Three Millennium Development Goal Fund

Analysis of gaps related to the national response to HIV and recommendations to the 3MDG Fund

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## Attachments

1 - 5 Five commissioning and contracting requirements attachments, one for each field of activity
6 Map of townships where Global Fund staff do not travel to
7 People met

## Abbreviations

For the purposes of this report ‘care’ or ‘HIV care’ includes care, support, and treatment.

3DF Three Diseases Fund
3MDGF Three Millennium Development Goal Fund
ASEAN Association of South East Asian Nations
$ US or American dollars

# Executive Summary
The incidence or rate of new HIV infections in Myanmar has fallen to one fourth of its peak at the beginning of the new millennium and a majority of infections in the next three years will be among the three key populations of people who inject drugs, men who have sex with men, and female sex workers. There are one hundred and twenty thousand people living with HIV who are living with HIV in need of antiretroviral treatment. Forty thousand of them are currently receiving it and this number is expected to rise to 80,000 over the next three years.

Myanmar hopes to meet the targets set by ASEAN Declaration Of Commitment of November 2011 of decreasing new infections and new infections among people who inject drugs by half from 2010 to 2015 and treating 80% people eligible for antiretroviral treatment. In order to achieve the target the country needs to prevent one thousand infections in people who inject drugs and one thousand infections among other key populations. It needs to scale up antiretroviral treatment faster than planned in the next two years.

The Technical and Strategy Group on AIDS has noted the above two issues and recommended that increased funding be made available for prevention among people who inject drugs and that more funding be dedicated to scaling up the provision of antiretroviral treatment. This plan takes note of stakeholder views on how to achieve the goals.

There is no national population estimate of the number of people who inject drugs and there is capacity for limited rapid expansion of the evidence-informed activities of needle and syringe distribution, methadone treatment, and targeted education that prevents HIV transmission among injecting drug users. Activities can be expanded while new sites for programming are investigated.

A few hundred of the fifty thousand prisoners in the country are receiving antiretroviral treatment through nongovernmental organisations but there are no prevention programmes for prisoners at all. Prisoners deserve the same right to health as those who are not imprisoned.

The National Tuberculosis Programme has a plan to scale up provider-initiated counselling and testing for people who are newly diagnosed with tuberculosis. This activity will find thousands of people who do not know they are infected.

There is marked geographic inequity in the provision of antiretroviral treatment. It is possible to increase the number of the sickest people on treatment in remote areas that will drive Global Fund investments to these sites when funding is turned over. People living with HIV can monitor the quality of care and report on quality so that it can be improved.

There is also a need to assess the role of the private sector in providing care.

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1 ASEAN Declaration of Commitment, November 011
Five fields of action in HIV proposed for funding by the 3MDGF over two years:

1) Prevention  
   HIV prevention and links to HIV care among people who inject drugs

2) Prevention and Care  
   HIV prevention and HIV care among prisoners

3) Care  
   Provider-initiated counselling and testing of people with newly-diagnosed tuberculosis

4) Care  
   Initiation of HIV treatment for the sickest in remote areas and development of a patient feedback mechanism to improve the quality of care

5) Care  
   Study of the private sector with a view to increasing quantity and quality of care in remote areas

Commissioning and contracting requirements are outlined for all five fields of action. The total proposed budget for these activities over the first two years of funding by the Three Millennium Development Goal Fund is $8,500,000.

Terms of reference and tasks of the consultant

The terms of reference of the consultant include the tasks:

Strategic approach

- Review of National Strategic Plan and supporting strategies for HIV, highlighting where these meet best practice in light of current international evidence on HIV;
- Summarise international evidence on the most effective interventions (including cost effectiveness) to address HIV in the context of similar epidemic;
- Identify any strategic gaps such as interventions covered, or coverage of key interventions e.g. through the health system levels or ways in which interventions are delivered;
- Identification of potential barriers in implementation of the response (e.g. lack of capacity and systems, as well as policy/legal barriers) and identify health systems strengthening work or reforms that may need to be addressed.

Financing

- Review scope of Global Fund (Round 9) and other donors (planned and existing) support for the national strategies;
- Compilation of an overview of available funds for HIV from all sources, including Global Fund reprogramming of Phase II of Round 9;
- Summary of available information on unit costs and value for money analyses of different partners and delivery modalities;
- Compilation of an overview of all stakeholders currently involved in the response to the three diseases, by disease and geographic focus.

Prioritisation

- Stakeholder views and perceptions on critical needs and priorities in the area of HIV with special focus on National Programme;
- Identification of specific hard to reach areas and underserved and vulnerable populations;
- Outline possibilities and feasibility of expanding priority support to HIV to hard-to-reach areas and populations including former conflict areas, mines and prisons;
• Outline guiding principles to be used for allocation of 3MDGF resources for Component 2 in line with Description of Action and the findings from the gap analysis. Principles should be based on international best practice, strategic and high priority needs given the burden of each disease and value for money;

Draft calls for Expressions of Interest, technical review criteria and process in light of these principles.

The scope of funding was outlined in the Description of Action of Multi Donor 3MDG Fund 2012-2016:

• Maintenance of high-priority HIV, malaria and TB interventions currently supported through the Three Diseases Fund and not readily supported by Global Fund Round 9 or subsequent rounds such as work in areas or with populations that the Global Fund cannot access.
• Top-up support to Component 1 townships where HIV, malaria and tuberculosis interventions are required based on the disease epidemiology but are not readily funded by the Global Fund Round 9 or subsequent rounds.
• Interim support for high priority interventions currently supported through the Three Diseases Fund, and not supported by Global Fund Round 9, and for interventions not supported by 3DF or Round 9, until the next round. Based on a gap analysis, this might include support for continued life-saving antiretroviral treatment where an organisation can demonstrate value for money, for first-line tuberculosis drugs, for containment of multiple drug-resistant tuberculosis and artemisinin resistance, and for safe blood.
• HIV, tuberculosis and malaria interventions funded under the 3MDG Fund will be consistent with national strategies and priority groups.
• Flexible funding to enable the 3MDG fund to respond to emerging health threats and emergencies that disproportionately affect the poor and marginalised.
• Complementarity with, and adding value to, Global Fund and other donor programmes.

The consultant met with a wide range of stakeholders during the process of developing this plan and report. A list of stakeholders is in Attachment 7. The final report document of the Three Diseases Fund final evaluation has not yet been published so was not available for review. The main findings were made available in verbal form at a meeting with members of the Fund Board.

Goals and targets

The national strategic plan used for the purpose of developing this inception plan is the Concise Version of the Myanmar National Strategic Plan and Operational Plan on HIV and AIDS 2011 - 2015. The first two targets in this plan are generally in line with the targets set in Millennium Development Goal 6, the Political Declaration on HIV and AIDS of the United Nations General Assembly of June 2011, and the ASEAN Declaration Of Commitment of November 2011 of decreasing new infections by half and treating most or all people eligible for antiretroviral treatment:

The national strategic plan targets are:

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 (sic) than 5,000 new infections will occur in 2015 and

2) 80% of people living with HIV, who are eligible, will receive life saving antiretroviral treatment based on the current national treatment guidelines and criteria (ie CD4 count

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2 Concise Version of the Myanmar National Strategic Plan and Operational Plan on HIV and AIDS 2011 - 2015, no publisher, undated
<200/mm³) that are nondiscriminatory with regard to gender, type of transmission, age, ethnicity, and location - 70,000 adults and children will be receiving antiretroviral treatment in 2015.

