MYANMAR

NATIONAL STRATEGIC PLAN ON HIV AND AIDS

2006-2010

Executive Summary

The HIV epidemics in Myanmar remain largely concentrated among people identified with high-risk behaviours, in particular sex workers and their clients, injecting drug users and men having sex with men; and populations identified as highly vulnerable on the basis of their young age, gender, mobility and social or occupational characteristics. This focus of the epidemics calls for the urgent strengthening of prevention, care and treatment programmes addressing primarily the needs of these populations. The responses to the HIV epidemic to date have been diverse and great sources of learning, and demonstrated the capacity to respond to the HIV epidemic successfully in Myanmar, but are not being implemented to a scale sufficiently enough to address the epidemic or mitigate its impact.

Confronting an unabated HIV epidemic, the Government of Myanmar decided to embark on a comprehensive prevention, care and treatment strategy which would build on the experience and enrol the participation of all actors committed to this goal. Accordingly, this National Strategic Plan was the first in Myanmar developed using participatory processes, with direct involvement of all sectors involved in the national response to the HIV epidemic. Contributions were made by the Ministry of Health, several other government ministries, United Nations entities, local non-government organizations, international non-government organizations, people living with HIV and people from vulnerable groups. The National Strategic Plan 2006 – 2010 was prepared following a series of reviews which looked at the progress and experiences of activities during the first half of the decade. These included a mid-term review of the Joint Programme for HIV/AIDS in 2005 and a review of the National AIDS Programme in 2006, as well as many diverse studies and reviews of particular programmes and projects. The National Strategic Plan identifies what is now required to improve national and local responses, bring partners together to reinforce the effectiveness of all responses, and build more effective management, coordination, monitoring and evaluation mechanisms. It builds on current responses, identifies initiatives which are working and need to be scaled up to have maximum impact, builds on key principles which will underline the national response, outlines broadly the approaches to be used for prevention, treatment, care and support, and delineates strategic directions and activity areas to be further developed in order to mitigate the impact of the epidemic. Ambitious service delivery targets have been set, aiming towards 'Universal Access' to prevention and care services.

The National Strategic Plan is composed of two parts: Part One, presenting background information, aim, objectives, key principles, strategic directions, approaches and information on roles of participating entities and coordinating mechanisms; and Part Two, presenting, for each strategic direction activity area, outcomes, outputs, indicators and targets. The subsequent formulation of a Plan of Operations and accompanying budgets will translate key principles and broad directions set out in the strategic plan into a directly actionable and costed plan relevant to all aspects of the national response to HIV and to all partners in this unprecedented effort.

Building on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar, the National Strategic Plan identifies the key principles underpinning both the plan itself and

its future implementation. Among these are: the adherence to the "Three Ones" principles – One HIV and AIDS Action Framework; one National Coordinating Authority; and one Monitoring and Evaluation System – the participation of people living with HIV in every aspect and at every stage of the strategy, a primary emphasis on outcomes, defined as targeted behaviour changes and use of services; and a focus on the Township level with selected "Accelerated Townships" receiving support towards accelerated programme implementation. Key principles bring into focus populations at higher risk and vulnerability and with the greatest needs, ensuring that their needs are met to the maximum extent possible and that their participation in activities concerning them is secured. The development and implementation of an enabling environment is central to this approach, recognizing the negative effects that lack of information, inequality, discrimination and non-participation have on the reduction of HIV related risk and vulnerability. The strategy will strive to scale up programme coverage and use of services to the maximum achievable levels of resource availability and implementing capacity. It will build on evidence as strategic information guides decision and action and will achieve value for money as financial and other resources are incrementally mobilized and efficiently used. Working across sectors of government will gradually expand as capacity is built. The strategy will rely on collaboration between government and other public, private and non-government entities while mechanisms for coordination at the central and peripheral levels are enhanced.

The National Strategic Plan for Myanmar aims at reducing HIV transmission and HIV related morbidity, mortality, disability and social and economic impact. Its objectives are to: reduce HIV transmission and vulnerability, particularly among people at highest risk; improve the quality and length of life of people living with HIV through treatment, care and support; and mitigate the social, cultural and economic impacts of the epidemic.

Strategic directions are primarily defined on the basis of beneficiary populations. They include the reduction of HIV-related risk, vulnerability and impact among sex workers and their clients, men who have sex with men, drug users, partners and families of people living with HIV, institutionalized populations, mobile populations, uniformed services personnel, young people, individuals in the workplace and, more generally, men and women of reproductive age. They strive to meet the needs of people living with HIV for comprehensive care, support and treatment through the scaling up of services and use of a participatory approach. In order to expand the ability of all actors to engage fully in this collaborative effort, strategic directions also include the enhancement of the capacity of health systems and the strengthening of comprehensive monitoring and evaluation mechanisms.

This National Strategic Plan is a living document: it lends itself to adjustments and revisions as further experience is gained, resources are mobilized and evidence of success and shortcomings is generated through monitoring, special studies and mid-term and end-of-term evaluations.

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Myanmar National Strategic Plan on HIV and AIDS 2006-2010

PART ONE

Guiding Vision, Key Principles and Approaches

SITUATION ANALYSIS

National epidemiological situation

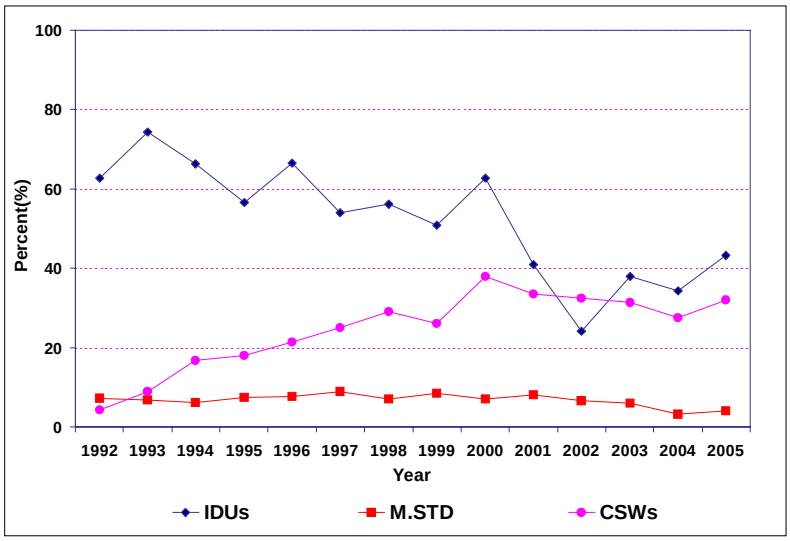
Surveillance of HIV and AIDS began in 1985. The first comprehensive surveillance system was developed in 1992, including surveillance amongst blood donors and AIDS reporting by health facilities. The first person with HIV infection was diagnosed in 1988, and the first person with AIDS diagnosed in 1991. Biennial HIV sentinel surveillance among different population groups began in 1992, along with the HIV surveillance among blood donors and AIDS case surveillance as reported by health facilities.

HIV sentinel surveillance has gradually expanded since that time to include 31 sites across all States and Divisions. Sampling has focused on urban and institutional based populations. Populations sampled for HIV sentinel surveillance include injecting drug users, sex workers, male and female patients with sexually transmitted diseases, pregnant women, blood donors and military recruits. New tuberculosis patients were included in sentinel surveillance from 2005. Each year, about 20,000 individuals are tested for HIV under the sentinel surveillance scheme and since 2003, a sub-sample of nearly 10,000 women and men is surveyed for HIV and STD related risk behaviours[1].

The Union of Myanmar has a population of 54.3 million. In 2004, a workshop organized by the National AIDS Programme, WHO and UNAIDS estimated that nearly 339,000 adults (15 to 49 years) were infected with HIV, representing 1.3 percent of the population. Incidence of HIV is estimated to be around 25,000 newly acquired infections each year[2].

Official surveillance data from 2004 show a slight decrease in rates of HIV infection among high-risk groups, but seemingly ascending trends between 2004 and 2005, as illustrated in Figure 1. By 2005, HIV prevalence in male

Figure 1. Trends in HIV Prevalence in various populations,1992-2005



[1] Behavioural Surveillance Survey 2003: General population and youth, National AIDS Control Programme, Ministry of Health, 2005

[2] Demographic impact analysis report, NAP/WHO/UNAIDS, 2005

clients of STI clinics was 4.07%, sex workers 31.98% and injecting drug users 43.24%. A decrease was reported between 2003 and 2005 in donated blood (0.73%) and new military recruits (1.33%) testing positive, while there was a decrease within pregnant women attending ante-natal care between 2004 and 2005 (1.32%). Recent trends need to be confirmed over time and other factors, like considerable geographical variation, especially between rural and urban areas, need further exploration.

One finding of concern in the pattern of HIV infection is that it is spreading significantly among younger people. Data from 2002 suggest that in some areas up to 1.8 percent of young people aged 15-24 are living with HIV.[1] Myanmar is one of the few countries in Asia able to report on HIV prevalence in groups at higher risk by age, and data reveal an important proportion of youth at risk: in 2003 the highest prevalence among commercial sex workers and injecting drug users was in young people under the age of 25.

Based on AIDS case reporting in 2005, it has been estimated that 67 percent of cases were attributable to sexual transmission, and 30 percent to injecting drug use. Three percent of cases may be attributed to vertical transmission and transmission through the blood supply or through unsafe injection practices. While transmission patterns need to be verified and updated, these data nevertheless indicate an epidemic driven by commercial sex and injecting drug use. After initial outbreaks among injecting drug users in the 1990s, HIV rates have risen rapidly among heterosexual men and women, while concerns exist about prevalence among men who have sex with men. Last available HIV prevalence data on men who have sex with men was 33.3 percent in 1996.

HIV and tuberculosis (TB) combine their effects as a dual epidemic of increased concern in Myanmar. It is estimated that approximately seven percent of adult TB patients are also co-infected with HIV. TB is reported to be the leading opportunistic infection in people living with HIV, with nearly 70 percent developing nearly active tuberculosis at some point of time. Formal structures for cooperation between TB and HIV programmes have been established and are currently active. Pilot projects are also contributing to programmatic learning. Access to voluntary and confidential counselling and testing for people with TB is a key intervention but is not offered in most areas. Strong informal mechanisms for co-management of people living with both diseases have emerged in some townships.

Overall, the HIV epidemics in Myanmar remain largely concentrated among people identified with high risk behaviours. This focus of the epidemics calls for the urgent strengthening of prevention, care and treatment programmes addressing the needs of those populations.

National response to the HIV epidemic

The national response to the HIV epidemic commenced in the mid-1980s. A multisectoral National AIDS Committee chaired by the Minister of Health was established in 1989 and a short term plan for the prevention of HIV transmission was launched in that same year.

The latest strategic plan on AIDS of the Government of the Union of Myanmar covered the period 2001-2005. In 2002, the United Nations developed the Joint Programme for HIV/AIDS Myanmar 2003-2005 to support the national response. Resources were mobilized to fund activities bilaterally, multi-laterally and through a $26 million multi-year pooled funding mechanism: the Fund for HIV/AIDS in Myanmar. The Fund provided resources to government, United Nations and non-government partners to carry out activities. From 2000 until 2005, activities in nearly all the major areas of HIV and AIDS programming were initiated in at least pilot sites, and some areas saw significant expansion. As an indication of programming volume, it was estimated that $18 million had been spent in 2004 by all governmental and non-government entities in Myanmar on HIV and AIDS activities.

[1] Myanmar report to the United Nations General Assembly Special Session on HIV/AIDS, 2002

This multi-sectoral National Strategic Plan 2006 – 2010 was prepared following a series of reviews which looked at the progress and experiences of activities during the first half of the decade. These included a mid-term review of the Joint Programme for HIV/AIDS in 2005[1] and a review of the National AIDS Programme in 2006[2], as well as many diverse studies and reviews of particular programmes and projects.

The magnitude of the epidemic had been recognized and the efforts to respond to it had indicated strong commitments of many partners to focus prevention, care and support efforts on the most vulnerable populations. Government, international and national non-government and private entities had contributed to the national response. The National AIDS Programme had successfully coordinated the inputs of national and international partners, and tools and technical guidelines had been produced for a broad range of programme components. Surveillance, monitoring and management systems were in place.

The 2006 review of the National AIDS Programme noted the need for improved mobilization of human resources, including the need to: expand the number of AIDS/STD Teams to cover all priority districts; strengthen local AIDS committees as forums to adapt national policies and programmes to local situations; and strengthen the health sector's response with an enhanced focus on the Township level. It also noted that people living with HIV were increasingly involved in the response, and that this involvement should be further developed.

There had been an incremental increase in prevention efforts, especially those focusing on condom promotion for sex workers and their clients, with the 100% Targeted Condom Promotion programme having expanded from four sites in 2001 to 170 sites in 2006; and on drug users, with various elements of a harm reduction strategy implemented in several regions and gradually improving collaboration between HIV programme implementers and police, leading to an improved enabling environment. Some effective interventions were in place for mobile populations, the blood safety programme had made good progress, and HIV education was occurring for youth in schools. Voluntary counselling and testing services were available in 45 AIDS/STD clinics across the country; care, support and treatment were gradually being made available, including provision of antiretroviral therapies and a Prevention of Mother to Child Transmission programme; and home based care had been rapidly scaled up in many locations in recent years.

However, the review also noted that the national response needed to become more sensitive to specific local needs. Further limitations included a lack of availability of a full range of services for a continuum of care in each area, a low number of people receiving antiretroviral therapy with an estimate of only 4 percent coverage of those in need at the end of 2005, programmes for injecting drug users and men who have sex with men not occurring on a sufficient scale to produce significant impact, and a scarcity of local community based organizations and relatively low participation of concerned communities, including people living with HIV in local contexts. Stigma and discrimination had been addressed, but further efforts were needed.

[1] Joint Programme for HIV/AIDS Myanmar 2003-2005: Findings and recommendations of the review team, 2005

[2] Review of the Myanmar National AIDS Programme, WHO, 2006

NEED FOR AND PURPOSE OF THE NATIONAL STRATEGIC PLAN

The responses to the HIV epidemic to date have been diverse and great sources of learning, and demonstrate that there is capacity to respond to the HIV epidemic successfully in Myanmar, but are not being implemented to a scale sufficiently enough to address the epidemic or mitigate its impact. This National Strategic Plan identifies what is now required to improve national and local responses, bring partners together to reinforce the effectiveness of all responses, and build more effective management, coordination, monitoring and evaluation mechanisms.

In accord with the global United Nations Declaration of Commitment on AIDS, the National Strategic Plan builds on current responses, identifies initiatives which are working and need to be scaled up to have maximum impact, builds on key principles which will underline the national response over the next five years, outlines broadly the approaches to be used for prevention, treatment, care and support, and delineates strategic directions and activity areas to be further developed in order to mitigate the impact of the epidemic. Ambitious service delivery targets have been set, aiming towards 'Universal Access' to prevention and care services.

Confronting an unabated HIV epidemic, the Government of Myanmar decided to embark on a comprehensive prevention, care and treatment strategy which would build on the experience and enrol the participation of all actors committed to this goal.

DEVELOPMENT OF THIS STRATEGIC PLAN

This National Strategic Plan was the first in Myanmar developed using participatory processes, with direct involvement of all sectors involved in the national response to the HIV epidemic. Contributions were made by the Ministry of Health, several other government ministries, United Nations entities, local non-government organizations, international non-government organizations, people living with HIV and people from vulnerable groups.

In a staged process, initial workshops were followed by specific workshops to formulate various components of the strategic plan, with an initial emphasis on projected outcomes (i.e. changes in behaviours and practices) and corresponding outputs (i.e. deliverables required to attain the identified outcomes). A Steering Committee chaired by the Director General of the Department of Health oversaw the entire process. A National Consensus Workshop in May 2006, with participation of more than 100 key partners in the national response, considered priorities and targets. The final strategic plan was reviewed and then endorsed by the Ministry of Health.

This Strategy is inspired by key principles borne out of experience in responding to HIV in Myanmar. It outlines what will be required for a more comprehensive and coordinated response, and identifies roles for different agencies and different sectors. At the outset of the planning process, key principles were formulated on the basis of national and international experience and best practice in responding to HIV. Importantly, these principles respond to findings arising from several recent programme reviews in Myanmar and address new challenges, in particular the need for rapid scaling up of what already works. These are summarized in Box 1 and further elaborated in Annex I.

Two of these principles were particularly relevant to the formulation of the strategic plan, including: (1) the priority attention it devotes to populations at higher risk of HIV infection, ensuring that the strategic plan is driven primarily by the specific needs and capacities of these populations; and (2) the use of expected outcomes (i.e. expected changes in behaviours and practices) as beacons orienting all activities subsumed in the Strategic Plan and the iterative "rolling" Plans of Operations which will be sequentially formulated during the life of the programme. Inspired by the key principles, specific strategic directions relevant to populations at higher risk, corresponding activity areas and expected outcomes were spelt out to serve as the starting point of the planning process. Approaches applicable to prevention, care, support, treatment and impact mitigation, and to the creation of the required implementing capacity, were then elaborated as a means to define the boundaries of the strategy and to inform priority setting. For each expected outcome, necessary outputs (i.e. key activities delivered in order to achieve these outcomes) were then formulated. Specific activities, targets and indicators suitable to provide a direction and monitor progress towards 'Universal Access' to prevention and care services were identified for selected outputs and outcomes recognized as the most critical products of the strategy. These elements of the National Strategic Plan will be further extended to specific activities in a forthcoming Operational Plan. Once at an advanced stage of development, the strategic plan was then structured as follows:

- **Part One:** Presenting background information, aim, objectives, key principles, strategic directions, approaches and information on roles of participating entities and coordinating mechanisms;

- **Part Two:** Presenting, for each strategic direction activity area, outcomes, outputs, indicators and targets.

The subsequent formulation of a Plan of Operations and accompanying budgets will translate key principles and broad directions set out in the Strategic Plan into a directly actionable and costed plan relevant to all aspects of the national response to HIV and to all partners in this unprecedented effort.

Box 1. KEY PRINCIPLES UNDERLYING ALL STRATEGIES

This National Strategic Plan identifies the following key principles as essential to ensuring a more effective national response to the HIV epidemic. These principles build on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar. The key principles will underpin more effective national and local responses to the challenges of meeting the objectives of this strategic plan. They are described in more detail in *Annex 1* to Part One of this National Strategic Plan.

1. The "Three Ones" principles will be adhered to: One HIV and AIDS Action Framework; one National Coordinating Authority; and one Monitoring and Evaluation System.
2. Participation of people living with HIV: they should participate in every aspect and at every stage of the programme.
3. Emphasis on programme outcome: the strategy will emphasise targeted behaviour changes and use of services.
4. Scaling up: programme coverage and use of services will be expanded at the maximum achievable pace.
5. Accelerated Townships: selected townships will receive support towards accelerated programme implementation.
6. Population focus: supporting key populations at higher risk and vulnerability and with the greatest needs.
7. Participation: vulnerable people and local communities will participate in programme design, development and implementation.
8. Enabling environment: the strategy will foster enabling environments conducive to an effective response to HIV.
9. Building on evidence: strategic information will guide decision and action.
10. Value for money: financial and other resources will be incrementally mobilized and efficiently used.
11. A multisectoral response to HIV: working across sectors of government will gradually expand as capacity is built.
12. Partnerships: the strategy will rely on collaboration between government and other public, private and non-government entities
13. Effective Coordination: mechanisms for coordination on the central and peripheral levels will be enhanced.

