



FY 2015 Burma Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Burma.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

**Burma Country Operational Plan
(COP) 2015
Strategic Direction Summary**

August 12, 2015

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Goal Statement

The PEPFAR Burma team's over-arching vision is to support Burma to achieve its goal of epidemic control applying the "90-90-90" global targets as a framework for HIV program planning and prioritization. PEPFAR support in Burma will focus on technical assistance (TA) and targeted support to improve the cascade of HIV prevention, testing and treatment services, for key populations affected by high HIV prevalence, limited access and low coverage of HIV services. The 2015 Burma Country Operation Plan (COP) 2015 reflects the catalytic and informative role the PEPFAR Burma team is taking in supporting the Government of Burma (GoB) deliver on the goals of their National Strategic plan, namely in achieving high rates of HIV testing among key populations with early enrollment and high rates of retention in treatment services. To achieve this, PEPFAR Burma has identified four priority catchment areas based on the best available epidemiologic and other data and will support approximately 36 community sites providing prevention, care and treatment services. In addition, PEPFAR Burma will provide technical assistance to the public health care sector for rollout of decentralized Anti-Retroviral Treatment (ART) services, including improved access and retention for Key Populations (KP).

To accomplish this, PEPFAR Burma will continue and enhance close collaboration with all key in-country actors including the Government of Burma, civil society, the Global Fund (GF) and other stakeholders to leverage available resources and help direct efforts to towards epidemic control.

PEPFAR Burma is in a unique position to adapt its role in a country that is re-defining itself. In 2015 Burma will hold national elections that may re-set the government systems that have come before it. Over the coming year, PEPFAR will work closely with partners in government, civil society and the private sector to best position itself to strategically support the National AIDS Program (NAP) and civil society partners to significantly scale-up HIV testing and treatment services. PEPFAR will provide technical assistance to develop operational guidelines, protocols and strategies that are guided by national and international evidence and assist in developing laboratory and supply systems to sustain the program in the long-term.

In the second year of expansion of PEPFAR support, building on efforts started in 2014, the team aims to improve the cascade of HIV services for Female Sex Workers (FSW) and Men who have Sex with Men (MSM), increasing the focus on HIV testing and counseling with aggressive provision for immediate ART in those who are HIV infected across community-, private and public sector sites within the 4 catchment areas, as well as providing technical support to strengthen and improve strategic planning, implementation and monitoring for HIV treatment services in the national program. PEPFAR Burma will begin to engage in TA and support for services for People Who Inject Drugs (PWID) in the northern states of Kachin and Shan where HIV prevalence in this key population is highest and programs operate in a particularly complex environment that affects access to and establishment of quality health and HIV services.

The GoB and multi-lateral organizations (WHO, UNAIDS, GF) have requested both long term and short term TA from PEPFAR and are receptive to US Government (USG) recommendations. Through these partnerships PEPFAR will contribute to improve data collection, use and coordination for optimal program impact.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Burma, a sovereign nation bordered by Bangladesh, China, India, Laos, and Thailand, is made up of 15 states, 69 districts, 330 townships, and 13,276 villages. It has a population of 51,419,420 million and comprises 138 ethnic groups – 89% of whom are Buddhist. A military dictatorship controlled Burma's government for over five decades, but relinquished control in 2011. The GNI per capita in Burma in 2013 was US dollars (USD) 1182.6, ranked 174th in the world. The WHO reports that total expenditure on health, as a percentage of GDP (2012), is at 1.8%.

According to NAP Anti-Retroviral Treatment (ART) program data, at the end of 2014, 85,257 persons were receiving ART. This represented around 55.5% of all those in need of treatment as specified in 2014 revised national treatment guidelines which support initiation at CD4 500 threshold. The national program has set an ambitious treatment target of 106,058 as the target for ART by the end of 2016 (a 25% increase in less than two years)¹. However, supply chain and laboratory systems supporting ART scale up are not well-developed, and regular monitoring of results at all levels does not routinely occur. PEPFAR will provide technical support to improve the quality of HIV care and treatment services, as well as enhance strategies for effective decentralization working with the NAP as well as implementing partners.

Based on modeling and estimates established for HIV in Burma, 0.5% of adults, and 0.7% of pregnant women are HIV infected, with substantially higher HIV prevalence among FSW (8.1%)², MSM (10.4%)² and PWID (27.0%)³. An overall decreasing trend in prevalence has been reported among key populations over the last five years, although the quality of data is uncertain, and the decreasing trends may in part be due to high mortality rather than declining incidence. For example, the most recent estimates of HIV prevalence among PWID (27%) based on 2014 IBBS findings are substantially higher than reported in the NAP progress report which used HSS and HIV sentinel surveillance data. In addition, there is limited information at sub-national levels and the results do not include the large parts of the country where there is ongoing civil unrest.

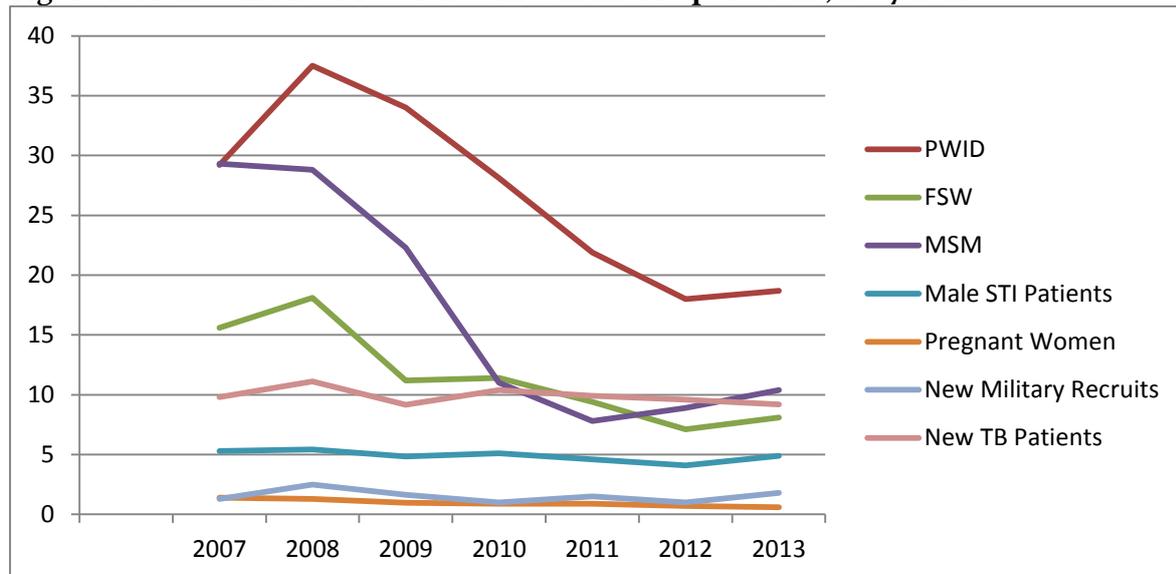
Keeping in mind limitations in data quality, Figure 1 below shows trends in HIV prevalence between 2007 and 2012, with prevalence remaining highest among PWID. In addition, prevalence appears to be increasing in the MSM population which will inform a prioritization of programming in COP15 to respond to key MSM prevention and treatment needs. In addition to high prevalence among KP, it points to the need for HIV screening and treatment among patients with Tuberculosis (TB) and Sexually Transmitted Infections (STI) where there is likely an overlap in risk behaviors. HIV Sentinel Surveillance (HSS) is conducted annually, with data reported from around 35 townships.

¹ Global AIDS Progress Report for 2012-2013, Myanmar, National AIDS Program (NAP), 31 March 2014

² NAP HIV Sentinel Sero-Surveillance, 2013

³ Preliminary PWID Integrated Bio-Behavioral Survey (IBBS) Findings, 2014

Figure 1: Trends in HIV Prevalence in Sentinel Populations, 2007-2012



Currently available key population (KP) size estimates are 70,000 for FSW² and 230,000 for MSM². PEPFAR fiscal year (FY) 2012 funds are supporting TA for surveillance activities to gather more accurate data for key populations in 2014-15. Data collection for the Integrated Bio-Behavioral Survey (IBBS) in PWID was completed in 2014, with preliminary findings suggesting size estimates of 83,000, but data analysis is ongoing and full release of findings are expected shortly. Results of the national drug survey will inform PWID activities and additional data received from national surveys, as well as from implementing partners will help to improve modeling estimates of the epidemic trends within Burma and facilitate further tailoring of the PEPFAR response.

Among the general population, HIV prevalence is estimated to be 0.5% in Burma (Spectrum 2013). Estimates by region or state are not available, and there is a need for validation, better use and analysis of existing information for a greater understanding of regional variability.

As described above, HIV prevalence among KP groups in Burma is substantially higher than in the general population. Most figures presented in tables provided below are national averages, disguising wide geographical variance (e.g. in surveys, HIV prevalence was 29% among PWID in Myikyina; 15% among SW and 21% among MSM in Pathein). State level data are available only for numbers of KP reached as shown in table 1.1.2a, however concerns about data quality limit use and interpretation.

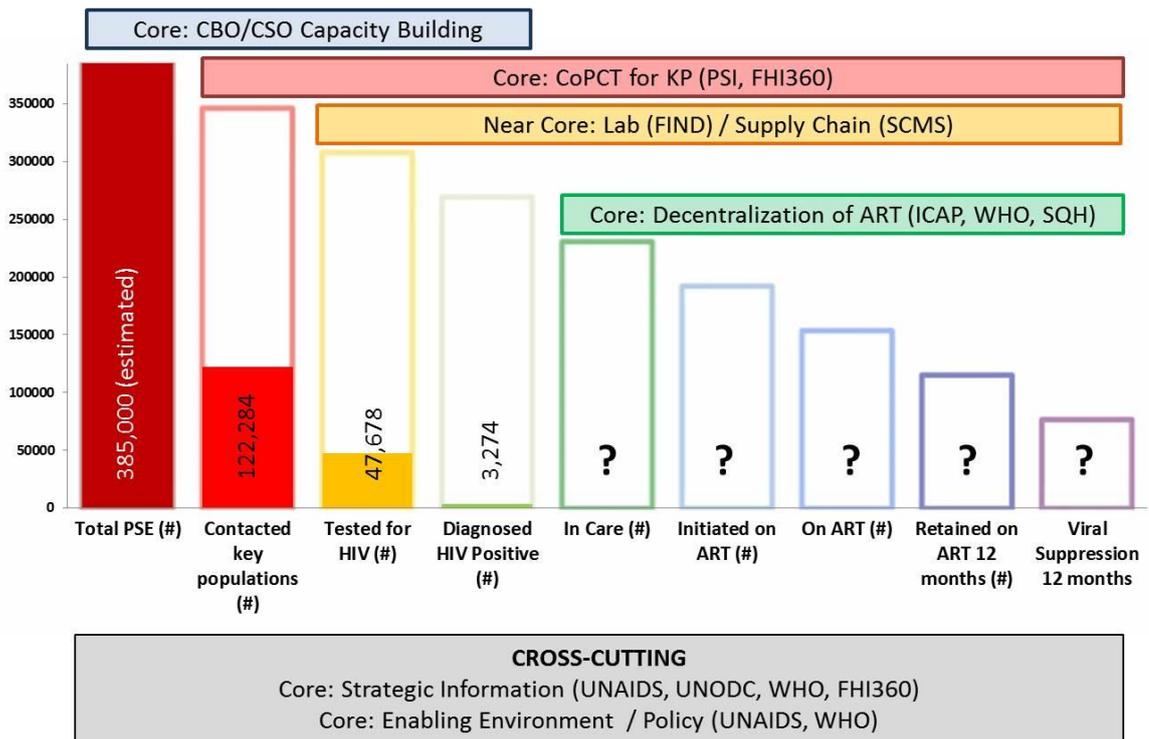
Incidence data for KP are not currently available, though estimates for new infections have been part of the AIDS Epidemic Model (AEM) model and projections. The PEPFAR team is concerned about potential future increases of HIV transmission through injection drug use and sharing of needles and syringes, should service provision for PWID remain inadequate or even decrease further. A significant drop in funding to support prevention programs for FSW, MSM and TG has already been observed. MSM and TG are expected to account for a growing proportion of infections; but too little is known about MSM and TG in Burma to be able to identify recent behavioral trends and hotspots with any accuracy.

While program data from the 2013-14 Mid-Term Review (MTR) of the Myanmar National Strategic Plan on HIV & AIDS suggests that increasing coverage has been achieved in terms of the numbers 'reached' with prevention interventions for both FSW and MSM, numbers accessing HIV Testing & Counseling (HTC) have remained alarmingly low (20.0% and 7.6% HTC coverage respectively). With only 13,968 FSW and 12,694 MSM reported as tested for HIV and receiving the result in 2012, there

is a need to prioritize HTC service provision for KP. Disaggregates for KPs by HIV sero-status were not available in the MTR report.

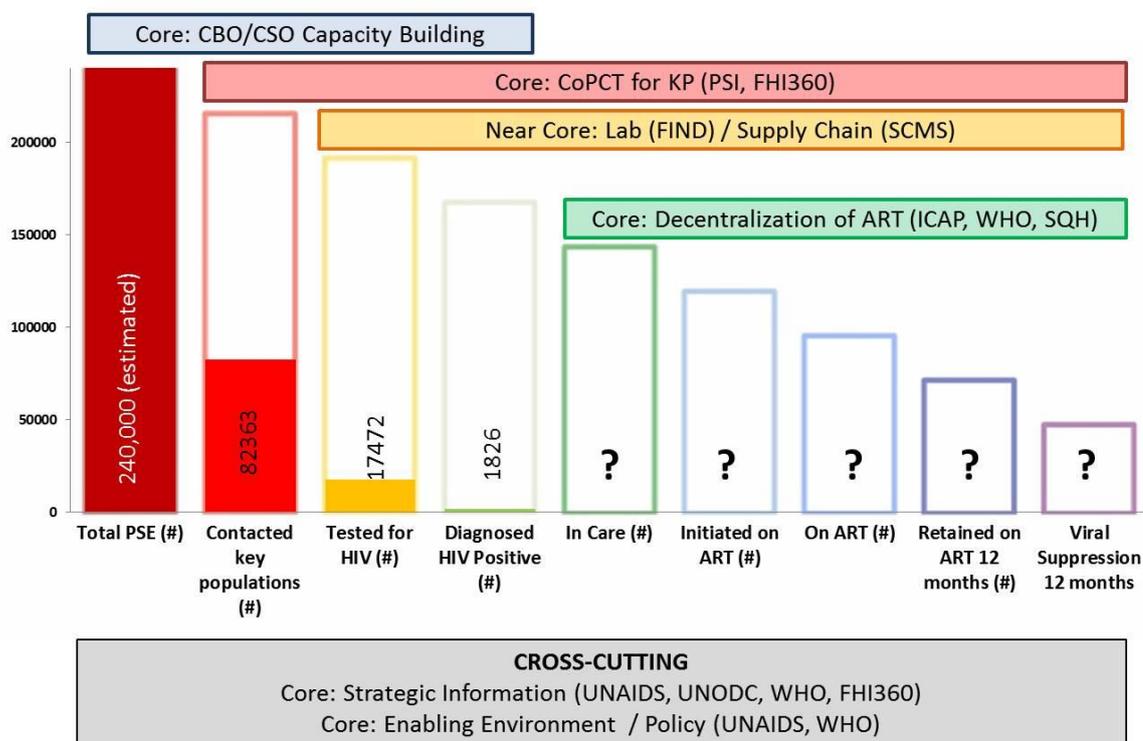
According to MOH national estimate data, of an estimated total of 383,000 KP, 122,284 were reached by PEPFAR-supported prevention programs. Of those reached by PEPFAR, 47,678 were tested for HIV, and 3,274 were diagnosed as HIV-positive.

Prevention, Care and Treatment Cascade



The same cascade for MSM using 2014 data shows that of an estimated 230,000 MSM, 82,363 were reached by prevention programs and 17,472 were tested for HIV among whom 1,826 were diagnosed as HIV-positive.

Prevention, Care and Treatment Cascade (MSM)



Both graphs as well as data tables below show that a large proportion of KP 'reached' are not being tested for HIV. Disaggregate data for KP on ART are not available, therefore it is difficult to ascertain whether KP accessing HTC and identified as HIV-positive are able to access and successfully enroll in ART services.

