The Republic of The Union of Myanmar

Country Situation; Policy Initiatives and Proposed Action for HIV/AIDS and Mobility

11-13 July, Bangkok, Thailand

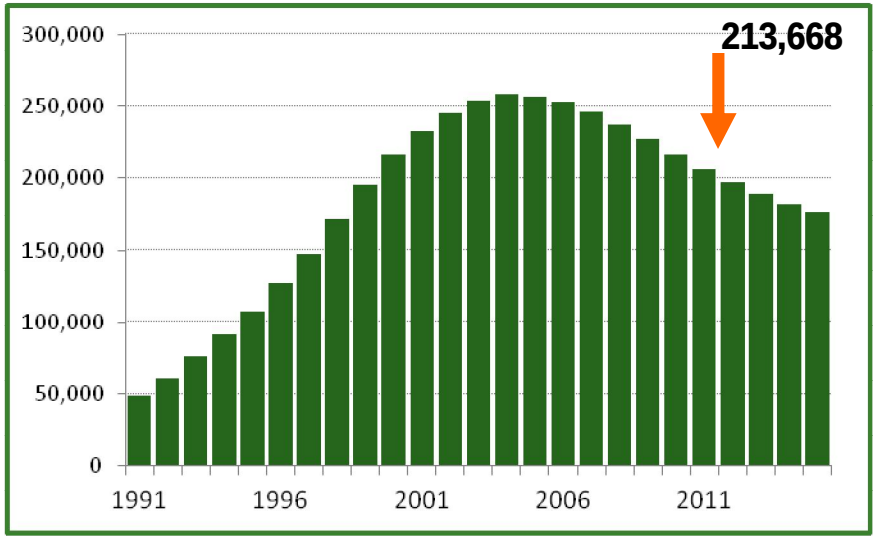
HIV/AIDS Situation in Myanmar

- First HIV positive case reported : 1988
- First AIDS case reported : 1991
- Main mode of transmission: Sexual Transmission

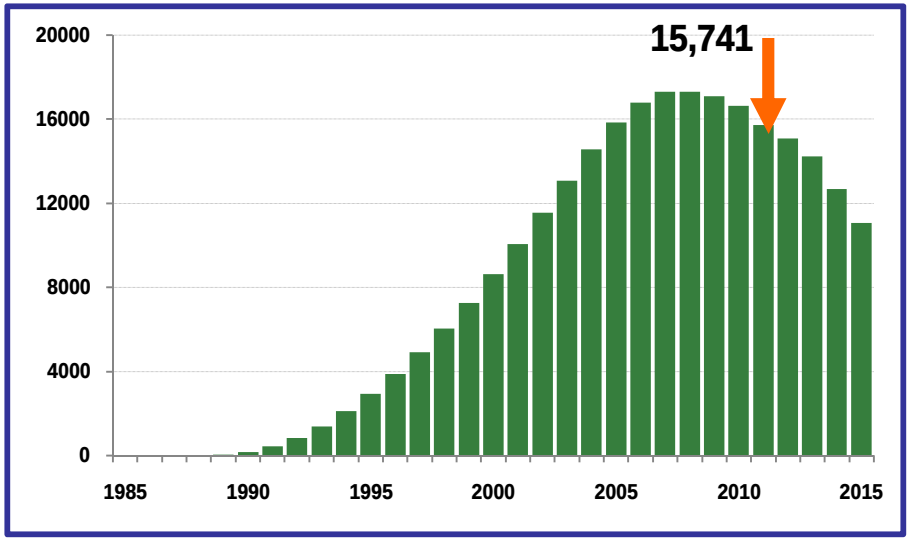
Regional and in-country workshop on Estimation and Projection of HIV/AIDS in Myanmar has been conducted biannually since 2005

According to the results of 2011 Estimation and Projection of HIV/AIDS in Myanmar:

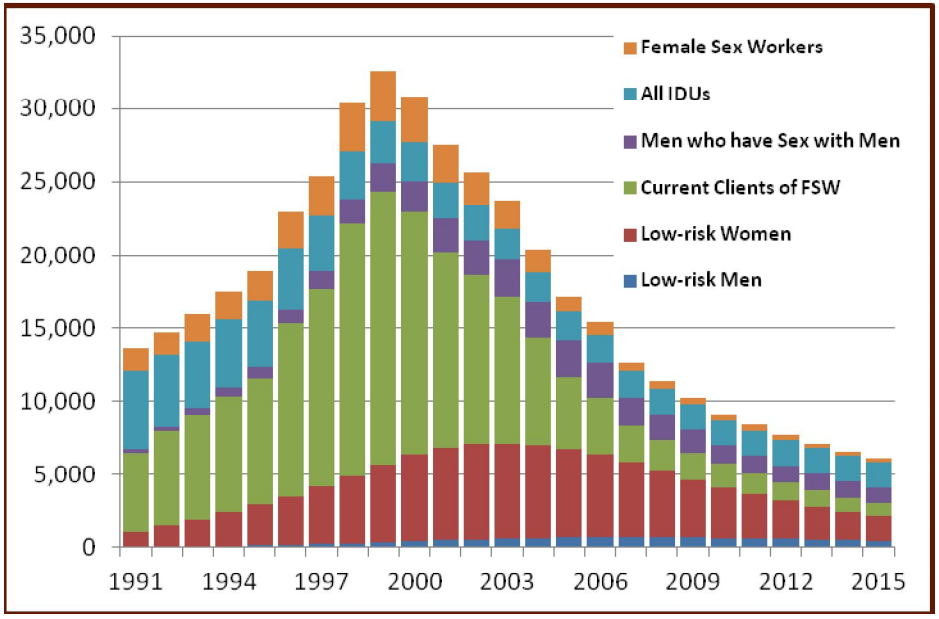
Estimated number of people living with HIV/AIDS (Adults + Children)