There are several issues that need to be considered in planning to meet these targets. The prevention target sets a reduction of new infections in all people as the standard and females as a subtarget. Men account for almost all of the population people who inject drugs and all of the population of men who have sex with men. More men are currently being infected than women and most women currently being infected are 'low risk women'. Reducing the number of new infections in men and women require different strategies. The authors of the target have not taken the gender dimensions of new infections into consideration.

The treatment target follows the ASEAN Declaration of Commitment practice of defining universal access to treatment as 80% of those eligible and not 100% of those eligible. This also represents a lost opportunity. The CD4 count threshold eligibility threshold in Myanmar was increased by the Ministry of Health from 200 to 350 cells per cubic millilitre in March 2011, increasing the estimated number of people living with HIV who are eligible for treatment from 80,000 to 120,000. Eighty per cent of this figure is 96,000 which has been unofficially designated as the new Myanmar target. Forty-five hundred children are also targeted.

The inclusion of the nondiscrimination phrase in the national target for treatment poses implementation challenges to ensure that men, children, any member of the three key populations (of people who inject drugs, men who have sex with men, female sex workers), people who live in states rather than regions, or people far from urban centres are not discriminated against in the provision of antiretroviral treatment.

There is a major omission in the text of the concise version of the plan: needle and syringe programming is not mentioned in the list of activities for people who inject drugs. Needles and syringes costs are, however, including in the calculations that produced the budget summary.

The major weakness of the current national strategic plan, recognised by many stakeholders, is that it sets few priorities among key populations. Many key populations are listed and most are accorded priority. Budgets have been calculated for all activities. Although this method may satisfy stakeholders who insist that all key populations are included in the plan, it provides little guidance as to which activities should be undertaken first or undertaken when resources are constrained.

It is remarkable that the country produces annual reports against the targets in the plan. Myanmar is one of the few countries in the world where annual progress against all targets can clearly be seen.³

**The epidemics in Myanmar**

HIV disease was the leading cause of mortality in Myanmar in 2010.⁴ The Strategic Information and Monitoring and Evaluation Working Group of the Technical and Strategy Group on AIDS has estimated a figure of 197,000 people living with the virus in 2012.⁵ The epidemic continues to be concentrated in the three key populations of people who inject drugs, men who have sex with men, and female sex workers. Other men and women are currently being infected but the large number of people in these other populations and their

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³ Progress Report 2011, National Strategic Plan for HIV/AIDS in Myanmar, no publisher, undated
⁴ Health in Myanmar 2012, Ministry of Health, The Republic of the Union of Myanmar, undated
distribution throughout the general population makes focused and effective prevention programming for these groups extremely difficult.\textsuperscript{6}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{incidence.png}
\caption{Incidence by key affected population – Myanmar 1995-2020}
\end{figure}

New infections or incidence can be estimated from prevalence using computer models. The number of new infections or incidence began to fall at the beginning of the new millennium and the rate of new infections is beginning to tail off. Myanmar achieved an ‘AIDS transition’, where the number of new infections fell below the number of people dying\textsuperscript{7}, over five years ago when the number of people dying was over 20,000 and the number of people newly infected was 13,000. By reversing the increase in incidence to a decrease in the last decade, Myanmar has met the first goal if not the first target of Millennium Development Goal 6.

Although the bar for 2012 in the graph above is small, it is possible to see that teal-coloured box is larger than the violet-coloured and orange-coloured ones together. There are as many new infections in people who inject drugs as among men who have sex with men and female sex workers combined.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{new_infections.png}
\caption{New infections by transmission route – Myanmar 2010-2020}
\end{figure}

The trajectory of the epidemics among the key population and others are clearly shown in the graph above. Unlike infections in all other populations, the number of new infections shown by an orange-coloured line in people who inject drugs is not decreasing. This epidemic is not under control.

![Graph 2: HIV prevalence among injecting drug users, HSS 2011](image)

Graphic 3 - Prevalence of HIV among people who inject drugs from the 2011 sentinel surveillance report

The epidemic among people who inject drugs is also geographically patchy. There is a threefold difference in prevalence between the lowest and highest prevalence sentinel sites. This is demonstrated in the graphic above from the sentinel surveillance report in 2011.8 The same report notes that the epidemic among female sex workers is also patchy, with the prevalence in Yangon at 18% over threefold higher than the prevalence in the lowest prevalence site.

As the epidemic among two key populations is patchy, aggregated figures showing a decline in prevalence for the entire country may be hiding important information. In order to determine whether epidemics in one location are declining, it is possible to conduct expensive, technically and ethically challenging direct methods to determine incidence in each area. Another method is to use current serosurveillance and behavioural surveillance methods to determine whether prevalence is declining over surveillance rounds among new injectors, men who have sex with men who are newly sexually active, and female sex workers who have newly entered this work. A recommendation on gathering strategic information with respect to this issue is made in this report.

The response to the epidemics

In most concentrated epidemics, it is recommended that the response to the epidemic has be focused on prevention of new infections among the three key populations of people who inject drugs, men who have sex with men, and female sex workers. In Myanmar, investments have also been made in the prevention of mother to child transmission.

The number of new HIV infections in the country began to decline before major financial investments in HIV prevention through the Fund for HIV/AIDS in Myanmar began in 2003.9 The rate of new infections currently stands at one fifth of the level it reached at the height of the epidemic. In order to meet the national target, it is necessary to prevent one to two thousand infections before the end of 2015. The most rapid decrease in the rate of new

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8 Results of HIV Sentinel Sero-Surveillance National AIDS Programme, Department of Health, Ministry of Health, March 2102.
infections must be achieved by increasing effective prevention activities among the key populations with the highest incidence. They are, in order, people who inject drugs, men who have sex with men, and female sex workers.

Myanmar has not yet met the target of Millennium Development Goal 6. The number of people currently receiving antiretroviral therapy stands at approximately 40,000, less than halfway to 80% coverage and a third of the way to 100% coverage. If the Global Fund Round 9 grant renewal process proceeds quickly and the grant is renewed, there are funds in the budget to have 80,000 people on antiretroviral treatment before the end of 2015.

What makes the response to the epidemics in Myanmar unique is 1) the implementers of activities and 2) the small amount of money spent on the response. It is not an unusual situation among countries with concentrated epidemics in Asia to have the majority of activities for the key populations of people who inject drugs, men who have sex with men, and female sex workers to be implemented by the nongovernmental sector and to have these activities funded through external sources. What is different in Myanmar is that both prevention and care are implemented and funded in the same way.

The total financial resources available for both prevention and care in the country over the last eight years average less than $30 million a year. About the same amount is spent a year in Cambodia with a less severe epidemic, little injecting drug use, and a population one fourth that of Myanmar. One hundred million dollars a year is spent in Vietnam though HIV prevalence is much lower there.

Overview of planned and potential funding by the Global Fund and other donors

Renewal documents are currently being prepared by two Principal Recipients to submit to the Global Fund secretariat for Phase 2 of a Round 9 HIV grant to run for a further three years from the beginning of 2013 to the end of 2015. The total request from the United Nations Office for Project Services Principal Recipient is for $50 M and from the Save the Children Principal Recipient is over $52 M so that it is expected that over $92 M of Global Fund resources will be available for HIV programming in the next three years.

The Global Fund secretariat is in the middle of a major architectural revision and the methods that will be used to allocate resources to countries will not be decided upon until two more Board meetings are held this year. What is known is that Myanmar has been designated as a "high impact" country by the Secretariat so that more human resources and maximal financial resources are dedicated to it by the Secretariat.10 If a call for new funding concept notes or documents is made by the Global Fund late in 2012 or early 2013 and the Board continues to support rapid signing of grant agreements, it is very likely that new Global Fund funds will begin to flow in late 2014 or early 2015.