AIM

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

OBJECTIVES

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

STRATEGIC DIRECTIONS

The strategy identifies thirteen strategic directions to address the most pressing needs of populations at higher risk and the essential enhancement of the capacity of health systems to help respond to these needs. In Part Two of the strategic plan target populations, implementing partners and activity areas, each with planned outputs and outcomes, are presented in a tabular form for each strategic direction. Within each activity area, specific activities will be planned, prioritized and costed in successive rolling Plans of Operations covering 2-3 year periods.

Strategic directions 1-11 are population focused. Strategic directions 12 and 13 are intended to create or further expand national capacity to formulate, implement, monitor and evaluate the strategic plan, update it as required and account for its achievements.

Strategic Directions: Focus on populations at higher risk and on essential support services

1. Reducing HIV-related risk, vulnerability and impact among sex workers and their clients
2. Reducing HIV-related risk, vulnerability and impact among men who have sex with men
3. Reducing HIV-related risk, vulnerability and impact among drug users
4. Reducing HIV-related risk, vulnerability and impact among partners and families of people living with HIV
5. Reducing HIV-related risk, vulnerability and impact among institutionalized populations
6. Reducing HIV-related risk, vulnerability and impact among mobile populations
7. Reducing HIV-related risk, vulnerability and impact among uniformed services personnel
8. Reducing HIV-related risk, vulnerability and impact among young people
9. Enhancing prevention, care, treatment and support in the workplace
10. Enhancing HIV prevention among men and women of reproductive age
11. Meeting needs of people living with HIV for Comprehensive Care, Support and Treatment
12. Enhancing the capacity of health systems
13. Monitoring and Evaluating

APPROACHES

Approaches embodied in the National Strategic Plan add a focus of action to all strategic directions. They aim at reducing HIV-related vulnerability, risk and impact in an effort to minimize inequalities in access to information, education and services as they relate to gender, urban vs. rural location, mobile vs. sedentary status, and other important economic, social and cultural factors which may affect individual and collective capacity to respond to the epidemics.

Primary attention and resources will be directed to building capacity and enhancing resilience among populations at highest risk and vulnerability, and to those facing the most severe impacts of the HIV epidemic. Community based activities will aim to reduce stigma and discrimination towards people infected and affected by HIV and towards those whose behaviours are perceived as being associated with HIV infection. In particular, initiatives will aim to reduce stigma and discrimination against sex workers, injecting drug users, and men who have sex with men, thereby ensuring that all these populations can play a central role in curbing the course of HIV and mitigating its impacts. Building on evidence generated through implementation of the National Strategic Plan, sound public health policies and practices will provide a framework for the design of focused approaches suited to specific populations.

Approach to prevention

Prevention of further HIV transmission will be based on recognition that there are three groups of people with differing levels of risk and needs (see also Annex 1, Section 6). Individuals included in these three broadly defined groups are not characterized by permanent levels of risk of acquiring HIV infection. Rather, individuals may move over time from one population group to another depending on events affecting their life (for example the need to secure a source of livelihood), the extent and quality of prevention to which they have access (resulting, for example in the adoption of safer behaviours and practices), or situations which may develop without their knowledge or intent (for example, due to being unaware of the concurrent sexual relationships of their spouses or partners).

Both the level of individual risk and the size of the population with which each individual is identified will determine the level of efforts and resources that will be needed to reach each individual with required information, support and services. Figure 2 is a schematic representation of this concept, without attempting exact quantification of risk or size of each identified population group.

For reasons of strategic simplicity, the National Strategic Plan recognizes the following three levels of risk and vulnerability:

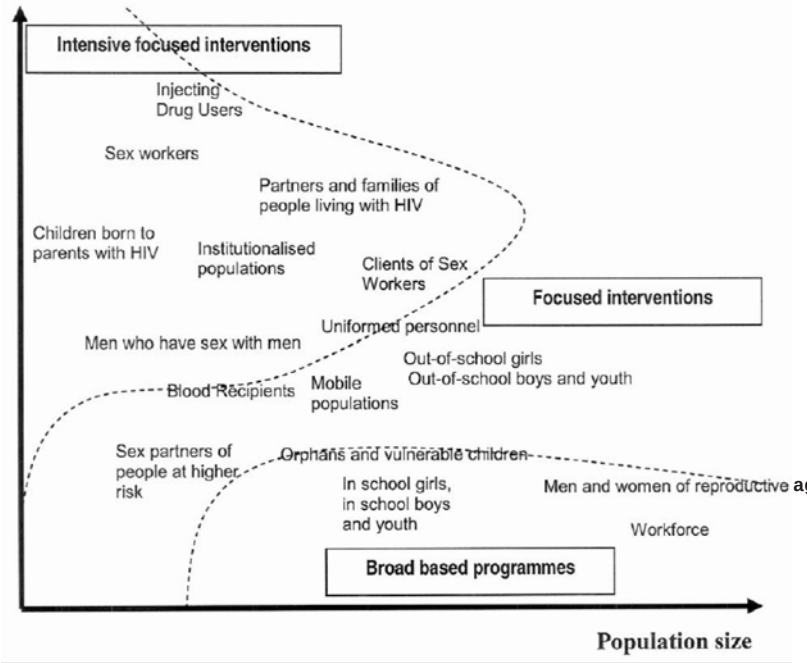
- Key populations at higher risk of acquiring HIV infection – those identified with behaviours or situations which engender higher than average prevalence of HIV (>5%) and who do not yet practise preventive behaviours consistently. These populations include sex workers and their clients, injecting drug users, men who have sex with men, regular sexual partners of people living with HIV, incarcerated or otherwise institutionalized populations and children born to HIV-infected parents. These populations are of primary concern as the extent and quality of support extended to facilitate their behaviour change are likely to be key determinants of the course of the HIV epidemics in Myanmar. Prevention focusing on these populations will be the utmost priority and will rely on high-intensity, sustained and focused interventions.

- Populations vulnerable to risk of HIV infection (1-5% HIV prevalence) – those who, for economic, social or cultural reasons are most likely to engage in risk-taking behaviours or be exposed to risk-generating situations in the near future. These populations include children and youth out of school, mobile populations and uniformed personnel, orphans and other vulnerable children. At the second level of priority, prevention focusing on these populations will include awareness raising, skills building through a combination of health and social programmes, vulnerability reduction through various means, and measures to ensure blood safety. Blood recipients are currently at low risk of infection, but efforts to protect the blood supply will continue to strive towards further minimizing this risk.

- Populations at lower risk of HIV infection (<1% HIV prevalence) – people displaying lower incidence of HIV and other sexually transmitted infections, who do not engage in HIV-related risk behaviours and who are not exposed to risk-taking situations. These people need to recognize the nature of HIV transmission and contribute to the collective response to the epidemic, as an essential component of developing an enabling environment. These populations include women and men in stable, monogamous relationships, in-school children and youth who have not yet experienced sexual activity, and women, men, boys and girls who consistently practise effective HIV prevention behaviours. Prevention for these populations will emphasize risk awareness and the introduction and reinforcement of protective behaviours through broad based information, education and access to prevention services. Prevention focusing on these populations will be considered as the third priority.

Figure 2. Schematic representation of combined vulnerability, risk and population size determining the type and magnitude of prevention efforts

This is a schematic representation only. Exact population size, vulnerability and risk of each group has not been quantified, and will be reviewed throughout the period of implementation of the National Strategic Plan.



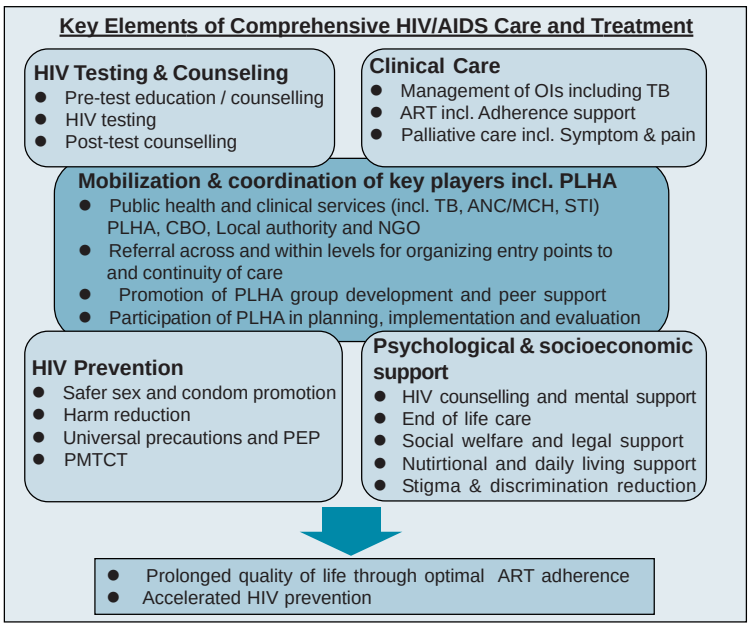
Approach to treatment, care and support

Services will be provided to those who are already infected and to their families, especially their children. Throughout the course of HIV infection, people living with HIV and AIDS will face a number of consequences of HIV infection including health problems (opportunistic infection and cancers), mental health issues (psychological distress), economic consequences (inability to work and cost of health care leading to poverty and food neediness), social and legal consequences (stigma, discrimination and other forms of negative social consequences), disability and premature death.(Figure 3).

The key health sector activities required to develop comprehensive HIV and AIDS care include:

- Clinical care: Diagnosis of HIV infection; prophylaxis and management of opportunistic infections including tuberculosis; symptomatic and palliative care; antiretroviral therapy; universal precautions and post-exposure prophylaxis; and prevention of mother to child transmission of HIV;
- Support: Counselling; psychosocial and financial support; support for caregivers and children affected by HIV and AIDS; reduction of stigma and discrimination;

Figure 3. Key elements of Comprehensive HIV/AIDS Care and Treatment



HIV and AIDS care will focus not only on medical care but will require a wide range of services including psychological, social and legal support in a context of supportive and enabling environments. Developing comprehensive care, treatment and support will require building on the experience accumulated in Myanmar in planning, capacity building, coordination, referral and monitoring. Broad based mobilization of the community and organizations working outside the health sector will be needed for comprehensive care to develop and be sustained.

- Health promotion and education: Information and education for people living with HIV and AIDS and their families about HIV and HIV care, in particular self-care and community-based care; nutrition; prevention of further HIV transmission; and family planning.

The above activities will necessitate a close interaction between the National AIDS Programme and partners engaged in related domains, in particular Tuberculosis and Reproductive Health. Close interaction with

other health initiatives (such as Malaria) will foster valuable exchange of experience across institutions and among staff engaged in health initiatives with strong community based components.

Outside the formal government-sponsored health sector, the participation of key actors will be supported, in particular:

- Local and international non-government organizations which have already engaged in treatment, care and support activities and will now expand their outreach, especially in rural areas;
- Private practitioners who will require additional knowledge and skills within a harmonized approach to diagnosis, treatment, care and support;
- Basic Health Staff who are the first and most accessible point of contact between people and their health system, and are called upon to provide basic health care, psycho-social and in some situations healing support and referrals for members of the community they serve;
- Members of the community, in particular where HIV has already led to increased need for care, treatment and support;
- People living with HIV and their families and partners.

To further develop treatment, care and support, innovative approaches and different models will be piloted, and ongoing evaluation and review of what works best will lead to development of national norms and standards which can then be amended as appropriate to meet specific local needs.

This will include development of a minimum package of requirements in treatment, care and support for all communities affected. Training manuals will be produced and disseminated and activities will be undertaken to build knowledge and skills. A core group of trainers will be developed, whose task will be to generate the capacity to scale up access to, and use of, services in a phased manner. There will be focused and immediate attention to the hardest hit communities.

With regard to the dual epidemic of HIV and Tuberculosis, key health sector activities include increased and strengthened formal collaboration between the National AIDS Programme and the National Tuberculosis Programme with continuous information sharing, joint planning and development of policies, protocols and operational guidelines, aiming for a decrease in the burden of Tuberculosis in people living with HIV and a decrease of the burden of HIV in people with Tuberculosis. The coordination of Tuberculosis and HIV services at the township level will be fully integrated into the continuum of care mechanisms for people living with HIV. The collaborative HIV and Tuberculosis joint efforts include counselling and HIV testing of Tuberculosis patients, and provision of HIV education, prevention and care services for Tuberculosis patients co-infected with HIV.

Services provided for treatment, care and support will require effective procurement and supply mechanisms. The quality of goods and supplies, particularly medicines and reagents, will be constantly monitored. Health systems will be strengthened in ways that ensure high quality provision of services and commodities including medicines.

Impact mitigation

Complementary approaches will be used to minimise the social, cultural and economic impacts of the epidemic. Where possible, these approaches will build on existing community capacity for human and economic development, and be directly linked to other approaches to treatment, care and support.

Orphans will be supported through existing community, social welfare and education services as well as other mechanisms including extended family support. Communities will be encouraged to plan for future support of those children whose parents are experiencing HIV related illness.

Mainstreaming of responses to the HIV epidemic with other aspects of human and

economic development will occur where feasible. This will ensure the integration of care and support for people living with HIV with other types of support already provided for the poorest members of communities. There is a reciprocal relationship between HIV and food security: lack of food security enhances vulnerability to HIV as people revert to livelihood strategies that may include social and cultural uprooting, mobility and engagement in risk-taking behaviours. In turn, HIV reduces productivity and leads to exhaustion of personal resources, including food supplies. Organizations already involved in poverty alleviation, community development, and overcoming food neediness will be engaged in township and community responses to the HIV epidemic. These will include non-health ministries and non-government organizations where appropriate.

Improving synergies between prevention, treatment, care, support and impact mitigation

All of the above approaches will, when effectively implemented, support and strengthen one another. For example, voluntary counselling and testing, while included in this strategic plan as part of the approach to treatment, care and support, can also be important to prevention as it enables people to talk with health services staff about minimizing their risk and changing their behaviours. HIV transmission is far less likely once people know they are infected, and people who are not infected can benefit from talking with trained counsellors before and after testing.

When testing is linked with counselling and occurs only on a voluntary basis, this makes it easier for people to find out whether they are infected with HIV, and helps to reduce stigma and discrimination. Reduction of stigma and discrimination can help communities work more closely with populations at higher risk, and can also ensure that treatment, care and support can be provided more easily and more consistently over the long periods required for effective treatment of people with HIV and AIDS. Early diagnosis of HIV infection can ensure that people with HIV gain access to early treatment, but only if voluntary counselling and testing services are able to make appropriate referrals for access to treatment. It will be important for townships to strike a balance between HIV-specific facilities and integration of HIV with other existing services, particularly in health. In some cases, HIV-specific facilities can be developed quickly in ways that ensure effectiveness. However, integration of HIV with the rest of the public, private and traditional health systems will lead to longer term efficiency and sustainability. Health systems require strengthening to make this possible, as is outlined in the next section, and in further detail under Strategic Direction 12 in Part Two of this National Strategic Plan.

All the approaches outlined above require community mobilization, scaling up and strengthening of health and other services, and coordination between different people and agencies working to reduce transmission and to provide treatment, care and support. A focus on the needs of people living with HIV and their families, informed by their active participation in defining what is needed in each community, will underpin successful approaches to prevention and care. Mitigation of the social and economic impact of the epidemic will be far easier in communities where people can talk about the epidemic in ways that do not stigmatise affected groups, and where they can therefore talk easily about planning for future community needs.

Within the period of this National Strategic Plan, emphasis will move from national coordination and evaluation of innovative approaches to home based care and support, towards development of specific initiatives tailored to the needs and capacities of local communities.

Strengthening Health Systems

This strategic plan recognises that if the HIV epidemic in Myanmar is to be confronted and contained, aiming to expand coverage of HIV and AIDS services and to reach the Universal Access targets, the national health system must be strengthened in many ways. This strategy endorses the recommendations of the National AIDS Programme external review aiming to strengthen the role of the National AIDS

Programme in leading the health sector national response to HIV and AIDS. Under Strategic Direction 12 in Part Two, the strategy includes fourteen approaches to address key elements of health systems strengthening, including building capacity for policy development, planning, multisectoral coordination, service delivery, monitoring and evaluation at the national, district, regional and local levels.

Through the process of developing this national strategic plan, leaders in many sectors have become aware of the need to build capacity at all levels in government and non-government organizations to create an effective response. Support for enhancing capacity to plan and guide the national response will continue.

HIV infection in medical settings will be prevented as a first priority. Blood and blood products must be safe. Sterile equipment will be provided, universal precautions promoted and safe disposal of waste assured. Health care workers will, within the period of this strategy, all gain access to post-exposure prophylaxis with antiretrovirals in cases of accidental exposure.

The best available local evidence will be used to inform planning and decision making. In analysing evidence, the government will take into account the experience of all stakeholders – communities, non-government organizations, private practitioners, all relevant government ministries and departments – as well as health ministry institutions. It is now the goal of every government that all should have access to prevention methods, treatment and care within the health sector. All people can therefore to benefit from current scientific knowledge, including those who are poor or difficult to reach.

ROLES AND RESPONSIBILITIES

Roles and responsibilities are addressed throughout the National Strategic Plan. In each strategic direction area and in the sections covering monitoring and evaluation and health systems development, roles of different constituencies are outlined, to be further detailed by specific actors in the rolling three-year operational plans. This section outlines general roles of key constituency groups.

Government – Ministry of Health and National AIDS Programme

The Government of the Union of Myanmar will lead the national response, drawing on the Three Ones principles and working in pursuit of the UNGASS Declaration of Commitment to which it has subscribed (see Figure 4 and Annex I, section 1). Led by the Ministry of Health and the National AIDS Programme, but drawing on many other ministries and departments, the Government will articulate its political commitment to respond to the HIV epidemic, mobilize domestic and international resources, design and implement policies, undertake direct service delivery in many programmatic areas, establish and oversee the necessary policy, strategy and coordination structures, monitor and evaluate the provision of services by all partners government and non-government, and provide an enabling environment for all partners, government and non-government, to contribute to the national response. The Government will identify and approve efficient ways and means for an increasing number of partners to contribute to the response to the HIV epidemic.

The government structure, in particular the formal health system, will serve as the backbone of the national response to HIV. It will do so through the marshalling of its institutions and services, skills building among existing personnel, the hiring and deployment of additional human resources as feasible, and the strengthening of procurement, supply and accounting mechanisms. The focus on Townships outlined in this strategic plan calls for major efforts to mainstream HIV work, using existing health and other services as means of delivering activities, goods and financial resources. Where alternate delivery mechanisms are found suitable, linkages and mutual accountability among partners from within and outside government will be essential to the optimal use of resources and the avoidance of wastage and duplication.

Government - Participation of other government sectors

The National Strategic Plan calls for significantly scaled-up action on the part of ministries beyond the Ministry of Health. All ministries have a role to play to prevent the transmission of HIV, to contribute to care and support for people living with HIV, and to facilitate enabling environments for the implementation of the response at all levels. With the exception of the Ministry of Health, few ministries have HIV strategies at this point in time, although several are already involved in prevention and some in care and support activities. It is premature at this stage, therefore, to identify detailed roles, outputs or outcomes by ministry, except in so far as roles for specific ministries have been identified in the strategic directions sections of Part Two of this strategic plan. Within the period of the National Strategic Plan, ministries other than Health will be supported to develop their own responses as opportunities arise, with direct assistance provided once requested for capacity building, policy development and programme implementation.

The two tables in Annex II aim to begin the process of improved planning and implementation by a large range of ministries through outlining key functions and

identifying *initial outcomes* that should be achieved by each ministry. Table 1 in Annex II addresses those ministries principally concerned with coordination, the enabling environment and facilitation of implementation, though some will also deliver services (especially the Ministry of Health). Table 2 in Annex II considers line ministries which will have responsibilities for delivering HIV prevention and care services.

