ENHANCING CAPACITY FOR HIV/AIDS PREVENTION AND CARE

UNDP MYANMAR

TECHNICAL REVIEW

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Executive Summary

In 1992 UNDP Myanmar initiated a project to support the long-term goal of slowing the further spread of HIV and to mitigate its social and economic impact. Subsequently in 1994, the Governing Council, in re-directing the UNDP assistance to programmes and projects with grassroots impact, included HIV/AIDS as a priority area of intervention. Thus the HIV/AIDS project, executed by UNOPS, was fully integrated into the grassroots oriented Human Development Initiative (HDI) programme implemented since 1994. There are two major HDI projects addressing community development - the Integrated Community Development Project (ICDP) and Community Development in Remote Townships Project (CDRT).

The project is now on its fourth phase and conducting two major forms of activity – supporting rural communities to undertake HIV/AIDS prevention and care activities and providing support to PLWHA.

The annual UNDP Independent Assessment Missions (IAM) over recent years made recommendations for the HIV project. In response the project made the appropriate adjustments.

In 2004 the IAM noted the changed circumstances since the original project design and recommended sharper focus. So the HIV project concentrated upon building the capacities of the community development workers in the ICDP and CDRT projects to mainstream HIV into community development. A Mid Term Review in 2005 identified ways to strengthen mainstreaming and explore HIV prevention amongst communities.

In 2005 the IAM recognised the progress made in re-designing the HIV project and questioned if it could be combined with the health education components of the ICDP and CDRT and if it should continue separately or be re-organised as a support unit for them. In 2006 a follow up technical review recommended building on current community development strategies by encouraging leadership and engagement of men, women and youth. In response the HIV project developed a community outreach education program in selected HDI villages that included capacity to act upon HIV prevention and mitigation activities. The project also supported the Greater Involvement of People Living with HIV/AIDS (GIPA) by participating in a process that lead to the formation of the national network the Myanmar Positive Group.

The 2007 IAM questioned the prevalence of HIV in the HDI areas and recommended the HIV project widen its coverage and focus on high risk groups and areas (regardless of whether they are within or outside HDI areas), and align activities with other HIV agencies.

The 2008 IAM recommended looking at the comparative advantages in focusing on awareness raising or support of people living with HIV/AIDS, and recommended the project concentrate upon training CDRT and ICDP to take over HIV awareness raising

responsibilities in the two project areas and wrap up such activities in other areas, freeing resources for work in peri-urban areas.

As a cosponsor of UNAIDS UNDP is also a member of the UN Joint Team on AIDS in Myanmar which has developed a workplan, the Joint United Nations Programme of Support for HIV (JUNSP), to support the implementation of the National Strategic Plan for HIV and AIDS in Myanmar 2006 – 2010. UNDP has made a number of commitments within this work plan. This is consistent with the role of providing leadership and technical capacity that is expected of UNDP, particularly in the Myanmar context where there are limited organisations working in HIV and major constraints on resources and expertise.

Until now UNDP has concentrated upon delivering services and not given enough attention to its role within the UN Joint Team and to contributing at a national level. Hence, many of the recommendations in this review re-emphasise the commitments that UNDP has already made to the Joint UN work plan and encourages UNDP to make it a priority to implement them. Apart from the contribution they will make to the national response to HIV some of these activities will also have direct flow on benefits for UNDP's activities.

After piloting various activities exploring integration with CDRT and ICDP as recommended by the IAM the HIV project found that it had not been able to accomplish effective integration. This was due to a range of factors: lack of attention to design and implementation, the need for specialist ongoing support to HIV prevention and community mobilisation activities, the stigma associated with HIV, and the complexity of encouraging behaviour change to prevent HIV infection and transmission. Consequently the HIV project's major activity now operates in parallel with HDI'S CDRT and ICDP projects.

The rationale for the project's HIV education activities at rural village level is that HIV vulnerability is due to men becoming infected when they have sex when away as migrant workers and then returning home to infect their wives, and, sometimes, children. Yet, as the IAMs have commented, there remains concern that the project is not operating in locations where HIV is a major threat. Various means have been used to identify priority locations but the project is still unable to ensure it is working in sites that are especially vulnerable to HIV. This is reinforced by the research conducted at project sites where it is unclear if the people have high enough rates of sex outside their relationships and visits to sex workers to warrant them being considered at risk of HIV. The JUNSP contains a proposal to support a study of migration flows and HIV vulnerability and UNDP should participate in this. Possibly it could be conducted in some of the townships where UNDP operates HIV activities. Overall, it should result in the creation of frameworks, assessments, and methodologies to use when identifying locations and designing HIV and migration activities that can subsequently be used by the project.

The HDI project is currently in the process of integrating the projects within it, including the HIV project. There are good signs that, unlike previous attempts, this process can

successfully integrate HIV. This will be compatible with spirit of the 2008 IAM recommendation by having HIV more integrated within the HDI model but still recognises that it is not suitable to enact the full recommendation to have the CDRT and ICDP staff take on responsibility for HIV education given the unique and specialist features of effective HIV prevention and education.

Great attention is being given to planning this integration. It will apply at programme and operational levels. It is proposed to create operational structures at township level which would allow for a suitable blend between integration and specialist expertise and capacity. A pilot approach will allow for a staged and adaptive process to explore the most effective way to create and implement this integration. It would be valuable to involve the HIV project staff in all stages of this process due to their prior experience with integration and understanding of the requirements of an effective community based HIV programme.

The HIV project responded to the recommendations from the IAM to broaden involvement, and also complied with its global policy, by supporting People Living with HIV and AIDS (PLWHA). This has mainly been in two forms – support with micro finance and support to the development and mobilisation of PLWHA Self Help Groups (SHGs). The micro finance support occurs both at village level as part of the comprehensive community based response model the project establishes as well as through SHGs which the project has supported to operate income generation schemes. The project has also played a key role in supporting the emergence of the national network of PLWHA, the Myanmar Positive Group, which in a short period has become an impressive advocacy and education organisation. There has been very rapid growth of the PLWHA SHGs across the country and UNDP has played a major role in supporting this and responding to the members needs.

It would be consistent with its role and commitment to date for UNDP to continue this support in three ways. One way would be to support a review of the most effective ways to provide income generation support to PLWHA and their households along with the most effective models to use for supporting micro finance amongst groups of PLWHA. The second activity would be to support a national capacity development assessment of PLWHA Self Help Groups. Thirdly, UNDP should meet with MPG and discuss the ways that it can provide ongoing support to this national network, and, particularly, with staffing, advocacy and operational activities. These three activities complement each other. They would result in a strengthened integrated PLHWA movement at local and national level which meets the needs of its members as well as the globally recognised need for PLWHA to be actively involved in the policy, operational and monitoring response at all levels.

Arising from its work with PLWHA is the need for UNDP to attend to HIV impact mitigation. At national level in Myanmar it is recognised that strategies for minimising the impact of HV upon individuals and their families and social networks have been neglected. With ever increasing numbers of PLWHA this has become a critical issue. UNAIDS and members of the UN Joint Team expect it will be a major issue in the

coming mid term review of the National Strategy for HIV and AIDS. Given that UNDP has played a major role in support to PLWHA, and that globally it is committed to impact mitigation, it would be appropriate for UNDP to demonstrate leadership and commission a national study into HIV impact mitigation.

Another area of UNDP responsibility is HIV and the workplace. However, it seems that little attention has been given to committing to project activities in this area and, given the range and extent of other activities that UNDP is already committed to and those recommended in this review, it might be prudent for UNDP to delay activities around HIV in the workplace.

The final area of activity is that of men who have sex with men and HIV vulnerability which has been assigned to UNDP in the UN division of labour. Since this group of men are at high risk of contracting and spreading HIV it is necessary for UNDP to demonstrate national leadership on this topic. Since it is a specialist and complex area to work in it is not appropriate for UNDP to directly conduct activities with these men. Within the country some organisations work with these men already and there has been some national level assessment conducted. UNDP should collaborate with the UN Joint Team to identify what is needed at the national level regarding leadership and strategic planning to respond to HIV and MSM.

Overall, the HIV project has concentrated upon implementing activities. Within that it has not managed to create sufficient expertise in particular models that it can contribute to the national response. Neither has it developed the conceptual and analytic understandings of HIV and Development that it should be providing to other development and HIV partners, nor has it shown the leadership that it expected from UNDP in the Joint UN response and in other ways nationally.

The project is going to need external technical assistance in order to rectify this. Currently, for a range of reasons, it does not have sufficient technical, conceptual and analytic capacity, or sufficient exposure to the epidemic in other settings, to be able to meet the project needs. The project needs to engage this technical expertise to assist those who are managing and implementing the project. It is also essential that the project collaborate closely with the JUNSP, including involving them in identifying the frameworks and terms of reference for studies and technical assistance. In this way UNDP is maximising the expertise available in Myanmar on HIV.

In final discussions with UNDP management at the conclusion of this evaluation it was decided that it was not necessary to attend to one component of the tasks expected in the Terms of Reference – review the project's results framework and recommend indicators if needed – as the project will use this report to inform a process of consideration and reorientation of the project over the near future.

Recommendations:

- **That to develop better understanding of migration and HIV and the associated sexual and injecting risk behaviours UNDP act upon its commitment in the Joint UN Programme of Support for HIV in Myanmar to participate in a review of development needs, migration flows and HIV vulnerability in selected townships identified by the National AIDS Programme lead prioritisation exercise.**

- **That UNDP act upon its commitment to the Joint UN Programme of Support for HIV in Myanmar to participate in improving understanding of the impact of gender on HIV transmission in Myanmar, particularly through: establishing a National Strategic Plan for HIV and AIDS Technical Support Group Gender Working Group; a gender audit of the Joint Team, the Global Fund CCM, and the UNAIDS Country Office; and a multi-partner gender review of the National Strategic Plan for HIV and AIDS.**

- **That the UNDP HIV Project involve experienced HIV social scientists in all stages of the design of HIV activities, especially education and prevention, and enable the implementation of well designed and resourced studies that assess the impact of project activities and inform subsequent activities.**

- **That UNDP commission a review of the most effective ways to provide micro finance support to PLWHA and their households, and the most effective model/s for supporting micro finance capacity amongst groups of PLWHA.**

- **That, in collaboration with the United Nations Joint Support Programme on AIDS, UNDP takes the leadership in addressing HIV impact mitigation and commission a national assessment of impact mitigation.**

- **That UNDP discuss with the Myanmar Positive Group the forms of support that UNDP can provide with a focus upon core support to staffing, advocacy and operational activities.**

- **That UNDP provide support for a national mapping, strategy and action plan to address capacity development of PLWHA Self Help Groups in Myanmar**

- **That, in collaboration with UNAIDS and the Joint Team, UNDP ensures that national level leadership and strategic planning is available to inform an effective response to HIV and MSM in Myanmar.**

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AFXB	Association Francois Xavier Bagnoud
APN+	Asia Pacific Network of PLWHA
ARV	Anti retroviral
ASV	AIDS support volunteers
CAP	Community Action Plan
CBO	Community based organisation
CCE	Community Capacity Enhancement
CCM	Country coordinating mechanism (GFATM)
CHAMP	Community HIV/AIDS Mainstreaming Project
CHEER	Community HIV Education in Early Recovery
CDRT	Community development in remote townships project
ER	Early Recovery
FHAM	Fund for HIV/AIDS in Myanmar
IAM	Independent Assessment Mission
ICDP	Integrated community development program
IEC	Information, education, communication
GFTAM	Global Fund to fight AIDS, tuberculosis and malaria
GIPA	Greater involvement of PLWHA
HBC	Home based care
HDCT	HIV and Development Cluster Trainer
HDF	HIV and development facilitators
HDI	Human development initiative
HDS	HIV and development specialist
HIV	Human Immunodeficiency Virus
IDU	Injecting drug use
INGO	International non-government organisation
JUNSP	Joint UN Support Programme on HIV/AIDS
MDG	Millennium development goals
MPG	Myanmar positive group
MSM	Men who have sex with men

NAP	National AIDS program
NGO	Non government organisation
NSP	National Strategic Plan on HIV/AIDS
PLWHA	People living with HIV/AIDS
PMTC	Prevention of mother to child transmission
SHG	Self help group
SRG	Self reliance groups
STI	Sexually transmissible infection
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	United Nations Development Program
UNOPS	United Nations Office for Project Services
VCCT	Voluntary confidential counselling and testing

Scope of the work

Objective
This assessment will primarily examine the strategies taken by the project in light of the recommendations made by assessment missions and the expected technical support role of UNDP in the national AIDS response. This assessment will also review the performance of the project in achieving its refocusing strategy, and provide recommendations on the appropriateness towards reaching the recommendations made by both IAM and the previous technical review missions reflecting the latest situation in the country, objectives and outputs as stipulated in the original project document, and the extent to which they have contributed towards reaching the desired outcomes.

Task
The consultant will undertake the following tasks:

- Review the project's current interventions and highlight the progress made and the appropriateness of the strategies in use as recommended by the previous review missions and in light of UNDP's assistance in Myanmar
- Assess cooperation mechanisms with ICDP and CDRT with a view of the dynamics of HIV and the community development initiatives, including the plans for the Nargis Cyclone affected Delta Region
- Assess activities collaborated with the groups of people living with HIV and AIDS and other partner organizations
- Review the project's results monitoring framework and recommend, if needed, appropriate indicators as well as qualitative studies that can validate the current impact assessments
    - Recommend the strategy, that the project could undertake fully reflecting the comparative advantage of the UNDP and its role in the national AIDS response beyond 2010

Outputs
The consultant will provide a draft report comprehensively detailing the assessment findings, recommendations and, lessons learned. The draft report is to be submitted to the UNDP management for discussion and comments prior to the departure of the consultant from Yangon. The consultant will be responsible for submitting a final report to the UNDP Resident Representative, UNDP CO Myanmar

Methodology
The review conducted a desk review in the UNDP HIV project offices in Yangon. There was considerable difficulty in conducting the desk review. Partly this was because it was not possible to discuss the project's history and evolution with those responsible for managing it. But also it was quite difficult to obtain a clear understanding from project documentation of the project's activities over time [including activities conducted by UNDP and those subcontracted to other agencies], of the changes made to activities, of the rationale for the changes. The reason for this is mainly because of the way that project

documentation was composed. For example, inconsistent and obscure descriptions of activities and projects make it difficult to obtain a comprehensive chronological mapping of all the activities the project was involved in, and their impacts and outcomes.