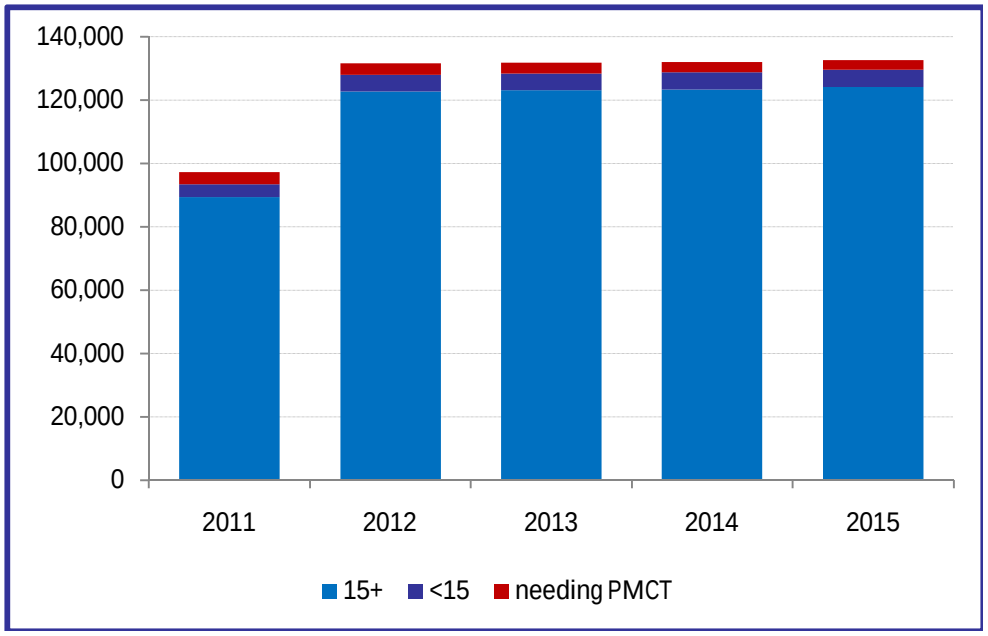
Estimated number of AIDS Deaths (Adults + Children)



