ASIA Briefing

Yangon/Brussels, 16 December 2004

international crisis group

MYANMAR: UPDATE ON HIV/AIDS POLICY

I. OVERVIEW

Myanmar's military government has acknowledged its serious HIV/AIDS problem in the two years since Crisis Group published a briefing paper.[1] This has permitted health professionals, international organisations and donors to begin a coordinated response. The international community has boosted funding and shown more willingness to find ways to help victims and counter the pandemic. Some government obstacles have been removed although the regime's closed nature is unaltered. The opposition National League for Democracy (NLD), which has generally opposed aid involving contact with the junta, has supported many HIV/AIDS steps because of the humanitarian imperative. The urgent need now is to boost the local staff capabilities and make more effective use of the money flowing into the country. In the process civil society and small NGOs and other local organisations can be fostered that can eventually help prepare a democratic transition.

Significant problems remain. About 1.3 per cent of Myanmar's[2] adults are believed to be infected with the virus, one of the highest rates in Asia. Government spending on health and education is perilously low, and the economy has been grossly mismanaged by the military. HIV continues to present serious risks to the population, to security and to Myanmar's neighbours.[3]

Critics of assistance to Myanmar have said the government would misappropriate any funds. This has not been the case so far. Increased international contact with the government on this issue has pushed it towards more pragmatic positions and opened up program possibilities that were not available in 2002. HIV prevention and treatment suffered then from a lack of resources and knowledge. Now the main constraint is the implementation capacity of groups involved in HIV prevention and AIDS care. The critical steps that need to be taken include:

- expansion of assistance through all available channels to border areas where the HIV problem is particularly intense;
- expansion of national capacity to deal with HIV, including more technical aid and training;
- expansion of support for local and community-based organisations to strengthen their capacity and enable them to be larger providers of grassroots education, counselling and treatment;
- more effective outreach to minority and ethnic communities with HIV/AIDS prevention education as well as counselling and treatment;
- streamlining of disbursement, evaluation and monitoring procedures for funding; and
- expansion of harm reduction programs.

The political situation in Myanmar is extremely uncertain. Former Prime Minister Khin Nyunt is now under arrest on suspicion of corruption. He had chaired a key government committee on health issues and had supported greater involvement of international NGOs in fighting HIV. It is now very unclear whether further steps forward will be possible.

II. THE POLITICS OF ASSISTANCE

Providing assistance to Myanmar has been controversial because of the NLD's desire that the international community maintain sanctions in an

[1] See Crisis Group Asia Briefing, *Myanmar: The HIV/AIDS Crisis*, 2 April 2002.

[2] A note on terminology. This report uses the official English name for the country, as applied by the UN, the national government, and most countries outside the U.S. and Europe. This should not be perceived as a political statement, or a judgment on the right of the military regime to change the name. In Burma/Myanmar, "Bamah" and "Myanma" have both been used for centuries, being respectively the colloquial and the more formal names for the country in the Burmese language.

[3] See Crisis Group Issues Report N°1, *HIV/AIDS as a Security Issue*, 19 June 2001.

effort to get the military to respect the 1990 election results. Despite being one of the poorest countries in Asia, Myanmar receives one of the lowest amounts of international aid.[4]

The humanitarian imperative of HIV has meant that both the government and the NLD have become increasingly willing to countenance expanded assistance. They agree that a continued humanitarian response is needed. The governmental National Health Committee and National AIDS Committee place HIV/AIDS third on the nation's list of priority health conditions after malaria and tuberculosis. Officials have repeatedly requested international assistance.

In a meeting with UN officials, local diplomats, and international NGOs (INGOs) in April 2003, NLD leader Aung San Suu Kyi voiced her support of the "Joint Program of HIV/AIDS in Myanmar" outlined below.[5] In subsequent meetings with UN system organisations, NLD officials continued to express support for the joint program.

There was some hope that the humanitarian response to HIV/AIDS, tuberculosis, and malaria would contribute to a dialogue between the military government and the NLD.[6] This has not happened. Indeed, crackdowns on the NLD have further imperilled its survival, and Aung Sang Suu Kyi remains under house arrest.[7] The political situation is in a state of particular uncertainty with the removal from office in October 2004 of the prime minister, Khin Nyunt.

While international engagement on HIV has not had a transforming impact on either the epidemic or the country's politics, it is possible to point to some positive developments with respect to the former. The international humanitarian response is also beginning to help the people of Myanmar develop the structures of civil society.[8] Several hundred Myanmar professionals and thousands of community volunteers on HIV are being supported technically and financially by international organisations. The HIV pandemic continues to challenge all governments and groups interested in the development of civil society; issues related to sexual behaviour, addiction, death, and equity in services require open debate. There is probably no better issue than that of HIV/AIDS to challenge the people of Myanmar to develop their own concepts of civil society, good governance, and equity.

Transparency, accountability, and the effectiveness of HIV programs in local organisations can play a vital role in building an open society. An international humanitarian response to HIV, tuberculosis, and malaria that includes civil society will also provide benefits in other fields of human development such as education, agriculture, and reproductive health.

III. THE EPIDEMIC

The Scale of the Epidemic. The epidemic has expanded since the last Crisis Group briefing but estimates of the total number of people living with HIV in Myanmar vary widely. The official government estimate, made with UN technical assistance in early 2002, is that there were fewer than 180,000 at the end of 2001. The UN Joint Program on HIV/AIDS (UNAIDS) estimated in July 2004[9] that there were 320,000 adults in Myanmar with HIV at the end of 2003. It further estimated a range of 170,000 to 420,000 people infected.