A courtesy visit was paid to the National AIDS Program in Nay Pyi Taw. Two project site villages were visited in Magway and Kyaukpadaung, However, due to travel times only a short visit was possible in each village. A visit was made to Labutta, in the Cyclone Nargis affected delta to observe the second day of the peer education training programme.

In Yangon a number of PLWHA projects were visited including to a Myanmar Positive Group consultation attended by many of their member SHGs. Visits were also made to the PLWHA Sunday Empowerment Group at Association Francis Xavier Bagnoud, the Yaung Gyi Thit, Spring Women's PLWHA and the Mittaya Gwin SHGs. Interviews were conducted with UNAIDS, WHO, UNFPA, UNICEF, the International HIV/AIDS Alliance and Pact Myanmar.

This review was originally scheduled to occur in 2008 but was delayed due to difficulty obtaining an entry visa. By the time the review occurred UNOPS had ceased implementing the project and its Agency Project Manager had departed. Also, the UNDP HIV/AIDS Programme Manager/HIV Focal Point was unavailable for the second and third week of the review whilst accompanying a donor mission, and was committed to other activities in the final week.

HIV in Myanmar

Myanmar has one of the most serious epidemics in Asia. The 2008 UNAIDS Report on the Global AIDS Epidemic notes that there are signs of a decline in Myanmar. HIV prevalence among pregnant women attending ante-natal clinics showed HIV prevalence of 1.5% in 2006, down from 2.2% in 2002. This has been attributed to the intensified interventions of many NGOs and UN agencies. Despite this decline the elevated prevalence of HIV among key populations at higher risk (sex workers, injecting drug users, men who have sex with men, STI clinic male attendees) is of concern

Currently there are an estimated 250,000 HIV infections in Myanmar; 80,000 of whom are in need of antiretroviral (ARV) treatment, and of which 15,000 are currently receiving ARV. Of those living with HIV there are 6,000 children under the age of 15. Up to one third of those living with HIV are estimated to be women, the majority most likely infected by their husbands or partners. Almost two thirds of those with HIV are under 24 years of age.[1]

There is currently little capacity to provide ARV to new people. The numbers of those in need of ARV increase with each year as, with the passage of time, the impact of HIV

[1] UNICEF World AIDS Day Statement 2008.

infection upon the immune system moves more people into the category of needing ARV to prevent critical deterioration towards AIDS and death.

It is estimated that in 2007 24,000 adults and 1,000 children died of AIDS.

Background to the Project

In 1992 the UNDP initiated a project to support the long-term goal of slowing the further spread of HIV as well as to mitigate the social and economic impact of the disease on the population of Myanmar. Subsequently in 1994, the Governing Council, in re-directing the UNDP assistance to programmes and projects with grassroots impact, included HIV/AIDS as a priority area of intervention. The HIV/AIDS project executed by UNOPS, was fully integrated into the grassroots oriented Human Development Initiative (HDI) programme implemented since 1994.

In line with the UNDP Executive Board mandate on Myanmar[2], and consistent with the spirit of the UNGASS Declaration and the United Nations Joint Programme on HIV/AIDS, the project focused on increasing the scale and effectiveness of community-based responses for HIV/AIDS prevention and care, and on mobilising additional resources for a multi-sectoral response to the epidemic. Special emphases were placed on raising the awareness of young adults and adolescents to the menace of the disease.

The first phase of the HIV/AIDS project, 1994 to 1996, emphasised awareness raising and prevention education for the general population. The project supplied condoms for prevention, and HIV test kits to ensure the safety of the blood supply in the country.

During the second phase, 1997 to 1999, the project built capacities of community volunteers in 15 HIV highly prevalent remote sites. They were trained and assigned in wards or villages to provide HIV education, and home based care services for PLWHA. The project also worked closely with other agencies and organizations. IEC materials were developed and distributed.

From 1999 until 2003, the third and fourth phases, the project increased its staff, opening five regional offices staffed by regional project facilitators (RPFs). In contrast to the projects earlier focus on the general population these activities were designed among high risk groups, with care and support for PLWHA in highly prevalent areas. Moderate income generation schemes for PLWHA were instituted in some areas.

[2] The UNDP Governing Council Decision 93/21decided that, until a country programme for Myanmar is considered at an appropriate time, all future assistance from the United Nations Development Programme and related funds to Myanmar should be clearly targeted towards programmes having grass-roots-level impact in a sustainable manner, as called for in the aforesaid decision 92/26, particularly in the areas of primary health care, the environment, HIV/AIDS, training and education, and food security;

Additionally, the project initiated capacity building of local organizations in high prevalence areas. The RPFs formed and trained volunteers, AIDS Support Volunteers (ASVs), to provide HIV prevention education, counseling, care and support. Through the years, local organisations emerged and were employed by the project to implement HIV interventions.

The IAM in 2004 noted circumstances in Myanmar had changed since the HIV/AIDS project started in the mid-'90s. At that time, substantial international assistance to the country such as the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) and the Fund for HIV/AIDS in Myanmar (FHAM) had allowed the entry of other stakeholders that changed the priorities for assistance. The mission viewed that the project would benefit from sharper focus, and recommended UNDP gradually refocus in areas in which the organisation had a comparative advantage.

Thus the project shifted its activities within the HDI service delivery areas. In collaboration with the community development projects, the HIV project built the capacities of community development workers of the ICDP and CDRT to mainstream HIV into their community development initiatives and to explore the links between HIV and Development. It also attempted to address women's concerns through a deeper understanding of how power imbalances affect the spread of HIV.

A mid term review of the HIV project conducted in April 2005 assessed the significance of the refocused project and recommended new directions for project activities reflecting the recommendations of the IAM report of 2004 and the expansion into HDI. The review recommended exploring ways to integrate HIV with other community development initiatives through a staged process using knowledge of both HIV and community development, better analysis of the underlying development conditions that affect HIV, and a gradual scaling up through partnerships, collaboration and advocacy.

The 2005 IAM recognised the progress made to re-design the HIV/AIDS project to support ICDP and CDRT projects. It asked whether HIV awareness-raising should be combined with broader health education in ICDP/CDRT, and if the HIV project should continue separately or be re-organised as a support unit for ICDP/CDRT.

The project was extended to 2006-2007. An addendum included a focus on capacity building of community groups in the HDI service areas through HIV mainstreaming in the HDI community development and micro finance projects. Certain project activities in the original project document were suspended. The changes resulted in a decrease in the number of project staff.

A follow up technical review recommended continuing to build on the community development strategies by encouraging community leadership and developing engagement of women, youth and men

In response, the HIV project developed and implemented two main areas of focus (which continue) – HIV prevention/education and mobilisation at village level, and support to PLWHA.

The HIV prevention and education is conducted as outreach education programmes in selected HDI villages. Pilot activities informed final programme design. It has two major components: outreach community education, and community capacity enhancement. It introduced a new community participatory methodology - Community Capacity Enhancement (CCE). The project trained community volunteers – women, men and youth - to implement the program.

The project also assisted the formation of a group of PLWHA, eventually the GIPA (Greater Involvement of People Living with HIV) Initiative Group. This later became the Myanmar Positive Group (MPG), the national PLWHA network, to which the HIV project provided core support until 2007, and since then, support to specific activities.

Also in 2006, the project expanded to address HIV vulnerabilities related to unsafe mobility and migration by partnering with the International Office on Migration (IOM) and World Vision on a programme for migration affected communities in Mon and Kayin States.

In 2007 the IAM believed that the great majority of the present and potential HDI beneficiaries are not affected by HIV given the low prevalence of the epidemic in areas covered by HDI. It was concerned that the project was not contributing to the goals of neither the HDI Project nor the National Strategic Plan for HIV and AIDS in Myanmar.

It recommended reconsidering whether the HIV/AIDS risks are sufficiently significant in all community development project areas to warrant the involvement of HDI personnel and systems. The IAM believed the HIV project should widen its geographic area, and limit its activities to awareness education; focus on high risk groups and high risk areas regardless whether within or outside HDI areas; and align itself to other HIV actors rather than the HDI.

As a result, the HIV project continued the community education programme in 7 HDI townships and initiated a livelihood programme with self help support groups of people living with HIV in Yangon and other major urban areas.

By 2007 the HIV project was addressing the growing need for psycho-social and economic support programmes for PLWHA by providing skills training to improve income generation. In collaboration with Pact Myanmar, a training programme on establishing and managing community health fund was conducted and provided revolving funds to 16 SHGs. The project also collaborated with the Association Francois Xavier Bagnoud (AFXB) to train families of PLWHA, especially women and girls, on livelihood skills.

The IAM 2008 commented that the HIV Project had taken steps to refocus on areas of high HIV prevalence and to populations at particular risk. It advised investigating the project's comparative advantages in focusing on awareness raising activities or activities supporting PLWHA. It also recommended the project focus on training of trainers in the CDRT and ICDP to become responsible for HIV education in their project areas and wrap up such activities in other areas, freeing resources for further work in peri-urban areas.

Another extension was sought for the Project to cover 2008 - 2010. Addendum 2 prescribes continued focus on capacity building of community groups to include areas outside HDI service delivery. An agreement has been reached between the UNDP and the Government of Myanmar to allow the project to work beyond the initial HDI areas and enter into new high risk areas.

Until 2008 the project was managed by UNOPS which was responsible and accountable for the overall use of resources and achievement of project objectives. UNOPS assigned an Agency Project Manager as the overall manager of the project responsible for delivering outputs from the project document. Additionally, the APM was responsible for initiating and managing activities related to resources and community mobilisation, policy development, advocacy and regional activities. The APM was also assigned to assist UNDP in its interaction with and collaboration with other partners in the UNAIDS Theme Group. From 2009 UNDP is directly managing the project.

Role in national response to HIV

The National Strategic Plan for HIV/AIDS (NSP) in Myanmar 2006 - 2010 includes the UNDP as a partner in the priority Strategic Directions for: 'Reducing HIV-related risk, vulnerability and impact among partners and families of PLWHA'. The Strategic Direction: "Reducing HIV-related risk, vulnerability and impact among mobile populations' refers to generic partnerships with UN agencies, it should be understood that UNDP plays a major role in this area. Similarly, 'Enhancing HIV prevention among men and women of reproductive age' does not specify which UN agencies are partners, but UNDP provides a major contribution to this Strategic Direction. With the recent allocation of responsibility for MSM and HIV within the UN division of labour UNDP will also become a partner in Strategic Direction: 'Reducing HIV-related risk, vulnerability and impact among men who have sex with men.'

UNDP implements activities without support to government offices or agents, and they are directly aimed at community beneficiaries. The UNDP HIV Project maintains communication with the Government of Myanmar National AIDS Programme and consults about project developments and activities.

As a Cosponsor of UNAIDS, UNDP plays an important role in the global AIDS response. UNDP recognises that addressing HIV is integral to achieving the Millennium Development Goals and particularly targets relating to reducing poverty, achieving

universal primary education, promoting gender equality, reducing child mortality, improving maternal health and combating tuberculosis.

UNDP's response to AIDS is guided by the UNAIDS division of labour, which assigns specific responsibilities to each of the ten UNAIDS Cosponsors and the UNAIDS Secretariat, in line with organisational mandates and comparative advantages. UNDP is the lead UN organisation for addressing the dimensions of AIDS relating to development planning and mainstreaming: governance of AIDS responses; and law, human rights and gender, including sexual minorities.

Project Objective and Strategy

The Objectives of the UNDP HIV/AIDS Project are:

1. to build capacities of communities to understand HIV and address HIV related issues affecting their communities
2. to promote and encourage the greater involvement of People Living with HIV/AIDS (GIPA)
3. to reduce the social and economic impact of HIV on PLWHA and their families; and
4. to build the capacities of the private sector to initiate a workplace HIV programme

Interventions

The UNDP HIV/AIDS project (in 2009) is conducting or planning the following interventions:

1. **Community outreach education** including peer education in selected HDI villages aimed at building the capacity of villagers to assess their risks to HIV and take appropriate measures to avoid HIV infection. In 2009 this will expand to commence in 5 new non-HDI townships identified as vulnerable to HIV and containing PLWHA

2. **Capacity building of community groups** to facilitate discussion with villagers regarding prevention and control the spread of HIV. Involves community initiative in developing their action plans which the project provides funds to implement. Collaboration with NGOs assists to enhance the capacity of the strategy.

3. **Income generation** for HIV affected families to reduce the social and economic impact of the disease - with emphasis placed on women and girls affected by HIV

- and to train and assist Self Help Groups to establish and manage community funds.

4. **Humanitarian, social and emergency support** to lesson the vulnerabilities of people affected by HIV, especially in emergency situations, through the provision of capital grants and nutritional support.

5. **Greater Involvement of People Living with HIV/AIDS (GIPA)** to promote the inclusion of PLWHA through the GIPA network – also fostering leadership among communities affected by HIV

6. **Work place programmes** to draw commitment and build capacity of the private sector to initiate HIV programmes and policies in the work place.

These six interventions will form the framework for this review.

HIV and Development

UNDP's Contribution to the AIDS response

> 'As a founding Cosponsor of the Joint UN Programme on HIV/AIDS (UNAIDS), UNDP plays an important role in the global AIDS response. UNDP recognises that addressing HIV is integral to achieving the Millennium Development Goals (MDGs), and particularly targets relating to reducing poverty, achieving universal primary education, promoting gender equality, reducing child mortality, improving maternal health and combating tuberculosis.
>
> UNDP's response to AIDS is guided by the UNAIDS division of labour, which assigns specific responsibilities to each of the ten UNAIDS Cosponsors and the UNAIDS Secretariat, in line with organisational mandates and comparative advantages. UNDP is the lead UN organisation for addressing dimensions of AIDS relating to development planning and mainstreaming; governance of AIDS responses; and law, human rights and gender; including sexual minorities."[3]

HIV and Migration

When the UNDP HIV project was planned in the early '90s it was believed that the spread of HIV was facilitated by Development factors – poverty, the movement of people, social and economic change, the status of women etc – and this would lead to the spread of HIV across, and deeply within, communities and countries. It was believed the cumulative impacts of HIV would threaten Development.