Estimated number of New HIV Infections



Estimated number of ART Needed

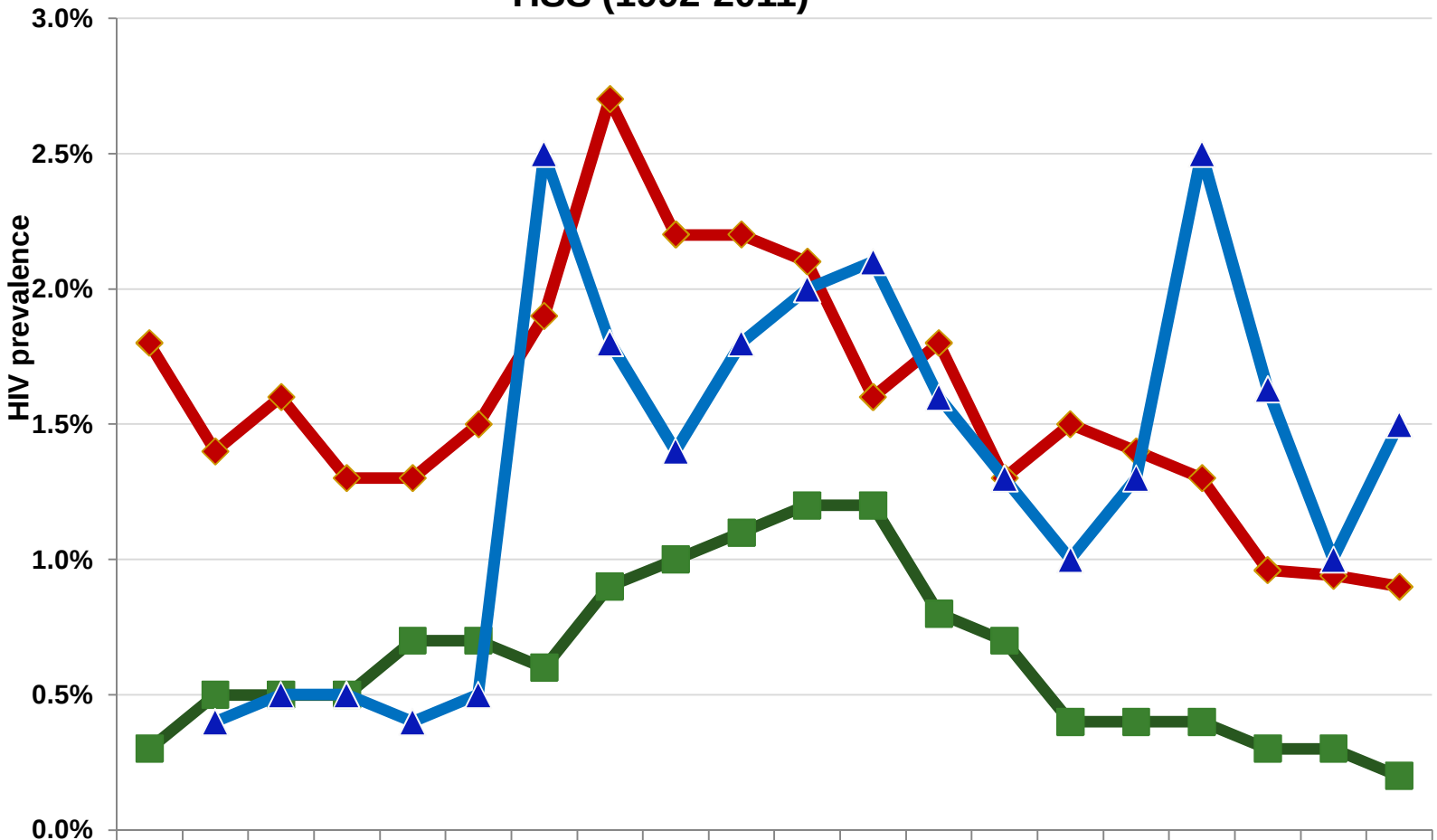


HIV Sentinel Surveillance

- Started in 1992
- The sentinel groups included are population

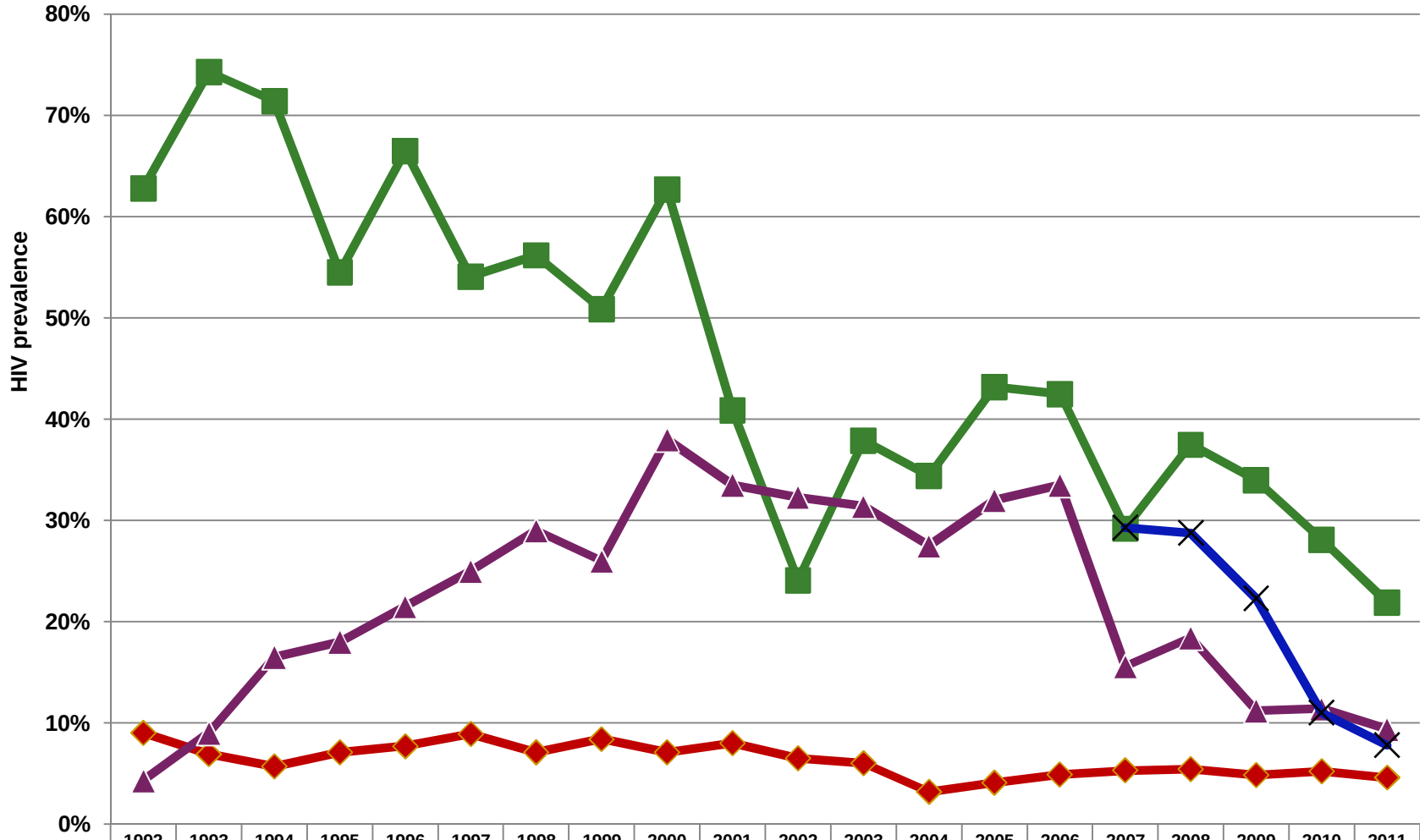
- **at low risk**: pregnant women attending antenatal clinics, new TB patients, new military recruits, blood donors; and
- **at high risk**: injecting drug users, men who have sex with men, female sex workers, male patients attending STD clinics.

Trends of HIV prevalence among low risk populations HSS (1992-2011)



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Pregnant women	1.8%	1.4%	1.6%	1.3%	1.3%	1.5%	1.9%	2.7%	2.2%	2.2%	2.1%	1.6%	1.8%	1.3%	1.5%	1.4%	1.3%	1.0%	0.9%	0.9%
Blood donors	0.3%	0.5%	0.5%	0.5%	0.7%	0.7%	0.6%	0.9%	1.0%	1.1%	1.2%	1.2%	0.8%	0.7%	0.4%	0.4%	0.4%	0.3%	0.3%	0.2%
Military Recruits		0.4%	0.5%	0.5%	0.4%	0.5%	2.5%	1.8%	1.4%	1.8%	2.0%	2.1%	1.6%	1.3%	1.0%	1.3%	2.5%	1.6%	1.0%	1.5%

Trends of HIV prevalence among most at risk populations HSS (1992-2011)



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Male STI patients	9%	6.9%	5.7%	7.1%	7.7%	8.9%	7.1%	8.4%	7.1%	8.0%	6.5%	6.0%	3.2%	4.1%	4.9%	5.3%	5.4%	4.9%	5.2%	4.6%
Injecting Drug Users	62.8%	74.3%	71.4%	54.5%	66.5%	54.1%	56.2%	50.9%	62.7%	40.9%	24.1%	37.9%	34.4%	43.2%	42.5%	29.2%	37.5%	34.0%	28.1%	21.9%
Female Sex Workers	4.3%	9.0%	16.5%	18.0%	21.5%	25.0%	29.0%	26.0%	38.0%	33.5%	32.3%	31.4%	27.5%	32.0%	33.5%	15.6%	18.4%	11.2%	11.4%	9.4%
Men Sex with Men																29.3%	28.8%	22.3%	11.0%	7.8%

Situation Assessment: Cross-Border Mobility

- With Socioeconomic changes, infrastructure development, and improved physical connectivity among the GMS countries, population movement is increasing within and across borders.
- Cross- borders mobility between Myanmar especially with China & Thailand has been seen for many years.
- Not much study was conducted for situation related to MMPs.

Situation Assessment: Cross-Border Mobility and HIV/AIDS

- Activities along Myanmar-Thailand Border related to HIV/AIDS/STI

- HIV & AIDS Prevention and Control Activities including STI Management, Voluntary Confidential Counseling and HIV Testing, Prevention of Mother to Child Transmission.
- Provision of Care and Support to the People living with HIV/AIDS and their families
- Collaboration for increasing access to HIV Care and Support services
- Myanmar-Thailand Joint Action Plan for cross border health development activities

Situation Assessment: Cross-Border Mobility and HIV/AIDS

- Activities along Myanmar-China Border

- MOU for Capacity Building, Information Sharing and Networking, Strengthening Capacity in Disease Control between Health Ministries in 2001.

- MOU for Reduction of HIV Vulnerability related to population movement by GMS Health Ministers in 2004

- 1st ASEAN-China Health Ministers Meeting back to back with 8th ASEAN Health Ministers Meeting in 2006

(HIV Prevention & Control was decided Potential Area of Cooperation)

Experience on Migrants Health

- High levels of migration: source, transit, destination and return especially in South-East Myanmar
- Local populations travel across to Thailand and beyond
- Internal migration also seen within country.
- Health facilities at air ports, sea ports and ground crossing points were upgraded.