The National AIDS Program of the Ministry of Health made use of technical assistance from the World Health Organisation to revise its official estimate in September 2004. Although no figure has yet been approved for release to the public, 340,000 at the end of 2003 was used in closed workshops during the estimation process.[10] 1.31 per cent of all adults were estimated to be living with HIV.

There are many ways in which an HIV sentinel surveillance process can be biased. Differences in rural or urban populations can change the figures. A sufficient number of subjects in each risk group may not be included. Injecting drug users living in the

[4] Total aid has been less than $3 a year per person in Myanmar. In comparison, Cambodia, Laos and Vietnam received per capital each year, respectively: $30.40, $53.20 and $21.90. UN/ESCAP Statistical Yearbook for Asia and the Pacific, 2002. All figures denoted in dollars ($) in this briefing refer to U.S. dollars unless otherwise noted.

[5] Crisis Group interview, Yangon, October 2004

[6] See Crisis Group Asia Report N°32, *Myanmar: The Politics of Humanitarian Aid*, 2 April 2002.

[7] See Crisis Group Asia Report N°78, *Myanmar: Sanctions, Engagement or Another Way Forward*, 26 April 2004.

[8] For more on the weak state of civil society in Myanmar, see Crisis Group Asia Report N°27, *Myanmar: The Role of Civil Society*, 6 December 2001.

[9] "Report on the Global AIDS Epidemic", Joint United Nations Program on HIV/AIDS (UNAIDS), July 2004.

[10] Crisis Group interview, Yangon, October 2004.

community or detained in drug treatment institutions may be included or excluded from testing. Sex workers may be tested in brothels or only if they are brought for testing by police while being taken to prison. Brothel based sex workers and karaoke based sex workers with different risk behaviours may be lumped together in order to obtain a large enough population to sample. Testing in the many townships may be done the same way every year or local changes may be made so that data may not be comparable from one year to the next.

All the above factors have influenced HIV sentinel surveillance in Myanmar recently. Small differences in choosing the test subjects and false assumptions about risk group behaviour can lead to large errors when figures are multiplied to reflect the situation in the entire country. National aggregate figures are seldom helpful to plan programs.

But there is no debate about the seriousness of the situation. Myanmar ranks in Asia with Thailand and Cambodia in having the highest percentage of its population with HIV.[11] The government accepts that the epidemic is expanding. Although there have been official statements that 70 per cent of infections are through sex and 30 per cent are through sharing injecting equipment,[12] there is no valid scientific evidence for this. Risks of infection are determined by asking people who test positive what their risks were -- misreporting is common.

Drivers of the epidemic. The sharing of injecting equipment by drug users is one behaviour that drives the epidemic. There are an estimated 150,000 to 250,000 injecting drug users in Myanmar,[13] mostly men on heroin. Myanmar has had in the past few years some of the highest HIV rates in the world among its injecting drug users. Official sentinel surveillance reports in 2002 demonstrated that over 90 per cent of injecting drug users in Myitkyina (Kachin State) and over 80 per cent in Lashio (Shan State) and in Mandalay, the country's second largest city, had been infected[14]. Many of these men have died. Very low access to needles and syringes nationwide leads to needle sharing both in drug and medical uses.

Although women sex workers are tested only in the two sentinel surveillance sites of Mandalay and Yangon, it is known that their customers have infected more than one third to one half of them.[15] It is much more difficult to know how many of these customers are infected as the police rarely arrest the men. Young military recruits, some of whom are customers of sex workers, are HIV tested by the military, but results are not made public.

What is known with certainty is that unprotected paid sex between men and women is a major driver of the epidemic. Sex work is common in places where men are far from their homes and have more money and power than women -- truck routes, border crossing points, and mining areas in particular. Engaging in sex work is a criminal act that is commonly suppressed so sex workers often move from one location to another.

Homosexual sex is not uncommon, not least at spirit medium festivals, as acknowledged by government officials. However, little research has been conducted on sex between men so it is not known to what extent it is a major driver of the HIV epidemic.

Seasonal migration driven by poverty leads to large numbers becoming infected. Jade and gem mining areas, with a nexus of injecting drug use, transactional sex, and seasonal migration, are commonly recognised as transmission hot spots by health professionals, and replicate UNAIDS findings in other countries.

Recent campaigns with migrant workers in Thailand led to the registration of 800,000 persons of Myanmar origin. Local HIV epidemics are more mature in Shan State, Kayin State, and Tanintharyi Division, as people who had migrated to Thailand and were infected there returned early in the epidemic. This led to the idea there was an "East to West gradient" of infection from the Thai to the Indian border and that infection was more common among non-Burmans.

[11] "Aids in Asia: Face the facts. A Comprehensive Analysis of the AIDS Epidemics in Asia", Family Health International (FHI), 2004 at http://www.fhi.org/en/HIVAIDS/pub/surv reports/aids_in_asia.htm Thailand has 1.6 per cent of its adult population infected and Cambodia 2.5 per cent.

[12] "Five-Year Strategic Plan for Reproductive Health in Myanmar 2004 to 2008", Part I (draft), Yangon, Ministry of Health, 2004 and Crisis Group interview, Yangon, October 2004.

[13] "Revisiting The Hidden Epidemic - A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS", The Centre for Harm Reduction, The Burnet Institute, Australia, January 2002.

[14] Sentinel surveillance data, National AIDS Program, Ministry of Health, Myanmar, 2002.

[15] Ibid.

