MYANMAR

MEDIUM TERM PLAN REVIEW

1993

.A

Joint Review of

Myanmar's Medium Term Plan

for

the Prevention and Control of AIDS

carried out by

The Department of Health, Ministry of Health

in collaboration with

the World Health Organization,

the United Nations Development Programme,

the United Nations Children's Fund,

and the United Nations International Drug Control Programme

4 - 17 October 1993

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List of Abbreviations

AIDS	=	Acquired immune deficiency syndrome
ANC	=	Antenatal care
APCP	=	AIDS Prevention and Control Programme
CCDAC	=	Central Committee for Drug Abuse Control
CHEB	=	Central Health Education Bureau
CSW	=	Commercial sex worker
DDTRU	=	Drug Dependency Treatment and Research Centre
DOH	=	Department of Health
ELISA	=	Enzyme-linked immunosorbant assay
GP	=	General practitioner
HIV	=	Human immunodeficiency virus
IDU	=	Injecting drug user'
IEC	=	Information Education & Communication
MCH	=	Maternal and child health
MMA	=	Myanmar Medical Association
MMCWA	=	Myanmar Maternal and Child Welfare Association
MRCS	=	Myanmar Red Cross Society
MTP	=	Medium Term Plan
NAC	=	National AIDS Committee
NAPCP	=	National AIDS Prevention and Control Programme
NGO	=	Non-governmental organization
PSI	=	Population Services International
STD	=	Sexually transmitted diseases
TMO	=	Township medical officer
TPHA	=	Treponema pallidum haemagglutination assay
UNDCP	=	United Nations International Drug Control Programme
UNDP	=	United Nations Development Programme
UNICEF	=	United Nations Children's Fund
VDRL	=	Venereal Disease Research Laboratory - a serological test for syphilis
WHO	=	World Health Organization

EXECUTIVE SUMMARY

AIDS is emerging as a major public health problem in Myanmar. Although only 85 cases of AIDS have been reported as of 30 June 1993, more than 100,000 people are estimated to be infected with HIV.

The Government of Myanmar launched a National AIDS Prevention and Control Programme in the late 1980s, and a three-year Medium Term Plan (MTP) for AIDS Prevention and Control has been implemented since 1991.

In 1989, a National AIDS Committee was established to formulate policy and coordinate AIDS prevention and control activities in the country. At present, this Committee is chaired by the Minister of Health, and comprises representatives from various Ministries as well as NGOs.

The MTP implementation in Myanmar has led to major achievements in creating public awareness on AIDS and HIV infection, the establishment of a sentinel surveillance system, condom promotion, counselling services, screening of blood donations, as well as many other activities which are characterized by multidisciplinary collaboration and decentralization of the programme.

In October 1992, the Government of Myanmar, in collaboration with WHO, UNDP, UNDCP and UNICEF, organized a review team to assess the adequacy and relevance of AIDS prevention and control efforts in the country. A number of recommendations for the improvement of programme were made. Since the MTP will terminate at the end of 1993, an additional external reveiw of the current MTP was conducted by national and international professionals during the period from 4-17 October 1993.

The objectives of the review were to assess the progress of the AIDS prevention and control programme, and to assist in the formulation of a new Medium Term Plan for AIDS Prevention and Control for 1994-1996. In the process of reviewing the programme, it was determined that many of the 1992 recommendations are still in the early stages of implementation. The levels of achievement of the previous recommendations are reported on in detail in the body of this report. The main aspects of the 1992 review recommendations have been incorporated into the current review.

The Review Team has concentrated its deliberations and made recommendations in 4 main areas:

(1) Prevention strategies and interventions;

(2) Reduction of personal and social impact of HIV infection;

(3) Reduction of the economic impact of HIV infection; and

(4) Programme Management.

Priority recommendations of the review team are:

1. All participating parties in the National AIDS Prevention and Control Programme should recognize the Programme, as defined in its policy

documents such as the Medium Term Plan, as the framework within which all support for HIV/AIDS prevention and control activities and strengthening national capabilities will be provided. The on-going development of such national policies will be undertaken under the auspices of the National AIDS Committee.

2. Plans of Action for HIV/AIDS prevention and control and should be developed by all ministries and departments, as well as for each State, Division and Township area to ensure comprehensive programme coverage up to the community level.

3. Within all Government Ministries and Departments, one "focal point" should be identified and charged with the planning, budgeting and implementation of AIDS prevention and control programme activities.

4. At Central Level, the official creation of posts within the AIDS Control Programme should be accorded a top priority by the Government. At State and Divisional Levels, a Team for HIV/AIDS should be established within the Department of Health's structure.

5. Develop an HIV/AIDS curriculum for schools which is supported by a Teacher's Training College curriculum to assist teachers to talk about Sexually Transmitted Diseases, AIDS and drug abuse issues.

6. Programmes for out-of-school youth should be developed by Non-Governmental Organizations and community action groups and should utilize linkages with economic sectors such as tourism, fisheries, transportation, and agriculture.

7. Members of the Censor Board from the Ministry of Information should be included in the Information and Education Subcommittee of the National AIDS Committee to facilitate a more rapid approval process for educational, mass media information and materials.

8. The development and implementation of targeted interventions should be based upon on-going operational research projects among targeted groups.

9. International Non-Governmental Organizations should be encouraged to utilize their experiences in other countries to assist in the development of HIV/AIDS programmes targeting specific risk groups in Myanmar.

10. The private industrial sector should be encouraged to develop a project for the local production and marketing of condoms to meet the country's current and future demand, as well as the potential for export to other markets.

11. Sufficient attention should be given by high level policy makers to the upgrading of STD services in order to effectively deal with the HIV/AIDS problem.

12. Additional effort to integrate HIV/AIDS and drug abuse prevention into widespread networks of the Social Welfare Department should be undertaken to take advantage of the resources and to access difficult to reach groups.

13. Provide clearer guidelines to all personnel involved in sentinel surveillance.

14. Arrangements should be made to provide appropriate and adequate community and home-based care and support for AIDS patients as well as their families.

15. Adequate supplies of drugs should be provided to treat STD, tuberculosis and common opportunistic infections. Possibilities for community cost-sharing in the treatment of AIDS cases should be explored.

16. Employers in all sectors should be encouraged to establish effective HIV/AIDS prevention programmes in the workplace.

17. Plans for prevention activities in border areas should be developed in collaboration with neighboring countries as appropriate, especially in new road development areas.

18. Increase efforts to encourage and support Non-Government Organizations and private sector participation in order to facilitate programme implementation.

I. PREVENTION STRATEGIES AND INTERVENTIONS

A. PREVENTION OF SEXUAL TRANSMISSION

1. Promotion of Safer Sexual Behaviour

1.1 Information, Education and Communication

Since the review of 1992, there has been a considerable increase in the number of education activities in order to raise awareness about AIDS and its sexual transmission. From Yangon to the smallest of villages, billboards, posters, and stickers warn people of its threat. Even in the absence of financial and technical assistance, many local level health officials have been implementing education activities and raising funds to support materials production on their own. IEC materials on AIDS were produced by various sectors, usually with technical advice from CHEB.

Health Education and Mass Media

Achievements

1. Billboards are being widely used to warn people about the presence of HIV and the dangers of AIDS.

2. Village "movie nights" (where the majority of the village congregates in a public square to view a film) are reaching thousands by showing AIDS education films.

3. Education materials and films have been distributed to township level divisions of Department for Information and Public Relations (Ministry of Information).

4. Newspapers have published articles written by authoritative writers on the spread of AIDS, and global, regional and national measures taken against it. Newspapers have published slogans, mottos, and cartoons occasionally to educate the masses. Also, the newspapers have given priority to publishing news reports on all kinds of activities, educative or preventive.

5. TV/Radio and print media time and space has been made available to the Programme for dissemination of HIV/AIDS prevention and control messages by the Ministry of Information.

Constraints

1. Production of media materials and messages can be an overly lengthy process due to various clearance procedures.

2. Mass media programming has been planned without developing a comprehensive, national communications plan and materials are being developed and implemented without being based upon a clear understanding of the targeted population's needs, interests, viewing times, etc.

3. There is limited knowledge about the coverage and characteristics of TV/Radio viewers and listeners in Myanmar, making it difficult to target the development and distribution of mass media messages and information.

4. The traditional cultural and religious values and beliefs of the people of Myanmar hinders the open and frank discussion of human sexuality and condom promotion.

5. The current focus on fearful messages is based upon a common misperception that people are easily frightened into changing their sexual behaviour.

6. There is an acute shortage of manpower in CHEB both at the central and divisional level, yet CHEB is responsible for the development of most educational materials. There are no full-time appointed CHEB staff in the APCP.

Recommendations

1. Include members of the censor board from the Ministry of Information in the IEC subcommittee of the NAC to facilitate a more rapid approval process for educational, mass media information and materials.

2. A strategic national communications plan should be based upon sound methodological research. Carefully designed market research should provide necessary information about target group preferences and viewing times/behaviors. A major objective of this national plan would be to improve the general social environment for discussing HIV/AIDS related issues.

3. Organize seminars/trainings for prominent social leaders (religious leaders, educators, community leaders) to increase their understanding of HIV/AIDS.

4. When developing educational campaigns and/or messages, their content should focus on the use of indirect approaches (e.g. promoting attitudinal changes in men, using representational or symbolic imagery instead of verbal explicitness) as opposed to explicit messages.

5. Reduce the amount of fear-based messages and focus media time and space for the promotion of positive, voluntary behaviour changes and the creation of a social environment conducive to the support of people affected by HIV/AIDS.

6. The APCP should be assigned at least two full-time health educators from CHEB to work solely on HIV/AIDS education programmes and materials development. These health education officers should also explore ways of including traditional folk media into the AIDS prevention programme.

7. Health educators of the APCP should develop a national materials development plan which would outline the extent and nature of its technical assistance to State/Division health educators.

8. State/Division CHEB offices should be provided more financial support in order to increase the development of educational materials at the local level.

Education, School-based and Out-of-School

Achievements

6. Under the leadership of some active TMO's, health education talks have been conducted in many Middle and High schools throughout the country.

7. There is a general acceptance of the need to develop AIDS education into the school curricula and there are current plans to develop specific AIDS education curricula for high schools and possibly middle schools.

8. HIV/AIDS is being integrated into the basic education curriculum of undergraduate and graduate medical and paramedical personnel through the Department of Health Manpower.

Constraints

7. Reluctance and shyness, even resistance of teachers to teach about human sexuality issues could slow the educational process.

8. Teachers have not yet been trained to teach about HIV/AIDS.

9. Out-of-School youth are difficult to access.

10. The majority of students drop-out of school after primary education in order to support their families. It would be beneficial to reach these youths before they leave the educational system.

Recommendations

9. Develop a HIV/AIDS curriculum for Teacher's Training Colleges which will provide in-service training to teachers on how to talk about STD/AIDS and drug use/abuse issues.

10. Develop and implement an AIDS/HIV in-service training programme for a select group of division/state level teacher trainers, using a "training of trainers" model. With support, they can then train others in their divisions/states by district/township.

11. Through NGO's such as the Red Cross, and community action groups (Youth, Sports, Women's, etc.), the APCP should sponsor the creation of more attractive programme incentives to recruit out-of-school youths where they can then be reached by HIV/AIDS programmes. Also, the APCP should also develop regular linkages with economic sectors such as tourism, fisheries, transportation, and agriculture in order to develop educational programmes targeted to out-of-school youth working in these sectors.

12. Consider development of primary school curricula where aspects of HIV/AIDS would be integrated, in order to reach students before they leave the educational system.

Specific Target Group Education

Achievements

9. In some areas, public STD clinic medical officers are trying to provide STD services and follow-up care directly in brothels. Since prostitution is illegal, this is a major advance.

10. In the central STD clinic, a separate service for CSWs has been created. The section provides STD services, counselling and follow-up for CSWs. About 200 CSWs are currently attending the clinic.

11. The CSW section has also established a peer counselling group with 21 volunteer peer counsellors who have been trained. As the programme has only been running for a month, it is not possible to assess its impact.

12. There is anecdotal information to suggest that there has been a reduction in the sharing of needles for drug injection and that users may be switching to other methods such as sniffing, smoking, and/or non-sharing behaviours.

Constraints

11. The high mobility of CSW's and fishermen makes on-going educational efforts (e.g. peer education) among these targeted groups difficult.

12. Lack of recognizable organization representing homosexual men and the non-recognition of male-male sex in all-male environments makes efforts to educate these men about the sexual transmission of HIV difficult.

13. There is a limited amount and quality of behavioural information on targeted groups.

14. There is a limited availability of targeted training and educational materials for use in the peer education programme for CSWs.

Recommendations

13. Consider changing the legal restrictions enough to enable NGO groups to conduct outreach efforts for sex workers.

14. Develop an on-going working group consisting of government and NGO representatives of special target groups (e.g. CSW's, IDU's, fishermen, etc.) with law enforcement officials to find ways of compromise in order to access these target groups.

15. Increase intersectoral cooperation between CHEB and industries (private and government) related to fishing/mining and other sectors, in order to develop and implement targeted interventions including peer education to fishermen and other industries where men (and women) leave home for extended periods of time.

16. Include specific mention of male-male sexual behaviour (namely unprotected anal intercourse with multiple partners) and its role in HIV transmission in all education programmes where targeted men are the audience.

17. Base the development and implementation of targeted interventions upon on-going operational research projects among targeted groups.

18. The APCP should encourage an increase in the amount of targeted education programmes (including materials development) to such groups as CSW's, IDU's, fishermen, and transportation personnel.

19. Encourage international NGO's to develop HIV/AIDS programmes targeting specific risk groups in Myanmar based upon their experiences in other countries.

Other Information, Education and Communication Programmes

Acheivements

13. In eleven townships of seven states and divisions, Community-Based Health Education programmes have been launched by CHEB. For example, in Monywa township, the CBHE programme recruited voluntary community members to teach villagers about HIV/AIDS.

Constraints

15. There was a lack of educational materials and technical support to integrate with the APCP.

Recommendation

20. In areas where The Community Based Health Education Programme operates, the APCP should better utilize this program's village networks for integrating HIV/AIDS education.

1.2 **Condom Procurement, Promotion and Distribution including Condom Social Marketing and Condom Quality Assurance**

Achievements

14. Condoms, though limited in supply, have found their way from Yangon to the village level via distribution by local health authorities.

15. There is a new willingness based upon a recognized need, to discuss the use and promotion of condoms.

16. Some health authorities have distributed condoms to local merchants so they may turn around and sell them for a small profit (e.g. 1-2 kyats).

Constraints

16. There is a very limited supply of condoms nation-wide which doesn't match need. Condoms are not available at all in the open market in rural areas.

17. Distribution schemes within the DOH structure are not regular or on-going, but based instead upon calling for reorders when the old supply runs out.

18. There is a general lack of understanding about condoms and, in fact, many people at the village/rural have never seen or used one.

