



**Evidence for a successful implementation
of the minimum package of HIV prevention
interventions in Burma**

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Foreword

This case study aims to share a successful implementation of the minimum package approach to HIV prevention for most-at-risk populations. The minimum package approach, which aims to implement a package of effective HIV prevention interventions in a coordinated fashion, is being implemented in a number of sites across the Mekong region. The program in Burma is one of the more established of these, and it presents a wealth of data that can be used to better understand the implementation of the Burma program and demonstrate its effectiveness. The experience from Burma may help inform other programs in the region.

Several non-governmental organizations are working to provide HIV prevention services to most-at-risk populations at sites across Burma. This report focuses on the experience of those organizations working in Rangoon.

Rangoon was selected due to the availability of comprehensive strategic information that includes data from tracking surveys, service utilization surveys, and program data. As the organizations working in Rangoon are targeting female sex workers and their clients and men who have sex with men, these are the populations that are discussed in this report.

A workshop held in Rangoon, Burma from November 6th to 10th, 2006 offered a review of the available data and discussion into the implementation of the minimum package approach. The workshop was attended by representatives from USAID's Regional Development Mission/Asia, Population Services International, Medecins du Monde, Medecins Sans Frontieres, and MEASURE Evaluation. This report is the result of that meeting.

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1. Introduction to the Minimum Package Concept

Targeting Most-at-Risk Populations

The Southeast Asia Mekong region, which includes Burma, Cambodia, the Lao People's Republic, Thailand, Vietnam and parts of southern China, has been described as the epicenter of Asia's HIV/AIDS pandemic. Unprotected sex with sex workers and injecting drug use are the primary modes of transmission in the region, HIV prevalence has been found to be notably higher among men who have sex with men, and highly mobile populations across the region have contributed to the spread of HIV. As the HIV epidemic in the region remains concentrated in vulnerable groups in many areas, prevention measures targeted at these groups can have a strong impact in reducing the spread of the epidemic.

The populations identified as those at greatest risk of acquiring and transmitting HIV in the region are female sex workers (FSW) and their clients, intravenous drug users (IDU), and men who have sex with men (MSM). Box 1 contains a more detailed description of these risk groupings. While these behavioral groupings have been useful for targeting prevention interventions, not all high-risk individuals fit neatly into one category. There is overlapping risk among these groupings, and some individuals may practice multiple risk behaviors. For example, in some settings it may be common for FSW to sell sex in exchange for drugs. Likewise, IDU may buy or sell sex in exchange for drugs. In addition, not all individuals in a given group are at high risk of HIV. For example, MSM in a mutually monogamous relationship with an HIV-negative partner, or IDU who decrease injecting drug use and avoid using non-sterile equipment, are at much lower risk of HIV infection.

BOX 1 – DEFINING MOST-AT-RISK POPULATIONS

Female Sex Workers (FSW) and Clients — Sexual intercourse with multiple partners increases the risk of exposure and transmission of HIV. Female sex workers, operating on an economic incentive to have more sexual partners, are a critical population to address with HIV-prevention programs. In addition, the connection to large numbers of men in the general population acts as a bridge for the virus to enter other, less at-risk individuals, and further highlights the importance of prevention with FSW and their clients.

Injecting Drug Users (IDU) — Sharing injecting equipment with someone who is HIV-positive is the most efficient means of transmitting HIV, and HIV prevalence can rise rapidly after introduction of the virus into IDU communities. HIV transmission through sharing of equipment is augmented by sexual transmission both among IDU and between IDU and their non-IDU sexual partners.

Men who have Sex with Men (MSM) — Receptive anal sex carries a much higher risk of HIV transmission than vaginal sex, and since most MSM engage in anal sex, male-to-male sexual transmission is an issue of great importance to HIV prevention. This behavioral risk category includes those who self-identify under international terms such as "gay" or various indigenous labels, men who sell sex to other men (male sex workers), and men who consider themselves to be heterosexual but who engage in sexual activity with other men.

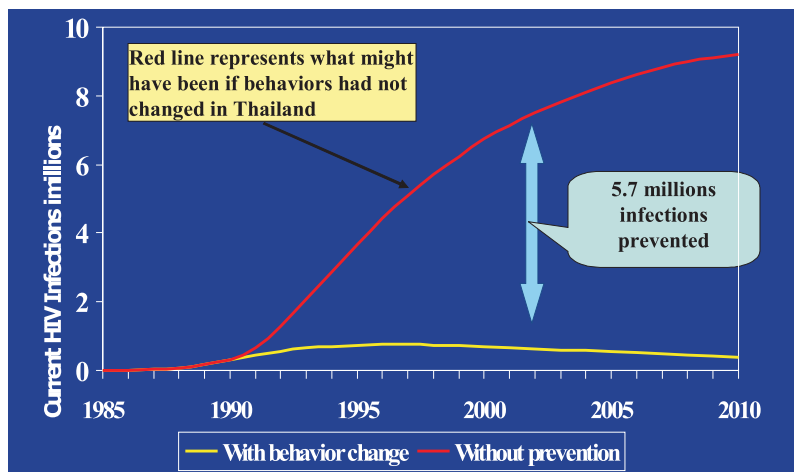
Source: Adapted from A framework for monitoring and evaluating national HIV prevention programs for Most-At-Risk Populations. UNAIDS 2007.

Focused Prevention

Changing HIV-related risk behaviors in most-at-risk populations is central to curtailing the epidemic's spread. Results from epidemic modeling indicate that focused prevention can and does work. In Thailand, the number of people living with HIV started to decline in the mid-1990s. This was largely due to the impact of the prevention programs put in place by Thai society. As figure 1.1 shows, in the absence of these efforts, HIV risk behavior (primarily unprotected sex in commercial encounters) would have continued, and Thailand would today have almost 6 million people living with HIV, roughly 15% of the adult population.

Figure 1.1 – The Impact of focused prevention in Thailand

Source: Tim Brown, East-West Center

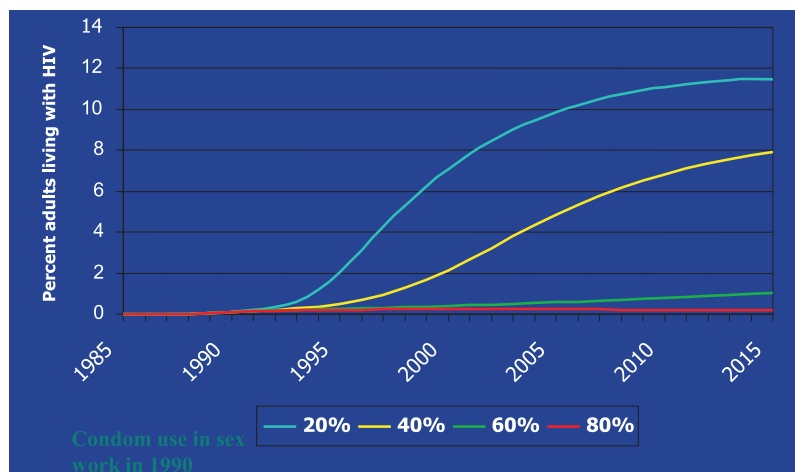


Maximizing Coverage

As can be seen in Figure 1.2, modeling of the epidemic in the region indicates that an increase in condom use in sex workers to 60% can prevent most new HIV infections in the population. The adoption of HIV prevention practices, however, requires reaching most-at-risk populations with effective interventions. These interventions must also be of sufficient quality and intensity to make a difference.

