BURMA

Country Operational Plan

COP 2016

Strategic Direction Summary

May 18, 2016

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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 by applying the "90-90-90"[1] 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 especially for key populations affected by high HIV prevalence, limited access and low coverage of HIV services thus far. The 2016 Burma Country Operation Plan (COP) aims to achieve high yield of HIV testing among key populations, and early enrollment and high rates of retention in treatment services for those who are HIV infected. To achieve this, close collaboration with all key in-country actors including the government and civil society as well as stakeholders such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and its partners will continue and be enhanced in an effort 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 held national elections that will re-set the government systems that have come before it. In fiscal year (FY) 2016, PEPFAR is working 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 TA to improve the quality of HIV treatment decentralization by developing strategies, operational guidelines and protocols that are guided by national and international evidence. PEPFAR will also assist in strengthening laboratory, information, and supply systems to sustain the program in the long-term.

In the next 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) and Transgendered Persons (TG). The focus will be on increasing the yield of HIV testing and counseling (HTC) with aggressive provision for immediate antiretroviral therapy (ART) for those who are HIV infected across community, private and public sector sites within the four 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 engage in TA and support for HTC 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 Government of Burma and multi-lateral organizations (World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Global Fund) have requested both long term and short term TA from PEPFAR and are receptive to U.S. government recommendations. Through these partnerships, PEPFAR will contribute to improve data collection, use, and coordination for optimal program impact.

[1] '90-90-90': Ninety percent of people who are HIV infected (PLHIV) know their status, ninety percent of PLHIV are receiving antiretroviral (ARV) treatment and ninety percent of PLHIV who are receiving treatment have achieved viral suppression

1.0 Epidemic, Response, and Program Context

Burma, a sovereign nation bordered by Bangladesh, China, India, Laos, and Thailand, is made up of one Union Territory, 14 states and regions, 74 districts, 330 townships, and 13,602 village tracts. It has a population of 51,486,253 million and comprises 138 ethnic groups – 89 percent of whom are Buddhist[2]. A military dictatorship controlled Burma's government for over five decades, but the country is currently undergoing a democratic transition. The gross national income (GNI) per capita in Burma in 2014 was U.S. dollars (USD) 1270, ranked 178th in the world. The WHO reports that total expenditure on health, as a percentage of gross domestic product (GDP) (2013), is at 1.8 percent.

According to the NAP 2014 Progress Report, at the end of 2014, 85,626 persons were receiving antiretroviral treatment. This represented 56 percent of all those in need of treatment as specified in national treatment guidelines. Forty-six percent of the people on treatment were females and seven percent were children aged 0 to 14 years. With TA provided by PEPFAR and other partners, accelerated ART scale up has started to show results and, while the official release of 2015 achievements is still pending, according to NAP, 94,691 individuals were receiving ART by the end of 2015. The national program has ambitious treatment targets, with around 106,058 as the target for ART by 2016 (Global AIDS Progress Report 2012-2013, NAP). However, supply chain and laboratory systems supporting scale-up are not developed, and regular monitoring of results at all levels does not occur.

Important policy and strategy changes in Burma include the transition to Test and Start for all persons living with HIV (PLHIV) that is a 'Core' activity for COP 2016. The existing Treatment Guidelines currently stipulate a policy of Test and Start for HIV-positive pregnant women, children under 5 years of age, Tuberculosis (TB) patients and key populations, but are expected to be revised in 2016 with roll-out of Test and Start for all PLHIV in January 2017.

Based on modeling exercises and population size estimations carried out for HIV in Burma, HIV prevalence is *[REDACTED]* substantially higher than described in the NAP 2014 progress report, which used HIV Sentinel Surveillance (HSS) 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.

[REDACTED].

HIV prevalence among key population groups in Burma is substantially higher than in the general population. Most available data are national averages, disguising wide geographical. *[REDACTED].* State and Region level data are available only for numbers of key populations reached and tested. *[REDACTED].*

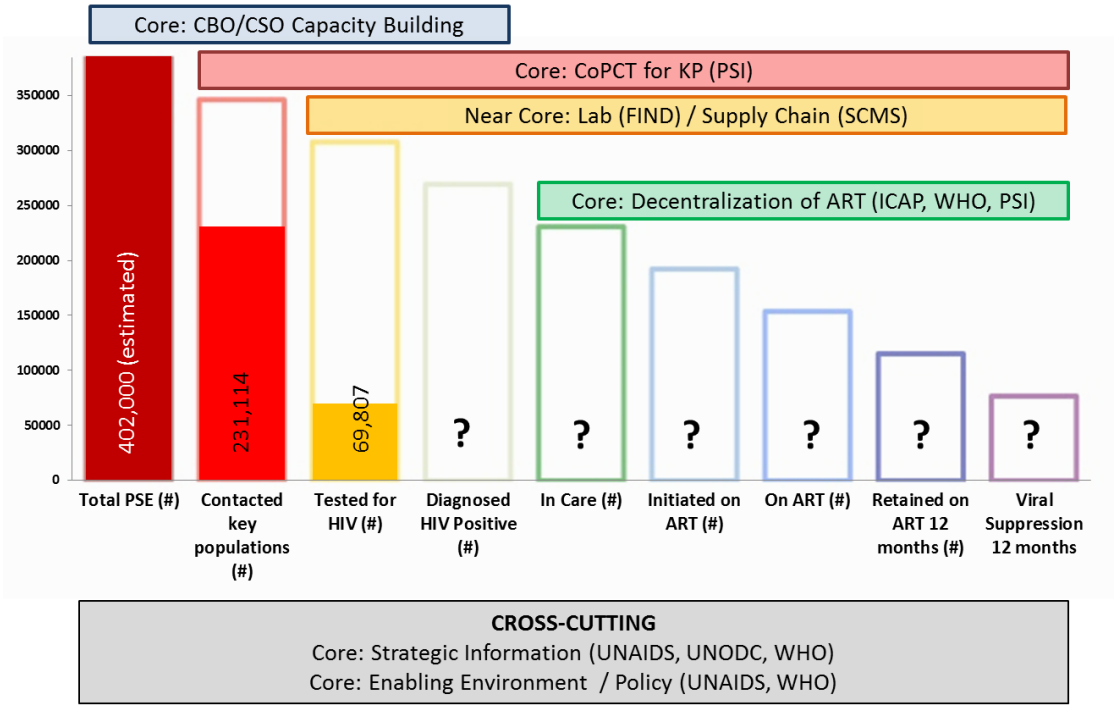
Incidence data for key populations are not available, though estimates for new infections have been part of the AEM model and projections. The PEPFAR team is concerned about potential future increases of HIV transmission through injection drug use and sharing of needles and syringes, should service provision for PWID remain inadequate or even decrease further. A

[2] Burma International Religious Freedom Report, U.S. Department of State, 26 October 29

significant drop in national funding to support prevention programs for FSW, MSM and TG has already been observed.

While available data suggests that increased coverage for FSW, MSM, TG, and PWID has been achieved in terms of the individuals 'reached' with prevention interventions, those accessing HTC have remained low. According to national estimate data and program data from the *National AIDS Program 2014 Annual Progress Report*, of an estimated total of 402,000 key populations, 231,114 were reached by NAP and other partners. However, of those key populations reached, only 69,807 were tested for HIV. Therefore, with only 22,433 FSW, 25,635 MSM and 21,739 PWID reported as tested for HIV and receiving the result in 2014, there is a need to prioritize HTC service provision for key populations. Disaggregates for key populations by HIV sero-status were not available in the NAP report.

Figure 2: National Key Population Prevention, Care and Treatment Cascade



Figures 1 and 2 as well as the data tables below show that a large proportion of key populations 'reached' are not being tested for HIV. Disaggregated data for key populations on ART are not available, therefore it is difficult to ascertain whether those key populations receiving HTC who are 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 key populations, service gaps are hard to identify and monitor over time. Collecting data on key population status at HTC, care, and treatment sites can be quite sensitive, and the PEPFAR program plans to provide TA 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 number of PWID who accessed HTC services, reported as 21,739 PWID tested and receiving their results in 2014, was still low (26 percent HTC uptake). The reported number of needles and syringes distributed in 2014 was 13.9 million. The number of PWID receiving Medication Assisted Therapy (MAT) with methadone was also alarmingly low at 7,872. This lack of 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, yet accelerated rollout of these services in geographical areas where injection drug use is most prevalent have significant challenges.

States that have the most PWID and highest HIV prevalence rates among PWID, including *[REDACTED]* Kachin state and *[REDACTED]* Northern Shan state[3], 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 fought for by Burmese and Chinese businesses, central government, allied Kachin and Shan paramilitary forces, local military commanders and the Kachin Independence Organization. Additionally, civilian-led anti-drug campaigns are on the rise, and include crop eradication efforts and forced detoxification programs for drug users. 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.

The program gaps identified above therefore point to the urgent need for HIV programs among key populations, 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 to help identify strategies to scale and strengthen services for PWID. In addition, the PEPFAR program will continue supporting surveillance and surveys and strengthening of the data collection systems to provide information needed to monitor the cascade, assess program impact, and better target services moving forward. The inclusion of civil society groups in the COP planning process over the past year will also continue, with new ways of collaboration utilized.

[33]Myanmar Integrated Biologic and Behavioral Survey among Persons Who Inject Drugs, 2014.

Table 1.1.1.a Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	51,486,253	100	N/A	-	N/A	-	N/A	-	N/A	-	2014 Census[1]
HIV Prevalence (%), Adults		*[REDACTED]*		N/A		N/A		*[REDACTED]*		*[REDACTED]*	*[REDACTED]*
AIDS Deaths	*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*
# PLHIV (2015)	*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*
Incidence Rate (Yr)		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		*[REDACTED]*		N/A	*[REDACTED]*
New Infections (Adults, 2015)	*[REDACTED]*						*[REDACTED]*		*[REDACTED]*		*[REDACTED]*
Annual births (2012)	1,008,964	100									UN *World Population Prospects. The 2012 Revision*
% of Pregnant Women with at least one ANC visit (new attendees)	845,623	60.8	N/A	N/A			N/A	N/A			Report on the evaluation of the 2011-2016 NSP on HIV
Pregnant women needing ARVs	3,798	0.3									Report on the evaluation of the 2011-2016 NSP on HIV
Orphans (maternal, paternal, double)											
Notified TB cases (2014)	141,957		N/A		N/A		N/A		N/A		2015 WHO Global TB Report
% of TB cases that are HIV infected[4]	6,412	11	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2015 WHO Global TB Report
% of Males Circumcised											
Estimated Population size of MSM[3]	*[REDACTED]*										*[REDACTED]*
MSM HIV Prevalence		*[REDACTED]*									HSS mean, 2014 *[REDACTED]*
Estimated Population Size of FSW[3]	*[REDACTED]*										*[REDACTED]*
FSW HIV Prevalence		6.3 *[RED*									HSS mean, 2014 *[REDACTED]*

		ACTED]									
Estimated Population Size of PWID[3]											*[REDACTED]*
PWID HIV Prevalence		23.1 *[REDACTED]*									HSS mean, 2014 *[REDACTED]*

[1]2014 Census data from: The 2014 Myanmar Population and Housing Census. The Union Report. Census Report Volume 2. Department of Population. Ministry of Immigration and Population. May 2015. Population includes enumerated and estimated numbers. National level census data are available by age or by sex, but are not disaggregated by age and sex.
[REDACTED] [4]Calculation based on 56,133 TB patients with known HIV status.

