National Guidelines
A Core Package for
HIV Prevention
Amongst Key Populations
in Myanmar

Source : John Rae/Global Fund

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The *Core Package for HIV Prevention amongst Key Affected Populations* plays a key role in defining the minimum standards of service delivery that implementers must be able to provide to meet the needs of their target populations. As a result, many implementing partners and members of the key affected populations contributed their time, energy and enthusiasm into creating these guidelines.

Abbreviations and Acronyms

ART	Antiretroviral therapy
BCC	Behaviour change communication
CBO	Community-based organization
DIC	Drop-in centre
FSW	Female sex worker
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HSS	HIV sentinel sero-surveillance survey
HTC	HIV testing and counselling
IEC	Information education and communication
M&E	Monitoring and evaluation
MoU	Memorandum of understanding
MSM	Men who have sex with men
NAP	National AIDS Programme
NGO	Non-governmental organization
NHL	National Health Laboratory
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PITC	Provider-initiated HIV testing and counselling
PLHIV	Person/people living with HIV
PMTCT	Prevention of mother to child transmission (of HIV)
PWID	People who inject drugs
PWUD	People who use drugs
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TCP	Targeted condom promotion programme
TG	Transgender
UIS	Unique identifier system
VCCT	Voluntary counselling and confidential testing

Contents

Introduction

The HIV situation in Myanmar

There were an estimated 189,000 people living with HIV in Myanmar in 2013. HIV prevalence in the general adult population in Myanmar has been declining steadily over the last decade, but remains relatively high among key populations such as people who inject drugs (PWID), men who have sex with men (MSM) and female sex workers (FSW) and their clients.[i] While there is a general downward trend in HIV prevalence among FSW and PWID, it has recently increased among MSM.[ii] Prevalence levels among younger FSW and MSM (under 24 years) suggest that young people in these two populations are at risk.[iii] High-risk sexual contact and the use of contaminated needles and syringes are the primary drivers of the epidemic among the key affected populations.[iv]

The number of new infections in Myanmar has been declining every year since 1999. Nevertheless, with an estimated 7,000 new infections in 2013, effective prevention remains a priority. The burden of new infections is increasing among people who inject drugs and men who have sex with men. A substantial proportion of new infections are also found among low risk women—who were infected by their male partners—but the numbers of new infections within this group are declining annually.[v]

The national response to the epidemic continues to be scaled up, with increasing collaboration among all stakeholders, and has likely contributed to the overall reduction in prevalence, particularly among FSW and PWID. Despite this, coverage of prevention services for populations at risk is still relatively limited.[vi] The challenges include laws that criminalize sex work, drug use and homosexuality, low levels of outreach to key populations at higher risk, especially in remote areas; inadequate awareness of HIV and sexually transmitted infections (STI) at both facility and community levels; poor access to HIV testing services; stigma and discrimination in health care settings, leading to low uptake of HIV testing and STI treatment services; fear of harassment and arbitrary arrest for

possession of condoms or needles and syringes; lack of government support for people living with HIV (PLHIV) and peer support groups involved in prevention activities; and difficulty in reaching the sexual partners and/or clients of FSW, MSM and PWID.[vii]

The mid-term review of Myanmar's National Strategic Plan on HIV and AIDS (2011-2015) highlighted the need for a defined 'prevention package' to standardise prevention interventions and ensure access to a minimum level of quality services.

What's in the Guidelines

These Guidelines describe the principles and core package of interventions required for prevention of HIV amongst people at highest risk of HIV in Myanmar – female sex workers, men who have sex with men and people who inject drugs. The package defines what needs to be in place for effective HIV prevention and outlines other programme elements and strategies that can facilitate delivery and contribute to enhanced outcomes. As a result, the first chapter, How to Start, outlines the key steps in assessing the need for, planning and implementing an intervention, and how to maintain standards. Chapter 2 looks at key cross-cutting issues that should be taken into consideration for each intervention and key population.

Chapters 3 to 6 describe the core interventions, explaining the essential elements of each, including the key actions that need to be taken by implementers. These are the minimum elements that need to be provided as part of the service concerned. These chapters also suggest how the intervention can be effectively integrated with other services, as optimal results are more likely to be achieved when beneficiaries are linked to a continuum of appropriate support and care. Guidance is provided on how to create and/or strengthen an enabling environment in which the intervention can be implemented more effectively. Finally, a 'Measuring Prevention' section in each chapter explains how to monitor the coverage, quality and effectiveness of each intervention. References to additional information and guidance are provided at the end of each chapter.

Chapter 7 provides a more comprehensive overview of monitoring and evaluation (M&E), introducing some of the key concepts and approaches to measuring the provision and effectiveness of the Core Package described in these Guidelines.

Who are the Guidelines for?

The Guidelines are designed for use primarily by those providing services in Myanmar's HIV response, through community, civil society and nongovernment organizations, to the key affected populations – female sex workers, men who have sex with men and transgender people, and people who inject drugs, as well as young people from each of those key affected populations.

They are intended to serve as a concise yet comprehensive reference to the minimum standards of prevention services required for an effective HIV response among key populations in Myanmar, for anyone involved in programme planning, implementation, monitoring and evaluation. In a climate of increasingly constrained funding, there is a growing demand for accountability from beneficiaries and donors on how resources are being used and what results are being achieved. It is hoped that these Guidelines will help service providers to deliver high quality interventions with clearly documented results.

Key Affected Populations in Myanmar

This section provides a brief overview of the intervention approaches for each key population.

Female sex workers (FSW)

Better investment in prevention is needed to sustain the downward trend in HIV prevalence. More effort is also needed to reach young female sex workers (see section on "Young People"). Better integration of HIV and sexual and reproductive health services, including a defined minimum package of services, will create more opportunities to reach FSW. It is important to reach the clients or sexual partners of sex workers to ensure that one or both partners remain uninfected, and to ensure that infected partners are linked with appropriate treatment and care.

Men who have sex with men (MSM) and Transgender people (TG)

Interventions for MSM and TG should be scaled up and efforts will need to reach those who are 'hard to reach'. Outreach and other provision of HIV services to MSM and TG is hampered by the criminalisation of homosexuality under the Myanmar Penal Code. Stigma and discrimination are major barriers for MSM and TG to access HIV services. Innovative approaches to reach "hidden" MSM need to be pursued to ensure those at highest risk are receiving critical health and HIV services.

The broad term 'men who have sex with men' encompasses a number of highly diverse sub-populations. MSM and TG in Myanmar often identify themselves using local indigenous terms such as *Achouk*: transgender women; *Apwint*: effeminate MSM; *Apone*: masculine MSM; *Te'enge*: MSM with female partners; and *Offer* : male sex workers.

Data on these communities, particularly transgender people, are scarce. It would be beneficial to understand this community separately from MSM to identify their particular needs. As in many parts of Asia, TG people in Myanmar are frequently involved in sex work, and, like other sex workers, TG sex workers in Myanmar are subject to extortion, arrest and incarceration that is continual and systematic.

It is important to reach the sexual partners (including clients) of both MSM and TG to ensure that one or both partners remain uninfected, and to ensure that infected partners are linked with appropriate treatment and care.

People who inject drugs (PWID)

Coverage of HIV prevention and harm reduction programmes, including the provision of sterile needles and syringes, methadone maintenance therapy, HIV education and distribution of condoms and other services, has expanded significantly in recent years but remains below the level needed for maximum impact. Harassment by law enforcement agencies continues to challenge service delivery. The needs of women who inject drugs in areas with high burden of injecting drug use should be addressed. If resources permit, it would also be beneficial to provide prevention information to drug users before they start injecting drugs. And, as with other key populations, their sexual partners should be reached with appropriate prevention interventions and linkages to support.
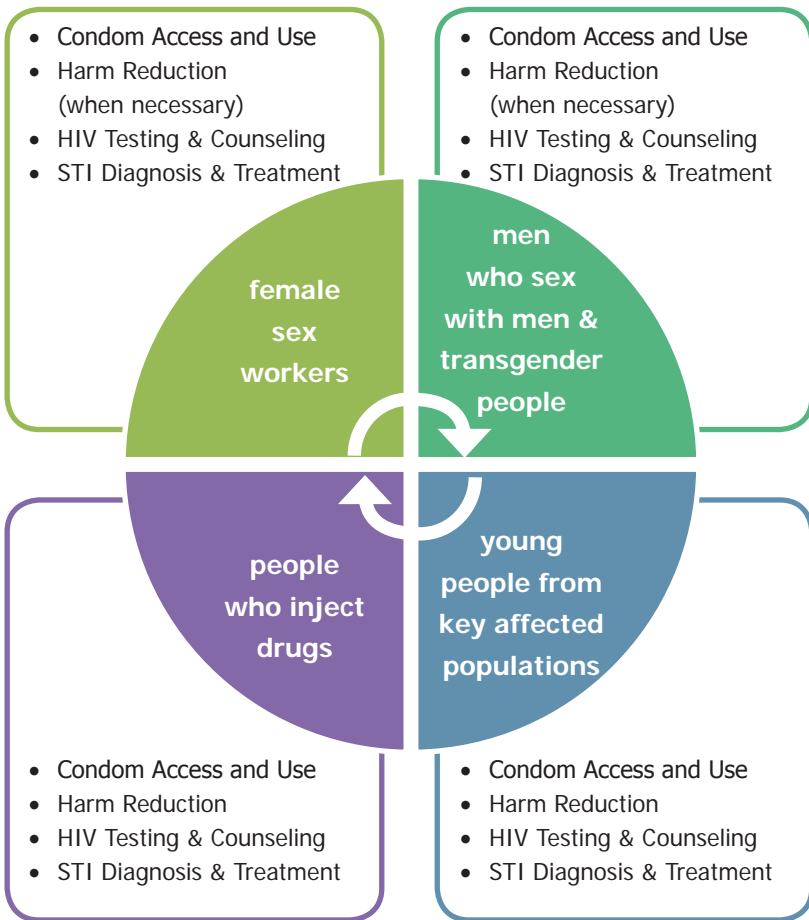
Young People from Key Affected Populations

Young people in key populations may require specific and more creative engagement strategies to promote uptake of services.[viii] Socio-cultural factors, including religious beliefs on sex before marriage, and a lack of clarity on the age at which young people can access health services without parental consent, can impede access to services. It is vital that young key populations are reached with accurate information on HIV risks and prevention strategies, and have access to youth-friendly prevention, harm reduction and reproductive health services.

1 How to Start

Summary of HIV Prevention Interventions by Target Population

- Condom Access and Use
- Harm Reduction
  (when necessary)
- HIV Testing & Counseling
- STI Diagnosis & Treatment

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- Harm Reduction
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- HIV Testing & Counseling
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female sex workers

men who sex with men & transgender people

people who inject drugs

young people from key affected populations

- Condom Access and Use
- Harm Reduction
- HIV Testing & Counseling
- STI Diagnosis & Treatment

- Condom Access and Use
- Harm Reduction
- HIV Testing & Counseling
- STI Diagnosis & Treatment

1. How to Start

These Guidelines describe the core package of HIV prevention interventions for key affected populations in Myanmar. They define the minimum standards of service delivery that implementers must be able to provide to meet the needs of their target populations in the local context with comprehensive, high quality services.

Setting up and sustaining HIV prevention services that meet these standards demands careful planning, prioritising and ongoing monitoring to ensure that objectives are being met and standards maintained. This chapter briefly outlines the key steps that service providers need to take.

1. Assess the current situation

Understand the local dynamics of the epidemic. Conduct a situational analysis that covers, among others, the size and characteristics of the affected populations in the area; the physical, political and social environment, including the economic and religious contexts in which you will operate; the needs of people from key populations and factors that influence their HIV risk and vulnerability; structural factors that might facilitate or hamper their ability to access services; and existing levels of service provision, by public health facilities, community and non-governmental organization (NGO)-based facilities and the private sector.

Consult, and encourage the participation of, local stakeholders, particularly key populations, in carrying out this assessment, but ensure their privacy is maintained and any sensitive data kept secure. Recognise potential bias in the information collected.

Local stakeholders may include civil society, including members of key populations, PLHIV, women's and youth groups and community networks; local government, including local health authorities and services; technical experts; law enforcement authorities; local leaders and gatekeepers, including religious leaders and teachers; owners and managers of entertainment establishments; and the private sector.

2. Decide on priorities

Based on the situational analysis, identify the priorities for service provision in the local context. Which key populations and sub-populations are most at risk? What interventions do they need? What interventions will have the greatest impact on the epidemic? Where, and at what scale, do interventions need to be provided?

As in the situational analysis, local stakeholders can be consulted in prioritising interventions.

3. Develop a plan

Once the priorities have been agreed, plan how the intervention will be implemented. Agree on indicators for monitoring and evaluation. Set targets and timelines. Decide on the most appropriate modes of service delivery. Decide how your intervention should be integrated with other services to provide optimal coverage for key populations.

Asses the financial, human and infrastructure resources needed to deliver the planned services. Is the intervention cost-effective? Assess the resources that are already available and decide how any additional inputs needed will be sourced (fundraising, recruitment etc.).

Determine the roles and responsibilities of each of the implementers, such as outreach workers, peer educators, drop-in centre managers, lab staff, etc., and their accountability for target achievement. Identify needs for capacity building and plan appropriate training.

Identify potential risks to implementation. These may be internal, such as funding or capacity gaps, supply chain issues or staff attrition; or external, such as policy changes. Assess the potential impact of each risk and put mitigating measures in place.

4. Implement

Implementation can begin once plans have been approved, contracts and memorandums of understanding (MoUs) signed and funds disbursed.

Be proactive in engaging potential clients and their partners through outreach, services and referrals. Use a mix of delivery models

to maximise reach, if appropriate. Develop and pilot innovative approaches.

Contribute to creating an enabling environment for the intervention and the wider response. Work in partnership with health systems, community networks and local communities. Monitor the impact of interventions on the local community and be proactive in addressing any issues.

At all times, ensure that service delivery is non-discriminatory, non-stigmatising, sensitive and responsive to the needs of key populations, and confidentiality and privacy are prioritised. Rights-based and gender sensitive approaches should be employed where required. Ensure that measures are in place to guarantee the safety of both clients and staff during service delivery.

5. Monitor and evaluate

Set clear and achievable targets. Systems and tools for ongoing monitoring of progress towards targets should be put in place and staff trained on how to use them. Measures to ensure data quality should also be in place and assessed periodically to ensure they are effective.

The programme should report on the national indicators set out in the National Monitoring and Evaluation Plan (and referred to at the end of each chapter). For more specific monitoring purposes, service providers can develop additional indicators to assess other aspects of the services they are providing or changes in the enabling environment. Service providers should also actively seek feedback from beneficiaries on the quality of services for example, and respond to suggestions, if possible.

