Joint Programme for HIV/AIDS: Myanmar 2003-2005

Mid-term Review

Findings and Recommendations of the Review Team

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LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
AFXB	Association Francois Xavier Bagnoud
AHRN	Asian Harm Reduction Network
ARHP	Australian Regional HIV/AIDS Project
AZG	Artsen Zonder Grenzen
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Drugs
ASEAN	Association of Southeast Asian Nations
BCC	Behaviour Change Communication
BSS	Behavioural Sentinel Surveillance
DFID	UK Department for International Development
DIC	Drop-In Centre
ETG	Expanded Theme Group
FHAM	Fund for HIV/AIDS in Myanmar
FSW	Female Sex Workers
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
IDU	Injection Drug User
IEC	Information, Education and Communication
KAP	Knowledge, Attitudes and Practices
MANA	Myanmar Anti-Narcotics Association
MNA	Myanmar Nurses Association
MSF-H	Medecins Sans Frontieres Holland
MSF-CH	Medecins Sans Frontieres Switzerland
MDM	Medecins du Monde
MSM	Men who have Sex with Men
MWMP	Men with Male Partners
NAP	National AIDS Programme
NAC	National AIDS Council
NGO	Non-Government Organisation
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother To Child Transmission
PLWHA	People Living With HIV/AIDS
PSI	Population Services International
SC UK	Save the Children UK
SC US	Save the Children US
SIDA	Swedish International Development Agency
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TORs	Terms of Reference
TWG	Technical Working Group

UN	United Nations
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNODC	United Nations Office of Drug Control
WHO	World Health Organisation
VCCT	Voluntary and Confidential Counselling and Testing
WV	World Vision

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Executive Summary

Myanmar is presently faced with the challenge of controlling a dual epidemic of Human Immunodeficiency Virus (HIV) and injection drug use. Injection Drug Users (IDUs) have a very high risk of infection, which can occur soon after an individual begins injecting. Sexual transmission is another major mode of HIV transmission. Commercial sex, which is driven by patronage of sex workers by men, is the largest contributor to this. Transmission is occurring heterosexually outside of the commercial sex industry and HIV is now in the general population. A substantial amount of sexual transmission of HIV is also taking place amongst men who have sex with men (MSM). It is thought that a significant proportion of male youth are at risk because of having early sex with sex workers. Some migrant populations are at increased risk as well. The trend of HIV infection amongst women attending antenatal clinics is upward and it is presumed that HIV is thus being passed on to babies at expected rates. Acquired Immune Deficiency Syndrome (AIDS) death rates have not been examined, but rising numbers of orphaned children are being seen and very few programmes to assist them exist.

As in other affected countries in the region, this is a serious and complex epidemic to tackle and the operating context is very challenging. Restricted access, whether due to geographical remoteness, government security operations or lack of permissions to move about, to particular areas and communities pose a major barrier to implementing and scaling up HIV/AIDS interventions where they are needed. The illegality of injecting drug use and commercial sex, combined with the mobility or transiency, for a variety of reasons, of individuals and communities also make it difficult to mobilise and sustain responses. A general climate of uncertainty and suspicion, and the legitimate worry of implementing organisations that their activities might be stopped at any time or worse that they will be shut down, is another obstacle.

The last two years have been a time of rapid change in the governmental response to the epidemic. New leadership on the issue has meant improved programming and better use of staff although significant technical and human resource capacity challenges remain in both these areas. The Ministry of Health has been especially supportive of HIV/AIDS responses. There has also been support from within the Ministries of Home Affairs, Education and Rail and Transport, amongst others. However with recent government changes there are signs that Ministries are focusing more strictly on their respective mandates and referring to the Ministry of Health on matters related to HIV/AIDS. Much work and progress remains to achieve a broad-based government response.

The health and social care infrastructure at decentralized levels is severely challenged. The human capacity, equipment and supplies, and medicines needed to mobilise a response matching the scale and severity of the epidemic are not in place there. Clear policy and operational frameworks, in the form of standards, guidelines and procedures, and for training and support supervision in applying them are lacking as well. Anecdotal information suggests that poverty and hardship are on the increase, and families and communities, whether affected by HIV/AIDS or not, must rely on themselves for care and support and welfare provision. The national budget for HIV/AIDS programmes is still restricted to the local

currency equivalent of tens of thousands of dollars a year and has not increased in the last two years, which makes it difficult for the government to even contemplate addressing these dimensions of the response. Whilst a number of bilateral and multilateral development agencies have successfully channeled funds for responding to HIV/AIDS in Myanmar as a humanitarian emergency, the prospects for resource mobilisation on a scale needed are not good, due to Western government sanctions that are in place against supporting the current Myanmar government.

The Joint Programme for HIV/AIDS: Myanmar, 2003-2005 was developed to strengthen coordination of the response to the epidemic in Myanmar. Its purpose is to change behaviour to reduce the transmission of HIV and to improve the health of People Living With HIV/AIDS (PLWHA). Work within the Joint Programme focuses on improving access to services to prevent sexual and injection drug use transmission of HIV and for HIV care and support. Interventions to enhance knowledge and attitudes about HIV-related issues and to enhance the enabling environment and organisational capacity to respond to the epidemic are also carried out.

The overall cost of the Joint Programme has been estimated at USD 88 million. The Fund for HIV/AIDS in Myanmar (FHAM) was established in January 2003 as a joint funding mechanism. FHAM has raised a total of US$ 23 million, with other sources contributing an additional US$ 26 million, to support the Joint Programme. 58 government and non-government implementing organisations have participated.

The Expanded Theme Group (ETG) on HIV/AIDS has overall responsibility for strategic oversight and governance of the Joint Programme. A Technical Working Group (TWG) provides management oversight to the implementation of the Joint Programme. In relation to each output, a Component Group has been set up and meets regularly for coordination purposes. The UN Joint Programme on HIV/AIDS in Myanmar (UNAIDS Myanmar) has a dual role of acting as a secretariat to these groups and providing co-ordination and monitoring and evaluation support to the Joint Programme. The FHAM management function is also housed within UNAIDS Myanmar, whilst FHAM contracting and financial accountability rests with UNDP.

A team of four consultants carried out a mid-term review of the Joint Programme between 16 May and 3 June 2005. The team met with each of the bodies responsible for managing and governing the Joint Programme; a range of Joint Programme implementing partners; the National AIDS Programme; The Minister of Health; and The Deputy Minister of Home Affairs. They visited a number of government-run health care, laboratory and drug treatment facilities and a selection of programme activities of Joint Programme implementing partners working in Mandalay and Yangon.

Component Group representatives prepared pre-review assessment papers outlining achievements, challenges, lessons learned and recommendations on a number of topics of relevance to the Joint Programme. In addition, the team gathered data during the review and read supporting documentation provided by UNAIDS Myanmar.

The dual purpose of the mid-term review was to assess achievements with reference to Joint Programme goals and to provide recommendations for the remaining period and the future programme. In particular, the review team was asked to answer the following questions:

- Are projects activities on track to produce stated programme outputs and results?
- Are planning and financial processes and mechanisms of the Joint Programme appropriate to address the context of the HIV/AIDS epidemic in Myanmar?
- Does the Joint Programme, as it stands, provide a suitable common action framework for the future and/or does it need to be revised?

Some significant achievements have been realised during the period 2003-2005. 33.1 million condoms were distributed in 2004. 170,000 patients with Sexually Transmitted Infections (STIs) were seen in the clinics of government and non-government organisations supported by the Joint Programme. 523 service delivery points were providing STI integrated services. There is some evidence from partner implementing organisations that syphilis levels are coming down in a few clinic populations, although this needs further substantiation.

A total of 545,000 needles were distributed in 2004, which represents a 2.6 fold increase on the number of needles distributed in 2003. Needle return rates range from 49% to 74%. Currently 23 townships have IDU intervention programmes, and 8 of those offer needle and syringe exchange. Within the 14 IDU drop-in centres supported under the Joint Programme, 7207 contacts with IDUs have been made. Partner implementing organisations reached 5595 drug users, although the proportion of injection drug users is not known.

Within the Joint Programme, there are a total of 152 STI clinics providing Voluntary and Confidential Counselling and Testing (VCCT), in 83 townships. The number of STI clients receiving HIV test results and post test counselling has increased considerably from 802 in 2002; to 11,070 in 2003; to 28,239 according to UNAIDS Myanmar data.

Overall 170,000 clients received HIV test results and post-test counselling in 2004. This figure represents a 31% increase above the 130,000 clients receiving results and post-test counselling in 2003. UNAIDS Myanmar reports that 70 townships, or 21%, of 310 townships now offers or refers for VCCT.

At present within the Joint Programme, there are 54 (Prevention of Mother-to-Child Transmission) PMTCT testing sites available in Myanmar. In 2004, 36 townships offered community-based PMTCT and 17 townships offered hospital PMTCT. This coverage reaches approximately 11% of all townships. In 2004, 406 eligible mother and baby pairs received Nevirapine (up from 194 pairs in 2003) through Joint Programme implementing partner organizations out of 690 pregnant women that were tested positive. In other words, of the women identified in PMTCT townships as being in need of Nevirapine, 59% received it.

Within the Joint Programme, Home-Based Care HBC is provided by 8 international and national non-government organisations working in a total of 40 townships. 3,800 people were receiving HBC under the Joint Programme as of May 2005.

Despite all of these achievements, it is unlikely that any of the outputs will be achieved by the end of the current Joint Programme period. To some extent this is to be expected as the outputs aspire to major changes, which can only be achieved in the medium- to long- term. Each requires that significant coverage and quality of a range of services and interventions would need to be in place.

However, coverage, which is not actually measured by any indicators, appears to be extremely low for all interventions. Most reach no more than a few hundred people. Current levels of coverage and quality of activities are not adequate to achieve programme effectiveness and it is currently difficult to justify the levels of resources that are being devoted to them.

Many of the proposed strategies under each output, and especially those relating to the enabling environment, of the Joint Programme framework are not yet being done and indeed some of them cannot be taken forward in Myanmar at this time. The framework may have inadvertently encouraged some partner implementing organisations to take up a broad array of activity and services, with relatively limited human and financial resources to take forward intensively any of them. For this reason it is recommended that the Joint Programme framework be revised to take on fewer outputs and fewer strategies within each output in a more focused and realistic way, in accordance with the limited resource availability. It was found that the partners who are working intensively to reach clearly identified target groups with quality interventions are having more success in achieving real prevention and impact mitigation gains.

The programmatic areas that the Joint Programme framework addresses remain relevant to the epidemic in Myanmar. However, it could be updated to better address identified gaps, such as behaviour change communication, and emerging areas, such as orphans and vulnerable children. Additionally, greater prioritisation needs to be given the Men who have Sex with Men (MSM).

Although it is premature to speak about achieving the purpose, or attributing it to progress against outputs, it seems clear that a much stronger emphasis on and mobilisation of effective behaviour change communication (BCC) programming at output level will be needed if the purpose will be achieved. Currently an unjustified level of resources is being spent on information, education and communication (IEC) activities and not enough on BCC, which can make a real difference in helping people to reduce their HIV risk.

There is significant variation in data reporting systems, non-reporting of data on several counts and unclear definitions of some of the core indicators within the Joint Programme monitoring and evaluation system. This compromises the usefulness and credibility of the data. It is recommended that the system be reduced to include a few key indicators, which

have the capacity to measure HIV/AIDS outcomes and which can feasibly be reported and interpreted, for each output. The cost of maintaining the system cannot be justified if the resulting data cannot be used effectively to understand progress in programme implementation and hold implementing partner organisations accountable for their performance.

In addition to collecting data on indicators, there is an urgent need for more partners to carry out formative research, using focused and rigorous methods, which could help them to better understand the groups that they are working with. This kind of data, which seems to be severely lacking, is a necessary basis for effective programming.

Systems for collecting and interpreting purpose level data do not appear to be in place. The planned behavioural sentinel surveillance has been delayed several times and it is unclear at this point when and how baseline and end-line data will be collected and made available for analysis.

Some confusion concerning the purpose and utilisation of the system, whether for monitoring and evaluation of the overall response or for programme monitoring and evaluation, appears to exist. Two separate frameworks are needed, one for monitoring and evaluating the national response, in line with the 'Three Ones' strategy, and another for providing partner implementing organisations with standards for and timely feedback on performance in programme implementation.

Whilst the current level of available financial resources falls short of the total estimated cost of the Joint Programme, in practice the disbursements of available funds have been modest, probably due to slow utilization and the very small size of individual interventions. Whilst it is clear that more resources than are currently available will be needed to scale up programmes, absorptive capacity to use large amounts of resources effectively appears to be generally lacking and this should be addressed first.

There is a need to strengthen strategic planning processes and mechanisms. While implementing organisations do regularly collaborate to carry out activities, they lack larger reference points to shape and guide their collaboration. This has had a detrimental effect on the progress in achieving outputs, which relies on inputs of multiple partners, as well as on progress and quality of programme implementation. In particular, the Joint Programme would benefit from having clearer positions on a number of key strategic policy issues. These include amongst others the overall balance amongst prevention, care and treatment responses; the level and kinds of support to be provided respectively to international and national organisations; and minimum quality standards to be achieved in programme activity design and implementation.

Because they aspire to achieve long-term outcomes, the Joint Programme framework outputs and associated strategies need to be supplemented with more detailed work plans, which are costed and which can realistically be achieved in the medium-term. This level of planning, which has been found to be generally lacking within the Joint Programme,

could help partner implementing organisations to be clearer about performance expectations and their defined contribution within the overall Joint Programme.

Overall the ETG, TWG and Component Group Co-chairs have worked in good faith to fulfill their governance and management responsibilities. The ability of the ETG *as a group* to engage closely with the Joint Programme is limited by its size and composition, and as a result it has not been able to meet fully its strategic oversight and guidance responsibilities. The structure of the TWG gives rise to potential conflicts of interest. As they are making FHAM allocation decisions, TWG members are working for organisations that are benefiting from the FHAM. Conversely, FHAM donor agencies are benefiting from these organisations making available large amounts of time of their senior staff members to participate in the TWG. These conflicts need to be resolved.

UNAIDS Myanmar has also acted in good faith to fulfil its terms of reference, which combines technical and management support provision and co-ordination roles, with regard to the Joint Programme. However, the potential for 'role confusion' is real.

Almost all of the partner implementing organisations very much need more specialised technical support, which they can access on an ongoing basis, in order to move forward their programmes on a technically sound basis. This kind of support, which aims to improve programme performance and effectiveness, is distinct from capacity-building support.

UNAIDS Myanmar currently lacks capacity, both in terms of technical expertise and numbers of staff, needed to fulfil this role to the extent that it is needed. The TWG also cannot fulfill this role and is not acting as a technical working group in the sense of setting standards for and ensuring technical quality. This seems to be due largely to the fact that it must devote much of its time to meeting its Joint Programme and FHAM management responsibilities.

Whilst the Component Groups have acted as a forum for sharing news and information, they have not fulfilled their purpose of reviewing and strategically co-ordinating progress toward achieving programme outputs. For this reason, the review team has concluded that the Component Groups are extremely costly relative to the benefits realized and should be disbanded.

The FHAM has proven to be an appropriate mechanism for supporting the Joint Programme insofar as it meets the participating donors' requirements. It has worked efficiently to the extent that three application rounds have been successfully completed since its inception in early 2003. However, evidence was found that its administrators have funded activities that were, and continue to be, developed without sufficient background information and data, or sufficient assurance of an enabling environment, which are needed for effective programme implementation.

The mechanism does provide FHAM donors with an in country programme and technical management presence, which they would otherwise not have, and with a close link to the

Joint Programme monitoring and evaluation system, which is also managed by UNAIDS Myanmar. However, this system still being developed and its value added to FHAM management or Joint Programme implementation has yet to be demonstrated.

The FHAM mechanism considers equally all applications and supports all recipients. A lesson learned from the Joint Programme is that national organisations need smaller amounts of money with relatively more organizational development support to develop their financial and other management systems. A new mechanism is needed to better support national partner implementing organisations.

Overall it is recommended that the Joint Programme adopt a simpler management structure so as to reduce co-ordination requirements, establish clearer lines of decision-making responsibility and remove potential conflicts of interest, and strengthen programme management and technical support provision. The revised structure could usefully accommodate additional organisations that have the capacity to take on the programme management and technical support provision roles.

It is not recommended that the Global Fund programme and Joint Programme management structures be merged at any level at this time. The review team questions whether this is the most appropriate or effective way to realise co-ordination between the two programmes. Whilst co-ordination is clearly needed, the National AIDS Programme seems best placed to lead this effort. Consolidating and strengthening the existing management structures so that they can better support Joint Programme strategic implementation should be the first priority.

As a framework for action, the Joint Programme is currently hampered by lack of transparency and accountability; lack of openness to share and confirm information and data; unwillingness or inability to provide needed technical support to each other; fear and lack of confidence to boldly implement programmes. Beyond any adjustments to structures and mechanisms that can be made, a new basis for achieve the aspirations of the Joint Programme is needed. Inherent conflicts of interest must be eliminated for this to happen, and for this reason a ‘firewall’ must be established between funding and other co-ordination and implementation mechanisms.

It was widely reported to the review team that the Joint Programme management structure has not successfully fostered the active and equal participation of national government and NGO representatives. This unfortunately lends weight to an existing perception that the Joint Programme ‘belongs’ to UN agencies and international NGOs.

For effective action to be realised, the Joint Programme will also have to find new ways to realise inclusion, both of government representatives and stakeholder groups, including sex workers, injection drug users and MSM. Currently these two constituencies are far apart and the Joint Programme has found the middle ground of international and national government organisations and UN agencies, but the middle ground will not be enough to produce action.

Summary of mid-term review findings and recommendations

- The Joint Programme has successfully mobilized donor resources and a multi-sectoral response to HIV/AIDS in a very challenging situation, where a response is critically needed.

  - *The Joint Programme should be sustained and expanded.*

- Real progress, especially in establishing structures to co-ordinate the response at national and local levels and services within communities in a range of geographic locations, has been made in the relatively short period of time since the Joint Programme started only two years ago.

  - *Joint Programme implementing partners should continue and where possible build upon good work already begun, for example by documenting and replicating co-ordination and service delivery models, which have proven effective in the Myanmar context.*

- A handful of organisations, many of whom have worked on HIV/AIDS-related issues in Myanmar for over a decade, are now reaching significant numbers of people with interventions.