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

					KP HIV Prevalence (%)						
Key Pop	Name of Area	Type of Area	HIV Prevalence in Pregnant Women (%)	Gen Pop Size[1]	HSS	IBSS	KP Size Consensus (Range)[2]	Pop Size Estimation Method	Year	Reference	Notes
FSW	**Ayarwaddy**	Region		6,184,829							
FSW	Pathein	District	0.5	1,630,716	13.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS*[REDACTED]*	
FSW	**Kachin**	State		1,689,441							
FSW	Myitkyina	District	0.5	306,949	10.0	*[REDACTED]*	-	-	2014	2014 HSS	
FSW	**Yangon**	Capital	1.5	7,360,703	7.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS*[REDACTED]*	
FSW	**Shan East**	Sub-state		1,140,075							
FSW	Tachileik	District	1.8	177,313	6.4	*[REDACTED]*	-	-	2014	2014 HSS	
FSW	**Sagaing**	Region		5,325,327							
FSW	Monywa	District	0.3	757,358	3.5	*[REDACTED]*	Pending	Pending	2014	2014 HSS*[REDACTED]*	
FSW	**Shan South**	Sub-state		2,405,983							
FSW	Taunggyi	District	1.0	1,701,338	6.5	*[REDACTED]*	-	-	2014	2014 HSS	
FSW	**Bago West**	Region		1,973,233							
FSW	Pyay	District	0.0	910,912	2.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS*[REDACTED]*	
FSW	Mandalay	District	1.5	1,726,889	7.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS*[REDACTED]*	
FSW	**Mon**	State		2,054,393							
FSW	Mawlamyaing	District	0.5	1,232,221	3.5	*[REDACTED]*	-	-	2014	2014 HSS	
FSW	**Shan North**	Sub-state		2,278,374							
FSW	Lashio	District	0.3	612,248	2.4	*[REDACTED]*			2014	2014 HSS	
MSM	**Ayarwaddy**	Region		6,184,829							
MSM	Pathein	District	0.5	1,630,716	15.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS *[REDACTED]*	
MSM	**Yangon**	Capital	1.5	7,360,703	3.0	*[REDACTE*	Pending	Pending	2014	2014 HSS *[REDACTED]*	

					KP HIV Prevalence (%)						
Key Pop	Name of Area	Type of Area	HIV Prevalence in Pregnant Women (%)	Gen Pop Size[1]	HSS	IBSS	KP Size Consensus (Range)[2]	Pop Size Estimation Method	Year	Reference	Notes
						D]					
MSM	**Sagaing**	Region		5,325,327							
MSM	Monywa	District	0.3	757,358	1.5	*[REDACTED]*	Pending	Pending	2014	2014 HSS *[REDACTED]*	
MSM	Mandalay	District	1.5	1,726,889	7.0	*[REDACTED]*	Pending	Pending	2014	2014 HSS *[REDACTED]*	
MSM	**Bago West**	Region		1,973,233							
MSM	Pyay	District	0.0	910,912	-		Pending	Pending		2014 HSS	
PWID	**Kachin**	State		1,689,441							
PWID	Myitkyina	District	0.5	306,949	35.5	*[REDACTED]*	3570 (790-6360)	Triangulation[2]	2014	2014 HSS, *[REDACTED]*	
PWID	Waingmau	Township	N/A	106,366	-	*[REDACTED]*	1200 (1000-1400)	Triangulation[2]	2014	2014, *[REDACTED]*	
PWID	Bhamo	District	1.5	346,520	-	*[REDACTED]*	740 (520-950)	Triangulation[2]	2014	2014 *[REDACTED]*	
PWID	**Shan North**	Sub-state		2,278,374							
PWID	Lashio	District	0.3	612,248	17.5	*[REDACTED]*	4800 (3800-5400)	Triangulation[2]	2014	2014 HSS, *[REDACTED]*	
PWID	Muse	District	0.8	453,495	27.0	*[REDACTED]*	3000 (3000-4000)	Triangulation[2]	2014	2014 HSS, *[REDACTED]*	
PWID	Kutkhai	Township	N/A	174,652	-	*[REDACTED]*	1750 (880-2620)	Triangulation[2]	2014	2014 *[REDACTED]*	
PWID	**Shan South**	Sub-state		2,405,983							
PWID	Taunggyi	District	1.0	1,701,338	20.0	*[REDACTED]*			2014	2014 HSS	
PWID	Yangon	Capital	1.5	7,360,703	33.0	*[REDACTED]*	1920 (1440-2400)	Triangulation[2]	2014	2014 HSS *[REDACTED]*	
PWID	Mandalay	District	1.5	1,726,889	13.0	*[REDACTED]*	6000 (4500-7500)	Triangulation[2]	2014	2014 HSS *[REDACTED]*	
PWID	**Shan East**	Sub-state		1,140,075							
PWID	Tachileik	District	0.8	177,313	4.6	*[REDACTED]*			2014	2014 HSS	
PWID	**Sagaing**	Region		5,325,327							
PWID	Kalay	District	0.0	509,368	-	*[REDACTED]*	1200 (770-1800)	Triangulation[2]	2014	2014 *[REDACTED]*	
PWID	Tamu	District	N/A	114,869	-	*[REDACTE*	1200 (300-2130)	Triangulation[2]	2014	2014*[REDACTED]*	

					KP HIV Prevalence (%)						
Key Pop	Name of Area	Type of Area	HIV Prevalence in Pregnant Women (%)	Gen Pop Size[1]	HSS	IBSS	KP Size Consensus (Range)[2]	Pop Size Estimation Method	Year	Reference	Notes
						D]					

[1]2014 Census data from: The 2014 Myanmar Population and Housing Census. The Union Report. Census Report Volume 2. Department of Population. Ministry of Immigration and Population. May 2015. Population includes enumerated and estimated numbers. Sub-state and district data from the Census Data Sheet.

[2]Population size estimates for PWID derived by triangulating results of four methods (service multiplier method, unique multiplier method, RDS-A Successive Sampling- Population Size Estimation, and expert opinion) described in: Myanmar Integrated Biological and Behavioral Surveillance Survey and Population Size Estimates among People Who Inject Drugs. 2014 Final Report. Myanmar National AIDS Programme. 2015. (Pending official approval)

[3]IBBS ranges for MSM show HIV prevalence varies by MSM "type," tha nge, apone, and apwint, described in the COP 16 Gender Analysis Report

Table 1.1.2.a Cascade of HIV reached, care and treatment (12 months) for National Program by State in 2014

	Census (2014)	MOH Sentinel Sites (2014) (2014 and 2015 iBBS Prevalence)			MOH Progress Report (2014)									
State	Total Population	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[1]	# MSM Tested	% MSM Reached that were Tested[1]	# PWID Tested	# of Patients on ART
Ayeyarwaddy	6,184,829	15% (3-18)	13.0%	-	4,118	5,811	5,369	7,096	2,694	46	2,623	37	0	1,481
Bago	4,867,373	-	2.0%	-	5,010	7,313	5,741	9,076	3,247	44	4,221	47	0	1,284
Chin	478,801	-	-	-	12	12	12	12	10	83	0	0	0	44
Kachin	1,689,441	-	10.0%	35.5% (35-47)	2,744	4,221	2,018	2,105	543	13	271	13	4,117	12,637
Kayah	286,627	-	-	-	40	40	0	0	0	0	0	0	0	123
Kayin	1,574,079	-	-	-	885	1,318	475	653	303	23	38	6	0	428
Magway	3,917,055	-	-	-	1,923	2,908	2,865	4,173	730	25	832	20	0	2,802
Mandalay	6,165,723	7.0% (4-30)	7.0%	13.0% (16)	9,345	13,994	16,346	23,292	4,758	34	8,421	36	3,627	11,875
Mon	2,054,393	-	3.5%	-	2,328	5,407	1,950	3,265	1,750	32	880	27	0	2,350
Nay Pyi Taw	1,160,242	-	-	-	162	162	121	121	3	2	0	0	1	579
Rakhine	3,188,807	-	-	-	443	543	1,028	1,125	48	9	104	9	0	875
Sagaing	5,325,347	1.5% (2-32)	3.5%	-	3,840	5,662	4,536	8,092	957	17	1,682	21	609	3,350
Shan	5,815,384				5,150	7,173	3,387	5,016	1,795	25	1,160	23	13,142	8,546
Shan East		-	6.4%	4.6%										
Shan North		-	2.4%	17.5% (28-43)										
Shan South		-	6.5%	20.0%										
Tanintharyi	1,408,401	-	-	-	2,382	3,190	2,551	3,193	494	15	343	11	17	3,868
Yangon	7,360,703	3.0% (4-62)	7.0%	33.0% (29)	23,167	28,452	20,432	23,289	5,101	18	5,060	22	226	35,384
National	51,486,253	6.6%	6.3%	23.1%	61,549	86,206	66,831	90,508	22,433	26	25,635	28	21,739	85,626

[1]Percentage of KP tested is calculated with KP Reached High as denominator

The data in Table 1.1.2.a are from the NAP 2014 Progress Report as well as sentinel surveillance and provide some indication about larger numbers of key populations reached in regions with existing program support. However, because the value of the indicator "numbers reached" is not standardized and the type of services provided and intensity of contact with individuals varies substantially, the quality

of the data are questionable. However, the numbers in this table align with the PEPFAR prioritization of funding for Kachin, Mandalay, Shan (North) and Yangon.

Table 1.1.2.b Cascade of HIV diagnosis, treatment & viral suppression (12 months) for PEPFAR Targeted Outreach Project (TOP) Centers with complete clinical cascade by site[4]									
				HIV Treatment & Viral Suppression			**HIV Testing and Linkage to ART**		
	HIV Prevalence (%)	**Total PLHIV (#)**	**Total Reached with prevention program**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	0.6%	216,029	35275	482	N/A	N/A	30,328	1,754	*319*
Yangon	N/A	N/A	15,089	428	N/A	N/A	19,767	1232	265
Mandalay	N/A	N/A	15,000	54	N/A	N/A	8,752	420	54
Kachin	N/A	N/A	3,371	0	N/A	N/A	675	73	0
Shan (North)	N/A	N/A	1,815	0	N/A	N/A	1,134	29	0

[4] PEPFAR APR data, 2015

1.2 Investment Profile

Burma is a lower-middle income country with a GNI per capita of USD 1,270 (2014), ranked 178th in the world. WHO reports that total expenditure on health, as a percentage of GDP (2013), is at 1.8 percent.

Total spending for HIV was approximately USD 84.1 million in 2015, an increase from USD 68.9 million in 2014.[5] Burma's HIV response is heavily reliant on the Global Fund, which provided almost half of the total funding for HIV in 2015 (USD 41 million). PEPFAR began scaling TA activities 2014, and contributed 11.9 percent of total funding for HIV in 2015. According to the National AIDS Spending Assessment for Myanmar (NASA), in 2015, the Government of Burma contribution was approximately 12 percent of the total, USD 10.3 million, representing a substantial increase from 2014, when the contribution was USD 3.6 million.

With the re-establishment of Global Fund 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 (HSS) and Maternal Child Health (MCH) with only a small proportion of funding for HIV.

Despite the significant Global Fund investments, current funding levels are insufficient to support Burma's ambitious HIV program scale-up plans to achieve' 90-90-90,' 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 Global Fund with some contributions (USD 5 million) from the Burma government; therefore, PEPFAR Burma does not provide funding for the procurement of ARVs.

According to the 2015 NASA, 51 percent of HIV resources were targeted for HIV care and treatment programs. Spending for treatment has increased as the number of PLHIV receiving treatment has grown. At the same time, spending for prevention decreased from USD 19 million in 2014 to USD 18 million in 2015, mainly in programs for MSM and FSW. The Burma government only began funding for HIV programs such as STI treatment and harm reduction in 2013.

[5] Draft NASA Report, 2015

Table 1.2.1 Investment Profile by Program Area[6]

Program Area[7]	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	43,236,905	7	49	23.8	
Community-based care, treatment, and support					
PMTCT					
Laboratory					
Program management	19,364,797	7	63		
HIV testing services	18,991,241	15.6	34		
Priority population prevention					
Key population prevention					
OVC					
VMMC					
SI, Surveys and Surveillance	438,886[8]				
HSS	2,024,318	82	40		
Total	84,056,147	11.9	50	12	26.1

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GOB	% Other
ARVs				USD5,000,000	
Rapid test kits					
Other drugs					
Lab reagents					
Condoms		USD 626,688*			
Viral Load commodities					
VMMC kits					
MAT				USD 1,000,000	
Other commodities					
Total		USD 626,688		USD 6,000,000	

*Information about percent contribution is not available. In FY 2015 USG supported procurement and supplies for male condoms (quantity provided: over 20.7 million) through the Commodity Fund.

[6] National AIDS Spending Assessment, 2015; all amounts in USD

[7] Programmatic areas in NASA are classified as Treatment and care (including Lab), Program Management, Prevention, Enabling environment, Research, Training and Social protection/ Social services.

[8] M&E costs including IBBS spending, operational research, HSS, drug supply system, and patients' tracking system are compiled into Program management. The preliminary findings are not enough to calculate the percentages contributed by PEPFAR and Global Fund on the remaining research expenditure.