Ongoing activities/progress on Migrants Health

- Major emphasis on **health system strengthening**
- extending coverage of government health system to reach populations at remote areas such as rubber plantations, fishing villages, brick-making sites, mining areas, etc.
- Primary Health Care, MCH, RH, HIV, TB, malaria
- Health education, peer educations, STI/HIV prevention & control services
- Referral linkages with public and private health care providers
- Collaborating with UN agencies , NGOs ,CBOs and other related ministries

Ongoing activities/progress on Migrants Health (*contd.*)

- Community empowerment through supporting establishment and management of Village Mobility Working Groups (VMWG), health committees, and peer groups:
  - community mobilization for prevention activities
  - delivery of essential health commodities (e.g. bed nets, home-based care kits)
  - patient referral
  - sharing of knowledge on RH/MCH, HIV/AIDS, and other issues
- Capacity building of government basic health staffs, village health volunteers, and VMWG/HC members
- Financial sustainability through community's contribution and income generation activities (e.g. revolving funds)

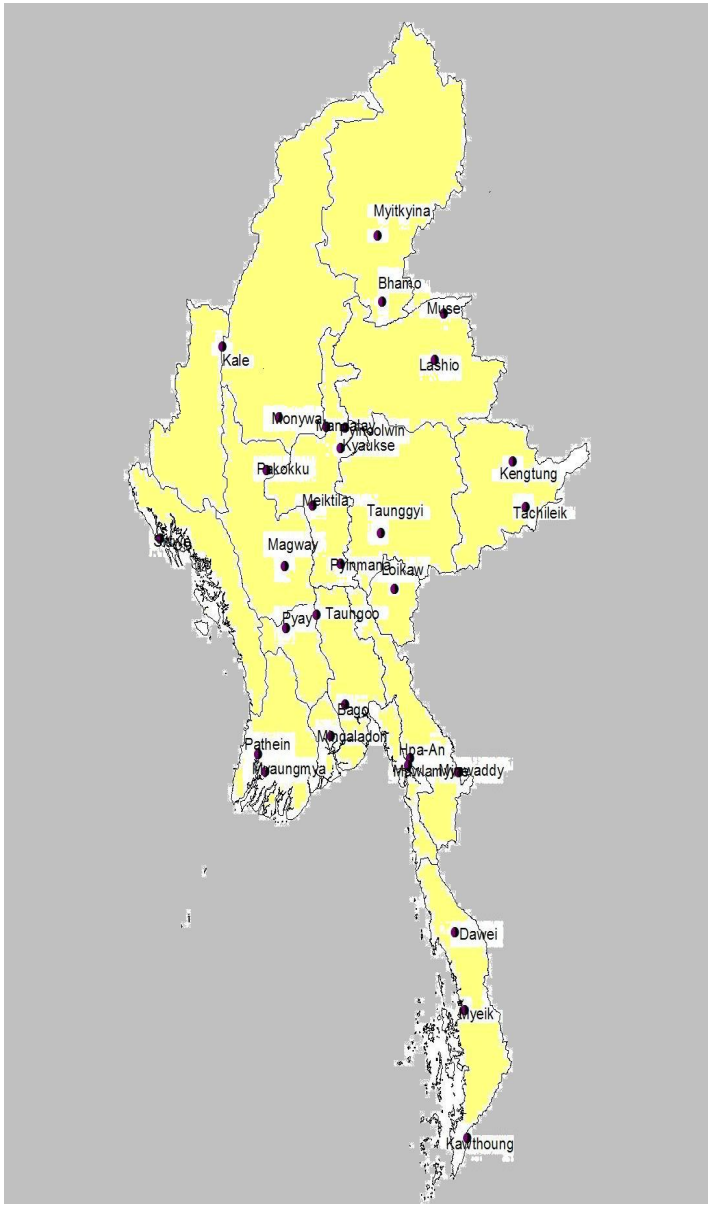
Adult ART sites (Public Sector, 2005 – 2010)

2005

1. Specialist Hospital Waibagi (Ygn)
2. Mandalay General Hospital (NAP+TB/HIV)
3. Tachileik hospital
4. Myawaddy hospital
5. Kawthaung hospital
6. Daewai General hospital

2006

7. Lashio General hospital
8. Taungyi Sao San Tun General hospital
9. Myitkyina General hospital
10. Monywa General hospital
11. Magway General hospital
12. Mawlamyaing General hospital
13. Pyay General hospital



2007

14. Mingladon Specialist Hospital
15. Pha-an General hospital
16. Sittwe General hospital
17. Pathein
18. Pyin Oo Lwin General hospital
19. Meikhtila General hospital
20. Kyauksae General hospital
21. MyeikGeneral hospital
22. Kyaingtong General hospital
23. Pakokku General hospital

2009

24. Myaung Mya hospital

2010

25. Loikaw General hospital
26. Bhamaw General hospital
27. Muse hospital
28. Kalay General hospital
29. Pyinmana General hospital
30. Taungoo General hospital
31. Bago General hospital

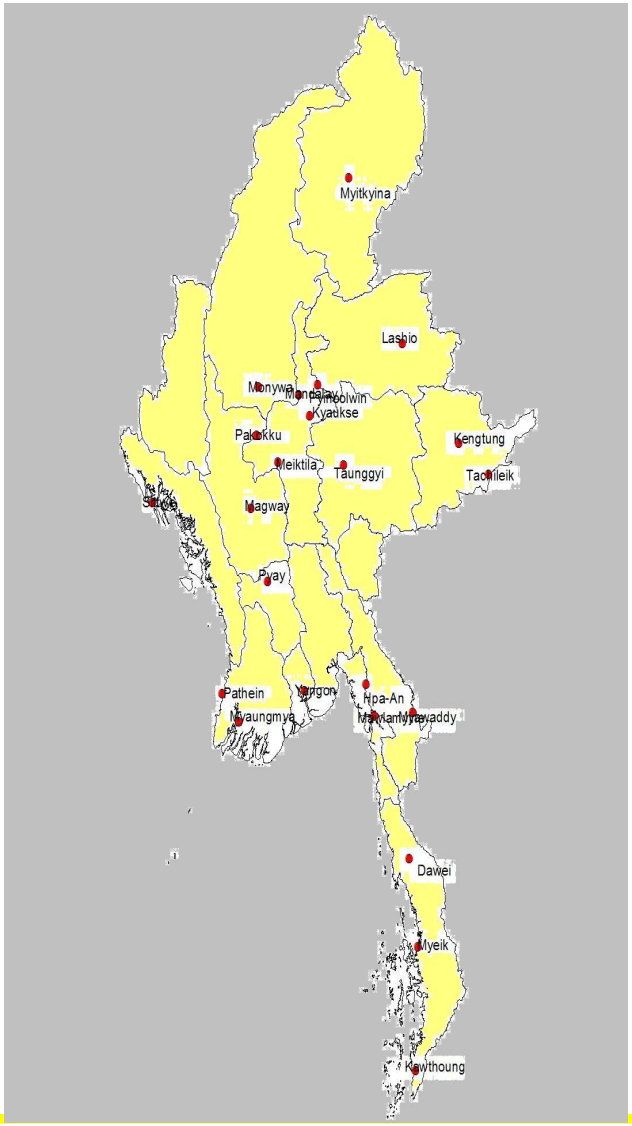
Paediatric ART site (Public Sector)
(2006 – 2010)