These days the epidemic is still heterogeneous and composed of many sub epidemics but it can be said with certainty that HIV transmission occurs throughout the country. Infections are occurring among Burman fishermen from the southern division of Tanintharyi and among Burman debt-bonded women sex workers in the southern city of Kawthaung. Female sex workers from the central dry zone are travelling to work on the Chinese side of the border near Muse in Shan State and in the guest houses of Bago in the Burman heartland where they are infected by their male clients from other Burman-majority areas.[16]

Mandalay is a particularly intense transmission location. By determining the types of HIV that infect people there, a team of researchers from the National AIDS Program and Japan has reported that the virus in Mandalay is mutating into unique recombinant forms.[17] This can only happen when many people with one type of HIV have sex or share injecting equipment with people with another type. People from other regions of the country, and from Thailand, China and India, are practicing high risk behaviours in Myanmar's second city.

IV. GOVERNMENT RESPONSE

The last two years have been a time of rapid change in the governmental response to the epidemic. New leadership on the issue has meant improved programming and better use of staff although problems remain in both these areas.

Leadership. A civilian Minister of Health has been in office during most of this time -- Professor Kyaw Myint, a chest physician with expertise in tuberculosis and a close professional interest in the National AIDS Program. Within the Ministry of Health, there have been two recent relevant changes due to the emigration of one National AIDS Program director and the death of his successor. The average age of officials in the Program is decreasing as younger staff trained overseas are hired and promoted. Externally hired accountants have recently been appointed to expedite expenditures and speed up program management and implementation. A governmental national strategic plan runs until the end of 2005 and a new strategic plan is being formulated.[18]

Programming. The government has approved the UN-initiated Joint Program described in detail below, and ministries are expanding activities including:

- targeted condom promotion in situations of high risk sex including all places where sex is sold;
- outreach, needle and syringe programs, and effective treatment for addictions (including methadone substitution) for people who inject drugs;
- "life skills" sexuality and decision-making training for young people, in and out of school;
- developing a minimum package of care for infected people including 1) voluntary counselling and testing; 2) antiretroviral therapy for those who meet criteria for treatment; and 3) joint TB/HIV programs;
- implementing a comprehensive four-component strategy for preventing HIV infection in mothers and young children;[19]
- creating an enabling environment for activities in HIV prevention, AIDS care, and impact mitigation; and
- expanding the national blood safety program.

Staffing. Although the regular government budget for HIV programs is still restricted to the local currency equivalent of tens of thousands of dollars a year[20] and has not increased in the last two years,

[16] Crisis Group interview, Yangon, October 2004.

[17] XV International AIDS Conference [ThOrA1364], Y. Takebe, Y. Ma, C. Yang, Y. Yokota, S. Kusagawa, R. Yang, X. Xia, K. Ben, M. Thwe, T. Aung, K.Y. Oo, H.H. Lwin, "Geographical hotspots of extensive intersubtype recombination in Asia: 'Melting pot' that generates diverse forms of HIV-1 unique recombinant forms".

[18] "National Strategic Plan for the expansion and upgrading of HIV/AIDS activities in Myanmar 2001-2005", Ministry of Health, 2001.

[19] The four-component strategy endorsed by the United Nations system organisations is composed of activities to 1) ensure access to antiretroviral medication, safer deliveries and infant feeding counselling and support to reduce mother to child transmission; 2) prevent women from becoming infected; 3) prevent unintended pregnancies among women with HIV; and 4) provide care and support for HIV+ women, children and families. "Reducing mother-to-child transmission of HIV: challenges and successes", U.S. Agency for International Development (USAID), Satellite session, International AIDS Conference, 11 July 2004, Isabelle de Zoysa, World Health Organisation.

[20] Proposal to the Global Fund, Country Coordinating Mechanism, Myanmar, 25 September 2002.

several hundred civil servants are employed by the Ministry of Health in the National AIDS Program and assigned to work full time on HIV and other sexually transmitted infections. They are stationed in teams in about 40 key townships controlled by the central government in which transmission of HIV is thought to be most common. Staff numbers have changed little over the last several years.

There is recent evidence of government willingness to work with international organisations that can provide external funding and technical assistance. The institution responsible for submitting proposals for funding to the Global Fund Against HIV/AIDS, Tuberculosis, and Malaria, the "Country Coordinating Mechanism", has made use of outside technical help to develop proposals for the Global Fund and implementation plans for the three priority diseases of HIV/AIDS, tuberculosis, and malaria. In 2002 only one expatriate worked full time on HIV and AIDS in the country. Today there are almost twenty such persons, and the number is growing. Government officials and INGO representatives note, however, that the country still has insufficient highly experienced international technical assistance.[21]

It is vital that the staff of the National AIDS Program who work at township level be involved in the implementation of HIV prevention and care activities and that generalist medical officers implement these activities in townships where there is no Program presence. The central level Program is heavily involved in implementing a few key activities. For example, several Yangon National AIDS Program staff are working full time providing a voluntary counselling and testing service in the capital when their time could be better spent training individuals and giving guidance to township level counsellors. The latter are easily influenced by local administrators who may want to use mandatory HIV testing in order to find cases. Guidance from the centre could help these local counsellors avoid mandatory testing as testing services expand nationwide.

Central level National AIDS Program staff need to delegate more of their current program implementation activities to the township level so they can devote more time to developing an environment for expanding those activities.

With the exception of the Ministry of Health, the Ministry of Education, and the Ministry of Home Affairs, central ministries are just starting to become involved in HIV/AIDS activities. Most of these are small scale pilot activities. The Ministry of Road Transport and Inland Waterways has ordered all applicants for commercial driving licences to undergo compulsory testing for HIV.[22] The Ministry of Industry is becoming involved in implementing HIV education programs for industrial workers. These are steps forward but all ministries need to be involved in effective prevention activities at the central level in Yangon and in local offices.