Figure 1.2 – High coverage is essential

Source: Tim Brown, East-West Center



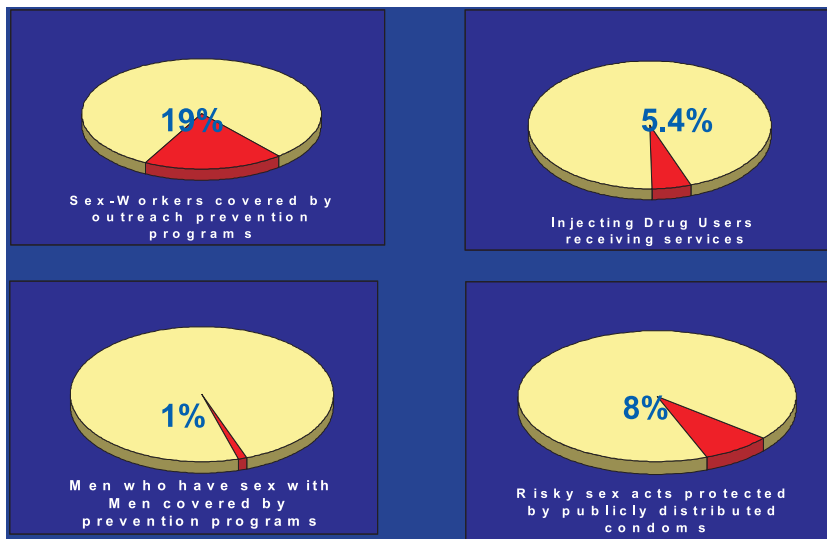
Current evidence indicates that coverage of most-at-risk populations across Southeast Asia is extremely low. Recent estimates indicate that fewer than one in five FSW are thought to be reached by effective HIV prevention interventions. The figures for IDU and MSM are much lower (see figure 1.3). Based on research conducted throughout the region, a lack of sufficient coverage for various high-risk populations prevents programs from having significant impact on the epidemic.

Key Point

There is a need to scale-up interventions rapidly and deliver interventions in targeted fashion where they are most likely to reach populations most-at-risk for HIV infection.

Figure 1.3 – Poor prevention coverage

Source: WHO, 2004

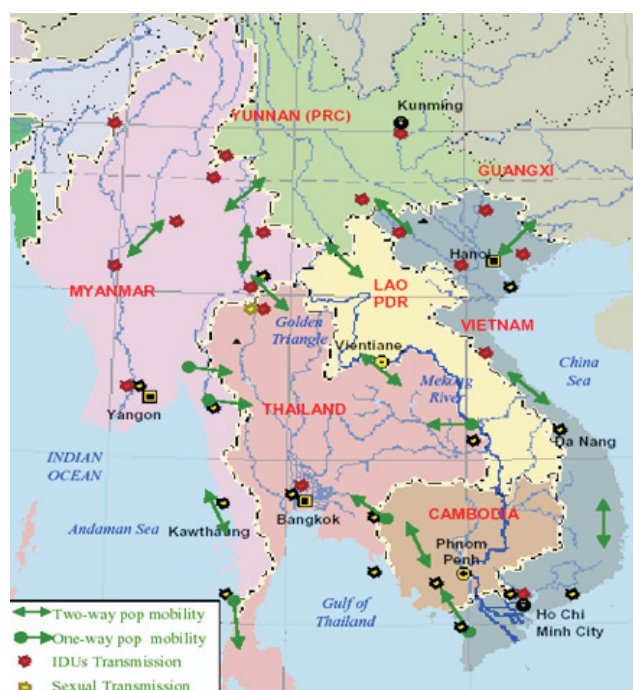


Targeting Hot Spots

For more strategic programming, HIV prevention interventions should target geographic areas or “hot spots,” where there is a convergence of risk behavior and where there are higher levels of HIV infection or potential for rapid spread of the virus. These are often urban areas, border towns, or other locations where larger concentrations of FSW, MSM, and IDU may be found. These hot spots are also often located in areas where populations are highly mobile – migrant workers and transportation drivers, for example – and are more likely to engage in sex work and other risky behaviors (see Figure 1.4). Rather than aiming to achieve national coverage, a program concerned with effectively allocating scarce prevention resources may aim instead to achieve coverage of these hot spots.

Figure 1.4 – Hot Spots in the Southeast Asia Mekong region.

Source: USAID Regional Development Mission/Asia, 2006

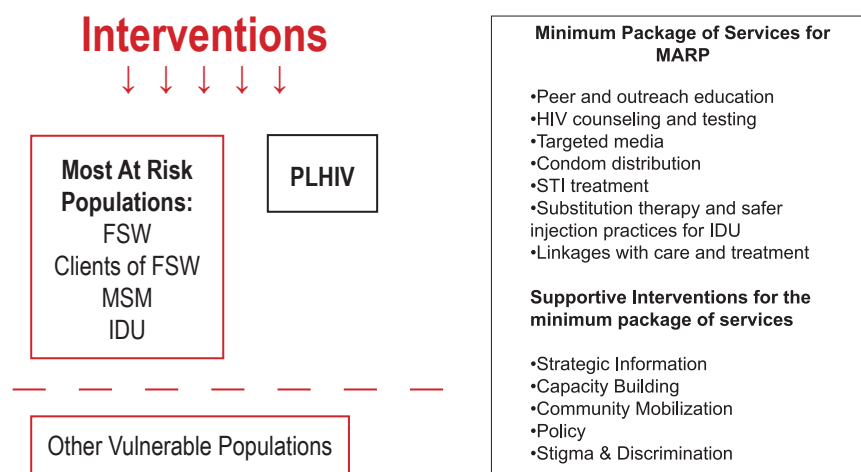


Packaging Effective Interventions

In order to more effectively program HIV prevention, care and treatment interventions, USAID and its partners are developing and implementing a minimum package approach in the Mekong region (see Figure 1.5). With a minimum package approach, a set of interventions is identified and implemented in a coordinated fashion. The mix of interventions in the minimum package depends upon the targeted population and includes components of prevention, care and treatment, though the primary emphasis is likely to be prevention.

Figure 1.5 – A Minimum Package of Services

Source: USAID Regional Development Mission/Asia, 2006



It is not expected that one organization or government/donor agency will provide all components of the package. Rather, through coordination of efforts across agencies, donors, and implementing partners, all components will be implemented at the site for the target population. In addition, links between components will ensure that the prevention needs of the target population are met. Strong links with HIV treatment and care services are also important so that people who are HIV-positive can be receive the additional services they need.

Box 2 describes the core services within the minimum package in more detail. There are five key services for FSW, MSM and their clients, with a sixth (promoting reduced unsafe injection practices) added for IDU. The combination of these services is designed to support the adoption of HIV prevention practices including reducing unprotected sex and unsafe injection practices. The package also includes linkages with treatment and care services for persons living with HIV (PLHIV). Supportive interventions that facilitate the successful implementation of these services includes efforts to reduce stigma and discrimination, improve policies and the legal environment, and mobilize the community.