[3] UNDP's Response to AIDS. Accelerating global progress on human development. HIV/AIDS Group, UNDP. New York. 2008

Recent epidemiology provides clearer understandings of how HIV is spreading in Asia. This was summarised in '*Redefining AIDS in Asia: Crafting an Effective Response*' the report of the Commission on AIDS in Asia March 2008.

In all Asian countries the epidemic is driven by injecting drug users (IDU), men who have sex with men (MSM), and sex workers and their clients. Whilst HIV is being spread within families – typically from husband to wife and potentially to children – these families do not transmit HIV further. This is an important distinction. Whilst HIV impacts upon families it is not being spread by them in ways that facilitate the greater spread of HIV across a community or country.

Further, it is also now believed that the majority of infections occur in situations where there are large numbers of people recently infected (and thus with high HIV viral loads which increase infectivity) mixing in situations where there are large numbers of concurrent sexual partners in concentrated locations.

In a Development context (not including IDU and MSM) this means that a likely priority focus for HIV prevention would be settings where there are large numbers of men gathering for work and where women have little access to employment and thus are likely to engage in formal or informal sex work. [4] Hence some examples of the focus for HIV prevention strategies would be urban centres and locations where men migrate for work.

The Commission on AIDS report states that casual sex amongst young people remains a minor factor in Asia's HIV epidemics but that significant resources have been aimed at this population.[5] It also states that, whilst the proportion of women becoming infected is gradually rising, they are mostly infected through having sex with their husbands or boyfriends - who themselves were infected during paid sex or through injecting drugs. Thus the most sensible way to prevent HIV infection rising among women is to prevent their husbands becoming infected in the first place.[6]

From the available epidemiology it appears that the HIV epidemic in Myanmar is consistent with that in other Asian countries.

The rationale for the UNDP HIV project's work on HIV prevention and education at community (village) level is that the villages in which it works are vulnerable to HIV due to migration whereby men are exposed to HIV through sex with other women (presumably sex workers) and, in turn, infect their wives and children.

Currently, the project is following the recommendation of the 2007 IAM to operate in sites particularly vulnerable to HIV and will establish 5 new priority sites. But it is difficult to assess if existing activities occur in priority sites that are most vulnerable to HIV. Originally the HDI workers selected villages based upon their knowledge of both

[4] *Know your epidemic, know your response: a useful approach if we get it right',* published as a comment in The Lancet, 6 August 2008. David Wilson, Head of World Bank Global AIDS Program. Daniel Halperin, Harvard School of Public Health.
[5] AIDS Commission Report. P. 7
[6] " p. 7

the pattern and extent of migration and of the presence of PLWHA. Since then the HIV project staff collect information about other villages to determine the sites for project expansion. This process is still being used to identify the villages to extend to in the new five non-HDI townships. It is difficult to assess the accuracy and relevance of the selected sites when this process is used.

To be able to work effectively on migration and HIV the project needs to have better understanding of two issues: migration patterns and extent, and the sexual (and possibly injecting) HIV risk behaviour of the migrating men.

When it has information about these two matters it is then possible to identify the priority locations for HIV prevention and education, and to focus upon the men and their behaviours that place them at most at risk for acquiring and transmitting HIV infection.

Currently, the project does not have sufficient information about either of these two matters. In fact, the information available from the recent survey of sample project villagers suggests that they have low rates of sex outside relationships and very low rates of visits to sex workers. This is further addressed later in the review.

The HIV project must develop better understandings of migration and HIV, and can do so in ways that assists the national need for creating and using strategic information and might be able to provide assistance with its own programme planning and monitoring.

The JUNSP in its program of support to the NSP 2006 - 2010 has identified that:

> 'Acknowledging the association of other Millennium Development Goals, the UN System will undertake a review of development needs, migration flows and HIV vulnerability in selected townships identified by the National AIDS Programme led prioritisation exercise, pending the National AIDS Programme's approval.'[7]

UNDP is already committed to this activity. UNDP participated in the creation of the JUNSP and is cited amongst the lead and contributing UN organisations responsible for this activity.

This review is investigating development, migration and HIV. 'Migration flows' supposedly would be mapping the movement of migrant workforce, including source locations and work locations. 'HIV vulnerability' would have to include an investigation of the risk behaviours (sexual and injecting) that place these migrants at risk of getting HIV infection and transmitting it to others.

By supporting this activity UNDP will be providing critical strategic information that the country requires to inform the design and implementation of more suitable and effective HIV interventions around mobility and migration.

The activity proposes that the National AIDS Program would lead a process to identify the townships in which the review will occur. UNDP could seek to interest the NAP in

[7] Joint United Nations Programme of Support for HIV in Myanmar

using some of the townships in which it (UNDP) conducts activities – or to link the review with the expansion to new townships that the NAP has recommended to UNDP on the basis that they are places with migrant workers and high HIV risk, including the presence of PLWHA.

Recommendation:

- **That to develop better understanding of migration and HIV and the associated sexual and injecting risk behaviours UNDP act upon its commitment in the Joint UN Programme of Support for HIV in Myanmar to participate in a review of development needs, migration flows and HIV vulnerability in selected townships identified by the National AIDS Programme lead prioritisation exercise.**

HIV and Gender

UNDP's policy and role regarding gender and HIV is:

> 'Gender inequality and unequal power relations between women and men continue to be major drivers of HIV transmission…UNDP develops capacities of national partners to effectively integrate gender-specific analysis and programming into AIDS responses. It facilitates the greater involvement of women living with HIV and women's groups in the design, implementation and evaluation of AIDS responses. UNDP also helps countries to address stigma and discrimination towards women affected by AIDS, including gender-based violence, trafficking, and the unequal burden of care. It also supports efforts to advance economic empowerment of women affected by HIV, and women's rights to property and inheritance…UNDP also emphasises the critical role of men and boys in championing gender equality for a strengthened AIDS response.' [8]

The UNDP HIV project addresses gender in a number of ways:

- attention to engaging young women and adult women as project volunteers
- support to women affected by HIV in villages (home based care {HBC}, counselling, reducing stigma and discrimination, economic and livelihood support) and in urban settings (livelihood support, support to general SHG, assistance with established of national network of women living with HIV)
- including gender as a topic in community analyses and discussion of HIV

[8] UNDP's response to AIDS: Accelerating Global Progress on Human Development. HIV/AIDS Group, United Nations Development Programme, New York, NY. 2008

- a proposal to establish a joint UNDP and United Nations Inter Agency Project on Human Trafficking and HIV/AIDS through safe migration and vulnerability reduction initiatives. (This will integrate with HDI including training staff.)

However, as the 2008 IAM commented 'the HIV/AIDS programme effectively addresses gender in its analysis and objectives. However, it is difficult to assess gender in the implementation and output stage…where it virtually disappears.' It recommends strengthening and monitoring the responsibilities of the (then UNOPS) project manager regarding advocacy, introducing and maintaining a gender sensitive approach/balance in programme implementation.[9]

In practice that the HIV project has managed to find a variety of ways of addressing gender, and some of them are effective (i.e. livelihood and income generation support for women with HIV and widowed by HIV). Yet overall, the project suffers from insufficient attention to exploring gender and HIV and explicitly addressing this in project activities. For example, whilst the project documentation states that a gender based approach is used in prevention and education activities – commonly encouraging women's ability to discuss sex with their partners and negotiate condom use etc - the project staff say that, due to the strong cultural traditions around gender roles and responsibilities there is resistance from both women and men towards this approach. Instead, when it comes to addressing HIV transmission between husband and wife, the project emphasises the love and trust that exists between the couple rather than using a gender based framework.

One of the priorities of the JUNSP 2009 work plan is Item 10: Gender. Its outcome is: 'Improved understanding of impact of gender on HIV transmission in Myanmar'.

The key activities identified under this Item are: 'establish TSG Gender Working Group, gender audit of JT, CCM and UCO, and multi-partner gender review of NSP (linking with/inputs provided to NSP review)'.

(It is assumed that according to the acronyms this is saying that it will: establish a Gender Working Group as part of the Technical and Strategy Group that is responsible for overseeing the implementation of the National Strategy for HIV and AIDS, conduct a gender audit of the UN Joint Team, the Global Fund Country Coordinating Mechanism and the UNAIDS Country Office; and conduct a gender review of the National Strategic Plan.)

Again UNDP has already committed to this activity. For each of the three activities the workplan cites the lead partners as UNAIDS and UNDP – since UNDP participated in this process it needs to continue its leadership in the area of gender and HIV by fulfilling its commitments under this workplan.

This workplan focuses upon national level activity. It is strategic for UNDP to concentrate upon facilitating these activities in preference to addressing gender and HIV

[9] Final Report. Independent Assessment Mission of the Human Development Initiative Myanmar 2008. UNDP Myanmar.

within its own project. By doing this UNDP will be creating national level knowledge, expertise and processes that it can then later use to help address gender and HIV within its own projects.

In particular, a thorough competent gender review of the NSP should identify a comprehensive gender based analysis and framework for HIV activities. This analysis and framework can subsequently be used to inform a gender analysis and strategy for the UNDP HIV project. Similarly, the experience of conducting gender audits of other agencies and processes can be used to conduct a gender audit of the UNDP HIV project, including the broader HDI project.

Recommendation:

- **That UNDP act upon its commitment to the Joint UN Programme of Support for HIV in Myanmar to participate in improving understanding of the impact of gender on HIV transmission in Myanmar, particularly through: establishing a National Strategic Plan for HIV and AIDS Technical Support Group Gender Working Group; a gender audit of the Joint Team, the Global Fund CCM, and the UNAIDS Country Office; and a multi-partner gender review of the National Strategic Plan for HIV and AIDS.**

Conceptual and technical capacities and leadership

The HIV project has given insufficient attention to investigating and analysing the HIV and Development features of the epidemic in Myanmar, and to contributing these at national level in ways that are expected from a leading UN agency.

Whilst it has conducted a diverse range of activities designed to impact on HIV and Development (e.g. enhancing community capacity, migration and gender), it is not clear that, within the project, enough attention has been given to the experience learned from these activities and then using this to inform and adjust the project's rationale and strategic direction, nor to inform the design of subsequent activities.

Furthermore, in project documentation - rationale, design document, reports etc - there is no reference to UNDP global HIV policy or global programming documents and resources. There is no reference to the HIV project being informed by and contributing to any of the major strategic and policy frameworks such as the National Strategic Plan for HIV and AIDS in Myanmar, the JUNSP, the Millennium Development Goals, UNGASS or Universal Access.

Although, due to the UNDP Mandate for its role in Myanmar, the project is unable to formally support the government response to HIV, the project needs to ensure that its strategies and activities are informed by and supporting the overall national response to

HIV. Whilst in practice it is doing this in elementary ways – through conducting HIV education and through support to PLWHA, including their mobilisation – there should be clearer evidence of how the activities of the UNDP HIV project are designed according to the requirements of the NSP. In particular, UNDP needs to be able to demonstrate how it is providing strategic leadership and facilitation around the key thematic, conceptual issues and information requirements which are essential to inform a comprehensive and well considered HIV response that suits the national and local circumstances.

Whilst UNDP participates in the Myanmar UN Joint Team on AIDS, UNDP should give more attention to sharing its activities and outcomes to other UN members. There is considerable potential for UNDP to increase its participation and contribution to the Joint Team. It is appropriate for UNDP to commit to taking a leadership and participatory role in the execution of areas that come under its technical responsibility according to the UN division of labour on HIV. It is also important that UNDP commit to providing other members of the UN team with information about its project activities and to involve other UN agencies, particularly UNAIDS in discussions about strategic development of the UNDP project and in the planning and implementing of activities.

Similarly, the project activities have too often operated in isolation from the broader HIV response within the country. This has manifest in two main ways. One is a lack of strategic liaison and planning which has created unnecessary overlap of activities. The second aspect is that the project has not participated in networking and information exchange with other projects working on similar activities. This means the project is unable to benefit from exchanging information, experiences and resources with other projects working to the benefit of all.

It is not clear that currently the project has the capacity to provide and satisfy these technical and conceptual requirements. Currently, the project staffing levels have been reduced due to the changeover from UNOPS to UNDP management and to the pending integration into HDI. Amongst the remaining staff there is experience with activities and implementation but not with the technical and conceptual components of HIV and Development. On the other hand the project staffs who have attended the Community Capacity Enhancement (CCE) training workshop are applying CCE methodology successfully in the field activities of the HIV project.

Some of the immediate priority activities (such as the MSM initiative, livelihoods for PLWHA, etc.) can be conducted by short term consultants or by sub-contracting to other Myanmar based organisations. However, for the longer term, the UNDP project needs to acknowledge that it will require an advanced level staff member with the technical and managerial capacity to address matters such as: developing strategic vision, creating innovative approaches, mobilising resources, demonstrating leadership, and providing policy advice.

Interventions

In this section each of the 6 current project interventions will be addressed. They are:

1. **Community outreach education**
2. **Capacity building of community groups**
3. **Income generation**
4. **Humanitarian, social and emergency support**
5. **Greater Involvement of People Living with HIV/AIDS (GIPA**
6. **Work place programmes**

Intervention 1: Community outreach education - including peer education in selected HDI villages aimed at building the capacity of villagers to assess their risks to HIV and take appropriate measures to avoid HIV infection. In 2009 this will expand to commence in 5 new non-HDI townships identified as vulnerable to HIV and containing PLWHA

Intervention 2: Capacity building of community groups - to facilitate discussion with villagers regarding prevention and control of the spread of HIV. Involves community initiative in developing their action plans for which the project provides funds to implement. Collaboration with NGOs assists to enhance the capacity of the strategy.

These two interventions are interconnected and so will be addressed together in this section.

The 2005 IAM recommended the project focus on mainstreaming HIV into the HDI's community development projects - CDRT and ICDP. To enhance the community development framework of UNDP's mission in Myanmar the project implemented activities with the goal of addressing the links between poverty and development and HIV.

