National Strategic Plan on HIV and AIDS, Myanmar 2021-2025

Ministry of Health and Sports

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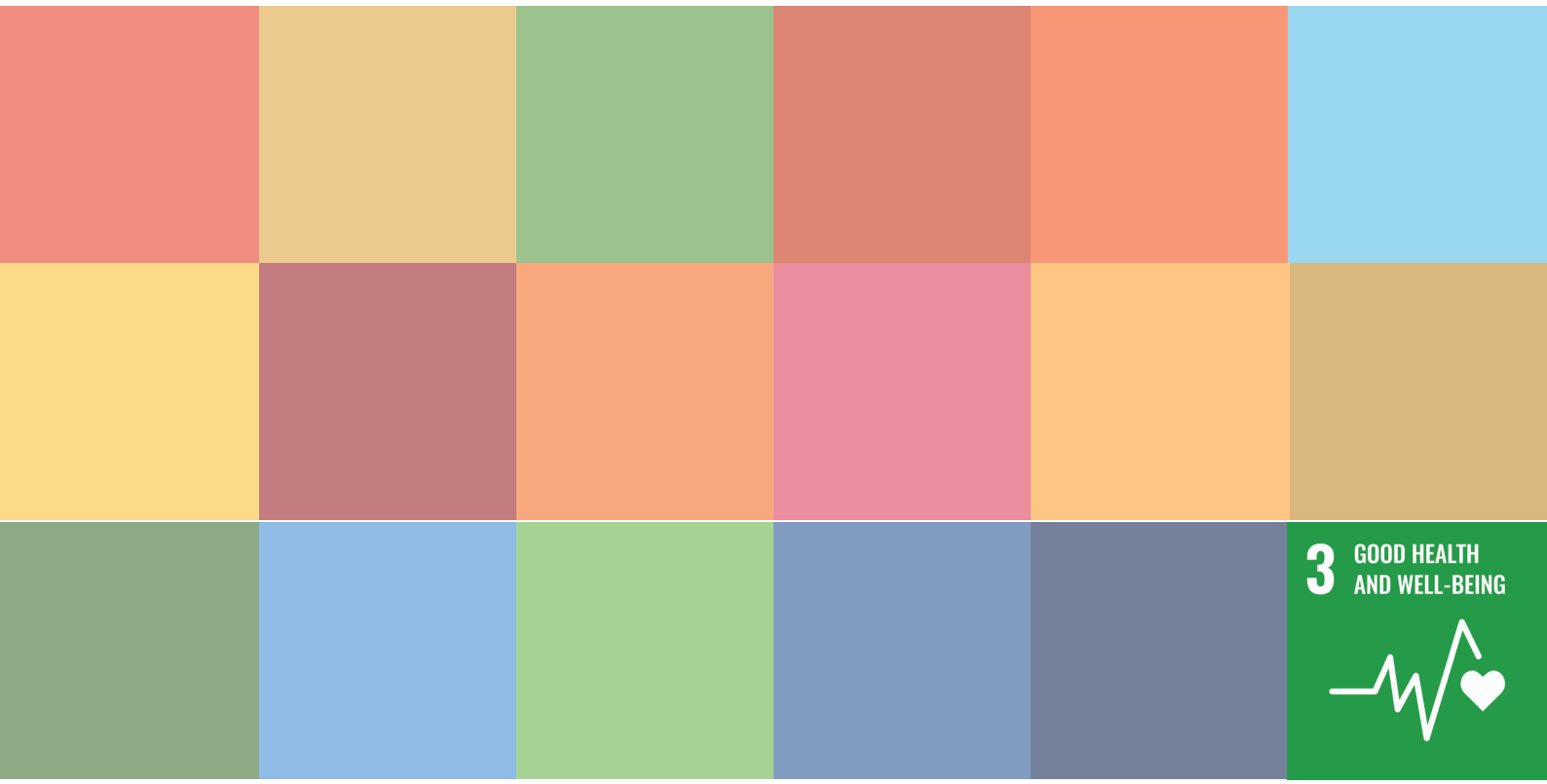

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Abbreviations and acronyms

ART	Antiretroviral Therapy
ARV	Antiretroviral (drug)
ASEAN	Association of Southeast Asian Nations
CBO	Community-Based Organization
CFM	Community Feedback Mechanism
CSS	Community Systems Strengthening
EHO	Ethnic Health Organization
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother-To-Child Transmission
EQA	External Quality Assurance
EQAS	External Quality Assurance Scheme
FSW	Female Sex Worker
GDI	Gross Domestic Income
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HBsAg	Hepatitis B Surface Antigen
HCV	Hepatitis C Virus
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioural Surveillance (survey)
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPT	Isoniazid Preventive Therapy
KP	Key Population
KPSC	Key Population Service Centre
LIMS	Laboratory Information Management System
LNGO	Local Non-Governmental Organization
MCH	Maternal and Child Health (Division)
M&E	Monitoring and Evaluation
MHSCC	Myanmar Health Sector Coordinating Committee
MMT	Methadone Maintenance Therapy
MoHA	Ministry of Home Affairs
MoHS	Ministry of Health and Sports
MPG	Myanmar Positive Group
MSM	Men Who Have Sex with Men
MTCT	Mother-To-Child Transmission

NAP	National AIDS Program
NCD	Non-Communicable Disease
NEQAS	National External Quality Assurance Scheme
NGO	Non-Governmental Organization
NHCP	National Hepatitis Control Program
NHL	National Health Laboratory
NIMU	National Health Plan Implementation Monitoring Unit
NSP	National Strategic Plan
NTP	National Tuberculosis Program
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PEPFAR US	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public–Private Partnership
PrEP	Pre-Exposure Prophylaxis
PSM	Procurement and Supply Management
PSE	Population Size Estimate
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RDT	Rapid Diagnostic Test
SDGs	Sustainable Development Goals
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
TPT	Tuberculosis Preventive Therapy
TSG	Technical Strategic Group
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children's Fund
UNION	International Union Against Tuberculosis and Lung Disease
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
VCT	Voluntary Counselling and Testing
VL	Viral Load
WHO	World Health Organization

Foreword

Now over three decades into the HIV epidemic in Myanmar, it is essential for us to progress to the goal of 'ending AIDS as a public health threat' as enshrined in our national and global commitment towards the Sustainable Development Goals (SDGs) of 2030. With ten years left to meet this milestone, the National Strategic Plan (NSP) on HIV and AIDS in Myanmar, 2021-2025 (NSP IV), reflects this ambition as well as represents a quantum and qualitative leap to address social, behavioral and health drivers of the HIV epidemic. The focus remains on HIV prevention and provision of treatment and continuum of health care to individuals, families and communities that are at greatest risk or vulnerable to the consequences of HIV and AIDS.

With this purpose in mind, the NSP IV was elaborated through an inclusive consensus-building process undertaken over four months in 2019 reflecting collective knowledge, field-level experience and strategic thinking on the way forward. This brought together policymakers, resource persons, implementers, and beneficiaries of the HIV program. Leadership was provided by the Ministry of Health and Sports coordinating with a range of stakeholders. The latter included representatives of governmental sectors, non-governmental organizations, development partners, the United Nations System, and, most importantly, service-providers and representatives of the communities living with or affected by HIV.

Despite having a 'concentrated' epidemic disproportionately affecting key populations and some regions/states more than others, the MoHS has confidence in the unique competence of public sector, non-governmental and community-based front-line workers and community actors to deliver on the ambitious goals set for NSP IV. Among those goals include the elimination of mother-to-child transmission, reaching 95-95-95 with regard to HIV testing, Antiretroviral Therapy and viral load suppression, and zero-related discrimination in health and other settings. Most important of all is that we witness a substantial decline in infection among people who inject drugs, men who have sex with men, transgender, sex workers, and prisoners [including the partners of these populations] as well as a decline in vulnerabilities and risks among young people, migrant workers and those facing humanitarian crisis.

The HIV response will continue to be based on the right to health and be part of Universal Health Coverage. By 2025, the transition would include that the National AIDS Program be aligned with the efforts of other programs to address Hepatitis, Tuberculosis, drug dependency treatment, Sexual and Reproductive Health, and relevant social policy issues.

Our faith rests in the successful implementation of NSP IV through the engagement of our population, especially in its diversity, including young people working with the health sector for the betterment of people's lives. We also acknowledge the commitment of all our partners, including development partners and the donors that contributed to this joint effort.

Dr. Thar Htun Kyaw

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Acknowledgements

The Myanmar National Strategic Plan for HIV and AIDS, 2021-2025 (NSP IV) reflects the insights and expertise of all stakeholders, as well as the contributions, time and energy of resource persons, organizations and communities who will continue to work together in partnership to achieve its goals and objectives.

This ambitious and innovative NSP will bring Myanmar closer to the goals of Sustainable Development Goals of 2030. We would like to express our gratitude to the United Nations, Development Partners, other Ministries, civil society, community members Ethnic Health Organizations, and individuals all who have greatly assisted the process of developing NSP IV.

Special thanks go to:

- Participants in the national multi-stakeholder meetings and thematic group consultations
- Key informants and respondents, the public and private health and related sectors, key populations and affected and concerned communities
- The Technical and Strategy Group for HIV for its valuable guidance
- UN agencies, LNGOs, INGOs, CBOs and community networks
- The core working group and the NSP IV consultant team

Gratitude is also expressed towards the organizations who joined the NAP, MoHS in supporting and funding development of NSP IV, including Access to Health Fund (ACCESS), the US President's Emergency Program for AIDS Relief (PEPFAR) through USAID and CDC, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNAIDS, UNICEF and WHO.

National AIDS Program

Department of Public Health

Ministry of Health and Sports

Myanmar

Executive Summary

The elaboration of the Myanmar National Strategic Plan for HIV IV (NSP IV) 2021-2025 was an inclusive process led by the National AIDS Program (NAP) under the Ministry of Health and Sports (MOHS) and represents consensus inputs developed in collaboration with an extensive range of partners and stakeholders. These include different Ministries, Departments and National Programs of the Government of Myanmar, development partners and the full range of implementing partners from the public health sector and related service-delivery contexts, including the private sector; international non-governmental organizations (INGO), local non-governmental organizations (LNGO), community-based organizations (CBO) and Ethnic Health Organizations (EHO); and priority and other affected populations as well as broader communities. The process was informed by three national reviews undertaken in 2019, including the Review of the Health Sector Response to HIV, the National Key Populations Review and the HIV Epidemiological Review. The Reviews and the NSP IV development process were carried out from the perspective of the HIV response within the broader health sector and in the context of the longer-term move towards Universal Health Coverage (UHC) in Myanmar.

Myanmar is a country with a low HIV prevalence in the general population, but with a high HIV burden among key populations and geographic locations. To this effect, the country was identified as one of the fast track countries[1] to end AIDS as a public health threat by 2030. In recent years, the Government of Myanmar has recognized HIV as a priority health issue and has made significant progress in responding to the epidemic, guided by the National Strategic Plan on HIV and AIDS III (NSP III) 2016 – 2020. Overall, new infections and deaths are declining, and treatment programs have been scaled up dramatically. Significant success is also noted in scaling up of HIV testing services, risk and harm reduction and prevention of mother-to-child transmission of HIV (PMTCT). The PMTCT program covered 98% of townships in the country by the end of 2019 stepping closer to the realization of the goal of elimination of mother-to-child transmission of HIV and syphilis by 2025. Antiretroviral Therapy (ART) coverage reached 77% of the estimated number of people living with HIV, a doubling of coverage in a period of five years. In addition, 85% of the total ART cohort received care in a public health sector facility, thus highlighting a major progress in the transition of ART provision from the private to public sector. These accomplishments reflect improved partnerships among public, private and community sectors, and an increase in domestic funding supported by dedicated international funding for the HIV response.

Co-infection with TB and viral hepatitis represents an increasing burden requiring urgent and coordinated action. Myanmar is one of 30 highest-burden countries with TB/HIV co-infection in the world[5]. However, since 2015, the coverage of TB patients with known HIV status has increased. In 2019, the TB/HIV program successfully screened 97% of patients in HIV care for TB and 95% of patients registered for TB treatment were tested for HIV. Myanmar also has significant co-infection of HIV with viral hepatitis B (HBV) and hepatitis C (HCV) ,and from 2017 to 2019 the public sector treated over 7,000 people for HCV[2]. In NSP IV, the NAP will take the lead, in coordination with National Hepatitis Control Program (NHCP), in managing the response to co-infection with HIV and HCV, with priority attention to key populations.

Strengthened surveillance and strategic information efforts have led to deeper and nuanced understanding of the epidemic dynamics of HIV in Myanmar, including risk factors for infection and determinants of vulnerability, transmission patterns, key populations at highest risk, and sub-national differences in the epidemic by States and Regions. Therefore, the national HIV response envisages a decentralized state and

regional operational plans to target the epidemic. In addition, there will be a continued effort to focus on service availability and delivery, through innovative solutions.

The MoHS, Ministry of Home Affairs (MoHA) and other sectors are also collaborating in the development of a national framework and action plan, including to strengthen health services in closed settings and prisons and to promote a comprehensive response to the consequences of drug use on health in the country. Substantial work has also been undertaken to reduce legal barriers to enhance access to services for key and vulnerable populations, and to promote the reform of punitive laws through a human-right based approach. Despite a significant increase in public funding for HIV, the country still largely depends on international funding to maintain the national HIV response, with international funds covering 80% of the national HIV spending in 2016-2017. Both significant opportunities and challenges remain.

The estimated HIV prevalence while relatively stable at national level, varies across states and regions. In Yangon and Mandalay Regions, the HIV epidemic is driven mainly by male-to-male and heterosexual transmission. Whilst, the HIV epidemic in northern areas in particular - i.e. Kachin, Shan North and Sagaing - continues to be fueled by injecting drug use and while reach and coverage of prevention, care and treatment has increased in scale, it remains insufficient outside of urban/semi-urban areas. An effective response is complicated by the availability of drugs, long-term conflict, security concerns, and the consequences of labour migration. Poverty, economic disparities and limited education and livelihood options are determinants of risks and vulnerability. In addition, there is limited access to health and social services in certain rural, remote and border areas.

Despite achievements of the harm reduction program to date, the estimated proportion of new HIV infections from use of contaminated injecting equipment has not shown substantial reduction, indicating the need for innovative and adaptive solutions to ensure harm reduction is effective. Comprehensive national policy is increasingly being developed to support more integrated national responses to broader public health and related development challenges, such as the National Strategic Framework on Health and Drugs.

Despite significant progress in ART coverage, there is sub-optimal access to treatment among key populations particularly among people who inject drugs (PWID). Therefore, significant efforts to improve HIV literacy, integrate services and enhance community access for HIV testing and linkage to life-long ART are needed. These efforts should also be made among men who have sex with men (MSM), female sex workers (FSW) and their intimate partners and those with multiple or overlapping risks. Young people within the key populations also face significant obstacles in accessing effective prevention and care services. In addition, there is also an increased risk in HIV and other STIs among domestic and international migrants due to their contexts of vulnerabilities. There also needs to be a consistent effort to ensure all people living in closed settings and prisons have access to HIV prevention and initiation of treatment for HIV, TB and viral hepatitis.

Further reduction of new HIV infections, co-infections with TB and viral hepatitis and the strengthening of the STI program requires tailoring responses to specific geographical settings, vulnerabilities and associated burden of infections. In addition, innovative prevention activities need to be tailored to each of the key population groups and regions. Examples include adapted online information and access to services using social media applications, assisted partner notification, self-testing and pre-exposure prophylaxis (PrEP).

In order to address the above challenges and build on existing opportunities, there are several significant strategic changes proposed in the transition from NSP III to NSP IV. Prominent among these is the continued move to more decentralized operational, partnership and financing platforms at state/region levels. There

are also changes to the overall geographic prioritization of efforts and resources in NSP IV, with two categories of HIV risk and burden (High and Low Priority Townships) compared to three categories in NSP III. This enables a more cost-effective use of limited financial, program and technical resources to the five high burden states/regions. Nearly 70% of townships categorized as high priority are in these five states/regions. The remaining high priority townships are found across other states/regions associated with specific demographic and socio-economic such as Kayin and Mon which are along the Myanmar-Thailand border.

There have also been changes proposed to the contents and delivery mechanisms for an 'Essential' and 'Comprehensive' Packages for HIV Services, with the Essential Package to be implemented in all 330 townships and the Comprehensive Package in all high priority townships. Service-delivery modalities will be tailored to specific contexts and population needs by strengthening the partnership between communities and the Public and Private sector. This initiative will involve increasing the number of trained and incentivized community outreach workers and peer educators working with public health services and ART health facilities to expand the coverage and reach of prevention, care and treatment. Targeted HIV testing, immediate enrolment, and early treatment initiation will be ensured through the provision of services tailored to key and priority populations. This is also designed to promote faster and greater access to ART, and testing and treatment for co-infection among key populations.

There is also a need for the greater inclusion of EHOs in partnership arrangements and more attention must be paid to the to domestic and international migrants, displaced/ refugee populations who may be subject to increased vulnerability.

In NSP IV, prevention and the elimination of mother-to-child transmission will be supported by a new and expanded tracking system for mother-baby pairs using a digital health platform. This platform will provide reminders to service-providers and patients and will be linked to community support mechanisms to reduce loss to follow up of the mother and baby pair.

There will be also be more attention to develop a comprehensive enabling environment through introduction of new laws as well as reform and revision of existing laws. It will aim to eliminate HIV-related stigma and discrimination in all health care settings by 2025. NSP IV will also include a Human Resources for Health Plan to respond to the chronic shortages in human resources in the public health sector. Other changes in NSP IV include a higher level of domestic financial support for the national response to HIV to support sustainability; and development of an innovative funding model for HIV service provision as the country moves closer to implementing UHC.

Results anticipated from NSP IV by 2025 are across all sectors of the national response, including elimination of mother to child transmission of HIV and syphilis. Reach and coverage of key populations and their partners will increase substantially with 95% of PWID and 10,500 of their sexual partners reached with combination prevention services and 95% of those reached will be tested and know their HIV status. By 2025, 61,393 (60%) estimated people who inject drugs will receive Opioid Substitution Therapy. Collaboration will occur with the National Hepatitis Program to ensure HBV and HCV testing, HBV vaccines and HCV treatment services for all priority populations. By 2025, 80% of PWID and test negative for HBV will receive the complete vaccination.

The NSP IV also aims to provide a comprehensive prevention service to 95% of MSM, transgender (TG) women and FSW, and subsequently get 95% of those reached, tested for HIV and aware of their status. In addition, comprehensive prevention services will also reach 14,250 clients and 3,450 regular partners of FSW.

Within each of the key population groups, a proportion of the youth will be targeted, and service provision will increase from 20,000 in 2021 to 30,000 by 2025.

In addition, comprehensive prevention services will also reach 14,250 clients of FSW and 3,450 regular partners of FSW and service coverage among young populations will increase from 20,000 in 2021 to 30,000 by 2025. Within each of the Key Population targets a proportion will also be youth.

The strategic plan also aims to provide HIV education and services to 81,000 mobile and migrant persons, including those in workplace by 2025. Among prisoners and other closed settings, over 80,000 will be provided prevention services and 95% of those will be provided HIV testing and know their results by 2025.

NSP IV aims to continue to significantly reduce morbidity and mortality, through increasing access to ART. By 2025, 95% of persons newly identified with HIV and 90% of all people living with HIV will receive antiretroviral therapy, with an aim to retain 95% on ART for 12 months after initiation and to ensure that they are virologically suppressed. Additional measures to reduce morbidity and mortality, include treating viral hepatitis C, which will be co-funded by external donors and other development partners based on the leadership of the National AIDS Program.

NSP IV aims to continue to significantly reduce morbidity and mortality, including through the increased access to ART. By 2025 among those people living with HIV (PLHIV) who are newly identified, 95% will receive treatment and 90% of all PLHIV will receive ART or approximately 225,285 PLHIV on ART. By 2025, 95% of people living with HIV and on ART will be retained on ART 12 months after initiation. There will be a significant effort to ensure that 95% of all people living with HIV on ART are virologically suppressed. It is also envisaged that new initiatives important to reducing morbidity and mortality – such as treatment of viral hepatitis C – will be co-funded by external donors and other development partners based on the leadership of the National AIDS Program, Ministry of Health and Sports.

Under NSP IV, the partnership between the community with public and private sectors will be further strengthened with 30% of community-based testing provided through community-led service delivery and elimination of HIV related stigma and discrimination in all health care settings. There will be an enhanced integration of HIV services within TB, STI, hepatitis, drug treatment and reproductive health services, and an improvement in gender responsive harm reduction services. There will also be a decrease in the number of punitive laws and policies; an increase in the number of protective laws and anti-discrimination policies for people living with HIV and key populations; an increase in the number of sites using/ implementing the community feedback mechanism; and an increase in the number of community-based legal aid service centres. There is also a clear provision within NSP IV to develop a more sustainable funding model to support the national response to HIV, including increasing domestic funding, especially for all treatment costs. NSP IV also looks in detail at ways to increase the domestic funding base to ensure more sustainable funding of the national response to HIV. This includes the development of strategies and innovative funding models including social contracting. There will also be attention to mobilizing resources domestically that can more sustainably support long-term programs such as ART provision, as well as trialing of cost recovery measures including co-payment and fee for service within a strengthened partnership between public, private and community service providers.

Successful implementation of NSP IV will require efficient use of resources while maintaining quality, increased collaboration and financial leveraging of partners and increased domestic allocation of resources. In anticipation of potential changes in the funding landscape, NSP IV aims to focus resources geographically,

streamline unit costs and will leverage public, private and community sector resources as collaborators to reach the 95-95-95 goals. The total gross resource needs for NSP IV were estimated at US$ 414 million over five years which will require major prioritization for the significantly lower level of expected resources.

NSP IV resource needs are optimized and reduced $46 million from the NSP III total funding needs of US$ 460 million. Although there are many new activities in NSP IV, unit costs were streamlined during the costing process by standardization of human resource needs, salary and operating costs, allowing for cost savings in NSP IV. The increase in resource requirements in NSP IV is attributable to the overall priority of significantly increasing reach and coverage of prevention, treatment and care in high-burden states/regions aiming to reach 95-95-95. This includes scale-up in prevention with new and innovative activities, hepatitis C treatment, moving towards elimination of mother to child transmission and establishing stronger systems and sustainable financing to support the implementing partnership. The proportion of gross resource requirements for treatment, care and support is 51% and for prevention is 41%.

1. Global Context and National Context in Myanmar

1.1 National Context

Myanmar is undergoing a period of significant change socially, economically and politically. Economic and political reforms have ushered in a period of rapid growth. New directions in social policy have also renewed hope for significant improvement in public service-delivery and social inclusion. For many decades, the financial investment in the social sectors was limited and the country faced challenges in its endeavor to provide essential social and health services for the entire population. In the public sector, shortages in human and financial resources continue to limit effective and efficient service-delivery and continuum of health care. This, in turn, contributes to lower service coverage rates and limited health outcomes across communities. There are also substantial disparities in health outcomes across geographic areas, socio-economic contexts and the urban-rural divide. Lastly, long-term security concern and internal displacement generally exacerbate inequities of access to services, particularly in the rural and remote regions of the country.

Myanmar's existing mortality rate is largely due to communicable diseases and injuries which are both treatable and largely preventable with improved health coverage. Pregnancy and childbirth-related factors remain among the leading causes of morbidity and mortality despite increased health spending and improvements in maternal healthcare. There are also wide geographic and socio-economic disparities. As an example, children in rural areas are more likely to be chronically under-nourished (32% stunting) than those in urban areas (20%). Further analysis of conditions is, however, limited by the lack of readily available health and nutrition evidence at township and smaller administrative levels.[1]

As a lower-middle income economy with a Gross National Income (GNI) per capita of US$1,210 in 2017, strong economic growth in Myanmar has translated into a reduction in poverty from 48 to 32 percent between 2005 and 2015. However, stark variations exist in the degree and types of disadvantages among states and regions remain in Myanmar, according to the Multidimensional Welfare in Myanmar report, which constructed a multi-dimensional index of disadvantage consisting of 14 non-monetary indicators related to education, employment, health, water and sanitation, housing and assets. Overall, rural populations are more than twice as likely as urban populations to experience multiple disadvantages.[2]

It is within this context, that Myanmar needs to substantially improve outcomes to attain the Sustainable Development Goals by 2030, including that of Universal Health Coverage (UHC). Other than communicable diseases, a rising burden of non-communicable diseases (NCDs) makes prioritizing essential health services even more challenging. These demands will have an impact on health financing policy decisions. Myanmar will need to invest more in the health sector—and increase the public share of health spending—to make substantial progress toward UHC and achieve the goals of the National Health Plan (NHP). In 2015, the total health spending in Myanmar was approximately 4.7 percent of the Gross Domestic Product (GDP). The public share of total health spending was just 23 percent, or about 1.1 percent of GDP, despite a substantial increase in government budgetary health spending since the fiscal year 2011-12. This was still low as compared to other countries at similar levels of development. With the low level of public spending on health, out-of-

[1] Page 3, Vulnerability in Myanmar, MIMU and Harp, June 2018
[2] Page 1, The World Bank in Myanmar

pocket payments end up filling the void. Out-of-pocket payments comprise 74 percent of health spending and place a large financial burden on households. [3]

Being a multi-ethnic society, Myanmar has a protracted history of tension and civil strife over many decades. Limited development in social and physical infrastructure and circumscribed access to public services, in many conflicted-affected areas in Myanmar, also pose challenges to the Government of Myanmar's efforts to reduce poverty and pursue comprehensive, sustainable development throughout the nation. [4]

Other than the security and economic development, concerns with the availability and access of drugs has direct health consequences resulting in very high prevalence of HIV and Hepatitis C (HCV) infection, particularly in the northern states of the country.

Lastly, it is to be noted that, in addition, Myanmar is one of the world's most disaster-prone countries, exposed to multiple hazards, including floods, cyclones, earthquakes, landslides and droughts. Along with Puerto Rico and Honduras, Myanmar is one of the countries most affected by climate change in the last 20 years, ranking third out of 184 countries in the 2019 Global Climate Risk Index and 12th out of 191 countries on the INFORM Index for Risk Management.[5]

1.2 Global Context

Myanmar continues to both benefit from and contribute to global learning and responses to HIV and co-infection. Since joining the Global Coalition on Prevention (GPC) in 2018, Myanmar has committed to global prevention targets and to tracking national progress towards these targets. Myanmar is also actively reviewing critical gaps along the continuum of prevention, treatment and care, including reaching and testing; testing and enrolling in care; and, enrolling in care and initiating and staying on ART. Pre-Exposure Prophylaxis (PrEP) and assisted partner notification are planned in Myanmar and piloting for HIV self-testing is underway in 2020.

1.3 Fast Tracking

As one of the countries with a substantial HIV burden in Asia, Myanmar was prioritized for the global Fast Track strategy with a set of targets to be reached by 2020, including achieving *90-90-90:* 90% of people living with HIV knowing their HIV status; 90% of people who know their HIV positive status are on treatment; and 90% of people on treatment have suppressed viral loads. Other targets include reducing the annual number of new HIV infections by more than 75% in 2020 and achieving zero discrimination. The targets are firmly based on an approach to leaving no one behind, that is grounded in human rights. The UNAIDS Fast-Track approach emphasizes the need to focus on the countries, cities and communities most affected by HIV and recommends that resources be concentrated on the areas with the greatest impact.

The approach outlines that particular efforts are needed in 30 countries that together account for 89% of new HIV infections worldwide. To Fast-Track national responses in these 30 priority countries requires extensive mobilization of human, institutional and strategic international partners as well as significant commitments from both national and international sources. The importance of reaching people most

[3] Page 5, Myanmar Health Financing System Assessment, Discussion Paper, World Bank Group, October 2018
[4] Page 9, Myanmar Sustainable Development Plan (2018-2030), Ministry of Planning & Finance, August 2018
[5] Page 1, The World Bank in Myanmar, Op. Cit.

affected by HIV is also outlined as key to ending the AIDS epidemic and concerns are raised about access to HIV services for people most in need.

Sub-national HIV Operational Plans in the five high disease burden states and regions of Sagaing, Kachin, Shan North, Mandalay and Yangon, provide a platform for fast-tracking this extensive mobilization and use of resources to achieve significantly greater reach, coverage and impact.

1.4 Alignment with the National Health Plan for Universal Health Coverage

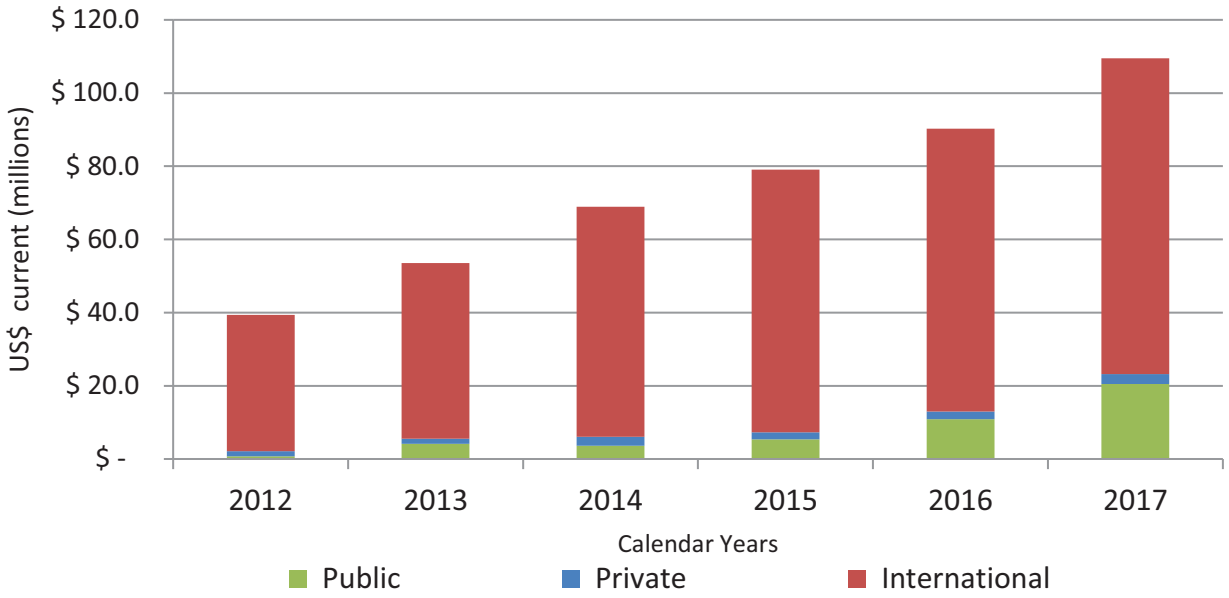
The new National Health Plan (NHP) for 2017–2021 has laid out the vision of achieving Universal Health Coverage (UHC) by 2030, choosing a path that is explicitly pro-poor. The NHP aims to improve the delivery of health services and financial protection for Myanmar's people through substantial investments in frontline service-delivery units, and through a range of reforms in the health system, including on health financing. Out-of-pocket expenditure by households remains the dominant source of financing for health. In 2015, out-of-pocket spending by households accounted for 74 percent of total health spending (MoHS 2017).[6] The NSP IV development process has included key stakeholders from the National Health Plan Implementation and Monitoring Unit (NIMU) and the Ministry of Planning and Finance to ensure consistency with the emerging strategic directions for a health financing system that will support Myanmar's pursuit of UHC and the health financing reforms necessary to realize the National Health Plan objective to provide an Essential Package of Health Services for the entire population.[7]

1.5 National financing, partnership approach and development partner context

HIV spending in Myanmar has been constantly increasing, reaching a record US$ 109.5m in 2017 which represents a 21% increase from the 2016 amount (US$ 90.3m). Public spending has increased in absolute and in relative terms of the national HIV spending, increasing from 2% of total HIV funding in 2012 to 19% in 2017. Despite this significant increase in public funding, the country still depends largely on international funding to maintain its national HIV response, with international funds covering 80% of the national HIV spending in 2017 and being the main funding source for most HIV programmatic areas. [8]

[6] The National Health Accounts for 2014–2015, published by Myanmar MoHS in 2017
[7] Page 1, Strategic Directions for Financing Universal Health Coverage in Myanmar, draft, March 2019
[8] Page11, Myanmar NASA, 2016-2017

Figure 1:HIV funding sources in Myanmar 2012 - 2017[9]



The Government of Myanmar provided USD 15 million per year for the duration of NSP III, mainly supporting the procurement of Antiretrovirals and Methadone contributing to increasing public sector management of ART program and opioid substitution treatment (OST). This important domestic contribution is combined with external financing to procure ARV pharmaceuticals and health products which are then channeled by the National AIDS Program (NAP) to the implementing partnership, including public, private and NGO health facilities and clinics. This is promoting accountable leadership for the delivery of results while increasingly financing a sustainable response. In order to reach the Fast Track targets and UHC, public funding needs to continue its expansion, especially as the current international funding environment is expected to decline or stagnate. While shifting from international to public funding, particular care needs to be considered in maintaining adequate funding to activities that have the biggest impact on the epidemic. In order to analyze whether resources are being allocated where the epidemic is concentrated, future HIV spending assessments will include a sub-national monitoring of HIV spending.

Over the course of NSP IV, the Government of Myanmar will progressively increase domestic financial support to the amount of 25% of total national AIDS spending to provide sustainable and secure ARV treatment, OST, adequate human resources for health, and to ensure access to the essential package of health services for HIV in all townships. Continued mobilization of both domestic and external financial resources will fund the implementation of sub-national operational plans in high burden regions/states. Additional investment by international development partners will enhance the country's efforts to respond more effectively to the HIV epidemic.

However, Global Fund for AIDS, Tuberculosis and Malaria (GFATM) grants still provide by far the majority of funding for the national response to HIV and for testing, care and treatment for HIV-TB co-infection. The Global Fund still accounts for 45-50% of total funding, which represents an increasing proportion of decreasing other external development assistance for health. The country is highly dependent on external

[9] Ibid

funding that it is vulnerable to losing their gains if, for some reason external funding, is not available at some point in the near future.

A wide range of national and international stakeholders actively participate in Myanmar's response to HIV, including: development partners; implementing partners; a range of Ministries, Departments and other bodies at national, states/regions, districts, townships level and below; private and community-based organizations; technical supporting partners; people living with HIV and key population-related communities; and academic institutions. NSP IV also rests upon an inclusive and multi-sectoral partnership approach which is important in facilitating more effective program implementation with increased collaboration with Social Welfare, Education, Police and Prison sectors, as well as other areas of the health sector – such as Reproductive Health and the Hepatitis program. In parallel, ensuring enabling policies and laws, including rights-based approaches, will allow key populations increased access to prevention and health care services.

Human resource constraints in the public sector require a focus on co-location of services, integration and continued implementation of innovative approaches to HIV prevention, testing and continuum of care. This includes using online platforms for risk assessment and referral; community screening by peers; self-testing; and strengthening the role of people living with HIV in enrolling and maintaining people on ART To maintain the momentum of a program delivered through a range of MoHS-led partnerships, the following activities should continue under NSP IV: the transition plan for ART patients calibrated to the capacity of the public sector; task shifting; and continued analysis of opportunities for public–private partnership approaches in service-delivery for HIV prevention, treatment and care.

1.6 Transition

There are several significant changes occurring in the transition from NSP III to NSP IV. Prominent among these is the move to more decentralized operational, financing and partnerships at state and region levels - which should facilitate increasing reach, coverage and impact to populations in complex contexts. State/Region HIV Operational Plans will also be supported by an expansion in the number of high priority townships and delivery of comprehensive service packages to high priority townships. The Operational Plans and geographic prioritization should allow proactive attention to scale up and strengthening of care, prevention and treatment services with reach, coverage and linkages supported by a significantly expanded cadre of trained, incentivized community network/peer educators. State/Region Operational Plans also represent a transition to an advocacy strategy linked with strengthened partnerships to ensure the convergence and integration of decentralized efforts associated with HIV, TB, Hepatitis, drug use prevention, drug use and its health consequences and address broader social vulnerabilities.

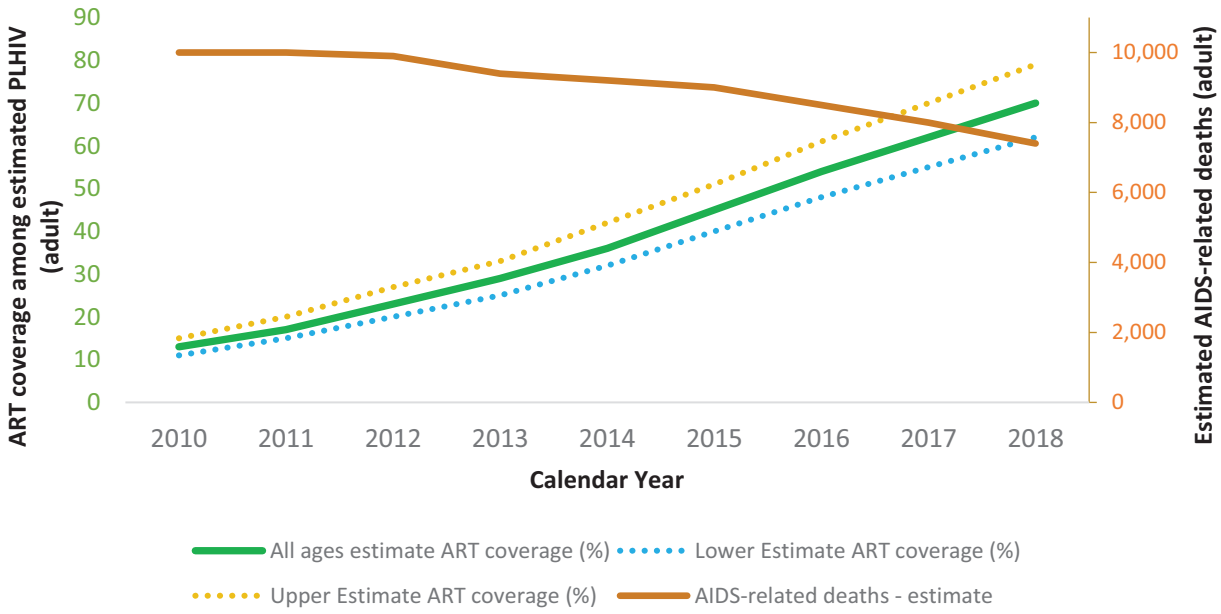
2. HIV Situational Analysis

2.1 Overview & Accomplishments Nationally

In Myanmar in 2019 there were an estimated 240,000 people living with HIV, including 10,800 children. Among the approximately 230,000 adults living with HIV, 38% were women and 62% were men.[10] National HIV prevalence among adults (15+ years) was approximately 0.57%[11] with higher and concentrated HIV prevalence among priority populations, including people who inject drugs (PWID), men who have sex with men (MSM), sex workers (FSW) and the intimate partners of all these priority populations in key geographic regions. In 2017, 75% of the total number of people living with HIV lived in 5 states/regions including Kachin, Shan North, Sagaing, Mandalay and Yangon.

Leadership from the Ministry of Health and Sports and the National AIDS Program, bolstered by significant partnerships, has resulted in an impressive increase in the number of people receiving ART to 185,859 in 2019 representing 77 % of all people living with HIV in the country including 83% of children. The increase in life saving treatment and significant prevention efforts has resulted in a downward trend in new infections to 11,000 and 7,800 HIV-related deaths in 2018[12]. Sustaining and expanding ART coverage and improving prevention coverage will now require increased partnerships with the community and private sectors during NSP IV.

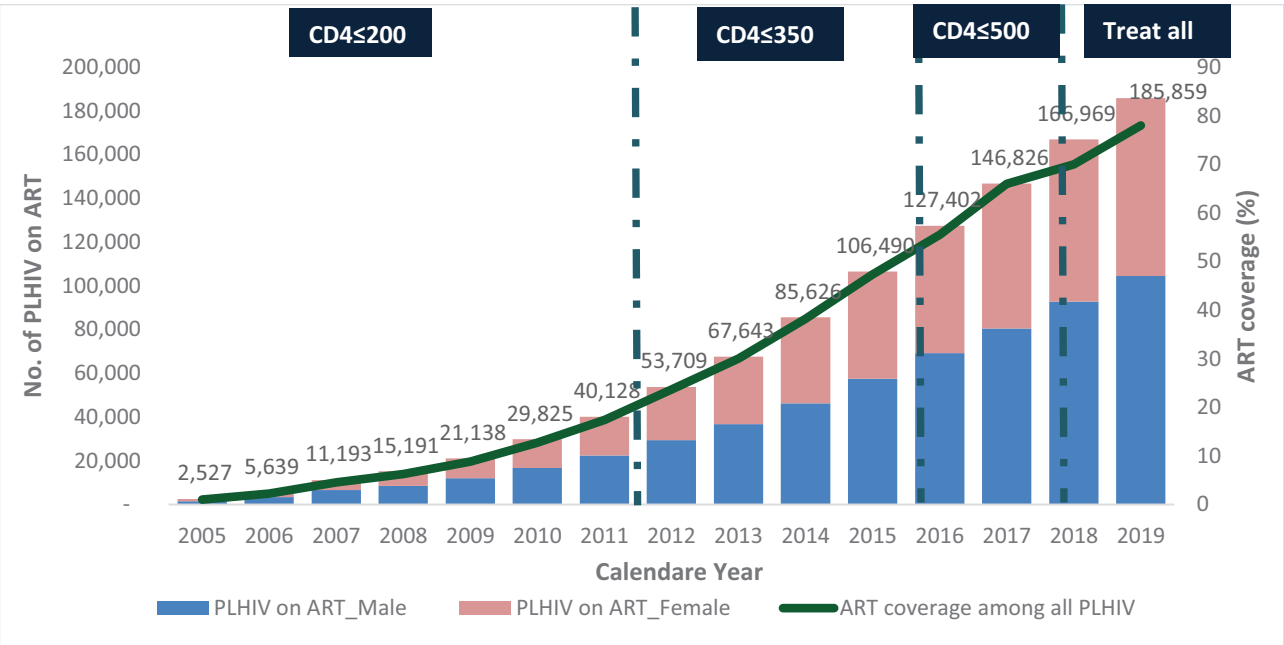
Figure 2:Coverage of people receiving ART and AIDS related deaths, 2010 – 2018 (Adults, aged >=15 years)



Source: National AIDS Program estimates and projections and ART program data, 2018

[10] UNAIDS AIDS DataHub, Myanmar, 2018
[11] AEM-Spectrum HIV estimates April 2019
[12] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Figure 3:People receiving ART (2005–2019)



Source: Program data, *National AIDS Program, 2019*

Despite significant national advancements in ART coverage, the reported number of key population access to ART seems to be lower than it should be. This is the urgent need of national program and partners to ensure that all vulnerable and key populations who confirmed HIV positive have access to life-saving ART.

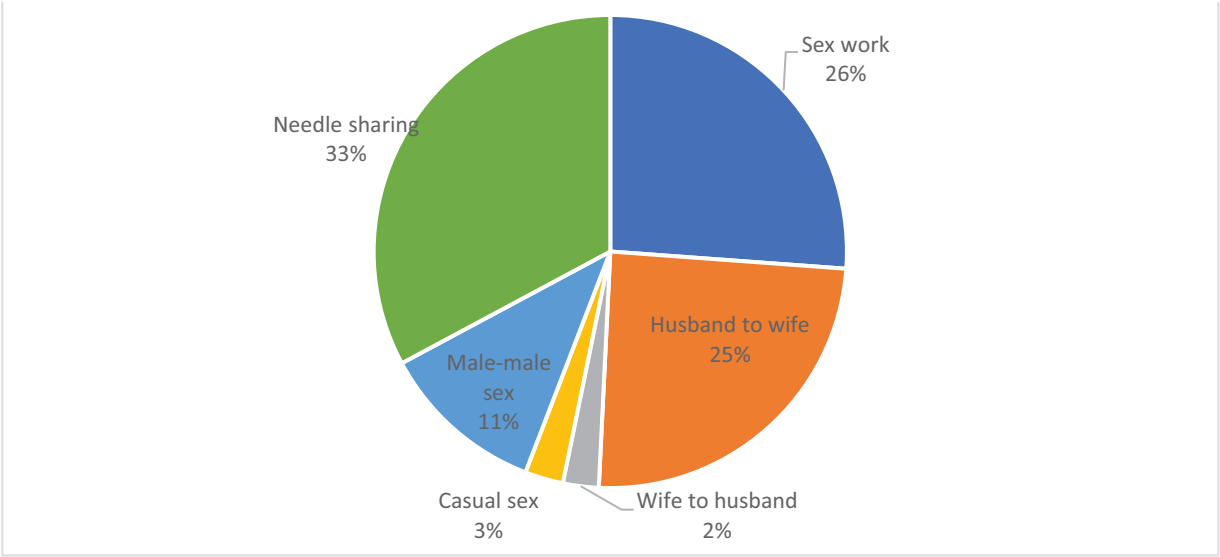
The key population, in particular people who inject drugs cited several obstacles to access including cost, time and a lack of perceived value of ART treatment when they do not feel sick. Significant efforts to improve education, integrate services and enhance community access for HIV testing and linkage to life-long ART treatment are needed for people who inject drugs and all key populations.[13]

New Infections

Annual new infections peaked in 2000, declining steadily every year, with an estimated national incidence of 0.2per 1000 population in 2018. Among the 11,000 new infections in 2018, needle sharing represented 33% and sex work related represented 26% of new infections. “Husband to wife” sexual transmission represented 25% of new infections generally described to be intimate partners including regular sexual partners and wives of HIV (+) clients of sex workers, regular sexual partners and wives of people who inject drugs and female partners of men who have sex with men. Male to male sexual transmission of HIV represented 11% of new infections nationally.[14]

[13] Report of National Key Populations HIV Program Review in Myanmar, APMG Health, Washington DC, August 2019.
[14] Ministry of Health and Sports, National AIDS Program estimates and projections, 2018

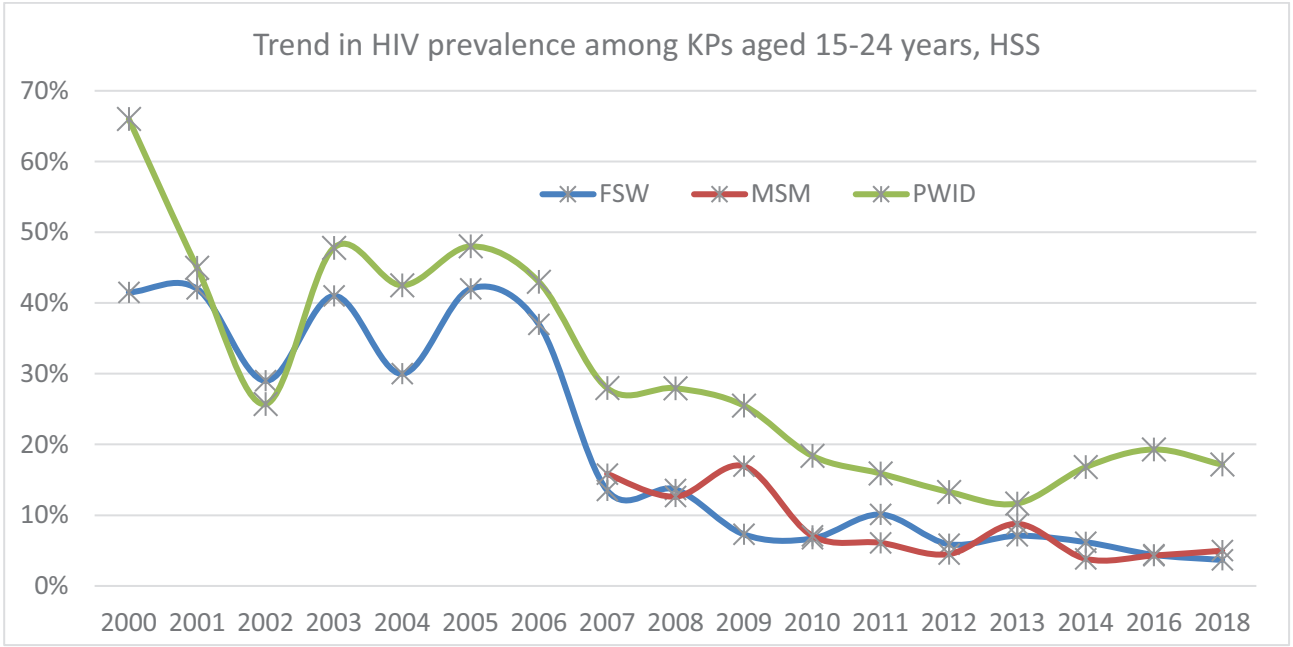
Figure 4:Proportion of new HIV infections by mode of transmission 2018



Source: National AIDS Program estimates and projections, 2018

As a proxy for incidence, the trend in HIV prevalence among key populations aged 15-24 years from the HIV Sentinel Surveillance (HSS) has shown sustained declines in HIV prevalence among female sex workers and men who have sex with men nationally since the mid-2000s. Yangon is an exception to the national HSS trend with increased HIV incidence among young men who have sex with men.[15] Among young people who inject drugs, there has been an increase in HIV prevalence since 2014, suggesting increasing HIV incidence in this population nationally.[16] With a growing HIV epidemic among key populations these data support the NSP IV strategy of increased and tailored responses for vulnerable populations in key geographic areas.

