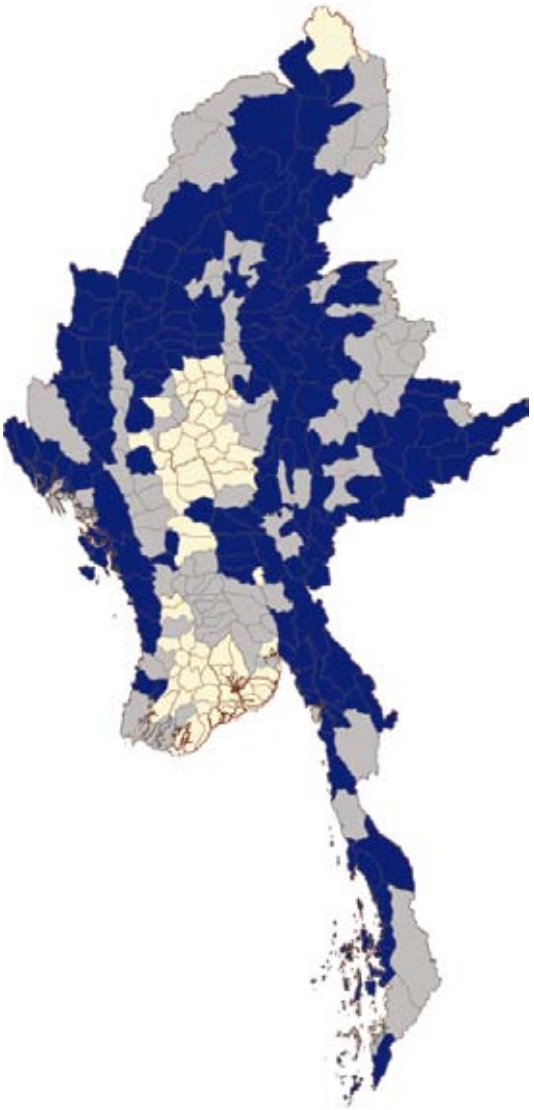
Three Diseases Fund Annual Report 2008

A pooled fund in Myanmar supported by Australia, the European Commission, the Netherlands, Norway Sweden and the United Kingdom



Full Report

ABBREVIATIONS AND ACRONYMS

3DF	Three Diseases Fund
AFXB	Association François-Xavier Bagnoud
AHRN	Asian Harm Reduction Network
Alliance	International HIV/AIDS Alliance
AMI	Aide Médicale Internationale
BI	Burnet Institute
CESVI	Cooperazione e Sviluppo (Italian NGO for cooperation and development)
CARE	CARE International in Myanmar
CB	Coordination Body (3DF)
CBO	Community-Based Organization
Consortium	Myanmar NGO Consortium on HIV/AIDS (CARE, MNA, MNMA and MSI led by SC-UK)
DoH	Department of Health
FB	Fund Board (3DF)
FHAM	Fund for HIV/AIDS in Myanmar
FM	Fund Manager (3DF)
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
IOM	International Organization for Migration
IP	implementing partner (3DF)
MANA	Myanmar Anti-Narcotics Association
MBCA	Myanmar Business Coalition on AIDS
MCC	Myanmar Council of Churches
MMA	Myanmar Medical Association
MMK	Myanmar Kyat (local currency)
MNMA	Myanmar Nurses and Midwives Association
MoH	Ministry of Health of Union of Myanmar
MSF-CH	Médecins Sans Frontières Switzerland
MSF-H	Médecins Sans Frontières Holland (also seen as: AZG)
MSI	Marie Stopes International
NAP	National AIDS Control Programme (2005)
NMCP	National Malaria Control Programme
NOP	National Operational Plan
NSP	Myanmar National Strategic Plan on HIV and AIDS 2006-2010 Myanmar National Strategic Plan on TB 2006-2010 Myanmar National Strategic Plan on Malaria 2006-2010
NTP	National Tuberculosis Programme
NGO	Non-Governmental Organization
PGK	Pyi Gyi Khin
PSI	Population Services International
SC-UK	Save the Children United Kingdom
TB	Tuberculosis
TSG	Technical Strategic Group (on each disease)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nation Office on Drugs and Crimes
UNOPS	United Nations Office for Project Services
VBDC	Vector-Borne Disease Control
WCM	World Concern Myanmar
WHO	World Health Organization
WVM	World Vision Myanmar

OTHER USEFUL ACRONYMS

ACT	Artemisinin-based Combination Therapy
AIDS	Acquired Immunodeficiency Syndrome (also seen as: Acquired Immune Deficiency Syndrome)
ART	Antiretroviral Treatment (also seen as: Antiretroviral Therapy)
ARV	Antiretroviral
BCC	Behaviour Change Communication
BHS	Basic health staff
CHW	Community health workers
DIC	Drop-in Centre
DOTS	Directly Observed Treatment Short-course
DST	Drug Substitution Therapy
HAART	Highly Active Antiretroviral Treatment
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
ITN	Insecticide Treated Net (also seen as: LLIN)
KAP	Knowledge, Attitude and Practice
LLIN	Long Lasting Insecticidal Nets
LTA	Long Term Agreement
MDR	Multi Drug Resistant
MSM	Men who have Sex with Men
MTCT	Mother-To-Child Transmission
NSEP	Needle-Syringe Exchange Programme
OI	Opportunistic Infection
OR	Operations Research
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PLHIV	People/persons Living with HIV*
PMTCT	Prevention of Mother-To-Child Transmission
PPM	Public-Private Mix (DOTS)
PTCT	Parent-To-Child Transmission
RDT	Rapid Diagnostic Test
SHG	Self Help Groups
SRH	Sexual and Reproductive Health
SS+	Sputum Smear Positive
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TMO	Township medical officer
VCCT	Voluntary and Confidential Counselling and Testing
VHW	Voluntary health workers

* Although ‘People living with HIV and AIDS’ (PLWHA or PLHA) is widely used, the currently preferred phrase is ‘People living with HIV’ (PLHIV)

Cover map: in dark blue Malaria endemic townships with 3DF support (134 townships), in grey colour endemic townships without 3DF support (89 townships), and in white townships with low or no Malaria risk

CONTENTS

I. EXECUTIVE SUMMARY

In just over two years (2007-2009), the Three Diseases Fund (3DF) has reached its full pace and granted total US$43 million in Round I grants, of which US$23 million in 2008, for 34 projects implemented by 23 partners drawn from five UN agencies, 15 international NGOs and a diversity of independent community-based organizations in Burma/Myanmar. In 2008, the fund extended all Round I grants to a second year.

Partner agencies are reaching out to beneficiaries with mobile and fixed clinics, GPs, trained health workers and public health services at township level. Support to the national disease control programmes is provided exclusively through UN agencies, WHO, UNAIDS and UNFPA for activities such as surveillance, monitoring, blood safety, voluntary testing and counselling, referral and provision of life saving medicines—TB and Malaria drugs, as well as ARV therapy.

In providing impetus for setting up coordination bodies for policy dialogue and inclusive technical planning, the donors to the Three Diseases Fund have created an innovative partnership with all key actors (NGOs, UN and Government-led disease control programmes) that paved the way for future humanitarian interventions in Myanmar.

The fund was an important driver for the establishment of a National Coordination Body chaired by the Minister of Health and of Technical Strategic Groups (TSG), which oversee the responses to HIV, TB and Malaria.

These are bodies, which allow UN agencies, NGOs, donors and other civil society partners to discuss national policy and operational plans with Ministry of Health, whereas the Three Diseases Fund contributes to programmes operated by the UN and NGOs with grants based on technical assessment and independent decision-making from the donors over fund allocation.

In 2008, the Coordination Body was replaced by the Myanmar Country Coordination Mechanism (M-CCM) leading the preparation of Myanmar application to Round 9 of the Global Fund (GFTAM), in which donors and partners to the Three Diseases Fund actively participated.

The fund promotes a culture of transparency in putting in the public domain—through mechanisms such as a website, a newsletter and a compendium of fast facts—key documents about the fund management. The website (http://3dfund.org/) recorded 10,495 visits over the year, 650 per month on average, with peaks to 1,400/month when calls for proposals were issued (Round II).

The fund is committed to working more closely with local NGOs and CBOs in recognition that many of them have strong grassroots networks and can reach beneficiaries in hard-to-reach areas not easily accessed by public health services or international NGOs. Among important strides, the fund earmarked US$700,000 to strengthen support to local organizations in a second round of grants (Round II). A call for expressions of interest focusing on local organizations was launched in January 2008 and proposals assessed during the year under review. Among 13 eligible organizations, eight signed funding agreements for maximum US$70,000 each on 16 January 2009.

Key stakeholders and beneficiaries must be able to feed back their views, issues, ideas into the funded programme on aspects such as access, equity, service delivery or supply management. The Fund Manager started to build the capacity of local grantees and to pilot a community feedback mechanism together with interested organizations.

WHO continued to manage a decentralised disbursement system with US$575,824 to support National Programmes with small amounts directly channelled to medical officers at township

level for activities such as training, drug transportation costs, supervision of beneficiaries, initial home visits and lab specimen collection in the three diseases.

The Fund Manager directly procures health commodities only for those partners, who do not have sufficient capacity internally and offers assistance in custom clearance for all partners. In 2008, 33 orders were placed on behalf of ten implementing partners for a total value of US$636,826, of which HIV procurement had the biggest share (57 per cent) followed by Malaria supplies (39 per cent). The Fund Manager procured antiretroviral pharmaceuticals at less than US$10/month per patient (total US$47,000 for 400 adult treatments).

Another key initiative in 2008 was the review of commodity tracking systems in partner agencies to guarantee international best practices in managing pharmaceuticals bought with 3DF grants. Delayed by the emergency response to the cyclone Nargis, the review assessed eight partners and 22 field sites in September and made recommendations for improvement.

It is estimated that 240,000 people are living with HIV and AIDS and around 70,000 are in need of ARV. In 2008 the Three Diseases Fund granted US$13 million to twenty implementing partners to take part in the national response to fight against HIV and AIDS. Through direct services or referral to other health facilities, these partners provided comprehensive care and treatment for people living with HIV and AIDS in 89 townships (all States/Divisions). Altogether 6,804 clients—6,385 adults and 419 children—received ARV therapy thanks to the Three Diseases Fund, which represents around 50 per cent of all ARV provision in the country.

Implementing partners carried out prevention activities to target groups in 106 townships (all States/Divisions). Targeted HIV prevention activities reached 62,220 sex workers, 143,984 of their clients, 62,589 men having sex with men, 36,941 injecting drug users and 17,427 families of people living with HIV and AIDS. Social marketing distributed over 23.8 million subsidised condoms, to which the fund partly contributed.

The fund granted US$3.4 million to seven implementing partners for TB projects, of which two operated integrated programmes including Malaria and/or HIV activities. It continued to support through WHO the National TB Programme (NTP), financing the TB drug transportation system for the whole country and the procurement of first line TB drugs covering additional needs. Public-Private Mix DOTS mainly implemented by the Myanmar Medical Association (MMA) in 26 townships contributed to detect 4,096 cases (all forms) managed in the TB national response (3 per cent of national total registered cases). Number of SS+ TB cases detected through WHO NTP was 34,192, of which 27,764 patients were successfully treated. Community-based DOTS projects contributed to the detection of 2,380 SS+ TB cases, of which 1,690 were successfully treated.

The fund granted US$4.4 million to seven implementing partners for Malaria projects, of which two were integrated programmes. The Malaria programme reached out to 134 endemic townships and a broad range of target groups through mobile and fixed clinics. The fund contributed to the distribution of 91,986 LLINs and insecticide treatment of 299,195 bed nets. Partners treated 712,627 Malaria cases with ACT and non ACT. Malaria activities were undertaken through WHO together with the National Malaria Control Programme (NMCP), Public-Private Mix programmes led by the Myanmar Medical Association, community-based projects and direct service provision from NGO partners.

The Fund Manager monitored all 32 field projects through total 22 field monitoring trips and visited eleven CBOs in seven townships for the assessment of Round II. Four donor visits were facilitated in 2008, permitting first-hand observation of funded projects in thematic and strategic geographic areas. Hard-to-reach areas and the border areas of Muse, Tachileik (Shan State), Maung Daw (Rakhine State) and Kawt Thaung (Tanintharyi Division) were reached by monitoring visits in 2008.

II. INTRODUCTION

The Three Diseases Fund (3DF) allocates grants to programmes targeting populations most-at-risks of HIV and AIDS (60 per cent), Tuberculosis (20 per cent) and Malaria (20 per cent) to provide them with access to essential medicines and related services.

Pooled funds of US$100 million are pledged over five years till October 2011 by six donors, Australia, the European Commission, the Netherlands, Norway, Sweden and the United Kingdom, whereas the United Nations Office for Project Services (UNOPS) is the Fund Manager on behalf of the Donor Consortium.

Relief of suffering is guided by the needs and priorities of the most urgent cases of distress, and the principles of humanity, neutrality and impartiality under the EU Common Position on assistance to Myanmar[1] and the Guiding Principles for the Provision of Humanitarian Assistance set out by the UN Resident Coordinator.

No funds are channeled through the government. Support to the national programmes for disease control, surveillance and monitoring is provided through WHO, UNAIDS and UNFPA. A direct disbursement mechanism (Fund Flow) to the value of US$ US$575,824 is managed by WHO to transfer the costs of training and service provision of township medical officers.

Out of 67 Expressions of Interest (EOI) in Round I from 43 organizations, reviewed by a panel of independent experts, 34 agreements were signed between the Fund Manager and 23 implementing partners from May 2007 onwards. All agreements have been extended in May and September 2008.

In 2008, the Three Diseases Fund granted twenty partners agencies working in HIV and AIDS for a total amount of US$13 million, which represents 34 per cent of the national response with a total investment of US$38 million for the country.

The fund supported seven implementing partners in the area of Malaria control in the most endemic areas with US$4.4 million or 61 per cent of the national response (total US$6.8 million).

Seven implementing partners received total US$3.4 million for TB programmes, which corresponds to 29 per cent of the national response (total US$8.2 million).

A Round II was launched in 2008 aiming at strengthening accountable and local organizations with small grants of maximum US$70,000. These grants were finalised for eight local agencies in January 2009.

A Round III to supplement and scale up services funded in Round I is foreseen for 2009.

[1] [1] Common Position 96/635/CFSP. (Australia shares the concern to address the humanitarian needs of the population)

1 FUND MANAGEMENT

1.1 Governance and Coordination with the Ministry of Health (MOH)

The Fund Board (FB) acts as governing body on behalf of the participating donors, and has oversight of the Fund Manager (FM). The Ambassador of the United Kingdom to Myanmar[2] chaired the board in 2008, while the three participating donor members were from DFID, Sida and the European Commission. In December, the Sida representative[3] for Myanmar took over the Chair by rotation. The board convened three times in March, August and December, participated in the Annual Review Meeting on 01–02 April and exercised their oversight responsibility by assigning a good number of action points to the Fund Manager such as the launch of Round II grants.

It was anticipated that the Chair of the Coordination Body of the national response, the Minister of Health, would engage with the Fund Board in policy dialogue. This normally happens back to back with board meetings. The emergency response to the cyclone Nargis (May 2008) postponed policy dialogue on nationwide programmes until the second semester.

The fund maintains a dialogue with the Ministry of Health at central level and through service delivery targeted directly at townships. The coordination has been two fold. The Chair of the FB has spearheaded high level engagement with the Minister in three meetings held during the second semester. The Fund Manager has focused on operational level bimonthly/quarterly meetings with the Department of Health (DOH) providing updates on fund activities to Programme Directors; these coordination meetings were held essentially during the last quarter of the year.

Technical and Strategic Groups (TSG), one per disease, are important partners to the fund as they are responsible for the National Strategic Plans (NSP) and for leading the development of the outcome-based countrywide National Operational Plans (NOP). To stay abreast with developments in priority setting, funding gaps and unit costing, the Fund Manager attended TSG meetings as an observer. In particular, good progress was made in HIV and AIDS.

In November 2008, the Coordination Body of the national response was revitalised by the opportunity of the Myanmar application to Round 9 of the Global Fund (GFTAM) and replaced by the Myanmar Country Coordination Mechanism (M-CCM).

1.2 Risk Management

When the Three Disease Fund was established, a risk management advisory group was set up to advise the Fund Board and Fund Manager on potential risks for the fund's operations. The group consists of the UN Resident and Humanitarian Coordinator, two resident donor representatives (AusAID, DFID) and the CEO of the Fund Manager.

The risks are identified and watched over in five categories: external political risks, internal political risks, programme development risks, fund management risks, and implementation level risks. The advisory group convened three times in 2008, updated a risk management matrix and submitted a brief report to the Fund Board summarising major changes in risks, mitigation

[2] HE Mark Canning (United Kingdom)
[3] Bengt Ekman (Sweden)

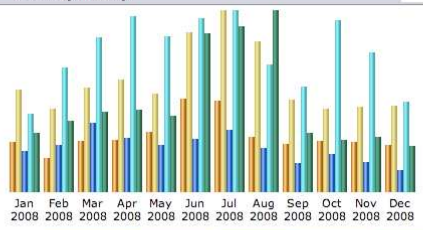
strategies and monitoring activities. A brief summary of the risk management work was included in the minutes of board meeting posted on the website at http://3dfund.org/fundboard/

1.3 Communication

In the long-standing politically charged range of views about the country, there are at all times risks that could undermine support for the fund, if concerns from a uniquely challenging set of stakeholders, from government counterpart to donor constituencies, NGOs, media and the public at large, are not monitored and addressed properly.

The Fund Manager's communication strategic plan defines, and adjusts on a rolling basis, how information is disseminated to national and international stakeholders (people directly involved in the programme or any other external organizations). Transparency and accountability on public funds use under the EU Common Position are fundamental principles in fund management. An update of the communication strategic plan initiated in 2007 was presented to and endorsed by the Fund Board in its August 2008 meeting.

Monthly history



Month	Unique visitors	Number of visits	Pages	Hits	Bandwidth
Jan 2008	390	803	3564	6782	143.79 MB
Feb 2008	266	653	4038	10827	172.61 MB
Mar 2008	395	820	5988	13416	194.13 MB
Apr 2008	410	884	4670	15254	200.12 MB
May 2008	471	769	4063	13499	186.56 MB
Jun 2008	729	1248	4590	15118	387.19 MB
Jul 2008	715	1421	5365	15759	402.79 MB
Aug 2008	433	1177	3826	11090	441.88 MB
Sep 2008	374	726	2476	9114	142.78 MB
Oct 2008	402	654	3278	14962	125.88 MB
Nov 2008	389	666	2574	12104	133.32 MB
Dec 2008	367	674	1867	7876	110.55 MB
Total	5341	10495	46299	145801	2.58 GB

The Fund Manager published at http://3dfund.org/ key documents about grant allocation in Round I (Year 1 and 2), the call for expressions of interest in Round II and related requests for proposals, minutes of Fund Board meetings, six-month progress and research reports, guidelines and policies on operations and procurement, and the Fund Board Aide-memoire on the Annual Review Meeting held in April 2008.