  - *The work of these organisations demonstrates that over time, intervention coverage sufficient to achieve HIV/AIDS outcomes and impact could be achieved.*

- However, overall the intervention profile and coverage is inadequate to achieve desired outcomes in preventing the further transmission of HIV and mitigating its impact. With a few notable exceptions, those who are most vulnerable and at highest risk of contracting HIV are not being reached and more information about their lives and HIV-related behaviour is needed. Too many of the available resources are being spent on information, education and communication interventions that do not move beyond awareness-raising.

  - *Implementing partners should develop concrete strategies and plans for moving beyond awareness-raising in their programmes, carrying out focused and robust formative research studies and intervention design processes, led by and for priority groups. Once evidence-based and well designed behaviour change communication programmes have been established, scaling them up should be a priority and targets for this set and monitored. Those with responsibility for Joint Programme governance and funds administration should promote and encourage this through strategic and performance management and the application of more stringent proposal review and approval criteria.*

- The Joint Programme is currently facing a dilemma in that more financial and technical resources are needed to improve and scale up intervention quality and coverage, but the absorptive capacity of the majority of implementing partners is limited.

- *The Secretariat should continue to actively mobilize additional resources for the Joint Programme, and programme these through the implementing partner organisations that can absorb them. However, programming large amounts of additional resources to partners that have not yet demonstrated the management and technical capacity to absorb them in support of cost-effective interventions should be avoided. These organisations should continue to receive the funding that they need, absorbing modest and steady increments where possible, along with structured technical support that can build their programme management and technical capacity.*

- Intervention quality, assessed in terms of likely effectiveness, value for money, and focus on results, was found to be inadequate for many Joint Programme partner implementing organisations. Only some engage on-the-ground, independent and expert observers to improve design and implementation. Many international non-government organisation partners appear to receive insufficient technical and information support from their headquarters offices.

  - *Performance standards should be raised at all stages of the programme process, from activity design through implementation monitoring to measurement and evaluation of results. Currently the Secretariat has an important role to play in ensuring accountability for performance throughout the Joint Programme. Clear decision criteria and procedures in cases where implementing partners fall short of performance standards need to be drawn up and applied.*

- The governance structures are functioning and have adequately and in good faith overseen Joint Programme management. However, the potential for conflicts of interest are inherent in the structures themselves. Some of them could also be streamlined for improved effectiveness and efficiency. In particular, some are having difficulty achieving their envisioned mandates because co-ordination and partnership imperatives have been merged and confused with strategic guidance, programme management, joint implementation and technical quality control functions.

  - *It is recommended that each of the bodies within the Joint Programme governance and management structure be reformulated in such a way as to remove conflicts of interest, separate co-ordination from governance and programme management and funding decision-making functions, and allow for more straightforward technical quality control. In particular, the team has suggested that a small governing body replace the current Expanded Theme Group structure, that renewed or new programme management and technical support organisations be introduced, and that the mandate of the Technical Working Group and the Component Sub-groups in their present form be narrowed or the groups disbanded altogether.*

- High level government and bilateral participation in championing and guiding the Joint Programme has waned in the past year and needs to be rejuvenated, especially to address important policy areas that could be critical to the programme's success and sustainability.

    - *The factors shaping this development are in many ways beyond the control of the Joint Programme Secretariat. The Secretariat continues to actively analyse the current governance and management structure, and suggest ways in which high level participation can be better encouraged and facilitated.*

- Significant variations in collecting and reporting data undermine the usefulness and credibility of the Joint Programme monitoring and evaluation framework, which aims to document progress and outcomes at a very high level of abstraction. Very few robust baseline measurements, which would be needed to measure outcomes and impact at that level, have been taken. For various reasons, information and data sharing amongst Joint Programme partners is constrained. More openness to share information is needed to improve overall programme effectiveness, as well as transparency and accountability.

    - *It is recommended that the current Joint Programme monitoring and evaluation framework be set aside for an interim period, so that attention can be focused instead on developing more robust activity level monitoring and evaluation systems with implementing partners. In this way, a firmer foundation for high quality and participatory data collection, reporting and analysis of performance across the range and diversity of Joint Programme intervention activities can be built. The resulting data and information can be fed into aggregate analysis of the achievements of the overall Joint Programme. Measurement of outcomes at a national level can be taken on at a later date, once responsibility and capacity in this area is clarified and built, and at such time as the environment might be more conducive to data and information collection and sharing on this scale.*

- Whilst partners regularly and informally collaborate to implement, there is a lack of larger reference points that Joint Programme partners can use to work together to achieve commonly agreed programme targets.

    - *If it is agreed amongst Joint Programme partners that they would like to work together in this way, costed strategic plans relating to each Joint Programme component are needed to facilitate this, along with annual work plans consolidating the activities of multiple implementing partners. Roles and expectations of participating partners in meeting planned time schedules and targets would need to be more clearly defined. Greater transparency in how resources available for a given Component are allocated amongst partners participating in it would also be advantageous.*

- Selection criteria and procedures used to allocate Fund for HIV/AIDS in Myanmar (FHAM) were different for each round and this caused misunderstanding amongst partners.

    - *A standard procedure for FHAM proposal review and approval, building on lessons learned from the various procedures employed to date, needs to be agreed, established and communicated widely.*

- The UNAIDS Secretariat, which is charged with Joint Programme co-ordination, monitoring and evaluation, the provision of programme management secretariat support and FHAM administration, is working hard to fulfill these functions, but it is currently stretched to meet human resource and technical requirements for meeting them.

    - *The UNAIDS Secretariat has been given a clear national level mandate for co-ordination and monitoring and evaluation, in accordance with bilateral and multilateral development agencies' support for its 'Three-Ones' principles. In taking this forward, the Secretariat is working actively within existing government structures of authority. It is recommended that the Secretariat continue this important work.*

      With regard to the programme management and funds administration functions, it is recommended that programme management organisation(s), with the capacity to provide tailored technical support to implementing partners, be engaged in accordance with revised Terms of Reference for this work. UNAIDS Myanmar could apply against the(se) Terms of Reference. Two or more such organisations could also be engaged in order to meet the distinct needs of international and national partners and/or partners working on different programme components.

Background

The Joint Programme for HIV/AIDS: Myanmar, 2003-2005 was developed to strengthen coordination of the response to the epidemic in Myanmar. It is the result of a continual process of consultation facilitated since 2000 by the United Nations Theme Group on HIV/AIDS. In 2002, the Expanded Theme Group (ETG) on HIV/AIDS was established to provide strategic guidance to the Joint Programme.

The purpose of the Joint Programme is to change behaviour to reduce the transmission of Human Immunodeficiency Virus (HIV) and to improve the health of People Living With HIV/AIDS (PLWHA). It has been articulated around 5 major outputs:

- Output 1: Access to services to prevent the sexual transmission improved
- Output 2: Access to services to prevent the injection drug use (IDU) transmission of HIV improved
- Output 3: Knowledge and attitudes improved
- Output 4: Access to services for HIV care and support improved
- Output 5: Enabling environment and capacity building

In relation to each output, a Component Group has been set up and meets regularly for coordination purposes. A Technical Working Group (TWG) has been established as well in order to provide management oversight to the implementation of the Joint Programme.

The overall cost of the Joint Programme has been estimated at USD 88 million. The Fund for HIV/AIDS in Myanmar (FHAM) was established in January 2003 as a joint funding mechanism to support the Joint Programme implementation and to ensure that it is well co-ordinated and multi-sectoral. To date, FHAM has raised a total of US$ 23 million from the Governments of the United Kingdom, Sweden and Norway. Other bilateral and multilateral, non-government and private funding sources have contributed an additional US$ 26 million to the Joint Programme for the period 2003-2005. These include government and international and national non-government partners. In early 2005, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) approved for grant funding a 3rd Round proposal for Myanmar. The grant will make available a further US$ 18 million for 2005-2006. A 5th Round proposal has been prepared and submitted in May 2005.

The HIV/AIDS situation and response in Myanmar

The first HIV infected individual was identified in Myanmar in 1988. The following year the National AIDS Control Program (NAP) was established. The first AIDS case, an IDU, was reported in 1992[1]. Subsequently 'AIDS' featured in the third and 'Drug Abuse' the seventh position in the list of twelve priority diseases of National Health Plan 2001-2006[2].

National Health Plan (2001-2006)
Priority Diseases

1. Malaria
2. Tuberculosis
3. Acquired Immune Deficiency Syndrome
4. Diarrhoea/Dysentery
5. Protein Energy Malnutrition
6. Sexually Transmitted Disease
7. Drug Abuse
8. Leprosy
9. Abortion
10. Anemia
11. Snake Bite
12. Eye Disease

It is important to note that in 1986 the most frequently recorded substance use problem at the treatment centre in Yangon, the capital city, was opium and codeine use and intravenous use of drug increased

[1] Thwe Min. HIV/AIDS Education in Myanmar; *AIDS Education and Prevention Jun* 2004 (Supplement A); 16; 170-177.
[2] Ministry of Health, Department of Health, Myanmar 2003. National Drug Abuse and Control Program (Annex B).

rapidly from 16% in 1986 to 79% in 1990[3]. Researchers however maintain that use of heroin in the community in large numbers started one decade earlier, which gradually transited from smoking to injection before it got reflected in the treatment centre records. Presently the country is faced with the challenge of controlling the dual epidemic of injection drug use as well as HIV.

Thus in Myanmar IDUs have a very high risk of infection. Infection can occur soon after an individual begins injecting. Because HIV infection has now been prevalent within this population group for several decades, many IDUs have died of AIDS-related causes and today many IDUs are developing AIDS and falling ill or dying. Their care and treatment needs are largely not being met. Only a small proportion of IDUs are being reached with harm reduction interventions. Currently national coverage is still too limited to really address the situation adequately, which even in covered areas programmes often cannot reach may drug users yet, due to the limited time these programmes have been implemented and the limitation on resources. Programmes to assist sexually active IDUs to protect themselves and their sexual partners from HIV have not yet been implemented in Myanmar. Whilst condom promotion and distribution for IDUs is part of most activities being implemented to reach IDUs, without assessing the risk perception of IDUs, their regular sex partners and actual usage of condoms in sexual relationships, the effect of condom promotion and distribution might not be obvious.

Sexual transmission is another major mode of HIV transmission in Myanmar. Commercial sex, which is driven by patronage of sex workers by men, is the largest contributor to this. As it is illegal to sell sex in Myanmar, the industry is under constant pressure from the law enforcement authorities and the pattern of commercial sex venues and transactions changes frequently as a result. Sex workers are extremely vulnerable and at risk for HIV. Only a small proportion of female sex workers are being reached with appropriate and comprehensive HIV/AIDS services and deaths amongst female sex workers are occurring at significant rates.

A substantial amount of sexual transmission of HIV is also taking place amongst men who have sex with men, and deaths amongst them are occurring at significant rates. Very few appropriate and comprehensive HIV/AIDS services are available to this group.

Transmission is occurring heterosexually outside of the commercial sex industry and HIV is now in the general population. It is thought that a significant proportion of male youth are at risk because of having early sex with sex workers. Some migrant populations are at increased risk and more work remains to be done to achieve adequate coverage of appropriate services for migrant populations.

The trend of HIV infection amongst women attending antenatal clinics is upward and it is presumed that HIV is thus being passed on to babies at expected rates. Some mothers and their babies are receiving nevirapine, but overall coverage remains low. AIDS death rates have not been examined, but rising numbers of orphaned children are being seen and very few programmes to assist them exist.

Challenges to mobilising a response

Currently the epidemic is still heterogeneous and composed of many sub epidemics but it can be said with certainty that HIV transmission occurs throughout the country. Infections are occurring among Burman fishermen from the southern division of Tanintharyi and among Burman debt-bonded women sex workers in the southern city of Kawthaung. Female sex workers from the central dry zone are travelling to work on the Chinese side of the border near Muse in Shan State and in the guest houses of Bago in the Burman heartland

[3] Hlaing T et al. Demography, Knowledge-Attitude-Behaviours and HIV infection among intravenous drug users 1993; Department of Medical Research, National Health Laboratory; Drug Dependency Treatment and Research Unit, Yangon Psychiatric Hospital; WHO/SEARO

where they are infected by their male clients from other Burman-majority areas[4]. Mandalay is a particularly intense transmission location. By determining the types of HIV that infect people there, a team of researchers from the National AIDS Program and Japan has reported that the virus in Mandalay is mutating into unique recombinant forms[5]. This can only happen when many people with one type of HIV have sex or share injecting equipment with people with another type. People from other regions of the country, and from Thailand, China and India, are practicing high risk behaviours in Myanmar's second city.

As in other affected countries in the region, this is a serious and complex epidemic to tackle, but with an added dimension in that the operating context is very challenging. Restricted access, whether due to geographical remoteness, government security operations or lack of permissions to move about, to particular areas and communities pose a major barrier to implementing and scaling up HIV/AIDS interventions where they are needed. The illegality of injecting drug use and commercial sex, combined with the mobility or transience, for a variety of reasons, of individuals and communities also make it difficult to mobilise and sustain responses. A general climate of uncertainty and suspicion, and the legitimate worry of implementing organisations that their activities might be stopped at any time or worse that they will be shut down, is another obstacle. Myanmar people are discouraged from interacting with foreigners, who due to their experience or expertise might be employed by implementing organisations. This fundamentally limits foreigners' ability to gain a full understanding of HIV/AIDS as it affects peoples' lives, which is needed to design appropriate and sensitive interventions, and to share HIV/AIDS-related skills, knowledge and information.

The last two years since the Joint Programme was developed have been a time of rapid change in the governmental response to the epidemic. New leadership on the issue has meant improved programming and better use of staff although significant technical and human resource capacity challenges remain in both these areas. A civilian Minister of Health has been in office during most of this time. A physician with expertise in Tuberculosis, the Minister has a close professional interest in the National AIDS Program and has been very supportive of all activities in this area. A governmental national strategic plan runs until the end of 2005 and a new strategic plan is being formulated in an open and inclusive manner[6]. The government has approved the UN-initiated Joint Program described in detail here and thus far endorsed its continuation.

Beyond the Ministry of Health there has been support for the response from within the Ministries of Home Affairs, Education and Rail and Transport, amongst others. However, with recent government changes, which are often sudden and unpredictable to outsiders, there are signs that Ministries are focusing more strictly on their respective mandates and referring to the Ministry of Health on matters related to HIV/AIDS. Much work and progress remains to achieve a broad-based government response and what progress has been made is in danger of being reversed due to government changes.

Similarly, the health and social care infrastructure at decentralized levels is severely challenged. The human capacity, equipment and supplies, and medicines needed to mobilise a response matching the scale and severity of the epidemic are not in place there. Clear policy and operational frameworks, in the form of standards, guidelines and procedures, and for training and support supervision in applying them are lacking as well. Anecdotal information suggests that poverty and hardship are on the increase, and families and communities, whether affected by HIV/AIDS or not, must rely on themselves for care and support and

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[4] International Crisis Group (2004) Myanmar: Update on HIV/AIDS policy, Asia briefing, 16 December 2004, p. 4; and Crisis Group interview, Yangon, October 2004.

[5] XV International AIDS Conference [ThOrA1364], Y. Takebe, Y. Ma, C. Yang, Y. Yokota, S. Kusagawa, R.Yang, X. Xia, K. Ben, M. Thwe, T. Aung, K.Y. Oo, H.H.
Lwin, "Geographical hotspots of extensive intersubtype recombination in Asia: 'Melting pot' that generates diverse forms of HIV-1 unique recombinant forms".

[6] "National Strategic Plan for the expansion and upgrading of HIV/AIDS activities in Myanmar 2001-2005", Ministry of Health, 2001.

welfare provision. The national budget for HIV/AIDS programmes is still restricted to the local currency equivalent of tens of thousands of dollars a year and has not increased in the last two years, which makes it difficult for the government to even contemplate addressing these dimensions of the response. Whilst a number of bilateral and multilateral development agencies have successfully channeled funds for responding to HIV/AIDS in Myanmar as a humanitarian emergency, the prospects for resource mobilisation on a scale needed are not good, due to Western government sanctions that are in place against supporting the current Myanmar government.

Review methodology

A team of four consultants, with combined expertise in research, programming and service delivery for HIV/AIDS prevention, care, support and treatment carried out a mid-term review of the Joint Programme between 16 May and 3 June 2005. The members were Dr Carol Jenkins, Dr Dilip Mathai, Dr Samiran Panda and Dr Anne Scott, who acted as the team leader. Representatives from the UK Department for International Development (DFID) and the Swedish International Development Agency (SIDA) each participated in a part of the review process.

A mid-term review itinerary, which is presented at Annex A, was developed in advance, in consultation with UNAIDS Myanmar, the NAP and the Ministry of Health, as well as with implementing partner organisation representatives. It was shared with the ETG and TWG for comment and approval.

The team met with each of the bodies responsible for managing and governing the Joint Programme; a range of Joint Programme implementing partners; the National AIDS Programme; The Minister of Health; and The Deputy Minister of Home Affairs. 58 implementing partner organisations, listed at Annex B, have participated in the Joint Programme.

They visited a number of government-run health care, laboratory and drug treatment facilities and a selection of programme activities of Joint Programme implementing partners working in Mandalay and Yangon. Visits to programme activities of Pakoku, Monywa, Lashio, Myitkyina, Hpakan and Khawtaung, which were originally planned, could not be carried out due to logistical constraints. It was a particular loss not to be able to see the activities in Lashio, which is the only township in Myanmar where comprehensive HIV interventions for IDUs including needle syringe exchange are in place. These interventions contribute significantly to achievements under Output 2 of the Joint Programme.

Representatives from each of the Component Groups kindly prepared pre-review assessment papers on a range of topics, listed in Annex C. The papers, which outline achievements, challenges, lessons learned and recommendations on a number of topics of relevance to the Joint Programme, not only helped to brief the review team, but also provided an insight into implementing partner organisations' experiences and perceptions of the Joint Programme.

The team gathered data during the review and read the supporting documentation provided by UNAIDS Myanmar. In general, tracking down information presented a challenge, as some of the research papers were not widely circulated and many of the cross-references were inaccessible.