Figure 5:HIV prevalence trends in young Key Populations from HSS, as a proxy for incidence



Source: HIV Sero-sentinel surveillance (HSS 2000-2018)

[15] *Ibid,* HIV Epidemiological Review, 2019

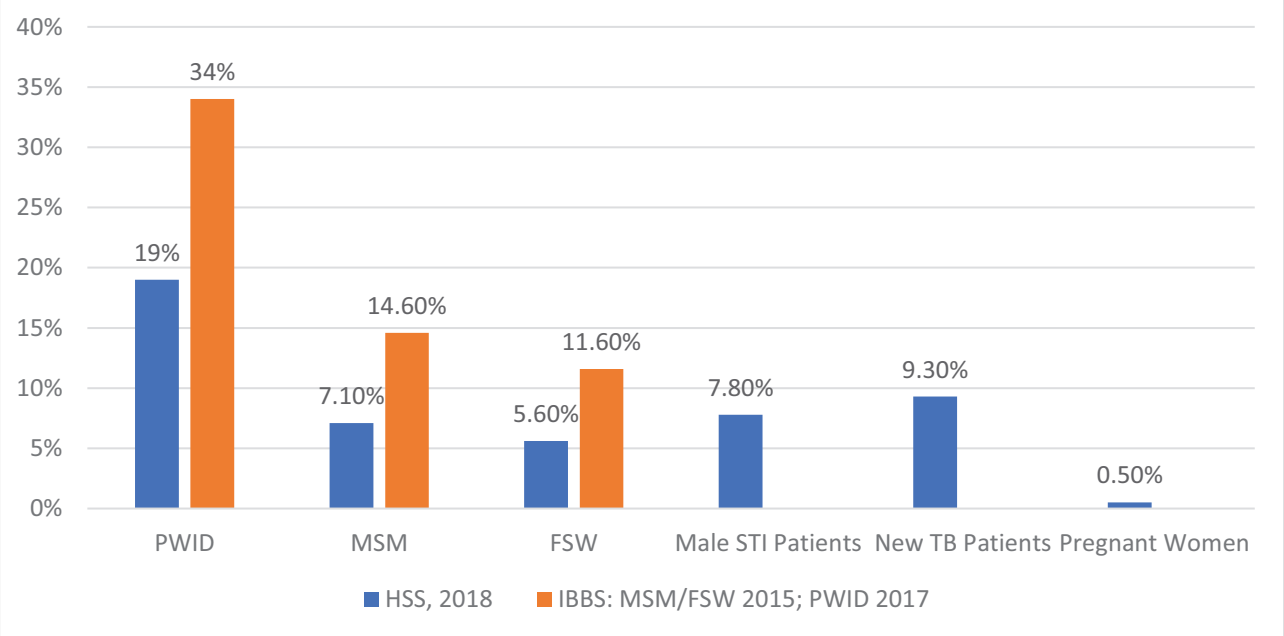
[16] HIV Epidemiological Review Republic of the Union of Myanmar, 2019. National AIDS Program, Ministry of Health and Sportss of Myanmar

2.2 Epidemiological Trends, Key Population Vulnerability and Geographic Variation

Key Population Vulnerability: In 2018, the HIV Sentinel Surveillance data suggested a national HIV prevalence of 19% among people who inject drugs, 7.1% among men who have sex with men and 5.6% among female sex workers and 9.3% among new TB patients. The IBBS estimated HIV prevalence was 34.9% people who inject drugs in 2017, and in 2015 HIV prevalence was 14.6% among men who have sex with men and 11.6% among female sex workers. In 2018, 10.4% of all people living with HIV newly enrolled in HIV care were detected as having active TB disease.[17]

Subnational HIV prevalence reveals geographic and population specific high HIV burdens of infections in Myanmar. The IBBS survey conducted in 2017-2018 among people who inject drugs shows very high HIV prevalence (up to 61%) in key townships in Northern Myanmar in Kachin, Sagaing and Shan North. The IBBS survey in 2015 among female sex workers also showed high HIV prevalence in Yangon at 25% with variation by geographic location and to a lesser extent by sex worker group. The IBBS survey conducted in 2015 among men who have sex with men showed very high HIV prevalence among men who have sex with men in Mandalay (22%) and Yangon (27%), among the highest in the Asia/Pacific region, with 6-7% HIV prevalence in other smaller towns.[18]

Figure 6:HIV prevalence among key and sentinel populations

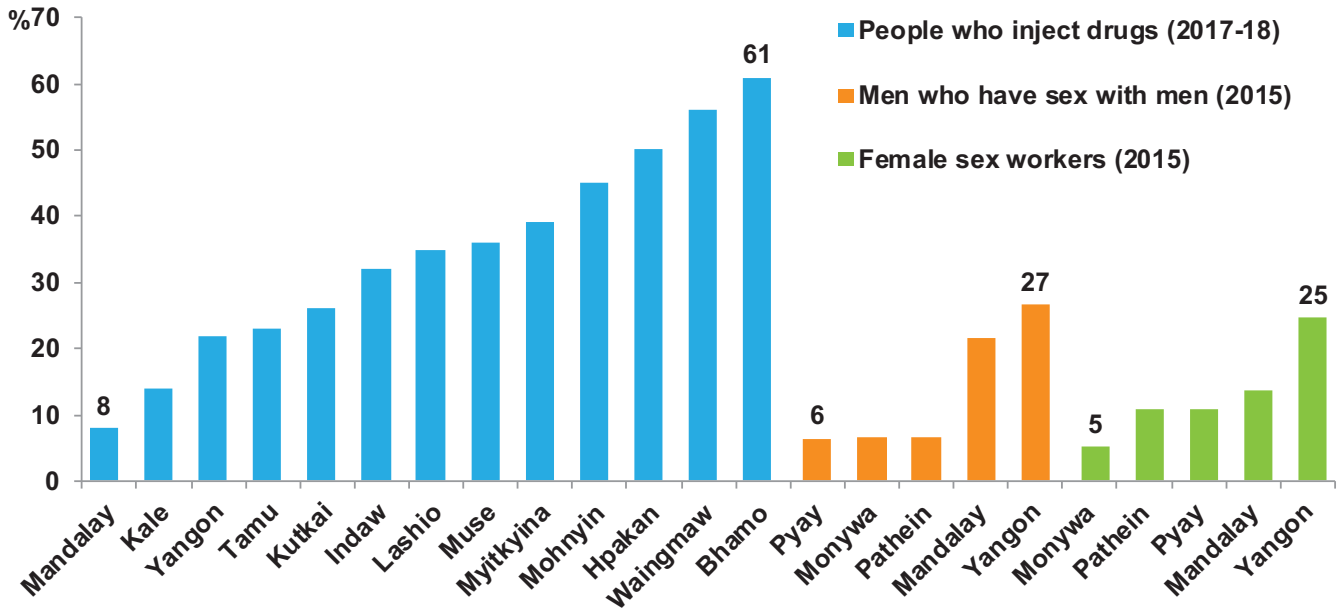


Source: National HIV Progress Report 2018, The National AIDS Program, Ministry of Health and Sports and IBBS MSM and FSW 2015; IBBS PWID 2017-2018.

[17] Global AIDS Monitoring Report, 2019.

[18] The FSW & MSM Surveys will be updated in December and new data should be added to NSP IV at that time.

Figure 7:HIV prevalence among key populations in surveyed IBBS sites, 2015-2018



Men who have Sex with Men:

HIV prevalence among men who have sex with men varied not only by the five survey sites but also by sexual orientation, gender identity and public expression of gender identity including *Apwint or* biological males whose gender identity is generally feminine*, Apone* biological males whose gender identity may be either masculine or feminine (further defined in Section D). The 2015 IBBS showed that men who identify as *Apwint* are at higher risk of HIV infection followed by *Apone*. *Apwint* are considered a '*rough approximation*' of transwomen, however there is no operational definition of "transwomen" in Myanmar. The estimated 62% HIV prevalence for *Apwint* in Yangon is exceptionally high compared with men who have sex with men and transwomen globally[19]. In 2015 the IBBS in Yangon among men who have sex with men showed a higher rate of partner change, a higher rate of selling or buying sex and lower knowledge of HIV and lower condom use all contributing to higher HIV prevalence.

Geographic Variations in Epidemic Dynamics

One of the strengths of the strategic information in Myanmar has been the development of sub-national models of HIV infection. Results have shown that epidemic dynamics vary by geographic location and key populations shown by the profile of new infections.

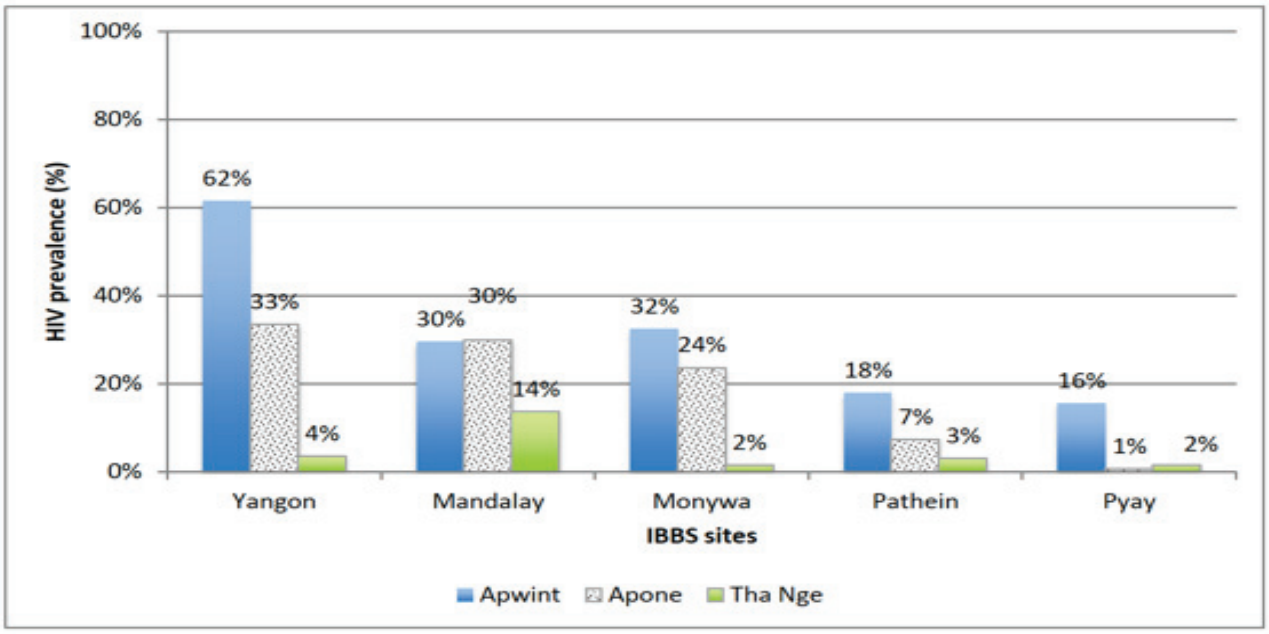
- In Yangon, the majority of new infections occur among men who have sex with men, clients of female sex workers and the female partners of key populations.
- In Mandalay, the modeling has shown a significant decline in incidence faster than any other area of the country. New infections in Mandalay are a mixture of people who inject drugs, men who have sex with men, female sex workers and their partners. Among men who have sex with men, Yangon and Mandalay represent the largest share of new infections.
- In Kachin, Shan North and Sagaing, new infections are primarily among people who inject drugs and their female partners. However, as in previous years, program data suggest that regions with high HIV

[19] HIV Epidemiological Review Republic of the Union of Myanmar, 2019. National AIDS Program, Ministry of Health and Sports of Myanmar

prevalence among people who inject drugs also present a high percentage of HIV positive test results among female sex workers representing a double burden and increased *environments of risk* for key populations.

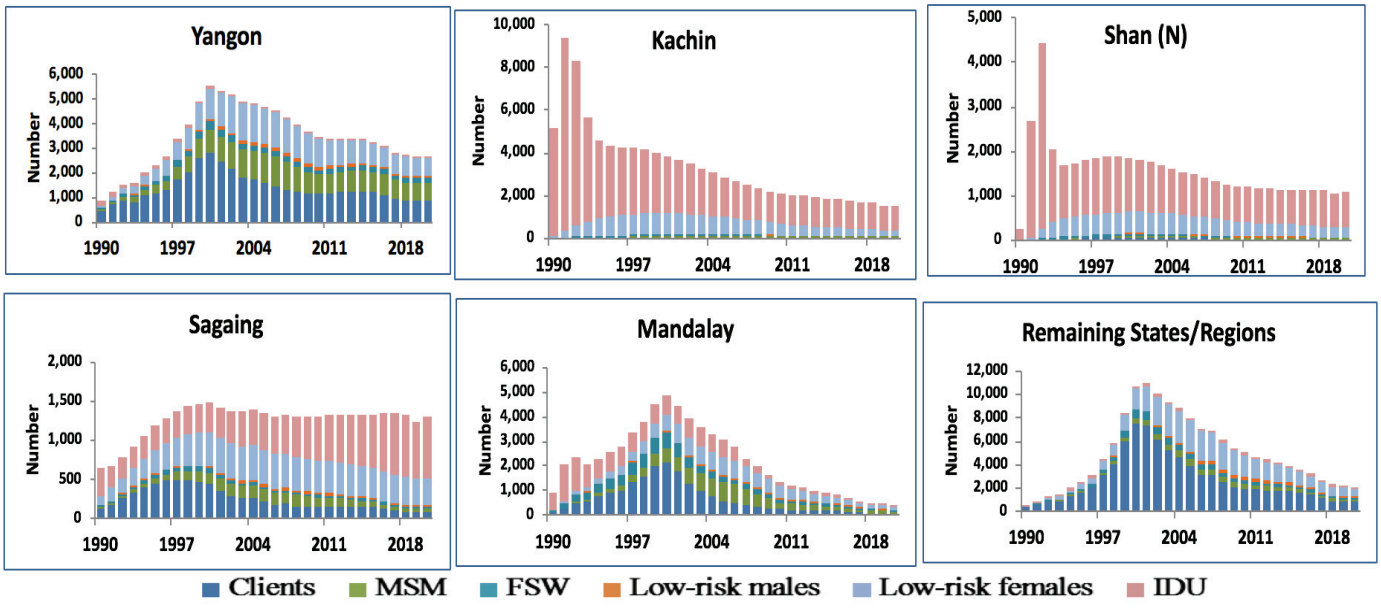
These data support the NSP IV strategy of the differentiated application of the Comprehensive Package of services locally tailored by population need in specific geographic settings. Further analysis of Mandalay's success may provide useful models for other regions.

Figure 8:HIV prevalence among men who have sex with men subgroups, 2015



Source: MSM IBBS, 2015

Figure 9:Annual New HIV infections by risk population at subnational level 1990-2020

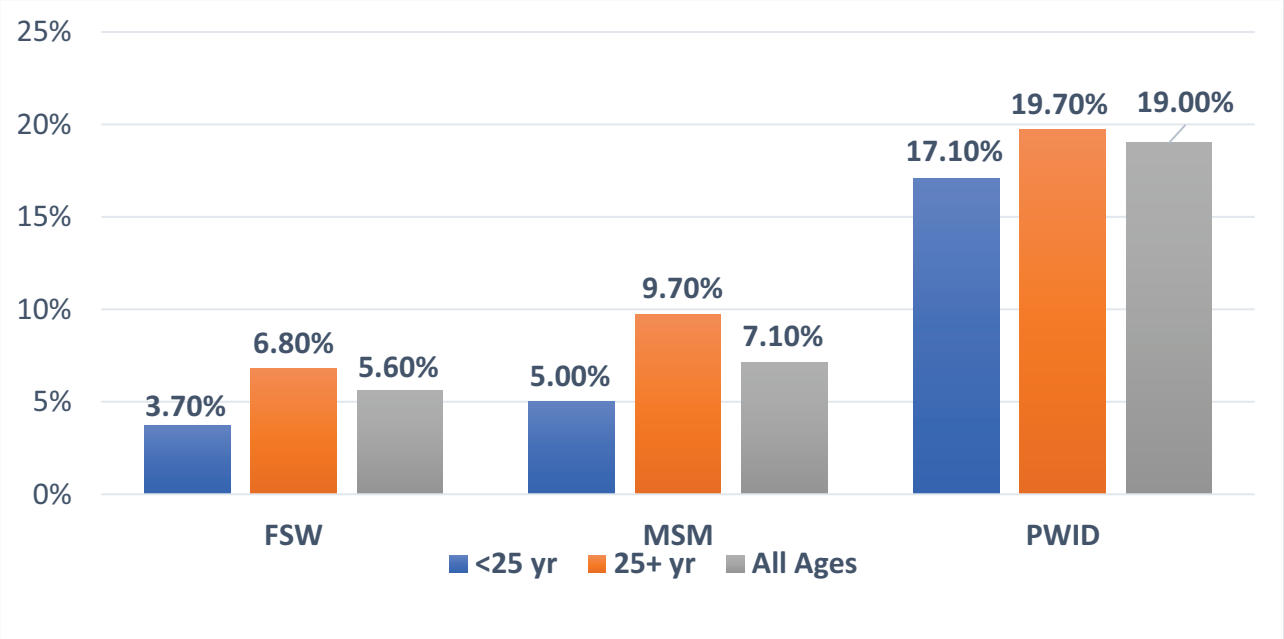


Source: AEM May 2108

2.3 Epidemiological challenges – Youth, Co-infections, Partners of KPs, MTCT

Young people under 25 in Myanmar who engage in unsafe behaviors have significant risk of HIV infection. Young injectors are at particularly high risk of HIV infection more than 4 times more than young men who have sex with men. The longer people engage in unsafe behavior the higher the possibility of HIV infection.

Figure 10:HIV prevalence among young sentinel populations by age group, 2018



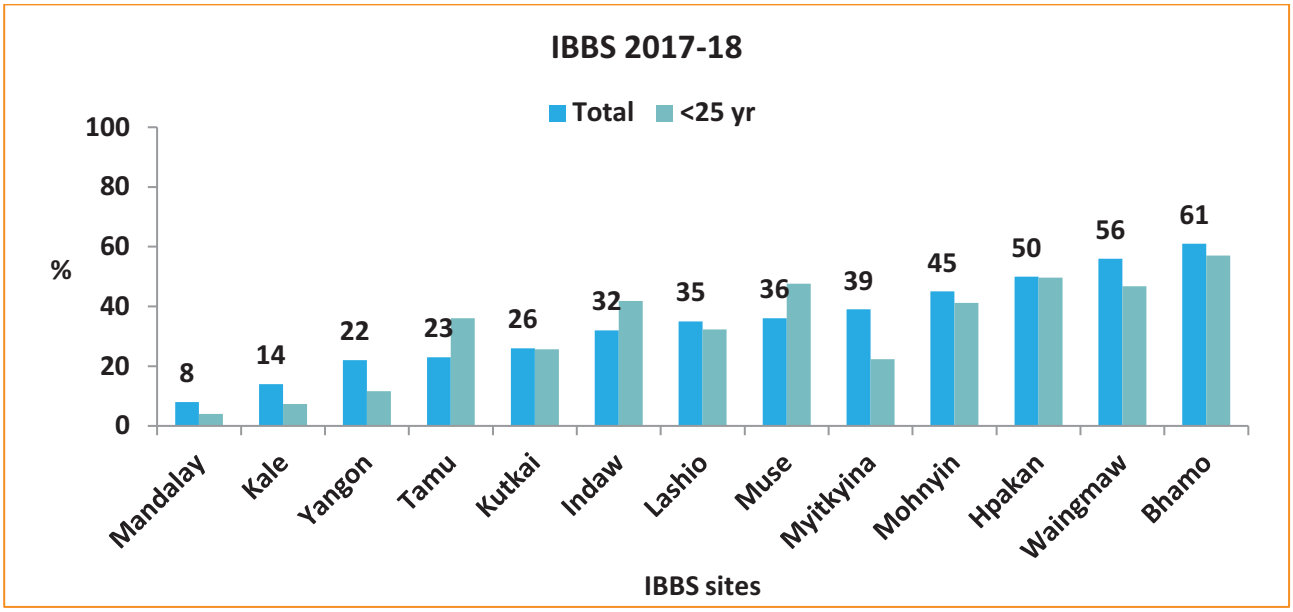
Source: HIV Sentinel Surveillance (HSS) 2018 cited in Global AIDS Monitoring 2019

Youth who use drugs and inject drugs

The IBBS among people who use drugs across all sites measured 20% HIV prevalence among those injecting for less than one year and 40% among those injecting for more than one year. This suggest that 1 in 5 neophyte injectors are getting infected in their first year of injecting and one in 2.5 are infected by their second year. Among those under 25 years old, some geographic settings showed very high levels of HIV prevalence, Figure 11. Availability and accessibility of non-injecting drugs has led to an increase in the number of people who use drugs (PWUD). The 2017 IBBS among people who inject drugs highlights that youth switch relatively quickly (within four years) from non-injecting to injecting drug use warranting improved policy, guidelines and services to address these risk factors among young people in Myanmar.[20]

[20] Paper entitled "Urgent need to address multiple high-risk behaviors and prevention HIV among young PWID" presented in Myanmar Health Research Congress 2019.

Figure 11:HIV prevalence among people who inject drugs by age group, IBBS 2017-18

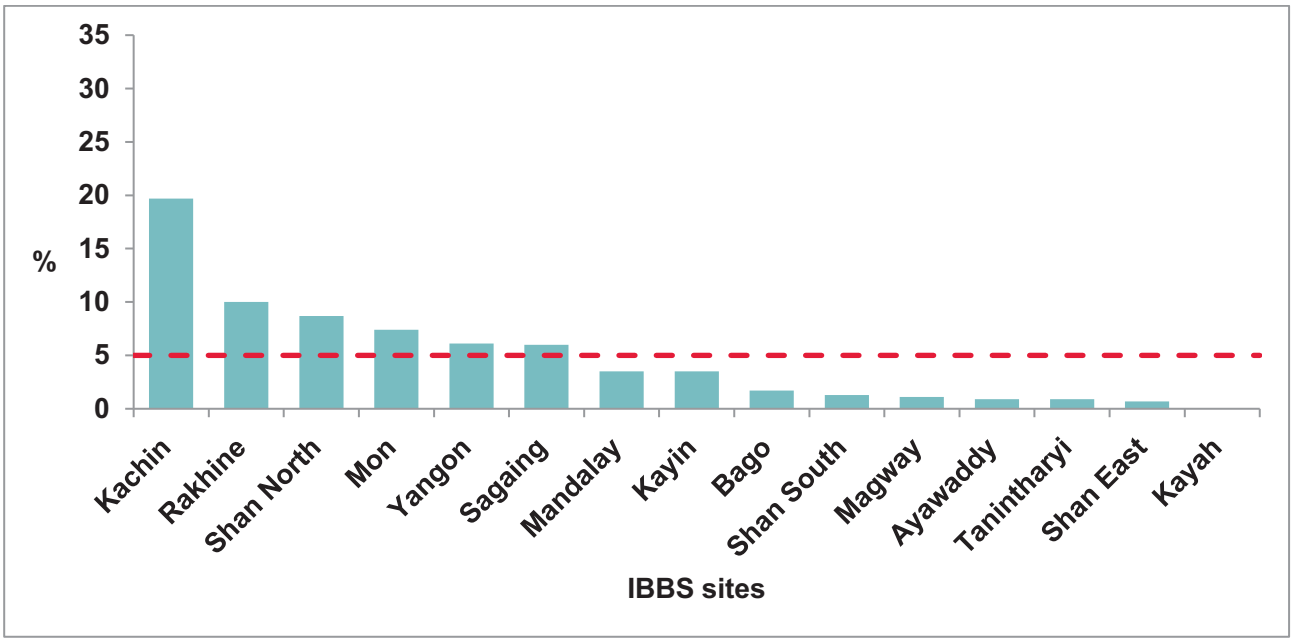


Source: Myanmar IBBS & Population Size Estimates among People Who Inject Drugs (PWID) 2017-2018, National AIDS Program Ministry of Health & Sport.

People in closed settings including prisons

Significantly higher HIV positivity has been found among prisoners with about 20% in Kachin and 10% in Rakhine and 7% in Mon. In 2019, more than 36,000 prisoners were offered HIV testing, 1,355 were initiated ART in the prison and total 3,182 prisoners were on ART across 45 prisons. While these are significant achievements, there is a need to expand HIV prevention coverage in prisons, to provide ART among HIV and HIV/TB prisoners and ensure stronger linkage between the prison and community health services from initial detention until prisoner release. All people living with HIV including pregnant women and their exposed children should receive ART treatment in prison and ensure the proper referral after release.

Figure 12:HIV positivity among prisoners by region, 2019

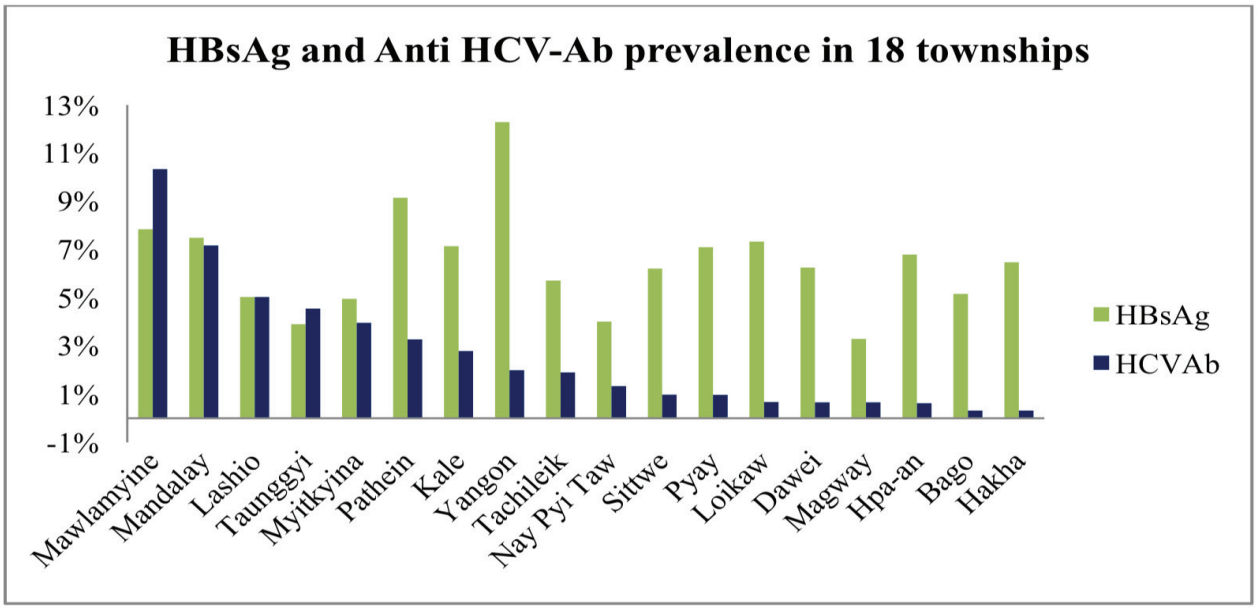


Source: Program data 2019

Co-Infections (HIV and HCV, HBV & TB)

The Hepatitis C (HCV) prevalence among people who inject drugs from the 2017-2018 IBBS survey was high at 56% overall and ranging from 27% in Myitkyina to 85% in Waimaw. Co-infection of HIV and HCV ranged from 4% in Mandalay to 55% in Bamaw. Prevalence decreased across all sites from 2014 to 2018 except in Mandalay, Bamaw and Waimaw; the latter two with a significant increase in co-infection. HBV prevalence was reportedly lower among people who inject drugs at 7.7% as was HIV/HBV co-infection. Syphilis was significantly lower at 1.5% among people who inject drugs except in Yangon at 5.7%. In Myanmar, a national sero-prevalence survey in 2015 estimated how common viral hepatitis was, with Figure 13 providing details. About 3.3 million people live with viral hepatitis B and close to 1.3 million live with viral hepatitis C, some of whom go on to develop the disease.[21] Efforts in prevention and treatment of HCV and HBV are limited and need to be expanded among key populations in Myanmar while the provision of syphilis treatment needs to be sustained and improved in key areas.

Figure 13:The prevalence of hepatitis B surface antigen and hepatitis C antibodies among the general population in 18 selected townships



Source: Department of Medical Research 2015. National hepatitis B and C prevalence survey 2015.

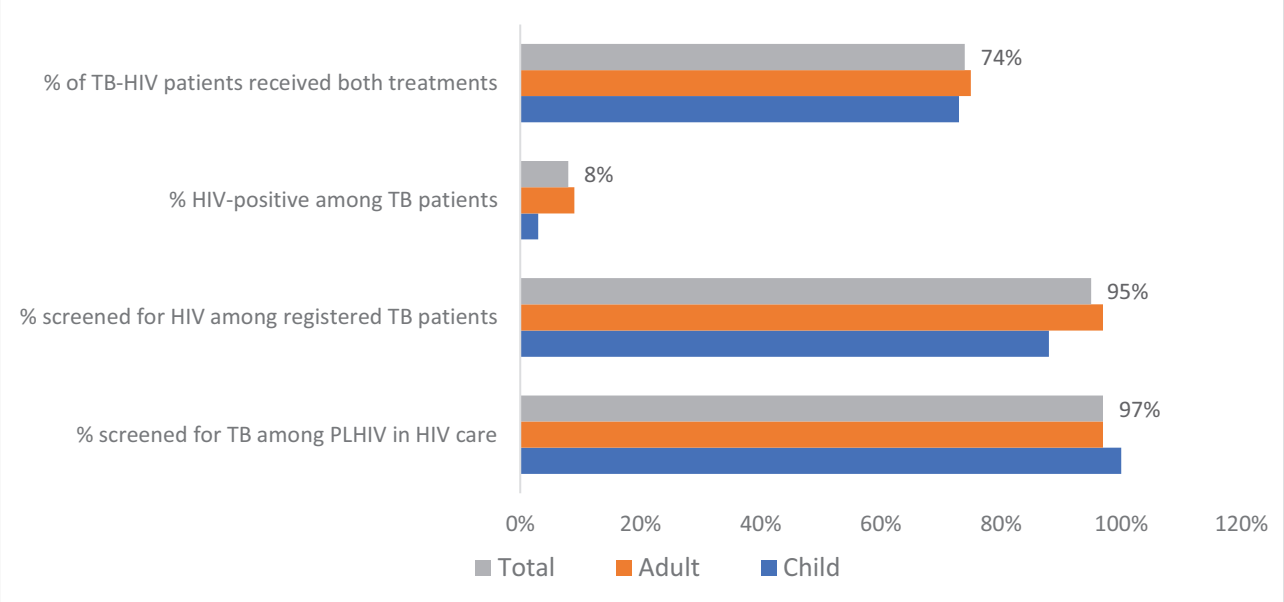
Myanmar has been one of 30 highest-burden countries with TB/HIV coinfection in the world. However, since 2015, the coverage of TB patients with known HIV status has increased. In 2019, the TB/HIV program successfully screened 97% of patients in HIV care for TB and 95% of patients registered for TB treatment were tested for HIV.[22] In 2019 among TB patients, 8% were found to be HIV positive. Among the patients newly enrolled into HIV care, 11% were found to have active TB disease. Of those adult patients with TB/HIV coinfection, 74% (7,281) were treated for both TB and HIV in the same year.[23]

WHO recommends that people living with HIV who are unlikely to have active TB disease should receive at least six months of isoniazid preventive therapy (IPT) as a part of a comprehensive package of HIV care. In

[21] WHO Myanmar Newsletter Special for World Hepatitis Day, 28 July 2019
[22] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[23] 2019 Program data of NAP and NTP

2019, 47% of newly enrolled HIV patients were assessed as eligible for IPT and among those 56% or 9,365 patients started IPT.[24] At a subnational level, the co-management of TB/HIV and IPT provision varies significantly by region with some areas underperforming.

Figure 14:TB/HIV co-management, 2019



Source:2019 Program data of National AIDS Program and National TB Program

Overall, Myanmar's capacity to diagnose TB and HIV has improved, however, despite the good TB screening and HIV testing results, there is a need to continue to increase the number of TB/HIV coinfected patients, including children, who receive both treatments. In addition, the causes for low IPT coverage among newly enrolled HIV patients should continue to be explored and improved systematically.[25]

Partners of Key Populations

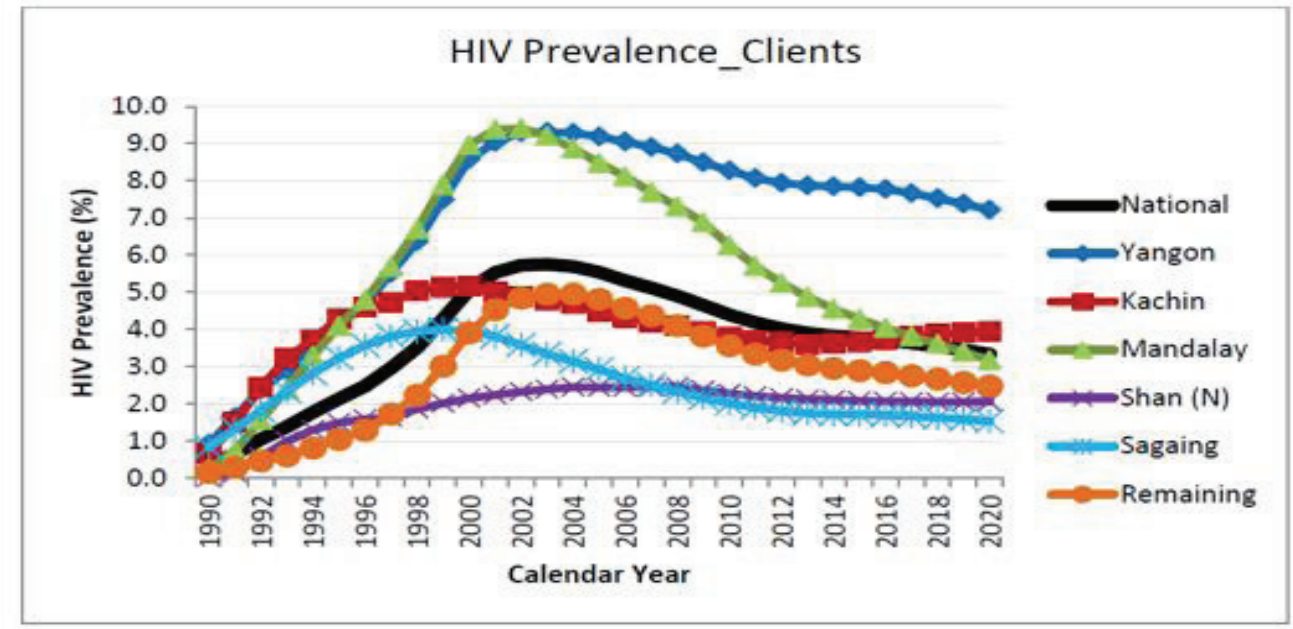
According to modelling data from the Ministry of Health and Sports in 2016, HIV prevalence trends among male clients of sex workers has shown a steady decline nationally with significant declines in Mandalay, however in Kachin there has been a slight increase and in Yangon they have remained stubbornly high. Increased investments and efforts to improve access to prevention and treatment for the sexual partners of key populations is required during NSP IV.

Prevention of Mother to Child Transmission (PMTCT)

By 2019, the PMTCT program had made significant progress with 99% coverage across 326 townships in the country providing services resulting in 88% of pregnant women receiving pre-test counselling and of those 95% got tested and received their HIV test result. Among HIV positive pregnant women, 82% (4,439) received antiretrovirals to reduce the risk of mother to child transmission. At a national level, 3,071 HIV exposed infants were provided ARV prophylaxis representing 57% of all estimated HIV positive pregnant women. Cotrimoxazole prophylaxis was provided to 30% of exposed babies and 25% were tested for early infant diagnosis (EID) within two months of birth. [26]

[24] 2019 Program data of NAP
[25] 2019 Program data of NAP and NTP
[26] National HIV Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Figure 15:HIV prevalence trends among clients of female sex workers

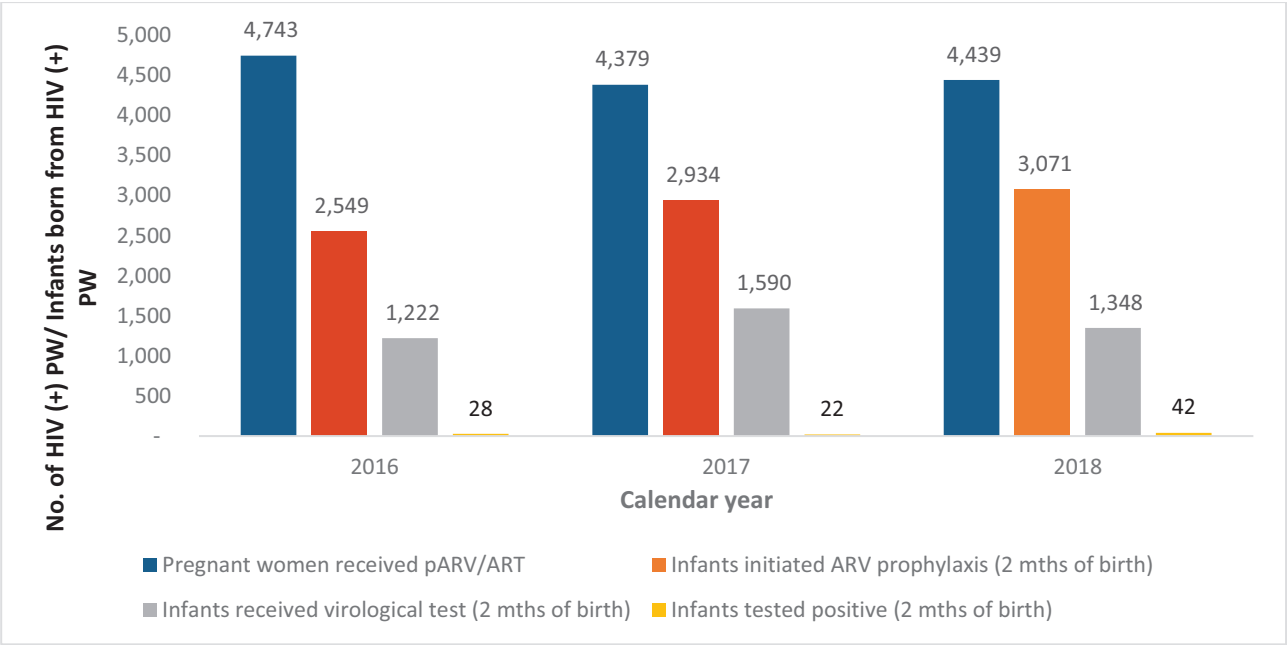


Source: AIDS epidemic Model, National AIDS Program Ministry of Health & Sport, 2016

NSP IV is committed to the elimination of mother-to-child transmission of HIV and syphilis.

Although the PMTCT program is performing well in identifying and tracking HIV positive pregnant women, the follow up care for HIV exposed babies and the follow up to ensure life-long treatment for HIV (+) women post-partum needs to be significantly improved to reach this goal.

Figure 16:Pregnant women receiving PMTCT services, infants initiated on ARV prophylaxis, infants received virological test and tested positive within two months of birth (2016-2018)



Source: National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

3. Strategic Framework for the National Strategic Plan (2021-2025)

The following strategic framework articulates the NSP IV 2021-2025 vision, guiding principles, goal and strategic directions.

3.1 Vision

By 2030, end HIV as a public health threat in Myanmar through fast-tracking access to a continuum of integrated and high-quality services that protect and promote human rights for all without financial hardship.

3.2 Guiding Principles

<table>
<tr><td colspan="4">Three ‘Ones’ – National Plan, National Coordination, M & E plan</td></tr>
<tr><td>Evidence based and results-oriented innovative interventions and global best practices that are cost effective and prioritized to maximize the impact of the resources resulting in quality health services targeting those most in need.</td><td>Fast-tracking, integrated, differentiated, decentralized, high quality services at the community level, and health and community systems strengthening to efficiently address co-occurring vulnerabilities and support the continuum.</td><td>Protection, and promotion of human rights, gender equity, and favorable policy and laws to eliminate stigma, discrimination and violence and remove obstacles to ensure access and uptake of HIV services and social protection through context-specific tailored approaches to the needs of populations.</td><td>Sustainable multi-sectoral partnerships including domestic financing, public and private sector and communities to jointly design, monitor and evaluate services and programs for maximum coverage and reach and ensure accountability.</td></tr>
<tr><td colspan="4">Universal access to health and development, towards achieving the Sustainable Development Goals</td></tr>
</table>

3.3 Goal

To further reduce HIV transmission and HIV related morbidity, mortality, disability and social and economic impact of HIV.

3.4 Objectives

1. Reduce HIV incidence among priority populations and their partners
2. Improve quality of care and increase accessibility for ART
3. Ensure viral suppression for all People Living with HIV
4. Improve the enabling environment to support the national HIV response

3.5 Strategic Milestones

- 95% of sex workers, men who have sex with men, people who inject drugs, and prisoners have access to combination prevention services
- 95% of people living with HIV know their status
- 95% of people living with HIV who know their status receive treatment and get viral load tested
- 95% of people on treatment have achieved viral suppression
- All people living with, at risk of and affected by HIV report no discrimination in all sectors especially in health, education and workplace settings.

3.6 Strategic Directions

Strategic Direction 1: Reducing new HIV infections

Strategic Direction 2: Improving health outcomes for all people living with HIV

Strategic Direction 3: Strengthening multisectoral Integration, gender and human rights based, people-centred community and health systems

Strategic Direction 4: Strengthening the use of strategic information and evidence to guide service delivery, management, and policy

Strategic Direction 5: Promoting accountable leadership for the delivery of results and financing a sustainable response *through advocacy, fund raising and a multisectoral approach in line with universal health coverage*

3.7 Summary of Strategic Directions and Priority Intervention Areas

Strategic Direction	Priority Intervention Area
1. Reducing new HIV infections	1.2 Increase scale of effective combination prevention interventions for priority populations and promote community led approaches 1.2 Maximize HIV testing and strengthened linkages to ART among priority populations and their sexual partners 1.3 Maximize efficiency in service delivery and enhance integration with other health services 1.4 Ensure enabling environment for priority populations and their sexual partners 1.5 Eliminate mother to child transmission of HIV and Syphilis
2. Improving health outcomes for all people living with HIV	2.1 Maximize linkage and improve access to care; immediate enrolment and ART initiation 2.2 Improve the quality of care maximizing retention and viral suppression 2.3 Integration of health services for co-infection and co-morbidity (TB, Hepatitis, STI, NCD, mental health, SRHR and prison health) 2.4 Enhance positive prevention 2.5 Strengthen and Integrate HIV-related PSM into one national Procurement and Supply Management (PSM) 2.6 Strengthen laboratory services in HIV and STI management
3. Strengthening multi-sectoral integration, gender and human rights based, people-centered community and health systems	3.1 Strengthen and expand Gender responsive and rights-based HIV service delivery models, ensuring continuum and quality 3.2 Strengthen the community to be engaged in service delivery. 3.3 Improve legal and policy environment at all levels 3.4 Integrate HIV in UHC and social protection schemes for priority populations and Orphans and Vulnerable Children (OVC) 3.5 Implement workplace programs and leverage other sectors involvement in the HIV continuum of services

4. Strengthening the use of strategic information (SI) and evidence to guide service delivery, management and policy	4.1 Generate and use strategic information to guide service delivery, program management, policy and financing. 4.2 Improve monitoring and reporting to provide quality data and effectively track NSP IV and improve performance at all levels. 4.3 Strengthen coordination and resource mobilization for SI. 4.4 Conduct research and evaluation and apply findings for programmatic improvement and policy change.
5. Promoting accountable leadership for the delivery of results and financing a sustainable response	5.1 Strengthen and sustain high level political and technical commitments including relevant legal frameworks 5.2 Sustainable Multisectoral HIV HRH plan 5.3 Ensure sustainable Financing 5.4 Improve Community Health Workforce 5.5 Strengthen governance management and coordination and accountability for delivery of results

3.8 Priority Populations

HIV programs are most effective when they address the social, gender and age groups with the highest HIV incidence rates and the largest number of current and new HIV infections while also being tailored to their socio-cultural and age specific context. In Myanmar, programs will define priority populations based upon regular epidemiological and sociodemographic analyses of data to determine the most affected population groups. This will ensure that the most intensive community and health services will reach those in greatest need. In the context of Myanmar, the NSP IV has defined the following priority populations:

People Living With HIV (PLHIV)

People infected with HIV whether aware or unaware of their status. In 2018, the total number of people living with HIV was estimated to be 240,000 including 9,800 children, 86,260 women and 140,740 men.

People Who Inject Drugs (PWID) and People Who Use Drugs (PWUD)

People who inject psychoactive substances including, but not limited to opioids, amphetamine-type stimulants, benzodiazepines and hallucinogens. The 2017 population size estimate of PWID = 93,000 representing mainly males. The size of female PWID will be investigated during NSP IV.

People who use stimulants without injecting, do so for the benefits (perceived and/or experienced). This applies to both legal and illegal substances. The range of drugs smoked, inhaled and taken orally are similar to those for people who inject drugs. There is also injecting drug use among some Sex Workers and Men who have Sex with Men.

Men who have Sex with Men (MSM)

Apwint are biological males whose public and private gender identity is generally feminine, but they may dress as men or dress and act as females. *Apwint* are generally more 'open' MSM and some could be considered 'transgender', but this term is not widely used in Myanmar.

Apone are biological males whose gender identity may be either masculine or feminine and may or may not express themselves femininely. *Apone* can be 'open' or 'hidden' MSM.
Tha nge are biological males whose gender identity is masculine with a sexual preference for *apwint* and *apone* as well as for women, however they are often 'hidden' MSM.

There are ***additional 'undisclosed' MSM*** in Myanmar. Research is required to further understand their risk and needs for services. The 2015 PSE was 253,210 with approximately half, 126,000 estimated to be apwint, apone and tha nge and the other half undisclosed.

Transgender persons (TG)

Transgender persons refer to persons whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. Transgender people may self-identify as transgender, female, male, transwoman or transman, trans- sexual, or one of many other transgender identities, and may express their genders in a variety of masculine, feminine and/or androgynous ways. In Myanmar, some transgender persons can be identified as *apwint.* The PSE for transgender persons will be investigated during NSP IV.

Sex Workers and their Clients

Include female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating. In Myanmar, the primary focus of HIV interventions has been on female sex workers, whereas data on male and transgender sex workers remain quite limited but will be investigated during NSP IV. The 2015 estimated size of the female sex worker population (aged between 15 and 49 years) was 66 056, and the population size of their male clients was estimated at 1 115 000.

People in Closed Settings (including prisons, detention and rehabilitation centers)

People in places of detention that hold people who are awaiting trial, who have been convicted or who are subject to other conditions of security. In 2019, there were 44 prisons, 5 remand prisons and 48 labor camps in Myanmar with 85,000 – 90,000 prisoners. In addition, there were up to 20,000 - 25,000 persons in pre-trial detention. There are 12 rehabilitation centers in Myanmar in 2019.

Sexual Partners of Priority Populations

Sexual partners of priority populations are at substantial risk of HIV and STIs based on risk behaviors. This includes regular sexual partners of people living with HIV, people who inject drugs and sexual partners of prisoners, sex workers and men who have sex with men. The continuum of services must reach partners of these priority populations with services to ensure that one or both partners remain uninfected, and to ensure that the partner living with HIV is linked with appropriate treatment and care.

Young Priority Populations and children

Younger members of priority populations (24 years and younger) are included within the men who have sex with men, transgender persons, people who inject and use drugs and sex workers groups. However younger

people need special attention due to rapid physical, emotional and mental development, complex psychosocial and socioeconomic factors and structural barriers to access and of services, particularly for those under 18. The size of this population has not yet been investigated.
In 2018, there were 9,800 children living with HIV with 80% receiving treatment.

Migrants

As defined by IOM in Myanmar is a person who lived away from their town or village of origin continuously for more than three months. A migrant worker is a person who regularly moves around various locations within Myanmar and beyond in a relatively shorter timeframe (e.g., traders, truck drivers). However, as HIV risk is related to engagement in risk behavior rather than being a member of this group alone, it is important to assess the risk behavior and respond effectively to this.

Overlapping Risk

High HIV prevalence among diagnosed TB cases, people with STIs, hepatitis C and B in Myanmar all require special attention. Some people from priority population groups engage in more than one high-risk behavior (e.g. injecting drugs and sex work, or men who has sex with other men who also inject drugs). Risk behaviors related to alcohol and other drug use can also be an issue among the priority population groups. The risk of transitioning from non-injecting drug use to injecting drug use will also be addressed with the priority population groups, as well as with other people who use drugs.

4. Operational Model

4.1 Geographic Prioritization for the national response to HIV

Myanmar is a concentrated HIV epidemic country – with higher and concentrated HIV prevalence among priority populations in key geographic regions. In 2017, 75% of the total number of people living with HIV lived in 5 states/regions including Kachin, Shan North, Sagaing, Mandalay and Yangon. Epidemic dynamics vary by geographic location and key populations. In Kachin, Shan North and Sagaing, new infections are among people who inject drugs and their sexual partners. In Yangon, new infections are largely among men who have sex with men, clients of female sex workers and sexual partners of key populations. New infections in Mandalay are a mixture of people who inject drugs, men who have sex with men, female sex workers and their sexual partners.