As sites and partners do not systematically monitor the 'reach-test-treat and retain cascade' for KPs, service gaps are hard to identify and monitor over time. Collecting data on KP status at HTC, care, and treatment sites can be quite sensitive, and the PEPFAR program plans to provide TA for improved M&E to establish cascade monitoring for both PEPFAR-funded and non-PEPFAR funded HIV programs moving forward.

Despite the very high HIV prevalence estimates for PWID, the 2013-14 MTR of the Myanmar National Strategic Plan on HIV & AIDS, revealed the proportion of PWID reached as well as those who accessed HTC services, reported as 4,540 PWID tested and receiving their results in 2012, and were extremely low. The reported number of needles and syringes distributed in 2012 was 8.7 million, representing 30% coverage, based on an estimate of 75,000 PWID. The number of PWID receiving Medication Assisted Therapy (MAT) with methadone was also alarmingly low at around 4% (n=2,909). This lack in services for PWID is likely based on the geo-politics of Burma, as HIV services have been focused on the Burmese heartland while ethnic peripheral areas such as Kachin and Shan states, where the majority of PWID reside, have historically received less attention. Needle and Syringe Exchange Programs (NSP), MAT and ART are known to result in HIV incidence reduction among PWID, and accelerated rollout of these services in geographical areas where injection drug use is most prevalent will be crucial.

States that may have the largest numbers of PWID and highest HIV prevalence rates among PWID, ranging from 35.5% in Kachin state and 20% in Northern parts of Shan state have been sites with

ethnic-driven movement for political autonomy for more than half a century and are caught in complex struggles for control of lucrative natural resources. Despite being rich in resources (e.g. jade, copper, gold, iron ore, coal, timber etc.) control over parts of these states is being fought over by Burmese and Chinese businesses, central government, allied Kachin and Shan paramilitary forces, local military commanders and the Kachin Independence Organization. A number of areas within these states cannot yet be freely accessed hindering provision of health and HIV services to people living and working there.

Program gaps identified above therefore point to the urgent need for HIV programs among KP, and provide an opportunity for PEPFAR to provide strategic TA to significantly improve the cascade of HIV prevention, care and treatment services for FSW and MSM, and help identify strategies to scale and strengthen services for PWID. In addition, the PEPFAR program will continue supporting surveillance and surveys, and strengthening data collection systems to provide information needed to monitor the cascade, assess program impact, and better target services moving forward.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	51,419,420	100%	N/A	-	N/A	-	N/A	-	N/A	-	2014 Census
Prevalence (%)		0.47		N/A		N/A		N/A		N/A	2014 GARPR
AIDS Deaths (per year)	12,000		N/A		N/A		N/A		N/A		2014 GARPR
PLHIV	200,000		N/A		N/A		63,000*		N/A		2014 GARPR; 2014 UNAIDS GAP Report*
Incidence Rate (Yr)		N/A		N/A		N/A		N/A		N/A	-
New Infections (Yr)	7,696										2014 GARPR
Annual births	N/A	N/A									-
% >= 1 ANC visit	N/A	N/A	N/A	N/A			N/A				-
Pregnant women needing ARVs	N/A	N/A									-
Orphans (maternal, paternal, double)	N/A		N/A		N/A		N/A		N/A		-
TB cases (Yr)	250,000		N/A		N/A		N/A		N/A		2011 WHO Global TB Report
TB/HIV Co-infection		27%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2013 WHO Global TB Report
Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
Key Populations											
Total MSM	230,000*										AEM, 2011
MSM HIV Prevalence		10.4%*									2013 HSS
Total FSW	70,000*										AEM, 2011
FSW HIV Prevalence		8.1%*									2013 HSS
Total PWID	83,000										2014 iBBS Preliminary Report UNAIDS
PWID HIV Prevalence		27.0%									2014 iBBS Preliminary Report UNAIDS

* Please note that while these data points have been provided there are concerns about quality of the data. New and better quality data will become available through FSW and MSM bio behavioral surveys planned for 2015/6 and supported by PEPFAR.

Table 1.1.1.a Key and Priority Populations Size Estimate and HIV prevalence by “Type of Area” and disease burden (prevalence) based on available data

Key Pop	Name of Area	Type of Area	General Adult HIV prev	Gen Pop Size	KP HIV Prevalence (%)	KP Size	Pop Size Estimation method	Year	Reference	Notes
FSW	Ayarwaddy	State		6,175,123	24.5%	N/A		2013	2014 Census; 2013 HSS	
FSW	Kachin	State		1,689,654	12.5%	N/A			2014 Census; 2013 HSS	
FSW	Yangon	Capital		7,355,075	11.0%	N/A		2013	2014 Census; 2013 HSS	
FSW	Shan East	State		N/A*	7.0%	N/A		2013	2013 HSS	* Total population for Shan East, South, and North: 5,815,384 based on 2014 Census
FSW	Sagaing	State		5,420,299	5.5%	N/A		2013	2014 Census; 2013 HSS	
FSW	Shan South	State		N/A*	5.5%	N/A		2013	2013 HSS	
FSW	Bago West	State		N/A**	4.5%	N/A		2013	2013 HSS	**Total population for Bago West and East: 4,863,455 based on 2014 Census
FSW	Mandalay	State		6,145,588	3.5%	N/A		2013	2014 Census; 2013 HSS	
FSW	Mon	State		2,050,282	3.5%	N/A		2013	2014 Census; 2013 HSS	
FSW	Shan North	State		N/A*	2.1%	N/A		2013	2014 Census; 2013 HSS	
MSM	Ayarwaddy	State		6,175,123	19.5%	N/A		2013	2014 Census; 2013 HSS	
MSM	Yangon	Capital		7,355,075	8.0%	N/A		2013	2014 Census; 2013 HSS	
MSM	Sagaing	State		5,420,299	7.7%	N/A		2013	2014 Census; 2013 HSS	
MSM	Mandalay	State		6,145,588	6.0%	N/A		2013	2014 Census; 2013 HSS	
PWID	Kachin	State		1,689,654	35.5%	N/A			2014 Census; 2013 HSS	
PWID	Shan North	State		N/A*	20%	N/A		2013	2014 Census; 2013 HSS	
PWID	Yangon	Capital		7,355,075	15.7%	N/A		2013	2014 Census; 2013 HSS	
PWID	Mandalay	State		6,145,588	12.5%	N/A		2013	2014 Census; 2013 HSS	
PWID	Shan East	State		N/A*	5.4%	N/A		2013	2013 HSS	

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) for National Program⁴

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	51,419,420	0.47%	200,000	N/A	67,643	84%	N/A	N/A	N/A	13,834
Population less than 15 years	N/A	N/A	N/A	N/A	4,925	N/A	N/A	N/A	N/A	892
Pregnant Women	N/A	0.7%	4,300 ⁵	N/A	3,066 ⁶	N/A	N/A	309,677	N/A	2,890
MSM	230,000	10.4%	N/A	N/A	N/A	N/A	N/A	17,472 ⁷	1,826 ⁷	N/A
FSW	70,000	8.1%	N/A	N/A	N/A	N/A	N/A	13,968 ⁸	N/A	N/A
PWID	83,000	27.0%	N/A	N/A	N/A	N/A	N/A	4,540 ⁹	N/A	N/A

⁴ Myanmar Global AIDS Response Progress Report (GARPR) 2014

⁵ 2014 UNAIDS GAP Report

⁶ 2014 UNAIDS GAP Report

⁷ 2014 UNAIDS

⁸ 2012 National Strategic Plan for HIV/AIDS in Myanmar Progress Report

⁹ 2012 National Strategic Plan for HIV/AIDS in Myanmar Progress Report

Table 1.1.2.a Cascade of HIV reached, care and treatment (12 months) for National Program by State in 2012 (SNU)

State	Census (2014)	MOH Sentinel Sites (2012)			MOH Progress Report (2012)										MOH ART Program Data (2014)
	Total Population by State	MSM Prevalence	FSW Prevalence	PWID Prevalence	# FSW Reached Low	# FSW Reached High	# MSM Reached Low	# MSM Reached High	# FSW Tested	% FSW Reached that were Tested	# MSM Tested	% MSM Reached that were Tested	# PWID Tested	# of Patients on ART by State	# of Patients on ART by State
Ayeyarwady	6,175,123	19.5%	24.5%		3,780	5,453	4,844	5,852	1,774	32.5	1,039	17.8		355	2,060
Bago	4,863,455		4.5%		2,393	4,464	3,794	8,065	2,063	46.2	2,459	30.5		440	1,284
Chin	478,690		0.7%			2		0	2	100				3	44
Kachin	1,689,654		12.5%	35.5%	2,750	3,783	1,315	1,783	351	9.3	140	7.9		7,935	12,384
Kayah	286,738					60		0	1	1.7				51	123
Kayin	1,572,657					146		11	38	26.0	1	9.1		194	428
Magway	3,912,711				1,039	1,373	1,116	1,947	118	8.6	119	6.1	338	1,448	2,802
Mandalay	6,145,588	6.0%	3.5%	12.5%	6,715	9,171	5,914	20,080	3,205	34.9	4,690	23.4	416	8,444	11,875
Mon	2,050,282		3.5%		3,098	6,058	2,101	3,136	1,360	22.4	175	5.6	1	1,382	2,350
Nay Pyi Taw	1,158,367														
Rakhine	3,188,963				1,415	1,801	941	1,294	142	7.9	25	1.9	4	702	875
Sagaing	5,329,299	7.7%	5.5%		2,001	3,863	2,711	4,561	506	13.1	404	8.9	32	1,168	3,350
Shan East	5,815,384		7.0%	5.4%	3,761	5,310	1,916	2,549	351	13.2	12	13.3	4	636	941
Shan North			2.1%	20.0%					314		234		1,612	4,715	5,678
Shan South			5.5%						34		8		50	1,141	1,811
Tanintharyi	1,406,434				1,429	1,827	879	1,865	266	14.6	116	6.2		2,905	3,868
Yangon	7,355,075	8.0%	11.0%	15.7%	14,485	16,880	7,363	16,924	3,443	20.4	3,272	19.3	20	22,190	35,384
National	51,419,420	10.4%	8.1%	18.7%	42,866	60,191	32,894	68,067	13,968	23.2	12,694	18.6	2477	53,709	85,257

*Note: Numbers tested HIV –positive not available

The data in Table 1.1.2.a are from the MOH 2012 progress report as well as sentinel surveillance and provide some indication about larger numbers of KP reached in regions with existing program support. However, because the value of the indicator “numbers reached” is not standardized and so services and intensity of contact with individuals varies substantially quality of the data are questionable. However, the numbers in this table align with the PEPFAR prioritization of funding for Yangon and Mandalay.

Table 1.1.2.b Cascade of HIV diagnosis, care and treatment (12 months) for PEPFAR Program¹⁰

					HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	Total Reached with prevention program	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	51,419,420	0.47%	200,000	122,284	2,813	197	N/A	N/A	47,582	3,260	44
MSM	230,000	10.4%	N/A	61,806	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW	70,000	8.1%	N/A	60,478	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PWID	83,000	27.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

¹⁰ 2014 PEPFAR APR data (DSD + TA)

Table 1.1.2.c Cascade of HIV diagnosis, care and treatment (12 months) for PEPFAR TOP Centers with complete clinical cascade by site ¹¹										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	HIV Prevalence (%)	Total PLHIV (#)	Total Reached with prevention program	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	0.47%	200,000	56,168	1,397	197	N/A	N/A	34,067	2,462	44
Ayeyarwady	N/A	N/A	6,078	343	16	N/A	N/A	5,496	345	5
Bago (East)	N/A	N/A	4,645	403	17	N/A	N/A	2,756	141	3
Mandalay	N/A	N/A	12,374	271	39	N/A	N/A	5,183	328	14
Sagaing	N/A	N/A	5,516	38	34	N/A	N/A	3,208	175	11
Yangon	N/A	N/A	24,143	253	76	N/A	N/A	15,218	1,348	11
Mon	N/A	N/A	3,412	89	15	N/A	N/A	2,206	125	0

¹¹ 2014 PEPFAR APR data (TA results only, DSD results not included for demonstration of clinical cascade)

1.2 National Investment Profile

Burma is a lower-middle income country with a GNI per capita of USD 1182.6 (2013), ranked 174th in the world. WHO reports that total expenditure on health, as a percentage of GDP (2012), is at 1.8%.

Burma's HIV response heavily relies on the Global Fund which provided around USD 26.8 million compared to USD 4.1 million provided by the Burmese government, USD 3.9 million by other donors including UN agencies and USD 4.6 million in bilateral funding in 2013¹². The GF National AIDS Spending Assessment (NASA, 2014) estimated GF contributions to funding for HIV at 50%, PEPFAR's contributions at 16% and the government's contribution only at around 8%.

With the re-establishment of GF support in 2011 after a gap of 6 years, donors who had been contributing funds to the HIV response under the Three Diseases Fund (the main source of HIV funding from 2008 to 2012), shifted their investments to a new funding mechanism, the Three Millennium Development Goal Fund (3MDG) fund. The 3MDG fund focuses primarily on Health Systems Strengthening and Maternal Child Health with only a small proportion of funding for HIV.

Despite the significant GF investments, current funding levels are insufficient to support Burma's ambitious HIV program scale-up plans, and existing donor commitments are insufficient to ensure adequate HIV services can be provided and accessed by all key populations and PLHIV in the country.

Funding for ARVs is supported mainly through the GF with some contributions (USD 5 million) from the Government of Burma; therefore PEPFAR Burma does not provide funding for the procurement of ARVs.

Available data on resource allocation within the HIV budget confirms that Burma has targeted a significant proportion of resources to care and treatment programs. The 2012 Progress Report of the National Response shows a substantial decrease in expenditures for prevention from USD 16.1 million in 2001 to USD 11.2 million in 2012, and a decrease in program coverage for specific areas including a reduction in the numbers of needles/syringes distributed from 9.2 million in 2011 to 8.7 million in 2012.

Table 1.2.1 Investment Profile by Program Area¹³

Program Area	Total				
	Expenditure	% PEPFAR	% GF	% GOB	% Other
Prevention	\$13.58M	21	45		
Care and Treatment	\$28.64M	9	47		
OVC	\$15,759	--			
Program Management & Administration	\$16.29M	11	59		
Training	\$620,824	32	19		
Social Protection and Social services	\$45,914	--			
Enabling Environment	\$2.60M	46	75		
HIV-related research	\$1.56M	96			
Total	\$63.38 M	16	50	8	26

¹² Draft NASA report 2012-13; Sustainability Index and Analysis for Burma 2015

¹³ GF, National AIDS Spending Assessment, 2014

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOB	% Other
ARVs			USD5,000,000**	USD5,000,000	
Rapid test kits			USD 400,000**		
Other drugs			USD1,000,000**		
Lab reagents			USD 600,000**		
Condoms		USD 427,160*	USD 700,000**		
VMMC					
Other commodities		USD 103,945*	USD 600,000**		
Total		USD 531,105	USD8,300,000		

*Information about % contribution is not available. In FY 2014 USG supported procurement and supplies for male condoms (quantity provided: over 12.6 million) and condom-compatible lubricant (quantity provided: 2 million) through the Commodity Fund.

**GF Fund amounts and breakdown were provided by only one of the two prime recipients, Save the Children (SC) that manages the funds to support civil society programs. SC states that funding amounts provided do not include funds for transport cost and PA fees, which if included would add another 15%. At the time of COP submission, information from UNOPS, prime recipient for health care sector support for HIV was not available.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	2,854,731				
USAID TB	1,427,365		1	320,000	TB-HIV co-infection
USAID Malaria	6,565,881				
Family Planning					
NIH					
CDC NCD					
Peace Corps					
DOD Ebola					
MCC					
Private Sector					
PEPFAR Central Initiatives					
Total	10,847,977		1	320,000	

1.3 Sustainability Profile

[REDACTED]

In a supply chain assessment where 60% represents a minimally functional system, Burma scored 40% in 2014. Technical assistance is needed to assist the NAP and GF for supply chain strengthening including commodity forecasting and developing a Logistics Management Information Systems (LMIS). There is also a need to strengthen procurement systems to support elements of the HIV service cascade such as HIV and CD4 testing, ART provision and monitoring of viral load (VL) suppression. Supply chain TA providers will work alongside laboratory and clinical experts in developing a functional strategy.

