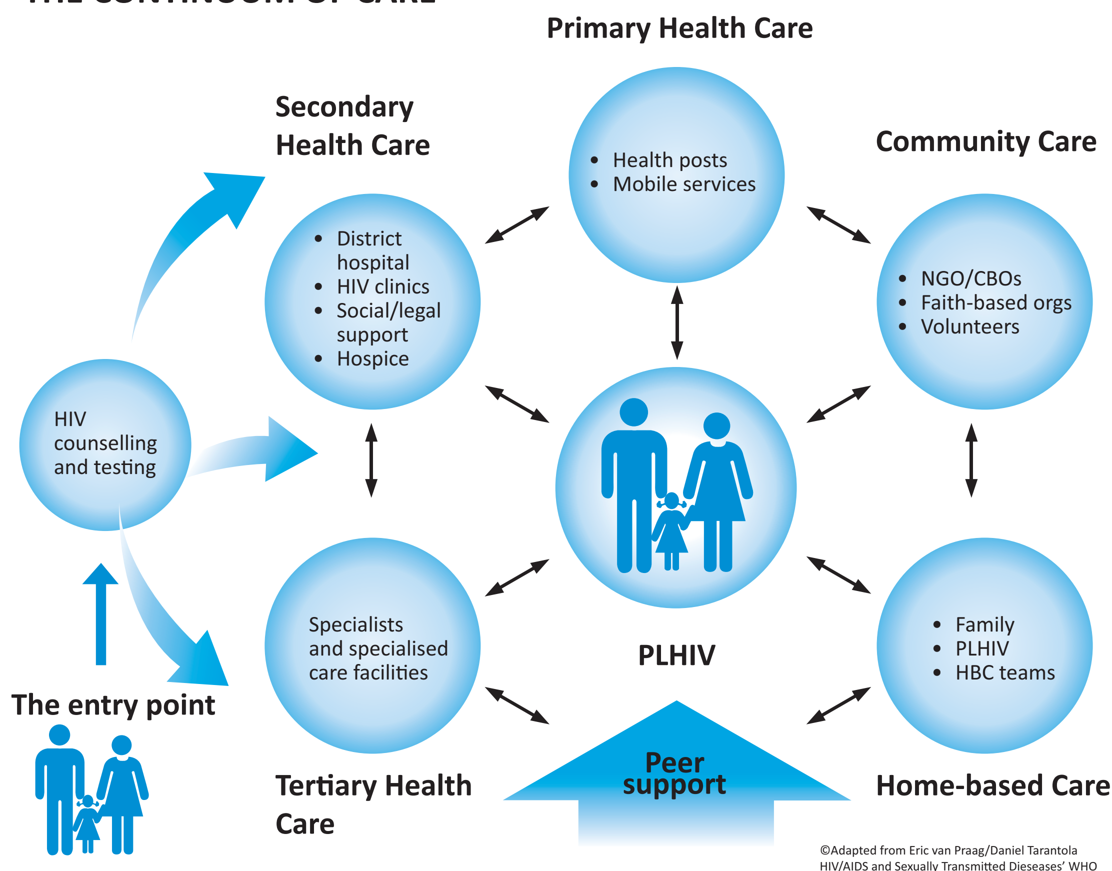
Partners to be mobilised
Ministry of Labour, Ministry of Industry, Ministry of Social Welfare, Relief & Resettlement, Ministry of Transport, Ministry of Rail Transportation, Ministry of Mines, Ministry of Construction, Ministry of Agriculture and Irrigation, Ministry of Energy, UMFCCI, Ministry of Livestock Breeding & Fisheries.

Strategic Priority II:

Comprehensive Continuum of Care for People Living with HIV

Continuum of care:
The continuum of care (CoC) is an effective strategy for scaling up HIV services. Care, treatment and impact mitigation services for HIV are increasingly available in Myanmar, but require more linkages and coordination.

Figure 5. Continuum of Care Framework



The CoC is complete set of linked care, tratment and support services provided at all levels from health facility (hospital/health centre) to community and home by government, NGOs, CBOs, FBOs, PLHIV and family members.

Source: Adapted from: Narain JP, Chela C and van Parrag E. *Planning and implementing HIV/AIDS care programme: a step by step approch.* New Delhi, WHO Regional Office for South-East Asia, 2007

CoC is provided both at health facilities and within community

Scarcity of financial and human resources make it a great challenge to increase ART provision from the present 28% coverage. Human resources could be increased with the involvement of private hospitals and general practitioners (GPs) who are widely present in all urban areas. Tapping into this resource will require an investment in GP training and supervision by MoH to promote correct use of ART and OI treatment for effective treatment and prevention of early drug resistance. Another challenge will be the friendly and continuous provision of ART services to at-risk, stigmatised groups that do not access services due to mobility or fear of discrimination by health staff. Improving the capacity of clinical staff in HIV case management will contribute to the improving of overall health service quality, hence strengthen the health system.

PMCT services cover more than one third of townships in Myanmar and are offered in ANC settings. In the future, PMCT will be offered to all women in areas with higher HIV prevalence and to women with high risk profiles. The CoC ensures that PMCT services, including couple counselling, are integrated into routine MCH and ANC services and linked to ART clinics for adults and children. The national guidelines on PMCT include counselling on voluntary contraception, natural vaginal child delivery and exclusive breastfeeding. The roles and responsibilities of different categories of staff will be clarified including the responsibility of pro-actively tracing clients lost to follow-up.

Intervention 1: VCCT, TB, ART, Community Home-Based Care, Health Facility-Based Care and Referral

Definition of population
People living with HIV and their families

Comprehensive continuum of care and treatment will be provided to all those who are infected and affected according to the guiding principle that no one shall be denied care and treatment on the basis of their cause of infection, gender, age, living arrangements, means of earning a living, ability to pay or other social or economic factors.

Highlights of interventions

- Home-based care, prevention and treatment are more widely available and are linked to community based care for impact mitigation and health facility based care
- Health facility based care (preventive, diagnostic, and treatment) is more widely available. Health facility-based care includes health centres, public, private for-profit / non-profit clinics, general practices, and hospitals (township and state/regional hospitals) provide services for ART, prevention and treatment of OIs, TB/HIV co-infected people, STI diagnosis and treatment, nutritional and palliative care "One-stop service centres" established.
- Increased capacity of health care providers (including general practitioners and TB staff) to provide clinical care and support to people living with HIV through continuing, pre- and in-service education and on-the-job training.
- Procurement and supply system of pharmaceuticals and laboratory reagents and equipments for ART, TB and OI strengthened.
- Enhance the continuum of care for people living with HIV by strengthening the referral mechanisms at all levels of the health system including community, home-based care services and health facilities (public and private sectors) and between prevention and impact mitigation.
- Self help groups for people living with HIV in different areas strengthened and their social capital developed. Capacity-development for networks of people living with HIV provided.
- Three Cs principle (informed consent, confidentiality and counselling) strictly followed and national guidelines for comprehensive testing and counselling (embracing VCCT and PITC) developed.