The only major bilateral donor for HIV that is not currently represented on the Three Millennium Development Goal Fund Board is the American USAID. With the information available to the consultant, it looks unlikely that regional and country funding for HIV in Myanmar will exceed the current $5 to $6 million a year over the next few years. Almost all of the present funding is given to international nongovernmental organisations to conduct prevention activities among the key populations of men who have sex with men & transgndered people and female sex workers. Prevention activities among people who inject drugs receives limited funding and needles and syringes are not funded. In the field of care, support, and treatment, only care and support are funded. There is no funding for antiretroviral treatment.

Australia's AusAID may also contribute to the response among people who inject drugs by adding to the pooled funding for HIV or having a standalone project outside of the Three

10 Global Fund Observer, Issue 184, 14 May 2012
Millennium Development Goal Fund. About $800,000 a year for three years is envisaged. AusAID is also planning continued support for capacity building for local nongovernmental organisations and networks working on HIV but no funding figure is available to the consultant.

The Japanese official development assistance agency JICA contributes less than $200,000 annually for support of blood safety. There is also a small amount of German governmental assistance to the response. The World Bank currently has no plans to fund HIV prevention or care in Myanmar. The Asian Development Bank is currently examining potential funding in prevention at infrastructure development sites, cross border programme, and digital communication.

Private funding largely supports the activities of a few international nongovernmental organisations. It is difficult to assess the magnitude of this funding but it may be as high as $8 million a year. It is difficult to predict future fund flows from these sources.

**International evidence on the most effective interventions and the most cost effective interventions to address the HIV epidemics in Myanmar**

**Condom use** has been proven to decrease HIV incidence. Male latex condoms have conclusively been demonstrated to decrease the chances of HIV transmission during heterosexual intercourse. A meta-analysis conducted twenty years ago demonstrated this impact and no further studies are needed. The effectiveness of condoms in reducing HIV incidence in a population depends on the frequency of use, the frequency of sexual partner change, and the nature of sexual networks in the population.

**Female condoms** have been demonstrated to prevent the acquisition of sexually transmitted infections but have never been conclusively demonstrated to decrease HIV incidence.

**Condom social marketing** as a method of condom distribution decreases HIV incidence. Although condoms have been shown to decrease the incidence of HIV in populations, there have been few studies to determine the impact of different methods of condom distribution. A recent meta-analysis of several studies used strict criteria to assess the results of these them to demonstrate that social marketing of condoms doubled the chance of condom use during the most recent sexual act.

**Needle and syringe programmes, opioid substitution treatment**, and targeted education, if combined with one or both of the previous two activities have a positive impact on the incidence of HIV infection among people who inject drugs.

Two United National system organisations and the Joint United Nations Programme on HIV/AIDS have published a technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. It proposes nine programmatic elements:

1. Needle and syringe programmes
2. Opioid substitution therapy and other drug dependence treatment

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14 WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, WHO, UNODC, UNAIDS, 2009
3. HIV testing and counselling
4. Antiretroviral therapy
5. Prevention and treatment of sexually transmitted infections
6. Condom programmes for injecting drug users and their sexual partners
7. Targeted information, education and communication for injecting drug users and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

Although the United Nations guidance document states: “There is a wealth of scientific evidence supporting the efficacy of these interventions in preventing the spread of HIV”, there is only conclusive scientific evidence of the impact of the first two: needle and syringe programmes and opioid substitution therapy and other drug dependence treatment for opiate users. There is little evidence that targeted information alone is effective in reducing incidence but there is a positive impact if it is combined with one or both of the others.\textsuperscript{15} The other interventions proposed by the United Nations system organisations may prevent sexual transmission or prevent people who inject drugs from dying of HIV but they have not been shown to prevent HIV through injecting drug use.\textsuperscript{16}

Only about ten per cent of methamphetamine users develop dependence. There is no scientific evidence that treatment of methamphetamine dependence decreases HIV infection. The association of methamphetamine with sexual activity and HIV infection is weak and may not be causative.\textsuperscript{17} Injectors of amphetamines should be included in needle and syringe and targeted education activities.

**Prevention of mother to child transmission** has a positive impact on HIV incidence in infants. There is clear scientific evidence from well designed randomised clinical trials to demonstrate reduced HIV incidence among newborns through the use of antiretrovirals in the time surrounding birth.

**Sexually transmitted infection control** has not been shown to have impact on HIV incidence. Sexually transmitted infections are spread by the same sexual behaviours as HIV and epidemics of sexually transmitted infections are often closely related to sexually transmitted HIV epidemics. It was formerly believed that the control of sexually transmitted infections would decrease HIV incidence in populations. The first trial to test this hypothesis appeared to show efficacy. But eight later trials using both syndromic treatment method currently in use in Myanmar and mass treatment in the community demonstrated no impact on HIV incidence. Sexually transmitted infection control has important personal and public health benefits, but not as a method of HIV prevention.\textsuperscript{18}

**Treatment as prevention** has not yet been shown to have an impact on incidence. The concept has received a lot of publicity and raised optimism in the year since one ‘proof of concept’ study demonstrated a reduction in transmission in couples in which one treated partner had HIV and the other did not.\textsuperscript{19} Only one field trial has been conducted and the trial did not demonstrate an impact on incidence in the community.\textsuperscript{20}

\textsuperscript{15} Multiple Authors. International Journal of Drug Policy. 16S, 2005
\textsuperscript{16} Louisa Degenhardt, Bradley Mathers, Peter Vickerman, Tim Rhodes, Carl Latkin, Matt Hickman. Prevention of HIV infection for people who inject drugs: why individual, structural, and combination approaches are needed The Lancet, Volume 376, Issue 9737, Pages 285 - 301, 24 July 2010
\textsuperscript{17} Methamphetamine use and associated HIV: Implications for global policy and public health - International Journal of Drug Policy 21 (2010) 347–358
\textsuperscript{18} Gray and Wawer, Reassessing the hypothesis on STI control for HIV prevention, The Lancet, Vol 371, 21 June 2008, p 2064
\textsuperscript{19} Multiple Authors, Prevention of HIV-1 Infection with Early Antiretroviral Therapy, New England Journal of Medicine 2011; 365:493-505
\textsuperscript{20} J Birungi, H Wang, M Ngolobe, K Muldoon, S Khanakwa, R King, P Kaleebu, K Shannon, L Lourenco, J Min, J Montaner, E Mills, Y Chen, DM Moore, Lack of Effectiveness of ART as an HIV Prevention Tool for Sero-discordant Couples in a Rural ART Program in Uganda source
Mathematical modelling has shown promise for treatment as prevention only if very high levels of antiretroviral treatment coverage are achieved in generalised epidemics and not concentrated ones. The concept has not yet been adequately field tested through implementation in communities. Its potential public health benefit in Asian sexual networks, in concentrated epidemics, in men who have sex with men, people who inject drugs, and sex workers have not yet been determined. There are ethical and human rights concerns that are just beginning to be addressed in considering implementation of the concept. Even if treatment turns out to be good prevention, prevention will always be the best treatment.²¹

There is at present no evidence that voluntary counselling and testing has an impact on HIV incidence in the community. One meta-analysis conducted over ten years ago showed that those who test positive generally increase condom use; those who test negative do not. This is the basis for normative guidance for intensive counselling for couples in which one member is living with HIV and one is not.²² Counselling and testing is, however, the gateway to care, support, and treatment.