Ongoing monitoring and periodic evaluation, alongside lessons learned from programme implementation, should feed into the planning cycle and inform the design of future interventions and the allocation of resources.

Refer to Chapter 7 and the National M&E Plan for further information and guidance.

Additional references
• Much of the content of the 'How to Start'section was adapted from WHO's Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014).

2 Cross-cutting Issues

Source : John Rae/Global Fund

Source : John Rae/Global Fund

2.   Cross-cutting Issues

Several of the intervention elements and enablers described in these Guidelines are cross-cutting components that need to be present in all interventions. They are described broadly below. Where necessary, additional considerations are noted in the relevant chapters.

Peer outreach

Peer outreach and education is widely used in HIV prevention work in Myanmar. Peer outreach interventions have been shown to increase HIV knowledge and condom use, and reduce use of non-sterile injecting equipment and needle sharing amongst people who inject drugs. Peers play a vital role in generating community demand and the confidence to access services.[ix] Done well, peer outreach is the part of the programme that reaches the largest proportion of the community, most regularly and with the most direct personal rapport.

The focus of peer outreach should be on locations where HIV risk behaviours may occur and where key populations that do not come to drop-in centres or other services can be found. This may involve reaching out to a wide range of sites, such as parks, shops, health clinics, NGOs, community-based organizations (CBOs), bars and workplaces. Peer educators and outreach workers should be encouraged to identify new hotspots where potential clients can be reached.

Good selection of peer educators is fundamental to programme success. Peer status is not a guarantee of success as a peer educator or outreach worker. Selection criteria need to be clearly defined to identify those likely to be effective; this process should include input from key populations. Retention of peer educators is essential for programme effectiveness and sustainability, but is difficult to achieve—training, supervision and mentoring, as well as payment that reflects the work performed, are key to retention.

Effective Outreach

To ensure good quality, effective peer outreach, a number of practices are needed:

- Base messages on quantitative and qualitative research among the target audiences: this includes what motivates the target audiences to stay healthy and adopt healthy behaviours (e.g. getting tested, using condoms consistently, using sterile injecting equipment, seeking treatment for STIs). Aim to dispel misperceptions, for example, about condoms being uncomfortable. Regularly collect feedback from peers on the messages.

- Design a standard interpersonal communication session with the peers: practice in the drop-in centre before going to do outreach in the field.

- Frequency of exposure to the messages is managed by scheduling peer visits to different hotspots or cruising points. Aim to reach as many new people from the community as possible with regular frequency (currently quarterly in Myanmar, but more frequently for new contacts).

- Train peer educators at least twice a year. New peers are coached by experienced peers during their first weeks of work. Train peer supervisors to observe sessions by peers, and give them feedback on those sessions (adherence to messages, attitude, communication skills). Outreach schedules and adherence to messages are also monitored by supervisors randomly. Outreach workers and peer educators should have access to supportive supervision and mentoring.

Referral systems

Outreach staff should understand the service needs of the key populations they work with and have knowledge of the locally available resources and support so that they can make appropriate referrals. Staff and clients at drop-in centres, clinics and other facilities should have access to a service directory or referral database. This is a comprehensive list of organizations or providers offering relevant services in the area. Interaction between local service providers can help to strengthen referral networks and establish referral pathways; standard operating procedures (SOPs) or MoUs between partners to formalise methods of

access can help to facilitate access for clients. Referral cards or client-held service record booklets allow clients and service providers to keep track of services received.

Accompanied referral, where clients attend a service with an outreach or peer worker, can improve the uptake and outcome of these other interventions, while also providing support for service providers.

Potential barriers to accessing referral services, such as the lack of a local ID card, should be considered. Service providers may need to work with other partners to ensure that all members of key populations have full access to the services they need.

Essential elements for an enabling environment

Eliminating stigma and discrimination in healthcare settings

Addressing stigma and discrimination is an essential strategy to ensure the effectiveness of HIV prevention programmes. All key populations experience stigma and discrimination in their daily lives in relation to their sexuality, gender identity or drug use and in relation to HIV. In particular, key populations often report stigma and discrimination in health care settings, making it difficult for them to use services where this occurs. Interaction and orientation with local authorities and service providers in health care settings, and closer coordination and linkage between community-based and facility-based prevention and care services can contribute to breaking down stigma and eliminating discrimination. Health services—including HIV testing and counselling (HTC), antiretroviral therapy (ART), management of STIs, opioid substitution therapy (OST), sexual and reproductive health (SRH) and family planning, and post-abortion care services—should also establish anti-stigma and anti-discrimination policies and codes of conduct, and closely monitor their implementation.[x] Communities and networks can be engaged to support key populations to document and report cases of discrimination and/or rights violations when they are accessing health services, and educate communities on human rights, including their right to health.

Building a supportive legal and policy environment

Punitive laws that criminalise the behaviours of key affected populations can also hamper their access to services, for example by forcing them to remain 'hidden'. Service providers can facilitate interaction and orientation sessions between civil society and local police and law enforcement agencies to sensitise the authorities to HIV programmes, non-discrimination and human rights, and encourage them to exercise discretion in applying such laws. As above, community-based organisations can be engaged to monitor cases of discrimination and rights violations and to build legal/human rights literacy among their communities.

Involvement and partnership of local communities in HIV prevention

It is important that government and non-government organizations, donor agencies, civil society (including faith-based organizations) and the private sector support community empowerment and involvement. Partnership and collaboration at the township level between key populations (individuals, groups and networks), community organisations and other key players such as National AIDS Programme (NAP) offices and health committees, NGOs, community leaders and local businesses can assist with the development of services, obtaining local funding, advocacy and addressing of stigma and discrimination. Collaboration can build community involvement and ownership, and support the definition of problems and solutions.

Communication and consultation about the programme with local communities, law enforcement agencies and other stakeholders should be repeated regularly to ensure that the messages reach incoming personnel.

Coordination and direction of the implementation of HIV prevention programmes

For optimal coverage and to ensure the cost-effective implementation of the core package of interventions in these Guidelines, coordination mechanisms at the national and local level will be required. Attention must be given to operational issues, such as which organization will deliver what product or service, how, and with what measure of quality.

3 Condom
Access & Use

Source : John Rae/Global Fund

Source : John Rae/Global Fund

3.   Condom Access and Use

Essential Elements of Condom Access and Use

1. Understand condom clients and the environment
2. Procure high-quality condoms and manage the supply chain
3. Expand distribution systems
4. Promote condoms at distribution points
5. Promote condoms at community, township and national levels

Correct and consistent condom use is a key approach to the primary prevention of sexual transmission of HIV and STIs among all key affected populations, [xi, xii, xiii] and is particularly important in relation to sex work.

Comprehensive condom programming integrates various activities including male and female condom promotion, communication for behaviour change, market research, segmentation of messages, optimized use of entry points (in both reproductive health clinics and HIV prevention venues), advocacy and coordinated management of supplies. The goal of condom programming in HIV prevention is to reduce the number of unprotected sex acts, which will, in turn, reduce the incidence of sexually transmitted infections, including HIV.

It takes advantage of a variety of entry points – not just clinics, but also, for hotels, brothels, pharmacies and youth centres. It requires the collaboration of the public and private sectors and demands a consistent and affordable supply of male and female condoms and lubricant. It also calls for the training of peer educators to effectively create demand for condoms among key affected populations and stakeholders and ensure that condom distribution is linked to other services.

Creating demand for condoms by convincing people at risk of HIV to use them correctly and routinely is important, but people who want to use condoms must also be able to obtain them. As well as ensuring an efficient supply chain, efforts must be made to create an enabling environment for condom use by facilitating communication and collaboration between key stakeholders, including local policy makers and law enforcement authorities. Local training of operational police on public health, HIV prevention, human rights and gender-sensitive programmes can go a long way to nurturing an enabling environment.

ESSENTIAL ELEMENTS

1. Understand condom clients and the environment

Key Actions

- Assess needs within a geographical area
- Identify barriers to access and use

Targeting of condom programmes requires understanding of key populations, their risk of HIV infection and the barriers to them using condoms. This includes epidemiological, sociocultural, and behavioural information on key populations and on the broader sociocultural and political environment.

A condom needs assessment will provide information about the risk of HIV infection and barriers to condom and lubricant use amongst key populations and their sexual partners. An assessment also provides information about the broader political and social/cultural environment and its impact in relation to condom programming. The information can be used to decide which groups to target with condom programmes.

When carrying out assessments, programmes should work in partnership with networks and individuals from key populations to provide access to their communities and to information regarding their varied needs.

2. Procure high-quality condoms and manage the supply chain

Key Actions

- Select products that meet the needs of the key populations
- Collect and report essential data
- Forecast condom needs
- Ensure condom quality
- Manage inventory, storage and transport systems

Maintaining a reliable and consistent supply of quality condoms, whether through free distribution or social marketing channels, requires a review and strengthening of all elements of the logistics system.

People are more likely to use condoms if they find them attractive as well as functional. Size, design, colour, scent and packaging are all important. The condom needs assessment should identify the condom and lubricant preferences of users and potential users.

To ensure that condoms and lubricant are available at all times, at least three types of essential data are needed - stock on hand, rate of consumption, losses and adjustments (the amount of stock that is not available for distribution due to loss, damage or reaching expiry date).

Use national and international standards when procuring.

Set up reliable systems to maintain supply to condom outlets.

3. Expand distribution systems

Key Actions

- Ensure easy access to condoms
- Match distribution channels to the needs of key populations
- Use multiple distribution channels and non-traditional outlets

Key populations and their sexual partners should be able to obtain male and female condoms and lubricant easily and when they need them. This includes locations where unsafe sex is negotiated or takes place, and where key populations meet socially. These locations will differ across and within key populations, and may include:

- brothels and other sex work venues

- entertainment venues, including karaoke bars

- motels, hotels

- festival sites such as spiritual "Nat" altars in major towns

- drug injecting locations

- places where young people meet and socialize

Condoms and lubricant should also be readily available through health, HIV prevention or other services, including places where harm reduction or drug dependence treatment services are offered:

- government and non-government STI and ART services and township hospitals

- drop-in centres

- other health and social services including family planning, sexual and reproductive health (SRH), antenatal services, general hospitals, community health centres and general practitioner clinics

- from peer outreach and other mobile services

- needle and syringe programmes, opioid substitution therapy (OST) and drug dependence programmes

- close to where key populations live or work

- in disaster, conflict and humanitarian settings

Condoms and lubricant can be distributed in a variety of ways. These include:

- Through peer educators and peer outreach workers during outreach and other contacts with key populations. Packaging condoms and lubricant with needles and syringes is an effective way of distributing them to people who inject drugs.

- Through networks and organisations of key populations that have direct access to their constituents. Sex worker networks and organisations are key distribution points for condoms to sex workers, pimps, managers and owners of sex work venues.

- From staff of HIV/STI, family planning, sexual and reproductive health and other health services and drop-in centres. This can include the waiting areas, bathrooms and clinic rooms of these services.

- Distribution through informal sources such as trishaw and taxi drivers as well as community social networks.

- Through a combination of free distribution programmes and social marketing, for example distributing low-priced condoms in outlets close to sex work venues, in combination with free distribution of condoms through peers and outreach workers.

Effective condom distribution requires a partnership between local CBOs and NGOs, networks of key populations, and the private sector.

4. Promote condoms at distribution points

Key Actions

- Make confidential condom counselling available to clients

- Train staff to provide counselling, information and referrals

- Focus supervision on condom service delivery

- Encourage partner communication and participation in counselling

- Display and distribute educational materials

Ready access to condoms and lubricant will not guarantee their use. Creating demand amongst key populations and their sexual partners requires awareness of HIV risk and the skills to use condoms correctly

and consistently, including the ability to negotiate with sexual partners for condom use. Access to individual counselling at condom distribution points should be available. Where this is not possible, displaying and distributing educational materials that give condom clients essential information on how to use condoms correctly is recommended. To improve counselling, there is a need to train and supervise providers in methods of condom promotion.

5. Promote condoms at community, township and national levels

Key Actions

- Use behaviour change communication (BCC) and education materials to promote condom use

- Tailor condom programming to key populations and sub-populations and their sexual partners

- Promote condoms through peer outreach and education

Behaviour change communication—including peer education—can increase knowledge, shape attitudes, and change behaviours among key populations and their sexual partners. Condom promotion can extend prevention coverage by working hand-in-hand with STI, HIV prevention, harm reduction, reproductive health, displaced population's health and other programmes. There is also a need to create a supportive political and sociocultural environment for condom use by raising awareness of HIV/AIDS; placing condom programming on the political agenda; and making condom promotion socially acceptable via advocacy to political, religious, community and business leaders.

Other issues

Contraception

Women who are living with or at risk of HIV have the right to determine the number and timing of their pregnancies and to safely achieve their reproductive intentions. However, many women affected by HIV lack access to family planning services and experience disproportionately

high rates of unintended pregnancy and abortion. This is particularly true for female sex workers, among whom condom use is generally considerably lower with their intimate partners than with clients. Moreover, sex workers experience high levels of sexual violence, including rape, commonly involving unprotected sex. Abortion is criminalised under Myanmar's penal code, except when it is necessary to save the woman's life. There is no exception for women who have been raped.[xiv] As a result, women resort to unsafe abortions, but frequently face difficulties in accessing care when complications arise.

Evidence demonstrates the greater efficacy of contraceptive methods other than condoms in preventing pregnancy. As a result it is recommended that the most effective strategy for preventing unwanted pregnancies and HIV/STI is dual method use—the use of condoms as well as another form of modern contraception, rather than condoms alone.

HIV prevention efforts among female key populations and the female partners of men at higher risk of HIV provide a critical opportunity to improve access to:

- screening for unmet contraceptive need through discussion of fertility intentions;

- counselling on the choice of contraceptive methods and understanding of the implications of different methods for preventing HIV/STI and unwanted pregnancy;

- the full range of contraceptive methods to enable women to choose the dual contraceptive methods that will work best for them;

- referrals to health care, including post-abortion care, that is friendly, non-discriminatory and non-judgmental.

Condom use with intimate partners

While most condom promotion messages with sex workers focus on condom use with clients and casual partners, promotion of condom use between female, male and TG sex workers and their intimate partners is also required. Peer educators play an important role in making sure that sex workers have information and skills to prevent HIV/STI and,

for FSW, unwanted pregnancy. Information needs to be relevant to sex workers' lives broadly, not just in the context of sex work. For example, community outreach workers from one CBO in Myanmar use examples from their own regular partnerships to engage in targeted counselling with sex workers around the need for protection in longer-term relationships. There is also a need for targeted communication to MSM, TG and PWID about condom use with their intimate and casual partners.