V. INTERNATIONAL RESPONSE

Priorities. There are several mechanisms for international agencies to support prevention and care programs in Myanmar. The most common is for bilateral official development assistance agencies to give financial help and funds for technical aid to one or more of the following: UN system organisations, INGOs, and government institutions.

The UN in Myanmar and a few key INGOs collaborated to develop the initial "Joint Program for HIV/AIDS in Myanmar" in late 2000.[23] It has been in constant revision since, reaching its most recent form in 2002, and is due for major changes after a review early in 2005. The Joint Program is overseen by the UN Expanded Theme Group on HIV/AIDS, composed of representatives of government, donors, INGOs, local NGOs, the UN cosponsors of UNAIDS, and the UNAIDS Country Coordinator. It is coordinated by a smaller Technical Working Group of representatives of the same constituencies.

In late 2002, key implementing partners prioritised these areas for interventions:

- targeted condom promotion and sexually transmitted infection prevention and care;
- interventions for injecting drug users;
- awareness raising for the general population with a focus on young people;
- care, compassion, and support for people living with HIV and AIDS; and

[21] Crisis Group interview, Yangon, October 2004.

[22] Crisis Group interview, Yangon, October 2004.

[23] "Joint Program for HIV/AIDS Myanmar 2003 -- 2005", United Nations Expanded Theme Group on HIV/AIDS, April 2004, http://www.unaids.org/html/pub/una-docs/jpmyanmar_15jul04_en_pdf.htm.

- development of an enabling environment for an expanded national response.

Funding. At the same time that the Joint Program was being formulated, a joint funding mechanism -- the "Fund for HIV/AIDS in Myanmar" (FHAM) -- was initiated. It uses the financial facilities of the UN Development Program (UNDP) and is executed by the country UNAIDS secretariat. The most substantial increase in funding in the last two years has been through this mechanism. The UK is the largest donor to the joint fund with the Swedish International Development Agency and Norway also contributing.

No money in the FHAM is earmarked for specific activities by donors. Rather, it is pooled and made available to governmental, UN, and non-governmental implementing partners. Two tranches of funding have been made available for over twenty implementing organisations who submitted proposals for technical review. Funding is competitive and is allocated on recommendations of a technical review group to the Technical Working Group.

Funds identified for disbursement through this mechanism from early 2003 through early 2005 total approximately $22 million. A further $17 million is available that is not channelled through the joint mechanism. This includes money contributed on a bilateral basis by a number of donors to the joint fund.[24] An additional $9 million is available from other sources, bringing total committed funding to almost $50 million. Implementing partners may not have reported other monies to the UNAIDS secretariat -- for instance, funds for condoms -- so this accounting may not be complete.[25]

Administration of the joint funding mechanism is primarily the responsibility of the UNAIDS secretariat in Myanmar. Implementing partners have complained about the cumbersome proposal procedure, monitoring and evaluation reporting mechanisms, and delays in disbursement of funds. There are also delays in use of the funds: the National AIDS Program is the main governmental implementing partner but has spent less than half its allocation for the first year of funding.

Administration of the FHAM is not sufficiently transparent. Implementing partners and agencies who submit unsuccessful proposals do not always see the reports of the funding decisions that are made by the Technical Working Group, and a first annual report has not been published one and a half years into the implementation phase. All implementing partners receiving funds from the FHAM will undergo auditing by the international firm KPMG. A second phase of funding for FHAM is not assured, and more donors are required to assure its long term viability.

More funding for the expanded national response to HIV will be made available through the Global Fund. The Country Coordinating Mechanism for Myanmar (with both governmental and non-governmental institutions) made two proposals for HIV/AIDS funding that were rejected on technical grounds and was then successful in the third round of funding in October 2003.[26] $20 million will be available in the tranche for the first two years, about half of which has been budgeted to support government programs.

It is anticipated that the UNDP will be the principal recipient of Global Fund money for HIV/AIDS as it already is for tuberculosis. A year has passed since the HIV/AIDS grant was approved but the implementation arrangements have not yet been worked out, and the grant agreement is not yet signed. If this does not happen by the end of 2004, the Global Fund may not make the grant.[27]

The U.S. Congress[28] has decided to restrict financing of the Global Fund by the amount of any Global Fund grants that go to the national government of Myanmar (the State Peace and Development Council, SPDC).

[24] For example, the European Union (EU) has provided nearly $6 million, and the U.S. $2 million. See the table at the end of the briefing.

[25] Crisis Group Interviews, Yangon, October 2004.

[26] http://www.theglobalfund.org /search/ portfolio.aspx? country ID=MYN.

[27] "...unsigned Round 3 grants should as of now 'no longer be considered approved' unless the Board decides to allow a further exceptional time extension based on information received from the Secretariat and national Country Coordinating Mechanisms. This time extension will be limited to a maximum of three months". Global Fund Observer 33, http://www.aidspan.org/gfo/archives/newsletter/GFO-Issue-33.htm.

[28] "Senators Call to Cease Fund to Burma....U.S. Senator Sam Brownback (R-KS), along with Senators Judd Gregg (R-NH) and Mitch McConnell (R-KY), last week called on the Global Fund to cease additional funding for Burma and other state sponsors of terrorism. In a letter to the executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Brownback and the senators asked for assurances that none of the $2.4 million initial disbursement for Burma by the Global Fund will be provided to the State Peace and Development Council, an illegitimate military junta ruling Burma.…", U.S. Campaign for Burma, 5 October 2004.

