FUND FOR HIV/AIDS IN MYANMAR

SIX-MONTHLY PROGRESS REPORT
(1 April 2004 - 30 September 2004)

30 March 2005

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNHCR·UNICEF·WFP·UNDP·UNFPA
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Introduction

The Fund for HIV/AIDS in Myanmar (FHAM), established in January 2003, aims to ensure a coordinated, comprehensive and multi-sectoral response to HIV/AIDS; it supports the implementation of activities and projects contributing to the objectives of the Joint Programme for HIV/AIDS: Myanmar 2003-2005. The FHAM is currently supported by the Department for International Development (United Kingdom), Swedish International Development Agency (Sweden) and the Government of Norway. FHAM provides approximately 25% of estimated total requirements for the Joint Programme (US$ 87 million) and 50% of current contributions.

Nineteen projects were funded for the first year[1] of the Joint Programme amounting to US$ 6,830,000. Some of them extended into a second year. In April 2004, a further 22 projects were approved for Round II funding for a period of 2 years amounting to US$ 12,800,000 *(summary of Round I and Round II projects and budgets attached).* This progress report covers implementation of projects by partners funded by FHAM from 1 April to 30 September 2004. It therefore includes the completion of projects from Round I in a No-Cost Extension period as well as the first six months of implementation by Round II partners.

While good progress was made in the first year of the FHAM, significant achievements have taken place in a number of areas in the first 6 months covered by this report (1 April to 30 September 2004). They include the scaling up of prevention (eg. STI service delivery strengthened in number and quality of providers) as well as care and treatment of people with AIDS. Despite constraints and some delays, interventions supporting the prevention of sexual transmission among Injecting Drug Users have moved from advocacy to implementation, albeit on a pilot basis still in a limited number of townships. Resources have contributed to increased coverage for both prevention and treatment activities, even though the gaps and needs remain significant. Achievements over the period are reviewed in the following pages and have been compared to estimated Joint Programme needs wherever possible.

Much of the first year of the Fund was spent setting up mechanisms and coordinating the management arrangements while at the same time ensuring a rapid start to implementation[2]. The objectives guiding Round II of the Fund for HIV/AIDS in Myanmar in the second year of implementation aimed to:

- Consolidate on the progress and achievements made in Year I
- Focus on priorities and gaps in terms of interventions and/or geographical areas
- Support and increase capacity for implementation among Implementing Partners
- Strengthen the monitoring of implementation including feedback

A significant achievement of these six months is the monitoring and evaluation system for the FHAM, harmonised largely with Joint Programme system and indicators. Progress in FHAM Round II is now tracked using standardised indicators reported by each Implementing Partner. This makes the reporting of aggregated progress possible and the contribution of FHAM resources to the Joint Programme easier to measure. As a result and for the first time, this report presents consolidated data for selected core indicators. An overview of progress for the Fund for HIV/AIDS in Myanmar was presented at the Expanded Theme Group (ETG) in December 2004.

In general, a responsive and flexible approach has been essential to support a range of projects and organisations with varying degrees of capacity for implementation and absorption. Building on the experience acquired during the first year of implementation, Round II ensures that resources remain focused on interventions that are most effective, while gaps in capacity have been identified and addressed as much as possible by encouraging links and synergies between organisations. By way of example, national organisations who are key to the response

[1] Myanmar Financial Year: 1 April 2003 to 31 March 2004 (FY 2003/2004)
[2] FHAM Annual Report 2003-2004

and partners providing technical expertise have been brought together for the implementation of Round II projects (for example the International HIV/AIDS Alliance, Myanmar Railways and the Burnet Institute).

I Progress and Achievements

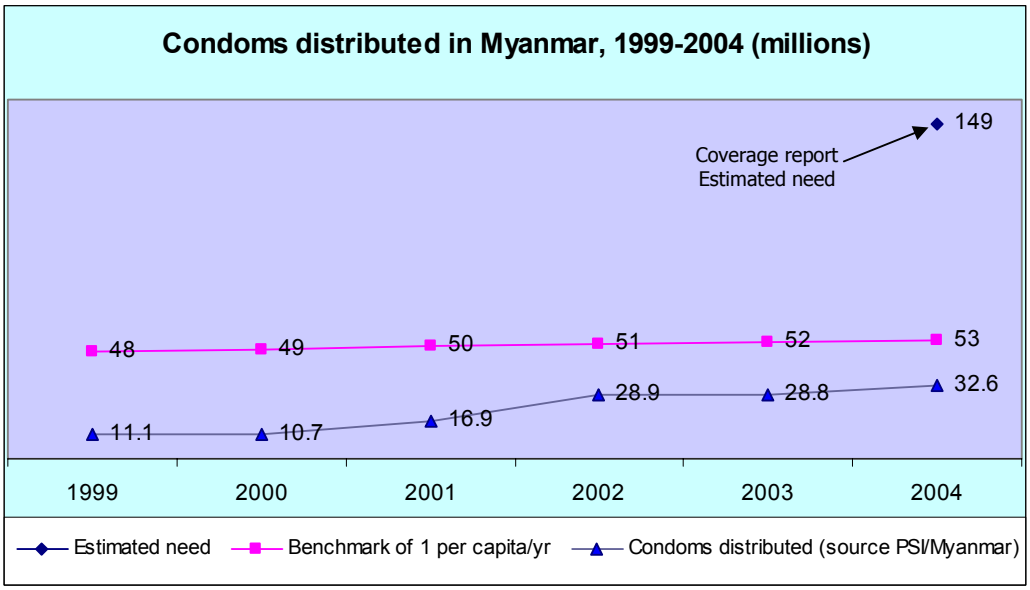
1. Access to services to prevent the sexual transmission of HIV improved (Joint Programme Component 1)

Eleven projects funded by the FHAM contribute to the prevention of sexual transmission (Component 1 of the Joint Programme). Funding contributes to two key outputs of the Joint Programme: "Increasing access to condoms and improving the capacity for the prompt and effective management of Sexually Transmitted Infections".

1.1 Access to affordable condoms for sexually active men, women and young people increased

Access to affordable and quality condoms remains a key objective of the Joint Programme and the 28,407,000 target to be distributed by the end of the year, and supplied through FHAM funding, is likely to cover 55% of the benchmark of 52,000,000 condoms for the whole country[3].

Chart 1.1

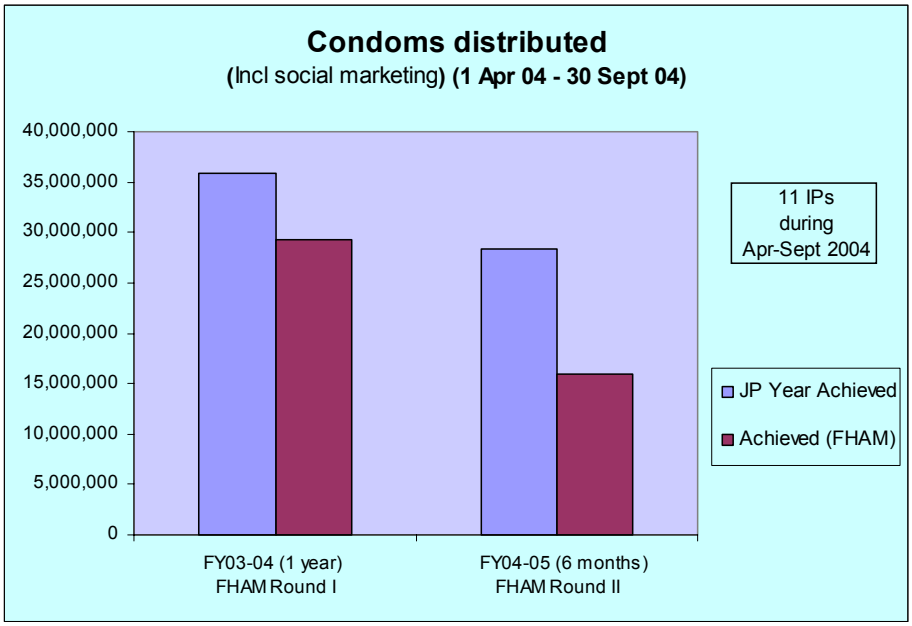


Condom distribution was carried out by 13 organisations through the social marketing of male and female condoms nationwide as well as their free distribution to high risk groups and young people. Stated targets were achieved and 17,436,435 condoms were distributed in the first six months of Round II implementation against a yearly target of 28,406,952 (61%). (Chart 1.1; Table 1) In cases where targets were not achieved, late supply of commodities was the main factor accountable for delays.

The "Aphaw" condom brand received wide media coverage in the printed media; an increase in its popularity among high-risk groups and in the general population was reported by PSI. Flavoured condoms were launched in 2001 and have clearly gained popularity; demand is increasing. The female condom was launched in 2003 and has been widely promoted, to offer women an additional option for protection. Although numbers distributed are still low, most female sex workers now have access to female condoms according to NGOs.

[3] This is equivalent to 20% of needs estimated at 149,000,000 condoms a year in "Coverage of selected services for HIV /AIDS prevention, care and support in low and middle income countries in 2003" (UNAIDS, USAID, WHO, UNICEF and the Policy Project)

Chart 1.2



In addition to social marketing, condoms were distributed during peer education sessions for high risk groups and young people, and other health education sessions. The distribution of condoms has been expanded through new projects including outreach activities targeting Intravenous Drug Users (IDU) in Lashio. For example, in just two drop-in centres a total of 8,000 condoms have been distributed over the 6-month period, targeting IDUs and vulnerable youths.

FHAM funding also contributed to the expansion of the 100% Targeted Condom Promotion (TCP) programme to an additional 20 townships (from 58). Elements of the 100% TCP strategy include 1) Advocacy to local authorities, 2) Availability and distribution of quality condoms and quality services for the treatment of STIs, 3) Peer education and outreach work targeting mobile population groups, 4) Effective behaviour change communication and 5) Monitoring and evaluation. Central level training for the health staff participating in the 100% TCP (78 townships) was conducted by the National AIDS programme. An evaluation of the 100% TCP programme by the National AIDS Programme (NAP) and WHO is scheduled for the first half of 2005.

There is now a high level of access to condoms in the country, with condoms both widely available and affordable. The increase in availability of condoms has satisfied an existing and unmet demand but the challenge remains to increase their use among high-risk and vulnerable groups by overcoming resistance and ensuring safer behaviours. There remains an urgent need to educate people to choose to use a condom. In a recent study of the reasons given by sex workers for non-use of condoms in paid sex, of those sex workers who reported not having used a condom, 94% said that their partner had objected. Behaviour change among clients is imperative.

Table 1. Progress on service delivery for the prevention of sexual transmission

	No-cost extension	**Round II**	**Total (1 Apr-30 Sept 2004)**
Condoms distributed	1,459,797	15,976,638	**17,436,435**
Patients treated for STI	3,066	68,037	**71,103**
Service delivery points providing integrated STI services (New)	354	354 (+121 new)	**476**
Referrals to STI services	Not reported	51	**51**

1.2 Capacity for the prompt and effective management of Sexually Transmitted Infections (STI) increased

In the private not-for-profit sector, the provision of quality treatment for STIs has now increased to 152 service delivery points offering treatment based on national guidelines in 71 townships. 121 additional service delivery points for the treatment of STIs were opened during April-September 2004. (Table 1.1) One partner opened a new Clinic/Drop-in Centre in Phan Kham, in the Wa special region of Shan State, in September 2004.