Female condoms

The female condom is a preventive commodity particularly relevant for FSW, MSM and TG people. Promoting the female condom requires the skills to demonstrate its correct use as well as an understanding of its advantages:

- It is stronger than the male condom and may be used for anal sex

- It is useful for FSW during menstruation

- Sex workers can use it when clients cannot maintain an erection when attempting to fit a male condom

- It requires less cooperation from the client.

HIV prevention programme workers should be trained to demonstrate correct use of the female condom for specific key populations. If financially possible this could include use of female pelvic models.

Note: Female condoms should not be re-used; in fact, clients of sex workers often need to be reassured that the female condom is not being re-used in order to feel comfortable using it.

Young key populations

Condom programmes should also meet the needs of young key populations. In 2010-11, HIV prevalence amongst younger female sex workers (<25 years) in Myanmar was close to that of the average for this group.[xv] To identify and address HIV prevention needs amongst young key populations, the following strategies are recommended:

- Know your local epidemic and develop evidence-informed, youth friendly programmes – include young key populations in Condom Needs Assessments.

- Integrate HIV programmes for young key populations into sexual and reproductive health services – assess the current access of young people to these services.

- Create enabling social and legal environments for young key populations. This may include clarifying young people's legal capacity to access HIV and SRH services independently.

- Include young key populations as partners in the HIV response.

- Routinely collect age and sex-disaggregated data.

INTEGRATION OF SERVICES

Please also refer to Chapter 2, 'Cross-cutting Issues'.

Progress has been made in Myanmar towards strengthening the integration of HIV-related services into wider health care systems. Condom programmes should serve as a key entry point to the continuum of HIV services by ensuring that strong linkages are in place.

1. Strengthen referral systems between services

Condom programmes can be a gateway through which clients can be referred to treatment or other interventions. Accompanied referral, where clients attend a service with an outreach or peer worker, can improve the uptake and outcome of these other interventions: programmes in Myanmar and elsewhere have noted that clients are more positively received when referred or accompanied by outreach staff. Incentives such as direct transportation support can also help to ensure that clients access the service. Services to which clients are referred should be sensitive, supportive and responsive to the needs of key populations, and preferably located close to the referring service or easily accessed by the client.

2. Establish linkages to both HIV-related services and broader health services, including reproductive health programmes

Clients of condom programmes can be referred to outreach and drop-in centres where they can access behaviour change interventions, partner counselling and referrals, and—at some sites—diagnosis and treatment of STIs, and contraception and counselling to prevent unintended pregnancy. Through outreach and drop-in centres they can also be linked with HIV testing and counselling, and then to ART if necessary; drug-related harm reduction services; drug/alcohol dependency programmes; tuberculosis (TB) screening, prevention and therapy; sexual and reproductive health services, including a full range of contraceptive methods; prevention of mother-to-child transmission (PMTCT); general antenatal, delivery and post-natal care; abortion (subject to legal requirements) and post-abortion care. Key affected populations may also need other interventions, such as legal services, social services and support in cases of unwarranted arrests or gender-based violence. Referrals to these services should be made if they are available.

3. General health services such as hospitals, community health centres and prison medical clinics provide services required by key populations

General health services are becoming more accessible and responsive to the needs of key populations. Many of the services above are available through public health facilities; for example:

- Family planning services provide sexual and reproductive health and HIV testing, and linkages to HIV care, support and treatment and PMTCT programmes.

- HTC is integrated into antenatal services to provide access to ARV prophylaxis for PMTCT. In Myanmar the percentage of pregnant women with HIV receiving ARV prophylaxis for PMTCT has increased by 68% in the past two years.

Some services offer clinics for different key populations on particular days. Referring services should be aware of such arrangements, and hours of operation, and inform clients accordingly.

4. Other entry points

There are a number of other opportunities for service integration. Examples include traditional healers, meditation practitioners and religious organizations providing spiritual and other support.

ENABLING ENVIRONMENT

Key components for a supportive environment for condom programmes

Please also refer to Chapter 2, 'Cross-cutting Issues'.

Policy, legal and regulatory frameworks

It is important that local regulations in support of condom programmes are issued, and that these frameworks and regulations are properly enforced. National and local governments need to support owners and managers of brothels and other sex work sites to routinely stock condoms and lubricant, normalizing condom use in sex work settings and supporting sex workers to negotiate for condom use, irrespective of national laws pertaining to sex work.

An Administrative Order was issued by the Government of Myanmar in 2000 directing police not to use condoms as evidence in the prosecution of sex workers. A study in 2011 found that the practice of police confiscation of condoms among sex workers had declined to different extents in each of the three sites in the study, although it had not been entirely eliminated.[xvi] More efforts are required to work with local law enforcement officials to raise awareness of human rights and public health approaches required for HIV prevention.

Condom promotion and distribution programmes are free of coercion

It is important that condom programmes have the full participation of key populations at all stages (design, implementation, monitoring and evaluation) and include measures to protect human rights, prevent corruption and ensure police support and cooperation.

Influential people engaged and supportive of condom programming and access for key populations

Key individuals include parliamentarians, ministers, religious and other community leaders. Institutions include the Ministry of Health, local health departments, law enforcement agencies, local clinic personnel and other relevant members of the health system. Key partners include networks of key populations and individuals, managers of entertainment establishments, nightclubs, brothels, guesthouses and hotels, others involved in commercial sex work and local authorities.

Key programme partners will often need training and capacity building to build understanding and support for condom programmes.

A coordinated approach

At present in Myanmar a number of condom programmes are operating; these include the 100% Targeted Condom Promotion (100% TCP), and programmes of NGOs and networks of key populations as well as condom social marketing. It is important to ensure coordination between these activities at all levels. In addition, effective condom distribution in sex work settings relies on a harmonized approach to HIV programming among the health, commercial and judicial sectors. For cost-effective programming, steps must be taken to ensure coverage of key populations and sexual partners in a way that minimises duplication and identifies and fills gaps in coverage.

Violence is addressed in condom programmes

Violence has been found to be significantly associated with sexual health risk amongst sex workers. This includes higher STI levels[xvii] and reduced condom use. Efforts to address violence against sex workers have demonstrated:

- Significant reduction in violence

- Increased condom use among sex workers and their clients

- Reductions in STIs

- Improved access to HIV prevention and treatment services

- Better health and social outcomes for sex workers.

To address violence against members of key populations, particularly gender-based violence against women and transgender people, service providers can document incidents of violence and provide and/or refer individuals to appropriate services, where available, including health care, emergency contraception, post-exposure prophylaxis, diagnosis and treatment of STIs, counselling, legal assistance, psychosocial support and shelter.

They can also facilitate partnerships between key populations, particularly community-led organisations, and key stakeholders at the local level, including police, venue and brothel owners, community leaders, long-term partners and clients of sex workers, lawyers, human rights institutions, and health care service providers to address violence against key populations.

MEASURING PREVENTION

Effective monitoring and periodic evaluation are recommended to ensure that the efficiency, effectiveness and acceptability of condom programmes are maintained. Client surveys, suggestion boxes, discussions during group gatherings are useful channels for collecting data. Operational research can assess barriers and facilitators to condom access and identify any weaknesses in the referral process and/or in linkages to services.

Both the Myanmar National Monitoring and Evaluation Plan on HIV and AIDS 2011-2015 and the 100% TCP collect data on the process, outcome and impact of condom programming. The condom indicators defined in the National Monitoring & Evaluation Plan on HIV/AIDS are as follows:

- % of FSW who used a condom at last sex
- % of MSM who used a condom at last sex
- % of PWID who used a condom at last sex
- % of young people who used a condom at last sex
- Number of condoms distributed for free
- Number of condoms sold through social marketing

Additional focus areas for monitoring could include:

- Whether condoms distributed reach key populations or not
- Levels of law enforcement and other key partner support
- Routine checking of condom quality
- Number of referrals to other services (especially HTC and STI), and whether clients accessed the services.

Additional references
- Condom Programming for HIV Prevention; An Operational Manual for Programme Managers. UNFPA, WHO, PATH.[xviii]
- Condom Programming for HIV Prevention; A Manual for Service Providers. UNFPA, WHO, PATH. [xix]
- National Guidelines for 100% Targeted Condom Promotion (100% TCP) Programme in Myanmar. National AIDS Control Programme, Department of Health, Ministry of Health.
- Guidelines: prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach. WHO, UNAIDS, GIZ, MSMGF, UNDP, 2011.[xx]
- Prevention and treatment of HIV and other sexually transmitted infections for sex-workers in low and middle-income countries; a public health approach. WHO, UNFPA, UNAIDS, NSWP, 2012.[xxi]

4 Drug-Related
Harm Reduction
S e r v i c e s

Source : John Rae/Global Fund

4.   Drug-Related Harm Reduction Services

Prevention of HIV transmission in relation to drug use primarily focuses on injecting drug use – specifically the use of non-sterile injecting equipment when people inject drugs. This is a major risk factor for HIV infection and for other blood-borne infections, in particular hepatitis C and hepatitis B.

Essential Elements of Effective Drug Related Harm Reduction Services

1. NSP:
   Needle and syringe programmes
2. OST:
   Opioid Substitution Therapy and other evidence-informed drug dependence treatment
3. HTC:
   HIV Testing and Counselling
4. ART:
   Antiretroviral therapy
5. STIs:
   Prevention & treatment of sexually transmitted infections
6. Condoms:
   Provision of condoms for people who inject drugs and their partners
7. IEC:
   Targeted information, education and communication
8. Hepatitis care:
   Prevention, vaccination, diagnosis and treatment of viral hepatitis
9. TB Care:
   prevention, diagnosis and treatment of tuberculosis

Preventing HIV and other harms among PWID—and providing them with effective HIV and drug dependence treatment—are essential components of the national HIV response. In order to curtail the rapid spread of HIV among PWID, but also to prevent onward transmission to other populations (including regular sexual partners and sex workers, and mother-to-child transmission), it is essential to implement a comprehensive package of nine interventions (see above). The *Comprehensive Package of interventions for the prevention, treatment and care of HIV among people who inject drugs*[xxii] has been widely endorsed.[xxiii] The interventions included in the Comprehensive Package are commonly referred to as a harm reduction approach to injecting drug use in relation to HIV and other co-infections.

These interventions can contribute optimally to preventing and treating HIV when available in combination, as each intervention addresses different factors relating to HIV transmission. Empirical studies and modelling have demonstrated that single interventions alone have only limited impact; to significantly reduce HIV transmission and other harms, combined interventions with high levels of coverage are required.

HIV prevention interventions for PWID in Myanmar currently have limited coverage, particularly in remote, border areas that are difficult to access due to conflict situations. Most importantly, any efforts to scale up coverage and uptake of services must address the stigma surrounding drug users and the widespread discrimination and police harassment of PWID that hamper their access to services. The support of community leaders and influential community members must also be sought to ensure local ownership and sustainability of the programmes.

ESSENTIAL ELEMENTS

1. Needle and syringe programmes

Key Actions

- Distribute needles and syringes for exchange free of charge or at low cost
- Sterile water and alcohol swabs
- Ensure safe disposal for used needles

Use of non-sterile injecting equipment by people who inject drugs is one of the most efficient methods of spreading HIV. HIV can live for

several hours or days in the blood remaining in a syringe previously used by a PWID with HIV. The next user of this syringe is therefore at high risk of infection. Ensuring that injecting equipment is not re-used is a key element of an HIV prevention programme amongst PWID.

Needle and syringe programmes (NSP) should provide injecting equipment (at a minimum, 1 ml and 3 ml syringes), sterile water and alcohol swabs. Products should meet the needs and preferences of the people who inject drugs. Explore the procurement and provision of low dead-space syringes, as there is evidence that they can contribute to a reduction in the transmission of HIV and hepatitis C virus (HCV).[xxiv] Products should be provided free of charge or at low cost. The WHO, UNODC and UNAIDS Technical Guide on target setting for PWID suggests that a mid-range target for needles and syringe distribution to have an impact on HIV transmission is 100–200 per PWID per year. Current achievement in Myanmar is consistent with this target, with 147 needles and syringes distributed per person in 2013.[xxv]

The effectiveness of NSP programmes in preventing HIV depends on adequate access, coverage and reach. PWID must have access to new needles and syringes when needed. Service models should be based on the needs of PWID using an optimal mix of outlets and service provision and type (see 'Service Models,' below).

Safe disposal of injecting equipment is important to safeguard both key populations and the local community. Service providers should budget for sufficient human resources, materials and transport for effective collection and disposal (drug injecting sites may be several hours distant from the drop-in centre or outreach headquarters). This includes the provision of sharps containers to PWID, needle disposal bins and sharps containers in areas where injecting occurs, and systems for collecting needles and syringes discarded in public places. Collectors must be provided with protective clothing and equipment, including appropriately sized containers for transporting the used products to the destruction site.

Injecting equipment should be destroyed through burial or incineration. Involvement of drug users and the local community in these activities is recommended, particularly on the location of incinerators or disposal sites.

The impact of NSP on HIV transmission can be increased if a range of additional services are offered, preferably at the same site, or through referral. These could include:

- Providing condoms and lubricants
- Providing bleach and other injecting equipment
  (i.e. tourniquets, pill filters, different gauge needles)
- Primary health care for problems such as abscesses
- Risk reduction information: how to reduce drug-related harm and methods for safe injection, overdose prevention and response
- Naloxone[1] for overdose treatment in opiate-using areas, drop-in centres, fixed and mobile NSP and at drug treatment services
- HTC, and linkages and referral to additional services including OST, drug dependence treatment, rehabilitation, STI services and HIV care, support and treatment.

NSP service models

Drop-in centres: these can be located close to areas where PWID congregate, and provide safe access to needles and syringes. Core interventions can be delivered to service users in the drop-in centre along with additional services (e.g. HTC, OST, STI treatment, ART, psychosocial support). Drop-in centres should have opening hours that maximise accessibility for the target group.

Fixed site needle and syringe outlets or 'depots': fixed sites for needles and syringes include dedicated outlets as well as NSP programmes in community health centres/health posts. Fixed site NSP programmes can also operate in hospitals and private pharmacies.

Mobile needle and syringe services: outreach workers conduct visits to locations where PWID can be reached, including places of work, 'shooting galleries' or areas where injecting takes place and entertainment areas. Outreach workers should be equipped to provide not only needles and syringes but also condoms, IEC materials, referral for STI screening and treatment, TB screening, HTC and any other referral that is deemed necessary for the PWID reached.