Partners
Government: NAP, Hospitals with ART services
State/Regional Ministry Departments; Township Level
INGO: AHRN, Alliance, AMI, AZG, Consortium, FXB, Malteser, MDM, MSF-CH, PPPH, PSI, the Union, MSI
Local NGO/CBO/professional association: MANA, MNMA, MPG, MRCS, MMA, PGK, Ratana Metta and other FBO
Network/CBO/Self Help Group: Myanmar Positive Group (See Annex III), 3N, Phoenix
UN: WHO, IOM, UNFPA,, UNICEF

Partners to be mobilised
Local NGO/CBO/professional association: MMA, more FBO
Community leaders
Private sector: general practitioners, private for profit clinic and hospitals, pharmacists

Intervention 2: PMCT and Reproductive Health

Definition of population
Men and women 15 to 49 years of age

Highlights of interventions

- All PMCT providers adequately trained on friendly attitudes and communication, counselling skills to discuss client risk behaviour, condom use, benefits/risks of HIV testing, safe sex behaviours after receiving HIV positive and negative test results, disclosure of positive result, ART prophylaxis, natural vaginal delivery and exclusive breastfeeding.
- Capacity for supplies planning and management developed so that PMCT providers have constant supplies of HIV tests, prophylactic ARV, condoms and contraceptives according to national guidelines.
- All PMCT providers instructed and committed to referral to clinical services, including ART, and impact mitigation services when appropriate.
- Antenatal clinics which are couple friendly so that men as well as women attend antenatal clinics
- Reproductive health policy and guidelines, integrating HIV prevention and care, adapted and implemented, with special attention to safeguard reproductive health rights of women

Partners
Government: NAP, Hospitals with ART services
State/Regional Ministry Departments; Township Level
INGO: AHRN, Alliance, AMI, AZG, FXB, Malteser, MDM, MSF-CH, MSI, PPPH, PSI, Save the Children, Union
Local NGO/CBO/professional association: MANA, MNMA, MPG, MRCS, MMCWA, PGK, Ratana Metta and other FBO,
UN: UNICEF, IOM, UNFPA, WHO, UNAIDS

Partners to be mobilised
Local NGO/CBO/professional association: MMA, more FBO
Community leaders, traditional birth attendants
Private sector: general practitioners, private for profit clinic and hospitals, pharmacists

Strategic Priority III:

Mitigation of the Impact of HIV on People Living with HIV and their Families

The group of services for impact mitigation covers a broad range of areas.

Support in nutrition and for daily living

People living with HIV and their families often require material support for basic needs including housing, food, transportation, clinical care and funerals. Small grants for income generating activities to help them start a small business and earn a living are often requested. The high costs involved in impact mitigation are beyond government capacity, and NSP II calls for development partners and the private sector to complement government efforts. Modalities must be found to mobilise funds for the support of community-based interventions as demonstrated by the communities that have been able to provide funds with support from the private sector, NGO, FBO and individuals.

Psychosocial support

Psychosocial support aims to assist people living with HIV and their families to cope with psychological and social challenges and maintain their hope to lead fruitful lives as productive, valued members of the community. Psychosocial support is needed to cope with HIV related stigma that remains widespread and plays a major role in fuelling HIV infection (by hindering openness and seeking testing) and in putting people with HIV into unnecessary hostile situations.

Legal support

In order to protect the rights of people living with HIV and at-risk populations facing discrimination on grounds of serostatus, gender, or sexual orientation, individual legal aid provided by legal professionals is an important component of creating such a supportive legal environment.

People living with HIV self help groups

Viable self help groups of people living with HIV are an essential component of effective impact mitigation because they are best placed to understand and respond to the needs of their peers. In 2010 there are more than 200 groups with about 10,000 members, but more groups need to be established. Their capacity is limited by poverty, illness, lack of training and discrimination; hence, they need strengthening through the support of NGO, CBO, NAP and other implementing partners. Groups should be strengthened to participate actively in and monitor service delivery.
Orphans and Vulnerable Children

Meeting the needs of OVC requires a response from Ministries of Health, Social Welfare, Women's Affairs, and Education, and from all social sector organizations. Community and home-based care should include activities to support OVC to increase their access to appropriate HIV prevention, care, treatment and support services.

Given the scarcity of data on OVC it is fundamental to start with a situation analysis study to understand their situation, and to map resources and gaps in action, and disseminate the study findings for advocacy and effective planning. In addition, data and indicators will be routinely integrated within existing information systems of the Department of Social Welfare and NAP for monitoring the Convention on the Rights of the Child and Myanmar Child Law.

Essential services for OVC include HIV counselling and testing, referral and follow-up to paediatric OI/ART services for all HIV positive children; access to education and support groups for young people and to specific self help groups for children living with HIV.

Intervention 1: Psychosocial, Nutritional and Economic Support

Definition of population:
People living with HIV, their families and communities

The impact of HIV has affected all aspects of social life. Discrimination based on serostatus calls for legal protection. Impact mitigation also acknowledges the inter-relatedness of economic stability and the emotional and physical wellbeing of individuals. The key areas of social support include: counselling and psychosocial support; economic support, food security, social protection initiatives including continuation of education for infected and affected children (see OVC in Intervention III.2) addressing the legal environment. The critical emphasis of this intervention is also to integrate the continuum of HIV prevention, care and treatment services with impact mitigation.

Highlights of interventions

- Package of psychosocial support activities, including counselling, developed and addresses isolation, depression, anxiety, other psychiatric impairment and serious interpersonal problems as a result of HIV and AIDS.
- Livelihoods and economic empowerment of affected communities and households enhanced.
- Food and nutrition security interventions among people living with HIV, their households and communities promoted and supported.
- Self help groups for people living with HIV strengthened and more confident in different areas of service provision within the continuum of care.
- Sensitisation and awareness creation on human rights and protection mechanisms of people living with HIV, their households, and self help groups.

Partners
Government: NAP, Ministry of Social Welfare Relief and Resettlement,
State/Regional Ministry Departments; Township Level,
INGO: AHRN, Alliance, AMI, AZG, Consortium, FXB, Malteser, MBCA,
MDM, MSF-CH, PPPH, PSI, Union
Local NGO/CBO/professional association: MRCS, MPG, MRCS, MMCWA,
PGK, Ratana Metta, MWAF, PACT
UN: IOM, UNDP, UNFPA, UNICEF, UNOPS, WFP,

Partners to be mobilised
Local NGO/CBO/professional association: more FBO
Community leaders, religious leaders
Private sector: Business and corporate sector

Intervention 2: Orphans and Vulnerable Children Infected and Affected by HIV

Definition of population
Orphans: children who have lost one or both parents due to AIDS

Vulnerable children: children infected or affected and whose parents are still alive (one or both parents infected). Other vulnerable children include children of sex workers and drug users because they have particular difficulties.