**BOX 2 – COMPONENTS OF A MINIMUM PACKAGE
OF HIV-PREVENTION SERVICES FOR MOST-AT-RISK POPULATIONS (MARP) ¹**

Peer Outreach and Education	Provision of HIV/AIDS information through interaction with the target population. Includes peer outreach, special events, large-group and small-group community events, hot lines, drop-in centers, and interactive Internet chat rooms.
Mass media	Provision of HIV/AIDS information through media (e.g. television, videos, radio shows, print materials, billboards, and websites) specifically targeted to MARP.
Condom distribution	Condom distribution or marketing that is either geographically targeted or branded for MARP. This also includes distribution and marketing of female condoms and lubrication.
HIV counseling and testing	HIV testing that includes counseling at the time that the results are given to clients.
STI treatment	Includes STI screening and/or diagnosis and treatment by medically trained staff.
Substitution therapy and safer injection practices for IDU ²	Safer injection practices, bleach, methadone and other substitution therapies
Linkages with care, support and treatment	Linkages and/or referrals to care, support and treatment services for persons living with HIV. This includes antiretroviral therapy (ART), non-ART medical care, prevention of mother-to-child transmission, psycho-social support and economic support.

¹ Since the preparation of this report, “Prevention with Positives” has been added as an additional component in the minimum package. This component includes those interventions that address the HIV prevention needs of HIV positive persons.

² Though non-U.S. government stakeholders provide needle exchange as part of the minimum package of services for IDU, USAID does not support nor promote needle exchange programs.

Source: MEASURE Evaluation and IPSR, Coverage-Plus Multi-Country Report

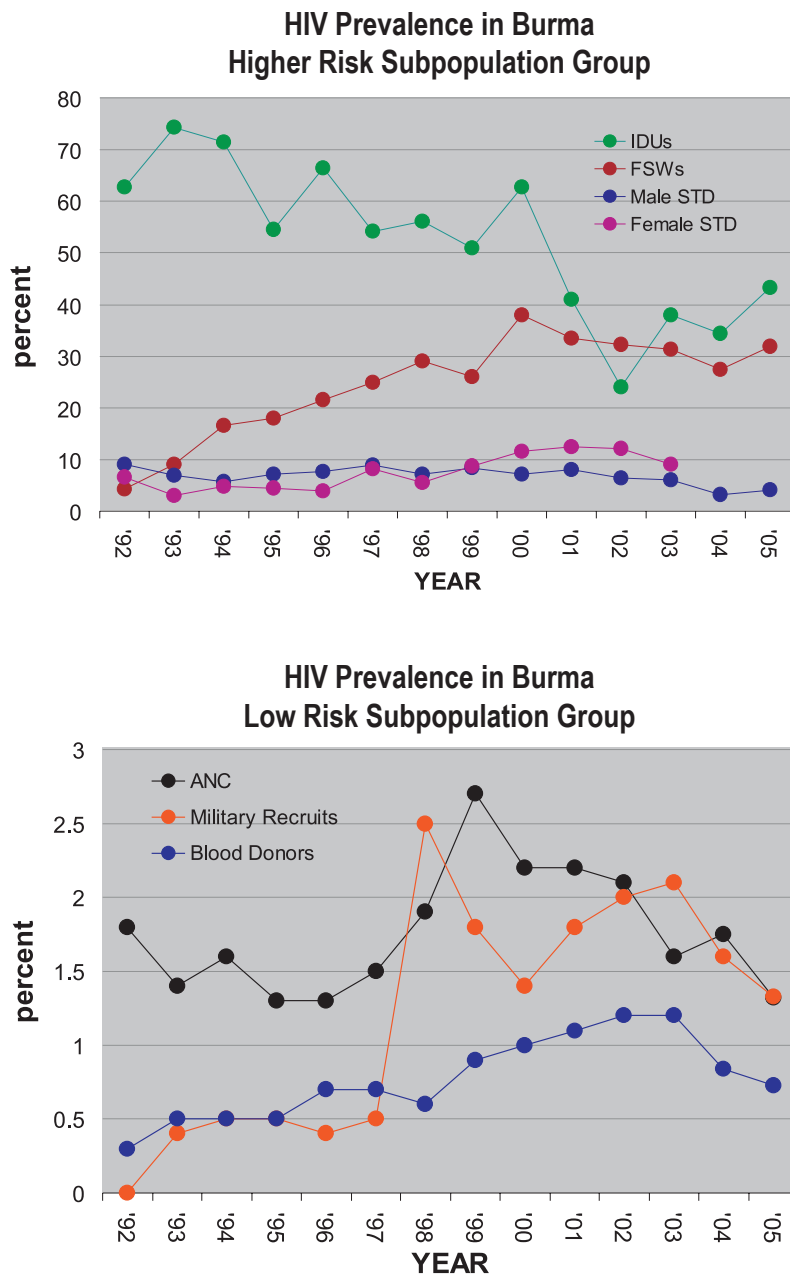
2. Implementation of the Minimum Package in Rangoon

Country HIV Situation

The spread of HIV across Burma varies widely in different geographic regions and among population subgroups. Official sero-prevalence data suggest a slight downward trend in HIV prevalence among low-risk groups (pregnant women attending ante-natal clinics, military recruits, and blood donors) in recent years (see figure 2.1). Reported prevalence in ante-natal clinics declined from a high of 2.7% in 1999 to 1.3% in 2005. Prevalence estimates among high-risk groups are generally considered less reliable. The available data, however, indicate that HIV prevalence among female sex workers has been relatively stable, at around 32%, since 2001. Estimates for MSM are not available. Prevalence among all groups is generally higher in Mandalay and in the north and east of the country than in the Rangoon area.

Figure 2.1

Source: National AIDS Program/Burma



Key Point

Five “hot spots” in Burma were chosen for focused interventions based on their concentration of higher risk populations and the potential for spread of HIV. The potential for building a minimum package of services was also considered based on implementing partner, government, and donor activities.

Of these sites, Rangoon was selected as the focus of this report due to the availability of comprehensive strategic information that allows for an assessment of the implementation of the minimum package. This information includes data from tracking surveys, service utilization surveys, and program data.

The great majority of new HIV infections are thought to be occurring among clients of FSW and, secondarily, among the FSW themselves. More than 40% of mobile working class males report having paid for sex in the last six months, and close to 30% report having done so in the last month. Injecting-drug use continues to be associated with very high risk of HIV, especially in the north and east of the country. Local experts are becoming increasingly aware that male-to-male sexual activity is much more prevalent than was previously thought.

While solid data are lacking, the National AIDS Program (NAP) estimates that there may be 40,000 FSW and 272,000 MSM in the country. While the NAP’s estimate of the number of FSW is probably reasonably accurate, the estimate for the number of MSM is probably less so, since this population subgroup is more difficult to define. Surveys among mobile working class males, however, suggest that 11%-13% had ever had sex with another man. Organizations working with IDU have estimated that there may be as many as 200,000 nationwide. The NAP also estimates that there are 1.1 million clients of sex workers.

Rangoon’s Minimum Package

The minimum package approached in Burma has evolved over time. Population Services International (PSI) is the largest international non-governmental organization (iNGO) providing HIV services targeted to MSM, FSW and clients of sex workers in Rangoon. The PSI program began more than 10 years ago, when funding was minimal, and its focus was on condom sales and promotion with only limited communication activities. Communication activities were scaled-up a few years later, first through outreach workers focusing on occupational groups (“clients of sex workers”) and subsequently through mass media and interpersonal communication (IPC) programs. IPC programs were intensified by recruiting peer outreach workers for FSW and MSM. The Targeted Outreach Program (TOP) was later established, and it includes peer educators and drop-in centers that provide recreational activities in addition to intensive outreach for behavior change and services for sexually transmitted infections (STI) and voluntary counseling and testing (VCT) services.

