Enhanced Outreach Approach: Documentation of a PEPFAR Innovation in Myanmar

November 2019

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Cover Photo: Instructors teach life skills-based peer education for HIV prevention to participants in Young People Project, Myanmar. © 2008 Aung Kyaw Tun, Courtesy of Photoshare
ENHANCED OUTREACH APPROACH: DOCUMENTATION OF A PEPFAR INNOVATION IN MYANMAR

November 2019

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DISCLAIMER

The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
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ABSTRACT

A key tenet of the President’s Emergency Plan for AIDS Relief (PEPFAR) and USAID/Burma’s HIV strategy is to support the development and introduction of innovations that can be adopted, amplified, and scaled up by other actors with other resources. In early 2016, HIV case finding at Population Services International (PSI) and the Myanmar-based Targeted Outreach Project (TOP) clinics for key populations remained at 4%–6%. Key populations included men who have sex with men, transgender women, and female sex workers.

TOP entered an “incubation period” where several new strategies were tested to improve HIV case finding. Case finding increased to 20% in 2017. The success of these approaches was called the “Enhanced Outreach” approach. Enhanced Outreach includes peer outreach performance-based incentives and routine outreach data analysis, online outreach, identification of new hotspots, and peer accompaniment to clinics for HIV care enrolment.

The Myanmar National AIDS Program and Global Fund adopted Enhanced Outreach and rolled out to its implementing organizations in 2018. In 2019, PEPFAR and USAID/Burma commissioned this documentation of the Enhanced Outreach approach to understand the extent to which PEPFAR contributed to scale-up, barriers and facilitators to scale, and lessons learned to apply to future PEPFAR innovations. The Enhanced Outreach approach was in initial stages of scale-up and has potential to support effective case finding for a large proportion of men who have sex with men, transgender women, and female sex workers in the densely population areas of Yangon and Mandalay.

Findings were made under the three documentation areas along with key recommendations to support program improvement and PEPFAR’s continued contribution to innovation in the country. In summary, PEPFAR’s investment in innovation in Myanmar with the Enhanced Outreach approach has greatly improved and impacted HIV programming for key populations. Future innovations should model the efforts of the Enhanced Outreach process.
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<td>Three Millennium Development Goal Fund</td>
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<td>ART</td>
<td>Anti-Retroviral Treatment</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>EO</td>
<td>Enhanced Outreach</td>
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<tr>
<td>EPOA</td>
<td>Enhanced Peer Outreach Approach</td>
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<tr>
<td>FSW</td>
<td>Female sex worker</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal year</td>
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<tr>
<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<tr>
<td>HCT</td>
<td>HIV Counseling and Testing</td>
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<tr>
<td>HTS</td>
<td>HIV Testing Services</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Biological and Behavioural Survey</td>
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<tr>
<td>KP</td>
<td>Key population</td>
</tr>
<tr>
<td>KPSC</td>
<td>Key Population Service Center</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NAP</td>
<td>National AIDS Program, Myanmar</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PR</td>
<td>Principal recipient</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure Prophylaxis</td>
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<td>PSI</td>
<td>Populations Services International</td>
</tr>
<tr>
<td>PUDR</td>
<td>Progress Update and Disbursement Request</td>
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<tr>
<td>PWID</td>
<td>People who inject drugs</td>
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<td>SC</td>
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<tr>
<td>SR</td>
<td>Sub-recipient</td>
</tr>
<tr>
<td>SSR</td>
<td>Sub-sub-recipient</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TG</td>
<td>Transgender</td>
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<td>TGW</td>
<td>Transgender women</td>
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<td>TOP</td>
<td>Targeted Outreach Project</td>
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EXECUTIVE SUMMARY

DOCUMENTATION PURPOSE AND QUESTIONS
The primary purpose of the assignment was to document USAID-supported Enhanced Outreach (EO) approaches to increase HIV testing yields in Myanmar among men who have sex with men (MSM), female sex workers (FSW), and transgender women (TGW). The objective of this assignment was to document USAID/Burma-supported EO approaches for increasing HIV testing yields, and the process and extent to which EO has been further amplified and scaled by the National AIDS Program (NAP), the Global Fund, the Three Millennium Development Goal Fund (3MDG), and others.

The assignment task was to trace the adoption and amplification process of the EO methodology developed by the President's Emergency Plan for AIDS Relief (PEPFAR), assess the extent to which adoption and amplification has occurred and its contribution to the national HIV/AIDS response, and provide actionable recommendations to USAID/Burma regarding how to successfully incubate and scale new approaches. The key questions were:

1. How and to what extent have PEPFAR-supported EO innovations been adopted and scaled up?
2. What factors enabled, and what factors inhibited, scale up?
3. What lessons learned can be adopted to future donor-supported efforts to develop and scale innovations for reaching 90-90-90 targets in Myanmar?

BACKGROUND
A key tenet of USAID's health and HIV programming strategy in Myanmar is to support the development and introduction of innovations that can be adopted, amplified, and scaled up by other actors with other resources. Mission programs under PEPFAR have been highlighted as a successful example of this kind of “incubator” approach for supporting new innovations that are in turn amplified by others. USAID-supported EO approaches are a key feature of USAID/Burma's PEPFAR programming, and a potential model for showcasing how USAID has been able to “incubate” new innovations in programming, and support scale-up through country platforms and other funding sources—which the Mission has referred to in shorthand as “Innovate-Adopt-Amplify.”

In early 2016, HIV case finding at the Targeted Outreach Project (TOP) clinics for key populations (KPs)—MSM, TGW, and FSW—implemented by Population Services International (PSI), remained at 4%–6%. After analyzing site-level data and interviewing peers, it was found that peer outreach workers were visiting and revisiting over-serviced, well-known hotspots, and no clear targets were set for HIV testing or positivity.

In March 2016, TOP entered an “incubation period,” a quality improvement approach, where several new strategies were tested to improve HIV case finding. Most importantly, there was a key shift in the outreach approach beginning with daily (even hourly) data management using “case finding calculators” and knowledge-sharing across outreach teams. Teams were able to quickly identify if areas had reached saturation and locate new hotspots for HIV testing services. The rapid feedback also engaged team members in finding and proposing solutions to support increased results. As a result of these efforts, HIV case finding increased from 5% in Quarter 2 Fiscal Year (FY) 2016 to 14% in Quarter 2 FY 2017 (and 12% in Quarter 4 FY 2017) at TOP clinics in USAID pivot areas, the highest yield among PEPFAR countries. (Figure 1) With the higher influx of newly diagnosed people living with HIV, USAID and TOP
introduced a case management system to ensure these newly identified HIV positive clients could access anti-retroviral treatment (ART). TOP increased immediate linkage to care: those clients entering care through online channels have a 93% ART enrollment rate and those entering through peer outreach have a 90% ART enrollment by Quarter 4 FY 2017.

The success of these approaches to increase yields was called the “Enhanced Outreach” approach and brought to the attention of a wider group of implementing partners in the HIV Technical Strategy Group (TSG), which is chaired by the Myanmar NAP. After a series of presentations and updates, the NAP agreed to adopt a set of these methods (daily data management, micro-mapping, new network and hotspot scouting), and train implementing partners working under the Global Fund and the 3MDG. EO operational manuals were drafted and, approved by the NAP, and Global Fund partners adapted and integrated them into national HIV programming.

**FSI/TOP HIV case finding trends 2011-2017**

Save the Children, a Global Fund Principal Recipient (PR), shared EO with sub-recipient (SR) and sub-sub-recipient (SSR) implementers through formal training and field-based mentoring.¹ The formal training included five out of seven SRs. The field-based mentoring included nine organizations: two SRs and seven other nongovernmental organizations (NGOs) and community-based organizations (CBOs) in Yangon, Mandalay, and Malamyine regions. Over half of the organizations were CBOs. PSI/TOP had already begun to implement EO once the Yangon pilot was evaluated, fine-tuned, and adapted.

Key components of the methodology included the continuous identification of new client populations to identify, reach, test, diagnose, and enroll clients in care. Peer management, use of technologies, analysis of overlapping risks, and active HIV positive case management and follow-up with HIV negative clients all were included in the innovative approaches for EO and reaching scale.

After more than a year of implementation of the EO approach, some Global Fund SRs showed substantial improvement in HIV Counseling and Testing (HCT) uptake and HIV case finding. Uptake is

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¹ UNOPS is the second Global Fund PR and primarily supports the National AIDS Program with their program implementation. UNOPS implementers do not use the Enhanced Outreach Approach. The team was unable to meet with them due to scheduling conflicts.
somewhat crudely calculated given the difficulty of excluding known positives from the base of calculation. From January to June 2018, crude HCT uptake ranged across Global Fund implementers from 24% to 65% for people who inject drugs (PWID), 63% to 73% among FSW, and 77% to 84% among MSM. While there have been significant improvements as compared to the previous year’s performance, there is clearly opportunity to improve, particularly among PWID. Case finding has also increased. (See table). However, there is substantial variation across SRs, with positivity rates ranging widely even where SRs are working in comparable environments targeting the same key population (GF RPF review, 2019).

Comparison of Global Fund Progress Update and Disbursement Request (PUDR) data for Reach to Test and Positivity for MSM and FSW 2016/2018

<table>
<thead>
<tr>
<th>GF PUDR Data</th>
<th>MSM 2016</th>
<th>MSM 2018</th>
<th>FSW 2016</th>
<th>FSW 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach to test</td>
<td>37% (51,567/139,074)</td>
<td>77% (53,555/69,111)</td>
<td>36% (35,757/97,001)</td>
<td>64% (36,654/56,493)</td>
</tr>
<tr>
<td>Positivity</td>
<td>5.4% (2,765)</td>
<td>6.4% (3,404)</td>
<td>5.2% (1,871)</td>
<td>4.5% (1,631)</td>
</tr>
</tbody>
</table>

Source: Global Fund PUDR, conducted by Adams, 2018

USAID/Burma commissioned a team of consultants to document PEPFAR’s contribution to scale for Myanmar’s HIV program through the EO innovation. The purpose of the documentation was to understand to what extent the innovation has been adopted and taken to scale, the factors that inhibited or enabled scale, and key lessons learned.

