



Global AIDS Response Progress Report

Myanmar

National AIDS Programme

Reporting period: January 2014 – December 2014

Submission date: 15 June 2015

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Acronyms and abbreviations

AEM	AIDS Epidemiological Model
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CSO	Civil Society Organization
DIC	Drop-In Centres
FSW	Female Sex Worker(s)
GARP	Global AIDS Response Progress
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSCC	Health Sector Coordination Committee
HSS	HIV Sentinel Sero-Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
INGO	International Non-Governmental Organization
KP	Key Population(s)
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MOU	Memorandum of Understanding
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MHSCC	Myanmar Health Sector Coordination Committee
MMT	Methadone Maintenance Therapy
MSM	Men who have Sex with Men
MTR	Mid-Term Review
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organization
NSP	National Strategic Plan
NSP II	National Strategic Plan II (2011-2015)
OVC	Orphans and Vulnerable Children
OSP	Opiate Substitution Programme
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PSE	Population Size Estimation
PWID	People Who Inject Drugs
SI	Strategic Information

STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection(s)
TB	Tuberculosis
TG	Transgender
TSG	Technical and Strategy Group
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organization
3MDG	Three Millennium Development Goals Fund

1. Status at a glance

1.1 Reporting process

National AIDS Programme (NAP) in the Ministry of Health (MoH) led the Global AIDS Response Progress Reporting process in Myanmar. Collection and compilation of data started at the beginning of March 2015. Verification of the data between NAP and partners followed through meetings, e-mail and telephone communication. Joint United Nations Programme on HIV/AIDS (UNAIDS), World Health Organization (WHO) and United Nations Children Fund (UNICEF) provided technical support to consolidate the data from different sources. The consolidated data on the Global AIDS Response Progress (GARP) indicators were presented, discussed and reconciled among partners at a validation workshop on 25 March 2015. All of the data are included in this report.

1.2 Status of the epidemic

The human immunodeficiency virus (HIV) epidemic in Myanmar is concentrated among men who have sex with men (MSM), people who inject drugs (PWID) and female sex workers (FSW). HIV prevalence in the adult population aged 15 years and older was estimated at 0.54% in 2014.¹ But data from HIV Sentinel Sero-Surveillance (HSS) indicates higher prevalence in 2014 among key populations: FSW 6.3%, MSM 6.6% and PWID 23.1%. Compared to 2012 data, the prevalence has declined from 7.1% in FSW and 8.9% in MSM, but has increased from 18% in PWID.²

Epidemiological modelling suggests that in 2014 there were around 212,000 people living with HIV (PLHIV) in Myanmar, 34% of whom were females.³ Nearly 11,000 people died of HIV-related illnesses, compared to approximately 15,000 in 2011.

An estimated 9,000 new infections occurred in 2014. Most HIV and AIDS cases are reported from large urban areas, and from the north-eastern and northern areas of the country where injecting drug use is widespread.

1.3 Policy and programmatic response

Government has demonstrated strong political commitment to the national HIV response and there is solid support from partners – UN and bilateral agencies, international and local nongovernmental organizations (NGOs), private entities and civil society. HIV is one of the priority diseases in the current national health plan and high-level officials publicly support HIV-

¹ HIV Estimates and Projections, AEM, Myanmar 2014 (December 2014).

² 2007-2014 HSS trends data, NAP.

³ HIV Estimates and Projections, AEM, Myanmar 2014 (December 2014).

related activities. In 2014, Government earmarked US\$5 million for antiretroviral (ARV) and US\$1 million for methadone maintenance treatment (MMT).

The national response is designed for wide collaboration and focused actions, which NAP coordinates through 45 HIV/STD Teams at sub-national levels. Monitoring and evaluation activities are coordinated by NAP's Monitoring and Evaluation (M&E) Unit.

The National Myanmar Health Sector Coordination Committee (MHSCC) provides oversight for acquired immunodeficiency syndrome (AIDS), tuberculosis (TB), malaria, and maternal, newborn and child health. The MHSCC comprises representatives from government, international agencies, donors, NGOs, the private sector and HIV positive persons. The representatives are selected by their respective constituencies.

The HIV Technical and Strategy Group (TSG) pools expertise from the constituencies represented on the HSCC. There are eight Technical Working Groups (TWGs), each of which focuses on specific programmatic areas including Strategic Information (SI) and M&E. TWGs are open to voluntary representation from stakeholders.

The Revised National Strategic Plan on HIV and AIDS (2011-2016) reflects recommendations generated by the 2013 mid-term review of the operation of the National Strategic Plan II (2011-2015) (NSP II).

The objectives are:

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

There are three strategic priorities:

- Prevention of transmission of HIV through unsafe behaviours in sexual contacts and injecting drug use;
- Comprehensive continuum of care for people living with HIV; and
- Mitigation of the impact of HIV on PLHIV, and their families.

Cross-cutting interventions support the strategic priorities:

- Health and community systems strengthening;
- Favourable environment for reducing stigma and discrimination; and
- Strategic information, research and monitoring and evaluation.

The National Strategic Plan (NSP) links prevention, treatment and care, especially in relation to prevention of mother-to-child transmission and HIV counselling and testing. It outlines the strategies, identifies the target populations, the implementing partners and the activities for each strategic priority. It prioritises reducing HIV transmission through unsafe injecting practices among PWID – the sub-population with the highest HIV prevalence – as well as antiretroviral therapy, reducing TB and HIV coinfection.

1.4 Indicator overview

Indicator	Status	Source	Value
Target 1. Reduce sexual transmission of HIV by 50% by 2015			
1.1 Young people: Knowledge about HIV prevention	Data available	BSS (2007)	47.5%
1.2 Sex before the age of 15	Data available	BSS (2007)	0.7%
1.3 Higher-risk sex	Data available	BSS (2006)	6.6%
1.4 Condom use during high risk sex	Data available	BSS (2006)	43.8%
1.5 HIV testing in the general population	Data available	BSS (2006)	11.3%
1.6 HIV prevalence in young people	Data available	HSS (2014)	0.7%
1.7 Sex workers: Prevention programmes	Data available	BSS (2008)	76.2%
1.8 Sex workers: Condom use	Data available	BSS (2008)	95.9%
1.9 Sex workers: HIV testing	Data available	BSS (2008)	71.1%
1.10 Sex workers: HIV prevalence	Data available	HSS (2014)	6.3%
1.11 Men who have sex with men: Prevention programmes	Data available	IBBS (2009)	69.1%
1.12 Men who have sex with men: Condom use	Data available	IBBS (2009)	81.6%
1.13 Men who have sex with men: HIV testing	Data available	IBBS (2009)	47.6%
1.14 Men who have sex with men: HIV prevalence	Data available	HSS (2014)	6.6%
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015			
2.1. People who inject drugs: Prevention programmes (needles per person and year)	Data available	Annual Reports	168
2.2 People who inject drugs: Condom use	Data available	IBBS (2014)	22.9%
2.3 People who inject drugs: Safe injecting practices	Data available	IBBS (2014)	86.0%
2.4 People who inject drugs: HIV testing	Data available	IBBS (2014)	22.2%
2.5 People who inject drugs: HIV prevalence	Data available	HSS (2014)	23.1%

Indicator	Status	Source	Value
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths			
3.1 Prevention of mother-to-child transmission	Data available	NAP	79.8%
3.2 Early infant diagnosis	No data		--
3.3. Mother-to-child transmission rate (modelled)	Data available	NAP	15.1%
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1 HIV treatment: Antiretroviral therapy	Data available	NAP	40.4% ⁴ 69.7% ⁵
4.2 HIV treatment: 12 month retention	Data available	NAP	82.1%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015			
5.1 Co-management of TB and HIV treatment	Data available	NAP	5,749
Target 6. Reach a significant level of annual global expenditure (US\$22–24 billion) in low and middle-income countries.			
6.1 AIDS spending (in USD)	Data available	NASA 2012 NASA 2013	39,422,290 53,517,925

⁴ This is based on the new GARP indicator definition where the denominator is all people living with HIV.

⁵ This is based on national ART eligibility criteria (≤ 350 CD4 count).

2. Overview of the HIV epidemic

HIV prevalence in Myanmar's adult population (aged 15 and older) is declining. It was estimated at 0.54% in 2014 and is projected to decline further to 0.44% by 2021.⁶ While there have been major gains through implementation of prevention and treatment programmes, annual HIV Sentinel Sero-Surveillance (HSS) data show that HIV prevalence among key populations (KP) including PWID, MSM and FSW remains very high. Table 1 summarizes the results from the latest round of HSS conducted in 2014.

Table 1. HIV prevalence among sentinel groups, HSS 2014

Sentinel Group	# tested for HIV	# HIV positive	Sero positive (%)	Range			95% CI (%)
				Min (%)	Median (%)	Max (%)	
Male STI patients	4,409	175	3.97	0.67	3.33	11.70	3.39-4.55
FSW	1,915	120	6.27	2.00	6.44	13.00	5.18-7.35
IDU	1,007	233	23.14	4.60	20.00	35.50	20.53-25.75
MSM	800	53	6.63	1.50	5.00	15.00	4.90-8.35
Pregnant Women	13,392	103	0.77	0.25	0.50	2.75	0.62-0.92
New Military Recruits	498	7	1.41	0.56	1.22	1.87	0.37-2.44
New TB patients	3,340	285	8.53	1.43	7.34	27.54	7.58-9.48
Blood Donors	20471	28	0.14	0.00	0.00	0.37	0.09-0.19

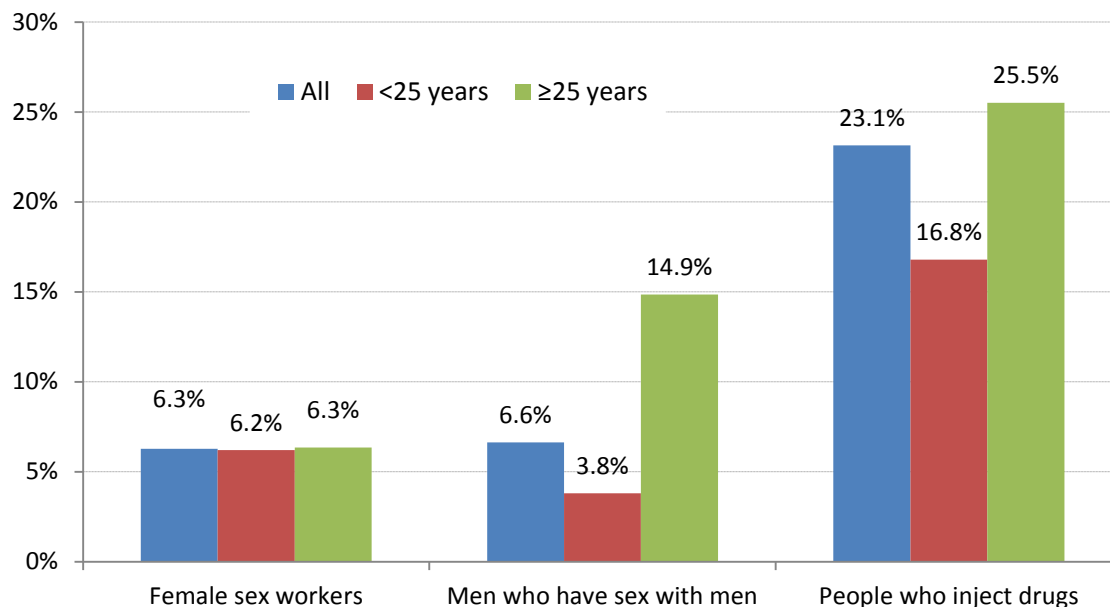
Source : HSS 2014, NAP

Myanmar has conducted annual HSS since 1992 among FSW, PWID, pregnant women attending antenatal care, blood donors, new military recruits and male clients of sexually transmitted infection (STI) services. Newly-diagnosed tuberculosis (TB) patients were added in HSS as a sentinel group in 2005 and MSM were added in 2007.

⁶ HIV Estimates and Projections, AEM, Myanmar, Dec. 2014.

HIV prevalence among MSM and PWID aged 25 or older was significantly higher at 14.9% and 25.5%, respectively, in 2014 compared to their younger counterparts (aged below 25 years), at 3.9% and 16.8%. Prevalence among FSWs in these two age groups is almost the same (Figure 1).

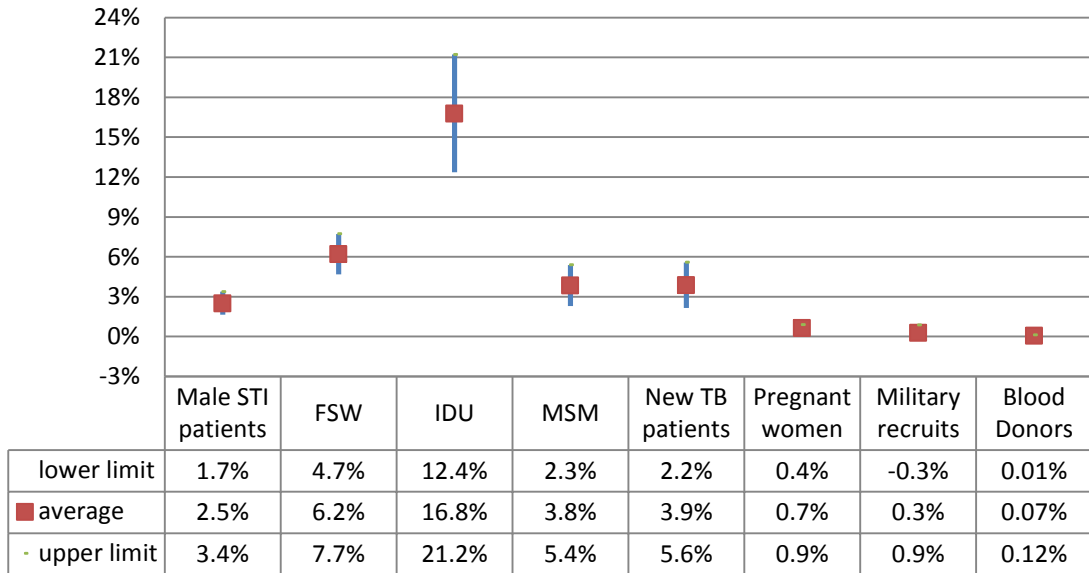
Figure 1: HIV prevalence among FSW, MSM and PWID (2014)



Source: 2014 HSS, NAP

The high prevalence among young PWID, relative to the other young KP (Figure 2), indicates the high HIV risks associated with injecting drug use and HIV vulnerability among young PWID. Several challenges are associated with reaching PWID with HIV prevention services in Myanmar. Opium use is endemic in the northern and north-eastern areas of the country where the drug is produced and trafficked and therefore available. Insecurity in disputed areas and remoteness of other areas are additional challenges to expanding the coverage of harm reduction programmes.

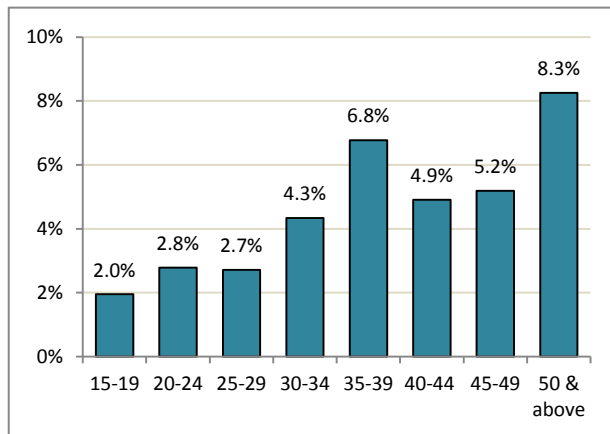
Figure 2: HIV prevalence among youth 15-24, HSS 2014



Source: HSS 2014, NAP

Figures 3-7 show HIV prevalence among sentinel groups disaggregated by age. Significant fluctuations in HIV prevalence among the age groups occur over the years, which is largely due to small sample sizes and small number of cases in some categories. Therefore data disaggregated by age should be interpreted with caution.