With responsibility for managing the review, the TWG developed and approved terms of reference (TORs) for it. These are presented at Annex D. The dual purpose of the mid-term review was to assess achievements with reference to Joint Programme goals and to provide recommendations for the remaining period and the future programme. In particular, the review team was asked to answer the following questions:

- Are projects activities on track to produce stated programme outputs and results?
- Are planning and financial processes and mechanisms of the Joint Programme appropriate to address the context of HIV/AIDS epidemic in Myanmar?

- Does the Joint Programme, as it stands, provide a suitable common action framework for the future and/or does it need to be revised?

Joint Programme partner organisations and key stakeholders reviewed and commented upon a draft report. Each Component Group met to discuss the draft and prepare written comments of report sections relating to its particular Component. The TWG met to discuss draft as well, and written comments were prepared on the basis of that meeting. This report version incorporates comments received, to the extent possible within the scope of the TORs. In particular, the team focused on addressing suggested revisions pertaining to factual error or where it was thought that the team's perceptions were incomplete or might have missed important dimensions or considerations. The remaining feedback is presented for the record at Annex E. The team is grateful for the time and effort that the TWG, partner implementing organisations, and other key stakeholders put in to review and comment on the first draft.

This final report sets out in detail the review team's considered answers to these questions, and associated conclusions and recommendations. The findings provided are based on the information gained during meetings and site visits and through documents provided and reviewed. There is limited evidence yet available about the results of the interventions. Analysis of the findings is therefore inherently subjective and based on the reviewers' judgement and experience. The team hopes that, despite the limitations encountered, this report will help point the way to a future direction, which builds on the achievements already realised within the Joint Programme.

Progress against Joint Programme Outputs

Output 1

Although 33.1 million condoms were distributed in 2004, this fell short of the estimated need of 149 million. The commonly used benchmark of one condom per capita per year would require 53 million to be distributed. As the number of condoms distributed in 2003 were 28.8 million and rose to 33.1 million in 2004, it would take another 5 years to reach the benchmark at current rates of increase. This is achievable in an even shorter period of time if more mass media promotion were enabled.

Approximately 35% of these condoms are freely distributed use levels are likely to be lower than distribution levels. Social marketing activities, which are tailored to different project activities being implemented under the Joint Programme, should be encouraged to achieve greater usage rates as well as greater future sustainability. Whilst male condoms are easily accessible everywhere but rural areas, the female condom is presently restricted to distribution through sex worker projects, and needs wider distribution and more outlets. Police harassment and arrest of sex workers continues to make it difficult for women to carry male or female condoms, despite a change in police regulations in 2001.

Output 1: Access to services to prevent the sexual transmission of HIV improved.

Output core indicators:
- Number of condoms distributed
- Percentage of sexually transmitted infection (STI) male and female clients at health care facilities appropriately diagnosed, treated and counselled using standardised protocols (UNGASS)
- Number of clients to STI services by age and sex

Output process indicators:
- Number of service delivery points providing integrated STI services

Some important associated behavioural indicators, such as the proportion of sex workers using condoms consistently in the past week, have not been collected (or reported) under the Joint Programme. In surveys

conducted in Mandalay and Yangon, 85% of sex workers report using condoms with all clients during the past week. This is a very high rate of condom use and probably represents some degree of over-reporting. Better methods of questioning are required for verification. Another one, "the % of young people (15-24) reporting use of condom during sexual intercourse with a non-regular sexual partner" has a reported 46.9% for paid partners and 10.5% with casual partners, but it is unclear if this is based on all young people or only those who are sexually active. One implementing partner reports these figures differently, stating that 24% of males report ever having had paid sex with 85% of these reporting use of condom at last paid sex. The indicator needs better characterization. Another reported datum, the % of IDUs who claim they "always" use condoms with sex workers is poorly defined. Indicators need to be specified better and the data sources, with methodologies, made more accessible to interested parties.

The 100% Targeted Condom Promotion programme is a government-led effort, supported by WHO policies. Due to success in the early 1990s in Thailand, these programmes have been promoted around Asia but, as shown in Cambodia, do more to empower police and brothel owners than sex workers themselves, a serious deficit with regards to sustainability. The programme in Myanmar is to be evaluated soon, and therefore was not reviewed extensively.

It is claimed that there were 170,000 STI patients seen in government and non-government clinics, including the PSI franchised Sun Clinics in 2004. Inasmuch as most STI patients access private practitioners, it is hard to know what the figure of 170,000 means. In addition, all doctors are not all adequately trained, remain reluctant to do a proper vaginal or rectal exam, and miss many diagnoses. For example, one doctor reported that trichomoniasis is not an STI because "normal women" get it. The indicator above defines a level of quality that is not captured in the data presented. Further, among women syndromic treatment misses a high proportion of infections (and overtreats others). Periodic presumptive treatment may be appropriate for some population sub-groups, but needs more investigation.

The third indicator for output 1, the number of clients to STI services by age and sex, was not reported. The number of service delivery points was reported as 523 but the nature of these is far too variable and cannot be considered as evidence of progress toward the goal of reducing sexual transmission. Other data appear to show an increase in self-medication for STIs probably because of the lower cost, in both time and money and the greater anonymity of the service encounter that it offers. It was reported that judgmental health workers and somewhat coercive methods used to recruit patients, especially, international non-government organisations and government AIDS/STD teams, are barriers to seeking services. However, self-medication from drug sellers has many disadvantages and is not likely to contribute positively to the control of STIs and HIV in the population.

There is some evidence from the Ministry of Health and Artsen Zonder Grenzen (AZG) that syphilis levels are coming down in a few clinic populations. This is encouraging and should be captured in the programme indicators.

STI services specifically designed for Men who have Sex with Men (MSM) are rare. Anecdotal evidence suggests that HIV levels are high in this population. MSM have not been prioritised within the Joint Programme. This needs rapid revision, for reaching them effectively will be critical to a successful response.

The briefing paper on gender, sexuality and MSM states that the estimate of 30,000 MSM in Myanmar is low but incorrectly states that 8% of men are MSM in other countries. Definitions need attention, both for improved specificity and accuracy. Are the criteria for being an MSM ever having had sex with another male, or having done so within last 5 years? Anal sex is the main issue, not sexual identity or preference, and the higher risk of anal intercourse in male-female as well as male-male relations should be stressed in all safer sex messages.

Output 2

Output 2: Access to services to prevent the IDU transmission of HIV improved

Output core indicators:
- Number of needles distributed to target group in the last quarter
- Total number of clients to IDU drop-in centres (DICs) by age and sex

Existing information collection system indicates that a total of 545,000 needles were distributed in 2004. This represents a 2.6 fold increase on the number of needles distributed in 2003. The needle return rate reportedly varies from 49% to 74%.

No information was provided on the number of IDUs to whom these needles were distributed. This poses a serious problem in assessing the access of IDUs to services, as access cannot be defined as mere presence of a service, however adequate. The total number of IDUs in locations having needle syringe exchange programmes based on scientific size estimation techniques was also not available, which made assessing what proportion of them was having regular access to sterile syringe and needles difficult. It should be noted that the estimation of IDU coverage by service providers might not be a practical and acceptable method in the Myanmar context. Special ad hoc studies might need to be conducted by independent reviewers in order to achieve this.

The population size of IDUs in Myanmar generated during an estimation workshop held in Myanmar in 2004 ranged from 12,000 to 60,000. Other sources have quoted higher ranges, from 150,000 to 250,000[7] and 90,000 to 300,000[8]. Limitations with all these estimates are that they were neither generated through indirect single or multiple methods nor through population surveys. Given the present high HIV prevalence among IDUs in the country and the fact that outreach services over the last two years have been able to establish contact with the IDUs who were never admitted to any addiction treatment centre, it is urgent that a refinement in the estimated size of IDUs in districts as well as in the country is attempted and that resource allocation for harm reduction services is made accordingly.

An effort to estimate the number of IDUs was made during the course of the present assessment with the help of partner implementing organisations working in Lashio. Using a multiplier technique revealed that the minimum number of current IDUs in Lashio would be 2000. Based on this figure a yearly requirement of sterile syringe and needles for them to inject safely would be 1,460,000[9], which is far higher than the approximately 55,000 needles and syringes currently distributed annually in Lashio. It must be stressed that this is a rapid estimation method used in the review to generate thinking about future directions for work in this area. It was not used with the intent of measuring the efficiency of the programme, and indeed would be inappropriate for doing this. The review team agrees that refined estimation techniques should be followed in future to come up with more robust estimates.

Given the limitation of the resource, if an IDU is advised to use one syringe and two needles for two days then also there will be a requirement of 730,000 needles and 365,000 syringes. This exemplifies how an adequate service delivery plan for needle syringe exchange should be developed. Otherwise containment of HIV epidemic will remain a distant dream. Whilst it is a significant achievement that harm reduction programmes, thought to be a distant dream 10 years ago, are now present in Myanmar, a delay of another 10

[7] Reid G. Revisiting the hidden epidemic. A situation assessment of drug use in Asia in the context of HIV/AIDS. Melbourne, Victoria (Australia): Burnet Institute, The centre for Harm Reduction; 2002.
[8] Carmen Aceijas et al Global overview of injection drug use and HIV infection among injection drug users. AIDS 2004, Vol 18 No 17: 2295-2303.
[9] Calculated as 2000 IDUs injecting 2 times a day for each of 365 days a year

years might see repetition of what has been seen in many south and south-east Asian country settings. In Manipur in Northeastern India, for example, 45% of the wives of HIV positive IDUs became infected with HIV within 6 years of documentation of the rapid spread of the virus. None of these wives had ever injected drugs and 98% were in monogamous married relationships[10].

Establishing links of needle syringe exchange programmes with other harm reduction services such as couple counselling, methadone or buprenorphine substitution, addiction treatment, administration of anti-retroviral therapy (ART) is also required, as success of efforts in limiting further spread of HIV in and from IDUs is intimately associated with the ability of the program to cater to the varying needs of different IDUs and addressing the interface between IDUs and other population groups. Implementing partners working in this area have started using these and other approaches in order to make harm reduction more accepted and this work should continue and be expanded.

Reaching out to the sex partners of IDUs including spouses and young IDUs below 22 years of age are two other important intervention areas, which are not being addressed and are not captured by core indicators. Approximately 45% of the IDUs are married. Limited available data however clearly indicates that the use of condoms by IDUs in marriage is very low. The chance of young injectors contracting HIV within a very short period of initiating injection drug use is very high.

At the time of the present assessment that whilst 23 townships had IDU intervention programmes, only 8 had needle syringe exchange. This highlights a gap in access of IDUs to comprehensive services. It should be noted, however, that needle and syringe exchange was just beginning in another 15 townships at the time of the review.

Further, access to needle and syringe exchange appears to be adversely affected by police crackdowns on shooting galleries. For example, one needle syringe exchange service was reportedly interrupted following law enforcement activity six times in the past six months. In some shooting galleries heroin is only sold on the condition that it will be consumed on the premises, which presumably reduces the risk of the dealer being tracked by police. The risk of HIV in such environments remains high due to inadequate supply of sterile injection equipments and increased chance of sharing among IDUs from different places and with different risk profiles gathering at such locations.

Suggested directions to enhance access of IDUs to HIV prevention services include:

- Policy advocacy, programme planning and estimation exercise to ensure access of a greater proportion of IDUs across Myanmar to a range of harm reduction services, including needle and syringe exchange
- Collection of appropriate monitoring data to adequately inform programme planning and implementation
- Effective advocacy and collaboration with different stakeholders at local level so that needle and syringe exchange can take place on the streets as well as in shooting galleries

Total number of clients coming to IDU DICs, the second core indicator for improved access to services is not being recorded to reflect attendance by IDUs and non-IDUs separately. Furthermore, the figure under this indicator, reported as 7207 in 14 DICs[11] actually reflects the number of contacts[12] made rather than the number of individuals contacted, which generates confusion. The indicator also does not specify the number of contacts per individual, thereby limiting the opportunity for drawing inferences on each individual's level of exposure to the intervention. Data on the age and sex distribution of the DIC attendees and the types of services received by them are also not being collected, although those were the requirements as per definition of core indicators.

[10] Panda, S., Chatterjee, A., Bhattacharya SK, et al. Transmission of HIV from injecting drug users to their wives in India. International Journal STD AIDS (2000) 11;468-473.
[11] Reported in the summary of strategic information collected M&E system of UNAIDS 2004
[12] Definition of Core indicators; Joint program for HIV/AIDS for Myanmar. (Appendix) page-32.

Figures reported by different partner implementing organisations under the monitoring indicator 'Number of drug users reached' add up to 5595. It is not known how many of them were IDUs, making it impossible to assess service coverage for IDUs. The only indicator used to measure improved access of IDUs to HIV care and support was the 'proportion of IDUs who report accessing VCCT in last 12 months'. No data was available on this.

Presently 3 of the 4 process indicators and 3 of the five output indicators for Output 2 are not in use in program monitoring. The indicators that are being used require immediate refinement to effectively track programme performance effectiveness. Ongoing IDU interventions were observed to be limited in reach, non-comprehensive in nature in most places, and frequently interrupted by law enforcement activities.

It is unlikely that the objective of reducing individual risk of HIV transmission among injection drug users and their partners will not be fulfilled in near future. Available secondary data does not indicate that any reduction in sharing of injection equipment has been achieved[13]. 90% of the IDUs participating in a focus group discussion conducting during the review reported sharing injection equipment with friends during the 'last injection episode'.

The prohibiting nature of the existing law for possessing syringes[14], hurried drug injection practices when in a state of withdrawal and lack of money to purchase new syringes and needles were among the commonly cited reasons for sharing. Future intervention should focus on addressing these challenges. Limiting the spread of HIV from IDUs to their sex partners and ensuring the safety of those recently graduating to injection are two additional requirements that must be met to fulfil this objective. In addition, the particular care and support needs of the many IDU living with HIV/AIDS must not be forgotten. These are currently not being addressed within the Joint Programme.

HIV prevalence in IDUs was reported as 34% in the 2004 sentinel surveillance. Table 1 below presents HIV sentinel surveillance results among IDUs for the period 1992 to 2003[15]. It is known that once HIV prevalence among a high risk IDU population reaches 20%, the epidemic within the population can become self-perpetuating, with even modest levels of risk behaviour leading to substantial rates of infection.[16,17]

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[13] A behavioural survey of 267 in-treatment IDUs published in 2004 that recruited samples from 12 different geographical sites reported sharing of injection equipment by 40% of the respondents (AD/MYA/03/G54 UNODC; Baseline survey report on environmental and behavioural risk among drug users). In another study, between November 1996 and September 1997, 272 drug users from the Myktyina detoxification centre were asked to answer an anonymous questionnaire, including personal data, drug abuse practices and high risk HIV injection practices. Irrespective of the type of drug, abuse patterns were equally divided into inhalation (40%) and intravenous injection (46.7%), with 11% using both methods. The use of the blow-pipe, a high-risk method in terms of HIV/AIDS infection, was limited to only 8% of all patients (14% of IDUs). Among heroin IDUs, 61% admitted sharing needles with other users in this study. Syringe sharing was associated with occupation (more with farmers), previous withdrawal episodes and an exclusive intravenous pattern of abuse (Guy Morineaua and Thierry Prazuckab, Drug-related behaviour in a high HIV prevalence rate population at Myktyina drug treatment centre, Kachin State, Northern Myanmar (Burma) AIDS 2000, Vol 14 No 14.

[14] The Burma Excise Act 1917 section 13- No person shall make, sell possess or use any hypodermic syringe or any other apparatus suitable for injection any intoxicating drug except under and in accordance with the conditions of a license granted under this act. Section 33- Whoever, in contravention of section 13, makes, sells, possesses or uses any hypodermic syringe or any other apparatus suitable for injection any intoxicating drug, shall be punishable with imprisonment for a term which may extend to 6 months, or with fine which may extend to one thousand rupees or both.

[15] Source: Central Committee for Drug Abuse Control, Drug Treatment Sector, Annual Report

[16] Des Jarlais DC, Marmor M, Friedmann P et al. HIV incidence among injection drug users in New York City, 1992-1997; evidence for a declining epidemic. *Am J Public Health,* 2000; 11:99-112.

[17] Holberg S. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health*, 1996; 86: 642-654.

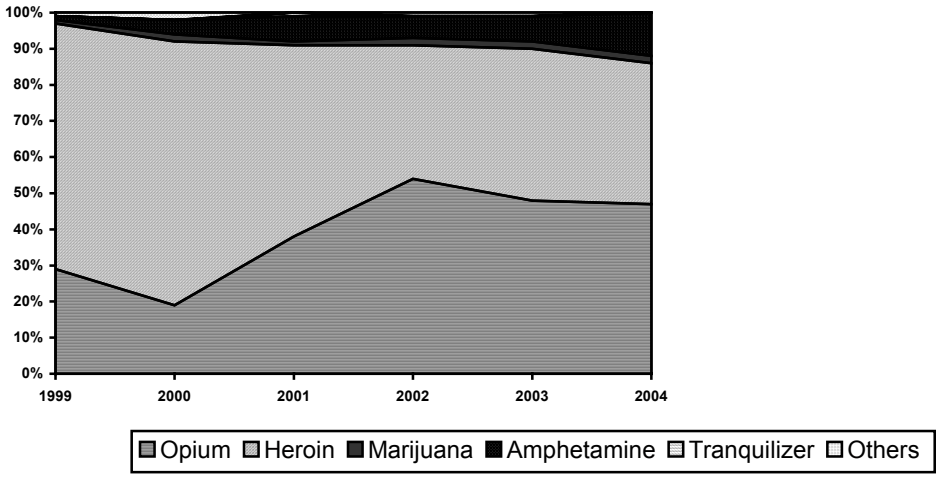
Table 1: HIV sentinel surveillance results among IDUs, 1992-2003

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Yangon	66.2	69.9	57.5	51.5	59	65.5	54.1	45.9	37.1	53.6	22	33.3
Mandalay	57.1	84.8	83.5	79	72.6	72.5	82.8	85.6	58.1	55.7	10	53.6
Mytikyina	77.5	93	90	90.9	90.9	76.6	79.6	70.8	90.2	52.5	30	42.6
Taunggyi	46.6	32.3	30.3	26.5	26.5	20.5	25	12	0	7	19	23
Lashio	40.6	28	22	59.7	59.7	30.1	53.2	66	76	55.6	73.3	77.8

It should be noted that in-treatment drug users do not necessarily reflect the overall situation of drug users, as many of them have never been to any drug treatment centre. Recent data collected by one partner implementing organisation highlights this difference.95% of its DIC clients were illiterate and 25% were 10-20 year old. Comparable figures from the government run addiction treatment centre at the same site were 9% and 6%, respectively.