In the field of care, support, and treatment, multiple studies have demonstrated that antiretroviral treatment gives people living with HIV longer and healthier lives, and decreases the risk of HIV-associated complications.²³ It also decreases the incidence of tuberculosis.²⁴ Cotrimoxazole also increases the quality of life and extends life of people living with HIV.²⁵

The largest home and community based care programmes are conducted in southern Africa and impact evaluations are rare. One recent review concluded: "The potential benefits of Home Based Care in the context of antiretroviral treatment provision are unlikely to be achieved or sustained as programmes are scaled up unless realistic policies are devised to promote staff retention and service integration within district health systems and to ensure sustainable sources of funding."²⁶

Although the size of the private sector contribution to treatment in the country is unknown, a recent meta-analysis did not find that the private sector in health was usually "more efficient, accountable, or medically effective than the public sector; however, the public sector appears frequently to lack timeliness and hospitality towards patients".²⁷

Cost effectiveness studies can guide decisions on resource allocation. In order to use a cost effectiveness study to determine the optimal use of resources in Myanmar, it would be necessary to conduct a high quality study in Myanmar to take into account the current state and trajectory of the various sub epidemics and costs of the potential responses to them. There have been as yet no published cost effectiveness studies of HIV prevention and

treatment in Myanmar. One is planned for later in the year. It is likely that a cost effectiveness study will show cost savings or cost effectiveness of prevention for all three key populations.

No high quality cost effectiveness study on harm reduction has recently been published in peninsular Southeast Asia. General findings from cost effectiveness studies of HIV prevention and care activities in all settings have found that the benefit of prevention is highest if programmes are introduced when HIV prevalence is still low and that prevention is most cost effective when targeted to high risk groups.

Cost effectiveness studies of antiretroviral treatment usually demonstrate higher cost savings or cost effectiveness when antiretroviral treatment is given at higher CD4 cell counts as patients who start antiretroviral treatment when they are healthier have lower morbidity and mortality so that there are fewer care costs.

Determining unit costs are another method of ensuring value for money. With respect to harm reduction, it costs $65 dollars a year to reach one person through outreach and $130 a year to reach one person through a drop in centre. One year of methadone costs $300. There are two reasons for high unit costs for harm reduction. One is that a basic package has continued to get larger with new activities that do not directly decrease HIV incidence. The other is that is it expensive to run harm reduction in the nonurban areas of Myanmar where injecting takes place. It takes place in terrain that is radically different from Dhaka or Ho Chi Minh City.

It is in providing antiretroviral treatment that unit costs become critical. The national strategic plan budgeted $423 a year and the actual average cost in 2011 was $473. Incomplete accounting of costs demonstrates a unit cost for the Ministry of Health of $287. The highest nongovernmental organisation unit cost was $877. Two other nongovernmental organisations were outliers with even higher unit costs. Unit costs for antiretroviral treatment in Yangon and Mandalay should be as low as they are anywhere in Asia. Unit costs in remote areas will be higher because of patient and material transport costs.

**Strategic gaps (programmatic, financial, coverage, geographic, and method of delivery)**

In HIV prevention there are clear strategic gaps that need to be addressed. In order to decrease the number of new HIV infections in the country it is necessary to take programmatic action only among the key populations of injecting drug users, men who have sex with men, female sex workers, and prisoners. This will also decrease the number of new infections among their regular and nonregular sexual partners.

**People who inject drugs**

Among injecting drug users, lack of a current national population estimate makes estimations of national coverage extremely difficult. The national population estimate of 75,000 was a rough estimate when it was made over six years ago. Since coverage cannot be accurately determined, only reach or the number reached can be accurately measured and reported.

The annual report on progress in 2011 towards fulfilling the National Strategic Plan for HIV/AIDS notes that approximately 30,000 injecting drug users were reached with targeted information last year, over nine million sterile needles and syringes were distributed, and

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1,600 people were taking methadone maintenance therapy. Almost all the activities to reach these people who inject drugs are in areas of Kachin state and Shan state that were identified as having large populations of people who inject drugs several years ago and where sentinel surveillance has demonstrated high prevalence. Yangon and Mandalay are also included.

The national nongovernmental organisations and international nongovernmental organisations that currently deliver services have the capacity to expand their reach beyond the areas in which they currently work to increase reach in contiguous areas where they know there are populations of people who inject drugs. These implementers state that they do not have the capacity to expand into other areas of the country without increasing their number of staff and receiving sustained multiyear funding for expansion to areas that are non contiguous with their current programme areas. Two of the five major implementing organisations are international nongovernmental organisations that would need changes to their memoranda of understanding to do so. All implementers recognise the need for more implementers to develop and interest in harm reduction and develop programmes

In order to determine where the activities are needed, it is necessary to determine where people inject drugs. Many staff of harm reduction implementing organisations listen to stories told by people who inject drugs and have already noted where there are large numbers of injectors who need programming. The ‘rapid assessment and response’ method has also been successfully used in the region to determine future sites for programming. Key sites need to be chosen and activities begun or rapid assessment and response exercises need to be undertaken as soon as possible.

There is often heated discussion among HIV professionals about the relative costs and value of reaching people who inject drugs with needles and syringes and targeted information through drop in centres or through outreach. The fixed location and fixed running costs of drop in centres increases total costs. In urban settings and some periurban and rural areas with concentrated populations of injecting drug users unafraid of arrest it is possible for outreach workers to work out of a small office and reach large numbers of people who inject drugs. In most of the periurban and rural areas of Myanmar in which injecting takes place it is necessary to have a safe place for people who inject drugs to come for needle/syringe and targeted information services so drop in centres must be used complement outreach to deliver these services. The drop in centre method of delivering services in areas where it is needed should not be discontinued.

The slow scaling up of methadone services in Myanmar is a concern to all people concerned with the right to health of people who inject drugs in the country. Only about 1,600 out of the tens of thousands of people with the disease of opiate dependence who would benefit from this treatment are currently on methadone treatment. Only a modest expansion of the number of people on methadone is planned with Global Fund Round 9 grant Phase 2 resources. The target is 4,000 over the next three years. This does not meet the national target of 8,000 by the end of 2015. The constraints on expansion need to be determined and urgent action taken to remove them. The Drug User Working Group of the Technical and Strategy Group on AIDS and the World Health Organisation need to lead this process and report to the Country Coordinating Mechanism on it. Even if the programme rapidly expands, people with the disease of opiate dependence will often live far from service delivery points and methods to meet their needs have to be expanded.

Although there never have been and at present there are no written national policies in harm reduction in Myanmar, implementers have been able to conduct activities though informal trusting relationships with local officials. A change in practice leads to unofficial ‘policy change’ in implementation sites. National level policy changes and written policies, if they are immediately implemented, may increase the speed with which programme reach can be
expanded. But these changes are almost certain to be slow and depend on forces largely outside the influence of official development assistance. Activities to change national policies are also not easily funded through the Global Fund as they may not produce results so do not fit with performance based funding.

In summary, there is clearly a major gap in increasing the reach of prevention programmes, estimating population size, and selecting sites for expansion. The constraints on expansion of methadone need to be determined and urgent action taken to remove them. National level policy changes can be encouraged but may not occur.

**Men who have sex with men**

There are few data points and surveillance sites to determine how quickly the epidemics among men who have sex with men in Myanmar are declining. Most epidemics among men who have sex with men in the region are concentrated in cities and the decline in prevalence demonstrated by sentinel surveillance in the two major cities in Myanmar is probably evidence that the severity of the epidemics is decreasing.