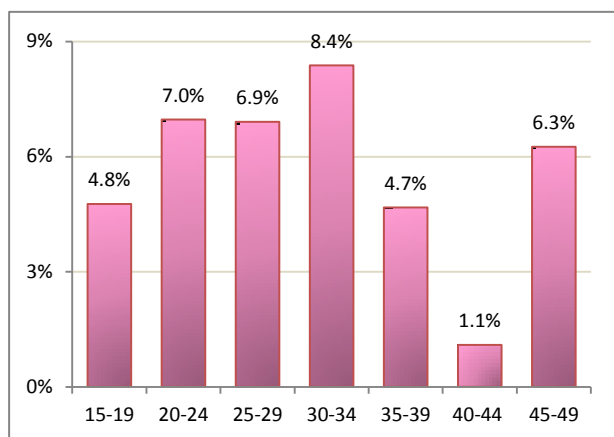
Figure 3: HIV prevalence among male STI clients



The higher prevalence among male STI patients aged 30 and above may indicate concurrent multiple-sexual partnerships with risks for HIV transmission among couples, as 53% of the sentinel population of male STI clients were married. Only 2% reported being separated or divorced.

Source: HSS 2014, NAP

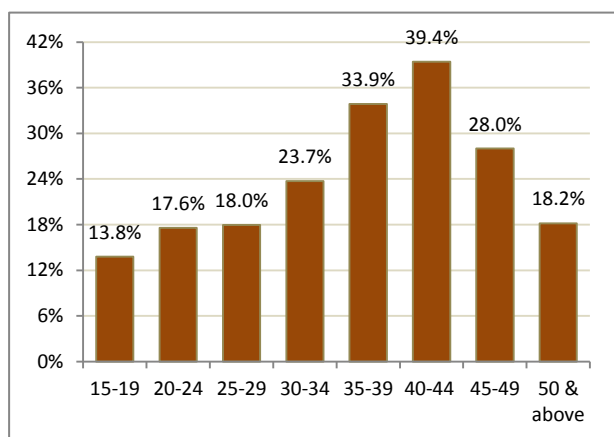
Figure 4: HIV prevalence among FSW



Source: HSS 2014, NAP

Marginal differences separate HIV prevalence among the age groups, and the average prevalence is 6.3%, except in the 40-44 age group. Forty-three percent of FSW reported being married, 7% separated or divorced.

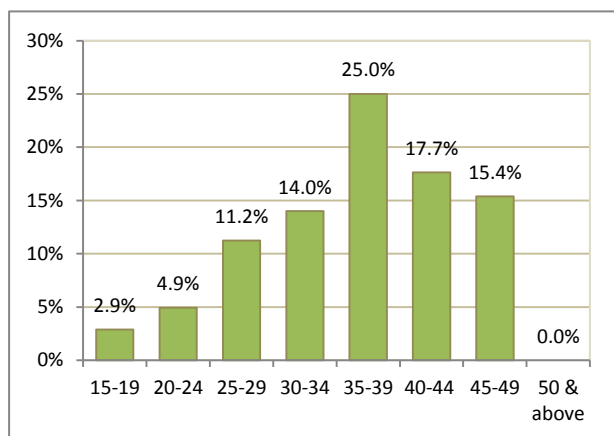
Figure 5: HIV prevalence among PWID



Source: HSS 2014, NAP

HIV prevalence among the age groups 35-39 and 40-44 is well above the average prevalence of 23.1%. Four in 10 of PWID aged 44-49 in the sentinel group tested HIV-positive, 44% were married and 3% were separated or divorced.

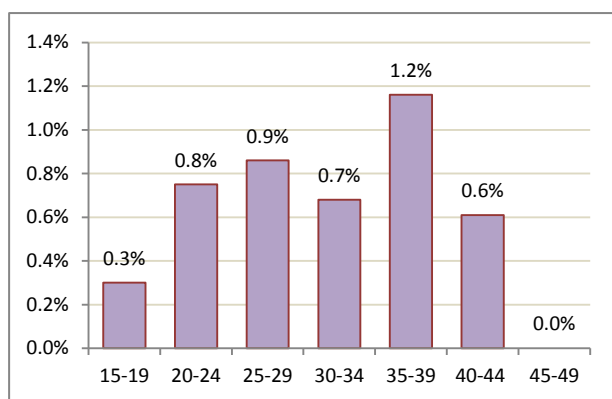
Figure 6: HIV prevalence among MSM



Source: HSS 2014, NAP

MSM in the age groups 25-49 have significantly higher HIV prevalence than the average prevalence of 6.6%. Twenty five percent of MSM aged 35-39 who were tested at the sentinel sites were found to be HIV positive compared to 2.9% in the age group 15-19.

Figure 7: HIV prevalence among pregnant women

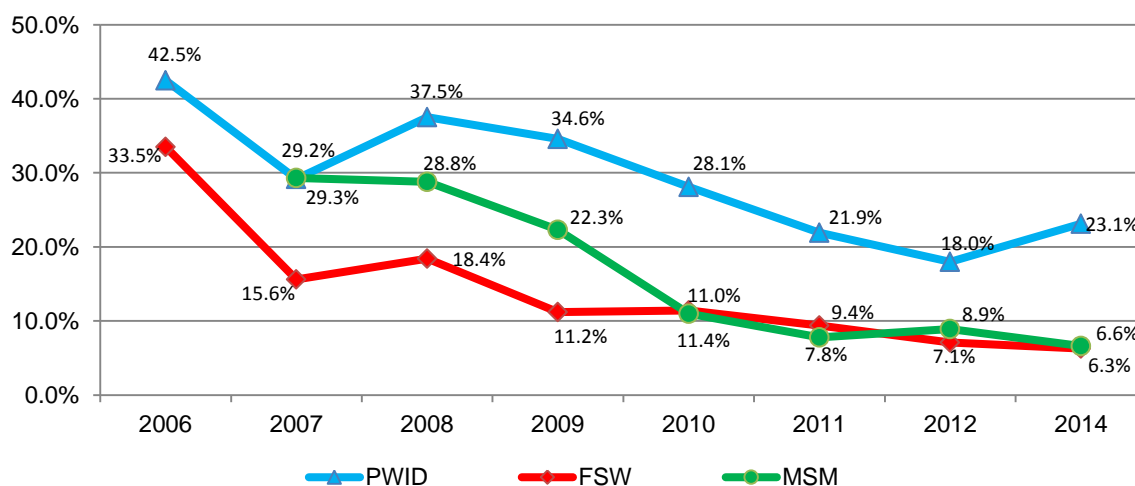


HIV prevalence among pregnant women in the 35-39 age group is nearly twice the average prevalence of 0.77%. Prevalence in the age group 15-19 is significantly lower than average at 0.3%.

Source: HSS 2014, NAP

Generally, there is a sustained downward trend in HIV prevalence among the sentinel groups reflecting the effectiveness of programmes for safer sexual behaviours and harm reduction which include HIV counselling and testing, STI treatment, ART, condom promotion and distribution, and the provision of free sterile needles and syringes. Figure 8 shows that prevalence rates in 2014 were well below their peaks in the mid-2000s.

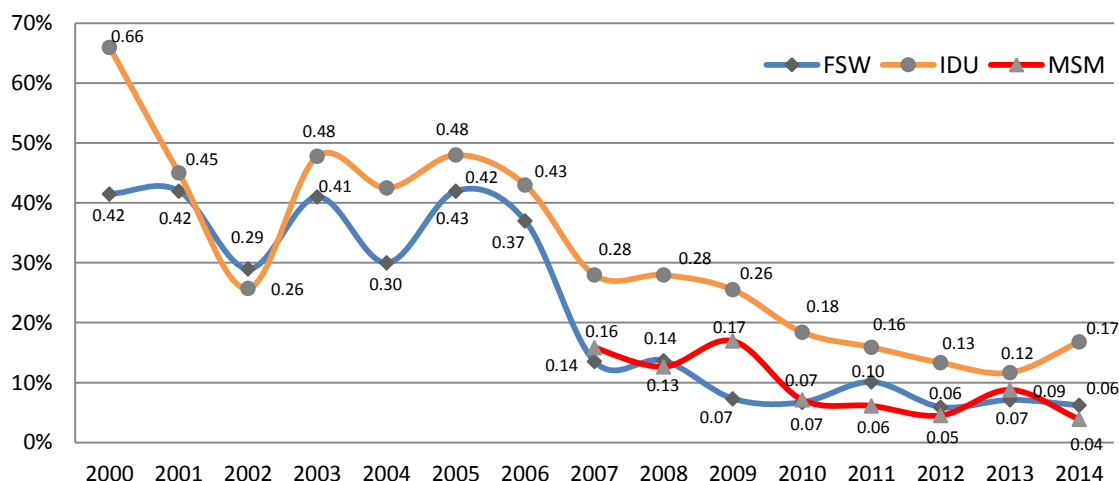
Figure 8: HIV prevalence among key populations (2006-2014)



Source: HSS 2006-2014, NAP

Since 2010, HIV prevalence among young MSM and FSW has remained below 10%. Prevalence among young PWID (Figure 9), though consistently higher overall, has fallen significantly despite some increase since 2012.

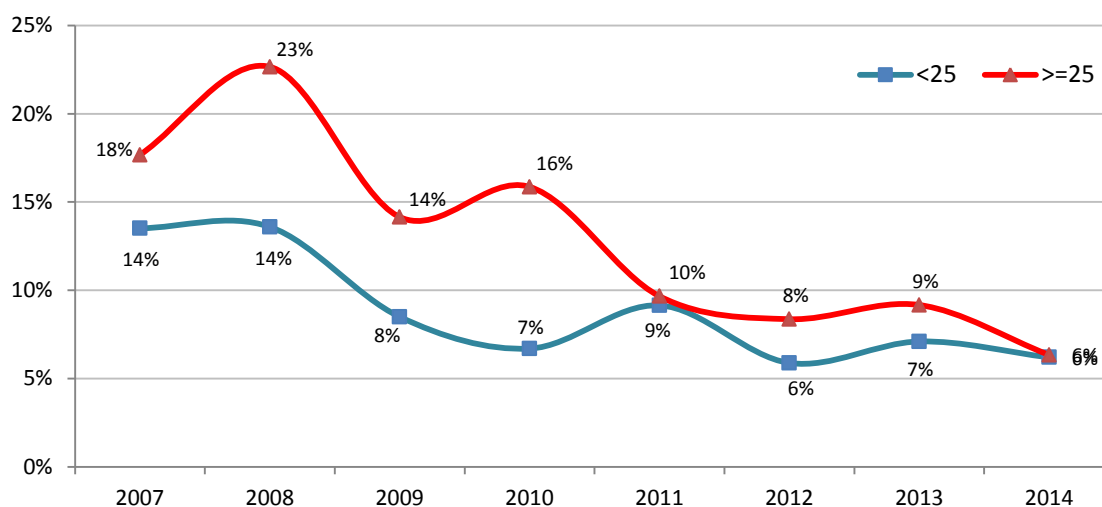
Figure 9: HIV prevalence among key populations (aged 15-24)



Source: HSS 2000-2014, NAP

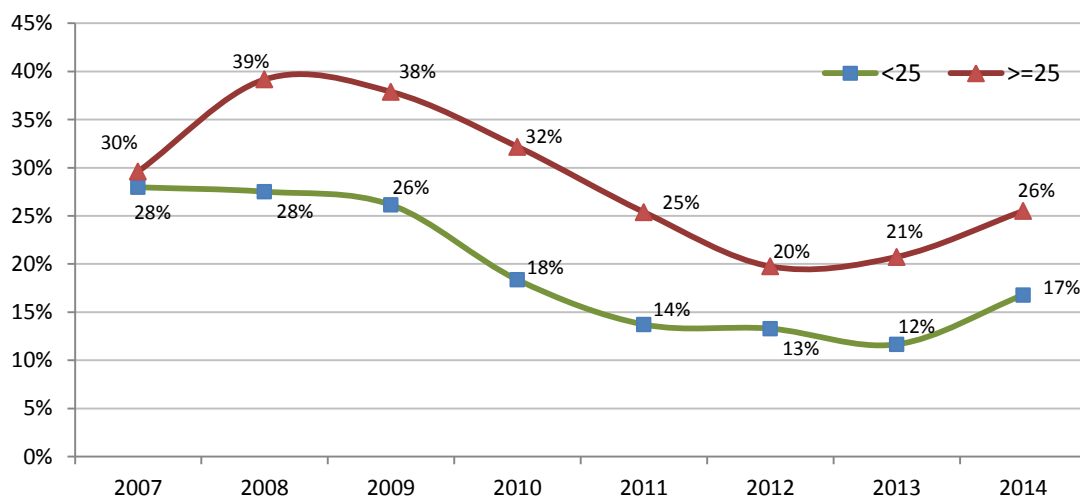
Figures 10, 11 and 12 show trends of HIV prevalence among younger and older FSW, PWID and MSM, respectively. The gap between FSW aged below 25 and 25 and above has narrowed since 2011 and remained close since. However, there is greater difference between prevalence among younger and older PWID and MSM. More research is required to gain understandings of the relative disparities of prevalence among the age groups.

Figure 10: HIV prevalence among FSW, disaggregated by age



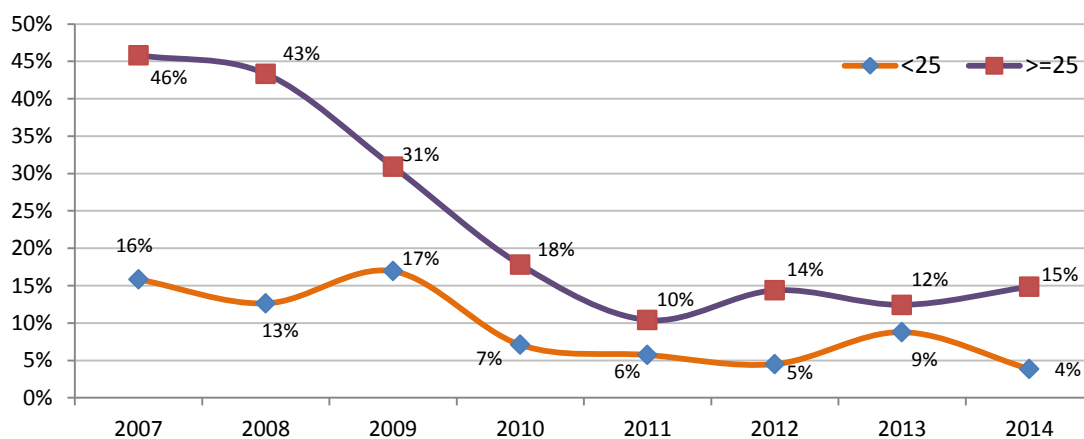
Source: HSS 2007-2014, NAP

Figure 11: HIV prevalence among PWID, disaggregated by age



Source: HSS 2007-2014, NAP

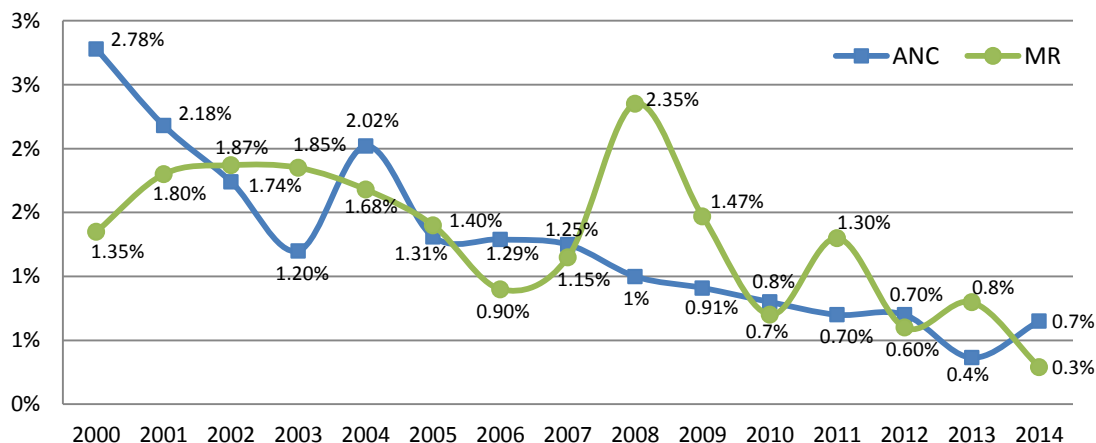
Figure 12: HIV prevalence among MSM, disaggregated by age



Source: HSS 2007-2014, NAP

Since 2009, HIV prevalence among young pregnant women has remained below 1%, (Figure 13). The prevalence among young new military recruits, assessed at two sites, has fallen and remained below 1% since 2012. The trend in both is consistent with the prevalence trend for the general population.