The HIV sentinel surveillance data collected from addiction treatment centre should be viewed cautiously, for it was reported that difficulties in recruiting sufficient subjects has led to mixed samples of treatment centre and prison subjects in the past[18] and non-government DIC attendees in the present. Lack of information about the criteria for selection of those tested causes further difficulty in interpreting surveillance data.

Figure 1: Trends in drug use reflected through new registered cases in Yangon, Mandalay, Kachin, Shan, Sagaing and Bago



Finally, as indicated in Figure 1 above, it should be appreciated that opium use (smoking or eating) and heroin injection in Myanmar is a dynamic phenomenon and their relative prevalence in the community is influenced by availability of drugs in the market, age at onset of drug use, location and occupation of individuals with respect to source of drug, peer pressure and several other factors. Careful formative research and a targeted intervention approaches are needed.

[18] GV Stimson. HIV infection nd injection drug use in the Union of Myanmar. A report to the United Nations International Drug Control Program. (Final Report, 9 February, 1994).

At present very few HIV intervention programmes for drug users in prisons exist. The Joint Programme should prioritise supporting more such programmes, as the disabling environment in prison settings amplifies the vulnerability of detained individuals.

Output 3

Output 3: Knowledge and attitudes improved

Core output indicators:
- Percentage of 15-24 year olds who correctly identify the three most common ways of preventing HIV/AIDS transmission (UNGASS)
- Percentage of sex workers who correctly identify the most common way of preventing HIV/AIDS transmission
- Percentage of IDUs who correctly identify the two most common ways of preventing HIV/AIDS transmission

Core process indicators:
- Number of youth peer educators/outreach workers involved in project by end of quarter by age and sex
- Number of sex worker outreach workers involved in project by end of quarter by age and sex
- Number of IDU outreach workers involved in project by end of quarter by age and sex
- Number of MWMP outreach workers involved in project by end of quarter by age and sex
- Number of PLWHA peer educators/outreach workers involved in project by end of quarter by age and sex
- Number of IEC/BCC materials distributed to youth, sex workers, IDUs by type

The core Output 3 indicators are concerned strictly with "knowledge" in particular Groups (including the confusing term 'MWMP' that was found during the review to be used inconsistently used to mean men with male partners, as per the UNAIDS Myanmar core indicator definitions, and men with multiple partners). No data on them was provided during the present mid-term assessment. There is little doubt that, with enough effort, levels of knowledge can be raised to very high levels. In no country has that directly correlated with levels of protective behaviours. The selected indicators should be replaced with indicators that measure how people perceive their own risk and whether that leads to a desire for HIV testing. It is also important to understand how people perceive their peers' behaviour, for effective peer education is based on modelling and peer pressure. Although it is difficult to educate people to perceive their own risk leading to a desire for HIV testing, it can be implemented if more adequate support is provided for these activities.

Further, social and economic constraints surrounding these groups have to be factored in to the monitoring. How many IDU or female sex worker (FSW) outreach workers were arrested within the past year? How many received a regular payment from their associated non-government organisations? How many report adopting safer behaviours? These factors are not captured in the indicators.

The process indicators for the output could potentially better capture methods of communication that might lead to behaviour change, but they would have to be refined and related to the number of persons reached by peer educators or outreach workers and services provided. It is important to distinguish between a one-off contact and repeated contacts, as behaviour in the most at-risk groups does not change without repeated contact.

One set of process indicators for this output attempts to capture the involvement of outreach workers/peer educators from particular Groups, and their sex and age distribution. Using the two different terminologies of outreach worker and peer education side-by-side generates confusion. For example, for the IDU Group, it was reported through UNAIDS Myanmar that a total of 154 peer educators were involved. However, the six

partners[19] involved in implementation of HIV intervention among IDUs also reported employing 177 outreach workers. The reporting format did not indicate whether these outreach workers were IDUs or not. The outreach workers of course were not exclusive for IDU intervention and had multi-task responsibility. Sex and age distribution of these workers was also not available with UNAIDS-Myanmar.

The other process indicator for this output, the number of Information, Education and Communication (IEC) materials distributed to various Groups, has no relation to the possible effectiveness of such materials. If the indicator were: number of different IEC materials or media created by the Groups, this would give a better picture of the involvement of the community members themselves in their own behaviour change programmes. Defining the number of different IEC materials or media created by community groups might also give a better picture of the involvement of community members themselves in their own behaviours change programmes.

Output 4

The review team located conflicting data for 2004 on the percentage of young adults accessing Voluntary and Confidential Counselling and Testing (VCCT). One 2004 market survey reports a figure of 2.7 percent, which is significantly lower than the figures of 21.6% (148 of 760 attendees) and 45.8% (39 of 69 attendees), which were calculated by the review team based on information provided during visits to the Mandalay VCCT centre and the central AIDS counselling centre in Yangon.

No data on the percentage of female sex workers who accessed VCCT in 2004 was available from UNAIDS Myanmar. Again, based on information gathered during site visits, the review team came up with figures of 2% (14 of 760 attendees) at the Mandalay VCCT centre, and 0.02 % (2 of 85 attendees) at the central AIDS counselling centre in Yangon.

Output 4: Access to services for HIV care and support improved

Output core indicators:

- Percentage of youth (15-24) who report accessing Voluntary and Confidential Counselling and Testing (VCCT) in last 12 months
- Percentage of sex workers who report accessing VCCT in last 12 months
- Percentage of IDUs who report accessing VCCT in last 12 months
- Percentage of MWMP who report accessing VCCT in last 12 months
- Number of clients by age and sex receiving HIV test results and post-test counselling
- VCCT acceptance rate among pregnant women, by age
- Number of people receiving home-based care (HBC)
- Percentage of health workers with accepting attitudes towards PLWHA

Output process indicators:

- Number of service delivery points (antenatal care, STI and IDU clinics) in private and public sectors, offering VCCT to standardized guidelines
- Number and percentage of townships offering or referring for VCCT

No data on the percentage of IDUs who accessed VCCT was available from UNAIDS Myanmar. For the Mandalay VCCT centre and the central AIDS counselling centre in Yangon, these figures as calculated by the review team are none out of 760 attendees and 0.02% (2 of 85 attendees), respectively.

[19] Asia Harm Reduction Network, Artsen Zonder Grenzen, Medecins Du Monde, Myanmar Anti-Narcotics Association, National AIDS Programme, United Nations Office on Drugs and Crime

No data on the percentage of MSM who accessed VCCT in 2004 was available from UNAIDS Myanmar or the central AIDS counselling centre in Yangon. None of the 522 male attendees at the Mandalay VCCT centre reported having sex with men. Some preliminary findings of an unpublished survey suggest that overall 2 to 3% of adult males acknowledge ever having had sex with other men.

As reported by UNAIDS Myanmar, the total number of clients receiving HIV test results and post-test counselling in 2004 was 170,000, representing a 31% increase above the 130,000 clients receiving results and post-test counselling in 2003. No breakdown by age and sex is available.

Table 2 below presents the 2004 figures, disaggregated by age and sex, obtained by the review team from the central AIDS counselling team in Yangon. At the Mandalay VCCT centre, it was reported that 760 of 787 attendees took post-test counselling and results in 2004. 522 of the attendees were male and 265 were female.

Table 2: Numbers of clients, by age and sex, receiving results and post-test counselling in 2004

Gender	0-4	5-14	15-19	20-29	30-39	40-49	50-59	60+	Total
Male	-	3	2	19	11	6	2	-	43
Female	-	2	-	12	7	4	1	-	26

The two Component 4 process indicators are both related to VCCT service provision. These are the number of service delivery points (antenatal care, STI and IDU DICs) in private and public sectors, offering VCCT with standardized guidelines, and the number and percentage of townships offering or referring for VCCT.

The United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) support NAP in implementing community-based Prevention of Mother-to-Child Transmission (PMTCT) in 36 centres in 24 townships. Both the uptake of VCCT services and the rate of return for results within this programme are low. Out of 69,907 clients, despite counselling, over 30,000 mothers were unwilling to accept HIV tests. However, it should be noted that the number of pregnant women that do receive HIV tests through this programme has increased steadily since 2003, a significant achievement.

UNICEF advocates and implements four prongs of PMTCT, including prevention of HIV infection among childbearing women; prevention of unwanted pregnancy amongst HIV+ women, prevention of HIV transmission from positive women to their babies; and care and support for positive pregnant women and babies. This report focuses largely on the third prong. This is because most of the progress made thus far has taken place with regard to this prong of the approach. However, to avoid misconception of what UNICEF and others are trying to do in Myanmar, it should be noted that they are focusing on prevention counselling for HIV negative cases, contraceptive counselling for HIV+ women, and male involvement.

Within the Joint Programme, there are a total of 152 STI clinics providing VCCT, in 83 townships. These are run by different implementing partner organisations, including NAP's AIDS/ STD teams and international non-government organisations. The number of STI clients receiving HIV test results and post test counselling has increased considerably from 802 in 2002; to 11,070 in 2003; to 28,239 according to UNAIDS Myanmar data. It was reported that every time a new service delivery point is opened, demand for services is greater than expected.

The 14 IDU DICs that are supported by the Joint Programme reportedly offer VCCT services, but it is not known how many IDUs use this service.

UNAIDS Myanmar reports that overall 70 townships, or 21%, of 310 townships offers or refers for VCCT. This service expansion is a significant achievement. However, VCCT services are available in less than a quarter of the townships in Myanmar. Speedy extension of services to the remainder of the townships is of

paramount importance. This will strengthen prevention efforts, and provide enhanced access to treatment and care.

It is also difficult to know how to interpret this figure. The quality standards of services could not be determined. Standardized guidelines, which are being used by all partners, are not in place. Indicators that attempt to measure rates of VCCT uptake, thus focusing on use rather than availability of the service, would perhaps be more useful for HIV programming. Similarly there is a need for research on the reasons why people are willing or reluctant to take a test.

Counselling is important and needs to be emphasized more. The review team observed that Joint Programme implementing partner organisations that have made a concerted effect to address counselling issues have seen increases in both the uptake of VCCT and the rate of returning for post-test counselling.

Overall VCCT services, including testing for PMTCT, are provided either directly through the NAP AIDS/STD teams, or in collaboration with non-government organisations, to about 70,000 clients[20]. Despite the observed increase of service utilization, access and uptake of VCCT services is still low when compared to both the need and demand for services.

UNICEF Myanmar estimates that over 1.3 million births occur annually. NAP estimates that the prevalence rate among pregnant women in Myanmar is 1.64%. Assuming a 1% prevalence rate amongst pregnant women, over 13,000 mothers are likely to be infected.

In 2004, 406 eligible mother and baby pairs received Nevirapine (up from 194 pairs in 2003) through Joint Programme implementing partner organisations out of 690 pregnant women that were tested positive. In other words, of the women identified in PMTCT townships as being in need of Nevirapine, 59% received it. Data on the age distribution of the mothers are not available.

Although no data on the percentage of infants born to HIV-infected mothers who are infected are available it can be estimated to be 24.78% using the United Nations General Assembly Special Session (UNGASS's) 2002 indicator formulas. These would indicate that the total number of children born to HIV + mothers in that year was 19 080[21]. An estimated that 4,724 infected children were born to HIV+ mothers in 2004 (without taking into account breastfeeding risks)[22] based on the UNGASS equation[23] and current levels of PMTCT interventions. However, in the absence of any intervention, it is estimated that 4,770 infected children would have been born to HIV+ mothers (again without taking into account breastfeeding risks)[24]. Thus the intervention has averted 46 mother to child infection transmissions, a 1% reduction of the estimated total. This measure would not reflect the impact of non-medical aspects of PMTCT. It should also be noted that this success rate is limited by the small coverage of the service, if PMTCT were available to all infected pregnant women the number of mother to child transmissions would be cut by 2,375. Nonetheless PMTCT services are responsible for providing the largest number of VCCT in Myanmar and for providing counselling training to all basic health staff in townships where they are sited

At present within the Joint Programme, there are 54 PMTCT testing sites available in Myanmar. There are five international non-government organisations addressing PMTCT along with government and United Nations agencies. PMTCT was piloted in 2 townships in 2001. In 2003 institutional based PMTCT started in

[20] Currently NGOs in Myanmar are not permitted to carry out HIV testing, but must refer to government facilities for testing. They can, however, provide associated counselling and support services.
[21] Calculated using Myanmar's Crude Birth Rate and female RH population [UN pop. Division database 2004] together with the estimated UNAIDS HIV prevalence rate for pregnant women.
[22] UNGASS formulaic calculations of % of HIV+ infants born to HIV infected mother of 24.78%
[23] UNGASS equation assumes 25% transmission rate and 50% efficacy of the current regeimn.
[24] UNGASS formulaic calculations this infection rate for children would be 25% of all children born to HIV+ mothers.

5 hospitals. In 2004, 36 townships offered community-based PMTCT and 17 townships offered hospital PMTCT. This coverage reaches approximately 11% of all townships.

Most of interventions focus on preventing vertical transmission of Mother-to-Child Transmission (MTCT). A few international non-government organisations delivering PMTCT services are linking eligible women to ART. UNICEF and UNFPA also include primary prevention activities. The lack of involvement of men remains a major constraint identified by all partners. At its PMTCT sites, UNFPA is encouraging involvement of male partners by offering free VCCT to partners of pregnant women. This is a promising model and its effectiveness should be monitored for potential documentation as a good practice.

The data above reveals that current national coverage of PMTCT is low. Fifty-four PMTCT sites are found in approximately 11% of townships. Whilst current interventions do reach approximately half of the presenting HIV+ women, the overall numbers of women tested is low. From comparison of field data and estimated calculations, it can be inferred that interventions reach only a fraction of potential clients. The need for programme scale up is clear.

To increase PMTCT uptake three things must happen. VCCT coverage must be extended through wider range of service areas, such as maternal and child health, treatment of STIs and principally antenatal care services. Antenatal care is a particularly important entry point because it may be one of the first times a woman has the opportunity to talk to a health worker about HIV. More women must be encouraged to utilize maternal and child health and antenatal care and utilization must increase as a result. Service provision must be free and confidential.

Midwives, auxiliary midwives and traditional birth attendants are key focal people for PMTCT. They are well placed to encourage women to utilize antenatal care and maternal and child health services and to provide information about PMTCT. International non-government organisations and United Nations agencies working under the Joint Programme have incorporated them into their activities, training them and providing them with safe birthing kits. It was reported that government midwives have a heavy workload. For this reason it is important to monitor that their PMTCT activities are well integrated into their existing scope of community work.

Information in the public domain regarding PMTCT regimes is constantly changing. Therefore, good coordination links are needed to establish, update and share minimum protocols for PMTCT. The Joint Programme would benefit from having these in place. Current national practices use a short-course single regimen. The international community has expressed a desire to adopt a longer course regime (starting at 28 weeks). If this regimen is adopted in Myanmar it must be accompanied by a strong emphasis on VCCT and maternal and child health and antenatal care services, so that cases can be picked up early. There should also be a standard regime for late presenters.

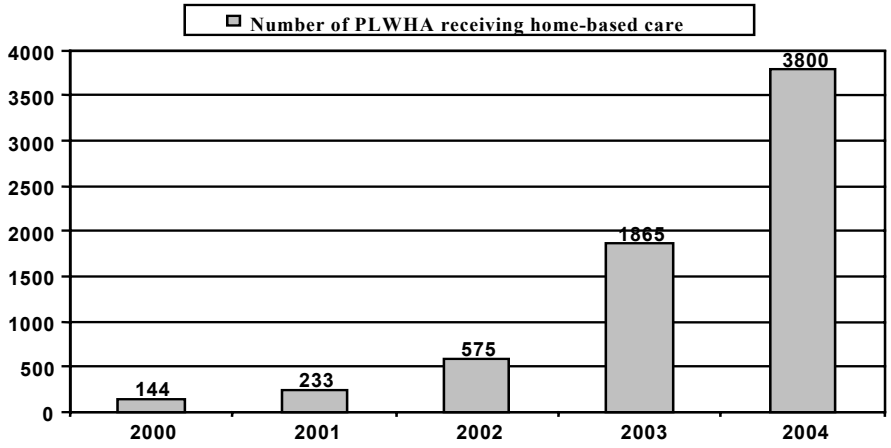
Partner implementing organisations' responses about the supply chain of Nevirapine tablets and infant suspension varied depending on their scale of activities. There does not appear to be an official protocol for purchasing drugs for PMTCT treatment. Nevirapine tablets and infant suspension is freely available in country at present. If PMTCT programmes are scaled up and there is a move towards a long course regime, issues around the supply chain might well arise in future. Coordination about this issue needs to involve WHO and the government and incorporate agreement on how supplies will be distributed, whether through central government stores or independent purchasing from approved drug lists. Representatives of partner implementing organisations using the longer course regime estimated that it takes between six to eight months to receive supplies through official channels. This raises a risk that unofficial channels to supplement supplies will be used. A coordinated and streamlined process is required to ensure adequate and timely availability of supplies.

A national policy on HIV/AIDS and breastfeeding is required. This should include recommended durations of breastfeeding, as well as address questions and uncertainties around formula feeding. Women that choose to breastfeed exclusively need to be supported at the community level. Education is needed to ensure understanding of the term exclusive and adherence to it. Current estimates of national rates for exclusive breastfeeding are very low, less than 20% in the first four months.

A structured system to follow up women and children after delivery should be in place. At the very minimum, support packages should include targeted post-natal care, promotion of breastfeeding, follow-up of the mother's HIV status, and testing for infants. These women (and in some cases the children) are eligible for ART. The aim is to keep as many positive women as possible on the radar for future inclusion for Opportunistic Infection (OI) treatment and ART as and when necessary. Additionally, positive women should be linked with other social and community support mechanisms within the community.