Laws that criminalize MSM, FSW and PWID remain in place, directly fuelling stigma and discrimination against these populations and impeding their access to HIV prevention, treatment and care services. For example:

- the Myanmar Excise Act 1917, makes possession of hypodermic needles illegal;
- the 'Narcotic drugs and psychotropic substances law of 1993', requires mandatory registration for drug treatment and imprisonment of PWID who have not registered;
- the Suppression of Prostitution Act 1949, enables police to charge SW with 'reputation' offences that can incur a 1-3 year prison term;
- section 35 of the Police Act 1945 enables police to arrest SW for 'loitering after dark'; and,
- section 377 of the Penal Code criminalizes "sodomy" and stipulates a penalty of imprisonment for up to ten years and a fine.

Leadership in the NAP have signaled that current legal reforms in parliament present an opportunity for advocacy with the appropriate sub-committees to change laws and ensure that relevant laws take into consideration the potential negative impact on key populations. The NAP has also expressed a desire to create a favorable environment for reduction of stigma and discrimination affecting KP (Strategic Plan 2011-2016). PEPFAR will join stakeholder's in country, and in particular work with civil society networks and organizations to advance changes in legislation.

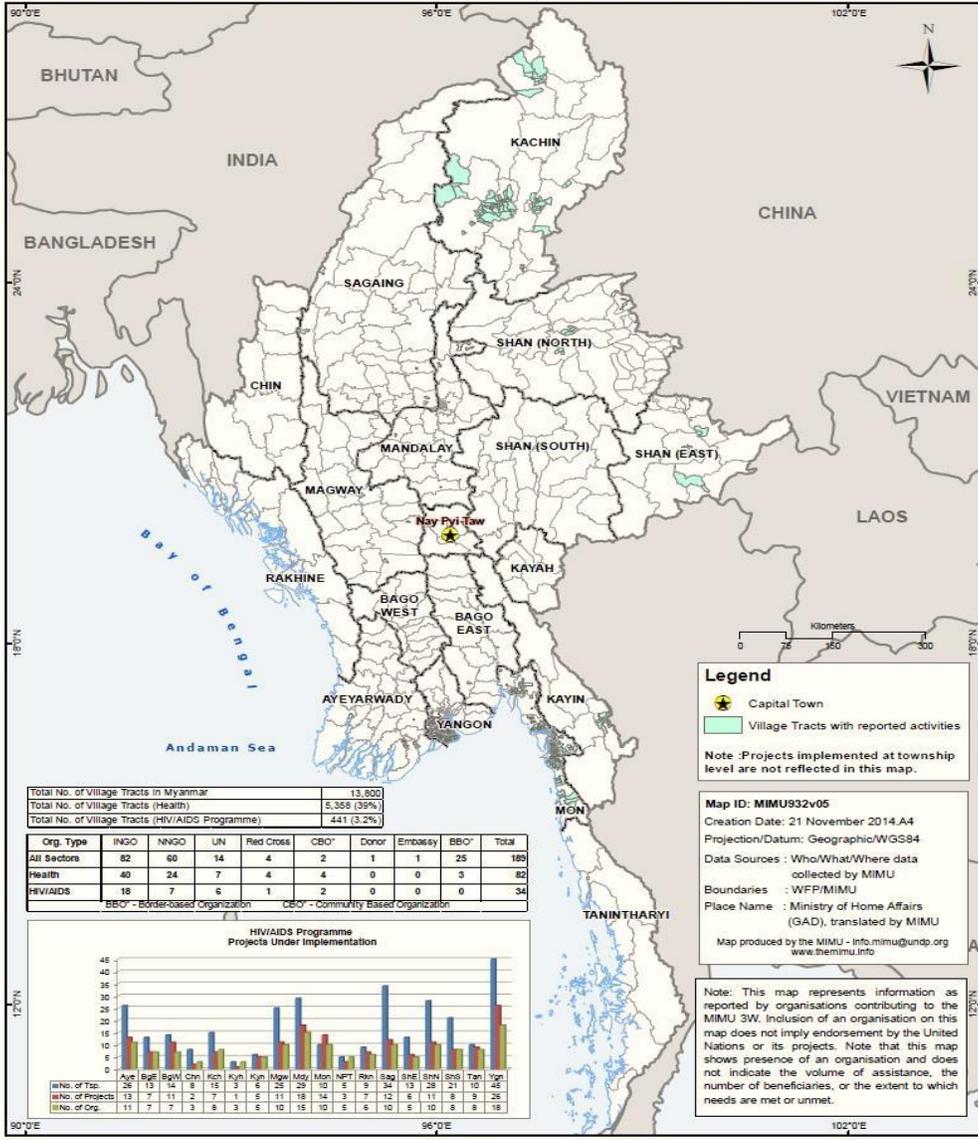
1.4 Alignment of PEPFAR investments geographically to disease burden

Very limited data are available to conduct in-depth analysis of investments by state and inform geographical prioritization in Burma. Because HIV burden / number of PLHIV by state are not available Figure 1.4.1 from the SDS TA/TC country template could not be produced. Given this caveat, PEPFAR Burma made use of existing data (primarily MOH data sets triangulated with USG IP data to inform the prioritization of geographic support moving forward in order to have the greatest ability to achieve epidemic control (within the existing resource envelope) within the country.

The map provided below shows program coverage for all organizations that support HIV programs in Burma as of November 2014, illustrating that overall coverage is still very low.



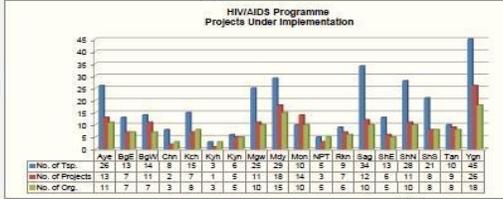
Myanmar Information Management Unit
HIV/AIDS PROGRAMME
 All Organizations' Projects Under Implementation
 Reported to the MIMU, November 3, 2014



Total No. of Village Tracts in Myanmar	13,800
Total No. of Village Tracts (Health)	5,358 (39%)
Total No. of Village Tracts (HIV/AIDS Programme)	441 (3.2%)

Org. Type	INGO	NGO	UN	Red Cross	CBO*	Donor	Embassy	BBO*	Total
All Sectors	82	60	14	4	2	1	1	25	189
Health	40	24	7	4	4	0	0	3	82
HIV/AIDS	18	7	6	1	2	0	0	0	34

BBO* - Border-based Organization CBO* - Community Based Organization



Legend

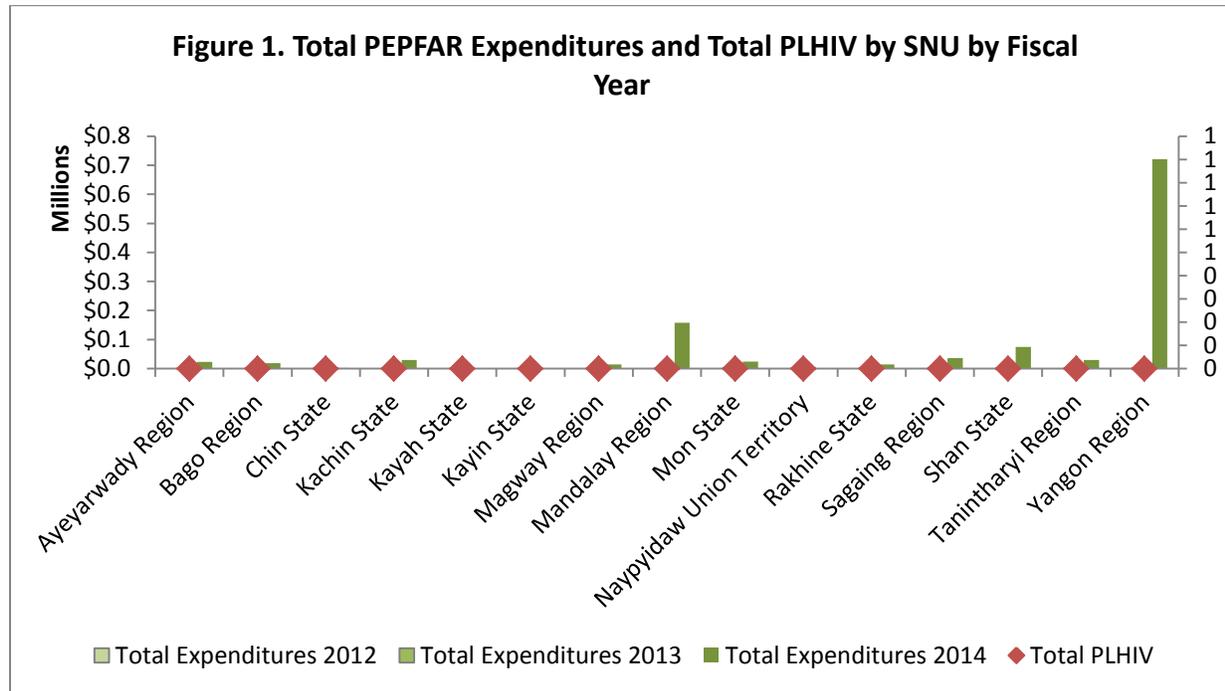
- Capital Town
- Village Tracts with reported activities

Note: Projects implemented at township level are not reflected in this map.

Map ID: MIMU932v05
 Creation Date: 21 November 2014.A4
 Projection/Datum: Geographic/WGS84
 Data Sources: Who/What/Where data collected by MIMU
 Boundaries: WFP/MIMU
 Place Name: Ministry of Home Affairs (GAD), translated by MIMU
 Map produced by the MIMU - info.mimu@undp.org www.themimu.info

Note: This map represents information as reported by organisations contributing to the MIMU 3W. Inclusion of an organisation on this map does not imply endorsement by the United Nations or its projects. Note that this map shows presence of an organisation and does not indicate the volume of assistance, the number of beneficiaries, or the extent to which needs are met or unmet.

Figure 1 shows PEPFAR expenditures by state, for PEPFAR funds spent in FY 2014, with most funds used during this time period coming from FY 2012, given the delays of approval and subsequent late arrival of COP 2013 funds.



PEPFAR expenditures reflect investments in urban settings in particular Yangon and Mandalay, where the highest numbers of KP live.

Given the lack of data for HIV burden by SNU, analysis such as PEPFAR Expenditure per ART patient and ART coverage by SNU and by year as proposed in the Standard SDS Template (Figure 1.4.2) cannot yet be produced or interpreted in a meaningful way. Following disbursement of COP 2013 funds and expansion of PEPFAR support including increased support for linkages and ART service expansion, more data will be available in the future and we expect to have improved and additional analysis in COP 2016/17.

Examining the expenditure analysis (EA) results for HIV Testing and Counseling (HTC) by PEPFAR’s implementing partner that supported direct services over the past year has however provided the PEPFAR team with some valuable information.

Figure 15: PEPFAR Unit Expenditures for HTC by Mechanism and Sub National Unit in Burma in Fiscal Year 2014

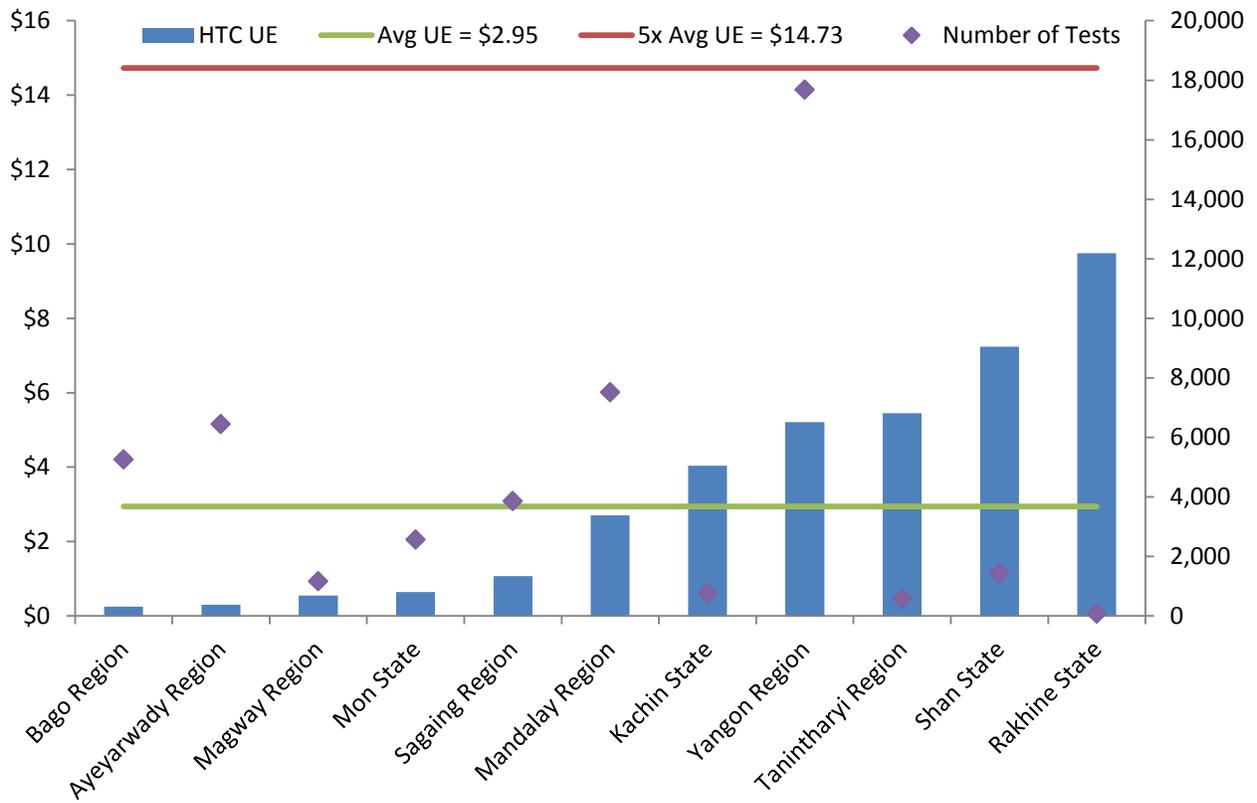
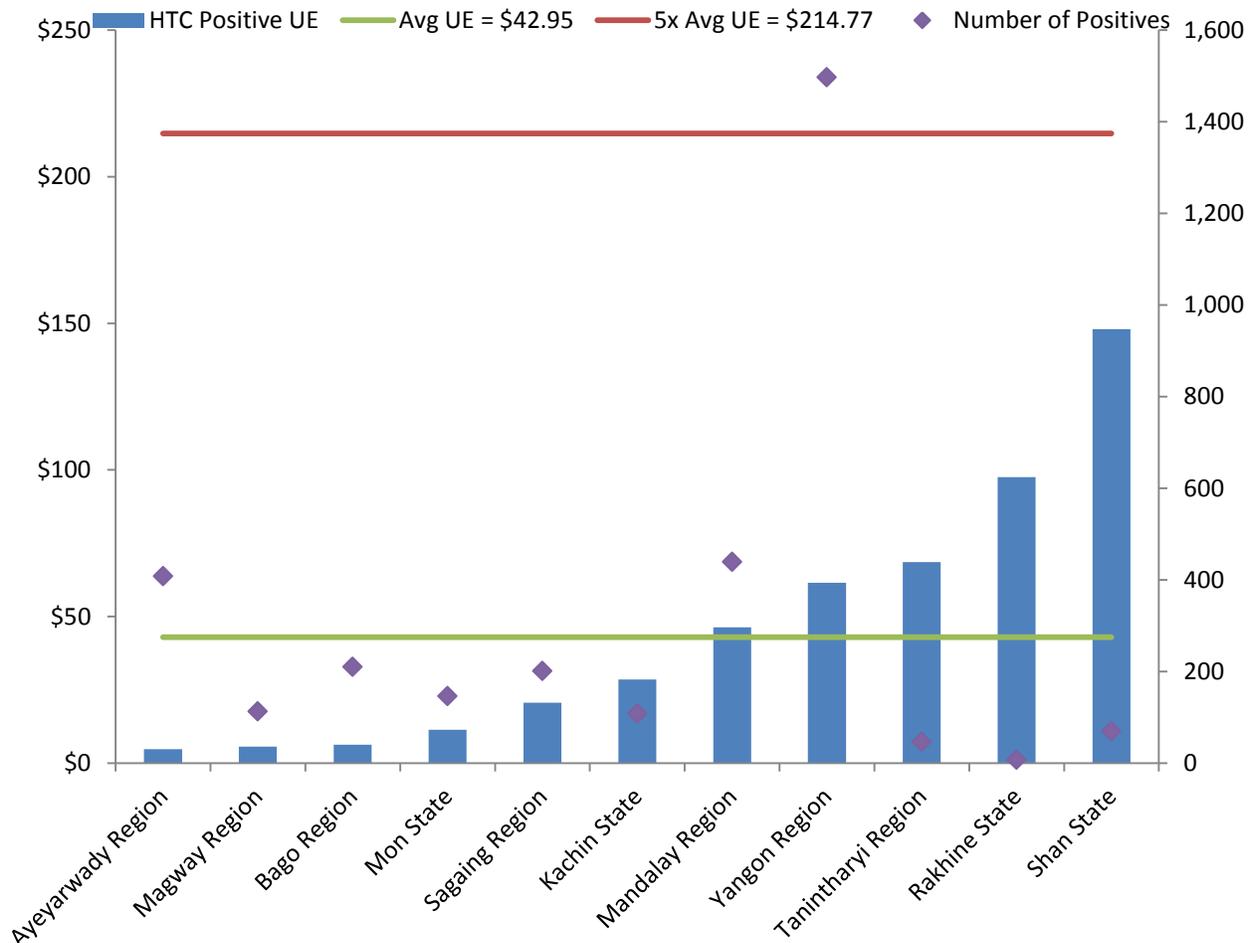