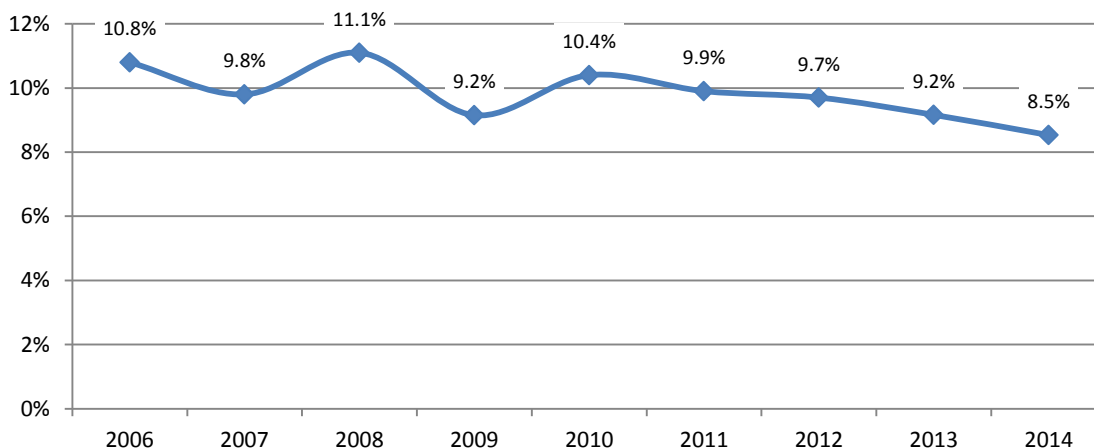
Figure 13: HIV prevalence among young (15-24) pregnant women and new military recruits



Source: HSS 2000-2014, NAP

Figure 14 shows a decline in HIV prevalence among new TB patients. While this is consistent with the overall trends for the sentinel groups, the prevalence among new TB patients remains relatively high and is evidence of the strong link between the HIV and TB.

Figure 14: HIV prevalence among new TB patients



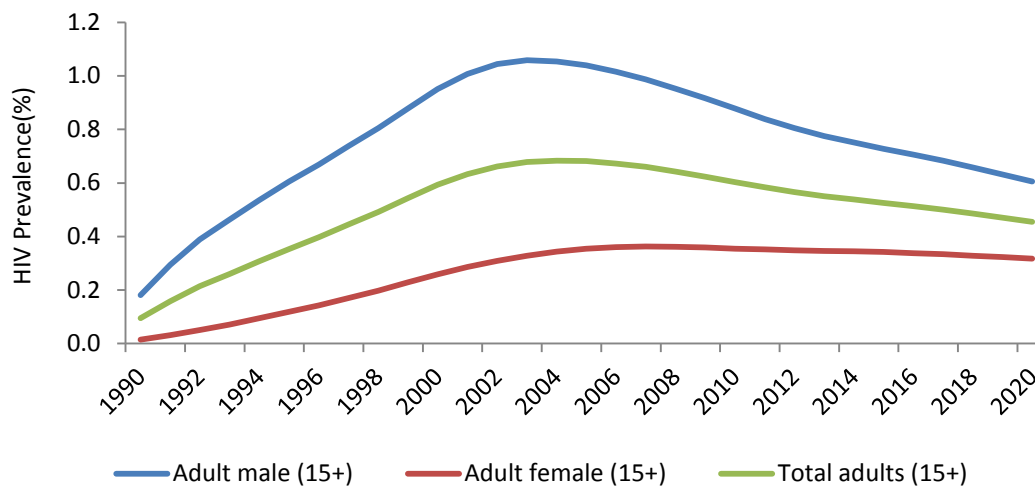
Source: HSS 2006-2014, NAP

Most recent modelling of Myanmar’s HIV epidemic done has offered new estimates and projections.⁷ HIV prevalence among the adult population has declined by more than half since it peaked in 2004. There are fewer AIDS-related deaths and fewer new HIV infections. This

⁷ HIV Estimates and Projections, AEM, Myanmar 2014 (December 2014).

downward trend is expected to continue over the next three years and beyond. But the drop in HIV prevalence is projected to be more gradual than in the past as more PLHIV will benefit from treatment and therefore live longer. Prevalence is projected to decrease only to 0.44% in 2021, if interventions continue at current levels (Figure 15).

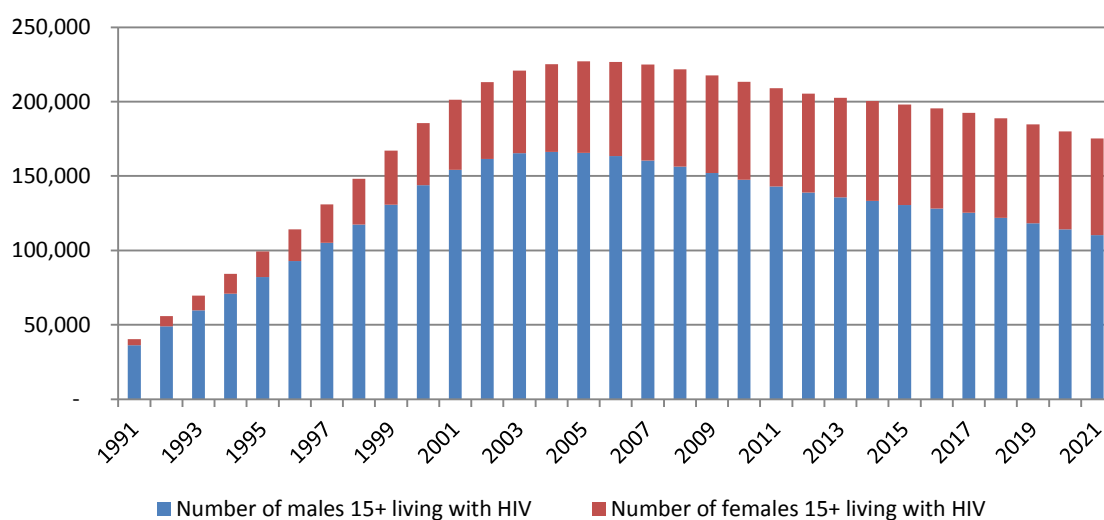
Figure 15: Prevalence in general population, 15 years old and above (1990–2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

Among the approximately 212,000 people living in with HIV in Myanmar in 2014 about one-third were females (Figure 16).

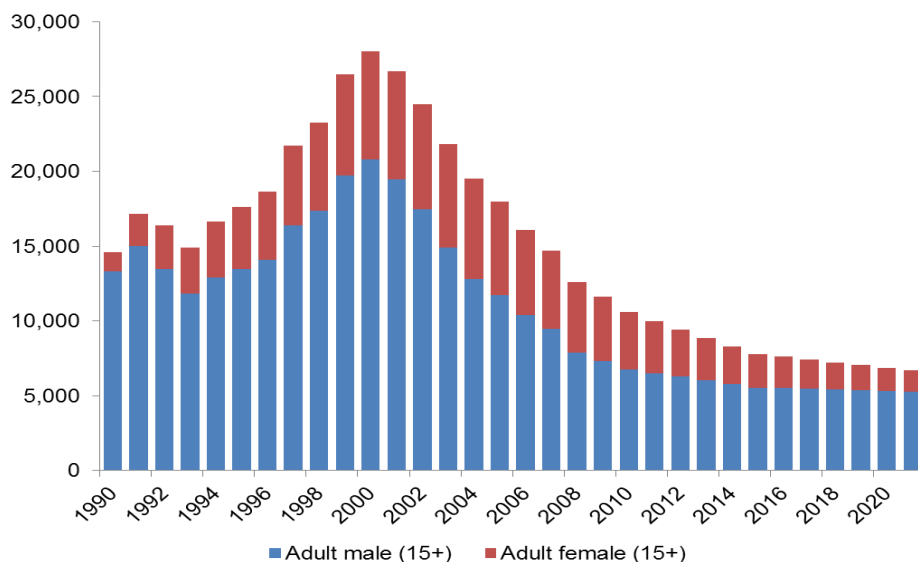
Figure 16: Number of people living with HIV by sex (1991-2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

Thirty percent of new HIV infections were among females in 2014. This proportion is expected to slightly increase until 2017 and then diminish. In 2021 it is estimated that 28% of new infections will occur among females.

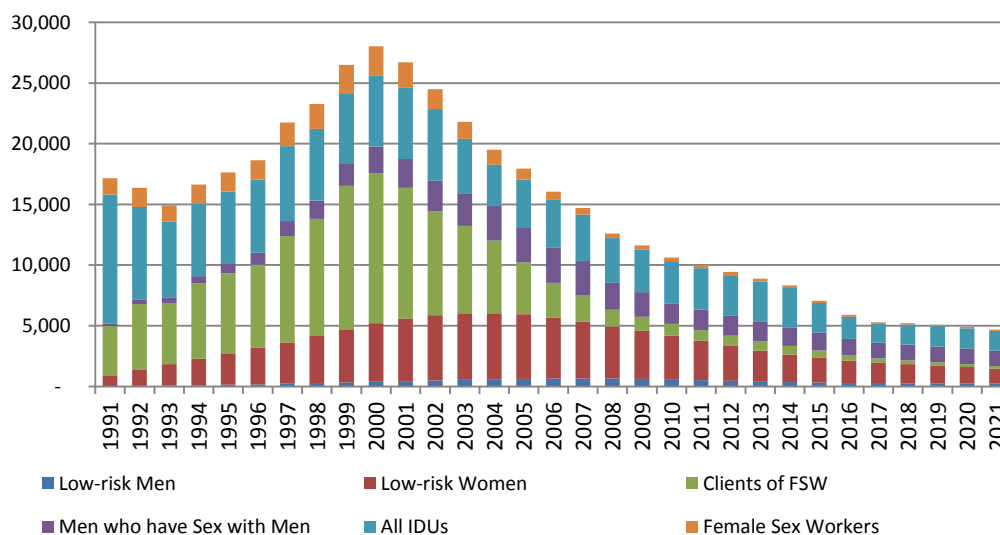
Figure 17: New HIV infections by gender (1990-2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

New HIV infections are expected to continue to decline across all populations groups, but some will be affected by the epidemic to a greater extent than others. In 2014 the highest proportions of new infections were among PWID (39%), low-risk women (27%) and MSM (18%) (Figure 18). Infections in these groups are projected to also make up the largest share of the total number of new infections in 2021 (PWID 35%; low-risk women 26% and MSM 27%).

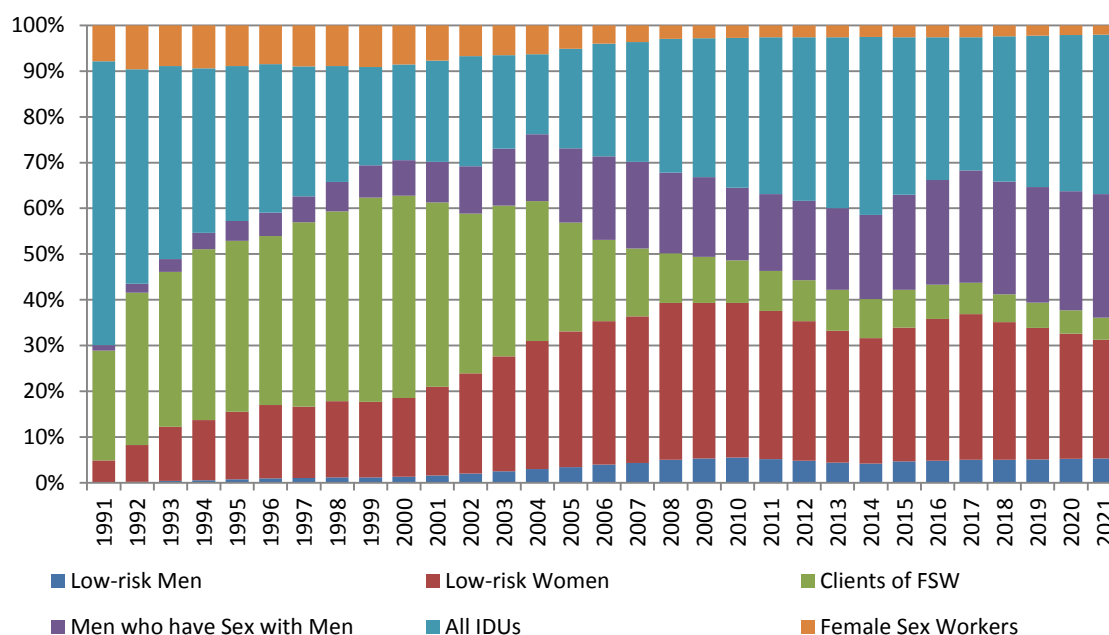
Figure 18: HIV incidence by key populations (1991-2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

Figure 19 shows that the relative burden of new infections shifts considerably over the years. High proportions of FSW and their clients were infected with HIV in the late 1990s. The knock-on effect of this was a swell in the proportion of women being infected by their male partners. After 2010, the proportion of new infections contributed by PWID and MSM also increased. But low-risk women still make up a considerable proportion of new infections, which indicates increasing transmission between intimate partners as significant proportions of male STI clients and PWID are married, and condom use among regular partners is very low.

Figure 19: Distribution of new infections among key populations (1991-2021)

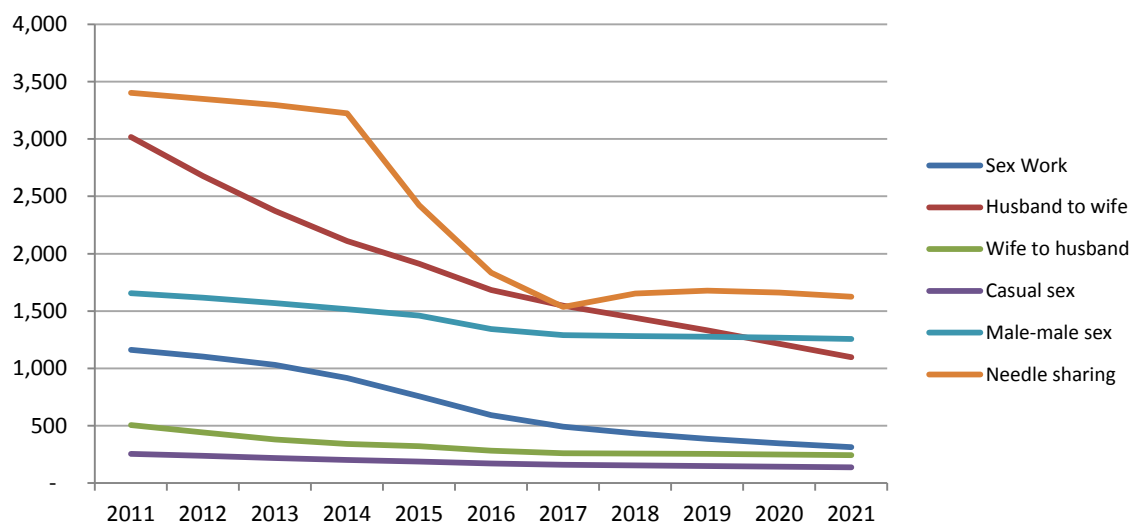


Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

Sharing contaminated needles (mainly male-male) will remain the primary mode of transmission of new HIV infections in Myanmar. But sexual contacts – male-male and heterosexual sex – also contribute significantly to the main modes of transmission, even though the number of new infections is projected to decline. The dominance of males among those newly infected suggests that there is a need to intensify targeted HIV prevention interventions for males, addressing in particular the risks associated with the construction of masculinity. Relatively small numbers of new infections are attributable to casual, non-commercial sex, and mother-to-child transmission. Infections due to these reasons will decline with the general decline in HIV incidence.

Projected trends in new infections by mode of transmission are displayed in Figure 20.

