MYANMAR NATIONAL STRATEGIC PLAN ON HIV AND AIDS

OPERATIONAL PLAN

MINISTRY OF HEALTH UNION OF MYANMAR

(April 2006 - March 2009)

Contents

1. Introduction

The Operational Plan 2006 -2009 was developed following the development of the National Strategic Plan 2006 – 2010.

The Operational Plan, using the National Strategic Plan as a guide for decisions on priorities and scaling up, provides a range of products associated with the planning, monitoring and implementation that require the input and involvement of many different stakeholders. A NSP flow-chart has been developed to clearly identify the steps, timing, and actors responsible for leading and/or being involved in processes (cf annex).

A training workshop was conducted in April 2006 on estimation of resources need and provisional rapid costing for resource mobilization. As a result, yearly targets and estimated cost of each component and sub-component of the strategic plan 2006 - 2010 were formulated. A core team of experts for the same to undertake future costing work was also formed.

The Operational Plan incorporates all existing resources. The three year Operational Planning Cycle aims to encourage longer term financing. Each year, 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.

Funding for Year 1 (April 2006 to March 2007) includes existing resources from the Global Fund and the FHAM which are mostly available up to December 2006. Funding to fill the gaps 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.

The Operational Plan is composed of a set of documents, including:

- description of the strategic directions and indicators with targets, including scaling-up and geographical priorities
- business plan and budget
- Monitoring and Evaluation Framework

2. National Strategic Plan on HIV/AIDS

The National Strategic Plan on HIV and AIDS, 2006 – 2010, was the first in Myanmar developed using participatory processes, with direct involvement of all sectors involved in the national response to the HIV epidemic. It 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 review of the National AIDS Programme in 2006 and a mid-term review of the Joint Programme for HIV/AIDS in 2005, as well as many diverse studies and reviews of particular programmes and projects.

The National Strategic Plan identifies what is 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. The Plan, building on key principles underlying the national response over the next five years, spelt out specific strategic directions relevant to populations at higher risk, corresponding activity areas and expected outcomes to serve as the starting point of the planning process. Approaches applicable to prevention, care, support and 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 inform priority setting. For each expected outcome, necessary outputs (i.e. key activities delivered in order to achieve these outcomes) were formulated. Specific activities, targets and indicators suitable to provide a direction and monitor progress towards 'Universal Access' to prevention and care services were expressed for selected outputs and outcomes recognized as the most critical products of the Strategy.

Aims:

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

Objectives:

1. Reduction of HIV transmission and vulnerability, particularly among people at highest risk.

2. Improvement of the quality and length of life of people living with HIV through treatment, care and support.

3. Mitigation of the social, cultural and economic impacts of the epidemic.

Strategic directions:

The National Plan addresses 13 strategic directions that are most pressing needs of populations at greater risk and essential enhancement of the capacity of health systems to help respond to these needs. Straetegic Directions 1 – 11 are population focussed, while Strategic Directions 12 – 13 are intended to create and/or further expand national capacity to formulate, implement, monitor and evaluate the Staretegic Paln, update it as required and account for its acievements.

3. The Operational Plan April 2006 – March 2009

This Operational Plan translates key principles and broad directions set out in the National Strategic Plan 2006 – 2010 into a directly actionable and costed plan for the first 3 years relevant to all aspects of the national response to HIV and to all partners.

3.1 Key issues

Primary attention and resources will be directed to building capacity and enhancing resilience among **populations at highest risk and vulnerability**, and to those most severely impacted by the HIV epidemic. Community-based activities will be directed to **reduce stigma and discrimination** towards people infected and affected by HIV and those whose behaviours is perceived as being associated with 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, and monitoring and evaluation system in line with the Three-Ones principles, will provide a framework for the design of focused approaches suited to specific populations.

3.2 Prioritization of Strategic Directions

The National Strategic Plan recognizes 3 levels of risks and vulnerability:

- 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. These populations are of primary concern as the extent and quality of support extended to facilitate their positive and sustained 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 effective interventions.
- Populations vulnerable to risk of HIV infection – those who, for economic, social, cultural reasons are most likely to engage in risk-taking behaviours or be exposed to risk-generating situations risk in the near future. These populations include children and youth out of school, institutionalized populations, mobile populations and uniformed personnel, orphans and other vulnerable children.
- Populations at lower risk of HIV infection– 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 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 practice effective HIV prevention behaviours.

Based on this consideration, the 13 Strategic Directions laid out in the National Strategic Plan are prioritized as follows:

Priority	Strategic Directions
Highest priority	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 familes of People Living with HIV
High priority	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
Priority	9. Enhancing prevention, care, treatment and support in the workplace 10. Enhancing HIV prevention among men and women of reproductive age
Fundamental overarching issues	11. Meeting the needs of people living with HIV for Comprehensive Care, Support and Treatment 12. Enhancing the capacity of health systems, coordination and capacity of LNGOs & CBOs 13. Monitoring and Evaluating

3.2. 1 Strategic Direction 1: Reduction HIV-related Risk, Vulnerability and Impact among Sex Workers and their Clients

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
% of sex workers that are HIV infected	*40,000*	31.98% [2]	*30.5*	*28.5*	*26.5*
% of sex workers that have a STI (syphilis)	*40,000*	25.0% (2005)	*23%*	*21%*	*19%*
% of sex workers that report the use of condom with most recent client	*40,000*	62%[1]	*70%*	*80%*	*90%*
% of clients of sex workers that are HIV infected (by proxy: male with STD)	*1,361,000*	4.07% [2]	*4%*	*3.5%*	*3%*
Output/Coverage Targets					
Sex workers reached by package of BCC prevention and STI prev/treatment	*40,000*	30,000[3] (2005)	*30,000*	*35,000*	*40,000*
Number of sex workers accessing VCCT	*40,000*		*10,000*	*15,000*	*20,000*
Condoms distributed (in million)		41 [4]	*46*	*51*	*56*

Priority rating: Highest priority prevention programme

Scaling-up Priorities

This is one area of prevention programming where significant progress has already been made, demonstrating the feasibility of undertaking peer education-based and outreach programmes for behavior change: in 2005 an estimated 30,000 sex workers were reached with varieties of this basic package including STI treatment. Social marketing of condoms targeted to clients has also proven effective. The National AIDS Programme's 100% Targeted Condom Promotion Program (TCP) underlines the Government's priority to expand condom programming, especially in high-risk settings. Challenges remain over having better data (including on mobility pattern of sex-workers), access (especially to indirect sex-workers) and the regulatory environment.

Resources will be aggressively invested in scaling-up peer education-based behavior change programmes in as many townships as possible. The Government's 100% Targeted Condom Promotion Programme, incorporating recommendations from the 2005 review, will focus on the enabling environment, especially through advocacy to township authorities and the creation of condom core groups, monitoring and coordination of programmes. Sustained advocacy is considered particularly crucial at township and central levels in order to ensure supportive involvement of other key non-health sector bodies such as the Ministry of Home Affairs and law enforcement authorities.

[1] BSS NAP 2003 [2] HSS 2005 [3] Estimates according to partners annual report 2005 – NAP [4] Partners annual report 2005 – NAP

Geographical Priorities

Investments should firstly focus on all urban areas, expansion of partnerships in 100% TCP townships to ensure coverage and strengthening of peer education-based programmes, and ensure minimal overlap between individual partners. The National AIDS Programme with support from UN agencies and other partners is encouraged to improve the national mapping of these activities.

3.2.2 Strategic Direction 2: Reduction HIV-related risk, vulnerability and impact among MSM

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
% of MSM that are HIV infected	*267,208*[1]	33% (1996)[2]	*33%*	*32%*	*31%*
% of MSM that have a STI (syphilis)		35.12% [3]	*35%*	*34%*	*33%*
% of condom use by MSM at last anal sex	*267,208*	67.0%[7]	*70%*	*72%*	*75%*
Output/Coverage Targets					
MSM reached by package of BCC prevention and STI prev/treatment	*267,208*	21,000 [4]	22,000	40,000	53,000
Number of MSM accessing VCCT	*267,208*		5500	16,000	25,000

Priority rating: Highest priority prevention programme

Scaling-up priorities

Programmes for men who have sex with men are relatively new in Myanmar. Informal data suggests that prevalence might be quite high amongst several population groups of men who have sex with men with different identities and behaviors. The current environment all lows for some community-based programming, while policy advocacy remains essential at higher levels. A situation analysis of the dynamics involved in MSM interactions need to be carried out and an appropriate strategy to be developed. Priorities are particularly to increase the number of urban areas in Myanmar with at least one community-based programme for men who have sex with men, alongside a series of awareness raising workshops for a variety of health and HIV service providers.

Geographical priorities

Currently, the most significant programmes for MSM are in Yangon and Mandalay. Situation analysis will provide useful information about priority areas for interventions.. This provision list will be used to guide initial investments.

[1] Scenario 2% of Adult male population – Tim Brown 2005 [2] MoH 1996 [3] NAP study Mandalay 2005 [4] Partners annual report 2005 – NAP

3.2.3 Strategic Direction 3: Reduction HIV-related risk, vulnerability and impact among Injecting Drug Users

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
% of IDU that are HIV infected	*60,000*	43.24% [1]	*41.00*	*39.00*	*36.50*
% of IDU that avoid sharing injecting equipment in the last month		65% [2]	*67*	*69*	*71*
% of condom use by IDU at last sex		34% (2005)	*40%*	*50%*	*60%*
Output/Coverage Targets					
Drug Users reached by Harm Reduction programme			75,000	120,000	180,000
IDU reached by Harm Reduction programme	*60,000*	11,500[3]	12,500	20,000	30,000
% of IDU accessing VCCT	*60,000*		4,375	7,000	10,500
Needles distributed to IDU's		1,2 M[4]	2	3	4
Number of IDU on MMT			300	1,000	2,000

Priority rating: Highest priority prevention programme

Scaling-up Priorities

Programmes for drug users in the 2003-2006 period demonstrated the feasibility carrying out harm reduction for Myanmar. Currently 15 DICs are running in 12 townships, but the coverage is probably sufficient (>50%) in only one township (Lashio). In all the other townships the coverage is estimated fewer than 50% and still requiring more coverage in the currently operated township and unaddressed ones. Methadone maintenance therapy started in 2006. Baseline figures are known of number of injecting drug users reached. As the exact number of the total number of either drug users or injecting drug users is currently only roughly estimated, targets in the short run will remain focused on absolute numbers of drug users reached (rather than percentages) and townships coverage. More comprehensive behavioral data with representation from most priority areas will be collected by upcoming surveys. Investments will focus on expanding coverage of community-based peer education and outreach prevention and support programmes, as well as scaling-up of MMT. Continued advocacy will be required to ensure an enabling environment, especially with non-health ministries. Interventions will need to cover as well spouses/partners and families of IDU's.