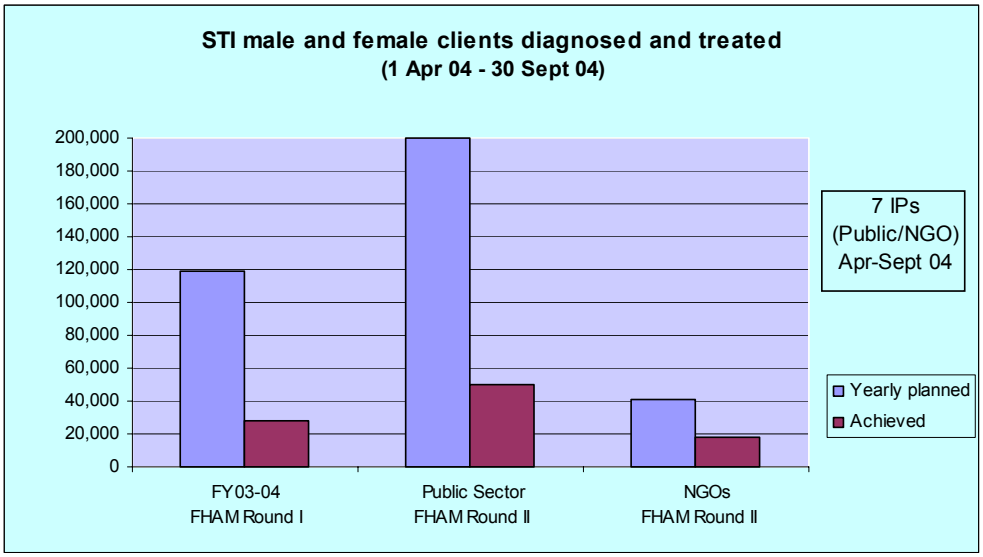
In the public sector, existing service delivery is also being strengthened through the provision of training and medical supplies to the NAP's 40 STD/AIDS teams, and to 284 township hospitals countrywide. Referral systems for the treatment of STIs in the Ministry of Rail Transport's (MRT) health service network is also being strengthened in 35 townships (11 MRT divisions).

National treatment guidelines have been updated following a consultation led by the NAP, with technical assistance from WHO and the participation of stakeholders from public and private sectors and NGOs. Training on the Syndromic Management of STIs has been provided to 108 General Practitioners in the private sector (Sun Quality Health network), refresher training to township medical officers and training to Basic Health Staff. 284 townships are currently using the treatment guidelines. STI counselling guidelines have also been produced and distributed by the NAP.

Four Implementing Partners offering services in public and private health facilities diagnosed and treated a total of 71,103 patients for STIs during the period. (Chart 1.3) The screening of pregnant women for STIs is routinely carried out by three NGOs and the National AIDS Programme (NAP). Many not-for profit private facilities screened and treated higher number of patients than planned in their original targets and have observed an increasing demand for quality STI treatment services.

Improving and increasing access to appropriate treatment for STIs remains a high priority for the Joint Programme. Strategies need to be developed to further increase the number and availability of quality treatment for STI. Every time that a new service delivery point is opened there is a demand for services. There remains a need for increasing the availability of quality treatment and to scale up the number of facilities providing this.

Chart 1.3



2. Access to services to prevent IDU transmission of HIV improved (Joint Programme Component 2)

Seven partners have been working to increase access to services preventing transmission of HIV among injecting drug users in the period April-September 2004. During this period, 4 Round I implementing partners continued in No Cost Extension (AHRN, UNODC, LOP, NAP & WHO) while one partner (MANA) progressed to Round II in April 2004. In addition, two new FHAM partners (BI-CHR, CCDAC) started preparations for implementation as part of Round II.

2.1 Access to harm reduction interventions increased

Two Drop-in Centres for IDUs, one in Tamwe Township, Yangon (MANA) and one in Lashio, Northern Shan State (LOP), continued to provide services including counselling, health education on harm reduction and safer sex behaviour, needle and syringe distribution, and primary health care (Chart 2). One lesson learned was that provision of primary health care services is an entry point for community acceptance, and this could be useful to consider when expanding coverage to new locations. During the reporting period, preparations were made for the opening of an additional outreach and drop in centre for IDUs in Northern Shan State (AHRN).

Under the supervision of trained field supervisors and the township steering committee, outreach workers were able to make more contacts and penetrate further within the IDU community in Lashio. The general community in Lashio has made significant progress in its understanding of the importance of needle and syringe distribution. Outreach workers routinely conduct health education on harm reduction and safer sex, and distribute condoms, needles and syringes to IDU beneficiaries. Clients are also referred to the project drop-in centre for counselling and for primary health care services, to the STD team for Voluntary Confidential Counselling and Testing (VCCT) service, and to the drug treatment centre. 182 IDUs were contacted by Tamwe outreach staff, and 228 by Lashio Outreach Project (LOP) staff. 28 IDUs were referred to STD teams for VCCT services (Table 2).

Myanmar language Information, Education and Communication (IEC) materials on safe injecting and safe sex practices, as well as on improving self-esteem, were acquired for distribution to IDUs. Two leaflets and a poster were also developed for the Lashio Outreach Project (LOP).

The Technical Coordination Unit (TCU/UNODC) provided a central location with the aim of facilitating liaison and enhancing coordination among partners for all aspects of Component 2 related activities. The TCU played a facilitation or coordination role in a number of Harm Reduction projects. Some of its activities have included coordinating the translation of 8 Harm Reduction documents; facilitating the planning of a Situation Assessment of Risk Behaviour in Taunggyi, the mid-term review for another Harm Reduction project, and a baseline study in Lashio township. In terms of strategy development, the TCU served as focal point for the development of implementing partners' proposals for FHAM Round II funding, holding coordination meetings in early April 2004. In addition, a two-day coordination workshop was held for FHAM- and non-FHAM funded partners of the Joint Programme Component 2 group. The "Operational Framework to Effective Interventions for Reducing HIV Infection from Injecting Drug Use" document was drafted in accordance with the recommendations of the FHAM Round II Technical Review Panel and with the assistance of an international expert. Two training sessions for outreach workers were held, one in Myitkyina and another in Lashio. The training in HIV counselling of staff members from "UNODC G54 Project" sites was also facilitated by the TCU.

The procurement of needles, syringes and condoms for distribution to Component 2 Implementing Partners was managed by the TCU, and preparatory steps were taken for methadone procurement. A procurement officer was recruited during this period, and will facilitate future bulk purchasing in terms of both cost and time.

The Central Committee for Drug Abuse Control (CCDAC) of the Ministry of Home Affairs is a key harm reduction partner, and is due to receive FHAM Round II funding, although it has not yet started implementation, pending signature of a contract. Because of the nature of the organisation, there is an opportunity to pioneer new activities in law-enforcement related fields, such as HIV/AIDS prevention in the Police Force and in prisons and alternative sentencing for IDUs. However, CCDAC does not have sufficient trained manpower to implement all activities. UNAIDS facilitated meetings between the Burnet Institute's Centre for Harm Reduction (BI-CHR) and CCDAC in the preparation phase of both project proposals, with a view to CCDAC obtaining appropriate and timely technical assistance from BI-CHR.

Chart 2

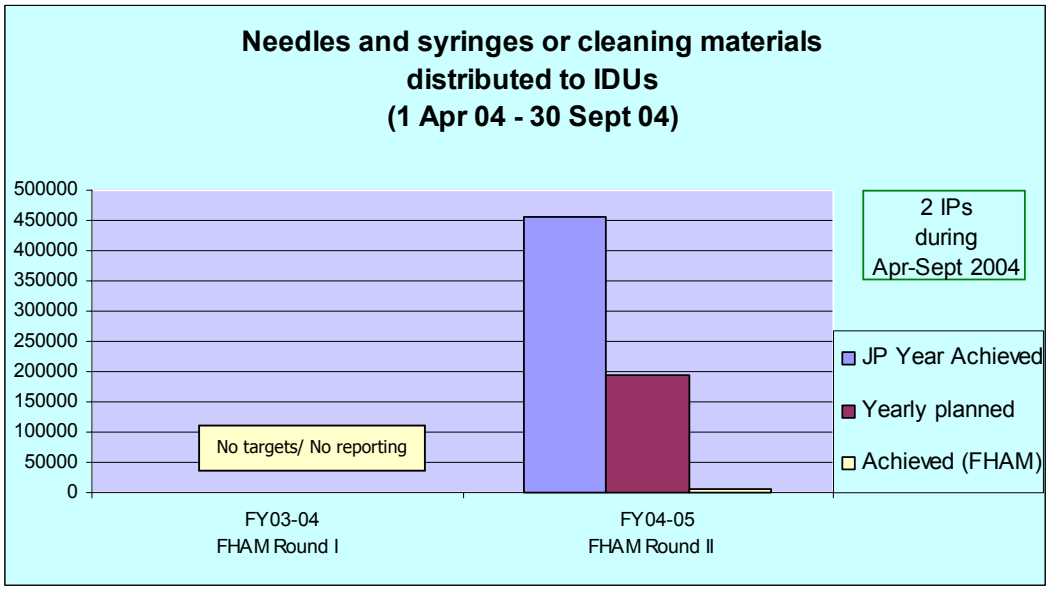


Table 2. Progress on service delivery for the prevention of transmission among IDUs

	No-cost extension	Round II	Total (1 Apr-30 Sept 2004)
No. of Needle & Syringes or cleaning materials distributed	6,085	898	**6,983**
No. of clients to Drop in Centres	701	335	**1,036**
No. of IDU Drop in Centre established (New)	0	1	**1**
No. of IDU receiving detoxification treatment	0	0	**0**
No. of IDU receiving maintenance substitution therapy	0	0	**0**
No. of IDU referred for drug treatment	2	12	**14**

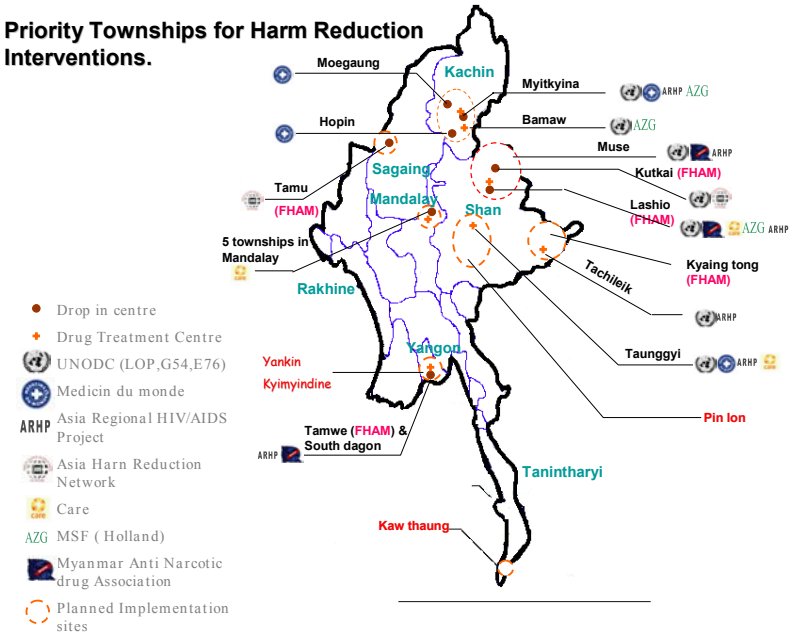
2.2 Access to and quality of drug treatment in institutional and non-institutional settings improved

Although a number of projects planned to make it available, methadone-based substitution therapy has been delayed pending official approval. Nonetheless, preparations have been made for methadone procurement, and although some uncertainty remains, significant progress towards making therapy available has been made during the reporting period, including the development, with participation of Ministry of Health, of *Guidelines for Methadone Maintenance Programmes* and a *Myanmar Harm Reduction Manual*. Technical assistance was provided by

WHO to establish support to the NAP and the Drug Treatment Centres of the Department of Health to develop technical guidelines on harm reduction and particularly methadone maintenance therapy and activities targeting drug users to establish an entry point to care and ART.