Highlights of interventions

- Psychosocial and spiritual support provided to OVC (particularly girls) and their family members.
- Livelihood and economic empowerment of affected communities and households enhanced.
- Food and nutrition security interventions among OVC, their households and communities promoted and supported.
- Community based responses that protect, care for and support OVC and their caregivers implimented. These responses include day care centres, psychosocial support, including foster care, formalized kinship care and social houses. Community centres for OVC established with support from government, INGO, FBO, self help groups and private sector.
- Conduct a situation analysis study to better understand the situation of OVC. Organize a seminar for disseminating the study findings and advocating OVC issue among stakeholders.
- Self help groups for OVC and informal gatherings for HIV positive OVC strengthened. These groups may for example offer recreation as well as support for ART therapy.

Partners
Government: NAP, Ministry of Social Welfare, Relief and Resettlement, State/Regional Ministry Departments; Township Level,
INGO: AHRN, Alliance, AMI, AZG, FXB, Malteser, MBCA, MDM, MSF-CH, PPPH, PSI, Save the Children, Union
Local NGO/CBO/professional association: MRCS, MPG, MRCS, PGK, Ratana Metta, MWAF, PACT
UN: IOM, UNDP, UNFPA, UNICEF, UNOPS, WFP,

Partners to be mobilised
Local NGO/CBO/professional association: more FBO
Community and religious leaders
Private sector: Business and corporate companies

Cross-cutting interventions

Interventions under the three Strategic Priorities alone will not sufficiently address the needs of programme implementers. In order to scale up essential interventions and increase coverage and quality, key systemic issues must be addressed. The cross-cutting interventions outlined here are identified as strategic interventions to address the challenges of improving the health systems and community response, reducing stigma and discrimination towards people living with HIV and improving evidence base and generating strategic information to inform the national AIDS response.

Intervention 1: Health Systems Strengthening (Including Private Health Sector), Structural Interventions and Community Systems Strengthening

Learning from the GAVI HSS focus on township planning and coordination
The GAVI HSS grant for Myanmar offers a partnership and coordination approach at township level that is relevant to HIV. The NSP II focuses on improved township coordination and planning based on the GAVI HSS model, which organizes a township-level planning and review team composed of NGOs, local authorities, Community Health Workers (CHW) and selected community representatives to develop and implement coordinated township health plans in 100% of HSS-targeted Townships by 2011. The indicator is that all HSS targeted townships have coordinated health plans that include the activities of local NGO, INGO, CHW and local authorities.

One of the key findings of the Review of NSP I was the considerable increase in the number and role of groups being formed to support prevention, care, treatment and support, comprising people living with HIV; men who have sex with men; female sex workers; drug users; local communities – including faith-based groups.

Cross-cutting Intervention I under Community Systems includes the intensive and long-term support required for capacity building and development of organizational and governance structures of community based organizations. International experience shows that a significant contribution to effective national responses to HIV comes from community-based organizations made up of the most-at-risk, affected and concerned populations. NSP II gives priority attention to building on the NSP I achievements of such community-based organizations.

Health Systems Strengthening

Inadequate health systems are one of the main obstacles to scaling-up interventions to secure better health outcomes for HIV and AIDS (and all other health problems). WHO[7] Health Systems Strengthening is based on six 'essential building blocks':

1. Effective leadership and governance (for strategic policy frameworks, effective oversight, coordination and coalition-building thorough regulations, incentives, and accountability)

[7] Everybody's business: health systems strengthening to improve health outcomes.
WHO's framework for action. Geneva, World Health Organization – 2007
http://www.who.int/healthsystems/strategy/everybodys_business.pdf

2. Good health financing system
3. Well-performing human resources
4. Well-functioning procurement and supply system for access to quality essential pharmaceutical, products and technologies
5. Good health service delivery
6. Well-functioning information system (Cross-Cutting Intervention IV.3 M&E)

Highlights of interventions

- Effective Leadership, Governance and Good Health Financing. Strengthen policy-setting, coordinating, planning, financing and costing, monitoring and evaluation and reporting roles of the Ministry of Health, the National AIDS Programme and Local Government

- Well-Performing Human Resources. Develop a coherent plan for the overall strengthening of human resources for the HIV and AIDS response in the Ministry of Health, NGO and private sectors, including general practitioners, pharmacists, drug sellers and traditional practitioners.
    - Continuing training of general practitioners to apply standards and guidelines for testing, care, and treatment (PMCT, ART, TB, OI, STD) in place with collaboration of NAP.
    - Approaches for engaging pharmacists and drug sellers effectively in HIV and AIDS service provision identified.
    - Collaboration with traditional medicine practitioners and exchange of knowledge between traditional and science-based medicine established and maintained.

- **Well-Functioning Procurement and Supply System.** Improve efficiency, timeliness and transparency of the system for procurement, storage, transport and distribution of supplies and commodities through system-wide training, and capacity strengthening programmes including development of guidelines and improving monitoring and evaluation.

- **Good Health Service Delivery.** Develop a realistic and sustainable plan for effective, nation-wide, government and private sectors, HIV laboratory capacity, confidential counselling and testing (VCCT), blood supply, universal precautions, standards and guidelines.

Structural interventions

Highlights of interventions

- Strengthen policy-setting, coordinating, monitoring and evaluation and reporting roles of the key non-health ministries.

- Strengthen national capacity to plan, finance and cost services, in order to identify the most viable and effective financing modalities and to design and implement effective and productive fundraising strategies.

- Develop a coherent plan for the overall strengthening of human resources recruitment, training, support and evaluation in key ministries engaged in HIV and AIDS activities.

Community Systems Strengthening

Highlights of interventions

- Increase the involvement of community-based organizations working with key populations at hight risk of HIV infection and people living with HIV in the national response to HIV through fostering greater participation in prevention, treatment and care services in their communities.
- Promote meaningful involvement and empowerment of people living with HIV and key populations at hight risk of HIV infection so that they are able to participate in programme design, development, implementation and evaluation.
- Strengthen the technical and management capacity and governance and organizational structures of community-based organizations.

Partners: Government, International Organizations, national and local organizations, donors.

Intervention 2: Favourable Environment for Reduction of Stigma and Discrimination

The existence of a favourable legal and policy environment as well as compassionate, understanding and supportive communities and institutions is critical to an effective and sustainable national response to HIV. These issues are referred to throughout NSP II, under guiding principles, and within specific interventions. Creative use of diverse types of mass media for stigma reduction can cater effectively to different audiences by taking into account linguistic differences and varying levels of literacy.

Highlights of interventions

- Strengthen the enabling environment for people living with HIV and their families through advocacy and education to ensure that interventions are as effective as possible.
    - International instruments to which Myanmar is signatory[8] used to help set common standards, sensitise stakeholders on their role as actors, and respond to the obligation to promote human development and wellbeing.
    - National policies, including the National Strategic Plan, workplace policies, in local language promoting compassion, understanding and access to services and jobs for people living with HIV and their families.
- Strengthen the enabling environment for most-at-risk populations through advocacy and education to ensure that interventions are as effective as possible.
    - Enforcement of policy in which condom possession is not used as liability of sex work.
    - Legal reform workshop

[8] e.g. Convention on the Rights of the Child, Elimination of all Forms of Discrimination against Women, General Assembly Session on HIV/AIDS Declaration of Commitment, 2001

- Support community mobilization, empowerment, and social transformation to change social norms and provide structural protection towards people living with HIV and key population at higher risks.
    - Intensive mass and targeted media campaigns promoting tolerance, compassion and understanding for people living with HIV and key populations at hight risk of HIV infection and their families.