Recommendations

21. Conduct a national condom promotion programme assessment by inviting one of the large social marketing firms (e.g. PSI, Somark, Porter-Novelli) to do the assessment and develop a national plan of action. This national plan of action would include such strategies as target group research, consumer demand increases, distribution schemes, monitoring condom use, etc.

22. The APCP should mobilize the industry sector to develop a joint-venture project to build a condom manufacturing business in order to meet current and future condom needs, perhaps even expanding into the export market.

23. In the short-run with limited supplies, develop proper inventory and divisional level distribution schemes as well as guidelines for priority distribution.

24. Condoms should be promoted by all relevant government sectors, NGO's and the private sector.

25. The APCP should develop guidelines to assure the quality of condoms produced and/or distributed in Myanmar.

26. The APCP should advocate for an exemption of import duties on condoms as per the WHO essential drugs list.

27. The APCP should develop a pilot project supporting the development of community-based women's cooperatives which would define the types of programmes and/or activities which can empower women to make their partners use condoms.

2. Diagnosis and Early Treatment of Sexually Transmitted Diseases

STD prevention and control is implemented through the STD and Skin Diseases Control Programme of the Communicable Disease Control Division within the Department of Health. STD services are provided through 35 mobile STD teams in Yangon, Mandalay and 23 other Townships throughout the country. There are altogether 372 personnel within the Programme including 2 venereologists (1 in Yangon and 1 in Mandalay).

The roles of the STD Control Programme related to HIV/AIDS prevention and control are: Medical care of STDs; Sentinel surveillance amongst sexual risk groups; Counselling of HIV-positive persons; STD and Counselling training of health care personnel and medical and para-medical students; and the epidemiological control of STD patients (i.e. partner notification).

Health care professionals of the STD programme have all received training on HIV/AIDS and HIV/AIDS information is being integrated into general STD treatment counselling sessions. However, due to a number of programmatic and social variables, attendance at public hospital STD clinics is low while the majority of patients seek diagnosis and treatment services from private, general practitioners or use self-treatment.

Achievements:

1. STD clinics have been integrating HIV/AIDS education into their routine STD counselling sessions.

2. STD health care workers have been trained in basic HIV/AIDS counselling and education. The training is also provided for social workers assigned to large hospitals.

3. Treatment guidelines for STDs, manuals for basic health staff, training modules and pamphlets have been developed by the STD Control Programme.

4. STD sero-surveys are currently being conducted amongst various groups (factory workers, high school students, rural villagers, etc.) in the Yangon area.

5. Condoms are regularly being distributed to STD patients attending government services.

Constraints:

1. Most STD patients (up to 90%) go to GPs for treatment, though most GPs do not have access to diagnostic facilities.

2. The educational and training materials developed by the STD team have not been pre-tested for their readability and understanding by target audiences.

3. The STD programme is constrained by the lack of laboratory supplies and equipment for full diagnosis of various STDs.

4. STD teams are often given very low priority at all levels. They suffer from lack of facilities such as space, manpower and drugs. They often do not

have access to appropriate rooms with privacy and conducive environments for medical examination and counselling.

5. Due to insufficient supply, condoms are distributed very sparingly to each patient.

Recommendations:

1. The status of the STD programme should be raised. High level policy makers should be sensitized to the close linkages between STDs and HIV/AIDS as well as the need to upgrade the priority given to STD services in order to effectively deal with the HIV/AIDS problem.

2. There should be closer collaboration with CHEB in design and testing of educational and training materials.

3. The STD Control Programme should be provided with adequate laboratory equipment and supplies to equip all reference centers to be capable of diagnosing major STDs, i.e. dark-field examination, TPHA, gonococcal culture and antibody sensitivity tests.

4. The STD Control Programme should develop a mechanism for accurately projecting the national needs of drugs for STD treatment, and sufficient quantities of these drugs should be provided to meet the national needs.

5. The manpower of the STD Control Programme should be strengthened. There is a need for the posting of venereologists at State/Divisional level to supervise Township medical officers on STD treatment, prevention and control.

6. Clinical STD treatment guidelines and flowcharts on diagnostic criteria should be developed and distributed to all Township Medical Officers and all Basic health workers.

7. Clinical guidelines and flowcharts on the diagnosis and management of STDs (syndromic approach) should also be provided to General Practitioners. STD diagnosis and management training programmes should also be organized for GPs in collaboration with groups such as MMA.

B. PREVENTION OF TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS.

1. Interventions to Reduce HIV in IDUs

1.1 Safer Injection Practices; Peer Education and Counselling

Achievements

1. The problems of IDUs are confined to some states and divisions only. Though information materials are needed for proper sterilization of needles and syringes, IDUs indirectly received the message to change the behaviour of needles sharing.

2. Some anecdotal reports point out the switching back of drug addicts from injecting heroin to smoking practices

3. Peer education programme is carried out in DDTRU of Yangon by the old patient to new ones. Counseling, both pre-test and post-test is being done by the trained counsellors.

Constraints

1. As a result of current legal restrictions on the availability of needles and syringes and on drug abuse, it is not possible to envisage interventions for IDUs targeted at needle exchange or the cleaning and sterilization of injecting equipments.

2. Counseling for IDUs is done only at drug treatment centers. Trained social workers are needed to carry out the HIV/AIDS counseling for drug users in institutions as well as in the community.

Recommendations

1. Provide more trained social workers, nurses, psychologists for counselling in the drug treatment centers.

2. A review should be undertaken of laws and/or practices to determine their impact on the effectiveness of programmes targetted at high risk groups such as injecting drug users and commercial sex workers.

3. Provide more trained social workers for follow up of the patients in the community.

1.2 Drug Use Prevention Programmes Including HIV/AIDS Education and Access to Non-registered Drug Users

Achievements

4. The CCDAC has integrated HIV/AIDS prevention into the on-going drug abuse rehabilitation programme operating under its supervision.

5. The Department of Social Welfare is co-operating closely with the APCP in relation to IDU and CSW, and has the a significant potential to further expand this collaboration through all its network.

6. Mass media like radio spots, radio plays, TV spots, TV plays and TV documentory are produced.

7. Narcotic education, exhibition, multisectoral narcotic shows, Health Education talks to the general public, students, Red Cross youth and focus group discussion are conducted for drug abuse prevention and HIV prevention. Accessibilty to non-registered drug users has started to develop through peer educators trained by DDTRU.

Constraints

3. NGOs participation for prevention of drug abuse and HIV/AIDS together is still insufficient and needs technical support, IEC materials and funding.

Recommendations

4. Additional effort to integrate HIV/AIDS and drug abuse prevention into widespread networks of the Social Welfare Department should be undertaken to take advantage of the resources and to access difficult to reach groups.

5. The NGOs should be given technical expertise and aid to develop expanded programmes for HIV/AIDS to reach the unregistered drug users.

6. A proposal for the experimental trial of a very well controlled and limited study on the efficiency and usefulness of an intervention targetted at IDUs on needles exhange or the sterilization of injection equipments should be prepared in consultation with an NGO, APCP, UNDCP, WHO and other related players and submitted for discussion and possible approval by CCDAC.

1.3 Treatment Facilities to Decrease Drug Use

There are 53,000 registered drug users in Myanmar in 1993. 30% of them are IDUs. The estimated unregistered drug users are four times this registered number.

Achievements

8. At present about ten drug treatment centers are offering treatment for drug users who voluntarily register at these centers. In addition to that, all government hospitals are providing treatment when drug users registered th-emselves at these places.

9. At the treatment center, services offered include detoxification, group psychotherapy, symptomatic treatment, health education and counselling on HIV/AIDS. Following treatment, the patients are transferred to the rehabilitation centers for vocational trainings such as live stock breeding and farming, over a six month period.

10. Some NGOs have started their own initiative to provide preventive and rehabilitative programmes.

Constraints

4. The current rate of relapse for rehabilitated drug users is very high (85%). There is also a shortage of easily accessible drug treatment centres and programmes.

Recommendations

7. NGOs, religious leaders and peers should assist in the treatment and rehabilitation of drug users.

8. The number of drug treatment centres or institutions dealing with the rehabilitation of drug users should be increased to ensure availability and accessability of treatment throughout all States/Divisions in the country.

2. Promotion of Action to Reduce the Need for Transfusions

Achievements

1. Physicians in hospitals are conscious of the need to minimize the use of blood and blood products.

2. The training curriculum for medical officers on management of HIV/AIDS and for training of trainer courses puts emphasis on reducing the use of blood and blood products. All the trainees attending these courses are thoroughly informed about the results of HIV antibody testing during the window period.

3. The information booklets for medical officers on HIV/AIDS have been developed. These booklets mention the preventive value of reducing the demand for blood transfusion.

Constraints

1. The training programme can not be undertaken simultaneously within a short period of time for medical officers in all States/Divisions because of the shortage of manpower in the AIDS Prevention and Control Programmes. The information booklets are not distributed to the newly recruited in-service medical officers and to the General Practitioners due to the limited number of copies printed.

Recommendations

1. Training programmes for medical officers in hospitals should be undertaken as early as possible in all States and Divisions.

2. The information booklets for medical officers on HIV/AIDS should be revised, printed and distributed to all newly appointed medical officers, all General Practitioners all over the country and to all graduates from Medical Institutes yearly.

3. The effectiveness of these trainings courses should be determined by the evaluation programme and the scientific studies concerning reduction in blood use.

3. Promotion of Safe Blood

3.1 Rational and Efficient Use of Blood

Achievements

1. This has been discussed in all training courses for medical officers on HIV/AIDS.

Constraints

1. There is misperception that a safe blood supply can be provided by a family member or relatives who donate blood.

Recommendations

1. The misconceptions surrounding the provision of safe blood should be overcome through donor education.

3.2 Donor Recruitment and Selection

Achievements

2. Donors are recruited primarily on a voluntary basis in all parts of the country. This is done by the family member and relatives of the patients, Red Cross Societies, voluntary and in-service fire brigades, military personnel, some NGOs, religious groups and the regular blood donors.

3. A total of 250,000 units of blood are donated each year. Donor deferral pamphlets are distributed to all blood banks and to some hospitals in many townships. Donors screening by questionaire method is implemented in most of the hospitals.

Constraints

2. Remunerated blood supply still exists in many parts of the country. Peer education programmes can not yet be undertaken for these groups.

Recommendations

2. Health Education on transmission of HIV/AIDS through blood transfusion should be given to general public and should give more emphasis on regular blood donors, NGOs, religious groups, Red Cross society members, persons from fire brigades, military personnel, and even the remunerated donors.

3. The non-renumerated blood donation system should be encouraged in all parts of the country. The roles of NGOs,religious organizations and fire brigades should be raised in order to seek more participation in donor recruitment for safe blood supply. The peer education should be promoted.

3.3 Screening and Testing of Donated Blood

Achievements

4. The percentage of blood units which are tested for HIV/AIDS Government hospitals in Myanmar is approximately 76%, although only 10% of the total hospitals are currently performing HIV tests. The expansion of HIV testing for donated blood aimed at 100% coverage in terms of hospitals as well as numbers of units donated.

5. Moreover, the last National AIDS Committee meeting decided to lay down the policy on safe blood transfusion in private medical centres. The development of instructions is being carried out by the Department of Health.

Constraints

3. Expansion of hospital coverage requires good communications and transport networks.

4. There is a lack of cold chain and storage systems and/or other supportive measures to ensure the quick distribution and reallocation of HIV test kits having a short shelf-life.

5. Unlinked anonymous testing is not carried out in all centres where blood screening is done. If so, confirmatory test will be needed to provide post test counselling and this will lead to a financial constraint on AIDS Prevention and Control Programme.

Recommendations

4. More test kits should be made available to hospitals where the transport, communications and electricity are not a problem.

5. Donor deferral system should be developed systematically in all of the hospitals in the country whether serological test for HIV is available or not.

6. Unlinked anonymous testing should be done in hospitals where counselling services cannot be provided and in hospitals where the sentinel surveillance is done in order to avoid the participation bias in the study.

7. In view of the need for 100% blood supply screening, pooling of serum should be systematically encouraged when appropriate.

8. Promotion of use of blood substitutes may be practised.

9. Rapid testing should be carried out where blood banks are not available and the urgent transfusion of blood is required.

4. Promotion of Sterile Conditions and Universal Precautions

4.1 In Health Care Settings

Achievements

1. Universal precaution and sterilization measures are carried out in many areas under the supervision of efficient medical officers and administrators. In places where electricity is scarce, the health care workers even use their own money for the expense of charcoal and gloves.

2. A one needle, one person policy is being implemented from the divisional to the rural health centre level. Many educated people and urban dwellers are aware of transmission through needles and skin piercing instruments. There is an increasing demand for disposable needles and syringes observed in large cities.

Constraints

1. Scarcity of electricity, insufficient supply of needles and syringes in the health centers and hospitals, and unavailability of syringes and needles with cheaper cost in the market retard the practice of universal precautions in 100% of health care settings.

2. Monitoring of sterilization procedures can not be done frequently by the responsible administrators in all places because of lack of manpower, vehicles, and fuel as well as communication constraints.

Recommendations

1. Mass media campaigns should place emphasis on use of well sterilized needles and syringes or disposable needles/syringes. The responsible administrators should inspect and insist frequently in all health care providing centers to ensure following universal precautions and sterilization methods.

2. The adequacy and coverage of electric power supply should be improved to facilitate sterilization procedures.

3. Because of the constraints on the administrator to go on field visits to monitor universal precautions, they should ensure training of all concerned staff on universal precautions.

4.2 Non-medical and Traditional Skin-piercing Activities

Achievements

3. Health authorities in some areas prohibit tatooing in the public festivals. Ear-piercing for girls to wear ear rings is done in all places but special needles are used for each individual case mostly by the medical officers.

Constraints

3. Accupuncture practised by Chinese traditional healers, exists in many parts of the country. Monitoring for sterilization of needles for that purpose has not been achieved yet.

Recommendations

4. Widespread dissemination of knowledge on using properly sterilized instruments for non-medical use should be done for the general public, covering ear piercing, tatooing and Chinese and Myanmar traditional needle prickings.

5. Promotion of Laboratory services

Achievements

1. Provision of supplies and equipment is satisfactory in Yangon and Mandalay laboratories.

2. In 1993, HIV testing can be done in 35 hospitals apart from those in Yangon and Mandalay. HIV spot test, Serodia HIV-1 and Genelavia (Mix ELISA) are given to these hospitals in various States and Divisions. STD clinics are also provided with diagnostic reagents.

Constraints

1. There is a serious lack of trained technicians and reagents for the laboratories throughout the country in support of HIV/AIDS prevention and control.

2. The lack of regular electricity supplies in many locations hampers effective laboratory diagnosis for programme support purposes.