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution
USAID MCH	$5,000,000			
USAID TB	$6,000,000			
USAID Malaria	$10,250,000			
Family Planning				
NIH				
CDC NCD				
Peace Corps				
DOD Ebola				
MCC				
Total	**$21,250,000**			

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
Central Commodity Fund	$626,688*					Condoms purchase for KP Prevention
Other PEPFAR Central Initiatives	HQ HOP15 (CDC) $550,000	-		-	-	Implementation and evaluation of KP sensitization training for public health care workers and structural interventions for KP friendly services
Total	**$1,176,688**					

*Information about percent contribution is not available. In FY 2015 USG supported procurement and supplies for male condoms (quantity provided: over 20.7 million) through the Commodity Fund.

1.3 National Sustainability Profile

A consultative process with civil society and other key stakeholders was used to complete the 2016 Burma Sustainability Index (SID). Civil society leaders consulted members of their organizations to determine scores for each of the domains and provided their feedback to the PEPFAR team in a half-day workshop. All meetings were held in the local language.

Planning and coordination was scored high. Of particular note was the level of engagement by civil society and other stakeholders in the planning process at the national level. It was noted, however, that local level planning is not routinely carried out. Within the governance and leadership domain, private sector engagement in a regular and sustainable manner was found to be a major gap.

Three of five domains in Health Systems and Service Delivery were determined to be unsustainable, including service delivery, human resources, and quality management. The low Health Systems and Service Delivery scores points out the long distance the Government of Burma needs to go to meet its goals and commitments to expand and sustain HIV and health services. PEPFAR can assist by providing TA related to delivering high-quality HIV care and treatment services that lead to improved patient outcomes.

In 2014, Burma scored 40 percent in a supply chain assessment, where 60 percent represents a minimally functional system. TA is needed to assist the NAP and Global Fund 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 testing, ART provision and monitoring of viral load (VL) suppression. In the next year, supply chain TA providers will continue to 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 '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 FSW with 'reputation' offences that can incur a 1-3 year prison term;
- Section 35 of the Police Act 1945 enables police to arrest FSW 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.

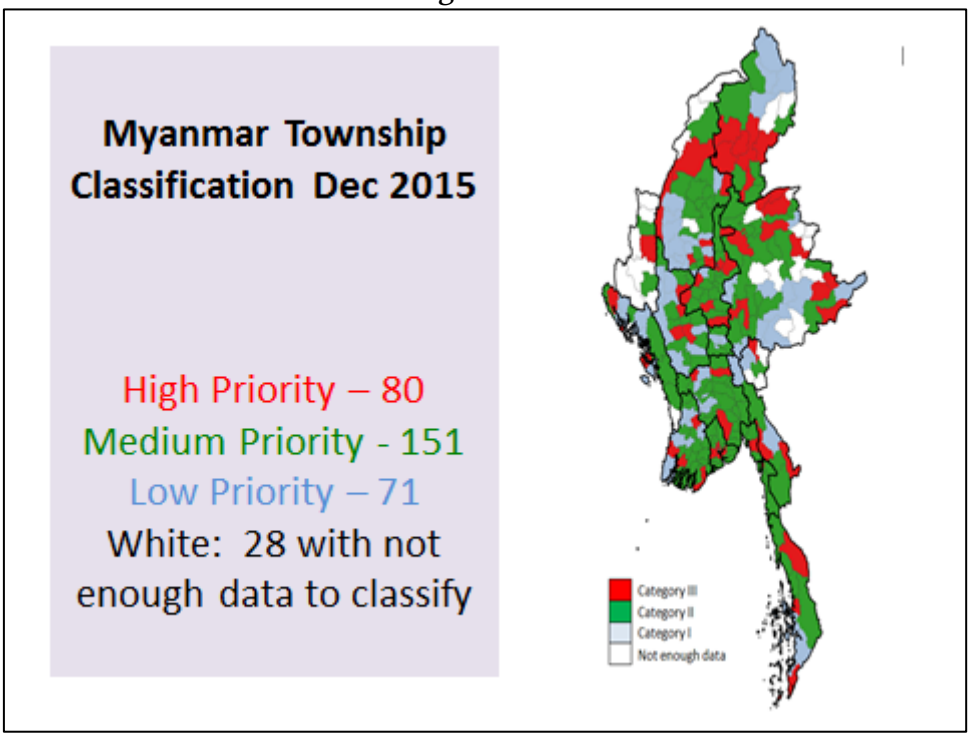
On a positive note, in December 2015, an amendment of the Myanmar Excise Act of 1917 that made the possession of hypodermic needles illegal was allowed to lapse without being renewed. This change can be attributed to advocacy by many in the PLHIV and PWID communities, with support from law enforcement.

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 key populations (Draft Myanmar National Strategic Plan for HIV: 2016-2020). PEPFAR will work with stakeholders in country, in particular work with civil society networks and organizations, to advance legislation that reduces stigma and discrimination.

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 and number of PLHIV by state are not available, Figure 1.4.1 from the SDS TA/TC country template could not be produced. However, during 2015, during the development of the "Myanmar National Strategic Plan for HIV III: 2016 – 2020", townships were categorized as high, medium and low burden (Figure 3, using the process of data triangulation. The results of the national triangulation align well with PEPFAR prioritization efforts carried out in 2015, which identified Yangon, Mandalay, Northern Shan and Kachin as priority catchment areas.

Figure 3: Classification of townships for HIV program planning, Draft Myanmar National Strategic Plan III: 2016 -2020



The map provided below (Figure 4) shows program coverage for all organizations that support HIV programs in Burma as of March 2015, illustrating that overall coverage is still very low.

Figure 4: National mapping of HIV/AIDS programs as of March 2015

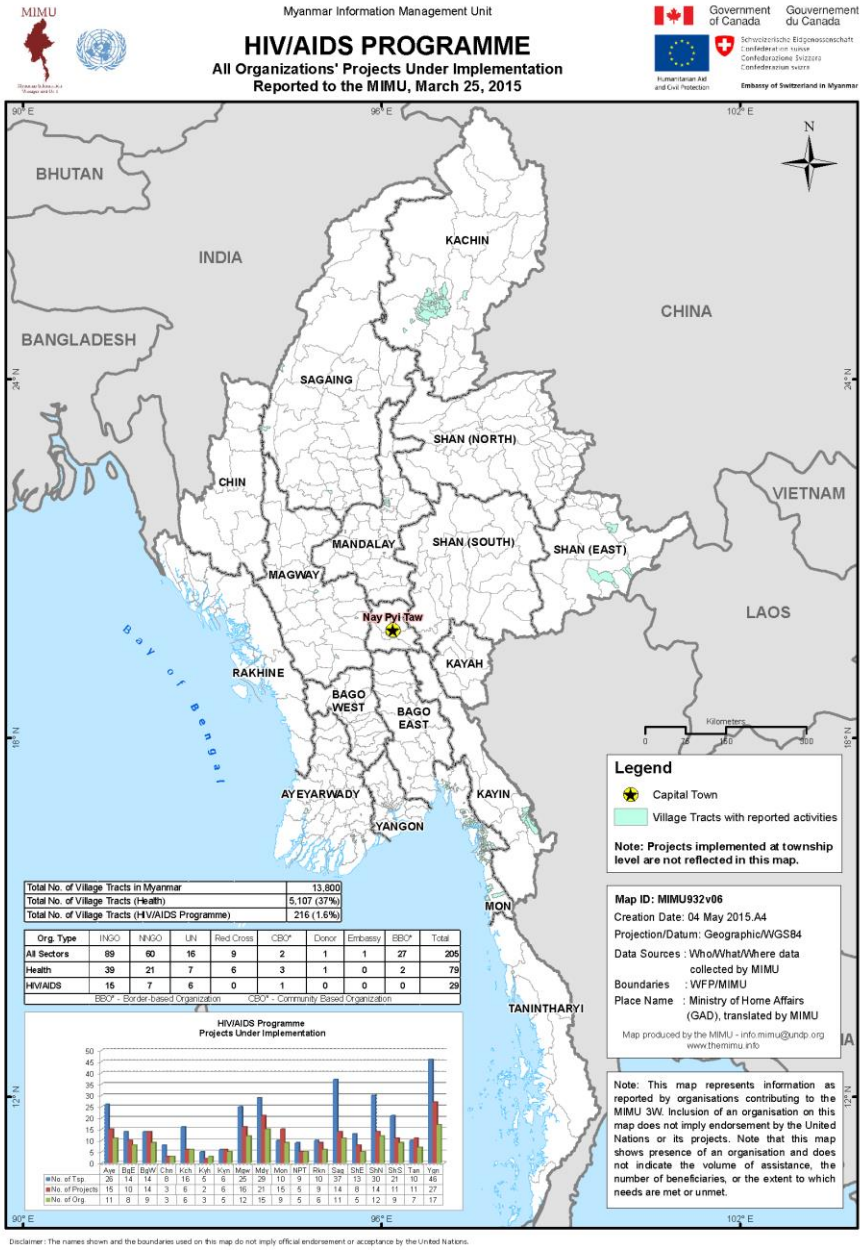
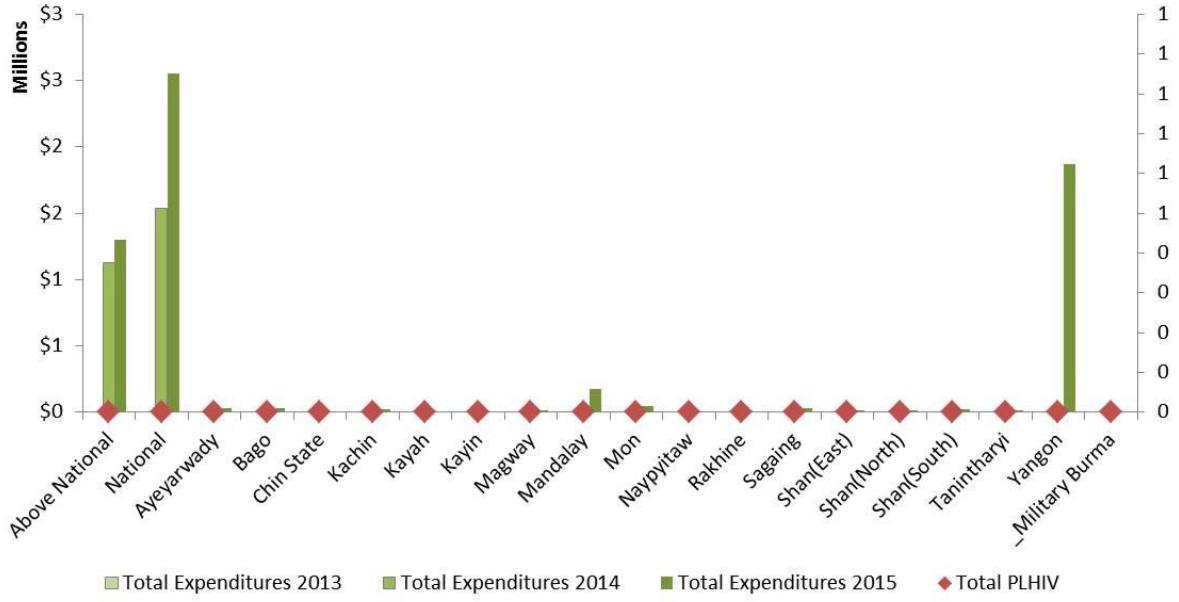


Figure 1.4.1 shows PEPFAR expenditures by state, for PEPFAR funds spent in FY 2015, with most funds used during this time period coming from FY 2013, given no funds were received in FY 2014. FY 2015 funds were disbursed in January 2016.

Figure 1.4.1: Total PEPFAR Expenditures and Total PLHIV by SNU by Fiscal Year



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

Given the lack of data for HIV burden by sub-national unit (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 be produced or interpreted in a meaningful way. Following disbursement of COP 2015 funds, the expansion of PEPFAR support including increased support for linkages and ART service expansion, and the "pivot" to four catchment areas in January 2016, we anticipate improved data and additional analysis in COP 2017.

Examining the expenditure analysis (EA) results for HTC by PEPFAR's implementing partner that supported direct services over the past year has, however, provided the PEPFAR team with some valuable information about the variability of costs across service points. Outliers include very low unit costs of per HIV test conducted in Bago and Ayeyarwaddy, 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 (Ayeyarwaddy, 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 the Global Fund 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 TA provide by PEPFAR Burma. The variability in the data will stabilize after the pivot in January 2016, and we expect more useful unit expenditure (UE) analysis next year.

