

Investing for Impact

From Resources to Results: Getting to Zero in Myanmar

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INVESTING IN AIDS – MYANMAR’S CASE

Through sustained prevention efforts among high-risk populations and a scale-up of treatment and care, since 2007, Myanmar has witnessed a decline in HIV prevalence among all key populations—female sex workers and their clients, people who inject drugs, and men who have sex with men. This was achieved largely without access to the substantial resources that have been available to other countries in the region to fund their responses to HIV and AIDS.

However, with an estimated 189,000 people living with HIV (PLHIV) and another 7,000 expected to be infected this year, Myanmar needs to continue to invest *now* in scaling up HIV prevention and treatment in order to achieve the Three Zeros: Zero New Infections, Zero AIDS-related Deaths, and Zero Discrimination.

Myanmar has secured substantial commitments from the Global Fund and other donors to finance the response until 2016. But even with these commitments, there remains unmet need particularly in area of harm reduction for people who inject drugs, and there is concern about how the response will be sustained post-2016, when the current funds run out. Major donors, such as the 3MDG fund (formerly the 3 Diseases Fund) are already beginning to scale back their contributions. Facing an unpredictable resource scenario, Myanmar needs to advocate for adequate funding of the HIV response and design a cost-effective, sustainable response that delivers enhanced coverage and greater value for money.

In the current climate of reform in Myanmar, there is a unique opportunity to put in place high-impact interventions, reduce inefficiencies and reallocate scarce resources to ensure maximum benefit for the people most affected by and vulnerable to HIV and AIDS. Political commitment to HIV and health in Myanmar is increasing. This commitment is already reflected in increasing health expenditures as a proportion of the GDP from 0.9% in 2010 by 1% a year, with a target of 5% by 2015.

This investment case:

- Considers the future trajectories of the epidemic in Myanmar,
- Identifies the mix and scale of strategies and interventions that will have maximum impact in Myanmar’s context,
- Calculates the resources needed, and
- Presents various resource and coverage scenarios, and their implications,

to demonstrate that, with predictable and sustainable financial flows, Myanmar can achieve substantial reductions in HIV incidence *and* AIDS-related mortality by 2020.

Getting to zero in Myanmar requires the right strategies which will have greatest impact

Maintain the focus on interventions for high-risk populations

Provide prevention services to 7,000 high risk MSM – cut 50% new infections among this group

Scale-up harm reduction for PWID – avert more new infection than any other interventions

Put 106,000 PLHIV on ARV treatment by 2016 – cut 50% AIDS-related deaths by 2020

BACKGROUND

Myanmar recognizes the HIV epidemic as one of its most serious health challenges: AIDS is one of the priority diseases in the National Health Plan. The country is committed to achieving a series of national and global strategic targets. The second National Strategic Plan on AIDS 2011–2015 (NSP II), which guides Myanmar's AIDS response, identifies three strategic priorities – HIV prevention, a comprehensive continuum of care for PLHIV, and mitigating the impact of the disease on PLHIV and their families.

A mid-term review of the NSP II implementation will take place in January 2014. One of the planned outputs is a one-year extension of the NSP II to 2016, which will allow the next Plan to accommodate the strategic implications of the Millennium Development Goal (MDG) achievements after 2015.

Although Myanmar is classified as a Least Developed Country, it has not had access to the investment flows received by other countries in the region due to its history of political isolation and sanctions.

With health expenditure at around 2% of GDP, Myanmar's health sector is severely underfunded. Through tax financing and social insurance, the Government plans to increase health spending to 5% to achieve universal coverage and reduce out-of-pocket expenditures.

After more than 40 years of military rule, Myanmar is now transitioning to democratic governance, pursuing economic reforms and taking steps towards resolving the long-running ethnic tensions and border conflicts. Economic growth is accelerating. Yet such rapid change brings challenges, triggering shifts in social and economic behaviour that can have far-reaching consequences.

The growing demand for labour, particularly in the informal sector, drives an increase in migration, both within and across borders.¹ Migrants frequently find themselves living and working in situations that place them at high risk of exposure to HIV infection, increasing the potential for HIV to spread. At the same time, the questioning of traditional beliefs and perceptions and the shifts in needs, aspirations and expectations can be catalysts for changes in behaviour, including sexual and drug-using behaviour. In this dynamic climate, Myanmar cannot afford to lose its focus on HIV prevention.

The global community is responding to Myanmar's transformation by beginning to engage more fully with the country; most of the Western sanctions have now been lifted. But with much of the world in economic crisis, potential investors need to be convinced that their investments will yield maximum returns.