2006

1. Specialist Hospital Waibagi (Ygn)
2. North Okkalapa General Hospital
3. Mandalay General Hospital

2007

4. Lashio General Hospital
5. Taungyi Children Hospital
6. Myitkyina General Hospital
7. Monywa General Hospital
8. Magway General Hospital
9. Mawlamyaing General Hospital
10. Pyay General Hospital
11. Tachileik Hospital
12. Pakokku General Hospital



2009

13. Myawaddy Hospital
14. Kawthaung Hospital
15. Myeik General Hospital
16. Pha-an General Hospital
17. Pyin OoLwin General Hospital
18. Meikhtila General Hospital
19. Pathein General Hospital
20. Myaungmya General Hospita
21. Dawei General Hospital
22. Kyaingtong Hospital
23. Sittwe General Hospital
24. KyaukSe General Hospital

2010

25. Kalay Hospital

International /National NGOs providing ANTIRETROVIRAL THERAPY

- 1) MSF (Holland) (Yangon, Lashio, Myitkyina,Phakant , Sittwe)
- 2) MSF (Swiss) (Dawei)
- 3) MDM (Yangon, Myitkyina,Moegaung)
- 4) AFXB (Yangon)
- 5) AMI (Yangon)
- 6) Consortium– (Save The Children , CARE ,MSI, MNA)
  (Mawlamyaing , Bago , Monywa)
- 7)IOM – Mawlamyaing
- 8)Malteser (Mong Lar , Pangkham)
- 9)Alliance (Yangon , Thanphyuzayat)
- 10)PSI (Yangon ,Nyaung Don)
- 11)AHRN (Myitkyina)
- 12) Burnet Institute (Mandalay , Theton)
- 13) Pyigyi Khin (Taungyi , Myingyan)
- 14) Ratanamyitta
- 15)UNION (Mandalay -7,Taungyi ,Lashio ,Pakokku ,Monywa, Meikhtila Myingyan ,Thaketa)

Milestones (PMCT)

- Feasibility assessment in Feb/Mar 2000
- Initiated as Pilot project in Tachileik & Kawthaung in 2001 as community based approach
- Hospital based activity started in (2003)in (5) hospitals
- Expanding yearly and as of (2011) :
- community based in (245) townships
- hospital based in (38) hospitals

ART Scale up plan with GF in 2011- 2012

2011

1. Hinthada (200 bedded)
2. Maubin (200 bedded)
3. Shwe Bo (100 bedded)
4. Thanlyin
5. Nyaung Oo (100 bedded)

2012

1. Loilem (200 bedded)
2. Hakha (100 bedded)
3. Nay Pyi Taw (1000 bedded)
4. *Thaton* (100 bedded)
5. Homalin (100 bedded)

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

1. When to start ART
i. HIV positive asymptomatic ARV naïve individuals – CD4 < 350 cells/mm3
ii. HIV positive symptomatic ARV naïve individuals- WHO clinical stage 2 if CD4 < 350 cells/mm3 OR WHO clinical stage 3 or 4 irrespective of CD4 cell count
iii. HIV positive pregnant women – CD4 < 350 cells/mm3 irrespective of clinical symptoms OR WHO clinical stage 3 or 4 irrespective of CD4 cell count
iv. HIV/TB coinfection ARV naïve individuals – presence of active TB disease if CD4 < 500 cells /mm3 (if MDR-TB, ART indicated regardless of CD4 count)
v. HIV/HBV coinfection – individuals who require treatment for their HBV infection irrespective of CD4 cell count

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

2. What antiretroviral therapy to start
i. HIV positive ARV naïve adults and adolescents – AZT or TDF + 3TC (or FTC-Emtricatabine) + EFV or NVP (d4T not preferred because of side effects, but if it is used initially, should not be for an extended period and should replace d4T with AZT or TDF)
ii. HIV positive pregnant women – same as above. AZT preferred but TDF acceptable. EFV preferred over NVP if CD4 count > 250 cells/mm3 because of risk of NVP toxicity; do not initiate EFV in first trimester. HIV positive women with prior exposure to MTCT - for details see text.
iii. HIV/TB coinfection – AZT or TDF + 3TC (or FTC) + EFV ; ART to be started 2 to 8 weeks after start of TB treatment ; NVP not recommended
iv. HIV/HBV coinfection – NNRTI regimens that contain both TDF + 3TC (or FTC)

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

3. Recommended second-line antiretroviral therapy
i. HIV positive adults and adolescents: a. If d4T or AZT used in first line therapy – TDF + 3TC (or FTC) + ATV/r(Atazanavir,ATZ) orLPV/r b. If TDF used in first line therapy – AZT + 3TC (or FTC) + ATV/r or LPV/r
ii. HIV positive pregnant women – same as for adults and adolescents
iii. HIV/TB coinfection – substitute rifabutin (150 mg 3 times/week) for rifampicin if available; if not available same NRTI backbone plus LPV/r or SQV/r(Saquinavir) with adjusted dose of RTV (LPV/r 400mg/400 mg BD or LPV/r 800 mg/200 mg BD or SQV/r 400 mg/400 mg BD
iv. HIV/HBV coinfection – AZT + TDF + 3 TC (or FTC) + ATV/r or LPV/r
* ABC and ddI can be kept as backup options if AZT or TDF cannot be used

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

4. PMTCT

i. ART for HIV infected pregnant women who need treatment for own health
ART eligibility criteria

a). All women with CD4 < 350 cells/mm3 irrespective of clinical symptoms

b). Clinical stage 3 or 4 regardless of CD4 count

When to start ART - As soon as feasible
Recommended first line regimens-

• AZT (TDF) + 3TC (FTC)+ NVP or EFV (EFV preferred if CD4 > 250 cells/mm3 but not in first trimester)