Partners: Government, international organizations, national and local organizations, donors, community, religious and private sector leaders, mass media

Intervention 3: Strategic Information, Monitoring and Evaluation, and Research

NSP II recognises that an effective M&E system is urgently required to monitor national programmatic inputs, outputs (coverage), outcomes (behavioural trends), impact, and to evaluate the effectiveness of NSP II. NSP II endeavours to strengthen capacity and the ability of systems to produce the strategic information that is urgently required to guide and review the national response to HIV, and to ensure that the rights and needs of marginalized and most-at-risk populations are responded to. Planned activities will be used to identify programmatic gaps; to develop focused, uncomplicated advocacy messages for HIV prevention, treatment and care. Strategic information, M&E and research priorities in NSP II include improved data collection and reporting; systematic national size estimations of key populations at higher risk; expanded and strengthened surveillance and behavioural studies of key populations at higher risk; and research to expand the knowledge base on HIV and risk behaviours, and on the impact of the range of interventions in prevention, treatment and care.

Highlights of interventions

- Monitoring system
    - M&E plan in line with the NSP operationalised:
        - Routine monitoring system functional
        - Research agenda developed
        - Information is collected, analysed and disseminated to stakeholders, including beneficiaries, on a regular basis
        - Programme costing and expenditures are assessed annually

- Strengthening the national HIV/AIDS surveillance and research system
    - Quality control mechanisms are fully integrated into the surveillance system

- Coordinating and cooperating with partners
    - Strategic Information and M&E Working Group established and functional to oversee development of M&E system, advise on research agenda and national estimation processes.

Annex

Annex 1: Implementation arrangements of the NSP

NSP II describes a vision for how a multisectoral and multi-partner response to the HIV epidemic can be expanded significantly within a five-year period. Managing this expansion will require a range of mechanisms and tools, including the cross-cutting interventions and the development of year operational plans with more detailed activities, potential partners, targets, indicators and indicative costing.

Funding will be sought from a variety of sources, including increased domestic contributions, pooled donor mechanisms such as the 3DF and its successor, donors, and future proposals to the GFATM.

The Operational Plan will begin in 2011. The operational planning cycles aim to encourage longer term financing and accommodate updates and changes. Implementation of the operational plan will be documented by annual review of progress that will take into account changing conditions and provide advice for annual planning adjustments.

A range of products will be associated with the planning, implementation and monitoring that require the input and involvement of many different stakeholders. These include:

- The strategic plan
- Up to date operational plans
- Annual progress reports on the national response based on agreed indicators as well as financial expenditure tracking.
- Specific strategies that will be developed for HIV and AIDS interventions in areas requiring improved coordination, elaboration or review, including strategies for prevention for the sexual partners[9] of high risk groups.
- State/Regional, district and township alignment to strategic plan
- Second Generation Surveillance
- UNGASS and other international reporting mechanisms
- Operational research in specific areas of programming where additional data and information are needed.

For those products requiring multiple partner input, flow-charts will be developed to clearly identify the steps, timing, and actors responsible for leading, providing technical support or being involved in different processes.

[9] Note: Sexual partner refers to spouse or any other sexual partner.

Annex 2: Roles, responsibilities and institutional arrangements

Government coordination mechanisms in related fields

The core coordination structures for HIV will interact with a variety of other mechanisms which have unique but related tasks, including the Government's National Health and National AIDS Committees, State/Regional, District and Township AIDS Committees, and the National AIDS Programme itself.

Beyond those focused directly on HIV or health matters, government structures which have important roles in the response to the HIV epidemic include the Central Committee for Drug Abuse Control and the National Education Committee. The roles of these committees are outlined in the table below.

Entity	Function for the Response to HIV	Chair & Membership
Government of Republic of the Union of Myanmar	Highest level oversight of political commitment to the response to HIV and AIDS	Head of Government of Republic of the Union of Myanmar
National Health Committee	Oversight of national health policy and implementation Approval of National Strategic Plan	Chair: Secretary 1 Members: Line ministries
National AIDS Committee	Oversight of HIV policy and implementation	Chair: Minister for Health Members: Line ministries
National Education Committee	Provide policy guidelines for implementation of education activities (basic and higher education) approval of education projects and coordination among ministries.	Chair: Secretary 1 Members: 13 education-related ministers

Entity	Function for the Response to HIV	Chair & Membership
Central Committee for Drug Abuse Control (CCDAC)	Policy and strategic guidance for harm reduction Technical delivery of harm reduction services Coordination with Anti-narcotic Taskforce	Chair: Minister for Home Affairs Members: Secretariat support: Ministry of Home Affairs, CCDAC
Myanmar Country Coordinating Mechanism (M-CCM) for AIDS, TB and Malaria	Oversight of the national response related to the three diseases of TB, malaria and HIV and coordination of the efforts of all partners. In relation to the Global Fund the M-CCM is mandated to develop and submit grant proposals to the Global Fund, and to provide effective grant oversight and support the implementation of grants that are funded by the Global Fund. Coordination of the all major programme related to the three diseases in country and supported by Technical and Strategy Groups and its Working Groups.	Chair: Minister of Health Members: • Government (10 members) • UN agencies (4 members) • Bilateral donors (1 member) • National NGO and Professional groups (3 members) • Community-based organizations (CBO) and faith-based organizations (3 members) • International NGOs (INGO) operating in-country (4 members) • Private sector (1 member) • People affected by HIV/AIDS, tuberculosis or malaria (2 members) • Academic sector (1 member)

This section outlines general roles and responsibilities of key constituency groups.

Government – Ministry of Health and National AIDS Programme

The Government of Republic of the Union of Myanmar leads the national response, drawing on the Three Ones principles, ensuring accountability to communities – especially the range of self help groups and CBO formed by people living with HIV, key population at higher risks and concerned communities – and funding partners.

