FUND FOR HIV/AIDS IN MYANMAR

ANNUAL PROGRESS REPORT

(1 April 2005 - 31 March 2006)

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UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

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Foreword

During 2005, the third year of operations for the Fund for HIV/AIDS in Myanmar (FHAM), implementing partners continued expanding the coverage of services for prevention of HIV and for care and support for people living with HIV/AIDS. The report for 2005 shows that FHAM funding supported an intensified response to HIV in Myanmar in several crucial areas – anti-retroviral treatment, support for HIV-infected and -affected people and families, voluntary and confidential counseling and testing, and outreach to vulnerable populations. This year's report details the resources made available to implementing partners and the results they obtained, highlighting achievements in a number of areas. One result of these achievements has been that additional resources for FHAM were contributed during 2005 by the Government of the Netherlands and, shortly after the closing of this reporting period, by the Australian Agency for International Development (AUSAID).

In addition to the expansion of FHAM-funded activities, several other events made 2005 a key year in the response to HIV in Myanmar. The most important of these was an inclusive and participatory process carried out by the Government to launch a new national strategic plan for HIV/AIDS. A mid-term review of the United Nations Joint Programme for HIV/AIDS and of the FHAM endorsed initiatives to align both of these programmes more fully with the "Three Ones". In the critical area of funding, donors expressed interest in continuing to invest in Myanmar. In response to the end of funding from the Global Fund for AIDS, Tuberculosis and Malaria in August 2005, a group of donors – Australia, the European Commission, the Netherlands, Norway, Sweden, and the United Kingdom – agreed to set up a new "Three Diseases Fund" to support critical programmes, including for HIV, that had previously received funding from the Global Fund, FHAM or bilateral programmes. The FHAM will be subsumed under this new funding structure, which is to become operational in early 2007. Towards the end of the reporting period, in March 2006, the first external review of the National AIDS Programme in 15 years was undertaken with leadership from WHO and the support of the rest of the United Nations system.

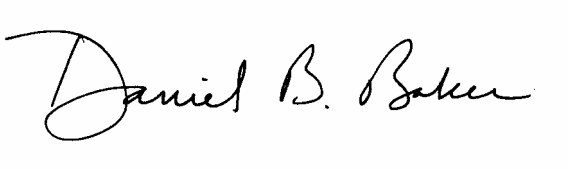
The investment of national and international resources in combating HIV in Myanmar is having an impact. Revised UNAIDS estimates suggest that the epidemic may have peaked in Myanmar at the beginning of the decade, which is indeed welcome news. However, the momentum achieved so far must be sustained, and it remains true that overall service coverage – the estimated percentage of people in need who are able to access prevention and care and support activities – remains unacceptably low. Among vulnerable populations, the most generous estimates suggest that up to 50 per cent of commercial sex workers are being reached by prevention activities, but this drops to something above 10 per cent for injecting drug users and a good deal less than 10 per cent for men having sex with men. Less than 10 per cent of the estimated number of people in need of anti-retroviral treatment are receiving it through the public health system.

One area that is still inadequate is the availability of voluntary and confidential counseling and testing services. The Government does provide such services in some localities and has recently granted approval for certain international non-governmental organizations (NGOs) to begin activities in this area, but coverage at the community level remains low. While general awareness-raising campaigns on HIV have improved tremendously in recent years, comparable with the scope of such programmes in other countries in the region, more could be done to make sophisticated use of the mass media – especially television – to address the multiple challenges that the HIV epidemic poses for Myanmar society as a whole. The new national strategic plan recognizes these and other needs and sets out strategies to address them.

What is needed – especially in this year of "Universal Access" – to increase service coverage in Myanmar? The first priority is for continued and expanded financial resources. Even with the projected contributions from the Three Diseases Fund, it is estimated that there will be a slight decline in international assistance in 2007 as compared to 2006. International donors need to examine their priorities and see what more could be done, realizing the regional and global implications if recent gains in addressing the epidemic in Myanmar falter. If such assistance is not forthcoming, the necessary scaling up of activities, as outlined above, will not be possible unless the Government is able to increase its own budgetary allocations for combating HIV/AIDS. Such allocations would be required not only in the health sector but in other social sectors as well, such as education and social welfare.

A second priority is to involve more actors in the response to HIV in Myanmar. Non-governmental actors are proving to be effective in reaching vulnerable populations, and their activities need to be buttressed by the support of the Government so that they can reach as many communities as possible. Thirdly, more research is required to help better understand the evolution of the epidemic in order to guide the response. The serological surveillance system in Myanmar is one of the oldest in the region and thus provides helpful trend data, but it needs to be updated and buttressed by a variety of studies and research – by all partners – that help explore critical behavioural issues.

The members of the United Nations Theme Group on HIV in Myanmar (FAO, IOM, UNDP, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO and the UNAIDS Secretariat) are proud of the demonstrable achievements that the FHAM has made. Support from the FHAM has resulted in real services accessed by people who require them urgently. We would like to thank all of those donors who have supported the FHAM in the past and to express our appreciation for the commitments that have been made thus far to the new Three Diseases Fund. We would encourage the international donor community as a whole to examine how their support could be used to make a difference in the lives of the people of Myanmar: their needs are certainly great but, as the FHAM has shown, progress can be made.



Daniel Baker,

Chair, UN Expanded Theme Group on AIDS

Introduction

This report presents the achievements of implementing partners of the Fund for HIV/AIDS in Myanmar (FHAM) for the fiscal year 01 April 2005 to 31 March 2006. This report is neither, therefore, a report on the HIV epidemic, nor a report on the wider national response to the epidemic in Myanmar.

The FHAM was established in 2003, and in the fiscal year 2005, donors contributing to the FHAM were the United Kingdom's Department for International Development (DFID), Sweden's Agency for International Development Cooperation (SIDA), and the Governments of the Netherlands and Norway.

This fiscal year 2005 report covers the second year of implementation for projects funded in Round II of the FHAM, and the first year of implementation of Round II(b) of the FHAM. At the beginning of 2005, the FHAM issued a more targeted call for proposals for Round II(b) of funding, with a focus on scaling up activities to reach key populations at higher risk of exposure to HIV with prevention services. These key populations comprise sex workers, injecting drug users, and men who have sex with men. Round II(b) of the FHAM also had as an aim increased access to AIDS care and support.

Funding rounds of the FHAM and their duration.

FHAM funding 'Rounds'	FY 2003	FY 2004	FY 2005 (this report)	FY 2006
Round I				
Round II				
Round II(b)				

During this year, the existing donors to the FHAM, with the European Commission and Australia's AUSAID, made a commitment to establishing a Three Diseases Fund to respond to AIDS, tuberculosis and malaria in Myanmar. This funding mechanism will supersede the FHAM. Therefore, instead of making a further round of funding under the FHAM, existing projects funded by Round II (which was due to end on 31 March 2006), and with track record of performance, were given the option of extension beyond 1 April 2006, using unallocated FHAM resources. This was with the aim of ensuring uninterrupted delivery of essential services until the new fund is operational. At the time of printing, it is expected that the Three Diseases Fund will be operational on 1 April 2007.

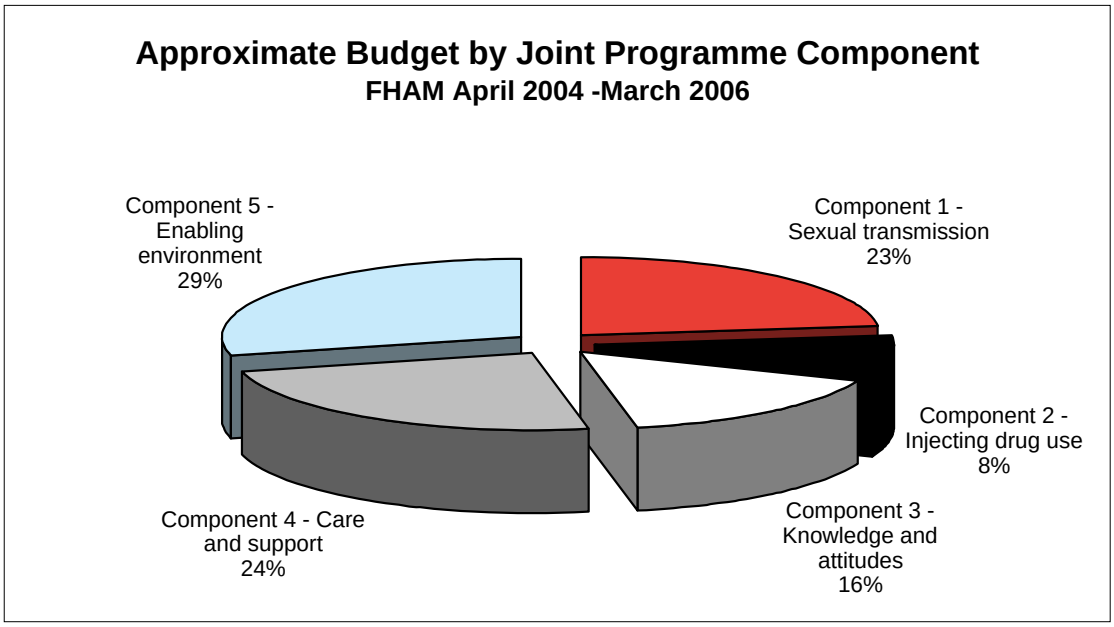
During this reporting period, the FHAM continued to operate within the contextual framework of the United Nations Joint Programme on HIV/AIDS in Myanmar. The Joint Programme identified five priority areas (Components) for action, with five primary outputs:

1. Access to services to prevent the sexual transmission of HIV improved
2. Access to services to prevent transmission of HIV in injecting drug use improved
3. Knowledge and attitudes improved
4. Access to services for HIV care and support improved
5. Essential elements of the enabling environment for an effective expanded national response strengthened

The lifespan of the Joint Programme initially was planned for the period 2003-2005. However its governing body, the UN Expanded Theme Group on HIV/AIDS, agreed in

December 2005 that the national response would continue to be resourced and monitored using this framework until the new National Strategic Plan on HIV had been established, and a new funding mechanism was operational.

An estimate of the total FHAM budget allocated to each of the above Joint Programme Components is represented in the figure below.



While the Joint Programme aimed in the context of Component 5, "to strengthen the essential elements of the enabling environment for an effective expanded national response" - through advocacy, improving monitoring and evaluation, capacity building, and improved coordination – for the purposes of this report, aspects of the above strategies have been mentioned in connection with the specific Components 1 to 4. For example, training for health care professionals on substitution treatment for injecting drug users has been reported in the related output, prevention of transmission of HIV in injecting drug use. Non-exhaustive lists of FHAM-funded research (reviews, surveys and studies) and manuals and guidelines developed that have not been mentioned in earlier sections are included as an annexe.

Highlights in Achievements

The fiscal year 2005 of the FHAM has been characterised by a scale-up in service provision for HIV prevention and AIDS care in Myanmar by FHAM implementing partners.

1. This year has seen a renewed focus on populations most at risk of infection with HIV, facilitated by the reinforcement round II(b) of the FHAM.
    a. 2,585 injecting drug users reached through FHAM projects, an increase of 61% on last year. Two drop-in centres and one outreach project were opened this year, bringing the total of FHAM funded locations to seven.
    b. 324,479 people at higher risk of infection reached through 63,233 HIV prevention education sessions, an increase of 70% for both people reached and sessions held on last year.
    c. Five new drop-in centres have been established to reach sex workers and men who have sex with men, and have been well frequented.
2. The number of individuals receiving antiretroviral therapy in FHAM-supported projects has increased more than four-fold this year, to 2,953 at the end of March 2006. Nonetheless, this remains much below the estimated needs in antiretroviral therapy.
3. Provision of home-based care has seen steady scale-up during this year to reach 5,785 persons, an increase of approximately 175% on the previous year.
4. Methadone treatment was made available near the end of this reporting period. The start of the methadone programme in Myanmar represents a significant milestone in service provision for the particularly vulnerable population of injecting drug users, both in prevention of HIV transmission and also the hope of greater access for this population to AIDS care services including antiretroviral therapy.
5. 37,800 individuals received HIV test results this year, completing the voluntary counselling and confidential testing process, an increase of 19% on the previous year. By the end of this reporting period, in-house HIV testing had been authorised for two eligible INGO partners, representing a positive change in regulations.
6. Total condom distribution increased by 30% on the previous year, with 42.6 million condoms distributed, either through social marketing or distribution free-of-charge.
7. Needle and syringe exchange to injecting drug user beneficiaries of FHAM-supported projects increased over three and a half times on the previous reporting period, to reach 156,000 in this year. All projects provide for return of used injecting equipment for safe destruction.
8. The number of clients treated for reproductive tract infections during this year rose by 14% to 155,000. This is widely thought to reflect an increase in providers of quality treatment and related awareness of services, as prevalence has been shown to have decreased.
9. The number of workplaces with HIV policies and programmes with support from the FHAM has increased to 41 from 25 last year. The number of trained peer educators involved in workplaces increased 75% on the previous year to 838.
10. Services for the prevention of mother to child transmission of HIV have been established in 14 additional townships, bringing the total of FHAM-supported townships to 26.

A number of achievements were made in support of the response to HIV.

11. An HIV demographic impact and projections workshop, organised during this period and facilitated by regional experts, permitted revision and updating of the estimation of the HIV epidemic in the country and in particular a more accurate estimation of the number of people living with HIV. This has had important implications in the estimated needs for antiretroviral therapy, and programmatic implications for prevention of mother to child transmission. This exercise also identified critical gaps in information, including a lack of data on men who have sex with men, and on injecting drug users. Some specific weaknesses in the current HIV surveillance system were highlighted for strengthening. The findings of this estimation have been taken into consideration in the development of the National Strategic Plan that started in 2006.
12. A planning process was completed to ensure stop-gap funding from 1 April until end November 2006 for projects funded through Round II of the FHAM, in anticipation of the availability of the new Thee Diseases Fund. Projects had to have demonstrated sound performance to date to be eligible for extension.

Progress and Achievements

Access to services to prevent the sexual transmission of HIV improved

Seventeen projects funded by the FHAM have been working for the prevention of sexual transmission of HIV (Component 1 of the Joint Programme). The two main outputs are increased access to condoms and increased capacity for the prompt and effective management of Sexually Transmitted Infections (STI).

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

Implementing Partners: NAP, AMI, Alliance, AHRN, Consortium, Malteser, MSF-H, MSF-CH, MANA, MBCA, MRCS, MRT, Partners, PSI, PGK, SC-US, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
1.1 Access to affordable condoms for sexually active men, women and young people increased			
Number of condoms distributed	32,867,486	42,616,027	75,483,513

Access to affordable and quality condoms remains a key objective of the response to HIV in Myanmar and FHAM funding has contributed to the distribution of 42.6 million condoms in the fiscal year 2005. This represents a 30% increase on the year before. It should be noted that the 42.6 million comprises 32.5 million distributed by Populations Services International (PSI). PSI uses FHAM funding to support the distribution and marketing of all condoms, but the condoms are purchased using funds from multiple sources. This year approximately 12 million condoms were purchased with FHAM funds, and 20 million using other funding.

In total, 17 implementing partners have provided condoms, including free distribution to key populations at higher risk of infection and to young people, as well as the social marketing of affordable male and female condoms and lubricants nationwide. FHAM has supported the expansion of the 100% Targeted Condom Promotion programme implemented by the National AIDS Programme (NAP) in 88 of the 154 townships covered.

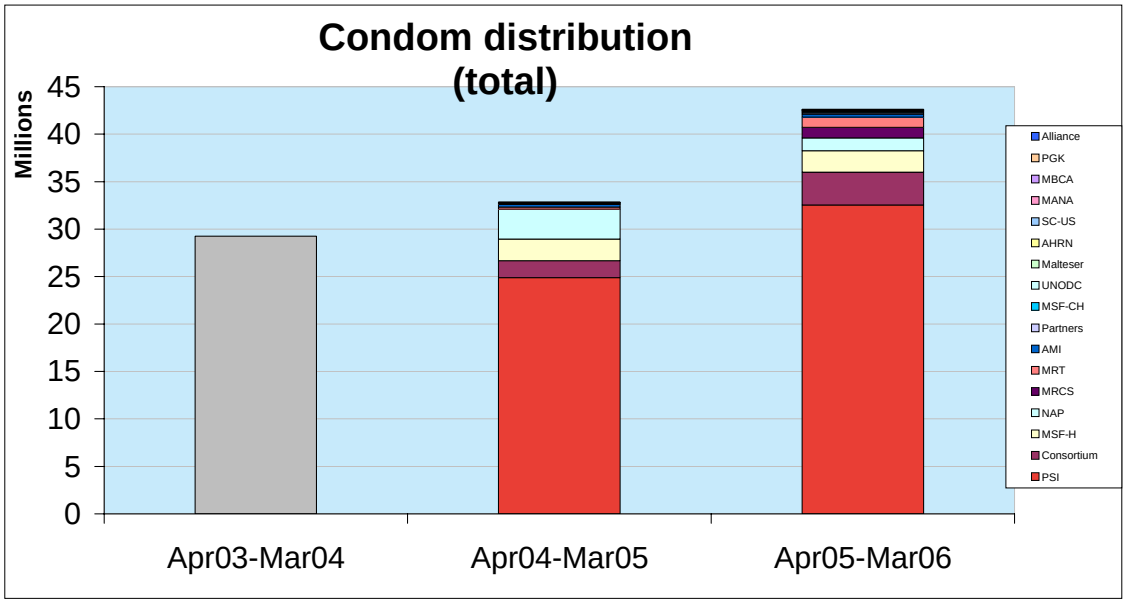
Continuing the trend seen in previous years, free distribution and social marketing of condoms increased in this year (chart 1.1). Condom sales through social marketing were reportedly 30% higher than last year. Corresponding increases in sales of female condoms (45%) and lubricants (51%) were also reported by PSI.