National Strategic Plan Targets

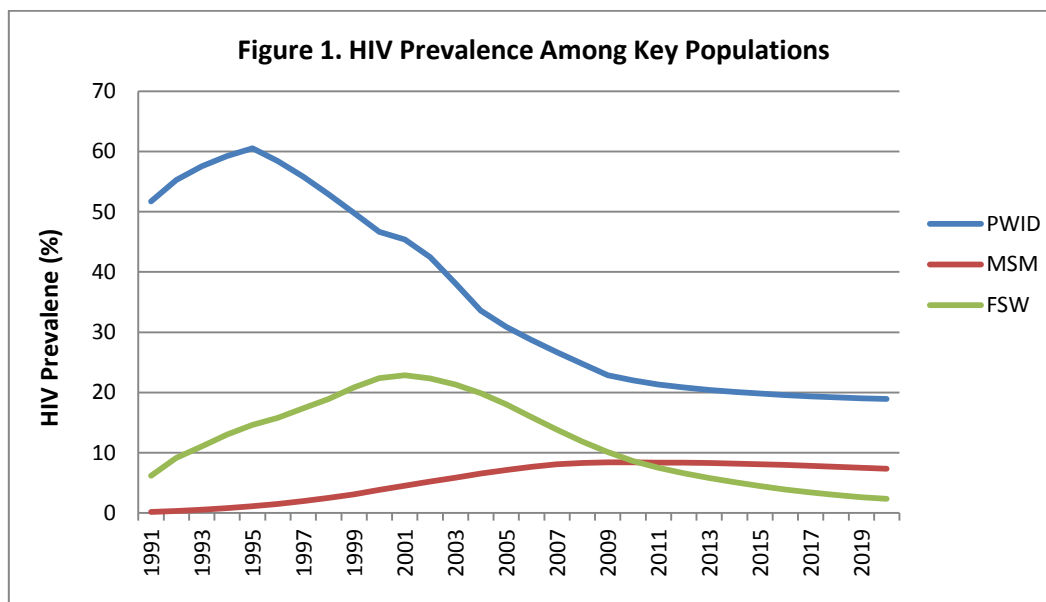
- The number of new HIV infections will be halved by 2015 (from estimated level in 2010), with the reduction of new infections among females being at least equal to the overall reduction; fewer than 5,000 new infections will occur in 2015;
- 80% of eligible PLHIV (96,000 adults and 4,500 children) will receive life-saving ARV. A plan to extend coverage to 106,000 PLHIV by 2016 was recently launched;
- More than 80% (2,680) of women living with HIV will receive ARV prophylaxis therapy to reduce the risk of mother-to-children transmission in 2015
- 48,500 people living with or affected by HIV will receive community home-based care and 15,000 orphans and vulnerable children will receive support in 2015.
- Condom use by female sex workers and MSM will be consistently above 80% and 70%, respectively, in 2015, and more than 80% of people who inject drugs will consistently avoid sharing needles.

This is a unique opportunity for Myanmar to assess the evidence, redesign programmes with a greater focus on value for money and impact, develop innovative models of financing and public-private partnership, and leverage both domestic and international contributions for a revitalised, optimised AIDS response that will get Myanmar to the Three Zeros.

¹ Asian Economies in Rapid Transition: HIV Now and Through 2031. aids2031 Working Group on Countries in Rapid Transition in Asia. Bangkok: UNAIDS; 2009

MYANMAR'S HIV EPIDEMIC

As of 2013, there are an estimated 189,000 adults living with HIV, of whom 37% are women. Myanmar's HIV epidemic is concentrated among people who inject drugs (PWID), with prevalence found at 18% in 2012; men who have sex with men (MSM), with prevalence at 8.9%; and female sex workers (FSW) (7.1%).² However, this disguises a wide geographical variance (prevalence at 29% among PWID in Myitkyina; 15% among FSW and 21% among MSM in Patheingyi). Among the general population, HIV prevalence is estimated at 0.47%,³ but this also varies widely across the country.⁴



Source: 2013 AEM exercise (not yet validated)

HIV prevalence is declining among all key populations and in other sub-populations, largely due to high rates of condom use (80% by clients with FSW; 70% by PWID with FSW); HIV incidence has also fallen. Building on this progress, new infections among FSW and their clients will come close to zero **if** the present high level of condom use can be maintained.

However, despite these positive trends, Myanmar's epidemic still ranks among the most severe in Southeast Asia. There is considerable uncertainty about the epidemic. New infections among PWID are still rising and by 2015 the single largest source of new infections will be the sharing of contaminated needles.

MSM are expected to account for a growing proportion of infections; but too little is known about MSM in Myanmar—thought to comprise some 220,000 gay men, male sex workers and transgendered people—to be able to identify recent behaviour trends and hotspots with any accuracy. It would be beneficial to look at transgender as a separate group in order to identify their specific needs.

One-third (over 2,200 in 2012⁵) of all new infections occur in female partners of key affected populations – mostly wives or girlfriends of FSW clients, PWID and MSM – who are infected through unprotected sex with their husbands.⁶ These women are also at risk of passing the disease on to their children if they do not get access to ARV prophylaxis. Moreover, recent prevention of mother-to-child transmission of HIV (PMTCT) data are showing increasing prevalence in certain locations that have never been reached by prevention interventions.