Focusing HIV investments in geographic areas with the highest HIV burden and potential risk, instead of a uniform approach across the country, will have the greatest impact on reducing new infections and reducing the morbidity and mortality associated with HIV. Through prioritization of the people and locations at greatest risk of infection, and adaption of the interventions to reflect the local epidemiological context, the geographic prioritized approach could substantially increase the efficiency and effectiveness of investments in HIV prevention. Myanmar's geographic prioritization strategy focuses on intensifying support to the states/regions where HIV burden is the highest, and it requires an analysis of geographical distribution of HIV risk and burden to optimize the national response. The unit of analysis is the township and a total of 330 townships are categorized into high and low priority based on the following variables:

1. Population size estimates of people who inject drugs, men who have sex with men and female sex workers (75 percentiles in any key population group)
2. HIV prevalence from the national program data
    a. Among key population
    b. Among tuberculosis patients
    c. Among pregnant women
    d. Among other vulnerable populations
3. Qualitative criteria
    a. Border townships and others with migrant, mobile, and displaced populations,
    b. Mining zones and economic zones
    c. Presence of large prisoner population
4. Expert opinion:
    a. Knowledge of local area with HIV risk behaviors or higher risk of transmission

Methodology of Township Geographic Prioritization

The methodology was an analysis of the geographical distribution of the burden of HIV and the risk of new infection, based upon the quantitative measure of the combined presence of key populations triangulated with qualitative criteria. Population size of key populations was the first criteria analyzed. The Population Size Estimation for female sex workers (2015) is 66,056 (range <10 – 2000); the Population Size Estimation for men who have sex with men (2015) is 125,759 (range <10 – 2,900) and the Population Size Estimation for people who inject drugs (2017) is 93,215 (<10 - >5,000). Using different cut off points of percentiles, township

prioritization was tested and consensus was achieved to use 75th percentiles of all three key populations. The townships with the presence of any of the three key populations with 75th percentiles were calculated and they were triangulated with the criteria 2, 3 and 4. The initial list was reviewed by key stakeholders during development of NSP IV, including local experts, NAP State/Region Officers and community members. Based upon the methodology described, the analysis resulted in 167 high priority and 163 low priority townships (Table 2).

What is new in the geographic prioritization in NSP IV?

- Two categories of HIV risk and burden (High and Low Priority Townships) compared to three categories in NSP III.
- Stronger and more robust methodology based on the most recent nationwide HIV surveys and available epidemiological data.
- Triangulation with experts who understand the local context very well.
- 113 (67.7%) of townships categorized as high priority are in the 5 high-burden states/regions.

Table 1:Summary of the distribution of townships based on geographic criteria by State and Region. *(See Annex B: List of High Priority Townships in NSP IV)*

State/Region	High Priority Township	% of Township Selected
Yangon	37	82%
Mandalay	22	79%
Kachin	15	83%
Shan (North)	17	71%
Sagaing	22	59%
Ayeyarwaddy	6	23%
Bago	7	25%
Chin	1	11%
Kayah	1	14%
Kayin	3	43%
Magway	6	24%
Mon	5	50%
Nay Pyi Taw	4	50%
Rakhine	3	18%
Shan (East)	4	40%

State/Region	High Priority Township	% of Township Selected
Shan (South)	10	48%
Taninthayi	4	40%
Total	167	51%

Table 2:Geographic distribution of need and risk based upon key population size

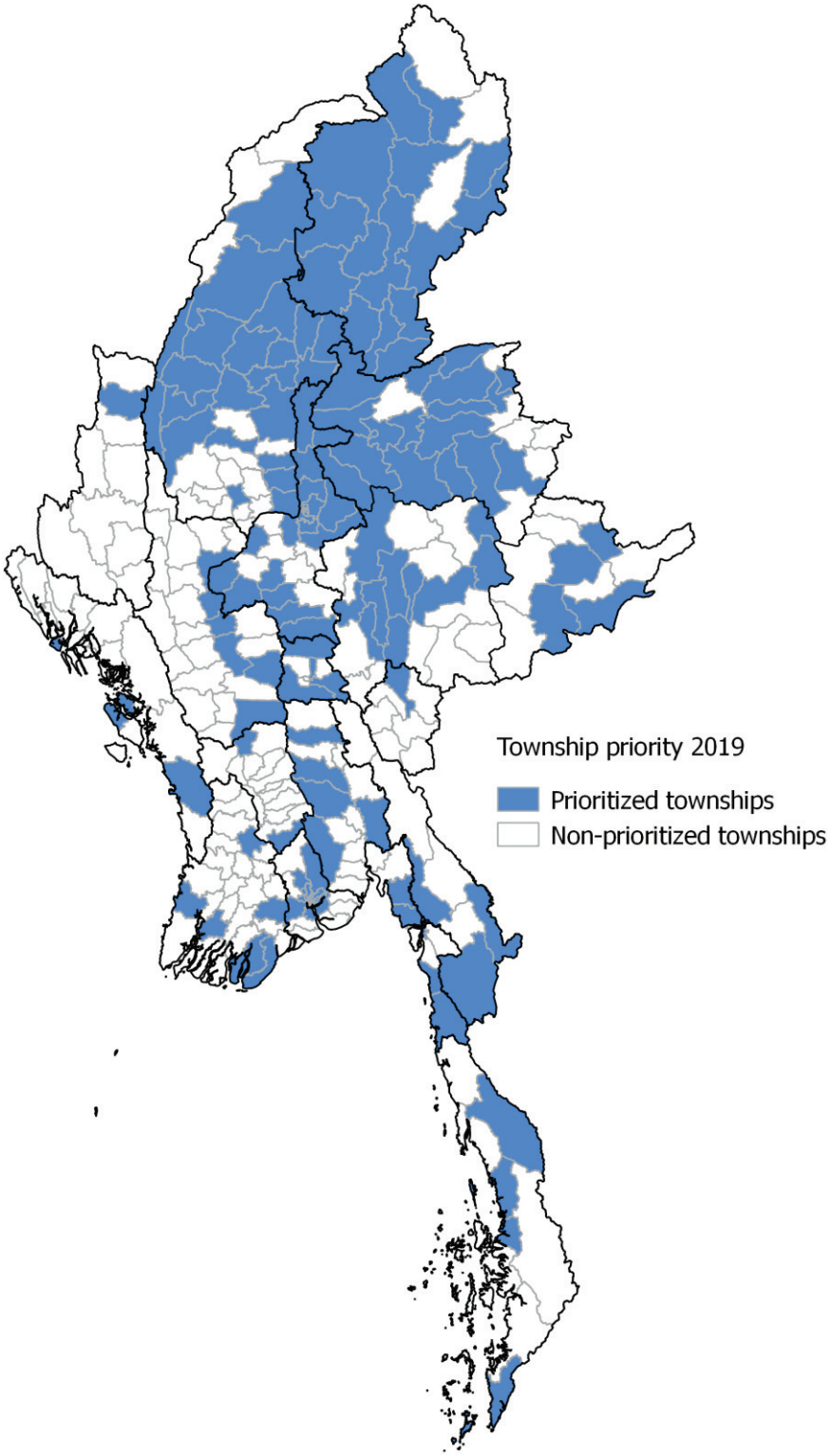
	FSW		MSM		PWID	
High priority townships	59,738	90%	100,941	80%	83,270	89%
Low priority townships	6,317	10%	24,818	20%	9,945	11%
Total	66,055	100%	125,759	100%	93,215	100%

(Remark: data is not available for adult HIV new infection and PLHIV by township priority.)

With this geographic township prioritization criteria, 90% of female sex workers, 80% of men who have sex with men and 89% of people who inject drugs are located in high priority townships. 67.6% of high priority townships are from Kachin and Shan North States, Sagaing, Yangon and Mandalay Regions. Most of the remaining states/regions in Myanmar have some high priority townships. (See Annex C: Percentage of Key populations covered in High Priority Townships, NSP IV)

Based on geographic prioritization of HIV risk and burden, population specific service delivery modalities and a package of interventions for high burden townships and low burden townships are developed. Across the country, a focused strategy tailors the set of interventions and the amount of resources allocated to the local epidemiological conditions, will optimize the effectiveness and efficiency of the national HIV response. The map of townships by priority is shown in map 1 below and it will be updated when additional information is available.

Map 1:Map of Myanmar by township priority for HIV response



4.2 Essential and Comprehensive HIV Service Packages

The Essential and Comprehensive HIV Service Packages have a range of prevention, testing, care and treatment elements that are tailored to the common and specific needs of priority populations and other vulnerable populations. Geographic context and specific population needs require the service delivery models to be tailored to account for these. The Essential Package for Health Service –HIV (EPHS-HIV) – will be delivered and available in all 330 townships in Myanmar. The Comprehensive Package for Health Service - HIV – (CPHS-HIV) – combines the EPHS with a range of additional services and commodities required for high priority townships which are mostly located in the 5 high-burden states/regions of Sagaing, Kachin, Shan North, Mandalay and Yangon. The fundamental principles of the EPHS and the CPHS and their service delivery models and approaches are that they rely on a strong partnership between the Government of Myanmar – with different Ministries, Departments and National Programs lead by the National AIDS Program and guided and supported by the National Strategic Plan for HIV and AIDS and National and Sub-National Operational Plans – affected populations and their broader communities, and private sector health facilities and service providers.

ESSENTIAL PACKAGE FOR HEALTH SERVICE - HIV

330 TOWNSHIPS

HIV prevention	HIV Testing Services	Care and Treatment	HIV integrated with other services*	Commodities	Enabling environment
1. Awareness raising 2. Behavior change communication 3. Sexually transmitted infection management 4. Sexual and reproductive health service 5. Blood safety	1. Facility-based HIV testing services 2. Community based HIV testing (BHS) 3. Community-referred HIV testing	1. ART at ART centers & decentralized sites 2. PMTCT	1. Tuberculosis diagnosis and treatment 2. Reproductive health and family planning 3. Antenatal care	1. Condoms 2. Lubricants 3. STI (Syphilis) • RTK & VDRL • STI drugs 4. HIV RTK 5. ARV 6. Minor OI, 7. IEC 8. PEP 9. Lab commodities 10. TPT	1. Community centered approaches 2. Normalization of HIV in Health care and community setting 3. Ensure access to essential HIV services for all marginalized people

** Sexually transmitted infection management: Deleted in integrated services because of overlapping and it is part of NAP HIV prevention components*

PEP will be available free of charge for occupational exposure and sexual violence victims.

The Comprehensive Package includes specific service combinations to respond to the mode of transmission - for injecting drug use, for sexual transmission, with additional services for overlapping risk (e.g. drug use and sex work or drug use and men who have sex with men, or all three). Community participation and engagement are an essential component of the service packages and their delivery. Among the priority populations and other vulnerable populations, people who use and inject drugs may be the most vulnerable and difficult to reach in terms of their complicated context, with stigma, discrimination and criminalization of their behavior.

This context is complicated by long-standing security concerns and the consequences of economic enterprises such as resource mining, especially in many parts of Kachin and Shan States, and to a certain extent in parts of Sagaing Region, where a significant proportion of people who use and inject drugs live. The drug trafficking also add to the complexities of the context and impact on access to and the effective implementation of service delivery for this population and their sexual partners. People who use and inject drugs – who live more distant from major urban centers which have more available co-located and nearby located services – face significantly more difficulty in accessing the services that they need. Priority populations and other vulnerable populations face stigma, discrimination and some criminalization because of their behavior, but those in urban settings may have comparatively more options to seek access HIV and other health care services

COMPREHENSIVE PACKAGE FOR HEALTH SERVICE - HIV

HIGH PRIORITY TOWNSHIPS

ESSENTIAL PACKAGE FOR HEALTH SERVICE – HIV PLUS FOLLOWING SERVICES WILL BE INCLUDED

Combination HIV prevention	HIV Testing Services	Care and Treatment	HIV integrated with other services	Commodities	Enabling environment
Refer to specific combination prevention packages for key and priority populations (structural, biomedical, behavioral)	1. Community based HTS (peer network) 2. Self testing 3. Index testing	1. Laboratory tests (as per treatment guidelines) Viral Load 2. Facility based (Satellite sites including PPP) 3. Community based care & support	1. Mental Health 2. Hepatitis C treatment 3. Drug treatment center 4. SGBV 5. Services for ATS users 6. Vocal and livelihood programs 7. NCD	1. PrEP 2. Major OI 3. NSP 4. OST (MMT/ Buprenorphine) 5. Naloxone 6. Hepatitis B and C testing 7. HBV vaccination 8. STI	1. Sensitization training on reducing stigma, discrimination, 2. KP friendly services, 3. addressing punitive practices 4. Securing legal protections to ensuring access to HIV care.

4.3 Service Delivery Models and Approaches

There has been significant transition from INGOs to NAP, MoHS for care and treatment service delivery under NSP III. ART treatment has been effectively transitioned from INGO service delivery to MoHS public health facilities under NSP III. However, INGOs remain the main implementers for prevention activities for priority populations and to a lesser extent for other vulnerable populations, while NAP, MoHS have the main responsibility for long-term ART provision, PMTCT and increasing responsibility for Opioid Substitution Therapy/Methadone Maintenance Treatment.

Important changes and innovations are included in NSP IV to expand the reach, coverage and effectiveness of prevention, care and treatment for priority populations and other vulnerable populations in designated high-burden townships which are mostly located in the 5 high burden states and regions of Sagaing, Kachin, Shan North, Mandalay and Yangon. The development of Subnational Operational Plans for HIV and AIDS in the 5 high-burden states and regions will strengthen decentralized management and support of scale-up and innovations in service delivery approaches. This is the rationale for the CPHS and for a more sustainable and comprehensive service delivery model and approaches – to reach more difficult to reach populations at higher risk of HIV and co-infections, with less access to the services necessary to prevent infection and support care and treatment in a timely manner.

The NSP IV development process recommended expanding and strengthening community-based service delivery by Community-Based Organizations and community groups who will provide services through the Key Population Service Centers including STI services and linkage to care. The NSP IV development process also recommended transition from INGO, LNGO service provision to community-led service delivery where possible, with NGOs to remain as technical support in the long run and to support community system strengthening. Operational and feasibility studies will also be scheduled in NSP IV of community groups operating Key Population Service Center-based clinic services, including assessing the need for memorandum of understanding and clinic registration. Ethnic Community-Based Health Organizations will also be more directly included in NSP IV and in-service provision, with a priority focus on domestic and international migrants and displaced persons engaged in risk behaviors making them vulnerable to HIV. The HIV Linkages Scale-Up is another important innovation to support significantly expanding the coverage and reach of the CPHS.

Innovations will include a demonstration or lead initiative of the provider-purchased model, trailing of fee for service and co-payment in accessing services and commodities such as PrEP and possibly ART, implementation of the Human Resources for Health Plan, and formalization of the Community Health Workforce – the latter two are designed to respond to the chronic shortages in human resources for health and are included under Strategic Direction 5 – Leadership and Financing.

Service delivery models and approaches

	HIV Prevention/Reach	HTS	Care and Treatment	Others
EPHS-HIV	1. Peer education 2. Health literacy promotion	1. Facility based (ART centers/DC sites with lab facilities) 2. Community 1. test (BHS) 2. Referred	• ART and PMCT at ART centers and DC sites, • Community/peer-led (support at ART/DC site, ART/adolescent counseling, defaulter tracing, Social support for referral, nutrition, hospitalization, funeral etc.)	Note: service delivery mostly will link to community/peer network together with THD/NAP team.
CPHS-HIV (High priority townships)	1. Enhanced outreach 2. Community based 3. KPSC 4. Youth-friendly service center 5. Mobile services 6. Community network/peer navigator 7. Social media recognising that elements of STI/HIV/HCV/TB diagnosis, care and treatment constitute both prevention and treatment	1. Enhanced outreach 2. Community based 3. KPSC 4. Youth-friendly service center 5. Mobile services 6. Community network/peer navigator 7. Community based linkage to care and treatment	Same as above + • ART at satellite sites (Facilities-based (public-NGO, NAP team- NGO) • PPP (private hospital, clinic, GP) under satellite sites facilitated by NGO	One-stop shop-whenever possible provide prevention, care, treatment and support service in combination. (partnership approach between MoHS/NAP, NGOs, INGO, EHO, community)

HIV Linkages Scale-Up to Deliver the CPHS

The proposed scale-up and strengthening of the partnership – between the NAP, INGOs, LNGOs and CBOs and affected populations and communities – that supports and coordinates community outreach workers and peer educators, is a strategy building on service delivery approaches effectively implemented on a smaller scale under NSP III. The scale-up and strengthening will take place under the direction of the State/Region Departments of Health in the five high-burden states/ regions of Sagaing, Kachin, Shan North, Mandalay and Yangon. Implementing and funding this initiative under NSP IV requires carrying out a rigorous operational feasibility to plan secondment of staff to State/Region Departments of Health, training, support and coordination of community outreach/peer educators at the different levels of administration and implementation, from state/region to district down to township and below.

In this context, trained and supported community outreach workers/peer educators who have the trust of priority populations, move between these priority populations and a range of health and other service facilities and providers to put priority populations and service providers in contact with one another and to support the building of trust, familiarity and continued contact between the priority populations and the service providers.

The use of trained and supported community outreach workers/peer educators has been done on a smaller scale in the past and mostly by national and international NGOs and Community-Based Organizations. This HIV Linkages Scale-Up will build on the lessons learnt to date to scale up the service delivery linkage approach under the direction of decentralized State/Region Health Departments with the technical and programmatic support of INGOs, LNGOs and CBOs. Work units will be created under the State/Region Departments of Health at State/Region level and at District level and staffed with seconded staff to coordinate and support the expanded numbers of community outreach workers/peer educators. Standardized training will be implemented at state/region level with technical and programmatic support from NGOs and CBOs. A standardized incentive package will be provided to community outreach workers and peer educators and oversighted from the state/region level.

Seconded staff at district level will coordinate and support with Township Medical Officers in deploying community outreach workers and peer educators to expand coverage of prevention activities and access to testing. The district level unit will also coordinate with decentralized State or Region health departments managing ART services to people living with HIV, and community outreach workers will provide support to assist case management and treatment adherence for the mostly stable ART patients between their six-monthly contact with the health facilities. Experience shows that it is important to include all components of this approach if it is to function effectively – standard training and incentivization, continuing support and management, effective links to Township Medical Officers and health facilities. The difference here is that overall management will be under State/Region Departments of Health.

4.4 Integration across services

While HIV testing, treatment and care coverage have been improving in Myanmar, significant numbers of priority and other vulnerable populations – including people living with HIV and those co-infected with TB and Hepatitis C – have reported either having limited access to or dropping out of care at various stages along the prevention and care continuum. There are multiple factors contributing to this, including the verticality of most services, distance to health facilities and the cost of travel, poor HIV literacy, low risk perception, and, in some cases, concern about confidentiality, discrimination and criminalization of risk behavior. Additional factors include the lack of a Unique Identifier Code (UIC) and no proper mechanism to track mobility of beneficiaries across townships and potential for double counting undermining the accuracy of reporting on access and retention on treatment.

Establishment of sustainable and cost efficient ‘one-stop shops’ where a range of services for priority and vulnerable populations are available in a confidential way would increase the access of vulnerable people to prevention, care and treatment. Co-location or location of a range of services in geographic proximity to one another may also contribute towards greater uptake of prevention, testing, care and treatment services. It will be important to conduct operational research under NSP IV to explore in a systematic way how the integration

and/or co-location of prevention, care and treatment services contribute or otherwise to the uptake of these services.

As sustainability has become a more prominent priority in responding to HIV, international organizations have increasingly supported the elimination of parallel systems and the integration of HIV services into health systems (UNAIDS 2010). Evidence on the integration of HIV services, indicates that there is potential for increasing testing coverage, treatment take-up and retention, cost efficiency and cost-effectiveness. It also suggests that integration could help to address HIV related social stigma, a factor in individuals' willingness to test and seek care and treatment. In addition, there is some evidence to suggest that integrating HIV services with other services can improve non-HIV outcomes related to the other health service(s) concerned. Global research indicates that there are many initiatives working on integrating services and different approaches being tried. Most of the results are positive: HIV service uptake and health outcomes improve, as do health outcomes related to the other health services into which HIV services are integrated.[27]

NSP IV will also conduct surveys and research into priority and other vulnerable population access to needed services and explore travel cost constraints and other operational issues negatively affecting access/continued access to needed services.

4.5 Partnership Approach, Service Delivery, and the Community

Partnership approaches to HIV prevention, care and treatment have been a critical part of the Myanmar national response to HIV for many years. The partnerships are with the communities affected and with a range of health service providers – public, private, local and international NGO and community-based. In addition, linking services within the broader community and involving community leaders can lead to long term societal support for services.

The partnership approach for HIV service delivery in NSP IV

Partner	Activity
Priority Populations	Prevention, outreach/peer education, access to testing and treatment, treatment adherence. Participation on national and subnational governance structures – MHSCC and TSGs. Key Populations involved in the management and evaluation of service delivery through Program Advisory Boards and Key Population participation in feedback mechanisms outlined in the Essential Package And also in the Community Feedback Mechanism for EMTCT and migrant.
People living with HIV	Prevention, self-help and mutual support, treatment adherence. Participation on national and subnational governance structures – TSGs. Supporting enrollment into ART and adherence,

[27] Integrating HIV services with other health services to improve care, retention and adherence, coping Report 7, International Initiative for Impact Evaluation, Heard, AC, Peterson, K, Modi, S, Esper, H, Calvo, F and Brown, New Delhi, 2017

Partner	Activity
Broader community and Community-Based Organizations	Fundraising, support to local initiatives, support groups, advocacy and intervention with police and other health and welfare activities. Involvement with and engagement of community leaders to support societal approval of services.
Faith-Based Organizations	Prevention, care and support for children and vulnerable youth, advocacy, fundraising
Public health – including NAP and other public health facilities	Prevention, testing, care and treatment; support to provision of health services in prisons and closed settings
Local and international NGOs	Prevention through Drop-In-Centers and outreach/peer education, testing, care and treatment; support to provision of services in prisons and closed settings. Support to community-based /led services.
Private hospitals	Testing, care and linkage to treatment. Linkages with Key Population support groups and CBOs. For EMTCT, coordination for proper care and treatment among HIV positive mothers and their families in private hospitals.

The partnership approach that characterizes service delivery and the enabling environment in the national response to HIV will be further formalized and strengthened across all Strategic Directions in NSP IV.

Social contracting will be demonstrated under NSP IV. Social contracting will channel domestic public financing and other sources of financing to support the role of the community/civil society in the national HIV response. This will strengthen the participation of CBOs and community-led activities in NSP IV. The Global Fund defines "social contracting" as mechanisms that allow for government funds to flow directly to CBOs to implement specific activities, though the term may vary by country or region (Global Fund, 2017). Governments can finance CBOs through a variety of methods, including grants, procurement and contracting, and/or third-party payments (UNDP, 2010).

NAP needs to use Global Fund financing for initial piloting then may go for blended sources of funds like some other countries. In parallel with government capacity to manage contracts, grants can be built up and national mechanisms can be established after 5 years of NSP IV. As NHP is also planning for a purchaser provider split, it might be good to streamline the two mechanisms together.

Community development linked to service delivery will also be a key component of the partnership approach in NSP IV. The aim will be to link community development of key populations with the involvement of influential community leaders and the delivery of key population services. This is sometimes called "bi-directional" community development and the purpose is to develop key population communities to be involved in advocacy and service delivery while also involving important community leaders to ensure services are accepted and supported by the broader community.[28] This is already occurring in some key places including in Kachin State where Drug User Committees (including MMT clients, PWID/MMT clients on ART and PWID support groups) are involved in management of services with an Organizing Committee (including village leaders, business and religious leaders) and NGO/CBO staff. This triangular management

[28] Report on Methods of Improving HIV Service Quality for Key Populations in Myanmar, APMG, August 2019

team support important decisions concerning service delivery while also ensuring community opposition in minimized. Models of 'bi-directional' community development will be further explored in NSP IV to see what effect combining Key Population Committees with local Organizing Committees could have on improving quality, access and sustainability of services for key populations.

4.6 Working with Ethnic Health Organizations

Throughout decades of ethnic armed conflict, the governance environment in many of Myanmar's non-governmental controlled areas (NGCA) has become deeply fractured, as ethnic armed organizations have established parallel governance systems, including healthcare departments. This has led to parallel Ministry of Health and Sports (MoHS) and Ethnic Armed Organization-linked health systems that exist in Kachin, Shan, Kayin, Kayah and Mon States. Coordination and cooperation between the systems have increased since ceasefires were signed in 2011 and 2012.[29]

In recent years Ethnic Health Organizations (EHOs) have been increasingly engaged as partners in the national responses to HIV, TB and malaria, especially in border regions of the southeast and north of Myanmar, including working with migrants moving between Myanmar and China and Thailand, as well as more vulnerable internal migrants moving for seasonal work. EHOs have also been engaged in harm reduction and prison health activities in parts of Kachin and Northern Shan States. In the past few years there has been collaboration in Kayah and Kayin States with MoHS and EHOs cooperating to deliver polio vaccinations to rural communities in areas previously inaccessible to MoHS. EHOs have also been responding to health needs for populations more remote from MoHS health facilities and coordinating with these facilities and State Health Departments. They have also been increasingly engaged with Sub Recipients of Global Fund grants, ADB grants and with Implementing Partners of the multi-donor 3MDG and Access to Health Funds as well as other development partner grants supporting health, human rights and development.

Although the EHO health system targets only a small proportion of Myanmar's total population, its catchment area encompasses some of the most geographically and politically hard-to-reach places in the country, where health disparities compared with urban areas are most extreme. In terms of achieving UHC, this population is usually the most expensive and the last to get services from government or elsewhere because of the challenges of delivery.[30] Also, some of the high HIV burden townships are in the catchment and coverage areas of EHOs.

The process of development of the National Strategic Plans for HIV & AIDS, TB and Malaria has included consultations with EHOs to reflect on principles of the emerging drafts as well as the key areas of coordination, collaboration, strategic information and access to a range of resources. EHOs provide access to priority populations and other vulnerable populations for HIV prevention, care and treatment – especially internal migrants and those returning from working in nearby countries. A two-day meeting between Ethnic Health Organizations in different parts of Myanmar was convened by UNAIDS on behalf the MoHS National Programs for AIDS, TB and Malaria. The meeting, held on 7-8 November 2019 in Mawlamyine City in Mon State discussed the main elements of the National Strategic Plans being developed for the 3-disease areas and issues relevant to EHO partnership, coordination and collaboration. Agreed follow-on action is summarized under Strategic Direction 1 on page 57.

[29] Page 1, Achieving Health Equity in Contested Areas of Southeast Myanmar, the Asia Society, June 2016

[30] Page 19, Ibid.

4.7 HIV in Emergency Settings

Myanmar is prone to various natural hazards that include earthquakes, floods, cyclones, droughts, fires, tsunamis, some of which have the potential to impact large numbers of people. There are also areas in Myanmar facing conflict and civil unrest resulting in large numbers of Internally Displaced Persons and conflict-affected persons. The humanitarian community in Myanmar, represented by the Humanitarian Country Team, in 2014 applied new guidance for Inter-Agency Response Preparedness as an action-oriented approach to enhance readiness for humanitarian response to ensure that effective and timely assistance is provided to people in need. The approach has been developed in collaboration with the Government, to facilitate coordinated and effective support to people affected by humanitarian crises.

Kachin State and Northern Shan State are in a state of protracted crisis, characterized by security concerns, and the consequences of economic enterprises such as resource mining. Over 100,000 people are sheltered in 170 Internally Displaced Persons (IDP) camps across the region. Many have been displaced since 2011. In addition to a static, encamped IDP population, violence continues to displace people from dozens of communities for shorter durations. These people are often forced to flee their homes several times in a year.

Despite conflict and uncertainty, IDP populations – together with local community organizations – are actively seeking solutions to reverse the hopelessness of prolonged displacement. Churches and monasteries that provide land and structures for IDP camps – together with the Joint Strategy Team members that administer the camps – provide the most meaningful protection inputs for displaced people in Kachin and Northern Shan States, including safe refuge and the provision of basic needs.[31]

NSP IV will include and ensure the following activities are carried out:

1. Effective contingency plans are developed and in place to avoid disruption to treatment continuation and prevention and support measures to support continued good health and well-being. This includes contingency planning for treatment continuation for people living with HIV, and those with co-infection with TB and viral hepatitis, especially HCV.
2. Operational guidelines will be nationally reviewed and operationally ready within the standard emergency response to enable government and cooperating agencies to deliver the minimum required multisectoral response to HIV during emergency situations.
3. All relief workers will receive a basic training, before the emergency, in HIV, as well as SRH for HIV and STI prevention for vulnerable girls and women, sexual violence, gender issues, and non-discrimination towards people with HIV and their caregivers.
4. Adequate and appropriate treatment supplies and prevention commodities specific to HIV will be ready to be pre-positioned as required.
5. Adults living with HIV and the caregivers of infants and young people living with HIV may be provided with an additional or buffer stock of Antiretroviral Treatment in the event of an anticipated emergency that may impact on continuation of treatment supply.

[31] Pages 6-7, Kachin and Northern Shan Context and Vulnerability Review, Harp Facility, October 2018

4.8 HIV in Border Areas

Migration within Myanmar and across its long borders, which cover Thailand, Laos, China, India and Bangladesh, is subject to a range of drivers which are complex and are critical in affecting how and why people decide to move. Of the 53.9 million people living within Myanmar, 70 per cent live in rural areas. Following the general election held on 8 November 2015 there have been dramatic economic and cultural changes which have brought an increase in foreign investment and has also been a driver of urbanization and rural to urban migration. Many people migrate internally as they want to improve their livelihoods, to follow their family members, for marriage, for education or to avoid poor socio-economic conditions. In 2014, 9.39 million people were internal migrants (which is approximately 20% of the population).

Regionally, Myanmar has grown to be the largest migration source country in the Greater Mekong Sub-region (GMS). The Myanmar Government estimate that there are 4.25 million Myanmar nationals living abroad. Regionally, drivers of migration can include higher wages in neighboring countries, conflict and environmental migration due to natural disasters among other factors. It is also reported that up to 70% of migrants living abroad are based in Thailand, followed by Malaysia (15%), China (4.6%), Singapore (3.9%) and the USA (1.9%). IOM estimates there could be as many as 3 million Myanmar migrants living in Thailand as at 2016. The highest numbers of migrants, according to the latest census, came from Mon State (427,000), Kayin State (323,000) and Shan State (236,000).[32] There are also an estimated nearly 100,000 refugees in nine camps along the Thai-Myanmar border according to UNHCR.

Currently, there is no standard package for cross border populations – specifically migrants and displaced persons, including those moving between Myanmar and Thailand, China and India. Among services needed, priority should be ensuring ART continuation for people who are staying and working in neighboring countries, as well as delivery of other HIV services based on feasibility and sustainability. It would be informative for needs and service provision to explore community to community partnership, organization to organization partnership or both to provide services such as awareness, HTS, referral, commodities provision, treatment in Myanmar facilities (to explore facilities in cross border cities) treatment follow up and continuation. The following activities need to be considered:

- Develop standard information and referral packages for pre departure and return.
- Situation analysis, mapping exercise with cross border cities.
- Discuss cross border issues together with TB and Malaria programs
- Consider the role of community networks and peer groups, NGOs for service delivery such as ART dispensing and follow-up tracing
- Reach-prevention-care and treatment: considered spectrum approach
- ART dispensing for longer duration (6 months or more) for cross border populations to support treatment continuity

[32] IOM International website, Countries, Myanmar, Overview https://www.iom.int/countries/myanmar

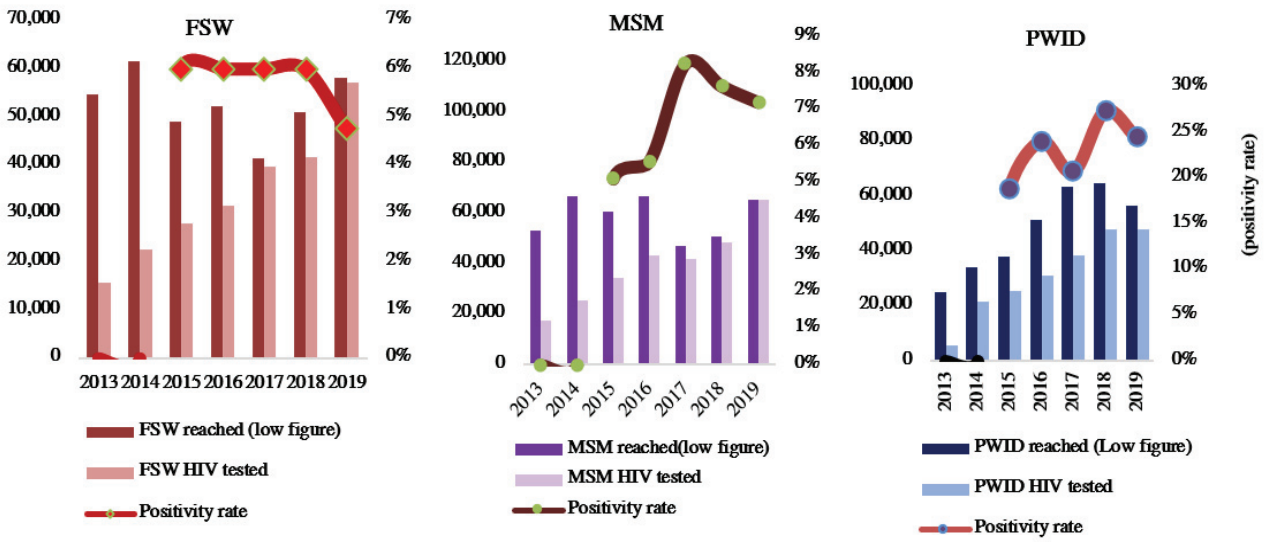
5. Strategic Directions and Priority Interventions

5.1 Strategic Direction #1: Reducing New Infections

5.1.1 Overview of Achievements

The recent HIV Program Review described Myanmar's package of services for key populations as among the 'most comprehensive in the world' while still requiring a few new design elements.[33] The roll out of the Enhanced Outreach Model (EOM) for female sex workers, men who have sex with men and people who inject drugs in 2016 has improved the effectiveness of outreach with a focus on identifying undiagnosed people living with HIV within key populations and providing them access to HIV testing. Among female sex workers, men who have sex with men and people who inject drugs there has been a steady increase in HIV testing since 2016 with reasonably high HIV testing acceptability rates. In 2018, HIV positivity rates in prevention programs were 6% of female sex workers, 8% of men who have sex with men and 27% of people who inject drugs nationally. Based on initial 2019 data collected by the end of January 2020, the positivity rate dropped to 5% among female sex workers, 7% among men who have sex with men, and 24% in people who inject drugs.

Figure 17:Number of Female Sex Workers, Men who have Sex with Men and People Who Inject Drugs reached by prevention program and received HIV test/post-test counselling, Myanmar 2013-2019



Source: Prevention and HTS program data

Based upon current measurement practices, analysis of prevention outreach and services in 2018 by Township suggests relatively high 'coverage' for key populations in high priority townships.[34] HIV positivity rates were alarmingly high among people who inject drugs in Kachin at 49%, with 28% in Sagaing, 20% in Yangon, 9% in Shan East, 8% in Shan North and 6% in Mandalay in 2018. The HIV positivity rate in Kachin

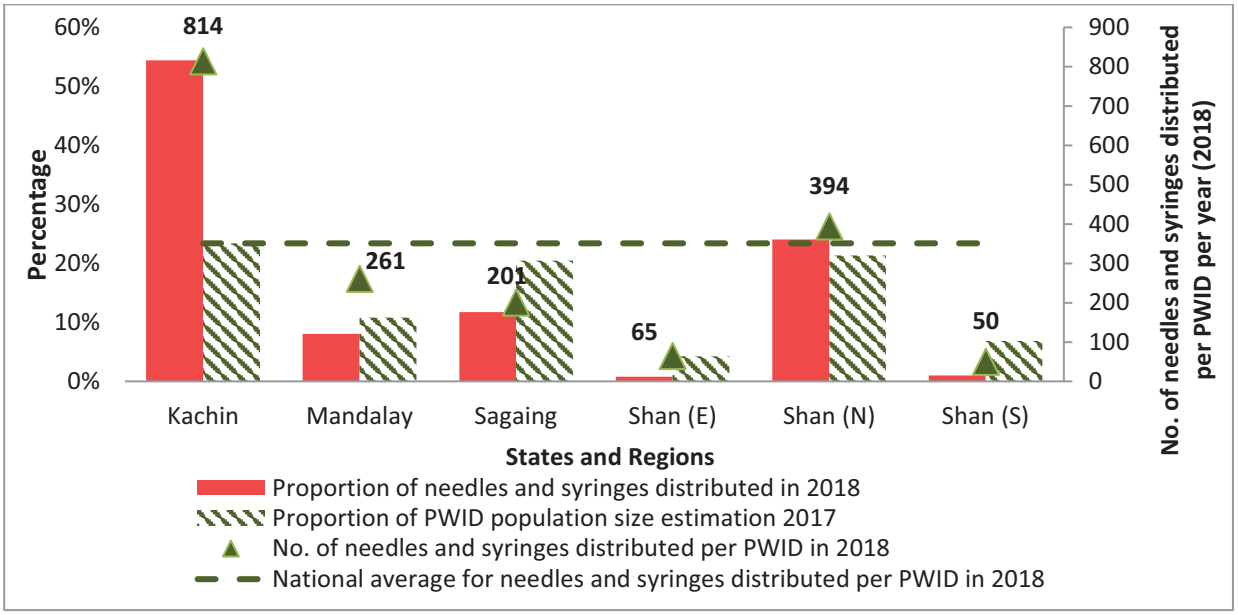
[33] Report of National Key Populations HIV Program Review in Myanmar, APMG Health, Washington DC, August 2019.
[34] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

among men who have sex with men was 10% and 7% among female sex workers in 2018. These subnational data reinforce the need for greater focus on geographic epicenters of HIV infection.

People Who Inject Drugs and their Intimate Partners

According to the NAP Progress Report[35] an estimated '69% (64,597) of people who inject drugs accessed prevention services' in 2018 exceeding targets in Kachin and falling short in Yangon. [36] This calculation is challenged by adjustments for double counting, the mobile nature of people who inject drugs and some queries about exact population size. Access to opioid substitution therapy (methadone maintenance therapy, MMT) has increased to close to 20,000 in 2019. While this does not reach the 2019 target, among those that do access MMT, 69% remain on it for at least 6 months[37]. The number of sterile needles and syringes distributed have significantly increased to nearly 33 million nationally in 2018. In Kachin, an average 814 sterile needles and syringes were distributed per person who injects drugs in 2018 followed by Shan North, Mandalay and Sagaing. With people who inject drugs injecting on average 2-3 times daily, this coverage should be adequate to assist in slowing the spread of HIV in Kachin, however, several stubborn challenges persist with new infections continuing. Consistent and equitable access to needles and syringes is challenged by the operational context with some geographic areas getting higher coverage and others none at all, there is a low risk perception among people who inject drugs, low condom use and a reluctance to access HIV testing and treatment. Expanded access to a comprehensive approach to HIV prevention and treatment are needed on a geographically equitable basis and improved reach among neophyte injectors.

Figure 18:Number and proportion of sterile needles and syringes distributed by State/Region, 2018



Source: National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Female Sex Workers and their Clients

According to the 2018 NAP Progress Report '92% of female sex workers in high priority townships received prevention services and 82% were tested for HIV and received their results.'[38] These efforts suggest that the

[35] Progress Report 2018, NAP
[36] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[37] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[38] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

female sex worker prevention program is well on its way to achieving the first of the three 90s for this population. Analysis by state is now identifying 'low coverage achievers' so that improvements can be targeted accordingly. Nationally, the number of female sex workers receiving STI treatment is relatively low at less than 18% of those reached due to lack of investment in this area undermining HIV prevention. Regular sexual partners and clients of sex workers also suffer due to lack of investment with only 8,103 clients (out of target of 206,490) reached with prevention services in 2018. All implementing organizations working on HIV prevention distribute condoms to key populations, including female sex workers and their clients and others who wish to practice safe sex. The majority of condoms are distributed free of charge and only 25% were social marketed. In 2018, 26 million condoms were distributed free of charge. Prevention outcomes will soon be measured through an upcoming IBBS among female sex workers in 2019/2020. Comprehensive prevention programs that reach sex workers, their clients and their regular partners are required. By initial results of 2019, prevention coverage and HIV testing among female sex workers continued to increase while positivity rate started to decrease.

Table 3: Prevention Output Coverage for Key Populations, 2018 and 2019*

Key Population	Output/Coverage Targets	Size Estimate	Baseline 2015	Target 2018	Results 2018	Preliminary results 2019*
Female Sex Workers	No. of FSW reached with HIV prevention programs	66,000[39]	35,443[40]	54,837	36,805[41] 50,906[42]	42,416 58,196
	No. of FSW who received an HIV test and who know the result in the last 12 months	66,000	27,865	43,249	41,720	55,759
	No. of clients of FSW reached with HIV prevention programs	1,115,530[43]	14,410	206,491	8,103	13,912
	No. of MSM reached with HIV prevention programs	126,000[44]	60,469	98,890	50,816[45]	66,428

[39] FSW PSE calculation 2015
[40] Adjusted for (1) duplication among different organizations in one township and (2) duplication between outreach and DIC and (3) mobility based on FSW IBBS 2015 results
[41] Adjusted for (1) duplication among different organizations in one township and (2) duplication between outreach and DIC and (3) mobility based on FSW IBBS 2015 results
[42] Adjusted for (1) duplication among different organizations in one township and (2) duplication between outreach and DIC
[43] Clients of FSW PSE calculation 2015
[44] MSM PSE calculation 2015 (reachable MSM only)
[45] Number of MSM reached by prevention adjusted for (1) duplication of MSM reached among different organizations in one township and (2) adjusted for duplication between outreach and DIC

Key Population	Output/Coverage Targets	Size Estimate	Baseline 2015	Target 2018	Results 2018	Preliminary results 2019*
Men who have sex with Men	No. of MSM who received an HIV test and who know the result in the last 12 months	126,000	34,528	74,930	48,545	64,870
People who inject drugs	No. of PWID reached with HIV prevention programs (Outreach and DIC)	93,000	37,846	57,937	64,597 [46]	55,934
	No. of PWID who received an HIV test in the last 12 months and who know the result	93,000	25,385	46,137	47,955	47,900
	No. of sterile injecting equipment distributed to people who inject drugs in the last 12 months	93,000	18.5m	25.4m	32.7m	35.1m
	No. of PWID receiving methadone maintenance	93,000	10,290	23,316	15,994	19,991
	% of individuals receiving methadone maintenance therapy for at least 6 months	93,000	65%	78%	70%	69%

*This is the initial data for 2019 which is collected by the end of February 1st week 2020. All the calculation adjustments same as in 2018.

Source: Program Data from the National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Men who have Sex with Men

The NAP Progress Report 2018 mentions a reach of close to '51,000 men who have sex with men with HIV prevention programs' or 51% in 2018. This is below the 2018 target of almost 99,000 men who have sex with men for 2018. Nonetheless, among those MSM reached, the uptake of HIV testing has steadily increased to 96% with an increase in STI treatment. [47] Funding reductions during NSP III decreased the number of drop-in centers, replaced by an outreach approach. HIV positivity rates were 11% in Yangon, 10% in Mandalay and Kachin and between 4-7% in other states and regions. Analysis revealed 'low coverage achievers' including Kachin; however, Yangon and Mandalay are estimated to contribute the largest share of new HIV infections among men who have sex with men, suggesting intensified efforts in these regions will help to achieve the first of the three 90's for men who have sex with men. As in female sex workers, 2019 initial results suggested that prevention reach and HIV testing among MSM is increasing significantly.

[46] Number of PWID reached by prevention adjusted for (1) duplication of PWID reached among different organizations in one township and (2) adjusted for duplication between Outreach and DIC

[47] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

5.1.2 Challenges

According to the NAP Progress Report and recent Key Population Review several factors are reducing the effectiveness of combination HIV prevention efforts in Myanmar.

Low Risk Perception: Risk perception among people who inject drugs and their sexual partners remains stubbornly low even in areas of high HIV prevalence. Among people who inject drugs in Kachin almost 56% report no to moderate chance of getting HIV despite one in two testing HIV positive. Unprotected sex is still common among people who inject drugs, female sex workers and men who have sex with men with their regular sexual partners. Nonetheless, the reported willingness to self-test or use PrEP was moderate to high among people who inject drugs, suggesting that improved counselling and increased access to a range of services could assist prevention outcomes.[48]

High "Background" HIV Prevalence: The requirement for prevention coverage to be effective is extremely high given the endemic nature of HIV and extremely high existing HIV prevalence in key populations, particularly people who inject drugs in Kachin, Sagaing and Shan North, but also among men who have sex with men in Yangon and Mandalay. Needles and syringes or condoms distribution alone may not slow the spread of HIV. Increased access to HIV testing for active people who inject drugs and high-risk men who have sex with men seems to be a critical step towards broader comprehensive services. However, there is a strong need for structural and broad community level involvement in comprehensive interventions that address behavioral, biological and environmental issues associated with HIV and drug use (see access to PrEP below).

High Risk of Initiation of Injecting: Initiation of injecting among people who use drugs in a context of high background HIV prevalence requires that initiators have access to clean needles or PrEP either before or extremely soon after adopting injecting behaviors to avoid HIV infection. Trialing PrEP with people who use drugs should be considered and expanded youth education and services integrated with drug use programming is necessary.

Rural and Remote Areas Service Delivery: Urban prevention coverage is higher, leaving rural and remote areas more vulnerable to new HIV infections. Consistent access to needles and syringes, condoms and other prevention services in rural areas are challenged by distance, and security concerns heavily impact access to prevention service delivery. Engagement with NGOs and EHO may help to bridge service delivery needs in some rural and remote areas.

Opioid Substitution Underutilized: Program data highlight the need to further scale up opioid substitution services and to have a distribution of quality services integrated into other HIV prevention, care and treatment services that is proportional to the severity of the HIV epidemic among people who inject drugs in key geographic areas.

Monitoring and Mobility: Prevention monitoring methods lack certainty including through the lack of Unique Identification Code (UIC) system inhibiting the program's ability to track and monitor prevention coverage and effectiveness. Coverage calculations are an approximation based upon estimated adjustment factors including for mobility and double counting contributing to inherent biases and undermining the accuracy of

[48] IBBS, PWID 2017-2018.

monitoring and management.[49] A UIC system could improve monitoring and link mobile populations across services.

Quality: According to the recent Key Populations Review, the Enhanced Outreach Model is not consistently implemented and there is a need to improve the quality, reach and yield to increase the strategy's effectiveness. There is a need to decrease the distance from outreach contacts with key populations to access to testing and treatment, as distance to testing and treatment increases the likelihood of loss to follow up. The provision of prevention services outside of fixed clinics and directly within the community in a trusting and convenient environment will increase the effectiveness of HIV prevention services.[50]

Biomedical Prevention: There is no easy access to post-exposure prophylaxis (PEP) outside of clinical settings despite reports from key populations of condom breakage and sexual assault particularly among female sex workers. In addition, pre-exposure prophylaxis (PrEP) has been trialed but is not yet widely available in high prevalence urban settings like Yangon and Mandalay for men who have sex with men or female sex workers and people who inject drugs in Kachin and Shan North.

All these challenges point to the fact that consistent and equitable access to multiple prevention strategies including commodities, education, services and structural interventions in both public and private settings are extremely challenged and not yet completely realized. NSP IV aims to address these challenges with improved and expanded services for priority populations and their sexual partners by increasing the quality, coverage, integration and efficiency of prevention service delivery – ensuring those that are HIV (-) have a chance to stay negative and those that are HIV (+) receive immediate treatment. Combination Prevention will include behavioral, structural and biomedical strategies as previously described. New innovative methods will be implemented tailored to key populations.

5.1.3 Service Delivery Approach & What is NEW for NSP IV

According to UNAIDS global guidance, the implementation of effective combination HIV prevention efforts require location-specific population approaches that address the heterogeneity of the HIV epidemic and people-centered approaches that empower communities to make informed choices about prevention options.[51] NSP IV has adopted these approaches and will strengthen prevention based upon evidence-informed, community-owned and rights-based principles. The Service Delivery Approach for prevention will include Public-Private-Community Partnerships that will provide the Essential Package for Health Service - HIV (EPHS-HIV) in 330 Townships and the Comprehensive Package for Health Service - HIV (CPHS-HIV) in 100% of priority townships, mostly located in the 5 priority states/regions. Service delivery will be tailored to the Priority Populations based upon need. Models of local organizing committees will be explored including 'bi-directional' community development linked to service delivery to ensure community acceptance of services. Enhanced efforts to improve the enabling environment will improve the knowledge about HIV and drug dependency among law enforcement personnel, health care workers and other workplace and educational settings and reduce stigma and discrimination to zero.

[49] Report of National Key Populations HIV Program Review in Myanmar, APMG Health, Washington DC, August 2019. And Review of the Health Sector Response to HIV, The Republic of the Union of Myanmar, 2019, Ministry of Health and Sports and WHO.
[50] Report of National Key Populations HIV Program Review in Myanmar, APMG Health, Washington DC, August 2019.
[51] HIV prevention 2020 Road Map. Accelerating HIV prevention to reduce new infections by 75%, UNAIDS.

In addition, under the leadership of the Ministry of Health and Sports (MoHS), and in cooperation with the Ministry of Home Affairs (MOHA) and the Ministry of Social Welfare, Relief and Resettlement, UNAIDS coordinated the development of the National Strategic Framework on Health and Drugs (NSF) with the objective to respond more effectively to the interconnected health, social and legal consequences associated with the use of illicit substances in Myanmar. The NSF on Health and Drugs complements and is fully aligned with existing national policies including NSP IV plans and strategies as well as with relevant international and regional declarations, resolutions and commitments adopted by the Government of Myanmar. The scope of the NSF does not include supply reduction, drug control or alternative development. Note that at the time NSP IV was developed it is planned that this report will be submitted to MoHS for approval and it is still unpublished, however during NSP IV, efforts to support the NSF will occur.