Condoms have been distributed in both urban and rural areas to groups including sex workers, their clients, men who have sex with men, STI treatment seekers, male mobile workers, seafarers, and in the workplace. Condoms have also been distributed in AIDS care and support projects, promoting condom use by people living with HIV in a 'Positive Prevention' strategy.

Partners have established supply systems with outlets in a wide range of locations including brothels, beauty salons, hostels, restaurants, tea shops, betel nut sellers, cinemas, billiard halls, bus terminals, trishaw stations and through midwives. Efforts have been made to improve availability and accessibility of condoms, including in

areas where people may go to look for sex. Distribution methods included social marketing by PSI at selected and strategically located retail outlets, and provision through PSI peer workers to sex workers and men who have sex with men. Peer educators distributed condoms free of charge in the workplace (MBCA, MRT, PARTNERS) to sex workers (AMI, PGK), and to youth (MRCS). Condoms were also distributed free of charge to highway truck drivers (Malteser, MRT). During the course of field monitoring visits to FHAM-funded projects, several partners reported that sex workers expressed preference for flavoured condoms, and that procurement of flavoured condoms had been increased accordingly. Some partners have reported low uptake of female condoms, however PSI's sales in social marketing were up 45% on last year. Partner projects have also been providing education on proper use of condoms, including use of games and contests to educate on safer sex including condom use, especially in rural communities and in groups of young women. One partner, the Myanmar NGO Consortium on HIV/AIDS (Consortium), reported advocacy with religious leaders in rural areas to create an environment where condoms are more accessible and acceptable for youth.

Chart 1.1

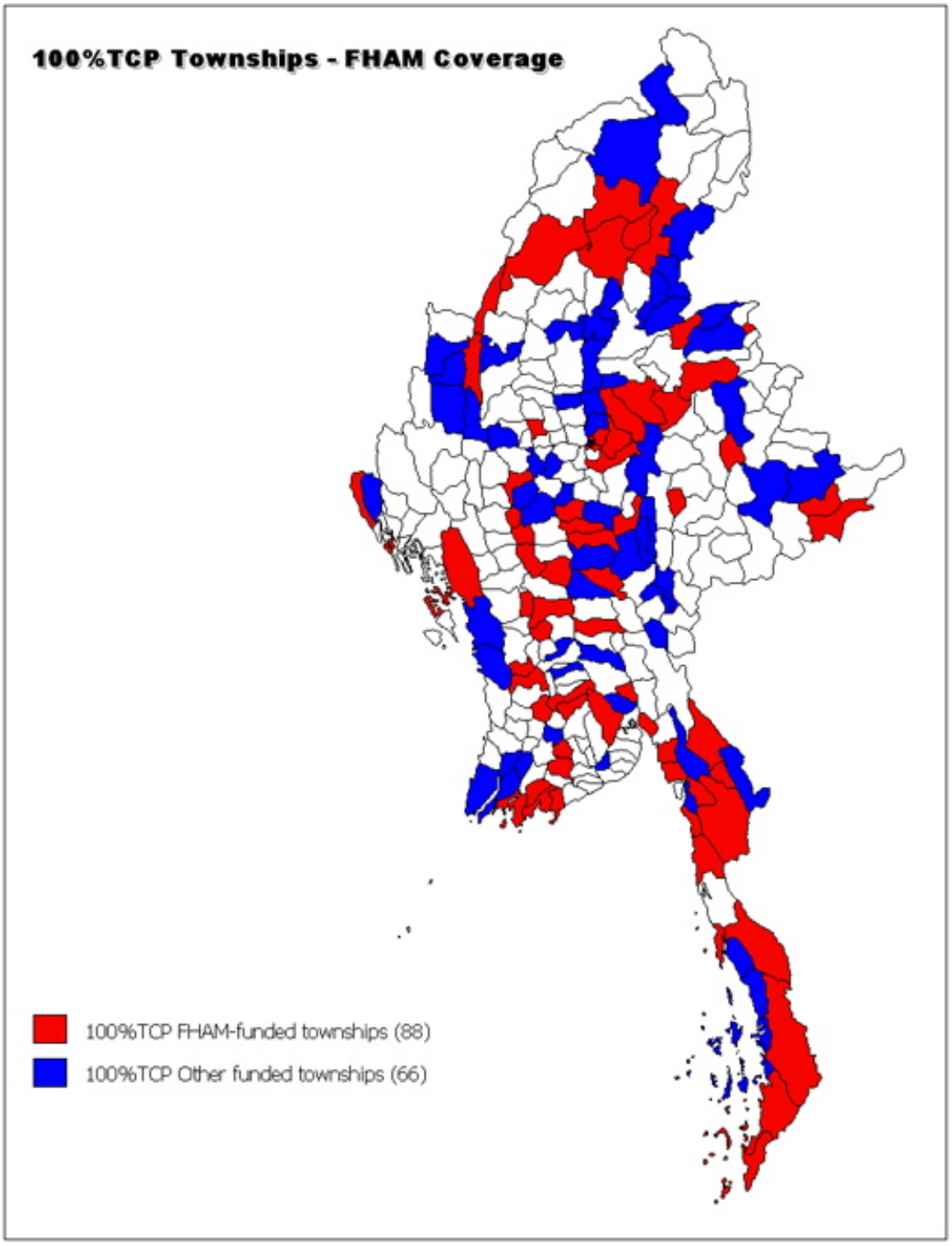


Although per capita condom consumption in Myanmar has increased four-fold over the last five years to around 0.9 condoms per capita in 2005, consumption remains less than that of Cambodia, Nepal or Thailand (around 2 per capita).[1]

An external, 2-week review of the 100% Targeted Condom Promotion (100% TCP) programme was held in July 2005 with the participation of international experts from WHO and the NGO sector with recognised experience in programmes for sex workers and 100% Condom Use programmes in Asia. Seven 100% TCP townships were visited, and findings with recommendations were shared during a dissemination meeting with all stakeholders. The report stated "the review team had the impression that there was a considerable variability in the performance of the 100% TCP programme in the different townships visited. Performance seems to vary with the maturity of the programme at township level (with good results observed in townships which were included in the pilot phase), but even more so, with the intensity of relevant programme inputs at the township level, and with the degree of ownership and cooperation of local stakeholders, and most particularly, senior law and order

[1] Source: NAP M&E unit

officials".[2] During 2005 the National AIDS Programme substantially increased the number of townships participating in the 100% TCP to 154. In 2006, WHO and UNFPA are supporting the National AIDS Programme for implementation of the Review's recommendations.



[2] *External Review of the 100% Targeted Condom Promotion (100% TCP) Programme; Findings and Recommendations of the Review Team*; MoH/WHO, Myanmar, July 2005

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

Implementing Partners: NAP, AMI, Alliance, Consortium, Malteser, MSF-H, MSF-CH, MBCA, MRCS, MRT, PSI, PGK, SC-US			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
1.2 Capacity of both private and public sector health facilities for prompt and effective management of STIs improved			
Number of clients to STI services	178,391	209,839	388,230
Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counselled	136,177	154,979	291,156
Number of service delivery points (SDP) providing integrated STI services	128	578	578
Number of referrals to STI services	231	858	1,089

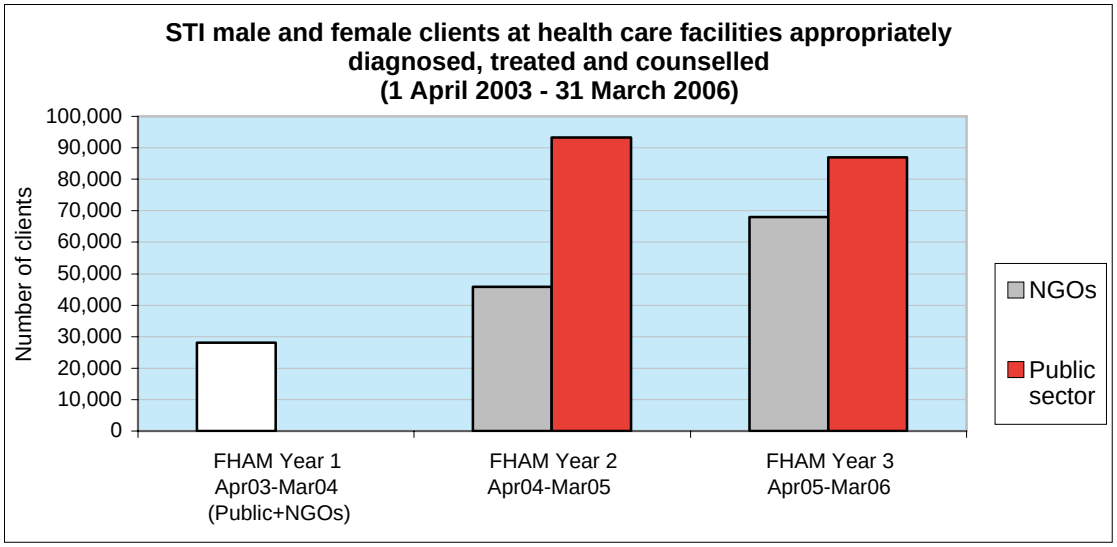
Nine FHAM implementing partners are working for provision of quality treatment for STIs, and the number of service delivery points offering treatment based on national guidelines has now increased to 578 by the end of March 2006. This includes 353 in the public sector, consisting of township hospitals and the National AIDS Programme's AIDS/STD teams service delivery points in 44 townships. In the public sector, existing service delivery was strengthened through the provision of training and medical supplies to the 44 STD/AIDS teams of the National AIDS Programme, and to 310 township hospitals countrywide. Referral systems for the treatment of STIs were noted during site monitoring visits, with implementing partners referring clients to the public sector and NGO clinics for free-of-charge treatment, as well as to general practitioners of the PSI-supported Sun Quality Clinics network.

The seven implementing partners directly providing STI treatment services in public and private health facilities diagnosed and treated a total of 154,979 cases of STI during the period (chart 1.2), representing an increase of 11% on the previous year. Over half of the total cases were treated in the public health facilities through the NAP. Not-for-profit private facilities screened and treated higher number of cases than planned in their original targets and have observed an increasing demand for STI treatment services. This is widely considered to reflect increased awareness of treatment availability, as opposed to any increase in STI prevalence.[3] One partner reported that the largest increase in clients accessing STI services was noted for the 25-49 years age group, followed by the 15-24 years group.

The Sun Quality Clinics is a network of private general practitioners supported by PSI, which provides STI treatment according to national guidelines, and along with health education, condom promotion and referral/treatment for sexual partners. Treatment in the form of pre-packaged kits is available through the network. Each kit consists of a single course of syndromic treatment for either ulcerative or non-ulcerative conditions, and is packaged with condoms and a referral card. Kits are affordably priced and are well accepted by clients. At the end of March 2006, there were 179 general practitioners in the Sun Quality Clinic network providing STI treatment services, a 64% increase on March 2005. Approximately 40% of the 31,000 clients treated through this network were female.

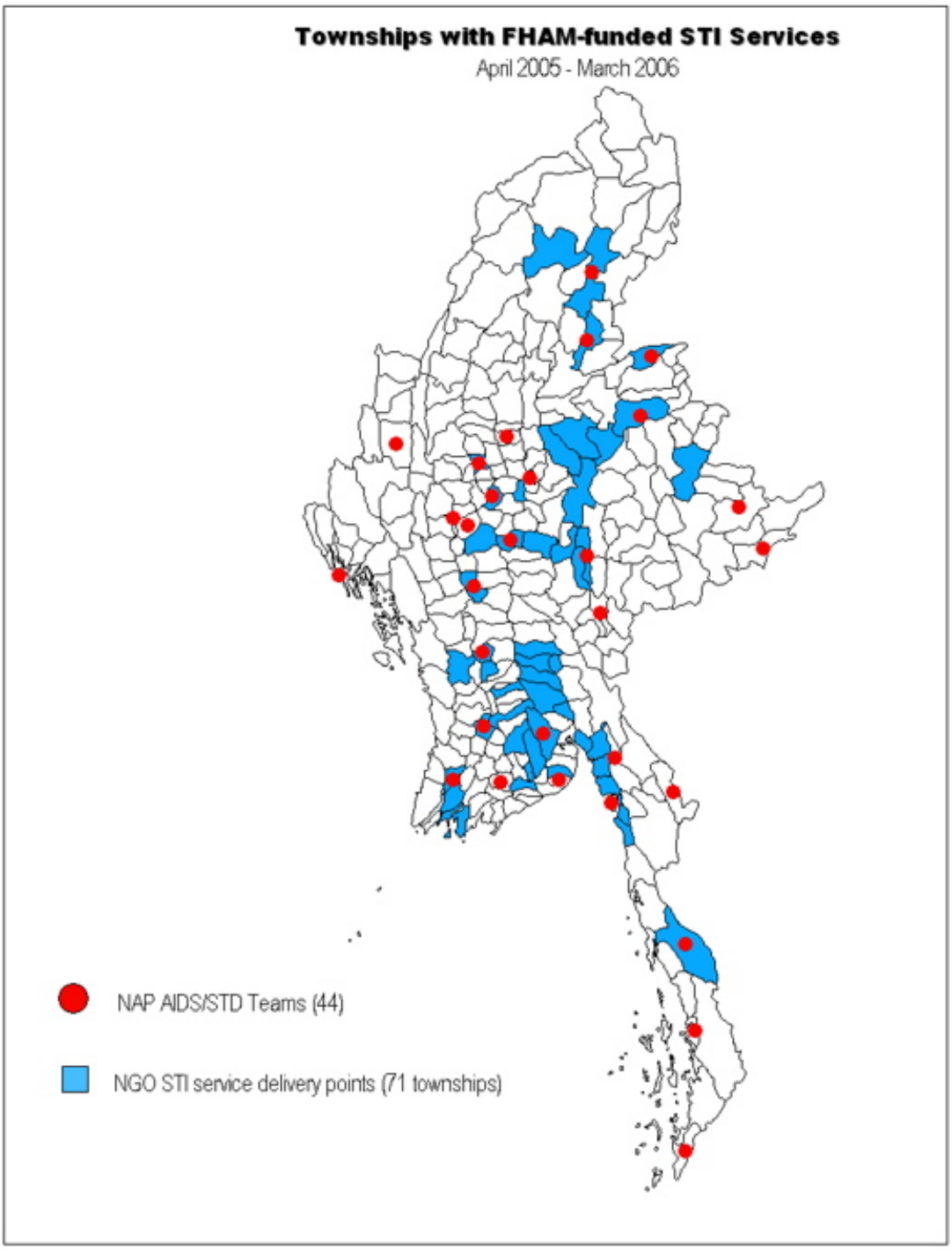
[3] A steadily declining trend in the prevalence of syphilis in pregnant women over a 12-year period was confirmed in a workshop on projections and demographic impact of the HIV epidemic in Myanmar, held in September 2005 by the National AIDS Programme with support of WHO, UNAIDS and the FHAM.

Chart 1.2



Some STI treatment is provided through outreach, especially towards sex workers, some of whom find it difficult to access clinics, either because of their working hours or for fear of stigma and discrimination. High prevalence of self-medication was mentioned as a constraint, and one partner reported that this led to lower numbers of clients than expected presenting for treatment at clinics. Periodic law enforcement closures of brothels and entertainment venues hindered implementation with sex workers, and contributed to the mobility of this population. It was reported that sex workers are highly mobile, moving from town to town every few months, presenting a challenge for follow up of STI treatment.

During the course of field monitoring visits by UNAIDS Secretariat FHAM team, it was noted in some areas that Township Medical Officers and AIDS/STD team leaders were reluctant to collaborate with INGOs, while in other areas there was evidence of collaboration and referral.


Townships with FHAM-funded STI Services
April 2005 - March 2006
NAP AIDS/STD Teams (44)
NGO STI service delivery points (71 townships)

Access to services to prevent transmission of HIV in injecting drug use improved

In this period, seven implementing partners have been working to increase access to services preventing transmission of HIV among injecting drug users (Component 2 of the Joint Programme). They comprise two government departments (CCDAC, DoH), two United Nations organisations, two international NGOs and one national NGO. Partners address the aims of this component either by direct service delivery, for example through outreach activities and drop-in centres (AHRN, CCDAC, MANA, UNODC), or through provision of technical assistance and coordination (NAP, BI-CHR, UNODC, WHO).