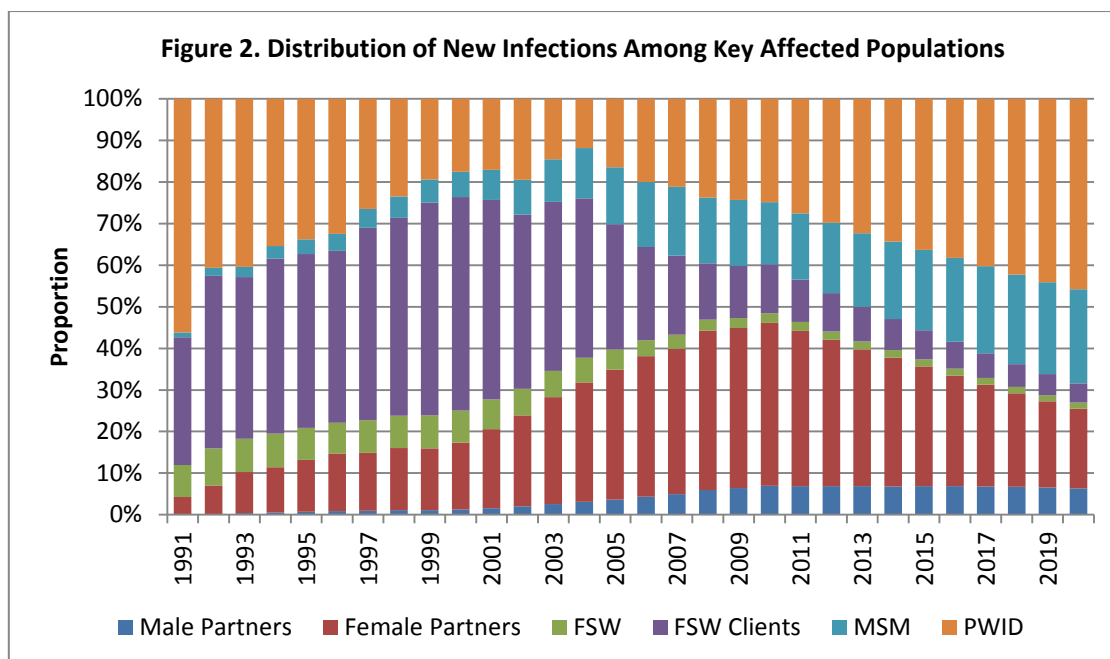
² National Strategic Plan for HIV/AIDS in Myanmar: Progress Report 2012. Draft – not for circulation

³ HIV Estimates and Projections. National AIDS Programme, Ministry of Health of the Union of Myanmar. 2011

⁴ Indicated by prevalence among ANC clients—a proxy for the general population.

⁵ Myanmar AEM exercise, 2013 – not yet validated

⁶ Just 11% of FSW clients (PSI TRAC 2010), 22% of PWID (IDU BSS 2008) and 21% of MSM use condoms with their regular female partners (IBBS 2009, PSA 2008)



Source: AEM 2013 (not yet validated)

WHO ARE WE REACHING NOW?

Prevention services

Prevention efforts in Myanmar focus on reaching the most-at-risk populations with a package of behaviour change interventions, condoms and lubricants (along with clean needles and syringes and methadone maintenance therapy for PWID), STI testing and treatment and HIV testing and counselling, with referral to treatment and support for those who need it. Coverage increased to around 65% of FSW and 70% of MSM across the country last year, but just 30% of the country's estimated 75,000 PWID (through outreach and drop-in centres). Access to methadone maintenance therapy (MMT) doubled to 4% last year,⁷ but only 8.6 million sterile needles were distributed to PWID in 2012,⁸ far short of the 75 million needed.

ART coverage for PLHIV

ART coverage has expanded rapidly since 2008, contributing to a drop in the number of people dying from AIDS-related causes from over 19,000 in 2010 to an expected 15,000 in 2013. However, at the end of 2012, just 43%, or 53,000, of those thought to be in need of ART⁹ were receiving it. Myanmar aims to provide access to treatment to 85% of eligible PLHIV by 2016.

PMTCT

Out of an estimated 3,591 women in need, some 2,890 pregnant women accessed prophylactic ARV to prevent mother-to-child transmission in 2012, and 801 women received lifetime ART for their own health.¹⁰

⁷ Figures based on latest programme data and consensus among stakeholders, Investment Case consultation, Yangon, August 2013.

⁸ National Strategic Plan for HIV/AIDS in Myanmar: Progress Report 2012. Draft – not for circulation

⁹ Initiation at a CD4 count of $\leq 350/\text{mm}^3$: Guidelines for the Clinical Management of HIV Infection in Adults and Adolescents in Myanmar. Third Edition. NAP, Ministry of Health, Myanmar, 2011.

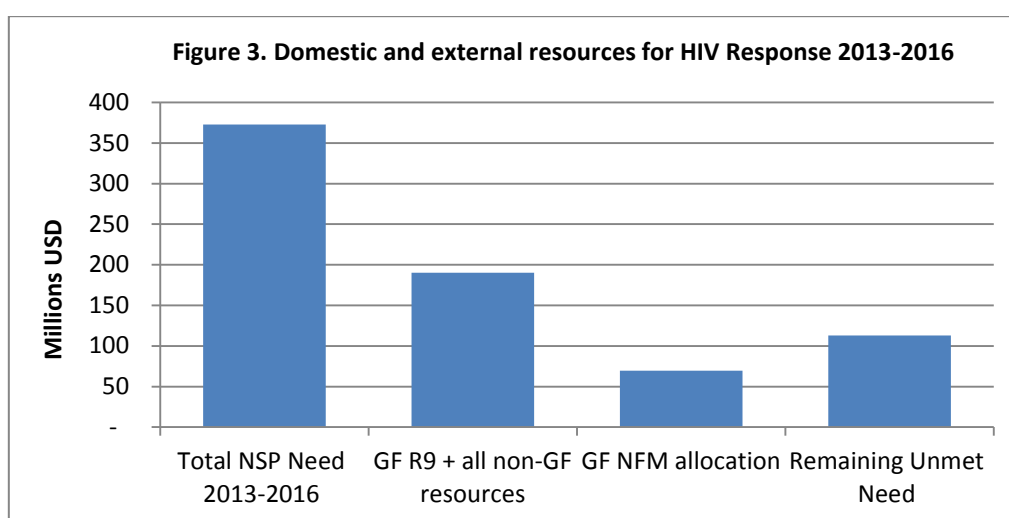
¹⁰ National Strategic Plan for HIV/AIDS in Myanmar: Progress Report 2012. Draft – not for circulation