[1] Naloxone is a medication called an "opioid antagonist" used to counter the effects of opioid overdose, for example morphine and heroin overdose. It is included in WHO's List of Essential Medicines. However the use of naloxone in Myanmar is severely curtailed by regulations prohibiting anyone other than medical practitioners from using a syringe.

2. Opioid substitution therapy (OST)

Key Actions

- Provide OST (methadone or buprenorphine) at an affordable price or free of cost
- Provide an adequate dose (methadone, 60-120 mg/day; buprenorphine, 8-24 mg/day)[2] for a sufficient duration
- Secure storage of medications
- Regulate provision of the drug

The information in this document does not replace the Ministry of Health's 2012 Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar.[xxvi]

OST, in addition to being an effective treatment for opiate dependence, is an intervention for prevention of HIV. The most commonly used opioid agonists are methadone and buprenorphine, both of which are on the WHO list of essential medicines. Effective use of OST significantly reduces the frequency of injecting drug use and thus the risk of HIV transmission. Long-term inclusion of OST programmes is indicated to achieve maximum benefits. The stability offered by OST can assist PWID who are living with HIV to commence and adhere to ART.

OST programmes must be client-friendly and accessible at times that allow clients to carry on a normal life, for example employment or education. OST should be provided free of cost or at a price that clients can afford. As with needle and syringe programmes, for OST programmes to be successful, adequate supplies of methadone or other substitution treatment must be guaranteed. OST programmes are usually clinic-based, and require secure storage of medications and regulated provision of the drug. Where there is a significant number of women who inject drugs, efforts should be made to increase their uptake of OST.

OST programme staff should be aware that interactions between methadone and drugs used in a variety of treatments, including for HIV and TB, may result in the need to adjust the methadone dose to avoid withdrawal symptoms or sedation. Clients must be encouraged

[2] WHO: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations; 2014

to inform staff of any changes to such treatment regimens.

3. HIV testing & counselling

The interventions described in Chapter 5: HIV Testing and Counselling, should also be implemented for PWID. This section presents some additional emphasis and considerations for PWID.

Key Actions

- Recommend provider-initiated HIV testing and counselling (PITC) for PWID
- Maintain confidentiality
- Encourage testing of intimate partners of PWID

HTC services in Myanmar are increasingly decentralised and there is scope for offering counselling and testing in drop-in centres (DICs) and other community settings. Taking into consideration the HIV infection risk of PWID and the low uptake of HIV testing among this population, PITC is recommended, but testing must be voluntary. Service providers should ensure that their staff access the HTC training offered by the NAP.

Rapid testing should be provided to facilitate same day results. Procedures for confirming positive screening results must be in line with national guidelines. Robust quality assurance measures should be in place at DICs and community-based sites that provide HTC, including participation in external quality assurance systems.

Confirmed cases should be immediately linked to treatment pathways. Accompanied referrals can facilitate access to treatment and care services for PWID, particularly in locations and sites where there are reports of discriminatory treatment of PWID.

The sexual partners of PWID should be supported to access HTC and other HIV-related and SRH services, including family planning and PMTCT.

4. Antiretroviral therapy (ART)

Key actions

- Increase access to ART for people who inject drugs

- Maintain confidentiality: drug use history should not be shared with law enforcement agencies
- Provide OST to improve treatment outcomes and adherence to ART
- PMTCT for women who inject drugs or are sexual partners of male PWID

With evidence on its 'treatment as prevention' benefits, ART should be a key intervention for PWID not only to prolong their lives but to reduce the risk of HIV transmission. Drug use history should not be a barrier to accessing ART. OST can also support ART adherence and treatment outcomes among PLHIV who are opioid dependent. Efforts could be made to integrate the provision of OST and ART more closely.

HIV-positive pregnant women who inject drugs or who are sexual partners of men who inject drugs should have immediate access to PMTCT services, along with support to manage drug dependence during pregnancy, including the provision of OST to women who are opioid-dependent. Women who are partners of drug users or are themselves drug users should also be provided with full options for reproductive health and receive health services that are non-discriminatory.

5. Prevention and treatment of STIs

The interventions described in Chapter 4: Sexually Transmitted Infection Diagnosis and Treatment Services, should also be implemented for people who inject drugs. This section presents some additional emphasis and considerations for PWID.

Key actions
- Develop STI screening and treatment capacity of health services that are accessed by PWID;
- Establish active referral pathways between STI treatment services and other services that are accessed by PWID;
- Ensure that mainstream STI treatment services are accessible and responsive to the needs of people who inject drugs.

Having STIs can increase the risk of HIV transmission through sexual

intercourse. PWID who engage in sex work and male PWID who have sex with other men have an elevated risk of exposure to STIs.

STI prevention strategies include condom distribution programmes and the promotion of safer sex practices through BCC and IEC, and are described elsewhere in these Guidelines.

To increase uptake of STI services by PWID, STI screening and treatment capacity can be built within health services that are accessed by PWID, such as drop-in centre-based clinics and OST sites; STI services could be co-located at sites accessed by PWID, such as NSP sites or drug treatment services.

Clear referral pathways should be established between STI treatment services and other services that are accessed by PWID. Accompanied referrals should be provided where needed to facilitate access. Service providers should facilitate interaction between PWID communities and mainstream STI treatment providers to ensure that their services are responsive to the needs of PWID.

6. Condoms: Provision of condoms for people who inject drugs and their sexual partners

The interventions described in Chapter 3: Condom Access and Use, should also be implemented for people who inject drugs. This section presents some additional emphases and considerations for people who inject drugs.

Key actions

- Provision of both male and female condoms plus lubricants
- Offer counselling on family planning and a comprehensive set of options for reproductive health to women who inject drugs or who are sexual partners of male PWID.

There is evidence that condom use among PWID in Myanmar varies considerably depending on the type of sexual partner; while condom use is relatively high in paid sex, few PWID use condoms with non-paid partners.[xxvii] Unprotected sex is one of the pathways for transmission of HIV among PWID, and between PWID and their sexual partners who do not inject drugs. Stimulant use is also associated with risky sexual behaviours. PWID who also engage in sex work may have an elevated risk of exposure to HIV.

There is a need to increase the accessibility and educate PWID on the need to use condoms with all their sexual partners, not only sex workers. Provision of condoms free of charge increases their accessibility and removes any cost barriers. Male and female condoms and lubricants can be made available at DICs, NSP sites, OST sites, and through outreach alongside targeted IEC. Women who inject drugs and female partners of PWID should be offered access to family planning and other reproductive health services.

7. IEC: Targeted information, education and communication for PWID and their sexual partners
Key actions
- Provide clear, targeted information on risks and risk reduction strategies
- Use a variety of media and formats
- Improve drug and ARV treatment literacy and awareness of rights

IEC materials and BCC programmes should provide information on risks associated with drug use, including HIV infection; hepatitis C infection, other injection drug-related health harms, abscesses/wounds and unsafe sex. They should also be clear and offer practical information on reduction strategies, such as overdose prevention and response; available services and how to access them (including harm reduction services, viral hepatitis services, general health services, and drug and alcohol addiction treatment); and legal rights.

Various media should be utilised, including web-based, social media and smartphone apps where appropriate. Counselling for individuals, couples and groups, as well as peer-led interventions, can be effective means to support the adoption of safer sex and injecting practices. All educational materials need to be practical, and suited to the cultural context of Myanmar. Print materials should be translated into local dialects when and where needed.

There is also a need for systematic and focused awareness raising among health care providers on drug use, harm reduction and drug dependency as a medical condition. Training on rights-based approaches for health care providers should be carried out where funding permits.

8. Prevention, vaccination, diagnosis and treatment for viral hepatitis

Key Actions

- Use BCC and IEC materials to raise awareness of hepatitis B and hepatitis C risks and transmission
- Offer hepatitis C screening and counselling to people who inject drugs
- Offer the rapid hepatitis B vaccination regimen, with incentives to increase uptake and completion, to people who inject drugs

Hepatitis C and hepatitis B are typically more prevalent among people who inject drugs than in the general population. PWID are principally at risk of HCV infection through the use of contaminated injection equipment. Among those infected with HCV or the hepatitis B virus (HBV), co-infection with HIV is associated with more rapid progression of liver disease and mortality.[xxviii] In a study of 22,344 PLHIV preparing to start ART in Yangon, Shan and Kachin states, 15% were co-infected with hepatitis C.[3] Among PWID, the figure may be considerably higher: a cross-sectional analysis of people living with HIV enrolled in the Integrated HIV Care Programme from May 2005 to April 2012 found that PWID had the highest risk of being co-infected with hepatitis C, with a co-infection rate of 47%.[xxix] The same study found prevalence of HBV-HIV co-infection at 10.2% among PWID.[xxx]

Developing health education packages, IEC materials and guidelines for behaviour change communication for PWID on reducing the risk of transmission of hepatitis B and C is the first step in raising awareness about viral hepatitis. A component on prevention and management of viral hepatitis should be incorporated in training for health care workers, outreach workers and peer educators.

Service providers should ensure that PWID have access to evidence-informed information about the prevention and care of viral hepatitis as well as the available treatment options.

Like the other essential elements of the package, interventions on viral hepatitis should be integrated with other harm reduction, HIV prevention and general health and psychosocial services, preferably at the same site, or through referral.

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[3] Médecins Sans Frontières Hollande (MSF-H), programme data, Yangon, Kachin & Shan cohort, as presentedat the National Consultation on Hepatitis C in Yangon, 28 May 2014.

Hepatitis B

Hepatitis B is typically more prevalent among people who inject drugs than in the general population. WHO therefore recommends offering hepatitis B vaccination using the rapid vaccination regimen (PWID may be more likely to be able to adhere to a 21-day schedule than to the regular 6-month schedule).[xxxi]

Female sex workers and men who have sex with men are also at risk for HBV, and should be offered hepatitis B vaccination.

Hepatitis C

HCV screening of PWID, as a population with high prevalence of infection, is recommended by WHO as an integral component of a comprehensive package of harm reduction interventions.[xxxii] Screening must be voluntary. Pre- and post-test counselling should be provided by trained counsellors. Repeated screening is required in individuals at ongoing risk.

If positive, another test—a ribonucleic (RNA) assay—is needed to confirm chronic HCV infection. Genotyping and staging are required before treatment can be initiated.

People infected with HCV are at elevated risk of liver disease, and should be offered counselling on liver care and alcohol reduction strategies (for those with heavy alcohol consumption), as well as on safe injection for their own health and to reduce the risk of onward transmission.

People who test negative should be counselled on reducing their risk of infection, for example by adopting safe injecting practices.

Due to prohibitively high costs, hepatitis C treatment is not yet available in public settings in Myanmar. Limited numbers of HIV-HCV co-infected patients are accessing treatment through the private sector. One international NGO is planning to pilot treatment for a small number of co-infected patients. The Ministry of Health has not issued any national guidelines for hepatitis C.

Community service organizations, networks of key populations, government and private health professionals, international and local NGOs, development partners and UN agencies have acknowledged the need to increase access to hepatitis C treatment, and a number of approaches are being explored.

9. TB Care: Prevention, diagnosis and treatment of tuberculosis

Key actions

- Implement a TB infection control strategy and have a case-finding protocol for both TB and HIV
- Isoniazid preventive therapy should be accessible to drug users living with HIV
- Treatment for active TB
- Active referral pathways between TB treatment services and services for PWID, and integrated screening and testing programmes

People who inject drugs are at higher risk of TB infection than the general population. Facilities used by PWID should therefore implement measures for TB infection control. PWID accessing other harm reduction and HIV prevention services such as NSP, OST, STI and outreach, should be counselled to access HTC and TB screening. If these services are not available on site, clients should be referred to the nearest HTC site or TB clinic. Mainstream TB services should be accessible and responsive to the needs of PWID.

Isoniazid preventive therapy should be available to PWID who are living with HIV if active TB has been excluded.

Other issues

Women who inject drugs

Women who inject drugs tend to be more marginalized and face greater stigma and discrimination than male injectors. Experience in Myanmar suggests that women are reluctant to access harm reduction services as they tend to be delivered in male-dominated environments and due to fear of stigma and discrimination. Although women account for only a small percentage of PWID in Myanmar, in areas where there are women who inject drugs, efforts are needed to ensure that their specific needs are met, including BCC, needle and syringe programmes and OST, in a female-friendly environment. They also need to be linked with PMTCT, family planning and sexual & reproductive

health, post-abortion care, nutrition and child support services, gender violence response, and legal services. Service providers can work with health services to ensure that commodities (condoms, needles/syringes) and referrals are provided through PMTCT and SRH settings.

Young people

Socio-cultural factors, including religious beliefs on sex before marriage and denial of drug use in schools and universities, make it difficult for young PWID to access harm reduction services. Specific strategies should be designed to reach this population.

Overdose prevention & management

Overdose is one of the leading causes of death among drug users. In addition to IEC on preventing overdose, providers of harm reduction services could train outreach workers and peer educators as well as PWID, their partners and families to recognise overdose and perform resuscitation. Service providers should also consider procuring and providing training on administering Naloxone (as mentioned under 'Needle and syringe programmes'), particularly when it becomes more widely available in nasal spray form. Ideally, naloxone would be made available for use by peer education and outreach workers.

Prisons and closed settings

Given the illegal nature of drug use, people who inject drugs are often in contact or detained within the criminal justice system – by police, by courts and in prisons. Ensuring continuity of HIV prevention and OST services for PWID in closed settings such as prisons and other custodial contexts is essential. In Myanmar, drug users, including prisoners, can start drug treatment as an outpatient at a hospital.

INTEGRATION OF SERVICES

Please also refer to Chapter 2, 'Cross-cutting Issues'.

1. Strengthen linkages between harm reduction and other services needed by key populations

Clients of harm reduction services need to be linked to all the services that make up the 9 essential elements described above. They may also require linkage to other related services, including sexual and reproductive health, family planning and antenatal care. PWID also have specific needs, including psychological support and dental care.[4] For all of these services, accompanied referral, where clients attend a service with an outreach or peer worker, can improve uptake and outcomes by overcoming barriers associated with stigma and discrimination.

2. Create demand for harm reduction services

Information on the risks of injecting and unprotected sex, as well as promotion of the whole range of harm reduction services, should be routinely included in HIV prevention interventions for PWID, including BCC and condom programming, as well as through other clinical services as mentioned previously (ART, TB and maternal and child health services).

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[4] Opiates and methadone therapy suppress salivation, which increases dental care needs for people who inject drugs.

ENABLING ENVIRONMENT

Key components for a supportive harm reduction environment

Please also refer to Chapter 2, 'Cross-cutting Issues'.