This would not restrict funding to NGOs or other local entities not controlled by the SPDC. This could compromise the non-political status of the Global Fund which makes grants solely on the technical merit of funding proposals that it receives, provided implementation arrangements meet its requirements.[29]

The Global Fund tuberculosis grant to Myanmar is a test case for the proposed HIV grant. Funds will be allocated to sub recipients by UNDP. Current implementation arrangements call for almost no funds to be allocated directly to the government -- government institutions will handle only small amounts for local training. The KPMG affiliate from Hanoi, an institution accustomed to developing transparent procedures in a challenging governmental environment, has been given the role of Local Fund Agent to oversee financial procedures.[30]

A unified monitoring and evaluation structure has been developed by the UNAIDS country secretariat and a core set of process, output, and outcome indicators promulgated.[31] All implementing partners in the joint program report on these indicators for funds received through the joint funding mechanism but need not report on them for activities funded from other sources.

Few UN system organisations have used large amounts of their own core money for HIV activities. Most of their funding has been extra budgetary, with funds raised specifically for HIV prevention and care. Most agencies have received funding from the FHAM. Among UN organisations in Myanmar, only UNICEF has raised sufficient money for its planned programs that it has not applied to FHAM. UN leadership in guiding effective implementation must develop now that funding is assured.

The above examples illustrate that it has been possible for donors, international organisations, and implementers to begin in the last two years to work directly with the government in ways that are transparent, accountable, and effective. There is no evidence that leakage of official development assistance funds is higher than in any other country in the region, and most informants think it is significantly less.[32] While most civil servants and local NGO leaders in the health sector in Myanmar have not worked with international technical assistance or funding since independence over 50 years ago, many of their expatriate counterparts in the HIV field say they have learned very quickly.[33]

VI. PROGRAM RESPONSES

Transmission through sharing needles. Financial resources are no longer a major constraint, but a shortage of skilled and experienced human resources and limited implementation capacity limit expansion of program activities.

Harm reduction for drug users, especially injecting drug users, has advanced in the last two years. Several pilot projects have been carried out to demonstrate the effectiveness of outreach activities, increased treatment for addictions, and needle and syringe distribution programs. Most are in Kachin and Shan states, almost all are externally funded, and most program implementers are INGOs.

The UN Office on Drugs and Crime has taken a leading role in technical coordination of these activities. Two major INGOs with offices in Yangon focus exclusively on harm reduction, and two others focus on health and have components of harm reduction in their activities. External technical expertise has included the most experienced technical experts and senior advocates in the world.

Supply and demand reduction of illicit drugs, especially opiates, has for several years been a government priority.[34] The multi-ministerial Central Committee on Drug Abuse Control, with its

[29] Those restrictions were incorporated into the Consolidated Appropriations bill for FY2005, requiring that U.S. funding of the Global Fund be reduced by the amount of Global Fund monies identified as going to the central government. The assumption is that this would neither affect direct bilateral HIV/AIDS aid going to non-governmental organisations or local entities where it could be demonstrated that they were not controlled by the State Peace and Development Council. However, the additional restriction undoubtedly will complicate approval of HIV/AIDS funding going to Burma. See H.R. 4818, Sec. 531 http://thomas.loc.gov/cgi-bin/cpquery/?&db_id=cp108&r_n=hr792.108&sel=TOC_648150&Op.cit. H.R. 4818, Sec. 531.

[30] Crisis Group interview, Yangon, October 2004.

[31] "Joint Program for HIV/AIDS Myanmar 2003 -- 2005", op. cit.

[32] Crisis Group interviews, Yangon, September and October 2004.

[33] Crisis Group interviews, Yangon, October 2004.

[34] "2004 Opium Poppy Survey in Myanmar", United Nations Office on Drugs and Crime and Central Committee for Drug Abuse Control, Myanmar, November 2004.

secretariat in the Ministry of Home Affairs, has a high profile and wields great power at central level. Senior officials in the Ministry of Home Affairs have visited Asian and Pacific countries to observe activities to reduce harm for drug users. Several have gone on multiple trips sponsored by both INGOs and UN system organisations over the last five years. These trips have not been one-off study tours but part of long-term study of how to implement harm reduction activities and rights based approaches. These officials have subsequently supported development of harm reduction activities by both governmental and non-governmental institutions.

Constraints continue to limit the effectiveness of these programs, however. The term "harm reduction" is rarely used in public statements so there is limited understanding of the concept at both central and local levels. Emphasis is often given to treatment of addictions as a means of reducing demand for illicit drugs on the market rather than stressing a range of activities to reduce harm. Most harm reduction activities are focused on heroin injectors rather than opiate users who are presently smoking or snorting drugs but who may begin injecting later. The legal status of methadone for substitution therapy is still uncertain. There is also a lack of leadership and expertise on harm reduction issues within the Ministry of Health and the National AIDS Program, so all governmental leadership must come from the Ministry of Home Affairs.

Harm reduction programs for drug users need to be developed further in areas where drug related HIV is a problem. Most drug use is concentrated in northern and eastern states, including areas where the government has signed ceasefires with ethnic minority groups, and local permission to conduct activities must continually be sought and local capacity built. Harm reduction activities must also be encouraged in custodial situations such as drug treatment centres, prisons, and detention centres.