In addition to the above, a number of harm reduction texts were translated into Myanmar language: a revised version of the Harm Reduction Manual; *Breaking the Link,* a UN Position Paper on Reducing HIV among Drug Users; and four Outreach Training Toolkits.

Figure 1



For Component 2, there is much coordination activity, but there remains a scarcity of service implementation such as outreach at field level. As a consequence there is advocacy for, and acceptance of, the need for harm reduction activities, but too low coverage to date. There is both a lack of, and the need for reliable data on the number of IDUs. However, it has been suggested that less than 5% of the IDU population nationwide is covered by Harm Reduction activities. As such there has been an insufficient impact on the HIV epidemic in this population, and therefore limited or no reduction of this key group as a driver of the wider epidemic.

3. Knowledge and attitudes improved (Joint Programme Component 3)

The main focus of Component 3 is on increasing knowledge and improving attitudes and behaviour surrounding HIV and AIDS. During the reporting period, 12 partners were implementing activities in Component 3 in No-Cost Extension, and 18 as part of FHAM Round II.

3.1 Knowledge of modes of transmission, perception of personal risk and attitudes regarding HIV/AIDS improved among general population

Two key activities are being implemented to improve the knowledge level of the general population: health education and Information, Education and Communication (IEC) material distribution. 21,135 health education sessions were conducted for the general population on HIV/AIDS prevention, care and support (Table 3.1). Special awareness sessions on Prevention of Mother to Child Transmission (PMCT) were also conducted for the general population to increase knowledge of, and access to, the PMCT programme. 103 workplace education sessions were held reaching 1,853 workers from industries including mining and railway industries, private sector, marine cadets and officers.

In addition, 661 mass awareness sessions, such as video shows, puppet shows and exhibitions were conducted by different implementing partners. Moreover, in order to increase awareness among the general population, a film about HIV/AIDS was produced and broadcast on the national television channel.

Different types of IEC/Promotional materials on HIV/AIDS were produced, and 1,156,657 units distributed over the 6-month period. One implementing partner reported conducting an evaluation of IEC, analysing the effect of IEC material, and carrying out a Knowledge, Attitudes, Practices and Behaviour (KAPB) Survey.

The services of an international consultant were provided by WHO to make an assessment and build a proposal for the development of a strategy for communication of HIV/AIDS health issues to the health sector.

Although these activities to increase knowledge have been implemented, their impact is as yet unknown, and remains to be assessed.

Table 3.1 Progress on delivery on Knowledge and Attitudes

	No-Cost Extension	Round II	Total (1 Apr-30 Sept 2004)
Number of health education sessions on HIV/AIDS conducted	2,134	19,001	**21,135**
Number of mass awareness sessions held (video shows/TV spots)	45	616	**661**
Number of IEC materials distributed to general population	548,882	607,775	**1,156,657**

3.2 Positive attitudes, safe sexual behaviours and practices in specific target groups improved

Eleven partners were implementing activities for specific target groups such as sex workers, injecting drug users and men who have sex with men. 28,452 individual/group counselling or health education sessions were conducted among target groups and the coverage increased by establishing and providing services through new drop-in centres, and also by expansion to new geographical locations (Table 3.2; Chart 3.1).

Peer Education was a key strategy used in working with specific target populations, and 879 peer educators from different target groups were selected, trained and involved in the project. In addition, 485 peer educators from specific target groups received training on different aspects of HIV/AIDS.

Needs-based IEC materials were developed for specific target groups, depending on geographical location, in Myanmar, Shan, Wa and Chinese languages, and a total of 497,215 IEC materials were reported distributed among target groups.

There is a continued need to increase targeted interventions among high-risk groups. Although a growing amount of output data has become available, there is still a significant lack of data on the impact of these activities on knowledge, attitudes and behaviours. This underlines the importance of future surveys to assess change in risk and risk-reducing behaviours.

Chart 3.1

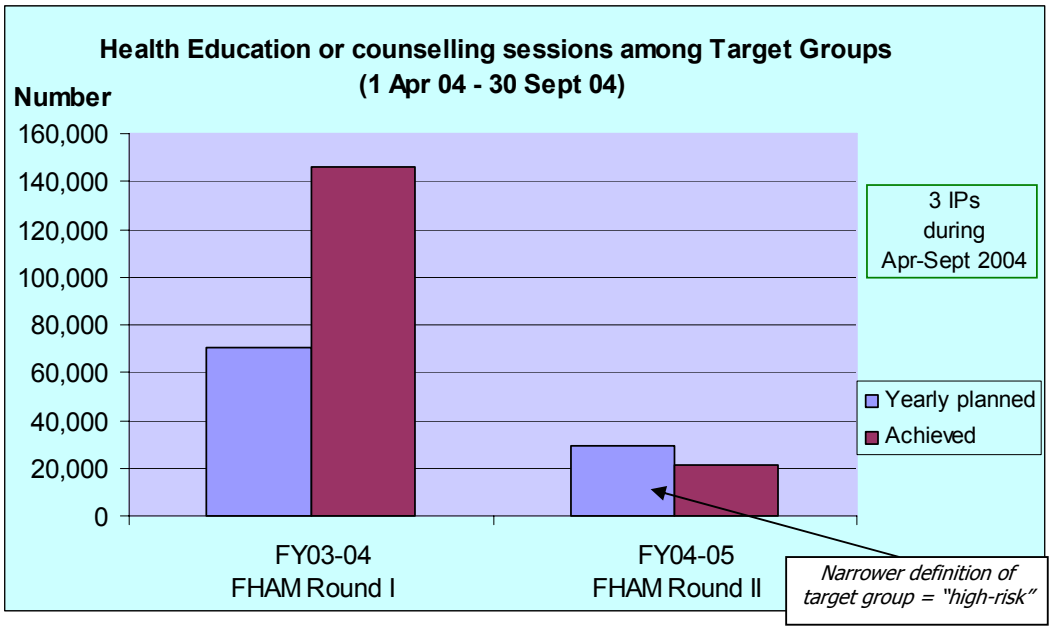


Table 3.2 Progress on delivery on Knowledge and Attitudes

	No-Cost Extension	Round II	Total (1 Apr-30 Sept 2004)
Number of health education or counselling sessions conducted among target groups	7,196	21,256	**28,452**
Number of IEC materials distributed to target population	2,500	494,715	**497,215**
Number of peer educators involved in project	118	761	**879**

3.3 Awareness of HIV/AIDS among youth improved

Sixteen implementing partners implemented activities focusing on youth during the period, and 2,023 health education sessions were conducted for in-school and out-of-school youth (Table 3.3). School HIV/AIDS education sessions took place in the context of personal hygiene

education, and teachers were trained (5 trainings) in communicating information on HIV/AIDS for in-school youth. In addition, 124,594 IEC materials were distributed to youth.

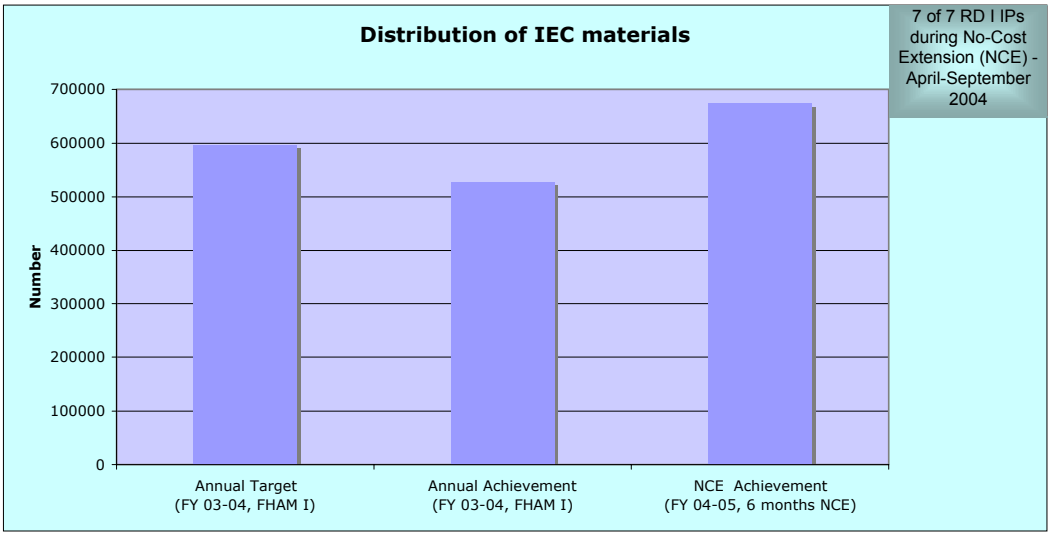
Table 3.3 Progress on delivery on Knowledge and Attitudes

	No-Cost Extension	Round II	Total (1 Apr-30 Sept 2004)
Number of health education or counselling sessions conducted for youth	1,953	70	**2,023**
Number of IEC materials distributed to youth	65,525	59,062	**124,594**

It is interesting to note that during six months of no-cost extension, the achievements made in IEC material distribution for the general population was greater than the yearly achievement of FHAM I (Chart 3.2), even with a smaller number of partners implementing activities during the no-cost extension period. Much of the health education and IEC production took place in the second quarter. As a result, most of the implementing partners exceeded the proposed targets in IEC material distribution (within a 3-month period), especially to the general population. This excess achievement during the no-cost extension period may in cases reflect budget-driven spending and highlights the need both to study impact of - and to monitor funds requested for - IEC materials carefully in all future FHAM activities.

Activities contributing to increasing awareness of HIV/AIDS have clearly benefited from the overall increase in resources in Myanmar. They include prevention and education sessions for targeted groups, production of IEC materials, large-scale media events, video shows and movies. There is currently insufficient data to inform programmes on the effectiveness of these activities and their actual impact on behaviour change, especially among target groups. The Behavioural Surveillance Survey for which a protocol is being finalised is expected to provide critical information for the Joint Programme on progress and achievements in relation to knowledge, attitudes and uptake of safer behaviours.