The project conducted pilot projects to identify the strategies to increase understanding of HIV and build community resilience to HIV.

First pilot project: Working with established groups in HDI projects

The first pilot began in March 2005 in Kachin State where CDRT had established Self-Reliance Groups (SRGs). These are community groups, mostly composed of women, established at village level as a vehicle for empowerment and a means for promoting various local economic initiatives by establishing savings and credit schemes. These SRG systems and their meetings were seen as a good opportunity to use the CDRT systems to introduce discussion of HIV in villages.

The HIV Project conducted a 5 day training of women from 3 townships to do HIV education in their villages and discuss HIV with their peers. These sites were selected by CDRT. The HIV project believes they were suitable because they contained people who travel away as migrant workers.

The project conducted a separate training with CDRT Community Development township level staff emphasising the link between HIV and Development. This meant that all the workers across the local levels of the CDRT had been involved in discussions about HIV, how HIV and Development interrelate, and the impacts of HIV on community development initiatives in the villages.

Over the next 3 months the project trained more SRG members. Overall, they liked the training and saw HIV education as part of their responsibility. The pilot was replicated in almost all CDRT villages in Northern Chin, Rakhine, Mon and Hpaan.

The HIV project did not work with ICDP in the 1st phase.

Lessons learned:

- Using the SRGs worked for women but not for men and youth.
- SRG women could reach 3-8 villages but it was tedious work, took up too much time and thus affected their own livelihoods. (Consequently the project did multiplier training so every village had an educator or trainer who is not necessarily a SRG member)
- The women identified that men need to be targeted as they are the ones who infect their wives and thus some children
- It was better to have separate sessions for sex and age groups to encourage better discussion

During the pilot the project noted the social and economic conditions in these areas that affect HIV vulnerability

- Mon, Kayin & Kachin are border states where migrants go to neighbouring countries. Chin State men go to Malaysia. When away there are restrictions on their ability to access information and services (including HIV education) because many are illegal workers, and because of language and culture barriers. Some men

came back home infected with HIV, sometimes returning when too sick to continue working.
- People from these areas also become internal migrants. After rice harvest half the young men go to gold or jade mines.
- There are villages near the highway to China which causes concern about exposure routes to the spread of HIV

Second Pilot Project: Working with men and youth.

Based on the experience of the first pilot a second phase was created. It operated in new project villages and did not continue working directly with SRG, although some of the volunteers were also SRG members.

Since the first pilot identified that SRG members could not reach men with education, and were too busy with their usual SRG work and own livelihoods the project created a training program for men, women and youth volunteer educators. They were selected according to criteria such as education levels and availability to commit to the project. Through a village mobilisation process volunteers were nominated, some self-nominated. This was done still done in collaboration with CDRT to continue the commitment to community development and mainstreaming.

Also the project revised all the education materials to make them suitable for different groups.

Lessons learned:

- Providing people with HIV awareness and education then creates increased demand for a range of associated needs: HIV testing, condoms, STI testing, treatment and counselling, medical care, and access to livelihood support. This showed that interventions cannot be limited to education alone but need to address a wide range of activities, service and referrals (which also shows the need for comprehensive attention to project planning and coordination with other agencies.)

Third Pilot Project: Involving community health educators

The next phase of the project, in 2005, expanded to training Health Education Service Providers from ICDP and Village Health Education Volunteers from CDRT. The intention was to explore further mainstreaming into both CDRT and ICDP, and to engage their project staff in HV activities.

Using HIV project funds the CDRT employed 3 HIV & Development Specialists (HDS) to work with CDRT Village Health Educator Volunteers in 3 CDRT sites (Mon/Hpaan,

Myitkyina and Northern Chin). The HDSs reported directly to their respective CDRT Area Coordinators. They got Technical Assistance and guidance from the HIV project.

This phase of the project was able to cover a much larger number of townships because of access to the HDI sites.

Lessons learned:

- Since health educators are in almost all of the HDI villages they are a significant resource for intensifying HIV education, and this can be expanded to include specialist services such as Home Based Care for PLWHA and counselling about HIV concerns. However, it requires additional specialist training for them and causes an increase in their work activities.

- HIV prevention initiatives by themselves do not assist the community to respond to the HIV related issues they face. An education program helps communities to understand how HIV can affect and impact on them and their community, and on development. An effective HIV education programme helps the community to become aware. This then creates the demand for assistance in helping to respond to what they have learnt in the education sessions.

- The education project had wider consequences and a flow on effect. It assisted the villagers to begin to understand more about the social and economic dimensions of HIV. It caused more PLWHA to disclose and seek help from community

- There were organisational and administrative problems with integration into the CDRT and ICDP Projects. At local level the Area Coordinators were reluctant to allow their workers to become involved with HIV work as this added to their work burden. (This appears to remain a legitimate concern.)

- There were operational problems at local level due to the different levels of authority of the HDI Area Coordinators and the HIV project's HDS. This reflects the lack of attention to program design and implementation that reduced the operational ability of the project.

As a result of these pilot activities to integrate or mainstream HIV into the HDI community development projects as suggested by the IAM the HIV project decided that it was necessary to retain a separate HIV and Development initiative. This is necessary due to the lessons it learnt about: the specialist nature of HIV work, the intensive dedicated work and personnel required, and the experience of trying to integrate with HDI community development projects.

Final Programme Design and Implementation: Community HIV/AIDS Mainstreaming Project (CHAMP)

In 2006, using the lessons learned from the pilot strategies, the HIV project developed an outreach HIV education programme. This is still the model being used.

Community volunteers, pairs of adult and young men and women from each village, were trained in HIV awareness, peer education, gender related issues to HIV vulnerability, and provision of HIV services, such as counselling and Home Based Care for PLWHA. They also distribute condoms as part of the prevention strategy.

The project introduced a new methodology 'Community Capacity Enhancement' (CCE) which has been promoted globally by UNDP. CCE is based on 'community conversations'. This is a contrast to usual approaches to HIV education where people are grouped together for HIV talks accompanied by the distribution of brochures and which often leave people with information but little capacity to act upon it.

Community conversations are a facilitated process of steps that help people to think through the situation and identify a way forward. Based in exploring values and behaviours using mutual learning processes, it encourages transformation of individuals and communities - men and women, young and old, wealthy and poor, those affected by HIV and those not.

The CCE process creates village HIV Committees which develop Community Action Plans (CAPs). Theoretically these CAPs should contain a broad community plan but, to date, in the HIV Project they usually focus on economic support for PLWHA. Typically they propose a community micro finance fund using initial financial support from UNDP.

The fund ensures participation of PLHWA and their households, but any villager can be a member and take loans. The profits can be used for financial assistance to HIV affected households for diverse needs: nutrition, multivitamins, medical services, transport to clinics, hospital assistance, educational and nutritional support to orphans, and for funerals. The profits can also be used on a broader community level to pay for such as the costs associated with VCCT, and for the purchase of audiovisual equipment for showing HIV educational materials. The CAPs can also recommend small grants to HIV affected households to assist with income generation. These funds are provided directly by the project, not from the community fund. However, it has meant that in some villages there are separate micro finance schemes run by the HIV project and HDI.

There are some differences between the HIV project's microfinance scheme and those generally operated by HDI. They are:

- HDI microfinance programmes have a lower ceiling for income generation loans which the HIV Project staff believe limits the ability to obtain sufficient funds for operating a viable livelihood activity

- HIV affected households and PLWHA have difficulty being eligible for the HDI community funds because of the impoverishment caused by HIV and because HDI schemes do not allow participation from the very poor

- The HIV community funds have the ability to use some of the profits created by interest to provide support to PLWHA whereas the HDI community funds operate solely as loans.

It should be noted that the CCE model requires extensive support and resourcing to facilitate its complex and ongoing processes and systems.

For this CHAMP project the HDS positions changed to HIV and Development Facilitators (HDFs) and returned to the HIV project's management. The HDF's main role is implementing CHAMP in 7 HDI townships – Magway, Kyaukpadaung, Pakkoku, Hpaan, Myitkyina, Mindat and Pinlaung.

The process of selecting the villages where the project operates reflects the unique constraints applying in Myanmar. Initially villages were proposed by HDI staff. Sometimes local authorities would not support the project establishing in some villages. The 2008 IAM mission experienced this when it visited a village where there was no evidence of HIV. The project had initially wanted to work in a nearby village that is vulnerable to HIV and which contains PLWHA, but the authorities opposed it, consequently the project chose the other village which was then later visited by the IAM.

The project employs 35 HIV and Development Community Development (HDCDs) workers who receive an honorarium and travelling allowance. Some are PLWHA, although not all are open about their status. The HDFs observe increased self esteem amongst these PLWHA HDCDs, especially as they can contribute to family finances.

The HIV project has trained 426 community volunteers who in 2008 provided outreach education to around 50,000 contacts (a person can have more than one contact).

As of December 2008 CHAMP operated in 71 HDI villages across 7 townships. CCE was used in 48 villages in 2007 and 56 villages in 2008. In 2007 211 community discussions (CAPs) were held and 437 in 2008. To December 2008 60 village HIV committees were established by local communities and implementing CAPs.[10]

The IAM 2007 was concerned that most of the HIV project's operations were in HDI villages which had low HIV prevalence. It recommended the HIV project widen its geographic coverage to high-prevalence areas, and to high-risk groups aligning its activities with those of other actors in HIV, rather than with other HDI projects. In the HDI areas the focus should be on most vulnerable groups such as returned migrants. The HIV project staff had already realised the need for the project to expand to non-HDI sites

[10] Results monitoring report. December 2008. Enhancing capacity for HIV/AIDS Prevention and Care Project. UNDP. Myanmar.

due to their awareness of other villages impacted by HIV. For example, a township might cover 200-300 villages but HDI might only cover between one to two thirds of these and HIV could be more prevalent in the other non-HDI villages.

Thus in 2009 the HIV project will extend to 5 non-HDI t/ships - Bago, Loilim, Loikaw, Thasi, Bamaw – with Yamethin in reserve as suggested by NAP. Through consultation with the NAP the townships were identified as being significant sites where HIV transmission could occur. For example, Thasi is a road and rail intersection. They also are suitable because of their HIV prevalence. For example, Bago has a substantial PLWHA population and a Self Help Group. Also there are few existing HIV interventions in these townships so they were identified as strategic locations to commence activities.

Lessons learned

- There are ways in which HIV can be mainstreamed into community development projects, but it requires dedicated strategic planning and monitoring to facilitate it programme-wide rather than rely upon individual settings and initiatives. The livelihood program was the best way to link HIV activities into the community development projects. CDRT has started including HIV affected households in their livelihood programs. The CDRT and ICDP have shared their Technical knowledge on livelihood and income generation through their specialists.

- With limited resources the HIV project can concentrate on providing HIV services and then use referrals to other agencies for other services. This avoids overlap.

- Keeping the interest and commitment of volunteers is one of the biggest challenges. Youth volunteer drop out is high because they leave to take up work. The project found it needed to give incentives to keep them motivated.

- There is insufficient supportive infrastructure for the HIV project at township level. Many of the HDCT are unable to use HDI facilities and thus have to store project materials in their own homes. There is a major problem with communication both to Yangon and to villages. It is especially difficult to access telephones that cause the local level staff to spend much time on communication which slows implementation of actual activities.

- Despite the villagers improved acceptance of PLWHA many of them remain undisclosed. In the HIV project's staff experience, PLWHA do not disclose to SRG and to ICDP and CDRT workers. The HIV project staff believe this is partly because these non-HIV project workers tend to be busy. It can also be due to how HIV-related stigma and discrimination can be internalised within PLWHA. Despite a supportive environment some PLWHA do not disclose because of their feelings about being infected. They can even be reluctant to disclose to the local HIV project staff, the HDCTs, who tend to be young people (in order to conduct

peer education with other young people). Instead some PLWHA will disclose to the older HDF when they visit.

- Often HIV causes impoverishment leading these households to seek urgent loans from money lenders, and at rates around 20%, much higher than usual. The need for financial assistance is one of the main reasons why PLWHA disclose to the HIV project. There are PLWHA in villages who have not disclosed to the project because they have not needed financial assistance.

Cyclone Nargis affected areas and project implementation

In the Cyclone Nargis affected delta area the HIV project has established the Community HIV Education in Early Recovery (CHEER) in 6 villages in Bogalay Township, is currently extending it to 6 villages in Labutta, and will later extend to 6 villages in each of Mawlamyaingyun, Ngapudaw and Kyaiklat. Villages are identified from a vulnerability assessment tool conducted in collaboration with the Township Early Recovery (ER) office and ER committees.

A pilot process is being used. It is replicating the model already used in the CHAMP project. The project concentrates upon HIV community based education using trained volunteers – men, women and youth - and facilitating community capacity enhancement activities. It will also establish a referral system for health, social and livelihood assistance.

The rationale developed by the project for operating in Nargis affected regions is concern about the consequent movement of people in and out of cyclone affected areas which increases vulnerability to HIV infection and, additionally, the potential for the trafficking of women and children. This is borne out by social impact monitoring which indicates the potential for long term socioeconomic impacts caused by decreasing productivity and increasing debt at all levels of community. This could cause large scale migration in pursuit of work.[11]

Furthermore, the large numbers of deaths caused by the cyclone has left many people without partners. Whilst impact studies have not looked at sexual relationship patterns and behaviours there should be concern about the longer term impact and consequences of the cyclone upon sexual relationships and behaviours. There are large numbers of men without sexual partners. There are large numbers of single women likely to experience financial hardship. This could lead to pressure on women left destitute by the ongoing unfolding socioeconomic impacts of the cyclone to provide formal or informal sex work.

Monitoring and evaluation of HIV education

[11] Post-Nargis Social Impacts Monitoring: November 2008. Tripartite Group. Myanmar.

There are a number of concerns raised by the data developed from the monitoring and evaluation surveys conducted by the HIV project.

There was no baseline survey done at the commencement of the project to use as a basis for mapping the impact of the project on people's changes to knowledge, attitudes and practices.