High numbers of tests conducted as well as higher numbers of positive tests in Yangon, Mandalay, and Ayeyarwaddy likely reflect a combination of higher concentrations of key populations, higher HIV prevalence among key populations, 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 historically served FSW and MSM.

1.5 Stakeholder Engagement

The PEPFAR team consulted with the NAP, the Global Fund 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 proposed activities. Discussions were held with Global Fund recipients to look at how Global Fund and PEPFAR can support and engage with Civil Society Organizations (CSOs) without duplicating efforts. The U.S. government team is represented on the Multi Health Sector Country Coordinating (M-HSCC) Mechanism that coordinates the support provided by Global Fund and other donors, as well as the Technical Working Groups (TWGs), for different areas of the HIV response. U.S. government staff have close collaborative relationships with both United Nations Office for Project Services (UNOPS) and Save the Children, the current Global Fund prime recipients, as well as take part in broader stakeholder meetings. As mentioned above, Global Fund 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 consulted in order to better understand the needs of key populations 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 FSW, MSM, TG, PWID and PLHIV networks are conducted bi-monthly and results of consultations during Burma's COP development are summarized in the Civil Society Engagement supplemental documents. Meetings informed the development a project to train CSO board members and volunteers on organizational development and to work on advocating for the policies, rules and regulations that will most affect their area of interest.

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

PEPFAR regularly engages with UNAIDS and WHO to review how both parties can support the NAP and likewise strategize on how to assimilate incoming data from various implementing partners and activities.

Close technical collaboration has been established with Ministry of Health (MOH) and NAP counterparts. The U.S. government 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 Global Fund contributions, which points to the importance of continuing to pro-actively and continuously engage in joint planning and prioritization with the Government of Burma and the Global Fund, as well as continuing to strengthen the collaborative relationships that will allow for PEPFAR to support quality improvements in HIV service provision in the public health care sector. Insufficient investment of domestic resources to services and systems that directly benefit control of the HIV/AIDS epidemic has

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 Government of Burma 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 key populations 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 closely monitored and the yield will be analyzed to assess whether this collaboration should be further expanded in COP 2017.

2.0 Core, Near-Core and Non-Core Activities

In COP 2016, PEPFAR Burma begins an emphasis on demonstrating program effect through an 'implementation incubator' for testing and refining program delivery, and quantifying impact. Sites in catchment areas will provide services across the entire service delivery cascade with the intent to demonstrate interventions that result in increasing coverage and impact. Impactful interventions will be exported to be covered by government and Global Fund resources for geographic and population saturation.

The PEPFAR team sees this COP as an opportunity to initiate and further refine 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 the PEPFAR team will continue to create a shared PEPFAR vision among PEPFAR implementing partners.

Although this is a time of transition for Burma, with some supportive policies that encourage decentralization of services and openness to HIV prevention in key populations, many geographic areas, such as in Kachin and Shan states, are still in conflict and remain beyond the reach of the national government health program and closed to U.S. government presence. 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, international NGOs, NGOs, and private providers to strengthen the current cascade of testing, care, and treatment, with the goal of early diagnosis, implementation of test-and-start, 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 key populations, with targeted community- and facility- based prevention, testing, and treatment services for FSW, MSM and TG in four high prevalence and volume catchment areas. Using data from the 2014 IBBS among PWID, PEPFAR Burma also plans to design and expand PEPFAR support for targeted services for PWID, in line with government policies supportive of prevention, testing, care and treatment for PWID, establishing operational plans, and identifying and preparing potential partners in current restricted areas for programming in the future.

Despite progress made at the policy level through introduction of Test and Start for TB/HIV co-infected patients in 2015, the development of the HIV and TB NSP in 2015/2016 and a comprehensive TB/HIV assessment in January 2016, TB/HIV co-infection continues to be a major problem. According to the 2014 HIV Sentinel Surveillance Survey, 8.5 percent of patients newly diagnosed with tuberculosis were HIV infected. Overall, 19,000 PLHIV developed TB in 2014, although only about 34 percent of them were detected and treated. Sixty percent of TB patients were tested for HIV, but only 36 percent of those who were found to be HIV infected received ART. To address this, PEPFAR Burma will continue to strengthen TB and HIV service provision through private sector General Practitioners (GPs) in the four catchment areas as well as further

strengthen TB and HIV services in the public sector, working in close partnership with the NAP, National TB program (NTP) and USAID's 'Challenge TB' program.

There is a need to enhance "testing and treatment literacy" so that persons at risk for HIV are aware of, and utilize HIV services. The particular challenge is creating a demand for and increasing access to services among key populations who do not yet know they are HIV-infected. PEPFAR will provide TA and help design interventions targeted to increase the efficiency/yield of HIV testing among key populations and high-risk patients, and develop systems so that those who are HIV-positive are immediately linked to, enrolled and retained in treatment. PEPFAR will use communication technologies just now emerging in Burma, such as instant messaging and internet-enabled smartphones, that will tap into the strength of social networks of key populations.

PEPFAR Burma will continue to support investments in laboratory and supply chain systems to improve HIV testing and treatment scale up. Consistent with the national commitment to achieve 90-90-90, PEPFAR will provide technical assistance to strengthen quality assurance for HIV testing, especially at the community level, and to initiate and scale-up routine VL monitoring, working in close partnership with Global Fund partners in the public and private sector.

Technical assistance in strategic information will include support for use of programmatic data to identify geographic priority areas to improve targeting of programs and services, particularly for key populations. Technical support will be provided to improve the quality and use of existing data and as well as identify data gaps. PEPFAR will continue to support use of bio-behavioral surveys among key populations and provide TA to improve sentinel surveillance coverage and procedures.

See Appendix A for a full and updated list of core activities.

3.0 Geographic and Population Prioritization

Although the lack of data on HIV prevalence or HIV burden beyond the national level remains a challenge, HIV prevalence and population size estimates for PWID, FSW, and MSM were updated in 2015 (please see section 1 for details).

According to NAP reports, by the end of 2015, approximately 94,631 adult PLHIV were on ART, representing 58.7 percent of individuals in need of ART[9] at a CD4 threshold of 500. Geographic distribution of ART patients shows Yangon, Kachin, Mandalay, and Shan states at approximately 42 percent, 15 percent, 14 percent and 10 percent of the total of patients on ART, respectively. With the introduction of Test and Start, an estimated total of 216,029 adults would be in need of ART, doubling the number currently receiving treatment.

High ART up-take and enrollment 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 high numbers of key populations in the major urban

[9] Preliminary report, AEM Dec. 2015. 94631/161331 adults.

centers. Kachin (population 1.7 million) and Shan states (population 5.8 million), are locations known for injection drug use *[REDACTED]*.

PEPFAR Burma will concentrate on improving service delivery for key populations in high burden catchment areas in these four regions and states through NGOs, private and public sector settings to enhance services and accelerate HIV diagnosis yield, treatment uptake and retention of key populations. At the national level, PEPFAR will continue to provide TA to strengthen ART decentralization and strategic information, laboratory and supply chain systems. To avoid a gap in services for key populations, existing PEPFAR support for key population activities through the TOP centers in non-focus catchment areas were transitioned to other support in 2015, based on discussions with stakeholders and other donors, in particular Global Fund.

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

Table 3.1 below describes key populations 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

Categorization	State/Region	KP Focus
High Priority Catchment Areas	Yangon	All key populations
	Mandalay	All key populations
	Kachin	New PWID Support, existing other key population support maintained
	Shan	New PWID Support, existing other key population support maintained

Five of the existing 18 TOP Centers that have been supported by PEPFAR and provided important community-based services to key populations over the past years, are located in the catchment areas in the high priority states. In order to reach greater coverage of key populations, three additional centers will be established: two in Yangon and one in Mandalay. PEPFAR Burma is working with Global Fund to ensure that ongoing support for ARV and other commodities in the four catchment areas will continue. There is huge potential to capitalize on results of this program to accelerate HIV prevention and treatment in Burma.

The Yangon TOP center received NAP approval to initiate 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 COP 2016 cycle. See section 4.8 for further details about decentralization of ART services.

The new collaboration with private sector GPs, described in more detail below, will be similarly aligned with the above geographical prioritization, focused in the high priority catchment areas in Yangon and Mandalay in areas with known higher concentrations of key populations or hotspots.

Over the COP 2016 cycle, 38 GPs have been identified to serve as ART dispensing clinicians. This responds directly to the Government of Burma's mandate to facilitate the scale up of ART services in regions with greater prevalence and key population densities.

The support to TOP Centers and GPs will be complemented by TA for the MOH for planning and scale-up of decentralized ART services, finalization of the Myanmar HIV National Strategic Plan and Operational Guidelines: 2016 – 2020, and roll-out of Test and Start for all PLHIV. As part of the PEPFAR enhanced strategy, TA will increase focus on establishing quality control indicators for HIV services and monitoring and strengthening key populations services in the public and private/NGO sectors.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

By the end of 2015, only 94,631 (58.7 percent) of the 161,331 adults 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 Global Fund withdrawal in 2005 and re-entry in 2011. The current Global Fund grant runs through December 2016, with a treatment target of 86 percent (106,058 individuals using the former CD4 < 350 cut-off point). However, with revision of the 2014 national HIV treatment guidelines[10], the estimated number of adults in need of ART increased to 161,331. Moreover, with transition to Test and Start, all PLHIV, estimated at 216,026, would become eligible for ART.

Based on a situation and policy analysis of the HIV epidemic in Myanmar (2015-2030) and the development of the 2016-2020 NSP, strategies for epidemic control have been further advanced and refined. The process for developing the NSP involved government and numerous other stakeholders and technical experts including the PEPFAR team. The situation and policy analysis takes advantage of the new key population data becoming available through the IBBS surveys conducted in 2014-15. Township prioritization based on disease burden and risk mimics PEPFAR's approach to geographic pivots made and supported by PEPFAR; and service packages proposed in the NSP for high, medium and low priority townships align with PEPFAR's approach to core, near core and non-core activities.

Transition to providing ART for all PLHIV through Test and Start is expected to begin in 2017, coinciding with the next Global Fund grant; the concept note for the new grant will be submitted in June 2016. The NSP also includes provision of Pre Exposure Prophylaxis (PrEP), aligned with new WHO recommendations (2015) for groups at significant risk and consistent with the focus on HIV programming for key populations. A timeline for introduction and roll-out of PrEP for key populations has yet to be developed.

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

Of the estimated 11,073 new HIV infections in 2015, about three quarters were among key populations, i.e. an estimated 28 percent of new infections occurred among men who inject drugs, 23 percent among sex worker clients, 13 percent among MSM/TG, and 8 percent among FSW. According to program data collected in 2014, HIV testing coverage has remained low at only 34 percent among FSW, 27 percent of PWID and 20 percent among MSM and TG.

During FY 2016, PEPFAR will place greater emphasis on increasing HIV testing and treatment yield among key populations who are provided with HTC services in the four priority catchment areas. Based on a successful pilot conducted in 2014 in Ayeyarwaddy, 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 other innovative recruitment methods to draw in high risk key populations that have not yet been tested for HIV. In addition, through collaboration and coordination with the Government of Burma, activation of ART services at the eight TOP sites serving key populations in the four catchment areas will greatly facilitate initiation and retention of HIV positive key populations onto ART. As the TOP sites are currently well positioned to serve key populations in the PEPFAR Burma priority areas, as well as provide key population-friendly services, it is expected that the treatment gap for key populations in those areas will be significantly reduced within the COP 2016 timeframe and further positioned to support treatment scale up beyond the COP 2016 cycle. As the sites will provide a full complement of services to key populations, they will also be well positioned to facilitate adherence support to key populations during the outlying years of the epidemic.

HIV prevalence is over 3.9 percent in male STI patients (HSS MOH 2014). 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 percent in network clinics) to justify the potential of finding new HIV-positive cases among people attending these clinics. PEPFAR will initiate the expansion of HTC services to providers in Yangon and Mandalay with high STI caseloads, but who are not yet doing HIV testing, in an effort to reach persons likely to be HIV-positive but who do not know their status. This year PEPFAR will start with 38 clinics that have more than 20 STI cases per month.

The same network will also be used to integrate ART services. With TA from PEPFAR, the NAP developed operational guidelines for involvement of GPs as dispensing outlets for ART. With PEPFAR Burma support, 38 GPs will be trained in order to serve as dispensing outlets. This model directly responds to government mandates to facilitate decentralization of ART services in key regions throughout the country (informed by epidemiological and implementing partner data).