Transmission through sex. One of the most obvious changes of the last three years has been greater government openness to talk about HIV issues. Some observers note this began with a speech by the then Secretary One, General Khin Nyunt, at a World AIDS Day observance in late 2001. Whether his recent political fall will impact on this new openness remains to be seen. Changes in leadership in the Ministry of Health and the National AIDS Program have also facilitated greater openness, leading to the inclusion of HIV issues at many levels of discourse on development.

The new openness in communication is most evident with respect to condoms as an essential part of the national response. International NGOs and government agencies promoting condoms have found that their staff members and national partners are now able to talk about them more easily, distribute them with fewer restrictions even in places where sex is sold, develop communication materials with less scrutiny, and use the mass media more quickly.[35] Condom demonstrations are now common in most HIV training activities.

Subsidised condoms sold and distributed through social marketing are available throughout the country. Distribution is projected to reach over 30 million in 2004, and there is evidence demand is increasing. Female condoms are being distributed through a social marketing program. Billboards promoting condom use are appearing outside Yangon. Condom advertisements, drawings, and articles are being published more often in newspapers and magazines. HIV education exhibitions featuring both governmental and non-governmental exhibitors highlighted condom use and were well attended by both schoolchildren and the general public in Yangon in late 2003 and in Mandalay in October 2004.

All educational materials produced on HIV/AIDS in Myanmar must pass scrutiny by a governmental agency. Some photographs, posters, and audio materials are not approved. This process also inevitably leads to delays in distribution of materials.

There is a need for the openness in discussions about HIV and condoms and in distribution of condoms to be expanded, so that other facets of the increasing humanitarian response to the sexually transmitted epidemic of HIV can develop. Openness on the part of the government will not be seen by most interested outsiders as an expression of moral failure but rather as an admission of the seriousness of the situation that will build trust in the government to lead an expanded response.

Prostitution is a crime in Myanmar -- both sellers and buyers of sex can be fined or imprisoned, though men who buy sex are rarely arrested. There is a wide range of venues and environments in which sex work takes place. Most harassment and arrests happen to women who work outside, on the streets or in parks. Women who work in most brothels, karaoke establishments, nightclubs, and restaurants are seldom arrested. Debt

[35] Crisis Group interviews, Yangon, October 2004.

bondage of sex workers and sex worker migration is common.[36]

There is registration of sex workers and regulation of sex work in a few border areas. There is also official acceptance of sexual minorities in border areas, where transvestite and transgender cabaret shows are sanctioned by local authorities for the entertainment of Chinese tourists.[37]

There is no central vice department in the Ministry of Home Affairs or in the central police administration. Suppression of outdoor sex work and crackdowns on prostitution are implemented solely by local authorities and police. This is more common in Burman heartland areas. Crackdowns are also initiated by local authorities who are expecting visits by high ranking central level officials. A new central government initiative to decrease human trafficking has led to the suppression of sex work in the town of Tachileik on the Shan State border with Thailand. This is an area where sex work has been regulated as an HIV prevention strategy so the human trafficking campaign has disrupted the HIV prevention program and led to greater vulnerability of sex workers to HIV.

Targeted condom promotion for sex workers and their customers has recently been expanded by both governmental and NGO implementing partners of the Joint Program. The National AIDS Program has taken new initiatives in openness by publishing Burmese and English guidelines for their targeted condom promotion program. A wide range of funding agencies including the UN Population Fund support this activity. Millions of condoms are distributed annually by the National AIDS Program for free use in many of the key townships where sex is commonly sold.[38]

It would useful for the government to take the same pragmatic approach to HIV prevention related to sex work that it has taken with HIV prevention related to drug use. Regulation of sex work already exists in limited areas. If their numbers can be increased and the niche for NGO and governmental partners can be expanded so they can work freely with sex workers in outreach, condom promotion, and care for sexually transmitted infections, this area of transmission can be reduced, and HIV incidence will decline. The enabling environment required for this work must be created in each township but permission must be generated first at the central level. As there is no government committee responsible for the prevention of sexual transmission of HIV equivalent to the Central Committee on Drug Abuse Control, a policy decision by the Minister of Home Affairs is needed. HIV prevention should not be connected in any way with campaigns to reduce human trafficking. While it is essential for campaigns against human trafficking to receive greater government, non-government and international support, they should not be conducted in any way that discourages full access to HIV prevention, counselling and treatment for sex workers.

INGOs working in the prevention of sexual transmission are no longer limited by funding constraints in their response to HIV in Myanmar.[39] This has lead to more collaboration. Two of the largest working in health -- Population Services International and Medecins sans Frontieres (Holland) -- commonly cooperate on HIV issues. Another positive development has been a grouping of partners, the NGO Consortium on HIV/AIDS for Myanmar. Composed of CARE International Myanmar, Marie Stopes International Myanmar, the local professional organisation the Myanmar Nursing Association, Save the Children UK, and World Vision Myanmar,[40] it uses the strengths of each member to expand greatly a comprehensive sexual transmission prevention program in 35 of the 60 townships in which they work.

INGOs continue to implement these prevention programs in what can only be called a very challenging environment. Their staff are vulnerable to pressure by local commanders and government officials. Staff travel to many areas is easier than in the past but there is still restricted access to ceasefire and border areas, and permission procedures can be lengthy. Importing vehicles to facilitate travel outside Yangon continues to be very difficult.