[1] HSS 2005 [2] UNODC report 2002 [3] Implementing Partners annual report 2005 – NAP [4] UNAIDS estimates for 2005

Geographical Priorities

The following table indicates the 29 priority townships currently indicated for drug use, and whether or not programmes exist. Investments should focus on i) continuing all current programmes, ii) expanding activities to townships in the table that are currently not covered.

Hpakant	Myawaddy	Kutkai	Pinlaung
Moegaung	Mogoke	Kyaingtone	Tachileik
Moemauk	Aung Myay Thazan	Lashio	Taunggyi
Puta-o	Chan Aye Thazan	Laukkai	Kawthaung
Myitkyina	Waingmaw	Maingshu	Tamwe
Tanai	Monywa	Monglar	Yankin
Bhamaw	Tamu	Muse	
Hpa-an	Hopan		

3.2.4 Strategic Direction 4: Reduction HIV-related Risk, Vulnerability and Impact among Partners and People Living with HIV

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Number of PLHIV involved in self-help groups	338,911(2004)	3,000[1](2005)	*5,000*	*8,000*	*10,000*

Priority rating: Highest priority prevention programme

Scaling-up Priorities

Most work in this area is done currently in the context of care, treatment and support (see Strategic Direction #11). There are a few additional programmes focusing on psycho-social support to people living with HIV (such as the Sunday Empowerment Group in Yangon), but these are limited. Outside of the care, treatment and support work, there is a need to ensure that people living with HIV have networks that they can turn to for support, ranging from psycho-social to socio-economic, including for income, to prevention behavior change. There is also a need to involve these networks in improved treatment support among people living with HIV.

Geographical Priorities

Current data is insufficient to adequately map current existence of self-help groups and informal networks of people living with HIV, although some partners are currently undertaking such exercises. What data exists suggests that efforts are largely limited to only a few numbers of people living with HIV involve in self help group and difficult to say what are the activities that they are participating. Stigma and discrimination against these groups hinder their involvement in self help groups. Pending improved information, investments are being prioritized to urban areas. The National AIDS Programme in collaboration with partners active in this area will be working to improve its strategic planning in this area within the first year of the 2006-2010 National Strategic Plan.

[1] HIV/AIDS International Alliance survey 2006

3.2.5 Strategic Direction 5: Reduction HIV-related risk, vulnerability and impact among Institutionalized population

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Prisoners reached by heath education	62,300[1]	5,000[2]	6,000	20,000	30,000
Number of prisoners having access VCCT		*Targets to defined after feasibility study*			

Priority rating: High priority prevention programme

Scaling-up priorities

Limited work has been undertaken to date on HIV in prison and other institutionalized settings. Accordingly, targets in the first year are low while programming opportunities are sought in the support of the National Strategic Plan. With support from the National AIDS Programme and technical partners, the Ministry of Home Affairs has activities outlined in the National Strategic Plan to advance planning in this area. Assessment of the feasibility of specific interventions, such as Voluntary and Confidential Counseling and Testing, strengthening care and support, should be carried out for institutionalized population within the context of Myanmar without delaying scaling up of interventions in this sector. Advocacy will be supported and undertaken with the aim of expanding programming opportunities.

Geographical coverage

Current level of activity is near zero in this area. Mapping is required as part of initial stages of strategic planning.

[1] Statistical Year Book 2001

[2] CARE and UNODC reports, 2006

3.2.6 Strategic Direction 6: Reduction HIV-related Risk, Vulnerability and Impact among Mobile Population

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Mobile and migrant population reached by package of prevention programme			100,000	110,000	121,000

Priority rating: High priority prevention programme

Scaling-up Priorities

Considerable activities are currently undertaken in this area. Due to the wide variety of projects falling in this category, data is impossible at this stage to aggregate into a cohesive picture. Main groups targeted currently include mining sites, transport workers (trishaw drivers, taxi and bus drivers, train employees, seafarers). Some activities falling into this category are seen firstly as workplace programmes, causing further challenges to efficient planning. Investment priorities are to i) finance all existing activities based on current reach and ii) fund improved data collection and mapping in order to better plan future expansion. As a high priority activity with a large potential population base, future expansion will have to take into account the need to focus activities in the areas of highest risk, as all mobile/migrant populations and their affected communities (see definition in National Strategic Plan) provide too broad a base to be addressed in current funding scenarios.

Geographical Priorities

Current data is insufficient to map adequately under-served but prioritized townships, activity sites and/or population groups. A planning workshop on mobile populations will address this issue. Transit points for cross-border population will be especially targeted; Myanmar will be looking for a coordination mechanism with ASEAN partners. Internal migrants should also be covered by programmes.

3.2.7 Strategic Direction 7: Reduction HIV-related Risk, Vulnerability and Impact among Uniformed Services Personnel

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Uniformed personnel reached by package of prevention programme		100,000[1]	50,000	200,000	250,000

Priority rating: High Priority Prevention Programme

Scaling-up Priorities

Current programmes in this area involving international assistance are limited to two or three activities working with the police. The current training of trainers programme for the police[2] should be financed so that it can coverage can be made national. Careful monitoring needs to ensure programme effectiveness. Advocacy with the Ministry of Home Affairs will seek to strengthen links between uniformed services and advances in security and public health in Myanmar. Although not currently involved in collaborative multi-partner work on HIV, the Ministry of Defense has been engaged in the National Strategic Planning process and providing them with technical support for the development of an HIV strategy is an immediate priority. This participation provides a window opportunity for NAP, NGO's and other international organizations to engage with concerned ministries for prevention and care activities.

Geographical Priorities

The current police training work is being carried out in 80 townships under Global Fund. Committed funding will enable the expansion of this activity to a larger number of townships. Resources will be allocated to fund its expansion to national coverage.
The following areas will be of priority starting 2006:

- border areas
- mining areas
- transit areas
- military units and police units

[1] Only partial package of services provided so far

[2] Supported by UNODC and CARE International.

3.2.8 Strategic Direction 8: Reduction HIV-related risk, vulnerability and impact among Young people

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
% of young people that are HIV infected	9,572,450	2.2% [1]	*2.09*	*1.98*	*1.87*
% of condom use by young people at last paid sex		78.34%[2]	*80*	*85*	*90*
% of youth who correctly identify the three common ways of preventing HIV transmission	9,572,450	21% [2]	30%	40%	50%
% of youth who reject misconceptions	9,572,450	27% [2]	30%	40%	50%
% of youth expressing accepting attitudes	9,572,450		*20%*	*30%*	*40%*
Output/Coverage Targets					
Out of school youth (15-24) reached by prevention programme		200,000 [3]	250,000	400,000	500,000
Young people (15-24) having access VCCT	9,572,450	20,000	30,000	50,000	80,000
In-school youth (10-16) reached by life-skills programme	2,450,000	900,000	900,000	1,300,000	1,800,000
% of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	39,405	36.3% [4]	50%	60%	70%

Priority rating: High Priority Prevention Programme

Scaling-up Priorities

Numerous programmes are currently working on youth programming, both in out-of-school and in-school contexts. This is a large population group, with widely varying at-risk behavior and vulnerabilities. Data is currently insufficient to map activities and coverage more precisely. There is not a specific national youth strategy currently defined, beyond that in the National Strategic Plan. With these limitations, scaling-up priorities will steer investments towards: i) ad-hoc scaling-up and expansion of existing out-of-school youth programmes, ii) national coverage of the in-school youth SHAPE life-skills programme, iii) improved national planning specifically targeted on youth.

Geographical Priorities

Aside from the formal in-school curriculum programme which has known coverage and expansion needs, data is currently insufficient to guide investments. Further data and strategic planning will be undertaken in the first year of this operational plan in the context of the National Strategic Plan 2006-2010.

[1] HSS 2005 for new military recruits [2] NAP BSS 2003 [3] Partners annual report 2005 – NAP [4] UNGASS report 2004

3.2.9 Strategic Direction 9: Reduction HIV-related Risk, Vulnerability and Impact in the Workplace

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Number of people in workplace reached by package of prevention programme	25,000,000	200,000[1]; [2]	*100,000*	*200,000*	*400,000*
Number of large enterprises practicing workplace policies			5	10	20
% of large enterprises who have HIV/AIDS workplace policies and programme			Survey to be conducted		

Priority rating: Priority Prevention Programme

Scaling-up Priorities

Workplace programmes in Myanmar have been developed on a largely ad-hoc basis. Although a national estimate of workers reached is currently available, greater detail is unavailable to assist planning. Many in this category are also mobile populations, for example seafarers. UNGASS data around large enterprises is not known. The National AIDS Programme with support from technical partners will have to develop specific strategies for prioritizing within this broad category for allocation of resources. Support to non-health Government ministries to develop workplace programmes is a priority. Investments will be allocated to i) continuation of current activities and ii) more detailed planning for this sub-sector, likely in collaboration with work on mobile populations.
Support should be also provided to the private sector to involve the workers in industrial zones.

Geographical Priorities

Current data is insufficient to geographically guide allocation of resources, particularly in the absence of a national sub-strategy around this area of work.

[1] Only partial package of service provided so far

[2] Partners annual report 2005 – NAP

3.2.10 Strategic Direction 10: Reduction HIV-related risk, vulnerability and impact among men and women of reproductive age

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Output/Coverage Targets					
Men and women of reproductive age reached by prevention programme	27,180,000	450,000 [1]	*600,000*	*800,000*	*1,000,000*
Adults accessing VCCT each year (excluding targeted pop)	27,180,000	81,674 [1]	*150,000*	*170,000*	*200,000*
% of people with STI appropriately diagnosed, counselled and treated		Survey to conduct	*40%*	*50%*	*60%*
Number of patients treated for STI		130,000	*150,000*	*170,000*	*190,000*

Priority rating: Priority Prevention Programme

Scaling-up Priorities

This is a very large population group. Programmes currently are restrained to a number of efforts around sexual and reproductive health, linked to varying degrees explicitly to HIV. Funding in this area is reserved to additional marginal costs for mainstreaming HIV work into existing sexual and reproductive health work, by either Government or non-Government partners. Existing PMCT programme should enhance prevention services to this population.