Recommendations

1. More hospitals need to be supplied with full equipment for HIV spot test and ELISA test.

2. Hospital laboratories should be given reagents to diagnose syphilis with VDRL test.

3. The laboratory technicians need refresher courses on HIV and other STD testing methodologies.

C. PREVENTION OF PERINATAL TRANSMISSION

Basic Health Staff including health assistants, lady health visitors, midwives, nurses and voluntary health workers consisting of auxiliary midwives and volunteers with the MMCWA have received some training about AIDS and HIV infection. They have been, in turn, talking to village women about HIV/AIDS. Antenatal clinic attenders participate in sentinel surveillance activities where data are showing seroprevalence rates as high as 3% in some areas.

At the divisional and district levels, MCH services are conducted under the leadership of the Divisional Health Directors and the Township Medical Officers, respectively. There are 348 MCH centers. If there are no MCH Medical Officers or school health medical officers, Township Medical Officers take care of MCH activities.

Achievements:

1. Basic Health Staff have received some training about HIV/AIDS and are beginning to incorporate this information into their regular perinatal services in clinic and/or during home visits.

2. Testing ofpregnant women is being done for sentinel surveillance at least on a voluntary confidential basis (although the testing should be anonymous).

3. In some cases when available, midwives have distributed condoms to the women.

4. UNICEF is sponsoring a pilot project to strengthen the quality of MCH/family planning services by integrating STD diagnosis and treatment procedures at MCH clinics.

5. Sterilization is available on a voluntary basis to HIV-positive women.

Constraints:

1. Inadequate condom supplies leave women at risk of infection.

2. Health personnel from the MCH center lack sufficient on-going counselling training to work with HIV-positive pregnant women.

3. There are misunderstandings about the appropriate application of anonymous and confidential testing as well as the notion of voluntary participation. Although sentinel surveillance samples for antenatal clinics should be unlinked and anonymous, they have been carried out on a linked but confidential basis.

4. There is no system for voluntary, confidential HIV testing with counselling for those requesting this service. The priority of maintaining an HIV-free blood supply precludes the use of HIV test kits for voluntary requests.

5. Women are not able to insist that their sexual partners use condoms.

Recommendations:

1. Increase the frequency and quality of training to all health care providers about counselling for special issues concerning HIV and pregnancy.

2. Provide clearer guidelines on sentinel surveillance among antenatal clinic attenders to lab technicians and Medical Officers undertaking sentinel surveillance work.

3. Use the TOT (training of trainer) approach to increase counselling training activities for MCH staff and MMCWA volunteers.

4. Encourage NGOs (national & international) partnership in AIDS prevention especially to mobilize community resources, and eventually to assist in home care service delivery.

5. NGOs (especially MMCWAs) could be a focal point for the development of women's support networks which can develop community-oriented methods of condom use compliance.

II. REDUCTION OF PERSONAL AND SOCIAL IMPACT OF HIV INFECTION

The present trend is to confirm clinical diagnosis of AIDS by laboratory tests only; therefore the actual number of AIDS cases might be greater than reported in the townships. Some people with HIV/AIDS are receiving clinical management at the government hospitals and at home but are not reported. In some communities, the family members, health workers and NGOs like MMCWA, MRCS are motivated to give counselling services.

The Social Welfare Department is involved in rehabilitation programmes for ex-drug users, CSWs (adult women training school), operation of orphanages and vocational training programmes to improve social and economic status of young women in the border areas.

Training on basic care and counselling is being carried out for Basic Health Workers and community leaders but not to the desired level.

Achievements

1. There is an on-going programme for training of trainers on HIV/AIDS prevention, control and management including counselling in States and Divisions.

2. Diagnostic guidelines for AIDS have been issued and clinical care is provided at general hospitals for the people with HIV/AIDS. Some people are getting care at their homes. Counselling services are given by STD teams and medical social workers at present. Families, NGOs and religious groups are supporting HIV/AIDS patients at home.

3. Discrimination is not a major problem in most situations in the health care setting and in the communities.

Constraints

1. Although clinical diagnostic criteria have been laid down, physicians are not always confident to diagnose AIDS without HIV tests which are not always readily available.

2. There is a shortage of drugs for effective and adequate treatment of tuberculosis and STD cases.

3. There is need to develop appropriate guidelines for effective home care as well as counselling for HIV-positive people and persons with AIDS and their families in the community.

4. Voluntary testing is not available in the government health centres due to insufficient test kits.

Recommendations

1. More public and private physicians should be trained to diagnose AIDS clinically and to provide effective management including counselling. This should be an on-going programme.

2. Provisions should be made for adequate supply of drugs to treat STD, tuberculosis and common opportunistic infections in AIDS. Possibilities for community cost sharing in the treatment of AIDS cases should be explored.

3. Community support and home care programmes should be intensified by training and utilizing NGO's. This should include training in counselling as well as community care.

4. Reference materials such as training manuals and modules on home care and counselling should be produced and distributed to implementers at all levels, including basic health workers, volunteers and NGOs at the community level.

5. Encouragement should be given to develop educational materials at local levels with technical assistance from the central level.

6. Specific guidelines for referring AIDS cases at various health care levels should be developed.

7. The Deputy Director in charge of the Tuberculosis Control Programme should be a member of the Medical and Social Care Subcommittee of the NAC.

8. Further efforts should be made to minimize discrimination against and stigmatization of certain high risk groups such as CSWs, IDUs and Men who have Sex with Men to encourage education, rehabilitation and voluntary testing.

9. Facilities should be made available for voluntary testing for HIV.

10. Arrangements should be made to provide appropriate and adequate community and home-based care and support for AIDS patients as well as their families when necessary.

11. A clinical management guideline/handbook should be developed and distributed to all hospitals.

III. REDUCTION OF ECONOMIC IMPACT OF HIV INFECTION.

There are two fundamental relationships concerning the economic impact of AIDS. The first relationship is between economic, social and cultural variables and the spread of HIV. The other is between HIV and AIDS and the performance of the economic and social system. The details of these relationships are summarized in Annex 4.

An effective National AIDS Programme must strengthen national capacity to identify and estimate the economic and social impact of AIDS; to act as a catalyst in the mobilisation of financial and human resources, and to establish operational planning to minimize the economic and social costs within a multisectoral framework.

Achievements

1. There have been some small scale studies on the economic consequences of AIDS. These include: (1) one study on truck drivers in Mandalay, (2) a study of Knowledge, Attitude, Behaviour and Practice of CSWs in Yangon, (3) a qualitative study on HIV and AIDS in Thai-Myanmar Border Townships, (4) a Study on Knowledge, Attitude and Practice and HIV amongst doctors in Yangon, and (5) a study HIV infection and IDU in Mandalay.

2. The workplan for 1993 contains activities which are intended to strengthen national capacity for applied policy research in Myanmar. These include a joint study with UNDP and the Institute of Economics on the Shan State Border Area to develop a methodology for more general application in Myanmar, and a proposal for UNDP/Asian Development Bank and Institute of Economics study of the Economic Costs of HIV and AIDS.

3. A National Workshop on the Developmental Consequences of HIV was jointly hosted with UNDP's Regional Project in 1992 and this was followed by a seminar on the Economic and Social Costs of HIV and AIDS in 1993.

4. Some achievements reported include: attempts to access the families of migrant workers; health education being given in factories and shipyard facilities, and in some mining establishments; and workers in some hotels and guest houses being given information on HIV.

5. There is one excellent study by International Fund for Agricultural Development on Agriculture in East Shan State which is a model of what is needed for developing effective policies for prevention of HIV and for developing interventions to reduce the economic and social impact.

Constraints

1. The existing MTP is still excessively health focused and most of the activities at all levels are being managed or undertaken mostly by the health sector. However, there is commitment, which should be increased, on the part of sectors other than Health to the creation of HIV/AIDS programmes and for planning for the economic and social consequences of the epidemic.

2. Lack of a planned and coherent strategy for protecting employees and clients/customers of their businesses from HIV infection.

Recommendations

1. There is a need for comprehensive plans for all concerned ministries in terms of resource allocation and the establishment of institutional structures for effective implementation.

2. Various tranport mode personnel, including airline staff, railway employees, seamen and those engaged in coastal tranport should be targeted for specific research-based interventions.

3. Employers in all sectors should be encouraged to establish effective HIV/AIDS prevention programmes in the workplace.

4. The military should be included as an important sector to target for effective workplace programmes.

5. To ensure sufficient supplies of drugs are available at all the various level of health care establishments for those with HIV related illnesses and AIDS.

6. To encourage greater local mobilisation of resources to support local activities especially in health.

7. Criteria for identifying economic vulnerability of both agrarian and household systems should be developed, and followed by the development of programme to reduce the vulnerability of these groups.

8. Plans for prevention activities in the border areas should be developed in collaboration with neighboring countries as appropriate, especially in new road development areas.

IV. PROGRAMME MANAGEMENT

A. PROGRAMME ORGANIZATION & COORDINATION

The National AIDS Prevention and Control Programme has been actively implementing the Union of Myanmar's HIV/AIDS prevention and control strategies since January 1991. The Programme's central coordination team (the AIDS Prevention and Control Project--APCP) has recently been enlarged (one Project Manager, 4 Medical Officers and 10 secretarial support staff), though all staff are still on secondment from other sections within the Department of Health.

Details of the Organization and Coordination of the Programme are provided as follows:

1. Planning and Implementation

1.1 Involvement of all Levels

The Review Team has noted that a high degree of the activities related to HIV/AIDS prevention and control at the central level have emanated directly from the APCP. At the State, Regional, District and Township levels, it also appears that very little independent State-, District-, or Township-level planning for HIV/AIDS prevention and control activities is occurring to date. Those activities which are being undertaken at local levels seem to be implemented more on an ad hoc basis than as part of a coordinated local, State or National plan for the prevention and control of HIV/AIDS.

1.2 Multi-sectoral Involvement and Committment at all Levels (staff, activities, support, etc.)

The Review has found that the various officers of the Department of Health (the APCP at Central level, State/Divisional, District and Township Health Directors and/or Medical Officers at their respective levels) seem to be serving as the primary (and in many instances only) personnel who are actually considered responsible for initiating or undertaking HIV/AIDS prevention and control activities. As noted above, the actual planning of activities does not seem to extend beyond the Central APCP team's level.

Additionally, it was noted that there is significant support for the Programme from the various United Nations' agencies working on HIV/AIDS prevention and control in Myanmar.

2. Intersectoral Coordination

2.1 NAC, Subcommittees and Township-Level Committees

The National AIDS Committee, chaired by the Minister of Health, has a wide multi-sectoral membership (see Annex 1), and has a total of six technical sub-committees which have been formed and are becoming increasingly active. Multi-sectoral State, Divisional and Township AIDS Committees, chaired by the respective State, Divisional or Township Law and Order Restoration Council Chairmen, have also been formed and are becoming functional in many parts of the country. These Committees do not as yet, however, seem to be providing active directives as to the various strategies to be pursued by the programme at each respective level.

The Subcommittees of the National AIDS Committee could serve a valuable role in ensuring and facilitating the close coordination and collaboration between the various Governmental and Non-Governmental groups and individuals represented in these Subcommittees.

2.2 Government Sector Involvement and Coordination

The Department of Health's Central Team (APCP) seems to be the primary catalyst in the coordination of the NAPCP's activities at both central and peripheral levels, with most of the governmental sector's response being directed and coordinated by this team.

2.3 Non-Governmental Sector Involvement and Coordination (including the Private Sector)

Many non-governmental organizations and private community-based groups have become sensitized to the problems posed by HIV/AIDS, and these groups and organizations are becoming increasingly active in their own ways (often at the local village level) in the implementation of some activities related to the overall HIV/AIDS prevention and control strategies in the country. These activities are often not, however, part of a larger coordinated plan to deal with HIV/AIDS in the locality, but rather the result of local initiative and concern regarding the HIV/AIDS problem. Many of these initiatives have also included local resource mobilization (from private donations or other sources) which has enabled them to undertake these activities.

On a national scale, the extensive national networks and concerns about HIV/AIDS of such organizations as the Myanmar Medical Association (MMA), the Myanmar Maternal and Child Welfare Association (MMCWA), the Myanmar Red Cross Society (MRCS), the Myanmar Council of Churches (MCC) and a number of others are a major potential resource available to the NAPCP. These groups need to be properly integrated into the planning and implementation of HIV/AIDS

prevention and control activities, especially amongst the easily accessable population groups considered at greatest risk (women, youth), as well as the more difficult to reach population groups currently involved in high-risk behaviours (Injecting Drug Users, Commercial Sex Workers, Migrant labourers engaging in multi-partner sex, etc.)

3. Programme Structure and Functions

3.1 Level of Programme Manager's Authority and Delegation

As can be seen by Figures 1 and 2, the current structure of the APCP is not as complete as the proposed structure, which it is hoped will obtain final Government approval in the near future, enabling the APCP to obtain the status of an official section of the Department of Health. The APCP Project Manager has the status of Assistant Director within the Department of Health.

3.2 Linkage with other Health, Social and Education Programmes

The APCP, through the respective Directors-General of various Departments within the Ministries of Health, Education, and Social Welfare, Relief and Resettlement, has initiated a number of collaborative activities with various Departments and officers responsible for programmes and projects of great relevance to the HIV/AIDS prevention and control efforts in the country. There are not as yet, however, specific focal points for HIV/AIDS prevention and control activity planning, programming and implementation within the other relevant Ministries or Departments, thus placing a greater burden of planning and programming upon the APCP.

3.3 Intra-Ministerial Collaboration

Willingness for intra-ministerial collaboration is apparent, though the necessary mechanisms to transform this willingness for collaboration into effective programme planning and implementation are needed.

3.4 Structure and Function of the Programme at the Peripheral Level

Already existing State, Divisional, District, Township and Rural Department of Health structures are at this time functionally responsible for HIV/AIDS prevention and control, though the proposal for specific structures responsible uniquely for HIV/AIDS programming (see Figure 2) are awaiting approval.

Achievements

1. The Department of Social Welfare is cooperating closely with the APCP in relation to IDUs and CSWs, and has a significant potential to further expand this collaboration throughout its networks.

2. The Central Committee for Drug Abuse Control has integrated HIV/AIDS prevention into the on-going drug abuse rehabilitation programmes operating under its supervision.

3. Major NGOs within the country have taken a leading role in integrating HIV/AIDS education programming and condom promotion into their on-going activities with the assistance of the APCP.

4. NAC has become more active over time; the NGO Sub-committee has been approved and is being formed.

5. Inter-sectoral collaboration is continuing primarily through the direct efforts of the APCP.

6. TV, radio and print media time and space have been made available to the Programme for dissemination of HIV/AIDS prevention and control messages by the Ministry of Information. In addition, the wide dissemination of printed material and information through the Ministry's Township libraries and reading rooms has also significantly extended the reach of HIV/AIDS prevention messages throughout the country.

7. Initial support and encouragement to NGO's has been provided and mechanisms for close coordination between the Governmental and Non-Governmental sectors are developing.

Constraints

1. The majority of AIDS prevention and control activities in the country are undertaken through or with prompting from one office (the APCP).

2. The mechanisms for coordination between all NAPCP participating parties (Government of Myanmar, donors, NGOs, etc.) do not appear to function smoothly at all times.