In 2008 the website recorded total 10,495 visits, 650 per month on average. From June to August 2008, monthly visits doubled to 1,400 during the short-listing of Round II targeting local NGOs and independent community-based organizations. Myanmar is fourth of the 25 top countries from where the website is browsed following the United States, Australia and Thailand; the United Kingdom is at the ninth rank.

From January 2008, the Round II has been widely advertised in local news releases and, internationally, through the UNIC[4] media network.

Printed materials in English and Burmese language such as a glossy compendium, a quarterly newsletter (starting from December 2008), a flyer and posters displayed programme results, coverage maps, stories of human interest, and articles about thematic activities from partner agencies (home-based care in HIV, harm reduction activities, etc.).

In frequent media interviews, the Ambassador of the United Kingdom to Myanmar on behalf of the Fund Board championed the good work of the Three Diseases Fund advocating for engagement from the international community to address huge needs in health in the country.

[4] UNIC is the United Nations Information Centre

The Fund Manager prepared press releases, key messages and talking points to respond to parliamentary questions and media queries.

The Fund Manager provided to DOH senior officials CD-ROMs with official documents such as agreements with implementing partners, progress reports, policies and operational guidelines and thus promoted a culture of transparency on all aspects of fund management.

An annual review meeting was held on 01-02 April 2008 in Yangon. It was the first occasion to bring together 160 representatives of all stakeholders, including donors, the Ministry of Health and implementing partners drawn from 23 non-governmental organizations and UN agencies. The meeting underlined the importance of the fund's work in the country.

"Important strides have taken place. We heard impressive first hand accounts of how the fund is making a real difference to many people's lives", the Fund Board Chair said in his concluding remarks.

Mobilising resources remains a priority, the review noted.

The Fund Board carried away suggestions and drew up recommendations for extending outreach and improving health delivery in the future.

On this occasion, partner agencies were given the opportunity to present project achievements in an exhibition ("Market Place").

1.4 Disbursement of Grants (Round I)

Grants were disbursed throughout the year as planned, without major delays. Payments were made within ten—median six—days, following submission of financial reports from partners.

Payment levels for each disbursement are based on reported and planned expenditures until the next reporting period, projected onto current cash balance. At times this practice required deviations from planned disbursement schedules to cover actual cash flow needs of each programme. A total of US$33,448,819 was disbursed based on expenditures reported on 31 December 2008 reports; this included provisions for planned expenditures until the next reporting period on 31 March 2009.

Grant absorption rates by implementing partners (IP) are mostly reflecting the ability to plan and implement by the end of each reporting period as a performance evaluation criterion among five technical domains assessed (see below under 1.5). Absorption rate is a ratio, where the nominator is the reported cumulative expenditure from the beginning of Round I until 31 December 2008 against the denominator of approved budget for the same period.

Partners' absorption rates over the year 2008 were 79 per cent on average with a median at 85 per cent.

See **Table 1.1** in the annexes.

1.5 Extension of Grants (Round I, Year 2)

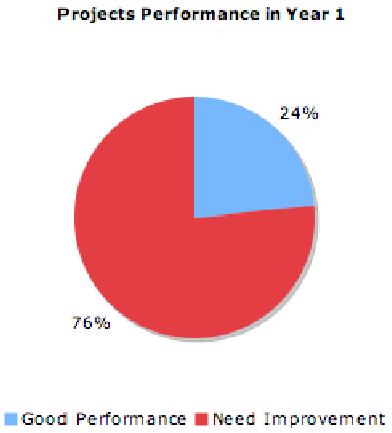
Grant extensions in Round I over a second year were made in two phases, in May and in September 2008. The extension process was based on performance evaluation, in order to incorporate the lessons learned in the first year. Extended agreements with partner agencies included adjustments to improve efficiency in management and services delivery.

In Year 2, partners were granted the same level of funding and best performers were given additional funds from pooled unspent funds. Out of 23 implementing agencies, eight partners

received extra funding amounting total US$738,932 to scale up activities, of which US$39,947 for TB, US$141,965 for Malaria and US$557,766 for HIV projects.

Performance evaluation of 34 projects was based on guidelines developed by the Fund Manager, field monitoring findings and partner reports submitted on 31 December 2007 and 30 June 2008 for agreements starting in May and September 2007 respectively.

The performance evaluation system considered five main domains.



Implementation rate: 20 per cent

Capacity to plan and implement: 15 per cent

Capacity to achieve results: 20 per cent

Quality of reports: 15 per cent

Quality of implementation: 30 per cent

Additional funding upon good performance allowed limited scale up of activities and geographical expansion to 15 new townships. Additional target groups (for instance, injecting drug users, men having sex with men and truck drivers) were included in behaviour surveillance.

See **Table 1.2** in the annexes summarising new activities in 2008.

1.6 Round II for CBOs

With the launch of a Round II targeting a diversity of independent local organizations, the year 2008 has been a milestone for the fund's commitment to work with local NGOs and CBOs in recognition that many of them can reach beneficiaries in parts of the country not easily accessed by public health services or international NGOs.

A special study was commissioned in 2007 to identify ways in which the fund could work more closely with community-based organisations. In response to this study, a call for expressions of interest (EOI) focusing on local organizations was launched in January 2008 with a deadline extended to 01 June.

Out of 63 EOI from 57 local organizations, the Fund Manager pre-selected 21 expressions of interest, of which only 13 were eligible due to registration constraints; two organizations withdrew. An independent technical review panel assessed and recommended to fund all the 11 proposals. Proposals and memoranda of agreement for the first eight grants of maximum US$70,000 each for one year renewable were prepared by the end of the year and signed in January 2009. More grants are expected to be allocated to local organizations in the future.

Intervention supported in Round II cover the following activities:

HIV and AIDS—Targeted intervention through harm reduction services for drug users and sex workers, behaviour change and community outreach, referral services for VCCT, and methadone treatment, STI diagnosis and treatment, condom promotion, home-based care for people living with HIV and vulnerable children, provision of OI treatment, scale up of ARV and focused prevention programmes for youth and vulnerable groups.

Tuberculosis—Community awareness, referral services for testing and treatment, DOTS provision, follow up of drop-out cases and treatment failure.

Malaria—Community prevention programmes, bed nets distribution, mobile clinics for diagnosis and treatment and training of community volunteers.

Grants to Round II partners are summarised in **Table 1.3** in the annexes.

1.7 Reallocation of Funds for Nargis-related Activities

Immediately after the cyclone Nargis (May 2008), the fund responded supportively to urgent requests from four partners and agreed to re-programme small amounts from unspent funds from Year 1 into disaster relief activities related to the three diseases in cyclone areas. However, the Fund Manager soon agreed with the Fund Board and the Department of Health to continue and focus on operations nationwide, where attention had weakened as a result of the emergency response in the delta. The table below shows a summary of re-programmed funds supporting activities in the Delta over the first three months after the disaster.

Organization	Amount in US$	Activities
IOM	62,060	**Integrated project for HIV, TB and Malaria**—Medicines and medical commodities for mobile clinic in affected areas
World Concern	31,260	**HIV project**—Capacity building of local groups for reproductive health activities targeting people affected by cyclone Nargis and production of IEC materials about HIV and relief resources
World Concern	17,410	**Malaria project**—Procurement of some 2,700 LLINs
Burnet Institute	99,978	**HIV project**—Capacity building for training modules in HIV in emergencies, training of trainers in psychosocial support for staff and civil society groups working in relief operation
Total	**210,608**	

2 FINANCIAL MANAGEMENT AND PROCUREMENT

2.1 Financial Status

Out of the pledged donor commitments of US$100 million (fluctuation of the dollar against other currencies has theoretically decreased this amount to US$96 million over the reporting period), contributions received from the six donors as of 31 December 2008, plus interest earned for three years, amounted US$59,149,962. The balance available on 31 December 2008 was US$16,657,177—already committed for on-going projects.

For 2008, funds amounting to US$19,466,828 were spent as follows: i) Fund Manager's operational cost = US$1,479,181; ii) support to Fund Board activities = US$76,231, iii) research and other policy development activities = US$112,399; and, iv) grants to implementing partners = US$16,625,733.

From 2006 to 2008, the fund incurred a total expenditure of US$42,492,785 out of which US$36,517,500 represented actual payments of grant instalments and unpaid commitments to 23 implementing partners.

These Fund Expenditures are reported in **Table 2.1** in the annexes —Financial Status Report. They represent the actual disbursements and accrual of unpaid instalments of contracts issued in 2008 with due dates of 31 December 2008 or earlier. Donor contributions arrived as planned; financial details are also shown in **Table 2.1**.

In April and August 2008, the Fund Manager signed amendments to extend Memoranda of Agreement with implementing partners by another year. As of 31 December 2008, total grants paid and committed to 23 partners amounted to US$43,571,211, including US$2,393,424 allocated during the bridging period (October 2006 to August 2007).

See **Table 2.2** about implementing partners grant status in the annexes.

Over two years, total funds were distributed between HIV and AIDS (59 per cent or US$25 million), Malaria (19 per cent or US$8 million), Tuberculosis (14 per cent or US$6.2 million) and Integrated services (8 per cent or US$3.5 million). Some 70 per cent (US$18 million) of the funds for HIV and AIDS activities were awarded to international NGOs, 22 per cent (US$5.6 million) to UN Organizations and 7 per cent (US$1.8 million) to local NGOs.

For UN Organizations, 59 per cent (US$4.7 million) of total funds were allocated to Malaria, 69 per cent (US$4.3 million) for TB. Integrated disease component was spent at 94 per cent (total US$3.3 million) for WHO (US$1,352,598) in the Fund Flow Mechanism and IOM for HIV, TB and Malaria activities (US$ 2 million). The remaining 6 per cent (US$212,540) went to an international NGO, CARE, for a combined TB and Malaria programme.

Detailed allocation of funds by disease component and recipient is shown in **Table 2.2.** and **Table 2.3** in the annexes.

In 2008 (Round I, Year 2) US$22,246,969 worth of grants was awarded to 23 implementing partners. International NGOs received 55 per cent of the funds, UN agencies 41 per cent, and local NGOs 4 per cent.

International NGOs received 67 per cent (US$9 million) for HIV and AIDS, 47 per cent (US$1.8 million) for Malaria and 40 per cent (US$1 million) for TB.

Out of 41 per cent of the funds granted to UN agencies, 25 per cent (US$3.4 million) was spent for HIV and AIDS, 53 per cent (US$2 million) for Malaria, 60 percent (US$1.8 million) for TB and 100 per cent (US$1.7 million) for integrated diseases.

To address the need of increasing the participation of local NGOs, the fund launched a Round II and eight grants were signed in January 2009 for a total value of MMK460,391,622 or approximately US$438,468 (maximum US$70,000 for each local partner).

See also **Table 2.3** in the annexes.

2.2 Fund Flow Mechanism

In 2008, WHO continued to manage a decentralised disbursement system ensuring support to National Programmes with funds directly channelled to local implementers at the township level and below. The Fund Flow Mechanism was extended for another year at the same level of annual funding (US$575,824).

The implementation modalities remained either as: (a) direct disbursement by Field Finance Clerks or on-site disbursement of funds serving mainly participants to trainings, meetings, workshops and drug transportation costs; and (b) reimbursement of claims for supervision and initial home visits, sputum collection and drug transport costs.

During the first year, WHO staff for this disbursement mechanism was composed of two international staff and 17 national staff (increased to 19 in Year 2). In mid 2008, six out of ten finance clerks were located to Myitkyina, Mandalay, Magway, Mawlamyaing, Monywa, Taunggyi, and the remaining four were stationed in Yangon serving adjacent States and Divisions as shown in Figure 2.4 in the annexes.

Under this disbursement modality, fifteen core support staff disbursed funds for 390 activities out of 439 implemented with the remaining 49 activities facilitated by either a WHO national consultant or a regional officer. Funds were disbursed to 10,133 participants in trainings, meetings, and workshops.

Lead times to reimburse claims for TB drug transportation (between several weeks and three months) was an issue. To improve this turn around time, a new system was introduced in Sagaing Division in October 2008. Two finance clerks were placed in the field for one week with fixed dates for drug collection, allowing on-site reimbursement to township medical officers. It was decided to continue this pilot system during the following quarter in January 2009.

Year 1 final report for the Fund Flow Mechanism indicated total spending of US$429,141 for the period 01 September 2007 to 31 August 2008 out of the total budget of US$575,824 or an implementation rate of 74.53%. The actual transfer cost (i.e. cost of channelling funds to the field) with the Fund Flow is US$0.56 for every dollar disbursed.

At the Annual Review Meeting held on 01-02 April 2008, the Fund Board requested WHO to fully operationalise the Fund Flow Mechanism and to develop a plan for TMO capacity building, which will lead to eventual management of the system by TMOs themselves. The Fund Board in its August 2008 meeting approved the piloting of the Fund Flow Mechanism through decentralised cooperation with local civilian administrations. Further planning with WHO for this pilot was followed through in early 2009.

Tables 2.4 and **2.5,** and **Figures 2.2, 2.3 and 2.4** in the annexes show the details of disbursement per activity and disease at township level.

2.3 Financial Audit of the Fund Manager and Implementing Partners

An international firm[5] audited the operations of the Fund Management Office from 17 to 29 April 2008. The Fund Manager received satisfactory rating in the areas of institutional arrangement, financial management and reporting, procurement and property management and partially satisfactory in the area of selection process and management of implementing partners. Recommendations were made and required immediate follow-up as follows:

- compliance with the Fund Board's decision on submission of logframes;
- close monitoring of fund position for better utilisation before further release of funds; subsequent instalments should be made according to implementation needs;
- regular monitoring of timely submission of certified and signed reports:
- no retroactive grant payments;

[5] Lochan & Company, Chartered Accountant, New Dehli, India

- close monitoring of the project budget balance position; to document reasons for variances and follow-up action to be undertaken for significant variances;
- close monitoring of interest reporting and plough back to programme resources;
- improvement in the audit reports of implementing partners should be communicated; and,
- procurement plan should be prepared and aligned with work plan.

As of 06 May 2009, four out of 26 recommendations remained opened.

All implementing partners were requested to submit an audited financial statement as per provisions in signed Memorandum of Agreement (MoA). Out of 18 local and international NGOs, ten submitted audit reports on or before the due date of 30 April 2008, five submitted on or before 31 May 2008, two submitted on or before 30 June 2008 and one in July 2008.

Financial audits covered the areas of financial management and reporting, procurement and property management. The auditors reported that implementing partners presented fairly financial position and transactions. Nine partners received partially satisfactory rating; no opinion was given for four partner agencies due to the limited review necessary to express an opinion and one was considered having appropriate internal control.

In seven cases, audit reports indicated non-compliance with the required output as per Terms of Reference (TOR) from the Fund Manager and inherent limitations in the conduct of the audit. The Fund Manager initiated new audits of international standard for these partners. For grants allocated in 2008, it was decided that all partners will be audited by an international auditor appointed by the Fund Manager.

The main findings from the audit of the implementing partners are:

- funds from abroad have been remitted under private arrangement, which is not in accordance with local law - i.e. Foreign Exchange Regulation Act promulgated with effect from 01 August 1947;
- there are no comprehensive guidelines for cash management, disbursement, human resources, procurement, inventory and stock management and control and travel activities;
- field activities were sometime implemented without proper authorization (ie expired MoU) from concerned Government Ministry; and,
- inaccurate and delayed financial reporting.

An Audit Action Plan was established and shared with implementing partners on 12 September 2008 for follow up and use in future reporting.

2.4 Procurement

The Fund Manager procures health commodities only for those partners who do not have sufficient capacity internally and offers assistance in custom clearance for all partners. In 2008 the FM placed 33 orders on behalf of ten implementing partners for a total value of US$636,826 (excluding freight charges). Total US$ 461,554 (72 per cent) worth of supplies was ordered through Long Term Agreements (LTA) established by UNOPS and other UN agencies. Some 70 per cent of supplies under LTA were delivered within five months following the initial request to the Fund Management Office.

A majority of orders were shipped partially, to allow faster delivery of items available in stock with the suppliers. Measuring the time between the initial requisition from the partner agency and the arrival of the commodities, 67 per cent arrived within five months, 14 per cent between

five and six months, 13 per cent between six and seven months and 5.7 per cent in more than seven months.

Reasons behind delivery time were: (i) expiration of LTA with UN agencies and delays in getting new long term agreements, (ii) changes in commodity list after the procurement process was initiated, and (iii) long lead times in the world market for certain commodities.

As a lesson learned, procurement should be undertaken against LTA as much as possible, in order to reduce lead times.

See **Figure 2.5** in the annexes.

Procurement related to HIV projects had the largest share with 57 per cent, followed by Malaria with 39 per cent. TB and integrated projects received four per cent of the supplies procured by the Fund Manager.

Approximately US$64,000 of the Fund Manager's procurement was spent on antiretroviral pharmaceuticals, of which US$47,000 for 400 adult treatments for one year. This gives an average cost per patient of less than US$10 per month. The remaining US$17,000 spent on antiretroviral pharmaceuticals was for oral solutions for children. In total 31,500 HIV tests were procured for a value of US$ 26,000. For Malaria the Fund Manager procured ACTs (Co-Artem) amounting to US$16,320, and 9,390 insecticide re-treatments kits and 41,620 long lasting impregnated bed nets for a value of US$ 215,500.

See **Figure 2.6** in the Annexes.

Commodity Tracking Review

To ensure that implementing partners have qualified commodity tracking systems in place, the Fund Manager contracted an external company[6] to review commodity tracking systems. This aimed at evaluating partners' organizational and technical capacity to safely and effectively manage their procurement, receipt, transportation, storage and distribution of pharmaceuticals and medical supplies.

In May 2008 the review of eight partners was postponed because of the cyclone Nargis and rescheduled for September 2008. The review assessed 22 field sites and eight headquarters of agencies in Yangon.

The review scored 50 topics covering the following five components: types of commodities procured, reception, warehousing, transportation and distribution. A number of commodities were traced throughout the supply chain from the arrival in the country to final distribution. Partners were rated *fully satisfactory* for 72 per cent of the topics assessed, with 16 per cent *needing development*, and one per cent both *exceeding expectations* and *fully unsatisfactory*.

Areas *needing development* are: physical storage facilities, consistent authorisation procedures, and lack of procedures to initiate distribution for pharmaceuticals getting close to expiry dates. Only one partner *exceeded expectations,* in the area of established and implemented supply administration procedures. As a lesson learned, implementing partners need to give more attention to procurement planning, correct storage conditions, and expiry dates in their commodity tracking systems, in order to prevent unnecessary losses of medical commodities.

See **Figure 2.7** in the annexes.