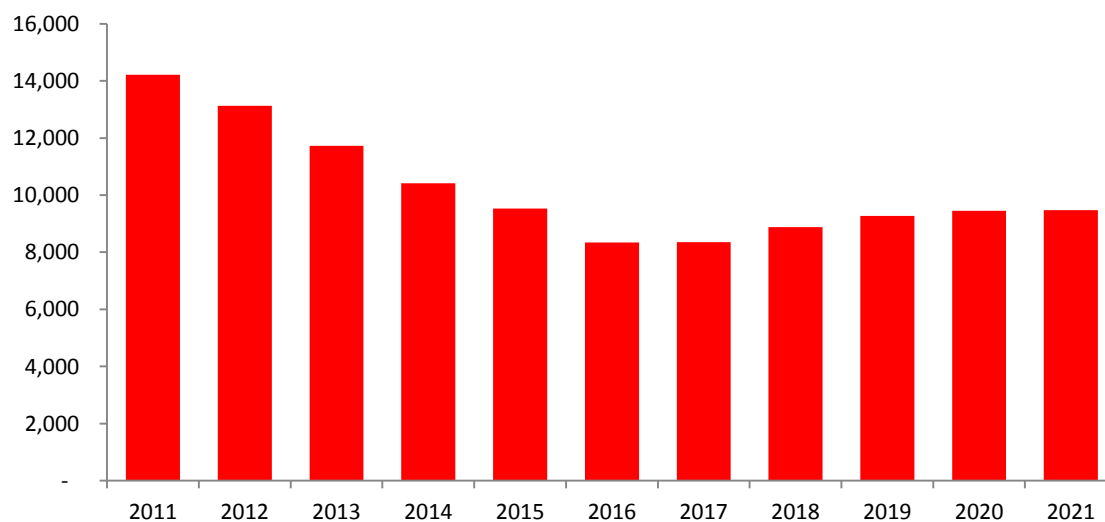
Figure 20: New infections by mode of transmission (2011-2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

The estimated number of annual HIV-related deaths was over 10,000 in 2014 (Figure 21). A decline and levelling off is expected over the next three years, as antiretroviral therapy and support services for PLHIV expand.

Figure 21: Number of estimated annual deaths due to AIDS (2011-2021)



Source: HIV Estimates and Projections Myanmar, AEM Dec 2014

3. National response to the epidemic

3.1 Policy environment

3.1.1 Myanmar National Strategic Plan on HIV and AIDS (2011–2016)

NAP and partners extended the duration of NSP II by one year to end in December 2016 in order to align the national plan with the end-date of the GFATM grant. This was one outcome of the 2013 Mid-Term Review (MTR), which assessed the relevance, effectiveness, efficiency and sustainability of strategies and activities against progress made since 2010 as well as assessing available resources, opportunities and challenges ahead.

Strategic information generated by the review has been used to adjust, revise and recast the NSP II and fill programmatic, financial and human resources gaps. The revised national strategy reflects the recommended revisions made in the MTR.

As a result, the following areas were given greater emphasis in 2014 in order to achieve by 2015 the Ten Targets set at the United Nations General Assembly High Level on AIDS in December, 2011:

1. Decentralisation of HIV counselling and testing and ART and provider-initiated counselling and testing.
2. Scaling up of public sector ART as well as more effective ways to respond to chronic care in decentralised settings.
3. Prioritising orphans and vulnerable children living with and affected by HIV.
4. Improving and interlink monitoring and reporting systems for ART, PMTCT and TB to generate relevant and better quality data.
5. More efficient use of existing financial and human resources.
6. Integration of harm reduction into community-based settings.
7. Strengthening community-based organizations and self-help groups for greater involvement.
8. Revitalising and strengthening coordination mechanisms, particularly at district and township levels.

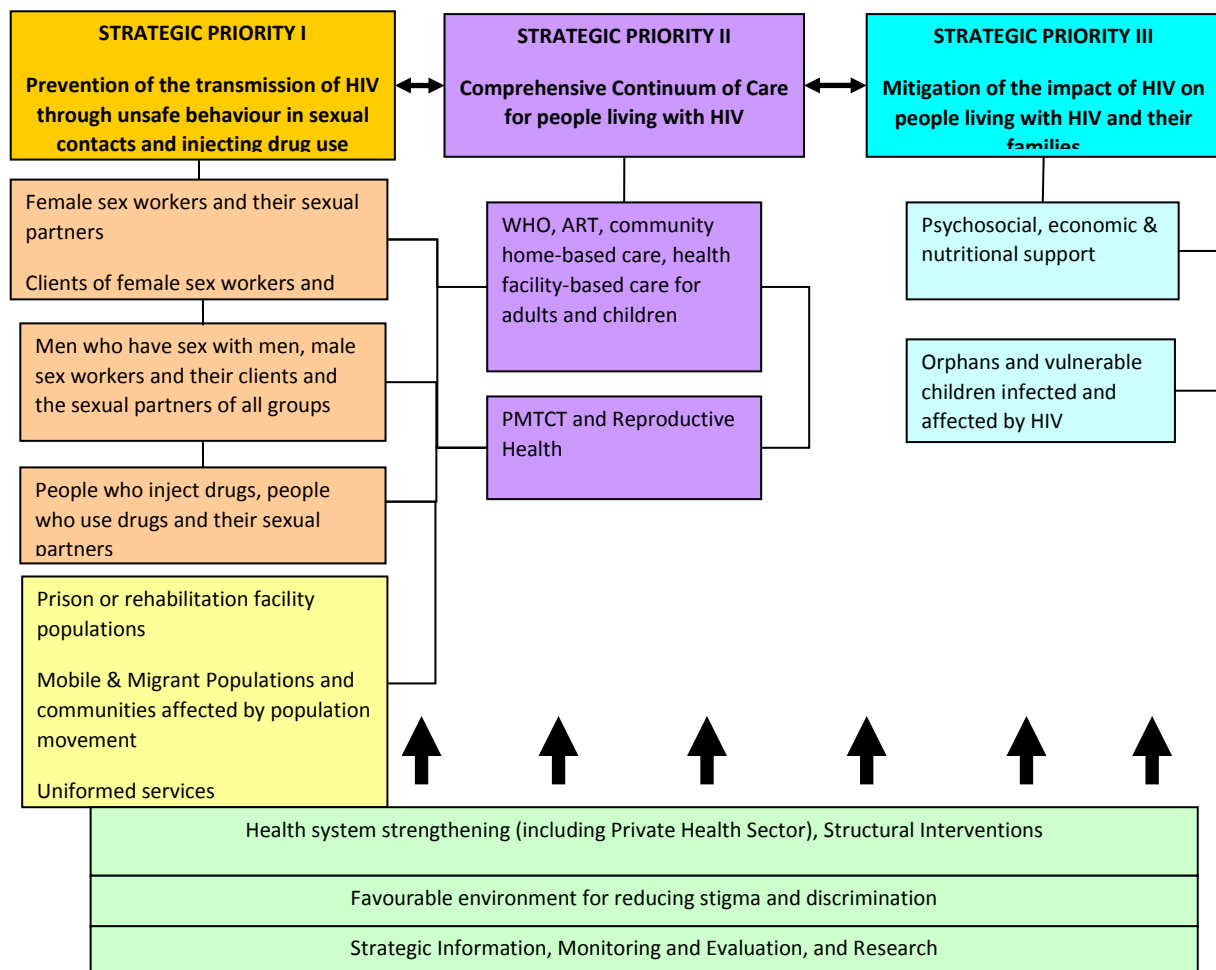
The 2013 MTR concluded that extraordinary efforts and commitment by all stakeholders were needed if Myanmar was to achieve the HIV-related Millennium Development Goal (MDG) targets by 2015, and that those efforts must not only be sustained, but also significantly scaled up to meet even more ambitious 2016 NSP targets set in the revised NSP II.

The revised NSP II aims to:

- Cut new infections by half of the estimated level of 2010.
- Bring ART to 86% of people who are eligible for treatment, based on the current national treatment guidelines and criteria of CD4 counts below 350, with no discrimination in regard to gender, ways of transmission, origin and location.
- Ensure 80% of women living with HIV receive antiretroviral prophylaxis to reduce the risk of mother-to-child transmission.

- Increase intervention coverage for groups with risk behaviours and support those in need.
- Mitigate the impact of AIDS.

Figure 22: Priority setting of the National Strategic Plan on HIV and AIDS, Myanmar 2010–2016



3.1.2 Travel restrictions

HIV testing is not a condition for entry, work or residence in Myanmar.

3.2 Programme implementation

For prevention interventions NSP II prioritizes the following key populations most at risk of becoming infected with HIV:

- FSW, their clients and the sexual partners of both;
- PWID and their sexual partners;
- MSM and their sexual partners;

- Transgender people, male sex workers, their clients and the sexual partners of both;
- Sexual partners of people living with HIV;
- Populations in closed settings (prison facilities, detention and rehabilitation centres); and
- Children born to HIV-infected parents.

3.2.1 Strategic Priority I: Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use

New sentinel surveillance data for key populations (HSS 2014) and new integrated biological and behavioural surveillance data as well as population size estimates (PSE) for PWID (Integrated Biological and Behavioural Surveillance (IBBS) 2014) have become available since the last round of reporting. HIV estimates and projections for key populations were completed in December 2014 using the AEM software. In addition, new SPECTRUM software has been issued in May 2015, and has been used in Myanmar to calculate core indicators, such as the coverage of treatment and prevention of mother-to-child transmission (PMTCT).

Preparations for FSW and MSM and transgender (TG) IBBS and Population Size Estimation (PSE) have begun. Surveys have been planned at five sites and survey instruments have been developed. A comprehensive IBBS/PSE Protocol for IBBS/PSE has also been developed, covering all of the key populations (KP), and questionnaires have been pre-tested and finalised. Data collection is scheduled to begin in early May and will run to mid-August 2015. Results from the IBBS/PSE are expected to be published in early 2016.

These developments are immediate outcomes of the development of a five-year surveillance and PSE plan developed by the NAP and partners. Financial support has been mobilised through the New Funding Model grant application mechanism of GFATM. The plan was informed by recommendations from an assessment of surveillance and PSE systems conducted in 2013. The assessment acknowledged the notable expansion to the surveillance system, documented the strengths and weaknesses of both and identified areas for improvements.

At the same time that up-to-date behavioural data is being produced, routine monitoring data is used to track progress in the expansion of programmes. The data shows that the coverage of prevention interventions to reduce sexual transmission has increased in 2013 from 2012.⁸ Reports indicate that, along with an 11% increase in expenditure on prevention activities targeting FSW, the number of sex workers reached with interventions has increased by 25%.⁹ These interventions include HIV education, awareness raising activities through outreach, distribution of condoms and referral to HIV counselling and testing (HCT) and sexually transmitted infections (STI) services. Both the number of prevention activities and the number of MSM reached by HIV prevention programmes increased across states and regions, even though there was a 15% drop in spending on prevention for MSM in 2013. There was also an increase in the number of PWID reached by HIV prevention and harm reduction interventions through outreach and drop-in centres. More than 66% of those reached were PWID.¹⁰ The number of sterile needles and syringes distributed to PWID has also increased considerably each year since 2010, with the exception of 2012 when funding flow for HIV-related interventions slowed.

⁸ National Progress Report 2013, NAP.

⁹ Ibid

¹⁰ Ibid

There have been some programmatic challenges. Data disaggregated by state and region show that free sterile needles and syringes may not have been distributed proportionally over the geographic areas where PWID are concentrated. Seventy five percent of sterile injecting equipment was distributed in Kachin State where injecting drug use is highly prevalent. A relatively large number of sterile needles and syringes were also distributed in Mandalay and areas of the Shan State. However some areas in Rakhine State, Yangon, and the Sagaing region received either no, or very few, harm reduction services. Despite the geographic expansion of programmes for PWID, the actual number of drop-in-centres (DIC) decreased in 2013 as one large organization was unable to implement its services during the year. The National Progress Report 2013 concluded that geographical coverage did not satisfy actual needs. Efforts are being made to address the challenges.

Scaling-up of harm reduction activities, such as the provision of methadone maintenance therapy (MMT), has continued in 2014, building on progress made in the previous two years.

The latest behavioural surveillance data collected among groups of the general population, specifically out-of-school youth, was in 2008. According to 2008 BSS, less than half of these young women and men aged 15-24 (47.5%) correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission (GARP indicator 1.1). It can be assumed that this group may have less knowledge of HIV than youth enrolled in school. In any case, it is impossible to know whether progress has been made in the expansion of HIV prevention-related knowledge as this kind of survey has not been repeated since 2008 and no survey among the general population has asked questions to assess HIV knowledge. Likewise, recent data on the proportion of young people aged 15-24 who have had sexual intercourse before the age of 15 is not available (GARP indicator 1.2). In 2007, this was 0.66%.¹¹

Even more outdated is the surveillance data measuring change in higher risk sex (GARP indicator 1.3), and on reported condom use in higher risk sex (GARP indicator 1.4).¹² According to the 2007 BSS, 6.63% of respondents reported having had more than one sexual partner in the past 12 months and 43.8% reported using a condom the last time they had sex.

Considerable efforts to scale-up interventions to prevent sexual transmission of HIV began in 2013 after Myanmar was awarded new funding from GFATM. These efforts have continued into 2014.

Much emphasis is being placed on promoting early HIV testing and enrolment in ART to improve treatment and prevention results. Efforts are continuing to recalibrate approaches to target the clients and partners of FSW and MSM. Efforts to reduce stigma and discrimination also continue to create a more enabling environment for the implementation of prevention programmes among key affected populations. A review of Myanmar's legal framework and its effect on access to health and HIV services for PLHIV and key populations (KP) made recommendations for developing a more supporting environment for reaching people at high risk of HIV infection.¹³

There are improvements in collaboration and coordination by stakeholders at national and sub-national levels. Though there is some progress, there is an urgent need to prioritize capacity

¹¹ 2007 BSS, NAP.

¹² Ibid

¹³ National HIV Legal Review Report, September, 2014.

strengthening and the involvement of community networks in the planning, implementation and monitoring of interventions for KP.

The 2014 IBBS among PWID has provided new data on prevalence and risk behaviours in this group that is at highest risk of HIV infection in Myanmar. The population size of PWID has also been estimated making it easier to evaluate coverage of services. IBBS and PSE among FSW and MSM will be done in 2015. New data will contribute to more robust strategic information that will be used to effectively target prevention efforts at KP and their sexual partners.

As mentioned above, no new behavioural surveillance data concerning the general population (GARP indicator 1.5) has become available since 2007 to measure progress made in recent years on the promotion of HIV counselling and testing (HCT). These questions will be raised in the first Demographic and Health Survey to be conducted in Myanmar in 2015. The 2007 BSS general population data found a testing rate of 11.3% among respondents.

Routine monitoring data, while not comprehensive, can provide an indication of trends. Data supplied by NGOs working with KP indicate that HIV counselling and testing (HCT) uptake has increased by more than 25% over 2012, a recovery from the decline in 2011-2012 due to reduced funding. In 2013, over 100,000 individuals among KP and their sexual partners were tested and received post-test counselling.¹⁴ The increase may be attributable to the NAP's decentralization of HCT. More than 90 townships started providing HCT services during 2013.

Despite some increase, HCT remains low, particularly among KP. One negative consequence of the low uptake of testing is the late enrolment of people in need of ART. This situation is expected to improve with the decentralization of HCT and ART making these services more easily available to those who need them. One problem in the past was that few NGOs were allowed to provide HIV testing services. With the introduction of rapid HIV tests, NGOs are being trained to provide HCT on a much larger scale and also in hard-to-reach areas of the country. Nevertheless, there needs to be intensive effort to ensure scale-up of HIV testing.

3.2.1.1 Sex workers, their clients and their sexual partners

There is no new surveillance data available to measure the percentage of sex workers reached with HIV prevention programmes (GARP indicator 1.7). The most recent source is BSS 2008, which shows that at that time 76.2% of FSW were reached by HIV prevention programmes.¹⁵ More up-to-date routine monitoring data indicates that coverage of prevention programmes for FSW has expanded in the past two years. However, precise measurement of coverage remains problematic in the absence of a unique identifier system that would allow double-counting to be avoided and would help track clients across different services.

HIV education and awareness raising activities in drop-in-centres (DIC) and through outreach programmes along with free condom distribution continue to be the mainstay of prevention efforts targeting FSW. The total number of condoms distributed in 2013 was 39 million, up from 38 million in 2012. These were distributed either free of charge or through social marketing.