There was a baseline survey done during HDI's Phase II in 1996. It included four townships where the project currently conducts HIV education, but it has only been doing this since 2007. It did conduct HIV training for the HDI community development workers there in 1998 and in 2004 so the increase in understanding of HIV, especially prevention, shown in later surveys there, could be partly due to the project.

The project has conducted 3 surveys to measure the levels of knowledge, attitudes and practices of the villagers covered by the HIV project. The first round was in January - February 2007, the second in November – December 2007, and the third in December 2008. Additional reference surveys - that done by HDI in 1996 and the national surveys conducted by the NAP and other agencies - can be used as references.

Overall, there is a range of reasons why the value of the survey data is uncertain.

One set of methodology was used for the first and second survey and another for the third. In the first two surveys the answers were prompted by asking 'yes' or 'no' questions. The third used multiple choice answers that required the participants to recall the answer and two new questions were added on sexuality. Project staff believe this caused a high rate of accurate answers in the first two surveys because the questions contained the answers. They also believe that the participants knew the answers to the third survey but this was not reflected in the data because the questions were hard to understand and because the interview process was conducted hastily.

The first two surveys were conducted by project outreach staff using a convenience sampling, the third was conducted by contracted independent researchers using random sampling. The third survey was conducted in 22 project villages and in 12 nearby non-project villages as a control group. The data was disaggregated by sex and age.

Project documentation and reporting on the surveys compares it to other surveys conducted in Myanmar but does not indicate if the methodologies are similar. Thus it is not clear if comparisons can be made.

Also it is difficult to understand the way that the project has written up the survey data. There is almost a tendency to cite impressive data as demonstrating the project's impact and explaining less impressive data as being distorted by the methodology. The project also appears to have not addressed some of the data, particularly around sexual behaviour outside of regular partnerships and visits to sex workers – data that would indicate the actual HIV risk behaviour of the people that the project is working with.

Overall, as a consequence of these factors it is difficult to know how accurate and useful the survey data is.

Attitudes towards PLWHA

The data about attitudes towards PLWHA seems to be straightforward. There was an improvement in attitudes towards PLWHA. In particular, 95% of participants are willing to care for a family member with HIV, and 82% would share a meal with PLWHA. There was a strong improvement in attitudes across the three surveys over time.

This shows that the project has been very successful in addressing the root cause of stigma and discrimination – giving information about transmission to show that people need not fear PLWHA and encouraging discussion about accepting PLWHA.

Knowledge of HIV transmission and prevention.

The methodology and data about HIV transmission and prevention is concerning and unclear.

In the final survey 86% of participants identified unprotected sex as a mode of HIV transmission. But knowledge of other modes of HIV transmission (mother to child and needle sharing) were extremely low.

In the first two surveys, 86% and 87% of adult men knew that HIV could be transmitted from infected mother to child, but in the third survey only 26% knew this. Adult female data is 90% and 89% in the first surveys and then 22% in the third. There are higher rates of knowledge about needle sharing, but, again, they are lower in the third survey.

It is a similar situation with knowledge about ways to prevent HIV. Eighty three per cent knew that condoms prevent transmission (however, 76% of the control group also knew this). But whereas in survey 1 and 2 84% and 88% of young men knew that another form of prevention was to have one faithful partner, only 21% of them knew this in Round 3. Amongst adult men 86% and 74% knew this in Rounds 1 and 2 compared to only 32% in Round 3.

When compared to national data on knowledge of three methods of HIV prevention the project data shows it to be very much higher in rounds 1 and 2 and much lower in Round 3.

Even allowing for methodological concerns this data suggests that the project needs to carefully monitor its HIV education programme. The data does show that the project has managed to convey the main information needed to prevent HIV infection and transmission – use of condoms. But it is unclear if participants understand the circumstances in which condom use is necessary and that HIV cannot be transmitted within committed faithful partnerships.

Sexual practice and condom use

There has been no significant change in rates of young people having sex and mean age of first sex. This indicates that messages to young people encouraging them to postpone having sex are not effective. Across the three surveys up to 42% of male youth and 35% of female youth have had sex and overall the rates are consistent. This suggests that the project needs to support young people in their choices, and provide them with education and assistance, rather than try to change them.

There is some uncertainty about the third survey data regarding condom use. This is because it is unclear if the question on condom use made a distinction between those having sex with their regular partner (when condoms would not be necessary) and those having sex with someone other than a regular partner (when condoms are necessary). Instead it appears to ask if all those sexually active are using condoms and then uses these answers. If this is a correct interpretation of the methodology then the data is not useful.

The data provided by the third survey about levels of sexual activity outside of regular partnerships (wives or girlfriends) raises some puzzling matters. Of the 167 young men in the survey 54 have had sex. Eight of these 54 have had sex with someone other than their spouse or girlfriend, and, of them, three had paid for sex, and all used condoms. This means that of 167 young men sampled in the project villages only 3 had visited sex workers. In the control villages the data was virtually the same for young men.

Similarly, of the 149 adult men in the survey who had ever had sex, 5 had had sex with someone other than their regular partner in the previous six months and none involved a sex worker. The data from the control group was similar except that of the 3 men who had sex outside their regular relationship 1 visited a sex worker.

This data suggests that the participants in this survey are at very low or nil risk of becoming infected with HIV. This data indicates very low levels of sexual activity outside of relationships and extremely low rates of visits to sex workers. It is likely that this is due to these people's pre - existing sexual attitudes and practices. That is, prior to the project there was not a higher rate of sex outside relationships and with sex workers which the project education message caused to significantly reduce. It raises the question about why the HIV project is operating in such places instead of in settings with higher levels of HIV risk activity. The data from the control villages reinforces low levels of risk - and it beyond the scope of this review to comment on what this suggests about the sexual behaviour of village men in the areas where the project operates but it suggests that in the project sites and surrounding areas there is very low risk of HIV infection and transmission.

Furthermore, the data does not indicate if these men are involved in migration, which restricts the capacity of the data to properly inform this project.

This data is of particular concern since the projects are meant to operate in villages where men migrate. The main rationale for the project is the belief that these men have sex with other women when living away from home, and that this happens on a significant scale that warrants the project's presence. The data presented from the survey does not support that these sites are priority places for the project.

It is difficult to know what to make of this data. On the one hand the survey data indicates a random selection of men in both the project and control sites do not have sufficient levels of sexual risk behaviour to justify needing education from the HIV project. On the other hand the HDI and the HIV project staff believe that based on their observation and experience these villages are at risk of HIV and many already contain PLWHA.

Ultimately, the project needs a good understanding of the sexual practices of these men when they travel for work. This requires good quality social research which can then be used to inform the design and evaluation of education and prevention strategies specifically targeted at village men at high risk of HIV infection and transmission.

This research needs to be ongoing to monitor the impact of the project's education strategies upon these men and to inform the revision of prevention strategies and methodologies.

It is probable that the capacity to design and conduct this level and quality of social research is not available locally. This is not unique to Myanmar but is common in many countries across the region. In a project with such a sizeable budget allocation it would be appropriate for UNDP to dedicate a substantial component of its HIV education programming budget to social science research as a core part of monitoring and evaluation. It is obvious from the projects' experience to date that unless it is accompanied and informed by high quality social research there is no certainty that the project is working with the most vulnerable populations and is having an impact upon HIV transmission.

This should occur from the beginning of project design so that the research and monitoring and evaluation are accepted as a core component of the project and to allow for the creation of the most effective research design. If necessary the project should seek external expertise in HIV social science.

HIV Behaviour Change Methodologies

Apart from the confusion that the data causes about the impact of the HIV prevention and education activities there are some features of the project which are common to other similar projects.

One of the lessons learned from the pilot projects that attempted to integrate HIV with other HDI activities is that HIV education and prevention work is complex and specialist.

It can not be just incorporated as a component of a general health education programme. It is difficult to encourage people to change HIV risk behaviour and to sustain this over time. It requires dedicated programming that can be tailored to local circumstances and is able to reflect upon successes and weaknesses and adapt programmes and activities accordingly. This is why the project introduced the Community Capacity Enhancement programme, for, like HIV projects worldwide, it is apparent that only a community-based comprehensive open ongoing process is an effective way to deal with HIV. There are no quick and easy ways to achieve the behaviour change that prevents the spread of HIV.

Attention can also be given to the project's use of peer education to encourage behaviour change. Peer education is commonly used in health education. Other agencies in Myanmar such as UNICEF are seeking to develop better understandings of peer education. For example, asking what a 'peer?' is, and investigating ways to improve training standards and programs. The HIV project has operated in isolation and needs to network with agencies conducting similar interventions to exchange information but, particularly, to identify and participate in technical and operational capacity development.

The difficulty experienced by this project in learning how to encourage people to move from knowledge to behaviour change occurs in many HIV education and prevention initiatives. This data indicates that the HIV project faces a serious challenge of investigating the barriers to its message being heard and acted upon. It also suggests that the project is not operating in areas of high risk to HIV infection. It is especially concerning that it remains such a substantial problem in a long-standing project with large budgets.

Recommendation:

- **That the UNDP HIV Project involve experienced HIV social scientists in all stages of the design of HIV activities, especially education and prevention, and enable the implementation of well designed and resourced studies that assess the impact of project activities and inform subsequent activities.**

Outcomes of attempts to integrate with HDI Community Development Projects.

Apart from some coordination around site identification and local level information exchange the HIV Project remains a separate project within the HDI. It runs parallel to HDI's ICDP and CDRT, and there is some coordination, but it is not integrated.

During the pilot phases the project did attempt to work closely with, and to use, CDRT and ICDP staff, but it did not assist the project to achieve its aims. Consequently, the HIV project developed its own activities within HDI villages including establishing HIV committees and Community Action Plans which usually establish village community micro finance operations – community funds and grants. These can operate in villages

where ICDP and CDRT have also established micro finance schemes. The HIV project has retained its own national and local level staff.

The HIV project consulted with other HDI projects on identifying the site villages and received some technical input from CDRT and ICDP staff on development issues

There are some key reasons why it has been necessary for the HIV Project to remain somewhat autonomous. These features are also relevant to considerations about the future nature of the HIV and the HDI projects. They are:

- **Programme design and management and monitoring.** It appears there was insufficient attention to the planning and implementation of the attempts to integrate the HIV project with the CDRT and ICDP project:
    - It is not clear that many CDRT and ICDP senior staff and field level staff (Area and Township Coordinators) have an understanding of the HIV Project or of HIV and Development. This restricted their ability to support the project.
    - More attention could have been given to the management and coordination arrangements at both programming and operational levels.

- **HIV as a specialist area of activity.** The specialist nature of creating and sustaining a response to HIV is not easily integrated within CDRT and ICDP. HIV interventions require comprehensive inclusion of and attention to: education and prevention, care and support, and stigma and discrimination. To attend to one without the others will fail to develop an effective response at community level. Also, as the project found, it is difficult to support and sustain behaviour change to prevent HIV infection and further transmission. Whilst men know about the need to use condoms it remains a challenge to get them to use them. For these reasons the project needed to have specialist dedicated staff at national and field levels. It has not been possible for ICDP and CDRT staff and village level volunteers to effectively incorporate HIV work into their work both because of the specialist nature of HIV work and because of their existing work loads.

- **Providing PLWHA access to microfinance.** The economic impact of HIV upon HIV affected households' causes many to become impoverished. The HIV Project has established micro finance programmes designed to suit the circumstances of PLWHA and their families. They participate in the HIV project's community fund, receive loans, and can get grants from the profits. The HIV project also provides funds for income generation. This model is different to that used by CDRT and ICDP whose community funds only provide loans. The HIV project staff believes that many PLWHA are ineligible to access the other HDI micro credit schemes as they operate from a classification of poverty levels – allowing membership of the 'poor' – whilst many PLWHA have entered the lower level of the 'poorest of the poor/very poor'. Also the HIV project allows a higher ceiling for loans than the HDI projects.

- **Framing a project around the circumstances and needs of PLWHA.** Due to the stigma and discrimination around HIV many PLWHA are very reluctant to disclose – this occurs across the globe. The project has found this happening even in villages which have improved their attitudes and openness towards PLWHA. In the project's experience PLWHA disclose when they become impoverished and need assistance. They also disclose privately and discreetly to project staff, sometimes even only to the HDF instead of local staff and volunteers. The HDF doubt that the PLWHA would be likely to disclose to CDRT and ICDP staff because they are busy with a range of activities whereas the HIV staff have dedicated their time to create a presence in the village and to making themselves available for the PLWHA to approach.

Ways forward for HIV education and integration within HDI

The HDI is currently in the process of designing and piloting an integrated project at both program and operational levels. It intends to include the HIV project within this. Within the approaches and frameworks currently being considered there is good potential for the systematic integration of the HIV project.

The HDI program will establish a common integrated framework. At operational level it will be structured around Township Operational Units. These will be responsible for identifying local strategic coordinated interventions and implementing activities. It is proposed that specialist functions (i.e. HIV, water and sanitation, micro finance, etc) will operate at this level and develop activities suitable for the local needs and circumstances.

Within this model it would be possible for the current activities conducted by the present HIV project to be continued but within a suitable balance between integration and retaining specialist expertise and capacity.

HIV prevention and education, community mobilisation, addressing stigma and discrimination, and those components of impact mitigation not covered by micro finance assistance, could be the responsibility of some form of specialist function at Township level. This would require technical expertise in these areas, the ability to identify and develop suitable strategies for local settings, and the capacity to monitor the implementation of activities. The actual ways in which these activities are implemented and who is responsible for them would be explored in the design and piloting of the new integrated approach.

The other main area of activity, income generation and financial support to HIV affected households could be incorporated within a general HDI microfinance programme. This would require adjustment to some of current criteria used. The incorporation of HIV affected households could also be part of a more equitable approach to supporting those in the community affected by illness, disability, as well as the poorest of the poor.

There would need to be specialist staff at national level providing technical capacity in such as HIV and Behaviour Change, Community Capacity Enhancement, and training.

It would be essential to closely involve the current HIV project HDF staff in all integration planning and processes because of their detailed knowledge of the current HIV project and the features that facilitate effective interaction with communities to establish and conduct effective HIV education and stigma and discrimination.

Part of the development of this project will require coordination with other agencies also conducting HIV activities. Already there is concern about overlap between the HIV project sites and those of other agencies also operating in the same locations or vicinity.