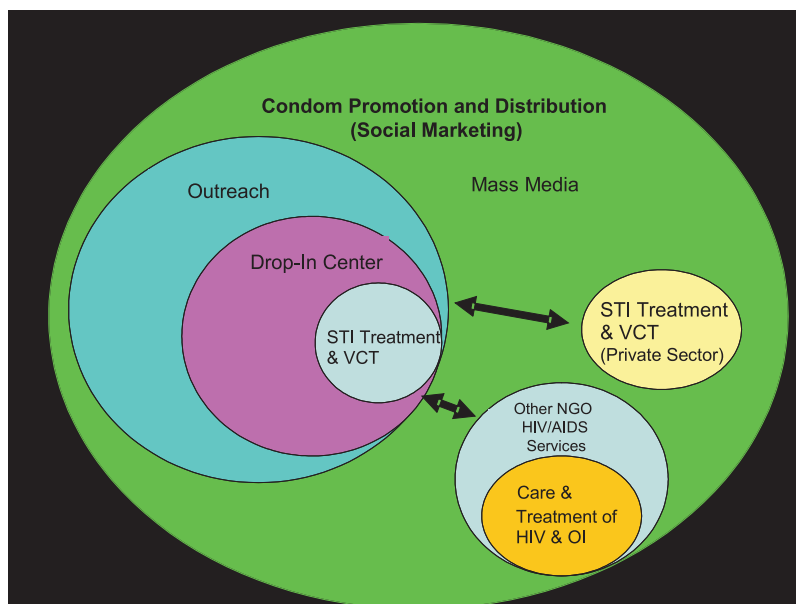
Key Point

Broad mass media efforts through TV commercials, billboards and other channels increased awareness of HIV and reduced stigma among the general population. This, in turn, facilitated a further expansion of outreach programs and a greater acceptance of HIV prevention interventions by the targeted communities. MARP become more willing to participate in community outreach activities and seek HIV-related services such as VCT.

Other organizations also provide components of the minimum package for MARP in Rangoon and at other sites in Burma. Medecins Sans Frontiers (MSF) provides STI treatment in brothels and supports treatment of FSW at STI clinics. The organization operates 22 clinics (five in Rangoon) that provide reproductive health services, STI treatment, VCT, and antiretroviral therapy. At the clinics in Rangoon, about 40% of the women report that they are sex workers. Medecins du Monde (MDM) targets services to FSW, MSM and IDU. IDUs are targeted in areas outside of Rangoon, and needle-exchange programs for IDUs are not a part of USAID-funded programs. The organization uses IEC to encourage referral to clinics for services, including care and treatment for persons living with HIV and AIDS, STI treatment, and VCT. MDM also conducts outreach in brothels and other locations and is exploring a peer-network approach as a more cost-effective outreach strategy.

Figure 2.2 demonstrates how the minimum package has been implemented in Rangoon within a broader social-marketing program. Targeted sales of condoms and water-based lubricants support the adoption of safer behaviors by all high-risk groups. Outreach and mass media target clients of sex workers with HIV prevention and risk reduction information to promote safer behaviors, while drop-in centers and community outreach empower FSW and MSM to reduce their risk. STI and VCT services are also provided within drop-in centers. The PSI strategy is further strengthened through links with other NGOs that also provide STI treatment and VCT services as well as care and treatment for persons living with HIV and AIDS.

Figure 2.2 – The minimum package in Burma



3. Reach of HIV-Prevention Services in Rangoon

Mass Media and Condom Promotion

Surveys among MSM, FSW, and mobile male occupational groups conducted in 2006 measured the reach of Rangoon’s program. Results indicate that HIV/AIDS messages through mass media channels reached almost all members of the surveyed groups (see Figure 3.1). PSI-branded mass media messages reach a large proportion of target populations via television, billboards, videos, and journals. For example, more than one-half of MSM and FSW surveyed had watched the PSI TV series, “Me Hmaung Thaw Alin” about HIV/AIDS, and one-third of men in mobile male occupational groups reported watching the series. Of all target groups, 80% - 90% reported seeing PSIs condom-promotion advertisements on television, journals, and billboards.

Access to condoms is nearly universal; almost all MSM, FSW, and mobile male occupational groups report that condoms are easily accessible (see Figure 3.1). Over the past four years, the number of retail outlets that carry condoms and water-based lubricants has doubled. This improved access to condoms is the result of increases in the number of traditional outlets, such as pharmacies, street vendors, and grocery stores, as well as in non-traditional outlets, such as brothels and massage parlors. While all of these outlets sell male condoms and lubricants, currently only select outlets near sex-worker venues sell female condoms. However, since the launch of lubricant and female condoms in 2003, lubricant sales have increased more than five-fold, and sales for female condom have increased more than six-fold. Male condom sales have steadily increased over time. Figure 3.2 shows the trend in product sales over the last four years for male condoms, water-based lubricant, and female condoms.

Figure 3.1 – Coverage of Mass Media and Condom Promotion Activities in Rangoon

Source: PSI/Burma

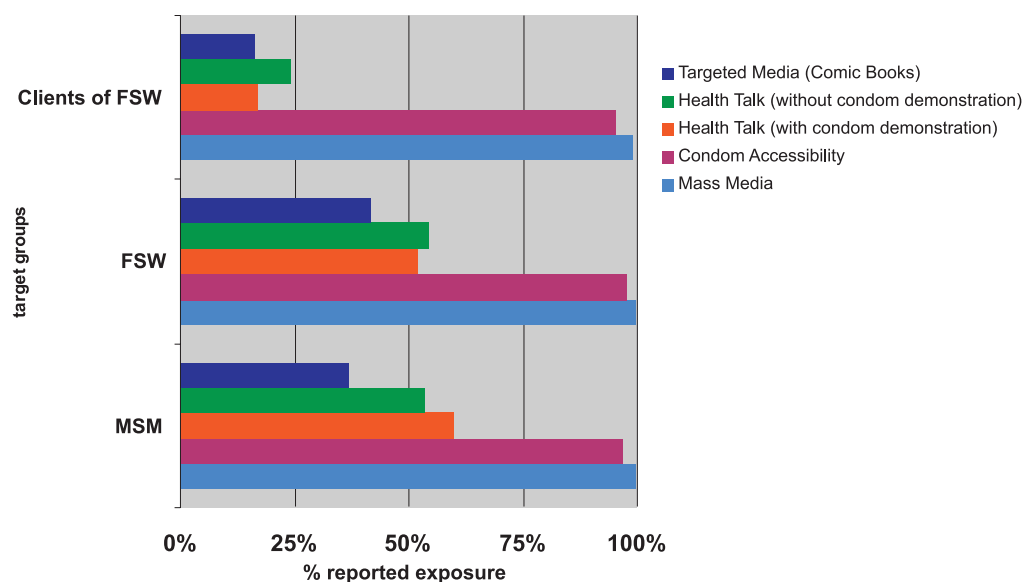
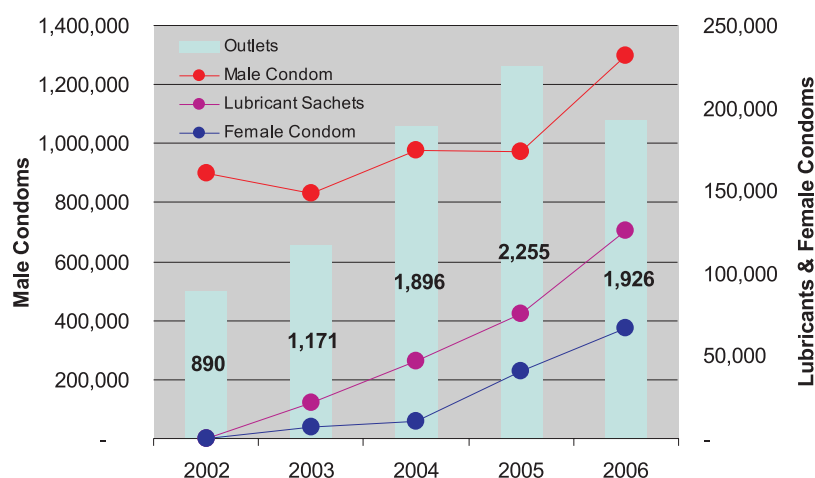