Prophylaxis for infants born to pregnant women on ART-
• All infants regardless of feeding mode – daily NVP or AZT (BD) for 4-6 weeks

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

4. PMTCT

ii. ARV prophylaxis for pregnant women who do not need treatment for their own health

When to start ARV prophylaxis

- As early as 14 weeks of pregnancy

Prophylaxis regimens for the mother-

Option A :

- AZT during pregnancy plus
- sd-NVP at onset of labour plus
- initiation of AZT + 3TC for 7 days postpartum (omit sd-NVP + 3TC if >4 wk AZT)

Option B: (continued until delivery or if breastfeeding continued until 1 week after breastfeeding has stopped)

- AZT + 3TC+ LPV/r (or ABC or EFV)
- TDF + 3TC (or FTC) + EFV

Prophylaxis regimens for exposed infants

Situation Assessment

Current access to medical interventions and ARV regimes for people living with HIV
1. Who is eligible and how to access ARVs,
2. ARV regimen in the country
3. Who buys and who produces the ARVs

4. PMTCT

Prophylaxis regimens for exposed infants
Option A:
• Breastfeeding infants –NVP from birth until 1 week after all exposure to breastfeeding has ended
• Non-breastfeeding infants – NVP or sd-NVP + AZT for 4 – 6 weeks
Option B:
• All infants regardless of infant feeding mode – NVP or AZT for 4 – 6 weeks

- Currently , UNOPS (PR of GFATM R9) procured all commodities including ART internationally and provided to HIV/AIDS patients by different SRs including NAP.

Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

Policy

- **Myanmar signed** MOU for Joint Action to Reduce HIV Vulnerability Related to Population Movement between following other GMS countries in 2004:

a. The Kingdom of Cambodia(8-11-2004)

b. The People's Republic of China(10-8-2004)

c. The Lao People's Democratic Republic(20-10-2004)

d. The Union of Myanmar(22-11-2004)

e. The Socialist Republic of Viet Nam(30-9-2004)

was signed in 2004.

- Heads of State from the six GMS countries including Myanmar signed a new MOU on Joint Action to reduce HIV vulnerability associated with population movement .(20 Dec 2011, Nay Pyi Taw, Myanmar)

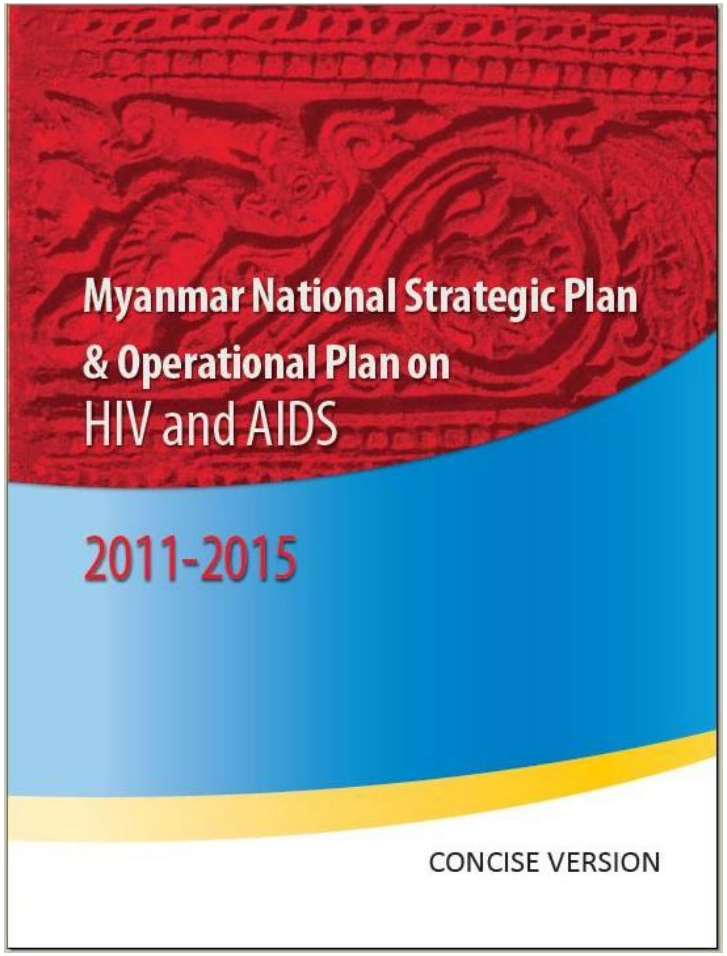
Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

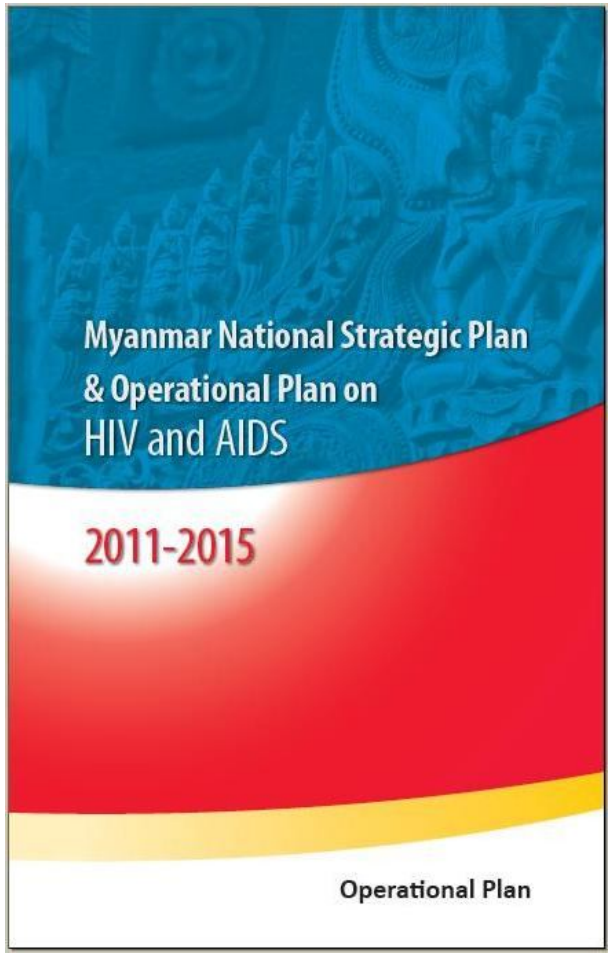
- National Health Policy (1993) in Myanmar include :
- To expand the health service activities not only to rural but also to ***border areas*** so as to meet the overall health need of the countries.
- To strengthen ***collaboration with other countries*** for national health development.
- To promulgate new rules and regulations in accord with the prevailing health and health related conditions as and when necessary .