Figure 15: PEPFAR Unit Expenditures for HTC Positive by Mechanism and Sub National Unit in Burma in Fiscal Year 2014



Data in Figure 15 provide first insights into outliers, such as very low unit costs of per HIV test conducted in Bago and Ayeyarwady, as well as high costs per test with a low number of tests performed in Shan and Rakhine. Low unit costs for number of tests performed in four states (Ayeyarwady, Magway, Bago and Mon states) are explained by a combination of direct service support and lower cost TA support. Of note, HIV test kit procurements are supported by GF and supplied to all PEPFAR-supported sites free of charge. As expected, unit expenditures are overall higher in regions where there are higher number of tests (including positive tests) provided, as these regions correlate with a greater degree and intensity of technical assistance provide by PEPFAR Burma.

High numbers of tests conducted as well as higher numbers of positive tests in Yangon, Mandalay, and Ayeyarwady likely reflect a combination of higher concentrations of KP, higher HIV prevalence among KP, and better coverage and service up-take between FSW and MSM. The states of Shan and Kachin are PWID hotspots, but PEPFAR supported centers located there served primarily FSW and MSM. As described in later sections, new strategies will be proposed to improve reach and services for PWID in two catchment areas in Northern and Eastern parts of Burma. The site supported in Tanintharyi was a new site and higher costs are at least in part related to start-up costs and are expected to decrease over

the coming year. Services in Rakhine were disrupted because of communal violence that explains the low yield over the past year.

1.5 Stakeholder Engagement:

The PEPFAR team has consulted with the NAP, the GF and its prime recipients, UNAIDS, and key civil society organizations during this year's COP planning process, to gather the data needed from all involved and to discuss activities the PEPFAR team proposes to implement. Discussions were held with GF recipients to look at how GF and PEPFAR can support and engage with Civil Society Organizations (CSOs) without duplicating efforts. The USG team is represented on the Multi Health Sector Country Coordinating (M-HSCC) Mechanism that coordinates the support provided by GF and other donors, as well as the Technical Working Groups (TWGs), for different areas of the HIV response. USG staff has close collaborative relationships with both UNOPS and Save the Children, the current GF prime recipients, as well as takes part in broader stakeholder meetings and TWGs. As mentioned above, GF prime recipients have requested and are tapping into the PEPFAR team's TA, with a recent request for laboratory TA as an example.

CSOs were engaged to understand the needs of KP as the government shifts to a decentralized ART platform, and what role PEPFAR could play to mitigate gaps and encourage testing and treatment enrollment and retention. Meetings with national CSO networks, including SW, MSM, PWID and PLHIV networks are conducted bi-monthly and results of consultations during Burma's COP development are summarized in the Civil Society Engagement Appendix. Meetings have informed the development of an umbrella project supported through an existing mechanism with UNAIDS where the CSO board members and volunteers will be trained on organization development and will work on advocating for the policies, rules and regulations that will most affect their area of interest.

In addition, CSO involvement will be 'mainstreamed' into all mechanisms supporting three main strategies for support of HIV service delivery, i.e. community-based TOP Centers, private sector general practitioners, and public health care facility HIV services. Peer navigators will be used to facilitate reaching key populations at community level and supporting enrolment and retention of Key Populations (KP) and PLHIV in services. Local CSOs, KP and PLHIV representatives will be involved in the design, monitoring and evaluation of PEPFAR supported services.

Meetings with UNAIDS and WHO looked at how both parties could support the NAP and likewise strategize on how to assimilate all incoming data from various implementing partners and activities.

Close technical collaboration has been established with Ministry of Health (MOH) and NAP counterparts. The USG team has supported TA for two national ART program assessments conducted in 2013 and 2015, and provided technical inputs into the government plans for expansion of decentralized ART service provision. Nevertheless the team acknowledges that PEPFAR is a more recent player in-country, and that PEPFAR funding is considerably smaller than GF contributions, which points to the importance of continuing to pro-actively and continuously engage in joint planning and prioritization with the GoB and the GF, as well as continuing to strengthen the collaborative relationships that will allow for PEPFAR to support HIV service provision in the public health care sector. Insufficient investment of domestic resources to services or system support that directly benefit control of the HIV/AIDS epidemic have been described in section 1.2 and 1.3, and the PEPFAR team will continue, together with other international and national key stakeholders, to advocate for increased GoB funding contributions and commitments.

In this year's COP, the PEPFAR Burma team proposes to enhance and expand collaboration with private practitioners. They serve as an additional point of service for KPs who have experienced stigma and discrimination at public health care facilities as well as TB and STI patients who may be accessing care in the private sector. Since this will be a new component of the PEPFAR Burma program, these activities will be carefully monitored and the yield will be analyzed to assess whether this collaboration should be further expanded in COP 2016.

2.0 Core, Near-Core and Non-Core Activities

USG has been funding limited HIV/AIDS activities in Burma for ten years and began expansion of PEPFAR programming in 2012 after the US Embassy in Rangoon re-opened. With a gap of funding in FY 2014 and late release of FY 2013 funding, many PEPFAR supported programs in Burma are new. Therefore, the PEPFAR team sees this COP as an opportunity to initiate activities that are consistent with strong country ownership, achieve high impact and that are sustainable and economically sound. PEPFAR implementing partners have been selected for their special technical expertise, programmatic experience and reach, and we will seek to create a shared PEPFAR vision among the partners.

Although this is a time of transition for Burma, with some supportive policies which encourage decentralization of services and openness to HIV prevention in KP, many geographic areas are still in conflict and remain closed to US government presence and beyond the reach of the national government health program, such as in Kachin and Shan states. Recognizing this, the PEPFAR team will focus on those activities that are feasible in the near term, while identifying opportunities for engaging in those areas through new partnerships or strategies.

The NAP has established ambitious targets for HIV treatment and has endorsed a strategy of sustaining growth in the public and private sector through decentralization. PEPFAR supported TA providers will work with government, INGOs, NGOs, and private providers to strengthen the current cascade of testing, care, treatment, with the goal of early diagnosis, early enrollment, high levels of retention in treatment for key populations, and preventing loss to follow-up at all stages of the cascade, while ensuring confidentiality and protection of medical records.

Service delivery components supported by PEPFAR will focus on KP, with targeted community- and facility- based prevention, testing, and treatment services for SW, MSM and TG in four high prevalence and volume catchment areas. PEPFAR Burma also plans to expand targeted services for PWID, in line with government policies supportive of prevention, testing, care and treatment for PWID, with an emphasis in 2015/2016 on obtaining better information, establishing operational plans, and identifying and preparing potential partners in current restricted areas for programming in the future. TB/HIV co-infection continues to be a major problem with 27% HIV prevalence in TB patients, but low HIV testing rates among TB patients. Working in close partnership with the National TB program and USAID's 'Challenge TB' program, PEPFAR will provide TA to support routine HIV testing of all TB patients and regular TB screening among PLHIV.

There is a need to enhance "testing and treatment literacy" so that persons at risk are aware of, and utilize HIV services. The particular challenge is creating a demand for and access to services among KP who do not yet know their status and have not yet been tested for HIV. PEPFAR will provide TA and help design interventions aiming for more KP and high-risk patients to get tested, and those who are HIV-positive effectively linked to, enrolled and retained in treatment. PEPFAR will use communication technologies such as instant messaging and internet-enabled smartphones just now emerging in Burma that will tap into the strength of social networks of KP.

PEPFAR Burma will continue to support investments in laboratory and supply chain systems to improve HIV testing and treatment scale up. Technical assistance in strategic information will include support for bio-behavioral surveys among KP, improved sentinel surveillance coverage and procedures and

emphasis on quality and use of data for planning and decision-making at all levels. See Appendix A for full list of core activities.

3.0 Geographic and Population Prioritization

The lack of HIV prevalence data and HIV burden beyond the national level makes PEPFAR planning and geographical prioritization particularly challenging. However, the PEPFAR team and their partners have sought to collect whatever data is available, are supporting activities to improve availability of much needed data such as KP surveillance and size estimates, and are conducting a careful analysis of existing data to inform the plan proposed for the coming year.

According to NAP reports, by the end of 2014, approximately 85,257 PLHIV were on ART, representing 55.5 % of individuals in need of ART. Geographic distribution of ART patients shows Yangon, Kachin, Mandalay, and Shan states at approximately 42%, 15%, 14% and 10% of the total of patients on ART, respectively. With the revised national HIV treatment guidelines, increasing the CD4 threshold for ART initiation to 500, an estimated 153,606 adults are in need of ART. The treatment gap has therefore been clearly identified.

Highest ART up-take and enrolment figures in Yangon and Mandalay are in part explained by large population sizes of 7.3 million in Yangon, and 6.1 million in Mandalay states (Provisional Government Census data, 2014) as well as the location of most important urban centers in Burma likely associated with higher numbers of KP. Kachin state, despite a lower total population size (estimated at 1.7 million), together with Yangon and Mandalay is among the states with highest proportion of people living in urban areas (2014 Census). Kachin and Shan states (total population in Shan state estimated at 5.8 million), are locations known for injection drug use, with the highest HIV prevalence among PWID estimated at 35.5% for Kachin state and at 20% for the Northern part of Shan state, according to 2013 NAP data.

PEPFAR Burma will concentrate on improving service delivery for KP in high burden catchment areas in these four regions and states in NGO, private and public sector settings to enhance services and accelerate HIV diagnosis, treatment uptake and retention of KP. At the national level, PEPFAR will provide technical assistance to strengthen ART decentralization and strategic information, laboratory and supply chain systems. In order to ensure there is not a gap in services for KP, existing PEPFAR support for KP activities through TOP centers in non-focus catchment areas will be gradually transitioned to other support based on discussions with stakeholders and other donors, in particular GF.

The newly initiated PWID program TA will target Kachin and Shan states.

Table 3.1 below describes KP for priority focus within the four catchment areas in the four states and regions over the next year.

3.1 Priority Catchment areas and Key Population Focus

Category	State/Region	KP Focus
High Priority Catchment Areas	Yangon	All Key Populations
	Mandalay	All Key Populations
	Kachin	New PWID Support, existing other KP support sustained
	Shan	New PWID Support, existing other KP support sustained

Four of the existing 18 Targeted Outreach and Prevention (TOP) Centers that have been supported by PEPFAR and provided important community-based services to KP over the past years, are located in the catchment areas in the high priority states. In order to reach greater coverage of KP, two additional centers will be established in Yangon. GF is currently providing 60 percent of funding support for TOP Centers, and PEPFAR will work with GF to ensure continued support to the 14 TOP centers that are located at urban sites or sites that are otherwise known as hotspots or within proximity of larger concentrations of KP outside of the PEPFAR catchment areas, as well as ensure ongoing support for ARV and other commodities in the four catchment areas. There is huge potential to capitalize on results of this program accelerate HIV prevention and treatment in Burma.

The Yangon TOP center received NAP approval to initiating clients on ART in January 2015 and two others have been designated as decentralized ART centers (one in Mandalay and one in Shan state). PEPFAR will work with NAP to seek approval for all TOP centers in the catchment area to begin initiating clients on ART over the COP15 cycle. Please also see section 4.8 for further details about decentralization of ART services.

The proposed new collaboration with private sector general practitioners (GP) described in more detail below will be similarly aligned with the above geographical prioritization and support GPs located in the high priority catchment areas in Yangon and Mandalay that serve sites with known higher concentrations of KP or hotspots. Over the COP15 cycle, there is potential that 30 GPs will be identified and receive to serve as ART dispensing clinicians. Again, this responds directly to the GoB mandate to facilitate the scale up of ART services in regions with greater prevalence and KP densities.

A new mechanism started last year to provide TA to NAP and partners for Care and Treatment for selected ‘best practices’ decentralized ART sites was initiated last year. Technical assistance for the MOH has focused primarily on assisting NAP with planning and scale-up for decentralized ART services. As part of the PEPFAR enhanced strategy, TA will increase focus on monitoring and strengthening KP services including supporting new “One Stop Model” sites, combining ART, TB and MAT services for PWID that are proposed amongst others in Yangon and Shan states.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

By the end of 2014, only 85,257 (55.5%) of those 153,606 in need of ART were enrolled in treatment, according to preliminary data from NAP. This is due in part to the relatively late start of government and public sector health care involvement in the delivery and scale-up of treatment services due to a number of factors, including GF withdrawal in 2005 and re-entry in 2011. The current GF grant runs through 2016, where the treatment target of 86% (106,058 individuals using the former CD4 < 350 cut-off point) had been set. However, with the new 2014 national HIV treatment guidelines¹⁴, the estimated number of adults in need of ART increased to 153,606.

Another major challenge has been the low number of KP with knowledge of their HIV status. Only 31.9% of the total estimated 383,000 KP have been reached, and only 12.4% have been tested for HIV. Of those tested 6.9% (3,274) were diagnosed as HIV positive last year.

During FY 2015/16 PEPFAR will place greater emphasis on increasing the number of KP provided with HIV testing and counseling services, and enrolled on ART in the 4 priority catchment areas. Based on a successful pilot conducted in 2014 in Ayeyarwady TOP Centers located in the catchment areas will be enhancing HTC service provision, including the introduction of mobile HTC services at hotspots as well as innovative recruitment methods to draw in KP that have not yet been tested for HIV. In addition, through collaboration and coordination with the GoB, activation of ART services at the 6 TOP sites serving KPs in the four catchment areas will greatly facilitate initiation and retention of HIV positive KPs onto ART. As the TOP sites are currently well positioned to serve KPs in the PEPFAR Burma priority areas, as well as provide KP-friendly services, it is expected that the treatment gap for KPs in those areas will be significantly reduced within the COP15 timeframe and further positioned to support treatment scale up beyond the COP15 cycle. As the sites will provide a full complement of services to KPs, they will also be well positioned to facilitate adherence support to KPs during the outlying years of the epidemic.

An existing HQ mechanism that includes partners with extensive experience with injecting drug users will be utilized to initiate support for PWID in Kachin and Shan states, beginning with further assessment and mapping of service gaps and needs. This will be followed by initiation of programming in these regions which best serve PWID in identified underserved areas.