DESIGN AND PROCESS
The team drew upon multiple methods or techniques to quickly and systematically collect and analyze data. The methods included document reviews, key informant in-depth interviews, focus group discussions, and direct observation during field visits.

The team developed interview guides for use and adapted the guides depending on the type of informant reached (e.g., donor, implementer, government, community-based organization, and site user).

Data analyses identified repeating patterns or trends evident in the information collected and linked to specific questions.

FINDINGS AND CONCLUSIONS
Question 1: How and to what extent have PEPFAR-supported enhanced outreach innovations been adopted and scaled up?

Save the Children, one of two Global Fund PRs in Myanmar, embarked on adoption and amplification of the PEPFAR EO innovation once results were observed in PEPFAR-supported sites through PSI/TOP. In collaboration with PEPFAR, Save the Children’s main approaches for adoption were to:
• Engage the NAP for sustainability and country ownership
• Build buy-in from CBOs and other implementing partners
• Develop EO operational guidelines for implementing partners with NAP collaboration
• Perform field-based coaching and mentoring
• Standardize training for all partners

The PEPFAR innovation has largely been adopted for Global Fund’s Myanmar HIV programming for MSM/TGW and FSW nationwide. EO started at one PEPFAR site in Yangon with PSI/TOP and through adoption and amplification in the Global Fund, has rolled out to more than 15 sites nationally through five SRs and more than 10 CBOs. The sites are based in and around Yangon in Mandalay serving urban MSM, TGW, and FSW populations. Due to overall population numbers, these sites are purported to reach a large proportion of MSM and TGW in the country. The documentation team was unable to ascertain the same for FSW. FSW frequently migrate to Yangon and respondents noted that the EO approach was reaching new people in that respect.

Save the Children went through a rigorous process to build buy-in for adapting the EO approach with feedback from government, implementing partners, bilaterals, and CBOs. The standardization of the EO approach through the operational guidance, in collaboration with the NAP and the Ministry of Health and Sports, also supported sustainability efforts in the use of this best practice in HIV programming.

Scale-up, however, was in the initial phase at the time of the documentation. The majority of GF Save the Children SR and SSR implementing partners are implementing EO, though the capacity to implement the EO package—and thus, the quality of implementation—varies considerably. The documentation team observed—and smaller CBOs reported—a difference in implementation ability for EO. Larger NGOs with a Key Population Service Center (KPSC) had an advantage. These advantages include more financial and human resources, stronger staff capacity, and the ability to maintain staff with lower turnover and stronger M&E systems. Furthermore, both larger NGOs and CBOs reported client preference for the KPSC’s one-stop shop services.

The larger versus smaller organizational implementation capacity also points to broader challenges of scaling up innovations. PEPFAR/USAID’s innovation of EO was focused on their site, with PSI/TOP in Yangon using a long-standing KPSC, technical staff with a history of innovation, and human and financial resources of a larger NGO with one-stop shop services. Rolling out the adapted EO package through the Global Fund meant troubleshooting different challenges in a variety of geographical settings and organizational capacities. This could account for the different increases in yield between the PEPFAR innovation and the Global Fund scale-up.

**Question 2: What factors enabled, and what factors inhibited, scale up?**
The documentation team identified salient themes from respondents of “what worked” in the Amplification phase of the Innovate-Adopt-Amplify Framework. These included:

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2 Key Population Service Centers are what are referred to as drop-in centers under the Myanmar National AIDS Program and Global Fund sites. These centers provide prevention and treatment of sexually transmitted infections, HIV prevention, testing and treatment services, and referral for individuals with TB co-infection.
• Data analytic capacity development at peer educator level for program, team, and individual performance improvement
• Use of systematic methods and team data analysis
• Maintenance of prevention coverage with HIV case finding
• Flexible schedules, performance-based payment
• Holistic cascade approach—following clients through care and treatment

The EO approach proved to be a catalyst to retool and update pre-existing HIV approaches in Myanmar. All the stakeholders interviewed agreed EO improved performance and increased their technical capacity to understand how to improve case finding, understand the HIV cascade, and be more flexible in how they achieve their results.

Enabling Factors

• The PEPFAR innovation model with USAID/Burma allows for a demonstration of effects and testing of components at a smaller scale before adaptation, adoption, and amplification.
• PEPFAR support provides the upfront costs of testing innovations and tailoring them to the Myanmar context. This unique arrangement for donor coordination and harmonization allows for global best practices to be adapted in-country and then adopted to a national program.
• Stakeholder engagement, buy-in, and trust building were key factors in success during the adoption and the amplification phase.
• The field-based mentoring and coaching of the implementing partners by consultants also played a role in enabling for scale.
• The overall flexible nature of the EO approach also is an enabling factor. Managers and peer outreach workers liked the performance-based nature and also the freedom to explore how to improve outreach on their own.
• The EO pivoted focus on data analysis and use from the bottom up is also an enabling factor to reach scale.
• One other factor that could enable scale-up is the EO app that was being piloted and is still being tested, an example of innovation incubation within Global Fund. The EO app can be used for real-time data monitoring and use by the peer outreach worker and supervisor (See table below for EO App functions).
• Another enabling factor was the attention and support for clients to know about and access the full HIV cascade. EO includes an HIV positive case management component with limited KPSC treatment initiation support and accompanied referrals to NAP sites.
**Enhanced Outreach App Functions**

<table>
<thead>
<tr>
<th>Outreach Job Aid</th>
<th>Program Management</th>
<th>M&amp;E</th>
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<tbody>
<tr>
<td>Alerts for missed referrals</td>
<td>Automated analyses</td>
<td>Cascade analysis</td>
</tr>
<tr>
<td>Prevention package prompt</td>
<td>Reach-to-test</td>
<td>De-duplication of clients</td>
</tr>
<tr>
<td>Real time performance against target</td>
<td>Test-to-enrolled</td>
<td>Record of all prevention package components</td>
</tr>
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<td>Hotspot positivity</td>
<td>Automated reports</td>
<td></td>
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<tr>
<td>Tool for outreach worker mentoring</td>
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<tr>
<td>Data for decision making</td>
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</tbody>
</table>

Source: Save the Children, 2018

**Inhibiting Factors**

- Many of the reported and observed inhibiting factors focused on the intensity of the EO approach, data management, and burdens Global Fund CBOs face in reaching targets and “competing” with larger NGOs with more resources. Respondents also reported inhibiting factors with a lack of, care and treatment support, and stigma and discrimination in healthcare settings and society.

- Respondents welcomed the new focus on HIV case finding and supporting clients through care, yet CBOs reported that there was a high burden for them to find HIV positive cases with fewer resources than larger NGOs that have one-stop-shop KPSCs and dedicated social media and medical staff.

- Peers for both CBOs and NGOs found the data entry burdens too high and that it was faster to record data on paper and then enter it into the app.

- Program managers reported that they were busy with reporting for donors, which left little room for overall data analysis for program improvement.

- Respondents also reported challenges with the app that could affect programming ability to rapidly reach scale.

- Overall, nearly all respondents reported linkages to treatment, the number of days it takes to initiate treatment, and treatment support as barriers to scale-up.

- Stigma and discrimination are also an inhibiting factors in reaching scale. Peer outreach workers face stigma and discrimination in their day-to-day activities. Stigma and discrimination also extend into government health care settings, and treatment initiation policies create more barriers for KPs.

**Question 3: What lessons learned can be adopted to future donor-supported efforts to develop and scale innovations for reaching 90-90-90 targets in Myanmar?**

The majority of the respondents gave feedback on lessons learned from the adoption and amplification phases. These eight lessons learned are:

1. Trust-building and stakeholder engagement from government to grassroots organizations are important components of the Innovate-Adopt-Amplify Framework.
2. Field-based mentoring allows for organizational and individualized support for implementation.

3. Care and treatment linkages and initiation need extra support and attention.

4. Technology has great potential to support the monitoring and tracking of clients along the HIV cascade using the EO app. Yet the app can also be a barrier for EO results, with constraints with the Burmese Unicode, the need for the app to be constantly connected to the Internet to complete the record, and reported app stability issues.

5. The new focus on data management and analysis from the bottom up has improved data use at various levels of program implementation, monitoring, and evaluation.

6. Transgender data needs to be disaggregated at program level and used to create specific interventions for this population.

7. Human resources are required for developing new innovations and in adopting and amplification.

8. Stigma, discrimination, and violence are the lived, daily realities of KPs, both as members of a community and as program staff.

**RECOMMENDATIONS**

*For PEPFAR Myanmar*

- Explore expansion of the PEPFAR Myanmar innovation mandate to include the provision of technical assistance to Global Fund partners and support for amplification, e.g., data management and use, TGW-specific strategies, and data analysis for program improvement.

- Ensure that future innovations are tested in settings outside of the PSI/TOP center. Garner perspectives from CBOs so that the adoption phase could be smoother and quicker. Additionally, there could be future innovations that “don’t work” in urban areas or for the KPSC that might work well in grassroots/CBO settings.

- Collaborate with national stakeholders, including, but not limited to, Global Fund, government, and KP communities for stigma, discrimination, and violence reduction strategies.

- Be aware of the current human resources and capacities for implementing new innovations and the technical, programmatic, management, and data requirements needs. Provide resources and support to ensure that there is a balanced approach when adopting new innovations into the national program, e.g., that EO implementation is not negatively impacted by the introduction of new innovations.

- Partner with stakeholders to strengthen care, treatment, and support for HIV positive clients and to develop policies and strategies to further operationalize Test and Start.