Services providers' attitudes and judgments have been identified as a barrier for service uptake in general, as well as for PMTCT. Some Joint Programme partner implementing organisations have made a concerted effort to improve the relationship between women and service providers. They have trained all health professionals and workers coming into contact with women about how positive attitudes, a non-judgemental approach, and confidentiality are essential for ensuring that women return for services and feel supported. For counsellors, ensuring that counsellor training continues after initial training sessions is a priority.

Figure 2: Number of PLWHA receiving home-based care, 2000-2005



Within the Joint Programme, HBC is provided by 8 international and national non-government organisations working in a total of 40 townships. According to information obtained from UNAIDS Myanmar, 3,800 people were receiving Home-Based Care (HBC) under the Joint Programme as of May 2005. Figure 2 above illustrates the steady rate of increase in recipients since 2000[25]. Criteria for eligibility of individuals for home-based care provision have not yet been developed for the Joint Programme, which makes it difficult to fully interpret the figures for this indicator.

[25] Australian Harm Reduction Project, Association of Medical Doctors in Asia, Care, Association Francois Xavier Bagnoud, Medecins Sans Frontieres Switzerland, PACT, World Vision, Myanmar Nurses Association, World Food Programme, and UN Agencies

In 2004, the number of people in World Health Organisation (WHO) Stage 3 or 4 was estimated to be at least 46,500[26]. If it can be assumed that HBC services are needed in the later stages of HIV/AIDS and if this figure can be used as a denominator for the purposes of trying to gain some sense of coverage, then it could be said that approximately 8% of those in need of HBC services are receiving them. However, this does not take into account distribution of coverage. Joint Programme implementing organisations providing HBC are only working in 40 of a total of 310 townships in Myanmar. It can be safely concluded that more remains to be done to achieve significant coverage HBC.

Variation in the content and quality of HBC services provided by different implementing partners was reported. The Component Group for Output 4 has considered developing a standardized HBC package along with eligibility criteria for receiving HBC services. These would certainly be beneficial, but due to operating constraints associated with the Component Groups, this has not yet happened.

The lack of organisations with expertise and capacity to provide home or facility based palliative care for the terminally ill is a notable gap in HBC delivery within this component of Output 4. Joint Programme donors should consider funding an international organisation with expertise in this area and facilitating its entry into Myanmar. The organisation could provide services directly and, importantly, help build the capacity of Myanmar health professionals and workers, as well as non-government organisations, in this area. No data are yet available on the percentage of health workers with accepting attitudes towards PLWHA.

Output 5

Output 5: Enabling environment and capacity-building

Core output indicators:
- National Composite Policy Index
- Amount of national funds spent by Government on HIV/AIDS
- Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes
- Percentage of schools with teachers who have been trained in life skills-based education and who taught it during the last academic year
- Number of mass media reports on HIV/AIDS
- Evidence that gender issues are being addressed by implementing partners
- Number of arrests of sex workers or percentage of sex workers who report that relationship with law enforcement authorities makes it harder for them to practice safer sex
- Second generation surveillance data (prevalence and behavioural) including all high-risk groups
- Evidence of Joint Programme feeding back monitoring and evaluation data to implementing partners

Output process indicators:
- Evidence that youth is meaningfully involved in design and implementation/activities
- Evidence that sex workers are meaningfully involved in design and implementation/activities
- Evidence that IDUs are meaningfully involved in design and implementation/activities
- Evidence that MWMP are meaningfully involved in design and implementation/activities
- Evidence that PLWHA are meaningfully involved in design and implementation/activities
- Number of youth advocacy events conducted at all levels
- Number of sex worker advocacy events conducted at all levels
- Number of IDU advocacy events conducted at all levels
- Number of MWMP advocacy events conducted at all levels
- Number of PLWHA advocacy events conducted at all levels
- Percentage/Number of people trained working with youth by type and sex
- Percentage/Number of people trained working with sex workers by type and sex
- Percentage/Number of people trained working with IDUs by type and sex
- Percentage/Number of people trained working with MWMP by type and sex
- Percentage/Number of people trained working with PLWHA by type and sex

[26] WHO 3x 5, 2004.

The output as worded 'Enabling environment and capacity building' has no verbal structure, and therefore it is not an output against which progress can be measured. It needs a term such as "developed", "assured" or 'enhanced', and the chosen terms should be defined clearly.

The amount of national funds spent on HIV/AIDS by the Government is reported to have increased from $30,000 in 2002 to $100,000 is 2004, a positive development.

UNICEF also uses the indicator of 'percentage of schools with teachers who have been trained in life based-skills and who taught it during the last academic year' and it is presumed that the data for this indicator largely emanates from its programmes. Whilst UNICEF reports that this has occurred in 32.1% of primary and 46.5% of secondary schools, the effectiveness of this programme as a means toward reducing HIV risk-taking behaviour in young people somewhat later in their lives, has not been evaluated. Because this type of school (and out-of-school) programme takes a developmental and educational approach, it is actually very difficult to assess its impact on young people without a carefully designed research project, using control groups, and following cohorts of young people for 5-10 years.

Another output indicator, 'the number of mass media reports on HIV/AIDS' is reported as the number of articles mentioning HIV and those with misconceptions. Without knowing how misconceptions are judged, it is difficult to use this indicator. It needs better specification. Ultimately, it would be more useful to know how mass media reports are influencing the attitudes and behaviours of identified target audiences.

Output 5 includes indicators on surveillance, number of arrests of sex workers and evidence of monitoring and evaluation information being fed back to implementing partners. Measuring the degree of harassment by police is valuable but implies action will be taken to try to diminish this. Advocacy is valuable but appropriately designed behaviour change programmes for police and their families would have greater impact. Second-generation surveillance has yet to begin in Myanmar. NAP has been doing behavioural surveillance this data has not been made public; hence credible behavioural data are available only from knowledge, attitude and practice (KAP) studies. In general, BSS methods are intended to measure trends and have limited value beyond this aim. If properly designed to track partners and linkages between sub-populations, BSS data can also indicate where the epidemic could move next. Other types of studies, such as network studies, in-depth qualitative studies to examine meanings and contexts of risk, are needed for designing interventions. Each behavioural change programme needs to monitor its own activities and impact, for programme improvement and evaluation. Feedback is necessary not only to implementing partners, but to the communities at risk themselves. The sharing of information within the Joint Programme was reported and observed to be minimal.

Output 5 also includes process indicators that seek to measure the 'meaningful' involvement of various at risk groups. The term 'meaningful' must be defined and operationalised more clearly before it can be measured adequately. Limited data on the involvement of some groups were obtained. Four partners reported 33 PLWHAS participating in care and support activities and in the planning and implementation stages of an activity to support orphans and vulnerable children in the community. The overall numbers of people from the different groups who are involved in programme activities appear to be small.

No data are available on the other process indicators listed for this output, including the number of advocacy meetings with PLWHA, or the number of people trained to work with at-risk groups. Most advocacy meetings held in Myanmar by all groups were reported to comprise of obtaining permission to do HIV prevention or care. Some training of health professionals and health workers has taken place as reported under Output 4 above.

Partner implementing organisations working under Output 2 have co-ordinated their advocacy efforts to gain the support of local stakeholders, power brokers and opinion leaders before initiating IDU intervention. This

is a good practice example, which should be documented and where possible replicated in other geographic areas for IDU interventions and adapted by partners contributing to the other outputs.

This output also intends to provide evidence that implementing partners are addressing gender issues. No data have yet been generated on this.

Responses to additional questions included in the TORs

To what extent are outputs likely to be achieved?

With the present variation in data reporting system, non-reporting of data on several counts and unclear definition of some of the core indicators of the joint program, it is impossible to make an educated guess about the extent to which outputs are likely to be achieved. The review team's subjective judgement is that it is unlikely that any of the outputs will be achieved by the end of the current Joint Programme period. To some extent this is to be expected as the outputs aspire to major changes, which can only be achieved in the medium- to long- term. Each requires that significant coverage and quality of a range of services and interventions would need to be in place. Coverage, which is not actually measured by any indicators, appears to be extremely low on all counts. Most reach no more than a few hundred people. Current quality standards achieved are assessed to be minimal.

Are there any unexpected outputs?

No unexpected outcomes were noted for Outcomes 1 and 3. For Outcome 2, the positive spin off of working through a Lashio township steering committee, comprising representatives from several sectors, which allowed implementation of comprehensive harm reduction intervention, was noted. Contrary to the experience in the past, outreach workers associated with this intervention were never arrested by police. Losing this momentum and failure to document this process for others to follow in different districts having injection drug use problem in Myanmar would be a great loss.

For Output 4, it was noted that the bulk of PMTCT programming has focused on the prevention of vertical transmission from mother to infant. This is an important and logical entry point to care, support, and treatment interventions. However, additional attention needs to be placed on primary prevention interventions. These include keeping HIV- pregnant women negative, especially at critical times during late pregnancy and during breastfeeding, helping to prevent unwanted pregnancies and ensuring safe pregnancies for HIV+ women. Diversifying PMTCT programming to emphasise work with groups in need of primary prevention and strengthening the linkages between prong three and other prongs of UNICEF's four pronged approach is required. Funds will need to be allocated specifically for these other aspects of PMTCT.

PMTCT should also be more widely promoted as an integral part of broader HIV prevention programming, especially amongst groups that are of reproductive age. Advocacy for PMTCT services targeted to the general public would be helpful as well. These are distinct interventions from health education messages. To achieve this within the Joint Programme, linkages amongst partner implementing organisations focusing on prevention and those providing PMTCT services must be made.

Although none of the core Output 4 indicators pertain to treatment, ART provision is included a strategy for achieving this output. NAP has prepared national HIV/AIDS clinical management guidelines, which also address ART provision. With the aim of introducing and scaling up ART in the public sector, in 2004 a technical team, constituted with support from UNICEF and WHO, assessed the human resources and support systems required for the procurement and supply management of ART. This process paved the way for increased coordination and cooperation in the efforts to scale up ART.

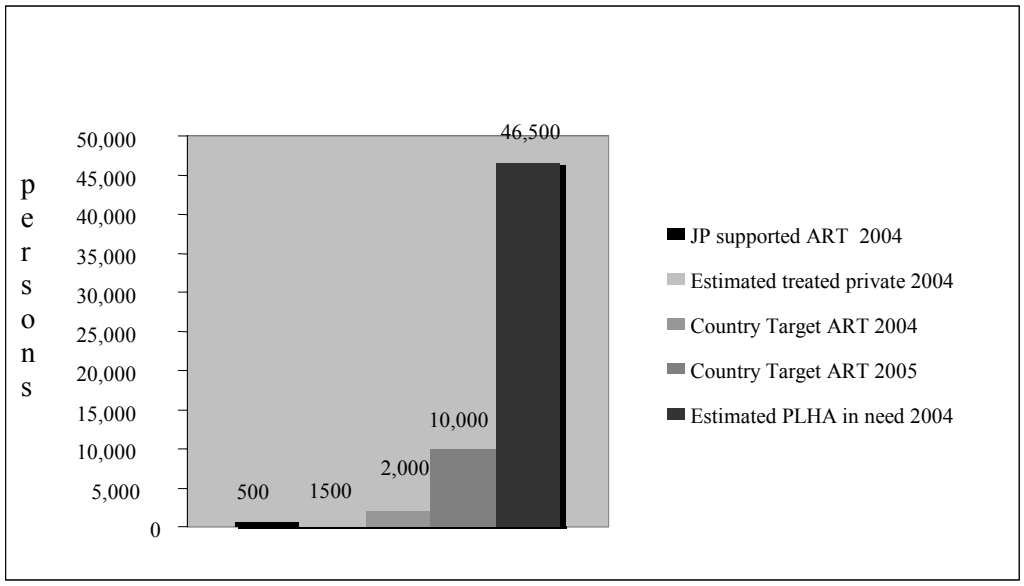
In 2005, ARV drugs were procured for NAP, through the United Nations Development Programme (UNDP), to start 115 patients on antiretroviral therapy. NAP plan to put 1,050 patients under ARV before the end of 2005 with the financial support of FHAM (400), GFATM III (250), Thai border programme (200) and Total/Union (200).

Twelve physicians from the Yangon and Mandalay General Hospitals have received training on the rational use of ARVs. The training of nurses and pharmacists to monitor adherence have not commenced and no larger plans to ensure adherence, for example by involving family and community members, are in place yet at either site. It was reported that the national HIV/AIDS clinical management guidelines have not yet been distributed at either site.

Patients in these hospitals have yet not begun to receive ARV drugs. The reported reason was that Efavirenz was not procured. It was felt that Efavirenz was needed for possible substitution, should Nevirapine drug toxicity reactions occur. In the meantime, some of the hospital patients are being treated with donated drugs, but regular and timely supply of ARV drugs to them is not assured.

Four international non-government organisations participating in the Joint Programme have also initiated ARV therapy for over 900 patients, with very good adherence rates. They have plans to scale up ART provision to reach approximately 2500 patients by the end of 2005.

Figure 3: Actual versus needed ART, 2004 and 2005[27]



Another concern is coverage. In 2004 WHO 3 x 5 estimated the number of people needing ARV treatment to be at least 46,500. Thus the number of people currently receiving ART represents less than 5% of the total number of people needing it. Figure 3 above compares actual ART provision with the estimated need for it. The level of unmet need is a compelling rationale for rolling out up national ART provision, but it is not clear that the resource investment to the public health system, which is needed to achieve this, are in place.

Undoubtedly, HIV/AIDS clinical management is needed to alleviate suffering, reduce stigma, mitigate the economic and social impact of the epidemic, and reinforce the achievements to date. It is also closely linked to VCCT provision, as evidence from other countries indicates that VCCT cannot be promoted effectively

[27] Data was obtained from UNAIDS Myanmar and from Joint Programme partners during review. WHO 3x5 documentation was also used. 3x5 refers to the WHO target to get 3 million people on ART by the end of 2005.

without offering treatment. NAP appears committed to provide ART. However, significant questions remain about the economic feasibility of rolling out ART to reach a significant number of people and the ability of roll out to be effectively supported within the current public health system. A significant amount of human resources development, community preparedness, support and logistics systems development, and resource mobilization is still needed to lay the groundwork for effective ART roll out.

More broadly, no rational analysis has been conducted, which could inform decision-making about the relative proportions of resources that should be allocated to prevention and advocacy, care and support, and treatment, with reference to overall resources available and the current HIV/AIDS situation in Myanmar. This analysis is very much needed as a framework for understanding whether and how to proceed with ART provision.

Estimates of need are further borne out by data obtained during the review. For example in 2004, the Public Health Laboratory in Mandalay confirmed HIV seropositivity among 10% of over 25,000 individuals screened. This included 3966 samples tested from symptomatic patients who needed confirmation of diagnosis. A fifth of these were seropositive. In the same period, over 300 HIV co-infected patients needing treatment for various OIs were hospitalised. The Public Health Laboratory reported that it refers about 5-8 patients were referred weekly to the outpatient department for HIV care. Currently only a small proportion of these patients receive the care or treatment that they need.

To what extent is the achievement of purpose attributable to the project outputs?

With regard to the Joint Programme framework, gaps do exist between the output and purpose and the purpose and goal levels. For example, none of the factors, such as nutritional support and support from school administrators and caregivers, which are considered to be effective in ensuring orphans' school attendance, a goal level indicator, are reflected at purpose or output level. As noted above, indicators that aim to capture perceptions of risk, which are more closely associated with the adoption of safer sexual behaviour, are lacking at output level. These and other gaps within the Joint Programme framework should be addressed, as they introduce a risk that the achievement of Outputs will not necessarily translate into the achievement of purpose and goal.

A general finding of the mid-term review is that minimal progress towards achievement of outputs has been made. It is premature to speak about achieving the purpose, or attributing it to progress against Outputs. Without a much stronger emphasis on and mobilisation of effective behaviour change communication (BCC) programming at Output level, it is unlikely that the purpose will be achieved. Currently too many level of resources are being spent on information, education and communication (IEC) activities and not enough on BCC, which can make a real difference in helping people to reduce their HIV risk.

An emphasis on such positive behaviour change should be more clearly built in to the Joint Programme framework at output level. Current partner implementing organisations lack capacity in this area of programming. Either significant technical support in this area should be provided to them, or a new partner implementing organisation with the requisite capacity should be identified and facilitated to build work in this area.

Systems for collecting and interpreting purpose level data do not appear to be in place. The planned behavioural sentinel surveillance has been delayed several times and it is unclear at this point when and how baseline and end-line data will be collected and made available for analysis.

Are planning and financial processes and mechanisms of the Joint Programme appropriate to address the context of the HIV/AIDS epidemic in Myanmar?

Whilst the current level of available resources falls short of the total estimated cost of the Joint Programme, in practice the disbursements of available funds have been modest, probably due to slow utilization and the very small size of individual interventions. At the end of FHAM Round I, 16 of 19 projects received no-cost extensions for up to another year due to inability to spend funds and meet targets.

The review team has not seen any basis for the estimated USD 88 million cost of the Joint Programme. However, this should be revised in a way that balances identified needs to scale up various programmes and experience of partner implementing organisations' capacity to undertake programme scale up. More resources would be needed to scale up programmes. However, absorptive capacity to use large amounts of resources effectively appears to be generally lacking.

There is a need to strengthen strategic planning processes and mechanisms. While implementing organisations do regularly collaborate to carry out activities, they lack larger reference points to shape and guide their collaboration. This has had a detrimental effect on the progress in achieving outputs, which relies on inputs of multiple partners, as well as on progress and quality of programme implementation. In particular, the Joint Programme would benefit from having clearer positions on a number of key strategic issues. These include amongst others the overall balance amongst prevention, care and treatment responses; the level and kinds of support to be provided respectively to international and national organisations; and minimum quality standards to be achieved in programme activity design and implementation.

Because they aspire to achieve long-term outcomes, the Joint Programme framework outputs and associated strategies need to be supplemented with more detailed work plans, which are costed and which can realistically be achieved in the medium-term. This level of planning, which has been found to be generally lacking within the Joint Programme, could help partner implementing organisations to be clearer about performance expectations and their defined contribution within the overall Joint Programme.

Is the coordination mechanism of the Joint Programme adequate for maximizing the outputs? What are the constraints to effective management of, and support to, the Joint Programme?[28]

The review team was asked to assess the co-ordination and financial, technical and programme management processes and mechanisms supporting the Joint Programme. Currently these are executed through UNAIDS Myanmar, the ETG, TWG and five Component Groups.