Figure 3.2 – Yearly Product Retail Sales and Outlets in Rangoon

Source: PSI/Burma



Peer Outreach and Education

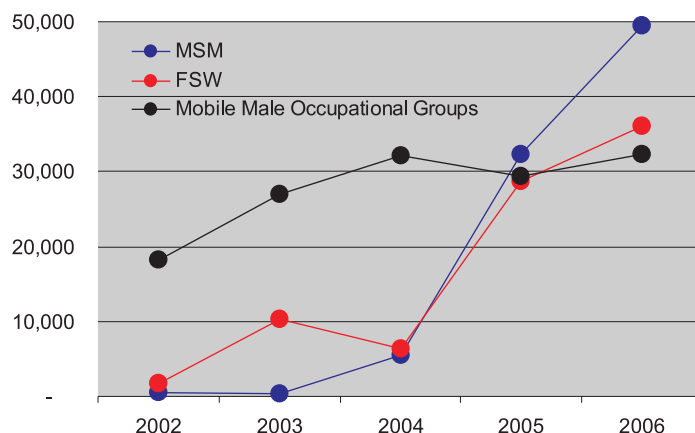
Peer outreach and education occurs both in the community and at the drop-in centers through one-on-one counseling as well as within small- and large-group activities. The influence of PSI’s expansion of TOP activities and the recruitment of additional peer educators can be seen in the large increase in outreach contacts for FSW, MSM, and mobile male occupational groups in Rangoon between 2002 and 2006. As seen in Figure 3.3, the number of outreach contacts for FSW increased 18-fold, contacts with MSM increased nearly 100-fold, and contacts with high-risk men nearly doubled. Drop-in center registrations have increased substantially since the facilities opened. Service statistics show that between 2004 and 2005, FSW registrations more than tripled, and MSM registrations increased more than 13-fold. This growth continued in 2005 and 2006 (see Figure 3.4).

Key Point

Extensive mass media and condom-promotion activities have contributed to a greater awareness of HIV and acceptance of outreach and other behavior-change interventions. This more supportive environment has enabled the expansion of outreach activities and the achievement of broad coverage of the target populations.

Figure 3.3 – Yearly Outreach Contacts in Rangoon

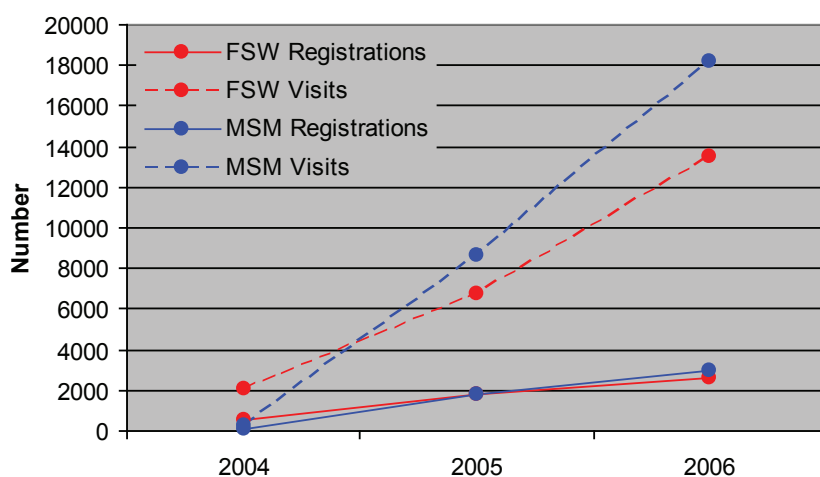
Source: PSI/Burma & MDM (for Rangoon)



The large increases in outreach contacts and drop-in-center registrations is encouraging. Data from the population surveys reveal success in achieving coverage of the target population with these interventions. Sixty percent of MSM surveyed said they had taken part in a condom demonstration, and more than half reported attending an HIV/AIDS talk. The majority of MSM surveyed said they had visited the drop-in-center in the last 12 months. Similarly, more than one-half of FSW said they had participated in a condom demonstration, and a similar proportion reported receiving an HIV/AIDS talk. Fewer men in mobile occupational groups, however, reported participating in a condom demonstration (one in six) and HIV/AIDS presentation (one in four). The size of this population makes achieving a high level of coverage with outreach activities more difficult.

Figure 3.4 – Yearly Registrations and Visits to PSI’s FSW and MSM Drop-in Centers in Rangoon

Source: PSI/Burma



While service contacts have increased, figures are only meaningful when evaluated within the context of target population size. The number of contacts is a good indicator of the volume of services provided, but most MSM and FSW have multiple contacts during any given time period. PSI estimates that there are approximately twice as many outreach contacts as there are persons contacted through outreach. Using these rough figures, all reachable FSW and two-thirds of reachable MSM have received outreach in the past year. Only a small proportion of clients of sex workers have received similar services (Figure 3.5).

FIGURE 3.5 – ESTIMATED COVERAGE OF OUTREACH ACTIVITIES (INCLUDES COMMUNITY OUTREACH, ATTENDANCE AT COMMUNITY EVENTS, AND VISITS TO DROP-IN CENTERS)

Target population	Estimated population size	Estimated number of persons reached	Estimated coverage
FSW	15,000 reachable ¹	15,000	100%
MSM	30,000 reachable	20,000	66%
Clients of sex workers	500,000 ²	27,000	5%

¹ reachable is defined as the FSW and MSM who would admit to sex work or male-male sexual behavior to their peers or to outreach workers
² Population in Rangoon 4 million x 50% male x 50% (15 – 49) x 50% (reported paid sex) = 0.5 million

Source: PSI/Burma

Targeted Media

Targeted media campaigns are implemented in both mass media channels and interpersonal channels. Behavior-change messages related to HIV prevention and condom promotion are advertised on television, journals, billboards, and also from video shows of mobile video units. Nearly all members of target populations have been exposed to mass media messages. At the interpersonal level cartoon booklets produced for sex workers and their clients are distributed to the target populations.

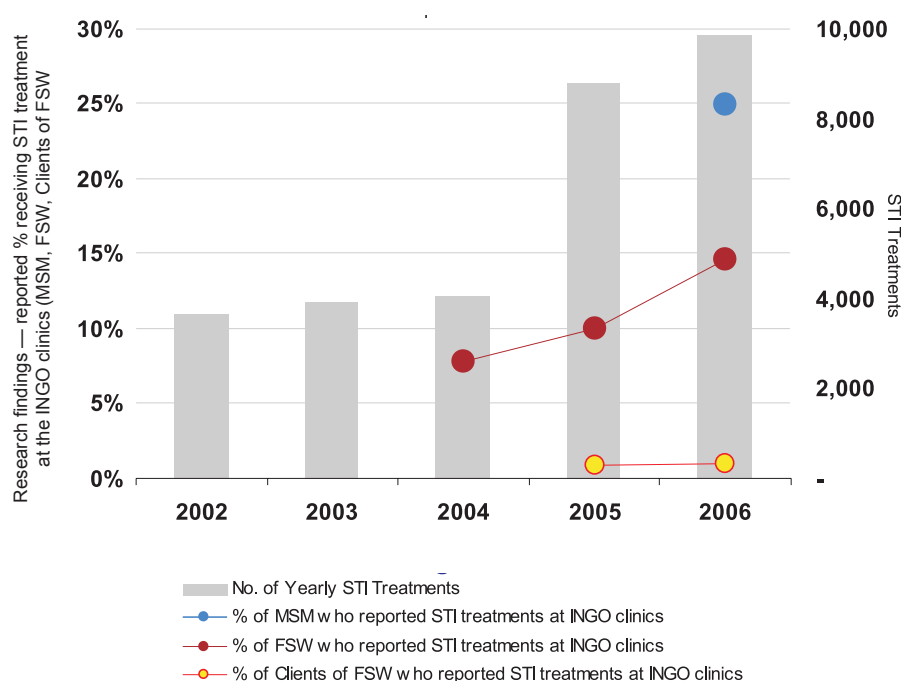
Of the populations surveyed, almost one-half of FSW indicate that they had read these comic books in the past six months; few sex worker clients (one in six) said the same. Although no comic books were designed especially for MSM, over one-third of MSM reported reading books designed for the other two target populations.