- Explore the development and testing of social and behavior change communication strategies for HIV prevention, treatment, and care. There is a dedicated social media outreach team that is already always listening to the conversations happening online. This input could be invaluable to developing online interventions.

- Explore how to reach the hardest to reach populations, e.g., closed networks and/or Facebook groups of straight- or masculine-identifying MSM. This may require recruiting someone from that group with different incentives or motivations.

- Design innovation interventions specifically for TG and stop lumping this population together with MSM. Use programmatic data for in-country advocacy and policy development.
For PEPFAR in Other Countries

- Explore how the PEPFAR innovation model in Myanmar could be replicated in other countries. PEPFAR could be the incubator and technical assistance provider while Global Fund is the implementing partner. Each country is unique so there should be caution against a one-model-fits-all approach.

For Future Innovations

- Follow the EO blueprint for Innovate-Adopt-Amplify and also be aware of innovation adoption fatigue.
- Care and treatment needs its own innovations. The majority of innovations discussed with partners, including USAID/Burma, were focused on HIV testing (e.g., community-based screening and HIV self-testing) and prevention (e.g., Pre-exposure Prophylaxis or PrEP). The care, treatment, and adherence side of the cascade is insufficient to truly support those who are HIV positive.
- Consider a plan for sustainability and how new innovations will integrate with existing implementation approaches.

CONSIDERATIONS FOR EO IMPROVEMENT

The documentation team talked to several implementing partners of EO for the Global Fund in Myanmar. They had their own ideas on how to best improve the approach and implementation. The team is sharing these here as considerations for improvement:

- Provide further technical assistance support for programmatic data analysis and use, NAP treatment policy guidelines and implementation, stigma and discrimination reduction strategies, and use of technology in reaching new KPs.
- More financial and human resources are needed to support HIV positive case management. The costs of providing support to a client are much higher than simply accompanying them to the center, e.g., transport, parking fees, food (as they often face long wait times).
- Indicators are needed to track the HIV case management on an aggregate level. If there are indicators for programs, there needs to be funding to support that indicator.
- Advocacy work with NAP is critical to reduce unnecessary steps and bottlenecks in ART initiation to fully benefit seropositive KPs.
- Local CBOs are the key actors in the success of EO and need to be strengthened along with international and other larger local NGOs. Local CBOs feel they are “in competition” with international or larger local NGOs. International NGOs and larger local NGOs need to work in support of local CBOs and build their capacity.
- Faster ART initiation and more ART support will be required with success of the EO. As such, an ART provision plan should be discussed with NAP and donor agencies so that all the seropositive KPs could be enrolled in ART irrespective of their CD4 count, according to the WHO guideline and to reach 90-90-90 target in Myanmar.
RECOMMENDATIONS ON HOW TO DOCUMENT BEST PRACTICES IN THE FUTURE

- Use “traditional” methods of external reviewers and reports.
- Explore the use of social media promotion with regular updates to global, regional, and in-country communities (e.g., tag PEPFAR and other partners, country audiences will need Burmese translation, etc.).
- Promote through webinars (external and/or Myanmar-led webinars), news articles, global/regional/national meetings and conferences.
- Use a variety of media, e.g., articles, pictures, short video stories, testimonials, guest writing on blogs, online engagement and discussions.
I. INTRODUCTION

USAID/Burma, through the support of the President’s Emergency Plan for AIDS Relief (PEPFAR), focuses on developing and testing innovations to improve the HIV cascade for Myanmar. USAID/Burma uses the Innovate-Adopt-Amplify framework to guide their programming nationwide. Through this framework, USAID/Burma tasked Populations Services International (PSI)/Targeted Outreach Project (TOP) to develop approaches to improve HIV testing uptake and HIV case finding. The implementers developed the Enhanced Outreach (EO) approach. USAID/Burma requested independent documentation of support in documenting the EO approach and the innovation’s contribution to reaching scale (Amplify). The documentation work was conducted from March to April 2019 in Yangon and Mandalay, through remote work.

DOCUMENTATION PURPOSE

The primary purpose of the assignment was to document USAID-supported EO approaches to increase HIV testing yields in Myanmar among men who have sex with men (MSM), female sex workers (FSW), and transgender women (TGW). The objective of this assignment was to document USAID/Burma-supported EO approaches for increasing HIV testing yields, and the process and extent to which EO has been further amplified and scaled by the National AIDS Program (NAP), Global Fund, Three Millennium Development Goal Fund (3MDG) Fund/Access to Health, and others.

The findings of this documentation may be used to highlight challenges, successes, and lessons learned in USAID/Burma’s unique PEPFAR aim of funding innovations within the Innovate-Adopt-Amplify framework, as well as to identify challenges and potential solutions so that these issues can be addressed during the remainder of the project. In addition, findings can inform decisions about future innovation and incubation programming.

The primary audience for this analysis is PEPFAR in Myanmar. The documentation may also be of interest to other partners in country including NAP, Global Fund Principal Recipient (PR), and PEPFAR and Global Fund implementing partners. Other key audiences could include the Ministry of Health and Sports and other implementing partners.

DOCUMENTATION QUESTIONS

The assignment task was to trace the adoption and amplification process of the EO methodology developed by PEPFAR, assess the extent to which adoption and amplification has occurred and its contribution to the national HIV/AIDS response, and provide actionable recommendations to USAID/Burma regarding how to successfully incubate and scale new approaches. The key questions were:

1. How and to what extent have PEPFAR-supported EO innovations been adopted and scaled up?
2. What factors enabled, and what factors inhibited, scale-up?
3. What lessons learned can be adopted to future donor-supported efforts to develop and scale innovations for reaching 90-90-90 targets in Myanmar?
II. BACKGROUND

A key tenet of USAID’s health and HIV programming strategy in Myanmar is to support the development and introduction of innovations that can be adopted, amplified, and scaled up by other actors with other resources. Mission programs under PEPFAR have been highlighted as a successful example of this kind of “incubator” approach for supporting new innovations that are in turn amplified by others. USAID-supported EO approaches are a key feature of USAID/Burma’s PEPFAR programming, and a potential model for showcasing how USAID has been able to “incubate” new innovations in programming, and support scale-up through country platforms and other funding sources—which the Mission has referred to in shorthand as “Innovate-Adopt-Amplify.”

In early 2016, HIV case finding at the TOP clinics for key populations (KPs), (MSM, TGW, and FSW), implemented by PSI, remained at 4%-6%. After analyzing site-level data and interviewing peers, it was found that peer outreach workers were visiting and revisiting over-serviced, well-known hotspots, and no clear targets were set for HIV testing or positivity.

In March 2016, TOP entered an “incubation period” where several new strategies were tested to improve HIV case finding. Most importantly, there was a key shift in the outreach approach beginning with daily (even hourly) data management using “case finding calculators” and knowledge-sharing across outreach teams.

As a result of these efforts, HIV case finding increased from 5% in Quarter 2 Fiscal Year (FY) 2016 to 14% in Quarter 2 FY 2017 (and 12% in Quarter 4 FY 2017) at TOP clinics in USAID pivot areas, the highest yield among PEPFAR countries (see Figure 1). With the higher influx of newly diagnosed people living with HIV, USAID and TOP introduced a case management system to ensure these newly identified HIV positive clients could access anti-retroviral treatment (ART). TOP increased immediate linkage to care: those clients entering care through online channels had 93% ART enrollment rate and those entering through peer outreach had 90% ART enrollment by Quarter 4 FY 2017. Overall treatment retention for MSM and FSW in PSI/TOP sites in 2017 was 86% (see Figure 2). For clients enrolled in ART in 2017, 86% achieved viral suppression.

Retention is defined as enrolled in ART, alive, and on ART 12 months after initiation.
The success of these approaches to increase yields was called the EO approach and was brought to the attention of a wider group of implementing partners in the HIV Technical Strategy Group (TSG), which is chaired by the Myanmar NAP. After a series of presentations and updates, the NAP agreed to adopt a set of these methods (daily data management, micro-mapping, new network and hotspot scouting), and train implementing partners working under the Global Fund and the 3MDG. EO operational manuals were drafted and approved by the NAP, and Global Fund partners adapted and integrated them into national HIV programming.

The EO approach was developed in-country and adapted from global and regional best practices. EO, at face value, shares some similarities with the USAID LINKAGES Project Enhanced Peer Outreach Approach (EPOA). The LINKAGES EPOA is a framework that is
adapted to each country context and has been rolled out in several other countries in Africa, Asia, and the Caribbean. While they can be compared to each other, there are key differences between the two programs.

The primary difference between EPOA and EO is how the two programs are conceptualized and packaged. Myanmar’s EO reaches KPs in hotspots and social networks, includes special attention to reaching higher risk populations within these networks, and has active case management for HIV positive and negative clients.

The LINKAGES EPOA is one component within three. The LINKAGES approach to outreach and linkages across the cascade includes peer outreach (primarily hotspot and Key Population Service Center (KPSC)\(^4\)-related with the HIV prevention package), EPOA (reaching high-risk KPs using chain referral methods and social networks), and peer navigation (accompanied linkages for care and treatment). More detailed descriptions of each of these components can be found in Box 1.

**Box 1. LINKAGES EPOA outreach program descriptions**

**Peer outreach**: Engages KP members regularly in activities for HIV prevention, testing, and related services. Peer outreach workers focus particularly on KP members who frequent “hot spots” or visit drop-in centers, where they can be contacted regularly for one-on-one or group conversations and to receive prevention commodities such as condoms, lubricant, or sterile needles and syringes.

**EPOA**: Complements peer outreach by engaging previously unidentified KP members for HIV prevention and testing—particularly those who are hard to reach and who may be at high risk of HIV, or HIV positive. EPOA is led by peer outreach workers, who engage KP members to persuade peers in their own social and sexual networks to be tested for HIV. It focuses on those who are not found at traditional hot spots, which is particularly important because technology changes the ways that some KP members contact and meet sexual partners.