Through PEPFAR TA much progress has been made in the development of models and tools for implementing and monitoring the decentralized ART rollout. Guidelines for clinical management of HIV were revised in March 2015, and the new NSP is based on '90-90-90' using emerging evidence and recommendations including the transition to Test and Start for all PLHIV. Job aids and training materials have been developed to support the decentralized ART roll-out, and a TA plan was approved by NAP. A TB/HIV assessment conducted in early 2016, will inform support for HIV and TB screening and co-infection management proposed in COP 2016. TA

provided for the development of operational guidelines for the roll-out of satellite and dispensing ART delivery outlets will complement PEPFAR's direct service delivery support provided through TOP Centers and GPs.

TA partners will continue to provide support NAP to implement '90-90-90', finalize the NSP, and develop operational guidelines. Particular emphasis will be placed on scaling up HIV testing of all TB and STI patients, and development of sustainable strategies for immediate 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 PLHIV as well as key populations, in particular for settings and groups with potential for high prevalence for both HIV and TB such as PWID. Sites receiving PEPFAR TA will establish or strengthen systematic TB screening among key populations and PLHIV.

PEPFAR will also support NAP and partners, including Global Fund, to adopt evidence-based HIV testing guidelines and develop operational strategies for rapid scale up of HIV testing among priority populations, including addressing quality control and supply chain needs at the community level. 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 NGOs, 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.

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 referenced 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 sub-national level data unavailable or too unreliable to use. To address this constraint, as noted earlier, PEPFAR will provide direct TA and work with partners to improve the quality of data available and improve analysis to make better use of existing information, as well as continue to support key population surveillance including size estimates needed for appropriate key population programming and prioritization.

Although the number of restrictive policies has decreased, key populations 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 continue to support strong collaborations with CSO networks documented through regular meetings and follow-up actions, as well as CSO capacity building activities. In addition, PEPFAR Burma will support NAP and selected sites with adaptation and use of training materials for clinical providers that will support establishment of key population-friendly services at public health facilities. SIMS tools will also be modified to address possible stigma and discrimination of PLHIV seeking other health services.

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 made the assumption that there would be no increased restrictions, from either the local government or USG, after the new government takes

office in April 2016. The current MOH is supportive of PEPFAR work and goals, but severely understaffed. Assuming this openness continues, and that the government systems established in April 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 Global Fund, WHO and UNAIDS.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY 17) *TX_NEW*	ART Coverage (APR 17)
Yangon	N/A	866	N/A	2,042	1,083	N/A
Mandalay	N/A	459	N/A	1,013	569	N/A
Shan (north)	N/A	20	N/A	139	115	N/A
Kachin	N/A	21	N/A	162	124	N/A
Total		1,366		3,356	1,891	

Table 4.1.2a Entry Streams for Adults Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) *TX_NEW*
Adults			
Clinical care patients not on ART HIV+ TB Patients not on ART HIV-positive Pregnant Women	*9,856*	986	789
Other priority and key populations	*11,260*	1,378	1,102
Total	21,116	2,364	1,891

Table 4.1.2b Entry Streams for Newly Initiating ART Patients by Key Populations(FY17)

Entry Streams for ART Enrollment	Tested for HIV (in FY17)	Identified Positive (in FY 17)	Newly enrolled on ART (in FY17)**
FSW	5,113	616	493
MSM & TG	5,113	617	494
PWID	1,034	145	116
Others (please specify)			
Total	11260	1378	1103

PEPFAR will work with MOH ART and Global Fund in order to designate all TOP centers in the four priority catchment areas as ART delivery sites. Until ART is approved by the MOH for TOP

centers, any newly diagnosed patient (including newly diagnosed KP, TB and STI patients) will be referred to an ART Center, per current MOH ART decentralization plans, where the respective patient will be initiated on ART before being transferred. Most ART treatment centers have non-PEPFAR partners already assigned and in place for support. Once the patient is stable 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.

Note: Table 4.1.3 is for VMMC and not applicable for TA/TA countries.

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
FSW	**PSE Only available in Yangon and Mandalay for FSW and MSM**	**N/A**	**8,521**
MSM/TG		**N/A**	**8,522**
PWID		**N/A**	**1,032**
Total			**18,077**

Table 4.1.4a Prevention Interventions for FSW to Facilitate Epidemic Control

Priority State	FY 2017 Target	Is GFATM and/or HCG proving Prevention Interventions for KP in this SNU? (Y/N)
Yangon	3,614	Y
Mandalay	2,981	Y
Kachin	452	Y
Shan	452	Y
Total	**7,499**	**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 2017 Target	Is GFATM and/or HCG proving Prevention Interventions for KP in this SNU? (Y/N)
Yangon	4,599	Y
Mandalay	3,795	Y
Kachin	575	Y
Shan	575	Y
Total	**9,544**	**Yes, GF funding provides funding for drugs and commodities of each site**

Note: Table 4.1.5 is for OVC and not applicable for TA/TA countries.

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 key populations. The core package of key population services, as outlined in the 2014 WHO Consolidated Key Population Guidelines and the PEPFAR technical considerations, will be provided at PEPFAR supported sites, with the majority of sites located in the four high priority catchment areas.

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 key populations 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 to support the TOP program in the priority areas, serving key populations across all groups, FSW, MSM, TG, and in COP 2016, PWID. TOP Centers provide a safe space for a range of important HIV prevention and care services. Since the end of last year, the provision of decentralized testing and ART services is rolling out across all TOP sites. This year there will be a vigorous campaign to increase HIV test yields across key population communities and to increase up-take of HTC services delivered on-site. PEPFAR Burma will explore innovative and promising approaches through its "implementation incubator" to increase testing yield. Sites have started providing ART services which will be expanded over the course of the year. Peer navigators will support successful linkages into Care and Treatment for key populations diagnosed as HIV positive and continue to accompany the HIV-positive key populations to support good adherence and retention in care.

TOP Centers have primarily served FSW, MSM and TG. This year PEPFAR is working to reach and improve services for PWID in Kachin and Shan states. If needed, 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 may be provided to the NAP.

As some areas in these states are in conflict and restricted in access by foreigners as well government health services, PEPFAR will provide TA and develop capacity of community-based civil society organizations to assist in 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 GPs working in the Sun Quality Health (SQH) Clinics, and the public health care workers at selected ART sites in the catchment areas, will be trained to provide key population-friendly services. Their sites and staff will also be connected with either existing key population community-based organizations (CBOs) and/or train key population peers to serve as link between the facilities and the key population 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 Prevention of 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 percent across states. In 2014, 522,108 (62 percent) of pregnant women were tested for HIV and received post-test counseling. Of those, 3,798 women (0.7 percent) were found to be HIV-infected, and 3,790 received ARV. Task shifting of HTC to midwives has increased HTC coverage in pregnant women during the past year, but challenges remain (e.g. test kit shortages). Low HIV testing rates may contribute to an underestimation of the number of pregnant women in need of ARV prophylaxis, and low yields in many areas suggest better targeting of services is needed. The Clinton HIV/AIDS Initiative (CHAI) and UNICEF are partnering with the Government of Burma in this response.

4.5 HIV Testing and Counseling

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 in 2016. Challenges observed in the field include knowledge gaps among HTC providers, poor testing and counseling practices, and weak referral systems for care and treatment for HIV-positive individuals. According to the WHO, the revised guidelines update recommendations on testing algorithms (in particular re-testing prior to ART initiation) and provide guidance on community testing and improved linkages, especially for key populations. Other gaps identified during the review 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 percent of 383,000 key populations have been tested for HIV. Of those tested, 6.9 percent were diagnosed as HIV positive. Both total number of key populations tested and positivity yield at PEPFAR supported sites will continue to be monitored, and HTC services will be strengthened to increase the proportion of key populations reached with HTC services. Many patients are diagnosed late, with CD4 levels less than 200. Nine percent of patients newly diagnosed with tuberculosis have HIV (2014 NTP program data). 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 non-standard and expired test kits are used.

During the second half of 2014 the TOP Center staff in Hinthada, Ayeyarwaddy, began offering mobile HIV testing through six FSW outreach visits. The approach proved highly successful, with mobile HIV testing comprising 10 percent of the overall testing for the entire year. Significantly, the HIV positivity rate at the TOP Hinthada Center was 12 percent 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 sires, HIV testing will be strengthened targeting in particular TB and STI patients, where high HIV positivity yield is anticipated and new patients for enrolment in HIV Care and Treatment are likely to be identified.

PEPFAR partners are providing HTC for key populations, however there is a need to better target testing to increase yield, 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 increasing access to HTC for PWID in identified appropriate geographical areas.

PEPFAR will provide TA to:

- Improve HIV testing yield, in the four priority catchment areas– through the use of innovative strategies such as mobile HTC services targeting in particular key populations;
- Strengthen linkages to 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 four catchment areas where there the numbers of key populations are greatest;
- Develop strategies to increase reach, testing, and referrals for PWID;
- Improve HTC yield and follow-up for key populations, 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 21,116 HIV tests and identify an estimated 2,364 (average yield of 11 percent) 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 635 PLHIV 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 to an additional 1,891 newly diagnosed PLHIV (and 3,356 currently in care) receiving at least one clinical service at 38 sites.

Despite concerns in regards to data quality and variation among age groups, the MOH reported HIV prevalence to be at 4.1 percent among male STI patients at HIV sentinel sites, with variations between age groups and peaks as high as 5.9 percent 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 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, including:

- Laboratory monitoring, in particular introducing routine viral load monitoring and scaling back CD4 (see table 6.1);
- Cotrimoxazole prophylaxis; and
- Interventions to optimize immediate initiation of ART, 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 to strengthen MAT services through the development of relevant guidelines and tools, and strengthen monitoring

and evaluation. Sites supported by PEPFAR will also establish effective referral mechanisms for PWID in high priority states, where applicable.

4.7 TB/HIV

Burma is among the highest TB burden countries in the world for drug-sensitive TB, multi-drug resistant TB (MDR-TB) and HIV-associated TB. It is therefore on the WHO composite list of 30 high TB burden countries.[11] The tuberculosis epidemic in Burma is generalized, with an estimated incidence of 369/100,000 population (2014), i.e. about 200,000 incident TB cases and about 9000 MDR-TB cases among the reported pulmonary TB cases in the country.

The burden of HIV-associated TB coincides with the underlying HIV epidemic in the country. The latest HIV sentinel surveillance in Burma indicates that about 8.5 percent of TB patients in the country were HIV positive in 2014. Overall an estimated 19,000 PLHIV developed TB in Burma in 2014, although only about 34 percent of them were detected and reported in that year.

According to the NTP, the proportion of TB patients with known HIV status reached about 60 percent in 2015 (3rd Quarter 2015), with about 9 percent being HIV positive. This is an improvement over 2014, when 56,133 TB patients had a known HIV status (40 percent) out of 141,957 reported TB cases (WHO Global TB report, 2015).

Of particular concern is that only a small proportion of TB/HIV co-infected patients are receiving ART and that little progress has been made in recent years. Only 37 percent of TB/HIV patients received ART in 2015, compared to 36 percent in 2014. PEPFAR supported a TB/HIV program assessment carried out by WHO and UNAIDS in partnership with the NAP and NTP in January 2016. Based on the recommendations in the assessment, PEPFAR will provide TA to strengthen TB/HIV services and improve communication and coordination between the two programs at the facility, state, and regional levels. PEPFAR will also identify innovative strategies to increase HIV testing uptake and ART initiation, beginning in the high burden, focus areas.

In addition, as described above, PEPFAR will work with 38 GPs in Yangon and Mandalay to scale up HIV testing for patients with tuberculosis, and 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 key populations and other high-risk patients to access clinical services.

PEPFAR will provide TA to:

- Develop and implement a Standard Operating Procedure (SOP) for TB/HIV collaborative activities, particularly with the aim of increasing ART initiation including 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 in the focus areas;
- Increase ART treatment access, including through decentralized sites, and monitor ART provision to HIV-positive TB patients on a quarterly basis;

[11] Global TB report 2015, World Health Organization, available at http://www.who.int/tb/publications/global_report/high_tb_burdencountrylists2016-2020.pdf?ua=1)

- Expand access to TB services for key populations; and,
- Implement more widely the Policy Guidelines for TB/HIV collaborative activities for PWID.