TB and HIV co-infection

Tuberculosis (TB) is a serious threat for PLHIV in Myanmar, with an estimated 20,000 new cases of TB-HIV co-infection every year.¹¹ The country has nearly triple the global rate of TB, with 180,000 new cases and 9,000 new cases of multidrug-resistant TB (MDR-TB) emerging each year, and extensively drug-resistant TB (XDR-TB) has also been detected. In 2012, 7,152 TB patients were reported to have tested positive for HIV and started ART.¹²

RESOURCES: HOW MUCH DO WE HAVE NOW?

In May 2013, Myanmar was awarded resources for the HIV response worth USD 69.5 million under the Global Fund New Funding Model. However, even with other domestic and international contributions, this still fall USD 113 million short of the USD 373 million needed to fully implement Myanmar's HIV/AIDS response until 2016.¹³



Source: Global Fund NFM application and award

These resources are currently focused where they have proven to have the greatest impact on mortality and incidence. ART has been scaled up to the point where almost half of all funding is now allocated to the cost of providing care, treatment and support for people living with HIV, and, as we have seen, this has contributed to a steep drop in AIDS-related mortality. Likewise, targeting resources for prevention on the sub-populations who are most at risk has had an impact on reducing prevalence and helped to prevent the spread of the disease into lower-risk populations.

CHALLENGES

Significant challenges have to be addressed urgently if Myanmar is to optimise its response. Several of these are critical enablers that need to be in place for programmes to reach their targets.

- Data on geographical hotspots and measured data on HIV incidence and AIDS mortality are lacking; the data on population sizes, HIV prevalence and programme coverage have many gaps. Behavioural data on key populations, particularly PWID in conflict areas and MSM, are outdated and/or drawn from insufficient data points. An impact assessment of the HIV programme is needed. Myanmar's recently developed 5-year surveillance and population size estimate plan will address some of these gaps.

¹¹ Tuberculosis in Myanmar: Progress, Plans and Challenges. WHO Country Office for Myanmar. 2012

¹² National Strategic Plan for HIV/AIDS in Myanmar: Progress Report 2012. Draft – not for circulation

¹³ As defined by the National Strategic Plan 2011-2015, with projections for 2016 based on trend increase from 2013.

- Service packages and programme costs vary widely between service providers. Cost-effectiveness analyses will be carried out in order to define the most impactful intervention packages for the country, and standardise unit costs.
- Parts of Kachin and Northern Shan states, where there is HIV prevalence of up to 30% among PWID and 5% among pregnant women, and Rakhine State, where the ongoing conflict has displaced one million people, are still largely inaccessible to service providers, although some sites are beginning to open up.
- Procurement & supply chain management, infrastructure, human resources, information management, financing and absorptive capacity, among others, all require significant strengthening before the health system can support an expansion of service delivery.
- Communities tend to have a competitive advantage over the public sector in terms of creating demand for HTC and other prevention and support services. Investing in strengthening and empowering communities to participate more fully in programme design and delivery will help to generate demand and improve coordination between service providers.
- HIV will have to compete for resources against other urgent health issues in Myanmar. TB prevalence is among the highest in Asia, with an estimated 9,000 cases of MDR-TB a year.
- Punitive laws and harassment of key affected populations by law enforcement personnel remain a critical barrier to programme delivery, particularly for needle and syringe programming.
- Stigma and discrimination are still widespread in Myanmar, according to representatives of the PLHIV network,¹⁴ and will continue to be a barrier to access, particularly through the public sector, unless addressed. A new Stigma Index study is needed so that progress can be assessed against the 2010 baseline.

OPPORTUNITIES

In line with its economic and political reform agenda, Myanmar is beginning to address some key gaps in policy, infrastructure and human resources and put in place strategies that, alongside the resources committed by the Global Fund and others until 2016, will support a significant scale-up of the national AIDS response.

- The Government has demonstrated its commitment to address the underfunding of the health sector with a substantial increase in budget allocations since 2011 and signalled its intention to further increase its contributions over the next few years. This commitment will hopefully leverage additional resources to sustain the AIDS response.
- There is strong collaboration between the Government, bilateral and multilateral donors and INGOs in the response. The transformation of the Global Fund Country Coordinating Committee (CCM) into the Health Sector Coordination Committee, chaired by the Minister of Health, gives a strong sign to potential investors that investments will be well coordinated and effectively utilised.
- Scaling up HIV testing and counselling, focusing on areas where prevalence is high, will help to ensure that people at high risk of infection know their status and access treatment. The planned decentralisation of HTC services through the public health system provides an opportunity to expand test and treat strategies, particularly if supported by targeted, community-led awareness raising campaigns.
- Stronger collaboration between the National TB Programme and the National AIDS Programme will also support an expansion of HCT. The planned nationwide coverage of TB-HIV collaborative activities by 2015,¹⁵ including provider-initiated counselling and testing, will ensure that more TB patients are tested for HIV and referred immediately to treatment if they are positive, and move Myanmar closer to the goal of eliminating TB.