Building a supportive legal and policy environment

In Myanmar, a challenge to the effectiveness of NSP is associated with enforcement of the Narcotic Drugs and Psychotropic Substances Law (1993). Under this law, compulsory drug treatment in Drug Treatment Centres operated by the Ministry of Health is required for those arrested for drug possession. There are ongoing legal review efforts to revise the law to make drug treatment voluntary, and not compulsory.

Police crackdowns on drug use are frequent and result in adverse consequences for people who inject drugs: disruption of service delivery; an increase in discarded injecting equipment; a decrease in the return of needles and syringes; and an increase in arrests of PWID or a perceived fear of arrest among PWID which places them out of reach or reluctant to access services and attend drop-in centres. This can prompt a relapse into drug use or a return to unsafe injecting behaviours.[xxxiii] There have also been reports of peer educators being arrested while distributing and collecting needles.

Law enforcement agencies, including police, are therefore key players in ensuring an enabling environment for the operation of NSP services. It is essential that NGOs delivering NSP work closely with law enforcement agencies to ensure that clients have ready access to services, and that possession of drugs (for personal use) and/or injecting equipment do not constitute an imprisonable offence. Similar assurances must be provided for outreach workers and local and other clinic staff. This can best be assured by strengthening the cooperation and coordination with local police, and encouraging police to consider the public health interest and use discretion in applying existing laws that hinder effective HIV programming, such as arrest for possession of condoms, needles or syringes.

Effective HIV prevention will be supported if health and law enforcement service providers have training on human rights, HIV information and the provision of non-discriminatory services. In addition, protective legislation, policies and guidelines need to be in place to ensure a

change in attitudes, values and behaviour amongst health and law enforcement personnel and the general public. Police should be supported to develop national and local guidelines in support of harm reduction approaches for police, health services and local communities.

Preventing and responding to violence

Violence or the fear of violence can act as a significant barrier to accessing HIV prevention services. PWID report experiencing violence (including sexual violence) in custody and in their dealings with the police. The illegal nature of drug use means that victims of violence are often reluctant to report it to authorities. Unfortunately, past experience of harassment or violence from law enforcement agencies reduces trust in the authorities.

Eliminating stigma and discrimination in healthcare settings

PWID often report stigma and discrimination in health care settings and an unwillingness to use services where this occurs. There are reports, for example, of PWID being asked to stop using drugs before they can access ART; and that HIV-infected PWID are not on the priority list to receive ART, partly due to the belief they will not adhere to the drug regimen.[xxxiv] Sensitising health care workers to the nature of drug dependency, the specific health needs of people who inject drugs and their right to health can help to reduce stigma and discrimination in service delivery.

Involvement and partnership of local communities in HIV prevention

Local communities may view the provision of sterile needles and syringes or methadone to PWID as encouraging drug use. To ensure support for harm reduction interventions it is important for service providers to take into consideration the views of family members and the local community. This includes consideration of the impact of drug use on relatives, their aspirations and expressed needs related to the daily problems they are facing.

Increased advocacy within the community, with the involvement and

participation of local law enforcement agencies, to demonstrate to affected families and members of the community the positive impact of harm reduction and needle and syringe programmes often helps to convince the community that these programmes can help re-integrate people who use drugs as productive members of society.

At the same time, involving drug users and local community members in monitoring and evaluating activities at the local level can increase community ownership of harm reduction programmes.

Creating a safe environment for staff

Service providers must put measures in place to ensure the personal safety of staff, including the provision of adequate protective clothing and equipment for people collecting and disposing of used needles and syringes; or access to post-exposure prophylaxis in case of accidental needle stick injuries. Outreach workers and peer educators should not be asked to work in an unsafe environment, for example where they could face legal consequences for carrying out programme activities, such as distributing needles or providing harm reduction information or condoms to young members of key populations.

Safe handling and disposal of needles and syringes

It is crucial to involve local community leaders in plans for NSP and to demonstrate to them the benefits of the harm reduction approach. Collection and safe disposal of used syringes is an essential element of this process, in part to ensure that local residents do not feel at risk of needle-stick injuries. Some NGOs have hotlines that people can call to report unsafe disposal of needles or seek advice for needle-stick injury. Consulting local communities on programme-related issues such as the location of disposal sites or incinerators, or involving them in the establishment of a hotline that citizens can call for clean up if they find a needle, could help to forge more constructive relations.

MEASURING PREVENTION

Systems should be in place to monitor the effectiveness and quality of harm reduction programmes, including uninterrupted supplies of commodities and OST drugs, safe disposal of needles and syringes, and ensuring that programmes meet the needs of PWID (including effective referrals). Programme impact on law enforcement and local communities should also be jointly monitored.

For NSP, changes in the local operating environment, such as changes in drug availability, emergence of new drugs and changes in policing approach, should be frequently monitored to ensure that service coverage remains optimal and responsive to the needs of PWID.

Operational research can assess barriers and facilitators to accessing harm reduction programmes and identify any weaknesses in the referral process and/or in linkages to services. Simple methods such as client surveys, suggestion boxes at drop-in centres and group discussion during outreach are also useful.

The indicators for reduction of drug-related harm in the National Monitoring & Evaluation Plan on HIV/AIDS are as follows:

- % of PWID who used sterile needles and syringes at last injection
- % of PWID reached with HIV prevention programmes
- Number of PWID reached with HIV prevention programmes (outreach)
- Number of PWID reached with HIV prevention programmes (drop-in centre)
- Number of sterile injecting equipment distributed to PWID in the last 12 months
- Number of PWID receiving methadone maintenance therapy
- Number of regular sexual partners of PWIDs reached with HIV prevention programmes

Indicators that require records of programmes providing services to key affected populations that are 'reached with HIV prevention programmes' should be defined as follows:

Reached for the first time within the calendar year through outreach intervention or through a health centre or drop-in centre with HIV intervention such as health education, STI treatment or HTC.

Additional focus areas for monitoring could include:

- Number of referrals to other services
  (especially HTC, NSP and OST), and whether clients accessed the services
- Partner counselling and HTC
- Retention on OST
- Client satisfaction

Additional references

- Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. WHO, 2014[xxxv]
- Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. WHO, 2012.[xxxvi]
- Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence. WHO, 2009.[xxxvii]
- The manual for reducing drug-related harm in Asia. Centre for Harm Reduction, Asia Harm Reduction Network, 2003.[xxxviii]
- Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar. Dept. of Health, Ministry of Health, The Republic of the Union of Myanmar, 2012.
- Guidance on counselling and testing for HIV in settings attended by people who inject drugs: Improving access to treatment, care and prevention. WHO, 2009.[xxxix]
- Guidelines for the screening, care and treatment of persons with hepatitis C infection. WHO, 2014.[xl]

Notes for the Reader

- ➔ Drug treatment is mentioned in the by-laws of the 1993 Narcotic and Psychotropic Substances Law.
- ➔ New Guidelines/SOP for Drug Treatment will be issued in 2014.
- ➔ Myanmar is working towards the nine core interventions of the comprehensive package for prevention, treatment and care of HIV amongst people who inject drugs.

5 HIV Testing & Counselling Services

Source : John Rae/Global Fund

5. HIV Testing and Counselling Services

HIV testing and counselling (HTC) provides an entry point to HIV prevention and continuum of care services.

> **Essential Elements of HIV Testing and Counselling**
> 1. Ensure free, confidential and consensual HIV testing and counselling in appropriate settings
> 2. Promote the need to 'know your HIV status'
> 3. Minimise barriers to HTC

HTC provides an entry point to HIV prevention in three key ways:

- Negative results can be used to reinforce prevention messages and highlight risk behaviour. People who test negative should be provided with information specific to their HIV risks, counselled on strategies to negotiate safe sex, and given access to condoms/sterile needles and syringes, etc. as appropriate.

- Positive results can be used to enable people to reduce the risk of transmitting HIV to others:

    - People who test positive are referred to HIV treatment services and initiated ART if indicated. This can reduce viral load and thus the risk of transmission of HIV to others.

    - People who test positive can be introduced to the concept of Positive Prevention (see below).

    - Positive results among pregnant women provide an entry point into programmes to prevent transmission of HIV from mother to child (PMTCT).

- PLHIV may be interviewed to identify which, if any, elements of the HIV prevention programme proved effective/ineffective, and what could be improved.

HTC can and should be provided through a variety of settings. All HTC services, however, must adhere to the following core principles:

Special Considerations for

HIV Testing and Counselling[xli]

- **Consent:** people receiving HTC must give informed consent, verbally or in writing. This includes being informed of the process for HTC and their right to decline testing. Mandatory or coerced testing is not supported.

- **Confidentiality:** the content of the discussion between the HTC provider and the client will not be disclosed without the consent of the person being tested. Clients should have access to HTC in settings that provide confidentiality and privacy.

- **Counselling:** HTC should include appropriate, high quality pre-test information and post-test counselling. Quality assurance, supervision and mentoring systems should be in place to ensure this. The use of well trained and supported peer and same sex counsellors is recommended.

- **Correct test results:** high quality testing services and quality assurance mechanisms should be in place to ensure provision of correct test results.

- **Connection and linkage to prevention, care and treatment:** this should include the provision of effective referrals to appropriate follow-up services, including long-term prevention and treatment.

ESSENTIAL ELEMENTS

1. Ensure free, confidential and consensual HIV testing and counselling in appropriate settings

Key Actions

- Provide consensual HIV testing
- Provide services during hours and in locations that are convenient
- Utilize professionally trained community counsellors
- Maintain confidentiality

Providing key populations with options from a range of models of HTC based on the five core principles (see 'Special Considerations') is fundamental to ensuring access. The use of rapid HIV diagnostic tests has also become an important strategy to decentralise and expand access to HTC, particularly in community settings.

At present in Myanmar some NGOs that have capacity (facilities, personnel and budget) are allowed to do HIV testing in their clinics and provide same-day results. This will become more widely available as more NGO staff access the HTC training offered by the NAP. Confirmation of the diagnosis is only done at the NAP's STI clinics.

As community-based testing is not yet widespread, ensuring access of key populations to facility-based HTC is essential. In Myanmar some services provide 'accompanied testing,' where a peer accompanies the client to a health facility or NGO for testing. The peer (who has been trained as a counsellor) then conducts the post-test counselling.

Effective partnerships between local public health and NGO/CBO facilities can also assist with access to rapid test kits and laboratory services, ensure that diagnostic facilities meet quality assurance standards and assist with training for community-based HTC counsellors.

HTC service delivery models

WHO recommends that countries offer a combination of approaches to HTC, using models that are appropriate for the nature of the HIV epidemic, acceptable, cost-effective and reach the communities most in need. There are two main approaches to HTC: provider-initiated testing and counselling (PITC), and client-initiated voluntary counselling and confidential testing (VCCT).

1. Provider-initiated testing and counselling (PITC)

PITC refers to HIV testing and counselling that is recommended by health care providers to people attending health care facilities as a standard component of medical care.

This requires that healthcare workers are aware of signs and symptoms of HIV together with a high index of suspicion (e.g. oral candidiasis indicative of HIV). History taking should include discussion about sex and drug use to identify possible HIV risk behaviour. All those who may have been exposed to HIV should be encouraged to undergo HTC. Healthcare workers need to be proactive, working on the principle of: if in doubt, refer for testing. Although PITC involves routinely offering HTC, people always have the option to decide against HTC. It should not develop into mandatory testing or testing people without first informing them.

Referral for PITC can be active, with members of key populations accompanied to the test location. Counselling and testing may be provided at the provider's facility or by referral to another HTC service.

2. Voluntary Counselling and Confidential Testing (VCCT)

VCCT (also called client-initiated HIV counselling and testing) is where individuals ask for HIV counselling and testing at a facility that offers these services.

VCCT usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. Voluntary HTC may be more acceptable to key populations at higher risk of HIV, especially if a trusted peer performs the counselling and testing.

2.1. Facility-based VCCT

This refers to HTC conducted in healthcare facilities, including in general medical practice, antenatal clinics and private clinics/laboratories, as well as in NGO clinics/drop-in centres.

2.2. Decentralised HTC

This refers to HTC conducted in facilities outside health institutions, through mobile services and in community-based settings. Community-based testing has the potential to reach key populations who do not usually attend health care facilities. There is evidence to suggest that community-based VCCT may also be an effective approach for offering HTC to the intimate partners of people living with and at higher risk of HIV.

In general, community-based HTC can achieve high HTC uptake rates and can reach HIV-positive individuals earlier, when they still have high CD4 counts. If they are promptly linked with treatment and care services, this can improve life expectancy and reduce HIV transmission at the population level. Evidence suggests that the level of linkage to care of community-based HTC is similar to that of facility-based HTC. WHO recommends that in all HIV epidemic settings, community-based HTC be adopted for key populations, with linkage to prevention, care and treatment services.

2. Promote the need to 'know your HIV status'

Key Actions

- Utilize peer outreach workers to create demand for HTC
- Provide clear IEC materials that have been tested with key affected populations

Regular discussion of HTC with key populations will, over time, build their capacity to make informed decisions about HTC. Reaching communities for this purpose may be easier where they can be approached as groups in locations such as drop-in centres or closed settings (prisoners). Harder to reach populations (e.g. men who have sex with men and people who inject drugs) may be reached by peer outreach workers and through networks and other organizations of key populations. IEC material such as brochures and posters may be helpful, but should be very clear, avoid jargon, and be field tested with target audiences

prior to printing and distribution. Normalizing HIV testing as part of an approach to healthier lifestyles can simplify promotion of testing to key populations.

Peer outreach strategies and IEC should be designed to increase uptake of partner testing.

Role of peer outreach workers

Peer outreach workers should be trained and tasked to:

- Provide information about HIV testing to clients
- Encourage clients to be tested for HIV
- Provide initial pre-test counselling for clients
- Accompany clients to HTC services
- Follow up as appropriate

Peer outreach sessions should be individualized, prioritizing one-on-one personal interaction, discussion and counselling. Counselling focuses on the benefits of testing, testing procedures and consequences of results. In services where PITC or decentralised HTC is available, health care workers also need to be trained to discuss HTC with key populations in a way that recognises their particular needs.

In partnership with key populations, campaigns to increase awareness about HTC and increase uptake should be undertaken in geographically prioritised areas. These need to emphasize the therapeutic and secondary prevention benefits of HIV treatment and address misperceptions about HIV testing and available HIV treatment and care options.[xlii]

3. Minimize barriers to HTC

Key Actions

- Involve communities in planning and implementing testing
- Establish linkages between testing facilities and volunteers and/or community organisations to facilitate the pre-counselling → testing → post-counselling → confirmation → treatment initiation process

To ensure that key populations are reached and feel confident to access HTC, structural, operational, logistic and social barriers—including stigma and discrimination—must be understood and

addressed. HTC should be arranged in such a way as to minimize these barriers, while providing necessary preparation for individuals to accept the test result.