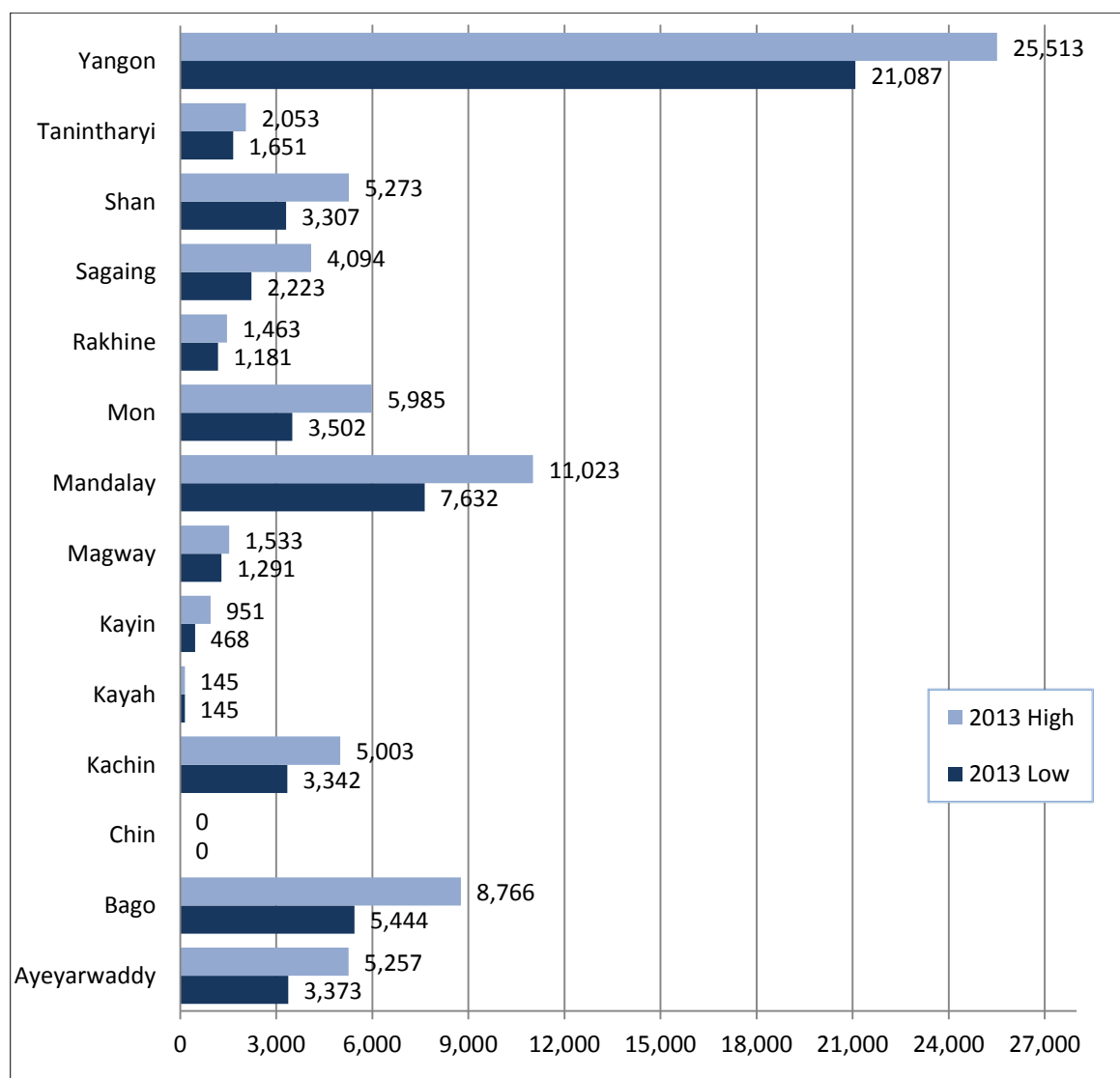
¹⁴ Ibid

¹⁵ 2008 BSS among Injecting Drug Users and Female Sex Workers, NAP.

Nevertheless, this is much less than the 45 million distributed in 2010, and more resources will need to be invested to scale up condom distribution programmes.

Whether condom use rates (GARP indicator 1.8) have increased in recent years as a result of condom distribution programmes will only be known once new data becomes available from the FSW IBBS. In 2008 BSS, FSW reported 95.9% condom use, which appears unrealistically high. This high rate may be explained by the fact that respondents in a survey tend to answer questions in a way that they think the interviewer will view favourably (i.e. desirability bias).

Figure 23: Female sex workers reached by state and region



Source: Progress Report 2013, NAP

HCT and sexually transmitted infection (STI) screening services are offered to FSW by service providers themselves and through referral. A detailed package of prevention services for FSW, which was refined in 2013, is being delivered by public health services and NGOs. National

guidelines have been developed to guide partners in the delivery of the core package of HIV prevention among KP.¹⁶

In 2014, HIV prevalence was 6.3% among FSW, down from 8.1% in 2013.¹⁷ At 6.2%, the prevalence among young FSW, aged 15–24, was almost the same as the average. In 2013, prevalence among young FSW was 7.1%, only marginally lower than the average. This is surprising in a context of a declining epidemic as one would expect prevalence to be lower in young people than in older people, which is the case for MSM and PWID. The fact that HIV prevalence among young FSW is consistently nearer to the average for the group suggests that young FSW are at relatively high risk and need to be targeted by interventions.

3.2.1.2 Men who have sex with men

As it is with FSW, no new behavioural surveillance data have become available in the past five years to measure progress made through the scale-up of the coverage of interventions targeting MSM. The 2009 IBBS found that 69.1% of respondents had been reached with HIV prevention programmes, as defined in the GARP measurement guidelines with regard to indicator 1.11.

According to the routine monitoring data, more MSM were reached by HIV prevention activities in 2013 than in 2012, after the numbers reached declined in the previous two years. Significantly, the increase was recorded across all states and regions, especially in Yangon, Bago and Sagaing.¹⁸ Yangon and Mandalay were the regions where the largest numbers of MSM were reached (Figure 24).

The proportion of men reporting they used a condom the last time they had anal sex with a male partner was 81.6% in 2009 (GARP indicator 1.12).¹⁹ As with reported condom use by FSW, this condom use rate seems too high. Desirability bias that often occurs in interviews is suspected. HIV testing was 27.3% in the 2009 IBBS (GARP indicator 1.13), but the current situation is not known as new data has yet to become available from the 2015 IBBS that is underway.

Routine monitoring data recorded a 37.6% increase in the number of MSM who received HCT in 2013 compared to 2012. Overall, there was a moderate increase in the number of MSM reached by the package of behaviour change communication prevention and STI prevention and treatment over 2012.²⁰ However, efforts are needed to reduce stigma and discrimination in communities generally, and make service facilities more user-friendly and accessible to MSM who are difficult to reach.

The 2014 HIV Sentinel Sero-Surveillance (HSS) found the HIV prevalence among MSM (GARP indicator 1.14) to be 6.6%, which is the lowest prevalence reported in this group and a significant drop from the 10.5% recorded in the 2013 HSS. It is difficult to explain this sharp decline in prevalence as HSS results may fluctuate for several reasons. Small number of sentinel sites (four in 2014 HSS) and small sample sizes could explain fluctuations as could any changes in the way

¹⁶ National Guidelines A Core Package of HIV Prevention Amongst Key Populations in Myanmar, NAP, 2014.

¹⁷ HSS 2013, 2014, NAP.

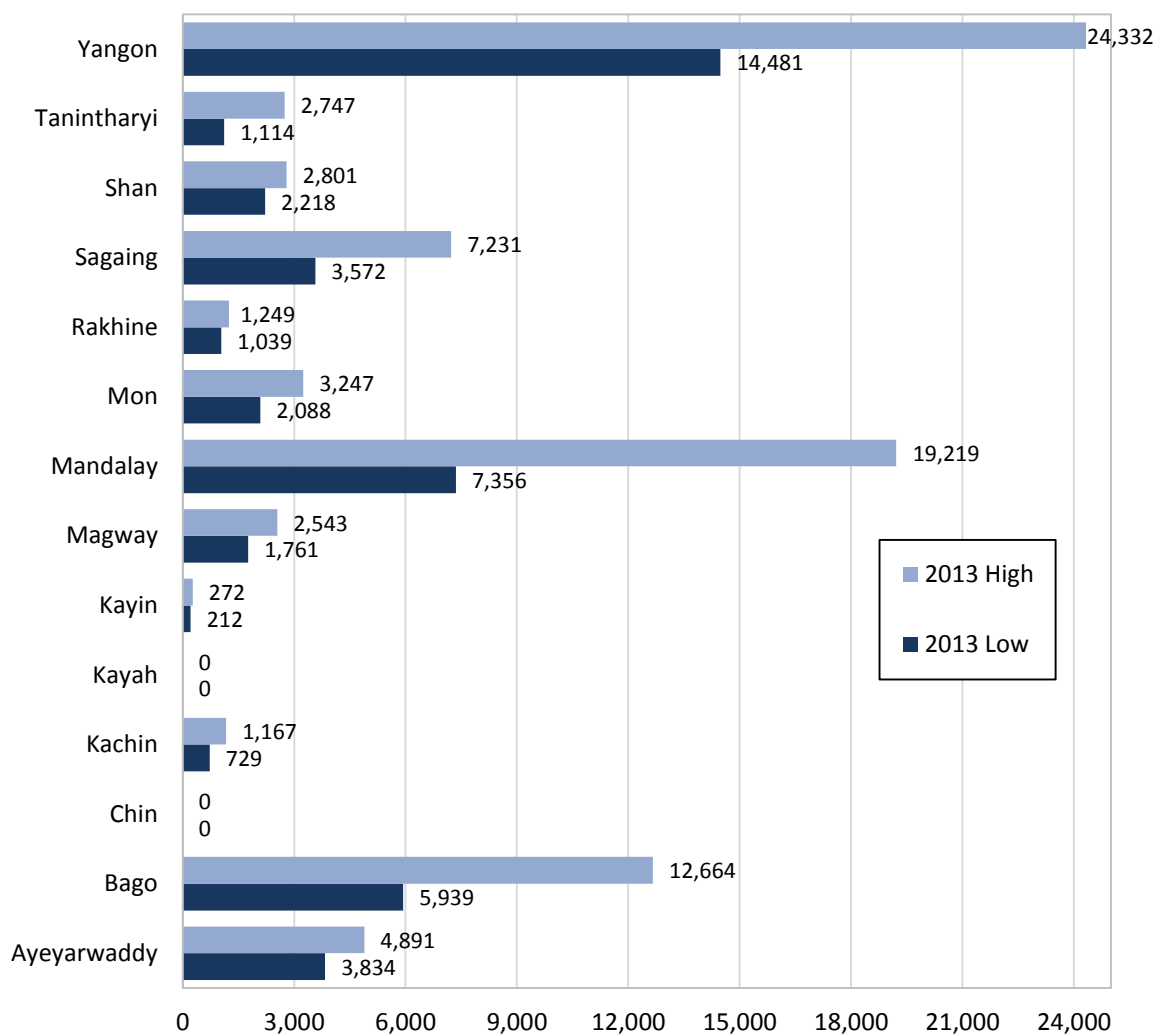
¹⁸ National Progress Report 2013.

¹⁹ 2009 IBBS among MSM

²⁰ Progress Report 2013, NAP.

the surveillance data was collected. It is important to triangulate data from multiple sources to get a clearer picture of the situation of MSM in the country. The prevalence in 2014 was also lower than that of 2012 (8.9%) and marginally lower than in 2011 (7.8%). Among younger men, aged 15-24, who have sex with men HIV prevalence was even lower at 3.8%, and noticeably lower than the average 6.6% in 2014.

Figure 24: Men who have sex with men reached by state and region



Source: Progress Report 2013, NAP

3.2.1.3 People who inject drugs, drug users and their sexual partners

Data collected by the IBBS among PWID at 16 sites in 2014 found HIV prevalence in this group to be 28.3%. This prevalence is much higher than that recorded by HSS 2014. In four townships HIV prevalence was close to 50%. Understandably, lower prevalence rates are recorded in HSS because this is conducted at facilities and therefore data reflects the situation of people who already are in contact with services. IBBS in 2014 found HIV prevalence among young PWID, aged 15-24 years, was 16.8% and among adults, aged over 25, prevalence was 25.5%.

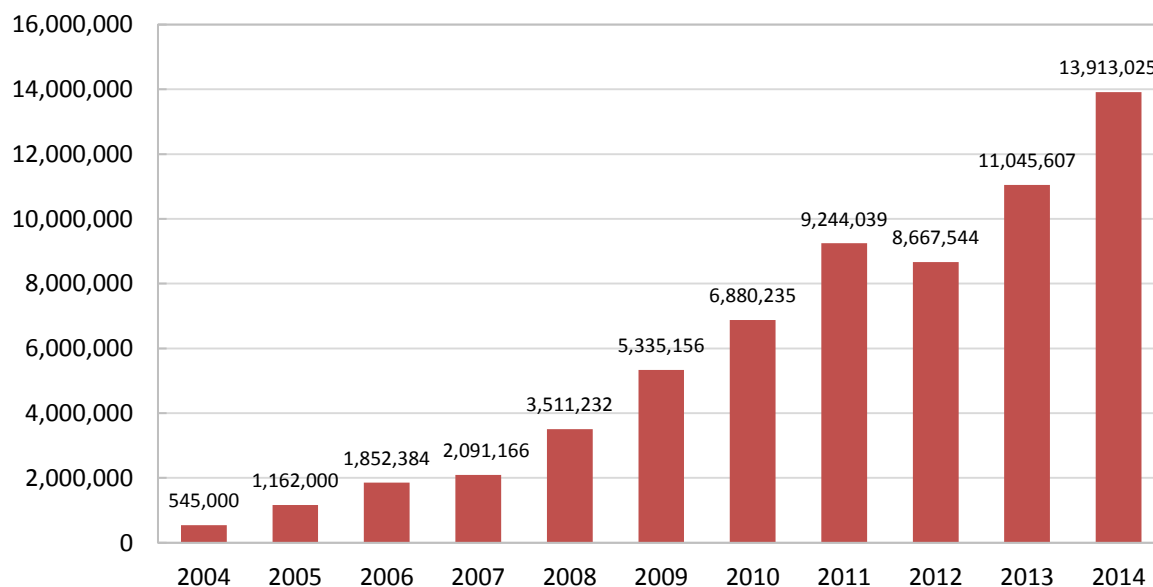
The population of PWID was re-estimated at 83,000 in 2014, which is higher than the estimate of 75,000 produced earlier through discussions and consensus among stakeholders. The 2014 PSE was produced by using service and unique object multiplier methods, wisdom of key informants and other techniques that have their own strengths and weaknesses, but, when triangulated, generate relatively robust population estimates.

Progress in increasing the coverage of prevention programmes for PWID in GARP reporting is measured through the number of sterile needles and syringes distributed. This number has significantly increased. Almost 14 000 000 sterile needles and syringes were distributed to PWID in the reporting period, up from 8.7 million in 2012 and more than twice the number distributed in 2010. Despite this encouraging trend, many more sterile needles and syringes need to be distributed. IBBS data in 2014 shows that access to sterile injecting equipment also varies considerably from place to place, with some areas being completely left out of needle and syringes exchange programmes.

The number of needles and syringes distributed per person who injects drugs per year (GARP Indicator 2.1) has also increased. This number in 2014 was 168. It was 147 in 2013 when the population of PWID was estimated at 75,000. Notwithstanding the increase in the number of needles and syringes distributed per PWID, there are concerns among those who serve the population that this number may be far too low and may reflect a poor understanding of the injecting behaviour of PWID. IBBS data from 2014 shows that the majority of PWID inject 2-3 times daily meaning that seven times as many sterile needles and syringes are needed each year than are currently distributed. More data is needed to measure and ensure the effectiveness of HIV prevention programmes among PWID.

The 2014 IBBS found 23% of PWID reported using a condom during their last sexual intercourse (GARP indicator 2.2). In the previous survey of its kind, 2007 BSS, PWID were asked about their condom use on the last occasion they had intercourse with FSW and 77.6% reported using a condom. The difference is due to the reference made in 2007 question to the use of condoms with commercial sex partners. Use of condoms with commercial sex partners is generally much higher than with regular partners.