¹⁴ Midterm Review of Progress on the Ten Targets in Myanmar. National AIDS Programme & UNAIDS. 2013

¹⁵ Tuberculosis in Myanmar: Progress, Plans and Challenges. WHO Country Office for Myanmar. 2012

- The Government has already indicated its intention to scale up ART to cover 85% of all those in need by 2016—an ambitious goal that will mean doubling coverage over the next three years. Decentralisation of treatment offers an opportunity to develop and implement innovative community-based treatment delivery models.
- Myanmar is committed to eliminating new infections in children (EMTCT) and has expanded PMTCT coverage across the country. The further integration of HCT into antenatal care (ANC) settings nationwide will support the planned scale-up of ART coverage as well as being the most cost-effective means of reaching female partners, who currently account for one-third of new infections.
- Funds from the recent Global Fund award have been allocated to support health system strengthening and community system strengthening and Human Rights activities. The planned capacity building, and particularly efforts to strengthen partnership and coordination between civil society and the public sector, will provide valuable support not only for the scale up of treatment and prevention programming.

MAKING THE CASE

WHERE SHOULD WE INVEST?

The evidence suggests that the maximum impact will be achieved by prioritising interventions with:

- **People who inject drugs.** If coverage remains at the present low level, HIV incidence among PWID will increase. However, the punitive policy environment and accessibility to ex-conflict areas where there are high injecting drug use and HIV burden needs to be addressed for scale up to be successful.
- **Men who have sex with men.** Around one-sixth of the total MSM population are estimated to be at significantly higher risk than other MSM due to higher risk behaviour. Prevention interventions for MSM need to focus tightly on this group, while expanding to more sites.
- **Female sex workers.** Infections related to sex work and from husbands to wives are declining faster than via other transmission routes. However, with the potential expansion of the pool of FSW in the wake of the rapid socio-economic changes in Myanmar, and the high mobility of FSW, prevention interventions must continue in order to maintain the current high rates of condom use.
- **Young FSW and MSM.** Surveillance data indicate that most FSW are infected within 2 years of starting work; similarly, MSM are most at risk when they first become sexually active¹⁶. More intensive efforts are needed to reach younger members of high risk populations before they become infected.

And that:

- Reducing incidence among FSW, PWID and MSM is the most cost-effective and impactful strategy for preventing new infections in female partners, but PMTCT and partner testing should be expanded in townships and districts where prevalence is rising;
- Decentralising HIV counselling and testing and switching to rapid HIV tests will support the prevention scale-up;
- To reach the goal of scaling up ART to cover 85% of those in need requires an immediate effort to expand and decentralise treatment sites; and
- Intensifying treatment of TB-HIV co-infection is essential for reducing AIDS-related deaths.

¹⁶ HIV Sentinel Sero-surveillance Survey Report 2012

THE SCENARIOS

With funding available over the next three years, Myanmar will be on the way towards a full scale-up of priority interventions. However, post-2016, the resource landscape is uncertain. The AIDS Epidemic Model (AEM) Version 4 was used to compare the impact of different scale-up scenarios on HIV incidence, AIDS-related mortality and resource needs up to 2020. Two scenarios show the possible outcomes if resources are not mobilised to continue a full scale-up after 2016. *The optimal scenario is a full scale-up of all treatment and prevention interventions from 2013-2020.*

Intervention Baseline Scenario

The baseline scenario assumes that all interventions, including ART coverage, are held at 2013 programmatic levels. By not changing prevention and treatment coverage, the decline in new infections and AIDS-related deaths would slow the progress made over the last few years in bringing the epidemic under control.

Scenario	FSW	High risk MSM	Low risk MSM	PWID (NSP)	PWID (MMT)	ART
Intervention baseline	65%	65%	5%	30%	4%	43%

No Replenishment Scenario

Under this 'no replenishment scenario' we assume that the Government will continue to provide lifelong treatment for all those on ART in 2016 (106,000 people), but will not initiate any new patients after 2016; there will be no further resources for prevention activities after 2016.

With no external financing whatsoever, the outlook gets significantly worse. Leaving aside the ethical issue of denying people essential life-saving treatment, the number of new infections in 2020 will almost quadruple compared to the full scale-up scenario, driving HIV incidence back to pre-2010 levels, and the current downward trend in mortality will have begun to reverse.

Scenario	FSW	High risk MSM	Low risk MSM	PWID (NSP)	PWID (MMT)	ART
No replenishment	67%	65%	1%	30%	5%	69%

Maintenance Scenario

This scenario envisages a 'minimal replenishment' of the Global Fund, whereby it can provide support to maintain but not scale up existing programmes, and a significantly expanded Government contribution. Treatment coverage is maintained at the 2016 level of 85%. Prevention coverage is also maintained at 2016 levels, with no further scale-up.

This would help to avoid almost as many AIDS-related deaths as the full scale-up scenario, while averting some 1,500 fewer new infections. The annual resource needs from 2017 to 2020, however, are almost as high as under the full scale-up scenario (See Table 1).