VCT and STI Services

Facility-based services, including STI services and voluntary HIV counseling and testing (VCT) are available through free-standing iNGO clinics, at the MSM and FSW drop-in-centers, and through private sector providers. MDM and MSF operate several clinics located throughout Rangoon, offering a range of clinical services including STI and VCT services. As a complement to these efforts, PSI offers laboratory-based STI treatment and VCT services at its drop-in-centers for MSM and FSW, and works with general practitioners who are members of its SUN Quality Health Clinic network in Rangoon to provide syndromic STI treatment.

Figure 3.6 – Yearly STI Treatment at INGO clinics in Rangoon Service Utilization and Coverage Data

Source: PSI/Burma, MSF/H, MDM ; MSM were included in the tracking survey from 2006 only.



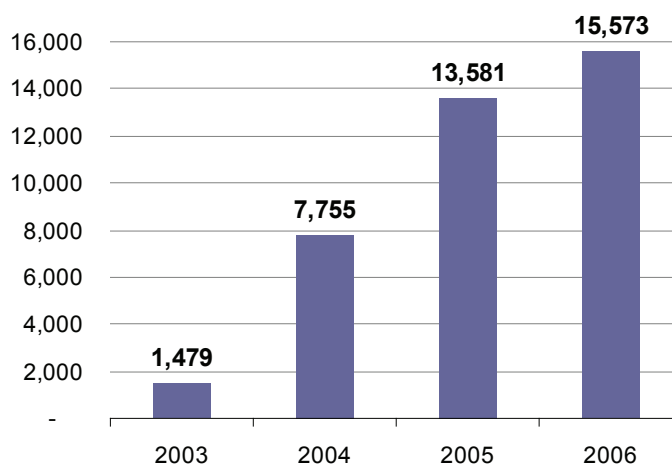
As a result of multiple organizations making STI services available, iNGO clinics provided almost 10,000 STI services for FSW and MSM in 2006. This is a two-fold increase since 2002 (see Figure 3.6). There were also an additional 40,000 STI consultations with iNGO trained providers through PSI's partnership with private-sector clinics. Many of these

consultations were likely to be with male clients of sex workers and other STI clients at higher risk for HIV. Findings from population surveys indicate that one in seven FSW and one in four MSM surveyed sought STI treatment at an iNGO clinic in the past year. Few men in mobile occupational groups surveyed reported seeking STI treatment. The survey did not capture STI consultations in the private sector. While this expansion of high-quality iNGO services is encouraging, the majority of MSM and FSW still resort to shops and pharmacies for self-treatment unless they perceive their symptoms to be particularly serious or persistent.

In 2006, there were more than 15,000 HIV counseling and testing sessions at iNGO clinics. (see Figure 3.7) Private VCT services for FSW and MSM were incorporated into the drop-in-centers and stand-alone sites for general population were also opened.

Figure 3.7 – Yearly VCT Sessions at INGO VCT Centres in Rangoon

Source: PSI/Burma, MSF/H, MDM



Key Point

Drop-in centers provide a safe place for FSW and MSM to seek STI and VCT services. High-quality services are also available at several iNGO-run clinics. The availability of quality and MARP-friendly services has resulted in an increase in service use. Outreach efforts reaching the majority of target populations also support the use of these services.

4. Quality & Intensity of Use of the Minimum Package

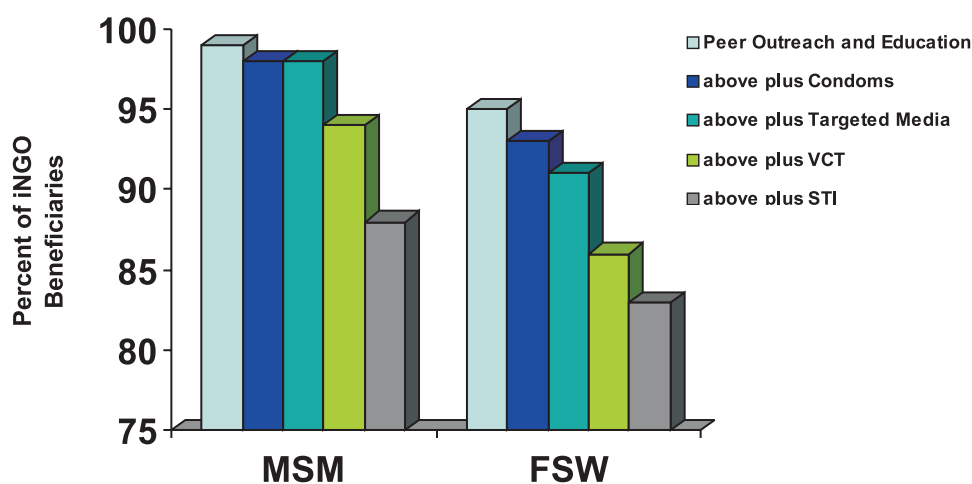
Use of a Package of Services

While it is important to consider whether the target population has been reached by individual components of the minimum package, it is also useful to assess whether individuals have received a complete package of interventions. Several organizations provide HIV prevention-and-care services to FSW, MSM, and high-risk men in Rangoon. PSI, the largest of the iNGOs, provides all components of the minimum package, while organizations such as MDM and MSF are major providers of clinical services. Ideally, the target population has access to all components of the minimum package through contact with these organizations.

Surveys of MSM and FSW who have had direct contact with these iNGO program (referred to here as program beneficiaries) indicate that most receive all targeted components of the minimum package. Peer outreach is the entry point for almost of the program beneficiaries and is the service most people receive. The majority of these MSM and FSW have received condoms directly distributed by program staff and targeted mass media through direct contact with the program, as well as HIV counseling and testing and STI consultations from iNGO-run clinics (see Figure 4.1).

Figure 4.1 – Most iNGO program beneficiaries in Rangoon use multiple targeted components of the minimum package

Source: MEASURE Evaluation & Mahidol University, 2006



Key Point

Most FSW and MSM who have been reached by iNGO programs receive multiple targeted components of the minimum package including peer outreach and education, direct condom promotion, targeted media, VCT and STI services. This indicates that there are few missed opportunities to provide program beneficiaries with the complement of effective HIV prevention interventions.