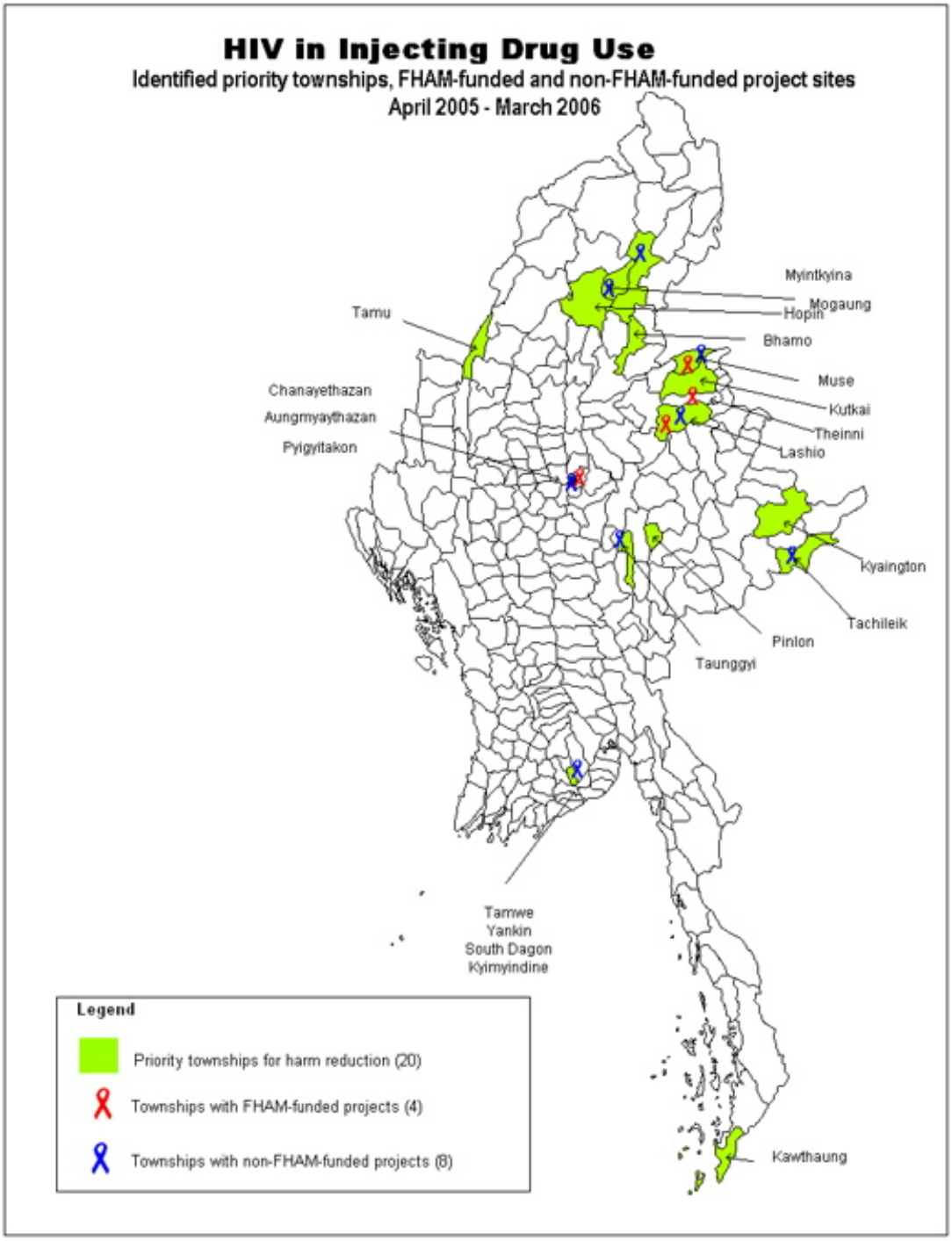
Access to harm reduction interventions increased

Implementing Partners: AHRN, MANA, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
2.1 Access to harm reduction interventions increased			
Number of needles and syringes distributed to IDUs	43,389	156,009	199,398
Number of needles and syringes returned	--	63,885	63,885
Number of IDUs reached through outreach workers or DIC	2,874*	2,585*	5,459
Number of IDU drop-in centres functioning	4	6	6

**Indicator was redefined from 'clients of DIC' to 'IDUs reached' in April 2005.*

Six drop-in centres for drug users have been operational this year in Northern Shan State, with support of the FHAM, an increase of two centres during this period. Five projects are based in Lashio township, where AHRN and UNODC operate one centre each in Lashio town, and MANA operates three centres in both urban and rural areas of the township. The sixth project was established in Muse in 2005 through a UNODC subcontract to MANA. In Lashio township, implementing partners operate within a system of allocation of wards, with access to drug users within the allocated ward. MANA previously operated one FHAM-funded drop-in centre in Tamwe township, Yangon, which was closed in 2005 to re-open later with alternative funding.

FHAM-funded outreach or drop-in centres reached 2,585 injecting drug users during this period. The relevant indicator was redefined in April 2005 at the start of Round II(b), from 'number of clients to injecting drug user drop-in centres' to 'number of IDUs reached through outreach workers or drop-in centres' to better capture the actual number of injecting drug users reached among clients of centres (and excluding non-injecting users, and family members accessing services, who are recorded separately). The 2,874 clients that were reached through drop-in centres in the previous year were not exclusively injecting drug users, as the figure also included some non-injecting drug users and family members.

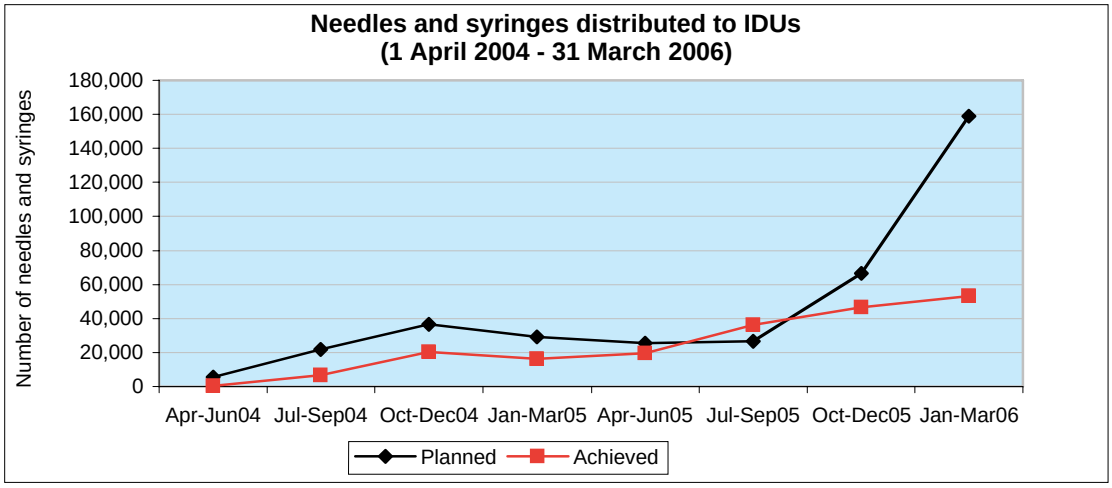


Significant expansion occurred in the area of needle and syringe exchange this year, with 156,000 needles and syringes distributed with FHAM funding, compared with 43,400 in the previous year (chart 2.1).[4] Return rates of used injecting equipment in the range of 60-80% have been reported, varying between projects. Chart 2.1 reflects the scale up of needle and syringe exchange planned in the targeted scale-up Round II(b) of the FHAM. It also reflects the reality that implementing partners have not been granted permission to initiate projects in new priority harm-reduction locations as planned, and as such have been unable to reach the targeted level of needle and

[4] The majority of needles and syringes distributed in Myanmar are provided with other funding. National M&E unit reports that 1.1 million were distributed in 2005.

syringe exchange, with a significant and widening gap between target and achievement at the end of this reporting period.

Chart 2.1



Services addressing HIV transmission through drug use were identified as a priority for scale-up in the reinforcement round II(b) of the FHAM. However, access to some identified priority locations, mostly in border areas, has not yet been authorised. Initial priority areas have been substituted with other areas (eg. Theinni for Kutkai). This had an effect of delaying planned implementation by many months.

Projects continued to provide services including counselling, health education on the prevention of HIV transmission and safer sex behaviour, condom distribution, primary health care, and needle and syringe distribution. Some partners also provide sterile water, disinfectant and alcohol swabs. All projects have provision for return or collection of used injecting equipment for safe disposal. Clients of drop-in centres include partners and family members of drug users, who are able to access medical and other services in the centres. Some projects provide recreational activities and facilities.

Drop-in centres are complemented in each location by an outreach project to contact drug users within the community. Various strategies have been employed this year to reach more drug users in the community. While mobilisation of peer educators from among drug users was possible, it proved a challenge and could not be implemented to the extent hoped for. In general it was difficult to gain endorsement of this strategy by law enforcement counterparts. One partner reported that collection of used and discarded injecting equipment by a “needle patrol” proved to be a less sensitive means of integrating drug user and ex-drug user volunteers into project implementation, and had a positive impact in garnering community support. In an effort to better match workers and clients, one partner selected outreach workers from the same community as where they would be doing outreach. A team of social volunteers was also recruited to support the project in the community through neighbourhood meetings and advocacy with local authorities. AHRN reported that holding health education sessions for people in the wider community, including distribution of condoms and IEC materials, was a useful means of advocacy and community mobilisation. Outreach workers refer clients to the project drop-in centre for counselling and for primary health care services, and clients may be referred onwards as needed to the AIDS/STD team or MSF-Holland for confidential HIV testing, to other health facilities (eg. TB clinics) and to the Drug Treatment Centre. It was reported that in areas where projects aimed

at HIV and drug use are being implemented the general public has made significant progress in understanding the importance of harm reduction.

One outreach project has been initiated by UNODC on a mobile basis – without the presence of a drop-in centre – in Theinni township, Northern Shan State. UNODC plans to open a drop-in centre in Theinni, and another in Tachileik in Eastern Shan State in mid-2006.

In 2005, the FHAM project with Central Committee for Drug Abuse Control (CCDAC) was signed after more than a year's discussions, which were interrupted in part due to a change in Minister. Activities began in the latter half of 2005. By the last quarter of the fiscal year (January 2006), however, two issues had arisen: firstly, the project was under-performing in terms of targets and the separate project management unit model was not working very productively; secondly, reacting to the issuance of new guidelines by the Government, the Ministry of Home Affairs initiated a general freeze on its relations with international partners. All memoranda of understanding that the Ministry of Home Affairs had with NGO partners were suspended in late January. Subsequent communications confirmed that activities could continue until greater clarity permitted permanent solutions. By the end of the fiscal year, all activities were still continuing, although their future was less secure than it had been before. As a result, after discussions with CCDAC, the FHAM Management Committee Chair sent a letter to CCDAC suspending the activity. As it is in the interest of the Joint Programme and the FHAM to do its utmost to keep CCDAC and the Ministry of Home Affairs engaged as a critical partner in the AIDS response, the FHAM Management Committee has agreed to reserve the funds until further review and encourage UNODC to organize a new design mission to look at technical assistance and programme support needs for the Ministry of Home Affairs.

During this period of implementation, the CCDAC was able to initiate a Project Steering Committee, which united multiple governmental sectors, and to establish four working committees to address rehabilitation centres, activities in the Myanmar Police Force, prisons, and alternative sentencing. The CCDAC succeeded in amending the admission criteria so that HIV-positive beneficiaries could register at rehabilitation centres, and publish new admission criteria to share with stakeholders. The CCDAC was also able to commence three vocational training courses within one rehabilitation centre, with 111 trainees benefiting.

In addition to direct service provision, a number of initiatives for coordination, capacity building and facilitation of implementation have been ongoing this year. ‘Drug Use and HIV’ (formerly Component 2) thematic group meetings have been held regularly in Yangon, and monthly Township Steering Committee meetings support a transparent and coordinated approach in project implementation at the local level. UNODC’s Technical Coordination Unit (TCU) centrally managed procurement of needles, syringes, condoms and other materials for distribution to Component 2 implementing partners, with bulk purchasing, and planning and logistical support.

Several technical tools and guidelines have been produced. Supported by Burnet Institute’s Centre for Harm Reduction, partners have worked closely to develop a training database and a standardised M&E system for harm reduction service providers. Burnet Institute developed a Harm Reduction Operations Manual for Myanmar in consultation with all harm-reduction implementing partners, who were testing it in the field at the end of this reporting period. Translation of such technical resource documents on harm reduction into Myanmar language was reported by implementing partners to be quite difficult, as it required specialist knowledge of technical terminology that few people have. Primary Health Care guidelines for

injecting drug users were developed through collaboration between WHO and the Department of Health, and through a series of consultations with NGOs in order to incorporate the collective existing knowledge and experience in primary health care provision for injecting drug users in Myanmar. The guidelines are pending approval by the Ministry of Health prior to dissemination to all service providers in public and NGO sectors.

As harm reduction and outreach activities targeting injecting drug users are still relatively new concepts for Myanmar, many project staff require coaching and close supervision in the field for proper implementation. Formal training sessions as well as informal mentoring and training were carried out by AHRN, Burnet Institute and UNODC as technical assistance to organisations working in harm reduction. Training topics have included a range of technical subjects:

> harm reduction, needle and syringe exchange programmes, peer education, confidentiality, drug counselling, behaviour change communication, outreach, communication with drug users, counselling for HIV testing (with NAP), ward-level advocacy;

as well as a range of related skills:

> team building, project management and planning, conflict resolution, strategic planning and problem solving, data collection, database management, report writing.

A baseline assessment and other groundwork for the establishment of a new drop-in centre/outreach project were carried out in Kutkhai township. However, despite the township's designation as a priority area for harm reduction interventions, permission for implementation was eventually denied.

One medical officer from the NAP successfully completed a diploma programme in Australia on public health with focus on harm reduction programmes. He has now returned to the NAP and is facilitating trainings on different aspects of harm reduction for other staff at NAP and the Department of Health.

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

Implementing Partners: AHRN, MANA, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
2.2 Access to and quality of drug treatment in institutional and non-institutional settings improved			
Number of IDUs having completed detoxification treatment	0	40	40
Number of IDUs receiving maintenance substitution therapy	0	12	12
Number of IDUs referred for drug treatment (detox and substitution)	35	80	115

FHAM implementing partners AHRN, MANA and UNODC referred 80 injecting drug users for drug treatment (detoxification or methadone substitution) at the Department of Health's Drug Treatment Centres this year, compared with 33 last year, although planned for 212 beneficiaries. Reasons cited for underachievement were the later than planned availability of methadone, and that drug users are said to prefer drug treatment on a community, out-patient basis instead of the long-term inpatient approach. Regulations regarding the registration of drug users were reported to

reduce access to rehabilitation programmes. Three partners had planned to implement methadone treatment, but this had not yet been possible due to delays in the procurement and importation of the methadone. Nonetheless, by the end of the period, the first 12 beneficiaries referred by UNODC's Lashio Outreach Project had been able to start methadone treatment within Department of Health's Drug Treatment Centre in Lashio, with methadone procured by WHO using other funds to support the start-up of the programme. Towards the end of this reporting period, the Department of Health's Drug Treatment Centres of Yangon, Mandalay, Lashio and Myitkyina started provision of methadone substitution therapy. The start of the methadone programme in Myanmar represents a significant milestone in service provision for the particularly vulnerable population of injecting drug users, both in prevention of HIV transmission and also the hope of greater access for this population to AIDS care services including antiretroviral therapy.

With FHAM resources, WHO was able to provide technical support to the Department of Health for the implementation of methadone treatment. During this year, the Ministry of Health approved the technical guidelines on methadone maintenance therapy for prescribers and dispensers. The guidelines, including a booklet for patients, were rolled out in conjunction with a series of advocacy and technical trainings as a preparation for the start of methadone treatment, with the participation of international experts in this field. As part of capacity building, WHO also organised training of trainers for 20 methadone prescribers and dispensers working in several Drug Treatment Centres and NGO programmes. One NGO, *Médecins du Monde* participated in the trainings and subsequently received the authorisation to become dispensers of methadone at their drop-in centres in Kachin State. The participation of NGOs providing services for injecting drug users in the methadone substitution programme is considered key to ensure a comprehensive approach in support to the needs of patients enrolled in the programme, and long-term treatment adherence.

Lessons learnt, as reported by partners working to reduce the harm associated with drug use.

- Provision of income generation activities will aid the rehabilitation and reintegration of drug users in the long term.
- Provision of primary health care services to drug users and their families is an aspect of implementation that is well accepted by community members. This has been considered when expanding coverage to new locations.
- Research suggests that use of amphetamine type stimulants is becoming more prevalent, and that this is linked with unprotected sexual behaviour. Some agencies are now starting to develop strategies to include HIV prevention services for users of these drugs.
- Transparency with local officials alleviates concerns and fears, and facilitates implementation. Continuous and persistent efforts in formal and informal advocacy towards authorities at all levels are essential for smooth implementation. The vital link between public health and law enforcement is vulnerable in Myanmar at present. The recent suspension of INGO MoUs with the Ministry of Home Affairs will increase the difficulty in gaining access to target locations for harm reduction, such as prisons and rehabilitation centres. Existing leaders in harm reduction in Myanmar will need broad and evidence-based support to advocate, at the highest levels of international cooperation, for harm reduction and international partnerships in service delivery.

Knowledge and attitudes improved

Increased awareness of the mode of transmission, means of preventing HIV, and perception of personal risk in the general population, in three key populations at higher risk (sex workers, injecting drug users, men who have sex with men) and among youth, are planned outputs of Component 3 of the Joint Programme. Activities also aim to improve attitudes in the general population towards those living with or affected by HIV.

With the start of Round II(b) of the FHAM, there was an increased focus on reaching population groups at a higher risk of HIV infection - primarily injecting drug users, sex workers and men who have sex with men. Certain mobile populations are also considered to be at a higher risk, and some implementing partners have provided services accordingly, for example for male migrant workers.

Seventeen implementing partners funded by the FHAM are working to improve the knowledge, perception of personal risk and attitudes towards HIV infection. Key outputs currently tracked include health education sessions conducted, peer educators trained and involved in programmes, and people reached through education sessions.

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

Implementing Partners: NAP, AMI, AHRN, Consortium, Malteser, MSF-H, MSF-CH, Partners, MBCA, MRCS, MRT, PSI, PGK, UNFPA, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
3.1 Knowledge of modes of transmission, perception of personal risk, and attitudes regarding HIV/AIDS and those living with and affected by HIV/AIDS, improved among the general population			
Number of health education (HE) sessions on HIV/AIDS conducted	41,468	57,697	99,165
Number of mass awareness sessions held [video shows/TV spots aired]	1,323	2,196	3,519
Number of IEC materials distributed to general population	3,384,392	1,121,145	4,505,537
Number of peer educators trained and involved in workplace education	481	838	838

Ten implementing partners were working to increase the knowledge of HIV in the general population. During the reporting period, 57,697 sessions were held to deliver health messages on HIV for the general population, compared with 41,468 on the previous year. Festivals, World AIDS Day activities, competitions, public talks, video shows, exhibitions and displays are the main awareness raising activities conducted to reach the general population. These events are important to help reach those at lower risk of infection, to increase understanding in the broader population, to reduce the stigma associated with HIV and to communicate messages about the disease, modes of transmission, and how services can be accessed. In addition, there were 2,196 mass awareness video showings, compared with 1,323 on the previous year, with the majority held by PSI using mobile video units transported by truck or boat, and reaching an average of 300 viewers at each showing. The NGO 'Partners' reported being able to hold sessions in teashops, markets, peer educators' homes and with some faith-based groups.