Geographical Priorities

The National AIDS Programme's list of 183 priority townships for work on HIV (linked to HIV prevalence) provides a guide for the scaling-up of these mainstreaming activities. Expansion of activities will involve building capacities of peripheral community-based workers to support HIV prevention and care activities in conjunction with TB and malaria program.

[1] Partners annual report 2005 – NAP

3.2.11 Strategic Direction11: Meeting the needs of people living with HIV for Comprehensive Care, Support and Treatment

Package of care and support with or without ARV	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
Impact/ outcome Targets					
% of TB patients that are HIV infected		10.3% (2005)	*9.8*	*9.3*	*8.8*
% People still alive at 1 year after initiation of ARV		94.6% [1]	*95*	*95*	*95*
Output/ Coverage Targets					
Number of People Living with HIV in need receiving ARV (including package of support)	67,000	3.7% [2]	*6,000*	*9,000*	*11,000*
Number of people receiving Cotrimoxazole as prophylaxis	250,000	7000 [2]	*10000*	*30,000*	*35,000*
Number of people receiving CHBC package of support (without ARV)	250,000	10,000 [2]	*15,000*	*20,000*	*25,000*
Number of TB/HIV co-infected patients referred to HIV services[3]			*800*	*1040*	*1520*
Prevention of Mother to Child Transmission					
Impact/ outcome Targets					
% of infant born to HIV infected mother that are HIV infected	8,000	24.78% [1]	*24%*	*23%*	*21%*
Output/ Coverage Targets					
Pregnant women having access to VCCT	1,283,382	138,885 [2]	*208,327*	*347212*	*607621*
% of mother-baby pair receiving a complete course of ART prophylaxis for PMCT	7,700	629 (8%) [1]	*12%*	20%	35%
Number of orphans receiving support		27,800[4]	*34,000*	*59,500*	*85,000*
Number of children in need provided with ARV	1960[5]	136 [2]	*150*	*350*	*500*

[1] UNGASS report 2004 [2] Partners annual report 2005 – NAP [3] Targets only for public health sector by NTP/NAP
[4] UNICEF Myanmar estimates 25,000 orphans in facilities ; Annual partners report for 2005 : 2,800 orphans supported– NAP/UNAIDS
[5] Workshop Demographic Impact of HIV – Nov 2005 Yangon

Priority rating: Fundamental overarching issue

Scaling-up Priorities

Further expansion of PMTCT and ART programs should be linked within a continuum of care approach. Systems to systematically refer all HIV positive pregnant women as well as TB/HIV co-infected patients for comprehensive HIV care at the time of HIV diagnosis should be established. Coverage of each essential service need to be expanded, including provision of VCCT services to TB patients. Referrals and utilization can be improved only after the services become available. Particularly, OI management, ART, community and home based care for infected and affected population, VCCT and PMCT should be made available more widely, utilizing available public health facilities, NGOs and GPs.

Health systems to support provision of HIV care including ART are being developed and strengthened. Priority should be given to supply management systems, the development of a comprehensive national HIV care training programme and support for ART sites from central level.

For the majority of people living with HIV/AIDS the entry point for community and home based care is self-referral or referral by a family or community member to a local home based care team. Barriers to referral due to the stigma associated with home visiting need to be addressed.

Given the maturity of the epidemic in Myanmar, it is expected that the number of AIDS orphans will increase. Accordingly, an assessment on the situation should be conducted to provide information for scaling up interventions.

Geographical Priorities

PMCT will aim for expansion towards a national coverage.

The expansion of Community and Home- Based Care and provision of ART services will be prioritized for HIV high prevalence areas and urban areas in the context of the Continuum of Care.

Expansion of activities will involve building capacities of peripheral community-based workers to support HIV prevention and care activities in conjunction with TB and malaria program.

3.2.12 Strategic Direction12: Enhancing the capacity of health systems, coordination and capacity of LNGOs and CBOs

Impact/Outcome Targets	Denominator	Baseline	Apr 2006 - Mar 2007	Apr 2007 - Mar 2008	Apr 2008 - Mar 2009
% of townships implementing HIV test with no stock out of HIV test kits	325	95%[1]	100%	100%	100%
Proportion of HIV testing laboratories participating in NEQAS for HIV serology		25% [1]	*50%*	*75%*[2]	
Output/Coverage Targets					
Proportion of transfused blood units screened for HIV	200,000	95.2% [3]	*100%*	*100%*	*100%*
Number of Service Delivery Points offering VCCT		122 [4]	211	295	414
% of need for PEP that is met			*100%*	*100%*	*100%*
Amount of national funds disbursed by government		78.05 MK [3]	206 MK[5]	To be calculated	
% of AIDS/STD teams with a local strategic plan including all partners		0	10	77	154
Number of AIDS committee meeting at national level			1	1	1
Number of AIDS committee meeting at state/divisional level			17	34	34
Number of AIDS committee meeting at district level			47	94	94
Number of AIDS committee meeting at township level			136	325	325

Priority rating: Fundamental overarching issue

Scaling-up Priorities

The blood safety programme which includes donor selection, donor deferral, and HIV screening of blood donations has made good progress. HIV testing is conducted in hospitals with the supply of test kits from the NAP. Main constraints include the lack of blood banking facilities especially and related infrastructure such as constant electricity supply, and the significant proportion of replacement blood donors.

VCCT is provided in a number of settings. Within the public sector the majority of VCCT is performed as part of the PMCT programme in health centres/sub-centres and hospitals. Access to VCCT should be expanded through opening of health centre/sub-

[1] National Health Laboratory/NAP data 2006
[2] Target to increase whenever regulation on blood transfusion is extended to private sector
[3] UNGASS report 2004
[4] Partners annual report 2005 – NAP
[5] DoH data for NAP only

centre VCCT to the general public, establishment of hospital VCCT teams including 'drop-in' access for the general public, routine offer of VCCT for TB patients, STI patients, IDU and MSM clients of Drop in Centers as well as the increase in the number of AIDS/ STD clinics. There is also a need for expanding the number of approved private not-for-profit VCCT services (particularly those run by NGO's) and establishment of outreach VCCT for most at risk population. HIV test kit procurement needs to be significantly increased to support current and future demand and HIV test kit supply management needs to be improved.

Priority should be given to strengthen laboratory support for VCCT, STI services, blood transfusion services, Opportunistic Infections and HIV and AIDS treatment and care.

As part of strengthening capacity of health system, it is also essential to reinforce community participation, i.e. by developing networks of voluntary community workers and for some areas with efforts of mobile teams, particularly in the case of hard-to-reach populations and populations from difficult-to-reach areas. Community participation includes as well the building capacity of CBOs to participate in the national response to HIV and AIDS.

Geographical Priorities

Priority should follow the expansion of the AIDS/STD teams clinics, as well as expansion of 100% TCP and where services are provided to high vulnerable groups, including hard-to-reach population and populations from difficult-to-reach areas.

3.2.13 Strategic Direction13: Monitoring and Evaluation

Priority rating: Fundamental overarching issue

Scaling-up Priorities

HIV second generation surveillance system should be updated to incorporate new elements, including new surveillance groups, increasing number of sites and sample size to allow comparison over time and among sites as well as strengthening behavioral surveys and STI surveillance.

There has been no surveillance or monitoring of HIV drug resistance so far. It is one of the priorities to undertake since HIV resistance testing was done in private sector for clinical purpose.

All partners report at the national level to NAP/UNAIDS on standard agreed indicators. Local partners should be requested to report to the local AIDS/STD Team on their activities through a standard format, using output and coverage indicators agreed in the national framework. Standard format currently utilized at national level by all partners could be adapted to the local level. Capacity building at local level/township/district level will give better data flow to a monitoring system.

Geographical Priorities

In line with the principle of the "Three Ones" monitoring systems will aim to cover the national response in a coherent and coordinated manner. The aim is to establish and / or improve a system that will inform the national and local response.
AIDS/STD Teams have the responsibility to implement NAP programmes and activities in their geographic area. Initially, particular attention may be given to townships with STD teams in order to establish data collection and management systems that can be rolled out to other townships. It should be strengthen reporting go through the state / divisional level where data will be compiled and sent to the central level.

3.3 Scaling up

Scaling up will include identification of "**accelerated 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.

3.4 Roles and responsibilities

Roles and responsibilities of key constituency groups: Ministry of Health and National AIDS Programme, other Government sectors, State, Division, Township and District AIDS Committees, UN , NGOs, people living with HIV, private sector and business coalitions and donors are outlined in the Strategic Plan document.

3.5 Institutional arrangements

Toward the efforts, institutional arrangements for implementation of the National Strategic Plan have been developed. The National Coordinating Body for AIDS, Tuberculosis and Malaria will oversees the policy guidance and identification of external support. This will be chaired by the Minister of Health. It will include participation of several ministries, UN organizations and non-government organizations. The Technical and Strategy Group (TSG) for HIV and AIDS, draws upon the technical expertise of UNAIDS cosponsors, will meet regularly to undertake planning, monitoring, trouble-shooting and other coordination exercises. Members from community organizations, professional associations, International NGOs and other members appointed by different ministries and health departments will contribute technical and policy expertise based on their organizations' involvement in the national response to the HIV epidemic.