National population estimates of men who have sex with men are notoriously imprecise. It is much more important to estimate the number of men who have sex with men who are highly sexually active. Another way of saying this is that it is necessary to determine the number of men who have the greatest number of sexual partners. They must be reached as a priority group. According to the latest national progress report, between thirty-five thousand and sixty-four thousand men who have sex with men were reached with prevention services last year. Action has been taken to produce a more precise reach figure in the next report.

There are no other changes that need to be taken in the national response to these epidemics.

**Female sex workers**

There is clear evidence of a rapid decline in prevalence among female sex workers, reflecting both deaths and a decline in incidence. A national female sex workers population estimate study has been conducted but the results have not yet been released.

Between forty-five thousand and sixty-two thousand female sex workers were reached with prevention services last year. Action has been taken to produce a more precise reach figure in the next report.

There are no other changes that need to be taken in the national response to the epidemic among female sex workers.

**Prisoners**

The fourth key population included in the national strategic plan is prisoners and rehabilitation facility populations. 'Rehabilitation facilities' is not defined. The only prevention activities that are noted as essential in the full version of the national strategic plan are provision of information and behaviour change support. Fewer than one in ten prisoners were reached by one activity last year: health education. No other activities were reported. There is no national prison HIV policy or HIV prevention and care plan. No reports on prison health are available and there has been no published national level survey on prison health.

There are at any one time about 50,000 people in 43 prisons in the country with a five or six

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31 Full Version of the Myanmar National Strategic Plan and Operational Plan on HIV and AIDS 2011 - 2015, no publisher, undated
32 Progress Report 2011, National Strategic Plan for HIV/AIDS in Myanmar, no publisher, undated
to one male to female ratio. There are about 8,000 held in Insein prison in Yangon and 4,000 to 5,000 in Mandalay, with about 1,000 each in prisons in Kalay, Lashio, Myitkyina, Sittwe, and Taunggyi. Some of the above prisoners are held in labour camps of 200 to 800 inmates each. There are two centres in Mandalay under the management of Mandalay prison and one centre in Thwante under the management of Insein prison that are used to detain only women who have been convicted of sex work related crimes. No population figures are available for them.

Prison department staff state that mandatory HIV testing does not take place but other informants state that women convicted of sex work related crimes do undergo mandatory syphilis and HIV testing. Syphilis prevalence among the three thousand of them tested is 10% but no clear data on HIV prevalence is available. It is reported by prison department staff that 600 to 700 prisoners are living with HIV so the minimum prevalence is 1.4%. Among prisoners are people who have been convicted of drug-related crimes, same-sex behaviour crimes, and sex work-related crimes. The prevalence of the disease of drug dependence among them is unknown. About 300 people living with HIV in prisons are receiving antiretroviral treatment through programmes run by international nongovernmental organisations.

In summary, there is clearly a major gap in reaching prisoners with effective support for behaviour change, the materials needed for prevention while in prison such as condoms, sterile needles & syringes, and methadone, and the knowledge of how to protect themselves inside and when they are released. There is also a gap in voluntary counselling and retesting prisoners who are presumed to be HIV positive, providing them with antiretroviral treatment, providing care for opportunistic infections, and running post release programmes to link them to care. Both prevention and care are strategic priorities.

Other groups included in the national strategic plan

Although mobile and migrant populations, uniformed services personnel, young people, and people in the workplace are all listed as key populations in the national strategic plan, there is no biological or behavioural data available to prove that any of these groups is any more at risk of HIV infection than their equivalent cohorts in the general population.

There has never been a published study on mobile and migrant populations in Myanmar that links serostatus with behaviour. Sentinel surveillance among military recruits demonstrates a great degree of variation of prevalence from year to year but prevalence is never much higher or lower than in the general population. Young sex workers and young people who inject drugs have lower or equal prevalence in comparison with older cohorts. There is no evidence that young people or ‘people in the workplace’ are at greater risk than older people or those who do not work in formal workplace settings.

Other populations are sometimes named as key populations or ‘most at risk populations’. Evidence-informed programming principles demand that it is proven that they are key populations before activities are implemented for them. An example is truck drivers. Though a behavioural study demonstrating high levels of condom use with sex workers has been undertaken, there was no serological study attached to it. So there is no evidence that truck drivers have higher HIV prevalence than any other occupational group. No HIV prevention programmes should be initiated for them.

As there is no evidence that HIV prevention programmes among these other populations will decrease incidence, there are no key strategic gaps in prevention among them.

Blood safety

Ensuring a safe blood supply produces a public good that protects the entire population. There is no known transmission of HIV through transfusion of blood or blood products at the
current time. Deferral programmes to prevent people who may be at risk of HIV infection from donating blood have led to a low rate of HIV detection in donated blood and almost blood in almost all facilities is now tested for hepatitis B, hepatitis C, syphilis, and HIV. The cost is for the first three is borne by the patient who is transfused.

Testing for blood safety quality assurance is paid for by a Japanese JICA-financed programme which ends in 2015. There is no national plan for funding of the HIV testing of donated blood and there is no plan to increase domestic governmental investment in HIV testing of donated blood. Few if any infections are occurring through unsafe blood. Continued donor funding for this activity is not a priority.

**Prevention of Mother to Child Transmission**

In 2011 there were 382,683 pregnant women tested for HIV through the national Prevention of Mother to Child Transmission programme. This is over half of all births assuming 48 million people and a population growth rate of 1.3% or over a third of all births assuming 50 million people and a population growth rate of 2%. This programme has achieved significant coverage.

Over three thousand of these women were treated with antiretroviral medications. Two thousand were treated with prophylaxis and nine hundred were already on antiretroviral treatment. If one in five of these pregnancies would have resulted in a perinatal infection then about four hundred infections were prevented. As the infections prevented were all in children, no secondary infections from them to others have been prevented.

Scaling up this programme to cover the entire population would have only a small impact on HIV incidence. It would not have as great an impact on HIV incidence as effective programming among key populations. As less than one per cent of those tested are seropositive it is a low yield method to find people living with HIV to enter care. It not the most efficient nor the least expensive method to find two thousand new HIV case detections a year. Prevention of mother to child transmission is not a programming priority for prevention or donor funding.

Pregnant women who are found to be living with HIV with CD4 cell counts less than 350 cells/mm³ should be treated for HIV with antiretroviral therapy according to the national treatment guidelines.

**Care, support, and treatment**

The gateway to care, support, and treatment for HIV is testing.

There is at present no national plan following the HIV national strategic plan to scale up testing of any kind. There are no figures for the total number of HIV tests done in the country in one year and there is no method to determine the number of tests done for diagnostic purposes among people who are ill. Another major gateway to care for the three key populations is voluntary counselling and testing. Less than half of the voluntary counselling and testing last year was conducted among these populations. Voluntary counselling and testing is underutilised among all three key populations, especially among people who inject drugs, but there is no current service delivery site or test kit gap. A third method is testing for prevention of mother to child transmission. Over a third of a million tests were performed last year but less than 1% were positive. This is a low yield method of testing as a gateway to care.

Another high yield method to increase people living with HIV who have access to counselling and testing is to increase provider-initiated counselling and testing among people who are newly diagnosed with tuberculosis. About one in ten patients who have newly-diagnosed tuberculosis are coinfected with HIV. Although there is no scale up plan for this method in
the HIV national strategic plan, the national tuberculosis programme has included a scale up timetable in its plan.

There is a major programming gap in antiretroviral treatment for people living with HIV. Almost 40,000 people are currently on treatment, and if Global Fund Round 9 Phase 2 funding proceeds as planned, there will be about 80,000 people on treatment by the end of 2015.