[6] SGS Ltd

3 CONTRIBUTION TO THE NATIONAL RESPONSE

3.1 Contribution to the National Response to HIV

In 2008 the Three Diseases Fund granted US$13 million to twenty implementing partners to take part in the national response to fight against HIV and AIDS.

HIV and AIDS Prevention Interventions

The National Operational Plan for HIV and AIDS has strategically categorised and prioritised different target groups for effective prevention interventions. Sex workers and their clients, men having sex with men, injecting drug users and families of people living with HIV and AIDS are targeted as the highest priority groups. 55 per cent of the total grants allocated for HIV and AIDS are used for prevention. Altogether twenty implementing partners, mainly local and international NGOs, provided packages of direct preventive interventions for different target groups in 106 townships in all States/Divisions.

Project townships are located in priority townships in which the coverage ranges from 23–76 per cent for different target groups.

See **Table 3.2** and **Figure 3.3** in the annexes.

As in 2007, each organization developed their own project design and adopted various strategies for the Year 2, from May 2008, providing ranges of prevention interventions: i) tailored behavioural change communication through peers on harm reduction and safer sex practices; ii) promotion and provision of preventive measures like condoms, needles and syringes; iii) creating enabling environment through advocacy to local authorities, law enforcement and communities; iv) direct provision or referral to quality treatment of sexually transmitted infection (STI) and voluntary confidential counselling and testing of HIV; and, v) creation of networks and self- help groups to promote prevention interventions and provide psychosocial support.

Eight implementing partners provided prevention services for sex workers and their clients and men having sex with men, six are for drug users, twelve for families of people living with HIV, four for mobile and migrant groups, four for youth. One local organization, MBCA is mainly targeting people at the work place and providing assistance to develop work place HIV policy.

See **Table 3.3** in the annexes.

Targeted HIV prevention activities reached 62,220[7] sex workers, 143,984 of their clients, 62,589[8] men having sex with men, 36,941 injecting drug users and 17,427 families of people living with HIV and AIDS through both outreach and drop–in–centre services. Altogether 23.8 million of condoms (male and female condoms) were promoted for all target groups. Over 75 per cent of these condoms were sold at highly subsidised prices through social marketing in 305 townships in all 14 States and Divisions and the rest were distributed free of charge to different target groups in 106 townships in the 14 States and Divisions.

See **Table 3.1** in the annexes.

[7] Due to service overlapping and lack of knowledge about the extent of migration of sex workers, data quality still needs to be improved. True figure is between is 47,000 – 61,000

[8] Data quality still needs to be improved due to service overlapping in some areas. True figure is between 50,000 – 62,000

See **Figure 3.1** and **3.2** in the annexes.

The National Operational Plan for HIV and AIDS has estimated the size of each target group and set annual targets for each strategic directions of the National Strategic Plan. Due to accessibility to target groups, number of partners, funding availability, lack of common definitions for some indicators and service overlapping in some townships, coverage of each prevention services for different target groups vary.

See **Table 3.4** in the annexes.

Comprehensive Care, Support and Treatment

It is estimated that 240,000 people are living with HIV and AIDS and around 70,000[9] are in need of ARV. Through direct provisions of care or referral to other health facilities, 15 partner agencies provide care and support services for people living with HIV and AIDS in 89 townships in 14 States and Divisions.

Six NGO partners provided comprehensive treatment, care and support services together with antiretroviral therapy for 4,594 adults and 329 children. WHO supported care and treatment services in the public health sector by the NAP through i) provision of HIV management training; ii) training of laboratory staff on OI diagnosis and CD4 counting; and, iii) procurement and distribution of antiretroviral drugs, cotrimoxazole for opportunistic infection prophylaxis and CD4 manual count reagents. Through WHO, 1,791 adults and 90 children received antiretroviral therapy in 25 ARV sites in public health services. During the reporting period, altogether 6804 clients: 6,385 adults and 419 children received ARV therapy with 3DF funding.

Eight partners provided diagnosis, prophylaxis and treatment of opportunistic infections; referral services to other health facilities for ARV, community based home based care, nutritional support and funeral support. All implementing partners provided technical and/or financial assistance to establish self help groups among people living with HIV and AIDS. Fifty self-help groups were formed with 9,674 people living with HIV and AIDS. Self-help groups are self – governing in nature and commonly implement peer counselling, psychosocial support to people living with HIV and AIDS and their families, provision or referral to peer support and health facilities, income generating initiatives to supplement the material and care needs of people living with HIV and AIDS and their families.

See **Table 3.5** in the annexes

Key Achievements in HIV

Number of people living with HIV involved in self-help groups	9,674
Number of people living with HIV receiving treatment for opportunistic infections	21,183
Number of adults over 13 years old with advanced HIV infection receiving antiretroviral combination therapy	6,385
Number of children (age 0–13) with advanced HIV infection who receive antiretroviral combination therapy	419
Number of people living with HIV who receive home-based care, including the package of support	19,081

[9] Report from the technical working group on Estimation and Projection of HIV and AIDS in Myanmar (NAP – Mandalay August 15 – 16 2007)

Prevention of Mother-to-Child Transmission (PMCT)

HIV prevalence among pregnant women at antenatal clinics has dropped from 2.2 per cent in 2000 to 1.2 per cent in 2008[10]. Prevention of mother-to-child transmission services are integrated at antenatal care clinics, providing counselling and testing of HIV for both pregnant mother and their partners.

Four implementing partners (AMI, MSF-Holland, MSF-Switzerland and Malteser) are cooperating with public health sector for prevention-of-mother to child transmission and 3,337 pregnant mothers accessed counselling and testing for HIV during the reporting period.

UNFPA supported the National AIDS Programme (NAP) in 46 townships with training of trainer (TOT) for HIV counselling, development and distribution of information education materials, training of laboratory staff for HIV testing, provision of HIV test kits, clean delivery kits, antiretroviral for HIV prophylaxis and medicines for OI prophylaxis for children born from HIV positive mother. 65,040 pregnant women accessed VCCT at public health facilities, hence altogether 68,377 pregnant women received this service with 3DF funding in 2008.

HIV Sentinel Sero–Surveillance Survey and Behavioural Surveillance

HIV Sentinel Sero–Surveillance and Behavioural Surveillance were conducted for selected sub-population groups to assess distribution and trends of HIV transmission and to determine the factors for use of public health action. These include pregnant women attending antenatal clinics, new military recruits, blood donors, injecting drug users, men who have sex with men, female sex workers and new TB clients in 34 sentinel sites of twelve States and Divisions in 2008. Behavioural surveillance has been on-going since 2000 to assess trends of knowledge, attitude and practice among specific target groups.

In 2008 surveillance targeted out-of-school youth population in urban communities in five townships. WHO provided technical assistance in revision of surveillance protocols, data collection and analysis, training of human resources and procured HIV test kits and other commodities. The surveys were completed as planned and the results disseminated in March 2009.

Blood Safety

WHO supported the blood safety programme in 342 laboratories across all States and Divisions. The main activities included: i) training for laboratory staff; ii) procurement and distribution of HIV test kits and consumables for blood collection; and, iii) conducting advocacy meetings at township level for safe blood donation.

Supporting Application of the Three–Ones in Myanmar

UNAIDS supported the National AIDS Programme in the Three-Ones application through four major interventions: i) supporting national monitoring capacity; ii) NAP procurement and supply management capacity; iii) NAP decentralised management planning; and, iv) decentralised and mass media general awareness raising. Almost all interventions were carried out during the reporting period. The third intervention has not been conducted due to a challenging start.

Good Practices

Coordination meetings took place at township level among implementing partners and local authorities and health system administrations. It helped not only to improve collaboration and

[10] National AIDS programme Myanmar – HIV sentinel Sero – surveillance Survey 2008

learning, but allowed effective use of resources. Implementing partners set up referral networks and partnerships with other service providers. These networks supported clients to receive complete package of HIV intervention from prevention, to treatment, care and support.

Implementing partners are assessing clients satisfaction and encourage them to provide feedback to the programme. For instance, all partners of the NGO Consortium for HIV led by SC-UK (CARE, MNMA and MSI) used a client feedback form, in which clients could make suggestions for improvement.

All partners recognise the importance of community involvement as an effective way to address the needs of the clients, as well as to promote sense of ownership for long term sustainability. This ensures that members of the community take part in programme implementation and management and, in some cases, even in the design of the project.

Challenges

Availability of services and transportation costs in some townships remain a challenge for the projects as well as for beneficiaries to receive early diagnosis and treatment of STI and HIV. Furthermore, limited access to antiretroviral therapy added to the burden on treatment and care of opportunistic infections. Related costs are almost the same as for ARV and sometime for a limited number of conditions, and even higher with unsecured outcomes delaying progress.

Limited knowledge of trends of targeted beneficiaries is another limitation. For instance, migration of sex workers, lack of common definitions for some indicators, service overlapping and double counting create difficulties in data compilation and analysis. In some areas, access to target beneficiaries is impeded from time to time due to the nature of the clients, security restrictions in the area, or special travel permissions.

3.2 Contribution to the National Response to TB

In 2008 the fund granted US$3.4 million to seven implementing partners for TB projects, of which two operated integrated programmes.

Support to TB control programme had various intervention modalities: i) support to the National TB Programme (NTP) through WHO strengthening the supply chain management, capacity building, monitoring and evaluation and outreach activities; ii) community-based DOTS and direct service provision including HIV high risk target group (drug users) for TB-HIV screening and referral to NTP for treatment; and iii) Public-Private Mix DOTS (PPM DOTS) assistance by trained providers (GP).

All TB implementing partners received the same level of grants in Year 2 and kept the same level of implementation. Some could scale up the number of beneficiaries and coverage at village level with the same funding. Two partners did not participate in a second year: CARE closed their project upon completing Year 1 due to other commitments in the emergency response to the cyclone Nargis; and, PSI completed a one-year contract for TB.

Contribution to the national response for TB is detailed in **Table 3.7** in the annexes. The results of the national TB response listed in the annex are therefore a consolidated collective achievement of all actors in country.

New activities are summarised in **Table 1.2**.

Coverage and access

Geographical coverage for TB community-based programmes and PPM DOTS appears lower in the reporting period, showing that the grant to PSI ended in March 2008, whereas PPM DOTS were mainly undertaken by the Myanmar Medical Association (MMA). PPM DOTS implemented by MMA in 26 townships (mainly do Scheme I, referral to NTP) contributed to three per cent of the detected cases managed in the TB national response.

Expansion to 30 points of sputum collection by the NTP (with an additional 10 in 2008) and its partners provided increased access to TB diagnostic facility by the community. IOM also expanded their additional TB diagnostic laboratory in two townships in Mon State.

AHRN opened a new drop-in centre in Kachin State, where clients could access TB-HIV screening and be referred to NTP and MSF-H/AZG for treatment.

See **Figure 3.8** on TB programme coverage by township in the annexes. New activities are summarised in **Table 1.2**.

Support to NTP

In 2008 the fund continued to support through WHO the National TB Programme (NTP), mainly in financing the TB drug transportation system for the whole country and with the procurement of first line TB drugs (covering additional needs), as well as in capacity building and monitoring. The NTP strengthened outreach activities in two border townships, Tachileik and Myawaddy with community-based approach and initial home visits to TB patients, as well as Public Public Mix DOTS in four general hospitals in Yangon. The public health sector also engaged with all health care providers in launching an initiative to establish international standards in TB care.

The fund was a driver for partnership and coordination in monitoring and evaluation through the Technical and Strategic Group for TB. Cohort review meetings were conducted in all 30 low performance townships aiming at a systematic review of the management of TB patients and their contacts. A pilot project started in two townships in Yangon based on lessons learned from the bridging period, which demonstrated significant improvement in treatment success rate and reduced defaulter rate.

The fund continued funding WHO to carry out its secretariat function for the TSG to provide technical assistance.

Community-based DOTS

Partners implemented community-based DOTS programmes in 26 townships to support the NTP. Empowering communities in case detection, DOTS provision, defaulter and treatment interrupter tracing through a network of community health volunteers were significant contributions to the national response.

As a result, the NTP reported less defaulters and higher treatment success rate in project areas. Expansion of TB screening laboratory facility in remote townships and establishment of new sputum collection points ensured increased access and case detection. Total case referral to NTP was 18,342 and defaulters only 89.

See **Figure 3.7** in the annexes.

PPM DOTS

The Myanmar Medical Association (MMA) PPM project supported by WHO has grown in 2008, mainly in systematic recording and reporting. MMA scaled up scheme II and III treatment provision in six townships out of the covered 26 townships. At present 516 GPs are included in the MMA support programme, of which 62 GPs provide DOTS. GPs have contributed with the detection of 1,736 sputum positive cases and 4,096 (3 per cent of national reported cases, all forms of TB) registered TB cases among 6,840 patients referred to NTP, which represents 5 per cent of total SS+ cases detected in 2008.

Key Achievements in TB

Cases	WHO NTP	Community-based DOTS	PPM-DOTS*
Number of SS+ TB cases detected	34,192	2,380	1,736
Number of patients successfully treated/completed treatment	27,764	1690	N/A*

* MMA's PPM DOTS scheme III has been initiated in the last quarter of 2008, results cannot be calculated yet

Details of the contribution to the national TB response are available in **Table 3.7** and **Figure 3.7** in the annexes.

Good practices

The coordination with township medical officers and establishment of strong referral networks is essential for smooth services delivery to the beneficiaries. The establishment and training of networks of community health workers created a momentum to increase case detection rate, as well as improve the quality of DOTS, not only limited to the partners' projects but also contributed to the national response at township level. Increased awareness of TB in the community was also a valuable result of the existence of this network embedded in the community.

Based on experiences learned in Year 1, all community-based projects kept providing effective support to patients for referrals (with transportation and lodging costs) as well as nutritional supplements to patients and their families, which was found to be beneficial in the clinical outcome. MMA PPM DOTS project also provided referral costs, sputum examination and CXR costs for poor patients, which increased case detection.

Supervisory visits conducted by project staff in the field had a positive effect on project implementation. Capacity building of township level management by WHO and the NTP has been an essential element of the national response. Similarly, collaboration of project field staff and basic health staff was crucial to have a better impact in the community. Continued training and education of GPs, as well as the harmonisation and simplification of data collection in the private sector, are important steps to improve quality of DOTS and to assess the results of TB control programmes.

Challenges

An alarming challenge is the free supply of anti-TB drugs, which are only secured until the end of 2009 from the Global Drug Facility. Without this support, all TB programmes would largely fail to deliver DOTS services and result in a much lower level of case detection and cure rates and

most likely a largely increased number of MDR-TB cases. Low coverage of community DOTS projects in remote villages and border areas, low community awareness and limited access to health facilities in those areas remain challenges to address.

Growing TB treatment failure cases and HIV co-infection reported by some projects and the occurrence of MDR-TB particularly at the Thai-Myanmar border highlights the need for strengthening TB-HIV screening in all modalities and systematic referral for MDR-TB treatment centres (currently funding two pilot programmes: NTP and MSH-H/AZG for total of 150 MDR patients). Some implementing partners have already integrated TB-HIV screening in Year 2 activities.

3.3 Contribution to the National Response to Malaria

In 2008 the fund granted US$4.4 million to seven implementing partners for Malaria projects, of which two were integrated programmes.

Support to the Malaria control programmes expanded gradually into areas with different intervention modalities: i) support to the National Malaria Control Programme (NMCP) through WHO ; ii) community-based malaria control programmes through trained volunteers and direct service provision by partners; and iii) Public-Private Mix Malaria programme through trained providers (GPs).

All partners received the same level of funding and some managed to scale up activities by expanding into new areas (e.g. expanding geographic coverage at village level, additional LLIN distribution in target villages, conducted operational research on efficacy of bed nets etc).

CARE community-based integrated TB and Malaria project closed in the first half of 2008. Nargis impacted implementation by delaying planned activities of many implementing partners and especially affected the National Programme. Training to Vector-Borne Disease Control (VBDC)/NMCP staff could not be completed since most of them were involved in the Nargis response for outbreak prevention.

Coverage and access

The Malaria programme reached to total 134 endemic townships and a broad range of target groups through mobile and fixed clinics. MMA expanded their Public-Private Mix programme and operated in 46 townships with additional set up of two fixed and mobile clinics in two remote Malaria endemic townships in Northern and Southern Shan state. The NMCP was active in the same 100 townships as in Year 1 and community-based programmes were implemented in 36 townships.

See **Figure 3.6** in the annexes.

Support to NMCP

WHO supported the NMCP in field supervision, training of township medical officers and basic health staff in Malaria control and management skills, and provided anti-malarial drugs, RDTs, LLINs and insecticide tablets for bed net treatment in 100 townships. IEC materials and BCC campaigns were strengthened. Total 8,200 LLINs were distributed and 182,001 bed nets were treated in net treatment campaigns,, and Township VBDC teams provided 187,576 ACT to *P.falciparum* cases. WHO and the Myanmar Council of Churches (MCC) conducted malariometric and KAP surveys in Kachin State.

Community-based Malaria Programme

All community-based programmes provided free diagnosis with RDT and ACT treatment, LLIN/ ITN for prevention, as well as transportation costs for referrals of severe Malaria cases and treatment costs. These programme supported networks of trained community health volunteers for early diagnosis and effective treatment. Capacity building of volunteers was scaled up together with intensive monitoring and supervision, allowing a smooth flow of commodities and better results against targets.

Coordination at township level between basic health staffs and field staffs/volunteers of NGOs needs to be strengthened. Integrated township plan for LLINs distribution has not been done yet. All partners reported high level acceptance and usage of LLINs/ITNs by community. Most implementing partners reported that new village development committees were initiated and supported.

Public-Private Mix Activities

PPM activities in Malaria control continued with MMA through WHO. MMA supported diagnosis and treatment by private providers (GPs) at subsidised prices. The medical association also distributed 1,850 LLINs and 3,675 bed net treatment tablets in 2008. Total 44,432 patients were detected by RDT and treated with 15,086 ACT. Direct service provision by fixed and mobile clinic approach was established. CESVI provided training, RDT and microscopy slides to 37 private GPs in project sites for screening of Malaria cases and referral of the poorest clients to CESVI clinics for getting standard treatment.

Key Achievements in Malaria

Number of LLINs distributed	91,986
Number of bed nets re/treated	299,195
Number of Malaria cases treated with ACT and non ACT	712,627

See **Table 3.6** and **Figures 3.4 and 3.5** in the annexes.

Good practices

Early detection and effective treatment of Malaria cases by trained basic health staffs or volunteers or GPs at community level is an international best practice to effectively tackle Malaria in communities. Severe Malaria patients also received support for referral to the health facilities as necessary, significantly reducing malaria mortality. Many implementing partners reported no more Malaria death in their project sites (also acknowledged by local communities). Many agencies introduced mobile teams, which appeared to be cost effective and a good approach for expanding services in hard-to-reach areas (even beyond target villages).