As detailed in the tables, in general, ministries other than Health will be encouraged and supported during the first years of the National Strategic Plan to take the following steps:

1. **Contributing to an enabling environment:**

   Each sector should contribute to the creation of an environment favourable to the reduction of HIV-related risk, vulnerability and impact among the populations it serves. This needed effort calls for a review of sectoral policies and programmes to ensure that they contribute to the reduction of HIV transmission and do not inadvertently increase directly or indirectly people's vulnerability to HIV, or create obstacles to their access to care, treatment and support. Each sector will ensure that any HIV testing within their sector is carried out in voluntary and confidential ways, and that HIV test results do not lead to exclusion from the workforce or from the benefits made available through their sector.

2. **Addressing the needs of sectoral workforces:**

   Each sector should review and modify its human resources policies and practices to ensure that the sectoral workforce receives appropriate information about HIV relevant to themselves, their families and the communities they serve. To this end, each sector should work with other partners to create enabling environments and opportunities to scale up prevention, treatment, care and support initiatives affecting their own sectoral workforce and communities, and to minimise the social and economic impact of the epidemic.

3. **Building sectoral capacity:**

   Each sector will collaborate with the National AIDS Programme to acquire and further develop the knowledge and skills needed to engage in both the creation of an enabling environment and the response to the needs of their workforce in relation to HIV. This will be a gradual process requiring specific plans of action and the identification of the needed financial resources.

Specific contributions by different ministries to the national response to HIV in Myanmar are proposed in Annex II. These may serve as a starting point in promoting the involvement of all sectors in the national strategy and in developing sectoral plans and budgets.

State, Division, District and Township AIDS Committees

State, Division, District and Township AIDS Committees already exist. Their roles and tasks will be clarified within the first year of implementation of this strategic plan. They will be supported and held accountable to undertake tasks related to situation assessments in their own areas, prioritization of communities needing assistance, involvement in analysis of surveillance data, coordination, monitoring and reporting.

United Nations

The United Nations (UN) has a variety of supporting roles, responding to the needs articulated in this National Strategic Plan. These include the provision of technical support to government and non-government partners in policy development, research, normative and technical guidance, planning, coordination, monitoring, procurement and implementation.

The UN also assists in advocacy for funding, oversight and assistance with implementation of programs implemented by government and non-government partners, assurance of cooperation with international agreements and programs on HIV and AIDS, and sharing of the results of research and advocacy for the application and adaptation to the national

context of international best practice. This includes cooperation in provision of opportunities, and mechanisms for the regional and global dissemination of information and lessons learned from the national response.

UN organizations will undertake this range of activities through various means. Concerning the provision of technical cooperation to government and non-government partners, UNAIDS and its co-sponsors have agreed to a Division of Labour which identifies comparative advantages of each UN entity and maximises the potential technical support to be provided by the UN (see Annex III).

Non-government organizations

The label 'Non-government organization' covers a wide spectrum of organizations from local non-government organizations, faith based organizations, community based organizations, formal and informal networks, through to national professional associations and international non-government organizations.

Their contribution covers a wide spectrum, including the provision of technical expertise and humanitarian assistance drawing on experiences from variety of programmes inside and outside Myanmar, design and delivery of care and prevention services, research, advocacy, participation in national and local strategic planning and monitoring, delivery of services to hard to reach populations, funding of programs, and capacity building of national partners. A critical role is to ensure that the views of communities and individuals for whom services are intended are articulated and put at the centre of design, implementation and monitoring of activities.

Non-government organizations, community based organizations and faith based organizations in Myanmar will continue to play crucial roles in the response to HIV by providing community leadership and guidance, faith-based spiritual guidance and leadership within communities, and advocacy in the interests of affected communities. These organizations will work directly with people and groups with specific needs who are not easily reached by the public sector, such as out-of-school youth, women, drug users, faith based groups and people living with HIV, facilitating their involvement in responses at the community level. They will provide implementation expertise at the community level, advocate for more volunteerism within communities, provide counselling, care and support for orphans and other vulnerable children and for people living with HIV. They will assist local communities to mobilise human, financial and material resources to support HIV interventions, motivate and support people living with HIV to establish self-help groups and participate in other programs, and strengthen community resilience to prevent increased transmission and to reduce discrimination and fear. They will integrate HIV prevention and control activities into sporting, religious and other local cultural events.

Myanmar has a broad range of professional associations and local non-government organizations which are already engaged in the national response to the HIV epidemic. These include the Myanmar Medical Association, Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society, Myanmar Nurses Association, the Myanmar Anti Narcotics Association, and the Myanmar Health Assistants Association. Over time, the contribution of these professional groups should be maximised through inter-sectoral cooperation at all levels. Their responses will continue to be supported, evaluated and improved throughout the period of implementation of the National Strategic Plan.

The international non-government organizations will work within the context of the national response and in collaboration with all other sectors involved in the response to provide technical and implementing expertise at all levels including research, planning, coordination, monitoring, procurement, and programme delivery. They will facilitate scaling up of interventions for prevention, treatment, care and support and work to conceptualise and then implement new and innovative approaches. As mentioned in the Three Ones principle, international non-government organizations, in partnership with the National

AIDS Programme and along with other stakeholders, will play an important role in evaluation of programmes at all levels, research and advocacy for the adaptation to the national context of international best practice, and present international experience for discussion and adaptation. Similarly, they will also facilitate and support capacity building with national partners; develop and apply behaviour change communication strategies including outreach, peer education and social mobilization; provide additional counselling, care, support and treatment to those infected or affected; identify potential new partnerships to address emerging or unattended priorities; provide support to strengthen enabling legal and ethical environments; and provide support for the mitigation of social and economic impact. Along with others, they will motivate and support people living with HIV to establish self help groups, and work to build the capacity of people living with HIV for involvement in policy and programme development. They will also assist with mobilizing international funding.

People living with HIV

The principle reasons for involving people living with HIV, and the ways this will be facilitated, are outlined in Annex I, Section 2. Their key roles will include:

- Facilitating networking and support for people living with HIV
- Identifying strategies to increase the well being of all people infected or affected by HIV
- Promoting positive living, self reliance and reduction of infection through education, prevention and care programs
- Coordinating, information sharing and advocacy to identify gaps in services and support
- Participating in strategic planning and program design
- Contributing their understanding to the identification of evaluation and research needs and responses to findings.

The private sector and business coalitions

The private sector will focus on expanding and accelerating the coverage of prevention and support initiatives within the work environment. It includes large scale private sector companies, local private sector businesses and community facilities including entertainment and food outlets where people gather on a daily basis. Large private sector organizations will be encouraged during the period of the National Strategic Plan to develop HIV-related workplace specific policies and practices, especially relating to the prevention of HIV transmission amongst the workforce and the hiring, deployment and care of people living with HIV and their families. Led by the Myanmar Business Coalition on AIDS, and working in collaboration with other partners in the national response, private sector corporations will develop policies and programmes consistent with the key principles of this National Strategic Plan.

The private sector will work to eliminate discrimination against workers on the basis of real or perceived HIV status, promote gender equality, promote healthy working environments, promote social dialogue among employees, ensure that HIV testing is voluntary and confidential, ensure that people's HIV status remains confidential, encourage employers to continue to employ people living with HIV, promote HIV prevention programmes in the workplace, and ensure that employees with HIV and their families have access to affordable health services and the benefits of occupational health schemes. Development of further Business Coalitions on HIV will be encouraged in townships, states and divisions.

Donors

Donors will provide funding, oversight and assistance with implementation of programs implemented by the all partners from all sectors involved in the national response to the HIV epidemic. They will act on the recognition that the impacts of the dynamic and powerful HIV epidemics on people, communities, nations and economies call for international cooperation and humanitarian assistance.

INSTITUTIONAL ARRANGEMENTS, OPERATIONS AND BUDGETS

Institutional arrangements

Figure 4 summarises the institutional arrangements for implementation of this National Strategic Plan. The text on the following pages explains these arrangements.

Country Coordinating Body for AIDS, Tuberculosis and Malaria

Implementation of the national response, policy guidance and identification of appropriate external support will be overseen by the Country Coordinating Body for AIDS, Tuberculosis and Malaria. This will be chaired by the Minister of Health. It will include participation of several ministries, UN organizations, non-government organizations and people living with HIV. It will be supported by a Secretariat consisting of the Director of Disease Control, the National Program Managers for AIDS, Tuberculosis and Malaria, and one representative from the Attorney General's Office. National strategies have been formulated for each of these important health issues and can be referred to for further information on their contents and linkages to HIV.

Technical and Strategy Group for HIV and AIDS

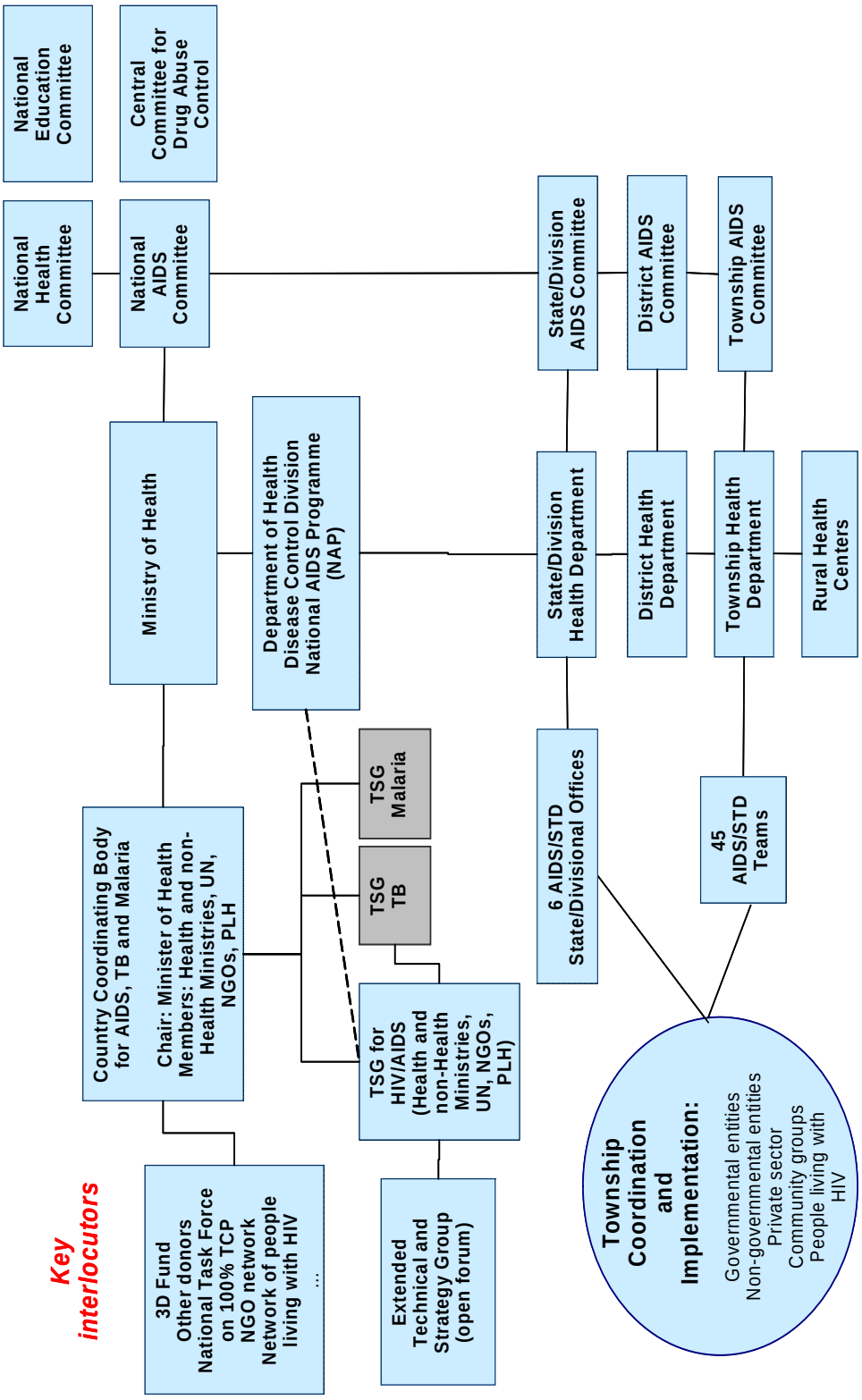
A Technical and Strategy Group will meet more regularly to undertake planning, monitoring, trouble-shooting and other coordination exercises. The Chair and Vice-Chair of the group will be the Director of Disease Control and the National AIDS Program Manager, drawing upon the technical expertise of UNAIDS co-sponsors, in particular UNFPA, UNICEF, UNODC and WHO.

The Technical and Strategy Group draws upon the technical expertise of all members, and when needed will seek involvement of other non-members to assist in its tasks. Secretariat support will be provided by the UNAIDS Secretariat. The Technical and Strategy Group will meet on a regular and frequent basis. Members who play a representational role (especially community organizations, professional associations, international non-government organizations and the UNAIDS Secretariat) will provide feedback to, and draw opinions and information from, their constituencies. Other members will be appointed by different government ministries and different departments of the Ministry of Health, and will contribute technical and policy expertise based on their organizations' involvement in the national response to the HIV epidemic. People living with HIV will be involved to ensure input based on understanding of living with the virus within communities affected by the epidemic. Over the period of implementation of the National Strategic Plan, networks of people living with HIV will be developed so that the people living with HIV can move from an advisory to a representative status. The membership of the Technical and Strategy Group will be determined at the outset of the National Strategic Plan and revised from time to time to respond to evolving needs.

Technical and Strategy Group Open Forum Meetings

Technical and Strategy Group Open Forum meetings will occur on occasions as appropriate. All partners in the national response to the HIV epidemic will be invited for special issues, presentations or other discussions.

Figure 4. Coordination Structure for the Myanmar National Strategic Plan on HIV and AIDS 2006-2010



Government coordination mechanisms in related fields

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

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

Entity	Function for the Response to HIV	Chair
State Peace & Development Council	Highest level oversight of political commitment to the response to HIV and AIDS	Head of State Peace and Development Council
National Health Committee	Oversight of national health policy and implementation Approval of National Strategic Plan	Secretary 1 State Peace and Development Council
National Education Committee	Oversight of national education policy and implementation	Secretary 1 State Peace and Development Council

Entity	Function for the Response to HIV	Chair
National AIDS Committee	Oversight of HIV and AIDS policy and monitoring of the epidemic and programmatic response Endorsement and submission of National Strategic Plan on HIV and AIDS Provide guidance and direction to State/Division, District and Township AIDS Committees	Minister for Health
Central Committee for Drug Abuse Control (CCDAC)	Policy and strategic guidance for harm reduction Technical delivery of harm reduction services Coordination with Anti-narcotic Taskforce	Minister for Home Affairs

IMPLEMENTATION OF THE NATIONAL STRATEGIC PLAN

This National Strategic Plan describes a vision for how a multisectoral and multi-partner response to the HIV epidemic can be expanded significantly by 2010. Managing this expansion will require a range of mechanisms and tools, including coordination and policy structures, capacity building of new and existing partners, the development of operational plans, and an enabling environment emphasizing community leadership.

The strategic plan presents medium term strategic directions with targets and indicative costing. More detailed resource planning will occur through development of a Three Year Operational Plan. Funding will be sought from a variety of sources, including increased domestic contributions, pooled donor mechanisms such as the 3-Diseases Humanitarian Fund for Myanmar, bilateral development agencies and other sources. Applying to future rounds of the Global Fund for HIV, Tuberculosis and Malaria is also foreseen.

The first Three Year Operational Plan will be developed in 2006. This will detail the first year's activities, partners and potential partners, and budgets. There will also be indicative budgets for the second and third years.

The Operational Plan will incorporate all existing resources, using the National Strategic Plan as a guide for decisions on priorities and scaling up. The three year operational planning cycle aims to encourage longer term financing. Each year, plans for the immediately forthcoming year will be developed in greater detail to ensure coordination, identify specific actors and geographical areas, assess key enabling environment issues which need to be addressed, and better plan financial flows. The annual review of a three-year rolling plan thus balances the desire for longer-term financing with the need for annual review of progress, changing conditions and more detailed planning.

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

- This National Strategic Plan
- Rolling Three-year Operational Plans
- Annual reports on the national response
- Semi-annual progress updates (from the Monitoring and Evaluation system)
- Specific strategies that will be developed for HIV and AIDS interventions in areas requiring improved coordination, elaboration or review, including strategies for the provision of a continuum of care, for prevention among the military, for mobile populations and for prevention among men who have sex with men
- State and Division strategic plans
- Second Generation Surveillance
- UNGASS and other International Reporting mechanisms (likely in 2008 and 2011)
- National HIV and AIDS Spending Assessments to track actual expenditures
- Operational research in specific areas of programming where additional data is needed. There are several areas which would benefit from operational research.

For those products requiring multiple partner input, flow-charts will be developed to clearly identify the steps, timing, and actors responsible for leading or being involved in different processes. The flow-charts will provide a means to ensure accountability by identifying clearly which actors are responsible for calling for inputs, preparing data, drafting texts, calling consultations and so on. They will also inform all stakeholders about what products can be expected to be produced by which actors, so that they can plan on having or using those products to help in their own work.

ANNEX I

KEY PRINCIPLES UNDERLYING THE NATIONAL RESPONSE TO HIV

This National Strategic Plan identifies the following key principles as essential to ensuring a more effective national response to the HIV epidemic. These principles build on previous experiences and lessons learned by all partners about what works best in the specific context of Myanmar. The key principles are intended to lead to more effective national and local responses to the challenges of meeting the objectives of this strategic plan. These principles will underpin approaches to prevention, treatment, care and support, and will enable more effective synergy between policies and programmes using these approaches.

"Three Ones" principles will be followed:

This Strategic Plan is consistent with global commitments to develop in each country, and then to gain international support for, the "Three Ones"[1], in accord with these specific principles:

- This *One HIV/AIDS Action Framework* will be a framework for the national response, not just the Government response, encompassing all actors and all activities within and outside the health sector
- The existence of *One National Coordinating Authority* will build on the Government's central leadership role, and also recognize the importance of participation of non-government sectors, including people living with HIV, in that coordination
- Further development of *One Monitoring and Evaluation System* will ensure accountability both to local communities, particularly to people living with HIV, and to funding partners, as well as the systematic analysis and use of the evidence needed to adapt the strategy to evolving realities, capacities and needs.

Participation of people living with HIV:

This Strategic Plan recognises the central and high level importance of involving people living with HIV in planning, service development and program implementation to meet all objectives. This participation will ensure that policies and programs are based on better understanding of how the people most affected experience various aspects of the epidemic including transmission of HIV, use of services and participation in communities. Information from people living with HIV will be an integral element of planning, implementation, monitoring, evaluation and research.

Participation of people living with HIV will be enhanced during the five years of the plan through further development of services which enable people to find out whether they are infected; promotion of empathy, and reduction of stigma and discrimination, so that people feel more confident to be tested, and people living with HIV feel more confident to discuss this openly with their friends, families, service providers and program implementers; fostering the development of small and large networks of people living with HIV, leading over time to the development of a national representative network; building capacity of people living with HIV to participate in planning coordination and programming mechanisms; and building capacity of others to understand, encourage and make use of the continuous involvement of people living with HIV. By

[1] Final Report of the *Global Task Team on improving AIDS coordination among multilateral institutions and international donors* (UNAIDS, 14 June 2005).

the end of the implementation of the National Strategic Plan, representatives of people living with HIV will be included in all relevant coordination mechanisms.

Emphasis on programme outcome:

Myanmar is committed to striving towards Universal Access to prevention, care and support by 2010. Specific targets have been set within each strategic direction area. These targets have been set by considering global Universal Access targets and then adjusting them according to an assessment of national capacity of all implementing and funding partners, based on programming experience and programme assessments preceding this plan. The targets identified within this strategic plan reflect the first round of these decisions. They may be modified over time as experience is gained and resources secured.