People who inject drugs, People who use drugs and their sexual partners

Harm Reduction Service Delivery will be provided through a partnership approach by a combination of fixed and mobile clinics linked to DICs, Enhanced Outreach and community-led services including a community supported case management approach for PWID and their sexual partners. A comprehensive prevention package will include sterile needle and syringe provision, overdose management, condom access, expanded access to psychological counselling/psychoeducation, and access or referral to welfare and other drug services. Community-based overdose management will be initiated with Naloxone. Additional focus of the provision of services to young injectors, concentrated and focused needle and syringe distribution to pre neophyte and neophyte injecting drug users who have a high risk of acquiring HIV will occur. The prevention partners will work with the Strategic Information team to develop and operationalize a National Unique ID system for HIV services. This will allow improved monitoring while ensuring privacy and confidentiality. This system will support prevention partners to implement a quality assurance and quality improvement program to expand prevention coverage while linking across multiple service delivery points. By 2025, 95% of people who inject drugs will be reached with combination prevention services, or approximately 97,699 people who inject drugs. The number of sterile injecting equipment will be increased to 37 million a year by 2025. In addition, 10,500 of sexual partners of people who inject drugs will be reached with combination prevention services. PrEP will be implemented with PWID resulting in 6,492 PWID on PrEP with the aim that 60% will continue on oral PrEP for at least three consecutive months.

Opioid Substitution Therapy including methadone will be expanded. One-stop-services at drug treatment centers will be improved and Opioid Substitution Therapy services will be decentralized within rural health centers with take-home doses. By 2025, 61,393 of people who inject drugs will receive Opioid Substitution Therapy with the aim of 80% continuing on therapy for at least 6 months. Efforts will be made to reach people who use drugs (PWUD) including ATS users and poly drug users to reduce the harm associated with drug use and expand access to drug use and HIV prevention services among this population. By 2025, NP IV aims to reach 65,000 PWUD with HIV prevention programs and 52,000 PWUD will have received an HIV test and know their results.

Expanded access to HIV testing for PWID, PWUD and their sexual partners will be available through DICs, clinics, integration with other services including TB, Hepatitis, and a new component implemented of self-testing and community-based testing will be implemented. There will be the introduction and expansion of index testing, partner notification and community-based screening among priority populations and their sexual partners. Confirmation HTS will be expanded at ART initiation sites. HTS will be further decentralized including in rural health and sub-rural health centers & Provider Initiated Testing and Counselling (PITC) HTS services will be promoted among clients affected by STI, TB/HIV, hepatitis B, C and others. Quality assurance and supervision systems will be expanded to include monitoring of quality of rapid HIV testing, counselling

and confidentiality. These efforts will result in 95% of people who inject drugs reached being tested and knowing their HIV status or 92,814 PWID by 2025.

Peers or community network members will partner with the public and private sectors through social contracting to play active roles to increase the uptake of prevention services, commodities, HIV testing and facilitated linkages to care and treatment through community supported case management for PWID and their sexual partners. By 2025, 30% of community-based testing will be community-led service delivery. There will be an enhanced integration of HIV services within TB, STI, hepatitis, drug treatment and reproductive health services and an improvement in gender responsive harm reduction services. Collaboration will occur with the National Hepatitis Program to ensure hepatitis testing, HBV vaccines and treatment services for priority populations. By 2025, 80% of people who inject drugs who test negative for Hepatitis B will receive the complete vaccination.

Models of community development will be explored to learn how best to ensure community acceptance of Harm Reduction services including involving influential village, business and religious leaders as members of organizing committees or other mechanisms and linking them to Drug Use Committees/Networks and associated services. Community acceptance and support for Harm Reduction service delivery is key to the success of expansion of service availability in NSP IV.

Table 4:Service Delivery - Harm Reduction

Existing KPSC	Community-Led	Public-Private-Community Partnership
1. Fix clinic + DIC 2. Enhanced Outreach: a) Harm reduction package b) naloxone (new) ~~c)~~ community-based testing CBS d) Referral 3.) Mobile clinic: a) Harm reduction package b) naloxone *(new)* ~~c)~~ community-based screening CBS d) Referral 4.) Psychosocial counselling and mental health *(new)*	1. Community-led (CBO, EHO, Community networks) – (*new)* a) Establish community-driven services (fully and independently led by CBO, EHO, community networks). The delivery model can be as follows: b) DIC+/- clinic + outreach services (in line with essential and comprehensive package of services) c) Community led KPSC *(new)*	1. Use of peer/community network members to strengthen and expand harm reduction services in public health sector and at the community level in high and low priority townships. This requires establishing partnership between the NAP, MoHS and the community network. 2. Public and Community /peer network partnership (*social contracting mechanism)* 3. Introduce use of peer community network members in the public health sectors (e.g., in township hospital, RHC, and sub-RHC to increase HTS and linkage to care and treatment. 4. Explore Community Development models involving local leaders to ensure community acceptance of services.

MSM, Transgender persons and their sexual partners

NSP IV will increase prevention service coverage for men who have sex with men in 100% of high priority townships with intensified and concentrated efforts in Yangon and Mandalay. An expanded initiative will be implemented through innovative social media aimed at hidden, undisclosed and unreached men who have sex with men to raise demand for information and link them to tailored services. NSP IV will expand the coverage and quality of men who have sex with men programs ensuring that the Enhanced Outreach Model is operational across all priority sites to improve education, condom and lubricant access, counselling and associated case management. This will be linked to a network of service providers that are trained in men who have sex with men and Transgender sexual health, HIV and associated services.

Service Delivery for sexual transmission of HIV will include a network of facility-based, field-based and community-led initiatives building upon past achievements. Facility-based services will be led by the MoHS NAP AIDS/STD team in collaboration with the Township Health Department and NGOs and Key Population Service Centers (KPSC) will provide the Comprehensive HIV Service Package. A network of Clinics including international NGOs and local NGOs who are men who have sex with men and Transgender-friendly will be trained and promoted. A new initiative of community driven services will be supported by social contracting to expand coverage of men who have sex with men programs (see Operational Model). Field-based peer education through the Enhanced Outreach Model will provide daily outreach linked to mobile services and fixed Key Population Service Centers including enhanced HIV testing access. There will be a new initiative of accelerated implementation of self-testing, index testing and partner notification and rapid initiation of PrEP in high prevalence settings with men who have sex with men and Transgender persons. Both male and female partners of men who have sex with men will be supported to access comprehensive services. At township levels the efforts will be coordinated by the Township Health Department in collaboration with public, private and community partners. Models of community development involving local leaders will be explored to ensure the acceptance and expansion of services for MSM/TG.

Table 5:Service Delivery – Public-Private-Community Partnership - Sexual Transmission

Facility-Based (fixed setting)	Field-Based	Community-Led
1. Public facility (STD team, Township Health Department (THD)) 2. KPSC 3. Clinic network	1. Peer Outreach (Individual daily outreach) 2. Mobile outreach (usually mobile outreach will be implemented by team) 3. Online Approach- using online platform in reaching and provision services	1. Establish community-driven services (fully and independently led by CBO, EHO, community networks). 2. Explore community development models to ensure acceptance of and enhanced availability of services.

A new initiative will support comprehensive health programs including HIV for Transgender persons. Based upon local analysis and international best practice Transgender health packages will be developed and implemented. These will include tailored outreach education, condoms and lubricant, HTC, psychosocial and gender-based violence support, and the development of materials and education on hormonal therapy for

Transgender with access and linkages to a network of STI, HIV, TB, Hepatitis and specific sexual health services. Population size estimations for Transgender will be developed and targets set during NSP IV.

While ensuring privacy and confidentiality, the men who have sex with men and Transgender prevention partners will work with the SI team to develop and operationalize a UIC for HIV services to improve monitoring. This system will support prevention partners to implement a quality assurance and quality improvement program, expand prevention coverage and monitor across multiple partner agencies. These expanded efforts will result in 95% of men who have sex with men reached by combination prevention services or 139,379 MSM by 2025. In addition, 95% of those men who have sex with men reached will be tested for HIV and know their status or approximately 132,410 MSM by 2025. A community supported case management approach will be strengthened with peer navigators to ensure enrolment in care and immediate access to ART treatment for HIV (+) men who have sex with men and Transgender persons.

Table 6:Implementing Partners for Sexual Transmission

Implementing Partners	**Comprehensive HIV Service Package**			**Essential HIV Service Package**		
	Facility-Based	Field-Based	Online	Facility-Based	Field-Based	Online
NAP/THD	**x**	**x**		**x**	**x**	
INGO	**x**	**x**	**x**			
LNGO	**x**	**x**	**x**	**x**	**x**	**X**
Community	**x**	**x**	**x**	**x**	**x**	**x**
EHO	**x**	**x**		**x**	**x**	

Female sex workers, clients and their regular sexual partners

There will be intensified and expanded efforts for female sex workers and their sexual partners to improve the coverage and quality of programs in townships with both Essential and Comprehensive HIV Service Packages. This will be accomplished by MoHS NAP, INGO, LNGO and community partnerships. While current coverage of female sex worker programs is suggested to be high, social media platforms will be used to reach hidden and unreached female sex workers to raise demand for services including “know your HIV status” campaigns. Low literacy materials will be developed, and gender responsive services implemented. The improved Enhanced Outreach Model will be operational in all priority townships and linked to Key Population Service Centers, mobile services and a network of trained private sector providers so that 100% of townships in priority townships are provided comprehensive prevention services. Condom social marketing and free access will be supported. There will be a new initiative of accelerated implementation of self-testing, index testing and partner notification and rapid initiation of PrEP in high prevalence settings for female sex workers, their clients and their regular sexual partners.

Collaboration with Reproductive Maternal and Child Health will enhance integration of HTS and STI services. Mechanisms will be initiated to report and receive post exposure prophylaxis (PEP) for occupational exposure and gender-based violence. Psychosocial and mental health services will be promoted for female sex workers and their partners and violence against female sex workers reduced by working with the Police Department. The sum total of these initiatives will result in 95% of female sex workers reached by prevention programs or 70,646 by 2025. Among those reached the aim will be that 67,114 FSW will receive an HIV test and know their result by 2025.

A community-supported case management approach will be strengthened with peer navigators to ensure enrolment in care and immediate access to ART treatment for HIV (+) female sex workers, clients and their regular sexual persons with the aim that 95% of newly diagnosed HIV (+) female sex workers will be enrolled in care and ART treatment.

HTS will be further decentralized into rural health, sub centers and PITC HTS services will be promoted among clients and regular partners affected by STI, TB/HIV, hepatitis and other health issues. By 2025, NSP IV aims to provide comprehensive prevention services to 14,250 clients and 3,450 regular partners of female sex workers.

Threats to Implementation and Enabling Environment initiatives

Several threats would potentially undermine efforts to reach the prevention goals of NSP IV. These include adequate financial and human resource allocation, capacity development among all partners, support for community-led initiatives and associated enabling environment requirements.

According to the National AIDS Spending Assessment (NASA), funding for prevention has steadily increased and in 2017 $29.7M USD was spent on Prevention which represented 27% of the total HIV spending.[52] Myanmar has improved allocation to key population programs and by 2017, 20% of total HIV spending was for key populations with expenditures of $14M targeted for people who inject drugs, $4.5M for female sex workers and their clients and $2.9M for men who have sex with men. Funding flows for prevention were approximately 16% from Public sources, 2% from Private funds and International funds represented almost 83% of prevention expenditures in 2017. The international funding sources for prevention were GFATM ($11M), Bilateral ($6.9M) and Multilateral ($6.3M) Agencies. Within prevention spending only PMTCT is nationally funded and all other key populations programs are 95-100% funded by international funding sources. An overreliance on international funding for key population prevention is a long-term threat to sustainability and a financial transition plan is required to ensure a progressive shift from international to public funding sources. Advocacy for adequate resources for key population prevention and its associated Public-Private-Community partnership will occur during NSP IV including increased domestic funding and social contracting mechanisms for community-led initiatives.

Concerning the enabling environment, several efforts will be undertaken in NSP IV. Operationalizing the National Drug Control Policy and associated sub national plan strategic framework on drug control will mutually support the goals of HIV prevention. NSP IV aims to promote and strengthen multisectoral collaboration and coordination at all levels to address facets of the drug problem in Myanmar. Law enforcement will be sensitized about HIV and drug dependency and alternatives to drug related offences and sex work will be sought. Provisions of the amended 1993 Drug Law Article 16C will be reviewed with the aim of reduced thresholds for possession of drugs for personal use. Efforts to decrease the number of punitive laws and policies including the Suppression of Prostitution Act 1949 and the Penal code section 377 will be enhanced (see SD #3.3). Efforts will be made to reduce to zero HIV related stigma and discrimination in health care, workplace and education settings.

[52] National AIDS Spending Assessment 2016-2017: Financing Flows and Spending in HIV. National AIDS Program, The Republic of Union of Myanmar Ministry of Health and Sports and UNAIDS, July 2019.

People in closed settings including prisons

High level coordination and collaboration continues between relevant national programs and departments in both MoHS and MoHA with the National AIDS Program and the Prison Department leading in the development of a National Strategic Framework for Health in Prisons and Other Closed Settings and an ambitious agreed plan for the strengthening of health services in closed settings including prisons with the help of international partners including INGOs. Health infrastructure continues to be constructed and renovated, as well as training for health officers and the continuing introduction of SOPs to support standardized service delivery.

In Myanmar, there are approximately 60-65,000 prisoners and up to 25,000 persons in pre-trial detention. A significant proportion of these individuals are members of key population communities. Service Delivery is a cooperation between the Prison Department of the Ministry of Home Affairs, NAP, MoHS, Local AIDS/STD Teams, UN agencies and NGOs. A comprehensive standard operating procedure for prison heath was developed and launched in 2018. Early screening for HIV was offered to all new detainees by prison health staff in four prisons: Insein, Mandalay, Myitkyina and Lashio. For other prisons across the country, NAP AIDS/STD teams visited regularly for health education, HIV/STI screening and ART provision. During 2018, HIV prevention services were provided to prison population in 15 of 17 states and regions, which represents significant progress. Prevention services in prison will be reinforced. In 2018, the NAP Progress Report suggested that 10,917 people in prisons and other closed setting were reached with HIV prevention including health education and HIV testing services.[53] This HIV testing figure increased to 36,072 by 2019 which is the highest during this decade.

NSP IV will strengthen and expand HIV services for prisoners and individuals in closed settings. A new initiative will include the Enhanced Outreach model/ peer education including psychoeducation will be implemented. There will be expanded access to HTS and STI care in all prisons and camps and promotion of HTS among sexual partners of prisoners and detainees. Linkage and integration of HIV to TB, hepatitis, drug treatment and other health services will occur. A continuum of HIV care and treatment services at entry, during incarceration and release will be established with linkage to community-based services outside of prison and camps. These enhanced efforts will support 95% of camps provided with STI Services. In addition, 95% or 80,750 prisoners will receive HIV prevention services and 76,713 prisoners provided testing and know their HIV status. Among those that test HIV positive 100% will be enrolled in ART.

Young Populations

Younger members of priority populations (25 years or younger) need special attention due to rapid physical and psychosocial development and poor access to services particularly for those under 18 years old. Young key populations are at risk of infection and represent an opportunity for prevention to keep the majority HIV free. In 2015 the HIV prevalence in the IBBS among young <25 year old female sex workers was 1% in Monywa, 7% in Mandalay, 9% in Yangon and 11% in Pyay.[54] The HIV prevalence in the 2015 IBBS among young <25 year old men who have sex with men was 14% in Yangon, 10% in Mandalay and under 5% in Monywa, Pathein and Pyay.[55] Data from the 2017 PWID IBBS suggest that young injectors (<25) are at significant risk of HIV infection with an overall HIV prevalence of 28% ranging from 4% in Mandalay to 57% in Bamaw.[56] These data suggest in certain locations young HIV (+) key populations require tailored prevention services and immediate access to care and treatment.

[53] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[54] Myanmar integrated biological and behavioral survey (IBBS) of FSW in five cities, 2016.
[55] Myanmar integrated biological and behavioral survey (IBBS) of MSM in five cities, 2016.
[56] IBBS, PWID 2017-2018.

While the NAP has conducted HIV prevention activities among out-of-school youth, these have reportedly decreased in 2018 due to decreased resources.[57] In NSP IV, a youth program for HIV will be strengthened and integrated in Key Population programs and Comprehensive HIV Services will be provided to young key populations. Social media efforts will ensure that young populations are reached with information to raise demand for HIV services and link young populations to youth friendly service providers. Tailored outreach education with peer educators and specific training for service providers concerning youth will occur. NSP IV efforts will ensure access to HIV testing without barriers due to age. Comprehensive Prevention service coverage among young populations will aim to increase from 20,000 in 2021 to 30,000 by 2025 and among those 7,500 will receive an HIV test and know their results. Within each of the Key Population targets a proportion will be youth and potentially tracked with new monitoring methods.

Ethnic Health Organizations and Mobile and Migrant Populations

During 2018, the NAP in collaboration with IOM and with support from ADB JFPR provided HIV services in five townships along the Myanmar -Thailand economic corridor. Progress was made in Kayin State including in Hpa-an, Myawaddy and Kawkareik. The highest number of mobile and migrant people reached with HIV prevention was in Mon and Kayin, which are states that border with Thailand. In Shan East, service expansion occurred in Tachileik. During 2018, significant numbers of mobile and migrant populations were also reached in other states and regions, such as Magway, Kayah (border with Thailand), Kachin (border with China) and Shan East (border with China and Thailand). In total in 2018, nearly 57,702 mobile and migrant and people in the workplace were provided with HIV education and services.[58] During 2019, around 50,000 of mobile and migrant people received HIV prevention services while more than 36,000 of them were tested for HIV. NSP IV aims to provide HIV education and services to 60,000 mobile and migrant people in 2021, with yearly increases to 81,000 in 2025.

Over many years, the EHOs have played a critical role in supporting the roll-out of health services in non-state or emergency areas and among migrant and mobile populations. Their role includes providing services on HIV, TB, Malaria, immunization, SRH and other health services with hard-to-reach populations in close collaboration with Maternal and Reproductive Health Unit, State and Regional Health Department. As previously described, a consultative meeting was held with Ethnic and Community-Based Health Organizations to map current activities and identify key areas for collaboration with NSP IV efforts. The MoHS consultation with EHOs held in Mawlamyine City in Mon State agreed on a number of follow up actions. From the EHO perspective a number of issues were discussed, including the availability, limitations and capacity of human resources, including volunteers. The main factors impacting upon health and service delivery – both favorable and obstacles, include the following: (i) status of local health information, health literacy and IEC materials available in local languages; (ii) domestic and international migration and displacement impacting upon access to and from health facilities and services and continuity of care; (iii) geographic remoteness and physical access issues; resource limitations including funding, health commodities and logistics; (iv) the limited strategic information available to support the planning, implementation and monitoring of health services, and (v) the policy context that impacts on EHO service provision.

The following actions were discussed and tentatively agreed between the National Programs and Ethnic Health Organizations:

[57] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[58] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

- Carry out situation assessments in geographic areas covered by EHOs including the availability and type of health services, epidemiological status of populations, mapping of migration patterns.
- Develop sub national or EHO-specific plans covering HIV, TB and Malaria within or aligned with Township and State Operational Plans.
- Conduct needs assessments related to medical and health equipment, health commodities and supplies.
- Develop supportive policies, guidelines and Standard Operating Procedures to assist in strengthened coordination, collaboration and assisted referral between EHOs and MoHS including EHO participation in the Executive Working Group of Communicable Diseases under the MHSCC.
- Assess and respond to the potential for capacity building, training and mentoring for EHO health care workers.
- Review and support the strengthening of EHO service provision including preventative services and information, diagnostic services for HIV, TB and malaria,
- Prepare costed workplans to support the above activities and identify and mobilize necessary funding.
- Include EHO participation in relevant disease-specific TSG development of the new funding requests to the Global Fund.

5.1.4 Priority Interventions – Harm Reduction & Sexual Transmission

1.1 Increase scale of effective combination prevention interventions for priority populations and promote community led approaches/initiative

1.2 Maximize HIV testing and strengthened linkages to ART among priority populations and their sexual partners

1.3 Maximize efficiency in service delivery and enhance integration with other health services

1.4 Ensure an enabling environment for priority populations and their sexual partners

Key Prevention 2025 Targets

Number of FSW reached with HIV Prevention Program	**70,646**
Number and % of FSW who receive an HIV test and knew their results	67,114 95%
Number of FSW who receive PrEP at least once in the last twelve months (Note: To conduct the PrEP demonstration project in FSW who have substantial risk of HIV transmission if funding is available.)	3,095
Number of MSM/TGW reached with HIV Prevention Program	139,379
Number and % of MSM/TGW who receive an HIV test and knew their results	132,410 95%
Number of MSM/TGW who receive PrEP at least once in the last twelve months	6,620
Number of PWID reached with HIV Prevention Program	97,699
Number and % of PWID who receive an HIV test and knew their results	92,814 95%
Number of sterile injecting equipment distributed to people who inject drugs	37.9 million
Number of PWID receiving Oral Substitution Therapy	61,393
Number of clients of female sex workers, partners of key populations and people living with HIV, people who use drugs, people in prisons and other closed settings, migrants and youth reached with HIV Prevention Program	303,170
Number of clients of female sex workers, partners of key populations and people living with HIV, people who use drugs, people in prisons and other closed settings, migrants and youth who receive an HIV test and knew their results	282,118

5.1.5 Activities, Partners, Results

Strategic Direction 1: Reducing New Infections		
Activities	**Results**	**Partners & Funding**
1.1 Increase scale of effective combination prevention interventions for priority populations and promote community led approaches/initiatives		
1. **Raise demand** for information and services including for hidden/undisclosed/unreached KPs and young populations through innovative social media and **increase health literacy** 2. **General prevention awareness education** to reduce stigma, discrimination in health, education, workplace sector and in prioritized geographical areas 3. **Enhanced Outreach linked to KPSC, Mobile, Community** a) **Identify** key populations (including young). b) **Provide** training for EOM including psychoeducation (mhGAP Version 2.0) c) **Improve and expand outreach education, counselling/ psychoeducation and case management** (partially new) d) **Provide overdose management including community-based overdose management** (Naloxone - new) e) **Provide HIV prevention commodities** f) Increase testing rates (see below) g) Increase integration/linkage to prevention, care/ treatment including HIV, TB, STI (see below) h) Increase integration with welfare and other drug treatment services i) **Improve gender and youth responsive** HIV prevention/ harm reduction services j) **Ensure EPHS-HIV services are provided in non-prioritized townships either through mobile outreach services from prioritized townships or local community peers.** 4. **Expand KPSC and Mobile services** in priority townships a) **Establish TG** packages (new) b) **Expand MSM** & **FSW and partner's services**	1. **95% of key populations reached by combination prevention services** 2. **40%** (or 41,136) of PWID receive **Opioid Substitution** Therapy 3. **100% of townships** in high burden States and Regions covered with prevention/Harm Reduction services 4. **95% of prisons & camps** provided prevention services (new) 5. **All IP adopt** and implement EOM and HIV case management approach & psychoeducation for Harm Reduction 6. **All KPSC** provide ART services in addition to tailored	**Lead:** MoHS NAP **Support:** UN, Donor and Technical Agencies **Implementing:** Local AIDS/STI Teams, Health Care Workers, Government Health Facilities, Prison Department, INGO, NGO, CBO, KP Network, Community Network, Private facilities (specialist hospitals and private general practitioners' clinic)

c) **Expand PWID/PWUD and partner's services** including behavioral and structural peer-driven interventions for HIV negative and ATS users d) **Expand MMT** in priority townships with high HIV prevalence/numbers of PWID e) **Establish and expand Youth friendly services** 5. **Introduce social networking strategy in townships with high number of key population, particularly MSM and FSW** (e.g., townships in Yangon region) 6. **Support UIC implementation** a) Pilot first in Yangon and Mandalay b) Expand to the other States and Regions with KP communities 7. **Expand Community based approaches** a) Train community members b) Mobilize community involvement in service delivery c) Enhance involvement in improving enabling environment 8. **Expand HIV prevention in Prisons and Labor Camps** a) Train and provide psychoeducation, peer educators (new) b) Conduct feasibility assessment of OST in prison and advocate for evidence-based drug treatment (including OST) in prisons and other closed settings (new) c) Linkage to TB, hepatitis, drug treatment d) Ensure continuum of HIV care/treatment at entry, during and release (new) 9. **Provide PrEP** for key populations with substantial risk of HIV and PEP for occupational exposure and gender-based violence victims. 10. **Implement Quality Improvement** for Prevention and Harm Reduction services with community involvement (co-initiative with Strategic Information) (new) 11. **Develop IEC materials and provide health education on hormonal therapy for transgender** (new) (SOP and guideline refer to care and treatment group/Operational Context)	prevention services 7. All sites of implementing partners provide overdose management including community-based overdose management	**Funding:** External, Public and Domestic

1.2 Maximize HIV testing and strengthened linkages to ART among priority populations and their sexual and drug injecting partners		
Activities	**Results**	**Partners & Funding Source**
1. **Update testing guidelines** to ensure the rapid scale-up of HTC and operationalize according to priority population needs 2. **Optimize HIV self-testing, index testing and ensure partner notification and expand community-based screening** among priority populations and their sexual and drug-injecting partners (new) 3. **Expand priority population and their sexual and drug-injecting partner testing:** a) **PWID, PWUD:** Provide HIV testing in community outreach, KPSCs, mobile & facility based. b) **MSM, TG and SW**: Provide HTS through community-based testing, KPSCs, mobile testing and facility-based prevention and care services. c) **Prisoners**: Expand voluntary HTS in prisons and promote HTS of sexual partners (new) d) **Rehab Centers**: provide voluntary HTS in all rehabilitation centers and promote HTS of sexual partners. e) **Mobile and migrants**: integrate through community sites, migrant health posts and workplaces. f) **Increase access for young** priority populations through youth friendly service centers. Strengthen access of services for children, and orphans and vulnerable children where needed. 4. Use **social media** for Know Your Status campaigns (to include in activities under 1.1 #1) 5. **Further decentralize HTS** (including rural health and sub rural health centers & promote PITC HTS services among clients/partners affected by STI, TB/HIV, hepatitis B, C and others. 6. **Ensure Quality assurance** and continuous quality improvement systems in place 7. **Develop local language** promotional materials, job aids and approaches to address ethnic minority populations and ensure access of these across services 8. **Strengthen peer navigators** to ensure enrolment in care and initiation of ART (see 2.1) 9. **Implement a quality improvement program**	1. **95%** of those reached with prevention program tested and know their status 2. **95%** of people from priority populations received a test in the last 12 months and know their results (disaggregated by PWID, MSM, TG, SW, migrants and prisoners) 3. **30%** of KP testing/EO/KPSC are **Community led activities** (new) 4. **95%** of newly diagnosed HIV positive people newly enrolled and receiving care and ART treatment 5. **95%** of all PLHIV are tested and know their HIV positive (including children and young people) 6. **100% of** prisoners testing HIV positive enrolled in ART	**Lead:** MoHS NAP **Support:** UN, Donor and Technical Agencies **Implementing:** Local AIDS/STD Teams, Health Care Workers, Government Health Facilities, Prison Department, INGO, NGO, CBO, KP Network, Community Network, Private Facilities (Specialist Hospitals and Private general practitioner's clinics) **Funding:** External, Public and Domestic

1.3 Maximize efficiency in service delivery and enhance integration opportunities with other health services		
Activities	**Results**	**Partners & Funding Source**
1. **Integrate HTS within TB, STI, hepatitis, drug treatment, prisons and RMNACH+ (provide SOPs, HIV test kits and training)** 2. **Integrate** voluntary and non-coercive family planning and STI services within HIV, particularly for KP 3. **Strengthen integration/collaboration** with the National Hepatitis Control Program to ensure hepatitis testing, HBV vaccines and HCV treatment are provided to priority populations. Provide HCV treatment for HIV HCV co-infected patients. 4. **Ensure linkages** of HIV (+) persons to comprehensive case management (see Care & Treatment) 5. **Promote medical and psychosocial interventions** including mental health services for key populations and their families 6. **Expand one stop services** at drug treatment centers where OST is available. 7. **Further** decentralize OST services, including within rural health centers and in the private sector including home doses. 8. **Provide** free-of-charge needles and syringes with community in close collaboration with key stakeholders, and private sector (eg., pharmacies, groceries and shops) in priority townships. 9. **Advocate for and Assess feasibility for** evidence-based drug treatment (including OST) in prisons and other closed settings. 10. **Expand** the provision of HTS and STI service in detention/prison camps. 11. **Ensure uninterrupted continuation** of services (OST, ART) at both entry and exit of detention/prison camps. 12. **Ensure** the safe disposal of medical waste and accountability from service providers.	1. TB, STI, Hepatitis, Drug Treatment Centers and RMNACH+ program adopt and implement HTS 2. Increase in the number of facilities screening for HIV, HBV/HCV, STIs 3. Increased availability of HBV vaccines for priority populations 4. 80% of PWID tested negative for Hep B receive complete vaccination (3 doses) 5. Increased number of private sector facilities screening for HIV, HBV and HCV 5. Increased number of People diagnosed with HIV receiving HBV vaccine and HCV treatment as needed. (Refer to care and treatment) 6. PEP available in all health facilities for occupational hazard and GBV 7. Medical and Psychosocial interventions of PWID/PWUD and their family members initiated 8. Increase the number of one stop shop services 9. Condom provision initiated and HTS/ STI services scaled up in detention/prison camps	**Lead:** MoHS NAP in collaboration with RMNACH+, Department of medical services, Prison Department National Program on Viral Hepatitis control, Government Health Facilities and Private sector **Support:** UN, Donor and Technical Agencies **Implementing:** INGO, NGO, CBO, KP Network, Community Network **Funding:** External, Public and Domestic

1.3 Maximize efficiency in service delivery and enhance integration opportunities with other health services		
Activities	**Results**	**Partners & Funding Source**
13. **Institute mechanisms** to report and receive post-exposure prophylaxis (**PEP**) for occupational exposure and sexual, gender-based violence 14. **Ensure collaboration** with MOE, MOHA, MSWRR, private sector and EHO (refer to enabling environment 1.5) 15. Integrate HIV services for **gender-based violence** one stop shop service operated by MSWRR 16. **Ensure access to young** key populations 17. **Conduct situation assessments** of health needs, services, epidemiological status and migration patterns in areas covered by EHOs 18. **Develop sub national or EHO-specific plans** covering HIV, TB and Malaria within or aligned with Township and State Operational Plans 19. **Conduct needs assessment** related to medical and health equipment, health commodities and supplies 20. **Develop supportive policies, guidelines and Standard Operating Procedures** to assist in strengthened coordination, collaboration and assisted referral between EHOs and MoHS including EHO participation in the Executive Working Group of Communicable Diseases under the MHSCC 21. **Assess and respond to the potential for capacity building**, training and mentoring for EHO health care workers 22. **Review and support the strengthening of EHO service provision** including preventative services and information, diagnostic services for HIV, TB and malaria 23. **Prepare costed workplans** to support the above activities and identify and mobilize necessary funding 24. **Include EHO participation** in relevant disease-specific TSG development of the new funding requests to the Global Fund	**10.** Strengthened coordination and collaboration between EHOs and MoHS health service provision	

1.4 Ensure an enabling environment for priority populations and their sexual and drug injecting partners		
Activities	**Results**	**Partners & Funding Source**
1. **Encourage** the operationalizing of the National Drug Control Policy and National Strategic Framework on Drug Control Policy 2. **Develop** sub national plan of drug control policy and strategic framework on drug control 3. **Review** some provisions of the amended 1993 Drug Law (e.g. article 16 C– review and establish quantity thresholds for possession of drugs for personal use) 4. **Enhance** the knowledge and understanding of community and faith-based organizations about harm reduction services 5. **Promote and strengthen** collaboration and coordination at all levels to address all facets of the drug problem (MoHS, MOE, MOHA etc) 6. **Sensitize law enforcement** about HIV and drug dependency to embed harm reduction in law enforcement practices/ enhance knowledge among prison staff/ rehab centers staff and health care workers 7. **Develop social reintegration** programs 9. **Ensure access to justice** and legal support by promoting and implementing community feedback and redress mechanism 10. **Advocate** and promote understanding on decriminalization of drug use, same sex behavior and sex work 11. **Address punitive laws**, policies and practices in relation to drug use, same sex behavior and sex work and offer alternatives to imprisonment at all stages for drug related offense and sex work 12. **Ensure access to HIV testing among youth** without any age barriers 13. **Address stigma and discrimination** in Health care setting, workplace, education and in all sectors 14. **Ensure meaningful engagement** of priority populations in planning, implementation and evaluation 15. **Explore and Evaluate Community Development Models** of engagement in and support for Prevention Services	1. Zero HIV related Stigma &Discrimination in health care, workplace and education settings 2. Provisions from the amended 1993 Drug Law that hinder effective HIV prevention among PWID are removed 3. Decrease number of punitive law and policies that hinder priority population access to HIV prevention, care and treatment services 4. Amend the punitive law and policies that hinder priority population access to HIV prevention, care and treatment services 5. Increase the number of Protective laws/ antidiscrimination policies for PLHIV and priority populations and implemented 6. Conducive environment for young people in access to HTS and other health services created 7. Enhanced knowledge about HIV and drug dependency among law enforcement personnel, prison staff, health care workers, and rehabilitation staff	**Lead:** MoHS NAP in collaboration with other ministries **Support:** UN, Donor, and Technical Agencies **Implementing:** Local AIDS/ STD teams, INGO, NGO, CBO, KP network, community network **Funding:** External, Public and Domestic

5.1.6 Priority Interventions – PMTCT

Overview of Achievements

The PMTCT program is the most geographically expansive HIV prevention program in the country with currently only the exception of very remote areas. The country supports mainly lifelong ART and ARV prophylaxis for PMTCT. Midwives are active in the screening of pregnant women largely at the community level and screening of pregnant women is available in all level of hospitals in Myanmar. Women who screen HIV positive at community and health centers are referred to the Township Health Department, ART center and ART decentralized sites for confirmatory testing and initiation of ART. Pregnant women with known HIV positive status on ART prior to getting pregnant must also report to the township health department, ART center and to the Obstetric Department at hospitals for delivery. In 2018, program data showed that HIV prevalence among pregnant women was 0.52%, suggesting through modelling that 5,400 pregnant women were HIV (+) nationally. As previously described, by 2018 the PMTCT program had made significant progress with 97% service coverage across 321 out of 330 townships and 38 hospitals in the country resulting in 88% of pregnant women receiving pre-test counselling and of those 95% got tested and received their HIV test result. Based on initial 2019 data, PMTCT services were available in 326 townships offering 90% of estimated pregnant women with pre-test counselling service. HIV prevalence among pregnant women was still around 0.5% in 2019.

Among HIV positive pregnant women, 82% received antiretrovirals to reduce the risk of mother to child transmission. At a national level, 3,071 HIV exposed infants were provided ARV prophylaxis representing 57% of all estimated HIV positive pregnant women. Cotrimoxazole prophylaxis was provided to 30% of exposed babies and 25% were tested for early infant diagnosis within two months of birth. [59]

Table 7:Progress Towards the Elimination of Mother to Child Transmission

Output/Coverage Indicator	Data Source	Size Estimate 2017	Baseline 2015	Target 2018	Results 2018
No. of pregnant women attending antenatal care services who received HIV testing	Program Data	1,107,312[60]	793,446	915,327	909,593
No. of pregnant women attending antenatal care services who received HIV test result with post-test counselling	Program Data	1,107,312	748,299	897,268	900,846
No. of HIV positive pregnant women attending antenatal care services who received HIV testing know their positive status	Program Data	5,402[61]	4,356 (86%)	4,536	4,753 (88%)

[59] National HIV Progress Report 2018, The National AIDS Program, Ministry of Health and Sports
[60] HMIS data
[61] Spectrum April 2019

Output/Coverage Indicator	Data Source	Size Estimate 2017	Baseline 2015	Target 2018	Results 2018
No. of HIV positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	Program Data	5,402	3,923 (77%)	4,351	4,439 (82%)
% of HIV exposed infants who initiated ARV prophylaxis	Program Data	5,402	2,169 (43%)	71%	3,071 (57%)
% of HIV exposed infants started on cotrimoxazole prophylaxis within 2 months of birth	Program Data	5,402	1,470 (29%)	66%	1,649 (30%)
% of HIV exposed infants receiving a virological test for HIV within 2 months of birth	Program Data	5,402	801 (16%)	60%	1,348 (25%)

Source: National HIV Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Challenges

Despite major achievements, there are clear gaps along the PMTCT cascade. The program is performing well in identifying and tracking HIV positive pregnant women, however, sometimes there are delays in providing results and pregnant women sometimes do not return for the test results. Partner testing is still low. In 2018, HIV testing among partners of HIV positive pregnant women was 38% and 16% among the partners of HIV negative pregnant women.[62] Partner testing coverage was slightly increased in 2019 to 36% in partners of HIV positive pregnant women and 25% in negative women partners. Improving partner testing would help reduce morbidity and mortality in family units.

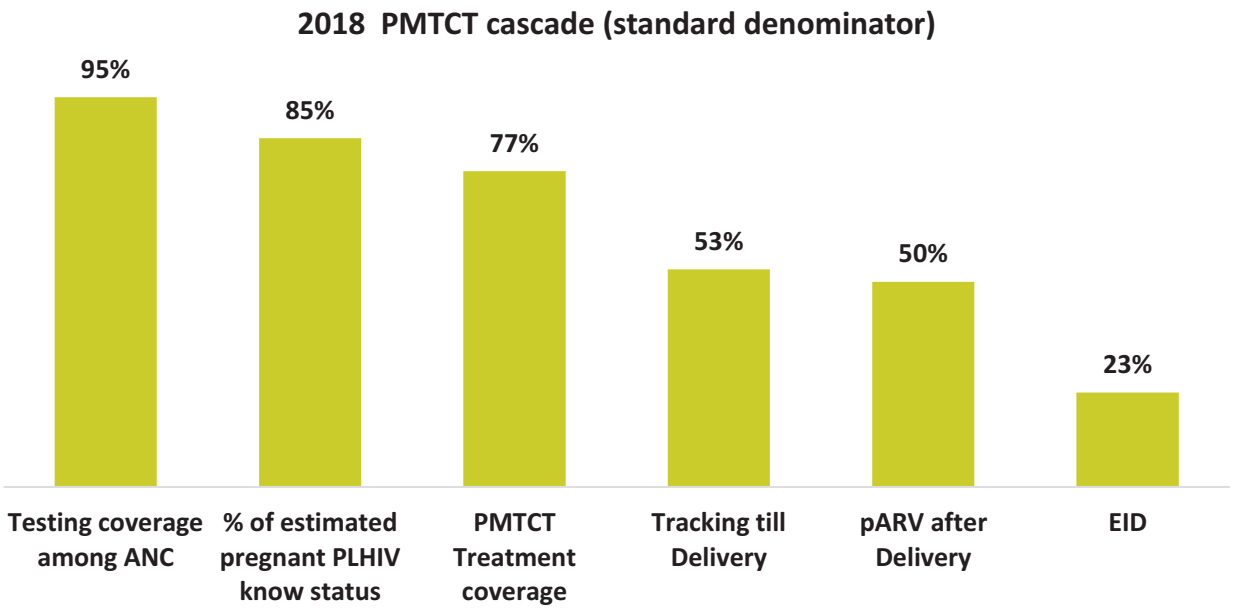
The recent HIV Program Review, identified that one of the major reasons for loss to follow up was that pregnant women are tested and provided ART by the Obstetrics Department in hospitals, but after childbirth, these women are not followed up by this department and the mother–baby pair is not tracked. A percentage of women do not report to ART services after delivery despite referral, resulting in loss to follow up of the mother and no testing of the baby. Migration is cited as one issue.[63] In terms of early infant diagnosis, most of the regions failed to provide early infant diagnosis to a large proportion of HIV exposed babies under 2 months of age with only 25% achieved nationally.[64] The highest achievers in 2018 were Kayah, Shan East, Kayin and Tanintharyi with 45-50% of exposed babies provided early infant diagnosis. The impact of loss to follow up at multiple levels is a steady decline of PMTCT coverage along the cascade with increase morbidity and mortality.

[62] PMTCT program data, 2018

[63] Review of the Health Sector Response to HIV, The Republic of the Union of Myanmar, 2019, Ministry of Health and Sports and WHO.

[64] National HIV Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Figure 19: Gaps along the PMTCT Cascade



Source: HIV PMTCT progress in 2018, NAP

95%: 95% of antenatal care and 95% of tested indicators for PMTCT

The Health Sector Review on HIV also reported that Syphilis test kits are in short supply and therefore the syphilis testing coverage among pregnant women was low. There is no data collection on congenital syphilis.[65] TB screening is done for the general population including pregnant women by National TB Program, however, there is no specific tracking mechanism to follow TB screening and treatment among HIV positive pregnant women. In addition, women's lack of empowerment and negotiating skills reduce the probability of condom use and partner testing, putting children at higher risk of mother to child transmission and losses in ART coverage within the family.

While the PMTCT program covers the largest geographical area of any program in 2019, there are only four townships in Kachin and Shan East that are geographical remote or have political instability and hence these areas do not have a PMTCT program. Improved collaboration with EHO may increase access to remote and politically challenging areas. Sub national analysis of the PMTCT cascade now allows for program managers to assess the declines in the PMTCT cascade on a geographical basis. The geographic areas of underachievement must be targeted with quality improvement efforts to increase coverage of PMTCT services to ensure elimination of mother to child transmission (MTCT).

[65] Ibid, Review of the Health Sector Response to HIV, 2019

Key Areas for EMTCT

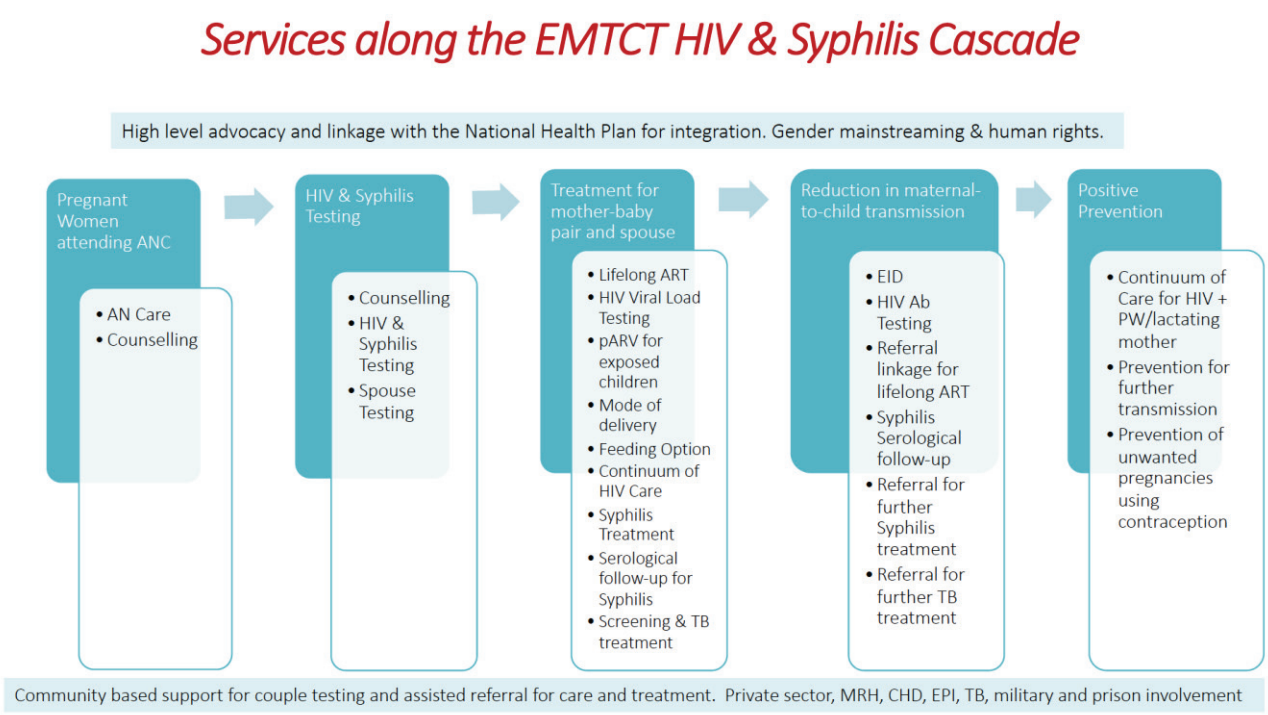
- Ensure PITC service for HIV and Syphilis to all pregnant women and their spouse in all settings
- Ensure ART and Syphilis treatment for all HIV-positive and/or syphilis-positive pregnant women and their spouse in all settings
- Ensure pARV and syphilis treatment for all HIV and syphilis exposed infants in all settings
- Rapidly expand early infant diagnosis (EID)
- Strengthen linkage to pediatric ART
- Gender mainstreaming and Human Rights including community engagement and meaningful participation of the spouses of pregnant women
- Quality improvement to ensure the greatest impact

Service Delivery Approach & What is NEW for NSP IV

To address these challenges, the PMTCT program plans to expand to all 330 townships in the country with geographic prioritization in line with the EMTCT action plan. This will allow resources to be focused on high burden areas while also supporting the improvement of underperforming geographic settings based upon need. Service delivery will occur through Public Private Partnerships with the Essential Package for Health Service – HIV (EPHS-HIV) on HIV made available in routine antenatal care services in all township while the Comprehensive Package for Health Services - HIV (CPHS-HIV) will be available in priority townships. An improved tracking system using a digital health platform for the mother-baby pair will be rolled out in collaboration with the Maternal and Reproductive Health and Child Health Development Divisions. A family-based approach through integrated primary health care will support co-management and co-supervision of HIV, TB, pregnancy and children. Same day treatment will be provided to women and their children. To enhance results, the engagement of community networks to assist HIV (+) pregnant mothers and post-partum mothers and children will occur to ensure support, improve partner testing and reduce loss to follow up.

Gender awareness campaigns for the community and gender mainstreaming trainings for the health staff will be conducted focusing on empowerment, negotiation skills and decision-making power of women for HIV prevention especially condom use, HIV and Syphilis counselling and testing for couples, and treatment services which will be crucial for EMTCT.

Figure 20:Services along the EMTCT HIV and Syphilis Cascade:



Threats to implementation success

Several threats may hinder the bold goal of the dual elimination of mother to child transmission of syphilis and HIV by 2025. According to the National AIDS Spending Assessment in 2017, over $2.2M USD was spent on PMTCT services or about 8% of the Prevention spending primarily coming from public funding sources. These resources include the cost of salaries for counseling services, testing reagents, ANC services and serological follow up. There are several new initiatives that will increase funding requirements for PMTCT including training to improve adherence counseling and resources to procure Syphilis test kits or dual HIV and Syphilis test kits particularly in high burden areas. Some efforts will improve efficiency, the decentralization of dried blood spot (DBS) collection for rapid expansion of early infant diagnosis would reduce costs and improve time to treatment for newborns. Adequate finances must be made available for human resources, community mobilization, commodities and some infrastructure to support elimination.

Under NSP IV activities will be conducted to advocate for high level political commitment for the EMTCT of HIV and Syphilis and for the linkage and integration with the National Health Plan for Essential Package for Health Service (EPHS) under NIMU. Associated policies and procedures must be adopted nationwide for full implementation of the program. Finally, as previously described, ongoing conflicts and hard to reach areas in non-government-controlled areas may hinder service delivery. In addition, linkages to prisons for care of HIV (+) pregnant women need to be explored. NSP IV will endeavor to collaborate with EHOs, INGOs, LNGOs and the community to overcome these challenges and establish integrated service delivery in these areas.

What is new in NSP IV?

A new and expanded tracking system for mother-baby pairs using a digital health platform will be established. This platform will provide reminders to service providers and patients and will be linked to community support mechanisms to reduce loss to follow up of the mother and child pair. A quality improvement program will be implemented to enhance outcomes. The overall approach will be integrated Family-Centered service provision to allow for broader support to the family unit and improved health outcomes as a whole; including the prevention of mother-to-child HIV and Syphilis transmission. With the efforts of National TB

Program, screening for active and latent TB and associated treatment will reduce the morbidity and mortality of the HIV positive mother and child. With additional resources and efforts there will be improved spouse testing through the establishment of couple testing corners and community-based testing in collaboration with CBOs. Materials in ethnic minority languages will be developed and programs for improved health literacy will be implemented. Social media and peer education will be used for prevention and to promote treatment. PrEP will be trialed and expanded for sero-discordant couples with substantial risk of HIV infection. These new and emerging areas should support the elimination of MTCT and prevention efforts as a whole.

One of the important gaps for EMTCT is low partner testing, which is a concern for a gender mainstreaming approach for EMTCT. To address this, health staff will be trained for gender mainstreaming for HIV to create an enabling environment for male partners to promote partner testing. As the disclosure between sero-discordant couples is related to Human Rights issue for EMTCT, awareness of the Public Health laws: "section-269 & 270 under Chapter XIV *CHAPTER XIV OF OFFENCES AFFECTING THE PUBLIC HEALTH, SAFETY, CONVENIENCE, DECENCY AND MORALS" will be raised and orientated to the health staff and the community* with the technical assistance of Attorney General Department.