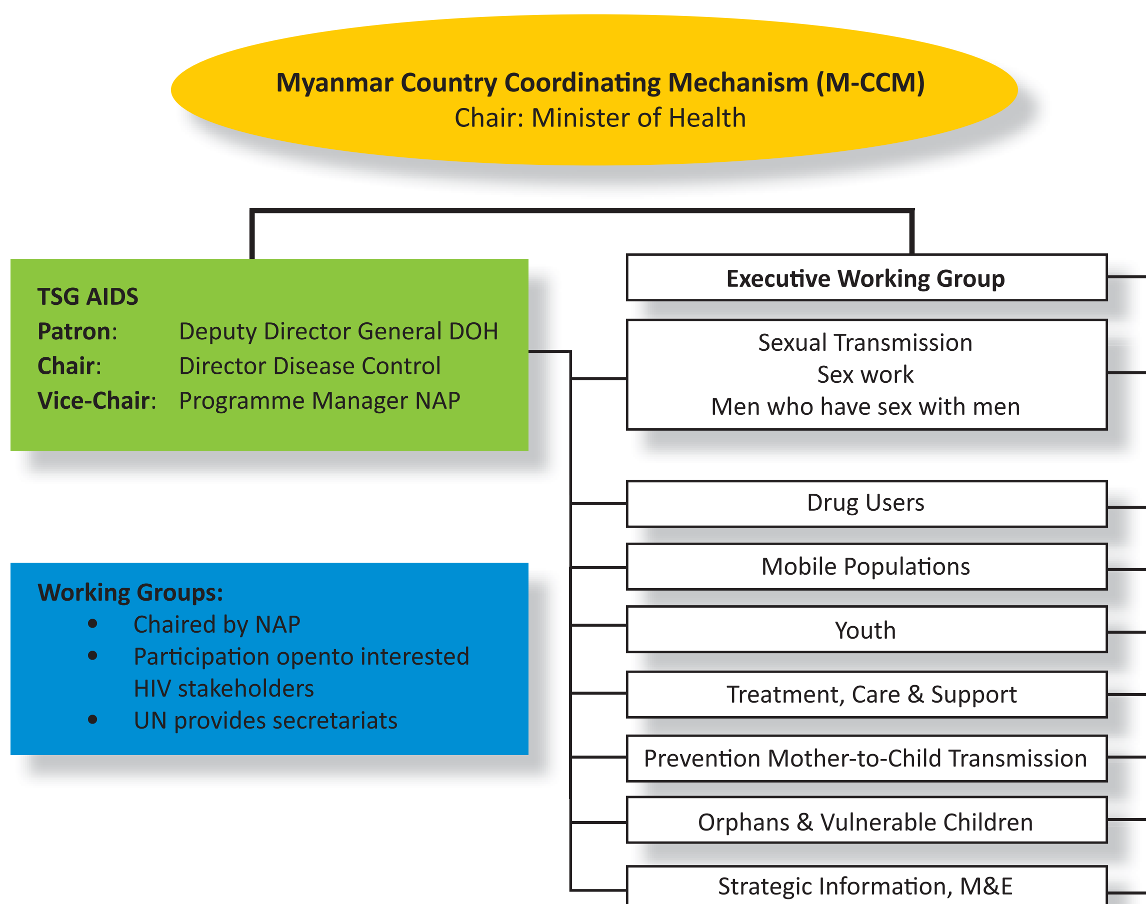
Myanmar Country Coordinating Mechanism

The Myanmar Country Coordinating Mechanism for AIDS, Tuberculosis and Malaria (M-CCM) is chaired by the Minister of Health, with the participation of other ministries, and includes UN organizations, non government and community organizations. This Body oversees implementation of the National Strategic Plan, provides policy guidance and identifies appropriate external support. The Secretariat consists of the Deputy Director-General of Disease Control, Director of Disease Control, the Programme Managers of the National Programmes for AIDS, Tuberculosis and Malaria, and one representative from the Attorney General's Office.

The formal health system serves as the backbone of the national response to HIV. NSP II calls for major efforts to mainstream HIV work with the focus on townships, using existing health and other services as means of delivering activities, goods and financial resources. If suitable alternate delivery mechanisms are identified, linkages and mutual accountability among implementing partners will be essential to the optimal use of resources and the avoidance of wastage and duplication.

The Technical Strategy Group (TSG) is chaired by the Director Disease Control and the Vice-Chair is the National AIDS Programme Manager. This group meets regularly to exercise planning, monitoring, troubleshooting and coordination through regular meetings. Technical expertise is drawn from the UNAIDS Secretariat and UNAIDS cosponsors including UNFPA, UNICEF, UNODC and WHO. Members including community organizations, professional associations, international and national NGOs and UNAIDS Secretariat participate and provide feedback and draw opinions and information from their constituencies. Membership of the TSG will be revised from time to time responding to evolving needs. Other members nominated or appointed by their ministries and other Departments of MOH will provide technical and policy expertise based on their organization's involvement in the national response to HIV. People living with HIV and representatives of high risk behaviour populations and concerned communities are important participants.

The TSG in turn reports to the M-CCM chaired by the Minister of Health.



The principal tasks of the TSG are:

- Coordination of implementing partners and their activities
- Advising implementing partners on technical matters
- Develop the operational plan
- Oversee annual assessment of and amendments to the operational plan
- Ensure monitoring and evaluation of the national response
- Monitor and support working groups on key issues
- Oversee implementation of the National Strategic Plan
- Advise the Coordination Mechanism on HIV related policy issues

The TSG delegates technical issues to the nine working groups (including two sub groups for Sexual Transmission). The working groups, which are open to all stakeholders, ensure that consultation is inclusive and that local expertise is used. The working groups communicate findings and recommendations to the TSG for consideration in the decision making process.

M-CCM and the TSG-HIV are the forums to ensure donor support are aligned with the national strategy to avoid overlapping and major gaps.

Other government sectors

NSP II calls for significantly scaled-up action on the part of ministries beyond the Ministry of Health. All ministries have a role to play to prevent the transmission of HIV, to contribute to care and support for people living with HIV, and to facilitate enabling environments for the implementation of the response at all levels.

NSP II includes priority attention to strengthening the functioning and role of ministries working with most-at-risk and vulnerable populations, including the Ministry of Home Affairs (Central Committee for Drug Abuse Control, Myanmar Police Force, and the Prison Department) in their work with drug users, people in closed settings (prison and rehabilitation facilities) and their understanding and support for a public health approach to key population at higher risks. The Ministry of Home Affairs also has a critical role to play in strengthening coordination at national and district/township levels. NSP II draws attention to strengthening the role of the Ministry of Social Welfare in their responsibility for contributing to the development of an overall impact mitigation strategy, including setting of standards for care of orphans and vulnerable children, improving gender-sensitive AIDS programming and services towards vulnerable women. The NSP II focus with the Ministry of Education will be to develop the implementing mechanisms to extend their prevention work to out-of-school young people who are most vulnerable and engaged in high risk behaviour.

State/Regional, District and Township AIDS Committees

Existing State/Regional, District and Township AIDS Committees will be revitalized with a priority focus on enabling national leadership and coordination roles and the key service delivery and implementation at township level, including Continuum of Care. They will be supported and held accountable to undertake tasks related to situation assessments in their own areas, prioritization of communities needing assistance, involvement in analysis of surveillance data, coordination, monitoring and reporting.

Coordination should be seen as an opportunity for inclusive convening of all partners at township level allowing for the participation of local organizations, networks and self help groups, as well as international organizations. Township coordination meetings should be regular and open opportunities for experience exchange, review and planning, and discussion of how to overcome challenges to effective implementation.