The topics identified in this review as needing further attention can be incorporated accordingly in the integration pilot project, and where possible the pilot project could provide opportunities for investigation or research. These topics are:

- **HIV and migration.** Elsewhere this review has identified the need for UNDP to participate in national processes for obtaining better understandings of the major migration patterns in Myanmar and the risks they present to HIV transmission. It is essential that future HDI activities establishing or consolidating HIV education activities ensure that the sites involve substantial migrant workers – either as source villages or migrant work locations.

- **Clear information about the HIV risk behaviour of HDI project beneficiaries.** The project needs to know about the HIV risk behaviour (sexual and injecting) of those for whom it is designing prevention and education and to be able to monitor the impact of the programme on this over time.

- **Mitigating the impact of HIV on households and individuals**. Elsewhere this report addresses the need for better understanding of the impact of HIV on PLWHA and their households – both regarding general impact mitigation and especially the most effective strategies for assisting with financial security, livelihood and independence.

Intervention 3: Income generation - for HIV affected families to reduce the social and economic impact of the disease - with emphasis placed on women and girls affected by HIV - and to train and assist Self Help Groups to establish and manage community funds.

Intervention 4: Humanitarian, social and emergency support - to lesson the vulnerabilities of people affected by HIV, especially in emergency situations, through the provision of capital grants and nutritional support.

Since there is overlap between these two interventions they are addressed together in this section.

The UNDP policy on Assessing and Mitigating the Impact of AIDS is:

> 'UNDP works to address the social and economic impacts of the epidemic through the provision of tools to assess the socio-economic costs of AIDS, and by implementing the provision of tools to mitigate impact at sectoral, community and household levels.' [12]

Support to livelihood assistance provides for both PLWHA's practical needs and is a strategy that encourages PLWHA to come forward and disclose and join with other PLWHA. It ends the isolation many experience but needs a safe framework and environment for doing this.

In Myanmar, strategies to provide assistance with income generation are increasingly needed. This is partly due to the increasing numbers of PLWHA. It is also due to the improved health experienced by those on ARV. As PLWHA become healthier they want to return to work and need assistance to commence it.

Two commonly cited reasons why PLWHA want assistance with income generation is so they can afford medical costs and treatments (including ARV) and for supporting their children with such as school costs.

Current project activities

The HIV project currently provides assistance with income generation and capital grants in two ways.

One way is through the micro finance and grants provided in the village level HIV education program through the community mobilisation Community Action Plans. Many of these plans create community funds in which PLWHA and others (non-PLWHA) participate and receive loans. The community can decide to use all or some of the profits to provide emergency assistance to PLWHA and HIV affected households. The HIV project also can provide direct grants to PLWHA in a separate process to that of the community fund. These grants are used to support income generation – typically to purchase a pig or cow or commence small scale trading.

Data does not appear to be available providing a breakdown of the actual number of PLWHA and HIV affected households involved in or being supported by the village based HIV interventions. Data is available on the number of village based HIV committees providing assistance. In 2007 16 committees/villages provided nutritional support and 25 did in 2008. Assistance with medical tests, treatment and care was provided in 2008 by 18 committees. In 2007 16 committees supported children to attend

[12] UNDP's Response to AIDS: Accelerating Global Progress on Human Development.

school and this increased to 24 in 2008. One funeral was paid for in 2007 and five in 2008. Counselling and support for VCCT associated costs was provided by 27 committees in 2007 and in 2008 by 28 committees.

The second way of providing assistance with income generation and capital grants is through the HIV project's support for micro finance schemes for PLWHA self help groups to establish and manage community funds. Grants are provided to capable SHGs that they can revolve either through micro financing or income generating activities. Since 2007 training and support is provided to groups in urban settings initially in Yangon, and then from 2008 expanded to Lashio/Theinni, Mandalay, Tamu/Kalay and Monywa.

From January 2007 until March 2008 Pact Myanmar was sub-contracted to operate these activities, since then the HIV project has picked up on directly working with the groups. Pact Myanmar designed an integrated prevention, psychosocial and livelihood support programme. It built up networks and informal organisations of PLWHA to be able to design and implement HIV prevention, care and treatment programmes, and psychosocial support. In addition, Pact helped these groups establish a self-owned credit and grant fund to assist with their livelihood and health needs. It provided training on transparent management systems and establishing a group managed revolving fund that supports the individual business needs of its members while providing a safety-net for emergency economic health needs associated with HIV. Pact worked with 15 (out of the existing 35) SHGs in Yangon and over 500 PLWHA for training, giving matching grants, community and home based care and caretakers training, and follow up capacity assessments.

In 2007 the project trained 17 SHGs on community fund management and 12 more in 2008. The actual number of SHGs that established community funds was 9 in 2007 and 27 in 2008. Of these 1 group in 2007 and 17 in 2008 used community funds to provide social support to members. The estimated number of households benefiting from the SHGs was 23 in 2007 and 395 in 2008.

The purpose of Pact's support to SHG was to facilitate autonomous self-empowered groups. They noted that often those PLWHA SHGs associated with INGO/NGOs had difficulty in operating independently or being able to perceive of themselves as taking responsibility rather than as recipients of services. This was reflected also in attitudes towards and participating in the matched grant programme where there was some resistance to making their own contributions to the programme. Over time Pact increasingly encouraged groups to be more responsible for their own funds and saw this as being consistent with their general livelihood support programmes and not reinforcing that PLWHA are different to other people and neither should nor deserve to be treated differently.

As the Pact project developed it began to replace direct matching grants with giving sub grants to groups. For example, as part of home based care and guardian care training Pact provided bicycles to the groups as requested for use for home visits. Overall, Pact raised questions about the most suitable models for providing financial assistance to PLWHA

groups. It became concerned that the availability of funds from Pact/UNDP saw the change from initial matched funding of 1:1 or 1:3 to that of 1:4. Partly this was believed to be due to the groups increasing awareness that funds were available. Pact became concerned that this model fosters dependency. In other projects in the country Pact requires the group to raise its own funds and Pact began to implement this model with PLWHA to some resistance from the groups.

Pact also identified concerns about the value of giving groups funds for income generation and proposes that it is more strategic to give the money to the groups for their own organisational capacity development.

Lessons learned from income generation, grants and support to SHGs

- All of those who have been involved in income generation – Pact, the UNDP project staff, and all the PLWHA SHGs - believe they are highly valued initiatives and are appreciated for the support they provide to individuals and families. In addition the SHGs recognise they need to properly manage these programmes and that there are also other benefits that flow onto the group such as strengthened support structures within the group and being able to provide help to members of the group and others in the community.

- Currently PLWHA who are amongst the poorest of the poor are not involved in these income generation initiatives (nor in SHGs). These people tend to be completely occupied with daily survival and obtaining food so do not have time to spend in a SHG or networks and thus do not access services. The Pact project recognised that these people cannot even afford the bus fare to attend SHG meetings and recommended providing support for travel and refreshments for the poorer PLWHA to enable their participation.

  The PLWHA SHG are aware of these other PLWHA and suggest that it they were able to offer them support with their basic needs such as nutrition then it would provide a point of contact upon which they could build other education, information and support services. Within the proposed new integrated HDI project attention should be given to providing capacity for those PLWHA amongst the poorest of the poor to able to participate in the micro finance scheme. Also the proposed review of capacity development for PLWHA SHG could consider strategies for providing support to PLWHA amongst the poorest of the poor and recognise that specific strategies might be required to reach and provide support to that population.

- Whilst all of the indicators are good, the project does not have data on the actual impact of micro finance schemes on PLWHA and their household income. Nor, based on the experience and observations of Pact is enough known about the most suitable model/s to use in supporting micro finance capacity amongst groups of PLWHA (both established and informal). Given that both of these activities will

be major, and increasing, programming areas, and that UNDP will be continuing to play a major role in supporting them, it would be appropriate to commission a review into the most effective ways to provide micro finance support to PLWHA and their households, and the most effective model/s for supporting micro finance capacity amongst groups of PLWHA. Pact Myanmar could be sub-contracted to conduct this.

- Providing support financial support to SHGs to operate micro finance programmes requires attention to the organisational and management capacities of the group. The national network of PLWHA, the Myanmar Positive Group, and some of the SHGs and partner organisations, has identified the need for a national assessment of the capacity development needs of PLWHA SHGs. There has been a rapid increase in the number of SHGs across the country in a short period of time. Many of them have the potential to play a major role in supporting their members but lack the skills, expertise and capacity to do so.

  This assessment would provide the framework for donors and partners could use to support the capacity development and for the SHGs themselves to use for their own strategic planning and organisational development. It could also be used by MPG to inform its national strategic plan and support to the capacity development of its member organisations.

  Since UNDP has already made a major contribution to the development of these SHGs it would be consistent for UNDP to provide the support for this assessment. (This assessment would need to liaise with the parallel review of the model/s for micro finance capacity amongst PLWHA groups.) This assessment is addressed in more detail in the following section on GIPA.

Recommendation:

- **That UNDP commission a review of the most effective ways to provide micro finance support to PLWHA and their households, and the most effective model/s for supporting micro finance capacity amongst groups of PLWHA.**

Impact mitigation

HIV impact mitigation – minimising the impact that HIV has upon individuals, families and personal networks - is an important emerging area in Myanmar. Members of the Joint UN Support Programme for HIV in Myanmar confirm that it will require considerable attention in the near future, especially considering that the National Strategic Plan for HIV and AIDS will have a mid term review later this year (2009).

HIV impact mitigation is a component of the National HIV Strategic Plan - Strategic Direction 4: Reducing HIV-related risk, vulnerability and impact among partners and families of PLWHA. But this section of the plan is not well developed. It does contain a basic coverage of the key features requiring attention (prevention strategies, behaviour change support, access to resources, counselling, support for children, addressing stigma and discrimination, etc) but concentrates primarily upon SHGs as the vehicle for implementation. Impact mitigation is also a component of Strategic Direction 11: Meeting the needs of PLWHA for comprehensive care, support and treatment. Whilst this primarily addresses medical, treatment and ARV it also commits to GIPA and involving vulnerable groups in program design, development, implementation and evaluation.

Similarly, whilst members of the JUNSP identify impact mitigation as a critical issue it is not well developed in the JUNSP work plan 2006 – 2010. Whilst the development of the plan was compromised by the attention given to Cyclone Nargis, the fact that the section of Strategic Direction 4 has no contents but refers to coverage under other sections illustrates the urgent need for attention to this matter at strategic and planning levels.

One reason for the need to increase attention to impact mitigation reflects the national priority previously given to prevention and education, rather than to care and support and quality of life of PLWHA. Elements of this continue. When developing the current Global Fund Proposal, due to concerns about containing the budget allocations between prevention and care, a number of care and support activities were placed under the prevention category. This is likely to cause complications with implementation and monitoring and evaluation, as well as to national mapping of the range and status of impact mitigation activities.

In addition to the priority given to prevention, the other reasons why impact mitigation requires attention are: the increasing numbers of people being diagnosed with HIV as more people use HIV testing services; increasing numbers of people being diagnosed with HIV or AIDS as, with the passage of time, they manifest symptoms from long term undiagnosed infection; the wellbeing experienced by those on ARV and interest in returning to work; and, the rapid growth of PLWHA SHGs which conduct programmes centred around impact mitigation.

Globally, UNDP is committed to impact mitigation. It is a sub-section of its policy on Development planning and mainstreaming one of its four priority global foci:

> 'UNDP works to address the social and economic impacts of the epidemic through the provision of tools to assess the socio-economic costs of AIDS, and by implementing strategies to mitigate impact at sectoral, community and household levels.'[13]

The UNDP HIV project has extensive involvement with and commitment to addressing community based strategies for minimising the impact of HIV at individual, family and community level. It is one of the lead agencies in the country that is addressing the

[13] UNDP's Response to AIDS: Accelerating Global Progress on Human Development. UNDP. NY, NY.

economic impact of HIV on PLWHA and their families. Hence it is appropriate for UNDP to take a leadership role in addressing impact mitigation and assisting in developing a more complex and detailed analysis of what is required in Myanmar and a strategy for achieving this. It can do this in collaboration with the JUNSP.

The strategy to take needs to be discussed further with counterparts – the JUNSP can consult with the NAP. One possibility would be to develop the components, framework and contents of an impact mitigation strategy for Myanmar.

The following topics could be considered as possible areas to include as part of an assessment of HIV impact mitigation:

- A comprehensive integrated framework is needed for analysis – economic and financial impact of HIV, care and support, continuum of care, access to treatment, stigma and discrimination, and psychosocial impact and support needs etc.

- An assessment needs to encompass all those affected by HIV in Myanmar – individuals, families, IDUs, MSM, and sex workers (and the families or personal/social structures of these last 3 populations); be based in the principle of equity of access; and give attention to all socio-economic levels (including the poorest of the poor). It should be shaped around the experiences, circumstances and needs of these people, and if necessary allow for specific distinctions such as for sex workers or for MSM, and not be conceived around a generic framework expecting it to suit all.

- The assessment needs to allow for the unfolding of the epidemic in families and communities (village and urban settings) over time (especially considering low levels of ARV access and the likelihood of extensive illness and dying). It needs to include children affected by HIV.

- A gender analysis and framework should be a core component of the assessment

- The assessment needs to consider access to the full range of HIV related services both medical as well as local level and community services and support, including identifying and addressing barriers.

Recommendation:

- **That, in collaboration with the United Nations Joint Support Programme on AIDS, UNDP takes the leadership in addressing HIV impact mitigation and commission a national assessment of impact mitigation.**

Intervention 5: The Greater Involvement of PLWHA (GIPA) – to promote the inclusion of PLWHA through the GIPA network – also fostering leadership among communities affected by HIV.

UNDP globally is committed to supporting the involvement of PLWHA. This is explicitly stated in two of the four components of its global policy on HIV. It is contained in the subtitle of 'Governance of AIDS responses' - 'Strengthening national capacity for inclusive governance and coordination of AIDS responses, and increasing participation off civil society and people living with HIV in the design, implementation and evaluation of AIDS Programmes.'