Annex: Flow Chart for Development process of National Strategic Plan

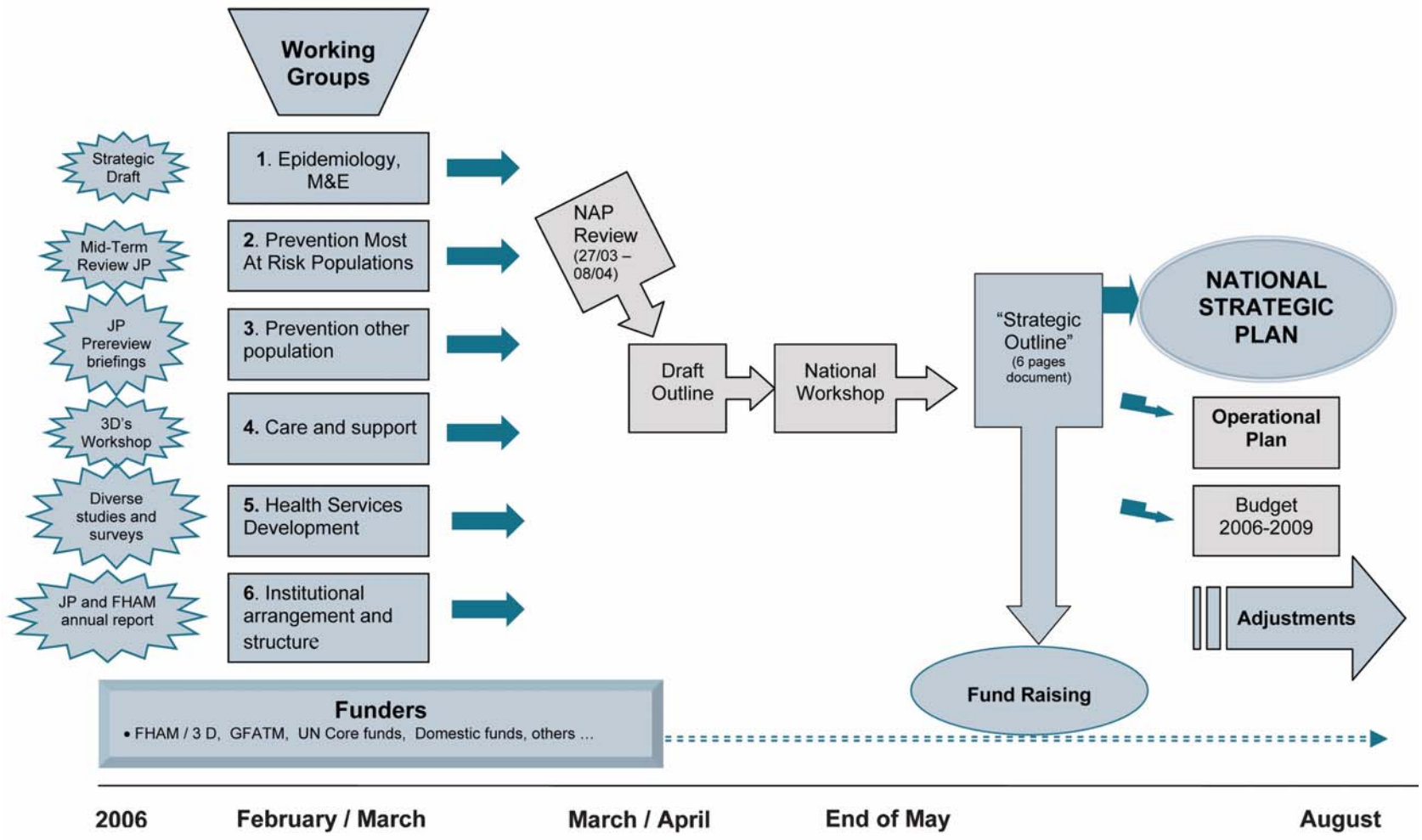


Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1100	**Sex-Workers and clients**						**1,755,254**		**2,062,850**		**2,370,446**
1110	Prevention package for Sex Workers				57.00	30,000	1,710,093	35,000	1,995,108	40,000	2,280,124
	- condom distribution	Access to resources - male and female condom provision, lubricants social marketing.	154 TCP Townships and see operational plan	STD teams, townships authorities, PSI, AZG, MDM, MSF-CH, AMI, Consortium, ARHP, Malteser, PACT, MRCS, others..	*14.40*		*432,000*		*504,000*		*576,000*
	- behavioural change	IEC – transmission, prevention, alternative safer sex practices and services provision. Ensured tailored Interventions including outreach services for direct and indirect sex workers groups. Ensured tailored Interventions including outreach services for direct and indirect sex workers groups			*25.03*		*750,821*		*875,958*		*1,001,095*
	- STI	STI and reproductive health services friendly services provided by public, private and NGOs			*6.95*		*208,545*		*243,302*		*278,060*
	- Support cost	Enabling environment – national policies in place to indicate need for programs for sex workers which respect consent and confidentiality. Participation of sex workers, including people living with HIV and/or clients if possible, in program design and implementation. Coordination and multisectoral cooperation amongst stakeholders (including nongovernmental organizations) and gatekeepers (e.g. local authority, police, managers and owners of entertainment establishments).			*10.62*		*318,727*		*371,848*		*424,969*
1120	VCCT	VCCT friendly services provided by public, private and NGOs		NGO's in collaboration with STD teams	4.52	10,000	45,161	15,000	67,742	20,000	90,323

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1200	**Men Having Sex with Men**						**1,250,145**		**1,788,603**		**2,515,786**
1210	Prevention package for MSM				57.23	21,420	1,225,961	29,988	1,716,345	41,983	2,402,883
	- condom + lubricants distribution	Access to resources is improved - condom and lubricant provision in education programs, social marketing, new sales outlets.	see operational plan	STD teams, PSI, Consortium, ARHN, AMI, AZG, MDM, PACT, MANA, PGK, UNODC, others..	*3.99*						
	- behavioural change	Information about risks for specific groups of men who have sex with men. Behaviour change support tailored for specific groups of men who have sex with men– peer education, negotiation skills, sexual skills.			*39.04*						
	- STI	STI and reproductive health services friendly services provided by public, private and NGOs			*2.70*						
	- Support cost	Men having sex with men are better able to initiate their own prevention and care and support programmes. Participation of men who have sex with men, including those infected with HIV, in advocacy, program design and implementation. Enabling environment – township environment is supportive of HIV prevention programmes and services for men who have sex with men.			*11.49*						
1220	VCCT	VCCT friendly services provided by public, private and NGOs		NGO's in collaboration with STD teams	4.52	5,355	24,184	16,000	72,258	25,000	112,904

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1300	**Injecting Drug Users and Drug users**						**2,746,021**		**4,508,089**		**6,872,188**
1310	Comprehensive package for IDUs				213	12,500	2,660,230	20,000	4,256,368	30,000	6,384,553
	- needles distribution	Access to needle and syringe programs and distribution are increased from drop in centres and through outreach programs. F?	29 priority townships and see operational plan	AHRN, ARPH, UNODC, AZG, MDM, CARE, MANA, BI, others..	*5.48*						
	- behavioural change	Strengthen drug education and HIV education for drug users and other young people; 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.			*111.71*						
	- Condom distribution	Condom promotion and distribution are increased from drop in centres and through outreach programs.			*2.40*						
	- Primary Health Care	Tailored services for young drug users and youth vulnerable to drug use established and improved – health as well as other social and support services.			*46.00*						
	- support cost	Participation of drug users, ex-drug users and their families, including people living with HIV, in program design and implementation for their own groups. Key community leaders learn about public health benefits of harm reduction programmes. Effective coordination and multisectoral involvement at local level exists for use of evidenced-based interventions and accountability. 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. Exposure of decision makers to international good practices (study tours, trainings, coaching).			*47.19*						

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1320	VCCT	VCCT friendly services provided by public, private and NGOs		NGO's in collaboration with STD teams	4.52	4,375	19,758	7,000	31,613	10,500	47,420
1330	Methadone Maintenance Therapy - behavioural change - Drugs and condoms - support cost	Drug dependency treatment, drug substitution treatment (methadone), therapeutic communities and outpatient drug treatment programs expanded. Scale up successful community based detoxification programs under the supervision of DDTRU/Drug Dependency Treatment and Research Units.	Drug Treatment Centers in ? Major sites	DTC, MDM, UNODC, WHO	220	300	66,032	1,000	220,108	2,000	440,216
1340	Support to DTC				600	6	3,600	30	18,000	30	18,000

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1,400	**Institutionalised Population**						**45,956**		**153,187**		**229,781**
1410	Prevention package for inmates + others				7.66	6,000	45,956	20,000	153,187	30,000	229,781
	- behaviour Change for Jail inmates	Capacity of institutional staff is developed through training and on-going continuing education. Information provided – transmission, prevention, alternative practices and negotiation skills through peer education. Improved knowledge of institutionalized individuals, their families and spouses. Referrals to counselling, testing and treatment services	All prisons and psychiatric hospital	STD teams and Minister of Home Affairs, UNODC, Care, MDM, others..	*2.54*						
	Condoms	condom provision, social marketing			*3.00*						
	- STI management	Voluntary confidential counselling and testing, **STI services**, support for behaviour change and harm reduction, appropriate resources including condoms, are available within institutions.			*1.74*						
	- support cost	Capacity strengthening of Social Welfare Department, psychosocial services and support systems. Increased participation of vulnerable groups in tailored interventions for institutionalised groups, as well as increased participation of relevant stakeholders (Ministries and bodies as well as NGOs). Coordination and multisectoral cooperation amongst stakeholders and gatekeepers at all levels. Advocacy has occurred at township and local levels. Advocacy outside institutions to develop township support for HIV related programmes within institutions – advocacy amongst decision makers and communities. Advocacy and linkages with law enforcement agencies to gain their support for HIV prevention, treatment, care and support programs. National guidelines in place to ensure HIV interventions take place in institutions including prisons.	All prisons and psychiatric hospital	STD teams and Minister of Home Affairs, UNODC, Care, MDM, others..	*1.38*						

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1420	VCCT	**Voluntary confidential counselling and testing**, STI services, support for behaviour change and harm reduction, appropriate resources including condoms, are available within institutions. ?? **Offer HIV prevention, including Voluntary and Confidential Counselling and Testing**, and "Map" services as part of compiling information about local networks.	All prisons and psychiatric hospital	STD teams and Minister of Home Affairs, UNODC, Care, MDM							

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1,500	**Mobile Population/Migrants**						**1,185,944**		**1,304,538**		**1,434,992**
1510	Prevention package for Mobile Population				11.86	100,000	1,185,944	110,000	1,304,538	121,000	1,434,992
	- condom		see operational plan	STD teams, local authorities, PSI, PACT, IOM, AZG, Consortium, WVI, others..	*1.56*						*65,494*
	- behavioural change	Increased prevention programs (including referral for care info) at border points and transit zones for out-migration (BCC programs, etc) carried out collaboratively across borders and Prevention programs are integrated into infrastructure (large construction) projects			*8.06*						
		More community-based prevention and care/treatment/support programs are implemented and Interventions focusing on mobile young people as they are likely out of school and more vulnerable									
		Safe places (drop-in centres) for mobile population at destination communities and border points.									
		Focus on industries employing youth, such as fishing industry and informal/cottage industry.									
	- STI				*0.58*						
	- Support cost	Mobility Thematic groups are established at national, state and township levels. Advocacy to authorities and decision-makers to address increased vulnerabilities of mobile populations (at national, state and township levels).	see operational plan	STD teams, local authorities, PSI, PACT, IOM, AZG, Consortium, WVI, others..	*1.66*						
		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.									
		Bilateral collaboration among neighboring countries increased to facilitate referrals, transport, safe return, continuity of care for mobile persons, etc.									
		Research on attitudes towards mobile population in general, including young people) to improve/inform advocacy and programming.									
1520	VCCT (cf men and women of reproductive age)			NGO's in collaboration with STD teams							