Policy development, programme implementation and monitoring of the response will focus on the need to produce specific outcomes. Consistent with this principle, priority will be given to initiatives that have a direct impact on reducing HIV transmission, reducing HIV-related morbidity, mortality and disability, and mitigating the social and economic impact of the epidemic. These outcomes are recognized as being the most significant results of dissemination of knowledge, provision of services and availability of commodities.

Outcomes will be dependent on evidence based strategies that comply with best public health practices supported through the creation of enabling policy and cultural environments. In particular, the national response will strive towards equal access to information, education and services. Outputs will reduce discrimination and avoid creating further stigma or discrimination, respect people's confidentiality, and focus on proven approaches that save lives. The approaches used will encourage and enable regular use of condoms in risk prone situations, reduce HIV-related harm associated with drug use, and facilitate access to all appropriate forms of care, treatment and support.

Scaling up:

In order to reach expanded targets, a major focus of this strategic plan will be on scaling up of initiatives that have been demonstrated to be effective. There will be initial and ongoing identification and review of which types of initiatives are the most effective. There will also be ongoing analysis of barriers to reaching targets.

Capacity building will be an essential feature of methods used for scaling up. This will occur in multiple ways at many levels. Community groups and service providers in many fields will receive training leading to improvements in prevention, care, treatment, support and impact mitigation. Facilities for these services will be improved, along with improvements in management of procurement and supply, to ensure that quality diagnostic and therapeutic products, and other commodities needed for sustained prevention, care and treatment, are regularly available. Effective programme management at all levels will be developed and improved. Public health human resources and infrastructure in government, non-government and private sectors will be further developed to enable more effective implementation of care and support initiatives. Many local non-government organizations, community organizations, networks of people living with HIV, professional organizations, faith based organizations, the education sector and other non-health ministerial departments will be assisted to improve organizational capacity as a means of underpinning likely success in scaling up of a broad-based, participatory response to the epidemic. Capacity building in cross-organizational communication, collaboration and consensus building will ensure the development of effective partnerships at all levels. To this end, technical assistance to improve management, coordination and evaluation of initiatives at township, district, state, division and national levels will be systematised and further enhanced.

To ensure effective and consistent methods are used for scaling up, management tools, training methods and training materials will be reviewed and standardised, and the impacts of these efforts on policy makers and programme

managers and implementers will be regularly evaluated over the initial five years of implementation of this strategic plan. This will enable further engagement of many people and organizations at different levels, while simultaneously ensuring that new initiatives best respond to needs and are managed and implemented in ways that are consistent with the key principles of the National Strategic Plan.

Accelerated Townships:

The National Strategic Plan accords the utmost priority to activities focused on facilitating more active responses within townships, with emphasis on facilitating direct engagement of people in local communities, empowering and supporting them to develop and engage in their own responses.

This strategic plan was developed with knowledge of what was already effective in 2006. At that time, it was recognised that some townships already have very effective responses to the HIV epidemic while others do not. Factors underlying success vary. This strategic plan recognises that there are high levels of risk in some townships more than others (e.g. some townships had more sex workers or more drug users than others). The epidemic and its impacts are more visible in some townships (e.g. many people were already ill or had already died in some townships), and this has already led to accelerated responses. Different townships, for various reasons, have experienced high levels of community involvement, external assistance and access to people in urban and rural areas – these factors have made it easy to develop responses, and will continue to be encouraged. Enabling environments based on supportive policies were already in place in some townships, communities were already more interested in becoming involved , and other aspects of human and community development were already in place.

Scaling up will include identification of "accelerated townships" – townships where the needs are greatest and where existing programs, services, leadership, enabling environments and community involvement are promising of rapid capacity enhancement. These townships will be allocated further resources to enable rapid scaling up of what already works along with new initiatives, ahead of other townships where conditions for effective responses to the HIV epidemic do not yet prevail. This scaling up will be carefully evaluated, including comparison of different processes used for scaling up in different townships. Thus, within the first three years of implementation of this strategic plan there will have been scaling up of effective programs in selected townships, along with enhanced knowledge of how such scaling up can occur in less advanced townships.

Population focus: Supporting key populations at higher risk and vulnerability and with the greatest needs:

Utmost priority in attention and resources will be given to initiatives which support populations at higher risk of HIV transmission, and people with the greatest needs as a result of the impact of the epidemic. The participation of people from these highly vulnerable and risk-prone "groups" (understood as the assembly of people who share attributes of HIV-related risk, vulnerability and exposure to likely impact), in particular people living with HIV, will be essential components of ongoing analysis to identify populations forming these groups, their specific needs and the best ways to address those needs. Understanding developed from this participation will form an integral element of information sought through epidemiological and behavioural surveillance.

Key populations at highest risk and vulnerability in Myanmar include sex workers, clients of sex workers, drug users, men who have sex with men, and partners of people living with HIV. Partners of clients of sex workers are also vulnerable (their partners might be married women who have no idea that their husbands are engaging in high risk behaviours), as are institutionalised populations and children born to parents who have HIV. For these populations, there will be intensive, narrowly focused interventions using a range of strategies to promote behaviour change.

A second category of vulnerable populations includes those people – adults, youth and children – most likely to become part of the above-mentioned groups in the near future, and those affected by the epidemic as a result of the social and economic impacts of HIV-related illness and death in their families or communities. Although they might not yet be identified through surveillance data or other forms of evidence, this strategic plan identifies vulnerable groups as including out of school children and young people, orphans and other vulnerable children, mobile populations and uniformed services. For people in these vulnerable groups there will be focused interventions promoting understanding and skills development and an active effort to determine what social interventions might work best. For this large population, responses will be based on analysis of what optimal levels of information, education and services might best respond to their needs and how economic, social, cultural and other factors may influence vulnerability to HIV. Special consideration will be given to recognizing differences in needs related to gender, age, urban or rural status, educational attainment, occupation and mobility.

A third category of populations, often referred to as the "general population", includes people who are not at recognized high level of vulnerability to HIV. These include women and men who do not engage in HIV-related risk taking behaviors. Broad-based prevention initiatives for these populations will provide information, education and services conducive to reinforced and sustained protective behaviors, stimulate their engagement in the reduction of risk and vulnerability within their own communities, and combat stigma and discrimination towards those assumed to be at higher risk of HIV infection.

Participation: involving vulnerable people and local communities:

This strategic plan recognises that the most effective initiatives to meet all objectives will occur in communities. Improving understanding, facilitating behaviour change, providing services and mitigating impact all require the active involvement of people in townships and districts. Informal groups and networks that have emerged in Myanmar will be further developed and replicated; populations at higher risk and vulnerable people will be engaged in program development and implementation.

Where possible, initiatives will be undertaken by community based organizations whose members are closest to the people most vulnerable to HIV transmission and to the impacts of the epidemic. Faith based organizations will be engaged to promote understanding and build connections between vulnerable people and others in their communities. Young people – girls and boys, in and out of schools – will be encouraged to engage in local community responses. Local community organizations will be developed and assisted to build their capacity to lead local responses to the HIV epidemic.

Enabling environments:

Enabling and supportive environments will be developed and constantly improved, through Government leadership and introduction of policies at national and local levels to support more effective collaboration and partnerships between all people involved in implementation. The cultural environment in which activities take place will also be improved as outputs of the strategic plan foster better community attitudes towards people who are vulnerable and towards people living with HIV. The combination of policy and cultural environments will facilitate more effective locally based responses to the HIV epidemic.

Policies will be articulated in different sectors, and clear national guidelines will be established and widely disseminated. A full range of partners, government and non-government, national and international, will be encouraged to support efforts in Myanmar to mount activities in line with this strategy to respond to HIV and AIDS, in line with international best practice. In the context of humanitarian assistance extended to vulnerable communities by national and international entities, activities will be in line with international humanitarian law and human rights.

Special efforts will be made to reduce stigma and discrimination through specific initiatives designed to do this, as well as by ensuring that responses to the HIV epidemic do not in themselves inadvertently promote stigma and discrimination. Enhanced cultural environments will encourage people to support each other, seek to promote empathy and understanding between different groups within the community, and reduce vulnerability by ensuring that people have access to basic services regardless of what population they belong to, the patterns of their risk-taking behaviors or their ethnic origin, social status, gender, nationality, political opinions, race or religion.

To be successful, the public health programmes described by this National Strategic Plan will have to further strengthen community capacity to respond to the epidemic in Myanmar. Past experience in the country has shown that an improved enabling environment can stimulate communities to build their own capacity to better respond to HIV. Some adjustments to current practices – designed during an era when HIV was not present in the world – may further enable community efforts which are proven effective to prevent the transmission of HIV. The public health of communities can be better protected from HIV, for example, through: expanded access to information about and organizations working on HIV; the creation of informal support groups, especially of people living with HIV but also other groups of all kinds such as women's groups, professional associations and businesses; and through pragmatic programmes which reach out to communities at higher risk in a manner that is supported by policies and laws.

Building on evidence:

The initiatives outlined within the strategic plan will be improved through further develop-ment and more effective use of monitoring, evaluation and surveillance. Coordination mechanisms and new institutional arrangements will ensure that improved information will be directly used to inform improvements in policies and programmes. Improved evidence bases will be used to ensure that initiatives to be developed and scaled up are likely to be effective, and not likely to produce unintended consequences such as stigma discrimination or violations of privacy. Policy development will lead to more effective sharing of information, results of evaluation, evidence and baseline indicators including surveillance and behavioural surveillance.

Value for money: Mobilization and efficient use of resources:

Activities will be developed in ways that ensure cost effective and sustainable use of resources. Priority will be given to initiatives which improve community capacity to engage in ongoing responses to all aspects of the epidemic, working towards sustainability through minimizing dependence on centrally controlled programmes and external funding.

Mobilization of financial resources will be an ongoing process. This strategic plan presents a medium term vision with targets and forms the basis for indicative costing. More detailed resource planning will occur through development of three-year rolling operational plans. Funding will be sought from a variety of sources. Improved accountability mechanisms will ensure that all players use resources effectively and efficiently, and are able to report to their funding sources – both domestic and external – about how resources are used. Optimal financing mechanisms will be developed to allow resources to flow rapidly to entities engaging directly in township level activities.

Working across sectors of Government:

The nature of the epidemic and the multi-faceted responses required to curb its course and mitigate its impacts means that government sectors other than Health must become more active in developing responses to the HIV epidemic. In the years before development of this strategic plan, different ministries have been involved in the national response to the HIV epidemic. For example, the Ministry of Education has developed programs for in-school youth, the Ministry of Home Affairs has enabled development of innovative programs to assist drug users to avoid HIV transmission, and the Ministry of Railways has developed effective peer education programs

for staff and for people who use their transport services.

However, there has not always been consistency in approaches, continued involvement, effective collaboration between ministries, or direct involvement of all ministries whose participation in the national response to HIV would be important.

This strategic plan describes key decisions and actions each sector may consider as its contribution to the national response to HIV and outlines specific roles for government ministries and departments which are immediately concerned with highly vulnerable populations (Annex II). It also outlines processes to advocate for the involvement of other ministries and to carefully build their capacities to participate in the national response. The engagement of other sectors of government will occur through staged processes, will be monitored and evaluated throughout the period of the plan, and will recognise that not all ministries want to be involved simultaneously nor have instant capacity to appreciate the nature of the epidemic or the potential benefits of their participation.

Partnerships – collaboration between government, national and international non-government partners and the private sector:

This strategic plan recognises the importance of involvement of all actors. Government, professional associations, national and international entities, researchers, and the private sector will work together to engage the cooperation and collaboration of communities and the participation of the people most affected by the epidemic.

Involvement of different actors will be developed through processes consistent with other components of the strategic plan – analysis of current responses, capacity building, improving enabling environments, and improving mechanisms for coordination and collaboration. This collaborative response to HIV which has underpinned the open process applied to the development of the present strategy will occur at national, state and division, and township levels.

The most effective processes to facilitate this will be identified through monitoring, evaluation and the sharing of information and experience. Scaling up of collaborative mechanisms will be carefully managed and promoted as the evidence is produced about what is most effective at each level and in different parts of the country.

Enhanced Coordination:

Enhanced capacity for coordination and collaboration between different sectors will occur through improvements and refinements in institutional arrangements. This will ensure efficiency, foster peer learning among institutions and the dissemination of good practice, and maximize effective use of resources. Coordination is required not only for planning and implementation of activities, but also for technical assistance efforts by the United Nations and other international partners.

New coordination structures will be multi-sectoral and mobilize a variety of government and non-government partners to ensure effective coordination and planning of policy development. Planning of technical and skills development will occur through collaboration between government, non-government and UN entities. Coordination will address commonalities between HIV, tuberculosis, malaria and other pressing health and social domains, enable technical expertise to be harnessed from a variety of sources, and enable more effective participation of people living with HIV and other people who are vulnerable to or affected by the epidemic.

District and Townships AIDS Committees will play central roles in coordinating the design of local programmes, overseeing the development of the institutional and human resources needed for effective responses, and maintaining the highest possible level of programme and financial accountability.

ANNEX II

POSSIBLE CONTRIBUTION OF DIFFERENT MINISTRIES TO THE NATIONAL RESPONSE TO HIV IN MYANMAR

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

Ministry	Function	Initial Outcomes
Ministry of Health	Leadership on policy, strategy development, coordination and monitoring for HIV Technical management of health service systems for care and treatment and linkages to other disease management Technical delivery of national HIV prevention programs Technical responsibility for HIV/STI research, surveillance and monitoring	National Strategic Plan and Operational Plan developed and implemented TSG operational National AIDS Committee meeting regularly National AIDS programme capacity strengthened
Ministry of Home Affairs	Policy on links between law enforcement and public health for 100% Targeted Condom Promotion and other HIV programs Delivery of prevention and impact mitigation programs for HIV across police and prison departments and in prisons Policy development, coordination and delivery of IDU harm reduction program Facilitation of expanding number of national non-government organization partners Support Township AIDS Committee decisions and programs at township level through General Administration	Operational plan for contributing to HIV response

Ministry	Function	Initial Outcomes
Ministry of Defence	Design and implementation of HIV prevention and impact mitigation policies Articulation of senior-most political support for the national response to HIV	Statement of support for implementation of National Strategic Plan in all regions Develop HIV prevention and care strategy for the military
Ministry of National Planning and Economic Development	International cooperation and coordination through the Foreign Economic Relations Department (FERD) Development planning to ensure resources allocated for HIV programs	Development of policy to support implementation of National Strategic Plan
Ministry of Progress of Border Areas and National Races and Development Affairs	Ensure regions of the country where they work are sufficiently covered by HIV prevention and care and support programs Coordination of HIV actions in their areas	Assessment of HIV actions in Ministry of Progress of Border Areas and National Races and Development Affairs areas Development of HIV strategy to support actions in their area
Ministry of Foreign Affairs	International cooperation & coordination	Facilitation of entry of new international partners working on or financing HIV activities
Ministry of Finance	Administration of disbursement systems for HIV and AIDS funding Coordination of resource allocation and reporting across government sectors	Initial assessment of HIV allocation and expenditures

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

Ministry	Function	Initial Outcomes
Ministry of Education	Policy on HIV workplace education for staff Administration and delivery of in school & out of school HIV education programs	Development of multi-year HIV prevention strategy for education
Ministry of Social Welfare, Relief and Resettlement	Policy development for support and care of vulnerable children in and out of training schools HIV policy for out-of-school children Workplace policies to minimise negative impacts of HIV and develop prevention programs for staff and residents across adult training schools and rehabilitation centres Administration and Coordination of prevention and care programs in institutional settings Coordination of prevention, care and support programs with community participation and institutional settings	Assessment of impact of HIV on Ministry of Social Welfare, Relief and Resettlement work planning Development of multi-year HIV prevention and care and support strategy
Ministry of Immigration and Population	Design and implementation of policies to prevent negative impacts of HIV and AIDS	Assessment of interaction between Ministry of Immigration and Population and HIV Development of HIV prevention strategy
Ministry of Religious Affairs	Facilitation and coordination of expanded role of faith-based responses to HIV Delivery of HIV program with support of religious communities	Development of HIV strategy

Ministry	Function	Initial Outcomes
Ministry of Information	Strategic development of mass media campaign Authorisation for national publications dissemination	Development of HIV prevention strategy
Ministry of Labour	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention in all workplaces Technical coordination of workforce HIV prevention programs	Review of labour regulations impact on HIV prevention and care Development of HIV prevention program
Ministry of Construction	Design and implementation of workplace policies to prevent negative impacts of HIV and AIDS, and address prevention Technical coordination of construction sector-based HIV prevention programs	Assessment of impact of HIV on Construction Development of HIV prevention strategy
Attorney Generals Office	Legal reform to protect people living with HIV (in the workplace) Legal reform to enable access and outreach for HIV practitioners working at community level	Review of legal environment on HIVtransmission and prevention actions
Ministry of Railway	Workplace policy to prevent negative impacts of HIV and address prevention Technical coordination of transport sector-based HIV prevention programs	Review of current HIV prevention and care activities Design of HIV prevention and care program
Ministry of Agriculture and Irrigation	Design and implementation of policies to prevent negative impacts of HIV and AIDS Coordination of agricultural sector based prevention programs Coordination of food security and distribution mechanisms	Development of HIV prevention program

ANNEX III

TECHNICAL SUPPORT ON AIDS: DIVISION OF LABOR OF UN ORGANIZATIONS IN MYANMAR AGAINST GLOBALLY DEFINED AREAS OF WORK

Technical Support on AIDS: Division of Labor of UN Organizations in Myanmar against Globally Defined Areas of Work

GLOBALLY DEFINED TECHNICAL SUPPORT AREAS	*Myanmar Lead UN Organization*	*UN Main Partner Organizations in Myanmar*
1. STRATEGIC PLANNING, GOVERNANCE AND FINANCIAL MANAGEMENT		
1. AIDS, development, governance and mainstreaming, including instruments such as PRSPs, and enabling legislation, human rights and gender	*UNDP*	*UNAIDS Sec, UNICEF, WHO, UNFPA, UNHCR, UNODC*
2. Support to strategic, prioritized and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work	*UNAIDS Sec*	*UNICEF, UNFPA, WHO*
3. Procurement and supply management, including training	*UNICEF*	*UNDP, UNFPA, WHO, UNAIDS Sec, UNODC*
4. AIDS workplace policy and programmes, private-sector mobilization	*UNAIDS Sec*	*UNDP, UNFPA*
2. SCALING UP INTERVENTIONS		
Prevention		
5. Prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually-transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services	*WHO*	*UNICEF, UNFPA*
6. Provision of information and education, condom programming, prevention for young people outside schools and prevention efforts targeting vulnerable groups (except injecting drug users, prisoners and refugee populations)	*UNFPA*	*UNAIDS Sec, UNICEF, UNODC, WHO, IOM*
7. Prevention of mother-to-child transmission (PMTCT)	*UNICEF*	*UNFPA, WFP, WHO*
8. Prevention for young people in education institutions	*UNICEF*	*UNFPA, WHO, WFP*
9. Prevention of transmission of HIV among injecting drug users and in prisons	*UNODC*	*UNDP, UNICEF, WHO*
10. Overall policy, monitoring and coordination on prevention	*UNAIDS Sec*	*All Cosponsors*
Treatment, care and support		
11. Antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections (adults and children)	*WHO*	*UNICEF*
12. Care and support for people living with HIV, orphans and vulnerable children, and affected households.	*UNICEF*	*WFP, WHO, UNAIDS Sec*
13. Dietary/nutrition support	*WFP*	*UNICEF, WHO*
Addressing HIV in emergency, reconstruction and security settings		
14. Strengthening AIDS response in context of security, uniformed services and humanitarian crises	*UNAIDS Sec*	*UNHCR, UNICEF, WFP, WHO, UNFPA, UNODC*
15. Addressing HIV among refugees and related populations	*UNHCR*	*UNFPA, UNICEF, WFP, WHO, UNDP, IOM*
3. MONITORING AND EVALUATION, STRATEGIC INFORMATION, KNOWLEDGE SHARING AND ACCOUNTABILITY		
16. Strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy, and monitoring and evaluation, including estimation of national prevalence and projection of demographic impact	*UNAIDS Sec*	*UNDP, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO*
17. Establishment and implementation of surveillance for HIV, through sentinel/population- based surveys	*WHO*	*UNAIDS Sec*

Myanmar National Strategic Plan on HIV and AIDS 2006-2010

PART TWO

Strategic Directions, Activity Areas, Outputs, Outcomes and Indicators

Myanmar National Strategic Plan on HIV and AIDS 2006-2010

PART TWO

Strategic Directions, Activity Areas, Outputs, Outcomes and Indicators

This document presents a population and service-focused set of strategic directions, each grouped into activity areas. For each activity area there are defined outcomes, outputs, suggested targets, monitoring indicators and implementing partners. Outcomes and outputs have been chosen according to their relevance to achieving the objectives of the National Strategic Plan, and then appraised according to their measurability.