Population Services International was able to produce five television spots this year (stills below), which were aired during popular sports broadcasts, and featured the well-recognised mascot *Bothinyo* promoting *Aphaw* brand condoms with the safer sex messages “Can’t tell by looking” and “Let’s keep *Aphaw*”.

Bothinyo stills, *Aphaw* condom TV spots (permission of PSI Myanmar)

The FHAM has continued to support workplace interventions in Myanmar. By the end of this fiscal year, the Myanmar Business Coalition on AIDS (MBCA) had facilitated implementation of workplace HIV programmes in 41 private-sector businesses, compared with 25 last year. In the public sector, Myanmar Rail Transport continued its workplace HIV prevention and STI treatment referral activities among staff, while HIV education sessions were held for workers in the Ministry of Industry with the facilitation of UNFPA. Both MBCA and Partners reported that it was harder to reach factory workers than originally planned, as many factories in the main project areas had been closed, and that largely only workers in small-scale industries could be reached. Workplaces are varied, including for example, construction sites, brick factories, garment factories, food and drink processing, timber and furniture factories, bus terminals, hotels and a naval academy. Most factories do not allow peer educators to carry out dissemination of information during working hours, and so they can only use their own private time (such as lunch time) for health education sessions. Other partners including the Consortium, NAP, and PGK, have carried out health education sessions among workers, for example seafarers and trishaw drivers. UNFPA supported HIV prevention education in the Ministry of Industry.

Peer-education has been widely used as a strategy. Peer educators among workers and seafarers are raising HIV awareness in the workplace, with 838 peer educators involved at the end of the reporting period representing a 74% increase on the figure for the year before (481 peer educators involved) (MBCA, MRT, PGK, UNFPA). Peer educators conducted Behaviour Change Communication (BCC) sessions, often combined with condom demonstration and distribution.

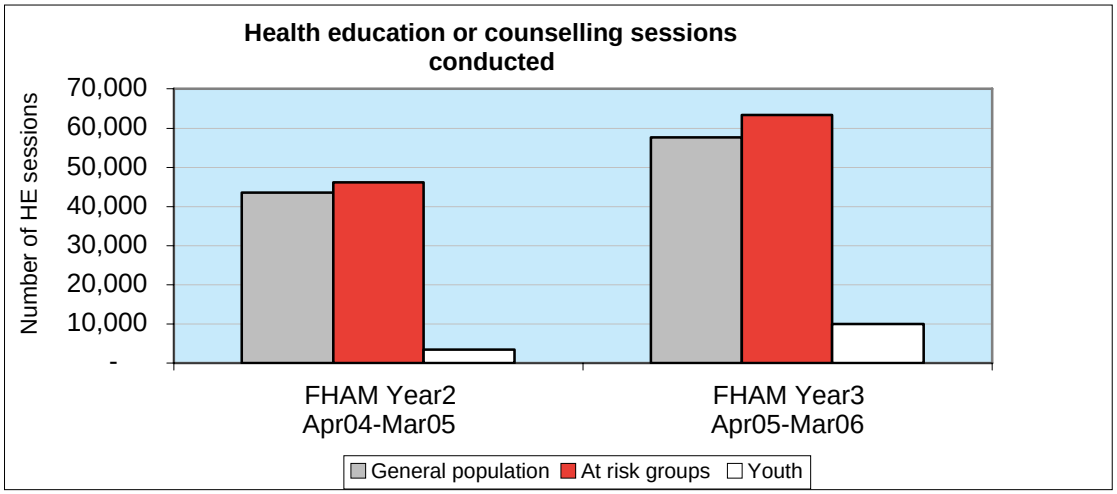
4,505,537 IEC materials have been distributed to the general population, and HIV IEC and promotional materials were produced in several of the languages spoken in Myanmar.

Positive attitudes, safe sexual behaviours and practices in key populations

Implementing Partners: NAP, AMI, Alliance, AHRN, Consortium, Malteser, MSF-H, MSF-CH, PSI, PGK, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
3.2 Positive attitudes, safe behaviour and practices in specific target groups improved, (includes consistent condom use and safe injecting practices for IDUs)			
Number of HE or counselling sessions conducted among target groups	37,063	63,233	100,296
Number of people among target groups reached through HE sessions	190,971	324,479	515,450
Number of IEC materials distributed to target groups	1,315,516	1,024,327	2,339,843
Number of peer educators trained and involved in project (SWs, MSM and IDUs)	1,605	1,507	1,507

Twelve partners were working to improve attitudes, behaviour and practices in key population groups at a higher risk of HIV infection, including sex workers, injecting drug users and men who have sex with men. Activities include individual/group counselling, health education sessions, and peer education. Some 63,233 health education or counselling sessions were held for populations at higher risk, reaching 324,479 persons. Chart 3.1 compares sessions held for targeted groups in fiscal years 2004 and 2005. Coverage was increased by establishing and providing services through new drop-in centres (for sex workers, injecting drug users and men who have sex with men) and many of these have proved very popular (AHRN, AMI, Consortium, MANA, PGK, PSI, UNODC). Partners have reported being able to gain the confidence of their beneficiaries, including sex workers and owners of entertainment venues, and to establish networks for reaching men who have sex with men with prevention messages and services. Townships with projects to reach sex workers are shown in the map below. Townships were selected on the basis of NGOs having authorisation to work there, and as planned in the approved FHAM project proposals.

Chart 3.



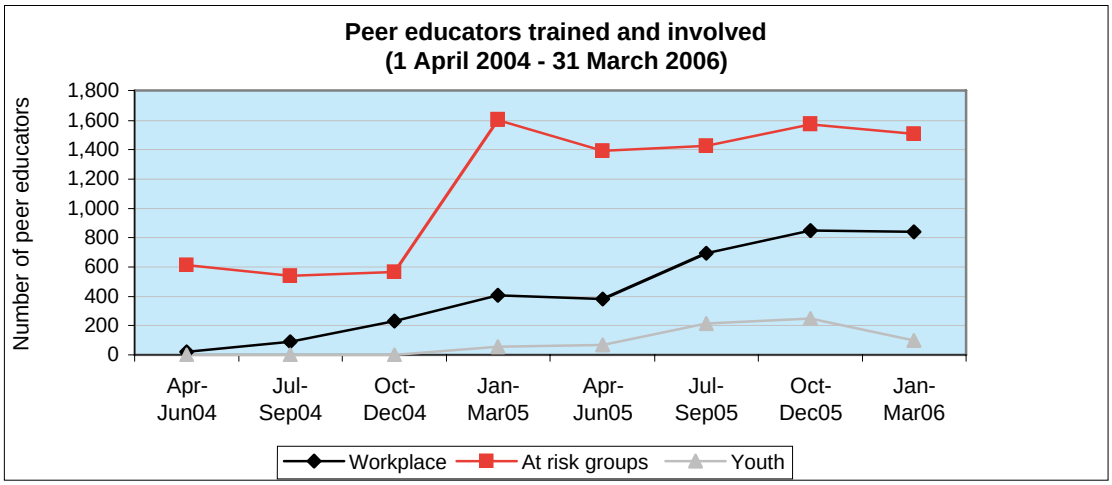
1,507 peer educators from specific target groups were involved in the projects of 12 implementing partners at the end of this one-year period. As an example, by the end of March 2006, PSI reported a total of 65 peer educators comprising 32 men who have sex with men and 33 sex workers actively involved in project sites in Yangon, Mandalay, Taunggyi and Pathein. However, some confusion remains among

implementing partners concerning the definition of peer educators. For example, one implementing partner reports one figure which includes its outreach staff with peer educators, which contributes a sizeable number to their reported total of 1,368, and therefore to the total nationwide. This change in reporting is reflected in chart 3.2, by a sizeable increase during the first quarter of 2005 in the number of peer educators working with at-risk populations. In response to the variation in activities classed as peer education, a review of peer education in Myanmar in 2006 is planned with support from the FHAM.

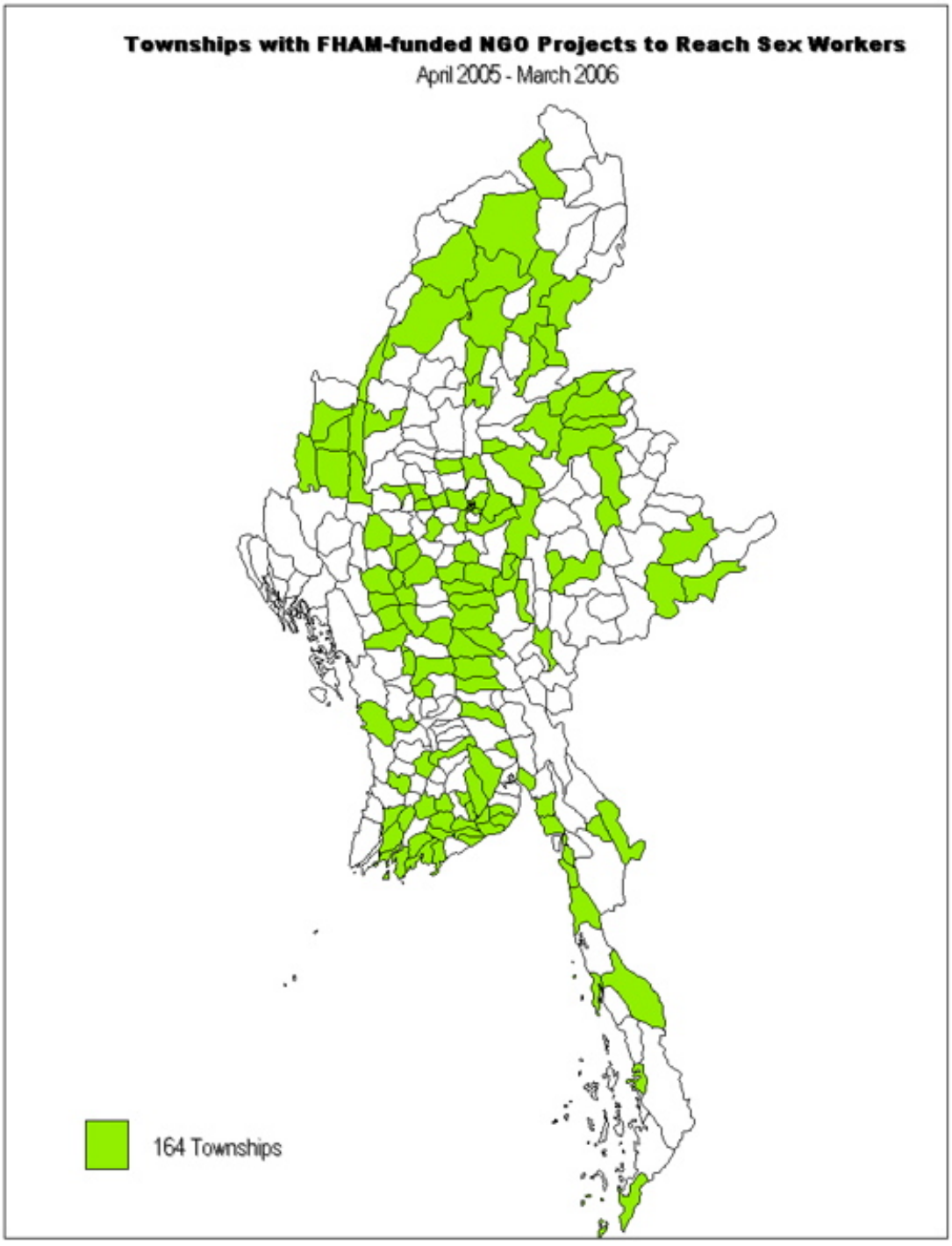
For injecting drug users, 980 education sessions were conducted by outreach workers and in drop-in centres, contacting 2,585 injecting drug users for information and education to encourage safe sex and safe injecting practices. At-risk youth were also targeted by projects focusing on drug use, and 1,350 contacts received counselling and support services such as primary health care within youth activity centres.

Two international expertise agencies, the International HIV/AIDS Alliance and Burnet Institute's Centre for International Health, have facilitated formation of informal self-help groups and CBOs through seed-grants to work with sex workers and with men who have sex with men, building on strong existing community networks among the targeted populations in each locale. The Alliance reported that self-help group leaders have proved to be highly motivated to collaborate on HIV issues, having witnessed many community members affected by the virus. As these are informal groups, capacity to implement HIV projects is low, and has been strengthened by training peer facilitators in facilitation skills and participatory groups discussions to promote positive norms towards safer sex. Efforts have been needed to promote a non-discriminatory attitude towards sex workers and an approach focused on empowerment.

Chart 3.2



The National AIDS Programme initiated Behavioural Surveillance Survey (BSS) in 2000 and, with the support of WHO, conducted a survey at seven sites in late 2003 to assess knowledge, attitude and behaviours around HIV transmission and prevention in the general population and youth. The findings were published in 2005. With support from the FHAM, the National AIDS Programme is working with WHO, UNAIDS and a local research company to broaden behavioural surveillance by including more groups and populations at higher risk of exposure to HIV. Methodology and questionnaires have been designed and are being finalised by the Ministry of Health.


Townships with FHAM-funded NGO Projects to Reach Sex Workers
April 2005 - March 2006
164 Townships

Awareness of HIV/AIDS among youth improved

Implementing Partners: NAP, DEPT, Consortium, Malteser, Partners, MRCS, UNFPA, UNODC, SC-US			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
3.3 Awareness of HIV/AIDS among youth, improved			
Number of targeted HE or counselling sessions conducted for youth	1,424	10,069	11,493
Number of youth reached through HE sessions	14,989	169,867	184,856
Number of IEC materials distributed to youth	751,801	1,126,475	1,878,276
Number of peer educators trained and involved in project	57	100	100

Youth of 15-24 years old represents approximately 30% of the population of Myanmar, and 14 partners implemented activities focusing on youth during the period. 10,000 health education sessions were conducted for in-school and out-of-school youth, reaching almost 170,000 participants (chart 3.1) (Consortium, MRCS, Partners, UNFPA, UNODC). This represents a sizeable increase on the previous year, when 1,424 sessions reached 15,000 youth.

Consortium employs a life-skills training approach, provided within the framework of adolescent reproductive health, primarily to out of school youth. Specific HIV-prevention education is delivered through small group discussion, and youth peer educators provide information in youth-friendly drop-in centres. UNFPA supported the establishment of Youth Information Corners to provide a range of IEC materials in Rural Health Centres. Community-based youth peer education is the focus of the Myanmar Red Cross Society (MRCS) FHAM project in four townships known to have significant mobility of young workers across the border into Thailand.

100 youth peer educators were involved in the FHAM-supported projects of MRCS, Save the Children-USA and UNODC at the end of March 2006, compared with 57 at the end of the previous reporting period (chart 3.2). 1,126,475 IEC materials targeting young people were distributed, representing an increase on the 751,800 distributed in the previous year (Consortium, MRCS, PARTNERS, SC-US, UNFPA, UNODC).

Lessons learnt

- It is important to keep peer educators motivated, as high dropout rate of peer educators has been reported for most projects. Regular meetings and training may contribute to maintaining peer educator motivation. The mobility of youth and of sex workers was reported as a significant challenge to keeping peer workers involved in projects. Peer educators in the workplace have been lost when workforces were downsized.
- Some confusion exists among implementing partners on the definition of peer education. Peer education, health education and outreach are often confused and interchanged.
- One implementing partner reported that it proved a challenge to identify local NGOs and CBOs that have an interest and an appropriate attitude for working with sex workers and men who have sex with men. Many local NGOs/CBOs in Myanmar are faith-based organisations, which have found it difficult to address sex work and sex between men.
- In the business sector, accessing executives can be difficult initially because they are either unaware or unconvinced of the need for HIV prevention programmes, or feel that they do not have time. Several factories were closed down altogether, and so implementing partners were unable to reach the

number of workers they had planned.

- HIV education for younger people has been reported by implementing partners to be culturally sensitive. It was reported that some parents were reluctant to allow adolescent children to participate in HIV prevention education sessions.

Access to services for HIV care and support improved

Expanding coverage of quality care, treatment and support services for people living with HIV is the goal of this component (Component 4 of the Joint Programme). This includes scaling up access to appropriate antiretroviral therapy (ART), treatment for AIDS-related infections, and care and support in the community. In addition, it aims to increase coverage of quality voluntary, confidential testing and counselling (VCCT) and prevention of mother to child transmission (PMTCT) services. The projects of 14 FHAM-funded implementing partners contribute to this component.