Figure 25: Number of sterile needles and syringes distributed in Myanmar (2004–2014)

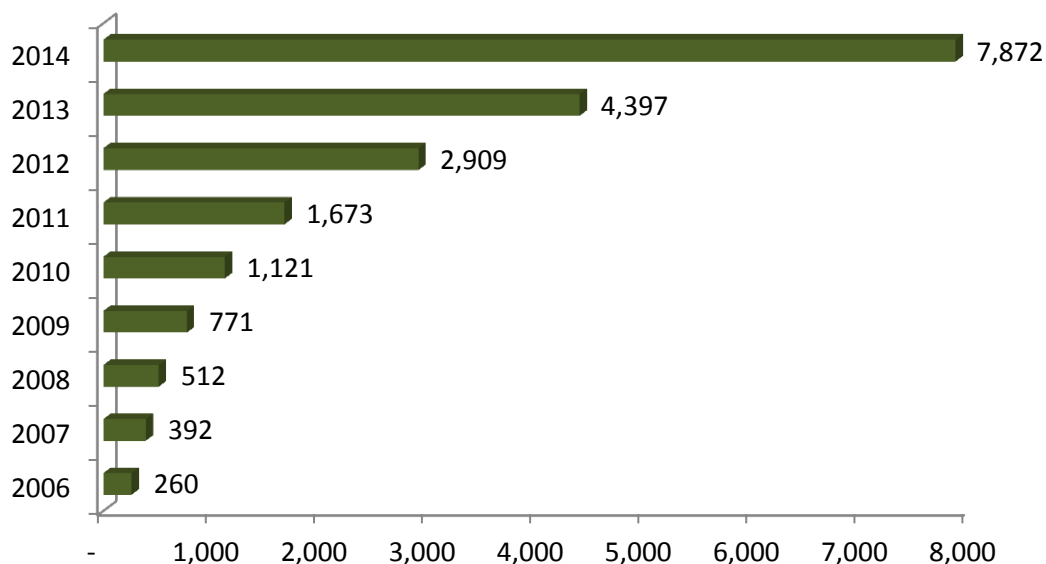


Source: NAP, 2015

In the 2014 IBBS, the percentage of PWID who reported using sterile injecting equipment the last time they injected (GARP indicator 2.3) was 86.0% compared to 80.6% in 2007 BSS. This shows an increase in safe injecting practices. In 2014 87.1% of PWID aged 15-24 reported use of sterile injecting equipment last time they injected compared to 85.7% of those aged 25 years and older.

The percentage of PWID who reported having received an HIV test in the past 12 months and who knew the test result (GARP indicator 2.4) was 22.2% in 2014, even lower than the 27.3% registered in 2007. Only 16% of PWID aged 15-24 and 25% of PWID aged 25 or older said they had received HIV tests and knew their results. These low levels of HIV testing raise serious concerns about the adequacy and coverage of prevention services among this group which is at highest risk of HIV infection.

While overall the coverage of HIV prevention and harm reduction programmes for PWID is expanding, questions about whether programmes are having the desired effects remain. Information gathered through routine monitoring of programme outputs shows that the provision of sterile needles and syringes, coverage of MMT, HIV education and distribution of condoms, and other services for PWID have grown significantly but more needs to be done to promote HIV awareness and behaviour change that can help avert new infections.

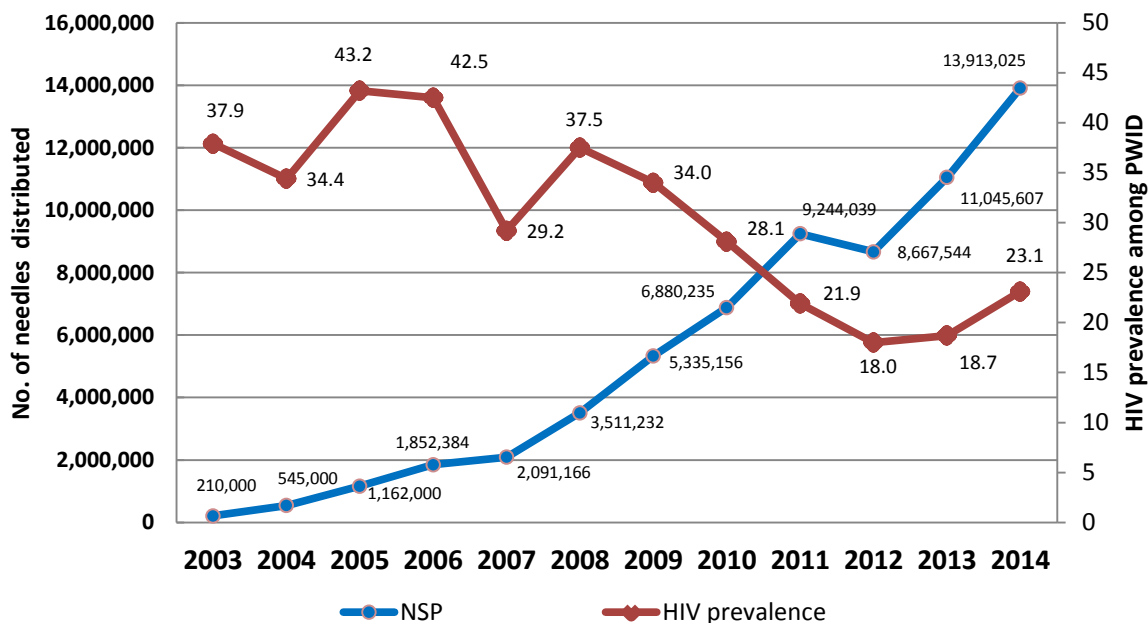
Figure 26: People on methadone treatment (2006–2014)

Source: NAP, 2015

At the end of 2014, there were 34% more patients on MMT than there were in 2013. An average dose of 60–80 milligrams of methadone is offered daily at 35 opium substitution therapy (OST) sites, up from 22 in 2013. In the reporting period 7 872 patients, of whom 118 were females, received treatment, up considerably from 2 909 in 2012 (Figure 26).

The 2013 mid-term review (MTR) recommended that the methadone maintenance therapy (MMT) and sterile needles and syringes programmes should be expanded significantly to achieve a meaningful reduction in new HIV infections among PWID. The MTR recommended that new and more innovative ways were needed to reach those most difficult to reach. Increases in the distribution of free sterile needles and syringes that are properly used should have a direct impact on lowering the number of new HIV infections. However, needle and syringe exchange programmes still encounter resistance in the community because of views that these programmes encourage drug use. MMT programmes are more accepted by communities. There is a need to foster awareness among the wider public of the benefits of these interventions for PWID and communities at large and invest in creating environments free of stigma and discrimination. Also, in the long term, needle and syringe programmes (NSP) must increasingly become the entry point for treatment.

Figure 27: Needle and syringe distribution and HIV prevalence among PWID (2003–2014)



Source: NAP, 2015

HIV prevalence among PWID has declined from 28% in 2010 and fluctuated between 18% and 23% over the past four years, signifying further gains from prevention efforts. HIV prevalence among PWID remains the highest among the key populations, which is largely due to the difficulties in providing adequate prevention services in geographical areas that are hard to reach. These include mining areas, border areas and areas of civil unrest where there are pockets of very high HIV prevalence and high injecting drug use. Another challenge to HIV prevention services to PWID is the Excise Act 1916 that proscribes the (unauthorised) possession of needles and syringes.

Stronger political commitment, legal reforms and significant investments will be required to meaningfully reduce the impact of HIV on PWID. More financial resources have become available through support by the GFATM and Three Millennium Development Goals Fund (3MDG), which will help in engaging more organizations in the delivery of services targeted at PWID.

As the number of sterile needles distributed increases, HIV prevalence among PWID declines. Figure 27 shows how the scale-up of this key prevention program corresponded with falling prevalence among PWID. However, the upward swing in prevalence is of concern.

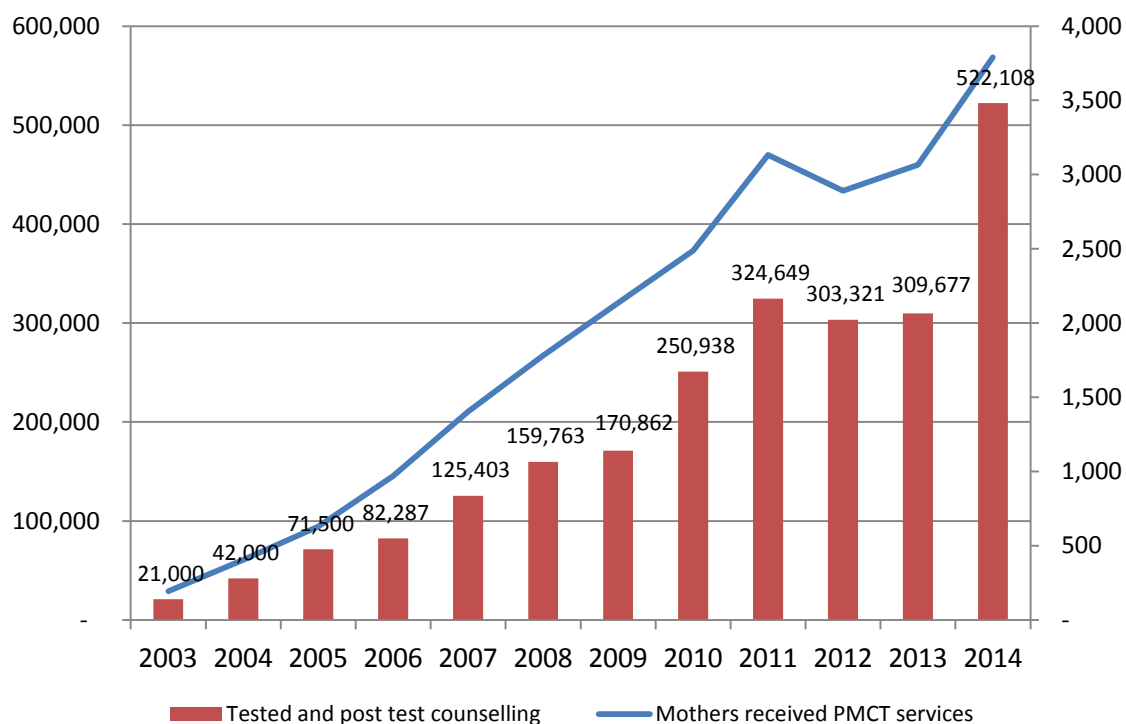
3.2.2 Strategic Priority II: Comprehensive continuum of care for people living with HIV

3.2.2.1 Prevention of mother-to-child transmission of HIV

Progress is on track to adhere to national targets of zero new infections among children in Myanmar. The percentage of HIV-positive pregnant women who received ARV prophylaxis to

reduce the risk of mother-to-child transmission was 79.8 in 2014, according to indicator calculations based on the number of HIV positive pregnant women who delivered in the past 12 months and the estimated number of those requiring prophylaxis because of their HIV positive status (GARP indicator 3.1). At the end of 2013, 90.2% of HIV-positive pregnant women had received ARV prophylaxis.

Figure 28: HIV counselling for pregnant women and ARV prophylaxis (2003–2014)



Source: NAP, 2015

The lower value in 2014 may be due to an underestimation of the number of pregnant women in need of ARV prophylaxis in the 2013 calculations.²¹ This may also account for the very high (68%) increase in this indicator measurement in the reporting period January-December 2013 over the previous reporting round. HIV testing rates among pregnant women are relatively low and significant numbers of pregnant women chose not to return for the results of their tests (Figure 28).

While there has been progress in the number of pregnant women accessing HIV testing and getting test results, much remains to be achieved under the decentralization of PMTCT services. In 2013, the number of pregnant women accessing antenatal care (ANC) services who received pre-test HIV counselling was 708,161. Of these women, 364,104 accepted to get tested for HIV and 309,257 of those who took the test received the test results along with post-test counselling.

The percentage of infants born to HIV-positive women who received a virological test for HIV infection within two months of birth (GARP indicator 3.2) cannot be measured because the infants were not always tested within two months. However, 558 infants, including infants

²¹ This estimation comes from the 2010 HIV Estimates and Projections, AEM Myanmar 2010-2015.

tested at over two months of age, were tested for HIV in 2014. The data to properly measure this indicator according to global definitions is expected to be available next year. Under the revitalised Early Infant Diagnosis (EID) programme using Dried Blood Sampling (DBS); all eligible infants will be tested within the first two month after birth.

A rapid assessment conducted recently indicates that some progress has been made in the decentralization and expansion of HIV testing, which is being integrated in all ANC settings nationwide.²² This should facilitate further progress towards achieving the national target of zero new HIV infections among children. Continued capacity building and health systems strengthening are also important areas being addressed.²³ There is need for greater investments to improve the links and referral between HIV, sexual and reproductive health, and maternal and child health services, which will also contribute to the overall strengthening of health systems.

3.2.2.2 Care, treatment and support

The number of persons receiving ART at the end of 2014 was 85 626 (GARP indicator 4.1), representing 40% of all persons estimated to be living with HIV. Of the number of persons receiving ART, 18 947 newly initiated treatment during that year. Approximately 212 000 people in Myanmar were living with HIV in 2014. The estimated number of those eligible for treatment in 2014 was 122,860 according to national treatment guideline of treatment for people with ≤ 350 CD count, 6341 of whom are below 15 years old.²⁴

Overall, 27678 adults and children were newly enrolled in HIV care in 2014, 15 843 males and 11 833 females. The number of children aged below 15 years enrolled in HIV care was 2056.

Table 2: Number of people receiving ART (2013 and 2014)

	Adults (15+ years)		Children 15 years and below)		Total
	Male	Female	Male	Female	
Dec 2014	43,368	36,310	2,953	2,995	85,626
Dec 2013	34,216	28,502	2,562	2,363	67,643

Source: ART routine monitoring, NAP, 2013 and 2014

Many more PLHIV were treated in public facilities than NGO facilities in 2014 compared to the past (Figure 25). Of those receiving ART, 45% were treated in the public sector and 52% in the

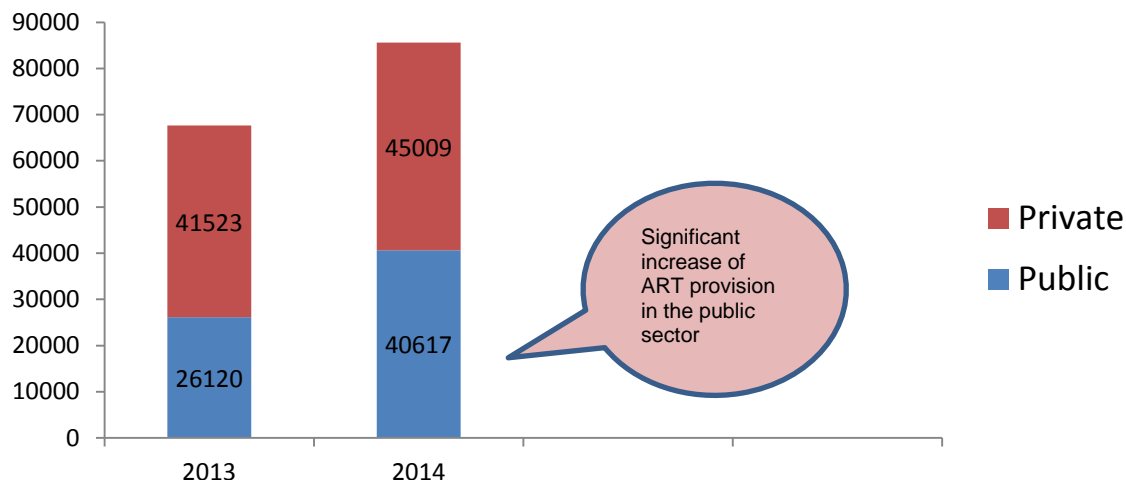
²² Assessment of ART Decentralized sites debriefing, NAP, March 26, 2015.

²³ Health in Myanmar, Ministry of Health, 2014.

²⁴ Eligibility for receiving ART in Myanmar is set at ≤ 500 CD4 count from 2015 onwards.

NGO sector signifying an increasing shift in ART services from private to public sector (Figure 29). The number of patients estimated to be on ART by the end of 2016 is 144 437.