The ETG is comprised of government, donor agency, international and local non-government organisation representatives, and UNAIDS cosponsor representatives in Myanmar, as well as the UNAIDS Myanmar Country Co-ordinator. Its role is to oversee successful implementation of the Joint Programme and provide policy and strategic advice on the allocation of FHAM resources.

The TWG is meant to support the ETG by providing technical advice on all aspects of Joint Programme implementation and approving and monitoring FHAM resource allocation. Its membership includes the United Nations (UN) and international NGO Co-Chairs of the Component Groups, the NAP manager, and a national NGO representative. The UNAIDS Myanmar Country Co-ordinator acts as Chair of the TWG.

Each Component Group is supposed to act as an open forum for review and co-ordination of the work of implementing partners towards the achievement of a Joint Programme component objective.

UNAIDS Myanmar has a dual role of acting as a secretariat to these groups and providing co-ordination and monitoring and evaluation support to the Joint Programme. The FHAM management function is also housed within UNAIDS Myanmar, whilst FHAM contracting and financial accountability rests with UNDP.

[28] Due to the overlapping nature of these two questions, the reviewers chose to address them together.

In general, the ETG has fulfilled its responsibilities as detailed within its overall TORs[29]. Previously it played an important role in obtaining high-level political agreement to respond to HIV/AIDS in Myanmar and today it is actively involved in negotiating the relationship between the Joint Programme and the Global Fund programme. However, the ETG has had less success in advocating on an ongoing basis for sustained and broad-based political commitment and for specific HIV-related policy reforms. Multi-sectoral government participation in the ETG is lacking and participation at Ambassador level, which occurred initially, has receded over time.

With 21 members, the ETG is large and not all members are able participate in quarterly meetings. Its ability *as a group* to engage closely with the Joint Programme is limited although individual ETG members, especially those that also sit on the TWG or within implementing partners, have done so. A high level of engagement is needed in order to fulfil some of the ETG's TOR responsibilities, for example to promote effective management of resources, improve partner co-ordination and collaboration, and monitor the performance of the UNAIDS Myanmar secretariat. The ETG has therefore not been able to meet fully these responsibilities and as a result strategic human and financial resource management of the Joint Programme has suffered.

Whilst broad based representation is a notable feature of the ETG, good practice in governance suggests that its ability to objectively provide strategic, financial and technical oversight of the Joint Programme and monitor the performance of the UNAIDS Myanmar secretariat is compromised by the fact that a number of TWG members and the UNAIDS Myanmar Country Coordinator, both of whom also have direct responsibility for FHAM management, sit on the ETG. The potential conflicts of interest introduced by this structure need to be addressed.

As with the ETG, overall the TWG has acted in good faith to fulfil its responsibilities as outlined in its TORs[30]. It has played a central role in decision-making, with regard to both the Joint Programme and the FHAM. The structure of the TWG also gives rise to potential conflicts of interest. As they are making FHAM allocation decisions, TWG members are working for organisations that are benefiting from the FHAM. Conversely, FHAM donor agencies are benefiting from these organisations making available large amounts of time of their senior staff members to participate in the TWG.

Many of the partner implementing organisations very much need more specialised technical support, which is neutral and objective and which they can access as and when needed to move forward their programmes on a technically sound basis. This kind of support, which aims to improve programme performance and effectiveness, is distinct from capacity-building support.

The review team found few indications that appropriate technical expertise in all aspects of programming (design, implementation and management, and monitoring and evaluation) has been mobilized to support partner implementing organisations, most of whom have never conducted a well-designed and evaluated HIV prevention or AIDS support or treatment programme previously.

No on-the-ground, independent and expert observers have ever been engaged to improve programme design and implementation. Most of the numerous consultants brought to Myanmar are brought in by United Nations agencies to work on their own projects, such as WHO guidelines or UNICEF life skills programmes. Most international non-government organisations do not have adequate technical back up from their global programmes. Smaller organisations do not have sufficient experience or capacity-building support to go beyond awareness raising.

[29] Annex 1: United Nations Expanded Theme Group on HIV/AIDS: Purpose and Terms of Reference, Joint Programme for HIV/AIDS: Myanmar, 2003-2005

[30] Annex 2: Technical Working Group on HIV/AIDS: Purpose and Terms of Reference, Joint Programme for HIV/AIDS: Myanmar, 2003-2005

The TWG is not acting as a technical working group as such. This seems to be due largely to the fact that it must devote much of its time to meeting its Joint Programme and FHAM management responsibilities. Little time is left over for ensuring that HIV/AIDS good practice is applied strategically across activities to achieve Joint Programme goals and outputs. A mechanism for assessing implementing partners' technical support needs and identifying external resources to meet them thus has not been established within the Joint Programme.

UNAIDS Myanmar has also acted in good faith to fulfil its TORs, which combine technical and management support provision and co-ordination roles. However, the potential for 'role confusion' is real. For example, agendas set through co-ordination of implementing partners might conflict with what is technically feasible or required to respond effectively to HIV/AIDS in Myanmar and these two might conflict again with donor funding priorities. As co-ordinator, technical support provider *and* fund manager, UNAIDS Myanmar is not well positioned to make the difficult decisions necessary in each situation and the potential for programme impact is consequently compromised.

Whilst the five Component Groups have been useful for exchanging information, they have not yet facilitated strategic co-ordination of partner activities, which would be required to maximize achievements in support of outputs. Participants identified the infrequency of meetings and the frequent turnover of Group co-chairs as two impediments to achieving this level of co-ordination. Additionally, strategic co-ordination would require decisions from implementing partner senior managers, who do not usually attend Group meetings. Collaboration between partners in programme implementation seems to occur largely outside of the Groups, through one-to-one meetings amongst senior managers. The review team received reports that participants have felt intimidated by the Co-chairs and thus did not feel supported to ask questions and learn. This is unacceptable.

The Groups do not appear to offer benefits that outweigh the co-ordination and time costs of maintaining them. Further, it may be questioned whether good standards of practice in transparency could be achieved in a co-ordination forum whose members are also competing for funds. For this reason, the review team's opinion is that these Groups should be disbanded.

Overall it is recommended that the Joint Programme adopt a simpler management structure so as to reduce co-ordination requirements, establish clearer lines of decision-making responsibility and remove potential conflicts of interest.

The composition and roles of the ETG should be modified to create a smaller group that can more closely guide the Joint Programme. Whilst the ETG has clearly been involved in overseeing the Joint Programme, what is recommended here is a smaller, committed group who can devote time to making complex and inter-related strategic, management and resource allocation decisions for the programme. The review team thinks that this would provide a clearer framework, in which implementing partners could operate, than currently exists.

In particular a Governing Board, or similar concept, of no more than 8 members who can regularly attend meetings on a quarterly basis is recommended. The membership might include for example (3) Donor agency representatives, (2) Ministerial level government representatives, (2) External HIV/AIDS experts and the UN Resident Co-ordinator. The addition of external HIV/AIDS experts to the group would help to ensure that intervention requirements to have an impact on the epidemic over the long term are taken into account.

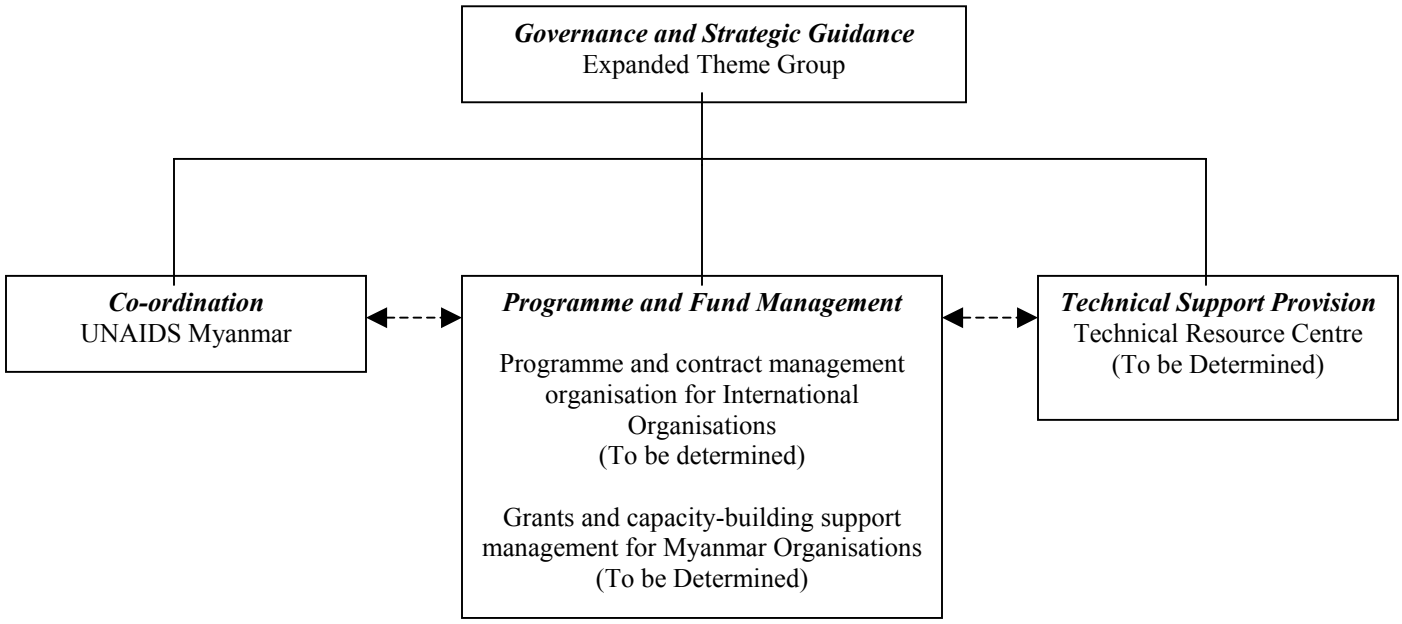
The Governing Board roles would be to:

- Proactively oversee strategic implementation of the Joint Programme;
- Monitor performance of organisations fulfilling other programme management and co-ordination functions (see below); and

- Set a framework for resource allocation and monitor resource needs

To focus UNAIDS Myanmar's role within the Joint Programme and address both the common and unique needs of implementing partners, the review team proposes that a new structure, as illustrated in Diagram 1 below, for Joint Programme fund, programme and technical management and programme co-ordination be established.

Diagram 1: Illustrative re-structuring of Joint Programme management and co-ordination structures



Under the new structure, UNAIDS Myanmar would have primary responsibility for programme co-ordination. It would focus on fostering key linkages that are critical to the future success of the Joint Programme. These might include, amongst others:

- The National AIDS Programme (NAP) for harmonizing the Joint Programme within the overall HIV/AIDS response
- The Myanmar government for policy advocacy
- The Association of South East Asian Nations (ASEAN) leadership for policy advocacy
- Programme and technical management organisation(s) for activity monitoring and evaluation (see below); and
- Donor agencies for resource mobilisation.

The revised structure would accommodate additional organisations that have the capacity to take on programme management and technical support roles, assumed until now by UNAIDS Myanmar. These roles would also be reconfigured slightly, with a view to strengthening the programme and technical management function of the Joint Programme and at the same time accommodating the different needs of Myanmar and international organisations.

Specifically the programme and technical management organisation(s) would have demonstrated capacity to:

- Establish and run a grants management function, utilizing FHAM funds, for Myanmar organisations;
- Establish and run a contracts management function, utilizing FHAM funds, for international implementing partners;

- Identify and source specialist technical support needed by all implementing partners to ensure effectiveness and efficiency of programme activity implementation; and
- Monitor and strengthen programme implementation and management progress and quality.

Each of these functions could be taken on by a separate organisation, or alternatively one organisation could take on more than one function, according to their demonstrated capacity to do so. Programme and technical management organisation(s) would report to the Governing Board and co-ordinate closely with UNAIDS Myanmar.

Core support from FHAM donors would be allocated as appropriate to support each function. The organisations responsible for programme management functions would be responsible for contracting international and national implementing organisations, respectively, to carry out programme activities.

It is not recommended that the Global Fund programme and Joint Programme management structures be merged at any level at this time. The review team questions whether this is the most appropriate or effective way to realise co-ordination between the two programmes. Whilst co-ordination is clearly needed, the National AIDS Programme seems best placed to lead this effort, in accordance with its mandate to co-ordinate all activities contributing to the national response. Consolidating and strengthening the existing management structures so that they can better support strategic implementation should be the first priority.

Is the Fund for HIV/AIDS in Myanmar (FHAM), as a "joint funding modality", an appropriate mechanism to support the Joint Programme? Is it working efficiently?

FHAM has worked efficiently to the extent that three application rounds have been successfully completed since its inception in early 2003. However, more robust systems for selecting applicants to receive FHAM funds need to be developed and communicated as a priority. FHAM has now had three application rounds. Different selection procedures and criteria were used for each round, fuelling perceptions that selections were made unfairly. One system must be developed, and clearly communicated, to support future funding rounds.

The FHAM team within UNAIDS Myanmar seems to play a largely administrative role and lacks senior-level staff members with the technical capacity and authority to monitor performance in this way. This has resulted in the funding of activities that were, and continue to be, developed without sufficient background information and data, or sufficient assurance of an enabling environment, which are needed for effective programme implementation.

Senior managers of organisations receiving FHAM funding appeared to have delegated responsibility for designing and overseeing activities to relatively inexperienced programme officers. Clear performance standards must accompany FHAM funding. Lines of accountability within the recipient organisation, as well as roles and responsibilities of the FHAM manager in providing support to the recipient organisation, must be further clarified.

A proper cost-benefit analysis would be needed to determine precisely the efficiency of the FHAM mechanism relative to other mechanisms that the FHAM donors might use. It would be worthwhile to conduct such an analysis, which is beyond the scope of this review, in order to confirm that the benefits of the FHAM mechanism do - or could potentially - outweigh the costs.

The FHAM mechanism incurs UNAIDS Myanmar administration costs, which stand at approximately 10% of the overall USD 22 million Fund value. This does not include the time costs of inputs from TWG and ETG members.

The FHAM has proven to be an appropriate mechanism for supporting the Joint Programme insofar as it meets the participating donors' requirements. It provides them with an in country programme and technical

management presence, which they would otherwise not have, and with a close link to the Joint Programme monitoring and evaluation system, which is also managed by UNAIDS Myanmar. However, this system still being developed and its value added to FHAM management or Joint Programme implementation has yet to be demonstrated.

The FHAM mechanism considers equally all applications and supports all recipients. A lesson learned from the Joint Programme, which is also borne out by experience from other countries, is that national organisations need smaller amounts of money with relatively more organisational development support to develop their financial and other management systems. A modified mechanism is needed to better support national partner implementing organisations.

Is the M&E framework and M&E plan appropriate for the objectives of the Joint Programme?

There is significant variation in data reporting systems, non-reporting of data on several counts and unclear definitions of some of the core indicators within the Joint Programme monitoring and evaluation system. This compromises the usefulness and credibility of the data. It is recommended that the system be reduced to include a few key indicators, which have the capacity to measure HIV/AIDS outcomes and which can feasibly be reported and interpreted, for each output. The cost of maintaining the system cannot be justified if the resulting data cannot be used effectively to understand progress in programme implementation and hold implementing partner organisations accountable for their performance.

The reasons why some indicators are not being collected or reported on should be analysed. If the indicators are still considered to be important, these reasons need to be addressed. If the indicators can be dropped from the framework because they cannot be feasibly measured or are not directly relevant to achieving HIV/AIDS outcomes, then they should be.

In addition to collecting data on indicators, there is an urgent need for more partners to carry out formative research, using focused and rigorous methods, which could help them to better understand the groups that they are working with. This kind of data, which seems to be severely lacking, is a necessary basis for effective programming.

Systems for collecting and interpreting purpose level data do not appear to be in place. The planned behavioural sentinel surveillance has been delayed several times and it is unclear at this point when and how baseline and end-line data will be collected and made available for analysis.

Some confusion concerning the purpose and utilisation of the system, whether for monitoring and evaluation of the overall response or for programme monitoring and evaluation, appears to exist. Two separate frameworks are needed, one for monitoring and evaluating the national response, in line with the 'Three Ones'[31] strategy, and another for providing partner implementing organisations with standards for and timely feedback on performance in programme implementation.

It is envisioned that the former framework would be developed through close consultation between UNAIDS Myanmar and NAP, and that NAP would eventually lead in maintaining it. The proposed programme management organisations would support partner implementing organisations to develop and maintain a programme monitoring and evaluation systems, which are appropriately tailored to their activities and which can effectively support programme performance.

Whilst the current level of available financial resources falls short of the total estimated cost of the Joint Programme, in practice the disbursements of available funds have been modest, probably due to slow

[31] The 'Three Ones' refers to one strategic framework for responding to HIV/AIDS, one co-ordinating mechanism, and one monitoring and evaluation framework.

utilization and the very small size of individual interventions. Whilst it is clear that more resources than are currently available will be needed to scale up programmes, absorptive capacity to use large amounts of resources effectively appears to be generally lacking and this should be addressed first.

Does the Joint Programme, as it stands, provide a suitable common action framework for the future and/or does it need to be revised?

Effective action for social change, which is perhaps the most fundamental requirement of the Joint Programme, relies on passion and commitment to a larger cause, a hunger to learn and perform, and a willingness to help each other. As a framework for action, the Joint Programme is currently hampered by lack of transparency and accountability; lack of openness to share and confirm information and data; unwillingness or inability to provide needed technical support to each other; fear and lack of confidence to boldly implement programmes. Beyond any adjustments to structures and mechanisms that can be made, a new basis for achieve the aspirations of the Joint Programme is needed. Inherent conflicts of interest must be eliminated for this to happen, and for this reason 'firewalls' must be established between funding and other co-ordination and implementation mechanisms.

It was widely reported to the review team that the Joint Programme has not successfully fostered the active and equal participation of national government and non-government representatives. This unfortunately lends weight to an existing perception that the Joint Programme 'belongs' to UN agencies and international non-government organisations.

For effective action to be realised, the Joint Programme will have to find ways to realise inclusion, both of government representatives and target group members. Currently these two constituencies are far apart and the Joint Programme has found the middle ground of international and national government organisations and UN agencies, but the middle ground will not be enough to produce action.

Given the evidence/information base available, are there gaps, which are not being addressed by the Joint Programme?