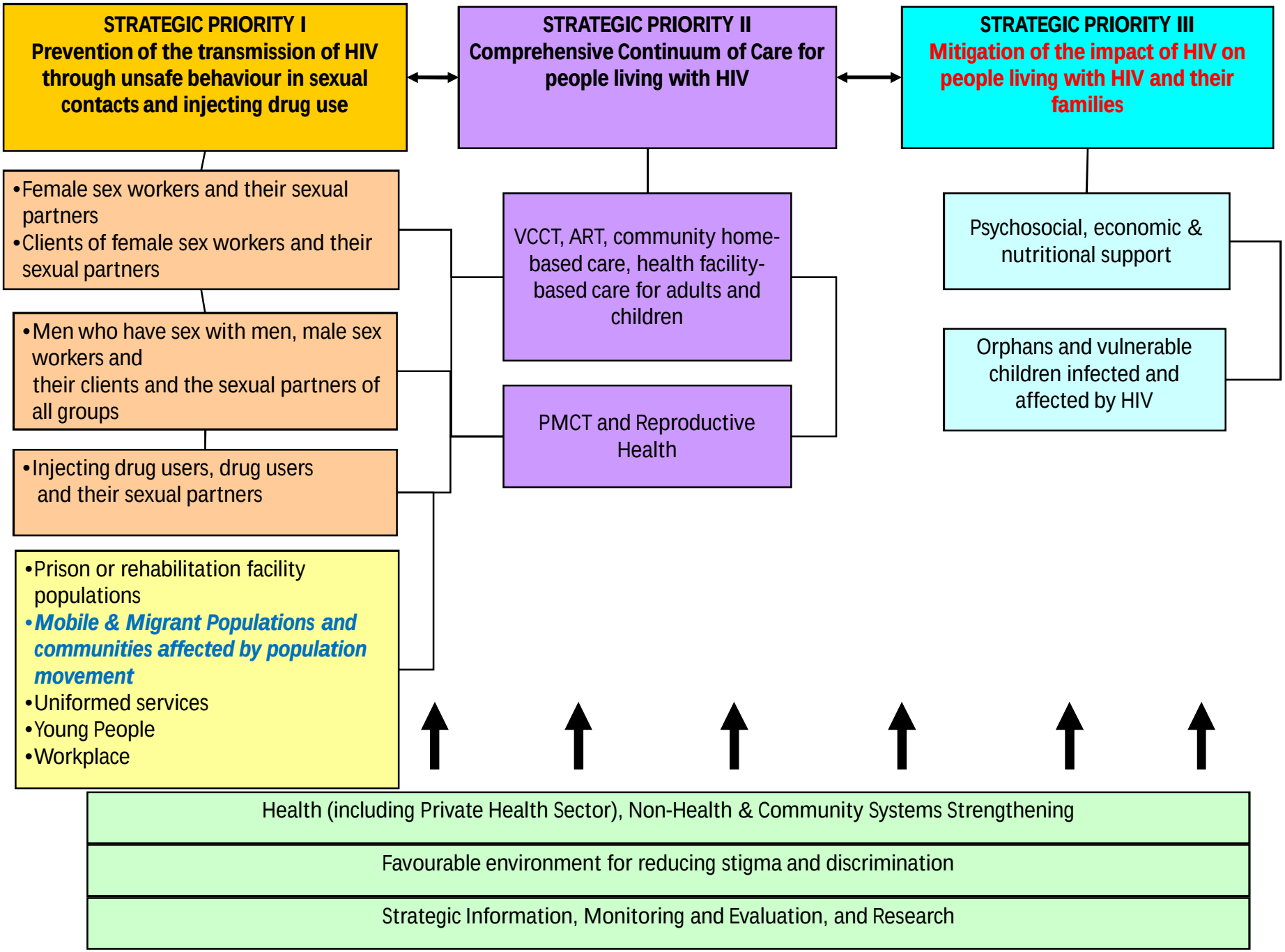
Policies & Regulations on HIV/AIDS and Migrant & Mobile Populations (MMPs) at Cross-Border Areas

- **AIDS is one of the priority diseases included in the National Health Plan of Myanmar**
- HIV/AIDS prevention and care activities have been carrying out as ***a disease of national concern*** since 1989.
- Established in 1989 under the **National Health Committee**, the National AIDS Committee served as an active multi-sectoral body for formulation of National Strategic Plan to prevent and control HIV and AIDS in Myanmar.
- **National Strategic Plan on HIV/AIDS (2006-2010) was developed and currently that of 2011-2015 has been in place for all partners.**