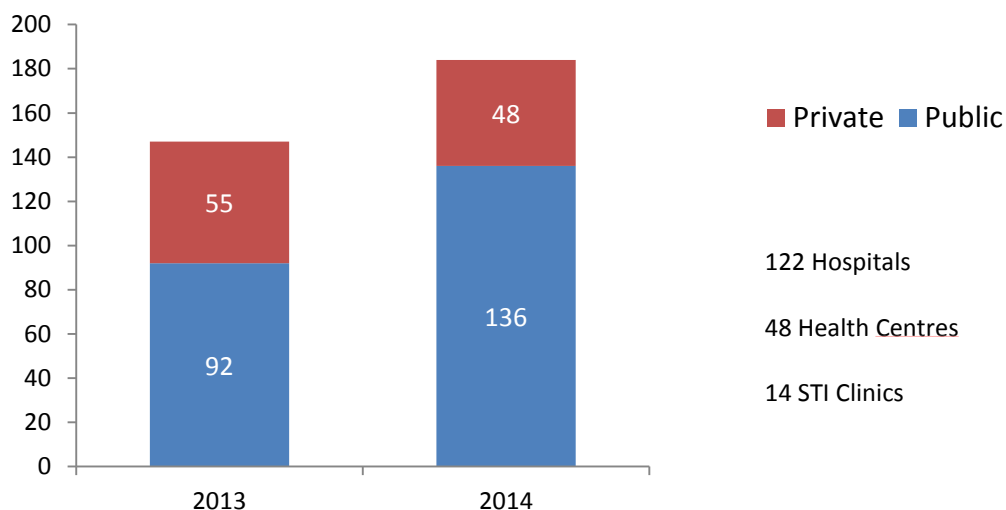
Figure 29: Number of adults and children currently receiving ART by sector



Source: NAP, 2015

Overall, ART services have expanded throughout the country. At the end of 2014, 184 health facilities were providing ART countrywide, an increase in the number of health centres offering antiretroviral treatment by 37 sites, compared to 2013. The sites were distributed between the public and private sectors 136 to 48, respectively, as shown in Figure 30, and provided wider geographical coverage. Of the 184 sites, 108 were providing paediatric specialist ART compared to 100 in 2013.

Figure 30: Total number of health centres that offer ART



Source: NAP, 2015

Geographic coverage of ART services will continue to expand through decentralisation making vital HIV services, such as counselling and testing, accessible to more people in need of treatment. Decentralization began in 2014 with 30 sites, by the end of 2015 more than 100 sites will have been established plus 75 main ART treatment centres. The numbers are projected to increase in 2016 to 150 decentralized sites and 80 ART centres.

Targets set for the scale up of ART are shown in Table 3. The number of PLHIV targeted for ART in 2016 will have increased by 44% over those targeted in 2014 under the new national treatment guideline which sets treatment eligibility at a ≤ 500 CD4 count, and improved access, improved availability of commodities, new service delivery models and more effective partnerships among service providers.

Table 3: ART targets with MoH and Global Fund new funding

ART target	2013	2014	2015	2016
CD4 count	≤ 350	≤ 350	≤ 500	≤ 500
ART need	120,032	123,550	162,012	161,100
ART target	67,643	76,668	100,265	110,370

Source: NAP, March, 2015

NAP put together cohort data from various ART providers and calculated the percentage of people who were still known to be on ART 12, 24 and 60 months after they started (GARP indicators 4.2a, 4.2b and 4.2c) (Table 4). Of those who initiated treatment, 82.1%, 77.8% and 75.1% are still known to be on treatment since they started ART in 2013, 2012 and 2009, respectively. The respective treatment retention percentage shown in the table cannot be compared because the data are from different cohorts.

Table 4: Percentage of people who were still known to be on ART 12, 24 and 60 months after they started treatment

	12 months (2013 ART initiated cohort)	24 months (2012 ART initiated cohort)	60 months (2009 ART initiated cohort)
% of people who are still known to be on treatment	82.1%	77.8%	75.1%

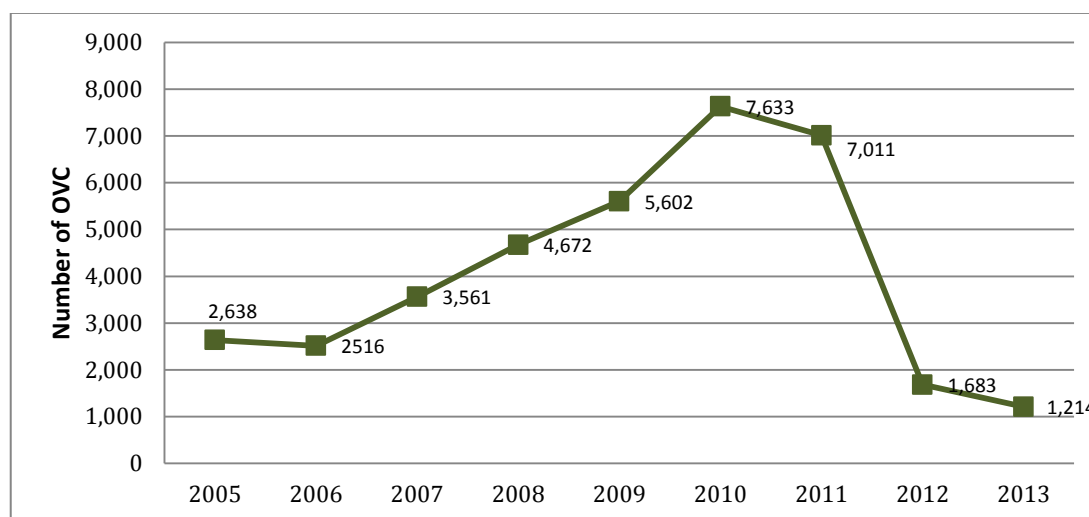
Source: NAP, March, 2015

The percentage of the estimated number of new TB cases among PLHIV that received treatment for both TB and HIV (GARP indicator 5.1) could not be calculated, as there is no estimation of the total number of TB-HIV coinfecting people in Myanmar. But in 2014, 4445 adults and children (2968 males and 1977 females) with HIV infection who received ART were started on TB treatment in accordance with the national HIV treatment guidelines. There were 3911 such patients in 2013.

3.2.3 Strategic Priority III: Mitigating the impact of HIV on people living with HIV and their families

The provision of psychological, nutritional and economic support for PLHIV, their families and for orphans and vulnerable children (OVC) affected by HIV was below target for the reporting period. Of the targeted 52,332, 55% PLHIV reported to have received at least one of the services of the community home-based package, a further fall of 10% from 2012. The drop was even steeper for OVC (Figure 31). Of the targeted 11 500, only 1214 were reported to have received any kind of support. This decrease has been attributed to the drop in financial resources and the policy shift from a specific focus on OVC affected by HIV towards a broader child-protection approach.²⁵

Figure 31: Orphans and vulnerable children receiving support (2005-2013)



Source: National Progress Report 2013, NAP

²⁵ National Progress Report 2013.

4. Best practices

4.1 Update of National Strategic Plan II following MTR

The results of the 2013 MTR were used in 2014 to update and improve the NSP and the costed NSP Operational Plan. For example, the plan was extended by one year (from 2011-2015 to 2011-2016) to match the GFATM funding cycles. Recognizing that the HIV response will not be successful without a supportive, enabling environment, more emphasis was placed on the important crosscutting issues such as gender, human rights and legal issues, following assessments of the situation and needs in each of these areas. Strategies and activities in the areas of prevention, treatment and care were also updated to enable Myanmar to achieve its ambitious targets, while identifying strategic opportunities to integrate HIV into wider health and development efforts.

Greater attention is given in the revised NSP II to the issues of HIV in humanitarian contexts. The strategic role of nutrition has also been recognised for both ART and TB patients. Interventions for strengthening strategic information were introduced on the basis of an assessment of surveillance and population size estimation systems that was carried out in April 2013.

The MTR results and proposed changes to the NSP II were discussed and agreed upon with a large number of representatives from Government, civil society, UN and donor agencies in a national validation meeting. Subsequently, NSP II targets were revisited and adjusted in consultation with members of different TWG. New costs of the NSP II were also calculated to inform resource mobilization efforts and develop a transition plan whose implementation will help fill financial gaps to achieve targets by 2016.

4.2 Scale-up and decentralization of ART and HCT

The fourth edition of the National Guidelines for the Clinical Management of HIV Infection in Myanmar has been developed during the reporting period.²⁶ These new guidelines were developed following several meetings with all stakeholders and expert support. The guidelines reflect global standards set by WHO and UNAIDS for treating and preventing HIV infection. The guidelines recommend greater flexibility and versatility for healthcare providers and a decentralised approach to the provision of treatment and prevention services. They introduced new instructions on ART initiation, drugs and regimes, PMTCT, co-infection with TB, Hepatitis B virus (HBV) and Hepatitis C virus (HCV) and post exposure prophylaxis (PEP). The guidelines also deal with HCT and provide the recommended algorithm.

The guidelines were issued at a crucial time when Myanmar is significantly scaling up HCT and ART through the decentralization of these services. Important progress has been achieved in this regard in the reporting period, which will be evaluated through a rapid assessment in early 2015. An important aspect of the scale-up of ART delivery is to decentralize HIV care and treatment to the township and more peripheral level with the aim of expanding access to these services by all those in need. Their proximity allows patients to save transport money and time in getting their treatment that used to be available only in hospitals and other major health care facilities.

²⁶ Guidelines for the Clinical Management of HIV Infection in Myanmar, NAP, 2014.

Decentralization of ART services is also pursued with the aim of decongesting main ART sites. Once stabilised on ART, patients are transferred from primary ART centres to decentralized ART sites for ongoing management supported by main sites when there are special needs. Main ART centres continue to be responsible for treatment initiation and the management of more complex cases including treatment failure. The decentralization process is contributing to a more even distribution of ART services across the country.

HCT is being decentralised in a similar way including through allowing NGOs to perform rapid HIV tests. This new feature is reflected in the National Guidelines for HCT which started to be updated in 2014 and will become available in 2015. HCT reporting formats have also been revised and improved in the reporting period for more effective monitoring and reporting of data to track progress made with the expansion of uptake in HCT. There is a strong commitment to foster early testing and diagnosis of HIV in order to enrol PLHIV earlier in treatment. Currently, average CD4 count of patients coming for HCT remains very low. More careful monitoring of HCT, pre-ART care, ARV treatment, patients adherence, retention and virological suppression is an important objective that will be pursued in coming years.

4.3 Strengthening of systems and integration for improved PMTCT

The rollout of Option B for PMTCT in 2014 has resulted in an increased coverage of PMTCT. There has been a notable scaling up of point-of-care HIV testing and early infant diagnosis, resulting in an increase to above 65% of pregnant women receiving antenatal care being tested for HIV (compared to 50% in 2013) and over 25% of exposed infants being tested using DNA PCR (compared to only 10% in 2013).

MoH made a firm commitment to better integrate mother and child health (MCH) and PMTCT programmes. Guidelines were incorporated into a Newborn and Child Health Manual that guides the work of primary health care staff. PMTCT will also be adequately reflected in the National Strategic Plan for Child Health Development in Myanmar (2015-2018).

The national PMTCT monitoring and reporting system was strengthened through an improvement of recording and reporting formats. The new formats will improve the generation of strategic information that is required to measure progress towards eliminating paediatric AIDS. Furthermore, the PMTCT database, which is housed at NAP, was further consolidated. Members of the AIDS/STD Teams at state, regional and township levels have started to be trained in how to use new reporting formats. They also learned more about how to use the data themselves to monitor and improve the implementation of the PMTCT programme.

Decentralisation of HCT to the township level and improvements in the PMTCT monitoring system has resulted in an increase in the number of pregnant women who tested for HIV and received prophylaxis to prevent transmission of HIV from mother to newborn. However, timely reporting of PMTCT data from township to regional and to state and central levels will have to be pursued with greater determination in the future. The establishment of a Laboratory Information Management System for Early Infant Diagnosis at National Health Laboratory (NLH) also represents an important step forward.

4.4 Production of valuable new strategic information

At the end of 2014 much needed new strategic information became available from two major sources: Myanmar's 2014 general census of the population and the Integrated Bio-Behavioural Surveillance (IBBS) survey and populations size estimates (PSE) among PWID.

The IBBS covered 16 sites, a much larger number of sites than in the past and produced much needed behavioural and prevalence data that were triangulated with data obtained from HSS. Triangulation methods were also used to extrapolate PSE from different townships to derive a final national estimate. The new PSE is 83,000, which is higher than the 75,000 estimated in the past.

New behavioural and prevalence data were used to develop up-to-date HIV estimates and projections through to 2023 with the AIDS Epidemiological Model (AEM) and SPECTRUM. The modelling helped determine HIV incidence, prevalence and mortality as well as the number of people in need of treatment and of ARV prophylaxis. Analysis of the modes of transmission has also been done to identify the main sources of new infections and to better target interventions.

Various research and evaluations were completed in the reporting period including a nationwide study on the socioeconomic impact of HIV. Data were collected by surveying a representative sample of the population using questionnaires. The results of the study will become available in 2015 once the data have been analysed and results interpreted.

Situational analyses were completed on HIV among PWID, MSM, TG and FSW to take stock of progress made through prevention efforts targeted at these key populations and to identify gaps that will need to be filled to reduce new infections. These assessments have helped determine areas of the national response where a scaling up of interventions is urgently required. For example, HIV prevention and harm reduction activities need to be expanded and more creative service delivery models developed to attain larger numbers of PWID including those who so far have proven difficult to reach.

A wide range of partners also engaged with NAP in a gender assessment to propose gender-responsive interventions. The assessment found that gender norms and constructs of masculinity and femininity obstruct the response to HIV and AIDS. Through a consultative process a set of new strategies were identified for inclusion in the revised NSP II (2011-2016), including the development of multi-sectoral programmes to prevent and respond to gender-based violence, especially violence affecting women, girls and transgender people.

Different studies on gender violence carried out since 2009 found that violence against women was largely hidden.²⁷ Few cases have been reported due mainly to shame, fears of further violence, low confidence among survivors in the police or their ability to access the legal system. Moreover, many women are likely to be unaware of the few existing services for survivors of gender violence. Much is expected from the National Strategic Plan for the Advancement of Women (2013-2022), which, among other areas, has laid out plans to address gender equality in intimate partner relationships. Meanwhile, two surveys to gather further data have been planned for 2015 to build up additional strategic information and shed more light on this issue.

²⁷ People Living with HIV Stigma Index, UNAIDS, 2009; Gender Assessment Report, UNAIDS, 2014; Behind the Silence: Violence Against Women and Their Resilience, Gender Equality Network, 2015.

While there are no specific survey data for the reporting period, stigma and discrimination associated with HIV remained high according to the earlier surveys. A recent situation assessment on orphans and children infected and affected by HIV found that stigma and discrimination were still prevalent within the extended families, school environment and in rural areas.²⁸ Efforts to create a supportive environment for HIV prevention and treatment, free of stigma and discrimination, remains a major priority.

4.5 HIV related spending and financial resource needs

A National AIDS Spending Assessment (NASA) was carried out at the end of 2014. The results were used to examine the funding landscape to identify resource needs and financial gaps. The new data has helped to gain a better understanding on how much money will be required to implement the revised NSP II and how much is likely to be available. It also was useful to determine which areas of the national response will need increased investments in the future.

Table 5: HIV related spending in 2012 and 2013 (USD)

	2012	2013
Total spending	39,422,290	53,517,925
Total spending per capita	0.74	1.00
Total spending per PLHIV	198	282
Care and treatment spending per PLHIV	92	137
Total estimated number of PLHIV ²⁹	200,000	190,000

Source: NASA 2012-2013, NAP

A total of US\$ 53.5 million was spent on HIV-related interventions in 2013.³⁰ This was significantly more than the US\$ 39.4 spent in 2012. Data for 2014 has not become available at the time of writing this report. Data for 2014, 2015 and early 2016 will be collected through another NASA. Meantime annual reporting of financial data has been discontinued because NASA is deemed a much more reliable source of this kind of information.

²⁸ Situation Analysis on Orphans and Vulnerable Children Infected and Affected by HIV/AIDS in Myanmar.