Intensive BCC and health education campaigns were introduced to explain the benefits of LLIN, resulting in high acceptance of bed nets in communities. However, there is a need for operational research for measuring the efficacy of LLIN lifetime and bed net usage among target population.

Collaboration between implementing partners and township/village health committees was crucial to ensure acceptance of volunteers and support from the community to enable data collection and to motivate them to work together with basic health staffs. TMO support allowed medical teams to see Malaria patients in prison and sometime prisoners were allowed to receive treatment in mobile clinics.

Challenges

Timely collection, analysis and reporting of data from community health workers was still a challenge to some programmes and required frequent refresher trainings and close hand-on training during supervisory visits.

Since RDT negative ratio was increased in most project areas, management of those cases in the lack of microscopy in remote areas remains difficult. This could lead to over treatment with non-ACT (CQ) for every suspect case. Therefore, many partners are considering the possibility to use combo RDT tests in Year 3. Some have started piloting the use of combo tests (which can detect both *Pf and Pv* species) and planned to conduct operational research on efficacy of different RDTs.

Although mobile clinics can reach remote areas, they cannot provide care beyond Malaria, which is a great challenge for the medical teams. There is increasing demand for services provided by fixed and mobile clinics beyond their capacity. Safety, security and transportation difficulties in remote areas remain a challenge for all programmes which limit their timely implementation. The lack of GPs and basic health staff in remote areas as well as high turnover of public health staff, particularly TMOs, still remain a challenge.

Low bed net coverage (<5% of needs reported by NMCP-WHO covered) compared to increasing demand remains a challenge for all partners in many areas.

3.4 Monitoring

The Fund Manager monitors funded projects by scheduled field monitoring visits together with six-monthly financial and technical progress reports from implementing partners. The FM not only measures the progress of project activities, but also the level of implementation of operational policies. Monitoring also includes crosscutting issues, such as gender, transparency and accountability.

During 2008 the Fund Manager monitored all 32 field projects through 22 field visits, covering all partners, of which:

- twenty partners in 42 out of 140 townships, where HIV activities are implemented;
- seven partners in 23 out of 134 endemic Malaria townships; and,
- seven partners in 22 out 325 covered by the National TB programme.

The Fund Manager visited eleven CBOs in seven townships for the assessment of Round II in October and November 2008 and facilitated four visits for donors in strategic geographic areas. Border areas such as Muse, Tachileik (Shan State), Maung Daw (Rakhine State), Kawt Thaung (Tanintharyi Division) were reached by monitoring visits.

See **Table 3.8** and **Figure 3.9** in the annexes.

The Fund Manager monitored project performance, including supply change management and met local authorities, field project staffs, volunteers and beneficiaries. Feedback and recommendations were provided to partners and follow-up visits arranged. Monitoring visits were undertaken by international and national officers, together with liaison officers of DOH. National officers also made independent trips.

Information sharing with local health officials at township level was strengthened in 2008, as the awareness of local authorities about fund activities remained low. In general, collaboration and coordination with all stakeholders has improved.

Intensive and frequent field visits had a positive impact on programme delivery against targets. Field observations aimed at quality implementation, better coordination and policy development.

3.5 Most Significant Change

The fund introduced the Most Significant Change (MSC) methodology as a qualitative and participatory monitoring and evaluation tool. In essence, changes are captured in the field, allowing direct involvement of beneficiaries and service providers. In October 2008, the Fund Manager provided training to all implementing partners, arranged with the Burnet Institute in Myanmar. A total of 44 participants from 23 organizations, fund management staffs and senior officials form DOH attended the two-day workshop.

Implementing partners shared with the Fund Manager MSC stories in their progress reports. Some partners trained their staffs to integrate the methodology in their existing monitoring and evaluation systems. Ten partners (AMI, Malteser International, MANA, UNODC, Pyi Gyi Khin, World Vision, Merlin, CARE, CESVI and Burnet Institute) shared project outcomes in fifteen MSC stories.

A significant change observed by CESVI Malaria project in Northern Shan illustrated the issue of accessibility. The strategic location of CESVI fixed clinic in a remote area, where main public health facilities are scarce, saved the life of an eight-month old girl by providing effective anti-Malaria treatment.

MSC stories from CARE, UNODC and MANA show cased behaviour change among former drug users, who now have drug-free lives due to an enabling environment created in drop-in centres and methadone treatment.

During the immediate aftermath of Nargis, a community volunteer from World Vision ensured continued provision of anti-TB drugs demonstrating the sustainability of a community-based project.

The quality of life of people living with HIV in Wa Special Region II, a hard-to-reach area, has improved for the beneficiaries of Malteser ARV programme.

4 OPERATIONAL RESEARCH

4.1 Funding Gap Analysis

In order to establish the financial needs of the National Programmes for HIV, Tuberculosis and Malaria, to map the financial resources that are available to meet this need and to identify the financial gaps in coverage, a gap analysis study was conducted by an international consultant in April 2008. The study concludes that investment in the national responses to HIV/AIDS, TB and Malaria in Burma/Myanmar continues to fall considerably short of what is required to implement the levels of service necessary to impact the spread of the epidemics as put forward in the National Operational Plans.

The table below summarises the actual funding gap for the three diseases for the period of the operational plans (2006–2009) and estimates of the funding gap up to 2010, based upon known commitments.

Operational Budget US$	**2006**	**2007**	**2008**	**2009**	**2010**	**Cumulative Total**
HIV/AIDS	30,346,972	43,470,970	51,983,506	62,581,609	74,644,928	**263,027,985**
Tuberculosis	13,467,871	18,809,749	18,477,025	18,477,025	18,477,025	**87,708,695**
Malaria	12,504,148	14,678,328	13,860,365	13,193,077	13,193,077	**67,428,995**
Available Funding	**56,318,991**	**76,959,047**	**84,320,896**	**94,251,711**	**106,315,030**	**418,165,675**
HIV/AIDS	26,979,076	30,860,121	38,280,146	23,755,598	15,661,263	**135,536,206**
Tuberculosis	3,599,811	4,882,590	8,163,328	3,327,675	1,646,510	**21,619,915**
Malaria	2,765,937	4,971,026	6,847,118	4,760,278	4,517,126	**23,861,485**
Total	**33,344,824**	**40,713,738**	**53,290,592**	**31,843,552**	**21,824,900**	**181,017,605**
Overall Funding Gap	**22,974,167**	**36,245,309**	**31,030,305**	**62,408,159**	**84,490,130**	**237,148,069**

Although the reporting requirements of various stakeholders are being met, a fundamental gap exists in that there is no comprehensive system of financial information available which consolidates the overall financial activities involved in the implementation of the disease responses and from which the 3DF can draw the financial information required for decision making in resource allocation. A strong, comprehensive system of financial management is required to deliver accurate, evidence based financial information that is necessary for the purposes of economic analysis.

National information on the burden of each disease is not as accurate as desired for various reasons. There is also no available information on the impact of the various interventions within each disease response, in either financial or physical terms. Performance data is not generally included in any current reporting requirements. To ensure a high degree of prioritization in the allocation of 3DF funds, it would be necessary to have evidence based recommendations on resource allocation between diseases and within each national strategic programme, whilst

considering the most cost-effective interventions in order to maximise impact on the three diseases. The 3DF would benefit from employing cost-effectiveness analysis to establish formulae for resource allocation, which reflect as precisely as possible the variation in need across the three diseases.

4.2 Gender Study and Gender Task Force

Gender is a social construct that differentiates the power, roles, responsibilities, and obligations of women from those of men in society. The fund established a policy environment for operation, which includes focus on gender equity.

The fund's Operational Guidelines highlight gender as a crosscutting issue to be addressed by implementing partners. The selection criteria for HIV projects include a requirement to address gender. Partners often identified gender equality as a general programme objective but did not incorporate activities to address gender issues or support gender mainstreaming in their programmes. In April 2008, a gender study was conducted by an international expert in consultation with all key stakeholders.

A three tier integrated gender strategy was developed in 2008, addressing the national policy level, management and monitoring systems, and implementation through partners. Strategy one recommends advocacy and support to a policy environment to mainstream gender by supporting amendments of fund policies and operational guidelines and guidelines for the allocation of grants. Strategy two proposes to create a gender sensitive environment by appointing a gender focal point in the Fund Management Office, building the capacity of team and partners, including gender sensitive component in technical proposal assessments and gender equality statement in communication and promotional materials. The third strategy is to mainstream gender in implementation and monitoring of the projects through gender sensitive indicators' development and collection of sex disaggregated data and a gender analysis.

In October 2008, the Fund Manager together with interested partners (AHRN, International HIV/AIDS Alliance, WHO, UNAIDS, UNFPA, MANA, Pyi Gyi Khin, AFXB, Burnet Institute), formed the Three Diseases Fund Gender Task Force, of which the Fund Manager acts as secretariat. The fund envisages all these efforts as complementary to existing gender initiatives by gender working groups at the national level. Sex disaggregated data in core indicators for each disease are included in progress reports since 2008.

4.2 Civil Society Involvement

During the later part of 2007, the fund commissioned a study to identity strategies which will enable local NGOs and CBOs to access 3DF support directly. The final report of the study, which was made available in March, 2008, made a number of recommendations including immediate funding for a special civil society round (Round II), combined with a number of capacity building initiatives to support and enhance the technical capacity of these local organizations.

Community Feedback Mechanism

At the same time, the fund assessed possibilities to set up a feedback mechanism to promote transparency, accountability and aid effectiveness for all granted projects. This study recommended implementing a Community Feedback Mechanism. It proposed a three-phase approach, consisting of carrying out a baseline review of existing community feedback mechanisms; building links with beneficiary communities; and creating structures for the implementation of a feedback mechanism.

A consultant was recruited in 2008 to plan, design and implement the Community Feedback Mechanism. A wide range of consultative meetings with stakeholders was initiated during the planning and design phase and a strategy developed.

The Community Feedback Mechanism is based on the recognition that communities where projects are being implemented have a major role in shaping the 3DF response and in ensuring that programmes and services are not only accessible to all those who need it but that their positive impact is felt in the larger community. Feedback from communities can be positive or negative. Although it may not be possible to respond appropriately to all feedbacks, the mechanism could still provide a basis for larger advocacy, requiring greater collaboration and a collective approach.

The tools and methods suggested for gathering feedback, as well as how to respond to feedback and address issues, were developed through consultative workshops and meetings with communities and key stakeholders.

Tools for Community Feedback Mechanism

- E-mail to directly send feedback to the Fund Manager
- Suggestion box in common places – like drop-in centres, community centres, health clinics etc.
- Awareness about the feedback mechanism and how to use feedback tools
- Community-feedback meetings facilitated by consultants who are not directly linked to programmes in the communities – once every six months
- Simple questionnaire to communities to share views and feedback with the Fund Manager – once a year
- Availability of “ready to post’ envelops for people to send feedback directly to the Fund Manager

The fund recognises that feedback from communities is not only crucial in order to improve impact of programmes, but that mistakes, when not addressed, can have serious consequences in the long-run. Taking action in the course of the project means good-practice can be replicated and not-so-good-practice rectified. Providing opportunity to communities to share their opinion (openly or secretly), voice their concerns safely and receive appropriate and timely response is an important aspect of accountability.

The Community Feedback Mechanism uses a common phrase ‘**A Kyan Pay Par**’ (“suggestion or feedback” in Burmese/Myanmar language) to describe the strategy and its importance.

5 CONCLUSION

2008 has been the first complete calendar year of the fund's operation, during which all programmes as well as support capacities were fully in place. The operational environment has shown no significant changes throughout the year, except when cyclone-related activities slowed down travel authorisations for a few weeks. The fund has been able to visit all project locations. Increasingly, field monitoring visits were perceived as an opportunity for the national programmes to conduct joint visits with the Three Diseases Fund. Senior Liaison Officers were assigned to Fund Manager's staffs from relevant disease control programmes.

Meetings between the Fund Manager and the DOH were institutionalised on a bi-monthly basis, as well as ad hoc if required, and had a positive impact in building trust and enhancing coordination of the programme. Also by attending the Technical and Strategic Groups (TSGs) as an observer and sharing data, reports and results of operational studies, the Fund Manager brought its activities closer to the national programming process.

The national M&E systems and national programmes responded to the momentum created by the fund by establishing large scale activities. However there is room for improving the harmonisation of national M&E systems and indicators as elaborated in the NOPs with the practices in the field. The intensified programmatic work of TSGs with respect to the potential new large scale funding expected from the Global Fund (GFATM) is hoped to have positive impact on the efficacy of the national coordination mechanism.

Quality of data from partners reporting in the fund's M&E system, as well as deviation in practices by national programmes using different indicators and data collection systems from the promulgated NOP M&E framework, pose some challenges to the fund to fit data easily into the national M&E system and make the demonstration of the fund's impact rather difficult. Because of the lack of clear definition of indicators and various interpretations of these indicators by partners, as well as unstable data reporting practice, the fund needs to promote further efforts to ensure the collection of reliable data. The TSGs initiated such improvement during the course of 2008. Progress is expected especially as Myanmar's application to GFATM Round 9 intensified programmatic work. The Three Diseases Fund is also reviewing its own targets and logframe.

Nevertheless the fund has been successful in delivering services to a large group of beneficiaries reaching to far corners of Myanmar. The sheer quantities of services provided thanks to 3DF grants are a clear indication of the impact of the programme. In the first Annual Review Meeting, held in April 2008, all actors lauded this success. It also demonstrated the goodwill surrounding the fund and reflected on its true potential through intensive cooperation in responding to the public health challenges that the three diseases continue to pose.

Regarding procurement of medical supplies, changes in the planning process/requirements - together with the fact that pharmaceuticals have to be sourced from the international market in strict adherence with international standards - cause fairly long lead times. Consolidating specific needs of implementing partners for procurement of commodities through the Fund Manager has been a challenge, and significant progress has been made through establishing a positive list of items in line with the national clinical protocols. These clearly define eligible commodities that partners can use in submitting their needs.

Possible solutions to shorten these lead times include increased use of Long Term Agreements in product acquisitions and a shift to move to multiyear grant agreements with implementing partners. Lessons learned will be utilised in making this mechanism more effective together with partners. Intensified commodity tracking has been useful to gather lessons and is foreseen to be continued in the future.

The launch of Round II and inclusion of local NGOs and CBOs among the partners has been a milestone achievement of the year. The process was complex and filled with practical and principle difficulties on its way, but the successful launch in agreement with the MOH has been a proof of the potential for a good programming and scaling up of the national response in innovative ways in the future.

The work carried out by these new partners will be closely monitored in 2009 and lessons will be utilised in adjusting this round to enable further inclusion of civil society based providers where they have comparative advantages in programming and service delivery in collaboration with the MOH in the future.

One of the areas of importance in the time ahead is the upcoming piloting of a Fund Flow Mechanism to the townships directly to assist the national programmes on the township level. Another such pilot launched in 2008 was the direct commodity provisions in the forms of LLINs, RDTs, and ACTs (for the value of US$36,000) to eight townships for use in their malaria control efforts for the benefit of the community.

These initiatives will require a close collaboration between the fund, DOH, national disease control programmes and WHO and should be an effective laboratory to further explore the ways to increase efforts to tackle the public health threats of the three diseases through innovative means.

The well established collaboration of the fund with key stakeholders has created the space to further assist in producing evidence for more effective programming, and the Three Diseases Fund will remain dedicated to assist through financing new studies and surveys. Commitments have been made to contribute to the National TB Prevalence Survey in 2009 and the fund will remain open to new areas.

One of the strengths of the Three Diseases Fund, which will be further focused on in 2009, is its intensive presence in the field and close collaboration with partners through frequent field visits. Feedback systems on findings and follow up of recommendations will be strengthened to ensure most effective implementation by sharing lessons learnt across the programme. The fund will look into ways to respond to requests from partners to provide a platform for sharing lessons and for discussions related to practicalities in disease specific programme implementation.

ANNEXES

List of Tables and Figures

ANNEX 1

Table 1.1. Disbursement/Absorption Rates

Partner		Disease	Reporting Period	Approved US$ Budget 31 Dec 2008	Cumulative Expenditure Reported	Absorption Rates	Remarks
1	AZG/MSF-H	TB	1-Sep-07 to 31-Dec-08	288,830.00	96,023.00	**33%**	MDR-TB delayed
2	UNAIDS	HIV/AIDS	1-Sep-07 to 31-Dec-08	460,809.51	169,999.56	**37%**	Recruitment of expert delayed
3	World Vision	TB	1-Sep-07 to 31-Dec-08	525,802.00	276,773.02	**53%**	
4	Merlin	Malaria	1-May-07 to 31-Dec-08	1,298,063.11	804,387.29	**62%**	
5	UNFPA	HIV/AIDS	1-Jul-07 to 31-Dec-08	918,018.00	578,571.00	**63%**	
6	CARE	HIV/AIDS	1-May-07 to 31-Dec-08	289,396.43	183,960.53	**64%**	
7	World Vision	Malaria	1-Sep-07 to 31-Dec-08	451,323.00	310,634.04	**69%**	
8	WHO	Malaria	1-Sep-07 to 31-Dec-08	3,352,707.20	2,394,708.00	**71%**	
9	World Vision	HIV/AIDS	1-Sep-07 to 31-Dec-08	449,503.79	327,140.33	**73%**	
10	UNODC	HIV/AIDS	1-May-07 to 31-Dec-08	1,636,770.00	1,216,638.82	**74%**	
11	AHRN	TB	1-Sep-07 to 31-Dec-08	157,888.89	121,374.54	**77%**	
12	BI-MM	HIV/AIDS	1-May-07 to 31-Dec-08	1,531,125.00	1,186,367.00	**77%**	
13	WHO	Fund Flow	1-Sep-07 to 31 Dec-08	767,765.33	600,208.00	**78%**	
14	WHO	TB	1-Sep-07 to 31-Dec-08	3,234,063.30	2,536,180.48	**78%**	
15	WHO	HIV/AIDS	1-May-07 to 31-Dec-08	2,469,092.56	1,974,749.26	**80%**	
16	World Concern	HIV/AIDS	1-May-07 to 31-Dec-08	285,979.20	229,745.10	**80%**	
17	Alliance	HIV/AIDS	1-May-07 to 31-Dec-08	615,221.00	525,197.00	**85%**	
18	World Concern	Malaria	1-May-07 to 31-Dec-08	203,160.13	173,582.97	**85%**	