5.1.7 Priority Interventions - EMTCT

Eliminate mother to child transmission of HIV and Syphilis

Key EMTCT 2025 Targets

Number of pregnant women attending antenatal care services who receive HIV & Syphilis testing	**1,073,811**
% of HIV positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	95%
Number of Syphilis positive pregnant women who receive treatment to reduce the risk of mother-to-child transmission	3,691
% of HIV exposed infants who are initiated on ARV prophylaxis	95%
% of HIV exposed infants receiving a virological test for HIV within 2 months of birth	100%
% of identified HIV positive infants who are initiated on ART by 12 months of age	95%

Activities, Partners, Results

Strategic Direction 1: Reducing New Infections (and) Improving Health Outcomes for all people living with HIV		
Activities	**Results**	**Partners & Funding Source**
1.5 Eliminate mother to child transmission of HIV and Syphilis		
1. Advocate higher level officials for political commitment on EMTCT 2. Implement EMTCT action plan 3. Link with National Health Plan for integration of basic packages into essential health care package under NIMU *Antenatal Care* 4. Enhance AN care coverage in all townships including hard-to-reach area and NGCA in collaboration with MRH and EHOs including migrants, mobile populations, adolescent and women with disabilities. *Testing* 5. Provide HIV and Syphilis testing services to all pregnant women and spouse 6. Improve spouse testing in hospital (creating couple testing corner) 7. Improve spouse testing with community-based screening in coordination with CBOs 8. Ensure HIV prevention among sero-discordant couple 9. Strengthen linkage to care through assisted referral *Treatment* 10. Ensure treatment access for all HIV positive mother and their exposed infants 11. Ensure treatment access for all syphilis positive mother and their exposed infants	<u>Impact Indicators</u> Mother to child transmission (MTCT) HIV case rate of ≤ 50 new pediatric HIV infections per 100,000 livebirths and MTCT of HIV of <5% in breast feeding populations <u>Process Indicators</u> 95% of pregnant women attending antenatal care services at least one ANC visit 95% of pregnant women attending antenatal care services who received HIV testing and test result with post-testing counselling in 2025 {coverage of pregnant women who know their HIV status of ≥ 95%} 95% of HIV (+) pregnant women received ART to reduce the risk of mother to child transmission in 2025 95% of HIV exposed infants initiated on ARV prophylaxis 90% of HIV exposed infants received a virological test for HIV within 2 months of birth	**Lead:** NAP, MRH, CHD, DOMS **Support:** United Nations, Donors, INGOs **Implementing:** MoHS, INGOs, NGOs, CBOs, EHOs and Private Sector **Funding:** MoHS and other donors

Strategic Direction 1: Reducing New Infections (and) Improving Health Outcomes for all people living with HIV		
Activities	Results	Partners & Funding Source
12. Provide psycho-social support and counselling for HIV (+) mothers and spouse 13. Ensure viral load testing to HIV positive pregnant women for mode of delivery and treatment purpose 14. Promote Family centered services approach (ie, same day follow up for positive parents and children) 15. Screening & Treatment for active and latent TB *Reduction in maternal to child transmission* 16. Improve EID coverage 17. Ensure serological follow-up for syphilis exposed infants 18. Improve follow-up of mother-baby pair for HIV and Syphilis *Cross-cutting* 19. Explore the involvement of medico-social personnel for counselling support coupled with the involvement of PLHIV networks for community adherence support 20. Sensitize all health care providers and stakeholders to eliminate stigma and discrimination 21. Ensure gender mainstreaming and human rights in PMTCT services; meaningful engagement, empowerment and negotiation for safe sex practices and HIV testing and counselling with gender sensitive approaches 22. Capacity building of gender mainstreaming and human rights approach for all health care providers and stakeholders aiming for EMTCT services 23. HR and Gender awareness campaign for greater community engagement towards EMTCT	95% HIV exposed infants started cotrimoxazole prophylaxis within 2 months of birth 100% of identified HIV positive infants initiated on ART by 12 months of age (mentioned in M&E) National Validation of elimination of mother-to-child transmission of HIV by 2025 <u>Syphilis</u> <u>Impact Indicators</u> Incidence of congenital syphilis ≤ 50 cases per 100,000 live births <u>Process Indicators</u> 95% of pregnant women attending antenatal care services who received syphilis testing in 2025 95% of syphilis+ pregnant women received treatment to reduce the risk of mother to child transmission in 2025 95% of syphilis-exposed infants received treatment National Validation of elimination of mother-to-child transmission of Syphilis by 2025	

Strategic Direction 1: Reducing New Infections (and) Improving Health Outcomes for all people living with HIV		
Activities	Results	Partners & Funding Source
24. Promote an enabling environment for voluntary services seeking practice 25. Ensure the tracking of mother-baby pair using National unique health identifier (UIC). 26. Enhance involvement of private sector in EMTCT 27. Increase collaboration with Hepatitis program and MRH, CHD, EPI, military and prison 28. Improve health literacy related to SRHR and HIV among community o Develop local language materials to address ethnic minorities *Positive Prevention* 29. Strengthen community empowerment to prevent HIV transmission including awareness raising and education on Public Health law for disclosure of HIV status between couples: ***Chapter XIV of Offences Affecting the Public Health, Safety, Convenience, Decency and Morals*** 30. Increase HIV knowledge using mass media, social media and peer education 31. Provide family planning education and counselling and condom distribution in coordination with MRH *Quality Improvement* 29. Conduct assessment and survey for quality of PMTCT program 30. Validate the progress of PMTCT program towards EMTCT 31. Monitor and evaluate the quality of PMTCT services regularly 32. Strengthen Quality Laboratory Services in collaboration with National Health Laboratory		

5.2 Strategic Direction #2: Improving Health Outcomes for People Living with HIV

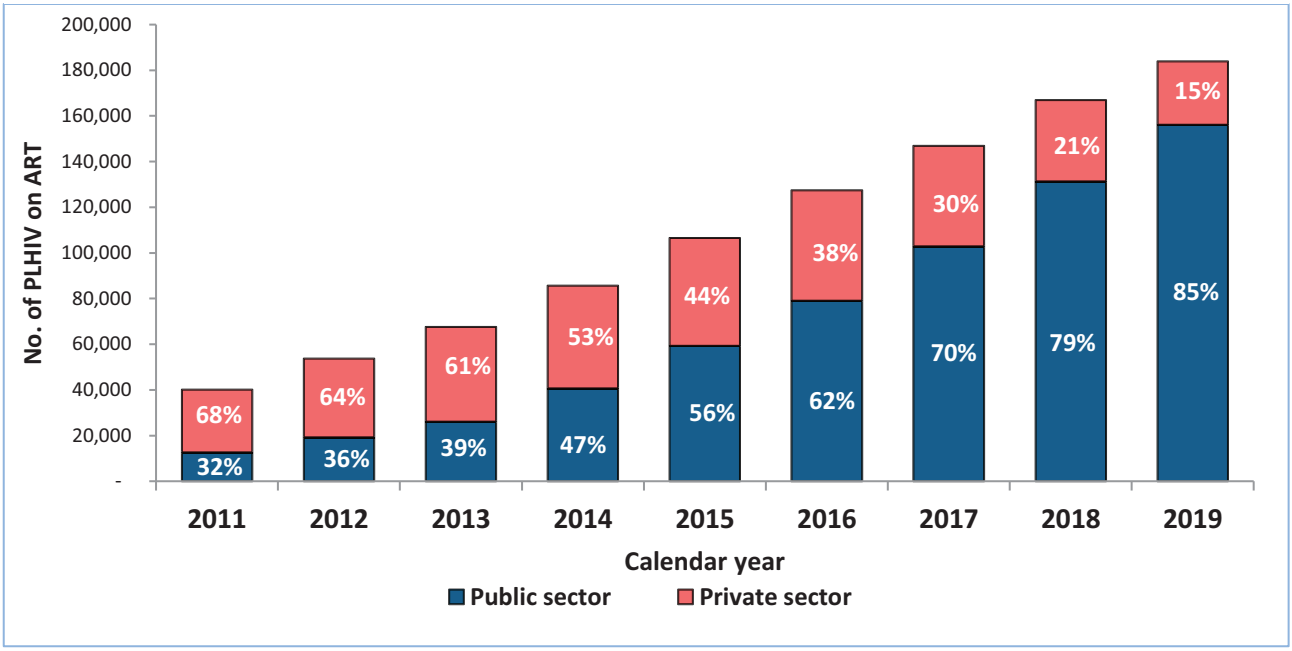
5.2.1 Overview of achievement

Antiretroviral Therapy (ART): Through effective partnerships, Myanmar has achieved a significant increase in the number of people receiving ART under the strong leadership of the National AIDS Program. In recent years, there had been a sharp increase in the number of public sector ART facilities which has led to better access to and availability of lifesaving ART services. In 2019, 184,624 people living with HIV were on ART with coverage reaching 77% of the total estimated number of people living with HIV in Myanmar including 83% of the number of children estimated to be living with HIV. More than 96% of the whole ART cohort are on first-line regimen down from 97% in 2013. As shown in Figure 21, by the end of 2019:

- 86% of people receiving ART were cared for through the public sector; up from 56% in 2015. This clearly indicated the shift in ART provision from the private to the public sector.
- 246 townships had public ART centers and decentralized sites.

This has translated into a reduction of estimated HIV related deaths by 49% since 2010, with AIDS deaths estimated at 6,700 in 2017.

Figure 21:Number of adults and children currently receiving ART by sector: public and not-for-profit private sector (2011–2019)



Source: Program Data, 2019

Reviews highlighted an acceleration of 19,000-20,000 people living with HIV newly registered in care every year. Significant efforts by the NAP, MoHS resulted in a three-fold increase in the number of ART centers and decentralized sites over a five-year period. At the end of 2019, there were 175 ART centers (138 by public sector, among those, 16 centers provided integrated HIV care by the UNION, and 38 by the non-profit private sector), including 128 pediatric ART sites and 194 decentralized sites. This represents a differentiated service delivery model with good examples of Public Sector- and NGO collaboration.

Figure 22:Total number of health facilities that offer ART by public and private sector (2011–2019)

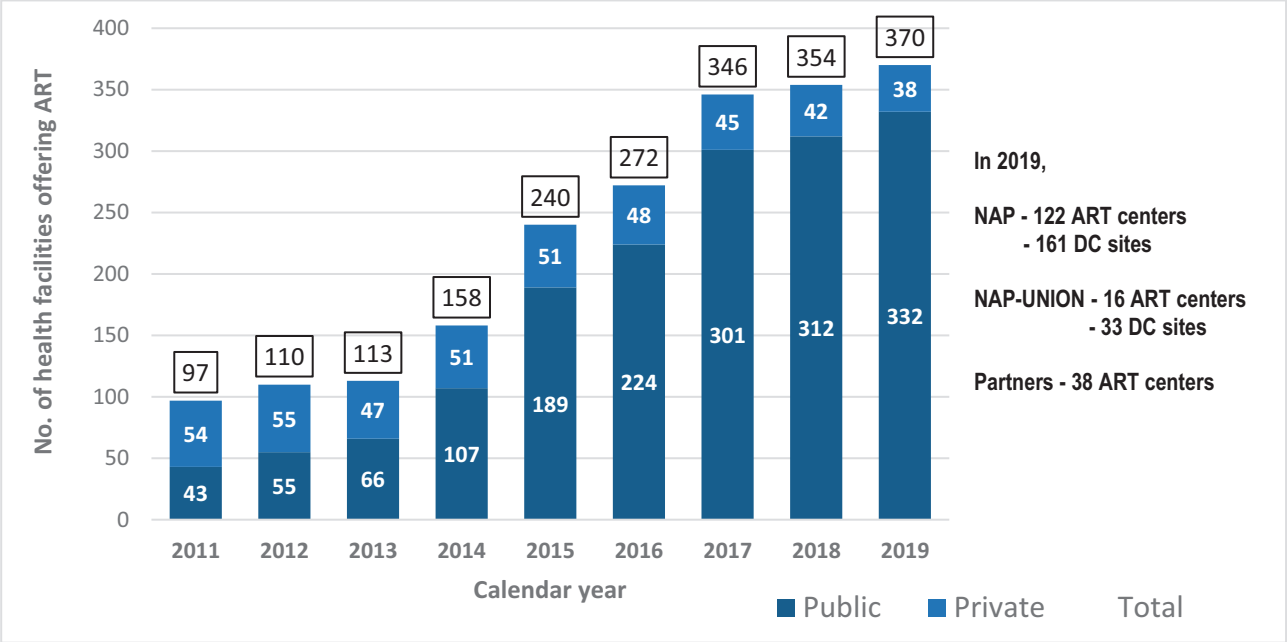
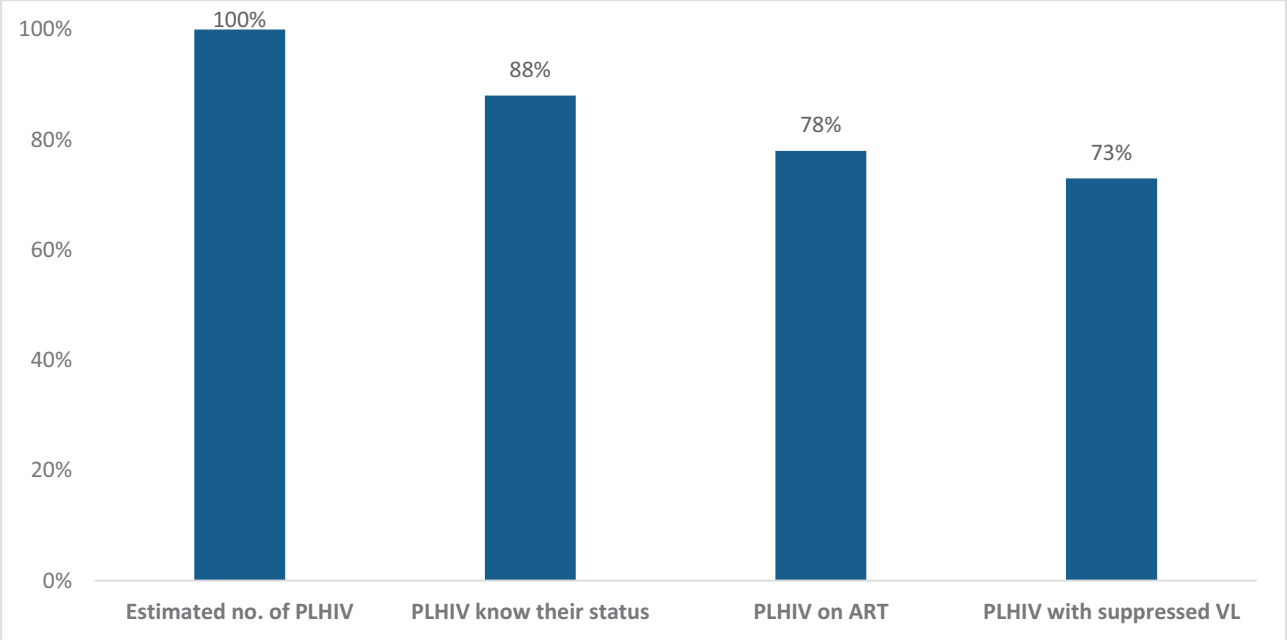


Figure 23:People living with HIV treatment and care cascade, cross-sectional 2018 [66](standard denominator-estimated people living with HIV)



Source: National AIDS Program Data, 2019

[66] Estimated PLHIV – from Spectrum modelling, April 2019
PLHIV know their status – PLHIV on ART end of 2017+PLHIV on cotrimoxazole and not on ART at end of 2017+ newly diagnosed PLHIV from HTS program during 2018 – death on ART during 2018 – one third of lost-to-follow-up on ART during 2018 (assumed death)
PLHIV with viral suppression – assumed that all the PLHIV on ART would have the same viral suppression level as that of PLHIV on ART tested for viral load during 2018 (weighted by people on ART at State/Regional level)

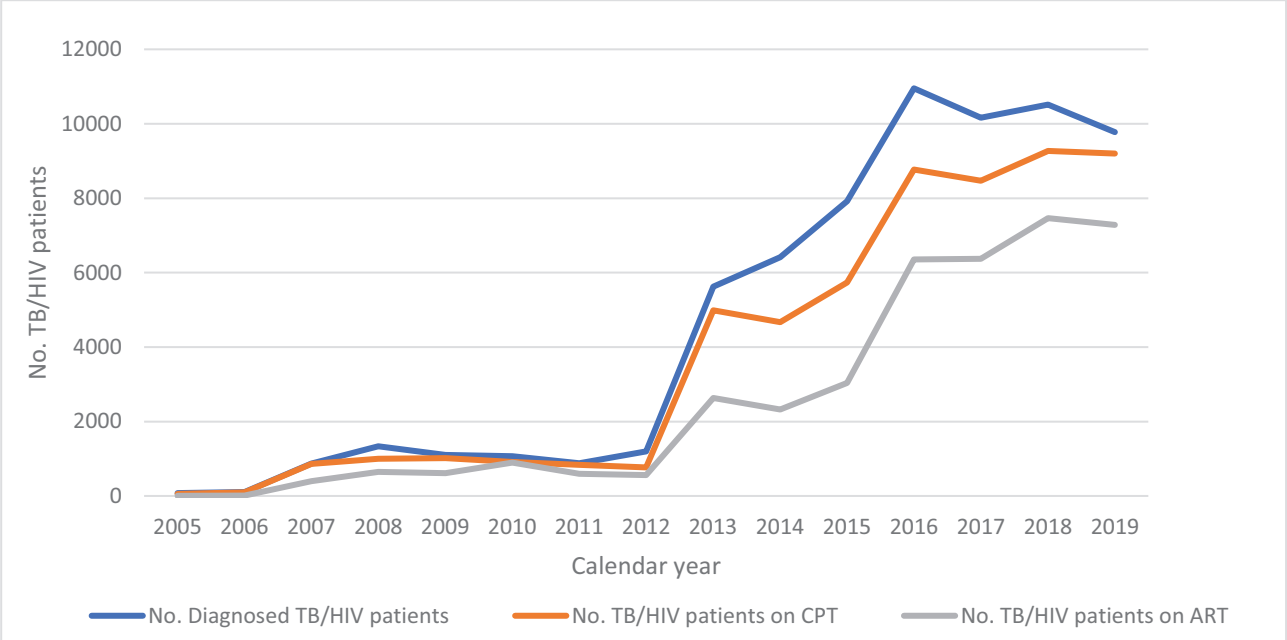
In 2017, ART initiation was accelerated by treating all people living with HIV regardless of CD4, adopting the 2016 WHO guidelines. In 2019, according to national modelling, out of the nationwide estimated number of people living with HIV, 80% knew their status, 78% received ART, and 73% were virally suppressed. A good viral suppression result was seen among >90% of those tested. Newer ARV regimens (e.g., dolutegravir) recommended by WHO guidelines were also adopted and applied in ART treatment Consequently, the Myanmar national HIV response was on track to reach many of the targets set for 2020.

HIV/TB infection and co-infection

Myanmar is one of the 30 highest TB/HIV burden countries in the world, with TB being a leading opportunistic infection for people living with HIV. In response to this, HIV/TB collaborative activities have been expanded to achieve full national coverage. It is vital to keep all established HIV/TB coordinating bodies at several levels functional, i.e., national, state/ region, district, township, and in all hospitals caring for both TB and HIV patients, ensuring consistent delivery of integrated care across partners and facilities.

Since 2015, the coverage of TB patients with known HIV status has increased. The HIV/TB program successfully screened 97% of patients with HIV care for TB and 95% of patients registered for TB treatment were tested for HIV and found 8% HIV positive.[67] 74% (7,281) were treated for both TB and HIV. Achievements for Cotrimoxazole Prophylactic Therapy was around 90%. It is clear that the country has made significant progress in the implementation of HIV/TB collaborative activities since 2012 (see Figure 24).

Figure 24:Progress of HIV/TB collaborative activities (2005 – 2018)



Source: National TB Program Progress Report, 2018

[67] National Progress Report 2018, The National AIDS Program, Ministry of Health and Sports

Among patients newly enrolled in HIV care, 11% were found to have active TB. However, in 2018, only 47% of HIV positive with active TB were assessed as eligible for TB Preventive Therapy and among those, 56% (9,365) were enrolled and treated for TPT (less than half the target) thus requiring additional effort. The number of HIV positive new and relapsed TB patients on ART during TB treatment (ART coverage among TB coinfected patients) was about 74%; also requiring additional effort.

HIV/HCV infection and co-infection

HIV and HCV share transmission routes and, for this reason, HCV prevalence among people who inject drugs from the 2017-2018 IBBS survey was high at 56% overall and ranging from 27% in Myitkyina to 85% in Wai Maw. Co-infection of HIV and HCV ranged from 4% in Mandalay to 55% in Bamaw. Prevalence decreased across all sites from 2014 to 2018 except in Mandalay, Bamaw and Waimaw. HBV prevalence was reportedly lower among people who inject drugs at 7.7% as was HIV/HBV co-infection. Myanmar National Strategic Plan on Viral Hepatitis 2016-2020 was developed with the aim of, in particular, scaling up of HCV and HBV prevention, treatment and care. However, the coordination and linkages between the two programs need to be strengthened. With the National AIDS Program to move towards national coordination of the response to HIV and Hepatitis co-infection and the Global Fund indicating funds may be provided for Viral Hepatitis C treatment, there should be better options for people with co-infection – especially people who inject drugs – under NSP IV.

People in closed settings including prisons

Standard operating procedures for health care were written, approved by the Ministry of Health and Sports and the Ministry of Home Affairs and they are in the process of being implemented. Some revisions have been requested by both Ministries. Much needed clinical space has been constructed at Myitkyina Prison in Kachin State, Lashio Prison in Northern Shan State, Insein Prison in Yangon Region and Mandalay Prison. The National TB Program has carried out Active Case Finding for TB through mobile screening missions to prisons and labor camps since 2014. A Coordinated Workplan on Prison Health has been developed between MoHS and MoHA and there is attention to mental health in prisons, starting with a workshop for prison health and administrative staff conducted in October 2019. A National Strategic Framework on Health Care in Prisons (2019-2023) and its operational plan are also being developed. A Situation Analysis for health care in prisons is still in progress at the end 2019.

NAP tracks the number of prisoners tested for HIV in 46 prisons, 28 remand prisons and 48 camps nationwide. Team Leaders and Assistant Directors from the AIDS/STD Team make periodic visit to prisons to promote health education, STI screening, HIV testing and ARV provision to prisoners and detainees testing positive for HIV are provided with comprehensive care and treatment services. At the end of 2019, 2,753 men and 419 women were accessing ART in prisons, 32% in Kachin, and 16% in Mandalay. In 2019, HIV and STI services were provided in more than 40 prisons. From 2017, under the leadership of respective NAP Teams, two NGO implementing partners strengthened health services in Bhamo, Kale and Monywa Prisons providing health education, HIV testing and counseling, Hepatitis B screening and vaccination, and STI screening and referral.

Continuing international support continues to the following activities: Provision of guidelines to all prison doctors; Capacity building of staff responsible for health care in detention including HIV related trainings; Provision of medicines and medical equipment based on needs/assessment; Skin disease treatment campaign; Infrastructure building and renovation of health facility in places of detention; Technical Assistance to all parties concerned with health care in detention (UN, WHO, I/NGO) and Access to health care outside the prison, including supporting the process, transport and escort to referral hospitals (OPD consultation, admission, investigations).

Procurement and supply chain system

As Myanmar has made significant progress in HIV testing and scale up of ART services, a stronger public health supply chain has played a key role in this progress by increasing reliable access to HIV commodities. National forecasting has been practiced for HIV commodities and standardized item codes are used across three National Programs (HIV, TB and Malaria). The government financial contribution for procurement of ARV has increased to over 40%.[68] A strong partnership has been established between NAP, MoHS and two PRs of GF for the procurement of ARV and related commodities.

Electronic based asset management has been developed and initiated for inventory management of health and non-health equipment. A supply planning tool including an early warning system has been introduced for monitoring ARV and viral load commodities stock; and an electronic based inventory management system (M-supply) has been set up at the central warehouse, sub -depots and transit camps in the public sector. A warehouse capacity assessment was carried out for the central warehouse as well as sub -depot/transit camps, and expansion of the warehouse according to the assessment is in process. Security measures and insurance are in place for all these warehouses.

Strengthening laboratory capacity

A strong national public health laboratory system is fundamental to health security and safety. NAP, MoHS together with the National Health Laboratory have put significant attention and effort on strengthening laboratory capacity. Currently, ISO accreditation for the HIV laboratory is in process for the National Health Laboratory. The quality of community-based HIV screening is ensured through systematic training and monitoring. Routine viral load testing was scaled up and CD4 is used only to address cases of advanced HIV and OI management. A sample drainage plan was networked for both high throughput and point of care viral load platforms for viral load and early infant diagnosis testing. Electronic database (Lab Accex) has been installed in all platforms for both the public sector and NGOs.

5.2.2 Challenges

Anti-Retroviral Treatment: As mentioned under HIV Situation Analysis, despite significant national achievements in ART coverage, key population access to ART needs to be significantly higher. The weak linkage and limited case management and tracking mechanism among prevention partners appear to be between detection to early enrolment in HIV care for Key Populations, especially PWID. The Program Review highlighted the significant burden on the public health system, without the required analysis, planning and strengthening in the provision of human resources to address quality service delivery. ART management and retention is impacted by migration and mobility especially due to security concerns, and border towns. Currently, care and treatment data reporting from private-for-profit ART providers to the NAP needs to be strengthened.

HIV/TB infection and co-infection: There is a need to continue to increase the number of TB/HIV co-infected patients, who receive both treatments. Even though access to integrated HIV/TB services is improving, access to ART remains sub optimal. Progress to reach set target (85%) for TB/HIV patients on ART by 2020 has been a challenge for both programs. Although NAP allows ART initiation for HIV/TB patients at township level, the

[68] National AIDS Spending Assessment 2016-2017, NAP, MOHS, UNAIDS

township team is reluctant to provide ART and these barriers at township level need to be addressed. Loss to follow up and mortality rates were very high in some areas, especially in the high burden northern states and regions with multiple challenges including drug use and security concerns and non-government-controlled areas.

There has been a significant gap in diagnosing TB and initiating treatment of latent TB infection across the country. Causes for low TPT coverage among newly enrolled HIV patients should continue to be explored and improved systematically. Strategies to tackle not only provider perspectives but also client's perspective should be considered.

HIV/HCV infection and co-infection: Viral hepatitis, in particular HCV and HBV, is also a growing cause of morbidity and mortality among people living with HIV. People with co-infection of HIV/HCV are at three times greater risk of progression to cirrhosis or liver cancer and have a 10-fold greater risk of liver-related mortality than mono-infected patients[69]. Globally, hepatitis related diseases have become the leading non-AIDS cause of morbidity and mortality among HIV infected individuals. Prevention and control of hepatitis can, therefore, make a significant contribution to saving lives by preventing cancer, thereby reducing the burden of non-communicable diseases.

In Myanmar, efforts in prevention and treatment of HCV and HBV are limited and need to be expanded among key populations. To address HIV co-infection with TB and viral hepatitis, there is a need to improve mapping, regular survey data and enhanced collaboration and information/ referral systems between programs. The overlapping burden of co-infection by geography, age and gender is limited currently. There is no reporting system of HIV/ Viral Hepatitis co-infection.

Health in prisons and other closed settings

Myanmar is unlikely to meet the objectives of National Strategic Plans for HIV and TB unless the incarcerated population declines. Comprehensive sentencing reform and alternatives to incarceration for substance use are urgently needed. Drug resistance will increasingly complicate the successful treatment of both HIV and TB including multidrug resistant TB and transmission of primary HIV resistance. Incarcerated people have insufficient treatment for substance use disorders. Funding remains significantly insufficient to support the implementation of SOPs and the establishment of recommended health services in prisons and closed settings, and treatment continuity and linkages between prisons, closed settings and source and destination communities for incarcerated people.

The Situation Analysis currently being conducted on health care in prisons and closed settings should provide important updates on the availability and progress towards implementing the following important services and standard procedures:

- The development of standardized confidential prisoner medical records. Standardization of health records to facilitate the provision of HIV and TB care consistent with established national guidelines.
- Standardized data collection and review of all in-custody deaths to provide the prison system with an accurate record of patient outcomes, especially with respect to HIV and TB.
- Standardized equipment and supplies for each prison.

[69] Myanmar National strategic plan on viral hepatitis 2016-2020

- Standardization of a national prison medication formulary and supply system. Effective treatment of HIV and TB requires an uninterrupted supply of medications consistent with national and international treatment guidelines. This is especially required in this time of increasing HIV and TB resistance.
- Increases in staffing of nurses and clinicians sufficient to meet the clinical needs of people in prisons and other closed settings.
- Intake clinical screening to ensure that all incoming prisoners are being screened for latent TB, active TB, and/or HIV.
- That all prisons have timely access to laboratory and radiography/imaging services that are necessary for the diagnosis and treatment of HIV and TB.
- The provision of adequate housing for prisoners with suspected or confirmed TB.
- The provision of systematic and comprehensive referral after release to ensure continuity of care, transfers, discharges and linkages to the community.

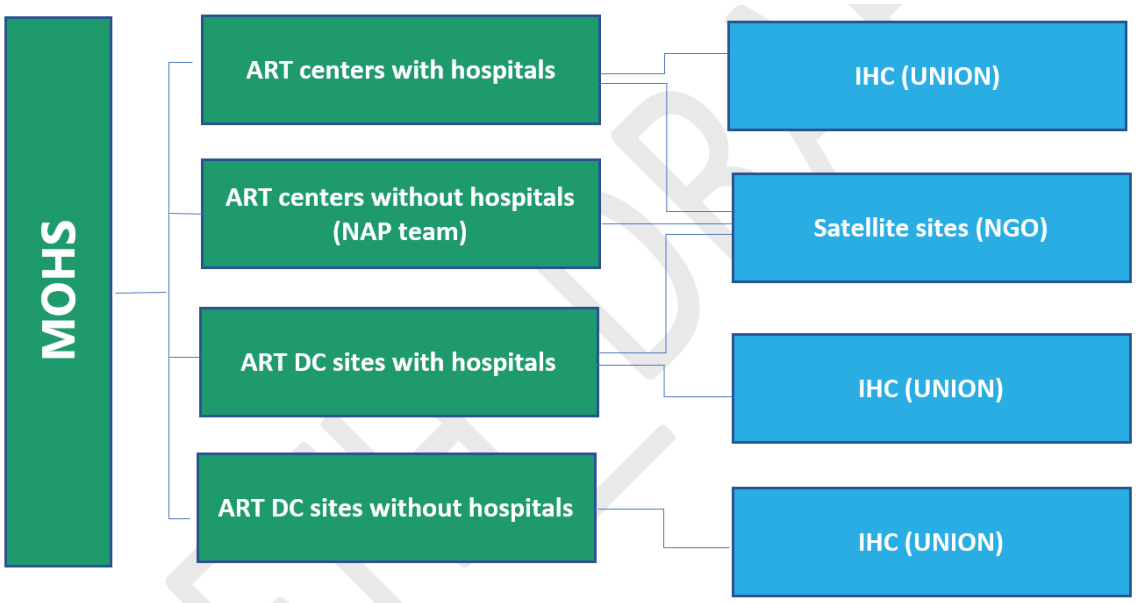
Procurement and supply chain system: A wide range of pharmaceutical products are needed for diagnosis, treatment, and prevention of HIV. In Myanmar, the supply chain system within vertical programs is very complex with parallel systems that are inflexible. Infrastructure is one of the hindering factors for a better supply chain system. Although electronic inventory management system is introduced at different levels, stock and inventory management are still mixed of both electronic and paper based, which are sometime time consuming. There are no standard operating procedures for management of expired and damaged HIV commodities, as well as other health commodities.

Laboratory capacity: The recent MoHS Reviews highlighted a number of weakness and issues needing attention including the following: that shortages of skilled laboratory human resources are widespread; that specimen transportation and varying turnaround time was a challenge; sub -optimal utilization of the existing platform for viral load testing; that the algorithm for early infant diagnosis needs to be revised, and that due to insufficient resources, testing for syphilis, other STIs, TB and hepatitis is limited. There is a NEQAS for HIV diagnosis in place, however, a proper scale up is needed to the participating sites. Multiple visits to testing and treatment centers are required since laboratory tests can be conducted only on particular days of the week causing loss to follow up.

5.2.3 Service delivery approach and What is new for NSP IV

Service Delivery Approach

- Expand ART services to all townships and selected sub -township level as indicated by burden of disease, while ensuring quality of care for patient safety
- Optimize ART provision at public sector and continue ART transition from private to public sector
- Key population friendly service in collaboration with NGOs and community
- Meaningful engagement and participation of the community in HIV care and support through networking in all townships (pre and post-test counseling, pre-ART, disclosure, adherence; partner notification, defaulter tracing, positive prevention, assisted referral linkage, case management, peer group meeting, viral load scale up: facilitating in scheduling of routine viral load testing of patients and sample transportation, data recording). The services may be tailored based on the burden of HIV new infection and risk and the needs of the priority populations.



What is new for NSP IV?

Care and treatment

- Facilitate ART initiation at selected sub -township DC sites (where there is limited HR or capacity) by respective district/regional NAP team's mentoring visit in high burden areas while maintaining quality of services
- HIV care service quality monitoring
- Reorganize counselling team to improve counselling capacity
- Social contracting to community for HR support in HIV care
- Pharmacovigilance system for new ARV
- Cascade analysis of key population across the continuum
- Linkage for integration of services - Hepatitis, NCD, SRHR and STI
- Partner notification and index testing as part of positive prevention
- Normalization of HIV as part of general medicine and optimize the ART cohort in public facilities
- Tele-mentoring for capacity building of ART service providers. Ensure continuum of HIV care and treatment services at entry, during and release from closed settings

PSM

- Integration: procurement, storage, distribution
- Expansion of electronic based LMIS up to service provision level
- Waste management for expired and damaged HIV commodities
- Institutionalization and sustainability of PSM including training courses

Laboratory

- Decentralization and capacity building of state and regional laboratory capacity to execute laboratory quality assurance (QA) and quality improvement (QI) functions in their catchment areas.Tester and site certification system for HIV diagnosis
- Expansion of NEQAS for all HTS confirmatory and VL testing facilities
- Improving STI diagnosis capacity in all townships
- Full coverage of Viral load testing and Early Infant Diagnosis through optimizing integrated high throughput and POC network including VL sample transport system
- Use of Dried Blood Spot (DBS) samples for viral load testing in remote areas
- Service availability for testing of HIV drug resistance
- Integration of laboratory services for different diseases/program whenever possible
- Introduction of self-testing and recency test in HIV surveillance

5.2.4 Priority Interventions

Maximize linkage and improve access to care, immediate enrolment and early ART initiation

Access to ART has increased dramatically in Myanmar since 2011. However, ART coverage remains low among some of the highest disease burden population such as people who inject drugs, which may be partially explained by poor testing to care linkages which may impact upon early attrition in the HIV treatment cascade. Targeted HIV testing, immediate enrolment, and early treatment initiation need to be ensured through the provision of services tailored to key and priority populations.

Myanmar has already adopted WHO guidelines to treat all regardless of CD4 count since 2017 Barriers which are causing delays between HIV testing and ART initiation, such as an unnecessary series of counseling sessions, will be removed. NAP strongly commits to provide ART services in all 330 townships of Myanmar, as part of the essential package of health services over the five years of NSP IV, including HIV service delivery at sub -township level in high burden priority townships. Innovative public, private and community partnerships should enhance priority populations' access to services including through public sector outreach in community settings, and through more formalized community roles in public sector health services. Peer network and self-help groups will be used as a channel to strengthen linkage between prevention and care. A clear and functional referral system, including assisted referral, and formalization of the peer role, will be established to reduce pre-enrolment defaulters at ART service centers.

In high priority townships, services will be integrated and linked in many ways trying to mirror the one-stop shop model which includes enhanced outreach, largely community and peer-led, with the intended outcome of reducing barriers to linkage to care and treatment. The intended outcome is either sustainable and qualified service integration or an integrated case management approach or both; of HIV together with TB, OST and STI and a good linkage with hepatitis treatment. Recognizing the needs of young people, services

will be strengthened in a user-friendly approach, to ensure counseling for adolescents and good ART adherence.

Improve the quality of care, maximizing retention and viral suppression

The proposed service model will be patient-centered which should minimize travel distance and time, reduce waiting time, dispensing ARV medications for longer duration, less frequent visits, and promoting adherence support through peer and support groups. With significant numbers of people on ART, there will be a need for a stronger multisectoral partnership between public, NGO and private sectors. Task shifting and decentralization of services will be ensured in this national plan. Continuation of ART transition from private (NGO) to the public sector will be taking place; however, key and priority population services will require a partnership approach between MoHS, NGOs, the private sector and the community. Community-led care and support will be implemented which includes outreach adherence counseling, psychosocial support, nutrition support, caretaker services for hospitalized and sick patients and funeral services.

HIV viral load testing is the recommended approach to monitor the treatment response to ART, in the latest WHO HIV treatment guidelines. Viral load is a marker of response to ART. The key goal of ART is to achieve and maintain durable viral suppression. Thus, the most important use of the viral load is to monitor the effectiveness of therapy after initiation of ART. Since NSP III, scaling up viral load testing capacity has been one of the priority interventions, and it will still apply for the next five years under NSP IV, as part of routine monitoring of ART patients.

With the growing scientific evidence of HIV viral load and transmissibility of HIV infection (Undetectable equals Untransmittable), it is significant that individuals with HIV who receive ART and have achieved and maintained an undetectable viral load cannot sexually transmit the virus to others. Hence, scaling up of viral load testing capacity to ensure HIV treatment monitoring is crucial.

Integration of health services for co-infection and co-morbidity (TB, Hepatitis, STI, NCD, mental health, SRHR and prison health)

Among people living with HIV, morbidity and mortality is increasingly driven by co-infection with other diseases, including hepatitis C and tuberculosis, and co-morbidity with non-communicable diseases. Successfully addressing the challenge of co-infection requires tackling the complexities of multiple epidemics, including reaching vulnerable populations and expanding access to new diagnostics and curative medicines. NSP IV focuses on a number of areas, taking advantage of overlapping populations and service delivery needs of HIV and related co-infection and co-morbidities.

It is essential that the National Strategic Plan for HIV 2021-2025 contributes to the broader health policy environment, encouraging integration of HIV with co-infections and co-morbidities, and strengthening health and community systems. The response to HIV, especially in resource-limited settings, has provided many lessons that can provide valuable information for the scale up of care in other disease areas, in particular HIV co-infection and co-morbidities. A less vertical approach that focuses more on populations than on individual diseases is needed and should be developed. This includes a need for the key concepts from the HIV differentiated service delivery movement to be applied to HIV co-infections and co-morbidities to improve the cascade of care, maximize efficiencies and reduce the burden on health systems. Above all, case management to ensure quick enrolment into all treatments without unnecessary and costly delay.

HIV/TB co-infection: To deliver the standard package of collaborative HIV/TB activities in all 330 townships is crucial in responding to HIV/TB co-infection in Myanmar, and the interventions will be enhanced to achieve desirable impact of TB/HIV collaborative activities nationwide and at all levels of the health system. Essential TB/HIV services to be implemented nationwide and at all levels of the health system include a) TB symptom screening during the initial and follow up visits, b) initiate treatment of latent TB infection, c) provide HIV testing, counseling, and prevention services to patients with presumptive and diagnosed TB, d) initiate early ART for all TB patients with HIV infection, e) provide cotrimoxazole preventive therapy for TB patients living with HIV, and f) practice standard infection control in all TB and HIV clinics.

HIV/HCV co-infection and infection: Despite recent breakthroughs and dramatically improved curative options, the response to the national HCV epidemic continues to be limited, and treatment remains out of reach for the vast majority of those affected. The intersection of HCV with HIV presents an opportunity to accelerate the national HCV response and to bring increased attention to those disproportionately affected by both diseases, in particular people who inject drugs. An effective referral linkage mechanism for HCV co-infected patients to the Hepatitis C treatment center needs be developed and there is a need for stronger collaboration between NAP and the National Hepatitis Control Program reach to the most vulnerable, affected population who need both treatments. Parallel with this is the need to conduct an operational feasibility into treatment options that can be used to support expansion of low-cost treatment sites in geographic proximity to major concentrations of coinfected people – especially the high burden states/regions and townships.

HIV/NCDs comorbidity: As HIV becomes a chronic illness, the growing population of people living and aging with HIV will be confronted with an increasing burden of non-communicable diseases. NAP is an important body of expertise and practical knowledge to address these issues, given their strength in a country where the health system is often weak. Addressing HIV/NCDs comorbidity will also protect today's investments in young people living with HIV. Whenever possible, opportunity should be sought for integration and strengthening of the linkage between HIV and NCD programs.

HIV and SRHR: HIV is the most serious sexually transmitted infection; therefore, a lack of access to basic sexual and reproductive health and rights increases a person's risk of contracting HIV. Sexual and Reproductive Health and Rights/HIV linkages offer important synergies in policy, program, and service delivery that support comprehensive sexual and reproductive health needs and rights of all people, including people living with HIV, within a framework of gender equality and human rights. Improving the quality of HIV and SRHR services should be targeted through:

- Safer sex education to prevent sexually transmitted infections, HIV and unwanted pregnancies.
- Family planning and HIV services, including fertility protection for those living with HIV.
- Prevention, diagnosis and treatment of sexual and reproductive health-related cancers.

HIV and Mental Health: People living with HIV and children whose families are infected with the virus may suffer mental health problems arising directly or indirectly from living with the virus. People living with HIV have to deal with the stigma attached in some communities to being HIV positive. Mental illness can arise as a direct consequence of HIV infection. Mental health problems are a critical aspect of the HIV epidemic for both infected and affected people. As mental health problems often hinder effective adherence to antiretroviral treatment, it is necessary to include mental health care as part of HIV treatment. Program attention is also needed to deal with mental health in vulnerable and orphaned children. While work with children who have developed mental health problems is vital, the most important thing is preventing children

from developing mental health problems. Families should be supported to take in and care for orphans, whilst orphans themselves need help to adjust to new and sometimes difficult situations.

Enhance positive prevention

To date, most HIV prevention campaigns, and strategies have focused their attention on people who are not living with HIV and very little attention has been placed on promoting prevention strategies to support people who are already living with HIV. An essential element of this approach is to ensure that people living with HIV live longer and healthier lives. This, in turn, will contribute to the well-being of their partners, families and communities. It encompasses a set of core elements that help people living with HIV to:

- Protect their sexual and reproductive health and avoid other STIs
- Delay HIV disease progression
- Promote shared responsibility to protect their sexual health and reduce the risk of HIV transmission.

Positive prevention is an effective and practical way to promote linkages between HIV and sexual and reproductive health issues. Most interventions focus on preventing onward transmission. There are very few documented examples of interventions that tried to move beyond reducing individual risk by offering a holistic approach to prevention, framed on a rights-based approach.

Strengthen and Integrate HIV related PSM into one National Procurement and Supply Management (PSM) System

One integrated system of supply and procurement plans, transport and distribution, and storage will be sought in NSP IV. The momentum of national quantification for HIV commodities (including ARV, OI medications, and others) by using a standard quantification tool across different funding sources and partners will be maintained. There will be a focus on closer collaboration and alignment of the current parallel HIV PSM system, and opportunities will be sought for efficiencies. Expansion of eLMIS up to the service provision level for data visibility and stock management support will be an important part of strengthening the HIV supply chain system. Proper waste management for the expired and damaged HIV commodities will be addressed.

Strengthen laboratory services in HIV and STI management

To provide timely and reliable diagnostic and support services for the national HIV response, strengthening of the laboratory system and capacity is essential. This will include expansion of diagnostic and monitoring of treatment services, laboratory network optimization, decentralization and capacity building and quality control and quality improvement. Increasing service coverage for HIV and STI – which will provide HTS confirmation, viral load testing, early infant diagnosis, and diagnosis of STI, will be prioritized. A sustainable human resource plan for the laboratory system and an integrated approach will be initiated. There will also be attention to strengthening the quality management system for HIV laboratory services such as streamlining HIV testing algorithm and accreditation of the reference laboratory.