There are other problems to be tackled in expanding effective prevention activities: too many concentrate

[36] "Mobility and HIV/AIDS in the Greater Mekong Subregion, Supang Chantavanich", Asian Research Centre for Migration, Institute of Asian Studies, Chulalongkorn University, Bangkok, Thailand, Asian Development Bank, 2000.
[37] Ibid.
[38] "Documenting the progress of 100 per cent Targeted Condom Promotion Program in Myanmar" and "Implementing the 100 per cent Targeted Condom Promotion Program in Myanmar", National AIDS Program, Department of Health, Ministry of Health, Myanmar, 2003.
[39] Crisis Group interview, Yangon, October 2004.
[40] "Programming in HIV Prevention and Care for Vulnerable Children including Orphans", Myanmar NGO Consortium on HIV/AIDS, October 2004.

on raising awareness of HIV instead of providing people with the tools needed to prevent infection; not all areas of the country where infections are occurring are covered; people at risk of infection continue to be marginalised; and coverage of condom promotion and harm reduction activities in pilot areas is still limited.

Care and support. Very limited progress has been made in the public health approach to HIV treatment and AIDS care in the last two years. Most people known to be infected die within a year of an AIDS-defining opportunistic infection. Myanmar has one of the world's highest rates of tuberculosis, which is a common opportunistic disease.[41] Almost all those with HIV who have access to antiretroviral therapy get care through the private sector and pay for their own medicine.

The only HIV treatment provided by the public sector is through a jointly implemented INGO and public hospital pilot project for 100 people in Yangon. A few other NGO pilot schemes are just getting off the ground. Plans have been formulated for considerable expansion of public sector treatment driven by the World Health Organisation (WHO) Three-by-Five target.[42] A minimum package of care services has also been agreed upon by a working group of governmental, INGO and UN representatives. Pilot projects of home and community-based care have been initiated.

Strict confidentiality by health care providers is rare. Stigma and discrimination against those with HIV or AIDS is common, especially in areas where the epidemic has recently become manifest. Groups of HIV positive people do not yet have permission to meet independently to develop their own advocacy agenda. Community development is needed of the minimal package of care and antiretroviral therapy initiatives, which could be used to begin to address stigma and discrimination.

Small local organisations. While it has been possible for donors to assure transparency, accountability, and effectiveness in working with both governmental and NGO structures, current humanitarian funding and technical assistance mechanisms have not served another group of organisations well. Small local organisations need humanitarian help. Although a few foreign observers have claimed there is no civil society in Myanmar, there is a host of small civil society organisations in the space between the family and the state that can be mobilised for HIV prevention and care.[43] The HIV epidemic can act as a catalyst for the development of these local organisations in preparation for a democratic transition.

A recent review[44] has found that the number of these middle ground, local NGOs and small community based organisations is increasing at an exponential rate. The reviewer estimated that there are almost 300 of the former and roughly 200,000 of the latter.

These organisations are extremely heterogeneous. Many are small and located in only one or two sites. Some are registered under the "Organisation of Association Law" or as religious groups, but many are not registered. There are Buddhist, Christian, Muslim and Hindu faith-based groups. There are fledgling groups of people living with HIV who are meeting with INGO support. There are small charity funeral services working only in one location. There are village library administrations run by civil groups, and most Burman villages have small associations composed solely of young men and young women. Local cooperatives are also often registered as community based organisations. None of these work directly with or is directed by the government or by local governmental authorities.[45]

Small local organisations have not received FHAM support and only rarely receive help through bilateral funding channels. There have been several initiatives to support these organisations in expanding the national response to HIV. The UNDP has funded the United Nations Office of Project Services to implement two consecutive projects to aid small local organisations. Two INGOs are working to build the capacity of community based organisations -- one works on program management for health related

[41] "Evaluation of needs for the use of antiretroviral therapy and recommendations for improving the quality of care", Dr Odile Picard, WHO short-term consultant, May 2003.
[42] The WHO Three-by-Five target is to put 3 million people on antiretroviral treatment by the end of the year 2005. Myanmar has set a target of 10,000 people.

[43] "Civil Society in Myanmar", a presentation by Brian Heidel of Save the Children UK, Yangon, April 2004.
[44] Ibid.
[45] Excluded from this list of types of small local organisations are branches of the Union Solidarity and Development Association, the National League for Democracy, the Myanmar Red Cross Society, the Myanmar Maternal and Child Welfare Association, the Myanmar National Committee for Women's Affairs, and the Myanmar Anti-Narcotics Association. Three major professional associations -- the Myanmar Medical Association, the Myanmar Nursing Association and the Myanmar Health Assistants Association -- are also not included.

organisations, the other is beginning community development for sex workers, men who have sex with men, and people living with HIV. All these initiatives will help to build up a cadre of Myanmar community members and HIV professionals.

Support for local organisations can be implemented using one of these models or others can be developed. The next phase of funding through FHAM as well as bilateral donors should consider giving priority to these local organisations.

Ideally, these local organisations could undertake rapid scaling up of both prevention and care activities throughout the country, though realistically, this can be done in a comprehensive manner only in a few sites. A long term plan for building the implementation capacity of local organisations is needed. It might include activities for developing a communications network among local organisations, developing ecumenical alliances among faith based groups, developing human resources and technical capacity, supporting the registration process, and building program management and financial management capacity. If long term partnerships are forged with larger organisations and financial and technical assistance provided, the development of rights-based approaches will follow.

The military and police. There have been efforts in the past few years to provide international humanitarian assistance for HIV prevention activities to the uniformed services. Most of these have focused on the police.[46] The Ministry of Home Affairs has recently been an active and, by the standards of Myanmar, a progressive partner for international organisations in this respect. There has been less attention to another uniformed group -- the enlisted men and women of the armed forces (the Tatmadaw). These include the lower ranks and most of the fighting men of the ethnic groups.