Much of this care is provided by two programmes: one run by the international nongovernmental organisation Medecins sans Frontieres (Holland) and one joint governmental/nongovernmental programme in Mandalay and surrounding regions supported by the International Union Against Tuberculosis and Lung Disease. Seventy-two per cent of patients on antiretroviral therapy are cared for by these two institutions. If the patients currently being cared for by the Ministry of Health alone are included, this proportion rises to 83%.

National targets are set with a note on nondiscrimination. It is challenging to determine if there is discrimination based on gender, type of transmission, age, ethnicity, and location.

Among those currently on treatment, about 56% are men and 44% are women. As men are estimated to account for about 120,000 of 197,000 or 60% of the people currently living with HIV, there is little discrimination based on sex. A total of 2,995 children were reported to be on treatment with estimated coverage of 70%. Although the estimate of the denominator may be an underestimate, there does not appear to be discrimination based on young age. It is impossible to find out if there is discrimination based on advanced age.

There is no data on the type of transmission of people currently on treatment. Data on ethnicity is also collected but not reported so nondiscrimination or discrimination cannot be known.

There is clear discrimination based on location. Fifty-six per cent of those on treatment are receiving it in Yangon and Mandalay. And it is known that some of these people have migrated from other areas because it is not available near to their homes. Data is collected on their home locations but not reported.

In summary, there are three major strategic gaps with respect to the provision of antiretroviral treatment. One is the absolute number of people living with HIV who are on antiretroviral treatment must be increased. Another is to address the issues of geographic inequity. Finally, the quality of care during rapid scale up needs to be assessed and action taken if it is found that it can be improved.

**Stakeholder views and perceptions on critical needs and priorities especially geographic areas and vulnerable underserved populations**

With respect to HIV prevention, there is remarkable consensus on the prevention priorities among stakeholders. During interviews with the inception consultant, no key informants stated that there were any major programming gaps with respect to prevention of sexual transmission among men who have sex with men and female sex workers. Almost all informants noted that prevention programming priority should be given to people who inject drugs.

The HIV Technical and Strategy Group is responsible for providing technical advice to the Country Coordinating Mechanism and other decision makers on the strategic use of financial resources. The Group met on 8 May 2012 to plan a process for renewal of the Global Fund Round 9 grant from Phase 1 to Phase 2. It was noted in the minutes: "Sex worker and men who have sex with men programmes should continue as planned to ensure service coverage. Harm reduction should also continue as planned. In the case that savings can be
identified, harm reduction should be prioritized for additional funding." The meeting attendees also identified scaling up the number of people receiving antiretroviral treatment as a priority.

A document from this meeting also stated: "Men who have sex with men and female sex worker programmes need to be maintained at least at present level in order to protect gains made. Programmes for people who inject drugs need to be scaled up: Priority to needles and syringe programmes and targets for methadone can be revisited to a realistic level, and major scale up only envisaged if access to service delivery can be improved."%

There was no clear consensus by stakeholders on the role of civil society in the response to the epidemics. The consultant invited representatives of the national networks of the three key populations and people living with HIV to a consultation meeting. Although there were no focused recommendations for prevention, the participants made clear that the quality of care for people taking antiretroviral treatment were priorities for them. There is at present no mechanism for patient feedback on the quality of care.

**Conflict areas, mines, and prisons**

The terms of reference for the HIV inception consultant mention that consideration be given by the consultant to propose strategic activities in conflict areas, prisons, and mines. The Description of Action specifically notes that activities may be developed for the three key populations of people who inject drugs, men who have sex with men, female sex workers, and prisoners. Hard to reach areas are also included in the Description of Action for the Three Millennium Development Goal Fund.

**Conflict areas and border areas, sometimes called remote areas,** are in general underserved by HIV prevention and care services. Almost the entire eastern border of the country is underserved and there are areas on the western border also are underserved. Some of these areas have no services provided by the Republic of the Union of Myanmar. This is most easily demonstrated by mapping the townships reached by the national tuberculosis control programme which has ‘national reach’. A map of townships that are not reached is Attachment 6.

Some of the activities for people who inject drugs are proposed in these townships and there are people who are living with HIV in some of them that will be treated with antiretroviral drugs. A major limitation to developing greater reach and coverage in these townships is that there are few implementing organisations who can take on this work. Local administrations or armed forces may allow activities or they may not. There are few local nongovernmental organisations in them that can tackle the sensitive issues of drugs and sex in order to work with the key populations of people who inject drugs, men who have sex with men, and female sex workers. The consultant was unable to find a single organisation in conflict areas of Kayin state that works directly with these populations. International nongovernmental organisations are rarely given permission to work there.

Another challenge to working in conflict zones is that open conflict can erupt, causing disruptions in programme implementation. As this document was written, fighting broke out around the Kachin state mining area of Hpakant, limiting access there.

People who inject drugs form a larger proportion of the population in opium or heroin producing or transit areas than they do in other regions.

Finally, it is extremely difficult for staff of the Global Fund to visit these areas. If more of

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33 HIV Technical and Strategy Group Meeting minutes, 8th May 2012, Yangon
34 Gaps and priorities in Myanmar’s HIV response 2012-2015, Technical and Strategy Group AIDS, 8th May 2012
these regions are drawn into peace processes then this situation may change and Global Fund staff may be allowed monitoring visits.

**Prisons** are difficult to visit for everyone, including Myanmar citizens. It is extremely difficult for expatriate staff to be allowed access to visit. This severely limits visits by Global Fund international staff. It is only through implementing activities in prisons that trust will be built in order to expand the number of local and international staff of institutions who are allowed into prisons. For this reason a local nongovernmental organisation is recommended for prison activities. If local nongovernmental organisations do not respond to the call for expression of interest, a second call for an international nongovernmental organisation may be needed.

**Mining areas** are in the terms of reference because there is a confluence of injecting drug use and sex work in some mining areas. There is nothing in mining areas in Myanmar that specifically increases susceptibility to HIV infection.

Most mining areas are nominally open to international staff of institutions, including the staff of the Global Fund. Board members, Secretariat staff, staff of the Office of the Inspector General, and Local Fund Agent staff can make the journey in the winter or hot season to many mining areas. Monsoon rains make travel difficult for all visitors. The Chief Executive Officer of the Three Diseases Fund visited one of the most famous mining areas.

**Guiding principles and range of options for the Three Millennium Development Goal Fund**

The guiding principles for the list of options below include:

1) All activities proposed must be designed so that they are able to be funded from Global Fund financial resources, assuming that permission for people who are not citizens of Myanmar to visit conflict areas, prisons, and mining areas becomes easier to obtain in the coming years.

2) All activities in prevention are focused on the key populations of people who inject drugs, men who have sex with men, female sex workers, and prisoners. There are no prevention activities for the general population.

3) All activities in care are based on the principle of “Treat the sickest first”. Only those who meet the national initiation of treatment criteria will be treated, and those who are the most immunocompromised receive priority.

4) All monitoring and evaluation activities will use indicators and systems that can easily be used by Principal Recipients for present and future Global Fund grants.

There are five fields of action in HIV proposed for funding by the Three Millennium Development Goal Fund for the first two years of operation:

1) **Prevention** HIV prevention and links to HIV care among people who inject drugs

2) **Prevention and Care** HIV prevention and HIV care among prisoners

3) **Care** Provider-initiated counselling and testing of people with newly-diagnosed tuberculosis

4) **Care** Initiation of HIV treatment for the sickest in remote areas and development of a patient feedback mechanism to improve the quality of care
5) Care

Study of the private sector with a view to increasing quantity and quality of care in remote areas

1) Prevention - HIV prevention and links to HIV care among people who inject drugs

It is recommended that the provision of harm reduction programmes be expanded to reach more people who inject drugs.