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1,500	**Uniform Services**						**264,752**		**1,059,008**		**1,323,760**
1510	Package Prevention services				5.30	50,000	264,752	200,000	1,059,008	250,000	1,323,760
	- condom distribution (per person)	Condom promotion and distribution within all uniformed services.	.....Townships		*1.50*						
	- behaviour change	Capacity building for Behavior Change Initiatives within uniformed services.			*2.62*						
		Behavior Change Initiatives occur within all uniformed services at all levels, especially of new recruits and to promote health seeking behaviour and utilization of STI and VCCT health services by uniformed personnel and their families. Gender and sex-work issues addressed in prevention programs for uniformed services.	.....Townships	Defense, Police, CARE, UNODC							
		Referral systems established between uniformed and civilian health services,.									
	- STI	STI treatment capacity building for uniformed services health personnel	.....Townships	Defense, Police, CARE, UNODC	*0.32*						
	- Support cost	Participation of uniformed services personnel and their families in program design and implementation for their own groups. Involvement of uniformed services in collective responses against HIV as well as in partnerships in prevention, care and treatment.			*0.86*						
		Advocacy communication with senior officials and policy/decision makers – national, then in Accelerated Townships.	.....Townships	Defense, Police, CARE, UNODC							
		Research and special studies to better understand contexts in which unformed services and their family members are vulnerable to HIV transmission, extent of risk behaviours and attitudes within uniformed services.									
		Exposure and exchange opportunities for officials and policy/decision makers at National, State and Division and Township levels.									
1520	VCCT										

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1,700	**Young People**						**1,849,645**		**2,687,358**		**3,428,321**
1710	**Young peole out of school (15-24)**	**Prevention package**			5.43	250,000	1,358,673	400,000	2,173,876	500,000	2,717,345
1711	Behavioural Change	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. Community capacity for delivery of care is enhanced, including community capacity to develop their own youth-friendly services. Youth Centres are established that provide entertainment, recreation, information, education talks, group activities, use of internet Establish peer support groups that include families and children of people living with HIV, as well as people living with HIV themselves.	urban townships	STD teams, local authorities, AHRN, AMI, BI, Consortium, MRCS, PACT, PSI, MMCWA, MBCA, UNDP, UNICEF, UNFPA,UNODC, others..	*2.26*						
1712	Condom distribution (per person)				*1.08*						
1713	Support cost	More nongovernment organizations, International nongovernment organizations and Community Based Organisations, and the private sector, are officially involved in provision of youth-friendly services in collaboration with public health services. Young people involved in township coordination mechanisms. Advocacy for treatment for young people Ensure mobilization of parents and community leaders to address HIV-related issues through the Parent Teacher Associations at the township level. National and Township Communications strategies are developed. Existing central policies are disseminated to State, Division and Township levels, and Township initiatives are encouraged with central support. Develop and maintain policy to ensure peer education is available for all university students. Review and Standardisation of messages related to HIV and AIDS for adolescents and youth. More action research is used to determine if services are addressing young people's needs.	urban townships	STD teams, local authorities, AHRN, AMI, BI, Consortium, MRCS, PACT, PSI, MMCWA, MBCA, UNDP, UNICEF, UNFPA,UNODC, others..	*0.52*						

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
	VCCT	**Voluntary confidential counselling and testing**, STI services, support for behaviour change and harm reduction, appropriate resources including condoms, are available within institutions.	urban townships	STD teams, local authorities, AHRN, AMI, BI, Consortium, MRCS, PACT, PSI, MMCWA, MBCA, UNDP, UNICEF, UNFPA,UNODC, others..	*4.52*	30,000	*135,484*	50,000	*225,807*	80,000	*361,292*
1,720	**Young people in school (10-16)**				**0.39**	**900,000**	**355,488**	**1,300,000**	**513,482**	**1,800,000**	**710,975**
	Training of teachers + IEC	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	All primary and secondary schools	Ministry of Education / UNICEF							
	Pupils education (Life skills prog for Young People)	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). More schools, including monastic and faith based education facilities, develop Parent Teacher Associations and HIV education programs.									
		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).									
1730	**Orphans and Vulnerable Children**				***81.66***	**34,000**	**2,776,429**	**59,500**	**4,858,751**	**85,000**	**6,941,073**
		Program interventions linking youth "at highest risk" and especially vulnerable children to their less vulnerable peers. Increased use of media to raise community awareness and sensitivity to the needs of orphans and vulnerable children.	HIV high prevalence area	Consortium, local NGO's, CBO's, Ministry of Social Welfare / UNICEF, others..							
		Minimum standard of services for orphans and vulnerable children developed (Ministry of Social Welfare has schools for orphans, but there are not yet minimum standards for community and private sector facilities).									

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1,800	**Men and Women of reproductive age**						**1,028,105**		**1,235,323**		**1,487,702**
1810	Package Prevention services				0.58	600,000	**350,684**	800,000	**467,578**	1,000,000	**584,473**
	- condom distribution (per person)	Access to condom provision and promotion	see operational plan	STD teams, townships authorities, PSI, MMCWA, AZG, MDM, MSF-CH, Partners, AMI, Consortium, Malteser, PACT, MRCS, UNODC, others..	*0.36*						
	- behaviour change	Behavior change support – including participatory learning, peer education, negotiation skills.			*0.04*						
	- STI and reproductive health services	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			*0.04*						
	- Support cost	National strategy for risk reduction amongst low risk groups is developed. More research on effectiveness of IEC in supporting healthy behaviours, relevant behaviour change, and reduction of stigma and discrimination amongst the whole population. Reproductive health policy and guidelines, including HIV prevention, are strengthened and implemented. National policy and guidelines on stigma and discrimination developed, disseminated and evaluated.			*0.13*						
1820	VCCT	VCCT friendly services provided by public, private and NGOs		PSI, MSI and others (NGO's in collaboration with STD teams)	4.52	150,000	677,422	170,000	767,744	200,000	903,229

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
1900	**Work place intervention**						**619,938**		**1,239,875**		**2,479,750**
1910	Prevention package for workers				6.20	100,000	619,938	200,000	1,239,875	400,000	2,479,750
	- condom distribution (per worker)	Access to resources – harm reduction materials, condom provision, social marketing, support groups—in worksite settings. Access to 100% Targeted Condom Promotions.	All major factories, administration and construction sites, Indsutriallized zones	STD teams, MBCA, UNFPA, Myanmar Railways and Transportation , Consortium, PSI, AMI, ARHP, Partners, MMA, MANA, UNDP, Others..	*0.72*						
	- behavioural change	Behavior change communication including participatory learning, peer education and negotiation skills and worksite outreach programs. Prevention education provided to families									
		Referrals to Voluntary and Confidential Counselling and Testing and referrals to appropriate services which offer Couples Counselling and education for partners of People living with HIV. Referral systems for care and treatment are in place for workers, families and clients of non-Health ministries			*4.47*						
	- Support cost (includes enabling environment)	Private places in workplaces so that people can talk about HIV and reproductive health. More persons living with HIV and AIDS are involved in worksite prevention, treatment, care and support programs. Support and extend the range of available health services in government workplace settings where possible.	All major factories, administration and construction sites, Indsutriallized zones	STD teams, MBCA, UNFPA, Myanmar Railways and Transportation , Consortium, PSI, AMI, ARHP, Partners, MMA, MANA, UNDP, Others..	*1.01*						
		Informal work place managers to be invited to join Business AIDS Networks or to form other groups and networks. National Task Force on workplace policy formed.									
		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.									

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
2300	**Treatment Care and Support**						**10,608,701**		**14,866,192**		**22,808,730**
2310	**Providing Cotrimoxazole as prophylaxis**			Public Hospitals and STD teams, AZG, Consortium, MSF CH, MDM, AMI, ARHP, PACT, PGK, MRCS, WHO, WFP, others..	12.0	10,000	120,000	30,000	360,000	35,000	420,000
2311	- OI prophylaxis				*12.0*						
2320	**Package of care and support without ARV**				440	15,000	6,593,839	20,000	8,791,785	35,000	15,385,623
2321	- medical services	Strengthen the health system to reach affected communities. 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.		Public Hospitals, AZG, MSF-CH, MDM, AFXB, AMI, Consortium, Union, WHO, UNICEF, WFP, others..	*176.12*		*2,641,791*		*3,522,388*		*6,164,179*
2322	- OI treatment				*102.00*		*1,530,000*		*2,040,000*		*3,570,000*
2323	- Home Based Care	Community capacity for delivery of care is enhanced, including their capacity to develop their own care and support responses			*90.54*		*1,358,055*		*1,810,740*		*3,168,795*
2324	- Lab services				*50.00*		*750,000*		*1,000,000*		*1,750,000*
2325	- Support cost	Guidelines for HIV testing ensuring this is Voluntary and Confidential, and addressing stigma and discrimination, are followed. Local leaders support service provision for infected and affected families and children. Local resources are mobilized to support activities for infected and affected people.			*20.93*		*313,992*		*418,656*		*732,649*
2330	**Package of care and support with ARV**				574	6,000	3,444,509	9,000	5,264,053	11,000	6,552,753
2331	- medical services	Increased number of HIV treatment and care sites (public / private sector) to provide clinical care and support including TB/HIV; Continuum of care, support and treatment reaches the institutionalized populations.		Public Hospitals, AZG, MSF-CH, MDM, AFXB, AMI, Consortium, Union, WHO, UNICEF, WFP, others..	*86.57*		*519,403*		*779,104*		*952,239*
2332	- OI treatment				*48.00*		*288,000*		*432,000*		*528,000*
2333	- ART				*244.10*		*1,464,600*		*2,196,900*		*2,685,100*
2334	- Home Based Care				*90.54*		*543,222*		*814,833*		*995,907*
2335	- Lab services				*30.00*		*180,000*		*270,000*		*330,000*
2336	VCCT	Health staff trained and understand the importance of consent and confidentailaity as regards HIV testing. Systems in place for referral of patients from CHBC services, STI services, IDU services, TB services and inpatient facilities to VCCT									
2340	- Support cost				*74.88*		*449,284*		*673,926*		*823,687*