**Peer navigation**: Supports KP members who are living with HIV so that they enroll and remain in clinical care (especially ART). Peer navigators are trained individuals who are usually living with HIV themselves and who are often KP members (EPOA, p. 3).

The similarities between the programs include support for clients through the HIV cascade of prevention, care, and treatment; similar management structure with peer supervisors, peer educators, and recruitment of new peers for mobilization; and a performance-based system that encourages innovative thinking and flexibility to reaching new networks and targets.

There are more differences than similarities and these are mapped out in Table 1.

\(^4\) KPSCs are what are referred to as drop-in centers under the Myanmar NAP and Global Fund sites. These centers provide prevention and treatment of sexually transmitted infections, HIV prevention, testing and treatment services, and referral for individuals with tuberculosis co-infection.
Table 1. Comparison of LINKAGES Enhanced Peer Outreach Approach and PEPFAR/GF Myanmar’s Enhanced Outreach programs

<table>
<thead>
<tr>
<th></th>
<th>LINKAGES EPOA</th>
<th>PEPFAR/GF EO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure</td>
<td>EPOA is one component in three</td>
<td>EO encompasses the whole cascade</td>
</tr>
<tr>
<td>Peer Educator –</td>
<td>Called “Peer Mobilizers” and have similar functions; chosen based on</td>
<td>Called “Peer Educators (Outsourced)”; recruited criteria more on communication</td>
</tr>
<tr>
<td>terminology and</td>
<td>HIV risk behavior, having large social networks, and good communication</td>
<td>skills and location/hotspots and social networks</td>
</tr>
<tr>
<td>recruitment</td>
<td>skills</td>
<td></td>
</tr>
<tr>
<td>Peer Educator –</td>
<td>Receive less training than EOs of similar function; fewer reporting</td>
<td>More training and reporting responsibilities; more active engagement with</td>
</tr>
<tr>
<td>training and function</td>
<td>responsibilities; more of an emphasis on social networks of similar risk</td>
<td>clients over time; more emphasis on location and communities (than social</td>
</tr>
<tr>
<td></td>
<td>behaviors and chain referral networks (tracked through referrals)</td>
<td>networks)</td>
</tr>
<tr>
<td>Data analysis</td>
<td>Chain referral network software is more routinely utilized to analyze social</td>
<td>Routine team data management is utilized to identify other physical and social</td>
</tr>
<tr>
<td></td>
<td>network risk behavior; Peer Mobilizers aren’t as involved in data analysis</td>
<td>networks for reach</td>
</tr>
<tr>
<td>Compensation structure</td>
<td>Similar to EO</td>
<td>Similar to EPOA</td>
</tr>
</tbody>
</table>
III. DOCUMENTATION PROCESS AND LIMITATIONS

PROCESS
The Global Health Program Cycle Improvement Project (GH Pro) assembled a documentation team composed of three consultants: Ms. Dee Adams, Team Leader; Dr. Kyi Minn, Documentation Specialist; and Dr. Thu Naing, Logistics Specialist.

The team used a rapid appraisal approach and drew upon multiple methods and techniques to quickly and systematically collect and analyze data. The methods included document reviews, key informant in-depth interviews, focus group discussions, and field visits. Through an iterative participatory process, the documentation team formulated a list of questions for key informants, developed interview guides, and used probing follow-up questions to obtain information needed to fulfill the objectives of the documentation and to answer the questions set forth in the Scope of Work.

When possible, the documentation team triangulated data (the application of at least three different data collection methods or the application of one method among different groups of informants) to identify patterns or themes in the information assembled. These patterns helped to determine findings. Both quantitative and qualitative data served as a check on the validity of findings from any single method or source.

Many of the key informant interviews were in-person at sites in Yangon or Mandalay. The majority of the interviews were conducted by all members of the team. Some interviews were with a single respondent and others were with a group.

The team reviewed aggregate Global Fund Myanmar data to understand the potential effects of the adoption and amplification of the EO approach.

SITE VISITS
The documentation team visited USAID and Global Fund implementing partners at national and community-based levels in Yangon and Mandalay. The sites supported MSM, FSW, and TGW HIV prevention and care. Respondents included the Global Fund Sub-recipient (SR) Save the Children; USAID; three KPSCs in Yangon and one in Mandalay; and one community-based organization (CBO) in Yangon and two in Mandalay. The team also interviewed World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) representatives. The NAP representatives were aware of the documentation and were unavailable for interviews. For a list of stakeholders interviewed, please see Annex III.

DATA COLLECTION TOOLS
The team developed interview guides following the Innovate-Adopt-Amplify framework. The team used an iterative approach to qualitative data collection and asked probing questions on strengths, challenges, and lessons learned on EO and for future PEPFAR innovations. Please see Annex II for the Interview Guide.

Even though the data collection tools contained standard sets of questions posed to informants, the team’s interview protocol allowed for additional probing questions to be added during sessions with
informants. Similarly, if an informant offered additional information or volunteered other data relevant
to the scope of the documentation, the interviews also captured this information.

**ANALYTICAL APPROACH**
Analyses were oriented to identify repeating patterns or trends evident in the information collected.
Part of the analytical work was secondary, when relying on information already contained in reports and
existing background documents. Patterns were identified across all data collected and linked to specific
documentation questions.

**LIMITATIONS**
The primary limitation of the documentation was the rapid nature of the effort. The documentation
team had less than three weeks in-country and contracts were executed within days of the Team Lead’s
travel to the country. Therefore, there was very little time to conduct a desk review and much of the
visit was planned once the consultant arrived. During this time, the team had to design, plan, schedule
and conduct interviews, and conduct preliminary quantitative data analysis with Global Fund reports.
IV. FINDINGS

The PEPFAR EO innovation through PSI/TOP and the Global Fund EO adaption for adoption and amplification differed in a few ways.

The PEPFAR-supported innovation of EO, as developed by PSI/TOP, included seven key components:

1. **Daily data management**: A practice of daily data management to motivate, streamline strategy, and set clear, incentivized targets at daily meetings.
2. **Empowerment and flexibility in outreach**: Adjusting outreach daily based on knowledge garnered each day; working flexible hours for night outreach.
3. **Underserved populations/areas focus**: Seeking cases in new areas in daily-evolving outreach strategy to new locations, prioritizing most-at-need areas.
4. **Partner testing and using networks**: Actively testing partners and engaging informal networks among FSW and MSM/TGW populations.
5. **Technology**: Expanding online outreach and using Viber for coordination and private outreach talks.
6. **Building relationships with key gatekeepers**: For example, betel nut shop owners and stewards of public toilets know their communities well and can refer people to TOP and assist peer outreach workers.
7. **Active HIV positive case management**: Newly identified HIV positive clients could immediately access ART either through initiation at TOP Yangon or accompanied referral to the NAP.

Global Fund implementing partners, led by Save the Children (SC), adopted these approaches and simplified them into six key elements:

1. **Sourcing new places and networks (mapping)**
2. **Using technology for HIV prevention**
3. **Network approach to team**
4. **Getting “Yes to Test” for HIV**
5. **Role of outreach in enrolling in care**
6. **Maintain contact with HIV (negative) clients**

All of the components are similar to the PEPFAR innovation components. The difference, however, comes in terms of implementation and rollout. TOP Yangon, the PEPFAR incubation site, is a well-known brand for quality service provision in the country and is a large nongovernmental organization (NGO) with its own KPSC. The TOP site has permission from the NAP to initiate 400 clients per year for ART; they have a staffed social media team, clinically and culturally competent medical staff, a one-stop shop for services, and ease of access for service use.

For adoption and scale-up within Global Fund programs, however, the emphasis on HIV case finding, accompanied linkages to care, and HIV positive case management were all new approaches for many of the grassroots programs. This emphasis was needed in order to further shift the prior efforts of reach, prevention, and HIV testing and into expanding implementing partners’ perspectives for supporting the client through the HIV cascade, regardless of HIV seropositivity.
One difference between the PEPFAR innovation and the Global Fund adoption included routine program data analysis and use. PSI/TOP reported daily, and sometimes hourly, data management systems. Global Fund implementing partners, however, reported a wide range of team data analysis from daily to weekly to every two weeks.

After more than a year of implementation of the EO approach, some Global Fund SRs showed substantial improvement in HIV Counseling and Testing (HCT) uptake and HIV case finding. According to aggregate descriptive data analysis from the Global Fund Progress Update and Disbursement Request (PUDR) data, MSM/TGW implementers have seen the greatest improvement for uptake and case finding (see Table 2) (GF Program review, 2019). FSW, however, have seen an increase in HCT uptake but a decrease in seropositivity case finding.

**Table 2. Comparison of Global Fund PUDR Data for Reach to Test and Positivity for MSM and FSW 2016/2018**

<table>
<thead>
<tr>
<th>GF PUDR Data</th>
<th>MSM 2016</th>
<th>MSM 2018</th>
<th>FSW 2016</th>
<th>FSW 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach to test</td>
<td>37% (51,567/139,074)</td>
<td>77% (53,555/69,111)</td>
<td>36% (35,757/97,001)</td>
<td>64% (36,654/56,493)</td>
</tr>
<tr>
<td>Positivity</td>
<td>5.4% (2,765)</td>
<td>6.4% (3,404)</td>
<td>5.2% (1,871)</td>
<td>4.5% (1,631)</td>
</tr>
</tbody>
</table>

Source: Global Fund PUDR, conducted by Adams, 2018

The aim of this assignment was for documentation purposes and not for evaluating or assessing the Global Fund program. The documentation team, however, uncovered some reasons for this potential decrease in HIV case finding. FSW programs have adopted the EO approach and are tapping into previously undiscovered networks in communities and outside of the more “traditional” HIV programming of outreach to massage parlors, brothels, and karaoke bars. FSW in these communities have never been reached before, do not typically associate with other FSW, are younger, and may be at higher risk for sexually transmitted infections (STIs) and HIV infection. Trust-building is a key component in the success of EO approach, and FSW programs are currently building trust and networks within new communities.