Chart 3.2



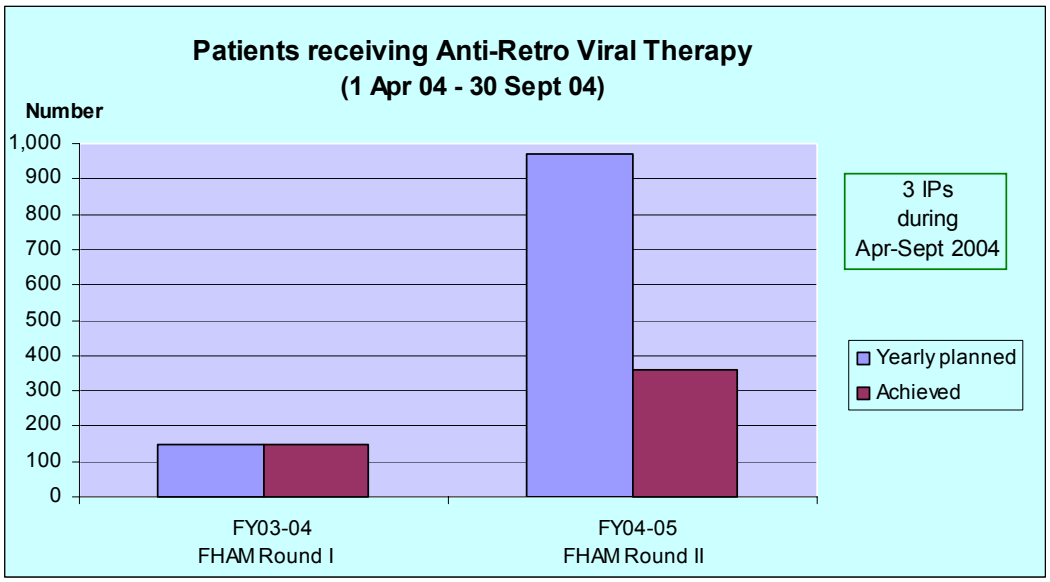
4. Access to services for HIV care and support improved (Joint Programme Component 4)

Component 4 aims to expand coverage of quality care, treatment and support services for People Living with HIV/AIDS (PLHA). It includes scaling up access to appropriate antiretroviral therapy (ART), treatment for AIDS-related infections, and care in the community. In addition, it aims to increase coverage of quality Voluntary Confidential Counselling and Testing (VCCT) and PMCT services. Twelve projects funded by FHAM contribute to this component.

4.1 Quality and access to care and treatment services for PLHA improved

Triple combination antiretroviral therapy (ART) was initiated in Yangon in 2003 through a project implemented by MSF-Holland and the Waibagyi Infectious Disease Hospital. While the pilot project continues and expands, a number of important steps have been made in preparation to scale up the provision of ART in public sector health services and increase the availability of quality treatment for patients with AIDS in Myanmar.

Chart 4.1



National care and treatment guidelines for opportunistic infections and antiretroviral therapy in adults and adolescents were developed with the technical assistance of WHO, and a draft has been submitted to the Ministry of Health for final approval. Progress has been made in drafting the clinical management guidelines of HIV/AIDS in children (NAP).

With the aim of introducing and scaling up antiretroviral therapy in the public sector, technical support was provided by a joint mission by UNICEF and WHO to the Ministry of Health in order to assess the mechanism and systems required for the procurement and supply management of ART in Myanmar. A mission by WHO in August also provided technical assistance to identify human resources and capacity requirements and draw a capacity plan for ART; the assessment report was shared with the Technical Working Group. A range of national and international stakeholders was consulted and involved in these processes, drawing on existing experience and paving the way for increased coordination and cooperation in the efforts to scale up ART.

By 1 October 2004, a total of 361 patients were receiving triple combination ART (355 patients through MSF-H and 6 patients by MSF-CH in Thanintharyi Division) (Chart 4.1). Screening, pre-treatment counselling and consistent patient monitoring have ensured excellent adherence to ART so far (from 97.42% to 99.84% in 6 months). During the period, ARV drugs were procured for the NAP through UNDP, to start 115 patients on antiretroviral therapy in 2005. An

additional order for 245 adult and 40 paediatric treatments will be placed, so that the NAP should be able to provide treatment for 400 patients by the end of 2005 (FHAM funding).

While scaling up ART, access to and provision of home-based care has also been increased and a total of 409 PLHAs received home-based care during the 6 months period, provided by 5 NGOs in 40 townships (31 ADRA, MNA; 58 WV; 279 MSF-H + 41 MSF-CH).

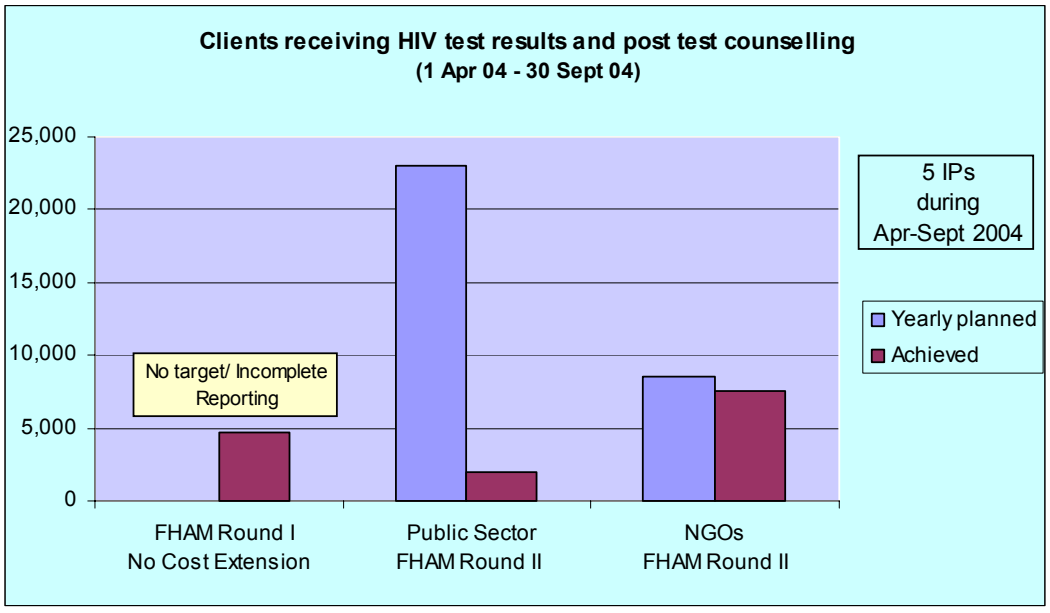
In terms of improving medical care for opportunistic infections, partners were diagnosing tuberculosis, and 635 patients received treatment during the reporting period. One organisation conducted 60 home visits by peer educators for case finding. Home visits were reported to be an effective approach for referral of suspected cases to appropriate health facilities for treatment, and peer educators were able to directly share health information and have personal contact within communities. The basic needs of 58 PLHAs were taken care of in terms of nutrition and treatment for opportunistic infections by one implementing partner, while another partner reported having identified potential candidates among persons affected by HIV (PLHAs and their families) for provision of a basic benefit package.

Achievements made so far and the recently published progress report on the 3 by 5 initiative highlight the urgent need for continued investment in treatment, care and support for PLHAs. As soon as the start-up phase of antiretroviral treatment in the public sector with appropriate follow-up care passes the initiation stage, additional resources will be essential to scale up in response to the needs.

4.2 Quality of and access to voluntary confidential counselling and testing services improved

Five organisations provided HIV test results and post-test counselling between 1 April and 30 September 2004, including direct provision of testing by the National AIDS Programme's 40 STD teams. During the reporting period, a total of 14,253 persons received HIV test results and post-test counselling services (Table 4, Chart 4.2). Although not able to carry out testing themselves, NGOs provide pre- and post-test counselling to clients receiving HIV test results. HIV serological testing was performed by the STD teams in testing centres, although implementing partners often elected to provide pre-counselling, with or without blood-sample collection, and to communicate test results to their clients in a post-test counselling package.

Chart 4.2



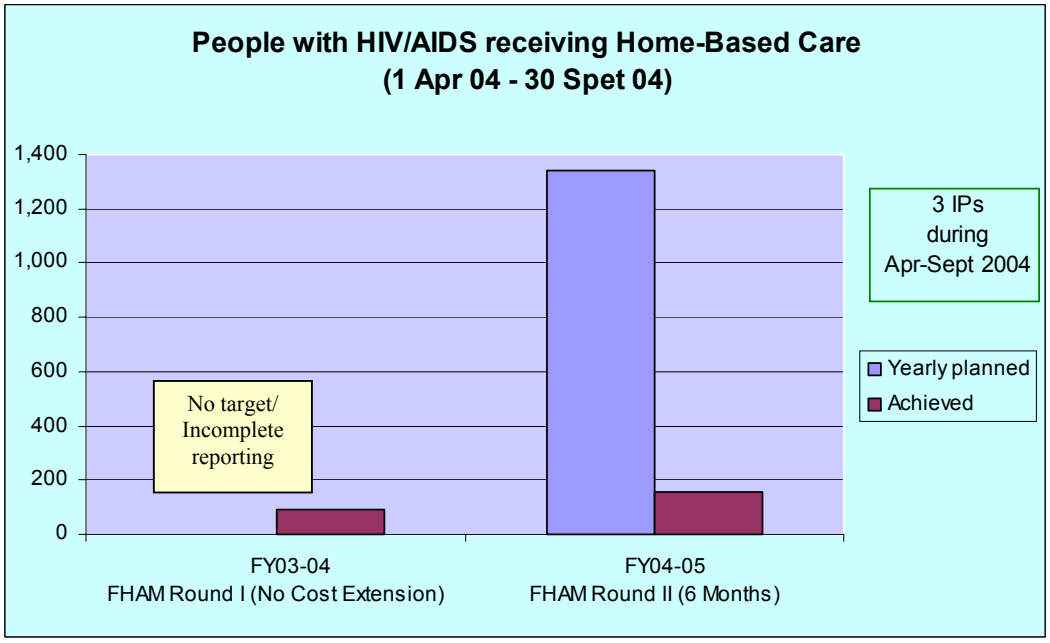
For FHAM Round II, the combined yearly target of 8,598 clients was almost reached during the first 6 months of implementation, with 7,533 clients, or 80% of the yearly target, having received HIV test results and post-test counselling. The majority of VCC (T) sessions were provided by one partner (MSF-H), which reported an uptake of 89% and 91% on VCCT offered in quarters 1 and 2 respectively. Interestingly, for planning purposes, a VCCT uptake rate of only 50% had been assumed. Other implementing partners chose to refer their beneficiaries to STD teams for VCCT, and 89 persons were referred in this period, 30 of whom were IDUs.

Technical support was provided to the NAP by WHO for the development of VCCT training manuals for trainers, of which one manual was designed specifically for harm reduction projects. Overall results reflect a growing demand within the population for access to quality VCCT services. Service provision for quality VCCT needs to be expanded urgently.