Partner		Disease	Reporting Period	Approved US$ Budget 31 Dec 2008	Cumulative Expenditure Reported	Absorption Rates	Remarks
19	IOM	Integrated	1-May-07 to 31-Dec-08	2,174,541.65	1,863,053.05	**86%**	
20	PSI	HIV/AIDS	1-Nov-07 to 31-Dec-08	1,625,725.54	1,397,209.80	**86%**	
21	CESVI	Malaria	1-May-07 to 31-Dec-08	1,103,573.70	959,061.51	**87%**	
22	PGK	HIV/AIDS	1-May-07 to 31-Dec-08	529,946.27	465,532.46	**88%**	
23	Consortium	HIV/AIDS	1-May-07 to 31-Dec-08	3,138,667.00	2,761,605.00	**88%**	
24	Malteser	TB	1-Oct-07 to 31-Dec-08	315,782.53	278,707.59	**88%**	
25	CARE	Integrated	1-Sep-07 to 31-Aug-08	212,540.00	191,091.56	**90%**	No Year 2
26	Malteser	HIV/AIDS	1-May-07 to 31-Dec-08	676,765.00	609,035.00	**90%**	
27	AHRN	HIV/AIDS	1-May-07 to 31-Dec-08	851,724.52	768,445.93	**90%**	
28	AMI	HIV/AIDS	1-May-07 to 31-Dec-08	468,706.05	423,990.56	**90%**	
29	MANA	HIV/AIDS	1-May-07 to 31-Dec-08	935,632.15	848,577.63	**91%**	
30	AFXB	HIV/AIDS	1-May-07 to 31-Dec-08	522,469.36	480,956.11	**92%**	
31	MBCA	HIV/AIDS	1-May-07 to 31-Dec-08	219,552.75	204,130.20	**93%**	
32	MSF-Switzerland	HIV/AIDS	1-Sep-07 to 31-Dec-08	679,652.00	659,883.24	**97%**	
33	PSI	TB	1-Jun-07 to 31-Mar-08	160,000.00	158,734.00	**99%**	Grant expired
34	AZG/MSF-H	HIV/AIDS	1-May-07 to 31-Dec-08	2,767,937.48	2,767,937.48	**100%**	
				32,071,724.60	**27,524,024.32**		

Table 1.2. Grant Extensions from Year 1 to Year 2
Summary of New Activities

Partner	New Activities	New Target Groups	New Geographical Locations	Remarks
HIV and AIDS				
AFXB	In Year 2 self-help groups encourage the initiation of new support groups in other areas of the country	HIV awareness for staff from public and private facilities to reduce stigma	Mudon (Mon)	
AHRN	Self-help group sessions	N/A	Two new sites, a drop-in centre and outreach site in Kachin State	Additional funding US$110,000 from pooled unspent fund from Year 1
AMI	New drop-in centre, increased access to HIV testing and antiretroviral treatment	N/A	New drop-in centre	Additional funding US$99,366.00 from pooled unspent fund from Year 1
AZG/ MSF-H	Procurement of reagent for viral count and antiretroviral	N/A	N/A	Additional funding, US$197,100 from pooled unspent fund from Year 1
Burnet Institute	Training in psychosocial care, counselling; training modules for CBOs on HIV in emergencies	Civil society groups involved in Nargis response	Cyclone affected areas	Funds reallocated for Nargis-related activities U$99,878.00 from unspent budget Year 1
Malteser	N/A	N/A	One new site in Special Region 4	Additional funding, US$100,000 from pooled unspent fund from Year 1
PGK	Procurement of CD4 machine and reagents for Taung Gyi hospital and increased number of ART clients	N/A	N/A	Additional funding, US$51,300 from pooled unspent fund from Year 1
World Concern	Capacity building for local groups in reproductive health activities and IEC materials	N/A	Cyclone affected areas	Funds reallocated for Nargis-related activities US$31,260 from unspent budget Year 1

WHO	Behavioural surveillance targeting new groups; support to antiretroviral treatment in additional general hospital	Men who have sex with men (Yangon and Mandalay); truck drivers in Muse (Shan) Tanunggo (Bago) and Mawlamyaing (Mon)	ART in Sittwe, Pathein, Phahan, Pyin Oo Lwin, Kyaut Sae, Meiktila, Myeik and Kyaing Ton	
TB				
WHO	TB-HIV activities (Sentinel surveillance for HIV prevalence; outreach activities by DOTS supervisors/providers for 500 TB patients in 30 border townships; pilot home visits by community DOTS plus providers for MDR TB patients	Targets proportionately increased in Year 2 (e.g. pilot home visit)	Cover all 325 townships already with transportation of TB drugs, HIV sentinel surveillance for TB patients in 15 sites	US$600,000 for first line TB drugs out of initial US$300,000 budgeted in Year 1 for second line drug, which were financed by UNITAID and reprogrammed for first line
MMA	Encouraged scale up in service provisions of PPM-DOTS providers from scheme I to II in more townships	N/A	Three new townships: Muse (Northern Shan), Tachilek (East Shan), Sittwe (Rakhine)	
AHRN	Expand existing comprehensive services for drug users (integration of TB screening, treatment and care); integrated DOTS services in existing drop-in centres and outreach programmes; psychosocial and treatment adherence support; establishTB self-help group	Sexual partners of drug users and community members	Two AHRN drop-in centres in Lashio and Laukkai (Northern Shan) included service delivery	Shifted programme towards direct service provision based on capacities built in Year 1
AZG/ MSF-H	N/A	N/A	N/A	Still in Year 1 with a no cost extension of MDR-TB project till December 2008; delayed approval for procurement of second line TB drugs
Malteser	Upgrade TB screening centre for sputum microscopy in Buthidaung township; expand TB diagnostic centre at Kyein Chaung Station hospital in Maungdaw North township	No new target group	Rathedaung township (no full DOTS coverage, for HE sessions only)	Additional funding US$39,597 from pooled unspent fund from Year 1

Partner	New Activities	New Target Groups	New Geographical Locations	Remarks
Integrated				
IOM	Emergency health assessment and response; establish two mobile teams and one support and assessment team to control TB and Malaria	Vulnerable Nargis victims	Ayeyarwaddy Division	Funds reallocated for Nargis-related activities US$62,060 from unspent budget Year 1
Malaria				
WHO	N/A	Target proportionately increased in Year 2 (e.g. LLINs and net treatment)	100 townships in Year 1	
MMA	Establish fixed and mobile clinics for Malaria prevention and control	N/A	Two high endemic townships: Kuttkai (Northern Shan), Nam San (Southern Shan)	
MCC	N/A	Target proportionately increased in Year 2 (e.g. LLINs/net treatment)	Eight townships in Year 1	
CESVI	More fixed and mobile clinics in all project villages; additional distribution of 6000 LLINs in project villages.	N/A	One new township: Thipaw (Northern Shan); 180 new villages in existing townships (three in Northern Shan, one in Mandalay)	Additional funding US$91,108 from pooled unspent fund from Year 1 New MoU did not allow further implementation in Wa Special Region 4; phase out of activities in two townships
MERLIN	New fixed and mobile clinics; integrated BCC strategy in local language; additional distribution of 7,100 LLINs in project villages	N/A	Two new townships: Haka (Chin), Kalay (Sagaing) Laputta dropped (low prevalence)	Additional funding US$50,461 from pooled unspent fund from Year 1 Malaria care in Delta maintained through Nargis funding and Merlin's programme
World Concern	Provision of diagnosis and treatment by trained volunteers in eight pilot villages; Nargis relief efforts - bednet provision in the delta area	Around 2700 families in Nargis affected areas	Four new townships (Moe Nyein, Sumpra Bum, Shwe Gu and Naung Mon) in Kachin	Mainly provide commodity supply (ITN) for Nargis relief efforts, US$17,410 from unspent fund Year 1

Table 1.3. Round II Grants – Independent local NGOs (LNGOs), Community-based (CBOs) or Faith-based Organizations (FBOs)

Partner	Disease	Type of Organization	Geographical Coverage	Grant total (MMK)
AIDS Support Group (ASG) - Tachileik	HIV	LNGO	Seven wards and 90 villages in Tachileik (SHAN-E)	76,590,600
Phaung Daw Oo Monastic Education High School (PDO Jivaka Project)	Integrated (HIV, TB, Malaria)	FBO	Ten villages and 11 wards in Patheingyi	76,924,000
Substance Abuse Research Association (SARA)	HIV	LNGO	Myitkyina Tsp (KACHIN)	77,000,000
Yadana Theikdi Parahita Orphanage and Monastic Education School : Mogoke(Metta Moe Health Care Project)	Malaria	FBO	Moegoke Tsp (MANDALAY)	76,338,000
Retana Metta Organization	HIV	FBO	Yangon	76,889,870
Mahaythi Women's Development Co-operative Society Ltd.	HIV	LNGO	Four wards in Mawlamyine	65,007,800
Community Development Association (CDA)	Malaria	LNGO	60 Malaria endemic villages in Hpa-an, 90 in Hlaing Bwe (KAYIN)	77,000,000
Myanmar health Assistant Association	Malaria	LNGO	143 villages in Ponnarkyun and Kyauk Taw townships, Rakhine	77,000,000

ANNEX 2

Figure 2.1. Sources of Funds

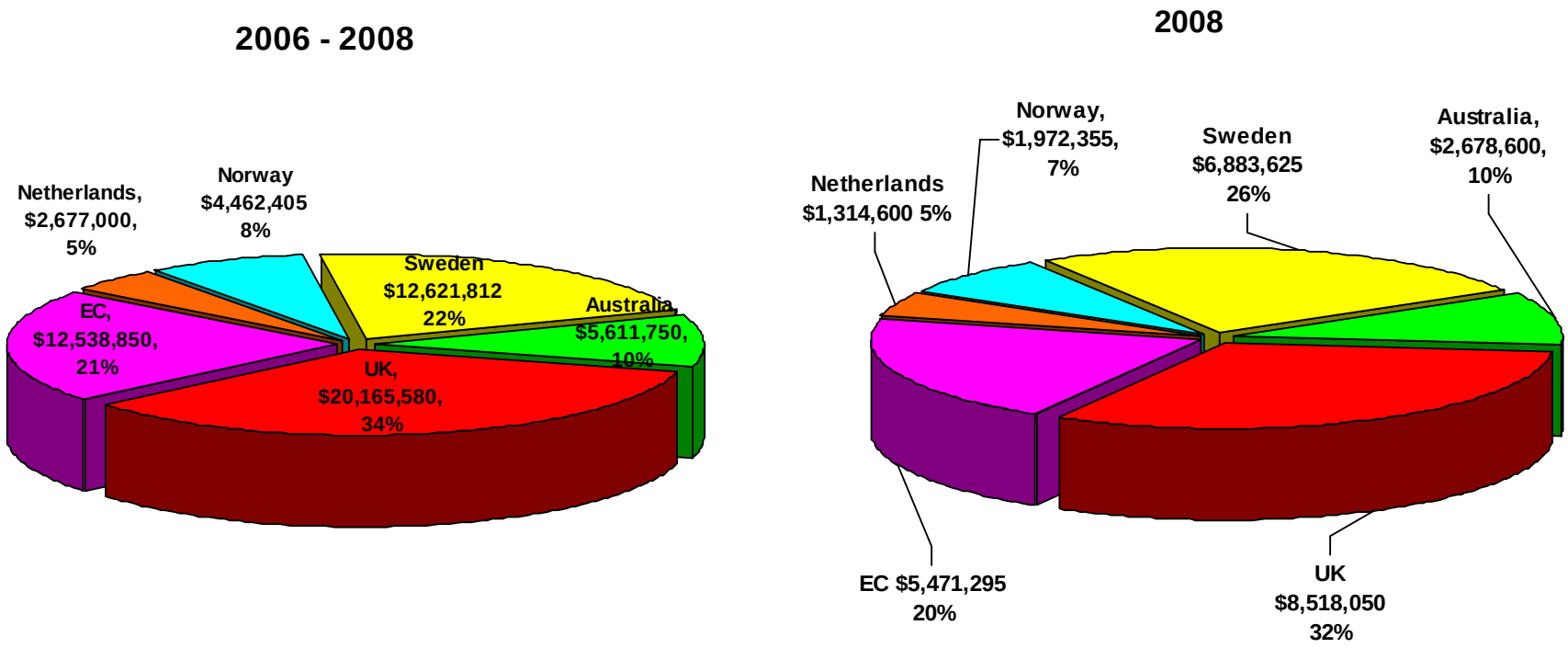


Table 2.1. Financial Status Report (in US$)

As of 31 December 2008

		2006	2007	2008	Total
Funds Received					
	AusAID	786,600	2,146,550	2,678,600	5,611,750
	DFID	2,661,540	8,985,990	8,518,050	20,165,580
	EC	-	7,067,555	5,471,295	12,538,850
	Netherland	-	1,362,400	1,314,600	2,677,000
	Norway	754,152	1,735,898	1,972,355	4,462,405
	Sida		5,738,187	6,883,625	12,621,812
	Interest	26,974	582,524	463,067	1,072,565
	Sub-total	**4,229,266**	**27,619,104**	**27,301,592**	**59,149,962**
Funds Expenditure					
Activity					
1	Provision of Funds to 3DF IPs	1,614,610	787,261	53,168	2,455,039
2	Operation of the FM Office	39,973	1,588,065	1,479,181	3,107,219
3	Support to the Fund Board	2,416	43,117	76,231	121,764
4	Grants - IPs (HIV/AIDS)		10,516,983	9,889,094	20,406,077
5	Grants - IPs (TB)		3,197,894	1,240,749	4,438,643
6	Grants - IPs (Malaria)		2,160,929	3,865,155	6,026,084
7	Grants - IPs (Integrated)		1,614,090	1,577,567	3,191,657
8	Research		60,756	112,399	173,155
	Sub-total	**1,656,998**	**19,969,094**	**18,293,544**	**39,919,638**
	Project Support Costs	113,191	1,286,672	1,173,284	2,573,147
	Total	**1,770,189**	**21,255,766**	**19,466,828**	**42,492,785**
Funds Available as at 31 December 2008					**16,657,177**

Table 2.2. Implementing Partners Grant Status

	Implementing Partner	Contract Duration	Contracted Amount US$			
			Bridging Period (Actual)	Year 1 (Actual)	Year 2	Grand Total
1	AHRN	1-May-07 to 30-Apr-10		429,799.04	587,650.00	**1,017,449.04**
2	Alliance	1-May-07 to 30-Apr-10		357,768.00	357,768.00	**715,536.00**
3	CARE	1-May-07 to 30-Apr-10		89,760.01	173,929.00	**263,689.01**
4	Save The Children Fund	1-May-07 to 30-Apr-09		1,646,548.58	1,840,179.00	**3,486,727.58**
5	Malteser	1-May-07 to 30-Apr-10		329,745.68	430,935.00	**760,680.68**
6	MANA	1-May-07 to 30-Apr-10		480,023.00	522,843.00	**1,002,866.00**
7	PGK	1-May-07 to 30-Apr-10		277,082.00	355,856.00	**632,938.00**
8	World Concern	1-May-07 to 30-Apr-10		153,218.00	153,221.00	**306,439.00**
9	AFXB	1-May-07 to 30-Apr-10		282,238.15	286,292.00	**568,530.15**
10	AMI	1-May-07 to 30-Apr-10		255,000.00	354,366.00	**609,366.00**
11	AZG/MSF-H	1-May-07 to 30-Apr-10		1,540,001.00	1,737,131.00	**3,277,132.00**
12	BI-MM	1-May-07 to 30-Apr-10		818,466.00	829,213.00	**1,647,679.00**
13	MBCA	1-May-07 to 30-Apr-10		129,819.78	130,000.00	**259,819.78**
14	PSI	1-Nov-07 to 31-Oct-09	781,606.35	1,477,177.00	1,477,177.00	**3,735,960.35**
15	World Vision	1-Sep-07 to 31-Aug-09		263,385.71	340,664.00	**604,049.71**
16	MSF-Switzerland	1-Sep-07 to 31-Aug-09		516,958.00	545,600.00	**1,062,558.00**
17	UNODC	1-May-07 to 30-Apr-10		679,131.93	928,100.00	**1,607,231.93**
18	WHO	1-May-07 to 30-Apr-09		955,062.00	1,508,124.00	**2,463,186.00**
19	UNAIDS	1-Sep-07 to 31-Aug-09		77,232.81	343,726.00	**420,958.81**
20	UNFPA	1-Jul-07 to 31-Aug-09		497,921.00	683,001.00	**1,180,922.00**
Sub-total (HIV and AIDS)			**781,606.35**	**11,256,337.69**	**13,585,775.00**	**25,623,719.04**

21	World Concern	1-May-07 to 30-Apr-10		111,137.00	111,871.00	**223,008.00**
22	CESVI	1-May-07 to 30-Apr-10	53,168.00	541,774.99	685,291.01	**1,280,234.00**
23	Merlin	1-May-07 to 30-Apr-10		511,526.71	734,880.29	**1,246,407.00**
24	World Vision	1-Sep-07 to 31-Aug-09		265,730.00	320,930.00	**586,660.00**
25	WHO	1-Sep-07 to 31-Aug-09	516,162.00	2,110,906.00	2,110,906.00	**4,737,974.00**
		Sub-total (Malaria)	**569,330.00**	**3,541,074.70**	**3,963,878.30**	**8,074,283.00**
26	AHRN	1-Sep-07 to 31-Aug-09		89,066.00	101,000.00	**190,066.00**
27	Malteser	1-Oct-07 to 30-Sep-09		238,876.00	278,473.47	**517,349.47**
28	AZG/MSF-H	1-Sep-07 to 31-Dec-09		96,023.00	430,559.00	**526,582.00**
29	PSI	1-Nov-07 to 30-Mar-08		160,000.00		**160,000.00**
30	WHO	1-Sep-07 to 31-Aug-09	694,855.00	1,806,589.00	1,806,589.00	**4,308,033.00**
31	World Vision	1-Sep-07 to 31-Aug-09		189,009.00	385,090.00	**574,099.00**
		Sub-total (TB)	**694,855.00**	**2,579,563.00**	**3,001,711.47**	**6,276,129.47**
32	CARE	1-Sep-07 to 31-Aug-08		212,540.00		**212,540.00**
33	IOM	1-May-07 to 30-Apr-10		912,162.00	1,119,780.00	**2,031,942.00**
34	WHO	1-Sep-07 to 31-Aug-09	347,633.00	429,141.00	575,824.00	**1,352,598.00**
		Sub-total (Integrated)	**347,633.00**	**1,553,843.00**	**1,695,604.00**	**3,597,080.00**
		Grand total	**2,393,424.35**	**18,930,818.39**	**22,246,968.77**	**43,571,211.51**