3. Some Departments under the Ministry of Health do not perceive themselves as being as actively involved in on-going HIV/AIDS training programmes and seminars as is possible.

4. Limited technical information on HIV and AIDS is reaching other Departments, and the information provided is usually available only to selected individuals.

5. Most NGOs do not have adequate manpower or financial resources to develop and produce HIV/AIDS materials required for their education and awareness programmes.

6. NGO participation is occurring in a relatively haphazard way; more effective coordination mechanisms are needed.

7. No effective mechanism currently exists for mutual feedback between "theory" as taught by the Department of Health Manpower and daily "practice" of the Department of Health and General Medical Practioners.

Recommendations

1. All participating parties in the National AIDS Prevention and Control Programme should recognize the Programme, as defined in its policy documents such as the Medium Term Plan, as the framework within which all support for HIV/AIDS prevention and control activities and strengthening national capabilities will be provided. The on-going development of such national policies will be undertaken under the auspices of the National AIDS Committee.

2. The APCP should become more responsible for the strategic planning and coordination of HIV/AIDS prevention and control activities in the country, and less responsible for the direct implementation of field-level activities throughout the country.

3. The planning and implementation of NAPCP activities needs to be delegated to and required of other programme levels to ensure comprehensive programme coverage up to the community level. This would include the development of Plans of Action for HIV/AIDS prevention and control by all Ministries and Departments, as well as for each State, Division and Township area.

4. More efforts need to be made to identify and support Non-Governmental and basic community groups and/or organizations with whom the NAPCP staff at all levels could plan and implement HIV/STD/AIDS programme activities in order to expand the reach of the programme and ensure that all target groups are addressed.

5. All the participating agencies active in the HIV/AIDS prevention programme need to ensure that the activities they plan and implement are thoroughly coordinated with the APCP and with each other to ensure effective programme implementation.

6. Closer collaboration between the DOH and the Department of Health Manpower is desirable in order to ensure an effective link between the teaching regarding HIV/AIDS and the field-level practices required and situations encountered. To this end, more use could be made of Department

of Health Manpower's personnel in HIV/AIDS training programmes and seminars so as to improve the linkage between theory and practice on HIV/AIDS.

7. The APCP should initiate the publication and dissemination of a regular newsletter-like report of HIV/AIDS to keep people within and outside the Health Ministry informed of the Programme's activities, as well as regional and global developments and news regarding HIV/AIDS.

8. The Department of Medical Research should be more closely involved in the basic research being conducted on HIV/AIDS in the country. A representative from Department of Medical Research could be associated with the proposed UNICEF study on HIV/AIDS knowledge, attitudes, and practices which is about to be undertaken.

9. The Department of Traditional Medicine's manpower networks should be utilized as resources for the dissemination of HIV/AIDS prevention and control messages a well as for the provision of counselling services.

10. Additional efforts to integrate HIV/AIDS into the widespread networks of the Department of Social Welfare should be undertaken to take advantage of the resources and access to potential risk groups available through this Department.

11. Extensive use should be made of the existing NGOs and their networks to assist in the development and implementation of pilot HIV/AIDS intervention activities targeted at specific risk groups and populations such as CSWs, IDUs, youth, etc.

12 More efforts need to be made to encourage and support NGO and private sector participation in order to facilitate programme implementation. This could include:

a) The regular inclusion of major NGOs in the monthly AIDS Programme coordination meetings to discuss programme strategy and implementation;

b) The regular provision of technical information about HIV/AIDS to assist in the development and evolution of NGO programming;

c) The identification and encouragement of additional NGO-implemented pilot projects under the overall umbrella of the NAPCP. These could include:

i. A system for the voluntary HIV testing and counselling of persons based upon a cost-recovery method with support from the APCP and United Nations' Agencies as appropriate;

ii. Additional intervention activities targeted at Commercial Sex Workers, Injecting Drug Users and Men who have Sex with Men to be undertaken by interested NGOs;

iii. Organizing special meetings to bring together interested secular and religious NGOs in order to consider NAPCP priorities and means to fully involve the various organizations in this Programme.

B. PROGRAMME STAFFING, FACILITIES AND ACCOMODATION

1. Staffing

1.1 National and International Staff

As noted above, the APCP should be reinforced through the addition of staff within the DOH structure. In addition, the WHO Technical Officer should be assigned as soon as possible.

1.2 Post Descriptions and Functions

As provided in Figure 2, new posts with clear descriptions of the functions and duties are in process of approval.

1.3 Staff Training

Training upon entry into the Programme is conducted for Programme staff, and opportunities for external study or courses is made available through existing Fellowship programmes.

2. Office Facilities

2.1 Office Equipment and Machinery

The APCP team and each respective State, Divisional, District and Township team should be provided with updated computer equipment and software to enable them to more efficiently carry out their duties.

2.2 Communications

Adequate communications capabilities (including direct local and external access lines for the APCP and at least one FAX machine for the APCP if not for all State and Divisional offices) should be provided.

2.3 Maintenance

Sufficient local capacity for the repair and maintenance of informatics and other office equipment seems to exist.

3. Office Accommodation

3.1 Adequacy of Office Space

The current APCP office space is woefully inadequate for the current complement of staff; it is expected that the new office space which is under renovation and which was to have been occupied as of 1 October 1993 will be available in the very near future.

3.2 Adequacy of Storage Space

The APCP has no equipment and supply storage space of their own, and rely upon the existing Department of Health structures for the provision of this space.

Achievements

1. Four Medical Officers and six support staff have been assigned to the APCP in addition to the Project Manager.

Constraints

1. The manpower available to the APCP at central, state and local levels is severely limited, which consequently hampers effective programme coordination and implementation.

2. The volume of work of the APCP requires additional informatics support in order to enable the programme to effectively carry out its responsibilities.

3. The office accomodation currently available to the Programme is inadequate in light of its current and projected size.

Recommendations

1. In order to improve programme implementation, additional human resources will need to be identified to enable the Programme to focus on the planning and implementation of HIV/STD/AIDS prevention and control activities in all sectors and at all levels. Specific consideration should be given to the following options:

a) At Central Level

1. Within the DOH, the official creation of posts within the AIDS Control Programme should be accorded top priority by the Government of Myanmar. Until sufficient posts are created to meet the requirements of the Programme, additional staff should be seconded or reassigned to the Programme to meet the current needs.

   These additional staff should necessarily include at least one Officer to assume responsiblity for the day-to-day administrative operations of the Programme, thus freeing the Programme Manager to focus more on strategic programmatic matters.

2. Within other Government Ministries and Departments, one "focal point" (at the Director or Deputy Director level) should be identified and charged with the planning and implementation of HIV/STD/AIDS prevention and control programming within each respective Ministry/Department, in collaboration with the APCP.

   The APCP should be responsible for assisting these focal points with the development of their respective HIV/AIDS workplans, and should provide an initial allocation of funds needed for the implementation of these plans. Each focal point should ensure that adequate funds are reserved by their Ministries and Departments within all subsequent annual budgets to continue providing support to their plans of action for HIV/STD/AIDS prevention and control.

b) At State and Divisional Level

As already proposed, a Team for HIV/AIDS should be established within the DOH structure who should be responsible for the planning and coordination of all HIV/AIDS prevention and control activities throughout the State or Division at hand. This Team would be responsible for the provision of all necessary support to HIV/AIDS prevention and control activities in the State or Division concerned, as well as for the monitoring and evaluation of those activies on a regular basis.

c) At Local and Community Level

All Township and STD Clinic Medical Officers as well as Urban and Rural Health Centre Officers should be provided with the necessary information and training to enable them to function effectively as the field-level planning, coordination, implementation and monitoring and evaluation agents of the NAPCP. The possibility of identifying "model" townships for the implementation of certain activities on a pilot basis can also be considered.

2. Additional office support supplies and equipment should be procured, including: (i) at least two 486-processor personal computers with the latest versions of basic software (i.e. WordPerfect 5.1, Lotus 1-2-3 version 3.1; dBase-IV; EpiInfo and EpiModel; etc.); (ii) one FAX machine with dedicated telephone line; (iii) at least one direct local telephone line and facilitated access to international (overseas) calling; (iv) two large-volume (over 10,000 copies per month) photocopy machines with document feeders, sorting bins, and colour copying abilities.

3. The new APCP office space on the ground floor of the DOH building should be made available to the APCP at the earliest possible moment to facilitate effective Programme operations.

C. TRAINING

Training programmes have been developed and implemented for various types and levels of health care personnel throughout the country.

Acheivements

1. Central and Divisional training of trainers was undertaken with reference to manuals already developed. Peripheral level training was conducted for basic health staff and community leaders.

2. Training of basic and advanced counselling courses was conducted at the central level. A basic counselling component was included in the basic health staff training

3. Training methods used were: lecture, lecture discussion, role play exercise, demonstration and case study methods.

4. Training modules, manuals and hand-outs were developed and distributed to the basic health staff. Educational materials have been produced centrally and locally.

5. Integration of HIV/AIDS into medical, paramedical and community health worker training was initiated.

Constraints

1. Training programmes are implemented in an ad hoc manner for various groups and in various areas.

2. Training reference materials are not currently available in adequate quantities or on appropriate subject matters to meet the needs of the volume of training envisaged.

3. The community leaders trained to support communities were too few in number to do community support program.

4. Continuing education programmes and reorientation training were not provided for Basic Health Staff to develop skills needed for their job.

5. Educational materials were mainly produced at central level and sometimes communication gaps were found between community training needs and materials produced.

Recommendations

1. Designation within the APCP of a Training Coordinator for the development and design of HIV/AIDS training materials and training programmes in collaboration with CHEB, Department of Health Manpower, and other Departments and target training groups.

2. The APCP should provide technical support and assistance to other Departments in the identification of HIV/AIDS-related training needs as well as the development of training programmes and training timetables for the implementation of these programmes.

D. PROGRAMME LOGISTICS

1. Transportation

1.1 Vehicles

The APCP has provided one vehicle to the DOH, with an additional two all-weather, all-terrain vehicles available to the APCP. It is expected that additional vehicles for each of the fourteen proposed State and Divisional teams will also be required.

1.2 Maintenance

Fuel and maintenance provisions within the DOH seem adequate for the operation and maintenance of the externally-provided vehicles.

1.3 Accountability

The vehicles currently assigned to the APCP are operated according to standard Government of Union of Myanmar
policies and regulations.

2. Supply Handling and Logistical Systems

2.1 Needs Assessment and Ordering

There does not seem to be a fixed system for the projection or estimation of Programme supplies, commodities or equipment needs. As shortages of commodities (especially HIV test kits and condoms) have been repeatedly identified as a major impediment to programme implementation, a clear system to estimate national requirements (on a monthly or quarterly basis) should be devised. Donor agencies should take the responsibility to ensure that all required supplies and commodities are procured and provided in the required quantities at the required moments.

2.2 Receiving, Storage and Dispatch

The APCP utilizes the DOH Medical Stores' system for storage, dispatch and distribution. The absence of any cold-storage capacity at the airport required faultless coordination between suppliers and consignees at the airport to ensure timely clearance and storage of perishable HIV test kits.

2.3 Distribution Systems

As above.

Achievements

1. APCP mobility has been assured and supplies and equipment, when delivered, are assured transportation through the existing DOH structures.

Constraints

1. Inadequate information regarding annual or quarterly supply and equipment needs, including such key commodities as HIV test kits and condoms, is collected or available at Central, State or Division level.

2. Delivery of perishable commodities (such as HIV test kits) must be closely monitored and coordinated at the level of the supplier and the consignee, as no cold-storage facilities exist at the airport for the storage of commodities awaiting customs clearance. Past experience indicates a problem with the receipt of advance warning of the impending arrival of perishable goods.

Recommendations

1. A comprehensive needs evaluation for supplies and equipment (especially consummable commodities such as condoms and HIV test kits) needs to be conducted to ensure the timely ordering and delivery of supplies and equipment to meet the Programme's demands. Advance annual projections of needs based upon inputs from Township, District, State and Divisional levels should be prepared and provided to the ordering agency at least ten months in advance of the supplies being required at field level.

2. Reliable cold-storage facilities should be developed at or near the airport for the receipt and holding of newly-arrived perishable supplies (HIV test kits). Lessons learned in the EPI programme could be shared in this regard.

E. PROGRAMME MONITORING, REPORTING AND EVALUATION

1. Programme Monitoring System

1.1 Monitoring of Activities

Other than at the central level, the planning and close monitoring of programme activities does not seem to take place. More needs to be done to ensure that the DOH structure as well as non-DOH Ministries and Departments assume necessary responsiblity for activity planning, implementation, and monitoring at each level of the programme from the centre to the periphery.

1.2 Supply Flow and Availability Monitoring

Likewise, a coordinated supply and equipment monitoring system should be developed (especially for HIV test kits) to ensure that supplies are being properly delivered and utilized with minimum of wastage.

1.3 Regular Programme Activity Reporting and Provision of Feedback

The above system would, in principle, allow for the submission or receipt of regular reports as well as the provision of feedback as required.

2. Surveillance and Research

2.1 AIDS Case Reporting

AIDS case definition was introduced in 1991, based on the Bangui criteria with the assistance of HIV positivity. Before that, physicians were very reluctant to report due to lack of an AIDS case definition. AIDS has been catagorized as one of the notifible diseases in Myanmar.

2.2 HIV Surveillance and Reporting

The ulitimate goal of HIV surveillance is to obtain data that are useful for planning action. While it is not necessary to wait for surveillance data to initiate prevention activities, experience strongly suggests that such data are very powerful aids for mobilizing efforts for the control of the epidemic.

The specific objectives of surveillence for planning action are:

-- To monitor time trends of HIV prevalence in selected population subgroups.

-- To document the geographical spread of HIV transmission.

An additional side benefit of such data is to provide some information, albeit incomplete, for estimating the HIV prevalence at the level of a region or a country. This inturn can be used for short term forecasting of AIDS cases and the burden on care system.

2.3 STD Surveillance and Reporting

There are 35 STD teams in 14 States and Divisions: 10 teams in Yangon, 10 teams in Lower Myanmar and 15 teams in Upper Myanmar. The STD control programme is headed by the Deputy Director (Epidemiology). Each team has one Medical Officer, one nurse, one or two investigators, two laboratory technicians, one clerk and labourers.

2.4 Behavioural and Ethnographic Studies.

A wide variety of behavioural studies have been undertaken by, or in cooperation with, the APCP to identify the risk behaviours of a variety of high-risk groups.

2.5 Biomedical Studies

A limited number of biomedical research studies have been undertaken in Myanmar.

2.6 Socio-Economic Studies

A study on socio-economic aspect of HIV/AIDS in certain communities is being planned in collaboration with the Institute of Economics.

3. Financial Monitoring System

3.1 Disbursement of Funds from Programme

A mechanism should be developed by the APCP for the monitoring of funds disbursed to other Ministries and Departments and NGOs on a regular (monthly) basis to ensure accurate reports of activity implementation and fund utilization.