4.3 Caring, protective and supportive environment for people living with or affected by HIV/AIDS improved

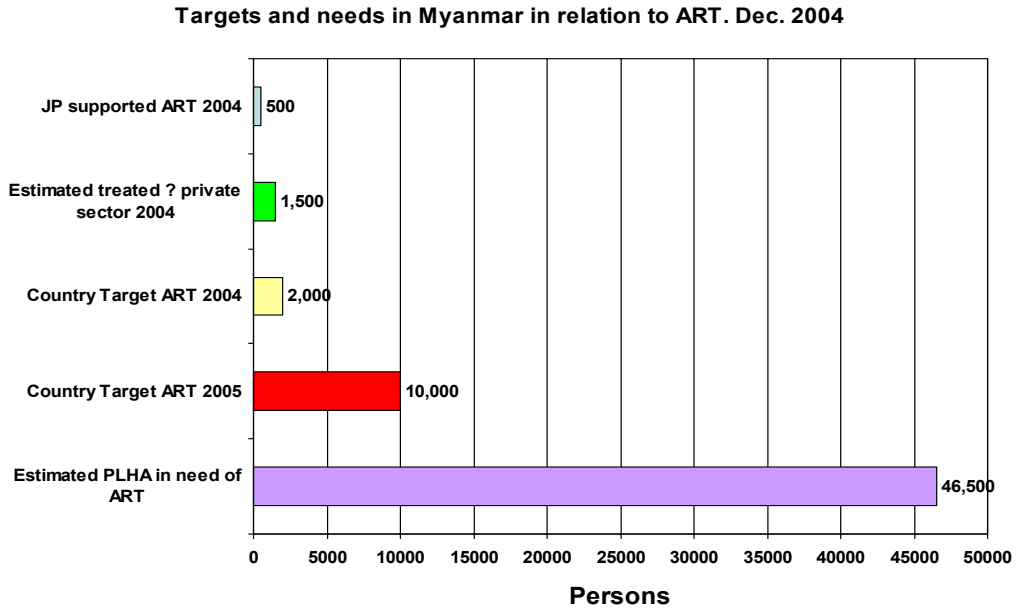
The care and support of PLHAs and their families has been undertaken in varying degrees by a number of implementing partners. The World Food Programme provided food assistance to a total of 128 patients (PLHA or chronically ill) and 78 families. One partner (WVI) provided care to 31 affected children through educational, nutritional or counselling support. They also conducted advocacy with relatives and extended families to ensure care and shelter for affected children. The participation of PLHAs has been ensured in Community Home Based Care working groups, with 33 PLHAs participating in care and support activities, in the planning and implementation stages (ADRA, MNA, PACT, WVI). Stigmatisation and acceptance of PLHAs in the community continue to be a challenge which these projects are addressing. 304,388 persons were reported to have participated in 18,083 health education sessions dealing with transmission and prevention of STI and HIV, and care, support and acceptance of PLHA. One partner was implementing community-based development activities through use of village health funds, and PLHAs and affected families were recipients of grants from these funds.

Chart 4.3



Unfortunately, with an estimated 46,500 AIDS patients in need of ART nationwide[4], very little impact can be claimed towards providing a caring, protective and supporting environment for PLHAs, and many challenges remain to achieving this goal (Chart 4.4).

Chart 4.4



Estimated PLHA (15-49 years old): 339 000

[4] WHO 3by5 data

4.4 Risk of mother-to-child transmission of HIV reduced Field implementation

In order to reduce the risk of transmission of HIV from infected mothers to their newborn, 1065 women received PMCT services through one implementing partner. From the group of 1065 women counselled about PMCT, 36 mother and baby pairs received Nevirapine at the time of delivery (MSF-H). In Round II, one additional implementing partner has initiated work through the NAP to provide institution and community-based PMTCT (UNFPA).

A number of Joint Programme partners are working to implement PMCT services (non-FHAM funded) and a total of 360 mother and baby pairs have received Nevirapine for PMTCT over the past year. 18,000 mother-baby pairs nationwide are estimated to require PMTCT. This shows once again a clear need to scale up the availability of PMCT nationwide, with current achievements falling well short of target and of estimated need.

Table 4. Progress on service delivery for care and support

	No-Cost Extension	Round II	Total (1 Apr-30 Sept 2004)
People receiving ARV therapy		361	**361**
PLHA receiving HBC	89	154	**253**
People receiving TB treatment	10	635	**645**
Clients receiving HIV test results and post test counselling	4,720	9,533	**14,253**
People referred to VCCT services	30	59	**89**
Mother/baby pairs receiving Nevirapine	Not reported	36	**36**

II Monitoring and Evaluation

The monitoring and evaluation (M&E) framework for the Joint Programme for HIV/AIDS in Myanmar was developed in March 2004 and finalised after consultations with Joint Programme partners in July 2004. The monitoring and evaluation system for the FHAM was developed on the basis of the Joint Programme Monitoring and Evaluation plan.

The Fund's M&E framework includes a core list of indicators that allow results-based progress to be tracked across Joint Programme priority objectives and outputs. The core indicators for FHAM support the dual purpose of programmatic monitoring and resource tracking. It therefore includes all relevant indicators for the Joint Programme as well as specific indicators common to different implementing partners and reflecting priority areas of the Joint Programme. The reporting on technical progress has been streamlined, in consultation with implementing partners, to reflect progress on selected indicators. As a result, and for the first time, it has been possible to present consolidated data for selected core indicators in this report.

Data reflecting progress on outputs is now available as part of the regular monitoring for the FHAM and focuses on results achieved towards Joint Programme objectives. Information and data on the impact of activities however is still insufficient and require specific studies. The Behavioural Surveillance Survey (BSS), in particular, for which a protocol is currently being finalised, is expected to provide critical information to inform the response and the future direction of efforts. The BSS is expected to provide yearly behavioural data for a number of high-risk and vulnerable groups.

The programmatic monitoring of activities funded by FHAM was carried out on a regular basis and 9 site visits were carried out to 15 projects in Lashio, Muse, Taunggyi, (Shan State), Monywa (Sagaing Division), Yangon and Mandalay.

At the same time, preparations are under way to carry out a Mid-Term Review of the Joint Programme. Programmatic achievements will be reviewed, together with the coordination and mechanisms supporting Joint Programme implementation in Myanmar.

III Capacity for Implementation

Resources have contributed to the increase in training and capacity-building activities in general, with a total of 877 trainings/workshops provided during the 6 month period of which 279 were provided to build the capacity of health-care providers. Training of peer educators also took place (35).

As a result of the needs identified in Round I, three new partners to the response now receive funding through the FHAM with the specific objective of building technical and managerial capacity of national partners through workshops and on-the-job training and mentoring. Technical assistance is being provided to national organisations in the implementation of interventions to prevent HIV transmission among Injecting Drug Users, to increase understanding and build expertise in Behaviour Change Communication (BCC) and to increase capacity among vulnerable groups and People Living with HIV/AIDS. The Burnet Institute's Centre for International Health provided BCC training to Myanmar Railways and on-going technical assistance to grassroots organisations, while Burnet Institute's Centre for Harm Reduction provides on-going technical assistance to a range of organisations, with a focus on Myanmar Anti-Narcotics Association (MANA) and the Central Committee for Drug Abuse Control (CCDAC). The International HIV/AIDS Alliance has identified a number of groups to receive its support in terms of capacity and seed grants.

Capacity remains a key issue to be addressed particularly in view of increased resources to be made available from the Global Fund (Round 3) for the implementation of HIV/AIDS-related activities. Although the need to build capacity and provide on-the-job training is recognised, the number of organisations specialised in, dedicated to, and able to provide training and technical assistance is still limited. Most of the capacity-building and training in the MoH and NAP, for example, is carried out by Medical Officers in the townships and STD Teams, thereby placing additional workload and responsibilities that reduce their availability for other (clinical) duties. Training activities in the National AIDS Programme workplan have been carried out, but many have been postponed due to competing requirements on the part of different health programmes (eg. Malaria, Maternal and Child Health, Tuberculosis…).

Scaling up treatment for patients living with HIV/AIDS will require sufficient trained staff to respond to the increasing demand for testing, treatment and home-based care. Significant strengthening in capacity in these priority areas will be essential over the coming months.

On-going support and capacity has been provided by UNAIDS to organisations implementing HIV/AIDS activities in the methods and tools to support project implementation, monitoring and reporting. Three training workshops were conducted to support national and international organisations' capacity in the use of SMART[5] indicators for monitoring and reporting under the Joint Programme. This has also included a number of working sessions with Implementing Partners (among which the National AIDS Programme) to build capacity for internal monitoring, reporting and evaluation.

Among the gaps highlighted by organisations in quarterly reports, the need for technical support and training are frequently stated. They include the need to ensure effective supervision, project management and monitoring at both national and field level, as well as training in finance required for implementation. Other areas identified include technical support or training on qualitative methods to inform monitoring and evaluation, including data collection and analysis for field project staff.

With the increased availability of resources for health and HIV/AIDS programming in Myanmar, a targeted approach focusing on priorities to capacity-building will be essential. Priority training needs and appropriate recipients have to be assessed in a systematic manner to avoid excessive burden on professionals receiving multiple trainings. Links and synergies need to be promoted, fostered and maintained to ensure that needs are met with methods that suit recipients and its organisations. UNAIDS proposes to convene a meeting of stakeholders to identify needs and plan capacity building, for example in monitoring and evaluation, work planning, reporting or other identified common technical issues.

Among the 22 projects funded in Round II, capacity for implementation varies greatly from one organisation to the other. The main factors identified which have hindered capacity for implementation include:

- Lack of technical and/or managerial expertise (and lack of support from some headquarters)
- Insufficient understanding of monitoring and evaluation
- Weak internal monitoring/systems within the organisation
- Staffing issues/high turnover and a limited pool of trained professionals
- Lack of familiarity with programmatic reporting and standard donor requirements - "Little experience of working under contractual relations with clear monitoring requirements" (Forsberg, May 2004)

[5] Specific, Measurable, Achievable, Relevant and Time-bound

IV Challenges Faced and Lessons Learned

Constraints stated by Implementing Partners

Resistance in the community

Some activities were not completely implemented due, at least in part, to constraints related to the acceptance of messages by the community, as well as cultural and environmental factors. For example, cultural constraints were experienced in some townships for conducting condom demonstration for young women. Occasionally it was not possible to use an anatomical model for condom demonstration since it embarrassed some women. Instead other materials were used, such as a banana shaped model or fingers, to avoid making female participants feel uncomfortable. One implementing partner reported that it was not able to distribute condoms as planned as the target had been overestimated.

Stigma and discrimination remain very prevalent in Myanmar, in common with many other countries. This has particularly been experienced in rural settings, and hampers access to services for those most at risk.

Access to high-risk groups

Some high-risk groups are by their nature engaging in activities that are illegal in Myanmar. This is particularly true for commercial sex workers and IDUs. Reaching these key high-risk groups can be problematic, as target beneficiaries are afraid of law-enforcement officers and of arrest. It was reported that, although they were interested in participating in the project, sex workers were afraid of being identified by the police. In some townships, sex workers are mobile and difficult to follow up for STI treatment. One implementing partner reported that it works in a border area where many sex workers are foreigners and fear deportation if discovered seeking health care or HIV testing. This has a negative effect on the number of sex-workers who come forward for sexual health services, and constrains the achievements of programmes like the 100% TCP.