HIV prevalence is over 4.1% in male Sexually Transmitted Infection (STI) patients (MOH 2012). To maximize HIV case finding and cost-effective ART provision, PEPFAR will work with a GP network that is already providing STI services, but not yet doing HIV counseling and testing for patients with STI or other HIV risk behaviors. As of December 2014, 1,102 GP clinics in this network were providing STI services. However, 856 were not yet doing provider initiated HIV testing (PITC). Of those sites providing HIV tests, the HIV positivity rate is high enough (6.6% in network clinics) to justify the potential of finding new HIV+ cases among people attending these clinics. PEPFAR will initiate the expansion of HCT services to providers in Yangon and Mandalay with high STI caseload, but who are not yet doing HIV testing, in an effort to reach persons likely to be HIV+ but who do not know their status. This year PEPFAR will start with 30 clinics that have more than 20 STI cases per month. By expanding PITC to that group, we

¹⁴ The CD4 threshold for ART initiation increased to 500; Initiate ART for HIV positives in sero-discordant couples, KP (FSW, MSM, TG, PWID), and TB/HIV co-infected patients irrespective of CD4

estimate we could do up to an additional 15,000 HIV tests in year one, with an estimated positivity rate of about 6.6%, and thus an HIV case finding rate of about 765 HIV cases, within the first year. In future years, provided funding is available, the full network can be brought on to do PITC.

The same network will also be used to integrate ART services. Currently 18 GPs within the network are providing ART. With PEPFAR Burma support, the 12 additional GPs will be trained in order to serve as ART-initiating clinicians. This model directly responds to GoB mandates to facilitate decentralization of ART services in key regions throughout the country (informed by epidemiological and IP data).

As mentioned above a new partner has begun to provide TA to NAP in 2014, primarily for the development of models and tools for implementing and monitoring the decentralized ART rollout. The IP is supporting community advocacy, training of providers, provision of ART job aids and tools, and establishment of PLHIV peer support systems with an emphasis on KP.

Technical assistance partners will provide TA to NAP at central level also for the scale up HIV testing of all TB and STI patients, and work with the national programs to develop sustainable strategies for provision of ART for TB patients who are HIV co-infected. Similarly TA will be provided to NAP to strengthen guidelines and develop/adapt tools for increased TB screening among People Living with HIV (PLHIV) as well as KP, in particular for settings and groups with likely high prevalence for both HIV and TB such as PWID. Sites receiving PEPFAR TA will establish or strengthen systematic TB screening for KP and PLHIV.

PEPFAR will also support NAP and partners, including GF, to adopt evidence-based HIV testing guidelines and develop operational strategies for rapid scale up of HIV testing, including addressing quality control and supply chain needs. Further details for laboratory support, including viral load testing, and supply chain management will be described in section 6 of this document. All sites, supported by PEPFAR in Burma, including NGO, private and public sector sites, will receive supervision and support for quality assurance and quality improvements through implementation of the Site Improvement through Monitoring System (SIMS). PEPFAR will work with partners to develop systems to track and use program results to monitor progress, including TA provided through UNAIDS.

Meeting the ambitious national ART targets will require in-depth strategic planning and monitoring to achieve the most impact with the proposed activities. As has been mentioned throughout this document, limited data of questionable quality presents a major challenge for selecting geographic priority areas and establishing targets. HIV prevalence data is limited mostly to national level, with lower SNU level data unavailable or too unreliable to use. To address this, as noted earlier, PEPFAR will provide direct TA and work with partners to improve the quality of data available and improved analysis to make better use of existing information as well as continue to support KP surveillance including size estimates needed for appropriate KP programming and prioritization.

Although restrictive policies have decreased, KPs continue to face significant stigma and discrimination within communities and at facilities, which are key barriers to accessing HIV testing and ART, and achieving viral load suppression. PEPFAR will work with CSO networks, UNAIDS and others stakeholders to identify the key barriers and identity strategies to overcome these barriers. In addition, the new Care and Treatment TA provider will support NAP and selected sites with adaptation and use of training materials for clinical providers that will support establishment of KP friendly services at public health facilities. SIMS tools will also be modified to address possible stigma and discrimination of PLHIV seeking other health services, such as reproductive health and family planning.

When determining resource needs for implementation of proposed activities, the PEPFAR team took into consideration the experience and reach of the organizations, their ability and willingness to re-focus efforts, specific technical strengths, and their ability to influence policies and strategies on a national level. The team assumed that there would be no increased restrictions, from either the local government or USG, following the results of the elections in late 2015. The current MOH is supportive of PEPFAR work and goals, but severely understaffed. Assuming this openness continues after the elections, and that the government systems established are similar to the existing ones, a high priority of PEPFAR will be to build capacity of the MOH, specifically the NAP, to lead and improve public sector HIV services, surveillance and monitoring, working in close partnership with donors and stakeholders, including GF, WHO and UNAIDS.

Table 4.1.1 ART Targets in Priority Sub-national Units (SNU) for Epidemic Control

Priority State	Site Name	IM/Partner	Currently on ART (by 20 Feb 2015)	Target for Current on ART by end of FY 2015	Target for Current on ART by end of FY 2016
Yangon	Yangon TOP	PSI TOP	188	250	400
	GP (15 clinics)	PSI/Sun			220
	QC	PSI	64	80	80
Mandalay	Mandalay TOP	PSI TOP/MOH	3	80	300
	GP (15 clinics)	PSI/Sun			300
	Meiktila TOP	PSI TOP/MOH			80
Kachin	Myitkina TOP	PSI TOP/MOH			60
Shan	Lashio TOP	PSI TOP/MOH			60
Total			255	410	1500

Table 4.1.2 Entry Streams for Newly Initiating ART Patients at Yangon TOP Center (FY16)

Entry Streams for ART Enrolment	Tested for HIV (in FY16)	Identified Positive (in FY 16)	Enrolled on ART (in FY16)
FSW	2875	230	80**
MSM & TG	4025	200	70**
PWID			
Others (please specify)			
Total	6900	430	150

** Note: The difference between the "Identified Positive" and the "Enrolled on ART" is because the "test and treat" policy is not yet fully in place, so many people found to have HIV may still need to go on the pre-ART register for some time, before initiating ART

The current ART data in Table 4.1.2 applies for only one PEPFAR supported ART site in Burma, the Yangon TOP Center which was granted permission by the MOH NAP to newly initiate patients on ART.

PEPFAR will work with MOH ART and GF in order to designate all TOP centers in the 4 priority catchment areas as ART delivery sites. Until ART is approved by MOH for TOP centers, under current MOH ART decentralization plans, any newly diagnosed patient (including newly diagnosed KP, TB and STI patients) will be referred to an ART Center where the respective patient will be initiated on ART and monitored for the first six months on ART. Most ART treatment Centers have non-PEPFAR partners already assigned and in place for support. If the patient is stable upon completion of the first six months on ART, he/she will then be referred to a decentralized ART site for continuation of ART and monitoring. PEPFAR will ensure high quality adherence and retention services and tracking for adherence in the catchment area with the use of new technologies.

Table 4.1.4 Prevention Interventions for Key Populations to Facilitate Epidemic Control

Priority State	FY 2016 Target	Is GFATM and/or HCG proving Prevention Interventions for KP in this SNU? (Y/N)
Yangon	16,583	Y
Mandalay	8,744	Y
Kachin	779	Y
Shan	2,301	Y
Total	28,407	Yes, GF funding for drugs and commodities

Table 4.1.4a Prevention Interventions for FSW to Facilitate Epidemic Control

Priority State	FY 2016 Target	Is GFATM and/or HCG proving Prevention Interventions for KP in this SNU? (Y/N)
Yangon	6,965	Y
Mandalay	3,672	Y
Kachin	327	Y
Shan	966	Y
Total	11,930	Yes, GF funding provides funding for drugs and commodities

Table 4.1.4b Prevention Interventions for MSM and TG to Facilitate Epidemic Control

Priority State	FY 2016 Target	Is GFATM and/or HCG proving Prevention Interventions for KP in this SNU? (Y/N)
Yangon	9,618	Y
Mandalay	5,072	Y
Kachin	452	Y
Shan	1,335	Y
Total	16,477	Yes, GF funding provides funding for drugs and commodities of each site

Program Area Summaries 4.2-4.10

4.2 Prevention

As is appropriate for a concentrated epidemic and the make-up of Burma's HIV epidemic, the PEPFAR program focuses its prevention support specifically on KP. The core package of KP services as outlined in the new 2014 WHO Consolidated KP Guideline and the PEPFAR technical considerations will be provided at PEPFAR supported sites, with the majority of sites located in the nine high priority states.

As during the previous year, PEPFAR will continue to tap into the Central Commodities Fund to procure and distribute condoms and condom-compatible lubricant for KP through all PEPFAR supported sites across all partners, while at the same time seeking to enhance long-term and sustainable condom and lubricant supplies through TA for management of commodities described in more detail below.

PEPFAR will continue support the TOP program in the priority areas, serving KP across all groups, FSW, MSM, and TG. TOP Centers provide a safe space for a range of important HIV prevention and care services. Since the end of last year, at a few selected sites, ART services were also provided. Over the coming year, activities conducted at the TOP Centers will focus on increasing demand and up-take of HIV Testing and Counseling (HTC) services delivered on-site. New approaches to recruit KP using social networking (e.g. peer-driven intervention models) will be explored and piloted at sites in high priority catchment areas. As mentioned above two sites have started providing ART services and these services will be expanded to an additional four sites over the course of the year. Peer navigators will support successful linkages into Care and Treatment for KP diagnosed as HIV positive and continues to accompany the HIV+ KP to support good adherence and retention in care.

TOP Centers have primarily served FSW, MSM and TG. PEPFAR will develop a new strategy to reach and improve services for PWID in Kachin and Shan states, including TA for interventions such as the provision of sterile needles/syringes (procured by Global Fund and/or MOH), hepatitis screening, overdose prevention and treatment and linkages to Medication Assisted Therapy (MAT) sites.

As some areas in these states are in conflict and restricted to access by foreigners as well government health services, PEPFAR will provide TA and develop capacity of community-based civil society organizations to assist gathering information about the needs of the populations in those areas and where possible begin basic service provision.

PEPFAR supported clinical partners such as the Sun Quality Health (SQH) Clinics and private GPs, and the public health care workers at selected ART sites in the catchment areas will be trained to provide KP friendly services. Their sites and staff will also be connected with either existing KP community based organizations (CBOs) and/or train KP peers to serve as link between the facilities and the KP community to ensure good mobilization for increased service up-take as well as support for adherence and retention.

(4.3 VMMC – not applicable)

4.4 Preventing mother-to child transmission (PMTCT)

Based on testing data of pregnant women from 2014, the HIV positivity rate for women tested ranged from 0.2-1.32% across different states. HTC for pregnant women in 2013 only showed 309,677 (43.7%) tested out of 708,624 who received pre-test counseling. Task shifting of HTC to midwives has increased HTC in pregnant women during the past year, but challenges remain (e.g. HTC kit shortages). Low HIV

testing rates may contribute to an underestimation of the number of pregnant women in need of ARV prophylaxis. PEPFAR Burma will provide limited TA through its laboratory technical support and in collaboration with other stakeholders (e.g. UNICEF) to assure quality HTC for pregnant women, access of ART for HIV positive pregnant women, and testing and treatment for exposed infants. Technical assistance provided for improved procurement and supply systems will include a strong focus on HIV Rapid Test (HRT) kit supplies.

4.5 HIV Testing and Counseling (HTC)

In January 2015, NAP conducted a review of the national HTC guidelines to make much-needed updates and align the guide with WHO and global guidance. Revised guidelines will be published shortly. Challenges observed in the field include knowledge gaps among HTC providers, poor testing and counseling practices, and weak referral systems to care and treatment for HIV-positive individuals. According to the WHO, the revised guidelines will update recommendations on testing algorithms (in particular re-testing prior to ART initiation) and provide guidance on community testing and improved linkages, especially for KP. Other gaps identified include lack of HTC Quality Assurance (QA) for all sites and testers, including the private sector, and the need for counselor and health care worker refresher training.

Only an estimated 12.4% of 383,000 KP have been tested for HIV. Of those tested 6.9% were diagnosed as HIV positive. Both total number of KP tested and positivity yield at PEPFAR supported sites will continue to be monitored and HTC services strengthened to increase the proportion of KP reached with HTC services. Many patients are diagnosed late, with CD4 levels around 100. Twenty-seven percent of patients newly diagnosed with tuberculosis have HIV. General practitioners working in the private sector account for a large proportion of HIV testing but QA and referral systems to treatment have not been established. In the national program, test kit stock-outs are reported, and expired test kits are used.

During the second half of 2014 the TOP Center staff in Hinthada, Ayeyarwady, began offering mobile HIV testing through six FSW outreach visits. The approach proved highly successful, with mobile HIV testing comprised 10% of the overall testing for the entire year. Also, significantly, the HIV positivity rate at the TOP Hinthada Center was 12% during calendar year 2014, making it the highest positivity rate of all TOP centers. Building on this experience, TA for mobile and outreach HTC strategies will be expanded to other sites within high priority regions.

Building onto the platform of the existing and enhanced collaboration with private GPs in the priority catchment areas as well as the TA provided to NAP and decentralized ART sites, HIV testing will be strengthened targeting in particular TB and STI patients, where high HIV positivity rates are anticipated and new patients for enrolment in HIV Care and Treatment are likely to be identified.

PEPFAR partners are providing HTC for KP, however there is a need to better target testing, establish routine quality control systems, link HIV-positive individuals to care and treatment, and closely monitor and track results. As mentioned above attention will be paid to increase access to HTC for PWID in identified appropriate geographical areas.

PEPFAR will provide TA to:

- Scale up HIV testing in the 4 priority catchment areas– through the use of innovative strategies such as mobile HTC services targeting in particular KP;

- Strengthen linkages to care and treatment to reduce the time from diagnosis to initiation of ART;
- Identify strategies to scale-up and monitor the supply and quality of HIV testing in community and facility settings, focusing in the 4 catchment areas where there the numbers of KP are greatest;
- Develop strategies to increase reach, testing, and referrals for PWID;
- Improve HTC and follow-up for KP, TB and STI patients in community and facility settings;
- Strengthen supply systems to reduce HIV test kit stock-outs and prevent use of expired or poor quality kits (see table 6.3); and,
- Develop systems to monitor and track clients through the cascade.

PEPFAR supported sites will conduct an estimated 19,300 HIV tests and identify an estimated 920 newly diagnosed HIV-positive individuals at a total of 36 testing centers.

4.6 Facility and Community-Based Care and Support

Over the past year, TOP Centers have provided TA for care and support to 2,813 persons receiving a minimum of one clinical service. Under the strategies outline in this plan, with engagement of the private GPs, targets in this area are expected to increase an additional 2,610 persons receiving at least one clinical service at 36 sites.

Despite concerns in regards to data quality and variation among age groups, the MOH reported HIV prevalence to be at 4.1% among male Sexually Transmitted Infection (STI) patients at HIV sentinel sites, with variations between age groups and peaks as high as 5.9% among 30-34 year-old male STI patients (MOH 2012). PEPFAR will provide TA for PITC for STI patients as well as support screening, diagnosis and treatment for Sexually Transmitted Infections (STIs) among Key Populations.

In addition, TA will be provided to NAP and sites directly supported by PEPFAR for the following care interventions that reduce mortality and morbidity among PLHIV as outlined in the 2014 PEPFAR Care and Support Prioritization Framework:

- Laboratory monitoring, including WHO staging, and if possible CD4 count and/or viral load (see table 6.1).
- Cotrimoxazole prophylaxis.
- Interventions to optimize retention in care and adherence to antiretroviral therapy (ART) and patient tracking across the cascade.

As part of the new focus on services for PWID, TA will be provided to NAP for strengthening of Medication Assisted Therapy (MAT) services through participation in the development of relevant guidelines, tools, and monitoring and evaluation. Sites supported by PEPFAR will also establish effective referral mechanisms for PWID in high priority states, where applicable. Among the new decentralized ART sites yet to be assigned to the new Care and Treatment partner, “one stop model” sites that provide integrated ART, TB and MAT services are also under consideration.