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
2341	**Prevention of Mother to Child Transmission**						1,008,156		1,680,262		2,940,459
2342	PMTCT (ARV and other clinical support)	PMTCT, care, support and treatment services available for general populations and risk groups, e.g. sex workers		Hospitals and Health Centers, AZG, MSF CH, Consortium, AMI, UNFPA, UNICEF, WHO, others..							
2343	*- includes VCCT for pregnant women*	Increased number and quality of voluntary confidential counselling and testing sites and services at antenatal care centres, maternal and child health centres in public and private sector.			*4.84*	*208,327*	*1,008,156*	*347,212*	*1,680,262*	*607,621*	*2,940,459*
2350	**Technical Training**		National				450,354		450,354		450,354

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
3000	**Policy and Advocacy**					**200**	**674,627**	**200**	**874,627**	**200**	**874,627**
3010	**Vulnerable Groups**					200	200,000	200	200,000	200	200,000
	Advocacy on vulnerable group	Mobilize communities including hard-to-reach populations to manage HIV and AIDS issues; foster local ownership of HIV and AIDS prevention and care activities		Local authorities, people from different sectors	1000	200	200,000	200	200,000	200	200,000
3040	**Advocacy (Leadership and Media)**						474,627		674,627		674,627
	Media partnerships on AIDS advocacy										
	Mobilization of national and community leadership		National and Township level				474,627		474,627		474,627
	Media education and advocay efforts			Newspapers, radio and television							
	International and National conferences: AIDS; Harm Reduction; AIDS Day		National level				100,000		200,000		200,000

Table1: Business Plan (2006 - 2009)

	Strategy/Activity set	Outputs	Priority areas	Potential partners	Unit cost	Targets 2006	Cost Yr1	Targets 2007	Cost T2	Targets 2008	Cost T3
5000	**Leadership and Management**						**904,120**		**2,661,480**		**3,138,480**
5010	**Management and coordination**						**374,120**		**461,480**	10,608	**538,480**
5011	- support to STD teams for development of local strategic plan	Strengthening STD teams including training and management skills.	44 STD teams		1,000	20	20,000	77	77,000	154	154,000
5012	- training of NAP and other services personnel	Increase capacity of National AIDS Programme staff to plan, coordinate and manage multi-sectoral action programmes.					330,000		*330,000*		*330,000*
5016	- multisectoral programming	Coordination and mulitsectoral cooperation amongst stakeholders (GOs, NGOs, and private) strengthened			120	201	*24,120*	454	*54,480*	454	54,480
5020	**Mainstreaming HIV/AIDS (capacity building)**		All townships	HIV/AIDS Alliance, Burnet Institute, UN agencies, Consortium, AFXB, NAP, others			**530,000**		**1,100,000**		**1,300,000**
	Support to CBO's and local NGO's	*Capacity of CBO's and LNGO's improved*					250000		*500,000*		*700,000*
	Support of Self-Help groups (PLHIV)	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. People living with HIV are included in all c			50	5,000	250000	8,000	500000	10,000	*500,000*
	Support of vulnerable groups networks	Promote meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so that thery are able to participate in programme design, development , implementation and evaluation.					30000		*100,000*		*100,000*

Table 2: Monitoring and Evaluation Framework

Standard Indicators (inc. UNGASS in blue)	Indicative standards	Denominator	Baseline (Year)	Suggested Targets (Universal Access…)		
				Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
Strategic Direction 1: Reduction HIV-related risk, vulnerability and impact among Sex Worker						
Impact/Outcome Targets						
% of sex workers that are HIV infected		*40,000*	31.98% (2005)	*30.5*	*28.5*	*26.5*
% of sex workers that have a STI (syphilis)		*40,000*	25% (2005)	*23%*	*21%*	*19%*
% of sex workers that report the use of condom with most recent client	80%	*40,000*	62%(2003)	*70%*	*80%*	*90%*
% of clients of sex workers that are HIV infected (by proxy: male with STD)		*1,361,000*	4.07% (2005)	*4.0%*	*3.5%*	3.0%
Output/Coverage Targets						
Sex workers reached by package of BCC prevention and STI prev/treatment	80%	*40,000*	30,000 (2005)	*30,000*	*35,000*	*40,000*
Number of sex workers accessing VCCT		*40,000*		*10,000*	*15,000*	*20,000*
Condoms distributed (in million)			41(2005)	46	51	56
Strategic Direction 2: Reduction HIV-related risk, vulnerability and impact among MSM						
Impact/Outcome Targets						
% of MSM that are HIV infected		*267,208*	33% (1996)	*33%*	*32%*	*31%*
% of MSM that have a STI (syphilis)			35.12% (2005)	*35%*	*34%*	*33%*
% of condom use by MSM at last anal sex		*267,208*	67.0%	*70%*	*72%*	*75%*
Output/Coverage Targets						
MSM reached by package of BCC prevention and STI prev/treatment	80%	*267,208*	17,850	21,420	29,988	41,983
Number of MSM accessing VCCT		*267,208*		5,355	16,000	25,000
Strategic Direction 3: Reduction HIV-related risk, vulnerability and impact among IDUs						
Impact/Outcome Targets						
% of IDU that are HIV infected		*60,000*	43.24% (2005)	*41.00*	*39.00*	*36.50*
% of IDU that avoid sharing injectiing equipment in last month			65% (2004)	*67%*	*69%*	*71%*
% of condom use by IDU at last sex			34% (2005)	*40%*	*50%*	*60%*
Output/Coverage Targets						
Drug Users reached by Harm Reduction programme	80%		6 DU for 1 IDU	75,000	120,000	180,000
IDU reached by Harm Reduction programme	80%	*60,000*	11,500	12,500	20,000	30,000
% of IDU accessing VCCT		*60,000*		4,375	7,000	10,500
Needles distributed to IDU's			1,2 M (2005)	2	3	4
Number of IDU on MMT				300	1,000	2,000

Table 2: Monitoring and Evaluation Framework

Standard Indicators (inc. UNGASS in blue)	Indicative standards	Denominator	Baseline (Year)	Suggested Targets (Universal Access…)		
				Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
Strategic Direction 4: Reduction HIV-related risk, vulnerability and impact among partners and PLHIVs						
Impact/Outcome Targets						
Output/Coverage Targets						
Number of PLHIV involved in self-help groups		338,911	3000 (2005)	*5,000*	*8,000*	*10,000*
Strategic Direction 5: Reduction HIV-related risk, vulnerability and impact among Institutionalized population						
Impact/Outcome Targets						
Output/Coverage Targets						
Prisoners reached by heath education		*62,300*	5,000	6,000	20,000	30,000
Number of prisoners having access VCCT				Target to redefined after feasibility study		
Strategic Direction 6: Reduction HIV-related risk, vulnerability and impact among Mobile population						
Impact/Outcome Targets						
Output/Coverage Targets						
Mobile and migrant population reached by package of prevention programme				100,000	110,000	121,000
Strategic Direction 7: Reduction HIV-related risk, vulnerability and impact among Uniformed services personnel						
Impact/Outcome Targets						
Output/Coverage Targets						
Uniformed personnel reached by package of prevention programme			100,000	50,000	200,000	250,000

Table 2: Monitoring and Evaluation Framework

Standard Indicators (inc. UNGASS in blue)	Indicative standards	Denominator	Baseline (Year)	Suggested Targets (Universal Access…)		
				Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
Strategic Direction 8: Reduction HIV-related risk, vulnerability and impact among Young people						
Impact/Outcome Targets						
% of young people that are HIV infected	MDG - 25%	9,572,450	2.2% (2005)	*2.09*	*1.98*	*1.87*
% of condom use by young people at last paid sex			78.34% (2003)	*80*	*85*	*90*
% of youth who correctly identify the three common ways of preventing HIV transmission	95%	9,572,450	21% (2003)	30%	40%	50%
% of youth who reject misconceptions	95%	9,572,450	27% (2003)	30%	40%	50%
% of youth expressing accepting attitudes		9,572,450		*20%*	*30%*	*40%*
Output/Coverage Targets						
Out of school youth (15-24) reached by prevention programme	30%		200,000 (2005)	250,000	400,000	500,000
Young people (15-24) having access VCCT (at least pretesting)	50%	9,572,450	20,000	30,000	50,000	80,000
In-school youth (10-16) reached by life-skills programme	45%	2,450,000	900,000	900,000	1,300,000	1,800,000
% of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	45%	39,405	36.3% (2004)	50%	60%	70%
Strategic Direction 9: Reduction HIV-related risk, vulnerability and impact among Workplace						
Impact/Outcome Targets						
Output/Coverage Targets						
Number of people in workplace reached by package of prevention programme	3%	25,000,000	200,000	*100,000*	*200,000*	*400,000*
Number of large enterprises practicing workplace policies				*5*	*10*	*20*
% of large enterprises who have HIV/AIDS workplace policies and programme			Survey to be conducted			
Strategic Direction 10: Reduction HIV-related risk, vulnerability and impact among men and women of reproductive age						
Impact/Outcome Targets						
Output/Coverage Targets						
Men and women of reproductive age reached by prevention programme	0%	27,180,000	450,000	*600,000*	*800,000*	*1,000,000*
Reproductive age accessing VCCT each year (excluding targeted pop,)	1%	27,180,000	81,674	*150,000*	*170,000*	*200,000*
% of people with STI appropriately diagnosed, counselled and treated	75%			*40%*	*50%*	*60%*
Number of patients treated for STI			130,000 (2005)	150,000	170,000	190,000