Quality and access to care and treatment services for people living with HIV improved

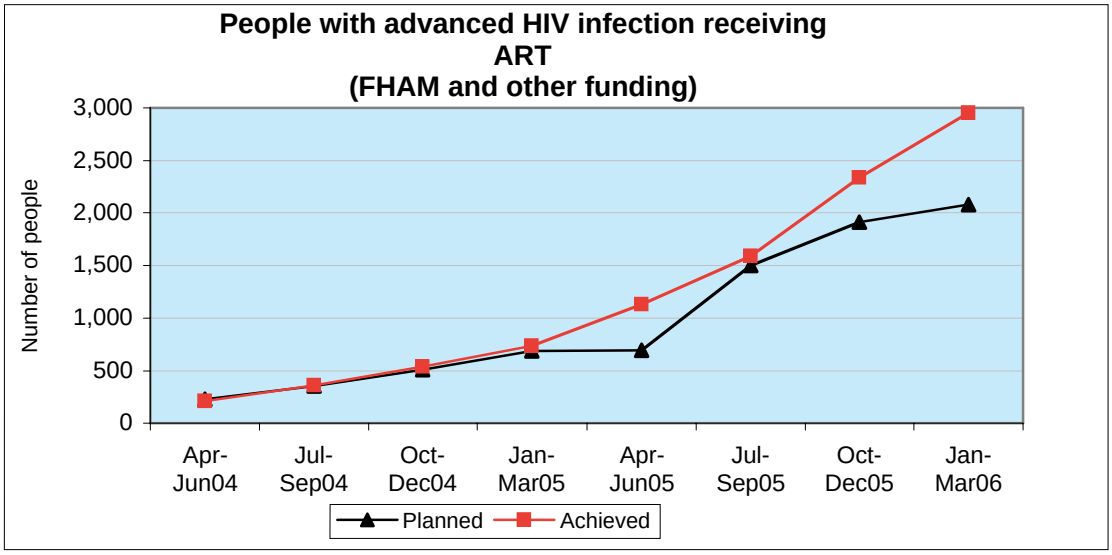
Implementing Partners: NAP, AMI, AFXB, MSF-H, MSF-CH			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
4.1 Quality and access to care and treatment services for PLWHA improved			
Number of people with advanced HIV infection receiving ARV therapy [UNGASS]	734	2,953	2,953
Number of PLHIV receiving home-based care (clinical/psycho-social)	2,108	5,785	5,785
Number of PLHIV receiving diagnosis and treatment for Opportunistic Infection	1,900	5,021	6,921

Significant progress has been made in the provision of ART in the last twelve months, with the number of persons receiving ART having increased more than four-fold to stand at 2,953 patients in March 2006, compared with 734 in March 2005 (chart 4.1). Five FHAM implementing partners are currently engaged in the provision of ART. To date, the majority of persons are receiving ART through the programme of MSF-Holland, followed by that of MSF-Switzerland. MSF-Holland reports the total number of people receiving ART in its programme to the FHAM, although the drugs are bought using FHAM and other funding. MSF-Switzerland similarly reported the total number of beneficiaries, which at the end of the period was 418 persons, of whom 271 were being treated with drugs bought using FHAM funds. Important progress was made when the NAP started to provide ART during this period, in June 2005, in Waibargi Hospital in Yangon, and in the Mandalay General Hospital. This now includes several paediatric patients. However, progress in rollout and scale-up of ART provision in the public sector has been slower than anticipated. *Aide Médicale Internationale* and the *Association Francois-Xavier Bagnoud* were also both able to initiate ART provision in this period. Approximately 150 health-care workers including doctors, nurses and pharmacists were trained in a series of workshops on HIV/AIDS clinical management including ART and opportunistic infections. A team of 15 doctors was established as trainers and is operational in rolling out training sessions at State/Division and township levels, with support from the WHO.

With FHAM resources, Yangon's Waibargi hospital and Mandalay General Hospital have had their capacity as referral centres for AIDS care strengthened, and have been upgraded to regional training centres. The upgrading of Mandalay General Hospital also facilitated the implementation (with non-FHAM funding) of the integrated care project for TB/HIV co-infected patients, in which approximately 130 patients had started ART by the end of this period.

Procurement of antiretroviral drugs was reported to be challenging, with delays for INGOs in obtaining import authorisation, and since some ARV drugs are not yet registered in Myanmar. One INGO was initially only able to procure ARV drugs locally from the primary supplier and therefore unable to benefit consistently from international prices and discounts, but subsequently was supported by MSF-Holland for international procurement. Procurement of ARV through the UN system has also proved slow at times. One international and one national procurement officer were recruited this year, with joint support of the FHAM and the GFATM, to facilitate and strengthen procurement and supply management of FHAM and GFATM medical supplies, including ARVs.

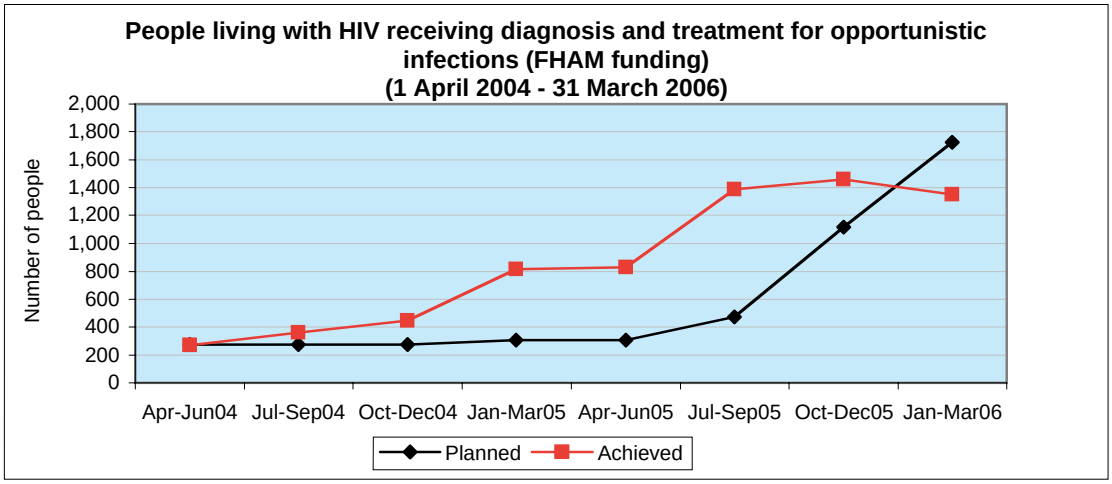
Chart 4.1



There is high demand for antiretroviral therapy, but availability remains too low. One partner expressed an ethical dilemma in promoting HIV counselling and testing without being able to offer ART to persons in need. Concern was expressed about 'self-medication', but this likely refers to obtaining drugs on prescription from private sector practitioners. Occasional instances of mono- and bi-therapy in the private sector have been reported, and concerns shared about knowledge of treatment adherence and its implications.

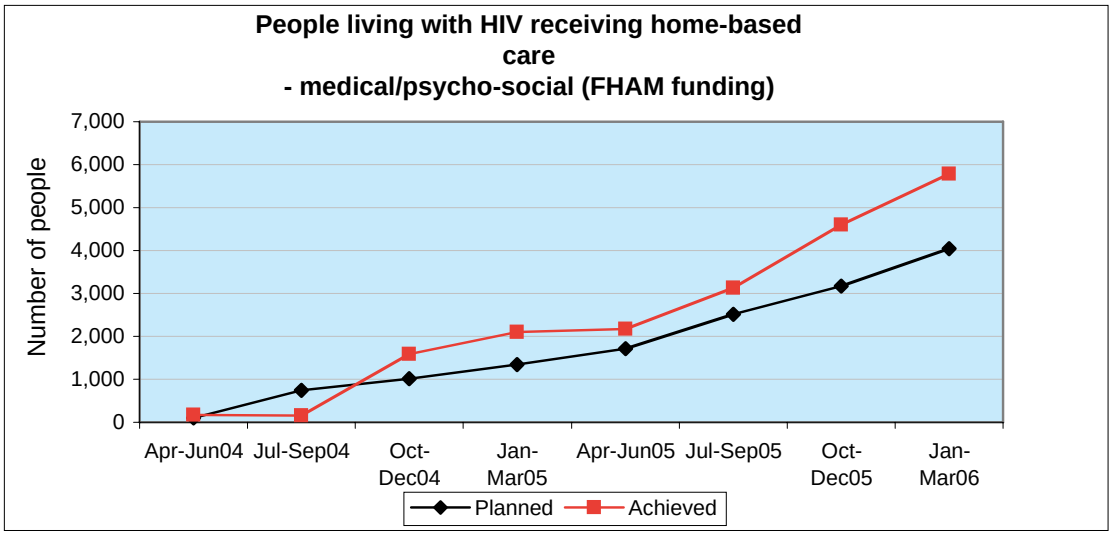
In addition to ART, the provision of medical care to persons living with HIV also includes prophylaxis and treatment of opportunistic infections, including tuberculosis. This has also increased over the last year with support from the FHAM (chart 4.2).

Chart 4.2



Provision of home-based care has continued to be scaled up significantly during the year with FHAM funding. 5,785 persons were receiving care at the end of March 2006, around 40% more than planned (chart 4.3), and significantly more than the 2,100 people receiving care at the end of March 2005. Partners report that demand for services is high, and higher than capacity, especially once people become aware of service availability. Townships with FHAM-supported home-based care services are shown in the map below. Selection of townships was based on the original approved FHAM project proposals, and on presence of NGOs in these locations.

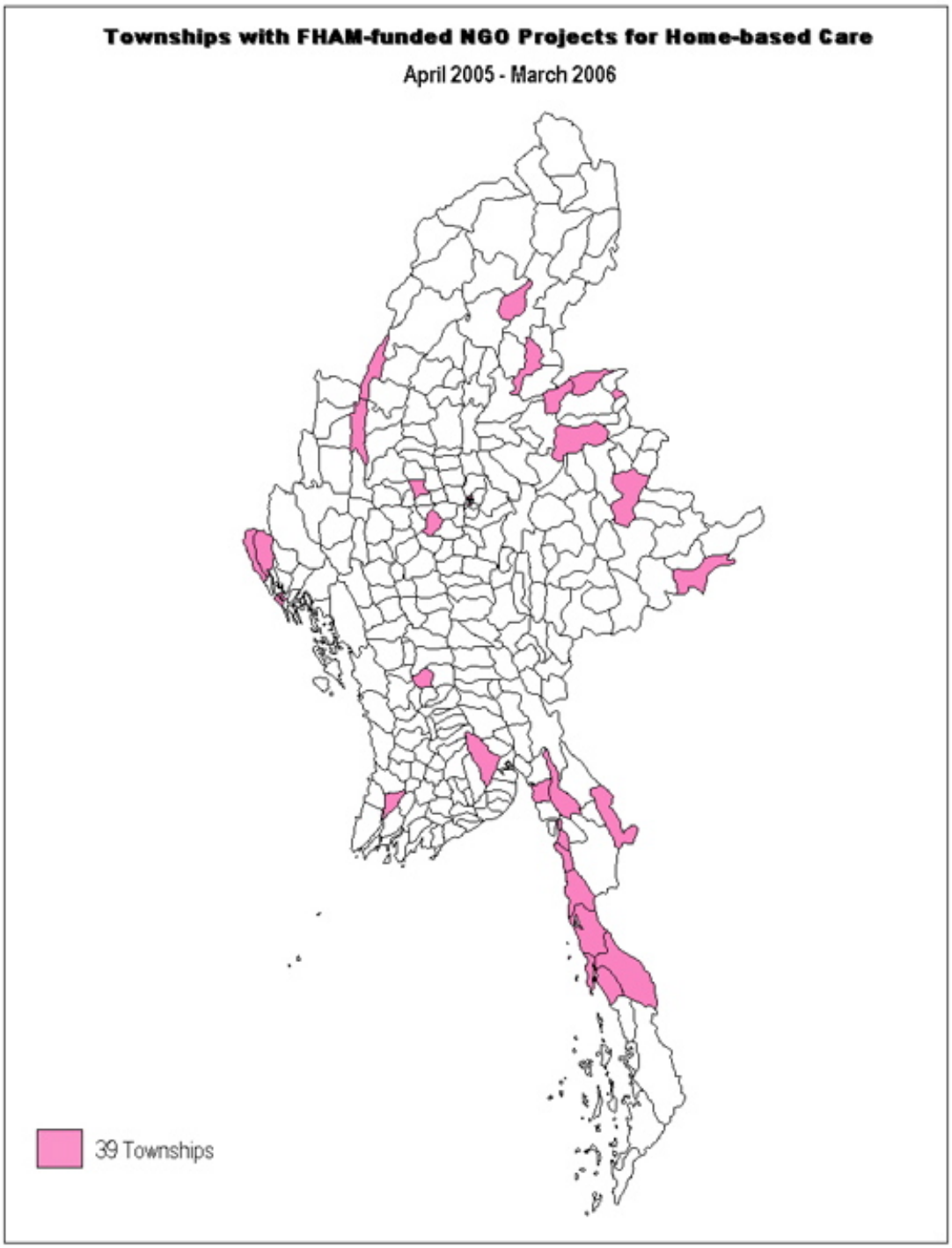
Chart 4.3



Provision of care to people affected by HIV has included nutritional support for people living with AIDS and their families, home-based care for patients with mobility difficulties, psychosocial support (including medical emergencies, hospital visits, child education support and funerals), and palliative treatment and care for the terminally ill. Formal home-based care is provided through auxiliary midwives, volunteers, community care providers and family members. Services provided include home visit, counselling, nutritional support, material support, care and treatment for minor illnesses, and referral for treatment of opportunistic infections. The Alliance has been supporting eight community-based organisations to provide a range of care and support services. The Consortium operates two models of home based care, one

where medical kits are provided for basic nursing care and referral is provided for opportunistic infections, and another with nursing support that enables the treatment of minor opportunistic infections.

One lesson learned is that nutrition support is a much needed component of care programmes, as families of people living with AIDS often face food insecurity, with high demands on family members to be carers in place of doing paid work.



WHO organised a consultation workshop on home based care provision for people living with HIV with the participation of the NAP and stakeholders involved in

community-based service provision, including MSF-Holland, *Médecins du Monde*, and AFXB, and the Consortium members Myanmar Nurses Association, CARE, and MSI. The main outcome of this consultation was the delineation of community home-based care models and tools for Myanmar, and the agreement by all partners on the need for standardisation of tools and packages of services within the continuum of care.

An HIV demographic impact and projections workshop was organised by WHO during this period and facilitated by regional experts. This permitted revision and updating of the estimation of the HIV epidemic in the country, and in particular a more accurate estimate of the number of people living with HIV. This has had important implications for the estimated needs for ART, and programmatic implications for prevention of mother to child transmission. It estimated that the total need for ART in 2006 would be approximately 66,000 persons from 373,000 people currently living with HIV. Approximately 7,400 pregnant women would be in need of services to prevent transmission of HIV to their child. This exercise also identified critical gaps in information, including a lack of data on men who have sex with men, and on injecting drug users. Some specific weaknesses in the current HIV surveillance system were highlighted for strengthening. The findings of this estimation have been taken into consideration in the development of the National Strategic Plan that started in 2006.

Although coverage has increased over the last year, in the light of the above estimates and when compared with the demand it still remains low for all care and support services. As communities become aware of services available, more people seek to access the services. Demand for home-based care and for services for orphans and vulnerable children has increased to such a point that it outstrips the resources available and current ability to deliver. One partner reported that many persons living with HIV present for services at such an advanced stage in AIDS-related disease progression that treatments are less effective, more costly and represent more of a demand on resources for ongoing financial support from families. The same partner also considered that many care and support projects are not able to perform fully since the complete range of services for people living with HIV is not available in all project townships. More resources are needed for scale-up of coverage for care and support services.

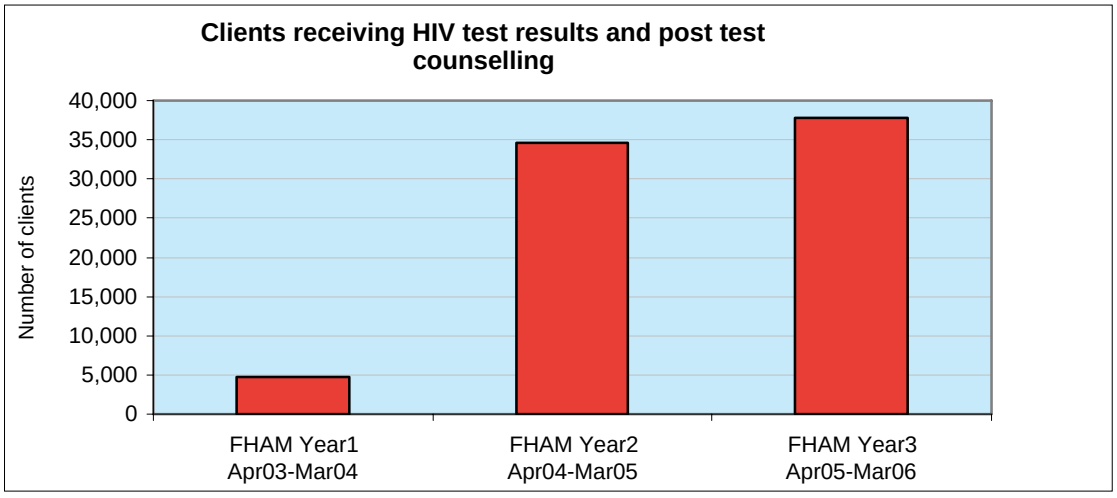
Quality of and access to voluntary confidential counselling and testing services improved

Implementing Partners: NAP, AMI, Alliance, AFXB, Consortium, Malteser, MSF-H, MSF-CH, PSI, SC-US, MANA, MBCA, PGK, UNFPA, UNODC			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
4.2 Quality of and access to voluntary confidential counselling and testing services improved			
Number of clients accessing VCCT services **	--	27,995	27,995
Number of clients receiving HIV test results and post-test counselling **	31,883	37,800	69,683
Number of people referred to VCCT services	645	2,996	3,641
Number of services delivery points providing counselling and testing with minimum conditions to provide quality services	--	22	22

** Note: Indicators are not paired, but independent of each other. Breakdown in Annexe 3.

Nearly 38,000 individuals received HIV test results along with post-test counselling during this year, approximately 40% more than the 27,000 planned for the period, and a slight increase on the previous year (chart 4.4). Although eleven implementing partners reported against this indicator, HIV testing largely remains restricted to public health facilities, with NGO projects either referring clients, or forwarding coded blood samples for testing, and carrying out the post-test counselling back within their own project. There has been an indication during this year that approved, eligible NGOs may soon be able to commence testing within their own projects. PSI and Marie Stopes International, a member of the Consortium, were given official permission to start testing in March 2006. To scale up counselling and testing significantly in Myanmar will require approvals for a greater number of partners to be able to provide these services.