Use of Services from Multiple Organizations

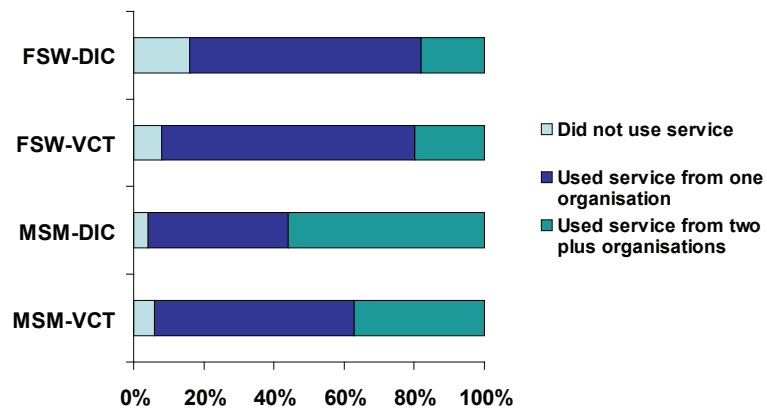
Surveys of program beneficiaries also indicate that beneficiaries of one organization freely use the services of another. Program beneficiaries may use the same services from two different organizations or use different services. For example, an MSM may visit drop-in centers operated by different organizations. Alternatively, an FSW may use VCT services

provided by one organization and visit the drop-in center of another (see Figure 4.2).

Most beneficiaries are informed about the availability of services from other organizations when they come into contact with peer-outreach workers. This communication increases beneficiaries' access to a complementary range of HIV-prevention services and gives them more options where they can receive these services.

Figure 4.2 – Many iNGO Program Beneficiaries use the Same Service from More than One Organization

Source: MEASURE Evaluation & Mahidol University, IPSR

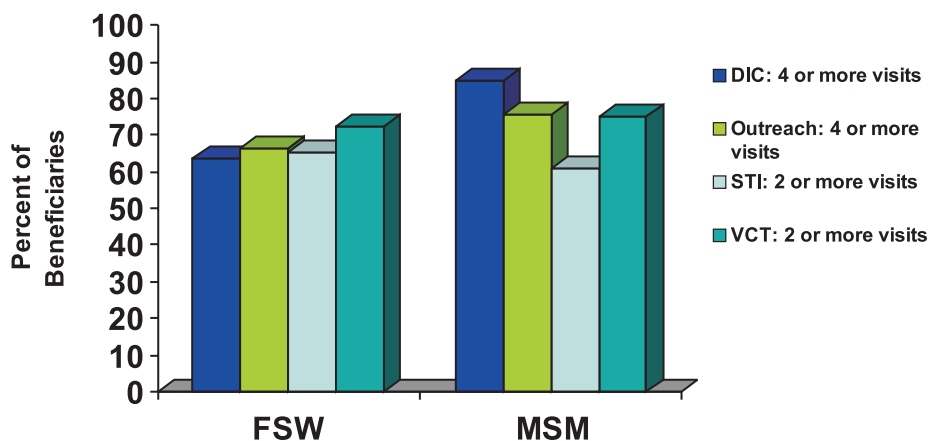


Intensity of Service Use

With several organizations providing outreach in communities, more than one drop-in center for MSM and FSW populations, and several organizations offering STI and VCT services, MSM and FSW who have been reached appear to receive intensive services. As seen in Figure 4.3, roughly two-thirds of MSM and FSW who have been in contact with iNGO programs have received four or more outreach contacts in the last year, made four or more visits to the drop-in center, or had two or more visits to an STI or VCT clinic.

Figure 4.3 – INGO Program Beneficiaries' Intensity of Service Use in Last Year

Source: MEASURE Evaluation & Mahidol University 2006.



Key Point

The availability of multiple targeted components of the minimum package at one site and the involvement of more than one organization contribute to the high intensity of service use seen among program beneficiaries in Rangoon.

5. Achieving Behavior Change

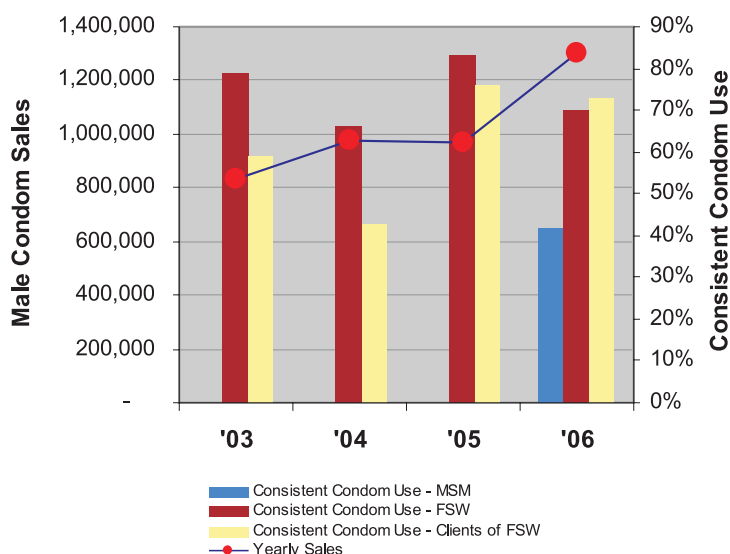
Levels of Condom Use

Over the past several years, there has been scale-up of HIV-prevention interventions in Rangoon, and a large proportion of the target populations are reached by the minimum package. To determine whether most-at-risk populations have adopted risk reduction behaviors, implementing partners annually track behaviors such as condom use.

Four years of trend data were available for FSW and their clients (see Figure 5.1). Between 2003 and 2006, rates of condom use among FSW fluctuated, with levels in 2006 similar to those in 2003. Consistent condom use was already very high in 2003, with nearly 80% of FSW reporting that they used a condom with all clients in the past week. With condom use already at such a high level, it may be difficult to achieve further increases, even with a substantial scale-up in program efforts. However, there has been progress in the past four years in increasing consistent condom use among men identified as clients of sex workers.

Figure 5.1 – Availability and Use of Male Condoms in Rangoon

Source: PSI Burma; MSM were included in the tracking survey from 2006 only.

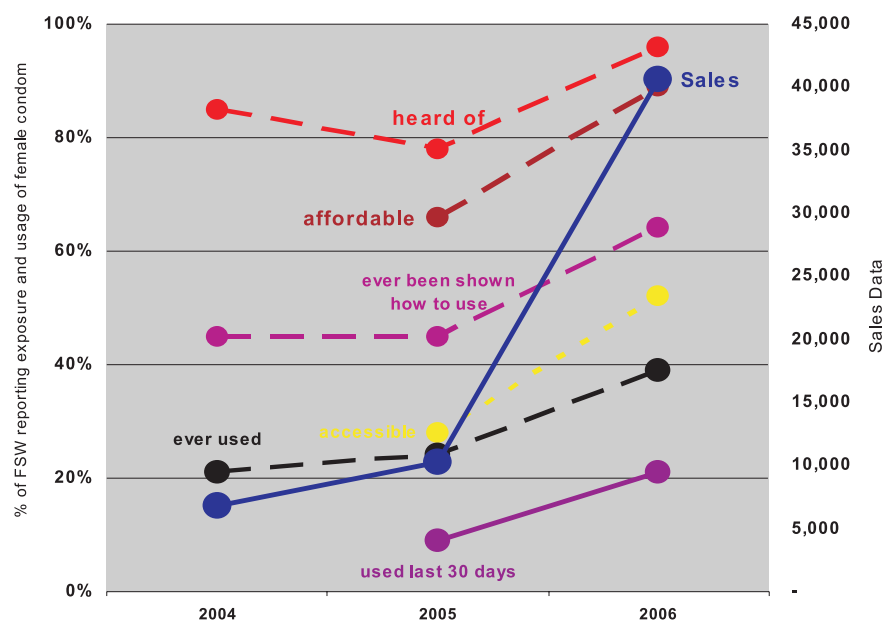


While no trend data are available for condom use among MSM, less than one-half of men reported consistent condom use in 2006.