²⁹ These estimates are the ones produced and published in 2010 which were available prior to the ones produced in December 2014.

³⁰ NASA 2012-2013, NAP.

5. Major challenges and remedial actions

5.1 Reform of policy and legal frameworks

A comprehensive national legal review was carried out for the first time in 2014 at national and sub-national levels. The results of the review were presented in a report recommending steps to reform outdated laws and policies hampering implementation of HIV prevention and treatment efforts.³¹ Six priority areas were identified to address stigma and discrimination against PLHIV and populations at particular risk of HIV infection and to create an enabling environment.

The development of guidelines to prevent discrimination in health care, education and employment settings was deemed a major priority as well as the amendment or suppression of legislation hampering the HIV response, including provisions in the Suppression of Prostitution Act 1949, Narcotics Law, Penal Code, Prevention and Control of Communicable Diseases Law, Prisons Act and the Excise Act of 1917. The review also recommended an update of the Patents Bill to ensure it reflects trade-related aspects of intellectual property rights. Concrete steps were already taken to operationalize the recommendations of the legal review with a number of laws being in the process of being reviewed (i.e. 1993 Drug Law and the Patent Bill, drafted in 2013).

Situational analyses were completed on HIV among PWID and TG to take stock of progress made through prevention efforts targeted at these key populations and identified gaps that will need to be filled to reduce new infections. These assessments will help to determine areas of the national response where a scaling up of interventions is urgently required. For example, HIV prevention and harm reduction activities need to be expanded and more creative service delivery models developed to attain larger numbers of PWID including those who so far have proven difficult to reach.

5.2 Community systems strengthening

Continued efforts are needed to strengthen the role of civil society in the national response to the HIV epidemic. Civil society organizations (CSO) have growing expectations for their full participation in decisions concerning funding opportunities, planning and coordination. These expectations are increasingly met. CSOs are represented on all of the various TWGs and the Myanmar Health Sector Coordinating Committee. The HIV Technical and Strategy Group (TSG) is also open to all interested parties to attend and welcomes participation from civil society organizations and KP. PLHIV are also represented on a Joint Parliamentary and Community Network Consortium Committee on HIV and Human Rights, established in 2014 and chaired by a Member of Parliament that heads the Parliament Health Upgrading Committee with members from civil society, PLHIV and UNAIDS. The Parliamentary Committee on Population and Social Development, Rule of Law and Human Rights has been encouraged to allow civil society a more meaningful participation in HIV-related policy reforms. These include national guidance on non-discrimination and confidentiality, access to medicines for people in police detention and reproductive health rights of HIV positive women.³²

³¹ Ibid

³² National HIV Legal Review Report, UNDP/UNAIDS/Pyoe Pin Programme, 2014.

A greater number of NGOs have come forward to help in delivering services to address HIV among PWID and implement harm reduction activities, including in areas that have so far been underserved. More service providers are still needed in this area of the national response, which is the one with the greatest challenges and gaps.

There is still a need to simplify and streamline procedures of negotiating a Memorandum of Understanding (MOU) with the counterpart government authorities. NGOs and community-based organizations (CBOs) have reported difficulties in expanding their services due to the lengthy and complex procedures in extending MOUs.

There are also issues related to the perceived sensitivities around HIV prevention activities among MSM, FSW and PWID, which result in police crackdowns on needle and syringe programs and resistance from some ethnic and faith-based communities. Further efforts are necessary to improve coordination among implementing partners and stakeholders including the police, community leaders and members. Also, the willingness and openness of stakeholders to address local level issues needs to be more deliberate.

Involvement of local popular football players in advocacy sessions and training focusing on HIV has helped in mobilizing support for KP and PLHIV and improving HIV awareness and knowledge. This initiative highlights collaborative efforts around the HIV response among actors other than the regular development partners and their awareness of social responsibility.

6. Monitoring and evaluation environment

The national monitoring and evaluation plan is the framework for coordinated and effective implementation of the national response. It outlines the monitoring and evaluation (M&E) system, which monitors programmatic inputs, outputs, trends, impact and evaluates the effectiveness of the NSP. The M&E Unit in NAP coordinates the monitoring and reporting on the national response. The Unit has trained staff and is operational, but M&E and strategic information capacity needs strengthening and more M&E staff are needed at national and subnational levels.

Nevertheless, routine monitoring systems continue to improve. Reporting standards and mechanisms have been aligned with the principles set out in the national M&E guidelines. There are ongoing efforts for improvements with good progress being made with the help of all the relevant stakeholders.

Myanmar regularly produces annual and global reports (i.e. Annual Progress Reports; GAPR Reports, etc.). A MTR of the progress against the NSP II has been conducted as planned in 2013. Data are regularly collected and disseminated.

The national surveillance system has been further developed and new behavioural and population size estimation data have been made available in 2014 for PWID. IBBS and PSE among FSW, MSM and TG will be conducted in 2015.

Concurrent routine monitoring systems are being reinvigorated to measure the results of efforts to scale up treatment, care and prevention interventions.

Assessments of programme expenditures have been done annually through annual reporting. A National AIDS Spending Assessment (NASA) was also done in 2014. Many different research projects have been implemented making useful new information available, while an HIV research agenda is being developed as part of a broader health-related research agenda.

Capacity to compile, present, analyse and interpret data from different sources at township and regional levels continued to improve. Efforts to improve the use of data at the subnational levels to better understand the epidemic in the local context and to design interventions continue. Data feedback mechanisms need further strengthening as partners continue to report annually, mainly through their central offices in Yangon, and feedback of data and information to sub-national level needs to improve further.

6.1 Oversight

The multi-stakeholder Technical and Strategy Group on HIV (TSG) oversees and coordinates the implementation of the operational plan, including monitoring and evaluation of the national response. TSG reports to, and advises, the National Health Sector Coordination Committee (HSCC) on HIV-related policy issues.

6.2 National AIDS Programme

The NAP is mandated to coordinate, monitor and evaluate the national response to HIV/AIDS. The M&E Unit in NAP is responsible for all aspects of data management, including dissemination of results to partners and stakeholders. An Assistant Director and support staff carry out the functions, which include data collection from all partners as well as gathering the routine data generated by the AIDS/STD teams. In addition, the M&E Unit oversees reviews and evaluations to measure programme outcomes, and leads the surveillance, population size estimations and other research activities. The NAP, with assistance from UNAIDS, also leads the annual progress reporting process whose results are published each year in a major report that has very wide circulation.

6.3 State or Region, District and Township levels

AIDS/STD Teams established by the NAP, at state, regional, and township levels coordinate M&E activities in their respective areas. They also monitor programme activities of implementing agencies in the public and private sectors, NGOs and CBOs and report to the central M&E Unit at NAP. There were 47 AIDS/STD Teams in total in 2014. Where there is no AIDS/STD Team, data such as those on ART, PMTCT and HCT, which must be collected quarterly from the health care providers, are reported through the Township Medical Officer to the M&E Unit of NAP.

6.4 NGOs, CBOs and the private sector

Implementing partners in the NGOs, CBOs and private sectors are responsible for monitoring their own programme activities and outputs. The information from the data they collect and analyse is shared with the district/township AIDS/STD Teams using the prescribed format for routine annual reporting.

6.5 M&E system data flow

AIDS/STD Teams and implementing partners of HIV programmes are required to report routinely on programme indicators that are relevant to the activities they carry out. Standard forms are used to collect field-level data for the annual reporting. The M&E Unit coordinates the data collection and manages data from HSS, IBBS and other national-level surveys.

6.6 Strategic Information and M&E Working Group

The SI/M&E TWG is one of the working groups of the TSG. The SI/M&E TWG collaborates with all HIV service providers to streamline M&E procedures and practices in Myanmar aimed at reducing the chances for duplication and to assure data of the highest quality. It determines strategies and provides oversight for the planning and implementation of M&E measures for the national HIV response. The SI/M&E TWG also carries out joint M&E activities with other organizations and regularly shares important findings and feedback. State and regional AIDS/STD teams will continue to become more involved with these practices.

The NAP continues to advocate with the Government and donors for greater political commitment and financial investment in M&E. Routine and timely dissemination of information outputs including progress reports, surveillance reports and other research studies will ensure the most comprehensive picture of HIV trends, updates, achievements, challenges and recommendations in the national response are available to policy makers, donors and implementers.

6.7 Information products

Strategic information informs the national response. To meet this requirement, the monitoring and evaluation and reporting of results is carried out within agreed national and global indicator frameworks. The monitoring system aims to make reliable data on the epidemic and the response available to enhance NSP II programme planning. The M&E plan employs rigorous assessments to evaluate the efficacy, efficiency and cost-effectiveness of different programmes.

These are the main monitoring and evaluation outputs.

6.7.1 National Annual Progress reports

Reports on the implementation of the NSP are prepared with data consolidated from standard reporting formats that are submitted annually by all partners implementing HIV activities. The reporting format includes output as well as process indicators of the national monitoring framework that are included in the NSP M&E plan.

6.7.2 HIV sentinel surveillance reports

These present the results of annual HIV sentinel surveillance and are a very valuable source of data on trends in HIV prevalence. Because HSS is conducted at health facilities level, the data reflects mainly the situation of people who are in contact with services. Also, HSS do not produce relevant data on behaviours. This is why IBBS was conducted among PWID in 2014 and

will be carried out among FSW, MSM and TG in 2015. The IBBS will not only generate much needed data concerning behaviours and knowledge but will also produce data that are more representative.

6.7.3 Behavioural surveillance and integrated bio-behavioural surveillance survey reports

Data regarding the behaviours, knowledge and exposure to interventions of various KP are presented in BSS and IBBS reports. They should be carried out every three to four years but this has not been the case in Myanmar. To fill the gap in strategic information, an IBBS/PSE was conducted in 2014 among PWID and IBBS and PSE among FSW, MSM and TG will be done in 2015.

6.7.4 Expenditure reports

These provide analysis of spending on HIV-related interventions compared to resources that were available in a given year by spending categories and donor sources. The National AIDS Spending Assessment (NASA) collects the data and prepares the report.

6.7.5 HIV estimations and projections

Myanmar has revised these estimates and projections at the end of 2014 and again in March 2015 using the upgraded AEM and SPECTRUM models.

6.7.6 Other reports

Various reports of research and studies are published in Myanmar. The design and instrumentation used for research of different kinds are normally presented for advice to the SI/M&E TWG whose members provide technical inputs.

6.8 M&E systems strengthening

In 2013, Myanmar set 15 priority actions to be taken in the years ahead to strengthen HIV/AIDS M&E systems. This was the result of a thematic paper prepared during the MTR by members of the SI and M&E TWG. The paper discussed the main achievements and challenges ahead for obtaining evidence needed to better understand the epidemic and target the national response in a cost-effective manner to achieve ambitious targets. Table 5 shows the progress made on these priority actions.

Table 6: Priority actions and progress

Priority	Progress
1. Increase the number of NAP M&E/SI staff at national and sub-national levels.	While there are limited options to increase government staff, additional staff were recruited with support from WHO, Pyi Gyi Khin and the Government with resources of the Global Fund.
2. Develop capacity of NAP staff and epidemiologists at national and subnational levels in implementation and supervision of data collection, analysis and interpretation, and in triangulation and use of data from different sources.	NAP trained several AIDS/STI Teams in decentralisation of M&E principles and data management. Various staff were also trained in surveillance and population size estimation methods as part of the PWID IBBS/PSE that was conducted in 2014.
3. Continue decentralization of M&E and subnational capacity development.	Additional funding was mobilised by NAP to accelerate the process and build more M&E capacity at subnational levels.
4. Further standardize reporting formats and alignment of reporting practices (e.g. for ART).	Reporting formats have been upgraded including NAP's annual progress reporting form to reflect improvements made in the National M&E Plan following the 2013 MTR and the updating of NSP II in 2014. Some indicator definitions have been amended (e.g. HIV/TB) and some reporting requirements clarified (i.e. annual financial reporting was discontinued).
5. Expand ART cohort studies and consolidate the use of early warning indicators.	Work has begun and will continue to improve reporting systems. This effort shall continue in 2015 as this remains a priority area requiring more investment.
6. Strengthen the HIV case reporting system to reduce reliance on prevalence surveys over time.	Consensus was reached that the HIV case and AIDS death reporting systems need to be reviewed in order to strengthen this important source of data and reduce reliance on prevalence surveys over time. This is also a major priority that will have to be further pursued. A plan is being developed to review case reporting system.
7. Implement the Three Interlinked Patient Monitoring Systems (3ILPMS) to integrate and strengthen health systems and track patients across several services—HIV/ART, TB, MCH/PMTCT.	Implementation of the Three Interlinked Patient Monitoring Systems has begun.

8. Expand and strengthen HSS and consider conducting it only every other year.	2014 HSS has been conducted and the results compiled. The next HSS will be in 2016 as the biennial cycle has been adopted.
9. Conduct IBBS together with PSE for each of the KAPs for at least two rounds including in new sites away from services and hard-to-reach hotspots.	2015 PWID IBBS /PSE has been completed and the draft report is available. Preparations for FSW, MSM and TG IBBS/PSE have started, surveys have been planned in five sites and survey instrumentation has been developed. A comprehensive IBBS/PSE Protocol for IBBS/PSE, covering all of the KP, has been developed and questionnaires have been finalised after pre-testing. Data collection will start in early May 2015 and last until mid-August.
10. Measure trends in STI prevalence among key populations and consider integrating with IBBS.	STI testing has not yet been included in IBBS/PSE surveys because of feasibility concerns. However, Hepatitis B and C and syphilis testing is currently done in these surveys.
11. Update HIV estimates and projections as new data becomes available, including census data.	New HIV estimates and projections have been developed in December 2014 by using new census data and data from the 2015 PWID IBBS and PSE. As an improved SPECTRUM software was still under development the estimates were further refined in the first quarter of 2015.
12. Develop and implement an HIV research agenda and carry out research on key issues such as uptake of HIV testing, condom use, stigma and discrimination (Stigma Index), HIV spending, unit costs.	An HIV research agenda is being developed as part of a wider health-related research agenda. In the meantime many new research projects have started such as the National AIDS Spending Assessment, Stigma Index, Study on the violence against female sex workers, Study of MSM risk behaviours, Study of the socioeconomic impact of HIV.
13. Conduct evaluation of new intervention models to assess their efficacy and cost-effectiveness, and the final evaluation of the NSP in 2016.	Reviews of prevention programmes for different populations have been conducted but more specific in-depth evaluation should be performed, for example, on why people are still reluctant to test for HIV or to get testing results and other key obstacles, which prevent achievement of the 90-90-90 vision.
14. Enhance the use of strategic information at all levels including through triangulation.	Use of strategic information from various sources has been further intensified in the past year. Data that have newly become available

	<p>have already been used in modelling of the epidemic to calculate the number of PLHIV, new infections, AIDS related deaths, number of people in need of ART and ARV prophylaxis. The data have also been used in reviews of programmes and assessment of efficacy of different interventions. More emphasis will need to be set on use of data at sub-national level to improve delivery of services and ensure better access to services by all people in need including KP.</p>
<p>15. Strengthen data feedback mechanisms and use of strategic information at sub-national level for the planning, targeting and tailoring of interventions.</p>	<p>This area of work needs to be pursued with more vigour, while capacity to compile, present, analyse and interpret data from different sources has to be built at township and regional levels.</p>

The telecommunication systems in Myanmar are developing but still remain quite weak. As stated in 2014 GARP Report, there are relatively few fixed-line telephones and faxes but use of mobile telephones has increased and there has been some expansion in coverage. Internet connectivity is not available in many of the peripheral locations, most of the communication is done by phone and much of the M&E data still has to be carried by hand. The situation is expected to improve in the near future.

It is also necessary to accelerate improvement of M&E capacity at the sub-national levels in order to facilitate a better understanding of the epidemic and the response in the different local contexts. States and regions with the greatest pockets of risk behaviour and HIV transmission should be prioritized for capacity development efforts. A considerable increase of skilled human resources at subnational levels is needed to carry out all of the M&E, surveillance, size estimation and strategic planning activities that are planned for the years ahead.

Governmental and legal reforms currently under discussion are expected to facilitate the growth of a favourable environment for HIV prevention interventions for KP and more support for PLHIV.

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