Table 2.3. Allocation of Funds by Disease Component and Recipient in US$

			Year 2			Grand Total		
	Bridging Period	**Year 1**	**Allocation**	**% of Recipient**	**% of Disease Allocation**	**Allocation**	**% of Recipient**	**% of Disease Allocation**
HIV/AIDS								
UNO	0	2,209,348	3,462,951	25%		5,672,299	22%	
INGO	781,606	8,160,065	9,114,125	67%		18,055,797	70%	
LNGO	0	886,925	1,008,699	7%		1,895,624	7%	
Sub-total	781,606	11,256,338	13,585,775		***61%***	25,623,719		***59%***
MALARIA								
UNO	516,162	2,110,906	2,110,906	53%		4,737,974	59%	
INGO	53,168	1,430,169	1,852,972	47%		3,336,309	41%	
LNGO				0%			0%	
Sub-total	569,330	3,541,075	3,963,878		***18%***	8,074,283		***19%***
TUBERCULOSIS								
UNO	694,855	1,806,589	1,806,589	60%		4,308,033	69%	
INGO	0	772,974	1,195,122	40%		1,968,096	31%	
LNGO								
Sub-total	694,855	2,579,563	3,001,711		***13%***	6,276,129		***14%***
INTEGRATED								
UNO	347,633	1,341,303	1,695,604	100%		3,384,540	94%	
INGO	0	212,540	0	0%		212,540	6%	
LNGO								
Sub-total	347,633	1,553,843	1,695,604		***8%***	3,597,080		***8%***
GRAND TOTAL	**2,393,424**	**18,930,818**	**22,246,969**		***100%***	**43,571,212**		***100%***

Table 2.4. Details of Direct Disbursements Handled by Fund Flow Mechanism

01 September 2007–31 August 2008

Activity Name	Planned	Completed	Individual Disbursement	Funds Disbursed (In US$)	Average Disbursement per Township	Disbursed by		
						Finance Clerk	National Consultant	Regional Officer
Tuberculosis								
Training	164	179	4,619			170	3	7
Workshop	17	17	631			16		1
Mobile Unit Missions	7	7	35			7		
Meeting	2	2	188					
Sub-total	**190**	**205**	**5,473**	**249,761**	**$ 768.50**	**193**	**3**	**8**
Malaria								
Workshop	101	100	4,133			77	5	18
Training	4	4	64			4		
Office Supply Provision	100	100	100			86		14
Sub-total	**205**	**204**	**4,297**	**80,228**	**$ 802.28**	**167**	**5**	**32**
HIV / AIDS								
Workshop	1	1	28			1		
Training	19	19	299			19		
Survey	5	5				5		
Data Collection	5	5	36			5		
Sub-total	**30**	**30**	**363**	**65,530**	**$ 655.30**	**30**	**-**	**-**
GRAND TOTAL	**425**	**439**	**10,133**	**395,519**		**390**	**8**	**40**

Table 2.5. Details of Reimbursements Handled by Fund Flow Mechanism

Activity Name	Unit	Planned	Completed	Total Funds Disbursed (in US$)	Township coverage	Average Disbursement per Township
Tuberculosis						
Supervision Visits	Claim	2,957	923			
Meetings - Evaluation	Meeting	400	417			
Meetings - Cohort	Meeting	120	43			
Meeting - Advocacy	State/division	16	16			
Sputum Collection	Claim	1,000	94			
Initial Home Visit	Claim		110			
Drug Transport Cost	Claim	1,300	998			
PPM DOTs Activities	Claim	8	8			
Sentinel Surveillance	Site	10	10			
Sub-total	**-**	**5,811**	**2,619**	**129,251**	**325**	**397.70**
Malaria						
Supervision & Monitoring	Claim	2,124	129			
Impregnation of Bed Nets	Claim	10	9			
Health Facility Based Survey	Claim	10	10			
Malario - metric Survey	Claim	3	3			
Transport Charges - RDT	Townships	5	5			
Travel Cost - LLINs Dist'n	Townships	2	2			
TSG Coordination Meeting	Meeting	1	1			
Delivery Cost - Insecticide Tablets	Townships	3	3			
Sub-total	**-**	**2,158**	**162**	**51,404**	**100**	**514.04**
				15,529		
HIV and AIDS						
Advocacy Meetings on Blood Safety	Meeting	100	91			
Supervision Visits	Claim		8			
Transport Cost - ART	Site	13	13			
Sub-total	**-**	**113**	**112**	**15,529**	**100**	**155.29**
GRAND TOTAL	**-**	**8,082**	**2,893**	**196,184**		

Figure 2.2. Fund Flow Mechanism in Year 1 – Direct Disbursement per Activity and Disease

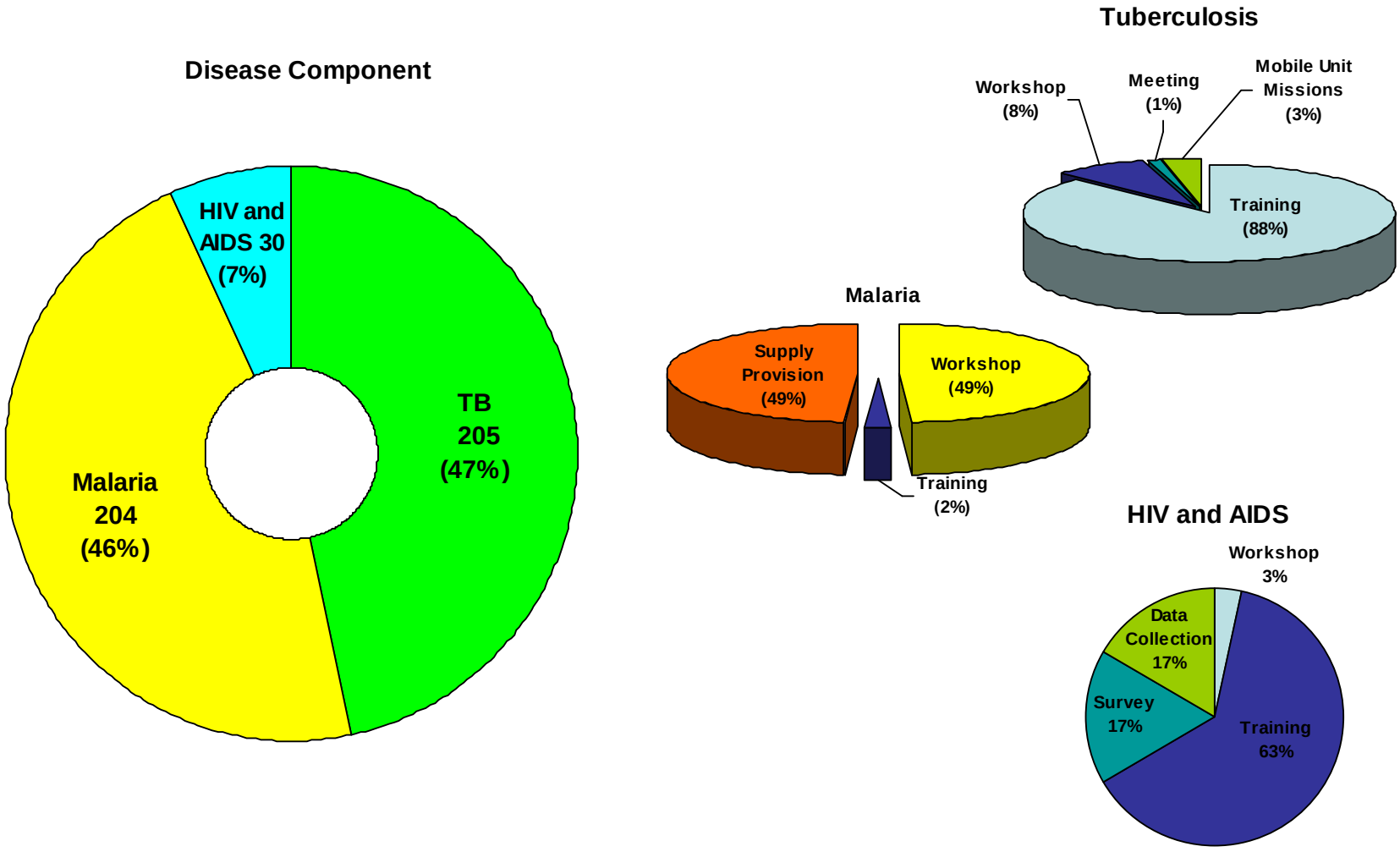


Figure 2.3. Fund Flow Mechanism in Year 1 – Reimbursement per Activity and Disease

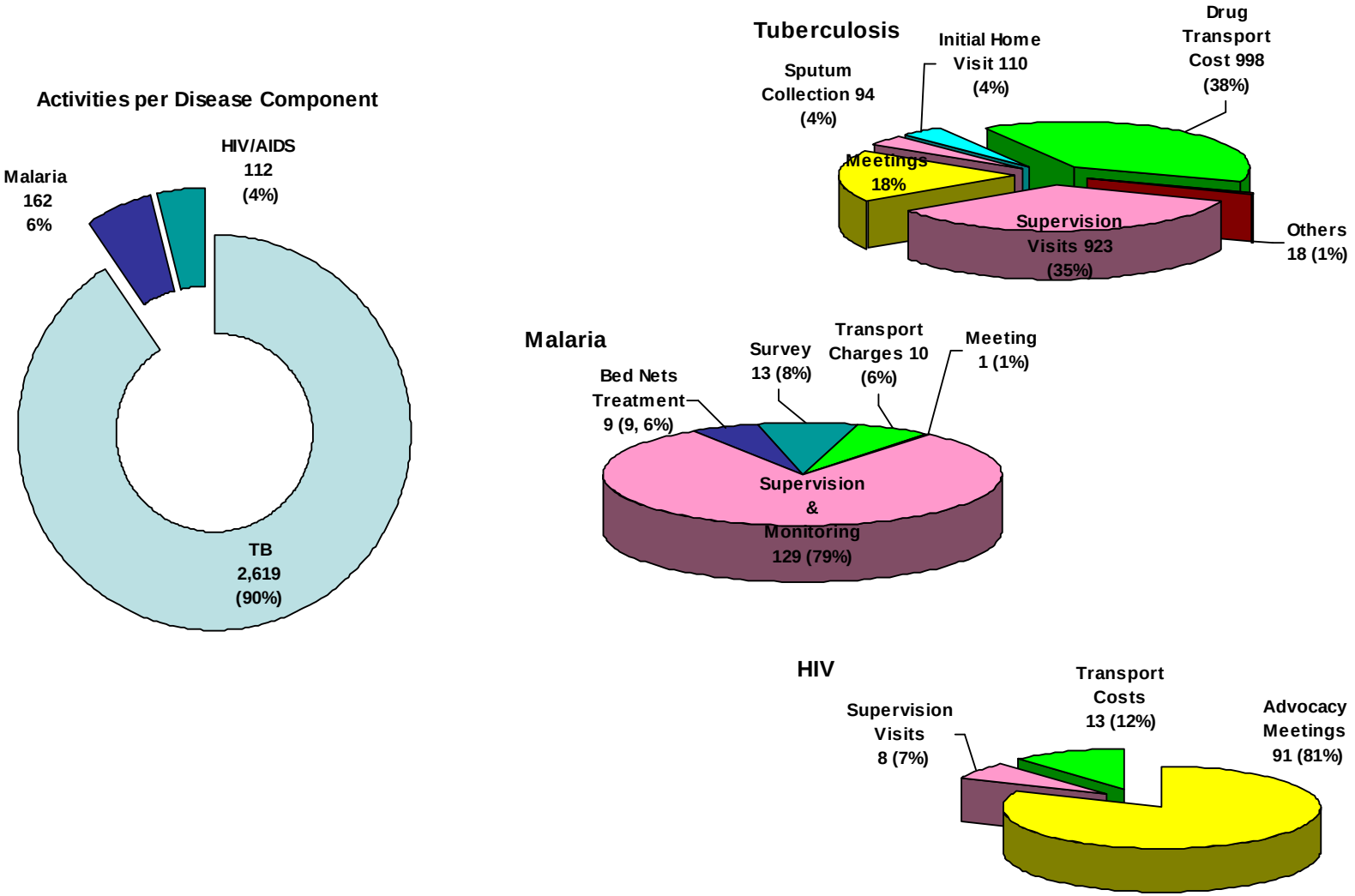
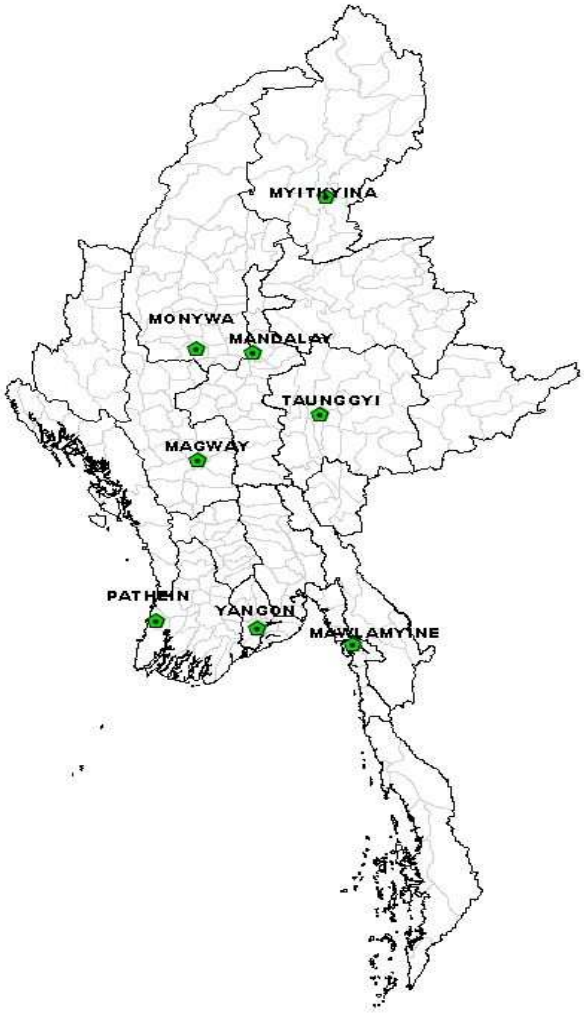


Figure 2.4. Locations of WHO Field Finance Clerks (Fund Flow Mechanism) in States and Divisions



Locations of Finance Clerks	Areas Covered
Myitkyina	Kachin State
Mandalay	Mandalay Division; Northern Shan State
Magway	Magway Division; Bago West Division, Southern Chin State
Mawlamyaing	Mon State; Kayin State; Bago East Division
Monywa	Sagaing Division; Northern Chin State
Taunggyi	Southern Shan State; Kayah State
Pathein	Ayeyawaddy Division (re-assigned to Yangon mid-2008)
Yangon	Yangon Division; Tanintharyi Division; Rakhine Division; Eastern Shan State

Figure 2.5. Lead Times for Delivery of Commodities

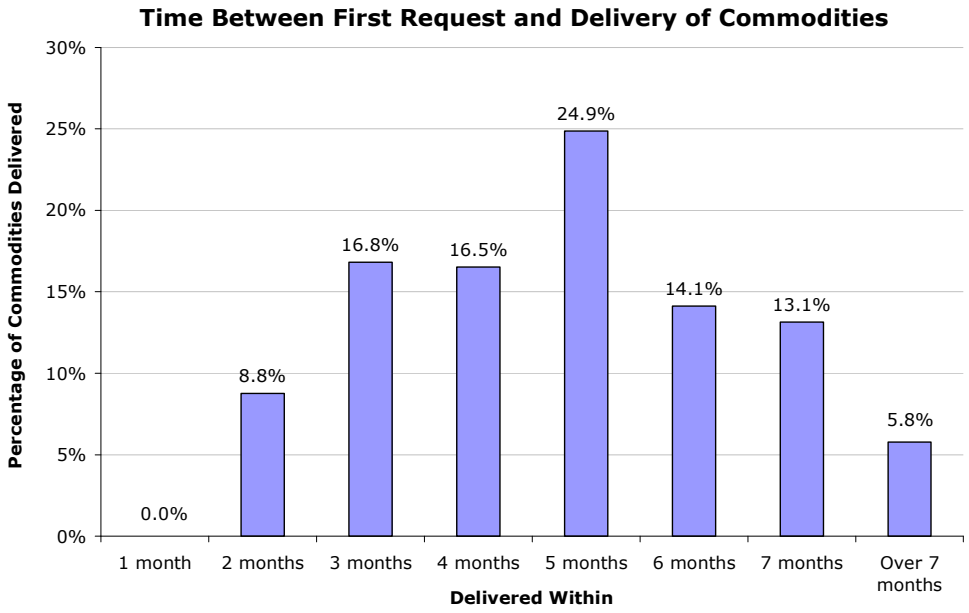


Figure 2.6. Procurement by Disease

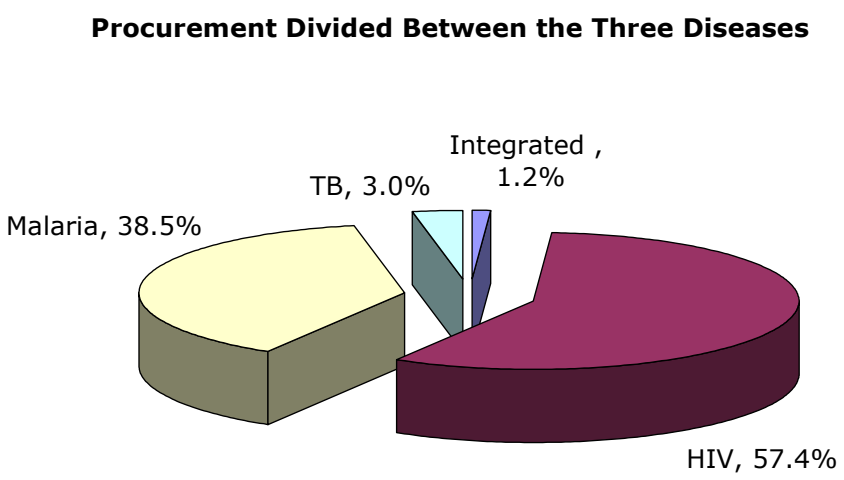
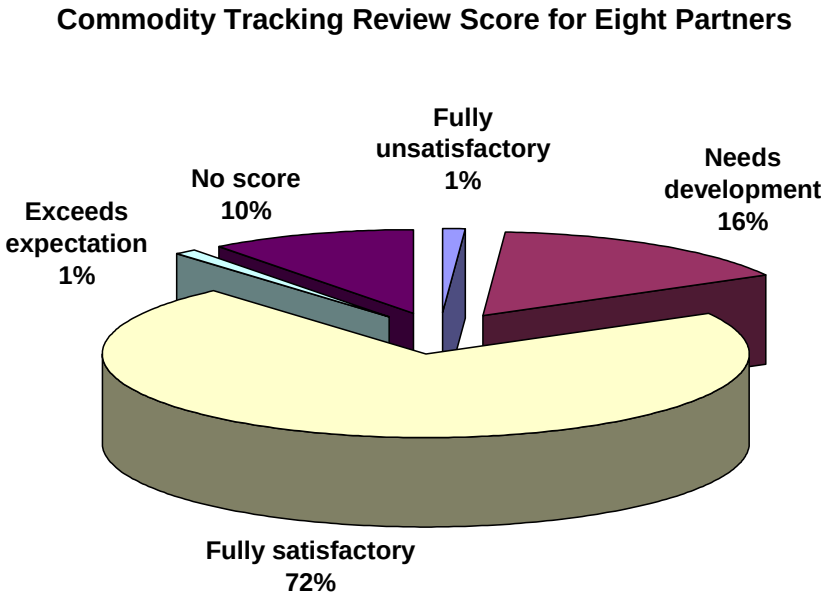