The limited availability of data to inform programme planning and implementation is a constraint frequently cited by implementing partners. There is still a lack of baseline data in Myanmar on high-risk groups and HIV. It has particularly been pointed out that data on HIV in IDUs is still lacking.

Environment

The requirement for authorisation to travel reduces the flexibility of organisations, imposes rigid planning, and results in slower implementation than often expected. The need for explicit permission for detailed activity implementation can often cause delay. One implementing partner reported that it had been unable to carry out training of government medical staff on STI case management as authorisation was still pending. Implementing partners reported that it was not possible to obtain permission to operate in some geographical areas, with reasons of security being stated. Unfortunately, some of these areas are often where services are most needed.

A number of problems are related with the sensitive nature of some of the proposed interventions. For example, procurement of methadone for drug-replacement therapy has proved to be less than straightforward, as importation of opiate compounds needs to be cleared legally. Wider issues remain in harm reduction where interventions may be seen by some as condoning illegal drug use. While such attitudes are more prevalent at peripheral/local levels, they can also be found at central level. In the case of needle and syringe distribution, some officials feared that IDUs might resort to selling needles and syringes provided by needle distribution projects to raise cash to purchase drugs. (However, given the controls on the numbers of needles and syringes distributed to individuals, this would not be feasible as a cash-generating proposition). Moreover, partners encourage the return of used needles for safe waste disposal.

The use of Peer Educators was reported to have met with some resistance. Some officials may fear that that IDUs or former IDUs might in fact promote drug use and that sex workers promote sex work. However, organisations might respond that the use of peer educators has proved to be one of the most effective approaches to educate and promote behaviour change among marginalised, high-risk target groups, in Myanmar and elsewhere.

Strict regulations surrounding the implementation of VCCT have not allowed potentially interested partners to provide VCCT services that include testing. Therefore it has been impossible to scale up VCCT nationwide, despite demonstrated high demand. There remains a high demand for counselling, while current policy is causing delays in providing results and counselling post-test. A policy that facilitates testing, with availability of HIV rapid tests, should allow rapid one-day testing.

Other constraints stated include the lack of availability of township/district level officials and authorities for advocacy due to their competing commitments. It was reported that advocacy activities did not progress as hoped because many of the authorities identified for advocacy meetings were not accessible.

Some partners are working in geographical areas inhabited by minority ethno-linguistic groups. In these areas, the language barrier is a challenge for implementation of day-by-day activities of their projects. It is difficult to recruit counsellors with minority language knowledge, and this pushes towards a policy of using peer educators. In a multi-ethnic, multi-linguistic, multi-cultural local setting, it is vital to have staff knowledgeable of local context and dialects.

The lack of specific clinical and training guidelines, added to the lack of experience in procurement of new medicines such as ARVs, has caused delays in procurement and availability of ARV treatment.[6]

A greater involvement of general medical practitioners in the response to HIV/AIDS was called for (by one organisation). Private sector GPs are already involved in testing for HIV and treating patients with AIDS and should be included to maximise coverage and synergies.

A number of partners experienced some delay in starting projects. Reasons cited for this included constraints from organisation headquarters, difficulty in planning due to lack of baseline data in certain geographical areas and target groups, and delayed disbursement of funding. Targets estimated on a 3-month basis were thus difficult to achieve.

Constraints in coordination and/or management arrangements

Some delays were experienced in implementing the M&E system that had been modified from the Joint Programme core indicators for Round II reporting purposes. This meant that reporting by certain partners was made in the FHAM I format, which was unsuitable for FHAM II monitoring purposes and made tracking of progress challenging for this reporting period. Capacity development of partners was needed and one-to-one support provided to ensure that reporting uses the core indicator definitions.

A number of factors such as capacity, internal organisational change or turnover of staff resulted in late or incomplete submission of quarterly technical and financial reports by some implementing partners, and this in turn led to delays in disbursements. Efforts were made by the FHAM to be responsive to partners' concerns and constraints.

[6] Subsequent to the ARV scale-up mission in July, the NAP and other Component-4 members are organising an ARV task force to coordinate technical issues regarding procurement and supply management of ARVs and other related core commodities.

Lessons learned

A responsive and flexible approach has been necessary to support a range of projects and organisations with varying degrees of capacity for implementation and absorption. Building on the experience acquired during the first year of implementation, a more focused approach to allocation decisions was used for Round II to ensure that gaps were identified and addressed while resources remain focused on interventions that are most effective.

In response to concerns about the lack of independence in the first review of proposals for the FHAM Round I, an independent panel of three international experts was recruited for the technical review of Round II proposals. Proposals submitted for Round II were reviewed by the panel using standard criteria such as technical merit, joint programme priority, value for money, capacity for implementation etc… Recommendations for the approval of funding were submitted to the Technical Working Group who made the final decision.

The process of Round II has also led to ensure that critical areas where links between organisations need to be promoted, made and maintained are effectively addressed. Important collaboration between the Burnet Institute's Centre For Harm Reduction, CCDAC and MANA was built into proposals and followed up. The Burnet Institute's Centre for International Health modified its plans for 2004-2005 to incorporate the immediate BCC training needs identified at Myanmar Railways.

The development of the Joint Programme, and the resulting coordination with the Government, has led to an improved environment, which is now more suitable for implementation of interventions in the main component areas. However, the sensitive nature of HIV/AIDS remains, and so it has been difficult to scale up. Some interventions have been implemented in a still unclear/unfavourable policy environment (eg. needle and syringe exchange, 100% targeted condom promotion in a context where it is difficult to gain access to sex workers). Therefore, there is still a need for high level commitment to allow scale-up of interventions targeting the most vulnerable populations. These pilot interventions started through FHAM funding and the Joint Programme need to be monitored closely so that positive results can be used as an advocacy tool, and their impact demonstrated to the Government.

Advocacy needs to be targeted at the appropriate level. Although at the local level all authorities may be contacted and briefed about the project, and voice support, it was found that, to allow the actual implementation of any project, future advocacy activities will also have to focus more on the highest authorities at regional level, ie. Regional Commander. The possibility of ever implementing projects in areas referred to as sensitive security areas may be doubtful.

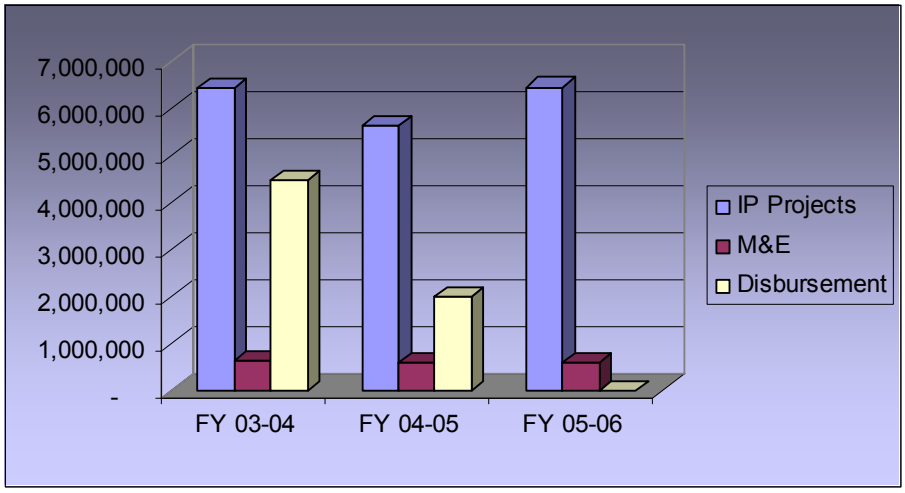
Collaboration of international and national NGOs helped to improve technical soundness while ensuring acceptance by the authorities/community for Harm Reduction in general and needle and syringe programmes in particular. While local/national NGOs are well accepted by the authorities and community, they may have little experience in harm reduction, although this is essential to prevent the transmission of HIV among IDUs. To have real impact, it is necessary that implementation is accepted by the community, and based on best practice and successful experience.

As a result of experience gained during the first year of implementation, the operational procedures governing management and disbursements for the Fund were reviewed to improve cash-flows and provide added flexibility for implementing partners during implementation.

V Financial Status and Utilisation of Funds

US$ 7.2 million were allocated for the first year FHAM implementation and contracts for a value of US$ 6.83 million were signed for the implementation of 19 projects. Additional projects supporting the overall Monitoring and Evaluation of the Joint Programme amounted to US$226,500, of a yearly provision of US$ 770,000. These include the development of the Joint Programme Monitoring and Evaluation Plan, the Behavioural Surveillance Survey, the Technical Review Panel for FHAM Round II, external audit and the recruitment of a short term Monitoring & Evaluation consultant. In the second round of funding, an additional US$ 13.3 million were allocated, of which US$ 12.8 million are for implementation and a provision of US$ 1,120,000 for monitoring and evaluation. Of this, US$ 708,080 were allocated and US$ 411,949 remain to be allocated by the Technical Working Group for monitoring and evaluation activities. As of 1 October 2004, a total of US$ 5.9 million had been disbursed of a total US$20.5 million available for implementation (Chart a).

Chart a) Summary of amounts budgeted and disbursed per financial year



Summary table of budget and disbursement by sector

Implementing Partner	BUDGET		FHAM FY 2003-04 (1 Apr 2003-31 Mar 2004)		FHAM FY 2004-05 (1 Apr 2004-30 Sept 2004)			
	FHAM Round I	FHAM Round II	FHAM Round I		FHAM Round I		FHAM Round II	
	(FY 2003-04) (USD)	(FY 2004-06) (USD)	Disburse-ments (USD)	Utilisa-tion (%)	Disburse-ments (USD)	Utilis ation (%)	Disburse-ments (USD)	Utilis ation (%)
Government agencies[7]	1,828,881	2,688,325	531,416	29%	197,180	11%	20,140	1%
INGOs	2,989,279	7,135,826	2,806,626	94%	102,595	3%	136,493	2%
NNGOs	225,975	409,805	225,975	100%	-	0%	88,958	22%
UN Agencies	1,379,798	1,786,121	956,480	69%	89,107	6%	140,110	8%
Monitoring & Evaluation	770,000	1,120,000	499,245	65%	44,909	6%	78,316	7%
UNDP Fees	77,000	112,000	80,202	104%	-	0%	-	0%
Grand Total	**7,270,933**	**13,252,077**	**5,099,944**	**70%**	**433,791**	**6%**	**464,017**	**4%**

[7] A provision of 2,532,325 is included in the FHAM Round II Budget for Government agencies. The Department of Education, Planning and Training, and Myanmar Railways are implementing but some Round II contracts (CCDAC & NAP) have not yet been signed.

Funds amounting to US$ 5,099,000 were disbursed for 19 Round I projects during the financial year 2003/4 (above table). Overall utilisation of funds in relation to budget varied between implementing partners from 29% to 100% during FHAM Round I.

A number of Round I projects required an extension into 2004/2005 financial year to complete planned Round I activities. Of 19 projects in Round I, three completed planned activities within 12 months and another sixteen partner projects were prolonged from 1 to 9 months. These No-Cost Extensions were to make up for initial delays, varying degrees in absorption capacity for some organisations and ensure the completion of activities. Many partners therefore started Round II implementation in or after September 2004. Delays in starting Round II projects and activities, and delays in the signing of contracts, account for a seemingly lower utilisation at the start of Round II (from 1% to 22% between April 2004 and end September 2004).