Table 2: Monitoring and Evaluation Framework

Standard Indicators (inc. UNGASS in blue)	Indicative standards	Denominator	Baseline (Year)	Suggested Targets (Universal Access…)		
				Apr 2006-Mar 2007	Apr 2007-Mar 2008	Apr 2008-Mar 2009
Strategic Direction 11: Meeting needs of people living with HIV or Comprehensive Care, Support and Treatment						
Package of care and support with or without ARV						
Impact/Outcome Targets						
% of TB patients that are HIV infected			10.3% (2005)	*9.8*	*9.3*	*8.8*
% People still alive at 1 year after initiation of ARV			94.6% (2005)	*95*	*95*	*95*
Output/Coverage Targets						
Number of People Living with HIV in need receiving ARV (including package of support)		67,000	3.7%	*6,000*	*9,000*	*11,000*
Number of people receiving Cotrimoxazole as prophylaxis			7,000 (2005)	*10,000*	*30,000*	*35,000*
Number of people receiving CHBC package of support (without ARV)		67,000	10,000 (2005)	*15,000*	*20,000*	*25,000*
Number of TB/HIV co-infected patients reffered to HIV care services				*800*	*1,040*	*1,520*
Prevention of Mother to Child Transmission						
Impact/Outcome Targets						
% of infant born to HIV infected mother that are HIV infected		8,000	24.78% (2005)	*24%*	*23%*	*21%*
Output/Coverage Targets						
Pregnant women having access to VCCT	80%	1,283,382	138,885	*208,327*	*347,212*	*607,621*
% of mother- baby pair receiving a complete course of ART prophylaxis for PMCT		7,700	629 (8%) (2005)	*12%*	20%	35%
Number of orphans receiving support		1,700,000	27800 (2005)	*34,000*	*59,500*	*85,000*
Number of children in need provided with ARV		1,960		*150*	*350*	*500*
Strategic Direction 12: Enhancing the capacity of health system						
Impact/Outcome Targets						
Output/Coverage Targets						
% of townships implementing HIV test with no stock out of HIV test kits	100%	325	95%	100%	100%	100%
Proportion of HIV testing laboratories participating to NEQAS for HIV serology	100%		25%	*50%*	*75%*	
Proportion of transfused blood units screened for HIV	100%	200,000	95.2% (2004)	*100%*	*100%*	*100%*
Number of Service Delivery Points offering VCCT			122 (2005)	211	295	414
% of need for PEP that is met	100%			100%	100%	100%
Amount of national funds disbursed by government			78.05 MK	206 MK	To be calculated	
Number of coordinating meeting held at all level (township/district/national)						
Number of township with a local strategic plan including all partners			0	20	77	154
Number of AIDS committee meeting at national level				1	1	1
Number of AIDS committee meeting at state/divisional level				17	34	34
Number of AIDS committee meeting at district level				47	94	94
Number of AIDS committee meeting at township level				136	325	325

Table 3: Summary Budget (2006-2009)

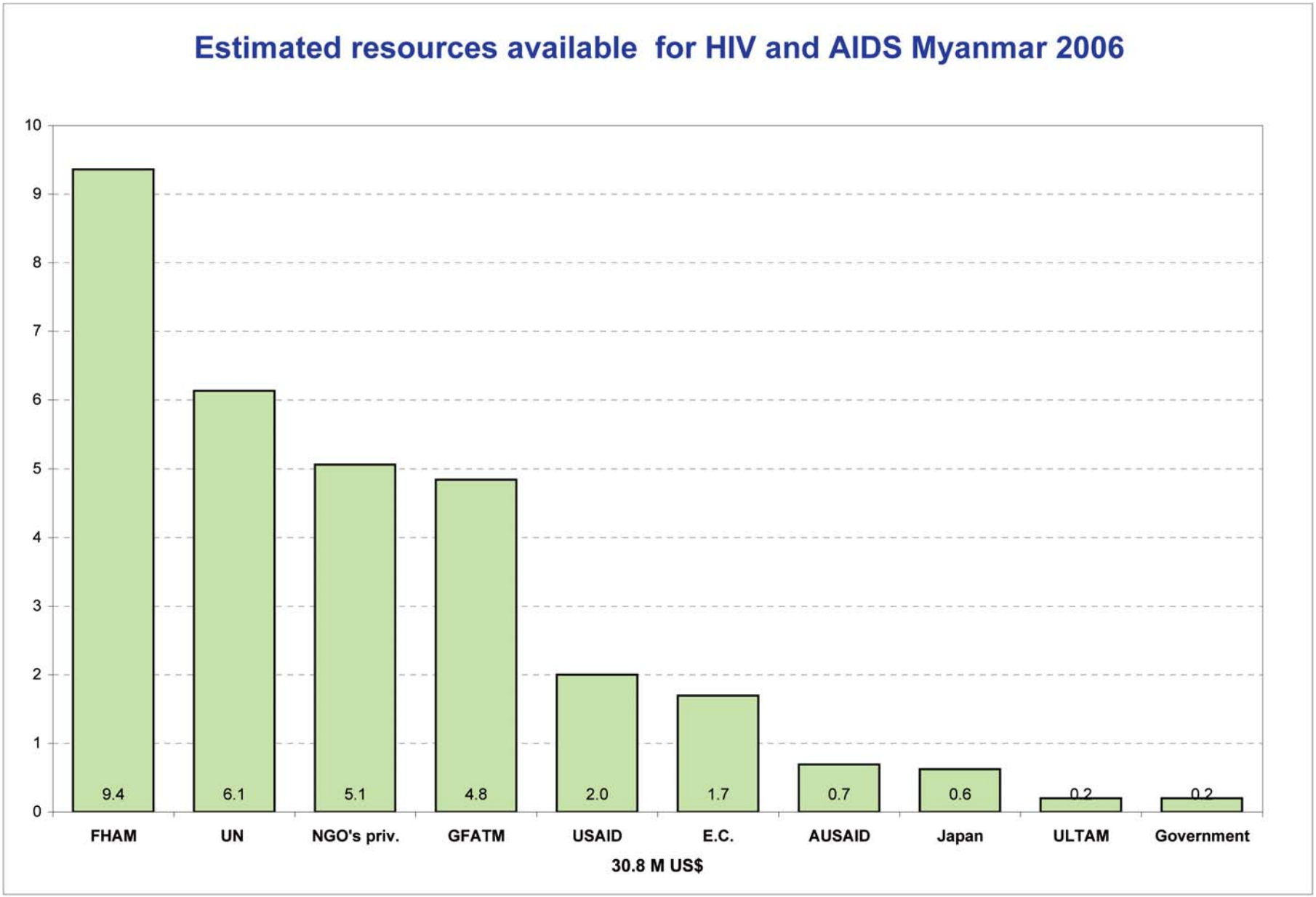
Component/Sub-component	Estimated Cost Apr 2006- Mar 2007	Estimated Cost april 2007- Mar 2008	Estimated Cost Apr 2008- Mar 2009	Expected funding Y1	Expected funding Y2	Expected funding Y3	Financing Partner 2006	Resource Gap Y1	Resource Gap Y2	Resource Gap Y3	Comments
1000 Targeted Prevention	**16,937,973**	**23,912,557**	**32,181,279**	**15,758,126**	**3,085,310**	**2,312,600**		**1,179,847**	**20,827,247**	**29,868,679**	
1100 Sex Workers	***1,755,254***	***2,062,850***	***2,370,446***	**1,812,518**	**100,000**	**60,000**	USAID, MDM, IHAA, AZG, E.C., FHAM, GFATM	**116,656**	**1,962,850**	**2,310,446**	Resource for Service for Sex workers partly reflected in Men and Women of reproductive age
Prevention package for Sex Workers	*1,710,093*	*1,995,108*	*2,280,124*	1,638,598							
VCCT	*45,161*	*67,742*	*90,323*	173,920							
								-	-	-	
1200 MSM	***1,250,145***	***1,788,603***	***2,515,786***	**1,071,920**	**100,000**	**60,000**	USAID, MDM, IHAA, E.C., FHAM, GFATM	**352,145**	**1,688,603**	**2,455,786**	Resource for Service for MSM partly reflected in Men and Women of reproductive age
Prevention package for MSM	*1,225,961*	*1,716,345*	*2,402,883*	898,000							
VCCT	*24,184*	*72,258*	*112,904*	173,920							
								-	-	-	
1300 IDUs and DU's	**2,881,021**	**4,558,089**	**6,922,188**	**2,995,716**	**767,000**	**548,000**	AUSAID, E.C., MDM, FHAM, GFATM	**(114,695)**	**3,791,089**	**6,374,188**	
Comprehensive package for IDUs	*2,660,230*	*4,256,368*	*6,384,553*								
VCCT	*19,758*	*31,613*	*47,420*	*86,960*							
Study and research	*135,000*	*50,000*	*50,000*								
Methadone Maintenance Therapy	*66,032*	*220,108*	*440,216*								
Support to DTC	*3,600*	*18,000*	*18,000*								
								-	-	-	
1600 Institutionalised population	**45,956**	**153,187**	**229,781**	**18,535**	**22,090**	**0**	*UNODC, CARE*	**27,421**	**131,097**	**229,781**	
VCCT	*0*										
Prevention package for inmates + others	*45,956*	*153,187*	*229,781*								
								-	-	-	
1400 Mobile population	**1,185,944**	**1,304,538**	**1,434,992**	**1,073,456**	**168,000**	**20,000**	*UNDP, FHAM, GFATM*	**112,488**	**1,136,538**	**1,414,992**	Resource for Service for mobile pop partly reflected in Men and Women of reproductive age
Prevention package for Mobile Population	*1,185,944*	*1,304,538*	*1,434,992*								
VCCT (cf men and women of reproductive age)								-	-	-	
								-	-	-	
1500 Uniformed services	**264,752**	**1,059,008**	**1,323,760**	**0**	**13,370**	**0**	*Min of Defence/ MoHA, CARE/UNODC*	**264,752**	**1,045,638**	**1,323,760**	Resources from Government?
Package Prevention services	*264,752*	*1,059,008*	*1,323,760*								
VCCT	*0*	*0*	*0*					-	-	-	
								-	-	-	
1700 Young people	***5,258,394***	***8,020,435***	***10,646,226***	**4,315,283**	**97,000**	**104,500**		**943,112**	**7,923,435**	**10,541,726**	
Young peole out of school (15-24)	**1,494,157**	***2,173,876***	***2,717,345***	***1,749,841***	60,000	62,000	*AUSAID, UNICEF, E.C., SCF, WVI, FHAM*	(255,684)	2,113,876	2,655,345	Resource for service for youth partly reflected in Men and Women of reproductive age
Package Prevention Services	*1,358,673*	*2,173,876*	*500,000*	1,315,041							
VCCT	*135,484*	*225,807*	*361,292*	434,800							
Young people in school (10-16)	**987,808**	**987,808**	**987,808**	***1,091,466***	0	0	*UNICEF, MoE?*	(103,658)	987,808	987,808	
Training of teachers + IEC	987,808	*987,808*	*987,808*								
Orphans and Vulnerable Children	***2,776,429***	***4,858,751***	***6,941,073***	***1,473,976***	37,000	42,500	*AUSAID, UNICEF, WVI, FHAM*	1,302,453	4,821,751	6,898,573	
								-	-	-	
								-	-	-	