Additionally, the MSM/TGW programming may not be as comparable to the results from the PEPFAR incubation site with PSI/TOP. Though the use of technology is similar across PEPFAR and Global Fund EO approaches, there was considerable difference in the use of technology from one Global Fund implementing partner to another. Very few Global Fund partners have the staff, time, resources, and capabilities to reach out to new clients online. Those who have these resources are able to reach higher risk MSM/TGW online. The majority of clients included in the online outreach are MSM and TGW, although there are some efforts to conduct outreach online with FSW.

As indicated by PSI/TOP in Figure 3, TOP introduced a dedicated social media outreach team in January 2017, which resulted in the same HIV yield of 21% for online contacts with over double the number of people reached and HIV positive cases identified. Global Fund is also currently piloting the use of a mobile app for peer outreach workers in their reporting and data management use.
As reported by SC in the Global Fund Review Request for Proposal (2019), “there is substantial variation across [Sub-Recipients] SRs, with positivity rates ranging widely even where SRs are working in comparable environments targeting the same key population.” Additionally, EO may be contributing to increased seropositivity among other vulnerable populations as reported from January to June 2018 from 4.7% to 28% (GF RFP, 2019). See Figure 4 for a summary of the timeline of events within the Innovate-Adopt-Amplify Framework.
Figure 4. Summary of key events for Enhanced Outreach in the Innovate-Adopt-Amplify Framework, August 2016 – March 2019

**Innovate**
- PEPFAR/USAID develop and pilot Enhanced Outreach Approach (August 2016)
- HIV case finding significantly improves

**Adopt**
- HIV Technical Strategy Group updates, endorsement (Oct and Dec 2016)
- Training for >10 GF IPs (Dec 2016 - Jan 2017)
- Field mentoring in three high burden areas (Feb – Mar 2017)
- NAP supported operations manual and begin scale-up across high burden areas; includes HIV case management and linkages to HCT (April 2017)

**Amplify**
- GF Sub-Recipients and Sub-Sub-Recipients gradually adopt standard EO approach across all sites (Jan. 2018 – March 2019)
- Improved data analysis and use for prevention coverage and HIV case finding
- Began active HIV case management (Q3-4 FY 2018)
- Pilot testing of Enhanced Outreach App in select sites in Yangon (2018), improves real time data use and analysis; planned rollout to all sites

**QUESTION 1: HOW AND TO WHAT EXTENT HAVE PEPFAR-SUPPORTED ENHANCED OUTREACH INNOVATIONS BEEN ADOPTED AND SCALED UP?**

**Findings**
SC, one of the two Global Fund PRs for HIV embarked on adoption and amplification of the PEPFAR EO innovation once results were observed in PEPFAR/USAID innovation incubation through PSI/TOP. SC’s main approaches for adoption was to:

- Engage the NAP for sustainability and country ownership
- Build buy-in from community-based organizations and other implementing partners
- Develop EO operational guidelines for implementing partners with NAP collaboration
- Perform field-based coaching and mentoring
- Standardize training for all partners

Engagement and buy-in from NAP was viewed as a critical component for the successful adaptation of the EO approach. SC and USAID consistently informed the HIV TSG—a working group comprised of donors, implementing partners, United Nations partners, and donors—of EO process and results and advocated for the approach to become a standard for HIV programming in the country. SC consistently
communicated with government leaders at the NAP in order to gain buy-in and eventually officially sign-on with their approval of the EO operational guidelines for MSM and FSW.

A national effort was pursued to garner buy-in from MSM/TGW and FSW communities, implementing partners, and national leaders. SC organized and led the first meeting with Myanmar national leaders in collaboration with UNAIDS, WHO, and other national implementing partners. The goal of this meeting was to invite leaders in the HIV response and seek their guidance on the learning program for enhanced HIV prevention to MSM, transgender (TG) people, and FSW. In this meeting, a draft learning schedule was presented to participants who guided and advised on the final package of learning that led to the workshop curriculum.

SC, in partnership with UNAIDS and the NAP, then organized a series of national workshops to introduce the EO approach and provide training on the use of the different elements within EO. These three national workshops included workshops for program and HIV service managers and learning workshops for FSW and MSM/TG people. This buy-in and input process for different levels of providers and communities fed into the adaptation and tailoring of the guidance to meet the needs of FSW and MSM/TG communities.

SC commissioned consultants to support this process and also to support the EO operational guidelines development, feedback process, and field-based coaching for the implementation. The operational guidelines were written in partnership with the NAP, Ministry of Health and Sports, SC, UNAIDS, WHO, and the Global Fund implementing partners and CBOs. The guidelines act as a manual to standardize and operationalize the EO approach. The guidelines encompass the HIV cascade of prevention, treatment, and care, and differentiate EO and HIV positive case management within the HIV cascade (Figure 5). Guidelines were developed separately for FSW and MSM/TG people.

**Figure 5. Enhanced outreach and case management in the HIV cascade**

The consultants also supported a field-based coaching program to further provide capacity development assistance to implement the EO approach into organizational structures and systems. This coaching program was provided to four CBOs in Yangon and three in Mandalay. Respondents agreed that the coaching and mentoring intervention was critical to changing organizational structures and thinking to implement EO. Many of the community-based respondents reported a need to transition their thinking
and practices from the “old way” of conducting HIV outreach, e.g., going to the same places over and over with the same people.

The majority—but not all—of MSM/TG people and FSW implementing partners received this individualized coaching. In the documentation process, the team talked to one organization that was only recently trained this year in the EO approach. The comparison of results from Table 1 above could reflect this gradual rollout of EO.

Conclusions

The PEPFAR innovation has largely been adopted for SC’s Global Fund’s Myanmar’s HIV programming for MSM/TGW and FSW nationwide. SC went through a rigorous buy-in process to adapt the EO approach with feedback from government, implementing partners, bilaterals, and CBOs. The standardization of the EO approach through the operational guidance, in collaboration with NAP and the Ministry of Health and Sports, also supported sustainability efforts in the use of this best practice in HIV programming.

Scale-up, however, is still in the beginning phase. The majority of implementing partners are implementing EO, though the capacity to implement the EO package varies widely. There was a stark difference between larger implementing partners and smaller CBOs and their ability and resources to implement the EO approach. For example, larger implementing partners had more staff and resources for a one-stop-shop KPSC versus smaller CBOs who had to find a friendly physician to do accompanied referrals for HIV testing. Though there is certainly a possibility for more expansive use of EO at scale, there are barriers for reaching harder-to-reach populations.

Furthermore, Global Fund is repositioning itself to address the HIV cascade more holistically rather than focusing solely on HIV reach, prevention, and testing. For example, referrals for care enrollment and treatment initiation were not previously tracked, but Global Fund will require SRs to report these results in 2019. Global Fund Myanmar began monitoring linkage to care for July – December 2018. There are no formal indicators for linkage to care, and the indicator is monitored in the comments section of Global Fund reporting. At the time of the documentation, the 2019 reports were unavailable. As data becomes more available post-EO rollout, linkages to care can be better described in these reports.

An innovation like EO requires more attention to the HIV cascade as a whole due to the very nature of HIV case finding. As more HIV cases are identified, supportive systems need to be in place to provide treatment initiation, accompaniment through NAP systems, and psycho-social support in navigating the mental and structural issues that arise.

QUESTION 2: WHAT FACTORS ENABLED, AND WHAT FACTORS INHIBITED, SCALE-UP?

Findings

The documentation team identified salient themes from respondents of “what worked” in the Amplification phase of the Innovate-Adopt-Amplify Framework. These included:

- Data analytic capacity development at peer educator level for program, team, and individual performance improvement
- Use of systematic methods and team data analysis
• Maintenance of prevention coverage with HIV case finding
• Flexible work, performance-based payment
• Holistic cascade approach—following clients through care and treatment

The EO approach proved to be a catalyst to re-tool and update pre-existing HIV approaches in Myanmar. All the stakeholders interviewed agreed EO improved performance and increased their technical capacity to understand how to improve case finding, understand the HIV cascade, and be more flexible in how they achieve their results. Some peer outreach worker respondents reported that actually seeing their individualized results encouraged them to perform better. Others reported that they felt more motivated with a performance-based payment system. Nearly all of the respondents noted the importance of focusing on the whole HIV cascade and now have the resources and mandate to support that effort.

The EO approach for Global Fund is in the process of applying the approaches at scale. There is an ongoing effort to provide technical and data management capacity development. The documentation team identified enabling and inhibiting factors that can support the program to reach scale. EO is still in the fine-tuning stage of implementation. The documentation team recognized current and future salient themes for enabling and inhibiting factors.

The purpose of the documentation was not to assess or evaluate the program, but to understand how to better advise PEPFAR/USAID in Myanmar for current and future support for innovations. The factors mentioned below are relevant as they do not exist within a vacuum, but in a potentially growing area of innovation incubation. The authors recommend viewing the inhibiting and enabling factors as areas to consider when rolling out future innovations for adoption and amplification, as these innovations would need to have been to be integrated into existing organizational and technological systems.

**Enabling Factors**

The PEPFAR innovation model with USAID/Burma allows for a demonstration of effects and testing of components at a smaller scale before adaptation, adoption, and amplification. PEPFAR/USAID provides the upfront costs of testing innovations and tailoring to the Myanmar context. This unique arrangement for donor coordination and harmonization allows for global best practices to be adapted in-country and then adopted to a national program.

Stakeholder engagement, buy-in and trust-building were key success factors during the adoption and the amplification phases. Government collaboration and inclusion ensures that this innovation—and future innovations—are sustained and streamlined in HIV programming nationally. Furthermore, a collaborative approach with other implementing partners and CBOs in the adoption phase allowed for these stakeholders to contribute to the development of EO rather than simply “rolling out” the intervention without buy-in.