Multilateral organizations, donors and international development partners

The United Nations plays a variety of supporting roles providing technical support to government and non-government partners in policy development, research, normative and technical guidance, planning, coordination, monitoring, procurement and implementation and advocacy for funding. Concerning the provision of technical support to government and non-government partners, UNAIDS and its cosponsors have agreed to a Division of Labour, which identifies comparative advantages of each UN entity to maximize the value of the technical support to be provided by the UN. UN agencies collaborate through a Joint UN Team mechanism, coordinated by a UN Theme Group on AIDS, with overall guidance from the UN Country Team.

International development partners and donors will contribute technical assistance, funding and advocacy support to the implementation of Myanmar's National Strategic Plan for HIV/AIDS. They also participate in the AIDS coordinating forums such as the M-CCM.

Non-government organizations including community-based organizations

Non government organizations covers a wide spectrum of organizations from local non government organizations, community-based organizations including self help groups and faith based organizations to national professional associations and international non government organizations. Their contribution covers an equally wide spectrum, ranging from the provision of technical expertise, design and delivery of care and prevention services, and capacity building of national partners.

NGOs will work directly with people and groups with specific needs who are not easily reached by the public sector. They will provide implementation expertise at the community level, advocate for more volunteerism within communities, provide counselling, care and support for orphans and other vulnerable children and for people living with HIV. They will mobilise human, financial and material resources, motivate and support for establishment of self help groups, and strengthen community resilience to prevent increased transmission and to encourage compassion and understanding of people living with and affected by HIV as well as to the situation and needs of people vulnerable to HIV.

Their responses will continue to be supported, evaluated and improved throughout the period of implementation of the National Strategic Plan.

International non government organizations will continue to provide technical and implementing expertise at all levels including research, planning, coordination, monitoring, procurement, and programme delivery.

An effective and scaled-up national response to HIV will only be successful with the full participation of CBO/self help groups including the following:

- People living with HIV
- Female sex workers
- Men who have sex with men
- Drug users
- Local communities – including faith based groups.

During NSP II there will be a priority focus on strengthening CBOs, in particular in: (1) Building the capacity and organizational functioning of CBOs to provide an increased range and quality of services through physical structure and organizational systems development, including improving financial and project management; (2) Building partnerships at the local level to improve coordination, enhance impact and avoid duplication of service delivery, and; (3) Sustainable financing focussing on supporting initiatives to plan for and achieve predictability of resources over a longer period of time for improved impact and outcomes.

People living with HIV

The key roles of people living with HIV will include:

- Facilitating networking and support for people living with HIV.
- Identifying strategies to increase the well being of all people infected or affected by HIV by promoting positive living, self reliance and reduction of infection through education, (positive prevention, treatment literacy, HIV prevention, VCT promotion, condom distribution), prevention and care programmes.
- Participating in strategy development, programme and activity design and review.
- Coordinating, information sharing and advocacy to identify gaps in services and support.

Private Health Services Provider

The private health sector plays an important role in HIV diagnosis, treatment and care. With de-regulated production and sale of pharmaceutical drugs, pharmacies are the most frequently used health care facilities and self-treatment is common.

Myanmar also has an active private medical sector and the importance of private general practitioners has grown to the point that they provide well above 50% of health care in urban areas and to a lesser extent in rural areas. For this reason NSP II seeks to increase the involvement of the private sector and to improve their practices in the management of people living with HIV, with and without TB.

NSP II calls for efforts to improve communication and coordination between private and government health service providers and to develop effective relationships between the private pharmacy sector and other providers of TB- and HIV-related services. The collaboration between for-profit and non-profit private (INGO) and public health sectors should be formalised at State/Regional and District and Township levels by inclusion of representatives of the private health sector in AIDS Committees or other appropriate HIV and AIDS management groups (e.g. STD teams).

Private sector

The private sector will focus on advocacy and training to strengthen the participation of owners and managers, entrepreneurs and business associations in HIV prevention, treatment and care. Strategies will be clarified for workplace interventions and types of workplaces targeted. In NSP II, the private sector will be encouraged to develop HIV-related corporate policies and practices consistent with the guiding principles of NSP II in collaboration with private sector and other partners. Development of further Business Coalitions on HIV will be strategically encouraged in townships, districts, states/regional prioritising geographic locations and populations where prevalence, incidence and impact are highest.

Annex 3: Envisaged contribution of different Ministries to the national response to HIV in Myanmar

Table 1. Ministries Principally Dealing with Coordination, Facilitation and Establishment of an Enabling Environment for the National Response

Ministry	Function	Initial Outputs
Ministry of Health	Leadership on policy, strategy development, coordination and monitoring for HIV Technical management of health service systems for care and treatment and linkages to other disease management Technical delivery of national HIV prevention programmes Technical responsibility for HIV/STI research, surveillance and monitoring	National Strategic Plan and Operational Plan developed and implemented National AIDS Committee meeting regularly M-CCM meeting regularly and coordinates AIDS programmes TSG operational National AIDS Programme capacity strengthened
Ministry of Home Affairs	Policy on links between law enforcement and public health for targeted condom promotion and other HIV programmes Delivery of prevention and impact mitigation programmes for HIV across police and prison departments and in prisons Policy development, coordination and support of PWID harm reduction programme Facilitation of expanding number of national non government organization partners Support Township AIDS Committee decisions and programmes at township level through General Administration	Operational plan for contributing to HIV response
Ministry of Defence	Articulation of senior-most political support for the national response to HIV	Statement of support for implementation of National Strategic Plan in all regions Develop HIV prevention and care strategy for the military

Ministry	Function	Initial Outputs
Ministry of National Planning and Economic Development	International cooperation and coordination through the Foreign Economic Relations Department (FERD) Development planning to ensure resources allocated for HIV programmes	Development of policy to support implementation of National Strategic Plan
Ministry of Border Affairs	Ensure regions of the country where they work are sufficiently covered by HIV prevention and care and support programmes Coordination of HIV actions in their areas	Assessment of HIV actions in NaTaLa areas Development of HIV strategy to support actions in their area
Ministry of Foreign Affairs	International cooperation and coordination, linking with regional inter-governmental organizations (i.e. ASEAN).	Facilitation of entry of new international partners working on or financing HIV activities
Ministry of Finance and Revenue	Administration of disbursement systems for HIV and AIDS funding Coordination of resource allocation and reporting across government sectors	Initial assessment of HIV allocation and expenditures

Table 2. Ministries Principally Implementing Activities for HIV Prevention and Care