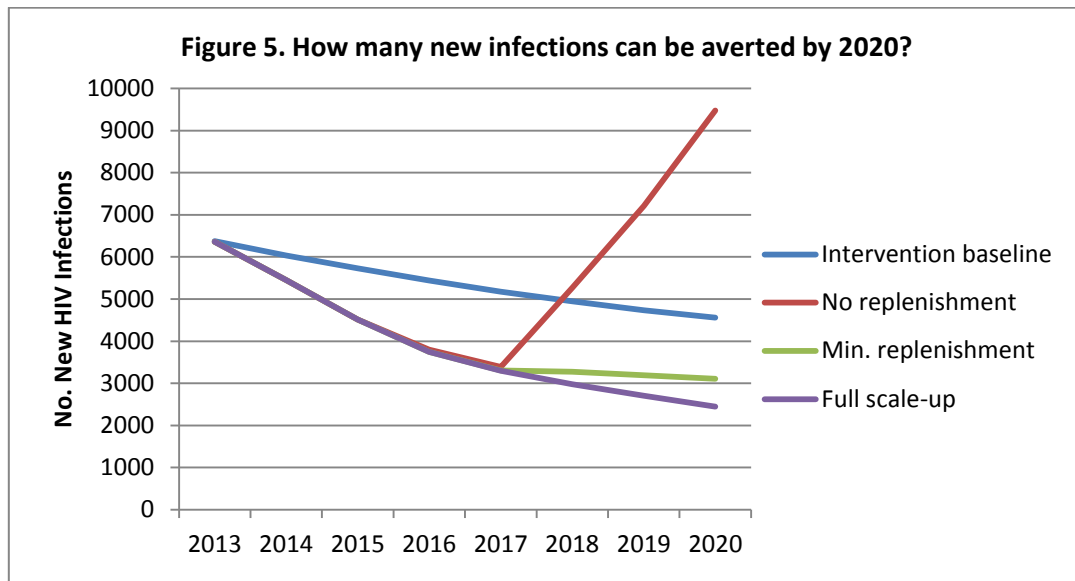
Scenario	FSW	High risk MSM	Low risk MSM	PWID (NSP)	PWID (MMT)	ART
Minimal replenishment	75%	75%	20%	45%	7%	83%

Full Scale-up Scenario

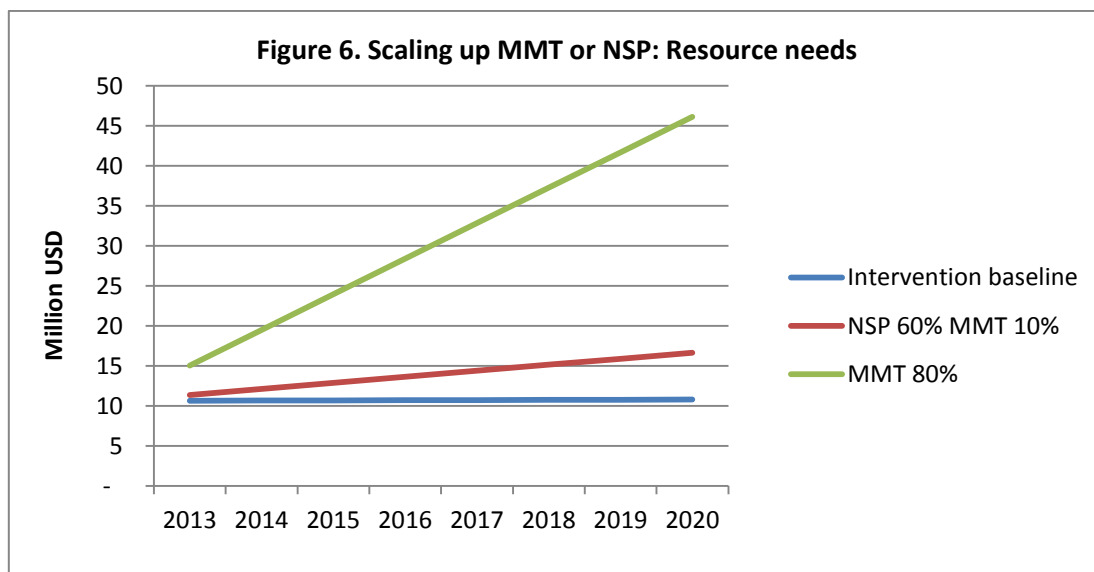
The full scale-up scenario entails all prevention and treatment intervention coverage increased to the maximum number thought to be reachable.

Compared to treatment, behaviour change interventions are relatively cheap: taking prevention to full scale over the 8-year period costs only USD 11 million more than not doing any further scale up after

2016 (see Table 1) and almost halves the number of new infections by 2020. By contrast, if prevention activities are not funded after 2016, all the gains made in the last 4 years will be lost: incidence will most likely revert to the 2009 level.