Key CARE AND TREATMENT 2025 Targets

Number of adults living with HIV who are receiving ART at the end of the reporting period	**218,184**
Number of children living with HIV who are receiving ART at the end of the reporting period	7,101
% of people living with HIV who are receiving ART	90%
% of newly identified and enrolled HIV positive people receiving treatment during the reporting period	95%
% of people with HIV and on ART who are retained on ART 12 month after initiation	95%
% of PLHIV on ART who are virologically suppressed	95%
Number and % of HIV positive new and relapsed TB patients on ART during TB treatment	14,250 95%
% of people newly enrolled in HIV care who are started on TB preventive therapy during the reporting period (IPT)	63%
% of FSW, MSM/TG and PWID who avoid health care because of stigma and discrimination in the last 12 months	10% (2023)

5.2.5 Activities, partners, and results

2.1	Maximize linkage and improve access to care; immediate enrolment and ART initiation		
	Activities	**Results**	**Partners & Funding Source**
	1. Minimize the time interval between HIV testing and ART initiation • Optimize the HIV result turn-around time and verification processes for rapid ART initiation • Expand EID testing using point of care platform at district level and strengthen linkage with private clinics for follow up of exposed babies • Enhance rapid ART initiation with continued adherence counselling (fast track pre-ART counselling approach) to reduce drop out after enrolment 2. Enhance accessibility to ART initiation to reduce drop out after diagnosis • Promote Key population service center approach to provide one stop comprehensive services for key population • Co-location of ART initiation and maintenance services in all MMT sites • Upgrade ART decentralized sites to ART center depending on capacity and experience to manage ART initiation. • **Facilitate assisted ART initiation at selected sub -township DC sites (where there is limited HR or capacity) by a trained and qualified medical doctor or NAP team leader from respective township/ district/ regional level and subsequent mentoring visits in high burden areas while maintaining quality of services.** • Empower role of Tele-medicine for ART initiation to reduce burden of patients from travelling one site to another. Explore and practice patient friendly ART clinic operation tailoring local context (E.g. Number	• Linkage to ART enrolment established in all townships • Increased integration of HTS and ART in MMT services • Differentiated model is implemented to improve ART enrolment and retention for each key and priority population (PWID, FSW, MSM, migrants, prisoners) • 90% of newly diagnosed PLHIV receiving ART • 100% of identified HIV positive infants initiated on ART by 12	**Lead:** NAP and DoMS including hospitals, NHL and DDTRU **Support:** UN agencies and development partners **Implementing:** INGOs, LNGOs, CBOs **Funding:** Domestic funding and Global Fund

	of ART clinic day based on the caseload and, flexible clinic operating times) 3. Establish clear and functional referral system with feedback mechanism to reduce pre-enrolment defaulters • Strengthen assisted referral from HIV screening to ART initiation involving community with documentation (receipt voucher should be returned immediately to assisted peer) • Formalize role of peers in PMTCT services for linkage of maternal lifelong ART and follow up on diagnosis of exposed babies • Analyze and evaluate the patient tracking outcome of case management for further improvement	months of age	
2.2	**Improve the quality of care maximizing retention and viral suppression**		
	1. Update national guidelines and SOPs based on most recent WHO guidance including: • Enhance test and start treatment regardless of CD4 count for all people living with HIV • Adopting most efficient and effective ARV regimen (eg. Recommend DTG as preferred regimen) • Management of advanced HIV disease, management of co-infection (TB, Hepatitis B and C, STI) and co-morbidity, management of long-term complications of ARV (Anti lipid, Anti Angina, dialysis replacement therapy) • Access to laboratory services for early detection of common OI and scale up of routine viral load monitoring • Task shifting and differentiated care including 6 months prescription 2. Disseminate the guidelines and SOPs and ensure all service providers are accessible to latest update information including use of innovative ways (e.g. Mobile app) and hard copies 3. Strengthen the implementation of the National Transition Plan ensuring the quality of care • Advocate and build capacity in hospitals and township health department under public sector for transition through innovative approach such as tele-mentoring, job aids to monitor the major complications	• Decrease rate of AIDS-related deaths per 100 000 population • 90% of adults and children retained on ART 12 months after initiation of ART • 100% of people living with HIV on ART received a viral load test in the last 12 months • 95% of people living with HIV on ART achieving viral suppression • 95% of PLHIV on ART	**Lead:** NAP and DoMS **Support:** UN agencies and development partners **Implementing:** INGOs, LNGOs, CBO, community networks, private hospitals and clinics **Funding:** Domestic funding and Global Fund

	• Analyze case load against absorption capacity of ART sites including human resources and logistics management and prepare according to needs including expansion of ART services 4. Expand decentralization ART services to the township level, sub -township level and station health units and rural health center, as indicated by burden of disease, while ensuring quality of care for patient safety 5. Establish a system for service quality monitoring including both clinical management and operation of ART services 6. Normalize the HIV as part of general medicine through advocacy and integration into HIV in curriculum of undergraduate and pre-service trainings; Sensitize health professionals to reduce HIV related stigma as part of curriculum of preventive and social medicine; and optimize patient cohort in all public facilities 7. Maximize retention and viral suppression through community mobilization and effective clinical management • Educate people living with HIV on Undetectable = Untransmittable concept to maintain adherence to ART and role of routine viral load monitoring • Ensure proper management of treatment failure/high viral load management at different level of ART service provision 8. Reorganize the counselling team and build counselling capacity of both public sector and peers for testing, partner notification, adherence and psychological support 9. Implement intervention for adolescent PLHIV care: Counselling on disclosure and SRHR and psychological support for transition from pediatric to adult care 10. Integrate nutrition component into comprehensive HIV care (e.g. high protein group, metabolic control diet, bone health, salt losing diet, diet to control weight gain) and explore/mobilize the resources to support HIV advanced diseases 11. Outsource the human resources in a more sustainable way through social contracting to community (eg. Formalize the involvement of PLHIV networks for counselling, case management along the continuum, data management, emergency response)	achieve viral suppression at 12 months after treatment initiation	

	12. Establish a system to collaborate with private sector (private hospitals) for capacity building on HIV care, quality assurance and information sharing 13. Establish pharmacovigilance system for new drugs 14. Evaluate the quality of life among PLHIV and cascade analysis of key populations across the continuum 15. Streamline HIV patient record system with other co-infections and co-morbidities to be able to capture the whole case and expand the standardized electronic based patient record system to all ART facilities		
2.3	**Integration of health services for co-infection and co-morbidity (TB, Hepatitis, STI, NCD, mental health, SRHR and prison health)**		
	1. Develop TB-HIV action plan based on the national guidelines and SOPs of TB and HIV • Enhance routine HIV screening for all TB patients including presumptive TB in HIV endemic areas • Ensure integration for intensified TB case finding (presumptive and diagnosed case) in HIV care • Strengthen system to ensure that TB–HIV coinfected patients are initiated ART promptly • ART initiation at TB clinics for HIV diagnosed TB patients and continue treatment at ART sites as pilot in selected sites • Assisted referral of co-infected cased where services are not co-located • Provide guidance and train for diagnosis and treatment of extrapulmonary TB in HIV patients • Develop a strategy for the efficient use of GeneXpert devices for the diagnosis of HIV, TB and viral hepatitis • Identify bottle necks and strategy to scale up LTBI treatment including adoption and piloting of new recommendation on shorter regimen • Integrate services of TB–HIV diagnosis and treatment for all priority populations including prisoners, miners and migrants • Strengthen knowledge and practice of the infection control in the HIV clinic by appointing focal for infection control and ensuring the administrative measure of	• Increased number of facilities providing ART services for people living with HIV with demonstrable infection control practices including TB control • 90% of TB patients who had an HIV test result recorded in the TB register • 90% of HIV positive patients who are screened for TB in HIV care and treatment settings	**Lead:** NAP, NTP, NHCP, National Non-Communicable Disease Program (NN-CDP), MRH **Support:** agencies and development partners **Implementing:** Public HIV care facilities, community networks, private hospitals and clinics, Ministry of Home Affairs, Ministry of Defense **Funding:** Domestic funding, Global Fund, Access

	infection control including UV lamp, air flow and clinic structure and operation 2. Interlink between HIV program and NCD program to screen and manage non-communicable diseases (NCD) among PLHIV as well as NCD clinic as an entry point for HIV screening • Include HIV screening in service packages of mobile community clinic together with NCD risk assessment: BMI, blood pressure, mental health, cervical cancer, breast cancer, RBS, oral cancer health, smoking including narcotic drugs, screening for COPD • Screen and manage NCD including mental health as co-morbidities of HIV patients at ART facilities at different level including NGOs and prisons ensuring availability of diagnosis and treatment of NCD • Promote healthy lifestyle among PLHIV to prevent NCD including physical activity, smoking and smokeless tobacco, alcohol and substance abuse 3. Collaborate with National Hepatitis Control Program for ensuring accessibility of Hepatitis B and Hepatitis C services • Develop joint workplans between NAP and NHCP • Screen Hepatitis B and C periodically among key population • Provide Hepatitis B vaccination for key population and PLHIV • Establish referral linkage mechanism for hep C co-infected HIV patients to Hepatitis C treatment centers in all states and regions and promote co-location of services in high prevalence areas • Mobilize resources and clinical capacity-building for HCV/HIV coinfection. 4. Screen all HIV positive patients for STI and provide treatment accordingly including anaphylactic shock management for syphilis treatment 5. Ensure accessibility to SRHR services by women living with HIV and provide Post-exposure prophylaxis (PEP) for gender-based violence cases	• 90% of HIV positive new and relapse TB patients received ART during TB treatment • 50% of persons with newly diagnosed HIV infection starting LTBI treatment • 90% of Hepatitis C coinfected HIV patients received Hep C treatment • 100% of newly diagnosed HIV patients screened for STI and received treatment • Increased number of ART facilities with integrated service for NCD screening and management • 100% of PLHIV in prisons, including who are under trial, accessed HIV services and linkage after release	

	6. Ensure HIV diagnosis and treatment services are accessible in all prisons • Expand HIV screening and ART treatment for all detainees including who are under trial • Establish post-release network through CBS and prepare the post-release package for both treatment and PMTCT services through proper and effective counselling to patients to seek the care as their own responsibility • Advocate with the police department for continuing of HIV care services including ART during incarceration period 7. Establish coordination and linkage with Ministry of Defense for providing HIV services 8. Information linkage between different programs by using unique identifier		
2.4	**Enhance positive prevention**		
	1. Enhance partner notification and index partner testing through proper disclosure counselling 2. Promote U=U among community for adherence as well as for reducing stigma and discrimination, including positive living 3. Ensure access to PMTCT services for exposed babies of women living with HIV 4. Provide access to HIV prevention commodities (condoms, lubricant, needles/syringes) by PLHIV	• All PLHIV are literate with U=U concept through community networks and self-help groups • Prevention of mother to child transmission is progressed towards elimination.	**Lead:** NAP and PLHIV community **Support:** UN agencies and development partners **Implementing:** community networks, CBOs, NGOs **Funding:** Domestic funding and global fund

<table>
<tr><td colspan="3">2.5 Strengthen and Integrate HIV related PSM into one National Procurement and Supply Management (PSM)</td></tr>
<tr><td>Activities</td><td>Results</td><td>Partners & Funding Source</td></tr>
<tr><td>1. Integrated Procurement and supply plans
Standardization of specifications and product codes of HIV commodities, and harmonization across ATM commodity list
Product selection and standardization of HIV service packages (basic and comprehensive packages)
Integration of basic HIV products into EPHS of UHC
Maintaining and improving demand base supply system with annual forecasting, Stock monitoring and Early Warning System
Establish the responsive supply system to the optimized ART regimens, Multiple month scripting (MMS) and newly emerging ART medicines
Implement national procurement and supply chain management of HIV commodities by integrating all implementing partners
Integrate into other health commodity procurement of MoHS (when MoHS procurement system is strong enough and ready for integrated procurement)
Designing, testing & roll out of integrated Procurement information management system
Coordinate with private & development sectors to ensure the in-country availability of quality assured, safe, effective & medicines and health technologies
2. Integrated storage with other health program products at central, regional and township level
Upgrade infrastructure of ATM warehouse in line with SOP, to facilitate integration and improve good storage practices at central and peripheral level up to the township level
Integration of HIV commodity storage into ATM warehouse at central, regional and township level and link with the national storage system
3. Integrated transport and distribution</td><td>• HIV commodity consumption data available up to the township level
• Minimal stock out of HIV commodities at township level
• Harmonize item specifications and item codes across ATM
• National Procurement of HIV commodities</td><td>Lead:
NAP and DoPH-PSM
Support:
UN agencies. Donors and INGOs
Implementing:
Global Fund principle recipients, INGOs, NTP, NMCP
Funding:
Domestic funding, global fund, PEPFAR</td></tr>
</table>

• Develop quality standards for transportation and distribution • Promote integration and outsourcing of transportation to third parties • Transport and distribution of HIV commodities integrated into ATM distribution system from central to the sub-depots, and readiness for integration into national transportation and distribution system • Reverse logistic system developed for transport of expired and damaged HIV commodities 4. **Expansion of eLMIS up to service provision level for data visibility and stock management support** • Capture of LMIS data for HIV commodities (including HIV lab data) up to township level into national eLMIS • Integration of ATM eLMIS monitoring system • Improve infrastructure for eLMIS up to township level to operationalize an integrated eLMIS of MoHS • Electronic requisition of HIV commodities from service delivery points to regional/central level • Capacity building of focal staffs for eHealth literacy • Strengthen LMIS governance, administration and data management to facilitate its integration with other health information management systems 5. **Governance, Financing and HRCD** • Increase skills and competencies of Supply Chain focal staffs in HIV program by attending the supply chain certificate, diploma and master courses developed by Department of Human Resource for Health (DHRH) of MoHS or any acknowledged institutions • Ensure the financing & budgeting of PSM functions in addition to the commodity budget for institutionalization and sustainability of PSM 6. **Quality Assurance** • Defining minimum standards and specification for medicines, diagnostics and other supplies to ensure the quality • In country quality monitoring of HIV commodities 7. **Waste Management**		

• Develop the clear policy document for the management of expired and damaged HIV commodities. This document should also be applicable to all other type of expired and damaged health products • Update SOP for management of damaged/expired and waste HIV products which can also be applied for other health products • Development of reverse logistic mechanism which transport the expired and damaged HIV commodities to central level where the official destruction can be taken place • Central destruction by incinerator and/or other modern destruction machines		
2.6. **Strengthen laboratory services in HIV and STI management**		
HIV and STI lab services coverage 1. Increase number of HTS confirmation sites with EQAS capacity up to sub -township level according to the needs and NGOs sites & private labs, NTP labs 2. Expand viral load testing and EID coverage through optimizing integrated high throughput and POC network and using DBS for viral load testing • Decentralize DBS sample collection for EID to sub -township level • Expand lab with capacity to perform viral load test using DBS 3. Update VL scale up plan for all platforms including HIV positive pregnant women in their 3rd trimester and strengthen the use of VL/EID monitoring tools 4. Ensure accessibility to CD4 facility as baseline investigation for OI management by all townships 5. Introduce self-testing and ensure linkage to HIV confirmatory service 6. Introduce recency test for surveillance 7. Establish mechanism/system to monitor HIV drug resistance using Genotyping /Phenotyping	• 100% of PLHIV on ART are tested for viral load • Increase in numbers of HIV confirmatory sites • More than 90% of HIV NEQAS (VL, Serology, CD4) participating laboratories with successful results	**Lead:** NAP and NHL **Support:** UN agencies. Donors and INGOs **Implementing:** Public facilities under MoHS, NAP, NHL, INGOs **Funding:** Domestic Funding, Global Fund, PEPFAR

8. Improve the diagnosis capacity of STI in AIDS/STD teams and expand to all townships 9. Ensure the lab commodities available in all townships in line with essential basic and comprehensive service packages **Quality management system of HIV lab services** 10. Streamline HIV testing algorithm to increase efficiency 11. Establish tester and site certification system for both HIV screening and confirmatory sites 12. Expand NEQAS for all HIV confirmatory sites and for all viral load testing sites including POC 13. Develop formal, clear and structured sample transportation network to ensure accessibility to viral load testing from all ART sites 14. Build QMS capacity at sub -national level to monitor the quality of HIV screening & confirmation and for sample collection and testing of EID/viral load 15. Decentralize the lab quality control and quality improvement to state and region level (Consider to set up the reference lab for HIV, STI and OI) 16. Ensure following SOP on waste management for labs and POC testing (Develop SOP for waste management of Gene X-pert cartridges) 17. Strengthen Lab information management system, for program coverage and quality performance, linking to patient management system and other eHealth system 18. Support ISO accreditation of reference labs (NHL and PHL) fulfilling the requirements of ISO including human resource and infrastructure **Infrastructure and integration of services** 19. Identify the sustainable human resource plan for lab system at public sector 20. Enhance coordination of monitoring workforce for quality control of HIV lab services at state and region level 21. Integrate the lab services for different diseases/program		

5.3 Strategic Direction #3: Strengthening multisectoral integration, gender and human rights-based, people-centred community and health systems

5.3.1 Overview of Achievements

Action on human rights, the enabling environment and strengthening HIV services

There has been increasing recognition and commitment to a multisectoral approach as more effective in terms of program implementation and results achieved. Consequently, there has also been increased collaboration by the National AIDS Program with other sectors, including social welfare, labor, information, education, police and prison sectors, as well as other areas of the health sector – such as school health, adolescent and reproductive health, and the hepatitis program – communities and networks, and the private sector. In parallel, there has also been increased recognition and commitment to ensuring an enabling environment, including rights-based approaches, understanding that these allow key populations increased access to prevention and health care services.

Substantial work has been undertaken to reduce human rights barriers to access to services for Key Populations in Myanmar, including key population community networks and networks of people living with HIV working consistently to promote an enabling environment advocating for the drafting of new laws and reform of existing suppressive laws. Law and policy reform and development also lifted some barriers, improving the enabling environment for key populations to access health care. Communities of people living with HIV and key populations were enthusiastically involved in advocacy with Parliament, leading to the amendment of the 1993 Narcotic Drugs and Psychotropic Sub stances law, launch of the National Drug Control Policy, and progress in the HIV law, law on sex work, and the intellectual property law. Sensitization of lawmakers and law enforcement agents and substantial legal literacy programs were conducted, reducing discrimination against women in the context of HIV, and monitoring and reforming laws, regulations and policies relating to HIV.

Representation in planning and governance structures was strengthened as CBOs and networks contributed to the formation of sub national HIV operational plans, and community representatives were included in state/regional HIV steering committees. Key populations and people living with HIV networks were empowered to lead the HIV prevention and linkage to care project in Rakhine State, where the public sector is the only implementing partner due to conflict. Capacity building of key populations, journalists and reporters, and stakeholders, various trainings and awareness-raising sessions were conducted on sexual and reproductive health and rights, gender-based violence, human rights-based and gender sensitive approaches to HIV, sexual orientation and gender identity, basic human rights, and legal literacy. The community feedback mechanism project widened its scope to capture more human rights aspects. Finally, as a result of continuous institutional capacity building of community-based organizations and networks, Myanmar Positive Group was selected as a Global Fund Sub Recipient in 2018.

People in closed settings including prisons

NSP III focused on the establishment of a comprehensive HIV package for prisoners in prisons in Myanmar. Still in planning stages as NSP IV was developed, the program will be implemented jointly by MoHS and MoHA with support from other Ministries/Departments, national and international agencies. A National Strategic Framework is currently being developed and targets will be set in the first year for comprehensive coverage and service delivery outcomes.

5.3.2 Challenges

Integration, gender-sensitivity, the enabling environment

Integration of the HIV program with other co-infection programs such as TB, HCV and HBV remains limited, as do integrated approaches to case management of co-infection. While gender-sensitive services are becoming more common, services for male and Transgender sex workers are very limited. Overall, the environment in Myanmar has changed considerably in recent years but more needs to be done to create a truly enabling environment for key populations to access needed services.

Legal and enabling environment

The work with parliamentarians, lawyers, community groups, advocates and Government counterparts focuses, both, on the rights to services for people living with and affected by HIV as well as for key populations. Substantive progress was made on the policy and laws that address drug use in 2018, although the rules and measures that govern their implementation have yet to be operationalized. A similar focus has been made on reducing punitive measures and introducing the right to health and services in the context of sex work. As of 2020, the HIV Bill providing a framework for protecting the right to treatment, care and social support, as well as to counter stigma and discrimination, was developed by MOHS and submitted to Pyidaungsu Hluttaw. The interaction between community representatives and the parliamentarians in Pyidaungsu Hluttaw is now regular.

However, challenges remain in addressing the rights and the status of same-sex contacts under existing laws. In addition, the current availability of services may limit access to HIV and other relevant health care, in particular for the intimate partners, female drug users, transgender women and young key populations. A policy has yet to be put in place to facilitate provision of HIV testing to young people below 18 years where there is no guardian consent. Efforts will continue to be made – such as through the community feedback mechanism, training and sensitization of health care workers, and legal aid – all of which involve the engagement of people living with HIV and key populations. Links have also been maintained with the police and local authorities on harm and risk reduction to key populations, which should be pursued by community groups with the support of UN Agencies and the National AIDS Program. Community resistance to harm reduction services remains significant in some localities and requires a systematic approach to advocacy.

5.3.3 Service Delivery Approaches & What is NEW for NSP IV

Service Delivery Approaches

Service delivery will be within a partnership approach delivered through public and private sectors including EHOs, communities and community-led services. Addressing legal barriers will be through policy makers such as parliamentarians and legislators at national and sub-national levels, and through lawyers and legal aid organizations.

Community Led Service Delivery includes the following:

- **Prevention:** Key Population Service Centers, Youth-Friendly Service Centers, prevention packages, community-based screening, peer enhance outreach, referral and linkage to ART care, and commodity distribution such as condom and needle and syringe.
- **Care and Support to the ART program using the case management approach:** Peer support at ART centers and Drop-in Centers, ART and adherence counseling, defaulter tracing and providing for ethnic

languages use, accompanied referral support, nutrition support, treatment adherence, hospitalization support, funeral support, and other clerical task such as patient data recording and data entry.

- **Human Rights and Gender:** Legal Aid Service, emergency support for victims of human rights violations, legal, human rights and gender awareness training, and evidence-based case collection on human rights violations.
- **Create an enabling environment:** review and reform punitive laws, community-led stigma and discrimination reduction among local authorities, education providers, workplaces, Community Feedback Mechanism, sensitization of health care providers in public and private settings to the concerns, behavior and needs of Key Populations, coordination and advocacy meetings with multisectoral authorities, capacity building on community mobilization and community system strengthening, participation in planning and monitoring of progress in the HIV response.

What is new for NSP IV?

A gender and rights emphasis are added to Priority Intervention 3.1 Strengthen and expand **gender-responsive and right-based** HIV service delivery models, ensuring continuum and quality. At an activity level this will be supported by an enhanced partnership linking government, private and civil society organizations and strengthened coordination with related ministries reaching cross border migrants, internally displaced people and human tracking survivors. There will also be strengthened multisectoral coordination and public-private partnerships to scale up service delivery. Additional capacity building of public, private and civil society partners is planned to ensure rights-based and gender mainstreaming across the continuum of care. Finally, there will be coordination with the Youth Affairs Committees at national and sub national levels to include HIV services in the implementation of Youth Policy. Key results include **increased coverage of HIV continuum services measured by increased % of facilities providing HIV specific services; increased percentage of ART patients treated by public facilities; increased accessibility of HIV services for cross border migrants, Internally Displaced Persons and human trafficking survivors and HIV prevention, care and treatment services are gender sensitive and apply rights-based approaches.**

Priority Intervention 3.2 Strengthen the community to be involved in service delivery will be supported at an activity level where feasible, through capacity-building and strengthening the work of EHOs to improve access to HIV services. Also new in NSP IV are the promotion and expansion of community-led services and formalizing and strengthening the role of the community in providing constructive feedback for improving health and social determinants of people living with and affected by HIV. Key results here include **at least 30% of all service delivery is community-led by 2025; an increase in the number of key populations and people living with HIV engaged in HIV prevention, testing and treatment programs; zero HIV related stigma and discrimination in healthcare, education and workplace settings; and increased community and civil society engagement in policy and legal framework changes and community feedback.**

Expansion of Priority Intervention 3.3 To improve the legal and policy environment **at all levels.** At an activity level this will be supported by advocating with related ministries for action on structural and policy issues affecting the HIV continuum of services for priority populations; thorough embedding of harm reduction in law enforcement practices, raising the knowledge of prison, rehabilitation center and healthcare staff and sensitizing law enforcement officers. The protective HIV law will be enacted and enforced to cover the rights of people living with HIV and priority populations, and diversion – alternatives to imprisonment – will be offered from the time of arrest, before trial and to reduce prison sentences. New activities under 3.3 include conducting a HIV legal review to inform the situation related to the legal and policy environment Key results include **elimination of HIV related stigma and discrimination in health care settings by 2025; a decrease in the number of punitive laws and policies; an increase in the number of protective laws and**

antidiscrimination policies for people living with HIV and key populations; an increase in the number of sites using/implementing the community feedback mechanism; and an increase in the number of community-based legal aid service centers.

There are laws to protect all individuals and to promote equal access and non-discrimination but these are not well operationalized effectively at all level of implementation. There is also needed to raise awareness of Public Health laws such as: Section-269 and 270 under Chapter XIV *Offences affecting the public health, safety, convenience, decency and morals for health staff and the community* to promote disclosure between sero-discordant couples. This can be implemented through collaboration between the General Administrative Department and the Attorney General Department. In most service delivery settings, stigma and discrimination are issues arising due to lack of awareness related to Universal Precautions, proper infection control procedures and the non-discrimination law (public and private hospitals).

Expansion of Priority Intervention 3.4 Integrate HIV in UHC and social protection schemes for priority populations **and infected and affected children.** Priority Intervention 3.4 provides specific attention to the situation and needs of infected and affected children in the context of UHC and social protection scheme provisions.

5.3.4 Priority Interventions

3.1 Strengthen and expand gender-responsive and rights-based HIV service delivery models, ensuring continuum and quality.
3.2 Strengthen the community to be engaged in service delivery.
3.3 To improve the legal and policy environment at all levels.
3.4 Integrate HIV in Universal Health Care and social protection schemes for priority populations and children living with and affected by HIV.
3.5 implement workplace programs and leverage other sectors involvement in the HIV continuum of services.

5.3.5 Activities, Partners, Results

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
3.1 Strengthen and expand gender-responsive and rights-based HIV service delivery models, ensuring continuum and quality		
1. Identify and engage new partners including EHOs to expand coverage, acceptability and sustainability of services (particularly in difficult to reach areas or areas with ethnic health authorities)	• Increased coverage of HIV continuum services measured by increased % of facilities providing HIV specific services	Lead: MoHS in cooperation with related ministries

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
2. Strengthen multisectoral coordination and public-private partnerships (PPP) to support expansion and scaling up of service delivery models 3. Enhance partnership and referral arrangements linking government, private and civil society organizations 4. Strengthen coordination with related ministries to promote the HIV services including HIV testing for cross border migrants, Internally Displaced Population (IDP) and Human trafficking survivors (Refer to operational context) 5. Build capacity for public, private, local civil society partners to improve quality and expand service delivery ensuring rights based and gender mainstreaming across continuum of care 6. Implement quality assessment and assurance mechanism across the continuum, facilitate accreditation where relevant) 7. Provide ongoing mentorship and professional learning 8. Coordinate with Youth Affairs Committees national and sub national level to include HIV services in the implementation of Youth Policy 9. Mobilize patients & community groups as treatment supporters (TB/HIV) and address stigma and discrimination that serve as barriers to seeking care among KPs, TB patients, women, to improve treatment access and outcomes in the community. 10. Conduct Stigma Index Survey. 11. Strengthen the Human Rights components of elimination of mother to child transmission implementation such as gender awareness	• Increased % of ART patients treated by public facilities • Increase accessibility of HIV services for cross border migrants, IDP and Human trafficking survivors • HIV prevention, care and treatment services are gender sensitive and apply rights-based approaches	Support: UN, donor and technical agencies Implementing: INGO, LNGO, CBO, Key Population and Community Networks Funding: External, public and domestic

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
campaigns for the community to address gender sensitive issues in HIV responses 12. Coordinate with MOE, MSWRR to effectively implement comprehensive sexual education (CSE) for in-school and out-of-school youth as well as for adolescents in vocational training centers. 13. Coordinate with different departments within MoHS and related ministries to develop comprehensive plans for the implementation of policy on Sexual and Reproductive Health Rights for youth.		
3.2 Strengthen the community to be engaged in service delivery		
1. Review, amend and ensure implementation of CSS strategy to strengthen community engagement that is inclusive of self-help groups at local levels 2. Build capacity and strengthen work with EHOs where feasible to improve access to HIV services 3. Promote and expand community led services where feasible (define community led services) 4. Empower and support community to reduce stigma and discrimination in healthcare, education and employment sectors 5. Empower and support community to effectively engage in legal and policy dialogue, rules and regulations of related laws 6. Formalize and strengthen community role providing constructive feedback for improving health and social determinants of HIV infected and affect populations	1. At least 30% of all service delivery is community-lead by 2025 2. Increase in number of key populations and people living with HIV engaged in HIV prevention, testing and treatment programs. 3. Zero HIV related stigma and discrimination in healthcare, education and workplace settings. 4. Increase community and civil society engagement in policy and legal framework changes and community feedback	Lead: MoHS in cooperation with related ministries Support: UN, donor and technical agencies Implementing: INGO, LNGO, CBO, Key Population networks and EHO network Funding: External, public and domestic
3.3 Improve legal and policy environment at all levels		

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
1. Assess structural and policy issues affecting the HIV continuum of services for priority populations and advocate with related ministries for change. 2. Build capacity and strengthen with law enforcement agencies, General Administration Department, media and other key stakeholders on HIV, sexual reproductive health and rights and Gender based violence 3. Sensitize law enforcement about HIV and drug dependency to embed harm reduction in law enforcement practices/enhance knowledge among prison staffs, rehabilitation centers staffs and healthcare workers 4. Sensitize and advocate to entertainment establishments which have risk of HIV transmission –to improve access to HIV services. Owners, supervisors will be targeted to increased HIV prevention and treatment services. Owners, supervisors will be increased awareness on health, social and rights of sex workers and other entertainment workers. 5. Improve and expand legal and paralegal support services for priority populations (i.e. through hotlines, counselling and linkages to legal aid programs) 6. Monitor HIV related human rights violations and legal barriers to accessing, treatment and care 7. Coordinate with related ministries to reform existing policies and laws to protect priority populations and infected and affected children from violence, stigma and discrimination and enhance access to HIV services. 8. Enact and enforce the protective HIV law to cover rights of people living with HIV and priority populations. While the process is going on, it is important to conduct public awareness so that community and public also aware of that importance of this law.	• Eliminate HIV related stigma and discrimination in health care settings by 2025 • Decrease in the number of punitive laws and policies • Increase in the number of protective laws and antidiscrimination policies for people living with HIV and key populations • Increase number of sites for community feedback mechanism • Increase number of community-based legal aid service centers	Lead: MoHS in cooperation with related ministries Support: UN, donor and technical agencies Implementing: INGO, LNGO, CBO, Key Population and Community networks Funding: External, public and domestic

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
9. Offer alternatives to imprisonment at all stages (at the time of arrest, before trial, to reduce prison sentences 10. Conduct HIV legal review to inform situation related to legal and policy environment		
3.4 Integrate HIV in UHC and social protection schemes for priority populations and infected and affected children		
1. Cost service delivery models including prevention, care, treatment and associated laboratory and commodity requirements 2. Integrate HIV in UHC legal framework 3. Explore and advocate with MOSWRR to integrate HIV sensitive policies for people living with HIV including children living with and affected by HIV in the national social and child protection policy and plan and advocate for funding it 4. Coordinate with MOE and MOSWRR to facilitate access to education and other supports for people – including children - living with HIV and affected by HIV. 5. Conduct advocacy for HIV sensitive programs in national disaster, conflict and emergencies management	HIV prevention, care and treatment essential services included in the UHC schemes	Lead: MoHS in cooperation with related ministries
3.5 implement workplace programs and leverage other sectors involvement in the HIV continuum of services		
1. Leverage and coordinate with other sectors for HIV prevention programming for business and enterprises (forestry, agriculture, fishery, mining) that attract priority populations 2. Strengthen health education and onsite HTC services, with referrals and linkages. 3. Advocate and coordinate with related ministries and other stakeholders for the	Increase HIV sensitive policies in Business and enterprises	

Strategic Direction 3: Strengthening multi-sectoral Integration, gender and human rights based, people-centered community and health systems		
Activities	**Results**	**Partners & Funding Source**
development of HIV workplace policy in private sectors 4. Advocate private sector companies to provide HIV services in workplace clinics and adopt peer education 5. Integrate HIV prevention services and TB screening at migrant health posts (move to prevention and care service) 6. Review the HIV situation in special economic and industrial zones that attract large numbers of migrants/workers to increase accessibility of HIV services 7. Enhance involvement of EHOs and faith-based organizations in providing HIV sensitive leadership and programs where appropriate 8. Establish linkage with non-health organizations to advocate with business and enterprises to sensitize HIV workplace issues		

5.4 Strategic Direction #4: Strengthening the use of strategic information and evidence to guide service delivery, management, and policy

5.4.1 Overview of Achievements

The purpose of this Strategic Direction is to improve the effectiveness of the response to HIV in NSP IV by strengthening the capacity for addressing the HIV epidemic and program monitoring to improve policy, planning, financial accountability and sustainability. Thus, Strategic Information (SI) provides the evidence base to reach the goal of reducing HIV transmission and HIV morbidity, mortality and disability along the HIV continuum with a focus on the highest risk populations in key geographic areas of priority.

Under the leadership of the National AIDS Program and in collaboration with multiple partners, Myanmar has developed a strong Second-Generation Surveillance system for tracking the trends in HIV and has built capacity among staff to utilize the data effectively. This system includes sentinel surveys, integrated biological and behavioral surveys, key population size estimates, routine data from programs and services, the use of epidemic modeling and special research projects. Through this system, Myanmar has characterized the nature and details of the heterogenic HIV epidemic in a complex country, identified the key

determinant factors that contribute to HIV infection and characterized the sub -regional variations of epidemic risk and burden.[70] There has been improvement in the process to estimate the size and geographic distribution of key populations most at risk of infection and the HIV epidemic among key populations has been tracked. This analysis has allowed an assessment of the interactions between key populations and others to project new infections and improve the effectiveness of HIV prevention, care and treatment efforts.

Strategic information and its application have also improved the quality of HIV responses and the efficiency of resource allocation. This has included the implementation of programmatic mapping to enhance targeting of the response to HIV at sub -township levels and the monitoring of the rapid increase in coverage of HIV testing and treatment. Based upon localized data analysis SI has developed HIV epidemic and response profiles for four of the five priority states/regions as the fundamental basis for the development of costed sub national HIV operational plans for Kachin, Shan (N), Yangon and Sagaing. The National AIDS Spending Assessment for the HIV response (2016-2017) has allowed tracking of resource use and greater mobilization of domestic investments. The NAP commissioned and published three external reviews of NSP III that have informed the development of all sections of NSP IV. These efforts will improve the transparency and accountability of the use of HIV funds at all levels.

Finally, the strategic information team has also modeled the impact of increased ART coverage translating into a reduction of HIV related deaths. Based upon all of these data and planning processes, numerous peer reviewed research papers and reports have been developed some of which have been presented at international conferences.

5.4.2 Challenges

Despite a well-functioning and robust system, additional challenges remain. Details can be found in the three recent country program reviews including the HIV Health Information Systems by the Ministry of Health and Sport. Some areas could be characterized as further refinements in a well-developed system, while others could be game changers for effectiveness monitoring, quality improvement and sustainability.

Second Generation Surveillance: There is a need to revitalize the systems and reports of HIV and STI cases and HIV deaths. Without a fully functioning system it is difficult to monitor prevention and treatment of STIs and to track the actual health impact of HIV care and treatment and progress towards eliminating HIV.

IBBS and HSS: Despite extremely useful data from these efforts further analyses of the data for program implications is warranted. In addition, there are some gaps. Formative research about female PWID and transgender persons would assist programs to adequately reach these populations. There is a need to develop a system to monitor the needs of incarcerated persons, migrant and mobile populations and ethnic minorities. Finally, since the Stigma Index is not representative, a representative sample for tracking stigma and discrimination could improve accountability to key populations.

Program Data and Health Information Systems: Estimates of prevention coverage include double counting and adjustments performed may lead to bias and recent reviews suggest that it is not possible to adequately

[70] HIV Epidemiological Review Republic of the Union of Myanmar, 2019. National AIDS Program, Ministry of Health and Sports of Myanmar.

measure the continuum of prevention, care and treatment.[71] As described previously, a unique person-level ID is needed to ensure accurate monitoring and quality improvement of the continuum from prevention to care and treatment. Therefore, without a UID the quality of aggregate reports to track the cascade is not ensured.

HIV Care, Treatment, Mortality Reporting: In HIV care and treatment, a policy and system to improve reporting efficiency is required. Technical assistance to assess the inter-operability of different provider systems, including private sector, to develop a Government-led approach that links IDs across platforms will allow for improved tracking across the cascade and collaboration across different disciplines. Defaulter tracing, drug resistance surveillance and collaboration on co-infection surveillance and reporting are important for the future. There is a need to fully implement the uniform medical record system with unique identifier and efficient data management systems (OpenMRS and link with DHIS2 and lab systems).

Program Evaluation: While there has been progress in prevention services, there are many 'models of prevention' implemented in the country with no evaluation of which model is the most effective and cost efficient. Implementation research in prevention and the development of a quality improvement program would enhance prevention effectiveness.

5.4.3 Service Delivery Approach and what is NEW for NSP IV

Service Delivery

The SI team is led by the NAP, MoHS and works in collaboration with the Department of Medical Services, other related vertical programs under DoPH[72], Drug Dependence Treatment and Research Unit (DDTRU), prison department, INGOs, LNGOs, CBOs and key population and PLHIV networks. Partners also include the Department of Medical Research, academic institutions including international universities, the UN and donor agencies. Strategic information focal persons in government and partner agencies are designated at national, regional/state and at local township levels. In NSP IV, decentralization and capacity building through training and mentoring will occur at all levels. Training will improve standardized recording and reporting systems. Local epidemic and response profiles will be developed to inform sub national planning. Collaboration with multiple partners will occur for data quality assurance. A quality improvement program to enhance the effectiveness of the local HIV continuum of services in line with the NHP will be implemented with partner agencies.

Myanmar has implemented OpenMRS software to support monitoring of ART patients, clinician decision support (e.g., CD4, viral load, IPT remainders) and improve recording and reporting of the ART sites. Open MRS training was provided for 110 sites out of 359 public and NGO ART sites as of Dec 2019. Among them, 65 sites have fully operational with completed legacy data and the rest in progress to use OpenMRS. OpenMRS is planned to be used primarily in ART centers but ART DC sites and ART satellite sites will follow later. OpenMRS will also integrate with Master Patient Index (MPI) for longitudinal patient monitoring and case-based reporting.

An expanded partnership approach with academic institutions for capacity building on research implementation and the application of findings for program improvement and decision making will occur.

[71] HIV Epidemiological Review Republic of the Union of Myanmar, 2019. National AIDS Program, Ministry of Health and Sports of Myanmar.

[72] NTP, NMCP, NHCP, NCD, Health Management Information System (HMIS) division

The surveillance plan and research priorities will be aligned with the geographic distribution of HIV epidemic burden and new infections.

Potential Threats

Pending HIS and data security policy: The Health Information System (HIS) in Myanmar includes disease surveillance and outbreak notification, census, data collection on patients, services records and program specific monitoring and evaluation. As the collection of person-centered Unique Identifier codes and HIV patient monitoring and case surveillance is expanded, data security becomes paramount to ensure privacy. This is of particular importance for PLHIV, who may be stigmatized because of their HIV status. Key and priority populations must be protected from disclosure that could have severe personal consequences, including violence, arrest, and persecution. *(See new initiatives below)*

Unsecure/limited resource for sustainability of SI activities: Limited Human Resources dedicated to strategic information continues to be an issue for the sustainability of SI activities. The National AIDS Spending Assessment (NASA) suggests that in 2017 $1.96 Million USD was expended on Monitoring and Evaluation (by all partners) and over $870,000 was spent on a combination of Operations Research and Surveillance, as a part of the total funds spent on HIV Management and Administration in Myanmar.[73] The NASA also reports that the research budget declined from $312,981 in 2016 to $116,396 in 2017. Over 96% of all funds spent on Management and Administration in Myanmar are internationally funded. The combination of limited human resources, shrinking funds for research and a heavy reliance on international funding for Strategic Information, are threats to the sustainability of SI efforts and activities.

Insufficient integration of SI considerations in program design, planning, implementation and evaluation: Strategic information's success relies on the collaboration and investment of multiple partners to prioritize the integration of monitoring and evaluation systems into day to day management processes. In addition, human resources and capacity development is required to use the data to make programmatic changes to improve the quality of programs. The quality of the data is inextricably linked to the effort expended in collecting and managing SI. There is an overarching threat that the network of government, private sector, NGO and community partners need additional human resources and capacity to prioritize the collection and use of quality data to improve the overall response to HIV. To overcome these potential threats, advocacy to ensure commitment of political will and leadership for policy development, resource mobilization and SI oriented program management will occur with the government, donors, partner agencies and the community.

What is new for NSP IV?

Open HIE and data security initiatives: Myanmar is in the process of developing a comprehensive data security policy for the Ministry of Health and Sports. The NAP will be involved in ensuring confidentiality and information security by ad vocating for policy development and exploring experience interchange with countries that have functional unique ID systems. During NSP IV a National Unique ID system for health (HIV and other services) will be developed and implemented. This will be used in conjunction with existing data recording systems to implement quality improvement in collaboration with respective programs across the continuum of services.

[73] National AIDS Spending Assessment: Financial Flows and Spending in HIV 2016-2017. National AIDS Program, The Republic of the Union of Myanmar Ministry of Health and Sports and the Joint United National Program on HIV/AIDS (UNAIDS).

Integration of quality improvement of interventions: Quality assurance is defined as a mechanism used to monitor a particular procedure or a process in order to ensure that it is up to the expected level of quality standards. Data quality assurance is already integrated into the efforts of SI and will continue to be emphasized during NSP IV. Quality improvement is a systematic approach to analyzing the current performance of a program/intervention in order to take the necessary actions to become more efficient and effective. During NSP IV, the SI team will utilize data to assist HIV program managers to develop quality improvement programs in HIV.

SI oriented program management: As the SI data, information and systems are expanding in Myanmar, it is necessary to invest in improved program management for the SI team as well as HIV program managers. This will include regular mentoring and training of supervisors and staff in new areas and support for managing expanding databases, associated human, financial and technical resources and capacity development in the utilization of data for program improvement.

Strategic Information Resource Community, National HIV forum and HIV Research database: The NAP, MoHS and many partners have invested in research to address the biological, behavioral and structural factors that increase risk of transmission, disease progression and the structural determinants. A HIV Research database would allow broader access and greater utilization of the data for improving the efficiency and effectiveness of the response to HIV in Myanmar. Support for the SI Resource Community will ensure regular exchange of data, priority setting and capacity building among the SI network. A National HIV Forum will allow open discourse and improved transparency across the government, private sector, NGO and community sectors to improve the national response to HIV.

5.4.4 Priority Interventions

4.1 Generate and use Strategic Information to guide service delivery, program management, policy and financing

4.2 Improve monitoring and reporting to provide quality data and effectively monitor the implementation of NSP IV and improve performance at all levels

4.3 Strengthen coordination and resources mobilization for Strategic Information

4.4 Conduct research and evaluation and apply findings for programmatic improvement and policy change

5.4.5 Activities, Partners, Results

Strategic Direction 4: Strengthen the use of strategic information and evidence to guide service delivery, management and policy		
Activities	Results	Partners & Funding Source
4.1 Generate and use Strategic Information to guide service delivery, program management, policy and financing		
Epidemic and response	1. Local epidemic and response profiles, sub	**Lead:** National AIDS Program, MoHS

Strategic Direction 4: Strengthen the use of strategic information and evidence to guide service delivery, management and policy		
Activities	**Results**	**Partners & Funding Source**
1. Coordinate the analysis of national and sub -national data to monitor trends to characterize the epidemic including priority townships 2. Support the development of local epidemic and response profiles and strengthen local capacity to conduct comprehensive programmatic mapping 3. Build capacity building and support planning tailored to national and sub national epidemic contexts to enhance the quality and effectiveness of local HIV continuum services in line with NHP 4. Use epidemic and response profiles to advise management, policy, research and financing *Data securities, use and integration* 1. Ensure confidentiality and information security by advocating policy development and exploring experience interchange with countries that have functional unique ID system *Surveillance* 1.Develop and implement a five-year detailed surveillance plan comprising BSS survey for key populations and priority populations including populations in special administrative area; drug resistance surveillance; and sentinel surveillance for drug toxicity 2. Conduct regular national and sub national modelling of the HIV epidemic	national plans developed and used 2. Functioning unique ID system with optimal level of data security policy and practice in place 3. Surveillance plan developed and implemented	**Support:** UNAIDS, CDC, ICAP, all partners **Implementing:** All implementing partners including CBOs, Networks, and EHOs **Funding:** Global Fund, Access to Health, PEPFAR, other domestic and external funding sources
4.2 Improve monitoring and reporting to provide quality data and effectively monitor the implementation of NSP IV and improve performance at all levels		

Strategic Direction 4: Strengthen the use of strategic information and evidence to guide service delivery, management and policy		
Activities	**Results**	**Partners & Funding Source**
1. Develop a comprehensive HIV M&E plan, SOPs, guidelines and training plans including decentralization of M&E, and roll out the plan 2. Strengthen Quality Assurance Plan and roll out the plan 3. Promote data analysis and utilization at sub -national levels (priority townships) 4. Report yearly progress of national and global HIV response including sub -national analyses 5. Develop and operationalize National Unique ID system for health (for HIV services) 6. Implement quality assurance and quality improvement in collaboration with respective programs across continuum of services and improve referral/linkage by using Unique ID 7. Conduct technical feasibility assessment, develop, scale up and evaluate electronic case-based recording and reporting system for HIV and STI 8. Collect mortality data and conduct regular data triangulation using data from routine mortality reporting and other available sources 9. Support the development of interoperability policy/guideline to ensure health information exchange among components of open HIE	1. HIV M&E plan, SOPs, guidelines and training plans updated, rolled out and decentralized 2. Routine Data quality assurance at all State and Regions completed 3. Data utilization at sub -national levels and townships for micro planning increased 4. National and global progress reports sub mitted annually including sub -national dis-aggregated data 4. National Unique ID system for HIV established 5. Electronic case-based recording and reporting system for HIV and STI established 6. Regular mortality data triangulation conducted 7. HIV health information exchange among components of open HIE developed	**Lead:** National AIDS Program, MoHS **Support:** UNAIDS, CDC, ICAP, all partners **Implementing:** All implementing partners including CBOs, Networks, and EHOs, Private sector **Funding:** Global Fund, Access to Health, PEPFER, other domestic and external funding sources
4.3 Strengthen coordination and resources mobilization for Strategic Information		

Strategic Direction 4: Strengthen the use of strategic information and evidence to guide service delivery, management and policy		
Activities	**Results**	**Partners & Funding Source**
1. Advocate and mobilize resources for a costed HIV M&E plan 2. Assess human resources for health (HRH) needs in HIV strategic information management and develop an HIV strategic information HRH plan linked to other sectors. Consider additional partners or outsourcing where needed to fulfil the decentralization of M&E capacity at township level 3. Strengthen M&E coordination among HIV, Hepatitis, TB, Malaria and Non-Communicable Diseases (NCD) 4. Build the capacity of strategic information staff including health care and peer workers through mentoring and training in data quality assurance, and quality improvement of services, utilization and evidence-based advocacy. 5. Create a resource community at country level for knowledge sustainability and transfer among SI staffs.	1. Costed M&E plan and HRH plan developed and implemented 2. SI resource community established and functioning 3. Coordination among HIV, Hepatitis, TB, Malaria and NCD resulting in improved program planning and monitoring	**Lead:** National AIDS Program, MoHS **Support:** UNAIDS, CDC, ICAP, all partners **Implementing:** All implementing partners including CBOs, Networks, and EHOs **Funding:** Global Fund, Access to Health, PEPFER, other domestic and external funding sources
4.4 Conduct research and evaluation and apply findings for programmatic improvement and policy change		
1. Regularly update National Research agenda for HIV 2. Mobilize resources for priority research questions (female PWID, PWUD, mobile and migrant populations) and build capacity to conduct research at all levels 3. Establish a National HIV research database 4. Conduct operational research on innovative interventions (self- testing, PrEP, index testing, social media-based interventions, geographic areas with optimal/sub - optimal service delivery.)	1. National HIV Research agenda regularly updated 2. National HIV Research database established	**Lead:** National AIDS Program, MoHS **Support:** DMR, Academic institutions,

Strategic Direction 4: Strengthen the use of strategic information and evidence to guide service delivery, management and policy		
Activities	**Results**	**Partners & Funding Source**
5. Advocate to include more HIV related risk behavior and network scale up for size estimation questions in the Demographic Health Survey (DHS) 6. Conduct regular evaluation for the effectiveness of intervention programs for KP and priority populations 7. Conduct National HIV forum for sharing the best practices and research findings with the involvement of multi-stakeholders (EHO, CBO, Networks.) 8. Conduct regular national and sub national NASA 9. Conduct HIV specific SARA	3. Operational research on innovative interventions (self-testing, PrEP, index testing, social media-based interventions) conducted 4. Findings from DHS applied for program improvement 5. Strategic inputs for quality improvement established for KP Interventions (and other areas) National HIV forum conducted at least 2 times during NSP IV National and sub national NASA regularly conducted every 2 years	UNAIDS, CDC, ICAP, all partners **Implementing:** All implementing partners including CBOs, Networks, and EHOs **Funding:** MoHS, Global Fund, Access to Health, PEPFER, other domestic and external funding sources

5.5 Strategic Direction #5: Promoting accountable leadership for the delivery of results and financing a sustainable response through advocacy, fundraising and a multisectoral approach in line with Universal Health Coverage

5.5.1 Overview of Achievements

There is strong leadership, political and financial commitment, and good program management. The operational plan of NSP III was developed under the leadership of the Ministry of Health and Sports, and the National AIDS Program with all round involvement of technical partners and stakeholders; and led to the development of four sub-national operational plans for Kachin, Shan (N), Yangon and Sagaing. The sub-national operational plans were being developed to address the epidemic in top priority states/ regions (Kachin, Shan North, Yangon and Sagaing). Ethnic and Community-Based Health Organizations and Key Populations are also actively included in this process, and engagement at the community level is good.
Financial commitment of the government to funding the HIV program has increased, and it provides at least 20% of funding for the HIV response. The government also provides funds for methadone maintenance treatment (MMT), procurement of antiretroviral medicines and other HIV related commodities. There is effective collaboration and coordination between the government and other stakeholders in the planning and implementation of services.

5.5.2 Challenges

Donor funding represents 80% of financial support for the national response to HIV. This leaves the national response at all levels – prevention and treatment; all of the achievements to date including at national, sub national and priority population level – highly vulnerable to the inevitable reduction in external development assistance as Myanmar moves towards attaining middle income status. At the same time, significant gaps in coverage remain while donor funding decreases are likely. This vulnerability and challenges to reaching a satisfactory level of reach and coverage of the related areas of prevention, care and treatment is exacerbated by the chronic shortage of human resources across all levels of health workers in the public health system.

Coverage and reach

Large parts of the five highest-burden states/ regions have limited coverage of harm reduction programs despite a widespread belief that, at least in Kachin, Shan North and Sagaing, there are likely to be people who inject drugs in majority of the townships. Although NAP has scaled up HIV testing services in prisons, the implementation of HIV Counselling and Testing activities in prisons still needs to be strengthened.

NSP IV Budget and Resourcing

A series of key stakeholder workshops and analysis were carried out in the development of the NSP IV budget. Through these consultations the previous costing of NSP III and expenditures were analyzed against the new NSP IV plan. Several significant changes are occurring from NSP III to NSP IV including a streamlining of geographic prioritization, changes in some details of service packages and delivery models for key populations and changes in the testing and treatment guidelines. A decision was made to redefine unit costs and reconstruct a costing tool according to the NSP IV service package framework using the latest national guidelines for HIV testing, ART, EMTCT roadmap, hepatitis C treatment, opioid substitution therapy and PrEP guidelines under the leadership of NAP. A full description of the process can be reviewed in detail in Annex E.

The unit costs analysis allowed for several cost cutting measures due to the streamlining of township priorities from three levels to two, a reduction in costs due to an analysis of expenditures and unused funds, a streamlining and standardization of operational management cost by service package, a plan to shift the roles of INGOs from service provision to capacity development for expanded community service delivery and the continuation of an increasing role for government, especially at state/region levels. These efforts improved cost efficiencies in accordance with geographically focused and tailored approaches for high and low priority townships with an emphasis on priority populations.

Essential Package of Health Service (EPHS)- HIV

The unit costs are detailed according to the Operational Models of NSP IV. The **Essential Package of Health Service (EPHS)- HIV** across 330 townships includes financing for an outreach model implemented by community members with standard commodities and service package linked to a simple integrated public sector approach. Services include health promotion, referral to public sector for STI, HTS, PEP (for occupational exposure and sexual violence cases) and linkage to integrated services for TB, ANC, SRH and NCD. The unit cost by year is below.

	2021	2022	2023	2024	2025
EPHS-HIV Prevention Unit Cost	$ 16.53	$ 17.02	$ 17.53	$ 18.06	$ 18.60

(Note: All figures are in US dollars)

The Comprehensive Package for Health Service (CPHS)- HIV: CPHS-HIV for high priority township will be implemented primarily in the 5 priority states/ regions as previously described. The financing includes support for **two Service Packages** - the first is an **Outreach Model** carried out by community/ peers using the enhanced outreach approach with standard commodities and service package linked to the public sector or NGO services. The second is the **Key Population Service Centers – KPSC and the enhanced outreach combination approach** that includes a mixture of key population-friendly one stop service and outreach model for comprehensive prevention with or without ART treatment. Two model sizes of small and large for each key population were costed with an estimated 30% of the target reached by large KPSCs and 70% by small KPSCs. The services include peer education, health literacy promotion, social media, harm reduction, overdose management and Hep B Vaccination (for PWID), STI, SRH, Hep B & C testing, TPT, PrEP, PEP and ART where integration is planned. Linkages and or integration for other services included TB, ANC, SRH, Non-Communicable Diseases, Drug Treatment Centers, mental health services, vocational and livelihood programs. The estimated percentage of key populations reached by different service delivery models was detailed with a plan to gradually shift the prevention unit running costs from mainly INGO service delivery to community-based services as their capacity is increased overtime. Costs reflect the changing role of INGOs with an emphasis on capacity building of the community.

Table 8: Percentage of key population targets reached with different service delivery models

KP	Service delivery models	2021	2022	2023	2024	2025
FSW	Through KPSC	80%	78%	75%	72%	70%
	Through peer/community-based	20%	22%	25%	28%	30%
MSM	Through KPSC	70%	68%	65%	62%	60%
	Through peer/community-based	30%	32%	35%	38%	40%
PWID	Through KPSC	95%	90%	85%	80%	80%
	Through peer/community-based	5%	10%	15%	20%	20%

Each of the unit costs is detailed below. The unit costs reflect the service delivery approach as previously described. Unit costs for all models differentiate costs for FSW, MSM and PWID.