Chart b) Summary of FHAM Round I budget and disbursement, incl. No-Cost Extension

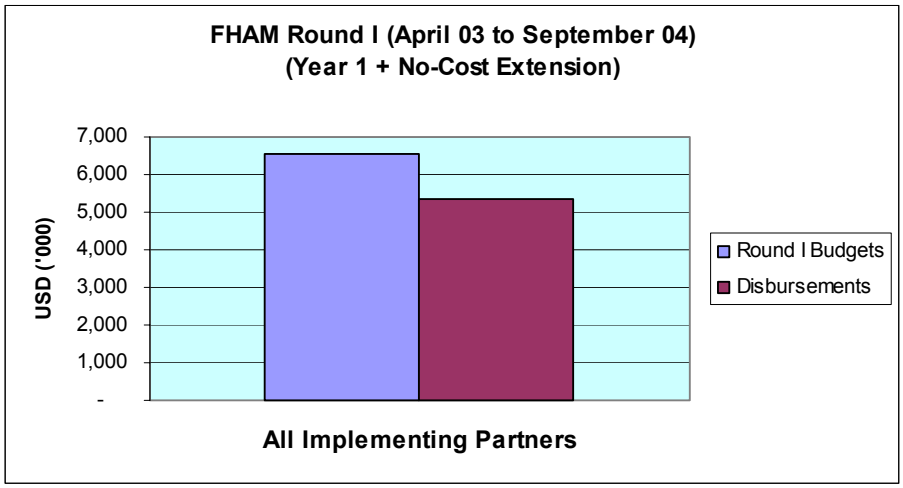
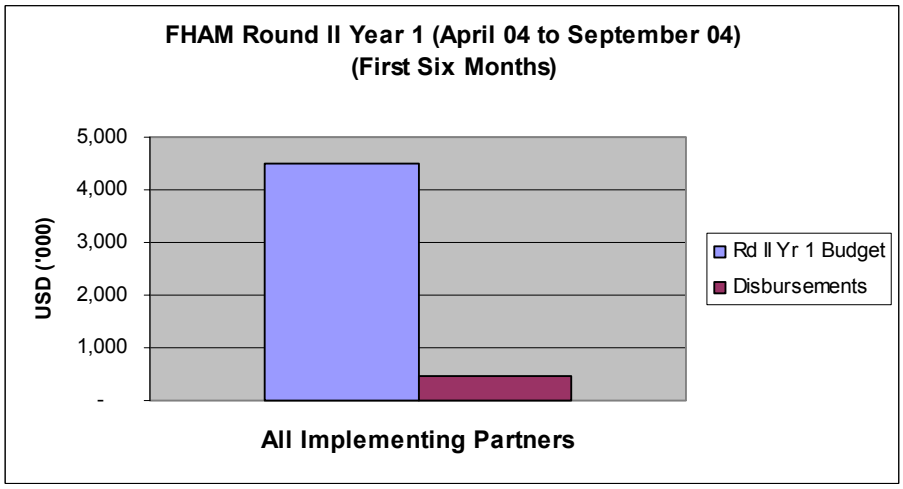


Chart c) Summary of FHAM Round II budget and disbursement, first six-month period



VI Conclusion and Strategic Issues

Monitoring data reported by organisations to the Fund for HIV/AIDS in Myanmar and the Joint Programme as a whole, now provide stronger evidence on gaps and priority areas of work for the Joint Programme for HIV/AIDS in Myanmar. The Review of the Joint Programme in May 2005 will also benefit from a stronger evidence base as well as provide recommendations to enhance the response. Although covering a relatively limited period of time[8], this report allows a number of conclusions to be drawn and strategic issues to be raised, on the strength of the data presented.

- The treatment of Sexually Transmitted Infections has seen some expansion since 2003 with additional support from the Fund for HIV/AIDS in Myanmar. The treatment of STIs is a critical component in the prevention of HIV transmission. 200 Service Delivery Points currently provide STI services in 83 townships[9]. Furthermore, in view of the expansion of care and treatment for HIV/AIDS, STI services constitute a major entry point for access to routine testing and treatment and care for HIV/AIDS. Monitoring data shows that quality treatment services are in high demand. Every time a new service delivery point is opened, the demand for services is higher than expected[10]. Access to appropriate treatment for STIs remains a high priority and needs to be improved and increased. Strategies need to be developed to further increase the number and availability of services providing quality treatment.

- Outreach programmes targeting women and men at highest-risk and providing education for HIV/AIDS, prevention and treatment options can work in Myanmar. Some projects already reach sex workers and their clients in formal and informal settings. Data also suggests that there are sufficient condom supplies in the country and the challenge remains to convince high-risk groups of the need to use them. In addition, more protection and commitment for these programmes is required by the authorities and better advocacy with the police is necessary to allow outreach activities to effectively reach groups at highest risk.

- There is an urgent and unmet need for services targeting IDUs such as Voluntary Confidential Counselling and Testing, ART, needle and syringe exchange, and substitution therapy. Pilot projects have demonstrated the feasibility of doing community-based IDU outreach including a degree of social support. However, the scale at present is far from sufficient, with less than 5% of the population within reach (currently 13 Drop-in centres in 9 townships in Myanmar[11]). Based on progress made to date, services need to be scaled up and coverage increased.

- Activities promoting knowledge and awareness of HIV/AIDS have benefited from the overall increase in resources. There is currently insufficient data to inform the Joint Programme on how effective these activities are and on their actual impact on behaviour change, especially among target groups. Recent evidence suggests that knowledge within the general population remains low, particularly among women, youth and those with lower levels of education. The Behavioural Surveillance Survey is expected to provide critical information on progress and achievements in relation to knowledge, attitudes and uptake of safer behaviours. Meanwhile, the effective use of different media needs to be developed and supported.

[8] 1 April to 30 September 2004
[9] UNAIDS data 2005
[10] UNAIDS, Fund for HIV/AIDS in Myanmar monitoring data 2005
11 UNAIDS data 2005

- The demand for Voluntary Confidential Counselling, and Testing has been consistently higher than anticipated and monitoring data[12] shows high achievements in the first six months of FHAM Round II implementation. Under the Joint Programme, VCCT is currently provided by 100 Service Providers in 69 townships[13]. Access to HIV testing needs to be significantly and rapidly scaled up, both to strengthen prevention and as an entry point for the treatment and care of People living with HIV/AIDS. The availability of testing needs to be increased by creating a new services delivery points over the next year offering testing through a range of entry points including routine health service delivery.

- A small proportion of PLWHA are currently being reached by programmes of any kind and less than 5% of AIDS patients requiring ART will be receiving treatment in 2005 from resources earmarked for treatment[14]. Treatment, care and support services (clinical, medical, psycho-social and community-based support) available at present fall dramatically short of meeting the estimated need and should be scaled up as a matter of urgency. The treatment target should be significantly increased. .

- With still comparatively limited resources and in light of the above, capacity building remains a core area requiring continued support under the Joint Programme. Increasing knowledge and building the technical and managerial skills of national partners and networks will allow organisations who are critical to the national response to scale-up their activities and will ensure sustainability. Capacity-building with a view to empowering vulnerable groups such as women and PLWHAs has started and will also require to be further strengthened.

In addition to resources from the Fund for HIV/AIDS in Myanmar (Round II), additional funds will also become available in 2005 through the Global Fund, to support a broad range of activities under the Joint Programme. In light of the increased resources and of the strategic issues emphasised above, it is recommended that the allocation of remaining funds available for Round III of the Fund for HIV/AIDS in Myanmar should focus on these gaps and strategic areas to strengthen the response.

[12] UNAIDS, Fund for HIV/AIDS in Myanmar monitoring data 2005
[13] UNAIDS data 2005
[14] Projects funded by the FHAM Rd II, GFATM and other sources will provide Anti Retroviral drugs for approximately 2000 patients in 2005, out of an estimated 47,000 patients in need of ART.

Table: Budget Overview

FHAM Round I, and Round II Year 1 (FY 2003-04 and FY 2004-05) (April 2003 to September 2004)

FHAM Round I and II Budget Overview of IPs				
ImplementingPartners for year 1 (2003-2004)		**Implementing Partners for Round II (FY 2004/5 & 2005/6)**		
Organisations	**Budget (USD)**	**Organisations**	**Approved Budget (USD)**	**Percentage**
Government Agencies	**1,828,881**	**Government Agencies (4)**	**2,688,325**	**21%**
NAP	1,828,881	*NAP (Provision TBC-depends on GFATM)*	*2,000,000*	
		CCDAC	532,325	
		Department of Education Planning and Training	50,000	
		Ministry of Rail Transportation	106,000	
INGOs	**2,989,279**	**INGOs (10)**	**7,135,826**	**52%**
AHRN	297,942	AHRN	200,000	
AMI	112,000	AMI	330,000	
Consortium (SC-UK)	660,131	Consortium (SC-UK, CARE, MSI, WV, MNA)	2,085,000	
MSF(Holland)-AZG	300,000	MSF(Holland)-AZG	1,018,182	
PSI	879,631	PSI	1,646,018	
ADRA	120,078			
AMDA	155,785			
PACT	368,558			
WVI	95,154	*(WVI is part of the Consortium Round II)*		
		Malteser	249,984	
		MSF - Switzerland (MSF-CH)	300,000	
		Partners	99,818	
		Burnet Institute - CHR (to support MANA & MMCWA, Ministry of Rail Transportation)	400,000	
		Burnet Institute - IHD	406,824	
		International HIV/ AIDS Alliance (to support only CBOs; MHA & PLWA groups only)	400,000	
NNGOs	**225,975**	**NNGOs (3)***	**409,805**	**5%**
MANA	81,807	MANA	100,000	
MBCA	50,000	MBCA	149,808	
MNA	94,168	*MNA is part of the Consortium Round II*		
		MRCS	159,997	
UN Agencies	**1,379,798**	**UN Agencies (4)**	**1,786,121**	**13%**
UNFPA	360,500	UNFPA	506,521	
UNODC	304,360	UNODC	700,000	
Outreach Activities (UNODC)	120,000	On going (Year 1)		
WHO	455,240	WHO	579,600	
WFP	139,698			
Sub Total	**6,423,933**	**Sub Total**	**12,020,077**	**91%**
Monitoring/Evaluation		**Monitoring/Evaluation**		
UNAIDS (Myanmar)	114,083	UNAIDS (Myanmar)	708,051	
UNAIDS (Geneva)	288,400	On going - (Year 1)	-	
Monitoring/Evaluation (Balance)	367,517	Monitoring/Evaluation	411,949	
M&E Sub Total	**770,000**	**Monitoring/Evaluation Sub Total**	**1,120,000**	**8%**
UNDP Handling Fee	77,000	UNDP Handling Fee	112,000	
UNDP Sub Total	**77,000**	**UNDP Handling Fee Sub Total**	**112,000**	**1%**
Grand Total	**7,270,933**	**Grand Total**	**13,252,077**	

* The percentage for NNGOs includes budget allocated to the MNA (USD 244,246) from the Consortium total budget.