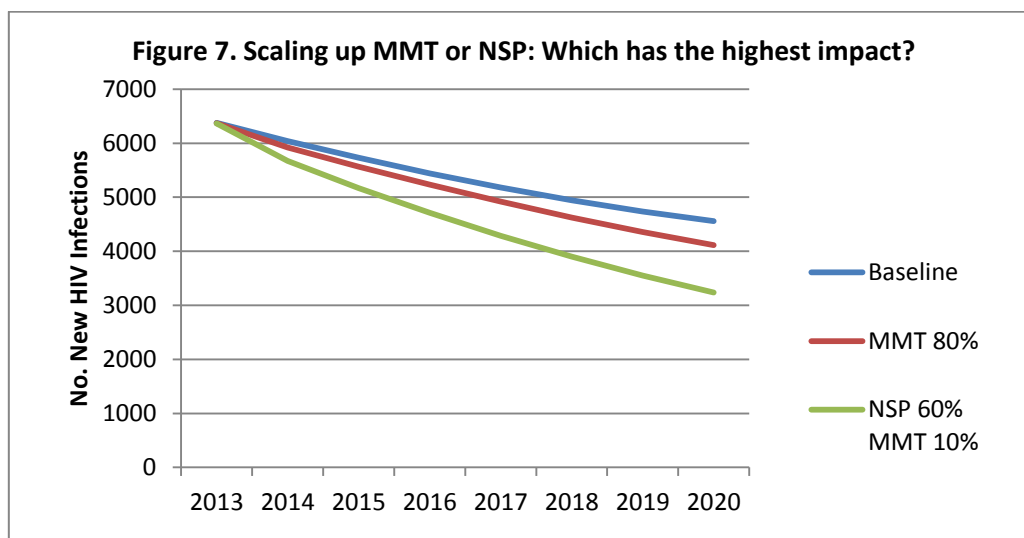
Taking prevention to full scale must include reaching more people who inject drugs with prevention and referral to testing and treatment services (including MMT). Providing clean needles and syringes will yield the highest return on investment and is the most cost-effective. With 60% of PWID accessing NSP, sharing is reduced from 30% to 13%, averting more than 1,300 new infections in 2020 by this intervention alone.



A full scale-up of MMT does not yield a good return on investment, at least in terms of reducing HIV incidence. Even though it would almost double the resource need (Fig. 6), reaching 80% of PWID with MMT would avert just 1,900 more new infections between 2013 and 2020 than maintaining coverage at the current level of 4% (Fig. 7). This may be due to high drop-out rates from oral substitution treatment programmes, or because PWID who are receiving MMT do not necessarily stop injecting, as found by the ART review in Myanmar.¹⁷ However, by reducing dependence, MMT does offer important benefits and is integral to rights-based programming. Scaling up MMT to a more feasible 10% coverage (as envisaged in the full scale-up scenario) would expand access to MMT

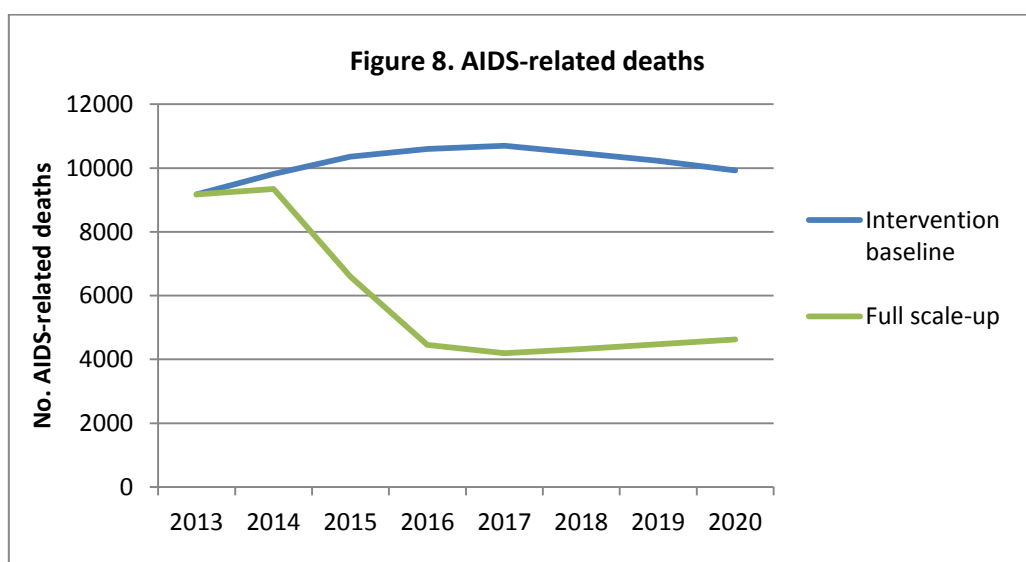
¹⁷ Joint Rapid Assessment of HIV Treatment in Myanmar (September 2013)

without diverting resources from higher impact interventions. If NSP and other prevention interventions are not funded after 2016, needle sharing will double¹⁸, and new infections will escalate to pre-2010 levels.



Doing 'business as usual' on treatment – that is, not scaling up ART from the current coverage of 43%, will see AIDS-related deaths gradually decline but remaining at a very high level. The treatment cost is around USD 40 million a year, but the long-term social and economic costs for families, communities and the country may be very much higher.

In contrast, scaling up ART coverage to 85% (106,000 people on treatment) by 2016 will halve the number of deaths in that year, saving over 6,000 lives. If no new PLHIV are initiated on treatment after 2016, AIDS-related mortality will start to rise again by 2020, whereas maintaining coverage at 85% will keep the mortality rate stable.