4.7 TB/HIV

Burma is among the 22 high TB burden countries worldwide with more than 140,000 TB cases notified in 2013¹⁵. A national prevalence survey carried out in 2009-2010 provided an estimate for all forms of TB

¹⁵ WHO. Global Tuberculosis Report, 2014. WHO, Geneva, Switzerland

of 598/100,000 population¹⁶. About 9000 cases of MDR-TB/rifampicin resistant (RR) TB occurred annually among those notified, while only 667 started treatment in 2013. Only 12% of TB patients knew their HIV status in 2013. One reason for the low numbers is because TB patients are not being tested for HIV, and do not know their sero-status. Of those tested 32% were positive of which 74% received ART. Around 20% of the estimated numbers of TB/HIV co-infected patients were on ART and 45,000 of the estimated 192,000 HIV cases were screened for TB, but provision of isoniazid preventive therapy (IPT) was low. TB treatment success in the 2012 cohort was 89% for new cases and 70% for retreatment cases. There was almost one microscopy laboratory for every 100,000 people and three culture capable laboratories nationally. There were 24 sites performing Xpert[®] MTB/RIF tests.

Provider initiated testing and counseling (PITC) is not the norm in all sites for TB patients; rather the paradigm is Voluntary Confidential Counseling and Testing. This “opt-in” approach is very likely leading to attrition in numbers tested for HIV.

Only a minority of TB and HIV co-infected patients currently access appropriate services, especially ART. The National Tuberculosis Program (NTP) and the NAP have agreed to collaborate to ensure ART is available for 100% of HIV-infected TB patients by the end of 2015. An important area of potential USG TA will be to start the discussions on a national level with both the NAP and NTP regarding the possibility of ART decentralization to include national TB clinics (currently there are over 2,000 TB clinics), where ART to HIV/TB co-infected clients could be provided.

In addition, as described above, a new strategy will be piloted this year, involving networks of private sector GPs who are also DOTS providers in 857 sites throughout the country. Initially, PEPFAR will work with 30 providers in two of the high priority catchment areas – Yangon and Mandalay -- and will assist in the scale up HIV testing for patients with tuberculosis, to establish protocols and procedures to enable expansion to the full network. This integration of TB and ART services at private clinics will provide an additional service point for KP and other high-risk patients to access clinical services.

In addition PEPFAR will provide TA¹⁷ to:

- Develop and implement a Standard Operating Procedure (SOP) for TB/HIV collaborative activities, particularly with the aim of increasing completed referral to ART sites;
- Support intensified case finding of co-infected HIV/TB individuals
- Improve and expand PITC for presumptive and diagnosed TB patients;
- Increase ART treatment access, including through decentralized sites, and monitor ART provision to HIV-positive TB patients on a quarterly basis;
- Expand access to TB services for KP; and,
- Implement more widely the WHO/UNAIDS/UNODC Policy Guidelines for TB/HIV collaborative activities for PWID.

4.8 Adult Treatment

MSF Holland introduced HIV treatment in 2003, in Yangon, Kachin, Shan and Rakhine states across 10 primary care and satellite sites. Initial access to ART was very limited with long ART waiting lists and median CD4 values at ART initiation well below 200. National scale up of treatment, particularly in the

¹⁶ WHO. Review of the National Tuberculosis Programme: Myanmar, 7-15 November, 2011. World Health Organization, Country Office for Myanmar

¹⁷ WHO, Review of the National Tuberculosis Programme: Myanmar, 1-11 December 2014, World Health Organization, Country Office for Myanmar

public sector, began in 2011 with the re-introduction of funding from GF. By the end of 2014, approximately 85,257 PLHIV were on ART, representing 55.5 % of an estimated 153,606 adults in need of ART. About half of the patients on ART are receiving services from NGO run facilities, primarily MSF, although the most rapid scale up of patients is occurring at NAP supported sites. Geographic distribution of ART patients shows Yangon, Kachin, Mandalay, and Shan states at approximately 42%, 15%, 14% and 10% of the total of patients on ART, respectively.

The current GF grant runs through 2016, where the goal of scaling treatment to 86% (106,058 individuals using a CD4 < 350) has been set, aligning with the *Myanmar National Strategic Plan and Operational Plan on HIV and AIDS: 2011-2016* (NSP). Over 60% of the ART services will be delivered by the public sector through approximately 85 NAP ART centers and 150 decentralized sites, with the number of NGO ART service delivery sites remaining relatively steady. In addition, with the activation of ART services at TOP facilities (contingent on GOB concurrence, ART services will be more closely linked to existing testing and support services for KP, which will facilitate further support of elements of the NSP related to scale up services for KP. A core principle of the scale-up of ART delivery in Burma is to decentralize HIV care and treatment to the township and peripheral levels whereby the primary ART centers will transfer more stable patients to township sites for ongoing management. The primary ART centers will retain responsibility for initiating newly diagnosed patients on ART, monitoring patients for the first six months on treatment, and managing complex health conditions including treatment failure. Further strengthening of ongoing supervision to ensure quality of care will be needed, with the PEPFAR Site Improvement Monitoring System (SIMS) utilized to support these efforts.

The national HIV treatment guidelines were revised in 2014, increasing the CD4 threshold for ART initiation to 500 and ART for HIV positives in sero-discordant couples, KP (FSW, MSM, TG, PWID), and TB/HIV co-infected patients irrespective of CD4. The revised guidelines also recommend fewer first and second-line treatment regimens and the use of viral load every 12 months to monitor for treatment failure.

There are no good estimates of HIV treatment among KP as KP disaggregates for ART patients served by township or region are not systematically collected. There are no estimates of the numbers of individuals who are receiving ART in the private sector. GF recipients are currently focusing primarily on the identification, testing and linkage of KP and other PLHIV with enrollment and ART initiation by NAP.

Funding for ARVs is supported mainly through the GF with some contributions from the GoB; therefore PEPFAR Burma does not provide funding for ARVs. However, according to a recent assessment by Supply Chain Management System (SCMS)¹⁸, drug stock-outs are common, CD4 equipment while widely available is often not functional, and access to viral load remains limited. In addition, the GF Office of Inspector General (OIG) audit also highlighted potential challenges for the expansion of ART services and quality at the ART centers and decentralized sites. Specific problems in supply chain management were noted in a number of facilities such as compromised supply safety, stores layout and accuracy/completeness of stock records.

The PEPFAR treatment strategy will provide targeted TA to the National AIDS Program in order to:

- Strengthen national systems and capacity to establish evidence-based operational guidelines for ART scale-up, including clinical protocols, commodities supply chain and laboratory systems that support timely ART initiation, patient tracking, adherence, retention and virologic suppression;

¹⁸ National Supply Chain Baseline Assessment, SCMS, 2014

- Monitor the progress of decentralization, establish evidence-based operational guidelines for implementation, and better use of information to guide placement or continuation of the facilities and quality HIV service delivery;
- Adapt global models and tools to assist the national program and GF monitor and improve access to quality ART services through provision of KP-friendly services for FSW, MSM, TG and PWID, including improved linkages with HTC, MAT, TB and other programs as well as KP sensitization training of clinical providers in public and private sectors;
- Develop a national strategy for the scale-up of viral load (VL) monitoring for more effective patient management for VL suppression, in coordination with other stakeholders and linked with CD4 scale-back ;
- Develop a national HIVDR surveillance strategy that includes plans for evaluation of acquired and pre-treatment HIV drug resistance, in coordination with other stakeholders;
- Engage civil society and other stakeholders on a regular basis to identify key bottlenecks in ART service access and quality, review results of program monitoring, and identify areas for more effective targeting to reach those who are not yet being reached including engaging and building capacity of private sector GPs supporting large numbers of patients with tuberculosis, clients of sex workers, and hidden KP.

4.9 Pediatric Treatment

At the end of 2013, 4,925 (7.3%) of HIV infected children were receiving ART in Burma. Through support from the GF, Burma will increase ART for pediatrics as part of its goal of 86% ART coverage. Currently stable pediatric HIV patients will not be transferred to decentralized sites, but cared for in ART centers, that receive support from non-PEPFAR funded partners. PEPFAR TA in select sites and to NAP will aim to increase PITC for index patients' families for greater pediatric identification and linkages of HIV-positive children and other family members. Laboratory TA will also aim to ensure quality testing for HIV exposed infants.

(4.10 OVC – not applicable)

5.0 Program Activities to Sustain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

Burma is a TA country, with the majority of services for HIV prevention, care and treatment provided by MOH and NGOs funded in a large part by the GF. The concept of a sustained site is thus not applicable to this setting. Support for direct service delivery provided by PEPFAR in Burma was limited to 18 sites or TOP Centers only, of which four are located in the four high priority catchment areas. TOP facilities receive additional funding from GF which supports some commodity and facility management support, PEPFAR will work with GF to develop a strategy for withdrawing PEPFAR support from non-priority TOP centers without compromising essential services for clients.

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

After 10 years of very low level funding, Burma began scaling up PEPFAR activities with COP 2012 funding. An early emphasis of the program is to collect/collate and analyze information in close partnership with GF and NAP in order to better inform and target programming especially related to

programs for KP and ART scale up. Long-term activities among KP prioritize those most at risk and focus on HIV testing, referrals and linkages to prevention and treatment.

Non-core activities in which PEPFAR Burma does not plan to initiate activities have been identified. Some areas will be supported through low level TA only as part of overall ART TA such as PMTCT and Pediatric Treatment. ARV and laboratory procurements are supported through the GF, with limited government contributions.

TOP Centers located outside the priority areas will be transitioned from 40% PEPFAR and 60% GF support to 100% GF support over the next six months

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Laboratory support and technical assistance provided by PEPFAR in Burma are guided by the goal of achieving “90-90-90”, thus ensuring quality HIV testing, adequate monitoring of patients on ART and viral load (VL) suppression are established and maintained. Access to quality HTC is critical for the identification of HIV-positive individuals and the scale up of ART. Strengthening of central, regional labs and service delivery sites’ capacity to conduct quality HTC will be critical to assuring quality testing is performed. Viral load testing capacity in Burma is very limited so far and VL testing is offered at only 2 sites, one in Yangon and one in Mandalay. While VL testing capacity is increased and brought to scale, strengthening of CD4 testing for the determination of ART initiation eligibility, OI prophylaxis and improved linkages to ART will be needed. The PEPFAR program will provide TA for the development of a phased plan for scale up of VL monitoring, in collaboration with relevant in-country government and non-governmental stakeholders, and in line existing equipment and platforms and aligned with CD4 scale-back strategy. In addition, TA will support the development of an HIVDR surveillance strategy with activities such as cross-sectional surveys of baseline HIVDR (PDR) in adults initiating, and of acquired HIVDR (ADR) in adults and children on ART for 12 (± 3) months at nationally representative sites.

1. Brief Activity Description	Name(s) of SNU where activity takes place (if this activity is at the national level, please write “National”)	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
		2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
Development of a quality management system, training curricula, SOPs, standardized log books for Quality Assurance (QA) for HTC and TA provision on testing algorithms, kit lot verification, personnel certification requirements, and proficiency testing using dried tube specimen based QC and PT.	National Health Laboratory and National AIDS Program, regional labs and select service delivery sites	Quality management system developed and implementation plan for DTS-based QC and PT programs developed, and HTC standardized logbook developed and approved by national program.	TA for rollout of DTS-based QC and PT programs and standardized logbook for HCT introduced at sites to ensure minimum standards are met.	HLAB 300,000	HLAB 200,000	FIND (2015)	Element 7 Quality Management Score 10.0	X					
Development of guidance to assure access and quality of CD4 testing, and TA provision to inform the selection of appropriate CD4 assays procured by the program	National AIDS Program, National Health Laboratory	Guidance and SOPS for CD4 testing developed and disseminated and procurement plans for appropriate CD4 assays in place.	Training materials developed and QC and PT programs for CD4 testing rolled out.	HLAB 300,000	HLAB 150,000	FIND (2015)	Element 7 Quality Management Score 10.0		X	X			

(e.g., GF, NAP), development of SOPs for standard procedures for specimen processing, testing, interpretation, reporting and quality monitoring system. Technical assistance for revised target setting in light of the goals for VL scale-up for patient monitoring and need for resource savings. Assessment of CD4 machines and functionality													
TA provision for a phased introduction of VL strategy that incorporates appropriate use of existing equipment, phases of planning, costing, feasibility analyses for scale-up and sustainability, such as specimen and platform selection, capacity building, training and supervision, establishment of quality management systems, strengthening of specimen transport networks, data collection, management and utilization reflecting collaboration of stakeholders across lab, clinical, programmatic and supply chain management.	National AIDS Program and National Health Laboratory	Phased viral load plan developed and disseminated	Training and technical assistance for roll out of viral load strategy in select	HLAB 100,000	HLAB 250,000	FIND	Element 7 Quality Management Score 10.0				X		X
Support the development of an HIVDR surveillance strategy with activities such as surveys of patients initiating ART, and acquired on ART.	National AIDS Program and National Health Laboratory		Protocols for a cross-sectional survey of baseline HIVDR (PDR), and a cross-sectional survey of acquired HIVDR (ADR) finalized and submitted for IRB approval		HVSI 100,000	FIND (2016)	Element 1 Epidemiologic and Health Data Score 8.7				X		X

6.2 Strategic information (SI)

As much of the data with regard to key populations in Burma is unreliable or out of date, SI has been identified as a core activity for FY 2015. Funding will be provided to improve the quality of surveillance systems and surveys, and strengthen analysis of surveillance and program data.

Limited data are available about injection drug use, one of the biggest drivers of HIV in the country; however, information on PWID is limited to a few surveys and areas in the country where a recent integrated bio-behavioral survey (IBBS) was conducted. More data are needed to identify key geographic and high-risk areas. Therefore, PEPFAR will provide technical support for further analysis of existing survey and programmatic data to identify high-risk geographic areas for better targeting of programs and services, particularly for PWID, as well as for conducting a data needs assessment and gap analysis to inform planning of future surveys or special studies. PEPFAR is also providing technical support for the development and implementation (including data management, analysis, interpretation, and reporting) of an umbrella protocol for conducting population size estimation exercises and IBBS among several key populations (FSW, MSM/TG and PWID). As secretariat of the Myanmar Health Sector Coordinating Committee (M-HSCC) which provides overseas national health programs, including GF programs and NAP, UNAIDS has the unique opportunity and responsibility to collect, compile, collate, and review HIV data from multiple sources. With PEPFAR support they collaborate with and as needed hire surveillance and monitoring and evaluation experts to provide technical guidance to NAP. These technical experts/consultants work with NAP to build their capacity to develop and implement protocols for data collection, management, analysis, interpretation, and reporting.

To address the need to monitor individuals through the HIV cascade there is a growing recognition of the need to develop a unique identifier system that would be appropriate for KP as well as electronic tools. A number of systems are being used/proposed in Burma and PEPFAR will provide technical support to identify feasible options, including mHealth tools.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Assessing PWID landscape		Report produced by Linkages.		IDUP 200,000	LINKAGES	Element 1 Epidemiologic and Health Data Score 8.7	X			X	
Staff support for improved coordination of program monitoring TA for protocol development, data management, analysis, and reporting.		Improved UNAIDS M&E support, ethical board approved-protocols and materials, timely review, clearance, and dissemination of reports by NAP and MOH		HVSI 200,000	UNAIDS (17111)	Element 1 Epidemiologic and Health Data Score 8.7	X	X	X		X

This activity will develop a pilot program using computerized applications to improve patient tracking and HMIS systems in clinics throughout Burma.		Apps developed Apps activated Apps in-use		HVSI 300,000	TASC4 ITC	Element 1 Epidemiologic and Health Data Score 8.7	X	X	X		X
Adoption and utilization of a suite of apps to track enrollment, compliance and adherence across the HIV/AIDS treatment cascade		Apps activated; Data collected		HVSI 150,000	CAP3D Follow-on	Element 1 Epidemiologic and Health Data Score 8.7	X	X	X		X
TA for KP (PWID, FSW, MSM, TG) bio behavioral surveys and population size estimation exercises to improve and standardize protocols and questionnaires; training materials; data management, analysis, interpretation, and dissemination	Report for PWID iBBS completed and disseminated; Protocols for FSW & MSM completed and submitted, and implementation started	FSW and MDM iBBS implementation completed and preliminary results available	(No new funding requested/support through prior year funding)		HQ TA, also LINKAGES	Element 1 Epidemiologic and Health Data Score 8.7	X	X	X	X	X

6.3 Health System Strengthening (HSS)

Supply chains supporting HIV programs in Burma are characterized by extensive fragmentation resulting in inefficiency and poor visibility of commodity and medicines availability. Two Principal Recipients and twenty-three sub-recipients of GF grants for ART operate independent vertical procurement and supply chain management systems, with different assumptions and some inappropriate calculation methods. Laboratory services for CD4 are similarly fragmented with multiple different platforms, no standardization or harmonization strategy.