Chart 4.4



The rate of return of clients to receive test results has been reported to vary between projects. One partner reported that only around 65% of sex workers returned for results and post-test counselling, while another partner claimed very high return rates. The high mobility of sex workers, combined with the lack of same-day testing, may account for the numbers of sex workers lost to follow-up.

During this period, the national External Quality Assessment Scheme (EQAS) for HIV serology organised by the National Health Laboratory (NHL) was developed and

implemented. During 2005 training on the organisation and implementation of national EQAS as well as protocols for national EQAS were implemented with technical support from WHO for laboratory staff from NHL, Mandalay Public Health Laboratory and lab technicians from selected blood transfusion laboratories and VCCT centres. Since then, the NHL successfully conducted two rounds of national EQAS during 2005 covering approximately 60 public health laboratories all over the country. The NHL is expected to expand the coverage of laboratories participating in the national EQAS to include mandatory participation of private (NGO) laboratories starting to implement HIV testing as part of VCCT services. The organisation of the national EQAS has important impact in ensuring best quality standards in HIV testing in the country. Moreover, the NHL and the NAP developed national guidelines for HIV testing, with the support of the FHAM and WHO. These guidelines set national standards for the provision of HIV testing particularly in VCCT and blood transfusion services and, added to the national EQAS, represent a critical tool for ensuring quality of HIV testing.

WHO and the NAP organised a regional, inter-country training-of-trainers workshop in Yangon. Subsequently, the NAP has started the development of general national guidelines on VCCT, which are currently in the stage of technical revision, and are due to be finalised soon. These guidelines also address counselling needs for specific groups at higher risk of infection, including sex workers, men who have sex with men, and injecting drug users.

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

No FHAM core indicators have been established for this output of the Joint Programme. Nonetheless, activities aimed at improving the caring, protective and supportive environment for people affected by HIV are intrinsic to the programmes of some FHAM implementing partners, including the Alliance, AFXB, Burnet Institute, and the Consortium.

A range of care and support services are being provided by CBOs and local NGOs with the capacity building support of the Alliance and Burnet Institute, including seed grants. These groups focus on psychosocial support, in particular counselling, either in the home or within gatherings. Some projects in addition provide some home-based care support, and many involve people living with HIV in the delivery of services and promote mutual support among people affected by HIV.

In addition, a wider range of support services has been made available. Self-help groups are improving empowerment of persons living with HIV. Some have been encouraged to develop their own action plans on how to support their members. Activities can include raising awareness among people living with HIV of different aspects of health care, meditation, cross visits to other groups, and income generation support. Likewise, activities include raising awareness in communities about HIV, to lessen stigma and discrimination and enhance acceptance of people living with HIV.

Some strategies have been reported to be effective in reducing stigma and discrimination, including: community education, particularly for youth; the positive attitudes by health-care personnel; social support and greater involvement of persons living with HIV in activities. However, and as in other countries, discrimination against people living with HIV and their children and families continues to be prevalent in Myanmar society. For example, this has been cited as a constraint for community

participation in taking care of orphans whose parents have died of AIDS-related illness and who have been judged to be 'bad people'. Conservative views are reported to be common among community leaders, confounded by low knowledge and understanding of HIV. More work is needed in educating community leaders and members at the local level to promote positive attitudes around HIV issues.

As the epidemic has progressed, the number of orphans and vulnerable children has increased. Education, nutritional support, medical care, psycho-social support and shelter are being provided, although as yet there is no standard package being provided in FHAM-supported townships, as demand outweighs the resources allocated. The Consortium is currently providing support to orphans and vulnerable children in 28 of its 37 FHAM-supported townships. Two models were tried to support education of orphans and vulnerable children. One lesson learned was that supporting community groups to represent the interests of children affected by HIV can be a more sustainable and less costly option than directly providing funds. For example, community groups have successfully advocated with head teachers to have the school fees of poorer children reduced or exempted. Such groups have also organized their own income generation to provide money for school books and uniforms.

Risk of mother-to-child transmission of HIV reduced

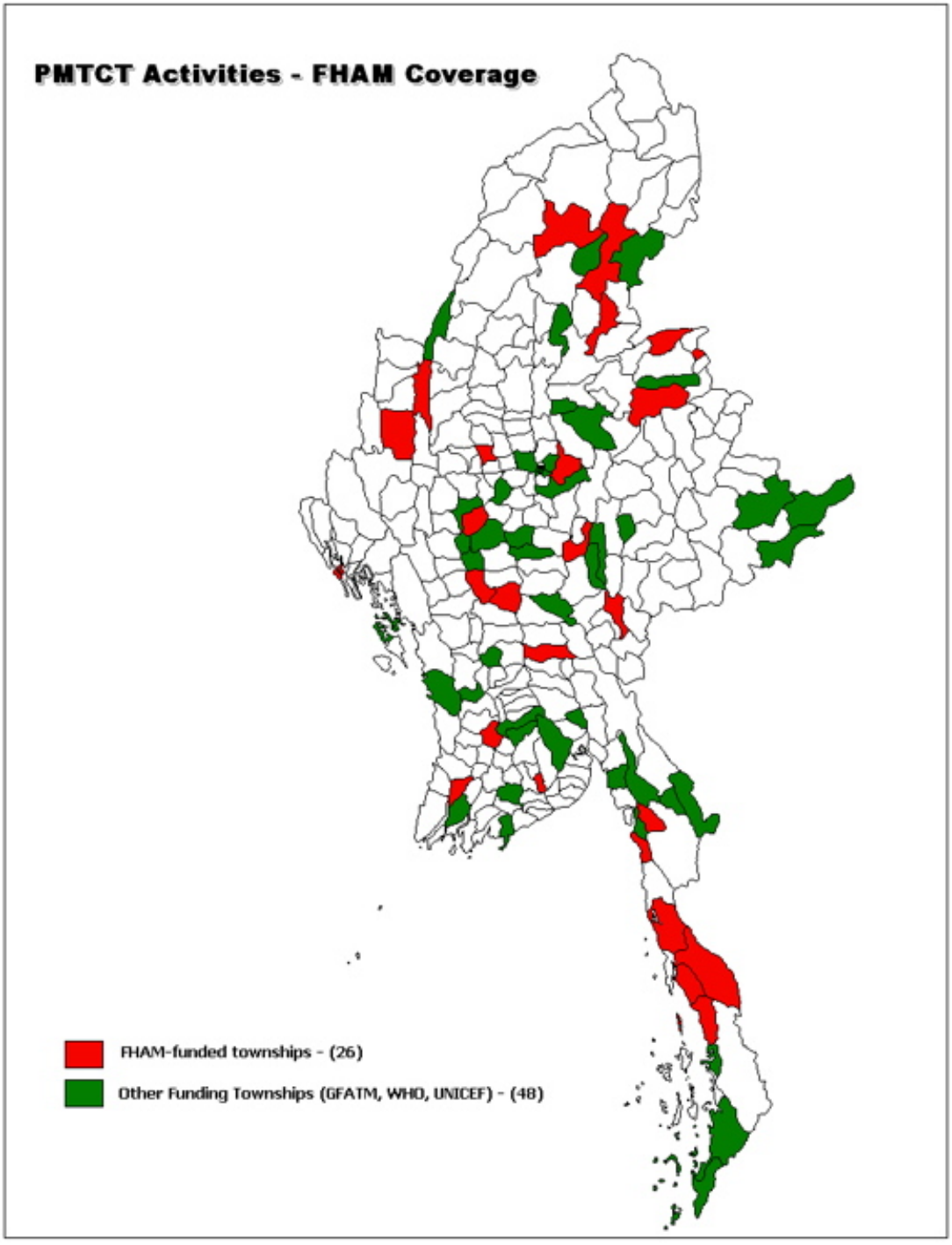
Implementing Partners: NAP, AMI, MSF-H, MSF-CH, UNFPA			
Core Indicator	**FY 2004**	**FY 2005**	**2 Year Total**
4.4 Risk of mother-to-child transmission of HIV reduced			
Number of mother/baby pairs receiving a complete course of ARV prophylaxis for PMTCT	122	201	323

The FHAM supported an increase in coverage of services for the prevention of mother to child transmission of HIV during this period. FHAM-supported townships are shown in the map below in red, and townships with other support (primarily UNICEF) shown in green. The FHAM-supported townships include those with NGO programmes, and others where PMTCT is implemented by the Department of Health and National AIDS Programme with the support of UNFPA's FHAM project. Townships for PMTCT services within the public health structures are identified by the National AIDS Programme in consultation with UNFPA and UNICEF. Where possible, UNFPA aimed to integrate PMTCT activities in townships where it has existing reproductive health projects.

The number of mother-baby pairs receiving antiretroviral prophylaxis in FHAM-supported townships increased during this reporting period to 201, compared with 122 in the previous period. However, this remained lower than planned, and in the public sector was reportedly due in part to late identification of new sites for service provision, delays in procurement, and delays in transfer of data (reporting) from project sites. In 2005, the impact estimation workshop estimated that approximately 7,400 women would need PMTCT services each year.

There has been a move towards hospital-based provision of PMTCT services in this period with nine sites starting with support from UNFPA, with training of basic health staff and hospital staff, and international procurement of supplies. UNFPA also continues to support community-based PMTCT in ten sites. PMTCT has been delivered in the contexts of antenatal and obstetrical care, and maternal-child health programmes. Efforts are ongoing to involve the male partners of women attending antenatal care, and to offer them an opportunity for counselling and voluntary confidential testing.

PMTCT services are also provided through the programmes of three FHAM NGO implementing partners, MSF-Holland, MSF-Switzerland and AMI. The majority of mother-baby pairs who received antiretroviral prophylaxis in this year with FHAM support did so through the programme of MSF-Holland (107). AMI reported that its support to PMTCT in 11 public health sector clinics was suspended early in 2005, but that it was able to continue in its own facilities.


PMTCT Activities - FHAM Coverage
FHAM-funded townships - (26)
Other Funding Townships (GFATM, WHO, UNICEF) - (48)

Fund Management

Programmatic and Financial Monitoring

The agreed FHAM workplans and budgets form the basis for programmatic monitoring of FHAM implementing partner projects. Each implementing partner submits quarterly technical progress reports of achievements against the targets set for the relevant indicators, along with a quarterly financial report. Additional advances are made when the FHAM unit at the UNAIDS Secretariat is satisfied that the reported achievements and expenditure correlate. Implementing partners report on cash balances remaining at the end of each quarter. If the cash balance exceeds the planned budget for the next two quarters, advances are held back until needed.

The analysis of achievements enables an assessment of the progress of programme implementation. Regular meetings with individual implementing partners are held to clarify issues identified in progress reports. Particular attention is paid to areas of underachievement, and discussions with implementing partners serve to identify any underlying constraints. In some cases constraints were considered important enough to justify a re-programming of planned activities, thus enabling the implementing partner to adapt workplans and budgets to changes in the operating environment or realignment of priorities.

The data extracted from the individual reports are compiled into a project-tracking database that follows the progress of the all FHAM partners against common core indicators. This enables the FHAM governance structures to have an overview of the outputs and coverage achieved in the overall programme. Data are also made available to the national M&E system.

In addition to the review of reports, the UNAIDS Secretariat FHAM team undertakes regular field monitoring trips. In the fiscal year 2005, a total of 11 monitoring trips were conducted covering 12 implementing partners in 24 different townships in 3 states and 6 divisions (table 5.1).

Table 5.1 FHAM monitoring visits in fiscal year 2005

Date	Geographical location	Implementing partners visited	Number of townships
May-05	Yangon (with DFID) - Hlaing Thar Yar, Dala and Waibargi hospital	MSF-H, AMI, NAP	3
Jun-05	Yangon– Mayangone Township	PSI	1
Sep-05	Yangon - Shwe Pyi Thar	Partners	1
Sep-05	Shan State - Aung Ban, Kalaw, Taunggyi and Pindaya	UNFPA, NAP	4
Sep-05	Bago Division - Taungoo	MRT	1
Sep-05	Yangon - Hlaing Thar Yar, Mayangone Kamaryut and Waibargi hospital	MSF-H, PSI, AFXB	1(4)
Oct-05	Magwe Division - Pyay, Magwe, Latpedan, Taung Twin Gyi	MRT, MBCA, NAP, PSI, Consortium	4
Dec-05	Thanintharyi Division - Dawei	MSF-CH, MBCA, PSI, NAP	1
Jan-06	Sagaing Division - Monywa, Tamu and Kalay *(visit postponed from May 2005)*	NAP, Consortium, PSI	3
Feb-06	Mon State - Tha Htone, Mawlamyaing Kayin State - Hpa-An	MRT, MRCS	3
Mar-06	Mandalay (with GF) - Mandalay, Meikhtila	NAP, PSI, Consortium	2
TOTAL		12	24

In 2006, these trips were increasingly planned jointly with the Global Fund technical monitoring team based at the UNAIDS Secretariat. The aim was to combine efforts in understanding and analysing the needs and challenges of operating at the township level. It was also considered necessary due to the large procurement component of the FHAM as well as the Global Fund, which required coordination in terms of prioritisation and utilisation of commodities notably for the public sector health services.

One lesson learnt is that national organisations may require additional assistance in the planning and proposal writing stages. One FHAM partner reported constraints to implementation as a result of sub-optimal planning. In this instance, the implementing partner reported lack of budget as a constraint for implementation of some planned activities. While adequate salary and administrative costs had been budgeted, not enough budget was planned to support activities. Additional and timely support for project planning should be factored in and provided for national organisations in the proposal phase of the next funding mechanism.

Procurement and Supply Management Systems

There are two different procurement procedures under the FHAM. International organisations with a proven track record procure their own supplies and commodities. No major issues have been reported for this approach, although one INGO partner reported that administrative procedures are becoming more difficult for importation of health products. National partners from government and civil society have their procurement carried out by UN organisations, usually UNDP, or in the case of partners working with drug users by UNODC. The National AIDS Programme has been affected by some delays in procurement.

In November 2005, with the anticipation of Global Fund implementation, a Procurement and Supply Management specialist was assigned to work on procurement of health products. The specialist initially concentrated on Global Fund related issues, but became increasingly involved in FHAM procurement. The technical officer works in particular with the National AIDS Programme to assist with their planning and to help with UN procurement. The position was designed as a UN inter-agency post in order to ensure that all relevant partners had access to the expertise. The position is co-funded by the FHAM and the Global Fund.

Financial Oversight

In line with the Operational Procedures of the FHAM, an internationally recognised auditing firm conducts yearly audits of the accounts of all implementing partners. KPMG has conducted an audit for the fiscal year 2004 in May 2005. The issues raised by the auditors have been shared with the implementing partners and all issues have been addressed. The audit for the fiscal year 2005 is ongoing.

Financial Status and Utilisation of Funds

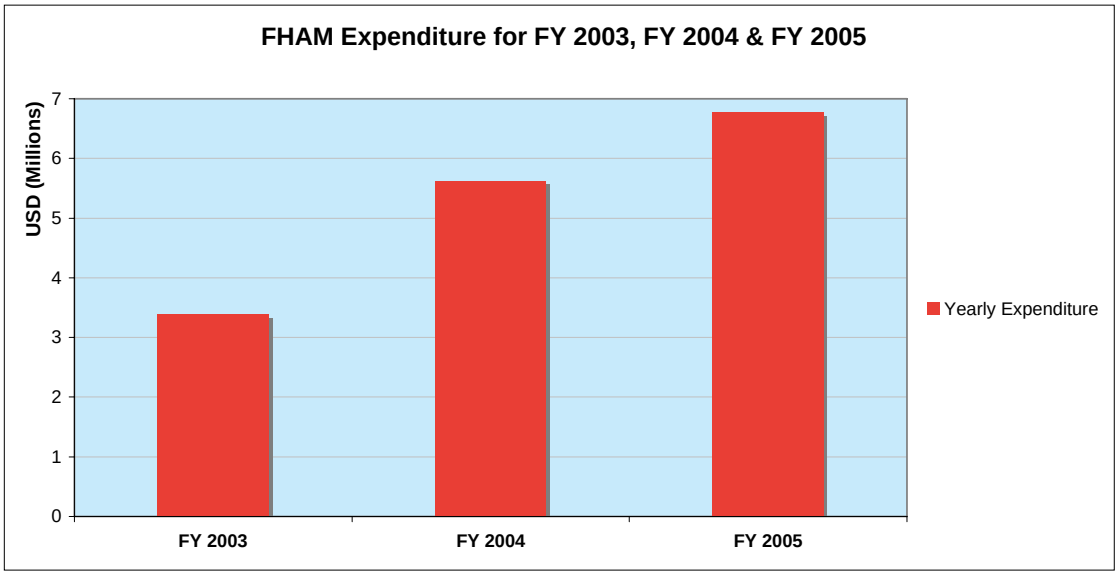
Overview

The total donor contribution disbursed to UNDP amounted to USD 24.7 million at the end of the fiscal year 2005 (table 5.2), with USD 23.9 million allocated to programmes. Actual disbursement to implementing partner projects amounted to USD 17.6 million, and actual expenditure by implementing partner projects was reported at USD 15.8 million by March 2006. Expenditures have seen a steady rise over time since the beginning of the FHAM in March 2003 to reach USD 6.8 million in fiscal year 2005 (chart 5.3).