Partner implementing organisations need to find ways to interact more directly and learn more about the lives of people who are vulnerable and at-risk, so that programmes can be appropriately tailored to their needs, and also to provide them with opportunities to shape programmes and policies. This will mean the difference between approaching stakeholders as passive recipients of services, which appears to be an approach most commonly taken within the Joint Programme, and helping them to make decisions and take actions in their lives. This is a necessary basis for effective behaviour change communication and currently a gap of the Joint Programme.

Partner implementing organisations reported that they are seeing an increasing number of orphans and vulnerable children (OVC). OVC programming is a distinct area, which is not included in the current Joint Programme and should be. Partner implementing organisations would benefit from technical assistance aimed at helping them to carry out formative research and then develop and implement appropriate interventions in this area.

Are the stated risks and assumptions still valid?

Statements about risks and assumptions are useful only insofar as they are monitored and where possible managed. The review team did not see any system in place for doing this. It should be the role and responsibility of the ETG, and it could be very helpful for making decisions about how best to periodically revise and refine the Joint Programme framework.

For example, a stated assumption at purpose level is that poverty alleviation strategies are implemented to raise self-esteem and decrease vulnerability [of people exposed] to high-risk situations that exacerbate HIV transmission. No such strategies were mentioned during the course of the review. If they are in place, linkages to them through the Joint Programme do not appear to be cultivated. If they are not in place, there do not appear to be any mechanisms for reviewing what this means for the Joint Programme and revising the framework accordingly.

Criteria are needed for revising risks and assumptions based on clear progress or lack thereof in realising them. How progress towards realising a number of critical assumptions could be made is not articulated in the Joint Programme framework. These include 'confidentiality assured', 'quality control assured for testing' and 'geographic access assured'. At the same time, some progress towards realising other assumptions has been made. These include 'access to mass media', 'access to workplaces' and 'accessibility of condoms'.

Some relevant developments in the operating environment, for example the economic situation in Myanmar, have occurred during the current period. The risks and assumptions should be updated prior to the next Joint Programme period to take account of these.

Does the Joint Programme provide an opportunity for policy dialogue, coordination and joint consideration of key issues and constraints, including issues of sustainability?

The Expanded Theme Group (ETG), which has active high-level Government representation, has had success over the years in negotiating with the Government an acceptable space for responding to HIV/AIDS in Myanmar. Its individual members keep open channels of communication with the Government and these provide a means to keep abreast of policy developments and respond to opportunities for policy dialogue should they arise. They are skilled and experienced in this area.

The Joint Programme has provided good opportunities for co-ordination and joint consideration of key issues and constraints within the local context of activity implementation. Similar opportunities at the overall programme level have been limited, due in part to lack of government participation in the Component Groups and Technical Working Group. However, the UNAIDS Country Co-ordinator, representing the Joint Programme secretariat, does liase closely with the NAP Programme Manager and key Ministry of Health personnel. Concerted effort has been made to reach out to other Ministries of relevant to the overall Joint Programme effort. This effort is important and should be continued.

A gap is the lack of involvement of the private sector. Whilst some organisations are working well with private companies for programme implementation, the Joint Programme could benefit from engaging the private sector in a more strategic way. For example, physicians treating patients in the private sector and pharmaceutical companies marketing ARV drugs have much to offer in the development of thinking and plans for ART roll out.

To date, issues of sustainability as they pertain to policy or programmes do not appear to have been raised within the Joint Programme.

Does the Logical Framework need to be revised?

Many of the proposed strategies under each output, and especially under Outputs 3 and 5, of the Joint Programme framework are not yet being done and indeed some of them cannot be taken forward in Myanmar at this time. The framework may have inadvertently encouraged some partner implementing organisations to take up a broad array of activity and services, with relatively limited human and financial resources to take forward intensively any of them.

For this reason it is recommended that the Joint Programme framework be revised to take on fewer outputs and fewer strategies within each output in a more focused and realistic way, in accordance with the limited resource availability. It was found that those partners who are working intensively to reach clearly identified target groups with quality interventions are having more success in achieving real prevention and impact mitigation gains.

The programmatic areas that the Joint Programme addresses remain relevant to the epidemic in Myanmar. However, it should be updated to better address the gaps identified above.

Should the Joint Programme be continued beyond 2005, and if so, in what form?

The Joint Programme continues to play an important and necessary role in enabling the response to HIV/AIDS in Myanmar, and on that basis it should be continued. The overall form of the Joint Programme is adequate. However, urgent attention must be paid to improving the pace, coverage and quality of programming taking place within it. Current levels of programme coverage and quality are not adequate to achieve programme effectiveness and they do not justify the significant levels of resources that are being devoted to them. The Logical Framework, planning and co-ordination mechanisms, and management systems and structures could all be revised to better foster improved programming. This will also require that partner implementing organisations, as well as organisations involved in the governance and management of the Joint Programme, find new and better ways to collaborate at all levels. An intervention to facilitate this is needed.

Annex A: Mid-term review itinerary

All team members

Monday 16 May	Tuesday 17 May	Wednesday 18 May
9.00 Induction briefing UNAIDS	**9.00** UN Resident Representative	
10.00 Technical Working Group	**10.00** Component 2 meeting	**10.00** Meeting with NAP
14.00 Component 1 meeting	**14.00** Component 4 meeting	**14.00** Component 3 meeting
16.00 Briefing with WHO	**16.00** Meeting with MSF-Holland	**16.00** Meeting with PSI
19.30 Team dinner	**19.30** Dinner with NAP and partners from government	**19.30** Dinner with UN Agency Representatives of TWG

Sub-team 1 – Samiran Panda, Carol Jenkins

Thursday 19 May	Friday 20 May	Saturday 21 May	Monday 23 May	Tuesday 24 May
Morning: Dala **9.00** AMI STI clinic **10.00** discussion with CSW, MSM **Afternoon:** team meeting	**10.00** Central STD clinic **14.00** National Drug Treatment Center **16.00** UNICEF	**12.30** Compass Research	**Morning**: team meeting **12.00** KPMG **14.00** IHAA **16.00** AHRN	**Morning**: team meeting **10.30** MDM **12.00** ICRC **15.00** UNODC **16.45** CARE

Sub-team 2 –Anne Scott, Dilip Mathai, Mike O'Dwyer (replaced by Asa Andersson on 24/05/05)

Thursday 19 May	Friday 20 May	Monday 23 May	Tuesday 24 May
Insein + Hlaing Thayar **9.00** AZG clinics *(8.30 at AZG office)* **12.00** Hlaing Thayar Hospital? **Afternoon**: team meeting	**9.00** National Health Laboratories **10.00** National Blood Center **13.00** Weibagi **16.00** UNICEF	**Morning**; team meeting **12.00** KPMG **14.00** IHAA **16.00** Central AIDS counseling team (Dilip) **16.00** PACT (Anne)	**Morning**: team meeting **15.00** UNODC **16.45** CARE

Wednesday 25 May All team members	Thursday 26 May All team members	Friday 27 May (Mandalay) Sub team 1: Jenkins, Panda, Scott	Friday 27 May (Mandalay) Sub-team2: Mathai, Asa Andersson
9.00 Review Team meeting / discussion	**10.00** Consortium	**9.00** PSI clinic	**8.30** Division Health Director
11.00 FHAM		**11.00** CARE project	**9.30** Mandalay Gal Hospital
12.30 Briefing lunch on Global Fund (UNDP)			**11.30** Public Health Laboratory
14.00 Component 5 meeting	**14.30** Flight to Mandalay	**14.00** STD Team	**14.00** STD team
16.00 ADRA (Anne)		**16.00** MSI	**16.00** MSI
19.30 Dinner with NGO's members of TWG			

Week 3

Monday 30 May	10.00	10.30	12.00	14.00	16.00
Anne Scott		UNFPA		Myanmar	Dy Minister Home Affairs

				Nurse Association	
Dilip Mathai				Myanmar Nurse Association	Myanmar Medical Association
Carol Jenkins	ARHP		Burnett Institute	MANA	Dy Minister Home Affairs
Samiran Panda	ARHP		Burnett Institute	MANA	Dy Minister Home Affairs
Asa Andersson	ARHP		Burnett Institute	MANA	Myanmar Council of Churches

All team members

Tuesday 31 May	Wednesday 1 June	Thursday 2 June	Friday 3 June
9.00 Review team formulation of recommendations regarding Round IIb proposals	**11.30** Meeting with Minister of Health	**12.00** Donor Briefing	**10.00** Meeting with the TWG to present recommendations regarding Round IIb proposal
	Review team meeting to finalise preparations for ETG and TWG	**14.00** ETG Meeting: presentation of preliminary conclusions	**14.30** Debrief with Implementing Partners

Annex B: Joint Programme partner implementing organisations

Adventist Development and Relief Agency (ADRA)
Association Francois Xavier Bagnoud (AFXB)
Association of Medical Doctors in Asia (AMDA)
Asian Harm Reduction Network (AHRN)
The International HIV/AIDS Alliance
Aide Médicale Internationale (AMI)
Australian Regional HIV/AIDS Project (ARHP)
Artsen Zonder Grenzen/Medecins Sans Frontieres Holland (AZG/MSF H)
Burnet Institute
Medecins Sans Frontieres Switzerland (MSF-CH)
Care
International Red Cross Federation
Marie Stopes International Myanmar
Malteser
Medecins du Monde (MDM)
PACT
PARTNERS
Progetto Continenti
Population Council
Population Services International (PSI)
Save the Children US (SC US)
Save the Children UK (SC UK)
World Concern (WC)
World Vision (WV)
Cholia Muslim Central Fund Trust
Karuna Myanmar Social Services
Muslim Central Fund Trust
Myanmar Anti-Narcotics Association (MANA)
Myanmar Baptist Convention (MBC)
Myanmar Business Coalition on AIDS (MBCA)
Myanmar Council of Churches (MCC)
Myanmar Health Assistance Association (MHAA)
Myanmar Medical Association (MMA)
Myanmar Maternal and Child Welfare Association (MMCWA)
Myanmar Nurses Association (MNA)
Myanmar Red Cross Society (MRCS)
Myanmar Young Crusaders
Phaung Daw Oo Monestray Education
Pyay Gyi Khin Women's Development Co-operative Society
Thirimay Women's Development Co-operative Society
Young Women's Christian Association (YWCA)
Central Committee for Drug Abuse Control (CCDAC)
Department of Educational Planning and Training (DEPT)
National AIDS Programme (NAP)
Ministry of Health
Ministry of Home Affairs
Monistry of Labour
Ministry of Social Welfare
Ministry of Rail Transportation (MRT)
Ministry of Religious Affairs

United Nations Population Fund (UNFPA)
United Nations Children's Fund (UNICEF)
United Nations Development Programme (UNDP)
United Nations Office of Operations Support (UNOPS)
United Nations High Commission for Refugees (UNHCR)
United Nations Office of Drug Control (UNODC)
World Food Programme (WFP)
World Health Organisation (WHO)

Annex C : Pre-review assessment paper topics

Component 1
Male and female condoms
STI treatment
VCCT
Gender, sexual norms and MSM
Integrated work with male and female sex workers

Component 2
Capacity-building
Advocacy
Coverage
Programme effectiveness
Indicators and data

Component 3
Youth
IEC materials
Knowledge and attitudes on HIV/AIDS
Public media
Mandate of Component 3

Component 4
ART, OI, HIV, TB and the structure of care
PMTCT
HBC
Working with PLWHA
Health care settings including safe blood, universal precautions and post-exposure prophylaxis
OVC

Component 5
Religious leaders
Co-ordination structures
Monitoring and evaluation
Capacity building including PLWHA
Workplace policy
FHAM

Annex D: Mid-Term review terms of reference

Review of the Joint Programme for HIV/AIDS Myanmar 2003-2005

Terms of Reference

Revised version 24 December 2004

A review of the Joint Programme for HIV/AIDS Myanmar 2003-2005 is to be conducted at mid-term to assess achievements with reference to its stated goals. The Review will as well provide recommendations for the remaining period and the future programme. These Terms of Reference outline the objectives and process to be followed.

I) Introduction

HIV/AIDS has become a national priority in Myanmar, as one of three priority communicable diseases identified by the Ministry of Health. In South-East Asia, Myanmar, as well as Thailand and Cambodia, have been identified by UNAIDS as the three highest priority countries.

UNAIDS 2004 estimates for the number of HIV positive individuals in Myanmar range from 170,000 to 620,000 (out of 53 millions habitants). Trends in official sentinel surveillance data show increasing rates of HIV infection among high-risk groups, especially sex workers. Low-risk groups like blood donors and pregnant women top respectively at 1.23 % and 1.64 %. Officially reported AIDS cases attribute 30% to intravenous drug use and 68% to heterosexual transmission. Though the men to woman ratio among reported cases is still 5:1, the number of infected women has increased in the last 5 years. Geographical mapping of officially reported AIDS cases shows that eastern states/divisions have been hardest hit. The central and delta regions had moderate rates of infection, with the lowest found on the western border.

In an effort to strengthen the coordination of HIV/AIDS response in Myanmar, the ***Joint Programme for HIV/AIDS for Myanmar, 2003-2005*** has been developed**.** The ***Joint Programme*** is the result of a continual process of consultation facilitated since 2000 by the United Nations Theme Group on HIV/AIDS. In 2002, the Expanded Theme Group on HIV/AIDS (ETG) was established to include other partners such as government, donors and non-governmental organisations (NGOs) that are active in fighting the HIV/AIDS epidemic in Myanmar.
The purpose of the Joint Programme is to "**change behaviour to reduce the transmission of HIV and to improve the health of People Living With HIV/AIDS**". It has been articulated around 5 major outputs:

1) Access to services to prevent the sexual transmission improved
2) Access to services to prevent the IDU transmission of HIV improved
3) Knowledge and attitudes improved
4) Access to services for HIV care and support improved
5) Enabling environment and capacity building

<u>Funding of the Joint Programme</u>

It was estimated in 2003 that the full implementation of the ***Joint Programme for HIV/AIDS for Myanmar, 2003-2005*** would require US$ 88 million. Over US$ 48 million have been confirmed by different donors so far:

- the Fund for HIV/AIDS in Myanmar (FHAM) was established in January 2003 to support the implementation of the Joint Programme. FHAM is a joint funding mechanism that aims to

ensure a coordinated, comprehensive and multi-sectoral response to HIV/AIDS and provides a mechanism to channel funding for donors who wish to support the joint effort. So far, FHAM has raised US$ 23 million for the 3 years period from the Governments of the United Kingdom, Sweden and Norway.

- in addition to FHAM, bilateral funds, NGO core funds, UN and private foundations' contributions have added US$ 26 million to the Joint Programme for 2003-2005.
- the Global Fund approved a 3rd Round proposal for Myanmar, which utilized the Joint Programme as a framework for activities. The grant, to be signed in early 2005, will inject a further US$ 18 million for 2005-2006.

II) Objectives

The Review of the ***Joint Programme for HIV/AIDS Myanmar 2003-2005*** will answer the following questions:

1. Are projects activities on track to produce stated programme outputs and results?

- What progress has been made for each output against the Core Indicators of the Joint Programme?
- To what extent are outputs likely to be achieved?
- Are there any unexpected outputs?
- What is the likelihood that project purpose and goals will be achieved?
- To what extent is the achievement of purpose attributable to the project outputs?

2. Are planning and financial processes and mechanisms of the Joint Programme appropriate to address the context of HIV/AIDS epidemic in Myanmar?

- Is the coordination mechanism of the Joint Programme adequate for maximizing the outputs?
- Is the Fund for HIV/AIDS in Myanmar (FHAM), as a "joint funding modality", an appropriate mechanism to support the Joint Programme? Is it working efficiently?
- Is the M&E framework and M&E plan appropriate for the objectives of the Joint Programme?
- What are the constraints to effective management of, and support to, the Joint Programme?

3. Does the Joint Programme, as it stands, provide a suitable common action framework for the future and/or does it need to be revised?

- Given the evidence/information base available, are there gaps which are not being addressed by the Joint Programme?
- Are the stated risks and assumptions still valid?
- Does the Joint Programme provide an opportunity for policy dialogue, coordination and joint consideration of key issues and constraints, including issues of sustainability?
- Does the Logical Framework need to be revised?
- Should the Joint Programme be continued beyond 2005, and if so, in what form?

III) Methodology of the Review

1) Pre-review of progress by Component Groups.

In relation to the 5 priority areas of the Joint Programme, 5 Component Groups have been set up at the start-up of the Joint Programme and are meeting on a regular basis for coordination purposes.

- Component 1: Access to services to prevent the sexual transmission of HIV
- Component 2: Access to services to prevent the Injecting Drug Use transmission of HIV
- Component 3: Knowledge and Attitudes
- Component 4: Access to services for HIV care, treatment and support
- Component 5**:** Enabling environment and capacity building

In order to prepare the Review, co-chairs of each of the 5 Component Groups will organise a pre-review of progress to date. While each component group will have the flexibility to determine the most appropriate method, at a minimum the pre-review must:

- ✓ assess the achievements against the set of Core Indicators for their group
- ✓ identify geographical or technical gaps or areas requiring policy change and/or scaling-up of activities.
- ✓ provide recommendations to modify or/and adjust the strategies related to their group.
- ✓ identify issues that transcend the Component group which should be further explored as cross-cutting during the Review itself

UNAIDS will support these pre-reviews by: providing a one-page guideline to co-chairs for what briefing papers might look like; provide data from the Joint Programme M&E system to aid with analysis; attend all Component planning meetings; contribute to drafting of briefing papers as any other Component group member as requested/appropriate. While each Component group is free to determine its own method, it is anticipated that Component groups may wish to identify a few themes for which short briefing papers could be prepared.

In the course of organising these Component pre-reviews, partners are encouraged to solicit the advice and expertise from within their organisation, from their regional offices and/or headquarters, for example, to assist with the pre-review. The Technical Working Group has agreed that local assistance can be purchased[32] to help Component Groups that feel they need the additional resources for the drafting of the pre-briefings. Alternatively, Component Groups may request that individual Reviewers (once Review team members are selected and finalized) may come early to assist with the pre-Reviews. Component Groups interested in pursuing either of these options should make the request to UNAIDS.

Component Groups should aim to have their briefings completed by mid February.