There are at least 400,000 armed lower ranks within the Tatmadaw,[47] approximately 3 per cent of the adult male population. Armed men in the ethnic forces are estimated to be at least 70,000.[48]

Little is known about HIV prevalence within the Tatmadaw lower ranks. Small numbers of recruits are tested in Yangon and Mandalay: in 2003 their HIV rates were 1 per cent and 3 per cent respectively. But these figures reflect sexual and injecting behaviours before they become soldiers. Large scale testing of Tatmadaw lower ranks would give a better reflection of behaviour after they have entered the army but if this testing takes place, results are not made public. There is no known HIV testing program in the ethnic armies.

In the current militarised situation, lower rank soldiers are almost everywhere in the country. Many are stationed far from their families so they are not subject to normative controls on their sexual and injecting behaviour that home communities usually provide. There is no peer-reviewed published research on their HIV risk behaviour or vulnerability to infection.

The Tatmadaw's own HIV prevention and care program reaches only a portion of the total force, mostly officers. The lower ranks of the ethnic armies are often not beneficiaries of HIV prevention and care programs at all.[49] Only a few of these armies even have HIV programs, and those may not develop evidence-based practices. Drug detoxification is sometimes enforced by locking heroin addicts in a room for cold turkey withdrawal. Modern treatment methods for addictions are unknown.

Highly effective programs for enlisted men developed in Southeast Asia for government armed forces and paramilitary organisations could readily be adapted for the Tatmadaw.[50] Many providers in the military health care system already face the epidemic in their daily practice and need much more support. The military medical college outside Yangon graduates the largest cadre of doctors in the country every year. Some professors and clinicians within the military medical establishment have expressed interest in

[46] For example, the Asia Regional HIV/AIDS Project has implemented a training project for police over the past year. "Operational Framework to Effective Interventions for Reducing HIV Infection from Injecting Drug Use", Joint Program for HIV/AIDS, Myanmar, 2003-2005, 6 July 2004.

[47] Jane's Intelligence Review, vol. 10, no. 11, 1 November 1998, p. 28.

[48] Crisis Group interview, Yangon, October 2004.

[49] For more details on the ethnic conflicts see Crisis Group Asia Report N°52, *Myanmar Backgrounder: Ethnic Minority Politics*, 7 May 2003.

[50] The unanimously-endorsed UN General Assembly Special Session Declaration of Commitment on HIV/AIDS, article 77, specifically names the uniformed services as a group to be reached with prevention services. Cambodia has developed one of the most effective programs in the region and has achieved high levels of coverage.

developing more effective prevention and care programs. The Department of Defence Medical Services could develop a comprehensive program within the structure of the Ministry of Defence.[51] UNAIDS has a substantial set of education, planning, counselling and treatment regimens for militaries that it offers some 50 countries.

The objective of a program for the Tatmadaw could be to develop an HIV prevention activity that could reach almost all enlisted men. For international funding to flow, written, transparent procedures meeting the needs of both donors and implementers would have to be established.

Developing a program for the ethnic armies is more challenging as they are composed of several much smaller organisations that are usually based far from Yangon. Regular and unrestricted access to these areas is difficult for both national and international staff of international organisations. But a major program for a majority of all the armed men in the country is necessary if the challenge of HIV in Myanmar is to be met effectively. Men in the armed forces cannot simply be ignored in the hope that prevention programs for the general public will reach them. They do not.

Other access issues must also be addressed. For an international humanitarian response to develop fully, both national and expatriate staff of international institutions require direct contact with program beneficiaries for monitoring and evaluation. Although access has increased considerably in the last two years, it is not yet adequate for effective programs for all people at risk. Access to prisons is restricted to the International Committee of the Red Cross and one small INGO. Access to ceasefire areas and the remote parts of states is allowed to most UN, but not always INGO, staff.

VII. CONCLUSION

Much has been achieved since 2002, including critical decisions by the military to address the problems of HIV. Much remains to be done by all organisations involved, particularly in these critical areas:

- provision of technical assistance to expand understanding of rights-based approaches;
- support for scaling up existing prevention and treatment programs;
- support for local NGOs and community groups so they can better respond to the epidemic;
- development of programs for enlisted soldiers; and
- use of community care to begin to address stigma and discrimination.

The military government also needs to adjust some of its approaches, particularly in these areas:

- delegate more program activities from central level National AIDS Program staff to implementers at township level;
- facilitate speedier disbursement and implementation of externally funded activities;
- recognise the priority of responding to the pandemic by increasing its own budget for HIV/AIDS programs and at the very least incorporating costs for treating soldiers into the defence budget;
- continue to expand harm reduction programs for drug users in the areas where drug-related HIV is a problem, including custodial situations (drug treatment centres, prisons, and detention centres);
- expand the recent openness about condoms to include all facets of humanitarian response;
- take the same pragmatic approach to HIV prevention related to sex work as it has taken with HIV prevention related to drug use;
- continue to expand access to ceasefire and border areas for all HIV professionals; and
- encourage more ministries to examine how they can adopt policies and programs for HIV/AIDS prevention, counselling and treatment, drawing on UNAIDS experience with other countries in inter-sectoral programs.

Donors have moved rapidly to expand funding for HIV activities in Myanmar but need to consider also the following steps:

- sustaining current levels of financial support through both the joint funding mechanism and other channels;

[51] Crisis Group interview, Yangon, October 2004.

- developing faster and more transparent proposal, disbursement, and monitoring and evaluation mechanisms for the Fund for HIV/AIDS in Myanmar; and
- working out quickly implementation arrangements for Global Fund grants for all three priority diseases so that programming can begin.

Yangon/Brussels, 16 December 2004