These interventions are required at national as well as service delivery levels, and adequate resources should be budgeted for this work. Key populations need to be involved at all levels.

Many providers cannot give same day or same session results. This is a barrier to accessing HTC. Service providers also report a lack of access to testing commodities. It is thought that many people who want to know their HIV status are still accessing testing through the private sector, which is usually without counselling. These people may not be in contact with outreach workers and other follow-up services, and may therefore not be linked with the treatment they need.

Rapid Testing

The availability of HIV rapid diagnostic tests has opened up opportunities to expand community-based HTC. To increase access to HTC, WHO supports the use of rapid tests, including their use by specifically trained and supervised lay counsellors in some settings. Rigorous training, supportive supervision and quality assurance need to be in place to ensure the quality (i.e., the accuracy) of results.

Rapid test kits are not widely available in Myanmar but access will increase. Rapid testing is already being offered to key populations in a number of settings, including facility-based (heath services), community-based (drop-in-centres) and mobile/outreach services, as well as through the PMTCT programme. NGO staff can use rapid tests if they have been trained by the NAP and the National Health Laboratory (NHL).[5] HIV test results should be given on the same day, following one screening test if the result is negative; if the result is positive, a second screening test is conducted (for example, Determine followed by Stat-Pak), and then the client is given their result. Clients who test positive will be referred to an NAP facility or an NGO site that participates in the NHL's external quality assessment scheme for further confirmation of the result and linkage to care, treatment and support services.

....

[5] As specified in a memorandum from the National AIDS Programme on the Decentralisation of HIV Counselling and Testing by NGOs, dated 11 August, 2014

The use of rapid tests with same-day results limits opportunities for clients to drop out of the process, and thus increases the likelihood of retaining them in HIV care or prevention services.

Young People

Special consideration needs to be given to HTC services for young people from key populations. Myanmar HIV Sentinel Sero-surveillance Survey (HSS) data suggest that female sex workers and people who inject drugs aged 15 to 19 years are at substantial risk of HIV.[xliii] Although there is no law or policy that stipulates the age at which a young person can obtain an HIV test without their parent's consent, local or professional norms may require such young people to be accompanied by their parents or guardians for all medical interventions, including testing. The lack of clarity around the legal age of capacity to access HTC may act as an impediment to young people presenting for testing due to fear of disclosure of risk behaviour—including sexual activity, sexual orientation and illicit drug use—to parents or guardians.[xliv] Clear policies for such situations are needed, including disclosure of positive results. Accompanied referral and on-site support is particularly important, especially where services are not youth-friendly or are difficult to access due to cost, opening hours, etc.

Confidentiality

All HTC clients must be confident that HTC is totally confidential. HTC sites must ensure that procedures to protect confidentiality in handling of medical records and internal reporting are robust. All staff must be trained in confidentiality, including avoiding discussions of patient status that might be overheard; training should be regularly reinforced. All clinic staff, including peer support workers, must be trained and supported to avoid judgemental attitudes, and other stigma and discrimination. Identification of HTC sites can be challenging. If signage is too explicit, potential clients may not want to enter, particularly if the site is located in a public space. Some countries have developed standard logos to identify test centres.

Some clients who are concerned about confidentiality may opt to be tested in private clinics or laboratories. To avoid loss of patients to follow-up, it is essential that these sites are integrated into the national HIV reporting system, and are expected to provide appropriate referrals for clients who test positive.

INTEGRATION OF SERVICES

Please also refer to Chapter 2, 'Cross-cutting Issues'.

1. Strong linkages and effective follow-up to high quality prevention, treatment, care and support services

Strong linkages to other prevention, treatment, care and support services are required to meet the needs of people living with HIV and their partners. Testing services should ensure that all PLHIV are offered immediate and effective pre- and post-test counselling and follow-up, including referral to peer support, and HIV care and treatment. All PLHIV who are eligible should immediately be offered ART.

For those who test positive, post-test counselling should not be considered as a 'one-time' event; it is the start of a life-long process. People who have just been informed of their HIV-positive status rarely recall all the information provided during the first post-test counselling session.

Clients should immediately be referred to a trained peer support worker (a PLHIV who has come to terms with having HIV), and arrangements should be made for ongoing contact. At various stages this will need to address, among others: disclosure to partners or children, and encouragement for them to access counselling and testing; having children, including access to PMTCT for women; harm reduction services for PWID; treatment literacy and adherence; prophylaxis; nutrition; social welfare services; etc. Many of these topics are included in the concept of positive prevention. HTC services must also be able to immediately and effectively link positive clients to health services, including HIV treatment and care; family planning/SRH; TB screening, prevention and treatment; mental health and psychosocial support.

Accompanied referral, where clients attend a service with an outreach or peer worker, can improve the uptake and outcome of these other interventions.

Clients who test negative should be provided with information specific to individual risks, and counselled on strategies to negotiate safe sex, access to condoms, sterile needles and syringes, etc. as appropriate.

2. Positive prevention

Prevention programmes often focus primarily on those at risk of HIV infection. However, it is clear that all cases of HIV transmission involve a previously infected person. Considering this, it is appropriate that prevention efforts should acknowledge the vital role of PLHIV in preventing new infections. Various approaches to what is also called Positive Health, Dignity and Prevention[xlv] have been proposed. Positive prevention must be based upon human rights, and requires the establishment of a supportive environment that also addresses the quality of life of PLHIV, their right to sex and sexuality, and freedom from discrimination. This is a sensitive topic, as it is crucial that PLHIV are not made to feel responsible for the epidemic, yet are given the support they need to protect their own health and that of others.

Positive prevention strategies should aim to support and empower people living with HIV to stay physically and mentally healthy, to prevent further transmission of HIV and to engage actively in advocacy and leadership. A core principle of positive prevention is the meaningful involvement and engagement of individuals and networks of people living with HIV throughout all levels and stages of the design, implementation, monitoring and evaluation of programmes and activities.

ENABLING ENVIRONMENT

Key components for a supportive HIV testing and counselling environment

Please also refer to Chapter 2, 'Cross-cutting Issues'.

Decentralising HTC

The integration of HTC into antenatal care services—up to midwife level in some areas—in Myanmar demonstrates that decentralised and expanded HTC is possible. Increasing the uptake of HTC will require a further expansion and decentralisation of the service to a larger number of public, NGO and community-based sites, which in turn will require service providers to invest in promoting HTC to key popula-tions, for example through targeted, community-led awareness raising cam-paigns and by strengthening linkage and referral systems to ensure that providers of other services promote HIV testing. Service providers

may need to increase the number and skills of their human resources (counsellors, testing and lab staff), and ensure that they are supported by SOPs and job aids.

The NAP's guidance on HTC, including decentralised testing and protocols for confirmation tests, is being updated. A memo was issued in August 2014 supporting decentralized HTC.[xlvi] Decentralisation provides an opportunity for service providers to explore innovative approaches to HTC, including counselling and testing at transgender -friendly salons, places where PWID gather, etc.

Robust quality control systems should be in place at all sites. NGO sites can collaborate with local or regional NAP offices and the NHL on periodic quality control.

Involvement and partnership of communities

Community organizations and networks of key populations themselves can play an important role in creating a supportive environment for HTC by facilitating interaction between communities and health facilities and by sensitising health care workers to the needs of key populations. Communities can work in partnership with health facilities to ensure that key populations receive adequate counselling and support during the testing process. They can also generate demand for HTC by raising awareness among key populations about HIV-related services, including HTC; educating them about their legal and human rights, specifically their right to health;[xlvii] and empowering them to demand greater accountability with regard to health service delivery and access.

Supply chain management

CBOs, NGOs and organizations of key populations should be actively involved in supply chain planning and management for HTC. Service providers need to keep accurate records to support logistics management. HTC commodities include test kits and reagents, as well as other commodities that should be available to key populations as part of an integrated prevention programme, including condoms and lubricant, and sterile needles/syringes. Service providers should also foster partnerships between local NGO/CBO and public health facilities to help facilitate access to rapid test kits and laboratory services. Community groups can play an important role in monitoring distribution bottlenecks and stock outs at the local level.

MEASURING PREVENTION

The quality and acceptability of different models of HIV testing vary with the setting. To maximise uptake of HTC, it is important to assess how well different HTC models, individually or in combination, identify people with HIV and how well they link them to care, treatment and support services.

Effective M&E and operational research is recommended to ensure that efficiency, effectiveness, quality of care and acceptability of HTC are established and maintained. Operational research can assess barriers and facilitators to HTC access and identify any weaknesses in the referral process and/or in linkages to services. Simple methods such as client surveys, suggestion boxes, discussions among groups or at other gatherings at drop-in centres are also useful.

HTC indicators already defined in the National Monitoring & Evaluation Plan on HIV/AIDS:

- % of FSW who received an HIV test in the last 12 months and who know the result
- % of MSM who received an HIV test in the last 12 months and who know the result
- % of PWID who received an HIV test in the last 12 months and who know the result
- Number of people who received an HIV test in the last 12 months and who know the result

Additional focus areas for monitoring could include:

- Number of referrals to other services (especially confirmation tests and HIV care), and whether clients accessed the services
- Partner notification, counselling and testing
- Client satisfaction

Additional references

- Service Delivery approaches to HIV testing and counselling (HTC): a strategic HTC programme framework. WHO, 2013[xlviii]
- Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes. WHO, 2011[xlix]
- HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV. WHO, 2013[l]
- Myanmar National Monitoring and Evaluation Plan on HIV and AIDS 2011-2015.
- National Guidelines for HIV Counselling and Testing in Myanmar.

6 Sexually Transmitted Infection Diagnosis & Treatment Services

6.   Sexually Transmitted Infection Diagnosis and Treatment Services

Essential Elements of STI Diagnosis and Treatment

1. Promote access to STI services for key affected populations and people living with HIV
2. Provide STI testing and treatment in a variety of settings
3. Provide STI testing and treatment for symptomatic and asymptomatic infections
4. Provide services that are friendly, non-discriminatory, voluntary and confidential
5. Provide HIV prevention interventions through STI services

Untreated STIs can increase susceptibility to HIV as well as increase the rate of sexual transmission of HIV. As such, STI prevention, testing and treatment are key components of a comprehensive package of services for HIV prevention amongst key affected populations, and in particular for FSWs, MSM and TG.

To meet the needs of key populations, STI services should be readily accessible, affordable and client-friendly and must be linked to other components of the HIV prevention programme. STI information and BCC should also be included in HIV prevention interventions. As with HIV testing, community-based STI testing provides a means of extending coverage and providing comprehensive services to key populations.

To achieve coverage and ensure quality and effectiveness in reducing HIV, STI services should be implemented at scale, using systematic, standardised approaches. Government STI clinics and other STI services in the private sector (including NGOs) should have close linkages with HIV prevention services.

ESSENTIAL ELEMENTS

1. Promote access to STI services for key affected populations

Key Actions

- Provide information on how to access STI services
- Ensure service acceptability – location, operating hours, confidentiality, attitudes

Key populations are not a homogeneous group with respect to STI prevalence, social or behavioural factors, and require specifically tailored and targeted STI services. For many members of key populations in Myanmar, lack of information about where to find services is a significant barrier to access. Stigma associated with STI also often prevents people from using STI services.

Sex workers

Access for sex workers to STI services is a priority because of their generally high frequency of sexual encounters and the higher potential for transmission of STI associated with their work. Other factors contributing to the STI risk for sex workers include:

- Barriers to service access such as stigma and discrimination
- Mobility and migration
- Barriers to control over the occupational health and safety conditions of their work and to health service access.[li]

MSM

Although there are several sub-populations within the key population of men who have sex with men in Myanmar, ranging from transgender to married MSM, available data[lii] and regional experience suggests that overall, MSM have a higher prevalence of STIs than the general population. Other reasons for prioritising MSM are:

- Sexual practices with a higher HIV and STI risk
- Poor health seeking behaviour
- Barriers to service access such as stigma and discrimination

PWID

PWID and people who use drugs (PWUD), including those receiving drug dependence treatment, should have ready access to STI services. Syphilis prevalence of 1.5% among PWID aged 15-19 in Myanmar is a cause for concern, particularly with regard to the HIV risk.[liii]

Drug use and STI

Use of amphetamine-type stimulants (ATS), primarily in pill and crystalline forms (shabu shabu, yaba, yama, etc.) has also been linked to increased STI and HIV risk. It appears that transmission is mainly associated with sexual risk behaviours: sex workers have reported that ATS use enables them to serve more customers and engage in prolonged sexual activity, but it may reduce their ability to negotiate condom use effectively.[liv]

How to ensure access to STI services

- Clinics and other services should be in convenient or accessible locations. Mobile services can be used
- Opening hours need to be suitable for target populations, including adolescents
- Promote rapid testing: same-day service for diagnosis and treatment should be offered
- Services for key populations should be provided at low cost or free of charge for those who cannot pay.
- STI services should be promoted and their use normalised. STI management can be presented as regular preventative health care, rather than being associated only with illness and treatment. This involves:
  - Advocacy with gatekeepers such as managers of sex venues and brothel owners, in support of sex workers visiting STI services and for outreach of STI services to sex work sites;
  - Promotion of STI services to HIV and other health and programme staff working with key populations.
- Increase service acceptability by ensuring that clinic environments are welcoming and guarantee confidentiality and privacy. This is discussed further in the fourth Essential Element (Point 4 of this section).
- Periodically re-assess clinic acceptability amongst key populations, for example, by using patient satisfaction surveys.[lv]

2. Provide STI testing and treatment in a variety of settings

Key Action

- Ensure a range of options to meet the needs of key populations

In Myanmar, STI services are available through government health facilities, private sector clinics and not-for-profit organizations. Key populations in Myanmar currently mostly seek treatment from general practitioners and NGO clinics. Matching the settings and methods of

STI service delivery to the needs of key populations will enhance the contribution of STI services to HIV prevention. Services can be provided through:

- Government STI clinics
- Primary health care services and antenatal services
- Private clinics run by NGOs and others
- Community settings such as drop-in centres
- Mobile clinics
- General practitioners

3. Provide STI testing and treatment for symptomatic and asymptomatic infections

Key Actions

- Ensure that clinics have the capacity to address the specific needs of key populations
- Encourage testing and treatment for partners

Detailed technical information regarding STI testing and treatment is provided in the Myanmar National STI treatment guidelines[6] and WHO Guidelines for the Management of Sexually Transmitted Infections.

STI services must have adequate facilities and capacity for STI testing, diagnosis and treatment among key populations. This includes adequate time to address their needs, in addition to well trained staff, testing commodities, laboratory equipment and pharmaceutical supplies.