The SCMS project commenced operations in Burma in FY 2014 with a brief to support the Ministry of Health and to coordinate the integration of supply chains to increase the efficiency and effectiveness of ART commodity availability and visibility. This extended to exploring the potential for efficiency improvements through integration of supply chain operations across, as well as within programs. In March 2015, a draft strategy document was developed and reviewed by a group of MOH and development partner stakeholders. This document will form the basis of an MOH supply chain master plan that will seek to improve the management of commodity distribution and the efficiency of the supply systems.

For FY 2016 the focus will be on supporting the national HIV program to further enhance its supply chain capability and efficiency. SCMS is working with the two GF PRs to create the first-ever national ARV and RTK five year forecast to be used in calculating potential funding gaps for different ART scale up scenarios. Further capacity building of PR and SRs to more accurately forecast HIV commodity requirements are underway, including the development of longer-term forecasts and creation/monitoring of supply plans. Technical Assistance is being provided to the MOH for the development of a single national warehouse and distribution system for the management of donor funded commodities including all HIV supplies. SCMS will also collaborate with CHAI to ensure the mSupply warehouse management system at the NAP central warehouse is optimized for sustainability and integrated with other vertical warehouse & distribution systems. The work to establish a harmonized LMIS, which will improve the availability of data to manage the HIV program at the national level, will be rolled out to NAP sites. New initiatives planned for FY 2016 include development of supply chain options to support decentralized HIV care and treatment. Decentralization has the potential to create low yield sites and reduce efficiency. The SCMS work will seek to mitigate the potential inefficiency through innovative supply chain management approaches. During COP15, PEPFAR Burma will continue to provide TA at the site level to improve the management (including forecasting) of HIV-related commodities. In addition, TA at the national level will inform improved forecasting that factors in GP and decentralized ART provision and support. The focus of this work will be to ensure the current inefficiencies in the CD4 network are not perpetuated into a new and expanding VL-testing network. Continued collaboration and cooperation is expected to maximize value for the national HIV program overall.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Develop and facilitate a national supply chain implementation plan for an integrated supply chain to ensure commodity availability for all programs (HIV, TB, Malaria, Essential Drugs, etc.)	Develop strategy in consultation with MOH and development partners Finalize and sign off plan with MOH senior management	Ongoing membership and support to the National Supply Chain Task Force. Assist the MOH with implementation of the supply chain strategy		OHSS 75,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8		X			
Forecasting and supply planning capacity building to ensure HIV commodities and medicines are available in the right quantities at the right time to support HIV treatment scale-up	One PR and three SR use a standard forecasting and supply planning system. 70 hospitals have the capacity to forecast their drug requirements. Two PRs committed to supporting the development of a single national 5 year ARV/RTK forecast and budget	A single national five-year forecast for ARV and RTK requirements including different scale up scenarios and estimated funding requirements. Information at national level to support MOH in its aspirations to become the GF PR. More accurate and consistent ARV and RTK forecasting between PRs and by SRs National AIDS Program has the capacity to lead future forecasting activities		OHSS 175,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X		X		
Enhance data availability for reporting, quantification, and resupply of program commodities through a harmonized logistics management information system (LMIS)	Map existing LMIS and determine the opportunities and benefits of harmonization Work with HIV and other programs to design an effective and harmonized LMIS to promote efficient data collection for the support of program scale up	Work with other development partners and National AIDS Program to introduce harmonized LMIS		OHSS 150,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X		X		

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Assist the MOH and facilitate development of the physical and operational designs of a new warehouse and distribution system supporting the HIV and other vertical programs which will enhance the quality and quantity of storage and distribution for HIV and other programs and hence enable treatment scale-up	Complete initial high level design options and cost estimates	Support MOH to complete a detailed design and development plan for the new warehouse		OHSS 125,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X		X		
Develop a five year forecast for HIV diagnostics and lab requirements using the ForLab tool and build the capacity of the MOH to forecast for the expanding HIV treatment program	Establish ForLab tool and engage NHL in the collection of data for national level quantification. Engage relevant development partners in the process and benefits of long term forecasting	Complete five year forecast with scale up scenarios and financial estimates to support DA1 and 90-90-90 through the national laboratory network		OHSS 175,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X	X	X		X
Support the MOH policy of decentralizing ART to determine supply chain solutions which avoid inefficiency	Map the current and proposed decentralized ART network and identify potential inefficiencies	Work with MOH, National AIDS Program and relevant development partners to develop supply chain solutions which ensure decentralization can operate with efficient commodity supply management		OHSS 250,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8			X		
Strengthen the warehouse management system operations	Develop master data, implement a WMS at CMSSD Mandalay	Work with CHAI at the National AIDS Program warehouse to revise master data, standard operating procedures, user reference manual, improve data quality, and integrate with		OHSS 125,000	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X		X		

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
		central warehousing distribution systems									
Establish procurement capability within the MOH to prepare them to assume the principal recipient role for the Global Fund	Train MOH staff in the procurement cycle, specification writing, and best practice. Draft procurement regulations. Propose the organizational design and outline roles and responsibilities for the new procurement unit in the MOH			OHSS 0	SCMS	Element 6: Commodity Security and Supply Chain. Score: 5.8	X		X		

7.0 Staffing Plan

PEPFAR Burma consists of a small but committed team. In April 2014, USAID hired a full-time HIV/AIDS Advisor and the CDC Country Director began in January 2015. Three vacancies will be filled in 2015, which will be critical to support SIMS and allow PEPFAR team greater opportunity to engage with NAP, GF and others in HIV programming in Burma. These include two Locally Employed Staff for CDC (one administrative and one technical staff) and one Direct Hire. Given limitations in funding and office space it is unlikely that the PEPFAR team in Burma will be able to grow in size in the next two years, so the team will also increasingly utilize expertise of USAID staff in the mission for key program support, such as program planning and communications, and work closely with technical experts from Headquarters and across agencies to develop and monitor strategies, as well as provide support for technical advisors within partner agencies, including WHO (for care and treatment) and UNAIDS (for strategic information and GF transition). PEPFAR Burma has also initiated regular Implementing Partner meetings to facilitate greater collaboration and sharing of technical expertise between partners, for example collaboration between PSI programs for KP and ICAP to address gaps in the HIV cascade for KP.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Non-core Activities
Site level	<ul style="list-style-type: none"> - TA and interventions that improve the KP Cascade and lead to increased HTC up-take and enrolment and retention of HIV-positive KP in Care & Treatment - PITC for TB, STI and KP patients as well as TB and STI screening and treatment for PLHIV through private and public health care providers - Strengthening of linkages between local KP CBOs and facilities - Reduction of stigma and discrimination at facility and community level (e.g. KP sensitization training for providers, capacity building for local KP groups and organizations) 	-Laboratory accreditation
Sub-national level	Strengthening of ART scale-up through TA for improved planning of ART roll-out and decentralization at state level	-Laboratory accreditation
National level	<ul style="list-style-type: none"> - SI, including SW/MSM/PWID IBBS, TA for improved cascade M&E - Support for policy, human rights, and advocacy with civil society organization networks - TA for national HIV program planning, coordination, and oversight, including participation in TWGs, collaboration with GF, TA for national GL development/reviews etc. - TA for improved supply chain management Strengthening of ART scale-up through TA for improved planning of ART roll-out and decentralization at state level - TA for QA and strengthening of laboratory support for HTC, CD4 and VL 	- Laboratory accreditation

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	<ul style="list-style-type: none"> - TA and support for HTC up-take and yield among KP, including innovative interventions, introduction of mobile strategies in high priority states - Strengthening of PITC delivered by private and public health care providers - TA for quality assurance and improvements for HTC - TA to normalize Rapid Tests for HIV Rapid Test Kit (HRT) procurement and delivery -TA to improve counseling and linkages to reproductive health services 		
Care and Treatment	<ul style="list-style-type: none"> - TA for private sector GPs for integration of ART services as well as increased screening of TB and STI patients - TA and training of public health care providers for improved quality and delivery of KP friendly care & treatment services - TA for MOH for planning, implementation and monitoring of decentralized ART service roll-out - TA for MAT service provision in conjunction with Care and Support for PWID - TA for selected model sites for integration of ART, TB, MAT and others services for PWID - TA for improved ARV procurements and supply management - TA for laboratory quality improvement for VL monitoring in high priority states and ART sites serving large numbers of KP and PLHIV 		
Prevention	<ul style="list-style-type: none"> - Support for community-based interventions to promote and increase HTC and other HIV service up-take, including use of technology and other innovative interventions - Support for KP Peer navigators that reach KP and facility access to HTC, Care and Treatment services and support adherence - TA for harm reduction in states targeted for PWID program support - Condom and lubricant procurement and supply through Commodity Fund (centrally funded through HOP) 		

TB/HIV	Core Activities - TA for improved TB/HIV integration including improved HIV testing for TB patents and TB screening for PLHIV and KP - TA for provision of Isoniazid prophylaxis and Cotrimoxazole for eligible PLHIV	Near-core Activities	Non-core Activities - TB drug procurements
Cross-Cutting	Core Activities		Non-core Activities
Lab	TA for improved lab capacity and QA for HIV testing, CD4 and Viral Load to increase access to quality HTC and improved monitoring of patients on ART		- Laboratory accreditation
Strategic Information	- TA for SW/MSM/PWID IBBS - PWID Assessment for Northern and North-Eastern states - TA for improved monitoring of 'reach-test-treat and retain' cascade for KP, including introduction of monitoring of ART retention - Support for policy, human rights, and advocacy with civil society organization networks		
Health Systems Strengthening	- TA for national HIV program planning, coordination, and oversight, including participation in TWGs, collaboration with GF, TA for national GL development/reviews etc. - TA for improved supply chain management		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Transition of 14 TOP Centers from 60% GF & 40% PEPFAR funding to 100% GF support	Transition to GF	\$ 0	\$0	1	Mid-2016	
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$US 0	\$US 10,000,000	\$US 10,000,000
Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	886,316
IDUP	Injecting and Non-Injecting Drug Use	819,461
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	1,258,454
HBHC	Adult Care and Support	362,942
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	1,910,336
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	93,096
HLAB	Lab	668,954
HVSI	Strategic Information	966,374
OHSS	Health Systems Strengthening	1,675,281
HVMS	Management and Operations	1,358,786
TOTAL		10,000,000

B.2 Resource Projections

The proportion of funding under prevention, are split between HVOP (around 2/3 of prevention funds) and IDUP (around 1/3 of prevention funds), reflect continued support and TA for improved prevention activities for FSW, MSM and TG under the HVOP budget code and newly initiated efforts for support and TA for PWID programs in three states with prevalent injection drug use.

Funding amount allocated under HVCT and HTXS reflect the focus on TA and support for an improved cascade of services for KP, including increased HIV testing, early enrolment and retention in treatment of HIV-positive KP and other PLHIV identified. Funding under the HVCT budget code also includes TA for PITC to increase HIV testing between TB and STI patients.

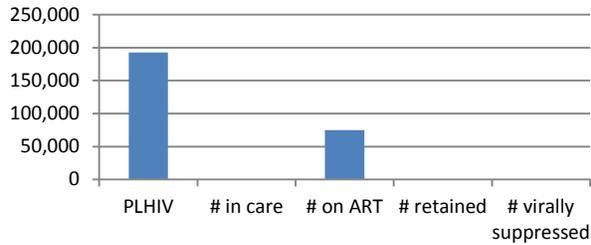
Funding under HVTB will support TA to develop and implement Standard Operating Procedures (SOP) for TB/HIV collaborative activities, particularly with the aim of increasing referral to ART sites and to increase routine TB screening of KP and PLHIV. Funding for HBHC reflects technical assistance to NAP and sites directly supported by PEPFAR for care interventions which reduce mortality and morbidity among PLHIV, support screening, diagnosis and treatment for STIs among Key Populations, and for strengthening of Medication Assisted Therapy (MAT) services through participation in the development of relevant guidelines, tools, and monitoring and evaluation of activities.

APPENDIX C

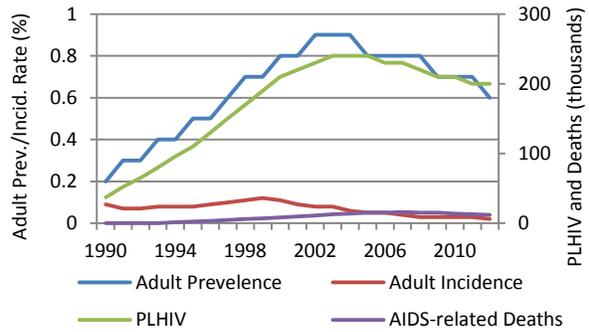
[REDACTED]

CONTEXTUAL DATA

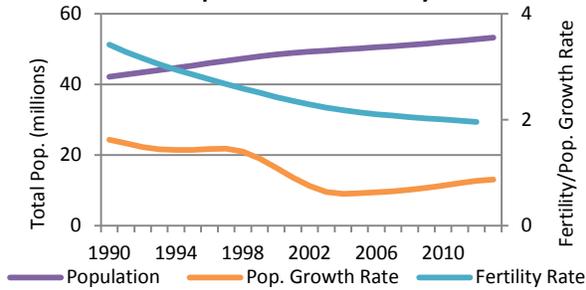
Care and Treatment Cascade



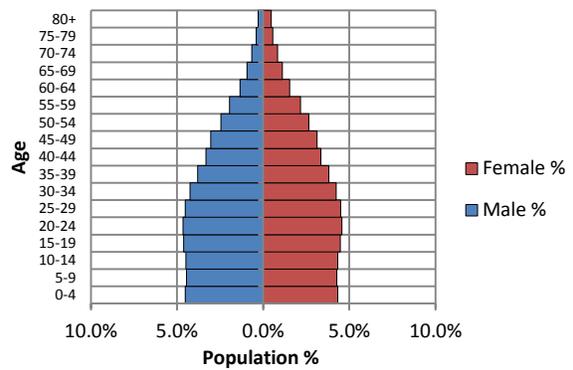
Epidemiological Data



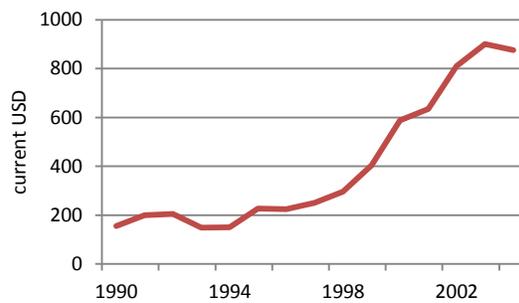
Population and Fertility



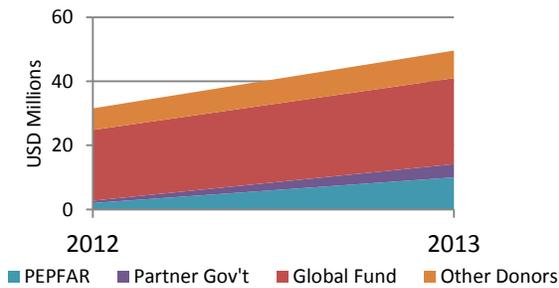
Population Pyramid (2014)



GDP Per Capita



Financing the HIV Response



APPENDIX D

The table below illustrates the key intervention areas supported by the three mechanisms providing technical assistance and/or direct service delivery at site level. Intervention areas listed below are aligned with core interventions highlighted in the 2014 PEPFAR Technical Considerations for Key Populations.