Ministry	Function	Initial Outputs
Ministry of Education	Policy on HIV workplace education for staff and students HIV policy for out-of-school children Administration and delivery of in school & out-of-school HIV education programmes	Development of multi-year HIV prevention strategy for education
Ministry of Social Welfare, Relief and Resettlement	Policy development for support and care of orphan and vulnerable children in and out of training schools Workplace policies to minimise negative impacts of HIV and develop prevention programmes for staff and residents across adult training schools and rehabilitation centres Coordination of prevention, care and support programmes with community participation	Assessment of impact of HIV on Ministry of Social Welfare work planning Development of multi-year HIV prevention and care and support strategy Reflection of HIV prevention and care needs in National Action Plan for the Advancement of Women
Ministry of Immigration and Population	Design and implementation of policies to prevent negative impacts of HIV and AIDS	Assessment of interaction between Ministry of Immigration and HIV issues Development of HIV prevention strategy
Ministry of Religious Affairs	Facilitation and coordination of expanded role of faith-based responses to HIV Delivery of HIV prevention programme with support of religious communities	Development of HIV prevention strategy
Ministry of Information	Strategic development of mass media campaign Authorisation for national publications dissemination	Development of HIV prevention strategy

Ministry	Function	Initial Outputs
Ministry of Labour	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention in all workplaces Technical coordination of workforce HIV prevention programmes	Review of labour regulations impact on HIV prevention and care Development of HIV prevention programme
Ministry of Construction	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention Technical coordination of construction sector-based HIV prevention programmes	Assessment of impact of HIV on construction activities Development of HIV prevention strategy
Attorney Generals Office	Support legal reform to protect people living with HIV (in the workplace) Support legal reform to enable access and outreach for HIV practitioners working at community level	Review of legal environment on HIV transmission and prevention actions
Ministry of Rail Transportation and Ministry of Transport	Workplace policy to prevent negative impacts of HIV and address prevention Technical coordination of transport sector-based HIV prevention programmes	Review of current HIV prevention and care activities Design of HIV prevention and care programme
Ministry of Agriculture and Irrigation	Design and implementation of policies to prevent negative impacts of HIV and AIDS Coordination of agricultural sector based prevention programmes Coordination of food security and distribution mechanisms	Development of HIV prevention programme

Annex 4: Monitoring and Evaluation plan

	Standard Indicators	Denominator	Baseline figure 2009	Targets				
				2011	2012	2013	2014	2015
	Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use							
I.1	Female sex workers and their sexual partners; clients of female sex workers and their sexual partners							
Impact/Outcome Targets								
1	% female sex workers who are HIV infected	40-80,000	11.2%	10%	9.5%	9%	8%	7%
2	% clients of female sex workers who are HIV infected	881,220	3.88%	3.3%	3.0%	2.7%	2.4%	2.0%
3	% female sex workers who used condom at last sex	40-80,000	95%		95%			
Output/Coverage Targets								
4	% female sex workers reached with HIV prevention programmes	40-80,000	76%		BSS			
5	% female sex workers who received an HIV test in the last 12 months and who know the result	40-80,000	71%		BSS			
6	Number of female sex workers reached with HIV prevention programmes	40-80,000	45,489	55,000	60,000	65,000	70,000	75,000
7	Number of clients of female sex workers reached with HIV prevention programmes	881,220	NA	88,122	110,153	132,183	154,214	176,244
8	Number of regular sexual partners of sex workers and clients reached with HIV prevention programmes	440,610	NA	10,000	15,000	20,000	25,000	30,000
I.2	Men who have sex with men and their sexual partners							
Impact/Outcome Targets								
9	% men who have sex with men who are HIV infected	224,000	22.3%	20.5%	19.5%	18.5%	17.0%	16.0%
10	% men who have sex with men who used condom at last sex	224,000	81%			85%		
Output/Coverage Targets								
11	% men who have sex with men reached with HIV prevention programmes	224,000	69%			BSS		
12	% men who have sex with men who received an HIV test in the last 12 months and who know the result	224,000	48%			BSS		
13	Number of men who have sex with men reached with HIV prevention programmes	224,000	59,985	65,000	70,000	75,000	80,000	85,000
14	Number of female sexual partners of men who have sex with men reached with prevention programmes	45,000	NA	2,250	2,813	3,375	3,938	4,500

I.3	People who inject drugs and their sexual partners							
Impact/Outcome Targets								
15	% People who inject drugs who are HIV infected	75,000	34.6%	31.20%	28.70%	26.10%	23.40%	21.00%
16	% People who inject drugs who used sterile needles and syringes at last injection	75,000	81%		84%			
17	% People who inject drugs who used condom at last sex	75,000	77%		80%			
Output/Coverage Targets								
18	% People who inject drugs reached with HIV prevention programmes	75,000	52%		BSS			
19	% People who inject drugs who received an HIV test in the last 12 months and who know the result	75,000	27%		BSS			
20	Number of People who inject drugs reached with HIV prevention programmes (Outreach)		NA	10,000	12,500	15,000	17,500	20,000
21	Number of People who People who inject drugs reached with HIV prevention programmes (DIC)		21,214	25,000	28,000	31,000	35,000	38,000
22	Number of sterile injecting equipment distributed to injecting drug users in the last 12 months	75,000	5,335,156	8,000,000	12,000,000	15,000,000	20,000,000	20,000,000
23	Number of drug users receiving methadone maintenance therapy	75,000	771	2,000	3,000	4,000	5,000	8,000
24	Number of regular sexual partners of people who inject drugs reached with HIV prevention programmes	20,550	NA	5,138	8,438	10,625	12,813	12,330
I.4	Prison or rehabilitation facility populations							
Output/Coverage Targets								
25	Number of prisoners reached with HIV prevention programmes	62,300	13,472	21,805	28,658	36,134	42,987	49,840
I.5	Mobile and migrant populations and communities affected by population movement							
Output/Coverage Targets								
26	Number of mobile and migrant population reached with HIV prevention programmes	NA	105,941	150,000	237,500	325,000	412,500	500,000
I.6	Uniformed services personnel (military and police).							
Output/Coverage Targets								
27	Number of uniformed services personnel reached with HIV prevention programmes	NA	15,601	30,000	35,000	40,000	45,000	50,000

	Standard Indicators	Denomi-nator	Baseline figure 2009	Targets				
				2011	2012	2013	2014	2015
I.7	Young people							
Impact/Outcome Targets								
28	% young people aged 15-24 who are HIV infected	NA	0.91%	0.85%	0.79%	0.72%	0.66%	0.60%
29	% young people who used condom at last sex	NA			BSS			
Output/Coverage Targets								
30	Number of out-of-school youth reached with HIV prevention programmes	2,653,750	184,191	200,000	212,500	225,000	237,500	250,000
I.8	Workplace							
Output/Coverage Targets								
31	Number of people in workplace reached with HIV prevention programmes	NA	49,192	100,000	125,000	150,000	175,000	200,000
I.9	Cross cutting interventions							
Output/Coverage Targets								
32	Number of people who received STI treatment in the last 12 months			118,745	132,838	143,695	151,387	155,567
	FSW	40-80,000		55,000	60,000	65,000	70,000	75,000
	Clients of FSW	881,220		35,249	38,553	39,655	38,553	35,249
	MSM	224,000		13,000	14,000	15,000	16,000	17,000
	PWID	75,000		2,000	2,500	3,000	3,500	4,000
	Prisoners	62,300		6,542	8,597	10,840	12,896	14,952
	Regular partners of MARPs	506,160		6,955	9,188	10,200	10,438	9,366
	Mobile and migrant population	NA						
	Uniformed services personnel (military and police).	NA						
	Young people	2,653,750						
	Workplace population	NA						