Table 5.2 Donor contributions to the FHAM FY 2003-2005

Donor commitment		FY 2003		FY 2004		FY 2005		TOTAL
		Currency	(USD)	Currency	(USD)	Currency	(USD)	(USD)
Gov't of Norway	NOK 16m	NOK 6m	823,079	NOK 10m	1,542,510	-	-	2,365,589
Sweden (SIDA)	SEK 40m	SEK 10m	1,287,000	SEK 15m	2,109,705	SEK 15m	1,751,300	5,148,005
United Kingdom (DfID)	GBP 10m	GBP 3.6m	5,990,300	GBP 2.7m	4,997,595	GBP 2.9m	5,013,491	16,001,386
Gov't of Netherlands	EUR 1m	-	-	-	-	EUR 1m	1,196,833	1,196,833
Total contributions			**8,100,379**		**8,649,810**		**7,961,624**	**24,711,813**

Chart 5.3



At the beginning of 2006, the temporary suspension of expansion (for new activities and to new locations) for partners with a memorandum of understanding with the Ministry of Home Affairs kept expenditure lower than initially planned. Likewise, delays in planning and procurement of health products for National AIDS Programme resulted in lower than planned expenditures.

In December 2005 the FHAM initiated a planning process that led to the extension of the grants for 15 implementing partners due to end at 31 March 2006 to 30 November 2006. These extensions consist of a mix of no-cost extensions (funds had already been allocated to that partner project, but adequate unspent funds remained to extend the project) and cost-extensions (additional funds were allocated to programmes with

evidence of good performance). An additional USD 2.4 million were allocated to service delivery through this process.

Utilisation

The utilisation rates of programme funds are one of several means to monitor the progress of implementation. Deviations in utilisation rates serve as a basis for discussion with implementing partners. Constraints and challenges are discussed and corrective action, such as re-programming of existing workplans are expected from implementing partners that under-perform.

The utilisation of allocated funds has overall been satisfactory (see tables in Annexe 1 for details). While some implementing partners have experienced delays in starting activities of Round II(b), the majority of partners are catching up and are expected to be on track in the following fiscal year.

The FHAM is of course only one source of funding for the national response to HIV in Myanmar. During calendar year 2005 an estimated USD 21.5m was spent on AIDS by all partners and from all sources, of which USD 7.9m was from the FHAM. In addition to other external donors, the Government of Myanmar also supported HIV activities, and an estimate of its expenditure is given below (table 5.4).

Table 5.4 Estimate of Government of Myanmar Expenditures on HIV, 2005

Government body	Kyat total per year	USD total per year*
NAP Yangon (professional and support staff, rent, travel costs)	9,600,000	$8,727
STD Teams (44) (professional and support staff, rent, travel)	60,720,000	$55,200
Other Health System (pro-rata: doctor, nurse, midwives, lab technicians, lab costs, hospital maintenance; Drug Treatment Centres)	71,121,600	$64,656
CCDAC (staff Yangon + 7 townships, travel)	1,326,000	$1,205
Social Welfare / Home Affairs (Women's Training Centre, rehabilitation centres)	6,480,000	$5,891
Efforts of other Ministries (prison clinics, railways clinics)	1,584,000	$1,440
TOTAL[5]	**150,831,600**	**$137,120**

*Exchange Rate 1,100 kyat *Source: UNAIDS*

[5] The figure does not include any estimate of expenditures by the Ministry of Defence on HIV.

Operating Environment

The Ministry of Health and its subsidiary, the National AIDS Programme, were fully supportive of FHAM activities and did all they could to minimize constraints. Most of the FHAM partners were able to implement their activities as planned. However, Myanmar remains a challenging environment and the operating environment for HIV activities in Myanmar during the third year of the FHAM was highly varied.

Increased application of travel rules in the first quarter of the fiscal year by the government resulted in reduced visits to field sites. International staff must apply for authorisation for every trip to project areas. The delay in acquiring travel permits for international project staff has hindered initiation and expansion of field activities in some cases. During May 2006, the Joint Programme Mid Term Review team was denied permission to travel to most proposed sites, with the exception of Mandalay. Two FHAM implementing partners had their activities interrupted, one of which for a five month period, while Memoranda of Agreement with the Ministry of Health were amended. International NGOs running medical clinics must have them registered, which in some cases has become a lengthy process. In such clinics, only registered medical staff can be employed, and some international NGOs have reported this to be a cause of delay in implementation.

In August 2005, the Global Fund Secretariat cancelled the grants for AIDS, tuberculosis and malaria, citing difficulties in the operational environment in general and the ability to visit project sites in particular. This increased the general tension in the environment.

By September 2005, however, new procedures seemed to be settling down and visits to project sites were again possible. All visits by UNAIDS Secretariat to project sites needed three weeks advance preparation for clearance by the authorities, and visits were now accompanied by staff from the National AIDS Programme in a role of liaison officer, to facilitate contacts with local authorities. International staff from implementing partners were again able to travel to visit sites for provision of support, training, and monitoring, although the process to request permissions now took longer. International staff of NGOs visiting their own project sites also needed to be accompanied by staff from the NAP.

In November 2005, the seat of government unexpectedly moved from Yangon to a new administrative capital, Nay Pyi Daw, near Pyinmana in Mandalay Division. This had a significant effect on decreasing access to government counterparts, and the projects of implementing partners that depend highly on this also experienced constraints as a result of the move.

During the final quarter of the year, in January 2006, those partners working on harm reduction issues with a memorandum of understanding with the Ministry of Home Affairs had their agreements suspended, likely due to the desire to shift the responsible line ministry from Home Affairs to other ministries. Ongoing activities were allowed to continue, however, and were never interrupted, although a moratorium on introduction of new activities and expansion to new project sites was imposed temporarily. Some international partners had reduced access to their project sites.

Finally, in February of 2006 the Ministry of Foreign Affairs, the Ministry of Home Affairs and the Ministry of Planning, issued new draft guidelines to the international community – United Nations organisations and NGOs alike – for the coordination and

registration of organisations undertaking humanitarian work. As of the end of the fiscal year, discussions were ongoing between the UN Resident Coordinator and the authorities concerning these guidelines. After a process of consultation with the humanitarian community – both from the UN and non-governmental organizations – the UN Resident Coordinator wrote to the Government outlining the humanitarian principles required for successful delivery of assistance.

Annexe 1: Utilisation Rates of Implementing Partners

Utilisation Rate = Percentage of total budget reported as spent
Contract Lifespan Elapsed = Percentage of time elapsed against total duration of contract

FHAM Round II (FY 2004 & FY 2005) as of March 2006
Implementing Partners ending March 2006

Implementing Partners	Budget (RII+IIb) (USD)	Expenditure (USD)	Utilisation Rate (%)	Contract Lifespan Elapsed (%)
	688,325	**200,228**	**29%**	
CCDAC	532,325	81,154	**15%**	**50%**
DEPT	50,000	13,148	**26%**	**100%**
MRT	106,000	105,927	**100%**	**100%**

Note: All of the above 3 implementing partners finished their contracts on 31 March 2006. Final audits are being conducted.

FHAM Round II+IIb (FY 2004 & FY 2005) as of March 2006
Implementing Partners ending November 2006

Implementing Partners	Budget (RII+IIb) (USD)	Expenditure (USD)	Utilisation Rate (%)	Contract Lifespan Elapsed (%)
	5,911,477	**4,625,652**	**78%**	
AMI	404,000	238,183	**59%**	**72%**
Consortium	2,085,000	1,788,662	**86%**	**71%**
Alliance	400,000	300,148	**75%**	**75%**
BI (CHR)	400,000	313,116	**78%**	**69%**
BI (CIH)	406,824	228,603	**56%**	**72%**
Malteser Germany	249,984	195,062	**78%**	**72%**
MSF(CH)	300,000	300,004	**100%**	**75%**
Partners	99,818	66,904	**67%**	**75%**
MANA	100,000	100,000	**100%**	**75%**
MBCA	149,808	140,000	**93%**	**75%**
MRCS	159,997	135,585	**85%**	**75%**
UNFPA	576,446	541,906	**94%**	**72%**
WHO	579,600	277,481	**48%**	**67%**

FHAM Round II+IIb (FY 2004 & FY 2005) as of March 2006
Implementing Partners ending March 2007

Implementing Partners	Budget (RII+IIb) (USD)	Expenditure (USD)	Utilisation Rate (%)	Contract Lifespan Elapsed (%)
	8,996,779	**4,255,374**	**47%**	
AHRN	597,475	238,604	**40%**	**60%**
MSF(Holland)-AZG	2,077,027	1,580,611	**76%**	**67%**
PSI	1,944,089	1,629,480	**84%**	**66%**
AFXB	238,808	74,100	**31%**	**40%**
SC-US	413,251	69,467	**17%**	**43%**
PGK	160,281	16,883	**11%**	**20%**
UNODC	1,565,600	558,862	**36%**	**61%**
NAP	2,000,248	87,367	**4%**	**43%**

Note: NAP expenditures do not include on-going procurement, as these have not yet been recorded as expenditures by the UNDP's accounting system.

FHAM Round II+IIb (FY 2004 & FY 2005) as of March 2006
Implementing Partners ending March 2006

Implementing Partners	Budget (RII+IIb) (USD)	Expenditure (USD)	Utilisation Rate (%)	Contract Lifespan Elapsed (%)
UNAIDS (Myanmar)	708,051	320,726	**45%**	**72%**
BSS	272,000	-	**0%**	
Review, Audit and Procurement	221,160	81,238	**37%**	
Others	648,744	243,291	**38%**	

Note: The UNAIDS FHAM budget was amended, and no-cost extension to the end of June 2006 agreed, to ensure that the FHAM programme management unit within the UNAIDS Secretariat remains in place until final reports are completed and processed.

Portfolio of FHAM Rd I, II & II(b) and Implementing Partner Budgets

Implementing Organisations	Round I (FY 2003)		Round II (FY 2004-05)		Round IIb (FY 2005-06)		TOTAL
	Allocated	Return	Allocated	Return	Allocated	Return	FY 2003-07
Government Agencies	**1,828,881**	**(117,000)**	**2,688,573**	**(30,000)**	**-**	**-**	**4,370,454**
NAP	1,828,881	(117,000)	2,000,248	-	-	-	3,712,129
CCDAC	-	-	532,325	-	-	-	532,325
Department of Education Planning and Training	-	-	50,000	(30,000)	-	-	20,000
Ministry of Rail Transportation	-	-	106,000	-	-	-	106,000
INGOs	**2,989,279**	**(209,803)**	**7,135,826**	**-**	**2,480,450**	**-**	**12,395,752**
AHRN	297,942	(5,864)	200,000	-	397,475	-	889,553
AMI	112,000	-	330,000	-	74,000	-	516,000
Consortium (SC-UK)	660,131	(1,072)	2,085,000	-	-	-	2,744,059
MSF(Holland)-AZG	300,000	-	1,018,182	-	1,058,845	-	2,377,027
PSI	879,631	-	1,646,018	-	298,071	-	2,823,720
ADRA	120,078	(1,782)	-	-	-	-	118,296
AMDA	155,785	-	-	-	-	-	155,785
PACT	368,558	(172,116)	-	-	-	-	196,442
WVI	95,154	(28,969)	-	-	-	-	66,185
Malteser	-	-	249,984	-	-	-	249,984
MSF - Switzerland (MSF-CH)	-	-	300,000	-	-	-	300,000
Partners	-	-	99,818	-	-	-	99,818
Burnet Institute - CHR (to support MANA and CCDAC)	-	-	400,000	-	-	-	400,000
Burnet Institute - CIH (to support MRT and other CBOs)	-	-	406,824	-	-	-	406,824
International HIV/AIDS Alliance (to support CBOs and PLWA groups only)	-	-	400,000	-	-	-	400,000
AFXB	-	-	-	-	238,808	-	238,808
SC (US)	-	-	-	-	413,251	-	413,251
NNGOs	**225,975**	**(5,014)**	**409,805**	**-**	**160,281**	**-**	**791,047**
MANA	81,807	(2,474)	100,000	-	-	-	179,333
MBCA	50,000	-	149,808	-	-	-	199,808
MNA	94,168	(2,540)	-	-	-	-	91,628
MRCS	-	-	159,997	-	-	-	159,997
Pyi Gyi Khin	-	-	-	-	160,281	-	160,281
UN Agencies	**1,379,798**	**(328,444)**	**1,786,121**	**-**	**935,525**	**-**	**3,773,000**
UNFPA	360,500	(31,092)	506,521	-	69,925	-	905,854
UNODC	304,360	(188,299)	700,000	-	865,600	-	1,681,661
Outreach Activities (UNODC-LOP)	120,000	(42,069)	-	-	-	-	77,931
WHO	455,240	(46,582)	579,600	-	-	-	988,258
WFP	139,698	(20,402)	-	-	-	-	119,296
Sub Total (Implementation)	**6,423,933**	**(660,261)**	**12,020,325**	**(30,000)**	**3,576,256**	**-**	**21,330,253**
Monitoring/Evaluation							
UNAIDS (Myanmar)	114,083	(21,774)	708,051	-	-	-	800,360
UNAIDS (Geneva)	288,400	-	-	-	-	-	288,400
Other Monitoring/Evaluation (Sub total)	229,465	(2,471)	438,160	(19,700)	450,995	-	1,096,449
M&E Plan Development	*42,285*	-	-	-	-	-	*42,285*
Project Tracking Database	*14,400*	-	-	-	-	-	*14,400*
Extended Behavioural Survey	*85,094*	-	*272,000*	-	-	-	*357,094*
FHAM Review Panel	*40,898*	-	-	-	-	-	*40,898*
External Audit	*20,000*	*(2,471)*	*60,000*	-	*55,000*	-	*132,529*
M&E Officer	*17,288*	-	-	-	-	-	*17,288*
GFATM Proposal Dvlmt	*9,500*	-	-	-	-	-	*9,500*
M&E Field Trip Visit	-	-	*6,160*	-	-	-	*6,160*
JP FHAM Review	-	-	*100,000*	*(19,700)*	-	-	*80,300*
Burnet Institute (TA for PGK)	-	-	-	-	*29,995*	-	*29,995*
Thematic Reviews	-	-	-	-	*50,000*	-	*50,000*
Procurement Officer (6mths) - International	-	-	-	-	*60,000*	-	*60,000*
Procurement Officer (4mths) - National	-	-	-	-	*6,000*	-	*6,000*
Extension of Global Fund SRs	-	-	-	-	*250,000*	-	*250,000*
Sub Total (M&E)	**631,948**	**(24,245)**	**1,146,211**	**(19,700)**	**450,995**	**-**	**2,185,209**
UNDP Handling Fee	81,004	-	112,000	-	140,749	-	333,753
Sub Total (Handling Fees)	**81,004**	**-**	**112,000**	**-**	**140,749**	**-**	**333,753**
TOTAL FUNDS ALLOCATED	**7,136,885**	**(684,506)**	**13,278,536**	**(49,700)**	**4,168,000**	**-**	**23,849,215**