4.8 Adult Treatment

Médecins Sans Frontières (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 public sector, began in 2011 with the re-introduction of funding from Global Fund. By the end of 2015, approximately 94,631 adult PLHIV were on ART, representing 58.7 percent of an estimated 161,331 adults in need of ART according to the current treatment guidelines (CD4>500). 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 percent, 15 percent, 14 percent and 10 percent of the total of patients on ART, respectively.

The current Global Fund grant runs through 2016, where the goal of scaling treatment to 86 percent (106,058 individuals using a CD4 < 350) has been set. In 2015, the NAP drafted a new strategic plan, the 2016 - 2020 NSP, which will be finalized in 2016. The new plan lays out strategies to achieve '90-90-90' and reach epidemic control. Specific strategies in the NSP include prioritization of activities based on geographic burden, and introduction of Test and Start for all PLHIV. During the next 4 years, an increasing proportion of the ART services will be delivered by the public sector through approximately 85 NAP ART centers and more than 150 decentralized sites, with designated NGO ART service delivery sites transitioning to the public sector by 2020.

Within the four priority catchment areas, PEPFAR will test innovative strategies to scale-up Test and Start for key populations, including accelerated activation of ART services at TOP facilities (contingent on government concurrence). As a result, HIV treatment services will be more closely linked to existing testing and support services for key populations, which will facilitate further support of elements of the NSP related to scale up services for key populations.

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, and managing complex health conditions including treatment failure. Further strengthening of ongoing supervision to ensure quality of care will be needed, with SIMS utilized to support these efforts.

National HIV Treatment Guidelines were revised in 2014, increasing the CD4 threshold for ART initiation to 500 and provision of ART for HIV positives in sero-discordant couples, key populations (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. With adoption of the new strategic plan in 2016, it is expected that the guidelines will be revised again to include Test and Start for all and phase-in of viral load for routine monitoring in 2016. The national program is also

considering options for longer periods between clinic visits – i.e., from every three to every six months in order to reduce costs and improve retention.

There are no good estimates of HIV treatment among key populations as key population 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. Global Fund recipients are currently focusing on the identification, testing and linkage of key populations and other PLHIV with enrollment and ART initiation by NAP.

Funding for ARVs is supported mainly through the Global Fund with some contributions (USD 5 Million in 2015) from the Government of Burma; therefore, PEPFAR Burma does not provide funding for ARVs. However, according to a recent assessment by Supply Chain Management System (SCMS)[12], drug stock-outs are common, CD4 equipment while widely available, is often not functional, and access to viral load remains limited. In addition, the Global Fund Office of Inspector General (OIG) audit also highlighted potential challenges for the expansion of ART services, including quality of services 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 NAP 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 under test-and-start, patient tracking, adherence, retention and virologic suppression;
- Monitor the progress of decentralization, establish evidence-based operational guidelines for implementation, and improve quality HIV service delivery, especially in the high-burden townships;
- Adapt global models and tools to assist the national program and Global Fund monitor and improve access to quality ART services through provision of key population-friendly services for FSW, MSM, TG and PWID, including improved linkages with HTC, MAT, TB and other programs as well as a key population sensitization training of clinical providers in public and private sectors;
- Develop a national strategy for the scale-up of viral load monitoring for more effective patient management for VL suppression, in coordination with other stakeholders and linked with CD4 scale-back;
- Develop a national HIV drug resistance 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 key populations.

4.9 Pediatric Treatment

[12] National Supply Chain Baseline Assessment, SCMS, 2014

At the end of 2013, 4,925 (7.3 percent) of HIV infected children were receiving ART in Burma. Through support from the Global Fund, Burma will increase ART for pediatrics as part of its goal of 86 percent 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. Laboratory TA will also aim to ensure quality testing for HIV exposed infants.

(4.10 OVC – not applicable)

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support 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 Global Fund. The concept of a maintenance site is thus not applicable to this setting and; therefore, table 5.1.1 is not included. Support for direct service delivery provided by PEPFAR in Burma is limited to eight TOP Centers in the catchment areas only. Those TOP facilities receive additional funding from Global Fund for commodities.

5.2 Transition plans for redirecting PEPFAR support to scale-up 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 Global Fund and NAP in order to better inform and target programming especially related to programs for key populations and ART scale up. Long-term activities among key populations prioritize those most at risk and focus on improving HIV testing yield, strengthened referrals and linkages to prevention and immediate treatment for those who are HIV infected.

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 Global Fund, with some Government of Burma contribution.

TOP Centers located outside the priority areas were transitioned from 40 percent PEPFAR and 60 percent Global Fund support to 100 percent Global Fund support in 2015.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Laboratory strengthening will continue to be a key priority: **Laboratory support and technical assistance** provided by PEPFAR in Burma is guided by the goal of achieving "90-90-90", with emphasis on three main key areas (a) ensuring quality of HIV testing (the first "90"), (b) adequate monitoring of patients on ART (the second "90"), and (c) roll-out of VL capacity (the third "90"). Laboratory TA will be aligned with PEPFAR technical considerations recommended transition to CD4 counts at baseline or initiation only and subsequent annual VL testing.

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 in the public sector, one in Yangon and one in Mandalay. MSF Holland provides support for a third VL site in Dawei, Tanintharyi Region. Some support for quality assurance for CD4 testing will still be needed during the set-up and expansion of VL testing capacity, while CD4 monitoring is being scaled back.

The PEPFAR program will provide TA for the implementation of a phased plan for scale up of VL monitoring, in collaboration with relevant in-country government and non-governmental stakeholders, and in line with existing equipment and platforms and a CD4 scale-back strategy.

Table 6.1.1 Key Programmatic Gap #1: Urgent need for scale-up of Viral Load (VL) testing capacity and quality assurance for HIV testing and ART patient monitoring						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM ID**	**Relevant SID Element and Score (if applicable)**
Inadequate quality assurance for HIV testing, especially for community testing	1. Quality control plan for community level screening/testing established and approved by NHL and NAP 2. Existing HIV testing training curricula adapted to include health center and community testing and training programs provided by NHL and designated NGOs 3. Logbook for HCT developed and standardized across NGOs and Public Health providers carrying out community HIV testing. 4. NGOs carrying out community level testing enrolled in quality control system with oversight by NHL.	Technical assistance to NHL and NAP to support development of quality control systems for scale up HIV testing in community settings, including improving laboratory adapting training curricula for health center and community settings, development of relevant SOPs, and standardized log books. Provision of TA to the National Health Laboratory to update testing algorithms for clinical and community settings, carry out kit lot verification, and develop system for personnel certification requirements	HLAB	$33,000	TBD (FIND Follow-on)	10. Laboratory

Shortage of laboratories with VL testing capacity for ART patient monitoring	1. Viral Load Scale-up Plan developed, endorsed by the HIV technical working group and approved by NHL and NAP. 2. Laboratory staff responsible for viral load testing in public sector laboratories receive training and mentoring on VL testing procedures and quality control 3. Specimen transport systems and requisition/reporting forms developed and approved by NHL/NAP 4. By end of 2017, all laboratories with PCR equipment carrying out viral load testing 5. All laboratories, public and private responsible for viral load monitoring under NAP enrolled in external quality control programs from CDC or NRL	Provision of TA to NHL and NAP to develop HIV viral load plan for routine monitoring and establish a national viral load committee with representation from clinical, laboratory, SI and supply chain sectors. TA to NHL and NAP on appropriate use of existing equipment to maximize output for manual and automated systems including development of laboratory protocols, training and mentoring laboratory staff, and introducing quality control. TA to develop specimen transport and reporting systems. Support enrollment in external quality control programs at CDC and NRL.	HLAB	$33,000	TBD (FIND Follow-on)	10. Laboratory
TOTAL				$66,000		

As described above, much progress has been made in regards to conducting key population surveillance and surveys over the past year. Detailed findings have been made available from the survey conducted for PWID and, although final analysis and a detailed report for surveys conducted for FSW and MSM in 2015 are not yet finalized, preliminary data for HIV prevalence and size estimates are now available to inform key population programming.

Nonetheless major data and information gaps remain and **Strategic Information** (SI) remains a core activity for COP 2016. HIV burden below national level and for priority areas and sub-national units (SNUs) remains unavailable, therefore more data is still needed to identify key geographic and high-risk areas. PEPFAR will provide technical support for improved availability and quality of programmatic data to identify geographic priority areas for better targeting of programs and services, particularly for key populations, as well as for conducting a data needs assessment and gap analysis to inform planning of future surveys or special studies. PEPFAR will support the hiring of surveillance and monitoring and evaluation experts to provide technical guidance to the NAP. These technical experts/consultants will 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, while maintaining client safety and confidentiality that is particularly important for key population clients, there is a growing recognition of the need to develop a unique identifier system that would be appropriate for key populations as well as being part electronic tools and a harmonized Monitoring and Evaluation (M&E) system. A number of systems are in use or proposed in Burma, and PEPFAR will provide technical support to identify feasible options, including mHealth tools.

Table 6.1.2 Key Programmatic Gap #2: Lack of key and quality data such as HIV burden below national level and programmatic data to monitor the HIV cascade in particular for KP unavailable so far						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP 2016 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM ID**	**Relevant SID Element and Score**
Low level of surveillance and M&E skills among MOH and NAP SI staff	1. Improved use of M&E data by NAP and the technical working groups, 2. Annual and quarterly reported prepared and reviewed in a timely manner, cleared by MOH and disseminated internally and externally.	Staff support for improved coordination of program monitoring, TA for protocol development, data management, analysis, and reporting	HVSI	$250,000	UNAIDS (17111)	13. Epidemiological and Health Data 15. Performance Data
Low level of surveillance and M&E skills among MOH and NAP SI staff	1. National Surveillance Plan for NSP III developed and approved by the MOH 2. Increased number of reports from additional analysis of IBBS and HHS survey data disseminated 3. Programmatic mapping protocol for townships developed, approved by IRB, and implemented in priority high burden townships	Staff support for establishment of a Surveillance System to reflect the NSP III. Staff support for development of programmatic mapping protocols and implementation of initial surveys in selected townships under leadership of NAP and in partnership with UNAIDS. Staff support for mentoring NAP staff on surveillance technologies and analysis of data.	HVSI	$400,000	TBD (UCSF)	13. Epidemiological and Health Data
Inadequate ability for monitoring of the HIV service cascade	1. Apps developed, activated and in use	This activity will develop a pilot program using computerized applications to improve patient tracking and HMIS systems in clinics throughout Burma	HVSI	$400,000	TASC4 ICT	15. Performance Data
	1. Apps activated and data collected	Adoption and utilization of a suite of apps to track enrollment, compliance and adherence across the HIV/AIDS treatment cascade	HVSI	$150,000	Cascade	15. Performance Data
TOTAL				$1,200,000		

Supply chains supporting HIV programs in Burma are characterized by extensive fragmentation resulting in inefficiency and poor visibility of commodity availability. Two Principal Recipients and twenty-three sub-recipients of Global Fund grants for ART operate independent vertical procurement and supply chain management systems, with different assumptions and some inappropriate calculation methods.

The SCMS project commenced operations in Burma in FY 2014 with a brief to support the MOH 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 forms the basis of an MOH supply chain master plan to improve the management of commodity distribution and the efficiency of the supply systems. The SCMS project ends in late 2016.

Discussions are beginning on what the next supply chain project will look like under the Global Health Supply Chain - Procurement and Supply Management Project (GHSC-PSM). In COP 2016, informed by SID findings, PEPFAR has assessed areas of sustainability gaps or weaknesses and have described how to address these gaps. Investments in the supply chain will ensure that new initiatives planned 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. PEPFAR will support technical assistance for decentralized distribution systems that promote multi-month ARV dispensing (e.g., every 3-6months) for stable patients. Regular joint forecasting (e.g., quarterly) and collaboration with the Global Fund is critical to understand and address commodity gaps. GHSC-PMS will be requested to clearly document ARV commodity forecasts and amounts that are committed by the Government of Burma and donors (especially Global Fund) for 2016, 2017, and 2018. 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. Better data through improved health facility level reporting to the logistics management information system can identify stock-outs more quickly and maintain a healthy HIV/AIDS supply chain. TA 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. Ensuring commodity security through robust storage and transportation plans, assuring quality products throughout the supply chain, and fostering local training solutions will build capacity of health professionals in HIV/AIDS supply chain.