3.2 Fund Availablility

To the extent possible, the APCP should be informed of the funds (eventually) being made available by other Ministries and Departments or NGOs at all levels for support to HIV/AIDS prevention and control activities, especially local resource mobilization by the NGO or private sector at the community level. All Ministries and Departments are encouraged to begin including budget lines for HIV/AIDS programme activities within the framework of their annual budgets.

4. Evaluation System and Programme Evaluation Indicators

The APCP should develop, in collaboration with other partners, clear programme progress and evaluation indicators which could be used to measure the future impact of the current HIV/AIDS prevention and control activities.

Achievements

1. Monitoring of MTP activities at the central level has been undertaken by the APCP.

2. At the end of June 1993, 85 AIDS cases were reported from 7 towns using the AIDS case defintion laid down by the National AIDS Committee. A simple reporting form has been developed and copies are being distributed to the various Township Health Departments.

3. The Myanmar AIDS Programme has established surveillance (mostly at sentinel sites) within a very short period of time. This has enabled it to have an insight into the spread of the epidemic in many parts of the country.

4. A wide variety of limited behavioural studies involving various high risk groups have been undertaken in the past year.

Constraints

1. Outside of activities carried out by the APCP directly, very little monitoring is conducted of activities undertaken by other Ministries, Departments, Governmental or Non-Governmental organizations in the States and Divisions.

2. No comprehensive monitoring of the supply flow is conducted within the APCP.

3. Detailed information regarding the field-level activities being undertaken by many Governmental and Non-Governmental groups is not readily available to the APCP.

4. Many physicians are still reluctant to diagnose AIDS cases clinically without the support of HIV testing.

5. Confirmation of an HIV positive result is difficult because of the need to send the blood samples to another reference laboratory.

6. Inexperience in the diagnosis and care for AIDS patients is a problem.

7. There appears to be a communication gap between the AIDS Programme and the peripheral staff on procedures, guidelines and recommendations about surveillance.

8. There is no surveillance system used in STD control activites.

9. There is no specific diagnostic test avaialble in all STD teams.

10. It is difficult to reach certain population groups such as homosexuals, CSWs and IDUs in the community to conduct behavioural and KAP studies regarding HIV/AIDS.

11. There are difficulties in performing behavioural studies in ethnic groups due to communication and cultural gaps in some regions of the country.

Recommendations

1. A comprehensive monitoring system to follow-up on orders placed, goods delivered and distributed, and eventual rates of consumption (especially for condoms and HIV test kits) should be developed in order to evaluate the use and to determine future supply and equipment needs for the Programme.

2. A comprehensive activity monitoring and reporting format, including information on target audiences, financial expenditure, and final results of each activity should be designed by the APCP in order to facilitate Programme monitoring and reporting.

3. Comprehensive Programme monitoring and evaluation Indicators should be developed by the APCP in collaboration with the other participating parties by June 1994 to enable the Programme to measure its current and future impact on the HIV/AIDS situation in Myanmar.

4. Expansion is required of the current training programmes for physicians in the diagnosis and care for the HIV/ AIDS both locally and internationally.

5. At least two different types of HIV test kit should be supplied to the hospitals to help in diagnosis.

6. Sentinel surveillance is the single method recommended for use in Myanmar for planning and advocacy. It uses unlinked anonymous testing. It is recommended to discontinue as much as possible "ad-hoc" surveys in different population subgroups.

7. Data from sentinel surveillance or other surveys should not be aggregated for analysis.

8. The minimum sample size requirement for sentinel surveillance is 200. For antanatal clinic it may be necessary to have higher sample sizes (minimum 300). Sentinel sites are chosen for their accessibility, the drawing of blood for a purpose other than exclusively HIV testing and the possibility to gather a sample size of at least 200 in a period of less than three months. It is recommended that a maximum of 15 sites according to the above criteria be used as sentinel sites in Myanmar.

9. Data from blood screening should be used to gain additional insights into the epidemic.

10. A surveillance system should be developed under the STD control programme to monitor the trend of STD prevalencein Myanmar. This should include the possibility of developing a reporting system of STD cases from hospitals and clinics directly, rather than only through STD teams.

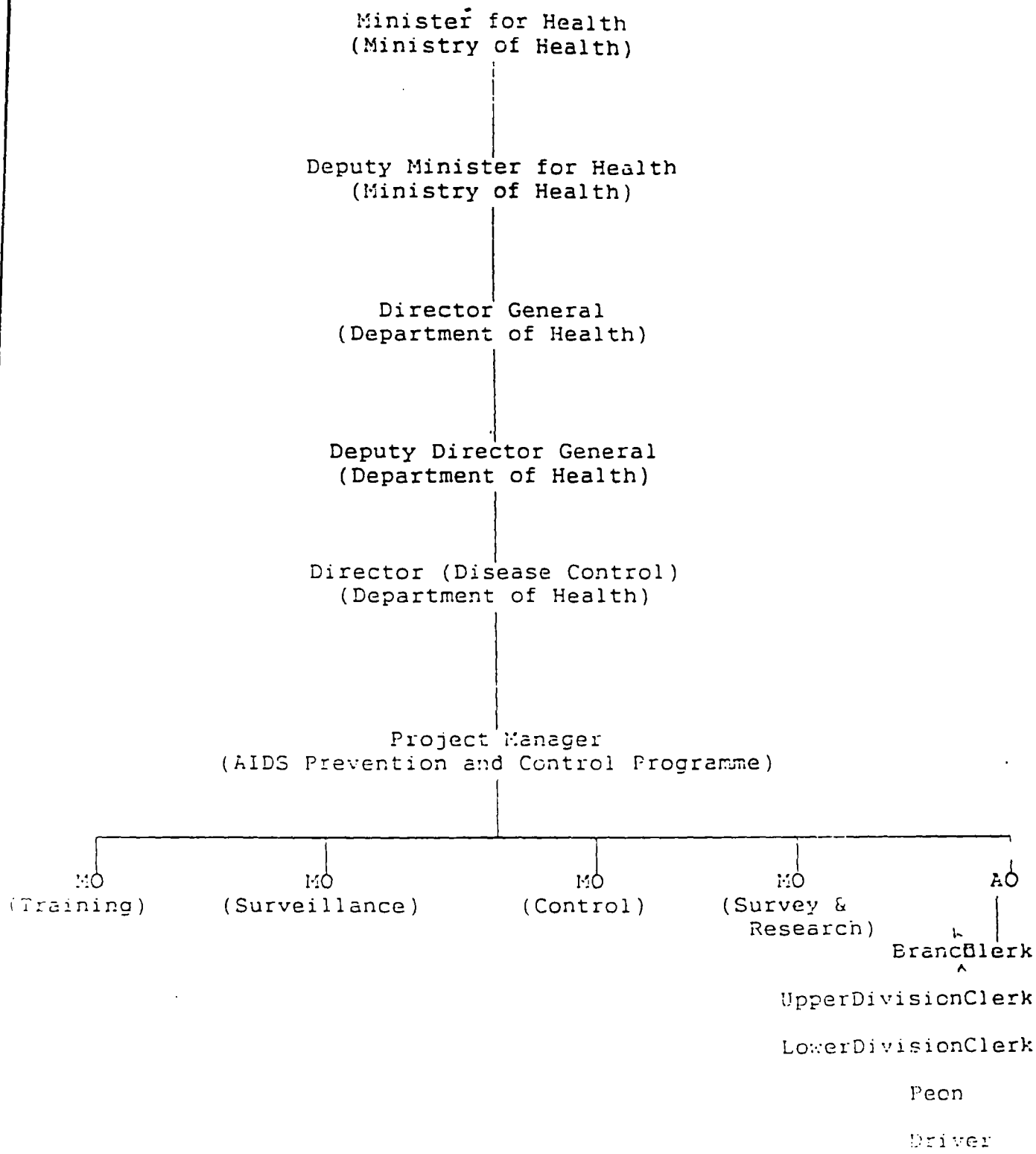
11. In collaboration with various research institutions and groups in the country, the APCP should undertake the responsibility to train social scientists in the various ethnic regions within the country so that they will be able to conduct behavioural studies unique to their specific regions.

F. PROGRAMME FINANCE

Details of the implementation of activities and budget distribution for the current year can be found in Annexes VIII, IX and X. Roughly one-quarter of the proposed activities for 1993 (27%) and one-fifth of the planned expenditures for 1993 (21%) have yet to be undertaken.

Figure 1

ORGANIZATION STRUCTURE OF AIDS PREVENTION AND CONTROL PROGRAMME



ANNEX I

LIST OF REVIEW TEAM PARTICIPANTS

REVIEW TEAM CHARIMAN

1. Prof. U Kyaw Tint, Professor & Head (Rtd.), Dept. of Preventive and Social Medicine, Institute of Medicine (1), Yangon.

REVIEW TEAM MEMBERS--MYANMAR

2. Dr. U Thaung, Director (Rtd.), Disease Control Section, Dept. of Health, GOM, Yangon.

3. Dr. U Ohn Maung, Lecturer/Consultant, Drug Dependency Treatment & Research Unit, GOM, Yangon.

4. Dr. U Swe Myint, Assistant Director (STD), Dept. of Health, GOM and Consultant, HIV/AIDS Counselling Team, Infectious Diseases Hospital, Yangon.

5. Dr. Rai Mra, Consultant Physician, Infectious Diseases Hospital and Consultant Haematologist, Yangon General Hospital, Yangon.

6. Dr. Khin Than Oo, Assistant Director, Central Bureau for Health Education, Department of Health, GOM, Yangon.

7. U Soe Naing Tun, Deputy Director, Dept. of Social Welfare, Ministry of Social Welfare, GOM, Yangon.

8. Dr. Daw Than Than Zin, Assistant Director, Dept. of Basic Education, Ministry of Education, GOM, Yangon.

9. U Thar Oo, Assistant Director (Broadcasting), Myanma TV and Broadcasting Department, Ministry of Information and Broadcasting, GOM, Yangon.

10. U Nyunt Wai, Cheif Reporter, News & Periodicals Enterprise, Ministry of Information and Broadcasting, GOM, Yangon.

11. Dr. Daw Nyo Nyo, Secretary, Myanma Maternal & Child Welfare Association, Yangon.

12. Mrs. Daw San Yin Kyi, Administrative Officer, Myanma Red Cross Society.

REVIEW TEAM MEMBERS -- EXTERNAL

13. Dr. J.P. Narain, Medical Officer & Team Leader, WHO/GPA/SEARO, New Delhi.

14. Mr. P.J. Brenny, Technical Officer, WHO/GPA-India, New Delhi.

15. Dr. Thierry E.C. Mertens, Chief, EVA/CNP/GPA, WHO, Geneva.

16. Dr. D. Winters, Consultant, CNP/GPA, WHO, Geneva.

17. Dr. Pattanayak, Ag. PCD/SEARO, WHO, New Delhi.

18. Dr. T. Prvulovic, Public Health Administrator, WHO/Myanmar, Yangon.

19. Prof. Desmond Cohen, Principal Economist, HIV & Development Unit, UNDP, New York.

20. Dr. Wiwat Rojanapithayakorn, Senior Expert in Preventive Medicine, Dept. of Communicable Disease Control, Ministry of Public Health, Bangkok, Thailand.

21. Ms. Phaik Choo Phuah, Programme Officer, UNDP, Yangon.

22. Dr. Christiane Dricot-d'Ans, Head, Health & Nutrition Section, UNICEF, Yangon.

23. Mrs. Daw Thazin Oo, Assistant Project Officer, Health & Nutrition Section, UNICEF, Yangon.

24. Mr. R. Ballard, Coordinator, Health Issues, Health and Personal Development Unit, Department of Education, Queensland, Brisbane, Austrailia.

25. Mrs. Daw Khyn Hla Munn, Programme Assistant, UNDCP, Yangon.

REVIEW TEAM SECRETARIAT

26. Dr. Hla Htut Lwin, Medical Officer, AIDS Prevention and Control Project, Yangon.

27. Dr. Min Thwe, Medical Officer, AIDS Prevention and Control Project, Yangon.

ANNEX II

PROGRAMME FOR MTP REVIEW TEAM IN YANGON
(October, 1993)

4-10-93 (Monday)	9:00-10:00 Hrs	- Meet with Director General Department of Health
	10:00-11:00 Hrs	- Meet with Director (Disease Control) Department of Health
	14:00-16:00 Hrs	- Briefing by Programme Manager Department of Health
5-10-93 (Tuesday)	9:00-12:00 Hrs	- Meeting among review team members Department of Health
	14:00-16:00 Hrs	----- do ------
6-10-93 to 12-10-93		- Field visit to 4 States/Divisions by sub-groups (detail plan for the 4 groups attached)
13-10-93 (Wednesday)	9:30-12:30 Hrs.	- Joint Meeting of Review Team sub-groups to discuss findings.
	12:30-14:00 Hrs	- Lunch
	14:00-16:30 Hrs	- Site visits by group:
	Group 1:	Infectious Diseases Hospital
	Group 2:	Central STD Clinic
	Group 3:	Counselling Team (IDH)
	Group 4:	Central National Blood Bank
	Review Report Drafting by sub-group Rapporteurs.	
14-10-93 (Thursday)	9:30-12:00 Hrs	- Visit to Drug Dependency Treatment and Research Centre
	14:00-15:00 Hrs	- Visit to National Health Laboratory
	Review Report Drafting by sub-group Rapporteurs.	
15-10-93 to 19-10-93	9:00-16:00 Hrs	- Preparing Draft Report
20-10-93 (Wednesday)	8:00-18:00 Hrs	- Presentation of Review Report Summary to National Consensus Workshop

PROGRAMME FOR MTP REVIEW TEAM FIELD VISITS

(October, 1993)

GROUP I **Field Trip to Kyaingtong & Tachileik**

6-10-93 (Wednesday)	5:00 Hrs	- Leave Yangon for Kyaingtong (by air)
	10:00-10:30 Hrs	- Meet with Divisional AIDS Committee, Kyaingtong
	10:30-12:00 Hrs	- Visit Kyaingtong Hospital and Drug Treatment Centre
7-10-93 (Thursday)	9:00-10:00 Hrs	- Meet with MMCWA, MMA and Red Cross Association
	10:00-12:00 Hrs	- Visit Yan Khan Village to observe Ahkha traditional weaving
	14:00-16:00 Hrs	- Visit Vocational Training School and Youth Training School, Kyaingtong Township
8-10-93 (Friday)	8:00-16:00 Hrs	- Visit Katou RHC, Kyaingtong Township to observe health activities carried out in the rural areas including AIDS prevention activities
9-10-93 (Saturday)	7:00 Hrs	- Leave Kyaingtong for Mongphyat (by car)
	Evening	- Meet with Township AIDS Committee
	Evening	- Visit Mongphyat Hospital (Night stop in Mongphyat)
10-10-93 (Sunday)	7:00 Hrs	- Leave Mongphyat for Tachileik (by car)
11-10-93 (Monday)	9:00 Hrs	- Meet with Tachileik Township AIDS Committee
	10:00-15:00 Hrs	- Visit Mongphone RHC, Tachileik Township to observe health activities carried out in the rural areas including AIDS prevention activities
12-10-93 (Tuesday)	9:00 Hrs	- Meet with MMCWA, MMA and Red Cross
	10:00-11:00 Hrs	- Visit STD Clinic and Tachileik Hospital
	13:00 Hrs	- Leave Tachileik for Yangon (by air)