Trust is also a big factor in rolling out this new approach to people and communities. By securing the trust of CBOs and collaborating with them on the adaptation of EO for their communities, the CBOs could then, in turn, further build trusting relationships with the current communities they currently serve as well as the new networks and communities they discover and tap into.

The mentoring and coaching of the implementing partners by consultants also played a role in enabling for scale. Organizations received direct guidance from a consultant with expertise in team management and coaching and provided actionable feedback on how to best implement EO within the existing
structure. Respondents reported that this coaching and capacity development stemmed stress within the organization in implementing a new system with managers and peer outreach workers.

The overall flexible nature of the EO approach is also an enabling factor. Managers and peer outreach workers liked the performance-based nature and also the freedom to explore how to improve outreach on their own. Some peer outreach workers felt empowered and applied an entrepreneurial spirit to finding new hotspots and networks (see Box 2). Peer outreach workers also used program data to measure their own performance and worked to “beat” their own numbers. Most peers reported that they do this work out of passion and compassion for their own communities.

### Box 2. Case Example: Innovative peer-led outreach strategy to reach new networks

A peer outreach worker in Yangon told how they used new-found freedom and flexibility in EO to reach new networks. Male grooming and massage parlors are a relatively new occurrence in Myanmar. At these parlors, migrant men from rural areas do the massages, shaving, or other grooming services rather than women. The peer worker tried to approach some of these parlors but was turned away because they were too “feminine.” So the peer worker used their own money (~$20) and became a customer. The peer worker built up a relationship with the owner, and when they were with the male masseur, asked him if he provides sexual services (they answered that they did) and also inquired about his knowledge on HIV prevention. The peer worker identified a new, untapped network of high-risk men. Unfortunately, the cost to enter the parlors are too high and this particular outreach worker cannot regularly attend.

EO’s pivoted focus on data analysis and use from the bottom up is also an enabling factor to reach scale. The EO approach demonstrates how peer outreach workers and their supervisors can analyze data together to better understand social and sexual networks, peer performance, and explore new hotspots. This new approach contrasted with the older HIV prevention approach of simply visiting the same sites over and over.

One other factor that could enable scale-up is the EO app, an example of innovation incubation within the Global Fund. The EO app can be used by the peer outreach worker and supervisor for real-time data monitoring. The EO app was developed from the ground up in order to be specifically suited for the Myanmar program and context. The app is used as an outreach job aid to support peer outreach worker quality and performance, program management for real-time, automated analyses, and monitoring and evaluation (M&E). See Table 3 for further details on the functions of the EO app.

### Table 3. Enhanced Outreach App Functions

<table>
<thead>
<tr>
<th>Outreach Job Aid</th>
<th>Program Management</th>
<th>M&amp;E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alerts for missed referrals</td>
<td>Automated analyses</td>
<td>Cascade analysis</td>
</tr>
<tr>
<td>Prevention package prompt</td>
<td>Reach-to-test</td>
<td>De-duplication of clients</td>
</tr>
<tr>
<td>Real time performance against target</td>
<td>Test-to-enrolled</td>
<td>Record of all prevention package components</td>
</tr>
<tr>
<td>Hotspot positivity</td>
<td></td>
<td>Automated reports</td>
</tr>
<tr>
<td>Tool for outreach worker mentoring</td>
<td></td>
<td></td>
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<tr>
<td>Data for decision making</td>
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</tr>
</tbody>
</table>

Source: Save the Children, 2018
Another enabling factor was the attention and support for clients to know about and access the full HIV cascade. EO includes an HIV positive case management component with limited KPSC treatment initiation support and accompanied referrals to NAP sites. Respondents reported that they were glad to see full attention to the HIV cascade for the communities they serve and not just HIV testing. The accompanied referrals were largely welcomed by clients and implementing partners as an additional means to support their clients. Global Fund SRs will begin tracking linkages to care starting in 2019.

**Inhibiting Factors**

Many of the reported and observed inhibiting factors focused on the intensity of the EO approach, data management, burdens CBOs face in reaching targets and “competing” with larger NGOs with more resources, care and treatment support, and stigma and discrimination.

Respondents welcomed the new focus on HIV case finding and supporting clients through care, yet CBOs reported that there was a high burden on them to find HIV positive cases with fewer resources than larger NGOs that have one-stop-shop KPSCs and dedicated social media and medical staff. CBOs also have to find a KP-friendly physician to do accompanied referrals for HIV testing. Many CBOs reported that their clients preferred the KPSCs for its “one-stop-shop” and culturally competent staff.

Peers for both CBOs and NGOs found the app data entry burdens to be high and that it was faster to record data on paper and then enter it into the app. Also, the app needed Internet connectivity to record information. These issues often resulted in peers doing double-data entry and stretching the time it takes for them to do their work.

Program managers reported that they were busy with reporting for donors, which left little time for overall data analysis for program improvement. Some respondents reported that they indeed collect data separately for MSM and TGW, but there wasn’t any in-house sub-analysis on that data because the donor doesn’t ask for it. Similarly, data is regularly collected among TGW and MSM on sex work as risk factors, but there hadn’t been any analyses on that data.

Respondents also reported challenges with the app that could affect programming ability to rapidly reach scale. The primary issue, which is a Myanmar-wide issue, is the use of Unicode Burmese within the app versus the common vernacular of Burmese. In short, the Unicode version is what is used in computer systems for data entry and analysis and respondents reported that it was like learning a new language. For example, people in Myanmar download a special keyboard app for their phone so they can type in the “old way.” This “new way” of writing was most difficult for lower literacy populations, such as FSW, and also attributed to the double data entry system.

Overall, nearly all SR and SSR respondents reported treatment initiation as a barrier to scale-up. One large KPSC in Yangon has permission to initiate 400 people per year, which they reported would reach that number around the first quarter of the year. Another KPSC reported the ability to initiate 30 people per year but could only initiate clients who need it the most. Peer outreach workers at CBOs reported that there are no budget allocations for logistics and other details with HIV case management support. For example, they pay for HIV case management support out of their own pockets with no reimbursement for expenses, e.g., motorbike parking, the Care (yellow) and Treatment (White) booklets, food and transport for themselves and clients, and lab tests, such as chest X-rays and kidney/liver function. There is also high variance of treatment initiation at the NAP; it can take a client between one and six months for treatment initiation. Even though the programmatic support often ends
after a certain period during care enrollment, peer outreach workers still maintain contact with clients, often using their own money to support them through the process.

Stigma and discrimination are also inhibiting factors in reaching scale. Peer outreach workers face stigma and discrimination in their day-to-day activities. Many reported experiencing insults from general community members, particularly if they are TGW or feminine MSM. They also experience stigma and discrimination, especially from MSM who are more “masculine” or non-gay identifying. These networks are very difficult to go into and peers reported that they are known to use high risk-taking practices, like condomless and group sex.

Peer outreach workers also reported police harassment, e.g., police using condoms as “evidence” for sex work, bullying outreach workers who work at night, and threatening arrest for extortion for money. Peer outreach workers said that the police view TGW outreach workers and beneficiaries as “ATMs” as they were the easiest to target and to get money from.

Stigma and discrimination also extend into government health care settings, and treatment initiation policies create more barriers for KPs. For example, FSW, MSM, and TGW, who either work during the day or rest during the day because they work at night, must go through a lengthy care enrollment process in some places before they can initiate treatment. These processes take time and money, and for some of these populations it ends up being doubly expensive as they have to miss work in order to go to the clinic. Frequently, peer outreach workers reported stigma and discrimination at the clinics themselves from health care workers—ranging from gossip to comments in the counseling room.

Conclusions

This documentation’s purpose is to advise PEPFAR Myanmar on how to inform current and future innovations. The EO approach laid the foundation for future innovations and also helps PEPFAR and other donors consider what needs, structures, and systems are already in place in Myanmar and whether there is adequate support to maintain EO along with future innovations like pre-exposure prophylaxis (PrEP) and community-based HIV testing.

Enabling and inhibiting factors are useful to consider for getting to scale with innovative HIV programming in Myanmar. Both the inhibiting and enabling factors are relevant for future innovations as the same inhibiting factors organizations are facing now with EO could be exacerbated with new interventions.

The EO app, for example, can be used for real-time data monitoring and use and could integrate and track other interventions, like PrEP, in its platform. But as it stands now, the app is labor- and resource-intensive—from changing or adding fields within the user platform to the double data entry with peer outreach workers. Future innovations will need to be tracked in some way when adopting them to Global Fund partners. Human resources will also need to be considered so staff will be able to maintain the gains from EO while incorporating newer innovation interventions.

Data management burdens also have an impact on data analysis for program improvement. This was evident in the lack of data analysis for TGW, despite some partners collecting disaggregated data on MSM and TGW. The HIV National Strategic Plan mentions TG but does not list TG or TGW as KPs. When asked, many respondents said that the NAP needs to define transgender people first. These conversations had begun at the national level at the time of the documentation.
The current team leader for the EO documentation had visited USAID/Burma in 2017 to set up a monitoring system to identify TG clients. PSI/TOP implemented a two-step gender identification system, and a question on sex work, and these data points were collected during outreach and tracked with clients throughout care. The team discovered that the Alliance also tracked TG clients, using the same system as PSI, but this tracking was not consistent across all partners. Since TG clients are lumped in with MSM, any data collected for TG clients was automatically aggregated under MSM. None of the implementers for both PEPFAR and Global Fund had separated or analyzed MSM and TGW data, let alone data on those who conduct sex work.