In the second component, 'Law, Human Rights and Gender', it states that UNDP will support the involvement of male and female PLWHA in the design, implementation and evaluation of national and local AIDS responses. Also '…to address marginalisation, social exclusion and discrimination, UNDP collaborates with key stakeholders, including government, civil society, religious and community leaders, media and artists, to promote human rights and challenge prejudices against PLWHA and most at risk populations.'[14]

The Myanmar National Strategic Plan on HIV and AIDS 2006 – 2010 also commits to the involvement of PLWHA. It is a key feature of both: Strategic Direction 4: Reducing HIV related risk, vulnerability and impact among partners and families of PLWHA, and Strategic Direction 11: Meeting needs of PLWHA for comprehensive care, support and treatment. A specific Activity Area in both is to 'Promote the meaningful involvement and empowerment of vulnerable groups, including people living with HIV, so they are able to participate in program design, development, implementation, and evaluation.' And amongst its outputs are: strengthen PLWHA SHGs, capacity building for PLWHA networks, including PLWHA in all related committees, and strategies for conducting HIV prevention programmes within PNWHA SHG to encourage members to not transmit infection.

In response to the recommendations of the 2004 and 2005 IAMs and the mid term review the HIV project, along with other partners, in 2006 helped start a group of PLWHA that became the GIPA Initiative Group. The HIV project facilitated access to funds from the Regional HIV/AIDS Practice Team, UNDP Regional Centre in Colombo, which enabled the GIPA group to implement activities. The HIV project linked the GIPA group to the Asia Pacific Network of HIV Positive People (APN+) who provided technical assistance for a training of self help support groups to enable them to link and network with each other.

The GIPA Project Initiative and the International HIV/AIDS Alliance conducted a national assessment of PLWHA SHGs in 2006. It mapped and reviewed the existing groups and identified the capacity building needs required to strengthen the groups and allow networking. One outcome of this activity was the creation of a national PLHA network, the Myanmar Positive Group (MPG). UNDP provided it with funds to establish and commence activities.

[14] ibid

The work of MPG was reviewed at a national workshop in February 2008. Sixteen SHGs from Yangon and 15 from elsewhere participated. The workshop reviewed the work of MPG, gave detailed attention to identifying priorities for further development, and produced a comprehensive meeting report. The eight main types of services provided by MPG at that point were:

1. Workshops on Organizational Development;
2. Trainings on Personal Prevention, Voluntary Confidential Counselling and Testing, and Training of Trainers ;
3. Education on Opportunistic Infections and ARV Treatment;
4. Developing IEC materials;
5. Events for promoting IECs;
6. Networking opportunities among self help groups;
7. Developing SHG directory, and;
8. Opportunities for representation.

The HIV Project's support to GIPA and to MPG ended in November 2007. MPG developed a project design proposal and submitted it to UNDP. They did not receive a response**.**

Since then UNAIDS has twice provided bridge funding to cover salaries and administration costs. This finishes in April 2009. The HIV/AIDS Alliance supports them with providing office space.

Since UNDP finished providing core financial support to MPG it has provided for some one off activities. It provided support to organise a World AIDS Day event. It has supported MPG to conduct treatment workshops for SHGs educating about ARV treatment and compliance to reduce developing resistance to ARVs

In 2008 UNDP gave MPG a grant to establish a Positive Women's Network. This brought together women from the member SHGs and has around 25-30 regular members. Using UNDP support the project provides livelihood assistance to 25 women-headed AIDS affected households. With UNAIDS support this network is planing a workshop with the participation of one of Asia's leading female PLWHA and member of APN+.

At present there are 127 Self Help Groups that are members of MPG. This represents a total of 6,853 PLWHA. These are in 6 areas – Kachin, Northern Shan, Yangon, Middle Myanmar, Mon, and Tanintharyi. This reflects an extraordinary growth of the PLWHA SHG movement in only a small number of years.

In addition to the activities covered in the review meeting report MPG has produced three sets of IECs (stigma and discrimination, positive inspiration, and the positive development manual), has trained 25 facilitators, and conducted various workshops for members on health education and treatment issues. It continues to build the network through encouraging the formation of new SHGs and is a member of the Asia Pacific Network of PLWHA and of various Myanmar NGO and Public Health networks.

MPG identified the challenges it faces as: dealing with the difficulty of not being registered and thus problems with operating events etc, having to rely upon voluntary staff because no staff positions have been funded, not having secure ongoing core funding, needing to increase their capacity to conduct representation and advocacy, needing to increase SHG coverage across all parts of the country, and the need to conduct advocacy with religious leaders and groups.

Against all this, the response mounted by MPG and Phoenix SHG to Cyclone Nargis is a strong indicator of the capacity of these organisations. They were able to coordinate significant operations on a substantial scale. The Cyclone was a tragedy but there were beneficial consequences for the PLWHA movement. The experience of mobilising and carrying out relief activities increased the bonds within, and the strength of, the networks. In communities where PLWHA had previously been stigmatised the neighbours turned to the PLWHA organised response for assistance, and some PLWHA proposed non-PLWHA neighbours for the project's assistance. Consequently, there has been a favourable shift in local community attitudes towards PLWHA. Where previously neighbours would not get water from a well at one PLWHA's house they now regularly use it.

Whilst it is not registered, MPG is a member of the Technical Strategy Group which is responsible for planning, monitoring, and coordination of the Myanmar National Strategic Plan on HIV and AIDS. The NAP expressed its support to involving PLHWA groups when it met with the review and stated that these groups played an important role at local level and should collaborate more with local authorities, not because they wanted to control them, but to allow better coordination of services.

The MPG participates in all key national HIV strategic planning and decision making meetings. They are members of the CCM, the national planning and coordinating body of the GFATM.

UNDP is in a unique position to provide support to GIPA – to the continued development of a strong and comprehensive PLWHA movement in Myanmar. It can do this in two complementing ways.

One way UNDP can support GIPA is by providing support to MPG, the national network. The leaders of MPG already demonstrate impressive qualities and have created a well considered national organisation that has a well developed understanding of its role and is developing the networks and supporting its members. MPG needs the committed support from agencies such as UNDP to help it operate as is expected. An organisation such as PMG is, in every country, considered to be an essential partner in the national response to HIV. Providing it with the financial and technical support to fulfil this role should be a priority for organisations such as UNDP. Support to MPG is also providing support to the various SHGs across the country as one of MPG's key roles is support and education to its member organisations.

Since it is consistent with UNDP's global policy and the role of UNDP within the UN division of labour UNDP should investigate how best it can provide support to the Myanmar Positive Group.

UNDP can approach this through discussions with MPG that consider their future plans, areas in which it needs assistance, and relationships with other donors,

The second way to support GIPA is by maintaining the support to income generation programmes in SHGs and through developing a capacity development plan for PLWHA SHGs. The PLWHA movement has identified it needs further assistance with the capacity development of SHG and requested that UNDP provide support with this. This would require an assessment of the capacity development needs of PLWHA SHGs. This would consist of a mapping of their capacity development needs, and then a strategy and action plan. This is compatible with the work that the International HIV/AIDS Alliance has been doing with some PLWHA SHGs and with general capacity development it does with other HIV community based organisations in the country. UNDP could sub-contract this task to the Alliance.

These two components are linked – the SHGs are the members of MPG – so UNDP would be supporting a complementing interrelated programme.

Support to strengthen MPG and SHGs also enables and facilitates partnerships with other agencies. For example, if the SHGs are operating effectively then UNICEF can establish partnerships with them to conduct education and programming around PMTC and treatments. Without these groups UNICEF is limited in being able to reach and work with PLWHA.

Recommendation:

- **That UNDP discuss with the Myanmar Positive Group the forms of support that UNDP can provide with a focus upon core support to staffing, advocacy and operational activities.**

- **That UNDP provide support for a national mapping, strategy and action plan to address capacity development of PLWHA Self Help Groups in Myanmar**

Intervention 6: Work place programmes

- to draw commitments and build capacity of the private sector to initiate HIV programmes and policies in the work place.

Support for workplace programmes is included in the interventions for the HIV project in 2009. Little information was available to the review about what is intended under this intervention. The project has commissioned a study of HIV policies used in various work

places in Myanmar. It contains some coverage of potential sectors work that might be considered for HIV workplace education and policy development but more attention would be needed on this before an informed strategic plan can be developed.

UNDP has taken a lead role in the UN system 'We Care' initiative for staff and dependents and will continue with a refresher course.

Considering that it appears little has been committed to activity on work place programmes it might be appropriate for UNDP to post phone expanding activities on this intervention given the attention required from other areas of national commitment and project activity. It should maintain its support in 'We Care'.

Sexual minorities

Whilst this topic is not amongst the current list of UNDP HIV Project interventions it has become a priority topic for UNDP. Within the UNAIDS division of labour UNDP has recently undertaken responsibility for sexual minorities.

> 'There is increasing recognition that the level of commitment and resources allocated to programming for sexual minorities such as men who have sex with men and transgender populations falls far short of what is required to curb the AIDS epidemic. These groups are particularly vulnerable to HIV, but routinely do not feature in national AIDS plans and are severely underserved by HIV programmes. UNDP, in collaboration with the UNAIDS Secretariat and Cosponsors, works to promote the implementation of HIV programmes for men who have sex with men and transgender persons, and advances the use of gender and human rights based approaches to address stigma and discrimination and other human rights violations against marginalise groups on the grounds of real of perceived HIV status, sexual orientation and gender identity.'[15]

The JUNSP workplan for 2009 specifies conducting qualitative research on MSM networks of transmission (presumably this means a study of the HIV transmission routes within MSM sexual networks).

The more comprehensive JUNSP plan to support the NSP 2006 – 2010 needs to be revised since UNDP has replaced UNFPA as the lead agency for MSM. However its contents can be used to indicate the role that UNDP can take and the priority activities required.

The JUNSP refers to reducing risk amongst MSM as a 'highest priority' activity of the National Operational Plan for AIDS 2006 – 2011 and thus commits the UN to supporting these activities at as high a level as possible. It identified that UNFPA as the lead UN

[15] ibid

agency would overall provide support consisting of 'conducting relevant research, providing technical support to the national programme and technical and financial support for service delivery by NGOs.'[16]

It is possible that, due to the UNDP Mandate for Myanmar, UNDP will be not easily be able to assume one of UNFPA's previous responsibilities, that of providing support to the national programme. Since it is critical that the UN provides this support to the national programme a solution needs to be discussed by the Myanmar Joint UN Team.

In addition to support to the national programme the UN plan specifies the main areas of activity that the UN will undertake to support reducing HIV risk, vulnerability and impact amongst MSM. These are scaling up, technical assistance, capacity development, research, and assistance with resource mobilisation. Since all of these components are essential to achieve an effective response to HIV amongst MSM it is necessary for UNDP to develop strategies that enables each of them to happen.

UNFPA has already commissioned an analysis of what INGOs are doing with MSM and HIV but it is unclear if this also provided a strategic plan for supporting scale up and identified technical assistance needs. This would seem to be a necessary requirement to inform both the national plan of action and the role of and assistance sought from UNDP. Central to any plan and intervention on this topic is an understanding of MSM sexual behaviour in Myanmar. It is important that from the beginning this area of work is clearly understood to not simply apply for those men considered to be obviously MSM. It needs the capacity to recognise and differentiate between gender, identify and behaviour, the ability to identify and map how these apply in Myanmar, and frame the most suitable strategies for incorporating them all in a comprehensive and all-inclusive strategy that covers gay men, transgenders and other men who have sex with men.

Such a strategic plan could also address social research including such as: processes for identifying research topics; ways of conducting research that involve researchers, community members, and NGO project staff; and specify whether capacity to design, implement and analyse the research is available in the country or if external assistance is required. The plan could also specify links with MSM activities and networks in other countries and regionally to ensure that Myanmar is involve in the emerging MSM HIV advocacy and information sharing systems and networks.

Working with MSM is highly specialist work and requires particular forms of sensitivity, knowledge and expertise. It is not something that can be easily undertaken by a generalist development agency. For these reasons it is not suitable for UNDP Myanmar to be directly involved in developing and conducting MSM interventions.

UNDP needs to take the leadership to facilitate the processes that will build the involvement of the appropriate agencies in addressing MSM and HIV interventions in Myanmar.

[16] Joint United Nations Programme of Support for HIV in Myanmar. How the UN system will support implementation of the Myanmar National Strategic Plan on HIV and AIDS, 2006 - 2010.

Based on discussions with UNDP HIV staff it appears there has been no consideration about the role that UNDP will take and the activities it will support, nor was any information available about the national level strategic response to date about MSM and HIV.

The following is a set of considerations that can be used when considering what appropriate activities:

- Recognising its lack of expertise in this area UNDP should form a partnership with UNAIDS in particular and the Joint Team as a way of developing the strategy it will follow in supporting MSM and HIV.

- Consideration can be given to the need for a national strategic MSM and HIV plan

- Members of gay and transgender groups and communities should be involved at all levels of planning and operations.

- Capacity development and community development of gay men and transgenders and their groups should be key and priority features of a national strategic MSM and HIV plan

- MSM PLWHA individuals and groups should be involved in strategic planning and responses

- Attention should be given to assigning leadership roles to INGO/NGOs in ways that leaves UNDP as the facilitator and provider of resources

- Recognising the unique constraints regarding NGO activity and registration UNDP is likely to need to be actively involved in sub-contracting and supporting informal groups

Recommendation:

- **That, in collaboration with UNAIDS and the Joint Team, UNDP ensures that national level leadership and strategic planning is available to inform an effective response to HIV and MSM in Myanmar.**

Annex A: Terms of Reference

Terms of Reference
Technical Review of the project
"Enhancing Capacity for HIV/AIDS Prevention and Care"
UNDP

1. Background

UNDP initiated, in 1992, a project to support the long-term goal of slowing the further spread of HIV as well as to mitigate the social and economic impact of the disease on the population of Myanmar. Subsequently in 1994, the Governing Council, in re-directing UNDP assistance to programmes and projects with grassroots impact, included HIV/AIDS as a priority area of intervention. Thus, HIV/AIDS project, executed by UNOPS, was fully integrated into the grassroots oriented Human Development Initiative (HDI) programme implemented since 1994.