Table 6.1.3 Key Programmatic Gap #3: Fragmented and inefficient supply chains supporting HIV programs						
Key Systems Barrier	**Outcomes expected**	**Proposed COP16 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM ID**	**Relevant SID Element and Score (if applicable)**
Existing supply chain inadequately designed to support decentralized of ART scale-up	1. Number of township medical stores with no ARV stock-outs 2. Number of SQH/GP clinics integrated into national HIV RTK/ARV supply chain 3. Number of agreements signed with pharmacies to participate in supply chain networks	Harmonized forecasting methodologies being used by all HIV/AIDS partners (regardless of funding source) to facilitate a national ARVs, RTKs, PMTCT and OI drugs forecast for Myanmar	OHSS	$175,000	GHSC-PSM	8. Commodity Security and Supply Chain
Poor forecasting of procurement for key HIV program commodities such as ARVs and RTKs	1. Directorate for Supply Chain Services created 2. Procurement systems in place 3. Number of hospital-based staff trained in procurement policies and methods	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 Implementation of an Early Warning System for ARV stock-outs	OHSS	$125,000	GHSC-PSM	8. Commodity Security and Supply Chain
Limited availability of data to support adequate quantification, reporting and management of re-supplies	1. LMIS operational	Enhance data availability for reporting, quantification, and resupply of program commodities through a harmonized LMIS	OHSS	$100,000	GHSC-PSM	8. Commodity Security and Supply Chain

Insufficient national integrated supply chain planning	1. Supply chain strategy operationalized 2. Support to the National Supply Chain Task Force	Combined harmonization and quantification 101 workshops on forecasting and supply planning	OHSS	$50,000	GHSC-PSM	8. Commodity Security and Supply Chain
Inadequate central warehouse management	1. Warehouse management systems connected across all implemented NAP sites to a central database.	Work with NAP warehouse to revise master data, standard operating procedures, user reference manual, improve data quality, and integrate with central warehousing distribution systems	OHSS	$100,000	GHSC-PSM	8. Commodity Security and Supply Chain
TOTAL				$550,000		

6.2 Critical Systems Investments for Achieving Priority Policies

As described in earlier sections, Burma has made great progress in identifying and determining what new strategies will be needed to achieve 90-90-90. Many of these have been captured and described in the draft Myanmar National Strategic Plan on HIV and AIDS: 2016-2020. The township categorization and classification into "high, medium or low" priority townships in particular mimics PEPFAR's approach and geographic pivot described in last year's COP 2015. The U.S. government team, PEPFAR-funded implementing partner agency staff and civil society organization and network representatives, have been pro-actively involved in the development of this new strategic plan and been able to contribute to content and help inform key decisions about future program directions and priorities.

An important policy in the NSP is the transition to Test and Start for all PLHIV. Burma's current Treatment Guidelines already stipulate Test and Start for HIV-positive pregnant women, children under 5 years of age, TB patients and key populations. The NSP includes Test and Start for all PLHIV, and the Global Fund concept note currently being developed with submission planned for June 2016, proposes January 2017 as the starting date for transition to Test and Start for all PLHIV.

In addition, PrEP has been included in the new strategic plan as an intervention to be offered for HIV-negative key populations and other priority populations at substantial risk, with plans to start with select pilot sites in high priority townships, though a timeline for this has not yet been outlined.

Last year, the development of a new HTC Guideline was completed with TA from PEPFAR and the final version is expected to be disseminated shortly. This new guideline is aligned with WHO's 2015 HIV Testing Guidelines. There are concerns amongst

stakeholders, including PEPFAR Implementing Partners (IPs), about operationalization and some of the practical implications of select new or existing but re-enforced requirements, such as the screening for triage at community level and the re-testing requirements for confirmation of the diagnosis and prior to initiation of ART. To respond to these concerns, plans for calendar year 2016 include the development of a guide for Community-based HTC, and the PEPFAR team and IPs will continue pro-active engagement and participation in the development of this tool. This new guide may include a new policy introducing and providing approval for trained and certified lay counselors to conduct HIV rapid screening tests at the community level, which will remove or substantially reduce barriers to accessing HIV testing among key and priority populations which do not currently access health facility based services for fear of stigma and discrimination.

Policy changes such as the transition to Test and Start for all in 2017, as well as new service delivery models including community-based HIV testing and screening, are included in the two tables below. Of note, other new service delivery models were developed under last year's COP 2015 and will be rolled out over the coming years, including the involvement of GPs in Burma as well as continued decentralization of ART services to support continued aggressive ART roll-out in Burma over the coming year.

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP 2016 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM ID**	**Relevant SID Element and Score (if applicable)**
Current Guidelines still limited to Test and Start for only select groups or populations (pregnant women, <2 y, TB & KP)	1. New Myanmar National Strategic Plan on HIV and AIDS III, 2016-2020, including the new Test and Start policy, finalized and disseminated 2. Full implementation of a national policy and guidelines for Test and Start 3. Full implementation of T&S SOPs for clinical service sites 4. ART quality assurance (QA) system in place and implemented to ensure adequate quality of T& S implementation	Continuation of TA through both USG staff and PEPFAR funded IP technical experts	HTXS	225,000	ICAP, WHO	6. Service Delivery
		TA to NAP for up-dating of existing ART guidelines and ART program tools and SOPs for transition towards Test and Start	HTXS	225,000	ICAP, WHO	6. Service Delivery
		TA for integration of QA activities to monitor implementation and roll-out of Test and Start as part of QA for the larger and decentralized ART roll-out	HTXS	100,000	ICAP	6. Service Delivery
		TA for revised ARV forecasting and planning of procurements to ensure adequate ARV supplies for roll-out of Test and Start	OHSS	62,500	GHSC-PSM	6. Service Delivery
Lack of operational guidelines for implementation of community-based HTC through trained and certified lay counselors to achieve the first "90" and increase the number of HIV+	1. National HTC guidelines finalized and disseminated 2. New companion guide for community-based HTC developed, finalized and disseminated 3. Tools needed for implementation of community-	Continued TA for finalization and dissemination of National HTC guidelines as well as pro-active engagement in development, finalization and dissemination of new guide for community-based HTC service delivery	HVCT	225,000	WHO, CAP3D/ Cascade, ICAP	6. Service Delivery
		Development of tools such as training materials, SOPs, job aids, new/revised HTC M&E tools etc. for use at community level	HVCT	275,000	CAP3D/ Cascade, ICAP	6. Service Delivery

persons identified and linked to Test and Start	based rapid testing through trained and certified lay counselors developed and shared with implementing partners	TA for revised HIV rapid test (HRT) kit supply forecasting and planning of procurements to ensure adequate HRT kits	HVCT	62,500	GHSC-PSM	6. Service Delivery
TOTAL				1,175,000		

As mentioned above, community-based ART service provision through select TOP centers and introduction of involvement of GPs as additional private sector providers for Provider Initiated HIV Testing and Counseling (PITC and ART services were already included in COP 2015 but will be continued through FY 2016 – 2017).

Barriers, outcomes and activities in table 6.2.2 therefore include new activities related to: (a) improved mobilization and recruitment, and HIV testing and counseling services for key populations to increase reach of high-risk key populations, increased demand and up-take of HTC, increased positivity yield, and successful linkage to Test and Start; and, (b) implementation of the new community-based HTC service delivery models that will be part of the new community-based HTC guide developed and implemented at the four priority catchment areas receiving direct support through PEPFAR.

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP 2016 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Associated IM ID**	**Relevant SID Element and Score (if applicable)**
Stigma and discrimination affecting identification of KP at community level and poor access of high risk KP to HTC services	1. Design and implementation of improved and innovative KP outreach and recruitment at four catchment areas receiving direct service support through PEPFAR 2. Improvements in the KP cascade addressing this particular barrier through increased identification of high risk KP monitored through e.g. numbers of KP reached, tested, tested positive and successfully linked to treatment	Implementation of innovative and cost effective peer driven and social network interventions to increase recruitment of high risk KP and facilitate increased access to HTC, including effective linkages to ART for HIV+KP	HVOP	200,000	CAP3D, Cascade	6. Service Delivery
		Use of new and low cost communication channels, media, mobile phone and web-based tools and apps for increased reach of KP, in particular MSM and TG	HVOP	200,000	CAP3D, Cascade	6. Service Delivery
		Design and implementation of effective interventions to reach PWID in particular for PEPFAR supported sites in Kachin and Northern Shan states	IDUP	300,000	CAP3D, Cascade, UNODC	6. Service Delivery
Barriers to accessing HTC services among KP who do not access facility-based services for fear of stigma and discrimination	Increased yield among KP tested and HIV+ KP identified and enrolled in ART through a combination of facility-based with new community-based HTC approaches	Implementation of new community-based HTS approaches for KP e.g. mobiles, HRT through trained and certified KP peers in four catchment areas directly supported by PEPFAR	HVCT	300,000	CAP3D, Cascade, UNODC	6. Service Delivery

High frequency of clinical visits required for stable ART patients that contribute to higher costs as well as potentially lower adherence	Guidelines revised and disseminated with up-dated requirements for stable patients on ART and lower frequency of clinical visits implemented	1. TA provided to MOH NAP for up-dating of ART guidelines to transition to 6 month-clinical visits and determine alternate models for dispensing and delivery of ARVs in between visits 2. New multi-month ARV prescriptions and less frequent clinics piloted and implemented at ART sites directly supported in 4 catchment areas to inform and refine ART program improvements	HTXS	150,000 100,000	1. ICAP, WHO 2. CAP3D, Cascade	6. Service Delivery
TOTAL				1,250,000		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

All PEPFAR Burma system investments proposed for COP 2016 have been included in tables 6.1 or 6.2. No additional information has therefore been provided in this section (6.3).

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. All vacancies have been filled. However, the team is still very limited in its ability to provide the level of support and oversight that is needed for PEPFAR programs and to regularly engage with NAP, Global Fund and others in HIV programming in Burma. To address some of the reporting and communication burden, PEPFAR Burma will support a 20 percent cost-share for PEPFAR Coordinator support from Cambodia.

Given limitations in funding and office space, it remains unlikely that the PEPFAR team in Burma will be able to grow in size in the next two years; however, if becomes feasible, priorities would be for clinical/laboratory expertise. In the meantime, the team will utilize creative hiring mechanisms such as the U.S. Embassy Employee Family Member system, short term contracts and purchase orders to bring on additional support technical assistance for managing the workload created by MER/SIMS/POART reporting requirements. PEPFAR will also utilize the 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 Global Fund transition).

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Non-core Activities
Site level	- TA and interventions that support decentralization and scale up of services across the entire service delivery cascade through as 'implementation incubator' - Strengthening of HTC and ART scale-up through public, NGOs and private service providers - TA and interventions that improve the KP Cascade and lead to increased HTC yield and enrolment and retention of HIV-positive KP in Care & Treatment through targeted community- and facility-based KP friendly services - Strengthen TB and HIV service provision through private sector General Practitioners - Reduction of stigma and discrimination at facility and community level to provide KP friendly services (e.g. KP sensitization training for providers, capacity building for local KP groups and organizations)	
Sub-national level	- TA and interventions to strengthen current cascade of testing, care and treatment to improve early diagnosis, test-and-start, high retention in treatment, and preventing loss to follow-up at pivot state level - Strengthening of ART scale-up through TA for improved planning of Test and Start roll-out and ART decentralization at state level - Design and expand targeted services for PWID, supportive of prevention, testing, care and treatment for PWID	
National level	- TA and interventions to support policy and strategy changes on the transition to Test and Start for all PLHIV - Support for the strategy of sustaining growth of HTC and ART in the public, NGOs and private sector through decentralization - Strengthen TB and HIV integrated services in the public sector, in close partnership with NAP, NTP and USAID's Challenge TB program - TA and support to design interventions utilizing communication technologies, aiming for more KP and high-risk	

	patients to get tested, and PLHIV immediately linked to, enrolled and retained in treatment - SI, TA for improved cascade M&E and use of programmatic data - Support the use of IBBS among KP and improved sentinel surveillance coverage and procedures - TA for improved supply chain management - TA for QA and strengthening of laboratory support for HTC and VL scale up		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

HTC	**Core Activities** - TA and support for HTC up-take and yield among KP, including innovative interventions, introduction of mobile strategies in high priority states - TA and interventions to support decentralization of HTC services in public, NGOs and private facilities - TA for quality assurance and improvements for HTC - TA to improve HIV Rapid Test Kit (HRT) supply forecasting, procurement and delivery	**Near-core Activities**	**Non-core Activities**
Care and Treatment	**Core Activities** - Strengthening of ART scale up through improved planning of Test-and-start roll-out and ART decentralization in public, NGOs and private sectors - TA and training of public health care providers for improved quality and delivery of KP friendly care & treatment services - TA for improved ARV procurements and supply management - TA for laboratory quality improvement to initiate and scale-up routine VL monitoring	**Near-core Activities**	**Non-core Activities**
Prevention	**Core Activities** - 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 designing and expanding targeted services for PWID, supportive of prevention - Condom and lubricant procurement and supply through Commodity Fund (centrally funded through HOP)	**Near-core Activities**	**Non-core Activities**
TB/HIV	**Core Activities** - TA for improved TB/HIV	**Near-core Activities**	**Non-core Activities**

	integration including improved HIV testing for TB patents, immediate ART, and TB screening for PLHIV and KP	
Cross-Cutting	**Core Activities**	**Non-core Activities**
Lab	- TA for improved lab capacity and QA for HIV testing, and Viral Load to increase access to quality HTC and improved monitoring of patients on ART	
Strategic Information	- TA for IBBS and sentinel surveillance system - TA for improved monitoring of 'reach-test-treat and retain' cascade for KP, including introduction of monitoring of ART retention	
Health Systems Strengthening	- 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	

Note: Table A.3 is not included because there are no non-core activities to transition.