Figure 2.7. Medical Commodities Tracking



ANNEX 3

Table 3.1. Achievements of Implementing Partners Against HIV Core Indicators

		July-Dec 07[1]	Jan-Jun 08	Jul-Dec08	July 07-Dec 08
No.	**Core Indicators**	**Total**	**Total**	**Total**	**Cumulative**
1	Number of people who have been reached at least once by any type of HIV **prevention programme**	**94,881**	**208,452**	**138,945**	**442,278**
1.1	*Women working as sex workers*	10,371	34,071	28,149	72,591
1.2	*Clients of women working as sex workers*	26,201	88,501	55,483	170,185
1.3	*Men who have sex with men*	7,285	35,528	27,061	69,874
1.4	*Men and women who inject drugs*	24,614	21,556	15,385	61,555
1.5	*Families of people living with HIV*	12,676	10,126	7,301	30,103
1.6	Others	13,734	18,670	5,566	37,970
2	Number of people who have received **treatment for sexually transmitted infection**	**29,378**	**47,813**	**41,206**	**118,397**
2.1	*Women working as sex workers*	4,167	17,886	16,538	38,591
2.2	*Clients of women working as sex workers*	3,614	19,050	11,395	34,059
2.3	*Men who have sex with men*	770	2,591	2,837	6,198
2.4	*Men and women who inject drugs*	46	120	65	231
2.5	*Families of people living with HIV*	539	269	173	981
2.6	Others	20,242	7,897	10,198	38,337
3	Number of people who have been accessed **HIV testing and counselling service** and have received their test results among:	**30,782**	**15,670**	**18,793**	**65,245**
3.1	*Women working as sex workers*	2,799	3,876	4,285	10,960
3.2	*Clients of women working as sex workers*	753	3,202	2,356	6,311
3.3	*Men who have sex with men*	867	1,558	2,131	4,556
3.4	*Men and women who inject drugs*	1,355	841	1,256	3,452
3.5	*Families of people living with HIV*	1,277	1,129	1,338	3,744
3.6	Others	23,731	5,064	7,427	36,222
4	Number of **condoms** (male and females) sold or distributed free of charge during the reported period among	**8,234,119**	**11,217,297**	**10,802,673**	**30,254,089**
4.1	Women working as sex workers	1,670,915	843,969	1,130,023	3,644,907
4.2	*Clients of women working as sex workers*	97,288	6,700	77,082	181,070
4.3	*Men who have sex with men*	194,548	179,785	236,048	610,381
4.4	*Men and women who inject drugs*	100,625	99,580	138,366	338,571
4.5	*Families of people living with HIV*	110,475	119,671	131,327	361,473
4.6	Others	6,060,268	9,967,592	9,089,827	25,117,687
5	Number of **needles** sold or distributed free of charge to injecting drug users during the reported period	**825,442**	**649,152**	**810,097**	**2,284,691**

[1] This figure includes all outputs regardless of the funding source

6	Number of people who have been reached at least once by any type of HIV prevention programme during the reported period among:	**68,042**	**33,538**	**44,651**	**146,231**
6.1	*Men women and young people in prison*	42	0	0	42
6.2	*Mobile and Migrant workers (at source, transit or destination)*	23,877	13,736	18,370	55,983
6.3	*Uniformed service personnel*	5,873	1,545	3,387	10,805
6.4	*Young people*	38,250	18,257	22,894	79,401
7	Number of people accessing **HIV testing and counselling** service for HIV and have received their test results during the reported period	**5,033**	**2,142**	**6,354**	**13,529**
7.1	*Men women and young people in prison*	0	0	0	0
7.2	*Mobile and Migrant workers (at source, transit or destination)*	1,148	389	263	1,800
7.3	*Uniformed service personnel*	56	79	27	162
7.4	*Young people*	1,344	1,426	1,043	3,813
7.5	Others	2,485	248	5,021	7,754
8	Number of **condoms** (male and females) sold or distributed free of charge during the reported period among	**549,228**	**852,109**	**995,518**	**2,396,855**
8.1	*Men women and young people confined in institutions*	3,100	0	0	3,100
8.2	*Mobile and Migrant workers (at source, transit or destination)*	131,574	337,028	341,543	810,145
8.3	*Uniformed service personnel*	30,774	7,738	3,052	41,564
8.4	*Young people*	162,782	235,084	404,127	801,993
8.5	Reproductive age	220,998	272,259	246,796	740,053
9	Number of people in workplace reached by **package of prevention programme**	**18,034**	**6,745**	**7,610**	**32,389**
10	Number of men and women of reproductive age reached by **package of prevention programme**	**202,783**	**117,656**	**75,976**	**396,415**
11	Number of people living with HIV involved in self helps groups to provide **psychosocial support** among them in order to reduce stigma and discrimination	**3,826**	**5,353**	**4,321**	**13,500**
12	Number of people with HIV infection receiving **treatment for opportunistic infections**	**12,489**	**7,815**	**13,368**	**33,672**
13	Number of people over 13 years old with advanced HIV infection receiving **antiretroviral combination therapy**	**9,839**	**5,248**	**6,385**	**6,385**
14	Number of people with HIV who receive **home based care**, including the package of support	**4,561**	**9,956**	**9,125**	**23,642**
15	Number of children (age 0-13) with advanced HIV infection who receive **antiretroviral combination treatment**	**579**	**259**	**419**	**419**
16	Number of pregnant women who have been accessing **HIV testing and counselling service** for HIV and have received their test results during the reported period	**26,389**	**1,854**[2]	**66,523**[3]	**94,766**

[2] Figures from public health facilities were not received at that reporting period
[3] Figures from public health facilities are included

17.1	# of HIV infected pregnant women and their infants born who received a complete course of **ART prophylaxis to reduce mother to child transmission**	**18**	**111**	**218**	**347**[4]
17.2	Percentage of HIV infected pregnant women and their infants born who received a complete course of **ART prophylaxis to reduce mother to child transmission**				
18	Percentage of transfused blood units **screened for HIV** in the reported period				

[4] Figures from public health facilities have not been received at the time of preparation of this report

Table 3.2. HIV Programme Coverage in Epidemiological Priority Townships

Target Groups	No. of Priority townships as per NOP[1]	No. of project townships	Coverage
Sex Workers	42	23	55%
Men Having Sex with Men	30	19	63%
Drug Users	21	16	76%
Mobile and Migrant Population (Transit)	43	10	23%
People living with HIV	34	26	76%

Table 3.3. Partners Working for Different Target Groups in HIV

Sex Workers	Clients of Sex Workers	Men Having Sex With Men	Drug Users	PHA and their Families	Mobile and Migrants	Uniform Service Personnel	Out of School Youth	People at Workplace	Reproductive Age Group
Alliance	AMI	Alliance	AHRN	AFXB	AFXB	AMI	AFXB	AFXB	AFXB
AMI	Consor-tium	AMI	CARE	Alliance	AMI	CARE	AMI	MBCA	AMI
Consortium	Malte-ser	Consortium	MANA	AMI	IOM	Malteser	Consortium		CARE
Malteser	AZG/MSF- H	AZG/MSF-H	AZG/MSF-H	Consortium	Malteser		Pyi Gyi Khin		Consortium
AZG/MSF- H	PSI	PSI	UNODC	IOM					MANA
PSI	Pyi Gyi Khin	Pyi Gyi Khin	World Concern	Malteser					Malteser
Pyi Gyi Khin	World Vision	World Vision		AZG/MSF-H					AZG/MSF-H
World Vision				MSF-Switzerland					
				Pyi Gyi Khin					
				WHO					
				World Concern					
				World Vision					

Table 3.4. HIV National Targets Vs 3DF Achievements in 2008

Target Groups		2008 Target set by NOP[5]	Achievements	Contribution to National Target (%)
1	Sex workers reached by package of BCC prevention	40,000	**62,220**[6]	156%
2	Number of sex workers accessing VCCT	20,000	8,161	41%
3	Number of sex workers reached by STI prevention and treatment	40,000	34,424	86%
4	Condoms sold or distributed (in million)	40	23.8	59%
5	Men having Sex with Men reached by package of BCC	45,000	**62,589**[7]	139%
6	Number of Men having sex with men accessing STI prevention and treatment	45,000	5,428	12%
7	Number of Men having sex with men accessing VCCT	15,000	3,689	25%
8	Intravenous Drug Users reached by Harm Reduction programme	30,000	**36,941**[8]	123%
9	No. of Intravenous Drug Users accessing VCCT	6,000	2,097	35%
10	Needles distributed to Intravenous Drug Users	4 million	1.46 million	36%
11	Number of IDU on MMT	1,000	480	48%
12	No. of Institutionalized population reached by health education	10,000	0	0%
13	Mobile and Migrant populations reached by package of prevention programme	246,000	32,106	13%
14	Number of mobile population accessing VCCT	2,700	652	24%

Table 3.5. Implementing Partners Providing HIV Treatment, Care and Support

Sr. No.	Treatment, care and support including ARVs	Treatment, care and support without ARVs
1	AFXB	AHRN
2	AMI	Alliance
3	Consortium	CARE
4	Malteser	MANA
5	AZG/MSF-H	Pyi Gyi Khin
6	MSF-Switzerland	UNODC
7	WHO	World Concern
8		World Vision

[5] Myanmar National Strategic Plan on HIV and AIDS – Operational Plan (2008 – 2010)
[6] Due to service overlapping and lack of knowledge about the extent of migration of sex workers, data quality needs improvement, true figure is between 47,000 to 61,000
[7] Data quality needs improvement due to service overlapping in some areas; true figure is between 50,000 to 62,000
[8] Data quality needs improvement due to service overlapping in some areas

Figure 3.1. Condom Distribution to Different Target Groups

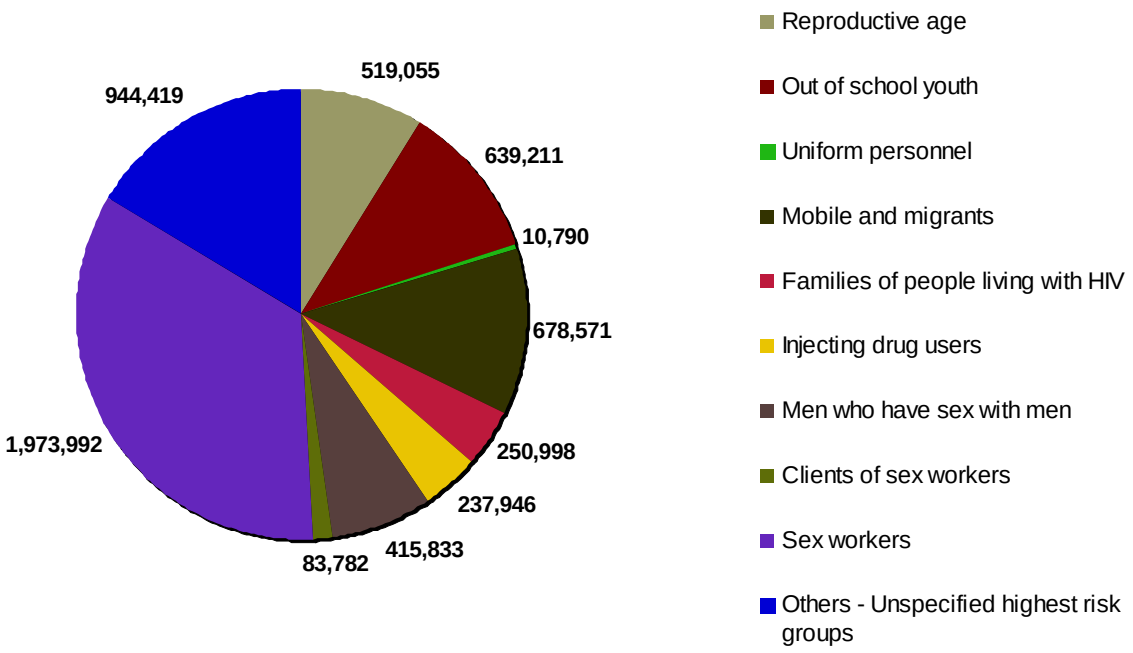
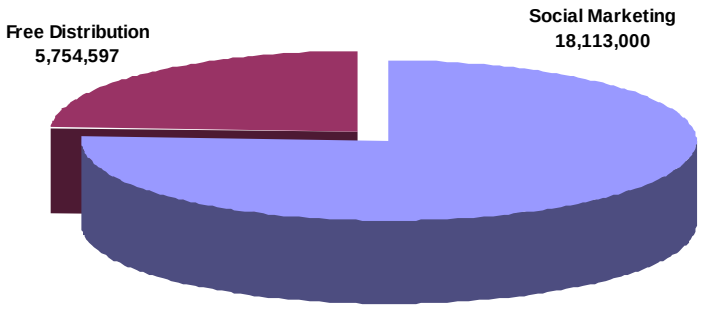
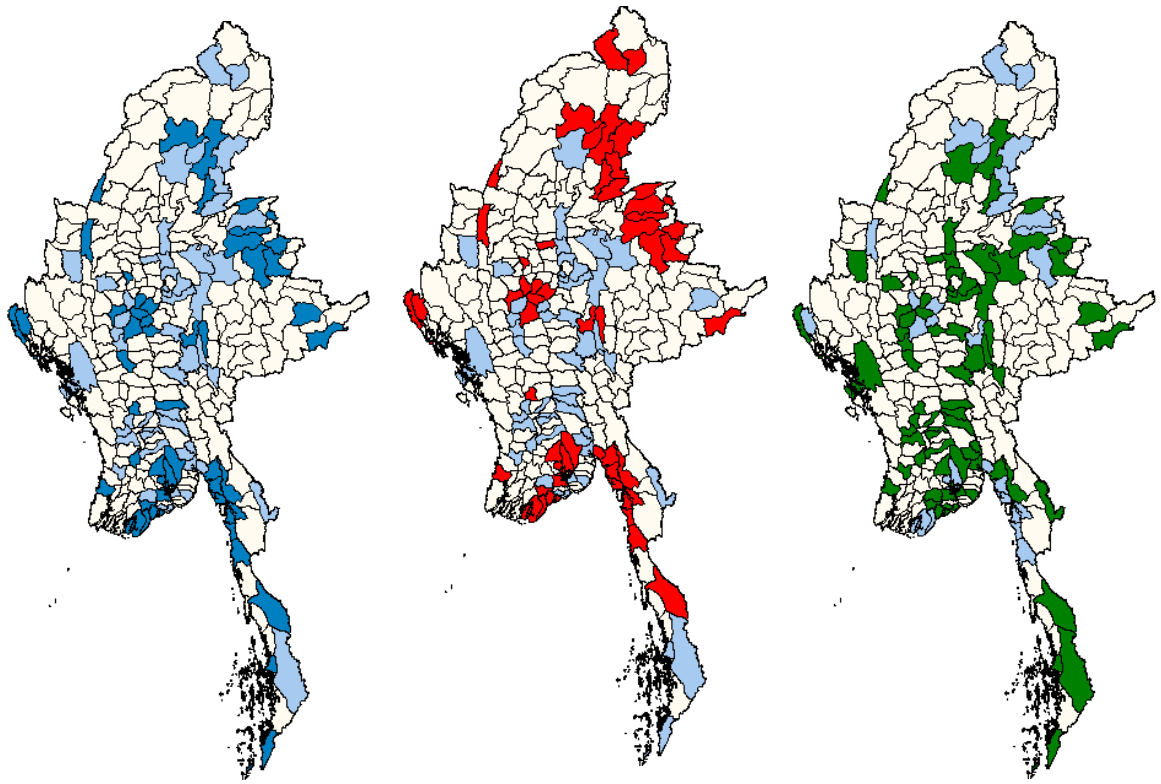


Figure 3.2. Condom Promotion with Social Marketing and Free Distribution



* 23.8 million of condoms were promoted through social marketing and free distribution

Figure 3.3. HIV Programme Coverage by Township



Other HIV areas | HIV prevention areas

Other HIV areas | HIV care and treatment areas

Other HIV areas | HIV care and treatment by PHS

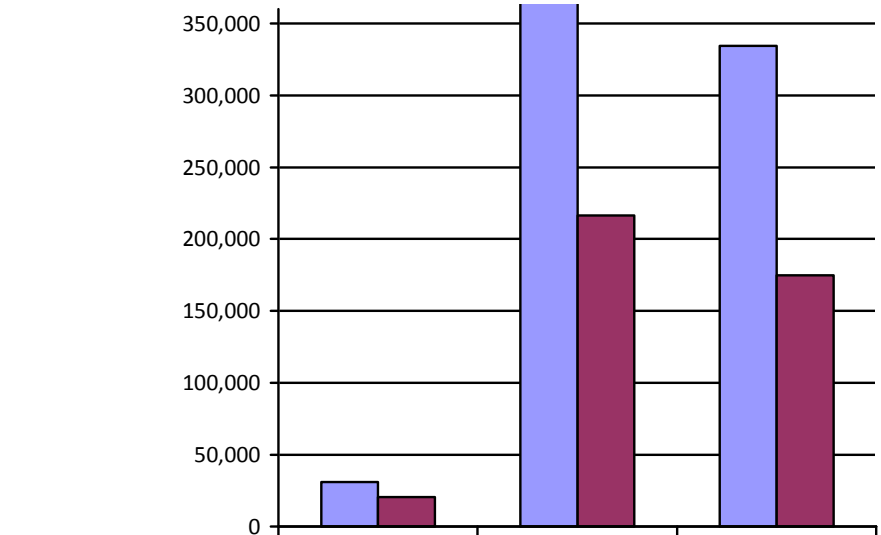
PHS = Public Health Sector

Table 3.6. Achievements of Implementing Partners Against Malaria Core Indicators

No	Malaria Core Indicators	Jul-Dec 07	Jan-Jun 08	Jul-Dec 08	Cumulative 2007-2008
1	Malaria morbidity rate: Severe and uncomplicated malaria (confirmed and probable cases) per year (per 1,000 people) in the Project intervention areas	N/A	N/A	N/A	N/A
2	Number of confirmed and probable malaria cases (by age group [<5yrs and >5yrs of age]and sex) treated in accordance with the national malaria treatment guidelines by the project clinics (both fixed and mobile) and/or private franchised clinics and/or village health workers/community health workers per reporting period.	31,039	379,298	334,410	744,7479
	Confirmed	20,533	216,331	174,805	411,669
	Probable cases	10,506	162,967	159,605	333,078
3	Proportion (and number) of population living in the Project area served by trained VHWs/CHWs and/or trained GPs.	N/A	683,557	2,560,347	2,560,347
4	Proportion (and number) of population at risk of malaria protected with ITNs, LLINs and/or IRS.	N/A	676,611	638,456	638,456
5	Proportion of patients who receive treatment from trained providers within 24 hours of onset of fever by age group [<5yrs and >5yrs of age] and sex.	558 cases	45%	43%	43%[10]
6.1	a). Number of ITNs/bednets re/treated per reporting period	43,000	281,616	17,579	342,195
6.2	b Number of ITNs/LLINs distributed per reporting period	24,628	59,978	32,008	116,614
7	Number and type of antimalarial treatment courses administered by the Project clinics, private clinics and VHWs per reporting period.	25,406	378,594	334,033	738,033
7.1	ACT	12,578	212,436	170,932	395,946
7.2	Non-ACT (CQ & Others)	12,828	166,158	163,101	342,087
8	Number of RDTs distributed and used by trained VHWs/GPs and health facilities per reporting period.	21,986	490,194	252,665	764,845
9	Number of trained CHWs/VHWs/GPs providing malaria prevention services and case management	727 (CHWs) 50 (GPs)	1,048(CHW)1 60 (GPs)	1,152(CHWs) 164 (GPs)	1,879 (CHWs) 164 (GPs)