Scenario	FSW	High risk MSM	Low risk MSM	PWID (NSP)	PWID (MMT)	ART
Full scale-up	85%	85%	35%	60%	10%	85%

¹⁸ By 2020, from 2012 baseline level.

The Full Scale-up Scenario will enable Myanmar to:

- Reach 20% more FSW with behaviour change interventions and reduce FSW infections almost to zero in 2020;
- Double the coverage of needle and syringe programming and reduce new infections among PWID by one-third;
- Maximise prevention coverage of high-risk MSM and reduce new infections in this group by more than half;
- Stop 11,500 people from being infected with HIV; and
- Scale up ART coverage from 43% to 85% and almost halve the number of deaths among PLHIV, saving more than 33,000 lives.

HOW MUCH WILL BE NEEDED?

Summary of resources required

The following table summarises the total cost and impact (from 2013-2020) of each scenario, as compared to the intervention baseline:

Table 1. Summary of Cost and Impact by Scenario

Scenario	Total new infections 2013-2020	Total new infections averted	Total AIDS-related deaths 2013-2020	Total AIDS-related deaths averted	Total cost 2013-2020 (million USD)	Total additional cost (million USD)
Intervention Baseline	43,008	N/A	94,076	N/A	328	N/A
No replenishment	45,467	(2,459)	62,673	31,403	467	140
Minimal replenishment	32,939	10,069	60,855	33,221	541	214
Full scale-up	31,487	11,521	60,820	33,256	552	225

Myanmar currently has USD 260 million to implement programmes up to end of 2016. Going for the full scale-up scenario by 2020 would require an additional amount of USD 292 million, roughly USD 73 million per year.

Cost assumptions

The model assumes a standardised package of activities under each key intervention area. The unit costs were agreed by a representative group of stakeholders¹⁹ at a national consultation in August 2013, based on current costs in Myanmar (the costs were agreed for now, pending revisions of unit costs that will take place with the Mid-Term Review of the NSP in January 2014). All costs incorporate the direct and indirect costs of service delivery as well as a component for costs related to creating an

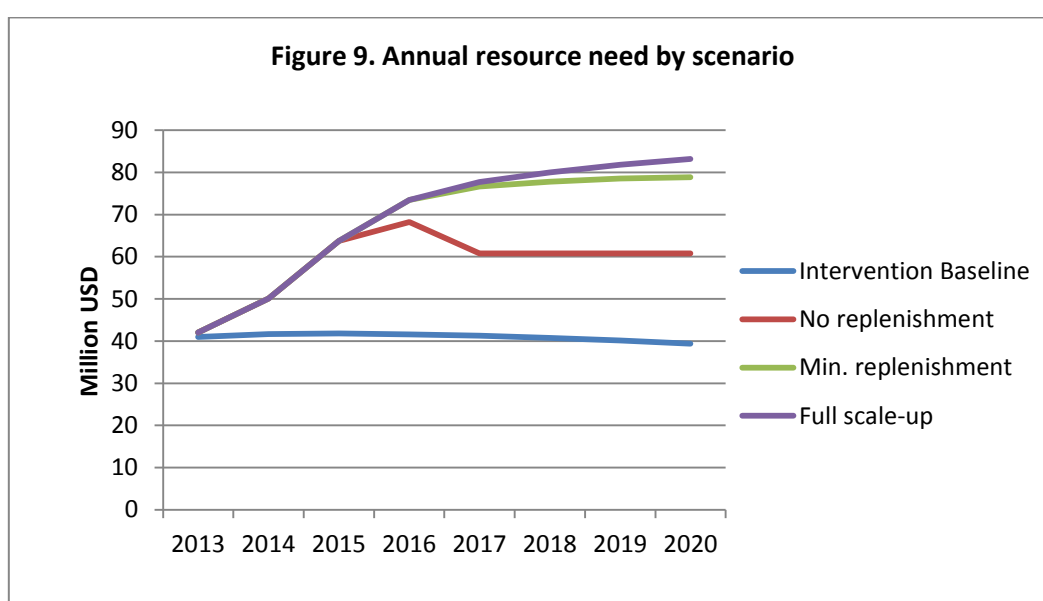
¹⁹ Including senior National AIDS Programme personnel, NGO and INGO representatives and UN representatives. National Consultation Meeting at UNAIDS Country Office, Yangon, 13-14 August 2013.

enabling environment for the intervention concerned. ART coverage includes the cost of ARV and OI drugs and medical monitoring.

Treatment demands high resource inputs, but significant efficiencies could be identified before 2016 that would reduce overall costs:

- Shifting to a single regimen for first-line ART (as recommended by Myanmar’s recent ART assessment)²⁰;
- Using rapid HIV testing;
- Developing harmonized, standard packages for prevention services; and
- Undertaking research on unit costs and cost-effectiveness analyses to identify further savings and more efficient service delivery models.

Moreover, spending on treatment is an investment, not a cost. Each infection averted leads to less expenditure on HIV-related treatment and care in future.



By targeting resources for greater impact, making service delivery models more cost-efficient, and increasing investment in critical enablers that make programme delivery more effective, investments in the Myanmar response will yield the maximum impact on reducing incidence and mortality by 2020 to reach the Three Zeros.

²⁰ Joint Rapid Assessment of HIV Treatment in Myanmar (September 2013)