GROUP II **Field Trip to Mandalay and Sagaing Division**

6-10-93 (Wednesday)	5:00 Hrs	- Leave Yangon for Mandalay (by air)
	11:00-12:00 Hrs	- Meeting with Divisional Health Director
	14:00 Hrs	- Meeting with Divisional AIDS Committee
7-10-93 (Thursday)	9:00-11:00 Hrs	- Visit STD Clinic and Public Health Laboratory
	11:00-12:00 Hrs	- Meeting with MMCWA Committee
	12:00-13:00 Hrs	- Meeting with MMA, Mandalay
	14:00-15:00 Hrs	- Meeting with Divisional Red Cross Committee and Township Red Cross Associations, Mandalay
8-10-93 (Friday)	9:00-12:00 Hrs	- Visit to South-East township Health Department to observe routine works and AIDS prevention activities
	14:00-16:00 Hrs	- Visit Cottage Industries to observe tapestry work
9-10-93 (Saturday)	8:00 Hrs	- Leave Mandalay for Sagaing (by car)
	8:30 Hrs	- Meeting with Sagaing Divisional Health Director
	9:00-10:00 Hrs	- Meeting with Divisional AIDS Committee
	10:00 Hrs	- Leave Sagaing for Monywa (by car) (Night stop in Monywa)
10-10-93 (Sunday)	9:00-10:00 Hrs	- Meeting with Monywa Township AIDS Committee
	10:00-11:00 Hrs	- Meeting with MMCWA Committee
	11:00-12:00 Hrs	- Meeting with MMA
	12:00-13:00 Hrs	- Meeting with Monywa Township Red Cross Association
	14:00-16:00 Hrs	- Visit Monywa Divisional Hospital and STD Clinic
11-10-93 (Monday)	7:00 Hrs	- Leave Monywa for Mandalay (by car)
		- Visit Allakappa RHC of Myinmu Township on the way to Mandalay, to observe health activities carried out in the rural areas including AIDS prevention activities
		- Leave Myinmu for Mandalay (by car) (Night stop in Mandalay)
12-10-93 (Tuesday)	12:00 Hrs	- Leave Mandalay for Yangon (by air)

GROUP III **Field Trip to Dawei and Longlon Townships**

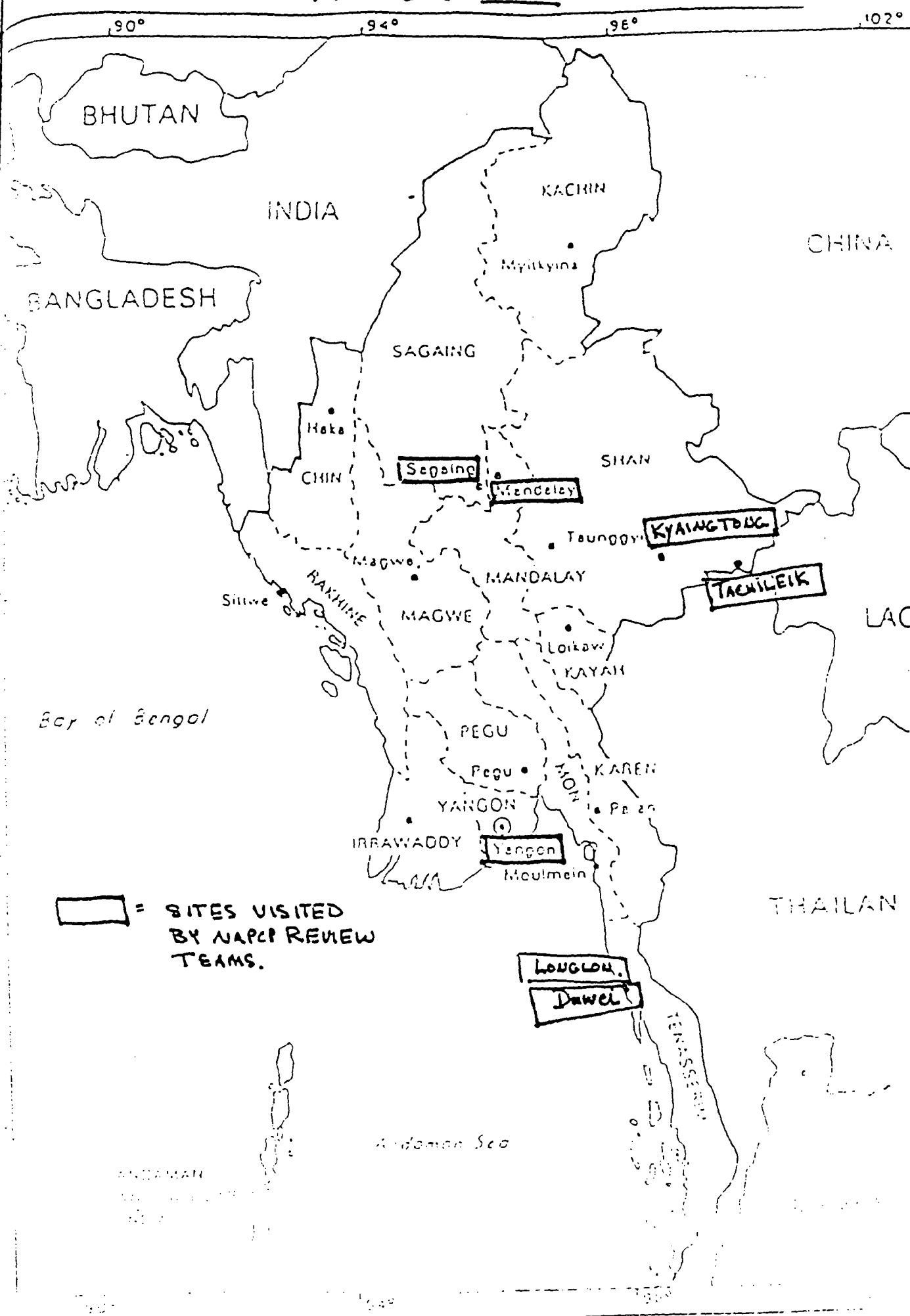
6-10-93	5:00 Hrs	- Leave Yangon for Dawei (by air)
(Wednesday)	11:00-12:00 Hrs	- Meet with Divisional Health Director
	14:00-15:00 Hrs	- Meet with Divisional AIDS Committee, Tanintharyi Division
7-10-93	9:00-12:00 Hrs	- Visit Dawei Divisional Hospital
(Thursday)	14:00-15:00 Hrs	- Meet with MMCWA, Dawei township
8-10-93	7:00 Hrs	- Leave Dawei for Longlon Township (by car)
(Friday)	8:00 Hrs	- Meet with Longlon Township AIDS Committee and visit Longlon Township Hospital
	11:00 Hrs	- Visit Innsauk RHC, Longlon Township to observe heath activities carried out in the rural areas includung AIDS prevention activities
	15:00 Hrs	- Travel to Maungmakan for night halt (by car)
9-10-93	8:00 Hrs	- Visit Maungmakan RHC to observe health
(Saturday)		activities carried out in the rural areas including AIDS prevention activities
	13:00 Hrs	- Leave Maungmakan to Dawei (by car)
10-10-93	9:00-10:00 Ers	- Meeting with MMA Committee
(Sunday)	10:00-11:00 Hrs	- Meeting with Divisional Red Cross Committee
	11:00-12:00 Ers	- Meeting with Township Red Cross Association
11-10-93	10:00 Hrs	- Leave Dawei for Yangon (by air)
(Monday)		
12-10-93		- Elective period
(Tuesday)		

GROUP IV **Central Review Team**

6-10-93 (Wednesday)	10:00-11:00 Hrs	- Meet with Officials from WHO
	11:00-12:00 Hrs	- Meet with Officials from UNDP
	12:00-13:00 Hrs	- Meet with Officials from UNICEF
	13:00-14:00 Hrs	- Meet with Officials from UNDCP
7-10-93 (Thursday)	10:00-11:00 Hrs	- Meet with Officials from Myanma Television and Broadcasting Department,Ministry of Information
	11:00-12:00 Hrs	- Meet with Officials from Department of Information and Public Relations, Ministry of Information
	12:00-13:00 Hrs	- Meet with Myanmar Medical Association
	13:00-14:00 Hrs	- Meet with Myanmar Council of Churches
8-10-93 (Friday)	10:00-11:00 Hrs	- Meet with Officials from Department of Health Manpower,Ministry of Health.
	11:00-12:00 Hrs	- Meet with Officials from Department of Medical Research, Ministry of Health.
	12:00-13:00 Hrs	- Meet with Officials from Department of Planning and Statistics, Ministry of Health
	13:00-14:00 Hrs	- Meet with Department of Traditional Medicine, Ministry of Health
9-10-93 (Saturday)		- Holiday
10-10-93 (Sunday)		- Holiday

11-10-93 (Monday)	10:00-11:00 Hrs	- Meet with Officials from Department of Basic Education,Ministry of Education.
	11:00-12:00 Hrs	- Meet with Officials from Department of Higher Education, Ministry of Education
	12:00-13:00 Hrs	- Meet with Officials from Department of Social Welfare, Ministry of Social Welfare.
	13:00-14:00 Hrs	- Meet with Deputy Director (Narcotic), People's Police Force.
12-10-93 (Tuesday)	10:00-11:00 Hrs	- Meet with MMCWA
	11:00-12:00 Hrs	- Meet with Myanmar Red Cross
	12:00-13:00 Hrs	- Meet with World Vision International

ANNEX ...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= SITES VISITED BY NAPCP REVIEW TEAMS.
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ANNEX IV

THE ECONOMIC AND SOCIAL CAUSES AND CONSEQUENCES OF HIV

A GENERAL: UNDERSTANDING RELATIONSHIPS AND SETTING OBJECTIVES

1. There are 2 fundamental relationships, and both are important. Firstly, the relationship between economic, social and cultural variables and the spread of HIV; who becomes infected with the virus and with what spatial distribution. Examples of important variables which have been identified as having a causal role in the spread of the virus include gender , poverty , economic and social mobility [which is more than the physical mobility of persons and includes the effects on values and traditional structures associated with the process of economic modernisation]. Identifying the critical variables and understanding the relationships between these and the spread of HIV is a prerequisite for effective policy and programme interventions for behaviour change. It will typically be the case that such interventions will not be those usually contained in an MTP but will be more in line with standard development strategies.

An effective National Programme for the containment of the spread of HIV must include activities to identify and understand policy relevant aspects of the economic and social framework, and to then formulate, implement and evaluate policy interventions.

2. The second relationship is between HIV and AIDS and the performance of the economic and social system. This has received more attention from social scientists in many countries, including Asia. The costs are much greater than those usually calculated by economists and include important psycho-social costs. Even the narrowly defined costings of the economists are a significant understatement of the probable impact of the HIV epidemic. Such calculations usually identify direct costs [largely health expenditures] and indirect costs [the value to society of the output lost due to higher mortality caused by HIV related illnesses]. An idea of the potential scale of the economic costs of AIDS is the estimate that by the year 2000 that Thailand will be worse off to the extent of $8 Billion. Costs are identifiable at
the level of households, communities, economic sectors and for the economy as a whole. The impacts are pervasive and effect all social and economic life, so that many of the hard won benefits of development are threatened [leading to poorer nutrition;

a worsening general level of health, and particularly the threat of a TB epidemic; an intensification of poverty, and a worsening of life expectancy for the general population].

An effective National Programme has to have as an objective the strengthening of national capacity to identify and estimate, where possible, the multiple economic and social impacts of HIV and AIDS; to act as a catylist in the mobilisation of financial and human resources, and to establish operational planning so as to ameliorate the economic and social costs within a framework which is multisectoral.

B ACHIEVEMENTS AND CONSTRAINTS

3. Paras 1 and 2 contain two general criteria for evaluating the existing MTP in terms of its relevance; both in terms of the extent to which it has advanced understanding of the economic, social and cultural causes of the spread of HIV, and has addressed these through programme activities, and through the development of national capacity to deal with the economic and social consequences. The latter would include activities of the National Programme to raise awareness of the developmental consequences of the epidemic so as to increase political and other commitment at the level of the community and of the nation.

4. It cannot be concluded that the MTP has achieved very much as yet by way of the strengthening of national capacity to analyse and quantify the economic and social causes and consequences of the epidemic.There have been small scale and very limited studies, including one on truck drivers in Mandalay; a study of KAPB of CSWs in Yangon, a qualitative study on HIV and AIDS in Thai-Myanmar Border Townships, a Study on KAP and HIV amongst doctors in Yangon, and a study HIV infection and IVU in Mandalay. This research is valuable but it is only a start in developing understanding of the complex factors relevant for effective policies and programmes. The MTP for 1993 contains activities which are intended to strengthen national capacity for applied policy research in Myanmar; a joint study with UNDP and the Institute of Economics on the Shan State Border Area to develop a methodology for more general application in Myanmar, and a proposal for a UNDP/ADB and Institute of Economics study of the Economic Costs of HIV and AIDS.

5. A National Workshop on the Developmental Consequences of HIV was jointly hosted with UNDP's Regional Project in 1992 and this was followed by Seminar on the Economic and Social Costs of HIV and AIDS in 1993. These are steps in the right direction in shifting perceptions about both the causes and consequences of HIV away from a health focus and to its developmental dimension. But it remains the case that the existing MTP is still excessively health focused and that in practise most of the activities at national , district, township and village levels are being managed/undertaken by the health sector. There is as yet no real commitment on the part of other sectors other than Health to the creation of programmes for the

prevention of HIV and for planning for the economic and social consequences of the epidemic.

C ACTIVITIES IN SPECIFIC SECTORS

6. There are examples of activities which address issues of prevention in some specific sectors but these are generally ad hoc and not sustainable. Again these represent activities by the NAP and MOH rather than responsible government departments/ministries. What are needed are comprehensive plans for each major area of economic activity; the allocation of resources, and the establishment of institutional structures for effective implementation. Examples of what is being done at the Divisional and Township levels in some places are attempts to access the families of migrant workers; health education in factories and shipyard facilities, and in some mining establishments; workers in some hotels and guest houses have been given information on HIV, and so on. These are all worthwhile but no-one supposes that by themselves they are sufficient to change risk behaviours, and they will thus be incapable of preventing the economic and social costs of the epidemic.

7. The following is a summary of the situation in specific sectors. It is less about what has been done to plan for the economic and social costs of the HIV epidemic, because very little has been done as yet, than about the economic vulnerabilities of these sectors.