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$1,000,000 US	**$9,000,000 US**	**$10,000,000 US**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$0
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$804,047
IDUP	Injecting and Non-Injecting Drug Use	$1,013,740
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$1,667,949
HBHC	Adult Care and Support	$276,182
PDCS	Pediatric Care and Support	$0
HKID	Orphans and Vulnerable Children	$0
HTXS	Adult Treatment	$1,904,125
HTXD	ARV Drugs	$0
PDTX	Pediatric Treatment	$0
HVTB	TB/HIV Care	$302,750
HLAB	Lab	$71,500
HVSI	Strategic Information	$1,356,875
OHSS	Health Systems Strengthening	$835,740
HVMS	Management and Operations	$767,092
TOTAL		**$9,000,000**

B.2 Resource Projections

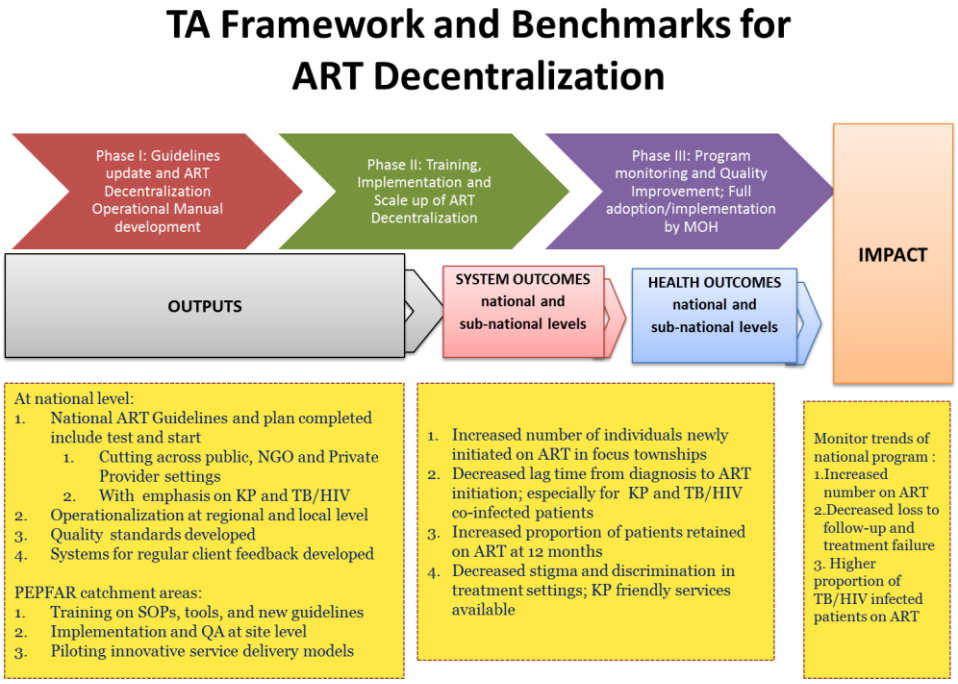
PEPFAR Burma has taken a critical look at the planning levels by budget code and by implementing mechanism for COP 2016 to ensure maximum impact of the funds. PEPFAR Burma utilized expenditure analysis data to provide target-based budgeting for the HVOP, IDUP, and HVCT budget codes and identified lump sum budgets by activity for the remaining budget based on expenditure data. The EA Data Navigation tool was used to provide unit expenditures for KP-FSW, KP – MSMTG, KP-PWID, and HTC based on FY 2015 work.

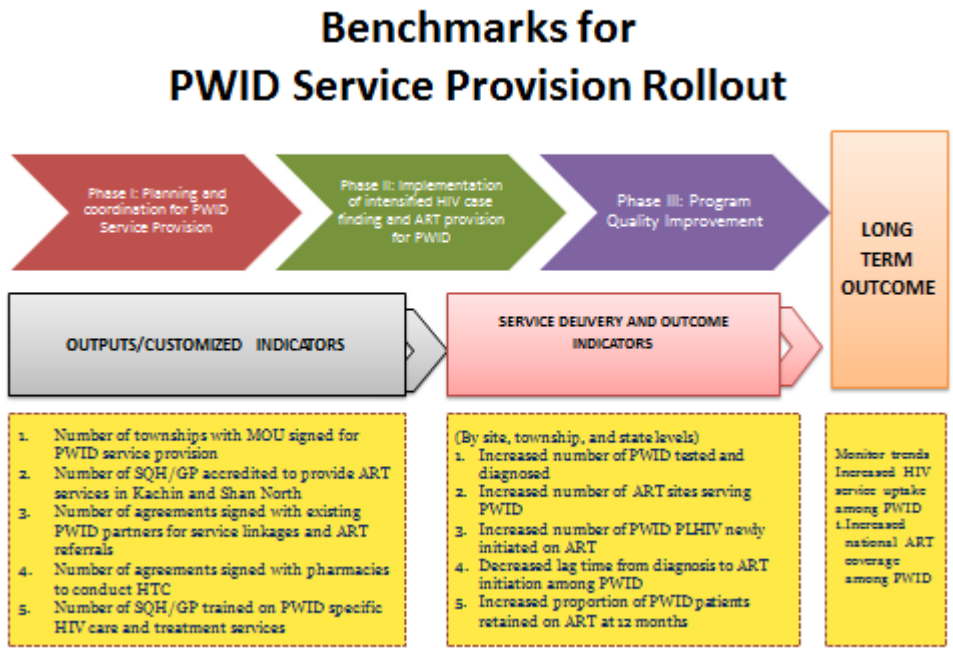
The unit expenditures that were initially calculated were then adjusted to reflect a decrease in Global Fund support for those activities. PEPFAR previously supported 40 percent of the funds in sites but will be taking over 100 percent in COP 2016. Therefore each UE was multiplied by 2.5. Specific details on the activities and justifications for budgeting can be found in the PBAC's lump sum tab activity description tab.

Beyond expenditure data, PEPFAR Burma triangulated data from current spend rates, projected activity budgets and considerations from external donor support. Of note is the increased level of investment for adult treatment, counseling and testing, injecting and non-injecting drug use. Theses figures reflect a shift in the program to provide increased direct service delivery as well as services for injecting drug users.

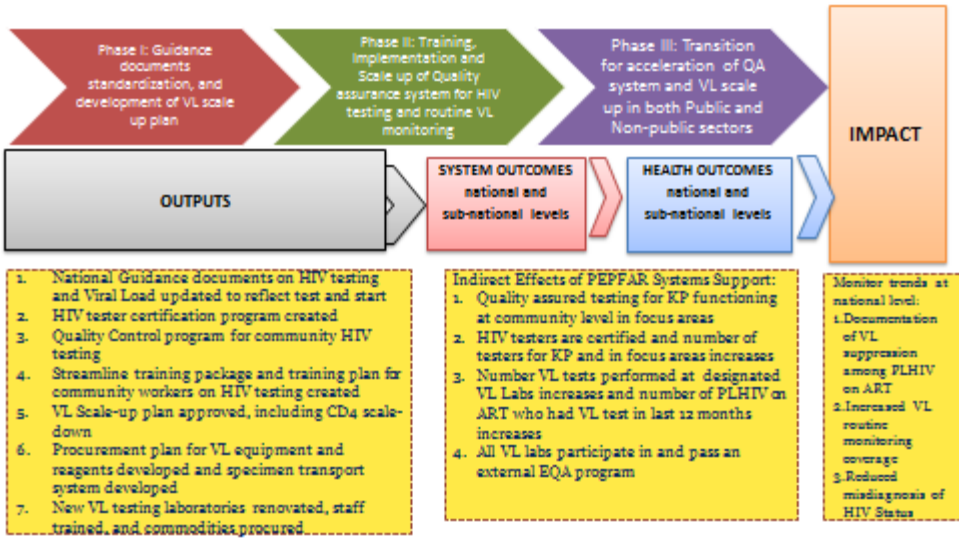
APPENDIX C

Systems Level Benchmarks

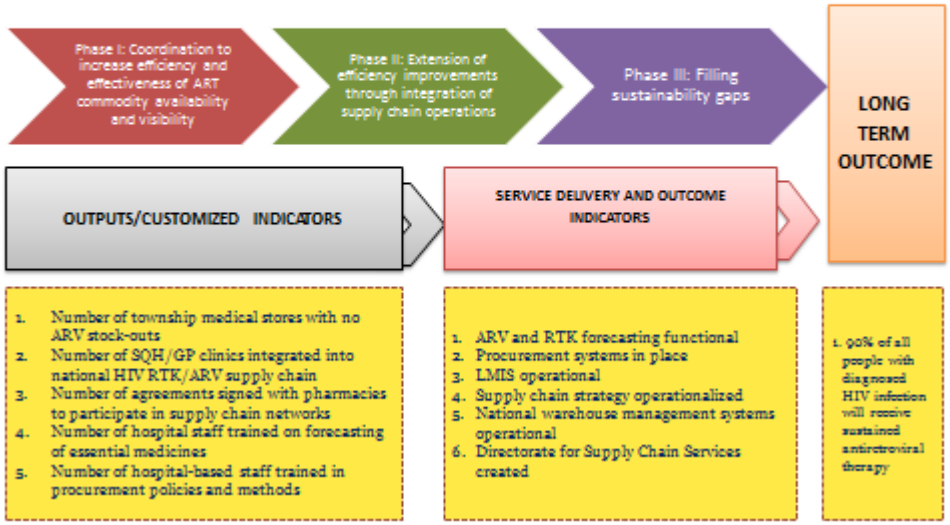
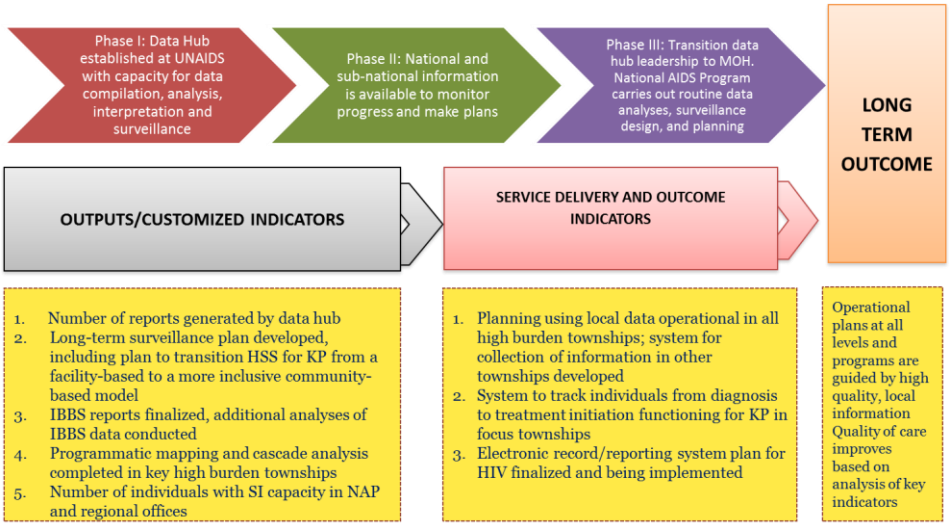




TA Framework and Benchmarks for Community HIV testing and Viral Load Scale-up



Benchmarks for Supports to Supply Chain



Benchmarks for Strategic Information Support