Annexe 2: Summary of Technical Progress Apr 2005 – Mar 2006

Yearly Achieved and Total 01 April 2005 to 31 March 2006

	CORE INDICATOR	FY 2004 ACHIEVED	FY 2005 ACHIEVED	TOTAL ACHIEVED
Component 1: Sexual Transmission of HIV				
1.1 Access to affordable condoms for sexually active men, women and young people increased				
1	Number of condoms distributed	32,867,486	42,616,027	75,483,513
1.2 Capacity of both private and public sector health facilities for prompt and effective management of STIs improved				
2	Number of clients to STI services	178,391	209,839	388,230
3	Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counseled	136,177	154,979	291,156
4	Number of service delivery points (SDP) providing integrated STI services	128	578	578
5	Number of referrals to STI services	231	858	1,089
Component 2: Injecting Drug Use				
2.1Access to harm reduction interventions increased				
6	Number of needles and syringes distributed to IDUs	43,389	156,009	199,398
44	Number of needles and syringes returned	--	63,885	63,885
7	Number of IDUs reach through outreach workers or DIC	2,874	2,585	5,459
8	Number of IDU drop-in centres functioning	4	6	6
2.2 Access to and quality of drug treatment in institutional and non-institutional settings improved				
9	Number of IDUs having completed detoxification treatment	--	40	40
10	Number of IDUs receiving maintenance substitution therapy	0	12	12
11	Number of IDUs referred for drug treatment (detox and substitution)	35	80	115
Component 3: Knowledge and Attitudes				
3.1 Knowledge of modes of transmission, perception of personal risk, and attitudes regarding HIV/AIDS and those living with and affected by HIV/AIDS, improved an				
12	Number of health education (HE) sessions on HIV/AIDS conducted	41,468	57,697	99,165
13	Number of mass awareness sessions held [video shows/TV spots aired]	1,323	2,196	3,519
14	Number of IEC materials distributed to general population	3,384,392	1,121,145	4,505,537
15	Number of peer educators trained and involved in workplace education	481	838	838
3.2 Positive attitudes, safe behavior and practices in specific target groups improved, (includes consistent condom use and safe injecting practices for IDUs)				
16	Number of HE or counseling sessions conducted among target groups	37,063	63,233	100,296
17	Number of people among target groups reached through HE sessions	190,971	324,479	515,450
18	Number of IEC materials distributed to target groups	1,315,516	1,024,327	2,339,843
19	Number of peer educators trained and involved in project (SWs, MSMs and IDUs)	1,605	1,507	1,507
3.3 Awareness of HIV/AIDS among youth, improved				
20	Number of targeted HE or counselling sessions conducted for youth	1,424	10,069	11,493
21	Number of youth reached through HE sessions	14,989	169,867	184,856
22	Number of IEC materials distributed to youth	751,801	1,126,475	1,878,276
23	Number of peer educators trained and involved in project	57	100	100
Component 4: Care, Treatment and Support for People Living with HIV/AIDS				
4.1 Quality and access to care and treatment services for PLWHA improved				
24	Number of people with advanced HIV infection receiving ARV therapy [UNGASS]	734	2,953	2,953
25	Number of PLHA receiving home-based care (clinical/psycho-social)	2,108	5,198	5,198
26	Number of PLHA receiving diagnosis and treatment for Opportunistic Infection	1,900	5,021	6,921
45	Number of people still alive 6, 12, 24 months after initiation of ARV	--	--	--
4.2 Quality of and access to voluntary confidential counseling and testing services improved				
46	Number of clients accessing VCCT services	--	27,995	27,995
27	Number of clients receiving HIV test results and post-test counselling	31,883	37,800	69,683
28	Number of people referred to VCCT services	645	2,996	3,641
47	Number of services delivery points providing counselling and testing with minimum conditions to provide quality srvices	--	22	22
4.3 Caring, protective and supportive environment for people living with or affected by HIV/AIDS improved				
4.4 Risk of mother-to-child transmission of HIV reduced				
29	Number of mother/baby pairs receiving a complete course of ARV prophylaxis for PMCT	122	201	323
Component 5: Enabling Environment				
5.1 Active support of opinion leaders for promoting a supportive environment for implementation of effective prevention and care activities increased				
30	Number of advocacy meetings conducted	406	529	935
31	Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	25	41	41
5.2 Multi-sectoral and coordinated partnership for planning and implementation strengthened				
32	Number of coordination and multi-sectoral meetings conducted	268	180	448
33	Number of best practices produced and distributed	1	1	2
34	Number of policies produced and distributed	--	0	0
5.3 Availability and utilization of data on programme impact, trends of HIV/AIDS over time and related behaviors driving the epidemic improved				
35	Needs assessment study conducted and report available	3	1	4
36	Number of base and end line studies conducted and report available	5	3	8
37	Number of evaluation or reviews conducted and report available	3	10	13
38	Number of operational research studies conducted (eg. Survey)	0	1	1
5.4 Capacity for implementation of HIV/AIDS prevention and care activities expanded at all levels				
39	Number of trainings or workshops conducted excluding health care providers and peer educators	87	153	240
40	Number of trainings conducted for health care providers	465	77	542
41	Number of trainings conducted for peer educators	64	79	143
42	Number of days of technical assistance provided to IPs	74	251	325
48	Number of counsellor trained for VCCT	--	233	233
5.5 Risk of HIV transmission in health care delivery settings reduced				
43	Number of health staff receiving post exposure prophylaxis	0	61	61

Note: Indicators numbered in bold were either new or redefined in April 2005, start of Round II(b).

Annexe 3: Achievements by Implementing Partners Round II, II(b)

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

Core Indicator	NAP	MRT	AHRN	AMI	Consortium	MSF-H	MSF-CH	Alliance	PSI	Partners	Malteser	MANA	MRCS	MBCA	UNODC	SC-US	Pyi Gyi Khin	NAP-NCE	Total
Number of condoms distributed	1,354,280	1,083,000	32,661	331,891	3,440,270	2,238,311	123,191	6,766	32,565,798	127,370	57,290	28,087	1,102,651	17,403	67,173	30,500	9,385	--	42,616,027
Number of STI male and female clients at health care facilities appropriately diagnosed, treated and counselled	6,688	--	--	1,536	14,168	20,180	180	--	30,974	--	1,013	--	--	--	--	--	--	80,240	154,979
Number of service delivery points (SDP) providing integrated STI services	353	--	--	3	11	18	--	--	181	--	0	--	--	6	--	6	--	--	578
Number of referrals to STI services	--	98	--	--	520	--	--	54	--	--	--	--	185	--	--	--	1	--	858

2. Access to services to prevent transmission of HIV in injecting drug users improved (JP Component 2)

	AHRN	MANA	UNODC	Total
Number of needles and syringes distributed to injecting drug users	12,742	21,405	121,862	156,009
Number of needles and syringes returned	--	--	63,885	63,885
Number of injecting drug users reach through outreach workers or DIC	1,633	270	682	2,585
Number of injecting drug user drop-in centres functioning	1	3	2	6
Number of injecting drug users having completed detoxification treatment	--	--	40	40
Number of injecting drug users receiving maintenance substitution therapy	--	--	12	12
Number of injecting drug users referred for drug treatment (detox and substitution)	57	5	18	80

3. Knowledge and attitudes improved (JP Component 3)

	NAP	MRT	AHRN	AMI	Consortium	MSF-H	MSF-CH	Alliance	PSI	Partners	Malteser	MRCS	MBCA	UNFPA	UNODC	SC-US	Pyi Gyi Khin	NAP-NCE	Total
Number of health education (HE) sessions on HIV/AIDS conducted	1	--	85	262	4,865	51,366	541	--	--	399	0	--	164	--	--	--	14	--	57,697
Number of mass awareness sessions held [video shows/TV spots aired]	0	4	--	--	86	463	--	--	1,400	--	2	8	12	221	--	--	--	--	2,196
Number of IEC materials distributed to general population	0	21,000	--	--	479,709	--	33,811	--	--	41,165	--	--	44,260	93,700	0	--	0	407,500	1,121,145
Number of peer educators trained and involved in workplace education	0	500	--	--	--	--	--	--	--	--	--	--	203	105	--	--	30	--	838
Number of HE or counselling sessions conducted among target groups	350	--	114	3,259	3,148	--	82	19	55,328	--	56	--	--	--	866	--	11	--	63,233
Number of people among target groups reached through HE sessions	--	--	1,031	17,006	4,707	--	--	282	299,909	--	20	--	--	--	1,467	--	57	--	324,479
Number of IEC materials distributed to target groups	--	--	10,606	--	376,956	595,413	--	11,280	--	--	19,375	--	--	--	10,697	--	--	--	1,024,327
Number of peer educators trained and involved in project (SW, MSM and IDU)	0	--	3	43	1,368	--	0	12	65	--	6	--	--	--	0	--	10	--	1,507
Number of targeted HE or counselling sessions conducted for youth	43	--	--	--	5,813	--	--	--	--	34	5	3,992	--	155	27	0	--	--	10,069
Number of youth reached through HE sessions	--	--	--	--	151,958	--	--	--	--	3,215	0	13,067	--	--	1,350	277	--	--	169,867
Number of IEC materials distributed to youth	0	--	--	--	771,655	--	--	--	--	8,131	--	31,172	--	65,000	67,181	1,836	--	181,500	1,126,475
Number of peer educators trained and involved in project	--	--	--	--	--	--	--	--	--	--	--	25	--	--	7	68	--	--	100

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

	NAP	AMI	Consortium	MSF-H	MSF-CH	Alliance	MANA	MBCA	UNFPA	UNODC	AFXB	SC-US	Pyi Gyi Khin	Total
Number of people with advanced HIV infection receiving ARV therapy [UNGASS]	144	3	--	2,373	418	--	--	--	--	--	15	--	--	2,953
Number of PLHIV receiving home-based care (clinical/psycho-social)	--	8	3,434	69	700	587	--	--	--	--	797	--	190	5,785
Number of PLHIV receiving diagnosis and treatment for Opportunistic Infection	0	--	--	4,609	--	--	--	--	0	--	392	--	20	5,021
Number of people still alive 6, 12, 24 months after initiation of ARV	0	0	--	0	--	--	--	--	--	--	0	--	--	0
Number of clients accessing VCCT services	0	739	4,155	22,953	--	--	--	--	--	148	--	0	--	27,995
Number of clients receiving HIV test results and post-test counselling	4,125	444	3,024	20,229	2,784	--	204	--	6,938	--	--	0	52	37,800
Number of people referred to VCCT services	--	--	2,687	--	--	15	--	30	155	33	76	--	--	2,996
Number of services delivery points providing counselling and testing with minimum conditions to provide quality services	--	3	--	19	--	--	--	--	--	--	--	--	--	22
Number of mother/baby pairs receiving a complete course of ARV prophylaxis for PMTCT	0	5	--	107	12	--	--	--	77	--	--	--	--	201

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

	NAP	MRT	AHRN	Consortium	MSF-CH	Alliance	BI-CHR	BI-CIH	PSI	Malteser	MANA	MRCS	MBCA	UNFPA	UNODC	WHO	UNAIDS	AFXB	SC-US	Pyi Gyi Khin	NAP-NCE	Total
Number of advocacy meetings conducted	0	4	107	273	55	--	--	--	--	13	--	20	44	--	11	--	--	--	2	0	--	529
Number of large enterprises/ companies that have HIV/AIDS workplace policies and programmes [UNGASS]	--	--	--	--	--	--	--	--	--	--	--	--	41	--	--	--	--	--	--	--	--	41
Number of coordination and multi-sectoral meetings conducted	0	--	--	29	--	1	--	--	--	1	--	45	--	--	37	--	61	--	--	6	--	180
Number of best practices produced and distributed	--	--	--	--	--	--	--	--	--	--	--	--	1	--	--	--	0	--	--	--	--	1
Number of policies produced and distributed	--	--	--	--	--	--	--	--	--	--	--	--	--	--	0	--	--	--	--	--	--	0
Needs assessment study conducted and report available	0	--	--	--	--	--	--	--	--	1	--	--	--	--	--	--	--	--	--	0	--	1
Number of base and end line studies conducted and report available	--	--	--	--	--	--	--	--	--	--	0	3	--	--	--	--	--	--	--	--	--	3
Number of evaluation or reviews conducted and report available	--	--	--	--	--	--	1	--	--	--	3	3	--	1	0	1	1	--	--	--	--	10
Number of operational research studies conducted (eg. Survey)	0	--	0	--	--	--	--	--	--	--	--	--	--	--	0	--	--	--	--	--	1	1
Number of trainings or workshops conducted excluding health care providers and peer educators	--	4	11	19	--	20	31	11	--	2	5	--	14	14	14	--	0	8	--	--	--	153
Number of trainings conducted for health care providers	3	--	32	--	--	--	--	--	--	3	--	--	2	13	2	9	--	--	0	--	5	69
Number of trainings conducted for peer educators	12	20	2	--	3	--	--	--	6	--	--	--	19	10	5	--	--	2	--	0	--	79
Number of days of technical assistance provided to IPs	--	--	41	--	--	--	113	55	--	--	--	--	--	--	42	--	--	--	--	--	--	251
Number of counsellor trained for VCCT	198	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	35	--	--	233
Number of health staff receiving post exposure prophylaxis	61	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	61

FHAM-funded research (surveys and studies, not described earlier)

- Baseline study (RAR, Rapid Assessment and Response methodology) on drug use in Laukkai, found significant use of amphetamine type stimulants in addition to injection of opiates (AHRN).
- Survey of 365 participants in Lashio on risk behaviour and injecting drug use (AHRN)
- Needs assessment and evaluation of service delivery by the project in Lashio (AHRN).
- Three CBOs were supported to carry out Participatory Community Assessments to assess the situation of sex work in Pyay, Kyaukpadaung and Mawlaymyine. (Alliance)
- A Rapid Needs Assessment was carried out in the Wa Special Region in 2005 to determine interventions needed for HIV prevention. (Malteser)
- KAP survey on HIV in 8 townships (Consortium)
- KAP survey on HIV was implemented involving 2,340 workers in the workplaces of three transportation departments at the beginning and end of the project. (MRT)
- KAP survey on HIV for 869 employees in 11 different workplaces, with focus group discussions in other workplaces for qualitative responses. (MBCA)
- KAP (4^{th} round) was carried out, in Yangon, Mandalay, Lashio and Myitkyina, with consistent sample population as the third round, including trishaw and taxi drivers, truckers, highway drivers, fishermen, miners as sentinel male target group and female sex workers. (PSI)
- KAP (1^{st} round) study on men who have sex with men was carried out in 2006, with 828 men interviewed in Yangon and Mandalay. (PSI)
- Cluster sampling survey and qualitative mid-term assessment and annual evaluation using focus group discussions and individual interview method were employed for end-line survey, mid-term assessment and annual evaluation. (MRCS)
- Mid-term project review (BI-CHR)
- A review of its HIV projects was performed by UNFPA in 2006.

Manuals and Guidelines developed

AHRN

- Technical Manuals/Guidelines
  - Drop-in-Centre Operating Guidelines,
  - Harm Reduction Outreach with Needle & Syringe Exchange Guidelines,
  - Drop-in-Centre Database Users Manual,
  - Social Volunteer Harm Reduction Manual,
  - Case Management for drug users.
  - Handbook for street workers entitled "On the Road Again" (translation)

AMI

- Updated or created guidelines and technical manuals for use within AMI project:
  - In-house guidelines for clinical management (adult) of PLWHA, VCCT, Counselling guidelines
  - Guidelines for clinical management (children) of PLWHA (in process)
  - Clinic guidelines for PEP

BI-CHR

- Harm Reduction Operations Manual, designed to enhance the delivery of quality harm reduction services to drug users in Myanmar. The manual was developed in association with AHRN and UNODC-TCU and is mid-stage of translation. The first section addresses organisational issues for management and protocol, staffing issues, mobilising community support and M&E. The second section of the manual discusses operational issues for service delivery and includes: drop in centres, primary health care services for injecting drug users, outreach, needle and syringe programs, peer education, drug treatment and substitution therapies, and VCCT.

Consortium

- Marie Stopes International published a general counselling book, booklets on STIs, and a treatment flow chart for STI management for use by project staff.

DEPT

- Developed and produced a training manual for teacher training colleges, and a resource book for trainee teachers on how to communicate HIV-prevention messages.

Alliance

- Developed a number of modules for participatory discussion activities for key populations; adapted from similar work developed by the Alliance in other countries and translated into Myanmar for the Alliance partners. One module is for men who have sex with men (ME+N) and one for people living with HIV (Positive Prevention).
- Translated a book *Between Men,* which gives a basic understanding of issues related to working with men who have sex with men, intended for interested organisations or those starting work with this community.
- Following an IEC workshop by sex workers, the Alliance is finalising the development of a booklet on safer sex for sex workers. Laid out in a Questions and Answers format, the booklet provides basic information on health-related questions commonly asked by sex workers, and details of safer sex techniques.

MBCA

- MBCA's experiences with workplace programmes were compiled in a document as "Best practices and lessons learnt". Topics covered include the importance of workplace programmes, key points in advocating business people and challenges faced.

MSF-H

- Management of patients with HIV/AIDS, March 2006.
- Notes on Management of HIV Infection in AZG/NAP programme Myanmar, Per Bjorkman
- Anti-retroviral therapy in Myanmar: lessons from a practical experience, May 2005
- HIV counselling manual, August 2005.

WHO

- Methadone technical guidelines for prescribers and dispensers: for the implementation of the methadone programme.
- Methadone information booklet for patients, in Myanmar language: Informative booklet for patients enrolled in methadone programme and their families. This booklet has also been used as advocacy tool for other officials at the Ministry of Health and local authorities as a way to introduce them to the methadone programme and gain their support.
- AIDS care guidelines for children: Clinical technical guidelines for clinicians involved in the provision of AIDS medical care to children.
- Primary Health Care guidelines for injecting drug users: for use by health care workers involved in providing basic health services for injecting drug users, in both the public health and NGO sectors.
- National guidelines for HIV antibody testing: for use by laboratories either in the public sector or the private and NGO sectors involved in HIV testing, particularly for blood transfusion services, VCCT and HIV testing in the context of clinical diagnosis in hospitals.
- VCCT operational guidelines (still in draft)
- National protocols for EQAS for HIV serology testing: used by the National Health Laboratories for organising regular rounds of EQAS in Myanmar.

Acronyms and abbreviations

FHAM/Joint Programme Implementing Partners	
AFXB	Association François Xavier Bagnoud
AHRN	Asia Harm Reduction Network
AMI	Aide Médicale International
BI-CHR	Burnet Institute's Centre for Harm Reduction
BI-CIH	Burnet Institute's Centre for International Health
CCDAC	Central Committee for Drug Abuse Control; Ministry of Home Affairs
Consortium	Myanmar NGO Consortium (5 member NGOs below)
CARE	CARE International
MNA	Myanmar Nurses Association
MSI	Marie Stopes International
SC-UK	Save the Children-UK
WVI	World Vision International
DEPT	Department of Education, Planning and Training
FHAM	Fund for HIV/AIDS in Myanmar
Alliance	International HIV/AIDS Alliance
LOP	Lashio Outreach Project (UNODC)
Malteser	Malteser International
MANA	Myanmar Anti-Narcotics Association
MBCA	Myanmar Business Coalition on AIDS
MDM	Médecins du Monde
MRCS	Myanmar Red Cross Society
MRT	Ministry of Rail Transportation
MSF-CH	MSF-Switzerland
MSF-H	MSF-Holland (AZG)
NAP	National AIDS Programme, Dept. of Health; Ministry of Health
PARTNERS	Partners NGO
PGK	Pyi Gyi Khin
PSI	Population Services International
SC-US	Save the Children-USA
TCU	Technical Coordination Unit (UNODC)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
Other acronyms	
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral(s)
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
SW	Sex Worker(s)
ETG	United Nations Expanded Theme Group on AIDS
FY	Financial Year
IDU	Injecting Drug User(s)
IEC	Information, Education, Communication
IP	Implementing Partner
JP	Joint Programme for HIV/AIDS in Myanmar
M&E	Monitoring and Evaluation
NCE	No-Cost Extension
PLHIV	Person(s) Living with HIV
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection(s)
TCP	Targeted Condom Promotion
VCCT	Voluntary, Confidential Counselling and Testing