The feasibility of outputs will depend on resource availability, partners' willingness or capacity to engage, and the evolving policy environment at national and township levels. Each three year Operational Plan will consider the feasibility of different outputs at that time and determine which activities will be implemented as part of the national response. Outputs marked with an asterisk * are important but may not be feasible in the short term.

This National Strategic Plan is a living document: it lends itself to adjustments and revisions as further experience is gained, resources are mobilized and evidence of successes and shortcomings is generated through monitoring, special studies and mid-term and end-of-term evaluations, in 2008 and 2010, respectively.

STRATEGIC DIRECTION 1. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG SEX WORKERS AND THEIR CLIENTS

Target Groups: Sex workers, their clients and other sexual partners.

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Information provided – transmission, prevention, alternative safer sex practices and services provision.	Increased proportion of sex workers practising safer behaviours to prevent HIV transmission.
Access to resources - male and female condom provision, lubricants social marketing.	Increased proportion of clients of sex workers practising safer sexual behaviours.
100% Targeted Condom Promotion Programme strengthened and expanded following recommendations of the review of the program.*	
Ensuring tailored interventions for direct and indirect sex workers groups (freelance sex workers, entertainment workers, beer girls, hotel workers, some brothel based sex workers, young sex workers), including outreach services.	
Integration of information and support for sex workers with prevention programs of specific ministries and workplaces (e.g. Railways programs will also work with sex workers who interact with railways staff) (e.g. Tourism programs will inform tourism staff about interaction between sex workers and tourists and tourism staff).*	
Linkages including referrals to counselling, testing, treatment (antiretroviral therapy) and care as well as to other existing services such as drop-in-centres providing primary health care and social services.*	Increased proportion of sex workers who were in need sought and got access to appropriate services.

OUTPUTS	OUTCOMES
Voluntary counselling and testing, STI, reproductive health services sex worker friendly, public sector.	
Voluntary counselling and testing, STI, reproductive health services sex worker friendly, private sector (including non-government organization programs).	
Prevention of Mother to Child Transmission, care, support and treatment services available for sex workers.	
Peer and outreach education programs targeting male groups identified as potential clients of sex work.*	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Sex worker support groups established and functioning.*	Programs improved and focused on improving responses to HIV and AIDS.
Participation of sex workers, including people living with HIV and/or clients if possible, in program design and implementation.	
Build understanding of communities about issues affecting sex workers.*	Understanding and empathy for sex workers is increased (Stigma and Discrimination reduced).

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
Enabling environment – national policies in place to indicate need for programs for sex workers which respect consent and confidentiality. Enforcement of policy in which condom possession is not used as liability of sex work.*	Prevention programs and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence against sex workers.

OUTPUTS	OUTCOMES
Enabling environment – township environment, including from law enforcement and other authorities, is supportive of programs and services for sex workers.*	Programs and services more effective as trust is developed between implementers and sex workers.
Coordination and multisectoral cooperation amongst stakeholders (including non-government organizations) and gatekeepers (e.g. local authority, police, managers and owners of entertainment establishments).	
Research and special studies to better understand the context of sex industry including brokers and types of clients in order to improve prevention and care programs.*	
Working environment for sex workers improved in establishments and entertainment facilities.	Vulnerability to HIV is reduced as sex workers increase their capacity to care for themselves and each other.
Recovery, re-integration and social services for women who want to leave sex work, including services tailored to the needs of under-age sex workers.	Increased proportion of sex workers able to reintegrate into other work and social environments.

Partners

Ministry of Health, Ministry of Social Welfare, Relief and Resettlement, Ministry of Home Affairs, Ministry of Tourism, Ministry of Transportation, Ministry of Railways, Ministry of Progress of Border Areas and National Races and Development Affairs (NaTaLa), UN entities (UNFPA, UNICEF, UNAIDS, WHO) ; International Non-Governmental Organizations (PSI, MSI, MDM, Care, WVI, HIV/AIDS Alliance, Consortium, MSF, AMI, Malteser, AFXB…); Local Non governmental and professional organizations and CBOs (MNA, MMA, MRCS, Pyi Gyi Khin…); Entertainment Facilities, Hotels and Motels, Trishaw drivers association.

Suggested targets

Estimated number of sex workers in Myanmar: 40,000[1]
Estimated number of clients of sex-workers: 1,100,000

[1] Estimation workshop 2004

Standard Indicators (inc. UNGASS in blue)	Indicative standard targets[1]	Baseline situation in 2004 or2005	Suggested target for Myanmar	
			2008	***2010***
Sex workers reached by prevention program	60%	30,000	40,000	40,000
Number of sex workers accessing VCCT			20,000	25,000
% of sex workers that are HIV+		32%	26.5%	TBD
% of sex workers with syphilis		25%	19%	TBD
% of sex workers that report the use of condom with most recent client	80%	62%	90%	90%
% of clients of sex workers that are HIV infected		4.07%[2]	3%	2%
Condoms distributed		41 M	56 M	TBD

[1] Millennium Development Goals, UNGASS, Universal Access..
[2] As clients of sex-workers are difficult to reach, prevalence in male with STD is used as proxy indicator

STRATEGIC DIRECTION 2. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG MEN WHO HAVE SEX WITH MEN

Target Groups: Men who have sex with men and their female sexual partners.

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Mass information provided – transmission, prevention, condom use, lubricants, and alternative sexual practices. Information about risks for specific groups of men who have sex with men.*	Increased proportion of men who have sex with men practising safer behaviours to prevent HIV transmission. Increased proportion of men who have sex with men and women practising safer behaviours with male and female partners.
Behaviour change support tailored for specific groups of men who have sex with men – peer education, negotiation skills, sexual skills (e.g. how to use lubricants).	
Access to resources is improved - condom and lubricant provision in education programs, social marketing, new sales outlets.	
Voluntary counselling and testing, STI services, treatment (incl. ART) care and support in a friendly for men who have sex with men manner, public sector.*	Increased proportion of men who have sex with men sought and got access to appropriate services. Reduced STI and HIV incidence amongst men who have sex with men. More men who have sex with men know that they are infected with HIV.
Voluntary counselling and testing, STI services, treatment (incl. ART) care and support in a friendly for men who have sex with men manner, private sector (including non-government organization programs).	
Friendly services for young men who have sex with men established and improved – health as well as other social and support services.*	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Men having sex with men are better able to initiate their own prevention and care and support programmes (i.e. activities could be capacity building activities, etc.).	Reduction of risk behaviour among men having sex with men
Participation of men who have sex with men, including those infected with HIV, in advocacy, program design and implementation (i.e. activities could be support to local support groups and networks).	Programs improved as they become more tailored to the expressed needs of beneficiaries. Behaviour change increases as education becomes more effective – e.g. men become more confident to negotiate and practise safer sex with other men, and more willing to care for each other. Stigma and Discrimination reduced.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
Enabling environment – national policies in place to indicate need for programs for men who have sex with men.*	Prevention programs and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence against visible groups of men who have sex with men. Programs and services more effective as trust is developed between implementers and men who have sex with men.
Enabling environment – township environment is supportive of HIV prevention programmes and services for men who have sex with men.	
Coordination and multisectoral cooperation amongst stakeholders (e.g. local authority, police, managers and owners of entertainment establishments).*	
Research and special studies to better understand contexts in which men have sex with men and to improve prevention and care programs.*	Prevention able to reach more men who have sex with men, in ways that are more helpful.Care and support more effectively able to respond to the specific needs of men who have sex with men.

Partners

Ministry of Health, Ministry of Social Welfare, Relief and Resettlement, Ministry of Home Affairs, Ministry of Tourism, Ministry of Transportation, Ministry of Railways, Ministry of Progress of Border Areas, National Races and Development Affairs; UN entities (UNFPA, UNAIDS, UNICEF, WHO) ; International non-government organizations (PSI, MSI, MDM, Care, WVI, HIV/AIDS Alliance, Consortium, MSF, AMI, Malteser, AFXB); non-government organizations, professional organizations and CBOs (MNA, MMA, MRCS, Pyi Gyi Khin); Entertainment Facilities, Hotels and Motels.

Suggested targets

Estimated number of men who have sex with men in Myanmar: 272,300[1]

Standard Indicators (inc. UNGASS in blue)	Indicative standard targets	Baseline situation in 2004 or2005	Suggested target for Myanmar	
			2008	***2010***
Number of MSM reached by prevention program	80%	17,850	41,983	62,000
% of MSM that are HIV+		33.0%[2]	31%	TBD
% of condom use by MSM at last anal sex		67%[3]	75%	80%
Number of MSM accessing VCCT			*25,000*	TBD
% of MSM with STI		35.2%[3]	33%	TBD

[1] Baseline scenario, 2% of adult male, Tim Brown, Yangon 2005
[2] MoH 1996. Only data source available for MSM. Actual figure may differ.
[3] Preliminary findings NAP MSM survey Mandalay 2005

STRATEGIC DIRECTION 3. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG DRUG USERS

Primary target group: Primarily drug users, with a special focus on injecting drug users

Secondary target group: Sexual partners and families of drug users and youth-at-risk

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Specific interventions for drug use primary prevention particularly for youth.	The proportion of youth engaging in drug use is reduced.
Strengthen drug education and HIV education for drug users and other young people – mass communication to include information about how to prevent HIV transmission associated with drug use and abuse, as well as drug demand reduction.	Increased proportion of drug users practising safer behaviours to prevent HIV transmission through drug use. Increased proportion of drug users practising safer behaviours to prevent HIV transmission through sex. Increased proportion of drug user's access education and behavioural support through institutional and non-institutional interventions.
Behavior change education and outreach for specific groups of drug users – peer education, skills in safer drug use and safer sexual behaviour, peer support, life skills.*	
Access to needle and syringe programs and condom promotion and distribution are increased from drop in centres and through outreach programs.*	
Primary health care provided for drug users (i.e. services provided by Drug Treatment Centres, drop-in centre, etc.).	
Referrals to counselling, testing, rehabilitation and treatment services for drug users.	Increased proportion of drug users sought and got access to appropriate services. Reduced STI and HIV incidence among drug users and their partners, friends, fellow-users, clients
Develop of programs to include family/ caregiver in all aspects of recovery and support.*	

OUTPUTS	OUTCOMES
Drug dependency treatment, drug substitution treatment (methadone), therapeutic communities and outpatient drug treatment programs expanded.	More drug users know if they are infected with HIV, and get proper counselling More drug users able to stop using drugs and reintegrate into society using appropriate detoxification and treatment methods Drug users who are living with HIV have access to the social support they need to help them benefit from treatments for opportunistic infections and from anti-retroviral treatment. Social and psychological support for drug users is improved, especially for people living with HIV.
Scale up successful community based detoxification programs under the supervision of Drug Dependency Treatment and Research Units (DDTRU).	
Voluntary confidential counselling and testing, STI services, treatment for opportunistic infections, tuberculosis, and ART are provided in settings that are friendly for drug users and vulnerable youth. (Settings include public and private sector, non-government organizations and for-profit services).*	
Tailored services for young drug users and youth vulnerable to drug use established and improved – health as well as other social and support services.	
Alternative vocational training for drug users, especially people living with HIV (reinsertion and socio economical reintegration), promoted through community programs.*	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Participation of drug users, ex-drug users and their families, including people living with HIV, in program design and implementation for their own groups.	Programs improved as they become more tailored to the expressed needs of beneficiaries. Behavior change increases as education becomes more effective – e.g. drug users become more confident to negotiate and practise safer drug use and safer sex, and more willing to care for each other.
Local support groups and networks inclusive of drug users and ex drug users are established to support sustained behavior change and empower participation with a focus on economic and income generating activities.*	

OUTPUTS	OUTCOMES
Ex-drug users contribute to local coordination groups.* Link local networks to assist one another and share best practices.	Compassion, understanding and empathy for drug users are increased (Stigma and Discrimination reduced). This makes it easier for the community to support HIV prevention, care and support for drug users.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
Key community leaders learn about public health benefits of harm reduction programmes (i.e. activities are advocacy and education of community leaders).	Prevention programs and services able to expand and to operate more effectively. Standard and multisectoral approaches used nationally, based on evidence of what works. Better links between prevention, education, treatment and rehabilitation initiatives. Less stigma, discrimination and violence against drug users. Programs and services more effective as trust is developed between implementers and drug users. Institutional policy and practices changed or reviewed (e.g. alternate sentencing, deferment policy). Enabling environment supportive of programs and services for drug users
National policies in place to indicate need for multisectoral programs for drug users, including prevention, education, treatment and rehabilitation, in line with the broad definition of Drug Demand Reduction (activities are advocacy, media use, etc.).*	
Effective coordination and multisectoral involvement at local level exists for use of evidenced-based interventions and accountability (i.e. activities are local level advocacy and support for coordination).	
Strategic information gathered and available, including needs analysis and documentation of impact and good practices of programs and policies. Compile best practices and lessons learned at district and state level to replicate and provide evidence-basis for policy change recommendations.	Better understanding of the extent of drug use and the health and social needs of drug users.
Exposure of decision makers to international good practices (study tours, trainings, coaching).	Policy makers and program designers are aware of what works best in other countries and other locations within Myanmar.

Partners

Ministry of Health and all health related government bodies and partners (MOH, NAP, DOH, and Drug Treatment Centres); all law enforcement government bodies: Ministry of Home Affairs, Central Committee for Drug Abuse Control (CCDAC); Ministry of National Planning and Economic Development FERD; Ministry of Social Welfare, Relief and Resettlement; Ministry of Education,

Ministry of Progress of Border Areas and National Races and Development Affairs (NaTaLa); National non-government and professional organizations (MANA …) Community Based Organizations; UN entities (UNODC, UNAIDS, UNICEF, WHO, UNFPA, UNHCR, IOM); International non-government organizations (AHRN, Burnet Institute, MDM, Care); Regional Project (Asian Harm Reduction Project); Networks of Drug Users; Networks of people living with HIV (including current and former drug users).

Suggested Targets

Estimated number of injecting drug users in Myanmar: 60,000[1]
Estimated number of non-injecting drug users:

In collaboration with CCDAC and DDTRU, the National AIDS Programme will lead a national exercise working with local multisectoral implementing partners to estimate local populations, current coverage to help set future targets

Standard Indicators (inc. UNGASS in blue)	Indicative standard targets	Baseline situation in 2004 or2005	Suggested target for Myanmar	
			2008	***2010***
Drug users reached by prevention programme			180,000	TBD
IDU reached by Harm Reduction program	80%	11,500	30,000	40,000
IDU accessing VCCT			*10,500*	*TBD*
% of IDU that are HIV infected		43.2%	36.5%	TBD
Needles distributed to IDU's		1,2 M	*4 M*	*TBD*
% of IDU that avoid sharing injecting equipment in last month		65%	*71%*	*TBD*
% of condom use by IDU at last sex Number of IDUs on substitution therapy (MMT)		34%	*60%* *2,000*	*TBD*

[1] Estimation workshop 2004

STRATEGIC DIRECTION 4. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG PARTNERS AND FAMILIES OF PEOPLE LIVING WITH HIV

Target Groups: Partners and families of people living with HIV

Objective: Reduce HIV transmission and improve quality of life for the partners and families of people living with HIV

Activity Area 1. Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by age, gender, location, and transmission behaviour.

OUTPUTS	OUTCOMES
Prevention strategies developed that are appropriate for partners of different groups, including sex workers, drug users, men who have sex with men.	Transmission to partners and families of HIV infected people is reduced Number of HIV-infected children is reduced, particularly among families of people living with HIV Number of HIV-infected people who are re-infected is reduced
Behavior change support – including participatory learning, peer education, negotiation skills.	
Access to resources – harm reduction materials, condom provision and promotion, support groups.	
Couples counselling and education for partners including trained counsellors for people living with HIV.	
Prevention education provided to children of people living with HIV who are at risk.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Partners and families of people living with HIV involved in self help groups (either separate groups, or they are invited to join groups of people living with HIV). Participation of groups of people living with HIV in design and implementation of programs for their partners and families. Participation of partners and families of people living with HIV in design and implementation of programs.	Programs improve as they become more tailored to the expressed needs of beneficiaries. Behavior change increases as prevention activities become more effective. Treatment, care and support improved as services respond to expressed needs of the partners and families of people living with HIV. Understanding and empathy for people living with HIV is increased (Stigma and Discrimination reduced), so that partners and families are more able to understand and respond to their own needs.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
National policies in place promoting stigma reduction and access to services for partners and families of people living with HIV. Advocacy has occurred at township level, to ensure recognition of needs of partners and families of people living with HIV. Township environment is supportive of programs and services for partners and families. Coordination and multisectoral cooperation amongst stakeholders and gatekeepers (e.g. local authorities, health services, social welfare services), increasing recognition of the needs of partners and families of people living with HIV.	Prevention programs and services able to expand and to operate more effectively. Treatment, care and support services and community activities are more easily able to reach and support people living with HIV who might not yet know they are infected. Better links between prevention, care and support. Better connections between people living with HIV and the rest of their local communities. Less stigma, discrimination.

Partners

MOH, relevant Ministries including the Ministry of Social Welfare, Relief and Resettlement, Township AIDS Committee; International and national non-government organizations including MMCWA, MWAF, MNA, MMA, MRCS, PACT, SC-UK, others; UN entities (UNICEF, UNDP, UNOPS); Community-Based Organizations and professional organizations; Support groups of people living with HIV.

Suggested indicators and targets

Estimated number of people living with HIV at an advanced stage of infection: 67,000

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
Number of People Living with HIV involved in self help groups		3,000	10,000	TBD

STRATEGIC DIRECTION 5. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG INSTITUTIONALIZED POPULATIONS

Target Groups

Men, women and children institutionalised within:

1. Prisons (those convicted and those under-trial; including children who have come into contact with the law or who are residing with their mothers)
2. Police lock-ups and other areas of temporary custody (including those in police stations, remand centres, and those for other temporary purposes)
3. Mental health institutions
4. Drug rehabilitation centres
5. Vocational training schools for women and girls (including Centre for Women Care and other schools)
6. Disability-related residential centres (including mentally retarded, deaf and dumb, school for disabled children, etc.);
7. Juvenile detention centres (including Department of Social Welfare training schools); and
8. Residential facilities for young people and children (including orphanages, and HIV positive children in nurseries operated by the Department of Social Welfare and or by private sector groups, including faith-based organizations)

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Information provided – transmission, prevention, alternative practices.	Increased proportion of institutionalized populations practising safer behaviours to prevent HIV transmission, including condom use and harm reduction behaviours
Behavior change support – peer education, negotiation skills.	
Access to resources - condom provision, social marketing.	
Interventions tailored for specific problems of different institutionalized groups by gender, age, and context.	
Integration of information and support programs for institutionalized populations with prevention programs of specific ministries and workplaces (e.g. residential treatment staff, non-government organization workers).	