HIV prevention among people who inject drugs includes the evidence-informed activities of provision of sterile needles and syringes, targeted information on HIV prevention delivered through outreach or drop-in centres, and condom distribution. Three additional activities that save lives or improve the quality of life for people who inject drugs and which may prevent HIV acquisition and transmission are overdose prevention and management, provision of painkillers during withdrawal, and vein care. Evidence-informed methadone maintenance treatment as opioid substitution therapy in Myanmar is a government administered programme and in sites where it is available, people who inject drugs will be referred to this programme.

Most implementing organisations refer people who inject drugs for the three evidence-informed activities of voluntary counselling and testing, antiretroviral treatment, and management of opportunistic infections including tuberculosis. At a few implementing organisation sites these services are provided by the implementing organisation. Finally, training and local advocacy can be programmed and budgeted separately.

Site selection for this package of activities is challenging as there has never been a national population estimate or large scale population mapping of people who inject drugs in the country, and there are many places in the country where it is unknown whether there are large numbers of people who inject drugs. What is known is that there are people who inject drugs in sites where organisations have been implementing harm reduction activities for them over the past decade. A wide strip of territory along the eastern border of the country from near Myitkyina in Kachin state to near Laukkaing in Shan state is known, as is the town of Lashio in Shan state. Current harm reduction programme implementers also hear anecdotal evidence of other sites. There are populations of people who inject drugs in several cities including Mandalay and Yangon.

There are only five organisations that have experience in the implementation of harm reduction activities in the country and that have currently expressed an interest in implementation or expanding reach or both.

- Myanmar Anti Narcotics Association (MANA) - local nongovernmental organisation
- Substance Abuse Research Organisation (SARA) - local nongovernmental organisation
- Asian Harm Reduction Network (AHRN) - international nongovernmental organisation
- CARE - international nongovernmental organisation
- United Nations Office on Drugs and Crime (UNODC) - UN system organisation

Representatives from these five institutions met twice in a collegial setting to plan sites, methods, activities, and targets to reach. It is recommended that these five institutions be commissioned and contracted to conduct harm reduction activities in defined geographic locations. Some of these are in mining and conflict areas. The total indicative budget for this activity is $2M a year over two years for a total of $4M. It is currently impossible to determine the remaining programming gap in the absence of a national population estimate. Funding should be sought from the Global Fund to continue these activities at the end of 2015. Expansion of harm reduction activities to new sites can then be undertaken, assuming that it is still a national priority.
If top up funding is available, it is recommended to commission rapid response and assessment exercises in four to five sites recommended by the Drug User Working Group of the Technical and Strategy Group on AIDS. It is also recommended that funding be made available for the five implementing agencies to employ implementation interns from local nongovernmental organisations that may be interested in implementation of harm reduction activities in future to build local implementation skills.

It is recommended that the Fund Board advocate for the expansion of memoranda of understanding for international nongovernmental organisations to places where injecting takes place so that these organisations can increase their contribution to the national response to HIV among people who inject drugs. It is also recommended that the Fund Board advocate for the rapid implementation of a national population estimate of people who inject drugs and the rapid expansion of methadone provision services. The Drug User Working Group of the Technical and Strategy Group on AIDS and the World Health Organisation need to lead the latter process.

It is proposed that this field of activity is implemented through commissioned services on a noncompetitive basis. Attachment 1 outlines commissioning and contracting requirements.

The risks for this proposed field of activity are largely in the risks of disruption of activities due to local conflict or disputes with local authorities. Distribution of needles and syringes by people who are not health care providers is illegal in Myanmar but to this date has been allowed by local authorities. As some of the activities take place in conflict areas or are surrounded by conflict areas, there is also a chance that programme activities will be disrupted.

2) Prevention and Care - HIV prevention and HIV care among prisoners

It is recommended that a call for expressions of interest be issued for local nongovernmental organisations that are interested in conducting HIV prevention and care activities in prisons in Insein, Mandalay, Kalay, Lashio, Myitkyina, Sittwe, and Taunggyi. This is a programme to be run for the full funding period of the Three Millennium Development Goal Fund or until it is clear that Global Fund staff can visit these prisons to speak with detainee participants in the programme. Funding should then be sought from the Global Fund to resource this field of activity. International standards will be met by this programme.

For prevention, about 18,000 prisoners should be targeted to be reached by prevention programmes over two years. This represents over a third of all prisoners in the country. All prisoners can be included in sex-segregated sessions. The first prisoners reached should be those convicted of drug-related crimes, same-sex behaviour crimes, and sex work-related crimes.

Small group sessions of five detainees each could be run every weekday. Two sessions a day in Insein prison will reach a majority of prisoners over two years. Two sessions a day in Mandalay prison should reach almost all of the detainees over two years. One session a day will reach all inmates in each of the five smaller prisons over a year. If the entire population of a prison is reached then the number of sessions and their frequency should be decreased to reach only new prisoners. These two hour long small group discussions should be led by a man for men prisoners and by a woman for women prisoners. The discussion guide needs to be developed before sessions are run and field tested on groups of former prisoners. Inside Out is one example of a curriculum.

For care, it is recommended that all people known to be living with HIV in all of these seven prisons who meet the eligibility requirements for antiretroviral treatment are provided treatment in the prison. HIV counselling and retesting will be guided by international guidance on testing in prison settings. After they are released they should be accompanied to an ART treatment facility by a staff member of the local nongovernmental organisation that implemented the prison activity.

The international nongovernmental organisation Medecins sans Frontieres (Switzerland) currently has a large antiretroviral treatment programme reaching over two hundred prisoners in Insein prison in Yangon. Other nongovernmental organisations reach small numbers of prisoners in the prisons in Mandalay, Lashio, Myitkyina, and Taunggyi. The proposed activities will not overlap or replace these activities unless there is an agreement made beforehand between the local implementing nongovernmental organisation and the international nongovernmental organisation.

Technical assistance in human rights, health, and detention will be provided to the local nongovernmental organisation so that they maintain high standards to promote the human rights of prisoners. There may be value in examining the HIV prevention and care programme in prisons in Indonesia to determine what can be done in Myanmar.

The total indicative budget for this activity is $100,000 a year for two years for a total of $200,000. Annual ongoing funding may be up to double the annual amount for this initial activity. Funding should be sought from the Global Fund to continue these activities at the end of 2015.

It is recommended that the Fund Board advocate for international technical assistance providers and Global Fund staff to be able to visit prisons that that this field of activity becomes eligible for funding with Global Fund resources. It is also recommended that the Fund Board set high standards for prison programming so that prisoners get as close as possible to the same standard of prevention and care services that people outside prisons receive.

Attachment 2 outlines a call of expression of interest and contracting requirements. This is a competitive process.

The risks for this proposed field of activity are two: 1) The first is in obtaining permission for staff of local nongovernmental organisations (or international nongovernmental organisations if no local nongovernmental organisation apply for funding) to work in prisons. Permission may not be given and activities may not take place or permission may be withdrawn and activities disrupted. 2) The second is that there is a clear risk that staff of local nongovernmental organisations will be co-opted into activities in prisons that do not respect, promote, or fulfill the human rights of the prisoners. It has been proposed by the Chief Medical Officer of the Prison Department of the Ministry of Home Affairs that local nongovernmental organisation staff be given an 'appointment letter' by the Prison Department. It is in this letter that roles of prison staff and local nongovernmental organisation staff be clearly set down.