STI service providers must be sensitive to and knowledgeable about the specific health needs of MSM and transgender people, and in particular ensure that STI examinations address anal STIs.

Syndromic management

Screening provides an opportunity to detect and treat STIs early as well as provide risk reduction counselling and access to male and female condoms and lubricant.

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[6] Updated guidelines will be available by early 2015.

The current National STI Guidelines in Myanmar favour a syndromic management approach to STI; however, the National AIDS Programme has indicated a preference to expand access to etiological diagnosis (based on laboratory testing). This is in line with global guidance.

Etiological diagnosis

Some STIs exist without symptoms. For example, the vast majority of women and a significant proportion of men with chlamydial and/or gonococcal infections experience no symptoms at all. This can contribute to delayed treatment and hence higher prevalence.

Screening with laboratory tests for treatable STIs, either following possible exposure or at pre-specified intervals, aims to identify and treat asymptomatic infections that would otherwise not be detected.[lvi] This generally involves quarterly history taking, physical examination and simple laboratory diagnostics (where available).

It is recommended that a system be established for sex workers to be screened for STIs with laboratory tests at pre-determined intervals. Screening should also be encouraged for other key affected populations at regular intervals and following possible exposure such as condom failures.[lvii]

Partners

To enhance the effectiveness of STI management and its impact on HIV transmission, there is a need for systems to identify and treat partners. This includes contact tracing, testing, follow-up services for key populations, provision of health education and counselling for treatment adherence.

4. Provide services that are friendly, non-discriminatory, voluntary and confidential

Key Actions

- Support clinic staff to deliver respectful, sensitive services
- Make confidentiality a priority

Stigma associated with STI often prevents people from using STI services. Successful management of STIs requires members of staff to be respectful of patients and not judgemental. Services should also be

responsive to the needs of different key affected populations, including young people. This can be achieved through:

- Training and ongoing support to clinic staff at all levels to understand key populations and address their own attitudes and sensitivities.

- Staff training and implementation of Standard Precautions.

- Selection and/or rostering[7] of staff with suitable skills and approach. The clinical skills required to address the sexual health needs of key populations include sexual history taking, and the diagnosis and treatment of anal STIs.

Increasing provision of STI training for general practitioners.

Confidentiality is essential for key affected populations. Training for all staff on confidentiality, development of clinic confidentiality policies, attention to how client files are labelled and discrete signage for STI services and clinics are recommended. (This issue is dealt with in more detail in the 'Enabling Environment' section).

5. Provide HIV prevention interventions through STI services

Key Actions

- Integrate basic HIV prevention services with STI management

As well as STI diagnosis and treatment, STI services should be able to provide a core range of HIV prevention services. Services outside this basic range may be by referral. Additional services can also be added over time.

Basic HIV prevention services that should be provided are:

- HIV prevention information
- Male and female condoms and lubricant
- Sexual history taking
- Risk reduction counselling
- HIV testing and counselling (HTC)

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[7] The practice of allocating staff to particular duties and/or shifts to ensure consistently high quality and efficient care.

INTEGRATION OF SERVICES

Please also refer to Chapter 2, 'Cross-cutting Issues'.

1. Strengthen linkages between STI and other services needed by key populations

Clients of STI services whose HIV, SRH and other health needs, including family planning, human papillomavirus (HPV) services and cervical cancer prevention, cannot be met by the service should be referred to other facilities. As well as health services, referral by STI service staff to peer outreach workers can enhance treatment adherence and link key populations to other HIV prevention information and support. Accompanied referral, where clients attend a service with an outreach or peer worker, can improve the uptake and outcome of these other interventions.

Clinic staff need to be aware of the specific needs of key populations with regard to sexual health, particularly among men who have sex with men, transgender people and female sex workers, and provide respectful, non-judgmental services.

2. Create demand for STI services

Information on STI risks and treatment, as well as promotion of STI services, should be routinely included in HIV prevention interventions, including BCC, condom programming, and harm reduction, as well as through other clinical services such as ART, TB and maternal and child health services.

ENABLING ENVIRONMENT

Key components for a supportive environment for STI diagnosis and treatment

Eliminating stigma and discrimination in healthcare settings

Key populations frequently experience stigma and discrimination in health care settings, which can deter them from seeking treatment for STIs.

Please see Chapter 2, 'Cross-cutting Issues', for strategies to reduce stigma and discrimination and build a more supportive environment for accessing healthcare and other services.

Supply chain management

CBOs, NGOs and organizations of key populations should be actively involved, alongside the government, in all aspects of supply chain planning and management for STI and other HIV-related services. Service sites must have adequate storage facilities and record keeping systems in place for pharmaceuticals and commodities, including condoms. Community groups can play an important role in monitoring distribution bottlenecks and stock-outs at the local level.

MEASURING PREVENTION

Effective monitoring and periodic evaluation are recommended to ensure that the efficiency, effectiveness, quality of care and acceptability of STI services are established and maintained. Operational research can assess barriers and facilitators to accessing STI services and identify any weaknesses in the referral process and/or in linkages to services. Simple methods such as client surveys, suggestion boxes at clinics, and exit interviews after counselling, are also useful.

The National Monitoring & Evaluation Plan on HIV/AIDS defines the following indicator for STI:

- Number of people who received STI treatment in the last 12 months

Additional focus areas for monitoring could include:

- Number of referrals to other services (especially HIV testing & counselling), and whether clients accessed the services
- Partner notification
- Client satisfaction

Additional references

- **This document does not replace existing guidelines:** the Myanmar National STI Treatment Guidelines (2005) and the WHO Guidelines for the Management of Sexually Transmitted Infections (2003) provide detailed technical guidance on testing and treatment of STI. An updated version of the National STI Guidelines will be available at the beginning of 2015.

7 Monitoring & Evaluation

7.   Monitoring and Evaluation

Monitoring and evaluation provides implementers, programme managers, decision makers and donors with information to assess the extent to which programmes are being implemented and objectives and impact achieved. This information can demonstrate whether resources are being effectively employed, and inform the planning and design of future responses and resource allocation.[lviii]

This chapter outlines some of the key concepts and practice of M&E in Myanmar and considers approaches to measuring the relevance and effectiveness of the Core Package described in these Guidelines. M&E activities are guided by Myanmar's National M&E Plan[lix] which describes core indicators used to assess the performance and results of the national response to HIV and AIDS. The plan also illustrates the national M&E system and how this functions.

Monitoring

The National M&E Plan defines monitoring as 'the routine tracking of priority information about a programme/project, its inputs and intended outputs, outcomes and impacts.'

- **Inputs** are the financial, material and human resources invested to carry out programme interventions that contribute to the production of outputs, including funds, commodities, equipment, facilities and staff.

- **Outputs** are the results of programme interventions, such as the number of HIV counselling sessions completed, the number of health care providers trained, and the number of condoms distributed.

- **Outcomes** are the medium term effects of the outputs, such as changes in knowledge, attitudes, beliefs and behaviours (e.g., number of people who tested for HIV and receive test results or the number of people who used a condom at last sexual intercourse).

- **Impacts** are the longer term effects achieved through the implementation of programme interventions as for example a decline in the number of new infections, number of people living with HIV and number of AIDS related deaths.

Service providers use monitoring to regularly obtain strategic information on the performance of the programme interventions and progress towards the achievement of their objectives.

Evaluation

Evaluation, according to the National M&E Plan, is 'the rigorous, scientifically-based collection of information about programme/intervention activities, characteristics, and outcomes that determine the merit or worth of the programme/intervention.' Building on the findings from monitoring, evaluation provides information about whether or not a programme or intervention is achieving specific objectives, and why.[ix] It is carried out intermittently, usually before the start of a programme or intervention and at the end of it as well as in the middle of its course mid-term review or evaluation).

Both monitoring and evaluation are aimed at providing reliable strategic information that can help to identify lessons learned and best practices to improve performance and inform decisions on future strategies and resource allocation.

In Myanmar, the national M&E system works at central, state/regional, district/township and implementation/service delivery levels to collect, analyse and disseminate information on the national response to HIV and AIDS. All of the institutions involved with the national response are expected to contribute to the monitoring and evaluation functions and to do so in a concerted manner. There is a collective aim to create a single, well-coordinated M&E system to track inputs and outputs and to assess the outcomes and impacts of the national response.

Entities working at the district or township level are primarily responsible for monitoring programme inputs and outputs (including coverage), collecting and analysing the programme data, and reporting to the NAP through routine reporting on standard indicators described in the National M&E Plan.

Monitoring data are collected from service and programme records. Service providers assign a staff member to be responsible for overseeing the M&E activities and for ensuring the quality of the data collected.

Monitoring the provision of a package of services

Monitoring the provision of a 'package of services' for HIV prevention, with the features presented in the preceding chapters, is complex. The package consists of several types of services and it is difficult to assess how many members of key populations are benefitting from the full package for a number of reasons. First, not all service providers provide all elements of the package in the same place. For instance, an NGO may provide condoms and lubricant for MSM, but refer them to the NAP for HIV testing. Secondly, not all individuals may need the same services. Thirdly, they may need services at different points in time. National guidelines outlining the frequency with which different members of key population should receive a particular service, and the exact quantity of consumables (condoms, needles, etc.) they should obtain, still need to be developed.

In order to obtain information from service providers on whether a client has received various elements of the package, a 'unique identifier system' (UIS) is needed.

To track clients across a continuum of services and to avoid double-counting, each client should be given a unique identifier code or number, finger-print) etc. Such a system is important to distinguish between the number of clients accessing a service (clients reached) and the number of client contacts for that service (implementers will ideally see each client more than once to ensure a high quality of service). The unique identifier enables service providers to record how many times an individual client has received a particular service, without recording any personal information (name, government-issued ID number).

It is important that service providers keep clients' identifier and data confidential. They should not identify individuals in their records and databases as belonging to key populations as the information could end up with law enforcement agencies. To avoid deterring people from accessing services, registering in an UIS should be optional for clients. Clients should feel safe using the service, and maintaining their

privacy and confidentiality must be the most important consideration at all times.[lxi]

Many non-governmental service providers in Myanmar are already using a UIS. However, the systems used by different organizations are not identical or compatible. Hence, tracking an individual across different services, and determining what different services this person has received, remains a challenge and makes it difficult to monitor access to the full package of services. Alternative sources of information are behavioural surveillance surveys where respondents are asked if they have received different kind of services.

Until a standardised UIS is established, service providers are expected to report on the core prevention indicators presented at the end of Chapters 3 to 6 and described in detail in the National M&E Plan. Information on the coverage, outcomes and impact of interventions will also continue to be collected through behavioural surveillance surveys. At the same time, service providers are requested to strengthen their services by including to the fullest extent possible all elements of the core package for each HIV prevention intervention (for instance STI treatment, HIV testing and counselling). They also need to ensure sound, service provider initiated referral between services to ensure clients can access additional elements of the package from other service providers in the same geographical area.

Key populations are not homogenous. Service coverage, uptake and outcomes can vary widely, for example between women and men who inject drugs; between younger and older members of key populations; between TG people, male sex workers and other MSM; and between brothel-based and street-based sex workers. Where relevant, service providers should consider disaggregating data by sex, age group and sub-population to identify and address disparities in access to services.

Quality

The quality of an intervention can make a key difference to its impact. WHO suggests several dimensions of quality for interventions, including effectiveness, efficiency, accessibility, safety, and acceptability to the target group.[lxii]

To assess these qualitative as well as quantitative dimensions of service provision, service providers can collect additional information through different mechanisms. The additional information could include:

- Total number of BCC contacts per client (to assess the frequency of services received)
- Number of clients reached in drop-in centres vs. number of beneficiaries reached in outreach settings
- Referrals made to other service providers, and whether services were accessed by the referred client
- Number of partners notified/counselled/tested/referred
- Number of clients reached by each element of the package, disaggregated by key population (for instance number of FSW treated for STI; number of PWID accessing HTC), although due to confidentiality considerations – which must be paramount – this may not be possible in public health settings

This information can be collected through programme records and/or facility-based surveys, which can be used to assess not only quality but other aspects of the service, such as basic infrastructure, drugs, equipment, test kits, equipment, client registers, and trained staff. These assessments are typically small-scale and conducted through facility inventory review, health worker interviews, client exit interviews, and client-provider observations. The national M&E Plan notes that the NAP can provide technical guidance and quality assurance to implementing partners on carrying out facility-based surveys.

Changes in the local enabling environment, such as the enactment or repeal of local bylaws, establishment of community-led organisations/networks, establishment or closure of other services, etc. that impact the implementation of interventions, can also be monitored.

Analysis of this data can be used to improve service delivery at the site or service provider level. The data could also be aggregated at regional or national level to contribute to assessment of the overall quality of the programme.

National M&E Plan

More information can be found in the Myanmar National Monitoring and Evaluation Plan 2011-2015, which provides guidance on the coordinated collection, analysis and use of data and the provision of information to track and evaluate the progress made in the national HIV and AIDS response. Service providers should use this document as a reference for monitoring and evaluating HIV prevention interventions.

Additional references

- Myanmar National Monitoring and Evaluation Plan on HIV and AIDS 2011-2015.

- Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes. WHO, 2011[lxiii]

- Strategic Guidance for Evaluating HIV Prevention Programmes. UNAIDS, 2010

8 Glossary

8.   Glossary

Advocacy: a method and a process of influencing decision makers and public perception about issues of concern in order to make changes in policies, laws and practices. Advocacy can be used to change existing policies and laws and to make new ones. It can also be used to make sure policies are put into practice.

Behaviour change communication (BCC): BCC is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behaviour change. BCC employs a systematic process beginning with formative research and behaviour analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences are carefully segmented, messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioural objectives. Outreach workers can deliver BCC during HIV education sessions, in drop-in centres and other locations.

Burden of disease refers to the number of people currently infected with HIV.

Community: in these guidelines, this refers to populations of sex workers, men who have sex with men, transgender people and people who inject and use drugs, rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, 'outreach to the community' means outreach to key populations, 'community-led interventions' are interventions led by members of key populations, and 'community members' are sex workers, MSM or PWID.

Local community refers to the residents of a township or village, of which key populations may be a part.

Community-based organizations (CBO): civil society, non-profit organizations operating within single or multiple communities. There are many variations in terms of size and organizational structure. Some are formally incorporated, with a written constitution and a board of directors (or committee), while others are much smaller and are more informal.

The continuum of care: a strategy to organize and provide HIV care, treatment, and support services to support people affected by HIV throughout their lifetime. It involves a system of linked and coordinated prevention, treatment and impact mitigation, tailored to meet local needs and circumstances.