AGRICULTURE; this sector together with other forms of primary production [forestry products especially] accounts for 26% of GDP and 70% of employment. Research from other countries confirms that some agrarian systems are especially vulnerable to the effects of HIV on the labour supply. It is possible to develop criteria for identifying vulnerability of both agrarian systems and of households [the latter will exhibit stress before the system does so]. This is not only a critically important task but it is also a complex one. It requires a capacity for undertaking applied social and economic analysis. It is not enough to gather data on production conditions for different crops throughout Myanmar, although this is essential, but to also understand gender relations [and the specificity of farm tasks], the causes and extent of social stratification [poverty and wealth co-existing together] and the implications of these conditions both for the spread of HIV and its economic and social impact. There is in existence at least one excellent study by International Fund for Agricultural Development on Agriculture in East Shan State [1991] which is a model of what data is needed for developing effective policies for prevention of HIV and for developing interventions to reduce the economic and social impact. It is important to see such applied research as having a dual function; to assess those factors which contribute to high risk behaviours [such as intense poverty for many families, the poor social

infrastructure of schools, health, housing, the lack of rural employment for both young women and young men, often leading to labour mobility, some of it across the border to Thailand]; and to determine the sources of economic vulnerability [the differential impact of changing labour supplies on different crops and on different producers].

TRANSPORTATION; this sector has a critical role to play in the integration of markets but is also seen as an important vector for the transmission of HIV. Many studies in many countries have confirmed that truck drivers in particular are prone to engage in high risk sexual behaviours [confirmed by the Myanmar study noted above, and by much more extensive analyses in Thailand]. But it is unlikely that such behaviour is confined to truckers alone and employees in other transport modes are just as likely to be at risk [including airline staff, railway employees, seamen and those engaged in coastal and river transport]. The issues which need to be addressed are not those relating to the sero status of transport workers for we know that they have a propensity to engage in high risk sexual behaviours, but how to reduce their influence as a vector for HIV infection. It is evident from the various studies that knowledge of HIV does not change behaviour so that programme interventions need to concentrate on how to bring about sustained behaviour change. At the simplest level this implies that employers have a responsibility for establishing effective workplace programmes [where applicable], but in the case of truckers it is much more one of identifying networks [at truck stops,sea ports, market centres] which have the possibility of influencing behaviour patterns. As for the direct impact of HIV and AIDS on the Transport sector, and indirectly on everyone else through cost shifting, there has been no research at all. Again models exist of what needs to be done [the study of trucking in Thailand by Giroud,1993]. More generally there are proposals to link the booming Thai economy by new road developments through Shan State with the huge consumer market in Yunnan [China]. This will lead to the rapid modernisation of a very traditional society [Shan State] and will draw young people especially into new economic activities [including transport in Myanamar and in Thailand].The need to develop prevention activities in the Border Area is self evident, but it needs to be much more complex than what has hitherto been done.

MILITARY; these have important security and public order functions in all countries. They are also one of the sectors in many developing countries with high sero prevalence rates. This is unsurprising in that they enroll precisely that age group which is likely to engage in high risk behaviours and are moreover likely to be located in places where access to CSWs is common and expected. More disputable is the argument sometimes made that the military are also a vector of infection. Irrespective of the actual position in Myanmar with respect to HIV in the military, where data are not available, it is still the case that they represent an important human resource which deserves to be protected from transmission. This represents the standard case for workplace programmes to protect the human investment embodied in the military. In part also to avoid subsequent health and dependents costs. Little directly targeted activity has been conducted so far under the NAP for the Military, and what has been

reported has been spasmodic and localised.

TOURISM; there is great unrealised potential for tourism in Myanmar both from within the Region [from Thailand and India] and from outside. There are however major logistical and other problems to be overcome before this sector becomes important economically. Once it does there will be critical matters, some relating to cultural destruction others to HIV transmission, which will need to be subject to careful planning. At this time the potential is largely in the future although there is a boom in small hotels, guest houses etc. in some cities [Yangon, Mandalay, Monywa, Tachileik]. Again there are localised efforts being made to inform hotel workers of the risks of HIV but this is largely being undertaken by the health authorities. What is missing is ny planned and coherent strategy for the sector both in order to protect employees from infection [employers from additional costs] and tourists from infection [or being a source of additional infection].

D. REDUCTION OF IMPACT ON LABOUR SUPPLIES

8. If there has been any effect of the NAP on maintaining aggregate labour supplies then it is certainly not measurable and quantifiable. It is certainly to be hoped that activities in respect of HIV prevention over the MTP have had some effect on HIV transmission but there is no way of estimating what the impact has been. In so far as HIV transmission is lower than it would otherwise have been then labour supplies will be greater and human investment have been protected. However this is the optimistic scenario and the data ,admittedly not reliable, suggest that infection is moving rapidly into the general population and as elswhere is concentrated on the critical working age group 15-45. So the threat to the aggregate labour supply remains but will not become an important constraint on development until the latter part of the decade. More important at the present are to achieve an efficient supply of drugs for those with HIV related illnesses so they can remain active members of the labour force and their communities/families. This is not presently the situation. Also critical, but not being directly addressed, are policies for protecting the skilled and more highly educated part of the labour supply. Most of the significant costs for the economy are caused not by the erosion of labour in general by HIV but the losses due to morbidity and mortality among those who represent high levels of social investment. The critical need to protect this segment of the labour supply from infection, how to do it, and who should do it, has yet to be grasped.

E. REDUCTION OF IMPACT ON PUBLIC EXPENDITURES

9. It is too early to reach any conclusions on this aspect of the economic costs of HIV and AIDS given that the generalised impacts on the economy and thus on the Budget lie in the future. At this stage of the epidemic it would be expected that policies for reducing transmission would require higher government expenditures rather than lower. This would represent the standard cost benefit view in favour of prevention- investment [expenditure] today avoids costs [creates benefits] in the future. This does not imply that all current HIV related expenditure is efficient and necessary. There is undoubtedly scope for rationalisation within the NAP and the health sector generally, which might yield small cost savings. And there is a case under very controlled conditions for experiments with cost recovery in health care [including charges at voluntary HIV testing centres]. One way of reducing the impact on public expenditure would be to encourage even greater local mobilisation of resources but there must be limits to this as a policy. There is much evidence that local communities are willing and able to generate large sums of money for local activities especially in health, and this commitment does need to be deliberately encouraged by policy makers.

F. RECOMMENDATIONS

1. Various tranport modes including airline staffs,railway employees,seamen and those engaged in coastal tranport are likely to be at risk.Appropriate intervetion specifically targetted to these group of people.

2. Employers should be encourage for esablishing effective workplace programmes.

3. Military establishment is an important human resource which needs to be protected for which NAP should provide necessary support.

4. To ensure sufficient supply of drug are available at all the various level of health care establishments for those with HIV related illnesses and AIDS.

5. To encourage greater local mobilisation of resources to support local activities especially in health.

ANNEX V

GOVERNMENT MINISTRIES AND CENTRAL BODIES

1. CENTRAL BODIES UNDER THE STATE LAW AND ORDER RESTORATION COUNCIL.

1) Office of the President

2) Office of the Government

3) Public Service Selection and Training Board

4) Office of the Pyithu Hluttaw

5) Supreme Court

6) Central Law Office

7) Central Account Office

8) Office of the Multi-Party Democracy General Election Commission

9) City Development Committee

2. MINISTRIES OF THE GOVERNMENT OF THE UNION OF MYANMAR.

1) Ministry of Defense

2) Ministry of Culture

3) Ministry of Home Affairs

4) Ministry of Forestry

5) Ministry of Industry (1)

6) Ministry of Industry (2)

7) Ministry of Agriculture

8) Ministry of Religious Affairs

9) Ministry of Health

10) Ministry of Transportation

10) Ministry of Transportation

11) Ministry of Hotel and Tourism

12) Ministry of Cooperatives

13) Ministry of Development of Border Areas and National Races

14) Ministry of Labour

15) Ministry of Trade

16) Ministry of Mines

17) Ministry of National Planning and Economic Development

18) Ministry of Finance and Revenue

19) Ministry of Social Welfare, Relief and Resettlement

20) Ministry of Information

21) Ministry of Livestock Breeding and Fisheries

22) Ministry of Education

23) Ministry of Foreign Affairs

24) Ministry of Rail Transportation

25) Ministry of Public Works

26) Ministry of Energy

27) Ministry of Communications, Posts and Telegraphs

28) Office of the Prime Minister

ANNEX VI

TRAINING OF TRAINER ON HIV/AIDS IN STATES AND DIVISIONS

	States/Divisions	Town	No.of trainee
1.	Mon State	Mawlamyaing	32
2.	Tanintharyi Divisions	Dawei	22
3.	Shan State(East)	Kyaingtone	29
4.	Mandalay Division	Mandalay	58
5.	Kayin State	Pha-an	22
6.	Yangon Division	Yangon	100
7.	Bago Division	Bago	45
		TOTAL	308

CLINICAL MANAGEMENT COURSE

1.	Mandalay Division	Mandalay	28

ANNEX VII

NATIONAL AIDS COMMITTEE SUBCOMMITTEES

1. Surveillance and Research Subcommittee.

1. Director (Disease Control) Department of Health.	Chairman
2. Deputy Director Directorate of Medical Service Ministry of Defence	Member
3. Director Department of Medical Research	Member
4. Deputy Director (Epidemiology) Department of Medical Research	Member
5. Deputy Director (Epidemiology) Department of Health	Member
6. Lecturer/Consultant Central STD Clinic, Yangon	Member
7. Head of Department Virology Section, National Health Laboratory, Yangon	Member
8. Projet Manager AIDS Prevention & Control Programme Department of Health	Member
9. Assistant Director (STD) Department of Health	Member
10. Assistant Director Department of Planning & Statistics	Member
11. Medical Officer AIDS Control Programme, DOH	Secretary

(2).Information and Education Subcommittee

1. Director (Broadcasting) Myanma TV & Broadcasting Department	Chairman
2. Director News & Periodicals Enterprises	Member
3. Director (Education) Basic Education Department Ministry of Education	Member
4. Director (University) Higher Education Department Ministry of Education	Member
5. Director Information & Public Relation Department	Member
6. Representative Department of Labour	Member
7. Deputy Director (Health Education) Department of Health	Member
8. Assistant Director (TV) Myanma TV & Broadcasting Department	Member
9. Assistant Director Department of Health Manpower	Member
10. Projet Manager AIDS Prevention & Control Programme Department of Health	Member
11. Assistant Director (STD) Department of Health	Member
12. Assistant Director Department of Indigenous Medicine	Member
13. Assistant Health Education Officer CHES, Department of Health	Member
14. Assistant Director (Health Education) Department of Health	Secretary

(3) Medical and Social Care Subcommittee

1. Director (Medical Care) Department of Health	Chairman
2. Director Social Welfare Department	Member
3. Professor/Head of Department Department of Medicine Institute of Medicine I	Member
4. Professor/Head of Department Department of Surgery Institute of Medicine I	Member
5. Professor/Head of Department Department of Obstetrics & Gynecology Institute of Medicine I	Member
6. Professor/Head of Department Department of Paediatrics Institute of Medicine I	Member
7. Medical Superintendant Infectious Disease Hospital	Member
8. Assistant Director (CHEB) Department of Health	Member
9. Assistant Director(Medical Social) Department of Health	Member
10. Team Leader AIDS Counseling Team	Member
11. Clinical Psycologist Yangon Psycheatric Hospital	Member
12. Projet Manager AIDS Prevention & Control Programme	Member
13. Consultant Haematologist Yangon General Hospital	Secretary

(4) Drug Abuse and AIDS Management Subcommittee

1. Director (Narcotic) C.C.D.A.C Ministary of Home & Religious Affairs	Chairman
2. Deputy Director (Narcotic) People's Police Force	Member
3. Deputy Director (Planning & Finance) Immigration Department	Member
4. Deputy Director Attorney General	Member
5. Deputy Director Immigration Department	Member
6. Representative Prison Department	Member
7. Project Manager AIDS Prevention & Control Programme Department of Health	Member
8. Assistant Director (STD) Department of Health	Member
9. Lecturer/Consultant D.D.T.R.U Yangon Psychiatric Hospital	Secretary

(5) Blood Transfusion Subcommittee

1. Director (Laboratory) National Health Laboratory Department of Health	Chairman
2. Head of Department/Pathologist Pathology Department Yangon General Hospital	Member
3. Deputy Director Pathology Department National Health Laboratory	Member

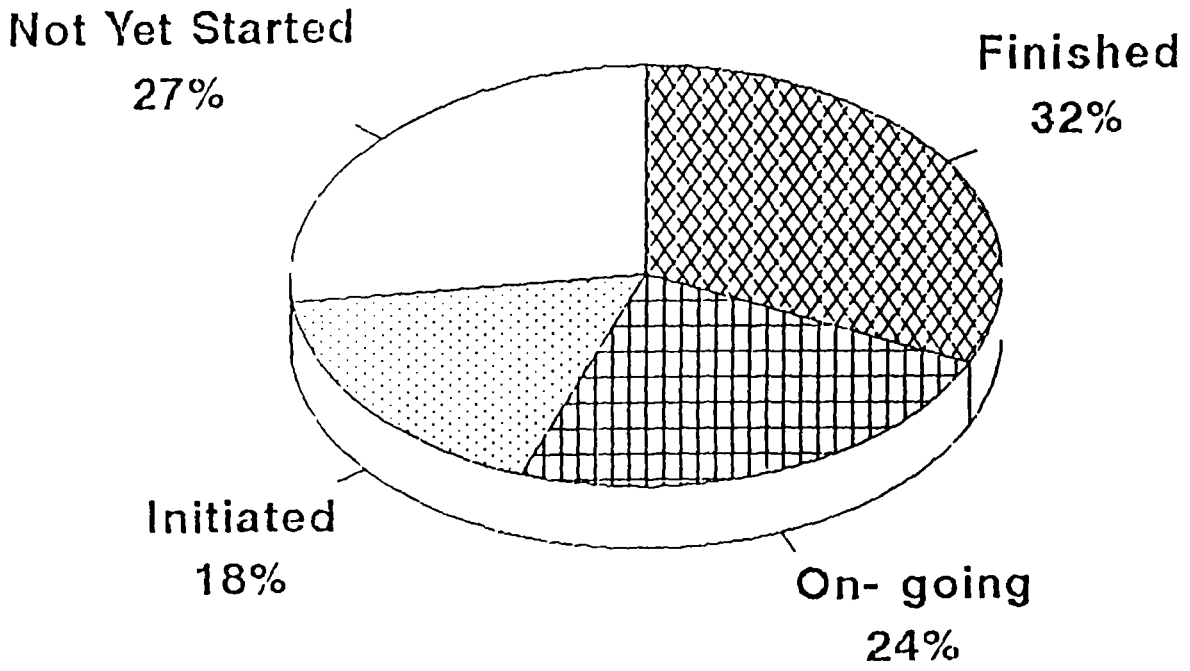
4. Project Manager AIDS Prevention & Control Programme Department of Health	Member
5. Head of Department/Pathologist Pathology Department Central Women Hospital Yangon	Member
6. Head of Department/Pathologist Pathology Department North-Okkalapa Hospital	Member
7. Honorary Secretary Myanmar Red Cross Association Yangon	Member
8. Head of Department Virology Section National Health Laboratory	Member
9. Assitant Health Education Officer Central Health Education Bureau Department of Health	Member
10. Chief Medical Officer Central National Blood Bank Yangon	Secretary