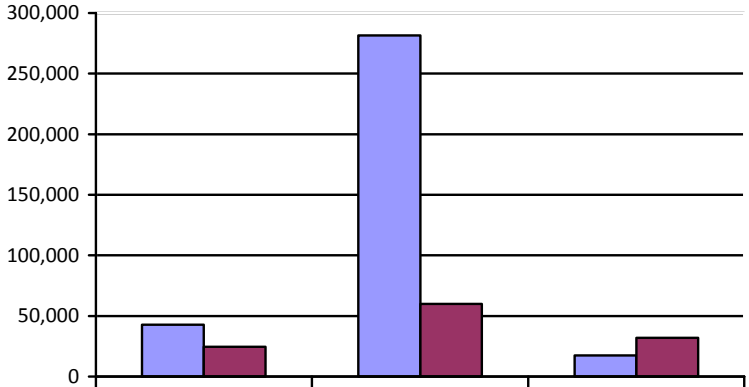
[9] It includes referral of severe Malaria cases to health facility
[10] Only 3 IPs reported

Figure 3.4. Case Detection of Probable and Confirmed Malaria Cases



	jul-dec 07	jan-jun 08	jul-dec 08
Total malaria cases detected	31,039	379,298	334,410
confirmed malaria cases	20,533	216,331	174,805

Figure 3.5. (Re)Treatment of ITNs and Distribution of LLINs



	Jul-Dec 07	Jan-Jun 08	Jul-Dec 08
ITNs	43,000	281,616	17,579
LLINs	24,628	59,978	32,008

Figure 3.6. 3DF Malaria Programme Coverage by Township

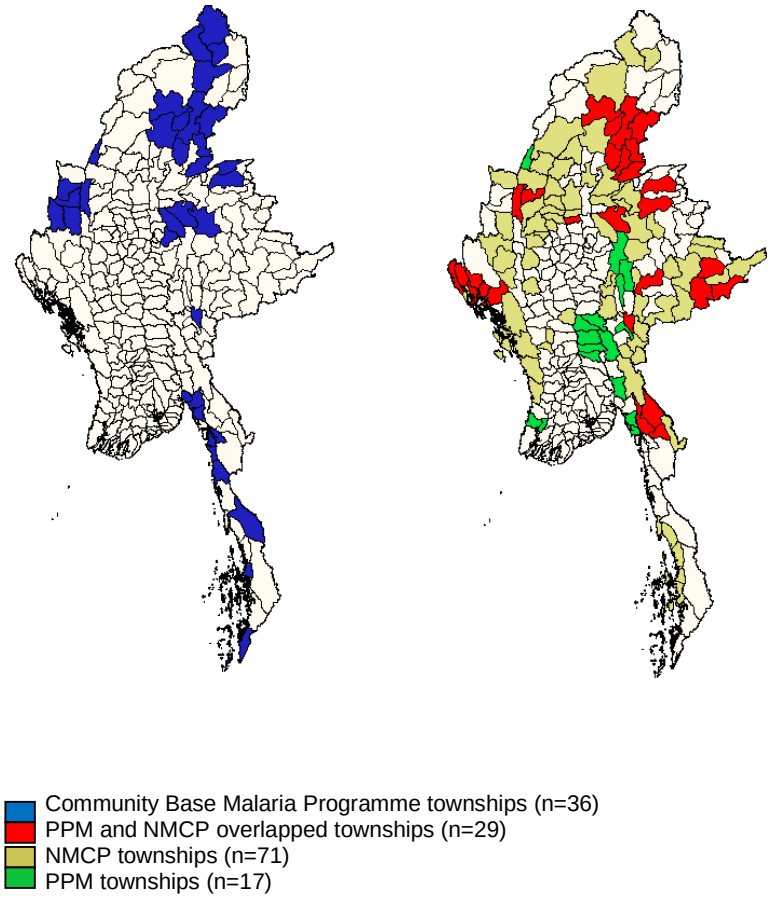
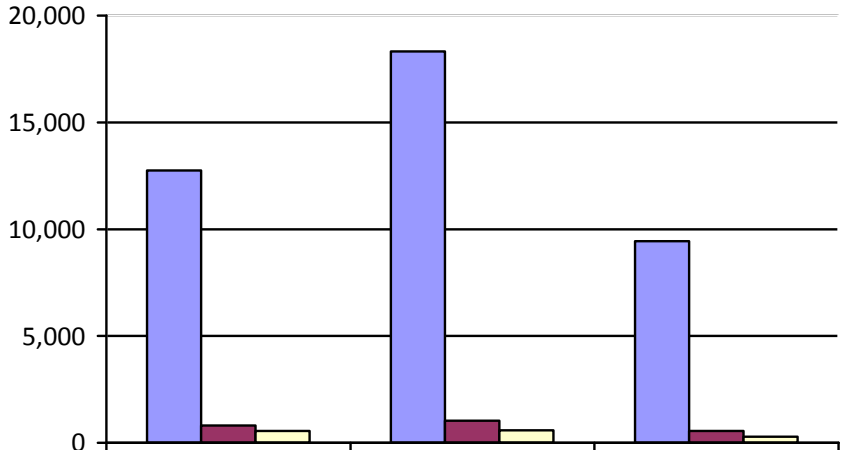


Table 3.7. Achievements of Implementing Partners Against TB Core Indicators

No	Core Indicators	July–Dec 07	Jan–June 08	July–Dec 08	Cumulative Total
1	Number of private medical doctors (GPs), basic health Staff (BHS), community Health workers/ village health workers/outreach health workers (CHW/VHW/OHW) by sex, trained on management of TB at health facility (HF) level and/or trained for active case detection, collection of sputum specimen and provision of DOTS	6,020	5,722	4,955	16,697
	BHS	5,219	3,014	3,029	11,262
	Medical officers		912	754	1,666
	CHW/VHW/OHW/DOTS providers	385	705	473	1,563
	GP	416	978	516	1,910[11]
	Informal service providers		113	183	296
2	No of laboratory technicians (by sex)	113	113	50	276
3	No (and percent) of new sputum smear positive TB cases (PTB ss+) (by sex) successfully treated during reporting period	1,736 (NGO) 12,759 (WHO-NTP)	1,106 (NGO) 18,329 (WHO-NTP) TSR-92%	584 (NGO) 9,435 (WHO-NTP) TSR-84.4%	3,426 (NGO) 40,523 (WHO-NTP) TSR-88.2%
4	No (and per cent) of defaulters (by sex) during reporting period	156 (NGO) 810 (WHO-NTP)	67 (NGO) 1,037 (WHO-NTP) Rate -5%	22 (NGO) 547 (WHO-NTP) Rate-4.3%	245 (NGO) 2,394 (WHO-NTP) Rate-4.7%
5	No (and per cent) of treatment failures (by sex) during reporting period	121 (NGO) 551 (WHO-NTP)	66 (NGO) 591 (WHO-NTP) Rate-3%	9 (NGO) 279 (WHO-NTP) Rate - 2.8%	196 (NGO) 1421(WHO-NTP) Rate-2.9%
6	No of sputum collection centres/points established during the reporting period	109	196	108	108
7	No of TB patients/families receiving allowance for transport or for diagnosis and treatment services at health centres and/or food/nutritional support.	9,226	22,173	16,541	47,940
8	No of new PTB ss+ cases detected by sex	2,512 (NGO) 13,863 (WHO-NTP)	1,482 (NGO) 20,162 (WHO-NTP) CDR-42%	898 (NGO) 14,030 (WHO-NTP) CDR-34%	3,914 (NGO) 48,055 (WHO-NTP) CDR -76%[12] (2008)
9	No of TB suspected cases referred to health facility by sex	14,645	12,757	13,332	40,734
10	No of people reached through BCC services	20,544	65,697	45,369	131,610

[11] Includes PSI's trained GPs. Currently active GPs of MMA is 516
[12] CDR and TSR rates are calculated based on WHO-NTP, of which data were not available in last reporting period

Figure 3.7. Outcomes of New Sputum Smear Positive TB Cases as Reported by NTP



	Jul-Dec 07	Jan-Jun 08	Jul-Dec 08
successfully treated	12,759	18,329	9,435
defaulters	810	1,037	547
treatment failures	551	591	279

For July-Dec 2008, data from WHO-NTP not provided yet (data from 149 townships)

Figure 3.8. TB Programme Coverage by Township

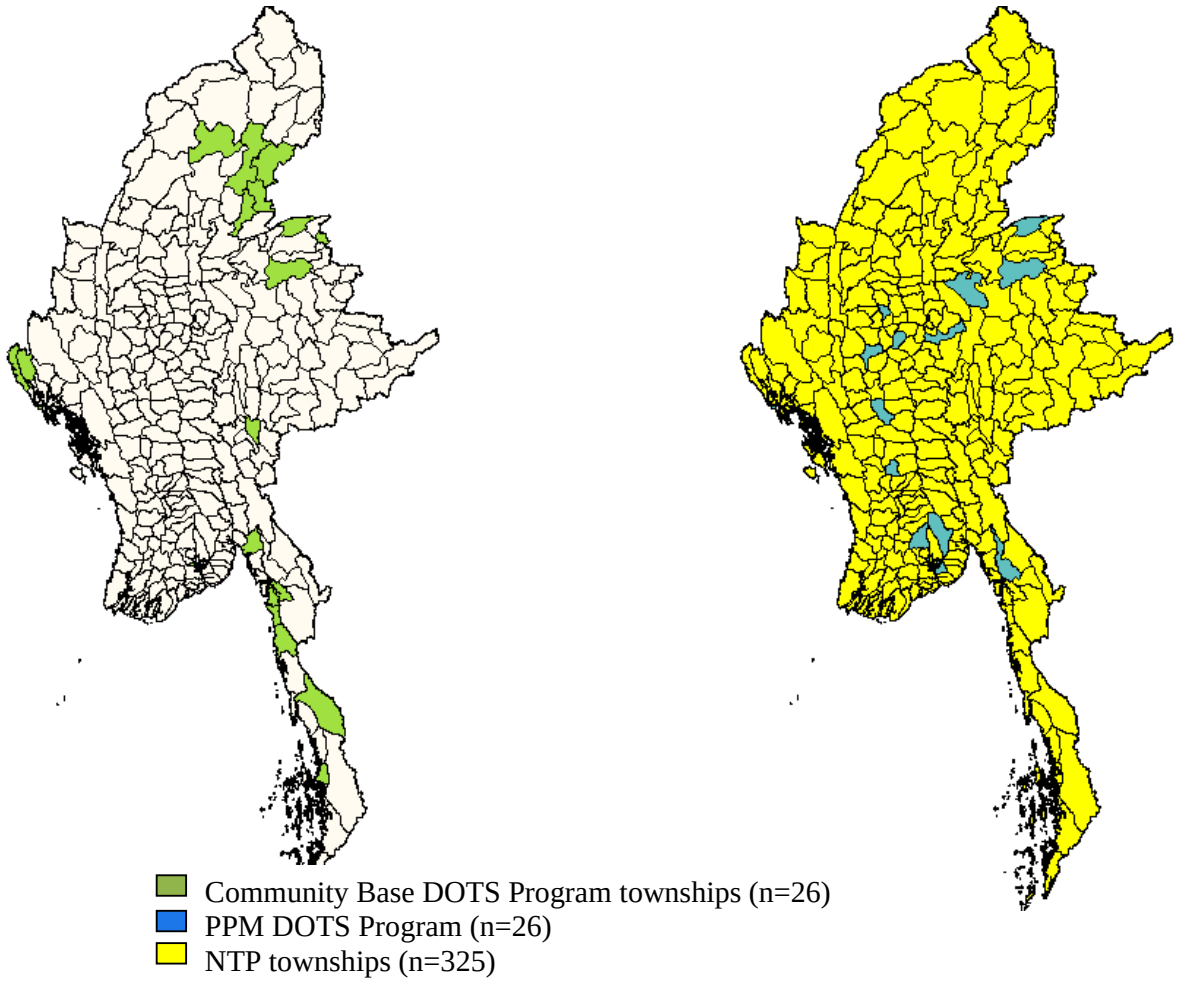


Table 3.8. Coverage of Monitoring Visits by Location, Partners and Disease

Date	States/Divisions	Townships	Implementing Partners	Disease
Jan-08	Ayeyarwady Division	Pa Thein	Consortium, MMA, PSI, Pyi Gyi Khin	HIV-Malaria
	Bago Division (West)	Gyo Bin Gauk	WHO-NTP	TB
		Paung De	WHO-NTP	TB
		Pya	MMA, WHO-NTP	TB
	Kayin State	Pha An	AIDS Alliance, World Vision	HIV
	Mandalay Division	Chan Aye Tha Zan	WHO-NAP	HIV
		Pyi Gyee Ta Gon	MANA	HIV
	Shan State (North)	La Shio	Consortium, MANA, UNODC, WHO-NAP	HIV
		Mu Se	Consortium, UNODC	HIV
		Thant Yan	UNODC	HIV
		Thein Ni	UNODC	HIV
Feb-08	Mon State	Maw La Myaing	IOM	HIV
		Than Byu Za Yat	IOM	HIV
		Ye	IOM	HIV
	Magway Division	Ma Gway	AIDS Alliance, MMA	HIV-TB
		Pa Kok Ku	MBCA	HIV
	Mandalay Division	Aung Myay Thar Zan	Consortium	HIV
		Chan Mya Tha Zi	Consortium	HIV
		Ma Har Aung Myay	Consortium	HIV
		Meik Hti Lar	PSI	HIV
		Pyi Gyee Ta Gon	Consortium	HIV
		Chan Aye Tha Zan	WHO-NTP	TB
		Pa Thein Gyi	WHO-NTP	TB
		Pyin Oo Lwin	CESVI	Malaria
	Sagaing Division	Mon Ywa	CARE, MMA, WHO-NTP	HIV-TB-Malaria
	Shan State (North)	La Shio	AHRN, MSF-Holland	HIV
	Yangon Division	Hlaing Tha Yar	World Vision	TB
		Yan Kin	MANA	HIV
Apr-08	Yangon Division	Hlaing Tha Yar	MSF-Holland, World Vision	HIV-TB
		Ma Yan Gon	PSI	HIV

Date	States/Divisions	Townships	Implementing Partners	Disease
		Min Ga Lar Don	WHO-NAP	HIV
		Oak Ka Lar Pa (N)	PSI, WHO-NAP	HIV-TB
		Thar Ke Ta	Consortium, MMA	HIV-TB
		Thin Gan Gyun	WHO-NAP	HIV
	Shan State (East)	Kyaing Tone	MMA, PSI, WHO-NMCP, WHO-NTP, World Vision	HIV-TB-Malaria
		Mong Lar	PSI	HIV
		Ter Chi Leik	MMA, PSI, UNODC, WHO-NAP, WHO-NMCP, WHO-NTP, World Vision	HIV-TB-Malaria
May-08	Tanintharyi Division	Da Wei	WHO-NMCP, WHO-NTP, World Vision	HIV-TB-Malaria
		Myeik	WHO-NMCP, WHO-NTP, World Vision	HIV-TB-Malaria
Jun-08	Bago Division (East)	Oka Twin	WHO	Fund Flow
	Shan State (South)	Yat Sauk	WHO	Fund Flow
	Kachin State	Bha Maw	MMA, MSF-Holland	HIV-TB-Malaria
		Man Si	MMA, World Concern	HIV-Malaria
		Moe Mauk	MMA, World Concern	HIV-Malaria
		Myit Kyi Nar	MCC, MMA, MSF-Holland, PSI, World Concern	HIV-TB-Malaria
		Waing Maw	World Concern	HIV-Malaria
		De Maw Soe	MMA	Malaria
		Loi Kaw	CARE, MMA, WHO-NMCP, WHO-NTP, World Vision	TB-Malaria
	Shan State (South)	Ho Pone	MMA	Malaria
		Taung Gyi	MMA, WHO-NTP	TB-Malaria
Aug-08	Magway Division	Ma Gway	WHO	Fund Flow
Period	States & Dividions	Project Townships	Implementing Partners	Monitoring subject
Sep-08	Rakhine State	Bu Thi Taung	Malteser, MMA, MSF-Holland, WHO-NMCP, WHO-NTP	HIV-TB-Malaria
		Maung Taw	Malteser, MMA, MSF-Holland, WHO-NMCP, WHO-NTP	HIV-TB-Malaria
		Sit Twe	MMA	Malaria
	Magway Division	Chauk	UNFPA	HIV

Date	States/Divisions	Townships	Implementing Partners	Disease
		Ma Gway	UNFPA	HIV
		Yae Nan Gyaung	UNFPA	HIV
	Mandalay Division	Nyaung U	UNFPA	HIV
		Mandalay city	PSI	HIV
		Pa Thein Gyi	WHO-NTP	TB
	Sagaing Division	Mon Ywa	Consortium, MMA, WHO-NAP	HIV-TB
Oct-08	Mon State	Kyaik Hto	World Concern	Malaria
		Maw La Myaing	Mahaythi	RII assessment
		Than Byu Za Yat	IOM, World Vision	TB-Malaria
	Ayeyarwady Division	Bo Ga Lay	CDA	RII assessment
	Mandalay Division	Pyi Gyee Ta Gon	MANA	RII assessment
		Pa Thein Gyi	Paung Daw Oo	RII assessment
		Moe Goke	Yadana Theikhti	RII assessment
		Moe Goke	MANA, Paung Daw Oo, Yadana Theikhti	RII assessment
		Pyaw Bwe	MANA, Paung Daw Oo, Yadana Theikhti	RII assessment
Nov-08	Sagaing Division	Ka lay	CARE, Consortium, MCC	HIV-Malaria
		Ta Mu	CARE, Consortium	HIV-Malaria
	Shan State (East)	Ter Chi Leik	ASG, MMA, UNODC, WHO-NMCP, WHO-NTP, World Vision	HIV-TB-Malaria-RII assessment

Figure 3.9. Township Monitoring Visits in 2008