OUTPUTS	OUTCOMES
Referrals to counselling, testing and treatment services.	Increased proportion of institutionalized populations has access to STI, HIV behavior change, harm reduction services, and condoms. Increased proportion of institutionalized populations has made use of voluntary and confidential counselling and testing services. Increased proportion of institutionalized populations knows their HIV status. Increased proportion of people in drug rehabilitation facilities has access to harm reduction services and resources. Reduced incidence of HIV arising from Maternal to Child Transmission which occurs when women are in institutions or soon after they leave institutions.
Voluntary confidential counselling and testing, STI services, support for behaviour change and harm reduction, appropriate resources including condoms, are available within institutions.	
Youth friendly services and programs developed within institutions where relevant and appropriate.	
Improved knowledge of institutionalized individuals, their families and spouses. Increased proportion of institutions provide counselling and treatment for Prevention of Mother to Child Transmission amongst people who are, or have been, in those institutions.	
Ensure treatment, care (for Opportunistic Infections including TB, Sexually Transmitted Infections, Anti-Retroviral Therapy, Post-Exposure Prophylaxis {for staff and inmates}, and Prevention of Mother to Child Transmission[1]—PMCT and PMCT plus) and support for people living with HIV in institutional settings and for the staff of these institutions. Provide methadone maintenance and drug treatment in institutions.* Procurement system in place to ensure regular and sufficient supply of drugs and other materials. Arrange referrals on discharge so individuals can continue treatment (including Antiretroviral Therapy and treatment for Opportunistic Infections).*	Institutionalized people living with HIV have longer, higher quality lives. Institutionalized people who use drugs are less likely to be involved in transmission of HIV, and less likely to acquire long term illness as a result of drug use while they are in institutions. TB is reduced in institutional settings. Decision makers and care givers in institutionalised settings are supportive of the objectives of this National Strategic Plan and are themselves involved in the national response to the HIV epidemic.

[1] This is needed only in a few prisons where women inmates can be accommodated (e.g. prisons in Yangon, Thayawaddy and Pathein)

OUTPUTS	OUTCOMES
Support and extend the range of available health services in the settings, including the infrastructure needed for TB control. Capacity of institutional staff is developed through training and on-going continuing education.	
Capacity strengthening of Social Welfare Department, psychosocial services and support systems.	More families have access to social welfare services including psychosocial services and support.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Increased participation of vulnerable groups in tailored interventions for institutionalised groups, as well as increased participation of relevant stakeholders (Ministries as well as NGOs)	Programs improved as they become more tailored to the expressed needs of beneficiaries. Behavior change increases as education becomes more effective. Stigma and Discrimination reduced within institutions.
Programs and services in prisons ensure confidentiality of prisoners having access to HIV related services.*	More prisoners seek access to relevant services, improve their health and reduce further transmission of HIV within prisons and within their own communities upon release. Community acceptance, understanding and empathy for children and adults living in institutions is increased (Stigma and Discrimination reduced)
Participation of people living with HIV in programs for institutionalized populations.*	Programs improved and focused on improving responses to HIV and AIDS.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
National guidelines in place to ensure HIV interventions take place in institutions including prisons.	Prevention programs and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence within institutions and within communities. Programs and services more effective as trust is developed between implementers and institutionalized groups Vulnerability to HIV is reduced as deinstitutionalized populations increase their capacity to care for themselves and each other. Township environment outside institutions is supportive of programs and services (decision makers and communities are supportive).
Advocacy has occurred at township and local levels to encourage institutions to participate in the national response to the HIV epidemic.	
Development of follow-up systems and structures at community level to assist with re-integration of institutional residents when they are released. Ensure confidentiality, psychosocial support and socioeconomic reintegration. Link institutional and community services. Offer HIV prevention, including Voluntary and Confidential Counselling and Testing, and map services as part of compiling information about local networks.	
Advocacy outside institutions to develop township support for HIV related programmes within institutions – advocacy amongst decision makers and communities.	
Coordination and multisectoral cooperation amongst stakeholders and gatekeepers (e.g. local authority, police, religious groups, managers and owners of entertainment establishments) at local levels.	
Advocacy and linkages with law enforcement agencies to gain their support for HIV prevention, treatment, care and support programs.	

OUTPUTS	OUTCOMES
Recovery, re-integration and social services for those who are de-institutionalized. Creation of a community-based visitor program to support reintegration and continuity of access to services for people when they leave institutions.	Increased proportion of institutionalized population is able to reintegrate into other social environments.

Partners

Ministry of Health, National AIDS Program, Ministry of Social Welfare, Relief and Resettlement, Ministry of Home Affairs (Prisons Department, General Administration Department, Myanmar Police Force and CCDAC), Township AIDS Committees, Yangon City Development Committee and Mandalay City Development Committee; Myanmar Women Affairs Federation and MMCWA; Non-government organizations: AHRN, Care, FXB, MDM, ICRC[1], Save the Children, Alliance, WVI; UN entities: UNODC, WHO, UNICEF, UNIAP, UNAIDS.

Suggested targets for Myanmar

Estimated number of prisoners: 62,300 (14% female)

Standard Indicators	Indicative standard targets	Baseline	Suggested target for Myanmar	
			2008	*2010*
Prisoners reached by health prevention program		5,000	30,000	TBD
% of prisoners accessing VCCT			TBD	TBD

[1] As ICRC has no MOU with the MOH currently, coordination with it may be a challenge

STRATEGIC DIRECTION 6. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG MOBILE POPULATIONS

Target Groups:

Mobile workers:
- Seafarers, formal and informal workers, cross border and other workers from inland water transport sector
- Truck, bus and taxi drivers
- Railway workers
- Sex workers and entertainment workers, cross border and other Pwe workers and performers
- Traders, including cattle herders
- Population in difficult to access areas

Seasonal and temporary migrants (workers who have a home and return to it):
- Construction workers (road, dams, bridges, other major projects – includes foreign workers)
- Migrant factory workers, including cross border
- Mining sites
- Agricultural sites (rubber, sugar-cane (includes cross border), maize (includes cross border), peanuts, pulses, rice, oil)
- Domestic workers

Migrants: (workers who don't go home; includes landless people without homes)
- Rural to urban and rural to rural
- Myanmar to other countries
- Other countries to Myanmar

Mobility affected communities:
Stable communities that interact with mobile people, including cities where mobile people come and rural areas where construction takes place or new industries are being developed. Priority communities should be identified and mapped for interventions.

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Increased prevention programs at border points and transit zones for out-migration (BCC programs, etc) carried out collaboratively across borders.	Reduction of risky behavior (sexual and other practices), and thus reduced HIV transmission, amongst mobile populations. More mobile people know they are infected with HIV and gain access to health services including treatment.

OUTPUTS	OUTCOMES
International/cross-border construction, infrastructure and natural-resource projects integrate prevention programs (as endorsed by UN Regional Task Force on Mobility and HIV Vulnerability Reduction and by ASEAN Task Force on AIDS).	
Prevention programs are integrated into infrastructure (large construction) projects wherever feasible (as endorsed by UN Regional Task Force on Mobility and HIV Vulnerability Reduction and by ASEAN Task Force on AIDS).	
Increased migrant-friendly services which are multi-lingual, well-known/advertised, and portable ("health history books", referral systems, etc.).	
Large companies and industries employing mobile populations implement more prevention and care/treatment/support programs.	
More prevention programs (including referral for care information) established in transit centers / hubs / channels.	
More community-based prevention and care/treatment/support programs are implemented in identified mobility-affected communities in a coordinated and participatory fashion using migrant-friendly methods (see above), linked to and supporting existing services wherever possible. Safe places (drop-in centres) for mobile population at destination communities and border points. Interventions focusing on mobile young people as they are likely out of school and more vulnerable because of lower education in general, lack of access to school-based programs, out of traditional community context with other sources of prevention information, living in mobile communities with other increased vulnerabilities. Focus on industries employing youth, such as fishing industry and informal/cottage industry.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Increased interaction between existing and new/neighbouring/potential source communities to share information/ knowledge/experience.*	Programs improve as they become more tailored to the expressed needs of beneficiaries. Behavior change increases as education becomes more effective. Reduced stigma against mobile people and workers who are living with HIV. Communities vulnerable to HIV because of their association with mobile populations become more resilient and able to make the most of mobility-related opportunities for development.
Community development processes to build HIV resilient communities by bringing together mobile and other people, including employers.	
Advocacy campaigns developed with the involvement of mobile people, including young people.	
Research on attitudes towards mobile population in general, including young people to improve/inform advocacy and programming.	
Participation of people living with HIV, including mobile people, in design and implementation of programs affecting mobile people. Provision of safe places gives mobile populations a sense of empowerment.	Programs improved and focused on improving responses to HIV and AIDS.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
Mobility Thematic groups are established at national, state/division, district and township levels. They receive capacity-building assistance and lead planning, coordination and implementation of HIV programs for mobile populations and mobility-affected communities. (ASEAN Member Countries have agreed to establish national thematic groups in 2006).	Prevention and care programs in Mobility and HIV become more effective as expertise is developed specifically for these complex issues.
Mobility and HIV vulnerability is addressed at national, state/division, district and township level.	

OUTPUTS	OUTCOMES
Increased cross-border multicultural cooperation relative to HIV vulnerability and mobility. Expanded authority and mechanisms for actors on both sides of a border to meet and program collaboratively.	Decision makers in economic development within Myanmar and across national borders recognise the importance of addressing the associations between HIV and mobility, and encourage development of prevention programs.
Advocacy to authorities and decision-makers to address increased vulnerabilities of mobile populations (at national, state and township levels).	
Stronger partnerships established between HIV and anti-trafficking policy makers and programs (including law enforcement, general administration, projects), and HIV prevention modules included in anti-trafficking programs.	HIV prevention is reinforced through integration with programs addressing other factors which make some mobile people vulnerable to exploitation.
Improved analysis of migration patterns using common tools to facilitate regional sharing (common database, mapping at state level, collection instruments, early warning systems etc.) leads to improved programs.	Programs focus on most-at-risk mobile people, and policy makers keep up with changes in patterns of mobility so that this focus remains. Programs in different locations are linked, so that mobile people can access continued prevention and care support as they move around.
Bilateral collaboration among neighboring countries increased to facilitate referrals, transport, safe return, continuity of care for mobile persons, etc.	

Partners

Ministry of Health, Ministry of Home Affairs, Ministry of Railways, Ministry of Progress of Border Areas, National Races and Development Affairs, Ministry of Agriculture, Ministry of Construction, Ministry of Social Welfare, Relief and Resettlement, Ministry of Labor, Ministry of Trade, Ministry of Immigration and Populatio, Ministry of Information; Non-government and private organizations: MRCS, MMCWA, MHAA, MWAF, MBCA, UMFCCI, Employment Agencies; PACT, CARE, Consortium, Save the Children, MSF; UN entities and other multi-lateral organizations: IOM, UN-IAP, UNICEF, WFP, UNDP/UNOPS, ASEAN Task Force on AIDS, UN Regional Task Force on Mobility and HIV Vulnerability Reduction.

Suggested Indicators and Targets

Estimated number of mobile/migrant population in Myanmar:

Standard Indicators	Indicative standard targets	Baseline 2005	Suggested target for Myanmar	
			2008	***2010***
Number of mobile/migrant population reached by prevention program			121,000	TBD

STRATEGIC DIRECTION 7. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG UNIFORMED SERVICES PERSONNEL

Target Groups: Uniformed services personnel and family members, including the military, police, prison staff, Bureau of Special Investigation, immigration, fire brigade, customs, other special forces in border areas and some civilians (e.g. working for the military in accounting and factories).

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender and transmission behaviour.

OUTPUTS	OUTCOMES
Capacity building for Behavior Change Initiatives within uniformed services.	Increased safe sexual behaviour including condom use among uniformed services personnel and family members.
Behavior Change Initiatives occur within all uniformed services at all levels, especially of new recruits.	
Condom promotion and distribution within all uniformed services.	
STI treatment capacity building for uniformed services health personnel.	Increased utilization of STI, HIV, counselling and PMCT health services by uniformed personnel and family members. Increased proportion of uniformed services and family members sought and received access to appropriate STI, HIV and voluntary counselling and testing services. Reduced STI and HIV incidence amongst men within uniformed services. More uniformed services and family members know that they are infected with HIV.
Behavior Change Initiatives to promote health seeking behaviour and utilization of STI and VCCT health services by uniformed personnel and their families.	
Clean injecting equipment and PEP supplies available, health staff trained in safe injection procedures and PEP procedures.	
Safe blood supply system ensured within all uniformed services health sections.	
Capacity building in voluntary and confidential counselling, HIV testing and referral networks for uniformed services health personnel.*	

OUTPUTS	OUTCOMES
Prevention of Mother to Child Transmission policies developed, supplies available, and health services staff trained.	Universal precautions in uniformed health services – clean injecting equipment, safe blood supply, and access to post exposure prophylaxis for health workers. Safe work practices (e.g. police aware of potential for needle stick injuries when dealing with drug users).
Referral systems established between uniformed and civilian health services, after initial advocacy and collaboration meetings at national level, commencing with Accelerated Townships.	

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Participation of uniformed services personnel and their families in program design and implementation for their own groups.	Programs improved as they become more tailored to the expressed needs of beneficiaries.
Involvement of uniformed services in collective responses against HIV as well as in partnerships in prevention, care and treatment.	Behaviour change increases as education becomes more effective – e.g. uniformed services personnel become more confident to negotiate and practise safer sex. Programs within uniformed services and civilian sectors are harmonious and mutually supportive.
Participation of beneficiaries in programs for uniformed services.* Gender and sex-work issues addressed in prevention programs for uniformed services	Programs improved and focused on improving responses to HIV and AIDS. Stigma and discrimination reduced for people living with HIV among uniformed services personnel.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
Advocacy communication with senior officials and policy/decision makers – national, then in Accelerated Townships.	Prevention programs and services able to expand and to operate more effectively. Better links between prevention, care and support.
Exposure and exchange opportunities for officials and policy/decision makers at National, State and Division and Township levels.	

OUTPUTS	OUTCOMES
Review of policies related to HIV-positive uniformed service members, once Antiretroviral Therapies are introduced and generalized.	
Research and special studies to better understand contexts in which uniformed services and their family members are vulnerable to HIV transmission, extent of risk behaviours and attitudes within uniformed services. Coverage of proven prevention interventions for police should be scaled-up quickly.	Prevention able to reach more uniformed services personnel who are vulnerable to HIV transmission, in ways that are more supportive of behavior change. Care and support more effectively able to respond to the specific needs of uniformed personnel and their families.

Partners

Government: Ministry of Health (NAP), Ministry of Defence, Ministry of Home Affairs, Ministry of Immigration and Population, Ministry of Social Welfare, Relief and Resettlement; National non-government and professional organizations: Myanmar Women Affairs Federation, Myanmar Maternal and Child Welfare Association; International non-government organizations: Care, PSI; United Nations: UNODC, UNAIDS, WHO

Suggested Targets

Standard Indicators	Indicative standard targets	Baseline	Suggested target for Myanmar	
			2008	*2010*
Uniformed population reached by prevention program ➢ Police ➢ Military		100,000	250,000	TBD

STRATEGIC DIRECTION 8. REDUCING HIV-RELATED RISK, VULNERABILITY AND IMPACT AMONG YOUNG PEOPLE

Target Groups

Children and young people less than 24 years old, especially:

1. Young people in schools including colleges and universities
2. Orphans and vulnerable children (including HIV affected and infected children)
3. Out-of-school vulnerable young people, including:
    a. Drop outs
    b. Those who have never been to school
    c. Street children
    d. Mobile youth
4. Young people in the work force (formal and informal)

Activity Area 1: Ensure availability and equitable access to a continuum of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, and transmission behaviour

OUTPUTS	OUTCOMES
Youth-friendly diagnostic, treatment, care and support services are more widely available (some are occurring now, but there will be support for rapid scaling up): • Community capacity for delivery of care is enhanced, including community capacity to develop their own youth-friendly services • More non-government organizations, International non-government organizations and Community Based Organizations, and the private sector, are officially involved in provision of youth-friendly services in collaboration with public health services • Increased number of HIV treatment and care sites (public and private sectors) that provide youth friendly services • More affected communities have youth-friendly services • Quality adolescent reproductive health services, including STI and HIV services, are established	More young people have reduced risk behavior related to HIV and STI transmission More young people are using adolescent-friendly reproductive health services, including access to: • Counselling and Psychosocial support· • Condoms (male and female) • Information, Education and Communication materials • Reproductive and other sexual health services, including STI diagnosis and treatment • Advocacy for parents to support these services • Public outreach • Social and Youth Workers • Social marketing techniques applied to support increased condom use • Drop-in-centres for youth

OUTPUTS	OUTCOMES
• Youth Centres are established that provide entertainment, recreation, information, education talks, group activities, use of internet • Education and support services available for students in schools, and institutions including universities, to address STI, alcohol and drug use issues, with linkages to HIV-related care and support services for students. Increased capacity of health care providers to provide clinical care and support to young people through continuing, pre- and in-service education and on the job training.	
A formalized community based care system is established that includes social and psychosocial interventions, including foster care, formalized kinship care and social houses (some action now occurring, but replication of what works is required). The community-based care system is linked with the continuum of care, support and treatment provided by the health sector. This will require: • Better and more nationally consistent coordination at the township level • Scaling up of existing activities that work.	More orphans and especially vulnerable children have reduced risk behavior related to HIV and STI transmission. More orphans and other vulnerable children have access to education, services, and basic needs including food security.More orphans and especially vulnerable children are using social and health services, including: • Peer education • Community-based self-help groups • Youth friendly centres, providing access to counselling, education and health care services. • Safe houses and temporary care facilities • Skill-based non-formal HIV/AIDS prevention education system developed and functioning. • Skill-based non-formal education programs Fewer especially vulnerable young people become “at highest risk”.

OUTPUTS	OUTCOMES
Review and Standardisation of messages related to HIV and AIDS for adolescents and youth. National and Township Communications strategies are developed, including: ● Updates for parents and families on HIV issues ● HIV Prevention Mass Media Communications Campaign (age and gender appropriate) ● Engage employers to raise awareness about prevention, care and support in the workplace ● Converging anti-trafficking and HIV prevention strategies in workplace settings ● Anti-discrimination programs in workplaces established ● Promote and publicise access points for young workers to youth services in the community ● Urban affluent youth reached through peer education and outreach ● Social marketing techniques applied to promote increased condom use· Skill-based non-formal education programs endorsed ● Forums for young people to discuss behaviour change communication.	More young people know how to avoid HIV/STI transmission, including HIV/ STI, adolescent and reproductive health, illicit use of drugs and alcohol related to HIV, STI infection and health in general. More young people are supported in healthy decision-making.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including young people and people living with HIV, so they are able to participate in program design, development, implementation, and evaluation

OUTPUTS	OUTCOMES
Establish peer support groups that include families and children of people living with HIV, as well as people living with HIV themselves. Experience with peer support groups documented so best practices can be shared.Advocacy for treatment for young people (availability of Antiretroviral Therapies, treatments for Opportunistic Infections and STI treatments will increase demand for involvement in prevention and care activities).	More young people are involved in the planning, design, implementation and evaluation of youth-friendly services. More young people have increased individual capacity (self-awareness, self-reliance and confidence, decision making, problem solving, communication skills) to maintain safe behaviours.