Table 3: Summary Budget (2006-2009)

Component/Sub-component	Estimated Cost Apr 2006- Mar 2007	Estimated Cost april 2007- Mar 2008	Estimated Cost Apr 2008- Mar 2009	Expected funding Y1	Expected funding Y2	Expected funding Y3	Financing Partner 2006	Resource Gap Y1	Resource Gap Y2	Resource Gap Y3	Comments
1800 Men and women of reproductive age	**1,028,105**	**1,235,323**	**1,487,702**	**2,398,899**	**1,635,850**	**1,338,100**		**(1,370,793)**	**(400,527)**	**149,602**	Resources include STI, condoms and VCCT for targeted groups (CSW, MSM, Mobile, Youth..)
Package Prevention services	*350,684*	*467,578*	*584,473*	1,529,299	1,257,550	894,800	*Japan, UNICEF, UNDP, USAID, MDM, WVI, AZG, E.C., FHAM, GFATM*	(1,178,615)	(789,972)	(310,327)	
VCCT	*677,422*	*767,744*	*903,229*	869,600	378,300	443,300		(192,178)	389,444	459,929	
								-	-	-	
1900 Workplace Intervention	**619,938**	**1,239,875**	**2,479,750**	**734,509**	**0**	**0**	*FHAM, CARE*	**(114,572)**	**1,239,875**	**2,479,750**	Resource for service for workers partly reflected in Men and Women of reproductive age
Prevention package for workers	619,938	*1,239,875*	*2,479,750*								
VCCT (cf men and women of reproductive age)											
								-	-	-	
Enabling Health sector	***1,209,068***	***1,051,251***	***1,331,251***	***869,535***	***30,000***	***30,000***		**339,533**	**1,021,251**	**1,301,251**	
2010 Strengthening Lab services	*356,751*	356,751	356,751	179,413	30,000	30,000	*Japan, UNICEF*	177,338	326,751	326,751	
2020 Strengthening supply management	*469,817*	54,500	54,500	440,122	0	0	*UNICEF, GFATM*	29,695	54,500	54,500	
2030 Support and training of community workers	*75,000*	250,000	500,000	0	0	0		75,000	250,000	500,000	
Field level implementers (support)	*60,000*	120,000	120,000								
2040 Support to 100%TCP	*247,500*	270,000	300,000	250,000			*FHAM, GFATM..*	(2,500)	270,000	300,000	
								-	-	-	
2100 Safe blood supply	**1,153,119**	***1,153,119***	***1,153,119***	367,756	152,000	152,000	*AUSAID, Japan*	**785,363**	**1,001,119**	**1,001,119**	MoH resources?
								-	-	-	
2200 Infection in health care setting	**286,279**	**286,279**	**286,279**	**100,000**	**0**	**0**		**186,279**	**286,279**	**286,279**	
Universal precaution	200,000	*200,000*	*200,000*	100,000	0	0	*UNICEF*	100,000	200,000	200,000	MoH resources?
Post exposure prophylaxis	86,279	*86,279*	*86,279*	0	0	0		86,279	86,279	86,279	
2300 Treatment Care and support	**11,616,858**	**16,449,164**	**25,511,369**	**8,162,520**	**3,984,350**	**3,853,350**		**3,454,338**	**12,464,814**	**21,658,019**	
2305 Providing Cotrimoxazole as prophylaxis	**120,000**	***360,000***	***420,000***								
2310 Package of support and care without ARV	**6,593,839**	***8,791,785***	***15,385,623***	**3,468,027**	**1,935,850**	**1,968,850**		3,125,812	6,855,935	13,416,773	
- medical services	2,641,791	*3,522,388*	*6,164,179*				*UNICEF, E.C., AZG, USAID, MDM, FHAM, GFATM*				MoH resources?
- OI treatment	1,530,000	*2,040,000*	*3,570,000*	2,061,334	1,271,550	1,271,550					
- Home Based Care	1,358,055	*1,810,740*	*3,168,795*	1,253,826	658,300	691,300					
- Lab services	750,000	*1,000,000*	*1,750,000*	152,867	6,000	6,000					
- Support cost	313,992	*418,656*	*732,649*								
								-	-	-	
2320 Package of care and support with ARV	**3,444,509**	**5,166,763**	**6,314,933**	***3,056,322***	***1,658,500***	***1,494,500***		388,187	3,508,263	4,820,433	
- medical services	519,403	*779,104*	*952,239*								MoH resources?
- OI treatment	288,000	*432,000*	*528,000*								
- ART	1,464,600	*2,196,900*	*2,685,100*				*AZG, MDM, USAID, FHAM, GFATM*				
- Home Based Care	543,222	*814,833*	*995,907*								
- Lab services	180,000	*270,000*	*330,000*								
- Support cost	449,284	*673,926*	*823,687*								
								-	-	-	
2330 Prevention of Mother to Child Transmission	**1,008,156**	**1,680,262**	**2,940,459**	*1,183,679*	*324,000*	*324,000*	*UNICEF, FHAM, GFATM, Japan, E.C., AZG*	(175,523)	1,356,262	2,616,459	Some training cost non accounted in budget?
Including VCCT for pregnant women								-	-	-	
								-	-	-	

Table 3: Summary Budget (2006-2009)

Component/Sub-component	Estimated Cost Apr 2006- Mar 2007	Estimated Cost april 2007- Mar 2008	Estimated Cost Apr 2008- Mar 2009	Expected funding Y1	Expected funding Y2	Expected funding Y3	Financing Partner 2006	Resource Gap Y1	Resource Gap Y2	Resource Gap Y3	Comments
2340 Training (ARV, OI,...)	**450,354**	**450,354**	**450,354**	454,492	66,000	66,000	*UN, Japan, FHAM, GFATM*	(4,138)	384,354	384,354	
3000 Policy and Advocacy	**797,377**	**1,074,627**	**1,074,627**	***916,800***	***23,000***	***25,000***		**(119,423)**	**1,051,627**	**1,049,627**	
Vulnerable groups/ Advocacy	*200,000*	*200,000*	*200,000*					200,000	200,000	200,000	
Advocacy (Leadership and Media)	*474,627*	*674,627*	*674,627*	517,324	13,000	15,000	*UNAIDS, AUSAID, UNICEF*	(42,697)	661,627	659,627	
Mobilization of national and community leadership								-	-	-	
Media partnerships on AIDS advocacy				279,158	10,000	10,000	*AUSAID, UNAIDS, Japan, UNDP, USAID, FHAM*	(279,158)	(10,000)	(10,000)	
Media education and advocay efforts								-	-	-	
Gender	*22,750*			22,750	0	0	*UNAIDS*	-	-	-	
International and National conferences: AIDS; Harm Reduction; AIDS Day..	*100,000*	*200000*	*200000*	97,569	0	0	*UNAIDS, FHAM, UN*	2,431	200,000	200,000	Cost 2006 include Toronto Conference
4000 Monitoring and Evaluation	***943,143***	***1,023,143***	***1,023,143***	***1,157,902***	***189,150***	***160,000***		**(214,759)**	**833,993**	**863,143**	
Surveillance system	*312,478*	*312,478*	*312,478*				*UN agencies and external donor funds*				
Special surveys	*50,739*	*50,739*	*50,739*								
Monitoring and Evaluation of the national response	*9,925*	*9,925*	*9,925*								
Central M&E Unit support cost	*100,000*	*100,000*	*100,000*								
External technical support	*350,000*	*350,000*	*350,000*								
External review	*50,000*	*50,000*	*50,000*								
Transportation	*70,000*	*150,000*	*150,000*								
5000 Leadership and management	**904,120**	**2,061,480**	**2,538,480**	***528,327***	***16,000***	***80,000***		**375,793**	**2,045,480**	**2,458,480**	
Management and coordination	***374,120***	***461,480***	***538,480***					374,120	461,480	538,480	
- support to STD teams for development of local strategic plan	*20,000*	*77,000*	*154,000*	10,000	0	0	*GFATM*	10,000	77,000	154,000	
- management training of NAP and other services personnel	*330,000*	*330,000*	*330,000*	337,198	8,000	10,000	*AUSAID, FHAM, GFATM*	(7,198)	322,000	320,000	
- multisectoral programming, support to decentralised health system	*24,120*	*54,480*	*54,480*		0	0		24,120	54,480	54,480	
Mainstreaming HIV/AIDS	***530,000***	***1,100,000***	***1,300,000***					530,000	1,100,000	1,300,000	
Support to CBO's and local NGO's	*250,000*	*500,000*	*700,000*	47,328	0	0	*AUSAID*	202,672	500,000	700,000	Some resouces non identified in donors contribution
Support PLHIV network	*250,000*	*500,000*	*500,000*	131,300	8,000	70,000	*IHAA, WHO*	118,700	492,000	430,000	
Support of vulnerable groups networks	*30,000*	*100,000*	*100,000*	2,500	0	0	*UNFPA, MDM*	27,500	100,000	100,000	
								-	-	-	
Procurement for Y2 first 6 months	*2,817,218*	*-2,817,218*									
								-	-	-	
Funding with no breakdown available and/or management and overhead costs				**4,293,706**	**2,038,500**	**1,739,000**	*FHAM, GFATM, UN, Myanmar*	**(4,293,706)**	**(2,038,500)**	**(1,739,000)**	
Total	**34,016,689**	**41,703,753**	**62,328,898**	**30,817,381**	**7,297,810**	**6,430,950**		**3,199,308**	**34,405,943**	**55,897,948**	


Estimated resources available for HIV and AIDS Myanmar 2006
10
9
8
7
6
5
4
3
2
1
0
9.4
6.1
5.1
4.8
2.0
1.7
0.7
0.6
0.2
0.2
FHAM
UN
NGO's priv.
GFATM
USAID
E.C.
AUSAID
Japan
ULTAM
Government
30.8 M US$

MYANMAR NATIONAL STRATEGIC PLAN ON HIV AND AIDS

OPERATIONAL PLAN

(April 2006 - March 2009)