In line with the UNDP Executive Board mandate on Myanmar[17], and consistent with the spirit of the UNGASS Declaration and the United Nations Joint Programme on HIV/AIDS, the project focused on increasing the scale and effectiveness of community-based responses for HIV/AIDS prevention and care, and on mobilizing additional resources for a multi-sectoral response to the epidemic. Special emphases are placed on raising the awareness of young adults and adolescents to the menace of the disease.

The first phase of the HIV/AIDS project, from 1994 to 1996, emphasized on awareness raising and prevention education for the general population. The project, at that time, supplied the required condoms for the prevention of HIV transmission, and HIV test kits to ensure the safety of the blood supply in the country. During the second phase, from 1997 to 1999, the project embarked on building capacities of community volunteers in 15 HIV highly prevalent remote sites. These volunteers were selected from the local populace and were trained and assigned in specific wards or villages to provide outreach education to prevent HIV, as well as home based care services for people who have AIDS. The project also worked closely with other agencies and organizations. Appropriate IEC materials were developed and distributed.

Starting from 1999 until the later part of 2003, which covered the third and fourth phases, the project broadly increased its staff, opening five regional offices in strategic areas staffed by regional project facilitators (RPFs). In contrast to earlier projects where the main activities were confined to awareness raising and prevention among the general population, projects were now designed among high risk groups, with care and support for persons living with HIV in certain highly prevalent areas. Moderate income generation schemes for support of persons with HIV were instituted in some areas.

In addition to the above-mentioned activities, the project initiated capacity building of local organizations in high prevalent areas. The RPFs continued to form and train corps of volunteers, known as AIDS Support Volunteers (ASVs), to provide basic services such as HIV prevention education, counseling, care and support. Through the years, local organizations have emerged and were employed by the project to implement HIV interventions.

The project is now on its fourth phase and continues to build the resilience of the communities to the socio-economic impact of the epidemic as has been a successful strategy. The project also enhanced local

[17] The UNDP Governing Council Decision 93/21decided that, until a country programme for Myanmar is considered at an appropriate time, all future assistance from the United Nations Development Programme and related funds to Myanmar should be clearly targeted towards programmes having grass-roots-level impact in a sustainable manner, as called for in the aforesaid decision 92/26, particularly in the areas of primary health care, the environment, HIV/AIDS, training and education, and food security;

capacities of communities to undertake HIV/AIDS prevention and care activities in priority geographical areas. The project shaped its strategic approach with the insights gained from experience in HDI started since 1994, and applied global lessons learned that reflected the changing nature of the pandemic. The following were key intervention strategies of the project.

- Building capacity of CSOs, CBOs, and NGOs to address challenges and issues resulting from HIV infection and AIDS within their communities through HIV prevention and AIDS care and support activities
- Increasing community support for people living with HIV/AIDS
- Condom promotion targeting migrant workers and female sex workers, hospitality girls and their sexual partners
- Documenting the lessons learned so as to contribute to knowledge and lessons learned for the benefit of UNDP and all partners
- Mobilizing additional resources for multi-sectoral activities responding to HIV/AIDS.

Project Assessments and refocusing of project strategies

An assessment of the HDI project in August 2004 noted that the circumstances prevailing in Myanmar has changed markedly from the time the HIV/AIDS project started in the mid-'90s. A substantial volume of international assistance to the country such as the Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) and the Fund for HIV/AIDS in Myanmar (FHAM) has allowed for the entry of other stakeholders that has changed the priorities for assistance. The mission viewed that the current project would benefit from sharper focus and recommended that UNDP gradually refocus the HIV/AIDS project in areas in which the organization has a comparative advantage.

In light of the recommendations of the assessment mission, the project gradually shifted its activities within the HDI service delivery areas. In collaboration with the community development projects, the HIV project concentrated on a training program to build capacities of community development workers of the ICDP (Integrated Community Development Project) and CDRT (Community Development in Remote Townships Project) in order to mainstream HIV into the community development initiatives of the two sister projects by incorporating HIV into their community development activities. This would enable them to interrelate HIV and development so that they can facilitate discussions and find solutions to the impact of HIV in their communities. The project mainstreamed HIV by involving Self Reliance Groups (SRGs) already established in the project sites to disseminate information and educate the communities about HIV and how to prevent infection. The education interventions by the SRGs address women's concerns and decision making and gain a deeper understanding of how power imbalances affect the spread of HIV.

A mid term review of the HIV project was conducted in April 2005 to assess the significance of the objectives of the refocused project and recommend new directions for project activities reflecting the recommendations of the HDI Assessment Mission report of 2004 and the planned HDI expansion. The mid term review recommended exploring ways to integrate HIV with other community development initiatives through a staged process that leads to the development of more effective responses that have emerged to date in both HIV and community development, better analysis of the underlying development conditions that affect HIV, and a gradual scaling up through partnerships & collaboration and advocacy.

The 2005 HDI assessment mission recognized the progress that has been made to re-design the HIV/AIDS project to support ICDP and CDRT projects. Without reaching conclusions, it asks whether: i) HIV/AIDS awareness-raising should be combined with broader efforts to promote health education in ICDP/CDRT; and ii) HIV/AIDS should continue beyond December 2005 as a separate, stand-alone project, or should be re-organized as a support unit for ICDP/CDRT.

A follow up technical review in 2006 recommended continuing to build on the current community development strategies by eencouraging community leadership, and to develop forums of engagement for women, youth and men.

In response to these recommendations, the HIV project has developed and implemented a community volunteer outreach education programme in selected HDI villages. The programme consisted of two major activities: outreach community education and community capacity enhancement to allow the villagers to address HIV related issues. The project introduced a new community participatory methodology called Community Capacity Enhancement (CCE) concentrating on community participation into development practices by creating opportunities for people to understand, discuss, decide and act on issues affecting their lives and to enable the communities to mitigate the impact of HIV within their communities. Making the most efficient use of staff resources, and so as not to over burden the community development workers of the sister projects, the HIV project employed community volunteers to implement the intervention. A new step towards expanding community groups in HDI sites has been taken by training community volunteers comprising of men and the youth to implement the education outreach program.

The project has also initiated the formation of a group of HIV positive individuals that was eventually called the GIPA (Greater Involvement of People Living with HIV) Initiative Group. Through the project's guidance and funds from the Regional HIV/AIDS Practice Team, UNDP Regional Centre in Colombo, the group implements a programme that seeks to advocate for the rights of HIV positive individuals to seek related information about antiretroviral treatment. The HIV project has linked the GIPA group to the Asia Pacific Network of HIV Positive People (APN+) who has provided technical assistance for a training of self help support groups to enable them to link and network with each other.

At the same time, the HIV project, in 2006, expanded its activities to focus on HIV vulnerabilities related to unsafe mobility and migration in Myanmar. The project partnered with the International Office on Migration (IOM) and World Vision to implement a programme for migration affected communities in the Mon and Kayin States.

The Independent Assessment Mission of 2007 noted that addressing HIV/AIDS is highly relevant in its own right and is consistent with the role of UNDP in the Myanmar National Strategic Plan on HIV & AIDS (2006 - 2010). It noted the HIV Project's compliance to 2005 IAM's recommendation that UNDP ensure more integration between the HIV and the community development project, and linkages with the operations of the SRGs and MF groups. The 2007 IAM however believed that the great majority of the present and potential HDI beneficiaries are not affected given the (low) prevalence of the pandemic in most of the areas covered by CDRT/ ICDP and the Micro Finance Projects and that by focusing on these areas, the HIV/AIDS Project has thus become less relevant to the achievement of both a set of unifying and achievable HDI goals, as well as the National AIDS Strategy, by operating in areas with low or no prevalence of HIV/AIDS, concluding that the HIV/AIDS project hardly fits in a refocused community development programme for which the IAM argues for. As such, it recommended that UNDP reconsider whether the HIV/AIDS risks are sufficiently significant in all community development project areas to warrant the involvement of SRGs and Micro Finance groups as well as the staff that serve them. The IAM also believed the HIV/AIDS Project would be better to widen its geographic area as required, and thus to limit its activities to awareness education; focus on high risk groups and high risk areas regardless whether these are found within or outside CDRT, ICDP or MF project areas; and align its operations to the activities of other actors in the field of HIV/AIDS, rather than with the HDI projects.

The Independent Assessment Mission of 2008 recently made the following comments:

- The HIV/AIDS project has taken steps to refocus its activities to areas of high prevalence and to populations at particular risk. The project management is advised to look into the project's comparative advantages in focusing on awareness activities or activities in support of HIV positive persons
- The HIV/AIDS programme should focus on training of trainers in the CDRT and ICDP to take over the responsibility for awareness raising activities in the two project areas and wrap up such activities in other areas, freeing resources for further work in peri-urban areas

In light of all these recommendations, the HIV project has continued the community volunteer outreach education programme in 7 HDI townships and initiated a livelihood programme with self help support groups of people living with HIV in Yangon and other major urban areas. By 2007, the HIV project

continued the initiatives taken in 2005 and 2006 and started to address the growing need for psycho-social and economic support programmes for persons living with HIV by providing skills training to improve the income sources of women, girls and persons affected by HIV. In collaboration with PACT, a training programme on establishing and managing community health fund was conducted for 31 Self Help Support Groups. The project has so far provided revolving funds to 16 SHGs. The project also collaborates with the Association Francois Xavier Bagnoud (AFXB) to train members of families of people affected by HIV, especially women and girls on livelihood skills to improve their income sources.

2. **Justification of Consultancy**

In the past few months, the HIV Project has been involved in developing plans to mainstream HIV into UNDP's ongoing integrated community emergency relief programme in the Delta, which was struck by Cyclone Nargis. During a natural disaster, the effects of poverty, powerlessness and social instability are intensified, increasing people's vulnerability to HIV and AIDS. In this regard, HIV/AIDS has therefore been identified as a cross-cutting issue that must be addressed in post-disaster complex emergencies as part of the overall humanitarian response.

A high level meeting of the UN General Assembly in June paid attention to marginalized and most at risk populations who continue to be disproportionately vulnerable to HIV in almost all contexts. As part of UNDP's lead role on HIV and Human Development, human rights and gender, and an increased commitment to expanding and improving work with most at risk groups, UNDP has recently assumed lead responsibility in the UNAIDS family for sexual minorities (with particular attention to men who have sex with men).

These unexpected events, along with the extension of the fourth phase of HDI until 2010, require a revisiting of UNDP's HIV and AIDS strategies.

3. Scope of the work

3.1 Objective

This assessment will primarily examine the strategies taken by the project in light of the recommendations made by assessment missions and the expected technical support role of UNDP in the national AIDS response. This assessment will also review the performance of the project in achieving its refocusing strategy, and provide recommendations on the appropriateness towards reaching the recommendations made by both IAM and the previous technical review missions reflecting the latest situation in the country, objectives and outputs as stipulated in the original project document, and the extent to which they have contributed towards reaching the desired outcomes.

3.2 Task/process/approach

Task

The consultant will undertake the following tasks:

- Review the project's current interventions and highlight the progress made and the appropriateness of the strategies in use as recommended by the previous review missions and in light of UNDP's assistance in Myanmar
- Assess cooperation mechanisms with ICDP and CDRT with a view of the dynamics of HIV and the community development initiatives, including the plans for the Nargis Cyclone affected Delta Region
- Assess activities collaborated with the groups of people living with HIV and AIDS and other partner organizations
- Review the project's results monitoring framework and recommend, if needed, appropriate indicators as well as qualitative studies that can validate the current impact assessments
  - Recommend the strategy, that the project could undertake fully reflecting the comparative advantage of the UNDP and its role in the national AIDS response beyond 2010

Process/approach

The consultant will undertake his/her tasks through the desk reviews of relevant documents to be made available prior to and during the review exercise, consultations with programme and project staff, UNDP senior management and other key stakeholders. A number of visits to the project sites are to be arranged for discussions and interactions with beneficiaries, volunteers and partner CBOs.

3.3 Outputs

The consultant will provide a draft report comprehensively detailing the assessment findings, recommendations and, lessons learned. The draft report is to be submitted to the UNDP management for discussion and comments prior to the departure of the consultant from Yangon. The consultant will be responsible for submitting a final report to the UNDP Resident Representative, UNDP CO Myanmar.

3.4 Qualifications required for consultant

The review will be carried out by an international consultant who has hands-on experience in the design, management, and evaluation of community based HIV/AIDS prevention and care interventions in resource-constrained settings and has a demonstrated capacity for strategic thinking. The consultant shall have a post graduate degree in the Social Sciences or health sciences. The international consultant should have a good knowledge of the country and have prior experience and exposure to the special circumstances governing UNDP assistance to Myanmar an asset.

3.5 Implementation Arrangement

- The consultant will be briefed by UNDP Country Office upon arrival in Yangon
- UNDP Programme Manager (HIV/AIDS) will work closely with the consultant to ensure that the ToRs are fully satisfied
- In close collaboration with UNDP, the HIV/AIDS project will provide logistical and administrative support to the consultant as needed. The National Project Coordinator of the HIV/AIDS Project will also ensure that all relevant data, materials and documentation are made available to the consultant. Following list of reference documents will be provided to the consultant.

HIV/AIDS Project document and its addendum
Project progress/operations and impact monitoring reports
Recommendations of the Independent Assessment Missions (IAM)
Previous technical review missions' reports
UNAIDS Division of Labor for Myanmar
UN Joint Support Programme on AIDS 2007 - 2010
HIV AIDS Response financial tracking report
Draft Myanmar HIV/AIDS Operational Plan 2008 – 2010
Regional AIDS Commission Report
Myanmar National Response to AIDS, Progress Report 2006 and 2007
National Strategic Plan of Action 2006-2010

- Advisory committee for the review will be formed in due course composing one PLHIV, representative from UNAIDS, UNDP Programme Manager (HIV/AIDS), National Project Coordinator (HIV/AIDS Project), and INGO working HIV intervention at the community level and working sessions with consultant will be organized
- Field visits will be arranged and accompanied by advisory committee members
- The consultant will provide a draft report prior to departure to allow for feedback and consultation in the final report.

3.6 Timing and Duration

The consultancy will be for four weeks in presumably starting in late January 2009.