Epidemic potential refers to the likelihood of new HIV infections occurring among different populations in different geographic locations. Epidemic potential is heavily influenced by the size of key populations.

The health sector is wide ranging and encompasses organized public and private health services (including those for health promotion, disease prevention, diagnosis, treatment and care); health ministries; nongovernmental organizations; community groups; and professional associations; as well as institutions which have direct input into the health care system (e.g. the pharmaceutical industry and teaching institutions).

HIV testing and counselling: enables people with HIV to know their status and is the gateway to HIV prevention, treatment, care and support services. Testing must be voluntary: pre-test counselling provides accurate information about the test and the implications of a positive or negative result, so that the client can make an informed choice. Post-test counselling offers support and linkage to essential services for those who test positive. Those who test negative are put in contact with primary prevention programmes and encouraged to undergo regular retesting.

Key populations: the groups or individuals most at risk of either contracting HIV infection or passing it on. They are at risk because their behaviour or circumstances make them vulnerable to engaging in HIV risk behaviour (e.g. unprotected sex, use of contaminated injecting equipment). Identifying and working with key populations can reduce HIV incidence within that group as well as in the wider population.

Men who have sex with men (MSM): an inclusive public health term used to define the sexual behaviours of males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular 'community'. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male-to-male sex takes place.

Micro-planning uses a set of tools that allow outreach workers and peer educators to collect and use data about the target groups with whom they work. Workers update this information on a daily, weekly, monthly, or annual basis, depending on the tool. This information guides their outreach activities and supplies data to the management information system for monitoring and evaluating performance.

Peer outreach: trained peer educators undertake outreach to their peers aligned to the target populations. Outreach is an effective method of reaching key populations, who can often be difficult to access. For sex workers, peer outreach is undertaken in locations such as brothels, entertainment venues and street locations where soliciting takes place. For men who have sex with men, peer outreach takes place in locations where men meet other men for sex. For people who inject drugs, peer outreach is undertaken in locations where people meet up or inject drugs. Peer outreach is a key component of community empowerment. Formal peer outreach is usually delivered through drop-in centres and in formal outreach programmes. These peers are paid an allowance or salary. Informal peer outreach is delivered through the community social network by individuals or members of self-help groups in their neighbourhoods and at the places they go to for social or sexual contact, or to inject drugs. This is largely done by volunteers who do not get paid for their work.

Peer education: peer education can take many forms, including group activities and discussions and one-to-one interactions on a range of health-related issues, including HIV, that are relevant to key populations. These are led by a peer who is matched, either demographically or through risk behaviour, to members of key populations. Peer education is a key component of community empowerment.

People living with HIV (PLHIV): people who are living with (infected by) HIV, either knowingly or unknowingly.

People who use drugs (PWUD): people who use illicit drugs and misuse pharmaceutical and prescription drugs. Methods of administration may include inhaling, smoking, ingesting, inserting and injection.

People who inject drugs (PWID): people who use illicit drugs by injection. Sometimes limited to 'Current PWID', referring to those who have injected drugs in the last 12 months.

Prevention: making sure that people have the knowledge, attitudes and behaviours and resources to protect themselves from becoming infected by HIV or transmitting HIV to others. It includes a focus on the environment in which people live and work.

Risk: the probability or likelihood that a person may become infected with HIV.

Sex workers: Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.

Transgender people: Individuals whose gender identity and/or expression of their gender differ from social norms related to their gender of birth. The term transgender persons describes a wide range of identities, roles and experiences which can vary considerably from one culture to another.

Vulnerability: results from a range of factors outside the individual's control that reduce the ability of individuals and communities to avoid HIV risk. These may include lack of knowledge and skills; limited quality and coverage of services; and societal factors, such as human rights violations or social and cultural norms.

Bibliography

Bibliography

1. Australian Government Department of Health and Ageing: Second National Sexually Transmissible Infections Strategy 2010-2013.
2. Centre for Harm Reduction, Asia Harm Reduction Network: The manual for reducing drug-related harm in Asia, 2003.
3. Dept. of Health, Republic of the Union of Myanmar: Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar, 2012
4. Family Health International: Minimum Standards – Targeted STI Services. FHI Bangladesh.
5. GNP+: Positive Health, Dignity and Prevention, 2013.
6. Maher, L. et al: Amphetamine-type stimulant use and HIV/STI risk behaviour among young female sex workers in Phnom Penh, Cambodia. Int J Drug Policy, 2011 May; 22(3):203-9.
7. National AIDS Programme, Republic of the Union of Myanmar: National Guidelines for 100% Targeted Condom Promotion (100% TCP) Programme in Myanmar.
8. National AIDS Programme, Republic of the Union of Myanmar: Myanmar National Monitoring and Evaluation Plan on HIV and AIDS 2011-2015.
9. National AIDS Programme, Republic of the Union of Myanmar: HIV Sentinel Surveillance Survey Report, 2012.
10. National AIDS Programme, Republic of the Union of Myanmar: Global AIDS Response Progress Report – Myanmar, 2014.
11. UNAIDS: Strategic Guidance for Evaluating HIV Prevention Programmes, 2010.
12. UNAIDS: Situation Assessment on Drug Use, HIV and the Response in Myanmar: Looking Forward, 2014 – 2016, 2014 (unpublished document).
13. UNDP: Sex Work and Law in Asia and the Pacific, 2012.
14. UNFPA et al: The HIV and Sex Work Collection; Innovative responses in Asia and the Pacific; 2013.
15. UNFPA, et al: Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions, 2013.

16. **UNFPA, WHO, PATH: Condom Programming for HIV Prevention;** An Operational Manual for Programme Managers, 2005.
17. **UNFPA, WHO, PATH: Condom Programming for HIV Prevention; A** Manual for Service Providers, 2005.
18. WHO: Guidance on testing and counselling for HIV in settings attended by people who inject drugs: Improving access to treatment, care and prevention, 2009.
19. WHO: Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence, 2009.
20. WHO: Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes, 2011.
21. WHO: Guidance on prevention of viral hepatitis B and C among people who inject drugs, 2012.
22. WHO: Prevention and treatment of HIV and other sexually transmitted infections for sex-workers in low and middle-income countries; a public health approach, 2012.
23. WHO: HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV, 2013.
24. WHO: Service Delivery approaches to HIV testing and counselling (HTC): a strategic HTC programme framework, 2013.
25. WHO: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2014.
26. WHO: Guidelines for the screening, care and treatment of persons with hepatitis C infection, 2014.
27. **WHO, UNAIDS, GIZ, MSMGF, UNDP: Guidelines: prevention and** treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach, 2011.
28. **WHO, UNODC, UNAIDS: Technical guide for countries to set targets** for universal access to HIV prevention, treatment and care for injecting drug users, 2009.
29. **WHO, UNODC, UNAIDS: Technical guide for countries to set targets** for universal access to HIV prevention, treatment and care for injecting drug users, 2012.

Endnotes

i   In 2013, HIV prevalence among people who inject drugs was 18.7%; among men who have sex with men, 10.4%; and among female sex workers, 8.1% (GARP Report 2014).

ii   National AIDS Programme: Global AIDS Response Progress Report – Myanmar; 2014.

iii   Ibid

iv   Ibid

v   Ibid

vi   Ibid

vii   Ibid

viii   WHO: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations; 2014

x   Ibid

xi   WHO: Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users; 2012. Accessed at http://www.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf.

xii   WHO: Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach; 2011. Accessed at http://www.who.int/iris/bitstream/10665/44619/1/9789241501750_eng.pdf.

xiii   Ibid

xiv   National HIV Legal Review Report, August 2014

xv   National AIDS Programme: Global AIDS Response Progress Report - Myanmar 2012.

xvi   UNDP: Sex Work and Law in Asia and the Pacific; 2012. p 142. Accessed at http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf

xvii   UNFPA et al: The HIV and Sex Work Collection; Innovative responses in Asia and the Pacific; 2013. Accessed at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/20121212_HIV_SW.pdf

xviii   Accessed at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/condom_prog2.pdf

xix   Accessed at http://www.unfpa.org/webdav/site/global/shared/documents/publications/2005/condom_prog.pdf

xx   Accessed at http://www.who.int/iris/bitstream/10665/44619/1/ 9789241501750_eng.pdf

xxi   Accessed at http://www.who.int/iris/bitstream/10665/77745/1/ 9789241504744_

eng.pdf

xxii   Technical guide for countries to set targets for universal access to HIV prevention, **treatment and care for injecting drug users. Geneva, World Health Organization, United Nations Office on Drugs and Crime, UNAIDS 2009,** www.who.int/hiv/pub/idu/ targetsetting/en/index.html.

xxiii   **Endorsed by WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund and PEPFAR. Ibid, p. 10.**

xxiv   **WHO, UNODC, UNAIDS: Technical guide for countries to set targets for universal** access to HIV prevention, treatment and care for injecting drug users, 2012

xxv   National AIDS Programme: Global AIDS Response Progress Report - Myanmar 2012. p 22..

xxvi   Guidelines on Methadone Therapy and Treatment of Drug Dependence in **Myanmar, Dept. of Health, Ministry of Health, The Republic of the Union of Myanmar,** 2012.

xxvii   National AIDS Programme: Behavioural Surveillance Survey 2007-08

xxviii   **WHO, UNODC, UNAIDS: Technical guide for countries to set targets for universal** access to HIV prevention, treatment and care for injecting drug users, 2012

xxix   **Sai Ko Ko Zaw, et al. Prevalence of hepatitis C and B virus among patients infected** with HIV: a cross-sectional analysis of a large HIV care programme in Myanmar-Tropical Doctor. Published on June 25, 2013 as doi:10.1177/0049475513493416

xxx   **Sai Ko Ko Zaw, et al. Prevalence of hepatitis C and B virus among patients infected** with HIV: a cross-sectional analysis of a large HIV care programme in Myanmar-Tropical Doctor. Published on June 25, 2013 as doi:10.1177/0049475513493416

xxxi   WHO: Guidance on prevention of viral hepatitis B and C among people who inject drugs, 2012

xxii   WHO: Guidelines for the screening, care and treatment of persons with hepatitis C infection, 2014

xxxiii   **UNAIDS: Situational Analysis on Drug Use, HIV and the Response in Myanmar: Looking Forward 2014 – 2016, 2014 (unpublished).**

xxxiv   Ibid.

xxxv   WHO: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations; 2014

xxxvi   Accessed at http://www.who.int/iris/bitstream/10665/77969/1/ 9789241504379_ eng.pdf

xxxvii   Accessed at http://whqlibdoc.who.int/publications/2009/ 9789241547543_eng.pdf

xxxviii   Accessed at http://www.who.int/hiv/topics/harm/manual2003.pdf

xxxix   **Accessed at http://www.who.int/hiv/topics/idu/care/GuidanceTC_IDUsettings.pdf?ua=1**

xl   Accessed at http://apps.who.int/iris/bitstream/10665/111747/1/ 9789241548755_ eng.pdf?ua=1&ua=1

xli   WHO: Statement on HIV testing and counselling; 2012. Accessed at http://www. who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/index.html

xlii   Regional meeting on Community Based HIV Testing: Challenges and Opportunities 10 -11 October, 2013 Bangkok, Thailand. UNAIDS Regional Support Team, Asia and the Pacific, WHO Regional Offices (South-East Asia & Western Pacific Regions) in partnership with APN +, APNSW, ANPUD, APCOM, APTN, 7 Sisters, USAID, Regional Development Mission Asia and CDC Southeast Asia Regional Office

xliii   National AIDS Programme, Department of Health, Ministry of Health Myanmar: HIV Sentinel Surveillance Survey Report; 2012. Accessed at http://www.aidsdatahub.org/dmdocuments/HSS_2012_Myanmar.pdf

xliv   National HIV Legal Review Report, August 2014

xlv   GNP+: Positive Health, Dignity and Prevention; 2013. Accessed at http://www.gnpplus.net/assets/positive_health_dignity_and_prevention_operational_guidelines_-_unaids_gnp_2013.pdf

xlvi   National AIDS Programme. Decentralisation of HIV Counselling and Testing by NGOs. Memorandum, 11 August, 2014

xlvii   WHO: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations; 2014

xlviii   Accessed at http://www.who.int/entity/hiv/pub/vct/htc_framework/en/index.html

xlix   Accessed at http://whqlibdoc.who.int/publications/2011/9789241 501347_eng.pdf

l   Accessed at http://www.who.int/hiv/pub/guidelines/adolescents/en/index.html

li   Rates of STI amongst sex workers are low in some countries. This has largely been through the presence of supportive legislation and regulation, establishment of safe sex as a norm, the availability of safe sex equipment and community-driven health promotion and peer-based interventions. Sustaining this achievement requires continuing support of prevention initiatives. Australian Government Department of Health and Ageing: Second National Sexually Transmissible Infections Strategy 2010-2013 p 10. Accessed at http://www.ashm.org.au//images/second_national_sti%20strategy_2010-2013.pdf

lii   National AIDS Programme, Department of Health, Ministry of Health Myanmar: HIV Sentinel Sero-surveillance Survey Report, 2012 fig 10. Accessed at http://www.aidsdatahub.org/dmdocuments/HSS_2012_Myanmar.pdf

liii   National AIDS Programme, Department of Health, Ministry of Health Myanmar: HIV Sentinel Sero-surveillance Survey Report, 2012

liv   Maher, L. et al: Amphetamine-type stimulant use and HIV/STI risk behaviour among young female sex workers in Phnom Penh, Cambodia. Int J Drug Policy. 2011 May;22(3):203-9. Accessed at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3104095/pdf/nihms275631.pdf

lv   Adapted from UNFPA et al: Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva, World Health Organization, 2013. Accessed at

    http://apps.who.int/iris/bitstream/10665/90000/1/ 9789241506182_eng.pdf

lvi   WHO: Prevention and treatment of HIV and other sexually transmitted infections for sex-workers in low and middle-income countries; a public health approach; 2012. Accessed at http://www.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf

lvii   WHO: Prevention and treatment of HIV and other sexually transmitted infections for sex-workers in low and middle-income countries; a public health approach; 2012.

lviii   National AIDS Programme: Myanmar National Monitoring and Evaluation Plan on HIV and AIDS 2011-2015

lix   Ibid

lx   UNAIDS: Strategic Guidance for Evaluating HIV Prevention Programmes, 2010

lxi   Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva, World Health Organization, United Nations Office on Drugs and Crime, UNAIDS 2009, www.who.int/hiv/pub/idu/targetsetting/en/index.html.

lxii   WHO: Quality of care: a process for making strategic choices in health systems; 2006; WHO, UNODC, UNAIDS: Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, 2012

lxiii   Accessed at http://whqlibdoc.who.int/publications/2011/978924 1501347_eng.pdf