3) Care - Provider-initiated counselling and testing of people with newly-diagnosed tuberculosis

Surveys have revealed that about ten per cent of patients with newly-diagnosed pulmonary tuberculosis in Myanmar are coinfected with HIV. Since all of these coinfected patients fall within the WHO clinical stage 3, they are all eligible for antiretroviral treatment irrespective of

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CD4 cell count\(^{38}\).

It is recommended by both the tuberculosis consultant and the HIV consultant that HIV testing be offered by health care providers to all patients with newly-diagnosed pulmonary tuberculosis. Funding should be made available for training in provider initiated counselling and testing by the National AIDS Programme. Funding should also be made available for HIV test supplies for national tuberculosis programme service delivery sites that are selected. Funding for antiretroviral treatment should be made available for the national tuberculosis programme to treat patients found to be coinfected in places where there is no other antiretroviral treatment available.

The total indicative budget for this activity is $200,000 over two years. Funding should be sought from the Global Fund to continue these activities at the end of 2015.

It is proposed that this field of activity is implemented through commissioned services on a noncompetitive basis. Attachment 3 outlines contracting requirements for the governmental institutions involved.

The risks for this proposed field of activity are few.

4) Care - Initiation of HIV treatment for the sickest in border and conflict areas and development of a patient feedback mechanism to improve the quality of care

There are three strategic priority actions that need to be taken with respect to care of people living with HIV. Treatment must be scaled up, geographic equity needs to be addressed, and quality of care needs to be assessed and improved.

Over the next three years Global Fund financial resources will be used to ensure that 80,000 people living with HIV are receiving antiretroviral treatment out of the estimated 120,000 people who need it based on the new treatment guidelines\(^{38}\). This exceeds the treatment target in the national strategic plan of 70,000 and is 83% of the ASEAN treatment target of 96,000 or 66% of the treatment target if the goal is to treat all people who are eligible. This represents a laudable achievement.

If all the HIV funds in the Three Millennium Development Goal Fund were used to fund antiretroviral treatment then an additional ten thousand people could receive treatment. If Three Millennium Development Goal Fund resources are used strategically then the issue of geographic inequity can begin to be addressed and quality of care assessed.

The national treatment guidelines state: “In practical terms, however, most patients with HIV will still be presenting when they will be quite ill and the CD4 count will be usually <200/mm\(^3\). Priority should be given to these patients for access to ART.” Few people would argue against the ethical principle stated in the guidelines that the sickest should be treated first.

It is recommended that funding be provided for antiretroviral treatment for up to four thousand people living with HIV with CD4 cell counts under 200 in the conflict or border (or both) geographic locations in which these treatment spots can be rapidly filled. These are the areas where it has been difficult for nonMyanmar citizens to visit. This should be undertaken for the first two years of Three Millennium Development Goal Fund operation. At this point the programme should be reassessed.

During rapid scale up of antiretroviral treatment, issues of implementation capacity of service

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\(^{38}\) National AIDS Programme, Department of Health, Ministry of Health. Guidelines for the Clinical Management of HIV Infection in Adults and Adolescents in Myanmar. 2011

\(^{39}\) Unpublished draft of 29 August 2102. Myanmar CCM Request for Renewal HIV.
providers often arise and quality of care may suffer. There is an opportunity for civil society to turn complaints into action. It is recommended that the Myanmar Positive Group be commissioned to develop a patient feedback mechanism in selected sites where antiretroviral treatment is being provided so that service delivery institutions and the Ministry of Health receive regular feedback on the quality of service from the patient's point of view and can take action to improve the quality of care.

The Myanmar Positive Group is the national network of people living with HIV. It is composed of member self help groups numbering over 200 consisting of about 9,000 people living with the virus. Technical assistance provision will be provided for this activity.

The total indicative budget for the initiation of treatment activity is $4M over two years. The indicative budget for the patient feedback mechanism is $50,000 a year. Funding should be sought from the Global Fund to continue these activities at the end of 2015. The remaining funding gap for HIV treatment must be recalculated before this funding is sought.

It is recommended that the Fund Board advocate for resources for continued scaling up of provision of antiretroviral treatment and for concerted action to address the major equity issue in provision of antiretroviral treatment - geographic equity.

It is proposed that this field of activity is implemented through commissioned services on a noncompetitive basis. Attachment 4 outlines commissioning and contracting requirements.

The risks for this proposed field of activity are few. There is a small risk that Global Fund resources will not be able to be used for a small number of patients who are begun on antiretroviral treatment who are outside the reach of antiretroviral treatment activities of the government of the Republic of the Union of Myanmar. These patients would then have to travel to sites closer to the centre of the country.

5) Care - Study of the private sector with a view to increasing quantity and quality of care in remote areas

The role of the private sector in provision of care for people living with HIV is currently unknown. The number of patients that receive care in the private sector is unknown, the number of providers delivering care and their location is unknown, movement of patients between both times of providers is unknown, and the quality of the care they provide is unknown.

It is recommended that funding be made available to commission a study of the role of the private sector in HIV care. The above issues need to be explored with an emphasis on provision of care for patients who are remote from large urban centres. If the private sector is found to be a viable service delivery mechanism for antiretroviral care in remote areas then it should be considered for future funding. Funding should be sought from the Global Fund to continue these activities at the end of 2015.

The total indicative budget for this activity is $50,000 over one year.

Attachment 5 outlines commissioning requirements. This is a competitive process

The risks for this proposed field of activity are few.

**Strategic information, monitoring and evaluation**

The strategic information needs have been outlined in the proposed activities:

- Among people who inject drugs, there is an immediate need for a national population estimate exercise to be performed and the results disseminated. The United Nations
Office on Drugs and Crime has funding for this.

- Rapid assessment and response exercises in potential new programme sites for injecting drugs users can be performed. But increasing the number of sites for service delivery for people who inject drugs must not be delayed by this.
- National HIV sentinel surveillance and sentinel behavioural surveillance, often called integrated biobehavioural surveillance when combined in one survey, needs to be continued. Questions on the length of time that respondents have been injecting or the length of time that respondents have been sexually active should be included in this surveillance. This study should not be conducted annually but should be conducted once every two years. There are several potential funders for this regular strategic information activity and there is no need for funding from the Three Millennium Development Goal Fund.

No operational research studies are recommended. Apart from continuing the integrated biobehavioural surveillance above, there are no recommendations for health systems strengthening.

There are very few new monitoring and evaluation issues raised by the proposed activities. Indicators that are part of the national indicator set that are currently being used for Global Fund resourced activities must be used in the Three Millennium Development Goal Fund log frame. One new activity will need to have indicators developed: the patient feedback mechanism to improve the quality of care. It is recommended that the Myanmar Positive Group, its technical assistance provider, and the Three Millennium Development Goal Fund monitoring and evaluation team work together to develop a one page monitoring and evaluation plan.

**Leadership and coordination**

The Technical and Strategy Group on AIDS, supported by its open working groups, is the best mechanism for leadership and coordination at the present time. The process for developing the national strategic plan for HIV and especially the development of the annual progress report on the strategic plan are among the best practices that improve the effectiveness of HIV prevention and care in Myanmar and that can be implemented in other countries with difficult implementation environments and constrained financial resources.

The Technical and Strategy Group on AIDS provided clear guidance for the development of this inception plan through written notes from their last meeting. Meeting notes should become public documents that are available on websites for all stakeholders to see and take action on. The Technical and Strategy Group on AIDS should report regularly to the Country Coordinating Mechanism - Myanmar and should begin to report regularly to relevant parliamentary committees.