Annexe 1: Summary of Technical Progress Round II, Year 1

Yearly Planned and Six Month Achieved

	CORE INDICATOR	6 MONTH TOTAL		YEARLY TOTAL	
		PLANNED	ACHIEVED	PLANNED	ACHIEVED
Component 1: Sexual Transmission of HIV					
1.1 Access to affordable condoms for sexually active men, women and young people increased					
1	Number of condoms distributed	15240600	15976638	28406952	15976638
1.2 Capacity of both private and public sector health facilities for prompt and effective management of STIs improved					
2	Number of clients to STI services	117520	57027	136600	57027
3	Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counseled	216860	68037	240650	68037
4*	Number of service delivery points (SDP) providing integrated STI services	126	130	160	130
5	Number of referrals to STI services	141	51	428	51
Component 2: Injecting Drug Use					
2.1Access to harm reduction interventions increased					
6	Number of needles and syringes or cleaning materials distributed to IDUs	2700	898	173476	898
7	Number of clients to IDU drop-in centres	150	335	568	335
8*	Number of IDU drop-in centres established	2	1	4	1
2.2 Access to and quality of drug treatment in institutional and non-institutional settings improved					
9	Number of IDUs receiving detoxification treatment	0	0	0	0
10*	Number of IDUs receiving maintenance substitution therapy	11	0	24	0
11	Number of IDUs referred for drug treatment	7	12	137	12
Component 3: Knowledge and Attitudes					
3.1 Knowledge of modes of transmission, perception of personal risk, and attitudes regarding HIV/AIDS and those living with and affected by HIV/AIDS, improved among the general population					
12	Number of health education (HE) sessions on HIV/AIDS conducted	20326	19001	40716	19001
13	Number of mass awareness sessions held [video shows/TV spots aired]	475	615	1213	615
14	Number of IEC materials distributed to general population	851814	607775	350206	607775
15*	Number of peer educators involved in workplace education	20	20	160	20
3.2 Positive attitudes, safe behavior and practices in specific target groups improved, (includes consistent condom use and safe injecting practices for IDUs)					
16	Number of HE or counseling sessions conducted among target groups	17750	21256	29570	21256
17	Number of people among target groups reached through HE sessions	71280	88391	155825	88391
18	Number of IEC materials distributed to target groups	753060	494715	1524070	494715
19*	Number of peer educators involved in project	992	338	1613	338
3.3 Awareness of HIV/AIDS among youth, improved					
20	Number of targeted HE or counselling sessions conducted for youth	110	70	1396	70
21	Number of youth reached through HE sessions	0	0	3050	0
22	Number of IEC materials distributed to youth	107550	59062	201800	59062
23*	Number of peer educators involved in project	50	0	120	0
Component 4: Care, Treatment and Support for People Living with HIV/AIDS					
4.1 Quality and access to care and treatment services for PLWHA improved					
24*	Number of people receiving ARV therapy [UNGASS]	641	361	972	361
25*	Number of people living with HIV/AIDS (PLWHA) receiving home-based care	750	154	1340	154
26	Number of people receiving treatment for tuberculosis	550	635	1130	635
4.2 Quality of and access to voluntary confidential counseling and testing services improved					
27	Number of clients receiving HIV test results and post test counselling	24855	9533	31598	9533
28	Number of people referred to VCCT services	30	59	420	59
4.3 Caring, protective and supportive environment for people living with or affected by HIV/AIDS improved					
4.4 Risk of mother-to-child transmission of HIV reduced					
29	Number of mother/baby pairs receiving nevirapine	45	36	2038	36
Component 5: Enabling Environment					
5.1 Active support of opinion leaders for promoting a supportive environment for implementation of effective prevention and care activities increased					
30	Number of advocacy meetings conducted	166	103	221	103
31*	Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	3	9	10	9
5.2 Multi-sectoral and coordinated partnership for planning and implementation strengthened					
32	Number of coordination and multi-sectoral meetings conducted	144	131	213	131
33	Number of best practices produced and distributed	0	0	2	0
34	Number of policies produced and distributed	0	0	500	0
5.3 Availability and utilization of data on programme impact, trends of HIV/AIDS over time and related behaviors driving the epidemic im					
35	Needs assessment study conducted and report available	1	0	6	0
36	Number of base and end line studies conducted and report available	4	1	8	1
37	Number of evaluation or reviews conducted and report available	1	0	7	0
38	Number of operational research studies conducted	1	0	3	0
5.4 Capacity for implementation of HIV/AIDS prevention and care activities expanded at all levels					
39	Number of trainings or workshops conducted excluding health care providers and peer educators	44	29	129	29
40	Number of trainings conducted for health care providers	353	279	374	279
41	Number of trainings conducted for peer educators	8	6	38	6
42	Number of days of technical assistance provided to IPs	0	0	104	0
5.5 Risk of HIV transmission in health care delivery settings reduced					
43	Number of health staff receiving post exposure prophylaxis	2000	0	2000	0

Annexe 2: Achievements by Implementing Partners Round II

1. **Access to services to prevent the sexual transmission of HIV improved** (JP Component 1)

	NAP	MRT	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	PSI	PARTNERS	MALTESER	MANA	MRCS	MBCA	UNODC	Total
Number of condoms distributed	3160000	0	32056	343018	1121942	47920	0	11245511	4933	13714	1999	0	5545	0	15976638
Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counselled	50000	n/a	1822	671	8598	12	n/a	6886	n/a	48	n/a	n/a	n/a	n/a	68037
Number of service delivery points (SDP) providing integrated STI services	40 +(284)	-	3	10	18	3	n/a	108	n/a	4	n/a	n/a	5	n/a	476
Number of (NEW) service delivery points (SDP)	n/a	n/a	0	1	n/a	3	n/a	108	n/a	4	n/a	n/a	5	n/a	121
Number of referrals to STI services	n/a	41	n/a	10	n/a	n/a	0	n/a	n/a	n/a	n/a	0	n/a	n/a	51

*CCDAC – Contract not signed yet
*AHRN – Project started after 1 October 2004

2. **Access to services to prevent IDU transmission of HIV improved** (JP Component 2)

	AHRN	MANA	Total
Number of needles and syringes or cleaning materials distributed to IDUs	0	898	898
Number of clients to IDU drop-in centres	0	335	335
Number of IDU drop-in centres established	n/a	1	1
Number of IDU referred for drug treatment	0	12	12

*CCDAC – Contract not signed yet
*AHRN– Round II Project started after 1 October 2004

3. **Knowledge and attitudes improved** (JP Component 3)

	NAP	DEPT	MRT	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	PSI	PARTNERS	MALTESER	MRCS	MBCA	UNFPA	UNODC	Total
Number of health education (HE) sessions on HIV/AIDS conducted	429	n/a	n/a	172	n/a	18083	132	n/a	n/a	41	50	n/a	94	n/a	n/a	19001
Number of peer educators involved in workplace education	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	41	0	n/a	41
Number of HE or counselling sessions conducted among target groups	9000	n/a	n/a	0	n/a	n/a	n/a	n/a	12233	n/a	23	n/a	n/a	n/a	0	21256
Number of peer educators involved in project	275	n/a	n/a	2	0	n/a	n/a	0	484	n/a	0	n/a	n/a	n/a	0	761
Number of targeted HE or counselling sessions conducted for youth	n/a	0	n/a	n/a	0	n/a	n/a	n/a	n/a	70	0	0	n/a	0	0	70
Number of peer educators involved in project	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	n/a	0	n/a	n/a	0	0

*AHRN– Round II Project started after 1 October 2004

4. **Access to services for HIV care and support improved** (JP Component 4)

	NAP	AMI	CONSORTIUM	MSF-H	MSF-CH	ALLIANCE	MALTESER	MANA	MBCA	UNFPA	UNODC	Total
Number of people receiving ARV therapy [UNGASS]	0	n/a	n/a	355	6	n/a	n/a	n/a	n/a	n/a	n/a	361
Number of people living with HIV/AIDS (PLWHA) receiving home-based care	n/a	n/a	0	113	41	n/a	n/a	n/a	n/a	n/a	n/a	154
Number of clients receiving HIV test results and post test counselling	2000	n/a	97	7370	28	n/a	n/a	38	n/a	0	n/a	9533
Number of people referred to VCCT services	n/a	n/a	59	n/a	n/a	0	n/a	n/a	0	0	0	59
Number of mother/baby pairs receiving nevirapine	n/a	0	n/a	36	0	n/a	n/a	n/a	n/a	0	n/a	36

5. Enabling environment: Policy development, advocacy, capacity building and research (JP Component 5)

	NAP	DEPT	MRT	CONSORTIUM	MSF-CH	ALLIANCE	BI-CHR	BI-CIH	MALTESER	MANA	MRCS	MBCA	UNFPA	UNODC	WHO	UNAIDS	Total
Number of advocacy meetings conducted	67	0	2	24	4	n/a	n/a	n/a	7	n/a	4	18	n/a	1	n/a	n/a	127
Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	9	n/a	n/a	n/a	n/a	9
Needs assessment study conducted and report available	n/a	n/a	n/a	n/a	n/a	n/a	0	0	0	n/a	0	n/a	n/a	n/a	n/a	n/a	0
Number of evaluation or reviews conducted and report available	n/a	n/a	n/a	n/a	n/a	n/a	0	n/a	n/a	0	0	n/a	0	0	n/a	0	0
Number of trainings or workshops conducted excluding health care providers and peer educators	16	0	2	5	n/a	0	0	0	0	0	n/a	4	2	0	n/a	0	29
Number of trainings conducted for health care providers	277	n/a	n/a	1	n/a	n/a	0	n/a	0	n/a	n/a	1	0	n/a	0	n/a	279

*CCDAC – Contract not signed yet
*BI-CIH, BI-CHR – Data not received
*AHRN– Round II Project started after 1 October 2004

Abbreviations used in this report

ADRA	Adventist Development Relief Agency
AHRN	Asian Harm Reduction Network
ART	Anti-Retroviral Therapy
ARV	Anti Retroviral
AZG	MSF-Holland
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CCDAC	Central Committee for Drug Abuse Control
BI-CHR	Burnet Institute's Centre for Harm Reduction
BI-CIH	Burnet Institute's Centre for International Health
ETG	Expanded Theme Group
FHAM	Fund for HIV/AIDS Myanmar
FY	Financial Year
IDU	Intravenous Drug User
IEC	Information, Education, Communication
IP	Implementing Partner
JP	Joint Programme
LOP	Lashio Outreach Project
M&E	Monitoring and Evaluation
MANA	Myanmar Anti-Narcotic Association
MHD	Malteser
MNA	Myanmar Nurses Association
MRT	Ministry of Rail Transport
MSF-CH	MSF-Switzerland
MSF-H	MSF-Holland
NAP	National AIDS Programme
NCE	No-Cost Extension
PACT	PACT NGO
PLHA	Person Living with HIV/AIDS
PMCT	Prevention of Mother to Child Transmission
PSI	Population Services International
STI	Sexually Transmitted Infection
TCP	Targeted Condom Promotion
TCU	Technical Coordination Unit
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drug Control
VCCT	Voluntary, Confidential Counselling and Testing
WHO	World Health Organization
WV	World Vision