OUTPUTS	OUTCOMES
Young people involved in township coordination mechanisms. Conferences and forums run by and for youth.	
Program interventions linking youth "at highest risk" and especially vulnerable children to their less vulnerable peers.	More young people are actively promoting healthy behaviour to one another.

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

OUTPUTS	OUTCOMES
Develop and maintain education policy to ensure HIV prevention education is part of the core curriculum in all schools (scale up existing activities that work but are not yet universally available). Develop and maintain policy to ensure peer education is available for all university students. HIV and AIDS media policy reviewed and strengthened. Increased use of media to raise community awareness and sensitivity to the needs of orphans and vulnerable children. Minimum standard of services for orphans and vulnerable children developed (Department of Social Welfare has schools for orphans, but there are not yet standards for community and private sector facilities). National guidelines for youth-friendly clinics developed with the participation of youth. Converging of anti-trafficking and HIV prevention strategies is continued and improved.	More policies are in place that promote and support young people's behavior change and avoidance of HIV-related risk taking behaviour.
Ensure mobilization of parents and community leaders to address HIV-related issues through the Parent Teacher Associations at the township level.	More parents are involved in providing services and supporting young people's behavior change.

OUTPUTS	OUTCOMES
More schools, including monastic and faith based education facilities, develop Parent Teacher Associations and HIV education programs.	More parents and family members are able to communicate with their children and support low risk behaviour.
Focal persons and task forces from relevant line ministries are identified to advocate, educate, and provide direction as champions of HIV prevention and care within their ministries. Existing central policies are disseminated to State, Division and Township levels, and Township initiatives are encouraged with central support.	Multisectoral support for and participation in, HIV programmes for youth. More young people know where to get all of the services they need to support them to reduce their risk behaviours.
Communications Strategy developed to continually update leaders at Township level about HIV and community development issues. Guidelines developed for how Township AIDS Committees can use the Communications Strategy to develop their own initiatives. Communications Strategy developed to continually update parents and families on HIV issues. This strategy to be implemented at Township level, with involvement of Parent Teacher Associations.	Communities more aware of HIV issues concerning youth.
Advocacy for authorities at different levels to support the development of youth centres for all youth in and out of schools (including advocacy to police and other local justice staff to ensure that their work supports national strategies).	More youth centres are established in more locations. More young people using youth centres.
More action research is used to determine if services are addressing young people's needs.	Use of relevant and effective services by young people is increased.
The quality of services is improved through the development of local monitoring systems. Capacity of local partners is built in monitoring, which is then conducted jointly by Township AIDS Committees and Non-Government Organizations.	Increased provision of quality health provider and community services. Increased use of relevant and effective health and social services.

Partners

Ministry of Education, Ministry of Health, Ministry of Social Welfare, Relief and Resettlement, Ministry of Science & Technology, Ministry of Defence, Ministry of Information, Ministries with technical focus at specific universities, e.g. Agriculture; State/Division Ministry Departments; Township Level Parent Teacher Associations, Township Education Offices, School Health Teams, Community Leaders, Religious schools & principals; UNICEF, UNFPA; Non governmental organizations (MRCS, Consortium..).

Suggested Indicators and Targets

Estimated number of young people (15-24) in Myanmar: 9,495,000

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
% of young people that are HIV infected (15-24)	MDG -25%	2.2%	1.97%	TBD
% of condom use by young people at last paid sex		78.3%[1]	90%	90%
% of youth who correctly identify the three common ways of preventing HIV transmission		21%	50%	TBD
% of youth who reject misconceptions		27.0%	50%	TBD
% of youth expressing accepting attitudes			40%	TBD

Estimated number of in school youth (5-15) in Myanmar: 7,490,000

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
Out of school youth (15-24) reached by prevention program	50%	200,000	500,000	TBD
Young people having access to VCCT		20,000	80,000	TBD
In-school youth (10-16) reached by life-skills programme		900,000	1,800,000	TBD
% of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year		36.30%	70%	TBD

Estimated number of orphans (0 to 18 one or both parents): *To be determined*

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
Number of Orphans and Vulnerable Children provided with support		27,800	85,000	TBD

[1] NAP BSS 2003

STRATEGIC DIRECTION 9. ENHANCING PREVENTION, CARE, TREATMENT AND SUPPORT IN THE WORKPLACE

Target Groups: Employees of formal and informal workplaces and their families.

Priority should be given to businesses with large work forces, businesses linked to mobile populations, and businesses related to sex work. These priority businesses include mining, construction, seafarers, truck drivers, entertainment businesses, karaoke bars, guest houses, and golf courses.

Activity Area 1. Ensure availability and equitable access to a combination of prevention, treatment, care and support services that are highly effective because they are flexible, tailored and targeted by age, gender, location, and transmission behaviour.

OUTPUTS	OUTCOMES
Prevention strategies appropriate for worksite employees are further developed and evaluated, and what works best is scaled up. All workplaces, commencing with the largest work sites, to develop programs to ensure that workers have: • Behavior change communication including participatory learning, peer education and negotiation skills • Prevention education provided to families • Worksite outreach programs • Private places in workplaces so that people can talk about HIV and reproductive health • Access to resources – harm reduction materials, condom provision, social marketing, support groups—in worksite settings • Access to 100% Targeted Condom Promotions • Referrals to Voluntary and Confidential Counselling and Testing, so that workers can safely find out if they are infected with HIV • Referrals to appropriate services which offer Couples Counselling and education for partners of people living with HIV.	HIV and STI among formal worksite employees reduced. More workers seeking and gaining access to prevention, treatment, care and support services.

OUTPUTS	OUTCOMES
Business AIDS Networks further developed and then work to strengthen HIV prevention work in informal workplaces such as tea shops and guest houses. Informal work place managers to be invited to join Business AIDS Networks or to form other groups and networks.	HIV and STI among informal worksite employees reduced. More workers and customers at informal workplaces seek prevention, treatment, care and support services.
Non-Health Government Sectors further develop HIV prevention, care and support services, commencing with strengthening of existing services in ministries with their own health sectors (e.g. Railways, Social Welfare, other workers' hospitals). These will include: ● Strengthening of existing health sections of non-Health ministries· Prevention, care and support are provided in workplaces (STI diagnosis and treatment, treatments for Opportunistic Infections, counselling, social support, leave, time off, zero tolerance to stigma and discrimination, insurance) ● Blood safety programs promoted in railway and worker hospitals· Ensure treatment, care (for Opportunistic Infections including TB, Sexually Transmitted Infections, Anti-Retroviral Therapy, Post-Exposure Prophylaxis for staff and clients, and Prevention of Mother to Child Transmission—PMCT and PMCT plus) and support for people living with HIV in worksite settings and for the families of employees ● Referral systems for care and treatment are in place for workers, families and clients of non-Health ministries ● Support and extend the range of available health services in government workplace settings where possible.	More government workers, their families and clients have access to HIV programs.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that they are able to participate in program design, development, implementation and evaluation.

OUTPUTS	OUTCOMES
Participation of employees and their families in workplace-related HIV prevention programs. Involvement of supervisors/managers in HIV programs. Local support groups and networks established in large workplaces where there are many vulnerable people or many people living with HIV.	Programs improve as they become more tailored to the expressed needs of beneficiaries. Behavior change increases as education becomes more effective. Understanding and empathy for vulnerable people in workplaces is increased (Stigma and Discrimination reduced).
More persons living with HIV and AIDS are involved in worksite prevention, treatment, care and support programs.	Understanding and empathy for people living with HIV is increased (Stigma and Discrimination reduced). Services for people living with HIV are improved.

Activity Area 3: Strengthen the enabling environment through advocacy and education to ensure that interventions are as effective as possible.

OUTPUTS	OUTCOMES
National Task Force on workplace policy formed and its development supported with: ● Capacity building programs for workplace leaders ● Strategic skills development ● Technical skills development This will lead to improved workplace HIV programs as well as: ● Strengthened linkages between the Division for Occupational Health and the National AIDS Program ● Policies on HIV and AIDS in the workplace are developed and implemented ● Business networks on HIV are formed at all levels and work on advocacy, fund raising, events, and program implementation ● Public media is used for advocacy to promote HIV programs in workplaces	Prevention programs and services able to expand and to operate more effectively. Better links between prevention, care and support. Less stigma, discrimination and violence in and around workplaces. Vulnerability to HIV is reduced as people living with HIV increase their capacity to care for themselves and each other.

OUTPUTS	OUTCOMES
• Business networks are linked with government and non-government organization programs on HIV • Business leaders become more active in advocacy to support HIV programs • Township environments are more supportive for HIV programs and services as local businesses indicate support for these Coordination and multisectoral cooperation is improved.	

Partners

Ministry of Health, Ministry of Labour, Ministry of Industry 1, Ministry of Industry 2, Ministry of Social Welfare, Relief & Resettlement, Ministry of Transport, Ministry of Rail transportation, Ministry of Mine, Ministry of Construction, Ministry of Agriculture and Irrigation, Ministry of Livestock Breeding & Fisheries, Ministry of Energy, MSF-H, Care, Partner, MMA, MBCA, UNAIDS, UMFCCI.

Suggested indicators and targets for Myanmar

Estimated number of working population: 25 Million

Standard Indicators	Indicative standard targets	Baseline	Suggested target for Myanmar	
			2008	*2010*
% of people reached by health education at workplace	3%	200,000	*400,000*	*3.0%*
Nbr of large enterprises who have HIV/AIDS workplace policies and program			20	TBD
% of large enterprises who have HIV/AIDS workplace policies and program			Survey to be conducted	

STRATEGIC DIRECTION 10. ENHANCING HIV PREVENTION AMONG MEN AND WOMEN OF REPRODUCTIVE AGE

Target Groups: Men and women 15 to 49 years of age who are at low risk of HIV transmission

Activity Area 1: Ensure availability and equitable access to a continuum of effective and high quality treatment, care, and support services that are flexible, tailored and targeted by location, age, gender, and socioeconomic status

OUTPUTS	OUTCOMES
National strategy for risk reduction amongst low risk groups is developed, including: ● IEC/BCC materials production and distribution ● IEC/BCC events ● Mobilization of community participation ● Advocacy at township level ● Collaboration of public and private sector ● Pre-marital counselling. More research on effectiveness of IEC in supporting healthy behaviours, relevant behaviour change, and reduction of stigma and discrimination amongst the whole population.	Low risk individuals have improved understanding of HIV and STI prevention, including safe sex and drug use. Low risk individuals are more supportive of HIV programs for vulnerable people and the populations at highest risk. More low risk individuals have access to IEC and BCC materials and VCCT and PMTCT. More low risk individuals have increased knowledge of HIV and STIs.
Reproductive health services for the whole population are strengthened: ● Integration of HIV prevention and care services with reproductive health clinics, maternal and child health clinics, youth centres, workplace clinics and other centres where women and men of reproductive age have access ● Male-friendly services are established· Male involvement ● Commodities are available, including HIV test kits, STI drugs, condoms, PMTCT packages).	More low risk individuals use reproductive health services, including: ● STI prevention ● Condom use ● VCCT ● PMTCT ● Pre-marital counselling. More men are seeking reproductive health services.

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in program design, development, implementation, and evaluation

OUTPUTS	OUTCOMES
Strategies to involve more men in HIV/AIDS prevention and reproductive health services including: ● Antenatal clinics which are friendly for couples, so that men as well as women attend antenatal clinics ● Partner notification strategies are developed in STI services ● Gender specific IEC and communication strategies are developed ● HIV prevention, treatment and care services work in places often frequented by men (drinking places, workplaces, monasteries, teashops).	More people of reproductive age are participating in HIV/AIDS prevention and care planning in their communities
Specific strategies developed to encourage more male young people and adult men to access health services.	More men are using HIV/AIDS, reproductive health, antenatal, and STI services

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

OUTPUTS	OUTCOMES
Reproductive health policy and guidelines, including HIV prevention, are strengthened and implemented.	Reduced stigma and discrimination. More people of reproductive age are aware of HIV and know at least two ways to prevent it.
IEC/BCC strategy and guidelines developed for low-risk populations, backed up with formative research and analysis of needs.	
Policy and guidelines on stigma and discrimination developed, disseminated and evaluated.	
Partners collaborate to improve referrals and coordination.	

Partners

Government: Ministry of Health (NAP, CHEB, MCH), Ministry of Information, Ministry of Education, and line ministries; Non-government organizations (MMA, MMCWA, MWAF, Women's Affairs Organization); Media professionals, IEC/BCC technical persons from UN agencies, non-government organizations; Men and women of reproductive age; people living with HIV and AIDS of reproductive age; Township authorities, health committee, chairs of local non-government organizations, township health, education and communication officers and local general practitioners

Suggested indicators and targets for Myanmar

Estimated number of women and men of reproductive age (15-49): 27.18 million

Standard Indicators	Indicative standard targets	Baseline	Suggested target for Myanmar	
			2008	***2010***
Adults accessing VCCT each year	1%*	81,674	*200,000*	300,000
Adults reached by prevention programmes	0%*	450,000	*1,000,000*	*1,000,000*
Number of patients with STI that receive treatment	75%	130,000	*190,000*	*230,000*
% of women and men with STI at health care facilities who are appropriately diagnosed, treated and counselled			60%	80%

** For non generalised epidemic*

STRATEGIC DIRECTION 11. MEETING NEEDS OF PEOPLE LIVING WITH HIV FOR COMPREHENSIVE CARE, SUPPORT AND TREATMENT

Target Groups

- People living with HIV
- Affected children, families, and communities

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

Activity Area 1: Ensure availability and equitable access to a combination of programs and services that are highly effective because they are flexible, tailored and targeted by location, age, gender, and transmission behaviour.

OUTPUTS	OUTCOMES
Voluntary confidential counselling and testing services are more widely available and are attractive to different types of people. Benefits and locations of voluntary confidential counselling and testing services and prevention of mother to child transmission services are promoted to communities as an entry point to care and support services. Create demand for care and support services through ● Awareness of benefits ● Stigma and discrimination reduction ● Networking of people living with HIV ● Providing services in a wider range of settings, including health and non-health ● Ensuring access to medical facilities for people living with HIV and AIDS ● Promote and provide services for TB/ HIV co-infected people.	More people know the benefits of Voluntary and Confidential Counselling and Testing and want to know their status. More persons living with HIV and AIDS and their families seek diagnosis, treatment, care, and support services. More TB patients seek to know their HIV status.

OUTPUTS	OUTCOMES
Increased number and quality of voluntary confidential counselling and testing sites and services at all levels (STI clinics, TB clinics, antenatal care centres, maternal and child health centres, stand-alone voluntary confidential counselling and testing services), in public and private sector. Confidentiality is protected. Establish "One-Stop Service Centers".	
Diagnostic, treatment, care, and support services are more widely available: · Community capacity for delivery of care is enhanced, including their capacity to develop their own care and support responses · More non-government organization CBOs and private sector officially involved in provision of services in collaboration with public health services · Increased number of HIV treatment and care sites (public / private sector) to provide clinical care and support including TB/HIV · Strengthen the health system to reach affected communities · Build the capacity of local care and support providers to meet the needs of their affected members · Extend health care services and social services to HIV affected persons in their homes through community level mechanism. Increased capacity of health care providers (including TB staff) to provide clinical care and support to people living with HIV through continuing, pre- and in-service education and on the job training. Procurement and supply system of pharmaceuticals and laboratory strengthened.	More people who need antiretroviral and/ or treatment for opportunistic infections are getting it A broader range of high quality services (including TB/HIV services) are provided at more geographical sites More people living with HIV have access to multiple services More TB/HIV co-infected people have access to comprehensive servicesMore communities take responsibility for the care and support needs of their HIV-positive members More people (including TB/HIV co-infected people) are adhering to their treatment protocols More families are accessing a holistic package of services More institutional populations have access to services

OUTPUTS	OUTCOMES
Continuum of care, support and treatment reaches the institutionalized populations (see target groups). Nutritional needs of people affected by HIV met.	
Provider roles (who, how, when, where, what, why…) are clearly defined for service delivery. Enhance the continuum of care for people living with HIV by strengthening the referral mechanisms between the all levels of the health system including community and home based care services and health facilities and between the public and private sector, and by establishing day care /drop in centres for people living with HIV. Psychosocial services are provided to affected families and communities, including counselling, legal support and succession planning, material, subsistence and economic support, care for orphans and vulnerable children, protection, especially for children, shelter and livelihood support, and spiritual space. The capacity of the social service system to reach the community level is increased. Mechanisms for increasing cross-sectoral collaboration are increased.	HIV and AIDS services are integrated into the health care system HIV services are integrated into the social welfare system There is a continuum of care provided by the health system, by social services providers, by the family and community
A minimum and holistic comprehensive package of care is provided through multisectoral collaboration at each level. The basic package is adapted to increase its attractiveness to key population subgroups (e.g., women, men, children, adolescents, sex workers, drug users, and TB patients).	Increased equity and efficiency of delivery Increased use of services by specific population subgroups
The quality of services is improved through action research. Studies of drug resistance are undertaken.* Increased capacity / knowledge of people living with HIV including adherence and options to treatment.	Increased provision of quality health provider and community services Drug resistance is prevented and controlled

Activity Area 2: Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in program design, development, implementation, and evaluation

OUTPUTS	OUTCOMES
Strengthen self-help groups for people living with HIV in different areas and assist them to build their social capital. Capacity-building for networks of people living with HIV is provided. Ensure security of people living with HIV by disclosing their status (job, property, physical, social etc).	More people living with HIV are involved in care and support groups More people living with HIV have paid roles in service delivery The skills and experience of people living with HIV are valued
People living with HIV are included in all related committees. Planning groups include a fixed percentage of people living with HIV and AIDS. People living with HIV have responsible positions in key organizations.	More vulnerable groups are involved in service planning and provision Marginalised groups are less "marginalised" Marginalized groups and people living with HIV feel more acceptance Income level at least maintained

Activity Area 3: Strengthen the enabling environment through advocacy at all levels and by increasing awareness of the general population

OUTPUTS	OUTCOMES
Establishment of policy against pre-employment and mandatory HIV testing.*	Increased compassion, understanding and empathy towards people living with HIV including amongst health care and social welfare providers at all levels, to reduce stigma and discrimination. More people know their HIV status. More people practice safe sex behaviour. More advocacy for people living with HIV at all levels
Guidelines for HIV testing ensuring this is Voluntary and Confidential, and addressing stigma and discrimination, are followed.	
Interventions to ensure access to services to all those in need including hard-to-reach populations in remote areas.* Interventions with participation of religious organizations.	More people living with HIV are able to access services, undertake productive employment. Religious communities are involved in providing support for vulnerable groups and people living with HIV. More hard-to-reach people living with HIV in remote areas access services.

OUTPUTS	OUTCOMES
Services are provided to orphans, especially health and education services.	More people with HIV come forward because they can access services for themselves and their children.
Ensure provision of comprehensive care and support for families and children affected by HIV.	
Local resources are mobilized to support activities for infected and affected people.	
Local leaders support service provision for infected and affected families and children.	
Correct education to the general public is provided through the media.	

Partners

Communities, People living with HIV and partners and families, Self help groups of people living with HIV, Government Ministries and Departments, Local Authorities, Township AIDS Committees, non-government organizations, community based organizations, Religious Groups, UN entities.