This is important for a few reasons. First, there was no knowledge on how much TGW were skewing MSM prevalence data. Globally, TGW are 50 times more likely to be HIV-infected than other reproductive age adults (Baral 2013), and Myanmar Integrated Biological and Behavioural Survey (IBBS) sub-analysis showed TGW to have a high burden of HIV (Myanmar IBBS). Including TGW with MSM data doesn’t give an accurate picture of the epidemic. Second, TGW usually have different sexual networks than MSM. A respondent-driven sampling study in Peru, for example, showed that TGW had completely separate sexual networks than MSM (Peru Trans Network, 2019). Finally, MSM interventions are overlaid onto TGW peers and without separate analysis and formative research specifically for these populations; future innovations may not be sufficient and adequate to reach TGW at scale.

Multi-stakeholder engagement and field-based mentoring are key components for the success of reaching scale. Ongoing technical assistance is still needed to help implementing partners refine and maximize EO and future innovations.

As more innovations are tested and subsequently rolled out, CBOs in particular need support on human resources, structural interventions, use of technology, and stigma and discrimination. More innovations could mean more burdens for resource and staff-constrained organizations at grassroots levels. More support is needed for HIV positive clients to reach treatment initiation.

Stigma and discrimination at various levels will also need to be considered when refining EO and rolling out new interventions. Community feedback on their experiences will be key in learning how to address at these different levels—community, police, health workers, etc.

**QUESTION 3: WHAT LESSONS LEARNED CAN BE ADOPTED TO FUTURE DONOR-SUPPORTED EFFORTS TO DEVELOP AND SCALE INNOVATIONS FOR REACHING 90-90-90 TARGETS IN MYANMAR?**

**Findings**

The key lessons learned repeat many of the conclusions mentioned above. The majority of the respondents gave lessons learned from the adoption and amplification phases. These eight lessons learned are:

1. Trust-building and stakeholder engagement from government to grassroots organizations are important components of the Innovate-Adopt-Amplify Framework. Government support and endorsement of EO were critical in adoption and setting the stage for future innovations. Implementing partner and community feedback was crucial in adapting an innovation from pilot to scale.
2. Field-based mentoring allowed for organizational and individualized support for implementation. This mentoring approach could be used when rolling out future innovations in the adoption and amplification phases.

3. Care and treatment linkages and initiation need extra support and attention. The HIV case management method within the EO approach has increased linkage and retention, yet there are structural and resource barriers that could improve these interventions. If an intervention like EO is finding more HIV positive cases, then more needs to be done to support those people to access HIV care and treatment. In some cases, implementing partners reported EO gains were being lost in the lengthy treatment initiation process.

4. Technology has great potential but can also be a barrier. With the pervasiveness of mobile phone technology in Myanmar, people are more connected than ever. Online outreach can reach those previously unreachable or only reached online. Messaging platforms connect peers and program staff for coordination in real time. The barriers, as mentioned previously, are the ability and literacy to use those applications. More training and capacity development is needed in order to better use technology for program improvement and to reach more higher risk populations (e.g., closed Facebook groups of high-risk MSM, paying for a Grindr membership to expand the geographic reach of social media staff, and providing human and funding resources for CBOs to use social media in their own outreach.)

5. The new focus on data management and analysis from the bottom up has improved data use at various levels of program implementation, monitoring, and evaluation. There is still a need to conduct data analysis for program improvement more broadly and understand how to better reach and serve clients.

6. Larger, more resourced NGOs, like PSI/TOP, can work with innovations and demonstrate and achieve results. Smaller CBOs and NGOs, conversely, struggle with the human resources, lack of a one-stop-shop, and skill set demands. As local solutions are implemented over time, local actors may have a harder time implementing future innovations. They may need more training and resources to take full advantage of new approaches.

7. TG data needs to be disaggregated at program level and used to create specific interventions for these populations. TG people, particularly TGW, are much more likely to be infected with HIV, face more stigma, discrimination, and violence than MSM and are more likely to be involved in sex work and less likely to find full-time employment outside of the beauty industry. Some Global Fund partners collect TGW data, but it is not analyzed or used to improve reach and retention for TGW. Not all partners use the two-step gender identification system to track TGW clients. There are opportunities here for PEPFAR partners to share knowledge on TG programming with Global Fund partners.

8. Human resources are required for developing new innovations and in adopting and amplification. Different skill sets may be required for, say, developing technical innovations when compared to the skill sets needed in adoption (e.g., coaching and mentoring). The EO approach can be labor-intensive with data management demands and linkages through the cascade, so future innovations need to keep in mind existing human resource burdens, particularly with care and treatment technical and implementation support that is needed to ensure KPs are making their way to treatment initiation and supported in adherence. Similarly, with an intervention like PrEP, different kinds of human resource support will be needed to support HIV negative people to stay negative with this intervention.
9. Stigma, discrimination, and violence are the lived, daily realities of KPs, both as members of a community and as program staff. Safety, security, and confidentiality need to be considered when developing future innovations. The EO approach has ensured all of these with checks within the program (e.g., unique identification codes). More can be done to decrease stigma, discrimination, and violence and empower communities and program staff to know their rights and provide avenues for reporting and redressing incidents.

Conclusions
USAID/PEPFAR’s Innovate-Adopt-Amplify strategy is an effective means of generating innovation to improve the effectiveness of the country’s HIV response. The incubation period that resulted in the EO approach and was adopted by Global Fund implementing partners greatly improved HIV case finding and overall program management and data use, and enhanced HIV positive case management. EO significantly improved the efficiency and effectiveness of programs, and future innovations have a more efficient means for dissemination and uptake by stakeholders at various levels. As the Global Fund approaches the amplification stage, EO has the potential to support the national Myanmar KP program in reaching more KP with HIV prevention, treatment, care, and support along the HIV cascade.
V. CONCEPTUAL FRAMEWORK

USAID/Burma requested the development of a conceptual framework for the Innovate-Adopt-Amplify process. Table 4 shows the different phases of the process with key components, missing components, indicators for scale, and best ways to document. Indicators for scale and the documentation rows are the same across all the phases. The key components and the “what’s missing” rows are summaries of what has been discussed above. The authors would like to note that Myanmar is only just beginning to enter into the Amplify phase, so the missing components section only reflects what was seen at the time of the documentation.

Table 4. Innovate-Adapt-Amplify Conceptual Framework for Myanmar

<table>
<thead>
<tr>
<th></th>
<th>Innovate</th>
<th>Adopt</th>
<th>Amplify</th>
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<tbody>
<tr>
<td><strong>Key Components</strong></td>
<td>Engaging Global Fund partners, including key population communities</td>
<td>Stakeholder engagement early and consistently (trust)</td>
<td>Standardized operational guidelines, practices, and trainings</td>
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<td></td>
<td>Adapting global international best practices to the local context</td>
<td>Feedback from stakeholders on how best to adapt and adopt (including</td>
<td>Technical assistance follow-up</td>
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<tr>
<td></td>
<td>Engaging global and regional technical experts on current best practices</td>
<td>stigma, discrimination, and violence)</td>
<td>Adapting innovations based on feedback from staff and clients</td>
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<td></td>
<td>Conducting a literature review on best practices</td>
<td>Field-based mentorship and coaching</td>
<td>particular to each organization</td>
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<td></td>
<td></td>
<td>Flexibility of innovation to be adapted to different contexts</td>
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<td></td>
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<td>Routine data availability, analysis, and use</td>
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<tr>
<td><strong>What’s Missing?</strong></td>
<td>Test interventions in different settings</td>
<td>Streamlined data management systems</td>
<td>Expansion of online outreach, interventions, and innovations</td>
</tr>
<tr>
<td></td>
<td>Engage government early on in the process and prepare for Adoption</td>
<td>Consideration for how innovations affect the larger program (not just</td>
<td>Resources and support for CBOs to carve out their own space or services (e.g., CBOs may be more adept at care, treatment, and support services)</td>
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<td></td>
<td>stage</td>
<td>discrete donor index indicators)</td>
<td>Considerations for how innovations and adoptions affect the</td>
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<tr>
<td></td>
<td>Continued technical assistance to Global Fund implementers</td>
<td>Considerations for human resources and what is needed for full adoption</td>
<td>full cascade, e.g., care, treatment, and</td>
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<td></td>
<td>Considering what scale means and if it should be considered in the</td>
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<td></td>
<td>innovation/incubation process</td>
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<td>Innovations for online interventions (online efforts are viewed as a</td>
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<tr>
<td>Innovate</td>
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<tr>
<td>tool and not as an intervention itself)</td>
<td>adherence support for clients</td>
<td>Measuring if and how much stigma, discrimination, and violence is increased or reduced by adopted innovations by staff and clients</td>
<td></td>
</tr>
<tr>
<td>Resources and support for CBOs and communities to develop their own innovations (e.g., a challenge grant for CBOs)</td>
<td>Measuring if and how much stigma, discrimination, and violence is increased or reduced by adopted innovations by staff and clients</td>
<td>Bringing implementers together again for iterative “scaling” feedback meetings</td>
<td></td>
</tr>
<tr>
<td>Considerations for stigma, discrimination, and violence and if the innovation would increase or decrease these experiences with staff and clients; consider how innovations could mitigate these incidences and experiences</td>
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<td></td>
<td></td>
<td>Bringing implementers together again for iterative “scaling” feedback meetings</td>
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**Indicators for Scale**

- # people for reach, test, treatment, retention, and viral load indicators (e.g. program data from care and support linkages)
- % clients satisfied with services at each part of the cascade (e.g. simple client feedback surveys using different emojis, stars for rating, etc.)
- Increased rate of initiation of clients over time
- Disaggregated data for each key population and sub-populations
- # of NAP centers implementing test and start; documentation on what test and start looks (e.g. immediate initiation, <2 weeks, etc.)
- Overall decrease in stigma, discrimination, and violence among each key population group

**Documentation**

- External reviews and reports
- Social media promotion and updates and tagging PEPFAR and other global partners
- Promote through webinars, news articles, global/regional/national meetings and conferences
- Explore mixed media—articles, pictures, short video stories, testimonials, online engagement and discussions
VI. RECOMMENDATIONS
FOR PEPFAR MYANMAR

• Explore expansion of the PEPFAR Myanmar innovation mandate to include the provisions of technical assistance to Global Fund partners and support amplification—e.g., data management and use, TGW-specific strategies, data analysis for program improvement, etc.