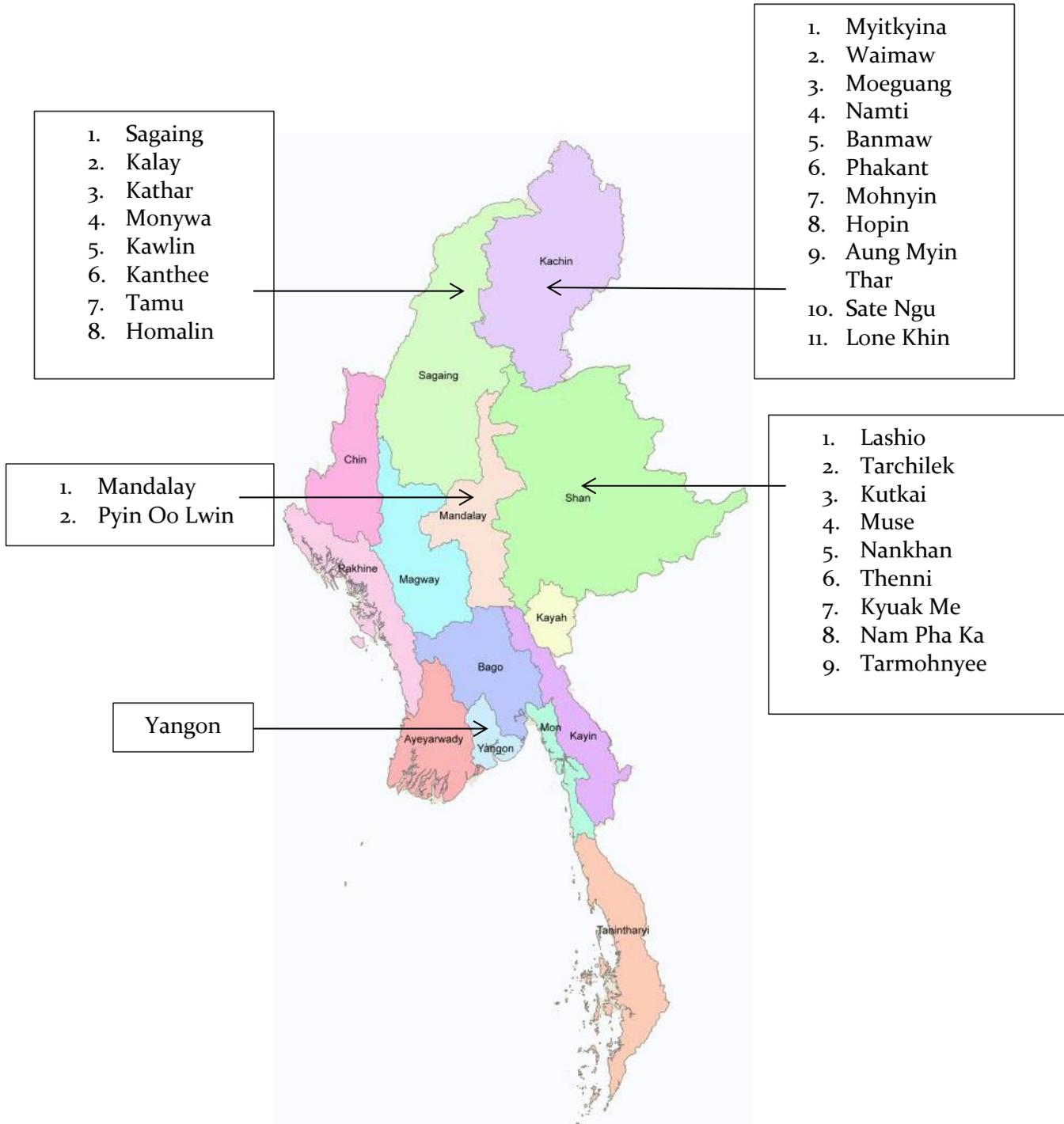
Mechanism or Organization	Health and HIV Services						Enabling Environment		
	Community Outreach	Condoms & Lubricant	HTC (Community level; Client- Initiated)	HTC (Facility level; Provider Initiated)	ART	TB/HIV	STI	Community Empowerment	Stigma & Discrimination
Targeted Outreach Program (TOP) DSD & TA - PSI	√	√	√	√	√	√	√	√	√
Care and Treatment TA for public sector - ICAP	-	√	√	√	√	√	√	-	√
Sun Quality Health (SQH) TA for private sector GPs - PSI	-	√	√	√	√	√	√	-	√

√ Main program focus

√ Also supported, but not the key focus of the respective program

APPENDIX E

Location and Number of Medication Assisted Therapy Sites in Burma – 2014



Burma COP15 Targets by Township: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Alone	-	-	-	-	-
Amarapura	469	26	33	23	23
Aungmyan	-	-	-	-	-
Bago	1,457	34	36	30	30
Bahan	1,186	83	75	75	75
Bhamo	-	-	-	-	-
Bilin	-	-	-	-	-
Bogale	-	-	-	-	-
Cahnmyathazi	5,903	389	518	355	376
Chauk	-	-	-	-	-
Chaungzon	-	-	-	-	-
Dagon Myothit (East)	-	-	-	-	-
Dagon Myothit (North)	-	-	-	-	-
Dagon Myothit (South)	1,105	64	70	102	102
Daik-U	-	-	-	-	-
Danubyu	-	-	-	-	-
Dawbon	552	31	35	29	29
Dawei	-	-	-	-	-
Dedaye	-	-	-	-	-
Einme	-	-	-	-	-
Gyobingauk	-	-	-	-	-
Hinthada	40	-	-	-	-
Hlaingbwe	-	-	-	-	-
Hlaingthaya	-	-	-	-	-
Hlegu	552	31	36	29	29
Hmawbi	-	-	-	-	-
Indaw	-	-	-	-	-
Ingapu	-	-	-	-	-
Insein	1,722	113	109	102	102
Kalay	482	-	-	-	-
Kamaryut	-	-	-	-	-
Kanbalu	-	-	-	-	-
Kawa	-	-	-	-	-
Kawhmu	-	-	-	-	-
Kawkareik	-	-	-	-	-
Kawlin	-	-	-	-	-
Kawthaung	-	-	-	-	-
Kayan	552	31	36	29	29
Kengtung	-	-	-	-	-
Khin-U	-	-	-	-	-
Kungyangon	-	-	-	-	-
Kyaiklat	-	-	-	-	-
Kyaikto	-	-	-	-	-
Kyaukpadaung	934	48	64	45	45
Kyauktaga	-	-	-	-	-
Kyimyindine	1,396	72	138	68	132
Labutta	-	-	-	-	-
Lashio	1,178	94	90	88	88
Letpadan	-	-	-	-	-
Lewe	-	-	-	-	-
Loilen	-	-	-	-	-
Madaya	-	-	-	-	-
Magway	189	-	-	-	-
Mahaangmyay	713	50	45	45	45
Mawlamyine	641	-	-	-	-
Mawlamyinegyun	-	-	-	-	-
Mayangone	552	31	36	29	29
Meikhtila	1,693	114	103	103	103
Mingaladon	1,105	64	70	58	58
Mogaung	-	-	-	-	-
Mogoke	934	48	64	45	45
Mohnyin	-	-	-	-	-
Monywa	951	26	33	23	23
Mudon	-	-	-	-	-
Myaungmya	-	-	-	-	-
Myeik	144	-	-	-	-
Myingyan	469	26	32	23	23
Myitkina	1,233	85	79	77	77

Burma COP15 Targets by Township: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Myittha	-	-	-	-	-
Nawngkhio	-	-	-	-	-
North Okkalapa	1,105	64	70	58	58
Nyaung-U	-	-	-	-	-
Nyaungdon	552	31	35	29	29
Nyaunglebin	-	-	-	-	-
Oktwin	-	-	-	-	-
Padaung	-	-	-	-	-
Pale	-	-	-	-	-
Pathein	1,609	-	-	-	-
Patheingyi	-	-	-	-	-
Paung	-	-	-	-	-
Paungde	-	-	-	-	-
Pwintbyu	-	-	-	-	-
Pyapon	-	-	-	-	-
Pyay	349	-	-	-	-
Pyigitaon	-	-	-	-	-
Pyinmana	-	-	-	-	-
Pyinoolwin	467	24	32	23	23
Sagaing	467	24	32	23	23
Shwebo	-	-	-	-	-
Shwedaung	-	-	-	-	-
Shwepyithar	552	31	36	29	29
Singu	467	24	32	23	23
Sittwe	16	-	-	-	-
South Okkalapa	552	31	36	29	29
Tachileik	44	-	-	-	-
Tada-U	-	-	-	-	-
Taikkyi	552	31	35	29	29
Tamwe	9,455	589	959	538	876
Tantabin	-	-	-	-	-
Taungdwingyi	-	-	-	-	-
Taunggyi	89	-	-	-	-
Taungoo	56	-	-	-	-
Taungtha	-	-	-	-	-
Thabeikkyin	-	-	-	-	-
Thaketa	1,105	64	70	58	58
Thanbyuzayat	-	-	-	-	-
Thanlyin	552	31	35	29	29
Thaton	-	-	-	-	-
Thayarwaddy	-	-	-	-	-
Thayetchaung	-	-	-	-	-
Thegon	-	-	-	-	-
Thingangyun	-	-	-	-	-
Wakema	-	-	-	-	-
Waw	-	-	-	-	-
Wetlet	-	-	-	-	-
Wundwin	-	-	-	-	-
Wuntho	-	-	-	-	-
Ye	-	-	-	-	-
Ye-U	-	-	-	-	-
Yenangyaung	-	-	-	-	-
Total	44,141	2,404	3,074	2,246	2,669

Burma COP15 Targets by Township: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Alone	-	-	-
Amarapura	-	-	-
Aunglan	-	-	-
Bago	-	1,967	-
Bahan	-	2,634	-
Bhamo	-	-	-
Bilin	-	-	-
Bogale	-	-	-
Cahnmyathazi	-	13,128	-
Chauk	-	-	-
Chaungzon	-	-	-
Dagon Myothit (East)	-	-	-
Dagon Myothit (North)	-	-	-
Dagon Myothit (South)	-	-	-
Daik-U	-	-	-
Danubyu	-	-	-
Dawbon	-	-	-
Dawei	-	-	-
Dedaye	-	-	-
Einme	-	-	-
Gyobingauk	-	-	-
Hinthada	-	59	-
Hlaingbwe	-	-	-
Hlaingthaya	-	-	-
Hlegu	-	-	-
Hmawbi	-	-	-
Indaw	-	-	-
Ingapu	-	-	-
Insein	-	2,602	-
Kalay	-	1,168	-
Kamaryut	-	-	-
Kanbalu	-	-	-
Kawa	-	-	-
Kawhmu	-	-	-
Kawkareik	-	-	-
Kawlin	-	-	-
Kawthaung	-	-	-
Kayan	-	-	-
Kengtung	-	-	-
Khin-U	-	-	-
Kungyangon	-	-	-
Kyaiklat	-	-	-
Kyaikto	-	-	-
Kyaukpadaung	-	-	-
Kyauktaga	-	-	-
Kyimyindine	-	-	-
Labutta	-	-	-
Lashio	-	2,456	-
Letpadan	-	-	-
Lewe	-	-	-
Loilen	-	-	-
Madaya	-	-	-
Magway	-	1,010	-
Mahaangmyay	-	1,584	-
Mawlamyine	-	1,471	-
Mawlamyinegyun	-	-	-
Mayangone	-	-	-
Meikhtila	-	4,264	-
Mingaladon	-	-	-
Mogaung	-	-	-
Mogoke	-	-	-
Mohnyin	-	-	-
Monywa	-	1,168	-
Mudon	-	-	-
Myaungmya	-	-	-
Myeik	-	1,030	-
Myingyan	-	-	-
Myitkyina	-	2,150	-

Burma COP15 Targets by Township: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Myittha	-	-	-
Nawngkhio	-	-	-
North Okkalapa	-	-	-
Nyaung-U	-	-	-
Nyaungdon	-	-	-
Nyaunglebin	-	-	-
Oktwin	-	-	-
Padaung	-	-	-
Pale	-	-	-
Pathein	-	2,574	-
Patheingyi	-	-	-
Paung	-	-	-
Paungde	-	-	-
Pwintbyu	-	-	-
Pyapon	-	-	-
Pyay	-	1,170	-
Pyigitagon	-	-	-
Pyinmana	-	-	-
Pyinoolwin	-	-	-
Sagaing	-	-	-
Shwebo	-	-	-
Shwedaung	-	-	-
Shwepyithar	-	-	-
Singu	-	-	-
Sittwe	-	372	-
South Okkalapa	-	-	-
Tachileik	-	362	-
Tada-U	-	-	-
Taikkyi	-	-	-
Tamwe	-	19,961	-
Tantabin	-	-	-
Taungdwingyi	-	-	-
Taunggyi	-	560	-
Taungoo	-	351	-
Taungtha	-	-	-
Thabeikkyin	-	-	-
Thaketa	-	-	-
Thanbyuzayat	-	-	-
Thanlyin	-	-	-
Thaton	-	-	-
Thayarwaddy	-	-	-
Thayetchaung	-	-	-
Thegon	-	-	-
Thingangyun	-	-	-
Wakema	-	-	-
Waw	-	-	-
Wetlet	-	-	-
Wundwin	-	-	-
Wuntho	-	-	-
Ye	-	-	-
Ye-U	-	-	-
Yenangyaung	-	-	-
Total	-	62,041	-

Burma COP15 Targets by Township: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Alone	-	-
Amarapura	-	-
Aunglan	-	-
Bago	-	-
Bahan	-	-
Bhamo	-	-
Bilin	-	-
Bogale	-	-
Cahnmyathazi	-	-
Chauk	-	-
Chaungzon	-	-
Dagon Myothit (East)	-	-
Dagon Myothit (North)	-	-
Dagon Myothit (South)	-	-
Daik-U	-	-
Danubyu	-	-
Dawbon	-	-
Dawei	-	-
Dedaye	-	-
Einme	-	-
Gyobingauk	-	-
Hinthada	-	-
Hlaingbwe	-	-
Hlaingthaya	-	-
Hlegu	-	-
Hmawbi	-	-
Indaw	-	-
Ingapu	-	-
Insein	-	-
Kalay	-	-
Kamaryut	-	-
Kanbalu	-	-
Kawa	-	-
Kawhmu	-	-
Kawkareik	-	-
Kawlin	-	-
Kawthaung	-	-
Kayan	-	-
Kengtung	-	-
Khin-U	-	-
Kungyangon	-	-
Kyaiklat	-	-
Kyaikto	-	-
Kyaukpadaung	-	-
Kyauktaga	-	-
Kyimyindine	-	-
Labutta	-	-
Lashio	-	-
Letpadan	-	-
Lewe	-	-
Loilen	-	-
Madaya	-	-
Magway	-	-
Mahaaungmyay	-	-
Mawlamyine	-	-
Mawlamyinegyun	-	-
Mayangone	-	-
Meikhtila	-	-
Mingaladon	-	-
Mogaung	-	-
Mogoke	-	-
Mohnyin	-	-
Monywa	-	-
Mudon	-	-
Myaungmya	-	-
Myeik	-	-
Myingyan	-	-

Burma COP15 Targets by Township: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Myitkyina	-	-
Myittha	-	-
Nawngkhio	-	-
North Okkalapa	-	-
Nyaung-U	-	-
Nyaungdon	-	-
Nyaunglebin	-	-
Oktwin	-	-
Padaung	-	-
Pale	-	-
Pathein	-	-
Patheingyi	-	-
Paung	-	-
Paungde	-	-
Pwintbyu	-	-
Pyapon	-	-
Pyay	-	-
Pyigitagon	-	-
Pyinmana	-	-
Pyinoolwin	-	-
Sagaing	-	-
Shwebo	-	-
Shwedaung	-	-
Shwepyithar	-	-
Singu	-	-
Sittwe	-	-
South Okkalapa	-	-
Tachileik	-	-
Tada-U	-	-
Taikkyi	-	-
Tamwe	-	-
Tantabin	-	-
Taungdwingyi	-	-
Taunggyi	-	-
Taungoo	-	-
Taungtha	-	-
Thabeikkyin	-	-
Thaketa	-	-
Thanbyuzayat	-	-
Thanlyin	-	-
Thaton	-	-
Thayarwaddy	-	-
Thayetchaung	-	-
Thegon	-	-
Thingangyun	-	-
Wakema	-	-
Waw	-	-
Wetlet	-	-
Wundwin	-	-
Wuntho	-	-
Ye	-	-
Ye-U	-	-
Yenangyaung	-	-
Total	-	-