They will be presented, by Component Group, during the Review to the entire Review team, as an open meeting to which all partners will be invited. These presentations will be followed by open discussion. These discussions will be held near the beginning of the Review, and will thus serve to establish a starting-point for the Reviewers' work. It will provide a basis for asking questions during individual and group interviews, project sites, and follow-up meetings.

2) **Independent Review of the Joint Programme**

A team of 4 or 5 consultants, including a team leader with strong expertise in leading national level reviews, will be selected by the Technical Working Group by the end of 2004 or early 2005.

This multi-disciplinary group of experts will assemble competencies in as many of the technical areas of Joint Programme as possible, including:

[32] With FHAM funding from the M&E budget.

- Sexual Transmission
- Injecting Drug Use
- Behavioural Communication Change
- Voluntary and Confidential Counselling and Testing
- Treatment and Care

The Team Leader will:

- Organize the collection of background documents for the Review team, including the pre-review documents of Component Groups
- Plan the work of the Review team with Component Groups, dividing work across the team members who shall all contribute to the findings and final report
- Organize the programme for the Review itself in consultation with the Technical Working Group
- Ensure the production of a final report, based on the inputs of all team members, according to the time-table
- Organize the presentation of the results of the Review to the Expanded Theme Group, depending on the timing. Ideally, the entire Review team is present for this discussion. The Expanded Theme Group will be responsible for taking decisions to guide the future direction of the Joint Programme in response to the Review.

The Team Leader will visit Myanmar to prepare the Review in late January or early February.

The Review by the Team Leader and the full Review Team will take place in late February or March. The Expanded Theme Group meeting will be timed, to the extent possible, around the presentation of the preliminary findings of the Review Team at the end of the Review.

The final report is mean to be sent to the Secretariat of the Joint Programme not later than 31 April 2005.

Review Team members will:

- partake in all aspects of the Review, including attending Component Group briefings, participating in site visits, and meeting TWG members, and presentation of findings to the Expanded Theme Group
- provide their own specific expertise to the concerned field of activity to assess.
- contribute to the elaboration of findings and the drafting of the report both in their specific areas of expertise and in general

To guarantee a comprehensive overview of the Joint Programme achievements, the Review Team will combine different type of assessments:

Activities suggested for the Consultant Team:

- **Entry Briefing with Technical Working Group**: The consultant team shall have an initial meeting with the Technical Working Group to confirm the schedule for the review and allow for questions, clarifications and comments on the part of either the Technical Working Group or the evaluation team. The pre-review reports prepared by each of the 5 Component Groups will be discussed during this meeting.

- **Field Visits to Partner Activities and Communities**: the consultant team are expected to make field visits, at least one of which will be a community visit. The schedule of visits will be organized by the Team Leader according to the following:

- Activities from all of the four priority technical areas
- Activities from rural and urban areas
- Activities from priority townships
- At least one visit to a non-priority township to provide context and point of comparison to priority townships
- Activities from all types of implementing partner (Government, non-government, national and international)
- Community visits which include discussions with a full variety of stakeholders and beneficiaries in a given community (i.e. to visit a community rather than a particular project, and through either open meetings and/or focus group discussions exploring of community views on AIDS)

- **Individual interviews**: the Consultant Team will interview a selection of donors, decision makers, implementing partners of the Joint Programme and PLWHA. The Technical Working Group and/or the Joint Programme Secretariat will suggest a list of persons to be met during the evaluation. Some groups may also be combined (for example, with donors).

- **Mid-point technical AIDS update workshop**: if feasible and confirmed as possible and desirable by the Team Leader and Technical Working Group, a selected global expert on AIDS may be requested to visit Myanmar and facilitate a workshop on trends in the epidemic globally and the most recent best practices. The timing would be chosen to add information to help with the formulation of recommendations.[33]

- **Final briefing with Technical Working Group**: a final briefing will be held with the Technical Working Group both to present preliminary findings and to comment on process issues related to the Review itself, such as constraints the Review team may have encountered prohibiting them from achieving all aspects of the Review, suggested follow-up steps, etc.

- **Meeting with the Expanded Theme Group**: presentation to the Expanded Theme Group meeting of findings, attended by all Review team members.

The principal interlocutor for the Review Team will be UNAIDS, acting on behalf and under the direction of the Technical Working Group.

VI) Logistics

UNAIDS Secretariat will be responsible for the logistics of the Review. This will include collection and dissemination of documents, organization of meetings, transport, accommodation, meals and venues.

Field visits will be considered according to availability and logistic constraints.

Venues: the Review Team will be based at UNAIDS office in Yangon.

VIII) Timing (to be revised)

Activity	Date
Submission of the final TOR to the Technical Working Group	24 Dec 04

[33] A name has been suggested during the Technical Working Group meeting of 22 December for further consideration.

Draft TOR sent to potential consultants	3 Dec 04
Submission of the TOR to the Expanded Theme Group	10 Dec 04
Reception of CV	10 Dec 04 (still open)
Selection of 3 consultants, including a team leader, by the Technical Working Group	22 Dec 04 (initial TWG discussion) Contracted by mid-January
Team Leader in Myanmar for meeting with Component Groups, TWG and to prepare the Review	end February
Pre-review reports finalised by each of the 5 Component Groups	Mid February
Team of Consultants in Myanmar	March
Presentation of first finding to the Expanded Them Group	Late March
Reception of the report from Team Leader	April

Main documentation to provide for the Review

Several areas of work have been carried out in the period leading up to the Review and a set of documents will be made available and discussed during the Review process. The key issues for which documentation will be provided to the review participants are listed below:

1. Point in time reports (31 October 2003 and subsequent): activities under the Joint Programme for HIV/AIDS Myanmar 2003-2005

2. Logical framework matrix for the Joint Programme
A logical framework matrix has been developed by UNAIDS, National Aids Programme and partners that provides a summary of the Myanmar Strategic Plan. It is a strategic framework that highlights the priority areas and outputs and provides a set of indicators for each. It forms the basis for more detailed planning and for monitoring and evaluation progress.

3. Monitoring and Evaluation plan
An outline Framework for M&E has been developed that ties in with the Logical Framework indicators and looks at consistency with international best practices and sectoral monitoring plans and indicators. The framework look at the various means of collecting required data and identifies affordable options where gaps currently exist.

4. Annual Report for the Fund for HIV/AIDS in Myanmar (FHAM) – Year 1

5. Implementing Partners reports, Seroprevalence, Behavioural Surveillance Surveys and Special Surveys results
These documents will be provided by the M&E Unit at UNAIDS and National Aids Programme when available.

6. Reports from the pre-review conducted by each of the 5 Component Groups

7. Other relevant reports covering the Joint Programme or the situation in Myanmar (eg. Best Practice)

Annex E: Additional comments received on the first draft mid-term review report

General comments

1. The report could be more balanced in highlighting good as well as poor results. A number of conclusions by the MTR are acknowledged as valid by our partners but the focus on the negative aspects is extremely strong and the draft insufficiently reflects what has effectively been achieved. Some good examples which are still missing from the current draft include capacity-building, linkages fostered and technical assistance built into projects (this is covered in two pre-review papers: on Capacity-building (C5) and on the Fund for HIV/AIDS in Myanmar (UNAIDS paper).

2. A general comment made was that while some of the pre-review papers prepared by the component groups were extensively quoted in the report, others were not reflected at all (eg. multisectoral work, workplace and private sector initiatives...).

3. The report as it stands may alienate some partners, could give way to more controversy and become an easy target for those opposed to any kind of support to the country. We need the final document to have a little more context and to better balance current gaps and deficiencies or areas for improvement with achievements made (there are some).

Component 1 comments

1. First, I think the process of the review itself was very good. The 4 consultants proved to be very strong. From our interactions with them, it seemed that they quickly came to a thorough understanding of the response to the epidemic here. As it stands, the report is disappointing because it does not help us move forward as much as I had hoped. It is a draft; I hope that at least some of the team members will invest the time needed to make the product worthy of the process, not "for the record", but to help us improve things.

2. It seems that, in some cases, the writers were afraid to state their analysis and conclusions unequivocally. We learn, for example, that "some" IPs are overstretched and unfocussed whereas "others" are having more success. Did we really need 4 top-quality consultants over 3 weeks to tell us that? After all that work, we read through 28 pages without any reference to cases that we all know about in the FHAM we over-funded organisations that could not deliver. I had hoped that the MTR would help us avoid these problems in the future.

3. They make blanket statements about lack of absorptive capacity and failure to achieve coverage. While these are generalised problems here, there are exceptions, and they should be clearly identified.

4. There are many problems with the recommendations for management and governance, but the main one is that they fail to address the key question: who will decide which organisations get how much to do what activities? This has always been the key problem with FHAM, for reasons that go far beyond the conflict of interest mentioned by the team, but the review seems to have made no progress on this issue. The proposed "governing board" is only supposed to "set a

framework for resource allocation". In any case, the presence of UNDP and Government on that Board make it inappropriate for deciding funding to UN and government agencies.

5. Much is made of the need for additional technical support. The review should specify why this is needed, given the plethora of technical support organisations already present (Burnett, UNAIDS, Alliance, WHO, AHRN). What is wrong with current provision for technical support and how would any proposed additional organisation address that?

6. In too many places, the report consists of pedantic, almost legalistic quibbling about the wording of outputs and indicators, definitions and data issues. It is true that the JP is weak in these respects. I would have expected the team to simply note that, up-front, and then to move on to present their judgement on progress and performance in each of the output areas based on the evidence available to them.

Component 2 comments

1. The group does not agree with some assumptions in the report, e.g. the statement that senior managers did not attend the component meetings regularly. In Component 2, senior managers did attend regularly.

2. It is not agreed that the component group be abolished. If necessary, the group will plan to change to a DU group with a revised TOR for information sharing, technical coordination, etc. on which the group feels working well. The groups wanted to maintain a forum.

3. The group has concern over the NGO position and how their voices be heard in any new proposed management structure. The group wants to be part of management process.

4. The group agrees to more support for national/local organizations and supports the idea that more money needs to go to capacity building

5. Size estimation alone is important but it could not lead to containment of the epidemic.

6. Concerns raised about the time reviewing and revisiting the JP structure might take.

7. Needs to review and revise monitoring mechanism with updated indicator set for each component

8. Component 2 agree on the fact that if the response doesn't meet the total need, the HIV epidemic will not be contained but the way it's put into word is quite hard and doesn't encourage the existing efforts to answer to the needs. We would like the reviewers to write it in a more positive way and to use also this argumentation for 2 main things: This argument justify in itself the existence of such component 2 to advocate in front of authorities the need of needle exchange programs which are still sensitive. This argument should be used to advocate in front of donors which are still reluctant for financing needle syringe programs.

9. More over, the idea of harm reduction and harm reduction projects are still new in this country and for that reason it's obvious that INGOs involved in such project will not cover at the

beginning all the need. At the end, it can make sense to start by pilot project before expending the coverage.

10. Globally, and compared to other countries, the decisive support during the first half of Joint Programme implementation from governmental bodies like the Central Committee for Drug Abuse Control should be emphasized.

11. IPs should have directions on the kind of Operational Research which should be conducted as recommended by the MTR and that they did not agree with the MTR suggestions on starting a new Country Strategy for Component Groups as this takes a long time and that the Component 2 has achieved considerable progress in this regard. However, they also expressed that more coordination in terms of structure is needed.

12. Component 2 should not be abolished, and that the present structure of the FHAM mechanism places them in an uncomfortable position because while the co chair is the head of an International NGO, they are also a member of the TWG. However, they agree to the MTR's recommendations that local NGOs should be supported and developed. In addition, AHRN also commented that it rests upon UNAIDS to decide on Management issues with regards to current conflicting positions as mentioned above. However, they do not agree on the remark by MTR that senior management personnel are giving their responsibilities to younger nationals. Apart from this, AHRN globally approves a lot of the comments and recommendation of the drafted document, though the wording should be sometimes modified.

13. A lot of findings of the MTR team happen to be problems raised by the partners themselves (See the Mid Term review Papers provided to the consultants), and the partners are seeking ways to overcome them through-coordinated efforts. If the partners agree on the weaknesses and the room for improvements, a neutral comparison with a lot of countries should also stress that: The low coverage is the direct result of the limited resources allocated to C2 programmes (adding all Joint programme resources), and the lack of partners willing to take this risk. These level of resources is ***significantly*** inferior to what is provided in Asian countries where size estimation, coverage are also not satisfying enough, assuming that the very implementation must reach a minimum critical size to be used as a basis of demonstration.

14. During the feed back given to the TWG and the NGO's: The mid term reviewers acknowledged the existence of running Drop in Centers, outreached-based needle/syringes, the delivery of health education and awareness building, the access to counseling and the condom promotion. They stressed that the IDU *component is advanced in terms of coordination*, at the Central Level (Component 2/Technical Coordination Unit) and also at the Township level (Some of the reviewers used the Township Steering Committee as a *good practice* that should be used/adapted/replicated in other sites). If the weaknesses have been described in length in the report, the achievements (that are probably more related to process than impact so far) are absent of the drafted document. This omission is unfortunate, as it had been achieved in a relatively limited amount of time, in a difficult environment, with decisive support of some governmental bodies (in Law Enforcement and Health Sector for instance).

Component 3 comments

1. In general, the document is strong on criticism (which component 3 is aware of) but weak on specific recommendations for taking things forward within the current Myanmar context. The review team has not fully taken into account the operating context.

2. The group worries that the review team did not take the information provided in the pre-review papers into account. By instance, the 7 page pre-review paper on Youth seems to have been ignored. Given C3 is sometimes referred to as the group which covers Youth issues, we would like to see more analysis on this population group.

3. The report has only 5 paragraphs on the component 3 while having multiple pages for others, e.g. the component 4. Only 5 paragraphs for Output 3 in the overall 51 page report is inadequate

4. The report did not highlight any of the current achievements or best practice, e.g. new modalities and links fostered to provide capacity to local organizations (e.g. Burnet CIH and CHR). The MTR recommended that a separate mechanism for supporting local organisations be developed. They seem to have omitted any description of existing mechanisms for grant projects and what they heard from the five local NGOs receiving grant funds. Although it is not explicitly recognised as a mechanism within the Joint Programme, both the Alliance and Burnet are playing the role of a grant making mechanism for local organisations.

5. No observation or analysis of youth or behaviour of youth was made, e.g. indicators to best capture the impact on youth behaviour not covered.

6. The report should provide options instead of single recommendation for a particular issue.

7. The report did not specifically mention the mechanism how to improve coverage.

8. Only a few of the group agree to abolish the component group.

Component 4 comments

1. Confusions and contradictory messages should be clarified, e.g. while suggestion to focus repeatedly and at the same time to increase coverage. Overall, a list of clear and context-sensitive recommendations, with priorities, would be appreciated.

2. Some in the group opposed a different funding criteria or mechanism for the national NGOs although the idea of providing technical support for and capacity building of the national organizations is strongly supported. It was suggested by some in the group to pool the technical resources currently available for local organization. Concern exist that the proposal for separate funding mechanisms for international and national organizations would lead to different thresholds for programme quality

3. The group felt that to abolish the component groups, it requires more analysis. There needs to be a structure similar to TWG. The TOR may need to be rewritten, the feed-back mechanism ensured, and different issues covered by ad hoc groups e.g. PMCT, HBC or ARV task forces

with the possibility to feed into policy. More detailed explanation on the proposed organizational structure and ToR for each new body proposed (because participants found interpretations even among this small group differed quite widely). The group, however, underscored impossibilities and concerns on the feasibility of management of the joint programme by a new international specialist agency to be established, with cost implication, and a different institution than UNAIDS.

4. Figures need to be verified with other organizations e.g. with NAP on PMTCT coverage. Concerns exist regarding the accuracy of figures in the paper throughout – and advice to check all, and particularly township health service figures with NAP

5. No mention of two out of the four 'prongs' of PMTCT strategy: prevention of primary infection of women and prevention of unwanted pregnancies in HIV infected women. This gives a skewed view of the achievements of the PMTCT programme. There is no quantitative information on these two 'prongs' but activities in these areas should be mentioned. Concern exists as well regarding how achievement so far of PMTCT programmes has been calculated (cf individual comments from UNICEF below). The report lacks as well a note that it is crucial to finalize national guidelines for PMTCT and VCCT for activity to increase.

6. The group 4, although, had no disagreement on the findings of the report overall.

7. It was reiterated that the review team has been assigned to provide options to improve the programme, and whether to choose an option, to implement it totally or partially should be decided by the IPs who have better understanding on the local context. Any agreements to change will have to be undertaken by the current governance structures

Component 5 comments

1. Insufficient recognition of what has been done so far, taking into account the constraints faced due to the Country's political situation. No understanding or recognition of the challenges the NGOs are facing; an insufficient balance was made in the statements, e.g. the report failed to acknowledge that the programme has been implemented only for 2 years.

2. At least 4 review papers were not reflected in the report (including "Workplace Policy" "Capacity Building" and "FHAM"). While some points from the pre-review papers were omitted some texts from the papers were included textually.

3. Insufficient representation of activities by local organization and by private sector (although covered in the pre-review papers). So were the diverse involvement of the government (e.g. that of the Education sector and the Railway ministry) and faith-based groups. Does not articulate voices of the NGOs – no courtesy to mention the names of the NGOs, action of Local NGOs missing. No mention of faith-based organizations (Christian, Buddhist and Muslim).

4. The report has no clear recommendations to the Component 5, whether its activities should be distributed among other components. The diagram (Page 23) showing the illustrative re-

structuring of Joint Programme and management and co-ordination structures is very vague. No mention of Component 5 is shown.

5. No useful guidance on how to provide technical capacity. It misses to point out the capacity and technical issues that the Joint Programme has been facing through FHAM experiences

6. The group worries on the potential damage that the report could do to the response. Ignoring the full picture from pre-review paper on FHAM, some unhelpful and misleading statements were made, e.g. on delay in disbursement, and low absorption capacity of the IPs by pointing out that 16 out of 19 projects in FHAM round 1 implementation had to take a no-cost extension. The reasons for No Cost Extension were complex and not only because of capacity (e.g. MoU, late start, etc.). The report could harm future funding potentials and therefore the group strongly disagrees with the statements. No mention of difficulties faced by FHAM projects, like delays in fund disbursements, fund flow, etc