Because male condoms have been promoted for several years and condom use has been high among sex workers for quite some time, it may be more useful to look at the adoption of female condoms which have been more recently introduced. Since the introduction of female condoms in 2004, sales have increased dramatically. With increases in FSW knowledge about female condoms, improved access, and improved perceptions of affordability, use has steadily increased. (see Figure 5.2).

Figure 5.2 – Female Condom Sales, Exposure and Usage (within Rangoon)

Source: PSI Burma



Focus on Non-penetrative Sex

Multiple messages for reducing HIV risk have been an important component of the minimum package. In addition to condom use, PSI has encouraged the practice of non-penetrative sex among FSW and MSM since 2005. Messages stress that sexual satisfaction can be achieved without penetration or the exchange of bodily fluids between partners. This strategy is one many FSW have used in the past, offering “fast sex acts” to their partners. PSI’s outreach team works to improve knowledge about non-penetrative sex and encourage FSW to use a non-penetrative strategy with clients who refuse to use condoms. In the anonymous monitoring done at the drop-in centers, FSW reported 32% of all sex acts were non-penetrative. Results from the 2006 population surveys show that 12% of males identified as sex worker clients reported having at least one instance of non-penetrative sex out of their last five sex acts with sex workers. Two-thirds of MSM who engage in sex work reported engaging in non-penetrative sex with one-time clients in the past 30 days.

Linking Intensity of Exposure to the Minimum package and Condom Use

An analysis of the 2006 survey data was undertaken to determine whether exposure to multiple components of the minimum package was associated with greater levels of consistent male condom use among MSM, FSW, and clients.

For MSM, exposure to peer outreach and education activities, in addition to mass media and condom promotion activities (core elements of the minimum package), was significantly associated with greater use of condoms as compared to exposure to mass media and condom social marketing activities only (see Figure 5.3). MSM who participated in two outreach activities, or who used the drop-in-center, were more likely to consistently use condoms than MSM who did not. While the data did not allow for a more detailed analysis, many MSM who visit the drop-in-center also appear to access STI and VCT services. Thus, exposure to multiple components of the minimum package is associated with greater use of condoms among MSM.

For FSW, there was a small but insignificant increase in consistent condom use in FSW

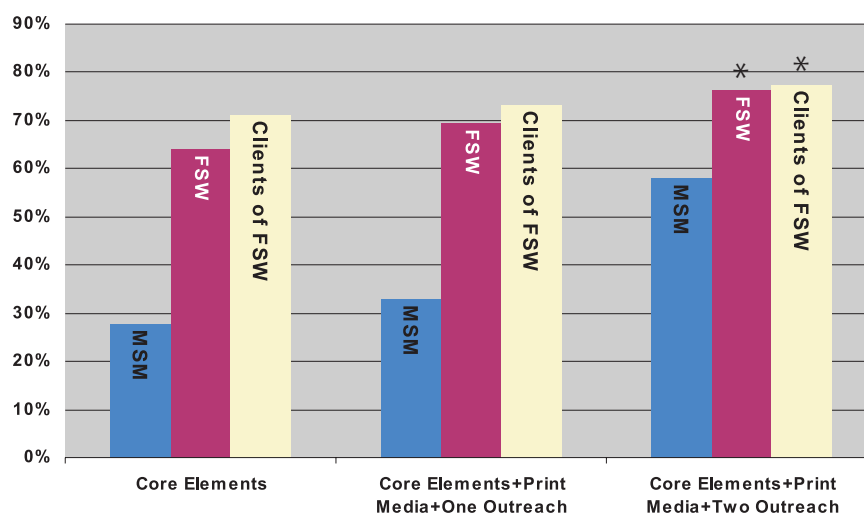
with a high level of exposure (two contacts with interpersonal communications staff or peer educators, or receiving targeted media) compared to FSW without exposure to peer outreach and education activities. If participation in the TOP drop-in center had been measured during the 2006 study of FSW, a stronger correlation may have been detected between exposure and consistent condom use.

No association was found between exposure to outreach and education activities for sex-worker clients, whose consistent condom use is already high with exposure to core elements alone. This is logical given that those core elements, condom social marketing and mass media, provide basic knowledge for behavior change for all populations. Additional elements, printed media and outreach, may become important for further incremental change.

Figure 5.3 – Percentage of Target Population’s Consistent Condom Use by Exposure to Elements of Minimum Package

Core elements are male condom accessibility and mass media

* Statistically significant association between exposure to program activities & consistent condom use



Key Point

Greater exposure to peer outreach and education activities had an impact on consistent condom use among MSM and, to a lesser extent, FSW. As condom use is already at a mature point, it is difficult to achieve additional positive trends among FSW. Efforts are however needed to maintain this level. Additional elements of the minimum package may also be needed to create incremental changes in this behavior.

Conclusion

Achieving Results in Rangoon

In the Mekong region, coverage of HIV prevention interventions among most-at-risk populations is still low. A more strategic approach to implementing a minimum package of HIV-prevention services to those most-at-risk is needed. In Rangoon, one of the hot spots for USAID-funded programs in Burma, years of implementation of the minimum package has resulted in broader coverage of the target population. In addition to the high exposure to mass media and condom social marketing activities, high utilization of services such as drop-in centers, STI services, and VCT has occurred. In fact, the majority of most-at-risk populations in Rangoon who have been reached, have been reached with multiple components of the minimum package. Behavior change among the target populations has been found to be correlated with exposure to the program activities.

Coordination and Collaboration

Partnerships between NGOs involved in delivering HIV services should be considered as key to the success of the program in Burma. The organizations collectively play a role in achieving the minimum package rather than operating autonomously. This results in a functional packaging of services where all elements are available and linkages between organizations insure that beneficiaries of one organization can also access services of another. Mechanisms for collaboration can be either formal or informal. Examples include an MSM working group that meets on a regular basis, outreach staff that spend time in the drop-in centers of other organizations, visits by staff to other clinics as part of training, creation of a network of referral for clinical services, and maps and lists of available services.

Sequencing and Nesting

The minimum package of targeted services includes mass media and social marketing. This core component achieves an initial level of behavior change. These efforts also create trust in the product and the organization providing the product, and facilitates the introduction of other interventions. Establishing safe places, such as drop-in centers, empowers these populations to demand their rights and access needed services. Targeted services, including peer outreach and education, STI screening and treatment, and VCT are then provided within this context of safety.

Added Value of the Minimum Package

Condom use among high-risk populations (and FSW in particular) has been relatively high in Burma for several years and is likely a result of the strong condom-promotion program. With this behavior at a mature point, it will be difficult to see additional positive trends. More elements of the minimum package may, however, be needed for incremental changes in behavior. With intensive efforts focusing on these populations including outreach and the creation of safe places to discuss condom negotiation, and the adoption of other safer behaviors, it would be irresponsible not to offer VCT and STI services. Integrating services within a minimum-package approach results in wider coverage of target groups, and higher utilizations of the services can be achieved. The minimum-package approach is a strategy that can be adapted into most ongoing HIV-prevention programs and is sustainable in the long term.

Appendix

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HIV/AIDS Follow-Up Tracking Survey: High-Risk Men from Rangoon, Mandalay, Lashio, and Myitkyina, Burma, January 2006, PSI/Burma

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