Comprehensive Package for Health Service (CPHS)- HIV – Outreach

CPHS-HIV Prevention (outreach)	2021	2022	2023	2024	2025
Female Sex Workers	$ 29.60	$ 30.49	$ 31.40	$ 32.34	$ 33.31
Men who have Sex with Men	$ 24.41	$ 25.14	$ 25.90	$ 26.67	$ 27.47
People Who Inject Drugs	$ 38.82	$ 39.99	$ 41.19	$ 42.43	$ 43.70

Comprehensive Package for Health Service (CPHS)- HIV – KPSC & Outreach

CPHS-HIV Prevention (KPSC)	2021	2022	2023	2024	2025
Female Sex Workers	$ 55.99	$ 57.67	$ 59.40	$ 61.18	$ 63.02
Men who have Sex with Men	$ 42.68	$ 43.96	$ 45.28	$ 46.63	$ 48.03
People Who Inject Drugs	$ 86.37	$ 88.96	$ 91.63	$ 94.38	$ 97.21

(Note: All Figures are in US dollars)

Costing for Drug Treatment Centers were analyzed separately and include the provision of opioid substitution therapy delivered mainly by the government with or without NGO support. It was assumed that 50% of Drug Treatment Centers will have NGO support staff transitioning to 25% by 2025.

Comprehensive Package for Health Service (CPHS)- HIV: Drug Treatment Center implementation will be integrated into existing services for approximately 10% of People Who Inject Drugs. The unit costs include Hepatitis C medicine (70% assumed non-cirrhotic and 30% cirrhotic), medical staff, laboratory investigation and management costs.

Hepatitis C Treatment for Key Populations including People Who Inject Drugs

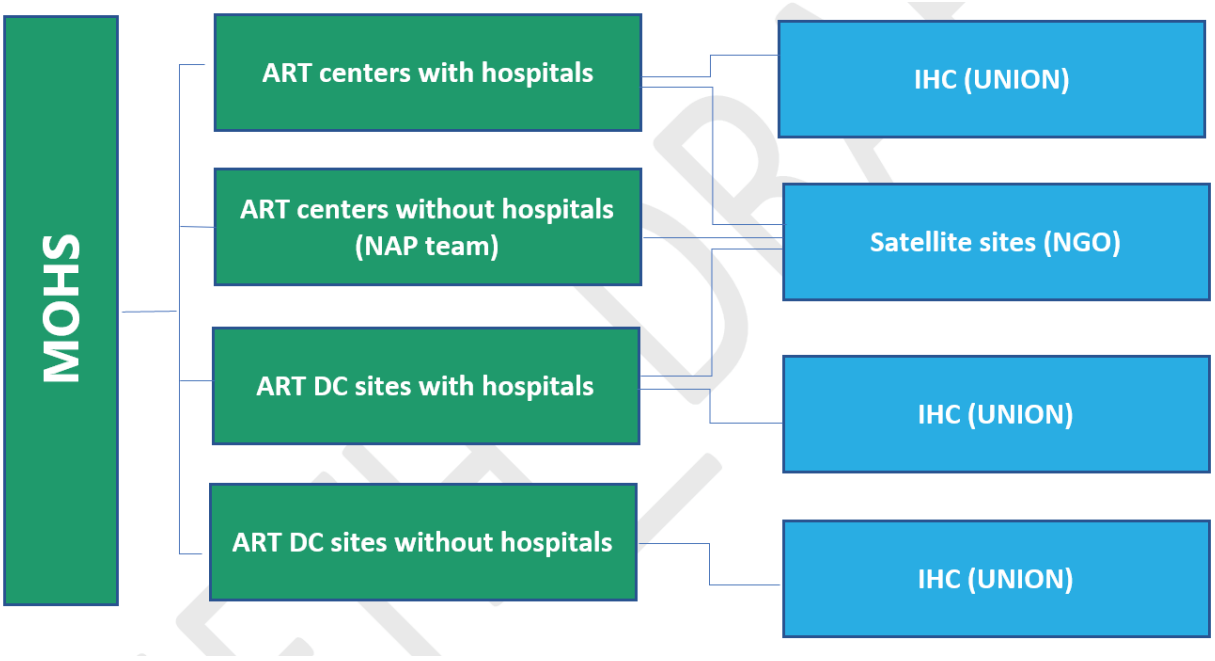
Hepatitis C treatment	2021	2022	2023	2024	2025
Number of Key Populations to treat for Hepatitis C	10,859	13,443	11,769	10,629	8,012
Budget requirement	$3,742,929	$4,633,675	$4,056,727	$3,663,826	$ 2,761,816

(Note: All figures are in US dollars)

The cost of **HIV treatment** was also reviewed with different models of ART provision adjusted to align service delivery units in the National Health Plan through:

1. ART centers with hospitals (through Government Hospitals)
2. ART centers without hospitals (through NAP Teams)
3. ART satellite sites/ KPSC satellite sites by NGO (through NAP Teams and ART centers)
4. ART DC sites with hospitals (through Township and Station Hospitals)
5. ART DC sites without hospitals (through Urban Health Centers and Rural Health Centers)

Figure 25:ART Service Delivery Models



Human resource needs for each model were standardized. Services include Hepatitis B and C testing, TB Preventative Therapy, OI treatment and prophylaxis, ART and patient support with linkages or integration with other services including TB, ANC, SRH, NCD, drug treatment, Hepatitis C treatment, mental health and vocational and livelihood programs. Services costs include staff, training, transportation, commodities, laboratory services, adherence support, enabling environment, program management and monitoring and evaluation. The cost of new versus existing patients were analyzed, see Annex E. It was agreed that stand alone NGO ART centers were not as cost effective as the integrated ART KPSC/ satellite model and assumptions were developed for a transition to the more cost-effective model.

ART Service Delivery Model Assumptions NSP IV

ART Service Delivery Models	2020	2021	2022	2023	2024	2025
ART center with hospital	36%	33%	30%	27%	25%	23%
ART center without hospital (NAP teams)	20%	20%	20%	20%	20%	20%
ART satellite sites/ KPSC satellite sites by NGO	6%	14%	17%	20%	20%	20%
ART DC sites (all 2 types)	23%	26%	30%	33%	35%	37%
ART center without hospital (NGO ART cohort)	15%	7%	3%	0%	0%	0%
	100%	100%	100%	100%	100%	100%

The unit costs for new and existing ART services were weighted according to the ART Service Delivery Model assumptions and then weighted by the estimated number of new and current ART patients in line with the M&E framework for NSP IV.

	2021	2022	2023	2024	2025
Average ART unit cost	$ 197.75	$ 186.20	$ 182.79	$ 187.70	$ 186.70

For additional details on the costing for the Elimination of Mother to Child Transmission, Gender and Human Rights, Strategic Information and Leadership, please see Annex E.

NSP IV Budget

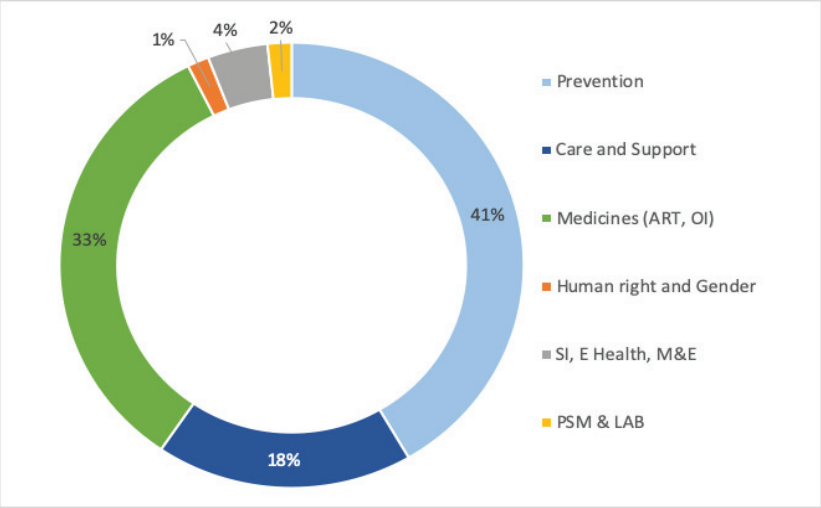
Based upon unit cost analyses a Gross Resource Requirement was developed for NSP IV from 2021- 2025. Successful implementation of NSP IV will require an efficient use of resources while maintaining quality, an increase in domestic allocation of resources and the financial leveraging of different partners to reach the 95-95-95 goals. The total Gross Resource Requirement for NSP IV was estimated at approximately $414 million over five years. This represents a modest reduction of $46 million in compared to the net resource requirement for NSP III and despite planned increases in all prevention and treatment targets at all levels. Unit cost analysis and streamlining of service delivery approaches will also allow increased geographical coverage in NSP IV.

Table 9:NSP IV Total Gross Resource Requirements based upon revised unit costs

Strategic Directions	2021	2022	2023	2024	2025	2021-2025
Strategic Direction 1: Reducing New Infections	27,828,137	33,338,122	36,580,939	39,798,513	41,678,891	179,224,602
Strategic Direction 2: Improving health outcomes for all people living with HIV	42,531,494	42,773,307	42,255,928	43,911,826	44,335,521	215,808,076
Strategic Direction 3: Strengthening multi-sectoral integration, gender and human rights based, people-centered community and health systems	1,261,325	1,223,675	1,217,350	1,185,500	1,259,850	6,147,700
Strategic Direction 4: Strengthening the use of strategic information (SI) and evidence to guide service delivery, management and policy	1,429,350	1,540,275	2,640,650	1,071,650	1,510,150	8,192,075
Strategic Direction 5: Promoting accountable leadership for the delivery of results and financing a sustainable response	1,130,300	1,204,600	968,100	1,005,600	805,600	5,114,200
TOTAL	74,180,607	80,079,979	83,662,967	86,973,089	89,590,011	414,486,654

The proportion of gross resource requirements for care and treatment including the commodities is 51% and for prevention 41% (Figure 26).

Figure 26: Proportion of gross resource requirements per thematic area



5.5.3 What is NEW for NSP IV

There are many issues identified as new for NSP IV within and across all Priority Interventions.

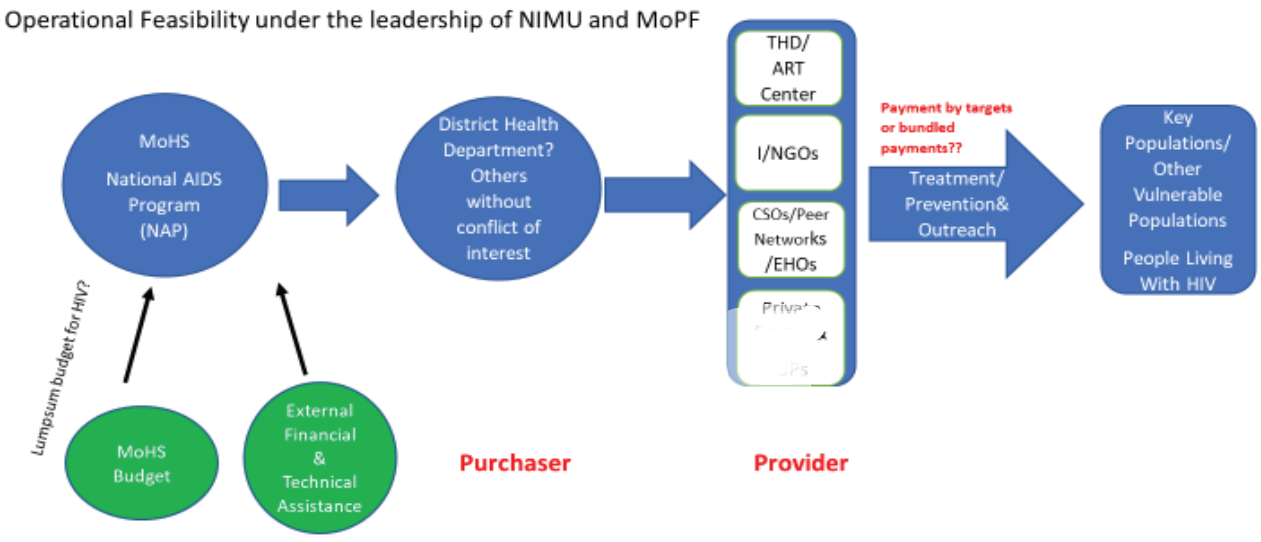
Within Priority Intervention 5.1 To strengthen and sustain high level political and technical commitments, several new issues and activities are included as follows: The inclusion of relevant legal frameworks in Priority Intervention emphasizes the importance of high-level leadership in NSP IV to move all ongoing legal reforms forward and make them effective. This will ensure that legal and policy frameworks are in place and reinforce both ministerial and parliamentarian leadership and engagement with people living with HIV and all key populations, including specific activities as listed in the activities table. The key result here is the development of a comprehensive, multisectoral legal and policy framework to guide and support the national response to HIV & AIDS and support leadership at all levels to strengthen and extend the enabling environment required for access to service, care and treatment.

A new Priority Intervention and a key new area in NSP IV is 5.2 A sustainable multisectoral HIV Human Resources for Health plan which includes an integration with other Departments and National Programs including TB, Hepatitis and Drug Dependency and Treatment Research Unit and the human resource needs

for Health in Prisons and Closed Settings. The HRH plan also requires a transition plan for Global Fund-financed and seconded staff positions, attention to training and capacity building, benefits and incentives, performance management, and attention to task shifting. Also included are institutionalization of the community workforce; formalizing of the Public Private Partnership and a sustainable plan to link with CBOs and Peer Networks as part of the transition plan when Global Fund support ends. The key result here is detailed needs assessments and national and sub national analysis and forecasting of HRH needs at all levels are instituted on a 2-yearly basis to ensure that HRH planning is consistent with the nature of services provided and delivery approaches responding to different contexts nationally. This will also provide a forum and a process to analyze and strengthen the Public Private Partnership for Health with community participation.

A new Priority Intervention 5.3 Ensure sustainable Financing includes an increase in Government of Myanmar (public) funding (an increase from the current Government of Myanmar budget by at least 25% - from 20% to 25% - to keep pace with expected GDP growth of 6.2% in 2018 to forecasted 6.8% GDP growth in 2020). The government contribution to be prioritized for "treatment, care and support" whereas international and other local resources will be mobilized more for "prevention and community system strengthening". **Mobilization of domestic funding for long-term programs** like ART needs to consider "sustainability" and "efficiency", such as through development of innovative purchasing models such as **contracting out to community** and **social contracting** piloted in collaboration with NIMU. Advocate for more funding from the other ministries and mobilize more private funding. Identify administration bottlenecks and pilot financing models appropriate for the country context such as **trust funds, taxation and co-payment**. Engage specialist clinics and hospitals as part of private sector engagement. **Develop an innovative funding model for HIV service provision in line with national UHC priorities.** The Global Fund to consider the PR-SR-SSR model in which NAP can subcontract private providers such as local NGOs, CBOs and networks to deliver services and outreach. Expand Government of Myanmar financing for non-commodity costs such as treatment outreach services and purchasing of services from private and NGO sectors and community health workforce through piloted provider payment mechanisms and performance-based financing, managed by a purchasing body. The key result here is to ensure that the national response to HIV, TB, HCV, and Syphilis is protected during the transition to UHC and eventual Government of Myanmar management of all national and external financial resources.

Figure 27: Possible Provider_Purchaser Model



A new Priority Intervention 5.4 Improve the Community Health Workforce. Establishing a Community Health Workforce under the Human Resources for Health plan. The key result here is that HIV will be clearly integrated into the Community-Based Health Worker policy adoption and implementation and linked with the Basic EPHS expansion plan.

A significantly new decentralized financing, management and partnership context through Priority Intervention 5.5 Strengthen governance, and management, coordination and accountability for the delivery of results but relevant to all priority interventions. There are significant additions and changes occurring in NSP IV in financial management, human resource planning and management, strengthening of the implementing partnership including especially the role of the private and community sectors and workforces, and the proactive and formalized participation of related ministries, department and national programs outside of the Ministry of Health and Sports. There is also a significant decentralization of operational planning and management and support for the implementing partnerships, illustrated by the transition of responsibility for treatment from NGOs to decentralized public sector health facilities. This will require unprecedented attention under Priority Intervention 5.5 in strengthening all levels of informed and engaged leadership, governance and management, coordination and accountability for the delivery of results. In particular this will require a new type of Operational Plan for NSP IV that is an integration of operational planning relevant to the national, state/ region and township levels. This new approach to operational planning will be supported by operational feasibility studies and analysis of the human resource, management and support structures, mechanisms and processes required to effectively manage and support a more decentralized and comprehensive implementing partnership.

5.5.4 Priority Interventions

5.1 Strengthen and sustain high level political and technical commitments including relevant legal frameworks.
5.2 A sustainable multisectoral HIV Human Resources for Health plan.
5.3 Ensure sustainable financing.
5.4 Improve the Community Health Workforce.
5.5 Strengthen governance, and management, coordination and accountability for the delivery of results.

5.5.5 Activities, Partners, Results

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
5.1 Strengthen and sustain high level political and technical commitments including relevant legal frameworks		
5.1.1 Legal and policy frameworks in place and reinforce with multi-ministerial and parliamentarian leadership and engagement of PLHIV and key populations ● Mandatory reporting of HIV cases from private sectors ● Policy on biometric and data security requirement ● Guidance for cross-border policy/ framework such as establishment of Government to Government agreement (Memorandum of Understanding with neighboring countries for cross border services) ● Patent law: MoHS to involve by-laws of patent law for ART production or packaging in country in future ● Policy brief for advocacy/ dialogue with policy makers and high-level decision makers (for examples: innovative interventions, health financing policy issues) Implementation of right-based activities which remove barriers of accessing health services (advocacy, policy review, sensitization program to stakeholders) **5.1.2 High-level advocacy events with MoHS and key relevant ministries and policy makers, and increase accountability of ministries and parliamentarians for enabling environment** ● Enabling environment and guidance on better coordination in conflict area and hard to reach area (including policy leadership for law reform)	Development of a comprehensive, multisectoral legal and policy framework to guide and support the national response to HIV & AIDS and support leadership at all levels to strengthen and extend the enabling environment required for access to service, care and treatment. -Increase in the number of laws and policies supporting national HIV response that are endorsed and effective. -The existing coordination platform will be strengthened together with wider involvement from other sectors. Operating at national and sub national levels to enable meaningful engagement	**Lead:** Parliament, NAP, MoHS, Ministry of Home Affairs, Civil Society Organizations and Community/ Peer Networks **Support:** United Nations System, INGOs, LNGOs **Implementing:** Parliament, NAP and other departments of MoHS, Civil Society Organizations and Community/ Peer Networks **Funding:** Government, Donors

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
• High level platform for multisectoral engagement to have strong leadership for EMTCT (dual elimination) **5.1.3 Continuous increase of the government budget for HIV**	with different service providers, ministries, parliamentarians and community networks at the national level and in the states and regions with relevance to different contexts.	
5.2 Sustainable Multisectoral HIV Human Resources for Health Plan		
5.2.1 HRH plan • Broader HRH plan not only for HIV but also to link/ integrate with other departments/ national programs (e.g. TB, Hepatitis, DDTRU) and include HR needs for health in prisons and closed settings • Sustainability/ transition plan for GF seconded staff positions • Full HR needs to be reviewed after all other thematic groups defined the activities • Motivation of staff ➔ Training/capacity building (resource mapping and creative planning for the efficiency) ➔ Benefit package/ incentive schemes ➔ Performance management system • To have professional staff for finance, logistic, procurement or capacity building of current staff/ mentoring by expert • Task shifting ➔ Enhance the use of primary health care (PHC) cadres, including PHS 2, in HIV outreach and support services	Detailed needs assessments and national and sub national analysis and forecasting of HRH needs at all levels are instituted on a 2-yearly basis to ensure that HRH planning is consistent with the nature of services provided and delivery approaches responding to different contexts nationally. This will also provide a forum and a process to analyze and strengthen the Public Private Partnership for Health with community participation. -Decrease in the number of vacant positions in public sector sites offering HIV prevention and treatment.	**Lead:** MoHS– Human Resources Administration, Department of Public Health, National AIDS Program, National TB Program, and National Malaria Control Program, Department of Medical Services **Support:** United Nations system, donors, INGOs, NGOs, CBOs, key population and PLHIV networks **Implementing:** All the partners listed above

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
➔ Institutionalization of community workforce with clearly defined HIV/AIDS service package/ functions for community cadres ➔ Involve private sectors (strategic purchasing); for example, formalized PPP (public private partnership) ➔ Strengthen the institutional capacity of local CBOs ➔ Develop specific field operational guidelines for outreach workers • Increase number of public sector sites offering KP-friendly services • Build a sense of ownership and ensure a proper task sharing among Department of Medical Services staff as part of ART transition plan (e.g. advocacy and training) ➔ Using PHS II in disease control activities with investments in capacity building for BHS on ATM services ➔ Collaboration between DOPH and DOMS staff ➔ Capacity building not only for basic health staff (BHS) but also for peers (community networks, Key Populations), EHOs and community volunteers (with the joint support of NAP and NGOs) • Sustainable plan to link with CBO/ Peer networks (in preparation for the scenario where GF supported seconded staff is stopped) **5.2.2 Optimize use of all available platforms for expansion of quality service delivery to meet needs of KPs and PLHIV** • Explore expanded testing,	- Increase in the number of trained DOPH/BHS, DOMS staff and community networks in line with ART transition plan and scaling up KP-friendly HIV services	**Funding:** Government, Donors

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
• Review plan for transition of ART patients to public sector and adjust as needed based on capacity, and service availability in public sector		
5.3 Ensure sustainable financing		
4.3.1 Increase government (Public) funding to 25% from 20% (or increase from current GOM budget by at least 25%, to keep pace with expected GDP growth of 6.2% in 2018 to forecasted 6.8% GDP in 2020) • Government contribution to prioritize for "treatment, care and support" whereas international and other local resources to be mobilized more for "prevention and community system strengthening" **5.3.2 Mobilization of domestic funding for long-term programs** like ART needs to consider "sustainability" and "efficiency", such as through development of innovative purchasing models (e.g. contracting out and social contracting) in the long run. • Advocate more funding from the other ministries • Mobilize more private funding (to increase to 2-3%) ➔ Identify and review the current private sector funding breakdown from NASA 2016-2017 ➔ Consultation workshop on how to increase the current funding and to develop mobilization plan ➔ Identify administration bottlenecks and pilot the financing models appropriate for the country context (e.g. trust fund, Taxation and Co-payment) ➔ Leverage income tax law such as tax exemption for CSR contribution ➔ Develop a phased roll-out plan for Corporate Service Investment (CSI) for HIV response	Ensure that the national response to HIV, TB, HCV, and Syphilis is protected during the transition to UHC and eventual Government of Myanmar management of all national and external financial resources. -20% to 25% of the HIV response financed with government budget - A proportionate increase in government expenditure in HIV prevention services - Private sector contribution to HIV response is increased to 3% at minimum. Operational feasibility of approaches to fund the PPP for Health including taxation, incentives for Corporate Social Responsibility contributions and a	**Lead:** M-HSCC, NAP, MOHS, PSM, Finance and Administration and Audit, NIMU **Support:** Ministry of Planning and Finance (MOPF), United Nations System, INGOs, NGOs and business corporations **Implementing:** NAP/MOHS, NIMU, State and Township Health Departments, Community/ Peer Networks, INGOs and NGOs **Funding:** Government, Donors

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
➔ Engage specialist clinic/ hospitals as part of private sector engagement **5.3.3 Develop Innovative funding model, including social contracting for HIV/AIDS service provision in line with national UHC priorities (pilot/ demonstration)** •GFATM – to consider PR-SR-SSR model in which NAP can sub -contract either a) private providers or b) local NGOs, CBOs and networks to deliver services and outreach. •Expand GOM financing for non-commodity costs such as outreach services and purchasing of services from private / NGO sectors and community health workforce through piloted provider payment mechanisms (e.g. bundled payment) and performance-based financing, managed by a purchasing body. • Activities to support sustainable financing ➔ Capacity building of MoHS planning and budgeting focal staff with the support of MoPF and other technical partners. ➔ Comprehensive assessment on the current intra-ministerial financial management ➔ Simplify and standardize MoHS financial management guidelines and Standard Operating Procedures ➔ Develop minimum standards for quality controls of non-MoHS providers from which services will be purchased ➔ Provide institutional capacity building to providers, specifically local community organizations/networks ➔ Assess service availability and readiness of potential non-MoHS providers to contract out (in	National Health Promotion Foundation as has been established in many countries. -Sustainable financing options are demonstrated by channeling government resources to community networks and private sectors for service scale-up. Ensure that external resources – financial, technical, human remain supportive of and aligned with financing, service provision and delivery innovation and reforms in the journey to UHC.	

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
line with Service Availability and Readiness Assessment [SARA], led by NIMU)		
5.4 Improve the Community Health Workforce		
5.4.1 Establish Community Health Workforce •Must link with HRH plan •HIV clearly integrated into CBHW policy adoption and implementation, and link with Basic EPHS expansion plan •Need to include outreach workers under HIV program like peer educators, case management supporters	-HIV is incorporated into the service package defined under the CBHW policy in line with basic EPHS roll-out plan	**Lead:** Department of Public Health, NAP and Human Resources Administration of MoHS, NIMU **Support:** United Nations System, INGOs, NGOs, Community/Peer Networks, CBOs **Implementing:** NAP/DOPH, DOMS, NIMU, State and Region Health Departments **Funding:** Government, Donors
5.5 Strengthen governance management and coordination and accountability for delivery of results		
5.5.1 Conduct operational feasibility studies and analysis of the financing modalities, human resource, management, structures, mechanisms and processes to	Effective and well-functioning stakeholder coordination and	**Lead:** M-HSCC, DoPH and DoMS of MoHS

Strategic Direction 5: Promoting Accountable Leadership for the delivery of results and financing a sustainable response – through advocacy, fund raising and multi-sectoral approach in line with universal health coverage		
Activities	**Results**	**Partners & Funding Source**
support a decentralized, more comprehensive partnership. **5.5.2 New approach to operational planning** to support decentralized and more comprehensive implementing partnership; integrating national, state/region and township levels. **5.5.3 Strengthen and maintain leadership of MHSCC** **5.5.4 Close coordination between DMS and DOPH at all levels** **5.5.5 Support and Strengthen State/ regional and township level health working group** (including public, private and communities* (including EHO)) *includes Key Populations, local communities, people living in EHO areas **5.5.6 Public Information sharing on the progress and results on HIV/AIDS** • In local language on website • Through National AIDS Conference	accountability mechanism in place and fully operational at national and township levels. (from NSP III)	**Support:** United Nations System, INGOs, NGOs and Community/Peer networks **Implementing:** M-HSCC, DOPH and DOMS of MoHS, NAP, State and Township Health Departments & Committees **Funding:** Government, Donors

Annexes

A. Development Process of NSP IV
B. List of High Priority Townships for NSP IV
C. Percentage of Key Populations Covered in High Priority Townships, NSP IV
D. Monitoring and Evaluation Plan
E. Budget Requirement

Annex A: Development Process of NSP IV

NSP IV was developed through an inclusive process lead by the NAP. The process was supported by a team of consultants drawing on 3 recent national reviews including the Review of the Health Sector Response to HIV in Myanmar, the Review of National Key Populations – HIV Program in Myanmar and the HIV Epidemiological Review. The Review of the Health Sector Response was effectively the Mid-Term Review of NSP III to provide input into NSP IV and the new Global Fund grant sub mission. The Review of National Key Populations was a review of the effectiveness, efficiency and quality of the design and implementation of HIV programs for key populations. The HIV Epidemiological Review looked at existing data to assess the status of the HIV epidemic and to recommend ways to improve the national response towards elimination of HIV with a focus on the geographic burden of HIV and specific key populations.

The Reviews and the NSP IV development process were carried out from the perspective of the vertical HIV program and from the perspective of the relationship of the HIV program with the broader health sector in the context of the longer term move towards Universal Health Coverage.
The development process was led by the discussion and output of 10 Thematic Groups reviewing achievements and challenges of the national response to HIV informed by the findings and recommendations of the 3 national reviews set against the objectives of NSP III. The consultant team developed Thematic Groups presentations to support the work of focal points, facilitators and people documenting outcomes of the process. The Thematic Groups included all areas of the national response to HIV. There was sharing of relevant outcomes across Thematic Groups as well as groups coming together for focused discussion of common issues. The Thematic Groups were inclusive, met several times over a 2-month period, and the process was almost exclusively lead by Myanmar key stakeholders.

Two related and parallel processes were carried out; one to develop the M&E framework for NSP IV, and another to develop a costing of NSP IV including an Optimization Workshop to support prioritization develop several funding scenarios for NSP IV. The output from the Thematic Groups informed the drafting of NSP IV as well as the that of the consultants and key stakeholders working on developing the M&E framework and the Costing and Budget for NSP IV. The output from these processes will inform the process of development of the next submission for funding to the Global Fund.

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Annex B: List of High Priority Townships for NSP IV

Sr.No.	State/Region	Township Name	Township (MM)
1	Kachin	Myitkyina	မြစ်ကြီးနားမြို့နယ်
2	Kachin	Waingmaw	ဝိုင်းမော်မြို့နယ်
3	Kachin	Tanai	တနိုင်းမြို့နယ်
4	Kachin	Chipwi	ချီဖွေမြို့နယ်
5	Kachin	Tsawlaw	ဆော့လော်မြို့နယ်
6	Kachin	Mohnyin	မိုးညှင်းမြို့နယ်
7	Kachin	Mogaung	မိုးကောင်းမြို့နယ်
8	Kachin	Hpakant	ဖားကန့်မြို့နယ်
9	Kachin	Bhamo	ဗန်းမော်မြို့နယ်
10	Kachin	Shwegu	ရွှေကူမြို့နယ်
11	Kachin	Momauk	မိုးမောက်မြို့နယ်
12	Kachin	Mansi	မန်စီမြို့နယ်
13	Kachin	Puta-O	ပူတာအိုမြို့နယ်
14	Kachin	Sumprabum	ဆွမ်ပရာဘွမ်မြို့နယ်
15	Kachin	Machanbaw	မချမ်းဘောမြို့နယ်
16	Kayah	Loikaw	လွိုင်ကော်မြို့နယ်
17	Kayin	Hpa-An	ဘားအံမြို့နယ်
18	Kayin	Myawaddy	မြဝတီမြို့နယ်
19	Kayin	Kyainseikgyi	ကြာအင်းဆိပ်ကြီးမြို့နယ်
20	Chin	Tedim	တီးတိန်မြို့နယ်
21	Sagaing	Sagaing	စစ်ကိုင်းမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
22	Sagaing	Shwebo	ရွှေဘိုမြို့နယ်
23	Sagaing	Wetlet	ဝက်လက်မြို့နယ်
24	Sagaing	Kanbalu	ကန့်ဘလူမြို့နယ်
25	Sagaing	Kyunhla	ကျွန်းလှမြို့နယ်
26	Sagaing	Ye-U	ရေဦးမြို့နယ်
27	Sagaing	Monywa	မုံရွာမြို့နယ်
28	Sagaing	Katha	ကသာမြို့နယ်
29	Sagaing	Indaw	အင်းတော်မြို့နယ်
30	Sagaing	Tigyaing	ထီးချိုင့်မြို့နယ်
31	Sagaing	Banmauk	ဗန်းမောက်မြို့နယ်
32	Sagaing	Kawlin	ကောလင်းမြို့နယ်
33	Sagaing	Wuntho	ဝန်းသိုမြို့နယ်
34	Sagaing	Pinlebu	ပင်လယ်ဘူးမြို့နယ်
35	Sagaing	Kale	ကလေးမြို့နယ်
36	Sagaing	Kalewa	ကလေးဝမြို့နယ်
37	Sagaing	Mingin	မင်းကင်းမြို့နယ်
38	Sagaing	Tamu	တမူးမြို့နယ်
39	Sagaing	Mawlaik	မော်လိုက်မြို့နယ်
40	Sagaing	Paungbyin	ဖောင်းပြင်မြို့နယ်
41	Sagaing	Hkamti	ခန္တီးမြို့နယ်
42	Sagaing	Homalin	ဟုမ္မလင်းမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
43	Tanintharyi	Dawei	ထားဝယ်မြို့နယ်
44	Tanintharyi	Myeik	မြိတ်မြို့နယ်
45	Tanintharyi	Palaw	ပုလောမြို့နယ်
46	Tanintharyi	Kawthoung	ကော့သောင်းမြို့နယ်
47	Bago	Bago	ပဲခူးမြို့နယ်
48	Bago	Kyauktaga	ကျောက်တံခါးမြို့နယ်
49	Bago	Shwegyin	ရွှေကျင်မြို့နယ်
50	Bago	Taungoo	တောင်ငူမြို့နယ်
51	Bago	Phyu	ဖြူးမြို့နယ်
52	Bago	Pyay	ပြည်မြို့နယ်
53	Bago	Thayarwady	သာယာဝတီမြို့နယ်
54	Magway	Magway	မကွေးမြို့နယ်
55	Magway	Yenangyaung	ရေနံချောင်းမြို့နယ်
56	Magway	Chauk	ချောက်မြို့နယ်
57	Magway	Taungdwingyi	တောင်တွင်းကြီးမြို့နယ်
58	Magway	Aunglan	အောင်လံမြို့နယ်
59	Magway	Pakokku	ပခုက္ကူမြို့နယ်
60	Mandalay	Aungmyaythazan	အောင်မြေသာဇံမြို့နယ်
61	Mandalay	Chanayethazan	ချမ်းအေးသာဇံမြို့နယ်
62	Mandalay	Mahaaungmyay	မဟာအောင်မြေမြို့နယ်
63	Mandalay	Chanmyathazi	ချမ်းမြသာစည်မြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
64	Mandalay	Pyigyitagon	ပြည်ကြီးတံခွန်မြို့နယ်
65	Mandalay	Amarapura	အမရပူရမြို့နယ်
66	Mandalay	Patheingyi	ပုသိမ်ကြီးမြို့နယ်
67	Mandalay	Pyinoolwin	ပြင်ဦးလွင်မြို့နယ်
68	Mandalay	Madaya	မတ္တရာမြို့နယ်
69	Mandalay	Singu	စဉ့်ကူးမြို့နယ်
70	Mandalay	Mogoke	မိုးကုတ်မြို့နယ်
71	Mandalay	Thabeikkyin	သပိတ်ကျင်းမြို့နယ်
72	Mandalay	Kyaukse	ကျောက်ဆည်မြို့နယ်
73	Mandalay	Sintgaing	စဉ့်ကိုင်မြို့နယ်
74	Mandalay	Tada-U	တံတားဦးမြို့နယ်
75	Mandalay	Myingyan	မြင်းခြံမြို့နယ်
76	Mandalay	Kyaukpadaung	ကျောက်ပန်းတောင်းမြို့နယ်
77	Mandalay	Nyaung-U	ညောင်ဦးမြို့နယ်
78	Mandalay	Yamethin	ရမည်းသင်းမြို့နယ်
79	Mandalay	Pyawbwe	ပျော်ဘွယ်မြို့နယ်
80	Mandalay	Meiktila	မိတ္ထီလာမြို့နယ်
81	Mandalay	Mahlaing	မလှိုင်မြို့နယ်
82	Mon	Mawlamyine	မော်လမြိုင်မြို့နယ်
83	Mon	Thanbyuzayat	သံဖြူဇရပ်မြို့နယ်
84	Mon	Ye	ရေးမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
85	Mon	Thaton	သထုံမြို့နယ်
86	Mon	Paung	ပေါင်မြို့နယ်
87	Rakhine	Sittwe	စစ်တွေမြို့နယ်
88	Rakhine	Kyaukpyu	ကျောက်ဖြူမြို့နယ်
89	Rakhine	Thandwe	သံတွဲမြို့နယ်
90	Yangon	Insein	အင်းစိန်မြို့နယ်
91	Yangon	Mingaladon	မင်္ဂလာဒုံမြို့နယ်
92	Yangon	Shwepyithar	ရွှေပြည်သာမြို့နယ်
93	Yangon	Hlaingtharya	လှိုင်သာယာမြို့နယ်
94	Yangon	Thingangyun	သင်္ဃန်းကျွန်းမြို့နယ်
95	Yangon	Yankin	ရန်ကင်းမြို့နယ်
96	Yangon	South Okkalapa	တောင်ဥက္ကလာပမြို့နယ်
97	Yangon	North Okkalapa	မြောက်ဥက္ကလာပမြို့နယ်
98	Yangon	Thaketa	သာကေတမြို့နယ်
99	Yangon	Dawbon	ဒေါပုံမြို့နယ်
100	Yangon	Tamwe	တာမွေမြို့နယ်
101	Yangon	Pazundaung	ပုဇွန်တောင်မြို့နယ်
102	Yangon	Botahtaung	ဗိုလ်တထောင်မြို့နယ်
103	Yangon	Dagon Myothit (South)	ဒဂုံမြို့သစ်တောင်ပိုင်းမြို့နယ်
104	Yangon	Dagon Myothit (North)	ဒဂုံမြို့သစ်မြောက်ပိုင်းမြို့နယ်
105	Yangon	Dagon Myothit (East)	ဒဂုံမြို့သစ်အရှေ့ပိုင်းမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
106	Yangon	Dagon Myothit (Seikkan)	ဒဂုံမြို့သစ်ဆိပ်ကမ်းမြို့နယ်
107	Yangon	Mingalartaungnyunt	မင်္ဂလာတောင်ညွန့်မြို့နယ်
108	Yangon	Dala	ဒလမြို့နယ်
109	Yangon	Seikgyikanaungto	ဆိပ်ကြီးခနောင်တို
110	Yangon	Kyauktada	ကျောက်တံတားမြို့နယ်
111	Yangon	Pabedan	ပန်းဘဲတန်းမြို့နယ်
112	Yangon	Lanmadaw	လမ်းမတော်မြို့နယ်
113	Yangon	Latha	လသာမြို့နယ်
114	Yangon	Ahlone	အလုံမြို့နယ်
115	Yangon	Kyeemyindaing	ကြည့်မြင်တိုင်မြို့နယ်
116	Yangon	Sanchaung	စမ်းချောင်းမြို့နယ်
117	Yangon	Hlaing	လှိုင်မြို့နယ်
118	Yangon	Kamaryut	ကမာရွတ်မြို့နယ်
119	Yangon	Mayangone	မရမ်းကုန်းမြို့နယ်
120	Yangon	Dagon	ဒဂုံမြို့နယ်
121	Yangon	Bahan	ဗဟန်းမြို့နယ်
122	Yangon	Seikkan	ဆိပ်ကမ်းမြို့နယ်
123	Yangon	Thanlyin	သန်လျင်မြို့နယ်
124	Yangon	Twantay	တွံတေးမြို့နယ်
125	Yangon	Hmawbi	မော်ဘီမြို့နယ်
126	Yangon	Hlegu	လှည်းကူးမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
127	Shan (S)	Taunggyi	တောင်ကြီးမြို့နယ်
128	Shan (S)	Nyaungshwe	ညောင်ရွှေမြို့နယ်
129	Shan (S)	Hopong	ဟိုပုံးမြို့နယ်
130	Shan (S)	Hsihseng	ဆီဆိုင်မြို့နယ်
131	Shan (S)	Kalaw	ကလောမြို့နယ်
132	Shan (S)	Lawksawk	ရပ်စောက်မြို့နယ်
133	Shan (S)	Loilen	လွိုင်လင်မြို့နယ်
134	Shan (S)	Nansang (South)	နမ့်စန်မြို့နယ်
135	Shan (S)	Kunhing	ကွန်ဟိန်းမြို့နယ်
136	Shan (S)	Monghsu	မိုင်းရှူးမြို့နယ်
137	Shan (N)	Lashio	လားရှိုးမြို့နယ်
138	Shan (N)	Hseni	သိန်းနီမြို့နယ်
139	Shan (N)	Mongyai	မိုင်းရယ်မြို့နယ်
140	Shan (N)	Tangyan	တန့်ယန်းမြို့နယ်
141	Shan (N)	Muse	မူဆယ်မြို့နယ်
142	Shan (N)	Namhkan	နမ့်ခမ်းမြို့နယ်
143	Shan (N)	Kutkai	ကွတ်ခိုင်မြို့နယ်
144	Shan (N)	Kyaukme	ကျောက်မဲမြို့နယ်
145	Shan (N)	Nawnghkio	နောင်ချိုမြို့နယ်
146	Shan (N)	Hsipaw	သီပေါမြို့နယ်
147	Shan (N)	Namtu	နမ္မတူမြို့နယ်

Sr.No.	State/Region	Township Name	Township (MM)
148	Shan (N)	Namhsan (North)	နမ့်ဆန်မြို့နယ်
149	Shan (N)	Mongmit	မိုးမိတ်မြို့နယ်
150	Shan (N)	Mabein	မဘိမ်းမြို့နယ်
151	Shan (N)	Kunlong	ကွမ်းလုံမြို့နယ်
152	Shan (N)	Laukkaing	လောက်ကိုင်မြို့နယ်
153	Shan (N)	Pangsang	ပန်ဆန်းမြို့နယ်
154	Shan (E)	Kengtung	ကျိုင်းတုံမြို့နယ်
155	Shan (E)	Mongla	မိုင်းလားမြို့နယ်
156	Shan (E)	Monghsat	မိုင်းဆတ်မြို့နယ်
157	Shan (E)	Tachileik	တာချီလိတ်မြို့နယ်
158	Ayeyarwady	Pathein	ပုသိမ်မြို့နယ်
159	Ayeyarwady	Pyapon	ဖျာပုံမြို့နယ်
160	Ayeyarwady	Bogale	ဘိုကလေးမြို့နယ်
161	Ayeyarwady	Maubin	မအူပင်မြို့နယ်
162	Ayeyarwady	Myaungmya	မြောင်းမြမြို့နယ်
163	Ayeyarwady	Hinthada	ဟင်္သာတမြို့နယ်
164	Nay Pyi Taw	Tatkon	တပ်ကုန်းမြို့နယ်
165	Nay Pyi Taw	Poke Ba Thi Ri	ပုဗ္ဗသီရိမြို့နယ်
166	Nay Pyi Taw	Pyinmana	ပျဉ်းမနားမြို့နယ်
167	Nay Pyi Taw	Lewe	လယ်ဝေးမြို့နယ်

Annex C: Percentage of Key populations covered in High Priority Townships, NSP IV

State/Region	No. of tsp selected	% of tsp selected	estimated no. of KP covered			% of KP covered		
			FSW	MSM	PWID	FSW	MSM	PWID
Ayewaddy	6	23%	6,012	5,100	584	72%	59%	32%
Bago	7	25%	3,736	7,122	522	85%	59%	36%
Chin	1	11%	28	53	220	36%	18%	45%
Kachin	15	83%	3,239	5,719	21,819	100%	100%	100%
Kayah	1	14%	70	229	40	62%	67%	46%
Kayin	3	43%	1,821	3,533	261	84%	85%	60%
Magway	6	24%	2,130	4,713	872	86%	59%	42%
Mandalay	22	79%	11,965	20,095	9,754	97%	92%	97%
Mon	5	50%	1,490	3,205	330	85%	69%	58%
Nay Pyi Taw	4	50%	1,188	1,537	252	78%	69%	68%
Rakhine	3	18%	552	1,338	678	71%	42%	49%
Sagaing	22	59%	5,537	10,277	18,119	95%	85%	95%
Shan E	4	40%	1,299	837	3,509	90%	73%	88%
Shan N	17	71%	3,737	2,506	18,220	96%	88%	92%
Shan S	10	48%	3,474	4,315	5,395	95%	88%	84%
Tanintharyi	4	40%	2,220	3,253	211	92%	80%	51%
Yangon	37	82%	11,240	27,108	2,484	97%	92%	87%
Total	**167**	**51%**	**59,739**	**100,941**	**83,270**	**90%**	**80%**	**89%**

Annex D: Monitoring and Evaluation Plan

Standard Indicators	Data Source	PSE/denominator 2019	Baseline data	Baseline (year)	Denominator definition	Proposed targets for NSP IV 2021	2022	2023	2024	2025
Female Sex Workers (FSW)										
Impact/Outcome Targets (FSW)										
Number of new infections per 1,000 FSW among the uninfected population of FSW	Modelling	69,272	16.60	2010	est. HIV uninfected FSW pop per year	5.52	4.75	3.98	3.21	2.43
% of FSW reporting condom use at last sex with client	HSS/BBS		81.1%	2015				90%		
% of FSW who avoid health care because of stigma and discrimination in the past 12 months	BBS		NA					10%		
Output/Coverage Targets (FSW)										
% FSW reached with HIV prevention programmes in the past 3 months	BBS		72.6%	2015				90%		
% of FSW who know their current HIV status	BBS		45.8%	2015				95%		
Number of FSW reached with HIV prevention programmes	Program data	69,272	58,196	2019	FSW PSE per year	61,267	63,832	66,113	68,383	70,646
Number of FSW who received an HIV test and knew the result	Program data		55,759	2019	FSW prevention reach per year	58,472	60,850	62,952	65,039	67,114
Number of FSW who received an HIV self testing (sub-target of total HIV testing)	*Program data*		*NA*			*585*	*942*	*1,299*	*1,656*	*2,013*
Number of FSW who received oral pre-exposure prophylaxis (PrEP) at least once in the past 12 months	Program data		NA		est. HIV uninfected FSW pop per year	791	1,874	2,809	3,025	3,095
% of FSW PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP	Program data		NA		FSW who initiated PrEP per year	40%	48%	55%	63%	70%
Men who have sex with men/ Transgender Women (MSM/TGW)										
Impact/Outcome Targets (MSM/TGW)										
Number of new infections per 1,000 MSM/TGW among the uninfected population of MSM/TG	Modelling	136,601	12.93	2010	est. HIV uninfected MSM pop per year	5.72	4.92	4.12	3.32	2.52
% of MSM/TGW reporting condom use at last anal sex	HSS/BBS		77.1%	2015				90%	-	-
% of MSM/TGW who avoid health care because of stigma and discrimination in the past 12 months	BBS		NA	0				10%	-	-
Output/Coverage Targets (MSM/TGW)										
% MSM/TGW reached with HIV prevention programmes in the past 3 months	BBS		71.0%	2015				90.0%		
% MSM/TGW who knew their current HIV status	BBS		49.6%	2015				95.0%		
Number of MSM/TGW reached with HIV prevention programmes	program data	136,601	66,428	2019	MSM PSE per year	100,080	111,202	122,440	133,797	139,379
Number of MSM/TGW who received an HIV test and knew the result	program data		64,870	2019	MSM prevention reach per year	95,379	105,895	116,503	127,209	132,410
Number of MSM/TGW who received an HIV self testing (sub-target of total HIV testing)	*Program data*		*NA*			*2,500*	*3,530*	*4,560*	*5,590*	*6,620*
Number of MSM/TGW who received oral pre-exposure prophylaxis (PrEP) at least once in the past 12 months	Program data		NA		est. HIV uninfected MSM pop per year	1,823	4,966	7,570	8,273	8,618
% of MSM/TGW PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP	Program data		NA		MSM who initiated PrEP per year	40%	48%	55%	63%	70%
People who inject drugs (PWID)										
Impact/Outcome Targets (PWID)										
Number of new infections per 1,000 PWID among the uninfected population of PWID	Modelling	95,264	50.32	2010	est. HIV uninfected PWID pop per year	29.48	24.61	19.73	14.85	9.97
% of PWID reporting the use of sterile injecting equipment the last time they injected	HSS/BBS		90.8%	2017			93.2%			95.0%
% of PWID reporting condom use at last sex	HSS/BBS		21.9%	2017			38.0%			50.0%
% of PWID who avoid health care because of stigma and discrimination in the past 12 months	BBS		NA				15%			10%
Output/Coverage Targets (PWID)										
% PWID reached with HIV prevention programmes in the past 3 months	BBS		34.2%	2017			68.9%			95.0%
% PWID who know their current HIV status	BBS		27.9%	2017			66.2%			95.0%
Number of PWID reached with HIV prevention programmes	Program data	95,264	55,934	2019	PWID PSE per year	73,449	79,402	85,427	91,526	97,699
Number of PWID received an HIV test and knew the result	Program data		47,900	2019	PWID prevention reach per year	61,062	68,366	76,088	84,235	92,814
Number of PWID who received an HIV self testing (sub-target of total HIV testing)	*Program data*		*NA*			*305*	*577*	*849*	*1,120*	*1,392*
Number of PWID who received oral pre-exposure prophylaxis (PrEP) at least once in the past 12 months	Program data		NA		est. HIV uninfected PWID pop per year	1,630	3,286	4,730	5,744	6,492
% of PWID PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP	Program data		NA		PWID who initiated PrEP per year	40%	45%	50%	55%	60%
Number of sterile injecting equipment distributed to PWID	Program data	95,264	35.1m	2019		36.1	36.6	37.1	37.5	37.9
Number of PWID receiving Oral Substitution Therapy at the end of reporting period	Program data	95,264	19,991	2019		29,716	41,111	48,725	57,679	61,393
% of PWID receiving Oral Substitution Therapy for at least 6 months	Program data	5,630	69%	2019	OST initiated PWID in previous year	80%	80%	80%	80%	80%