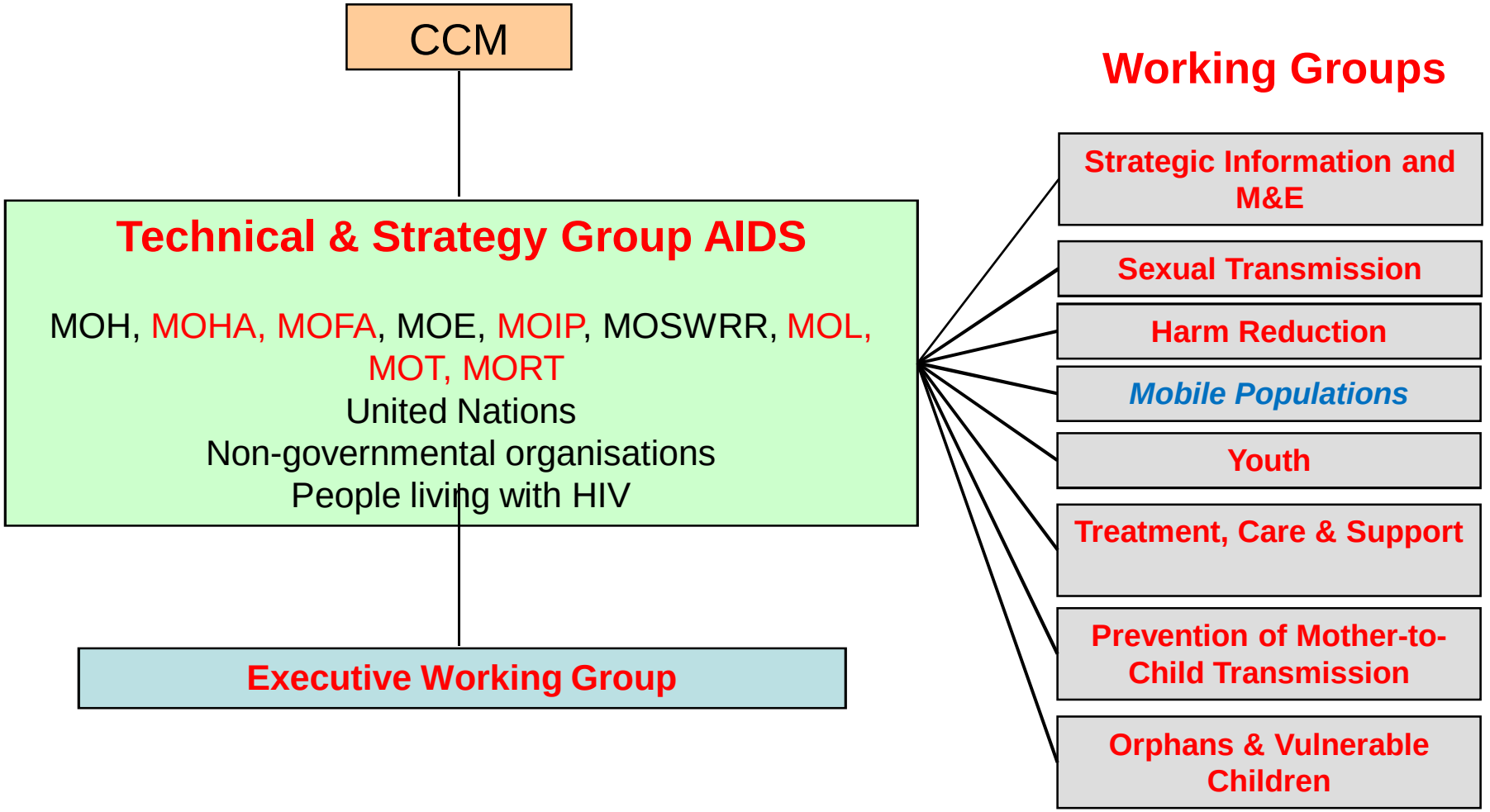
National Strategic Plan II and Operational Plan 2011-2015






STRATEGIC PRIORITY I
Prevention of the transmission of HIV through unsafe behaviour in sexual contacts and injecting drug use
STRATEGIC PRIORITY II
Comprehensive Continuum of Care for people living with HIV
STRATEGIC PRIORITY III
Mitigation of the impact of HIV on people living with HIV and their families
•Female sex workers and their sexual partners
•Clients of female sex workers and their sexual partners
•Men who have sex with men, male sex workers and their clients and the sexual partners of all groups
•Injecting drug users, drug users and their sexual partners
•Prison or rehabilitation facility populations
•Mobile & Migrant Populations and communities affected by population movement
•Uniformed services
•Young People
•Workplace
VCCT, ART, community home-based care, health facility-based care for adults and children
PMCT and Reproductive Health
Psychosocial, economic & nutritional support
Orphans and vulnerable children infected and affected by HIV
Health (including Private Health Sector), Non-Health & Community Systems Strengthening
Favourable environment for reducing stigma and discrimination
Strategic Information, Monitoring and Evaluation, and Research

Current Coordination Structure among partners



Proposed Joint Actions
for effective health services support system for MMPs

Short-term Priority Actions (2011-2012)

Outcome	Strategies	Actions/Activities
1.*Authorities, decision-makers and all other related stakeholders at national and township levels become more aware about MOU and JAP so as to address more activities for MMPs.*	*Mobility thematic groups comprised of representatives from different related Govt ministries, UN,NGOs/CBOs are formed or revitalize existing coordinating bodies at national, regional and townships level.* *Prepare advocacy tools.*	*Advocacy done .*
2. Stronger partnerships established between HIV and anti-trafficking programmes (including law enforcement, general administration), and HIV prevention modules included in anti-trafficking programmes.	*Prepare advocacy tools.*	*Advocacy done .*

Proposed Joint Actions
for effective health services support system for MMPs

Short-term Priority Actions (2011-2012)

Outcome	Strategies	Actions/Activities
3.More resource made available.	*Find both internal and external funding sources.* *Prepare evidence based advocacy tools.*	*Advocacy done .*

Proposed Joint Actions
for effective health services support system for MMPs

Medium-term Priority Actions (2011-2015)

Outcome	Strategies	Actions/Activities
1.More mobile/migrant populations know their HIV status and gain access to health services including treatment.	*Continuum from prevention to care, support and treatment programmes established at major hot spots/ mobility hubs with effective referral systems and networks.*	*Established migrant-friendly clinics or DICs .* *Provide VCCT and ARV,OI and STI drugs.*
2.Behaviour change increases as education becomes more effective. *Communities vulnerable to HIV because of their association with mobile/migrant populations become more resilient and able to make the most of mobility-related opportunities for development.*	*More community-based prevention and care/treatment/support programmes are implemented in identified mobility-affected communities in a coordinated and participatory fashion using migrant-friendly methods linked to and supporting existing services.*	*Conduct community-based awareness campaigns.*

Proposed Joint Actions
for effective health services support system for MMPs

Medium-term Priority Actions (2011-2015)

Outcome	Strategies	Actions/Activities
3.Evidence based advocacy tools and programming developed.	*Develop research protocols related to attitude towards mobile/migrant population in general and their associated risks and vulnerabilities to HIV along the migration routes led by National AIDS Programme in collaboration with other related partners.*	*Conduct research followed by dissemination.*
4.Bilateral collaboration among neighbouring countries increased to facilitate referrals, transport, safe return, continuity of care for mobile/migrant persons	*Expanded authority and mechanisms for actors on both sides of a border to meet and develop programme collaboratively.*	*Conduct regular cross border meetings.*

Proposed Joint Actions
for effective health services support system for MMPs

Medium-term Priority Actions (2011-2015)

Outcome	Strategies	Actions/Activities
5.Improved analysis of migration patterns using common tools to facilitate regional sharing (common database, mapping at state level, collection instruments, early warning systems etc.) leads to improved programmes.	*Establish database system on migrants.*	*Capacity building for HRs and provide facilities.*
6.Large companies and industries and workplace employing mobile/migrant populations implement more prevention and care/treatment/ support programmes.	*Develop or reinforce supportive instructions for employees.*	*Advocacy done .*

Thank you!