(6) NGO Activities Co-ordination Subcommittee

1. Director (Disease Control) Department of Health	Chairman
2. Executive Director Myanmar Red Cross Society	Member
3. Secretary Myanmar Medical Association	Member
4. Secretary Myanmar Maternal and Child Welfare Association	Member
5. Deputy Director Central Health Education Bureau Department of Health	Member

6. Deputy Director Public Health Department of Health	Member
7. Project Manager AIDS Prevention & Control Programme Department of Health	Member
8. Team Leader AIDS Counselling Team AIDS Prevention & Control Programme Department of Health	Secretary

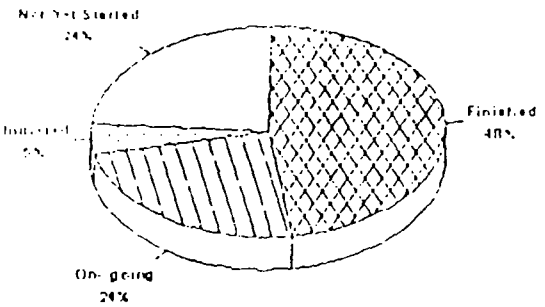
Overall Activities



To be carried out 97 Activities

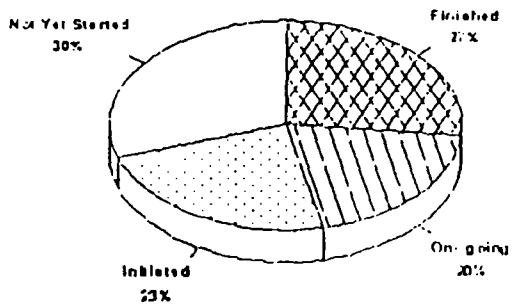
ANNEX VIII

Program Area: Management



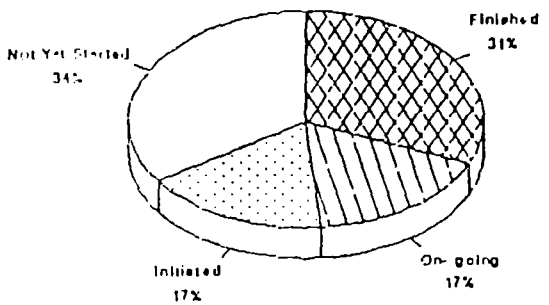
Total No. of Activities to be done is 21

Program Area: Health Education



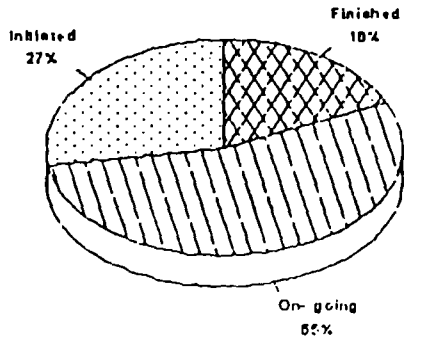
Total No. of Activities to be done is 30

Program Area: Surveillance and Control



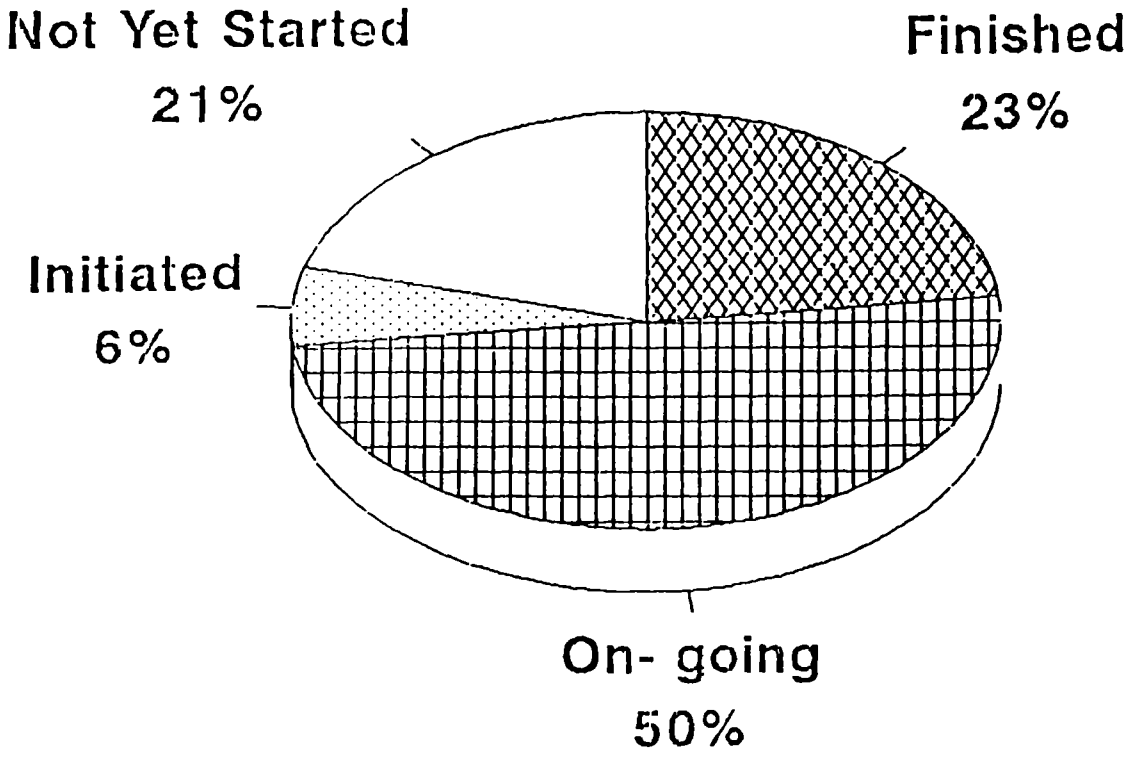
Total No. of Activities to be done is 35

Program Area: Laboratory Support



Total No. of Activities to be done is 11

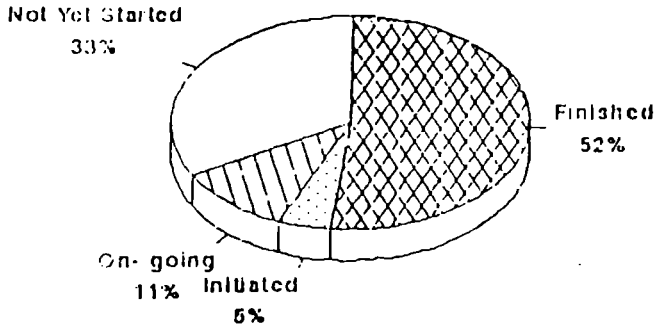
Overall Budget Utilization



Total Budget US $ 1,278,900

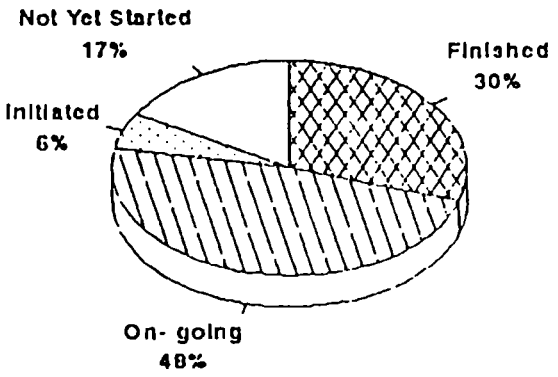
ANNEX IX

Program Area: Management



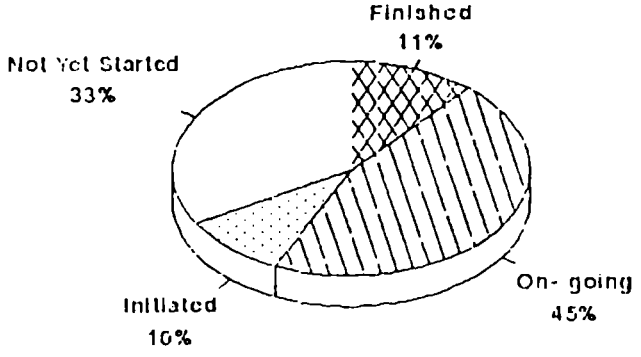
Total Budget US $ 208,500

Program Area: Health Education



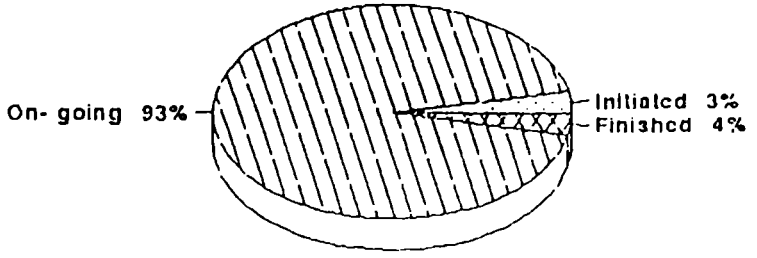
Total Budget US $ 463,000

Program Area: Surveillance and Control



Total Budget US $ 353,900

Program Area: Laboratory Support



Total Budget US $ 253,500

ANNEX X

SUMMARY OF IMPLEMENTATION (GPA 001, MTP 1993)

Programme Area: Management (210) 1993

Activity	Not Started	Initiated	Ongoing	Finish	Remark
1. National AIDS Meeting			X		
2. Subcommittee meeting			X		
3. Meeting directors of S/D				X	
4. Technical officer				X	
5. Secretarial/computer support					
(a) Admin secretary				X	
(b) Computer specialist				X	
6. Monitoring visit to project areas	X				Cost for international staff field visit
7. Formulation of MTP 2					
(a) Review of last year activi				X	
(b) Field assessment				X	
(c) Mission related to MTP formulation				X	
(d) MTP formulation W/S				X	
8. Reprogramme W/S				X	
9. W/S to identify role of NGOs		X			
10. Support to NGOs				X	
11. STC for workplace programme for AIDS	X				
12. Planning W/S for AIDS prevention in various ministries	X				
13. Support to various ministry for AIDS activities	X				
14. W/S on multisectorial programming for HIV epidemic	X				
15. Office maintenance			X		
16. Fuel service & Maintenance			X		
17. S & E			X		

ɔgramme Area : Health Education (220) 1993

Activities	Not Start	Init-ated	Ongo-ing	Fini-shed	Remarks
. Participation of MMR Reps in international & regio-nal AIDS meetings and W/S				X	
. Organized 2 day trainig w/s of township leaders,VHW teachers and MMCWA			X		
. Produce 6 folders for target groups		X			
.. Reprint booklet for BHW on HIV and STD management		X			
. Produce one comic book				X	
. Erect billboards in every S/D				X	
. Organized WAD		X			
. Produce radio programme (Q & A)	X				
. Produce radio spot			X		
. Broadcast radio spots	X				
.. Broadcast 3 radio plays	X				
. Produce a TV documentary			X		
. Produce TV spots			X		
. Evaluation of community leader's AIDS education	X				
. Production of posters in various ethnic languages	X				
. Organized production of dramas with various tour	X				
. Peer education for youth		X			
. Peer education for IVDU		X			
. Peer education for CSW		X			
. Subcription to periodicals and journals				X	
. Pamphlets on correct use of condoms				X	
2. To develop communication strategies			X		

Programme Area : Health Education (220) 1993

Activities	Not Start	Init-ated	Ongo-ing	Fini-shed	Remarks
3. Regional fellowships for 4 persons			X		
4. Training of traditional medical practitioners				X	
5. Production of communication materials	X				
6. Reprinting of booklets for MOs on sterilization				X	
7. STC sociologist training in behavioural research	X				
8. W/S on behaviour research	X				
9. Workshop for school teacher					
0. Supplies and equipments				X	

Programme Area: Surveillance and Control (230) 1993

Activities	Not Start	Init iate	Ongo ing	Fin she	Remarks
1. Reprint IEC materials,revised AIDS case definition		X			
2. W/S for medical specialist at S/D for clinical care		X			
3. W/S on clinical care for TMOs	X				
4. Train a clinician in Australia for AIDS care	X				
5. Train a clinician in India for AIDS care	X				
6. Quarterly report to WHO			X		
7. Study of clinical aspect of TB & AIDS		X			
8. Sentinel surveillance				X	
9. Providing S & E to sentinel surveillance sites				X	
10.Transportation of biological sample from sentinel surveillance sites to YGN and MDY				X	
11.Sentinel surveillance data processing				X	
12.Serosurvey for STD				X	
13.Refresher training for STD medical officers	X				
14.Training of trainer(TMO) for STD management	X				
15.Training of BHW in STD prevention and management	X				
16.Provision of diagnostic facilities for STD patients		X			
17.Distribution of condoms by STD clinic			X		

ɔgramme Area: Surveillance and Control (230) 1993

Activities	Not Start	Initiate	Ongoing	Finshe	Remarks
.Reprint of STD management guidelines		X			
.Regional fellowship tour for 2 STD medical officers				X	
.Two 4 days training course on HIV/AIDS counseling			X		
..Advance training course on counseling				X	
:.Management of opportunistic infection				X	
:.Training of GPs on AIDS care and counseling				X	
:.Reprinting and dissemination of guidelines on treatment and counseling of IVDUs		X			
:.Training of MOs from drug treatment centers				X	
:.Regional fellowship for HIV prevention among IVDUs	X				
'.Training of trainer for HIV/AIDS prevention and control				X	
:.Training W/S for BHW			X		
:. STC for social marketing of condoms	X				
:. Procure and distribute condoms			X		
.. Particpation in regional W/S on targetted intervention among high risk behaviour.	X				
:. W/S for prison officials on HIV/AIDS prevention	X				
:. STC for peer education	X				
:. STC for evaluation of training	X				
:. Supplies and Equipments			X		

>gramme Area: Laboratory Support (240) 1993

Activities	Not Start	Initiate	Ongoing	Finished	Remarks
Production of information materials for donor deferral		X			
Expansion of blood screening coverage			X		
Refresher course on laboratory diagnosis			X		
Field travel of lab technicians to township laboratory				X	
Expansion of HIV screening through pooling of serum in States and Divisions				X	
Continuation of blood screening in Yangon and Mandalay			X		
Training on lab diagnosis of opportunistic infection for 2 medical officers		X			
Establishment of quality assurance programme for HIV testing laboratory			X		
Training of lab. technicians on HIV testing		X			
).Screening of HBs antibody			X		
1.Supplies and equipments			X		