	Standard Indicators	Denominator	Baseline figure 2009	Targets				
				2011	2012	2013	2014	2015
33	Number of people who received an HIV test in the last 12 months and who know the result			66,974	84,413	106,296	133,178	153,726
	FSW	40-80,000	10,896	15,000	20,000	30,000	45,000	55,000
	Clients of FSW	881,220		22,031	27,538	33,046	38,553	44,061
	MSM	224,000	4,701	16,250	17,500	18,750	20,000	21,250
	PWID	75,000	3,854	5,000	6,250	7,500	8,750	10,000
	Prisoners	62,300						
	Regular partners of MARPs	506,160		8,694	13,125	17,000	20,875	23,415
	Mobile and migrant population	NA						
	Uniformed services personnel (military and police).	NA						
	Young people	2,653,750						
	Workplace population	NA						
34	Number of condoms distributed for free (in millions)		40 m	45 m	50 m	55 m	60 m	65 m
35	Number of condoms sold through social marketing	NA						
Strategic Priority II: Comprehensive Continuum of Care for people living with HIV								
II.1	VCCT, ART, community-based care, hospitals for adults and children							
Impact/Outcome Targets								
36	% adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		80.0%	81%	82%	83%	84%	85%
37	% adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy		NA	81%	82%	83%	84%	85%
Output/Coverage Targets								
38	Number of adults with advanced HIV infection receiving ART	76,631 (CD4 count <200)	19,603	30,200	40,050	50,100	60,050	70,000
39	Number of children in need provided with ART		1,535	1,800	2,100	2,400	2,700	3,200
40	Number of people living with HIV receiving Cotrimoxazole prophylaxis who are not on ART	50,428		10,000	12,500	15,000	17,500	20,000
41	Number of TB patients who are tested positive for HIV and have started ART during the reporting period	7,596	NA	2,127	2,725	3,323	3,921	4,519

	Standard Indicators	Denomi-nator	Baseline figure 2009	Targets				
				2011	2012	2013	2014	2015
II.2	PMCT and Reproductive Health							
Impact/Outcome Targets								
42	% Infants born to HIV infected mothers who are infected	4,600	22	15	13	13	12	11
43	% Pregnant women are HIV infected		0.96	0.90	0.85	0.80	0.75	0.67
Output/Coverage Targets								
44	Number of pregnant women attending ante-natal care services at PMCT sites who received HIV pre-test counselling	1,391,813	356,641	400,000	425,000	450,000	475,000	500,000
45	Number of pregnant women attending ante-natal care services who received HIV testing and test result with post test counselling	1,391,813	170,862	240,000	276,250	315,000	356,250	400,000
46	Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission	3,536	2,136	2,520	2,601	2,700	2,779	2,680
Strategic Priority III: Mitigation of the impact of HIV on people living with HIV and their families								
III.1	Psychological, economic and nutritional support for People Living with HIV and their Families							
Output/Coverage Targets								
47	Number of people receiving community home based care	50,428	31,361	48,430	51,335	52,332	50,927	48,500
48	Number of people living with HIV associated with self help groups	237,684	15,577					
III.2	Orphans and Vulnerable Children Infected and Affected by HIV							
Output/Coverage Targets								
49	Number of orphans and vulnerable children affected by HIV receiving package of support		5,332	8,000	9,750	11,500	13,250	15,000
IV. Cross-cutting interventions								
IV.1	Health System Strengthening (Including Private Health Sector), Structural Interventions and Community Systems Strengthening							
IV.2	Favourable Legal and Policy Context – Compassion and Understanding							
IV.3	Strategic Information, Monitoring And Evaluation, and Research							

Annex 5: Summary Budget

	Estimated cost (US$)				
	2011	2012	2013	2014	2015
TOTAL	49,612,291	58,325,041	67,151,040	76,143,105	84,709,412
I. Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use	17,385,606	20,165,917	22,958,053	26,011,015	29,085,886
Female sex workers, clients of FSW and their regular sexual partners	5,614,900	6,246,448	6,969,188	7,688,417	8,351,772
Men who have sex with men and their regular sexual partners	3,152,485	3,399,922	3,647,359	3,894,795	4,142,232
Injecting drug users/Drug users and their regular sexual partners	5,115,875	6,301,291	7,400,567	8,770,953	10,219,123
Prison or rehabilitation facility populations	237,125	311,650	392,950	467,475	541,999
Mobile population/migrants	730,964	1,157,359	1,583,755	2,010,150	2,436,546
Uniformed services	232,534	271,289	310,045	348,801	387,556
Out-of-school youth	1,329,054	1,412,120	1,495,186	1,578,252	1,661,318
Workplace intervention	372,670	465,838	559,005	652,173	745,340
Mass media	600,000	600,000	600,000	600,000	600,000
II. Comprehensive Continuum of Care for people living with HIV	17,815,657	23,238,210	28,894,784	34,601,195	39,946,938
ART and home-based care for adults and children	14,780,485	19,738,123	24,894,284	30,062,570	34,830,938
PMCT and reproductive health	3,035,172	3,500,088	4,000,500	4,538,625	5,116,000
III. Mitigation of the impact of HIV on people living with HIV and their families	5,690,151	6,280,038	6,707,326	6,930,018	7,065,712
Psychological, economic and nutritional support for people living with HIV and their families	4,124,959	4,372,460	4,457,363	4,337,669	4,130,977
Orphans and vulnerable children infected and affected by HIV	1,565,192	1,907,578	2,249,964	2,592,349	2,934,735
IV. Cross-cutting interventions	8,720,877	8,640,877	8,590,877	8,600,877	8,610,877
Health System Strengthening (Including Private Health Sector), Structural Interventions and Community Systems Strengthening.	7,223,027	7,143,027	7,093,027	7,103,027	7,113,027
Management and coordination	200,000	200,000	200,000	200,000	200,000
Strengthening lab services	500,000	500,000	500,000	500,000	500,000
Strengthening supply management	830,000	750,000	600,000	610,000	620,000
Infrastructure renovation and upgrading of health facilities	200,000	200,000	300,000	300,000	300,000
Safe blood supply	1,016,833	1,016,833	1,016,833	1,016,833	1,016,833
Prevention of HIV transmission in health care setting	2,476,194	2,476,194	2,476,194	2,476,194	2,476,194
Capacity building government	500,000	500,000	500,000	500,000	500,000
Capacity building civil society	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
Favourable Legal and Policy Context – Compassion and Understanding	200,000	200,000	200,000	200,000	200,000
Strategic Information, Monitoring And Evaluation, and Research	1,297,850	1,297,850	1,297,850	1,297,850	1,297,850
Surveillance system	554,850	554,850	554,850	554,850	554,850
Special surveys	193,000	193,000	193,000	193,000	193,000
Monitoring and Evaluation of the national response	550,000	550,000	550,000	550,000	550,000