Suggested Indicators and Targets

Estimated number of HIV-infected mothers in Myanmar: 7,500

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
% of infant born to HIV infected mother that are HIV infected	UNGASS: - 50% by 2010	24.78%	21%	TBD
Pregnant women having access to VCCT	80%	138,885	607,621	TBD
% of HIV infected pregnant women receiving a complete course of ARV prophylaxis for Prevention of Maternal to Child Transmission		1200[1] (14.3%)	35%	TBD

[1] UNAIDS estimation for 2005. UNGASS report 2004: 4.84%

Estimated number of people living with HIV at an advanced stage of infection: 67,000

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
% of TB patients that are HIV infected		10.3%	*8.8%*	TBD
People still alive at 1 year after initiation of Antiretroviral Treatment		94.60%	95%	TBD
Number of People living with HIV in need receiving ARV (include package of support)		3.7 %	11,000	TBD
Number of children in need provided with Anti Retroviral Treatment or cotrimoxazole	80% (Unite Children)		500	TBD
Number of people receiving Cotrimoxazole as prophylaxis		7,000	35,000	TBD
Number of people receiving Community and Home Based Care package of support (without ARV)	20%	10,000	25,000	TBD
Number of TB/HIV co-infected patients referred to HIV care services			*1,520*	TBD

STRATEGIC DIRECTION 12. ENHANCING THE CAPACITY OF HEALTH SYSTEMS

Activity Area 1. Strengthen policy-setting, coordinating, monitoring and evaluation and reporting roles of the National AIDS Programme

OUTPUTS	OUTCOMES
Increase the capacity of National AIDS Programme staff to plan, coordinate and manage multi-sectoral action programs. The multisectoral ***Technical and Strategy Group for HIV/AIDS***, under the chairmanship and direction of the Disease Control Division of the Department of Health, with the mandate to draft policy, oversee implementation and coordinate monitoring and evaluation is recognized as the key body providing support to the Ministry of Health and eventually to the National AIDS Committee. State/Division and District/Township AIDS Committees to adapt national HIV/AIDS prevention and care policies to local context.*	Myanmar's multi-sectoral public-private AIDS partnership functions productively and harmoniously The policy-level National AIDS Committee is better informed and prepared for high-level decision making Donor interests are clarified and addressed Resources are rationally allocated "Scaling up" activities are informed and effective Equitable program coverage is assured Resources are made available to State/Division and District/Township AIDS Committee for their function

Standard Indicators	Indicative standard targets	Baseline 2005	Suggested target for Myanmar	
			2008	*2010*
Number of AIDS committee meeting at national level			1	TBD
Number of AIDS committee meeting at state/division level			34	TBD
Number of AIDS committee meeting at district level			94	TBD
Number of AIDS committee meeting at township level			325	TBD

Activity Area 2. Strengthen national capacity to plan, finance and cost related health services, in order to identify the most viable and effective financing modalities and to design and implement effective and productive fund-raising strategies

OUTPUTS	OUTCOMES
Planning skills are improved within all stakeholder organizations in all sectors and at all levels.* Exploring different financing modalities for key HIV and AIDS services delivery within the health sector.*	Better operational plans based on the National Strategic Plan, especially at local level Adequate operating funds are available and the budget is allocated according to the priorities indicated in the National Strategic Plan
HIV and AIDS disbursements are assessed quarterly, by sector, and linked directly to prepared work plans.* Data collection systems are joined and reporting is coordinated and jointly submitted to the Ministry of Health. The National Strategic Plan's budget projection is presented annually to the Country Coordinating Body. Stronger advocacy skills are developed and concerted joint efforts for fund-raising are increased.	Adequate funding mechanisms for key HIV and AIDS services within the health sector are in place
The National AIDS Programme is capable of costing all program activities using standard tools, and of revising the national budget requirements annually. Starting need support. The National AIDS Programme produces an annual report of national expenditures using standard tools such as National AIDS Spending Assessment, with standard categories agreed by ASEAN membership.*	Allocation of funds is adjusted annually according to cost-effectiveness of the program and priorities determined in the National Plan
Financial Officers are in place and operational for the National AIDS Program and for State and Division AIDS/ STD teams.* Performance and cost are analysed by the National AIDS Programme annually.* Unit costs by thematic areas of intervention are revised annually.	Programme accountability of resources allocated and used is in place Duplicated efforts reduced or eliminated Stronger information base at both peripheral and central levels

Standard Indicators	Indicative standard targets	Baseline 2004 (M Kyats)	Suggested target for Myanmar	
			2008	*2010*
Amount of national funds disbursed by government (NAP only)		78.05	TBD	TBD

Activity Area 3. Develop a coherent plan for the overall strengthening of human resources recruitment, training, support and evaluation in the Ministry of Health and line ministries engaged in HIV and AIDS activities

OUTPUTS	OUTCOMES
Required competencies are defined for all levels of staff responsible for AIDS program delivery.Detailed human resources plan and post descriptions developed and updated for all staff positions involved in AIDS response in the Ministry of Health while supporting other line ministries in defining the roles of staff with HIV and AIDS related responsibilities.* A standardized instrument, based on essential competencies is developed for evaluation of job candidates, periodic testing of in-place staff, and re-planning of training activities.*	Human resources are in place and meet the needs of the national strategic plan. Optimal distribution, deployment of human resources.
Management skills of staff at all levels upgraded by in-country and international training activities.*	Programme management improved, especially at the peripheral levels,
A set of tasks for malaria, TB, HIV and other critical health issues is elaborated for a population-based cluster, and the support functions required at health centre, township and district levels determined.*	Strengthened integrated health activities at the local level.

Activity Area 4.: Improve the efficiency, timeliness and transparency of the system for procurement, storage, transport and distribution of supplies and commodities

OUTPUTS	OUTCOMES
The central level records and reports periodically on incoming commodities, medications, supplies and equipment from all sources. Procurement and supply officers are stationed at township level, with the responsibility of assuring uninterrupted delivery of goods to peripheral facilities.* Training, refresher training, and periodic performance evaluation are established for the support of supply officers. Emphasis is placed on determination of requirements, stock management and reporting, intermediate distribution strategies, etc. CMSD is doing this but not yet involving the HIV and AIDS staff. Requirements for commodities, drugs and equipment are estimated at the peripheral level and an upward system for advance requests is elaborated. Storage practices are rationalized; clear guidelines for storage are developed and implemented; strict use of stock cards is maintained.	Procurement and supply management systems in place meeting the goals of the national response to HIV and AIDS. Comprehensive and integrated HIV and AIDS Procurement Supply and Management systems are strengthened.

Standard Indicators	Indicative standard targets	Baseline 2004	Suggested target for Myanmar	
			2008	*2010*
% of townships implementing HIV testing with no stock out of HIV test kits	**100%**	**95%**	100%	100%

Activity Area 5. Develop a realistic and sustainable plan for increasing HIV and AIDS laboratory capacity and support throughout the country

OUTPUTS	OUTCOMES
All laboratory staff understands the prime importance of confidentiality, pre-test and post-test counselling associated with HIV testing.	The trust of the population in laboratory services is enhanced and the demand for services is high.
A rational and feasible plan is formulated for the distribution, establishment and maintenance of public health laboratory support for confidential testing, Anti-retroviral administration, treatment of opportunistic infections and maintenance of a safe blood supply.* National Laboratory Guidelines are made available to all sectors providing laboratory services. A coordinated CD4 testing program with wide geographical coverage is in place, progressively incorporating private sector testing.* Internal and external quality assurance systems are in place for all laboratories in all sectors.*	Patient care is based on reliable laboratory evidence. Patient care is conducted in accordance with international best practice. Patient confidence in the services provided by all sector is high.
The laboratories' capacity to project requirements for commodities is improved through training and consultation.	Supplies are distributed in a timely and equitable way. Shortages disappear; patient confidence and support improves.
Laboratory managers and technical staff are provided with initial and follow-up training at regular intervals.	Laboratories function in accordance with international best practice.

Standard Indicators	Indicative standard targets	Baseline 2004	Suggested target for Myanmar	
			2008	*2010*
Proportion of HIV testing laboratories participating to NEQAS for HIV serology		25%	TBD	TBD

Activity Area 6. Strengthen and expand the national network of voluntary, confidential counselling and testing services, including the use of the private sector (including non-government organizations) to provide these services

OUTPUTS	OUTCOMES
Health staff trained and understands the importance of consent and confidentiality as regards HIV testing. Expansion of EQAS network for HIV serology to cover laboratories in public health sector as well as NGOs and private.* Implementation of provider-initiated VCCT. Systems in place for referral of patients from community home based care services, STI services, IDU services, TB services and inpatient facilities to VCCT. Establishment of a counsellor technical support network. Private practitioners and private laboratories are trained in counselling techniques and adhere to testing standards.*	The role of Voluntary and Confidential Counselling and Testing as a critical entry point for HIV prevention and care activities is enhanced. Increased numbers of people presenting for voluntary, confidential, counselling and testing. VCCT is expanded to other sectors. VCCT service delivery points are diversified and multiplied. Counsellors strengthen their capacity through the technical support networks.

Standard Indicators	Indicative standard targets	Baseline 2005	Suggested target for Myanmar	
			2008	*2010*
Number of Service Delivery Points offering VCCT		122	414	TBD

Activity Area 7. Strengthen AIDS and STD teams taking into account their evolving roles and responsibilities balancing clinical service provision with their local coordination and public health overseeing role

OUTPUTS	OUTCOMES
The services provided by the AIDS/STD teams should be non-stigmatising and thus is suggested the consideration of changing the name e.g. "Sexual Health Centres".* Revise detailed terms of reference for all staff of the Centres (AIDS/STD teams), including required competences, management skills, *etc* Increased budget and staff are attached to these centres to reflect steadily increasing responsibilities: advocacy, training, sentinel surveillance, distribution of test kits, condom distribution, distribution of Antiretrovirals, STD treatment, supervision and monitoring.* Transport and communications capacity of the teams increased through the provision of adequate transport means and funds for the purchase of fuel.*	More effective delivery of preventive and care services at District, Township and community levels. Increased utilization of STD clinics by reducing stigma associated with attendance. A responsive, effective program management system in place to support local capacity in strategic planning and more effective program implementation. Improved local collaboration with the private sector and with non-government organizations. "User-friendliness" of STD and AIDS services improved; absolute confidentiality and anonymity assured. Increased coverage of preventive and care activities.

Standard Indicators	Indicative standard targets	Baseline 2004	Suggested target for Myanmar	
			2008	***2010***
Number of Townships with a local strategic plan including all partners		0	154	TBD

Activity Area 8. Ensure a safe supply of blood and blood products throughout the country

OUTPUTS	OUTCOMES
Blood transfusion services are re-organized according to the national policy.* Recruitment and retention of voluntary, non-remunerated, regular blood donors. A program for self-deferral of potential donors is in place. All donated blood is screened for HIV.* Training of clinicians for the rational use of donated blood. Internal and external quality control and assessment schemes for blood laboratories.	Safe blood and blood products are available throughout the country through a network of blood laboratories. The source of blood is voluntary, non-remunerated and regular donors everywhere in the country.

Standard Indicators	Indicative standard targets	Baseline situation in 2004 -2005	Suggested target for Myanmar	
			2008	***2010***
Safe blood (proportion of transfused units screened for HIV)	100%	95.2%	100%	100%

Activity Area 9. : Establish Standards and Guidelines for Prevention, Care and Treatment for persons living with HIV and AIDS: Promote the use of Standards and Guidelines in non-government organization and Private Settings; expand access to services

OUTPUTS	OUTCOMES
Multi-agency working groups meet regularly, as sub-committees of the *Technical and Strategy Group for HIV and AIDS (TSG)*, to establish and update a priority list of required guidance for clinical management. Review availability of standards and guidelines, determine further requirements with regional and global consultation, and review by the Technical and Strategy Group for HIV and AIDS. Guidelines take into account ethical and social aspects of care, support and treatment of people living with HIV, including emphasis on non-discrimination and equitable charging for services.	Prevention, care and treatment policies for HIV and AIDS in Myanmar are consistent with international best practice. Coverage of all essential services is expanded, including VCCT, STI management, harm reduction activities, OI management, ART, community and home-based care.

Activity Area 10. Ensure that HIV is not transmitted in health care settings

OUTPUTS	OUTCOMES
Training of health care staff in key principles of Universal Precautions, including injection safety, conducted periodically. Procurement of equipment needed for Universal Precautions in all hospitals. Post Exposure Prophylactic kits are available in sufficient quantity wherever risk of infection is present; detailed instructions for their use is provided. The disposal of hazardous waste is performed in accordance with international guidelines.*	Decreased risk of HIV transmission in health care settings. Awareness of the critical importance of post-exposure prophylaxis is universal among health care workers. Improved reporting of transmission incidents in health care settings. Utilization of Post Exposure Prophylactic kits is increased, and their use is made part of the standard consolidated health facility report on HIV-related activities.

Standard Indicators	Indicative standard targets	Baseline 2004	Suggested target for Myanmar	
			2008	*2010*
% of need for Post Exposure Prophylaxis that is met	100%		100%	100%

Activity Area 11. Private Medical Practitioners are partners in the national response and Adhere to National Standards and Guidelines

OUTPUTS	OUTCOMES
Explore potential effective referral systems between General Practitioners and other stakeholders providing HIV and AIDS services. The expertise and experience of private medical practitioners are mobilized in support of planning and implementation of the national response, and in educational and training activities outcome. Continuing training of private practitioners in collaboration with National AIDS Programme on standards and guidelines for testing, care, support and treatment.	The National AIDS Programme benefits more fully from the specialist expertise and practical experience available in the private medical sector. International best practice standards and guidelines for care are the norm for all health care facilities in Myanmar.

OUTPUTS	OUTCOMES
Private medical practitioners and private laboratories are full partners in the voluntary confidential counselling and testing and reporting network coordinated by the National AIDS Programme and the National Health Laboratory.*	Access to quality testing and expert counselling is increased. The national program has access to summary data concerning activities carried out in the private sector.

Activity Area 12. Enlist and sustain the collaboration of formal traditional practitioners in HIV and AIDS prevention and treatment activities, including counselling, care, support and referral activities

OUTPUTS	OUTCOMES
Explore different mechanisms for active participation of formal traditional practitioners in HIV and AIDS prevention and treatment as to define their role in service provision.	Coverage and effectiveness of preventive activities and continuum of care are improved. Collaboration is established and maintained with the Traditional medicine practitioners to improve their knowledge base and to enlist the fullest possible involvement of traditional practitioners in prevention and care activities.

Activity Area 13. Educate pharmacists, drug sellers and non-formal practitioners and enlist the fullest appropriate participation possible from these groups in promoting the goals of the National Strategic Plan.

OUTPUTS	OUTCOMES
Educating activities for drug sellers and informal practitioners are conducted regularly at District and Township levels and below.* Develop approaches for engaging drug sellers and informal practitioners in a positive way into HIV and AIDS service provision.*	Coverage of vulnerable populations is increased. The promotion of harmful and/or ineffective treatments is decreased. The impact and importance of non-formal practitioners to the successful implementation of the National Strategic Plan is recognized and their potential to make significant contributions is fully recognised and encouraged.

Activity Area 14.: Mobilise communities including hard-to-reach populations and populations from difficult-to-reach areas to manage HIV and AIDS issues in their communities; foster local ownership of HIV and AIDS prevention and care activities

OUTPUTS	OUTCOMES
Develop culturally sensitive protocols and strategies throughout the country. Local action plans are developed by involving local stakeholders. Share and disseminate good practices regarding local community participation in HIV and AIDS responses particularly in the area of awareness raising and prevention of HIV transmission. Participation by traditional medicine practitioners in furthering the National Strategic Plan.* Develop model approaches for collaboration between public sector with non-government and community based organizations working for hard-to-reach populations particularly in the area of awareness raising, prevention and linkages with care and support services.*	The local community capacity for improved local competence, local dialogue, action planning and monitoring are increased. Behavioural changes take place (*e.g.*, sexual behaviour and the greater inclusion of people living with HIV). Programme effectiveness improved through higher demand for preventive and care services, more consistent condom use, better supervision of Antiretroviral administration. Greater community capacity to deal with other development challenges. Increased coverage of preventive and care services for those in need.

STRATEGIC DIRECTION 13. MONITORING AND EVALUATING

Objective: To establish a national monitoring and evaluation system, in line with the Three-Ones principles, that provides strategic information to guide the national response to HIV and AIDS in Myanmar

Activity Area 1: Monitoring and disseminating programmatic responses provided by partners

LEVEL	OUTPUTS	OUTCOMES
National	M&E unit operational with trained staff and sufficient resources. M&E framework with indicators is developed. Programme Costing and Expenditures are annually assessed. Information is collected and analysed by M&E Unit and disseminated to stakeholders, including beneficiaries, on a regular basis. Reports provided to international frameworks (UNGASS, Millennium Goals, ASEAN) are submitted in time. Mid-term evaluation (2008) End-of-term evaluation (2010)	Policy makers use Strategic Information on a timely basis to develop and/or modify policies. Strategic Information is used for resource mobilization and allocation. Efficiency of programs is assessed Partners use data to improve/ adjust their programs. Myanmar is able to report to international agreed frameworks (UNGASS, Millennium Goals, ASEAN, etc). National Programme Strategy is revised as needed to respond to evolving needs, resources and capacity
Division / State	Regional M&E focal unit operational with trained staff and sufficient resources. Regional office collects and aggregates the information from township level and forward to central level. Regional office provides feedbacks to the township level.	Partners use data to improve/ adjust their programs.

LEVEL	OUTPUTS	OUTCOMES
Accelerated Program Townships	M&E focal person identified and trained. All partners report regularly on routine indicators using standardized tools. All data collected and aggregated from all partners are forwarded to State/Division level. Results of program are reported to stakeholders, including beneficiaries.	Community is aware of program results and activities. Services Providers use data to improve/adjust their projects.
Townships (including rural areas)	M&E focal person identified and trained. All partners report regularly on routine indicators using standardized tools. Results of program are reported to stakeholders, including beneficiaries.	Services Providers use data to improve/adjust their projects. Community is aware of program results and activities.

Activity Area 2: Strengthening the national HIV/AIDS surveillance system

LEVEL	OUTPUTS	OUTCOMES
National	Additional groups and sites are included in the HIV sero-surveillance system. Quality control mechanisms are integrated into the surveillance system. Existing STI surveillance will be improved by integrating other relevant STIs. HIV sero-incidence surveillance is introduced in high-risk groups. ART drug resistance surveillance system is introduced.	Integrated Second Generation Surveillance provides a reliable epidemiological profile. Surveillance information is used to inform programs in order to address gaps and emerging issues.

LEVEL	OUTPUTS	OUTCOMES
National	Additional groups and sites are included in the Behavioural Surveillance Survey. Mapping, size estimation and description of high risk groups are regularly conducted. HIV and AIDS projection and demographic impact analysis is conducted periodically.	
Division / State	Mapping, size estimation and description of high risk groups are regularly conducted. Surveillance activities are coordinated at division / state level. Decentralized laboratories capacity strengthened.	Better data transfer and improved quality of surveillance information.
Accelerated Program Townships	Staff trained on proper sampling procedures. BSS expanded to more Accelerated Program Townships. HSS expanded to cover additional groups.	Accelerated Programme Townships collect and forward data on selected group behavior and seroprevalence to central level.
Other Townships	HSS and BSS are introduced.	

Activity Area 3: Coordinating and cooperating with partners to generate additional information

LEVEL	OUTPUTS	OUTCOMES
National	Evaluation studies on specific HIV interventions conducted. Results of researches and surveys synthesized by M&E unit. M&E Task Force established for research technology transfer and exchange on Strategic Information. Economic evaluation studies on HIV intervention promoted. Capacity of conducting operational researches strengthened for M&E staff and partners.	Effectiveness of HIV intervention can be determined. Complete the Strategic Information by additional information from researches and surveys. Cost-effectiveness of programs is assessed.

MYANMAR

NATIONAL STRATEGIC PLAN

ON

HIV

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2006-2010