General and Other Vulnerable Population										
Impact Targets (General)										
Number of new infections per 1000 adult (15-49) person-years among the uninfected population	Modelling		0.50	2010		0.24	0.21	0.18	0.15	0.11
Number of AIDS related death per 100,000 population	Modelling		22.25	2010		10.39	9.01	7.63	6.25	4.87
% of PLHIV who report experiences of HIV-related discrimination in health-care settings in the past 12 months	Stigma index survey		53%	2016		20%				10%
Output/Coverage Targets (General)										
Number of (Clients of FSW, partners of KP and PLHIV, PWUD, people in prison and other closed settings, migrants, USP and youths) reached with HIV prevention programmes	Program data		166,117	2019		207,783	227,906	249,880	275,727	303,170
Clients of FSW			*13,912*	*2019*		*10,500*	*11,150*	*12,000*	*13,000*	*14,250*
Partners of FSW		*36,088*	*2,000*	*2019*		*2,600*	*2,830*	*3,060*	*3,200*	*3,450*
PWUD		-	*38,124*	*2019*		*45,000*	*50,000*	*55,000*	*60,000*	*65,000*
People in prison and other closed settings		*85,000*	*15,256*	*2019*		*45,000*	*50,000*	*60,000*	*70,000*	*80,750*
Mobile and migrant population/people at workplace		-	*80,008*	*2019*		*60,000*	*64,500*	*69,300*	*75,000*	*81,000*
Youth (15-24 yr non KP but high risk)		-	*4,334*	*2019*		*20,000*	*22,000*	*24,200*	*27,000*	*30,000*
Partner of PWID		*38,611*	*5,802*	*2019*		*7,200*	*7,900*	*8,700*	*9,600*	*10,500*
Partner of PLHIV (negative partner)		*46,156*	-	*2019*		*14,483*	*16,376*	*14,320*	*14,427*	*14,520*
Uniform service personnel		-	*5,837*	*2019*		*3,000*	*3,150*	*3,300*	*3,500*	*3,700*
Number of people who received an HIV test and knew their result (Clients of FSW, partners of KP and PLHIV, PWUD, people in prison and other closed settings, migrants, USP, and youth) by age group	Program data		149,035	2019		144,460	175,107	207,711	243,521	282,118
Clients of FSW			*37,921*	*2019*		*42,104*	*49,454*	*56,832*	*64,223*	*71,620*
Regular Partners of FSW						*4,044*	*5,055*	*6,109*	*7,673*	*9,325*
PWUD						*22,500*	*30,000*	*38,500*	*45,000*	*52,000*
People in prison and other closed settings			*36,072*	*2019*		*38,250*	*44,000*	*54,000*	*65,100*	*76,713*
Mobile and migrant population/people at workplace			*36,000*	*2019*		*18,000*	*22,575*	*27,720*	*33,750*	*40,500*
Youth (15-24 yr non KP but high risk)						*1,000*	*2,200*	*3,630*	*5,400*	*7,500*
Regular Partner of PWID						*2,880*	*3,950*	*4,785*	*5,760*	*7,350*
Partner of PLHIV (negative partner)						*14,483*	*16,376*	*14,320*	*14,427*	*14,520*
Uniform service personnel			*3,685*	*2019*		*1,200*	*1,496*	*1,815*	*2,188*	*2,590*
Number of people who received an HIV self-testing and knew their result (Clients of FSW, partners of KP and PLHIV, PWUD, people in prison and other closed settings, migrants, USP, and youth) (sub target of total HIV testing for OVP)			*NA*			*500*	*1,000*	*1,500*	*2,000*	*2,500*
% of PLHIV who have been tested and know their HIV positive status (1st 95)	Program data	238,391	80%	2018	est. PLHIV per year	91%	95%	95%	95%	95%
Prevention of Mother to Child Transmission (PMTCT)										
Impact Targets (PMTCT)										
% HIV-infected among HIV-exposed infants born in the past 12 months	Modelling		16%	2018	HIV-exposed infants born per year	10%	9%	7%	5%	<5%
Case rate of congenital syphilis per 100,000 live births	Modelling/Program data		NA		total live birth per year					<=50
Output/Coverage Targets (PMTCT)										
% and Number of pregnant women attending antenatal care services who received HIV testing	Program data	1,096,027	906,439	2019	est. pregnancy per year	1,023,743	1,061,438	1,066,597	1,070,637	1,073,811
% and Number of pregnant women attending antenatal care services who received Syphilis testing	Program data	1,096,027	516,795	2019	est. pregnancy per year	759,903	838,554	917,285	995,699	1,073,811
% and Number of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (including known case on ART)	Program data	5,266	4,232	2019	est. HIV+PW per year	92%	95%	95%	95%	95%

Number of Syphilis-positive pregnant women who received treatment to reduce the risk of mother-to-child transmission	Program data	5,230	2,080	2019	est. Syphilis positive PW per year	2,276	2,629	2,983	3,337	3,691
% of HIV exposed infants who initiated ARV prophylaxis	Program data	5,003	73%	2019	est. HIV+PW (live birth) per year	75%	80%	85%	90%	95%
% of Syphilis exposed infants who received treatment	Program data	4,968	30%	2019	est. Syphilis positive PW (live birth) per year	50%	61%	72%	84%	95%
% of HIV exposed infants receiving a virological test for HIV within 2 months of birth	Program data	5,003	52%	2019	est. HIV+PW (live birth) per year	58%	68%	79%	89%	100%
% of identified HIV positive infants who initiated ART by 12 months of age	Program data		NA		identified HIV postive infants per year	80%	84%	88%	91%	95%
Anti-retroviral Therapy (ART)										
Outcome Targets (ART)										
% people living with HIV and on ART who are retained on ART 12 months after initiation	Program data (cohort)		83%	2019	ART initiated PLHIV per year	90%	91%	92%	94%	95%
% of PLHIV on ART who are virologically suppressed (<=1,000 copies/ml) (3rd 95)	Program data	184,624	68%	2019	PLHIV on ART per year	75%	80%	85%	90%	95%
% of PLHIV on ART who are virologically suppressed among those tested for viral load	Program data	133,468	95%	2019	PLHIV on ART and tested for VL per year	95%	95%	95%	95%	95%
% of PLHIV on ART with viral load suppression (<1,000 copies/ml) at 12 months after treatmetn initiation	Program data (cohort)		93%	2019	PLHIV who initiated ART and tested for VL at 12 mths per year	95%	95%	95%	95%	95%
Output/Coverage Targets (ART)										
% of newly identified (reported) HIV postive people newly received treatment during the reporitng period	Program data		NA		newly diagnosed HIV positives per year	70%	76%	83%	89%	95%
% of people living with HIV who are receiving antiretroviral therapy (2nd 95)	Program data	238,391	77%	2,019	est. PLHIV per year	85%	90%	90%	90%	90%
Number of adults living with HIV who are receiving ART at the end of reporting period	Program data	228,877	176,697 (77%)	2,019	est. adult PLHIV per year	198,387	212,311	214,389	216,355	218,184
Number of children living with HIV who are receiving ART at the end of reporting period	Program data	9,514	7,927 (83%)	2,019	est. child PLHIV per year	8,150	8,197	7,860	7,489	7,101
Number and % of PLHIV on ART received viral load test	Program data	184,624	133,468 (72%)	2,019	PLHIV on ART per year	152,248 (74%)	177,036 (80%)	193,039 (87%)	209,135 (93%)	225,285 (100%)
Number and % of HIV-positive new and relapse TB patients on ART during TB treatment	Program data	0	7,397	2019	est. TBHIV patients per year	9,266 (72%)	9,957 (78%)	10,419 (84%)	10,275 (89%)	9,926 (95%)
Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period	Program data	35,572	0%	0	PLHIV on ART eligible for TPT per year	35%	50%	70%	80%	90%

Annex E: NSP IV Budgeting Process

NSP IV costing has been done through series of consultation with key stakeholders and 2 costing workshops. The process was informed by the thematic group discussions and main guidance from the operational context thematic group. There are several significant changes occurring in the transition from NSP III to NSP IV within the geographic prioritization, the service packages and delivery models, changes in testing and treatment guidelines and new initiatives that all need to be costed in operational, expandable and sustainable way. The costing tool previously used during NSP II and III was reviewed and analyzed whether it could accommodate the changes in the NSP IV. Also, prices for commodities were reviewed together with the UNOPS and Save the Children.

The purpose of the first consultation workshop was to present the HIV service package and service delivery models that the Operational context thematic group proposed, clarify the activities under each thematic group for unit costing, define standard resource needs for ART service delivery and set the targets for each service delivery model including scale up. The workshop was led by the NAP and included regional officers from NAP, focal persons from thematic groups and donors (GF PRs, Access to Health Fund, US CDC, USAID funded UHF project).

First costing workshop outputs included;

- A Consensus was agreed for the Essential and Comprehensive packages for Health Service (HIV),
- Other vulnerable population was agreed to be categorized as 1) Clients/ partners, 2) Youth, 3) mobile/ migrant, 4) prison, 5) workplace (institutional population), 6) uniform (training school),
- Essential Package for Health Service (EPHS)- HIV was agreed to be provided for all other vulnerable populations
- Cost for enabling environment should be added to the essential package for community system strengthening
- Community testing by BHS are in place already for PMTCT and it should be included under the essential package
- Linkage to care support cost should be included under prevention package to enhance ART initiation
- Patient support cost for ART and MMT in previous NSP are higher than actual use and need to be revised
- NCD should be included to link/ integrate with other services under comprehensive package
- Enhanced outreach for PWID should include community-based overdose management
- Current ART service delivery models were reviewed, the modality of ART service delivery and reference target population covered by each model were defined and human resource needs was standardized
- Patient support cost for ART and MMT in previous NSP are higher than actual use and need to be revised

Unit Cost for service packages

Following package of services were agreed to do the unit costing;

1. EPHS -HIV: Prevention
2. CPHS-HIV: Prevention
    - Prevention for each key population, FSW, MSM, PWID
        - Through Enhanced outreach, peer/community-based approach
        - Through KPSC and Enhanced outreach combination approach
        - Opioid substitution therapy (OST) through Drug Treatment Center (DTC)
3. EPHS -HIV: Care and treatment (ART provision)

- Through Government Hospitals (ART centers)
- Through NAP Teams (ART centers)
- Through NAP Teams/ ART centers (ART satellite sites/ KPSC satellite sites by NGOs)
- Through Township and sub-township hospitals/ health centers (DC sites)
- Through NGOs (Stand-alone NGO ART centers)- Plan to phase out this model in NSP IV era

4. EPHS -HIV: EMTCT

According to the outputs and agreement from the first costing workshop, the entire costing tool needed to be revised. The costing tool for unit costing was reconstructed according to the service package framework, using the latest national guideline for HIV testing, ART, PMTCT roadmap, hepatitis C treatment, opioid substitution therapy and draft-PrEP guideline in close consultation with NAP.

Data input tabs for epidemiological data, commodities price, staff salaries and drop-in centers running cost were added to the costing tool to modify easily in the future. Incidence data from NSP IV M&E framework for HIV test kits, prevalence and behavioral data from IBBS: MSM/FSW 2015; PWID 2017 for STI, hepatitis B and C, overdose, condom usage, needle and syringes usage, were used. Commodities prices, ART treatment regimen and current patients' ratio, staff salaries and operation cost were provided by UNOPS and Save the Children PRs. PSM cost 12% was applied to all commodities. Training and transportation costs were aligned to reflect the current market. Program management cost 15% and Monitoring and evaluation (M&E) cost 5%, inflation factor for human resources 3% per year were applied to all unit cost. STI treatment and HTS unit cost were calculated as package including staff time and commodities for the outreach models.

Reference targets for each service delivery model for key populations were updated according to Strategic thematic group (Table 1). The role of NGOs will evolve from implementers into a capacity development role for community service delivery. The prevention unit costs were mainly based upon INGO running cost and are shifted to community running cost gradually. Therefore, the unit costs are calculated to reflect the changing role and hence reduce cost and increased coverage overtime.

Table 10: Percentage of key population targets reached with different service delivery models

KP	Service delivery models	2021	2022	2023	2024	2025
FSW	Through KPSC	75%	72%	68%	65%	60%
	Through Peer/community based	25%	28%	32%	35%	40%
MSM	Through KPSC	70%	68%	65%	62%	60%
	Through Peer/community based	30%	32%	35%	38%	40%
PWID	Through KPSC	90%	90%	85%	75%	70%
	Through Peer/community based	10%	10%	15%	25%	30%

EPHS-HIV: Prevention

- **Target population**: KP, Clients/partners, Youth, Workplace, Mobile/migrant, Prison, Uniform (training school)
- **Geographic coverage**: 330 townships
- **Description:** outreach model carried out by community members with standard commodities and service package linked to a simple integrated public sector approach.
- **Services:** Health promotion, referral to public sector for STI, HTS, PEP (only for HCW and sexual violence cases),
- Linkage with/integrated in other services: TB, ANC, SRH, NCD
- **Reference target for unit cost**ing: 2,000
- **Cost component**:
    - Outreach worker remuneration, training, transportation
    - Commodities: IEC, Condoms, Lubricants
    - STI treatment, HTS cost
    - Referral
    - Enabling environment
    - Program management and M&E

	2021	2022	2023	2024	2025
EPHS-HIV Prevention Unit Cost	$ 15.57	$ 16.04	$ 16.52	$ 17.01	$ 17.52

CPHS-HIV: Prevention (Enhanced outreach, peer/community-based approach)

- **Target population**: FSW, MSM, PWID, Clients/partners
- **Geographic cove**rage: 167 High priority townships
- **Description**: outreach model carried out by community/peers using enhanced outreach approach with standard commodities and service package linked to public sector or NGO. Supervisor staff cost in the field are added and this cost can be used as reference for social contracting to local CBO or CSO or EHO without commodities. Unit cost for FSW, MSM, PWID is separately calculated.
- **Services**: Peer education, Health literacy promotion, overdoes management in the field (for PWID),
- Linkage with/integrated in other services: TB, ANC, SRH, NCD, referral to public sector for or NGO for STI, HTS, comprehensive care and treatment
- **Reference target for unit costing**: FSW-3,000, MSM-4,000, PWID-4,000
- **Cost component**:
    - Peer remuneration, training, transportation
    - Program officer, support staff
    - Commodities: IEC, Condoms, Lubricants, Needles and syringes, Naloxone
    - STI treatment, HTS cost
    - Referral
    - Enabling environment
    - Program management and M&E

CPHS-HIV Prevention (outreach)	2021	2022	2023	2024	2025
FSW	$ 27.40	$ 28.22	$ 29.07	$ 29.94	$ 30.84
MSM	$ 24.18	$ 24.91	$ 25.65	$ 26.42	$ 27.22
PWID	$ 38.48	$ 39.63	$ 40.82	$ 42.05	$ 43.31

During the second costing workshop, draft unit costs were presented and adjusted according to the participants recommendation on KPSC operating cost, standardization of human resource and average salary. Primary health care (medicines) was recommended to use $3 per PWID per year (from current expenditure) for PWID KPSC without ART. For KPSC with ART provision, medicine costs can be shared and used from OI treatments. Cups (usable) for drug treatment center are expensive and there are always extra cups in the sites because of some dropouts/missed doses and it was recommended to keep the cost of cups as it is but reduced the usage assumption to 80%.

CPHS-HIV: Prevention (KPSC and Enhanced outreach combination approach)

- **Target population**: FSW, MSM, PWID, Clients/partners
- **Geographic cove**rage: 167 High priority townships
- **Description**: A mixture of key population friendly one stop service and outreach model for comprehensive prevention and treatment with or without ART treatment. Unit cost for FSW, MSM, PWID is separately calculated for 2 models (Size) of KPSC, small and large, for each key population. Assumption agreed was large KPSC are for the big cities like Yangon, Mandalay, Myitkyinar, Phakant where key population sizes are big and operating cost is expensive and small are for other high priority townships, 30% of target will be reached through large KPSC and 70% through small KPSC. Small KPSC cost for MSM can be used as a proxy for youth friendly service centers.
- **Services**: Peer education, health literacy promotion, harm reduction, overdose management (for PWID), social media, STI, SRH, HTS, Hep B and C testing, Hep B vaccination (for PWID), Hep C treatment (for PWID and other KPs), TPT, PrEP, PEP, with or without ART
- Linkage with/ integrated in other services: TB, ANC, SRH, NCD, Drug treatment centers, mental health SGBV, Services for ATS users, vocal and livelihood programs
- **Reference target for unit costing:**
  - Large KPSC: FSW-3,500, MSM-4,500, PWID-5,000
  - Small KPSC: FSW-1,200, MSM-1,500, PWID-2,000
- **Cost component**:
  - KPSC Staff salary, Peer remuneration, training, transportation
  - Social media, hotline: online staff and related cost
  - KPSC operating cost: Facility, equipment, utilities, waste management
  - Commodities:
    - IEC, Condoms, Lubricants, PrEP, PEP, Needles and syringes, Naloxone for PWID
    - Hep B Vaccine and Hep C treatment, primary health care for PWID
    - Hep B & C test, ARV, OI drugs & lab commodities (costed under ART)
  - STI treatment, HTS cost
  - Referral
  - Enabling environment
  - Program management and M&E

CPHS-HIV Prevention (KPSC)	2021	2022	2023	2024	2025
FSW	$ 51.31	$ 52.85	$ 54.44	$ 56.07	$ 57.75
MSM	$ 35.17	$ 36.22	$ 37.31	$ 38.43	$ 39.58
PWID	$ 62.87	$ 64.75	$ 66.70	$ 68.70	$ 70.76

- **Hepatitis C treatment for PWID and other KPs:**
    - Hepatitis C treatment cost includes medical staff (doctor, nurse/counselor, lab) time, lab investigation including follow-up and Hep C medicine cost. Operation and program management cost will be covered under KPSC.
    - Hepatitis C medicine: $177 for non-cirrhotic (full course 12 weeks) and $306 for cirrhotic patients (full course 24 weeks). It was agreed to weigh the medicine cost as 70% non-cirrhotic and 30% cirrhotic.
    - Average Unit cost for Hepatitis C per patient per treatment (full course): $344.7

According to IBBS: PWID 2017, Hepatitis C prevalence among PWID was 56%, it was recommended to include Hepatitis C treatment under KPs prevention mainly for PWID and also other KPs. 64, 634 PWID were reached in 2018 according to NAP progress report 2019 and it is expected to reach new PWID 10% of the target every year according to M&E framework. To balance the workload and treatment scale up for KPs especially PWID, number of Hep C treatment need per year was estimated and the total budget is calculated with the unit cost for Hepatitis C.

Hepatitis C treatment	2021	2022	2023	2024	2025
Number of KPs to treat Hep C	10,859	13,443	11,769	10,629	8,012
Budget requirement	$ 3,742,929	$ 4,633,675	$ 4,056,727	$ 3,663,826	$ 2,761,816

CPHS-HIV: Prevention (Drug Treatment Center)

- **Target population**: People Who Inject Drugs
- **Geographic coverage**: 167 High priority townships
- **Description:** drug treatment center (DTC) providing opioids substitute therapy operated mainly by government with or without NGO support. Assumption suggested was 50% of DTC will need seconded staff (NGO support) in 2021 and then it will be transitioned over the time and 25% in 2025. There will be introduction of Buprenorphine to 3% in 2021 and scale up to 10% of the OST patients.
- **Services**: Opioids substitution therapy (OST)
- Linkage with/integrated in other services: KPSC, SGBV, Services for ATS users, vocal and livelihood programs
- **Reference target for unit costing:** 250
- **Cost component:**
    - DTC Staff salary (including seconded staff), Training, Transportation
    - DTC operating cost: equipment, utilities, waste management
    - Commodities: MMT, Buprenorphine, usable
    - Patient Support cost (Transportation allowance, Hospitalization)
- Enabling environment
- Program management and M&E

	2021	2022	2023	2024	2025
CPHS-HIV: Prevention OST cost	$ 186.60	$ 189.74	$ 192.87	$ 196.00	$ 199.14

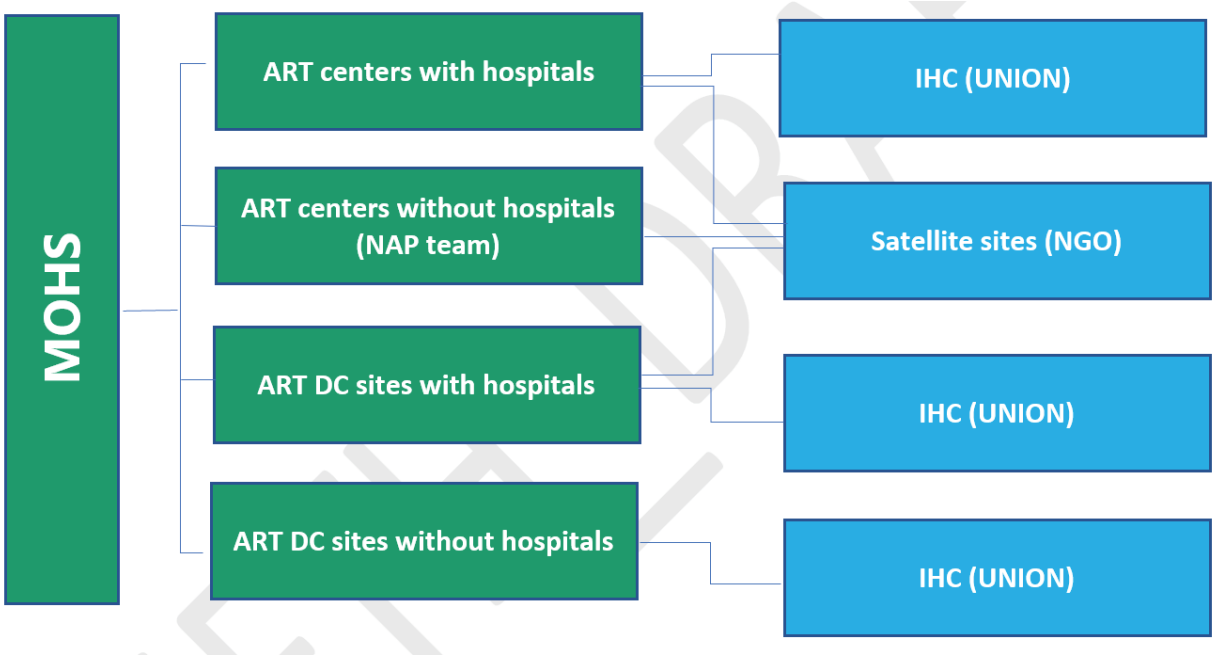
Unit cost for OST is weighted for Methadone usage and Buprenorphine.

EPHS-HIV: Care and treatment (ART provision)

- **Target population**: all people living with HIV
- **Geographic coverage**: 330 townships

- **Description:** All ART patients will be transitioned to public sector supported by NGO by the end of 2020 and Satellite site model will become a model for NGO to provide ART. Different models of ART provision through public sectors are adjusted to align service delivery units' level in National Health Plan as followings (Figure: 28). The diagram is for public sector and there are few NGO providing ART by their own cohort that are not included, for example MSF-H and MDM;
  1. ART centers with hospitals (through Government Hospitals)
  2. ART centers without hospitals (through NAP Teams)
  3. ART satellite sites/ KPSC satellite sites by NGO (through NAP Teams and ART centers)
  4. ART DC sites with hospitals (through Township and Station Hospitals)
  5. ART DC sites without hospitals (through Urban Health centers and Rural Health Centers)

Figure 28: ART Service Delivery models in Public Sectors and NGO collaboration



Assumption of moving from stand-alone NGO ART center to KPSC satellite (one stop service) model is as below:

ART Service Delivery Models	2020	2021	2022	2023	2024	2025
ART center with hospital	36%	33%	30%	27%	25%	23%
ART center without hospital (NAP teams)	20%	20%	20%	20%	20%	20%
ART satellite sites/ KPSC satellite sites by NGO	6%	14%	17%	20%	20%	20%
ART DC sites (all 2 types)	23%	26%	30%	33%	35%	37%
ART center without hospital (NGO ART cohort)	15%	7%	3%	0%	0%	0%
	100%	100%	100%	100%	100%	100%

Human resource needs for each model were standardized according to the first costing workshop (Table 11).

Table 11: Human resource distribution in ART service delivery models

Ref: for each ART center coverage 500 ART patients	ART center with hospital		ART center without hospital		DC site with hospital		DC site without hospital	
Staff	**PUB**	**NGO**	**PUB**	**Satellite**	**PUB**	**NGO**	**PUB**	**NGO**
Medical Superintendent/ TMO	Y				Y		Y	
Specialist	Y		Y					
Doctor	Y	Y	Y	Y	Y	Y	Y	Y
Nurse / Health Asst / Investigator	Y		Y	Y	Y		Y	
Lab technician	Y		Y	Y	Y		Y	
ART manager		**				**		**
Pharmacist	Y			Y				
Counselor	Y	Y	Y	Y	Y	Y	Y	Y
Outreach worker		Y		Y		Y		Y
Case management coordinator				Y				
Support staff	Y		Y	Y	Y		Y	
Data Assistant (M&E)	Y	Y	Y*	Y	Y*	Y	Y*	Y
Social worker	Y							

* *To be outsourced*
** *M&E*

Need to take account contribution of seconded staff (UNION, and PGK) attached in ART center/DC sites

- Patient support cost for ART in previous NSP were higher than actual use and was revised. New and existing ART patients' cost are calculated separately according to monitoring requirement (including laboratory investigation) and weighed among five different treatment regimens using current patient's distribution and also considering the transition plan to Dolutegravir from Efavirenz according to the recommendation from National AIDS Program ART review in 2019 as below.

ARV Drugs	New patients assumed %	Existing patients assumed %
ABC+3TC+EFV	2%	3%
ABC+3TC+LPV/r	1%	4%
AZT+3TC+EFV	3%	6%
TDF+3TC+DTG	46%	5%
TDF+3TC+EFV	48%	82%
ABC+3TC+EFV	2%	3%

- **Services:** Hep B & C testing, TPT, OI treatment and cotrimoxazole prophylaxis, ART, patient support
- Linkage with/integrated in other services: TB, ANC, SRH, NCD, Drug treatment centers, Hepatitis C treatment, mental health, community-based services, vocal and livelihood programs,
- Reference target for unit costing: 500
- **Cost component**:
    - ART site staff salary including Government staff, training, transportation
    - ART site operating cost: infrastructure
    - Commodities: Hep B &C test, CD4, viral load, TPT, OI drugs, cotrimoxazole, ARV
    - Lab services
    - Adherence support:

- Living support direct to patient cost (transportation, accommodation, nutrition, hospitalization, funeral, adherence support materials costs are standardized and assumed to support 50% of all ART patients)
- Patient support cost direct to outreach/community (psychosocial support, defaulter tracing). This cost can be used as reference for social contracting to local CBO or CSO or EHO

- Enabling environment
- Program management and M&E

The ART service package cost for the ARV naive individual is higher than that of the stable patient because of the recommended baseline investigations and number of viral load tests in the first year of ART treatment. Since the ART service provision through KPSC satellite model is more cost effective than stand-alone NGO based ART model, it is recommended to provide and maintain ART for the key populations through KPSC ART satellite sites under the close supervision of public sector (NAP) ART centers. Although current stand-alone NGO based ART provision model is expensive, the ART unit cost of KPSC ART satellite runs by NGO under the public sector (NAP) ART center is less expensive because operation cost including staff is shared with KPSC prevention service package. There are 2 types of ART DC sites, cost components are the same. Therefore, one standard unit cost is calculated for all DC sites in in the below table.

ART Service delivery models	New patients cost	Existing patients cost
ART center with hospital	$ 282.02	$ 167.83
ART center without hospital (NAP teams)	$ 259.71	$ 167.78
ART satellite sites/ KPSC satellite sites by NGO	$ 304.02	$ 222.63
ART DC sites (all 2 types)	$ 234.35	$ 156.71

Unit cost for new and existing ART cost were weighted according to the above proportion and then weighted again by new and current ART patients proportion according to M&E framework.

	2021	2022	2023	2024	2025
Average ART unit cost	$ 190.47	$ 179.66	$ 176.66	$ 181.41	$ 180.44

EPHS-HIV: EMTCT

- **Target population**: All pregnant women with HIV
- **Geographic coverage**: 330 townships
- **Description:** outreach and community-based testing carried out by basic health staff with standard commodities and service package linked to a public sector for comprehensive care and treatment. ART cost is calculated under ART and the target for pregnant women with HIV is the sub -set of total ART targets.
- **Services:** Health promotion, community-based testing, referral to public sector for STI (Syphilis), ART, early infant diagnosis (EID), Infant prophylaxis (syphilis treatment if necessary), follow up for mother and child
- Linkage with/integrated in other services: TB, ANC, ART centers
- **Reference target for unit costing**: 3,300 (150,000 population per township, fertility rate 2.2

- **Cost component**:
    - Basic Health Staff incentive, training, transportation
    - Commodities: EID, Infant prophylaxis, family planning
    - STI treatment, HTS cost
    - Community mobilization
    - Assisted referral
    - Enabling environment
    - Program management and M&E

	2021	2022	2023	2024	2025
EPHS-HIV: EMTCT cost for HIV positive pregnant women with ART	$ 9.93	$ 10.23	$ 10.53	$ 10.85	$ 11.17

In addition, funding to support EHOs to enhance AN care coverage in hard-to-reach area and NGCA through community-based service delivery package in collaboration with MRH and EHOs was separately budgeted. Digital health platform cost was also budgeted for mother-baby pairs tracking system for elimination of mother to child transmission.

The fundamental principles of the EPHS and the CPHS and their service delivery models and approaches are that they rely on a strong partnership between the Government of Myanmar – with different Ministries, Departments and National Programs lead by NAP, affected populations and their broader communities, and private sector health facilities and service providers. Strengthening partnership through regular coordination meetings and joint work planning, capacity building of community workforce, formalization of public private partnership and sustainable plan to link with community-based organizations and ethnic health organizations are essential costing components to support NSP IV implementation.

Unit cost are applied to the targets in the M&E framework and in addition to unit cost, the following system strengthening activities are costed for laboratory, procurement and supply chain to support strategic direction 1 and 2;

- HIV testing and ART expansion according to the plan (costed for both public and private sectors including renovation new ART treatment centers integrated in public hospitals/departments)
- Regular monitoring for quality assurance of HIV lab service
- Integration of Procurement and supply plans, storage, transportation
- Expansion of eLMIS for data visibility and stock management support
- Quality Assurance and Waste Management

Gender and Human rights

Since more attention is needed in NSP IV for multisectoral integration, gender and human rights-based, people-centered community and health systems, a series of high-level advocacy meetings, coordination meetings at all levels and trainings/capacity building is budgeted for;

- Community to be engaged in service delivery
- Formalizing public-private partnerships (PPP) and a sustainable plan to link with CSOs and Peer Networks as part of the transition plan
- Workplace programs and leverage other sectors involvement in the HIV continuum of services
- Creating more comprehensive enabling environment
- Introduction of new laws and reform and repeal of existing laws, and to eliminate HIV related stigma and discrimination in all health care settings by 2025
- Integration of HIV in UHC and social protection schemes for priority populations and Orphans and Vulnerable Children (OVC)

Strategic Information

In addition to regular a series of regular surveillances, HSS, BSS, HIV size estimation, SI working group meetings, trainings and monitoring visits, the following activities are costed under Strategic information:

- Capacity building trainings for analyzing national and sub-national data, operational plan formulation, programmatic mapping,
- A five-year detailed surveillance plan
- Development of National research agenda, National HIV research database and budget for priority research questions
- Technical assistance for
    - functioning unique ID system with optimal level of data security policy and practice in place
    - feasibility assessment, develop, scale up and evaluate electronic case-based recording and reporting system for HIV and STI
    - development of data quality assurance plan and roll out the plan
    - development of interoperability policy/ guideline to ensure health information exchange among components of open HIE (cost shared among ATM programs)

Leadership and financing

NSP IV addresses many issues for the sustainability and the following activities are budgeted under leadership and financing using current funding from Access to Health fund as a reference:

- A sustainable multisectoral HIV Human Resources for Health plan (HRH), costed on 3 levels - firstly at the level of a national operational feasibility consultation and workshop; secondly at the level of implementation in the 5 high-burden states and regions as pilot and thirdly at the level of nationwide implementation in remaining high-burden/ high priority townships including costing a transition plan for Global Fund-financed and seconded staff positions; costing of training and capacity building; costing of benefits and incentives. Costing for institutionalization of the community workforce is integrated to HRH plan and needs to be implemented together. The plan is over the five years of NSP IV and aim to be placed at operational level in all states and regions by 2025.
- Establishing a purchaser provider system initially in the 5 high-burden states and regions to purchase prevention, care and treatment services. Using pilot strategic purchasing project cost form the Access to Health Fund, this is cost for 5 high-burden states and regions.
- In addition to joint service delivery activities with national TB program, cross-cutting components like governance management and supervision, cross border policy and human resource for health plan are cost-shared with national TB program.
- Conducting regular national and sub-national levels National AIDS Spending Assessment (NASA).

NSP IV Budget

Successful implementation of NSP IV will require efficient use of resources while maintaining quality, increased collaboration and financial leveraging of partners and increased domestic allocation of resource. In anticipation of potential changes in the funding landscape, NSP IV aims to focus resources geographically, streamline unit costs and will leverage community, government and private sector resources as collaborators to reach the 95-95-95 goals. The total gross resource needs for NSP IV was estimated at US$ 414 million over five years (Table 2).

Table 12: NSP IV gross resource needs

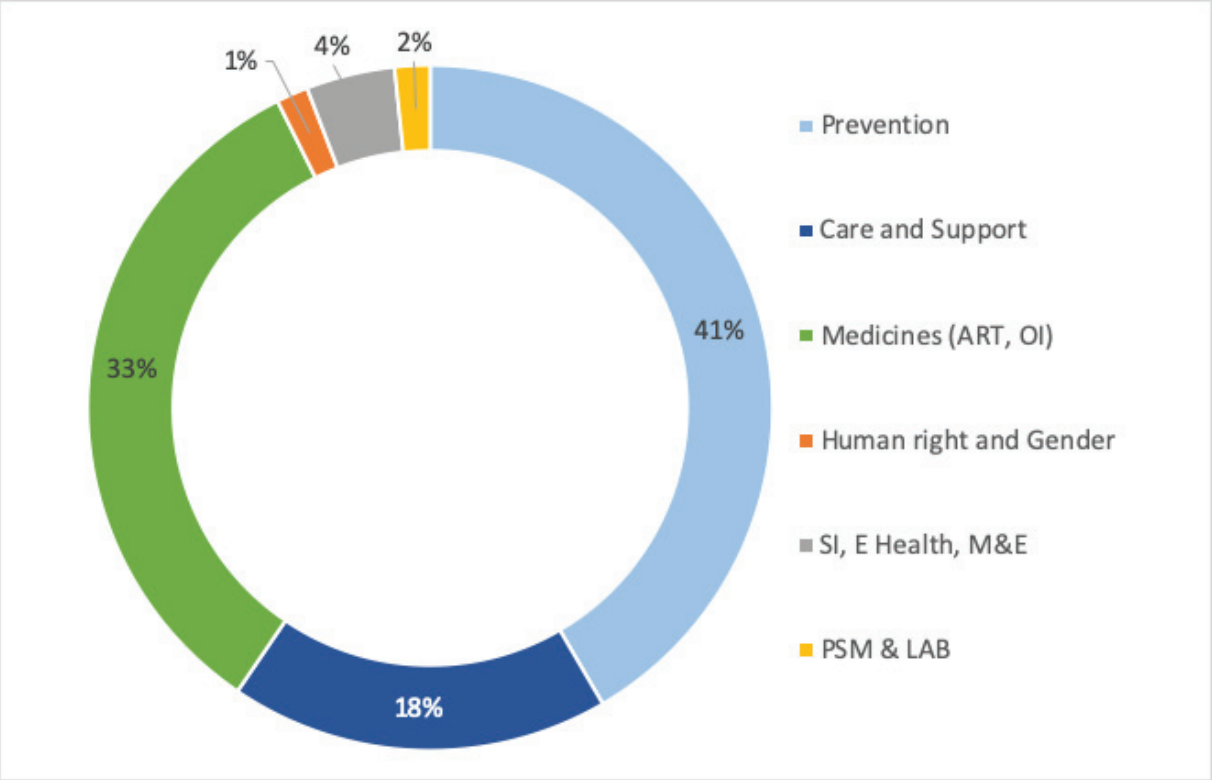
Strategic Directions	2021	2022	2023	2024	2025	2021-2025
Strategic Direction 1: Reducing New Infections	27,828,137	33,338,122	36,580,939	39,798,513	41,678,891	179,224,602
Strategic Direction 2: Improving health outcomes for all people living with HIV	42,531,494	42,773,307	42,255,928	43,911,826	44,335,521	215,808,076
Strategic Direction 3: Strengthening multi-sectoral integration, gender and human rights based, people-centered community and health systems	1,261,325	1,223,675	1,217,350	1,185,500	1,259,850	6,147,700
Strategic Direction 4: Strengthening the use of strategic information (SI) and evidence to guide service delivery, management and policy	1,429,350	1,540,275	2,640,650	1,071,650	1,510,150	8,192,075
Strategic Direction 5: Promoting accountable leadership for the delivery of results and financing a sustainable response	1,130,300	1,204,600	968,100	1,005,600	805,600	5,114,200
TOTAL	74,180,607	80,079,979	83,662,967	86,973,089	89,590,011	414,486,654

The NSP IV resource needs are dramatically reduced nearly US$ 45 M from the total funding need of the NSP III of US$ 460 million. Although many new activities are added in NSP IV, the unit costs were streamlined during the costing process by standardization of human resource needs, salary and operating cost thus allowing for cost savings in NSP IV. The increase in resource requirements in the new NSP is attributable to significant increase in coverage aiming 95-95-95, scale up prevention with new and innovative activities, hepatitis C treatment, moving towards elimination of mother to child transmission and establishing preparedness of sustainable financing and partnership. The proportion of gross resource requirements for care and support is 18%, for ART and OI medicines is 33% and for prevention 41% (Figure 29). Monitoring, supervision and evaluation including e-health, procurement and supply chain activities are also strengthened and costed accordingly. Below is the difference between the Strategic Direction costs of NSP III and NSP IV, full budget details can be found in Table 13.

2016-2020		*2021-2025*	
SD 1: Prevention	*$ 125, 176, 583*	*SD 1: Prevention*	*$ 179, 224, 602*
SD 2: Treatment	*$ 255, 609, 004*	*SD 2: Treatment*	*$ 215, 808, 076*
SD 3: Systems	*$ 66, 000, 000*	*SD 3: Human Right and Gender*	**$ 6, 147, 700*
SD 4: SI/M&E	*$ 7, 322, 442*	*SD 4: SI/M&E*	*$ 8, 192, 075*
SD 5: Leadership	*$ 6, 000, 000*	*SD 5: Leadership*	*$ 5, 114, 200*
TOTAL	*$ 460, 108, 028*	*TOTAL*	$ 414, 486, 654

**System strengthening cost has been shifted under SD 2: Treatment*

Figure 29: Proportion of gross resource requirements per thematic area



Through shared health systems, MOHS funding for HIV also includes maternal and child health, infrastructure costs for public health facilities that provide HIV programs, and general health care staff, among other components. Other ministries also provide modest contributions to the national HIV response through their respective budgets, including the Ministry of Social Welfare, Relief and Resettlement and Ministry of Home Affairs. Planned direct government contributions to implement NSP activities are estimated to increase 1 million every year.

(Budget Note: Community health work force are embedded in the service delivery under SD1 and SD2, EPHS, CPHS prevention through community/peer out-reach are all community workforce costs. The cost shown under leadership and financing is only for advocacy meeting. Formalization cost is combined with HRH plan)

Table 13: NSP IV Full Budget

Strategic Directions		2021	2022	2023	2024	2025	2021-2025
		$ 74,180,607	$ 80,079,979	$ 83,662,967	$ 86,973,089	$ 89,590,011	$ 414,486,654
Strategic Direction 1: Reducing New Infections		**$ 27,828,137**	**$ 33,338,122**	**$ 36,580,939**	**$ 39,798,513**	**$ 41,678,891**	**$ 179,224,602**
1.1	Increase scale of effective combination prevention interventions for priority populations and promote community led approaches/initiatives	*$ 24,146,948*	*$ 29,356,361*	*$ 32,269,213*	*$ 35,211,345*	*$ 36,653,002*	*$ 157,636,869*
1.2	Maximize HIV testing and strengthened linkages to ART among priority populations and their sexual partners	*$ 1,422,375*	*$ 1,611,737*	*$ 1,806,391*	*$ 1,997,491*	*$ 2,170,842*	*$ 9,008,837*
1.3	Maximize efficiency in service delivery and enhance integration opportunities with other health services	*$ 116,400*	*$ 116,400*	*$ 116,400*	*$ 116,400*	*$ 116,400*	*$ 582,000*
1.4	Ensure an enabling environment for priority populations and their sexual partners	*$ 67,000*	*$ 53,000*	*$ 67,000*	*$ 53,000*	*$ 53,000*	*$ 293,000*
1.5	Eliminate mother to child transmission of HIV and Syphilis	*$ 2,075,414*	*$ 2,200,624*	*$ 2,321,936*	*$ 2,420,276*	*$ 2,685,646*	*$ 11,703,896*
Strategic Direction 2: Improving health outcomes for all people living with HIV		**$ 42,531,494**	**$ 42,773,307**	**$ 42,255,928**	**$ 43,911,826**	**$ 44,335,521**	**$ 215,808,076**
2.1	Maximize linkage and improve access to care; immediate enrolment and ART initiation	*$ 39,339,377*	*$ 39,615,921*	*$ 39,261,701*	*$ 40,607,249*	*$ 40,650,942*	*$ 199,475,191*
2.2	Improve the quality of care maximizing retention and viral suppression	*$ 175,950*	*$ 164,550*	*$ 122,550*	*$ 122,550*	*$ 122,550*	*$ 708,150*
2.3	Integration of health services for co-infection and co-morbidity (TB, Hepatitis, STI, NCD, mental health, SRHR and prison health)	*$ 415,519*	*$ 526,303*	*$ 622,310*	*$ 724,487*	*$ 832,951*	*$ 3,121,571*
2.4	Enhance positive prevention	*$ 701,648*	*$ 888,833*	*$ 1,121,666*	*$ 1,359,841*	*$ 1,631,377*	*$ 5,703,365*
2.5	Strengthen and Integrate HIV-related PSM into one national Procurement and Supply Management (PSM)	*$ 1,196,600*	*$ 954,800*	*$ 504,800*	*$ 504,800*	*$ 504,800*	*$ 3,665,800*
2.6	Strengthen laboratory services in HIV and STI management	*$ 702,400*	*$ 622,900*	*$ 622,900*	*$ 592,900*	*$ 592,900*	*$ 3,134,000*
Strategic Direction 3: Strengthening multi-sectoral integration, gender and human rights based, people-centered community and health systems		**$ 1,261,325**	**$ 1,223,675**	**$ 1,217,350**	**$ 1,185,500**	**$ 1,259,850**	**$ 6,147,700**
3.1	Strengthen and expand Gender responsive and rights-based HIV service delivery models, ensuring continuum and quality	*$ 207,850*	*$ 147,850*	*$ 141,100*	*$ 81,100*	*$ 81,100*	*$ 659,000*
3.2	Strengthen the community to be engaged in service delivery.	*$ 712,400*	*$ 750,250*	*$ 778,250*	*$ 853,900*	*$ 898,250*	*$ 3,993,050*
3.3	Improve legal and policy environment at all levels	*$ 195,250*	*$ 163,250*	*$ 154,250*	*$ 109,250*	*$ 139,250*	*$ 761,250*
3.4	Integrate HIV in UHC and social protection schemes for priority populations and Orphans and Vulnerable Children (OVC)	*$ 124,575*	*$ 126,575*	*$ 117,000*	*$ 117,000*	*$ 117,000*	*$ 602,150*
3.5	Implement workplace programs and leverage other sectors involvement in the HIV continuum of services	*$ 21,250*	*$ 35,750*	*$ 26,750*	*$ 24,250*	*$ 24,250*	*$ 132,250*
Strategic Direction 4: Strengthening the use of strategic information (SI) and evidence to guide service delivery, management and policy		**$ 1,429,350**	**$ 1,540,275**	**$ 2,640,650**	**$ 1,071,650**	**$ 1,510,150**	**$ 8,192,075**
4.1	Generate and use strategic information to guide service delivery, program management, policy and financing.	*$ 298,800*	*$ 636,000*	*$ 1,210,800*	*$ 172,300*	*$ 710,800*	*$ 3,028,700*
4.2	Improve monitoring and reporting to provide quality data and effectively track NSP IV and improve performance at all levels.	*$ 831,800*	*$ 688,225*	*$ 668,800*	*$ 498,800*	*$ 588,300*	*$ 3,275,925*
4.3	Strengthen coordination and resource mobilization for SI.	*$ 128,450*	*$ 133,450*	*$ 128,450*	*$ 133,450*	*$ 128,450*	*$ 652,250*
4.4	Conduct research and evaluation and apply finding for programmatic improvement and policy change.	*$ 170,300*	*$ 82,600*	*$ 632,600*	*$ 267,100*	*$ 82,600*	*$ 1,235,200*
Strategic Direction 5: Promoting accountable leadership for the delivery of results and financing a sustainable response		**$ 1,130,300**	**$ 1,204,600**	**$ 968,100**	**$ 1,005,600**	**$ 805,600**	**$ 5,114,200**
5.1	Strengthen and sustain high level political and technical commitments including relevant legal frameworks	*$ 108,900*	*$ 134,900*	*$ 113,400*	*$ 55,900*	*$ 55,900*	*$ 469,000*
5.2	Sustainable Multisectoral HIV HRH plan	*$ 196,500*	*$ 181,500*	*$ 181,500*	*$ 181,500*	*$ 181,500*	*$ 922,500*
5.3	Ensure sustainable Financing	*$ 272,400*	*$ 608,200*	*$ 258,200*	*$ 608,200*	*$ 258,200*	*$ 2,005,200*
5.4	Improve Community Health Workforce	*$ 136,000*	*$ 111,000*	*$ 86,000*	*$ 86,000*	*$ 86,000*	*$ 505,000*
5.5	Strengthen governance management and coordination and accountability for delivery of results	*$ 416,500*	*$ 169,000*	*$ 329,000*	*$ 74,000*	*$ 224,000*	*$ 1,212,500*

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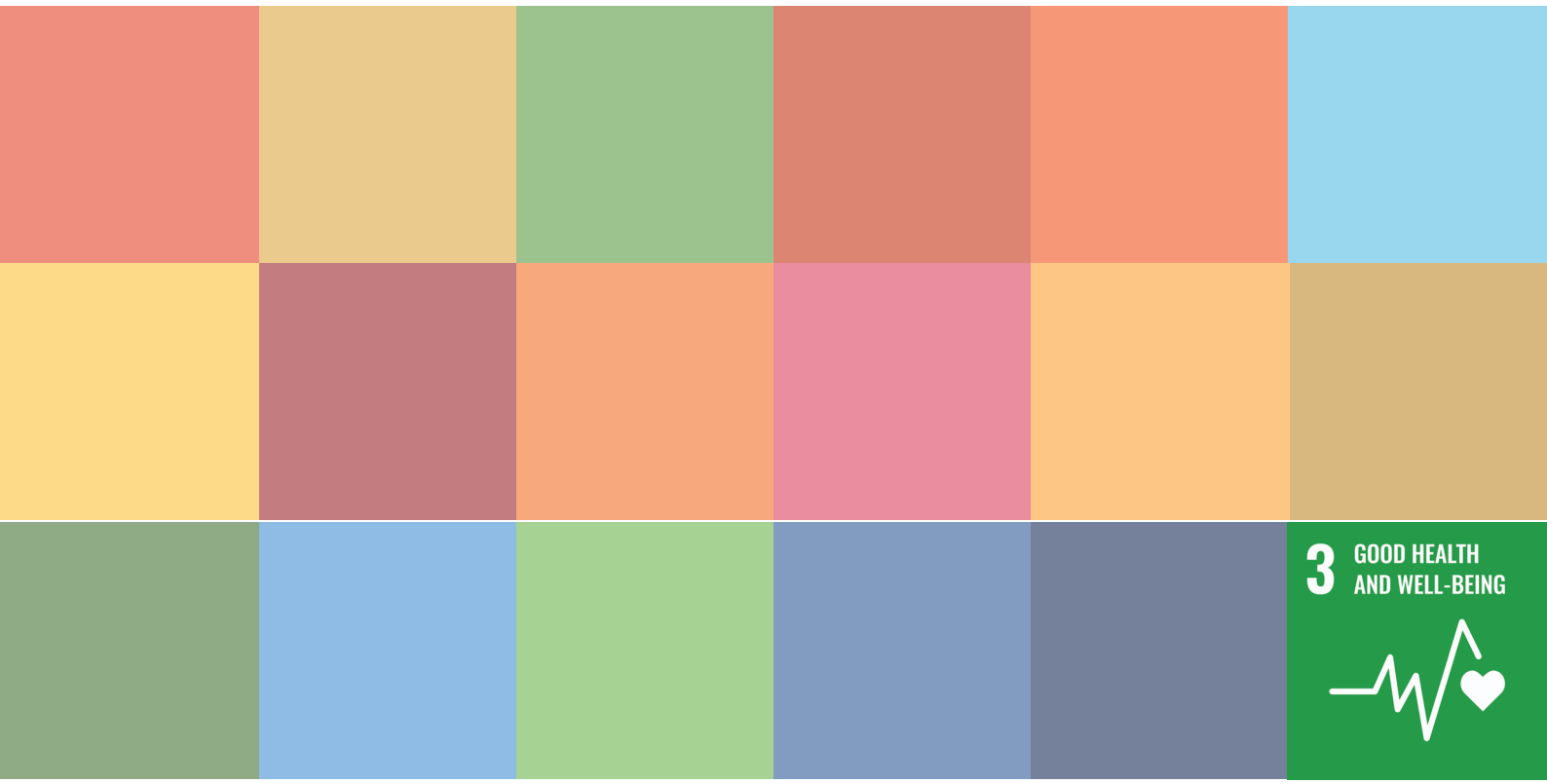
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