• Ensure that future innovations are tested in settings outside of the PSI/TOP center. Garner perspectives from CBOs so that the adoption phase could be smoother and quicker. Additionally, there could be future innovations that “don’t work” in urban areas or for the KPSC that might work well in grassroots/CBO settings.

• Refine the definition of “amplification” so that capacity development of and resource allocation for smaller CBOs and NGOs are acknowledged and planned so that they can implement future innovation. Ensure local solutions are piloted and adapted for various local organizational capacities.

• Collaborate with national stakeholders, including, but not limited to, Global Fund, government, and KP communities for stigma, discrimination, and violence reduction strategies.

• Be aware of the current human resources and capacities for implementing new innovations and the technical, programmatic, management, and data requirements that will be needed. Provide resources and support to ensure that there is a balanced approach when adopting new innovations into the national program—e.g., that EO implementation isn’t negatively impacted by the introduction of additional new innovations.

• Partner with stakeholders to strengthen care, treatment, and support for HIV positive clients and to develop policies and strategies to further operationalize test and start.

• Explore the development and testing of social and behavior change communication strategies for HIV prevention, treatment, and care. There is a dedicated social media outreach team that is already always listening to the conversations happening online. This input could be invaluable to developing online interventions.

• Explore how to reach the hardest to reach populations, e.g., closed networks and/or Facebook groups of straight- or masculine-identifying MSM. This may require recruiting someone from that group with different incentives or motivations.

• Design innovation interventions specifically for TGW and stop lumping this population together with MSM. As of this writing, the country is beginning to explore separating TGW from MSM, but the program does not need to wait for the country to catch up to separate the data for these two populations. The programmatic data, in fact, can be used for further advocacy and to inform how the country can catch up to global best practices. TGW have different needs and experiences than MSM, most likely have different sexual partners, and are at higher risk for HIV. A TGW-specific intervention developed for the growing transgender community in Myanmar is a high need for the country at this time.
FOR PEPFAR IN OTHER COUNTRIES

- Explore how the PEPFAR innovation model in Myanmar could be replicated in other countries. PEPFAR could be the incubator and technical assistance provider while Global Fund is the implementing partner. Each country is unique so caution against a one-model-fits-all approach.

FOR FUTURE INNOVATIONS

- Follow the EO blueprint for Innovate-Adopt-Amplify and also be aware of innovation adoption fatigue (e.g., rolling out multiple interventions at once or in close succession). Ensure that organizations are ready to take on new innovations, particularly CBOs.

- Care and treatment needs its own innovations, interventions, and indicators as soon as possible. The majority of innovations discussed with partners, including USAID/Burma, were focused on HIV testing (e.g., community-based screening and HIV self-testing) and prevention (e.g., PrEP). The care, treatment, and adherence side of the cascade is insufficient to truly support those who are HIV positive. More resources are also needed to support this side of the cascade.

- Consider a plan for sustainability and how new innovations will integrate with existing implementation approaches.

CONSIDERATIONS FOR EO IMPROVEMENT

The documentation team talked to several implementing partners of EO for the Global Fund in Myanmar. They had their own ideas on how best to improve the approach and implementation. The team is sharing these here as considerations for improvement:

- Provide further technical assistance support for programmatic data analysis and use, NAP treatment policy guidelines and implementation, stigma and discrimination reduction strategies, and use of technology in reaching new KPs.

- More financial and human resources are needed to support HIV positive case management. The costs of providing support to a client are much higher than simply accompanying them to the center—e.g., transport, parking fees, food (they often have long wait times).

- Indicators are needed to track the HIV case management on an aggregate level. If there are indicators for programs, there needs to be funding to support that indicator.

- Advocacy work with the NAP is critical to reduce unnecessary steps and bottlenecks in ART initiation to fully benefit seropositive KP.

- Local CBOs are the key actors in the success of EO and need to be strengthened along with international and other larger local NGOs. Local CBOs feel they are “in competition” with international or larger local NGOs. International NGOs and larger local NGOs need to work in support of local CBOs and build their capacity. There is already some support there with limited referrals to the KPSC, but the KPSC can’t “count” that test. Future innovations, such as supervised HIV self-testing and community-based HCT, may alleviate this feeling of competition.

- More ART will be required as the EO becomes more successful. As such, an ART provision plan should be discussed with the NAP and donor agencies so that all the seropositive KPs could be enrolled in ART irrespective of CD4 count, according to the WHO guidelines and to reach 90-90-90 target in Myanmar.
RECOMMENDATIONS ON HOW TO DOCUMENT BEST PRACTICES IN THE FUTURE

• Use “traditional” methods of external reviewers and reports.

• Explore the use of social media promotion with regular updates to global, regional, and in-country communities (e.g., tag PEPFAR and other partners, country audiences will need Burmese translation, etc.).

• Promote through webinars (external and/or have Myanmar-led webinars), news articles, global/regional/national meetings and conferences.

• Use a variety of media—e.g., articles, pictures, short video stories, testimonials, guest writing on blogs, online engagement and discussions.
ANNEX I. SCOPE OF WORK

Assignment #: 602 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 06/12/2018
Last update/Revised: 5-29-19
Amendment #2

I. Title: Trace the adoption and amplification process of the Enhanced Outreach methodology developed by PEPFAR, and develop solicitations and approval/classification documents for Mission staff positions

II. Requester / Client
☐ USAID Country or Regional Mission
Mission/Division: Myanmar / OPH

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☐ 3.1.1 HIV ☐ 3.1.4 PIOET ☐ 3.1.7 FP/RH
☐ 3.1.2 TB ☐ 3.1.5 Other public health threats ☐ 3.1.8 WSSH
☐ 3.1.3 Malaria ☐ 3.1.6 MCH ☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a final budget based on this SOW

V. Performance Period
Expected Start Date (on or about): December 3, 2018
Anticipated End Date (on or about): June 28, 2019

VI. Location(s) of Assignment: (Indicate where work will be performed)
Myanmar (Yangon and Mandalay) and remote support
VII. **Purpose of Consultant Assignment** (Purpose and need for consultant)

The purpose of the consultancy is two-fold:

a) To document USAID-supported Enhanced Outreach approaches to increase HIV testing yields.

b) To provide remote support for classification and establishment of new mission staffing positions.

**Objectives of Consultant Assignment**

The objectives of this assignment are:

a) Complete an analysis documenting USAID/Burma-supported Enhanced Outreach (EO) approaches for increasing HIV testing yields, and the process and extent to which EO has been further amplified and scaled by the National AIDS Program, Global Fund, 3MDG Fund and others.

Two position descriptions, approval documents and classification packages for two new OPH FSN positions: A Program Management Specialist for HIV/AIDS (FSN-12), and a GS-14 TB Program Advisor position (PSC).

VIII. **Background for Consultant Assignment** (Background of work related to this assignment)

**Component (a) Documentation of Enhanced Outreach**

A key tenet of USAID’s health and HIV programming strategy in Myanmar is to support the development and introduction of innovations that can be adopted, amplified and scaled up by other actors with other resources. Mission programs under PEPFAR have been highlighted as a successful example of this kind of ‘incubator’ approach for supporting new innovations that are in turn amplified by others.

In early 2016, HIV case finding at the Targeted Outreach Project (TOP) clinics for key populations (MSM, TG and FSW), implemented by Population Services International (PSI), remained at 4%-6%. After analyzing site-level data and interviewing peers, it was found that peer outreach workers were visiting and revisiting over-serviced, well-known hotspots, and no clear targets were set for HIV testing or positivity.

In March 2016, TOP entered an "incubation period" where several new strategies were tested to improve HIV case finding. Most importantly, there was a key shift in the outreach approach beginning with daily (even hourly) data management using “case finding calculators” and knowledge-sharing across outreach teams.

As a result of these efforts, HIV case finding increased from 5% in Q2 FY16 to 14% in Q2 FY17 (12% in Q4 FY17) at TOP clinics in USAID pivot areas, the highest yield among PEPFAR countries. With the higher influx of newly diagnosed PLHIV, USAID and TOP introduced a case management system to ensure these newly identified HIV+ clients could access ART. TOP increased immediate linkage to care: those clients entering care through online channels have 93% ART enrollment rate and those entering through peer outreach have 90% ART enrollment by Q4 FY17.

The success of these approaches to increase yields were called the “Enhanced Outreach” (EO) approach and brought to the attention of a wider group of implementing partners in the HIV Technical Strategy Group (TSG), which is chaired by Myanmar National AIDS Program (NAP). After a series of presentations and updates, the NAP agreed to adopt a set of these methods (daily data management, micro-mapping, scouting out new places), and train implementing partners working under the Global Fund and the Three Millennium Development Goal Fund (3MDG). EO Operational manuals were drafted and approved by the NAP. The new approach, adapted to each implementing group, is yielding results.

USAID-supported EO approaches are a key feature of USAID/Burma’s PEPFAR programming, and a potential model for showcasing how USAID has been able to ‘incubate’ new innovations in programming, and support scale-
up through country platforms and other funding sources – which the Mission has referred to in shorthand as “innovate, adopt, amplify”. USAID’s approach is summarized in the slide below.

Component (b) Development of PD and recruitment packages

The Mission plans to upgrade the current HIV Program Management Specialist position from FSN-I0 to FSN-I2 and requires support to update the position description and provide supporting documents for reclassification and approval of the new position. In addition, the Mission plans to establish a new TB technical advisor position, envisioned as a GS-I4 TCN PSC Program Advisor. Remote support is needed to develop caging and approval packages for these positions.

X. SCOPE OF WORK

Description of Work & Responsibilities
Describe the work to be done by the consultant(s) and what he/she/they will be responsible for.

- Complete an analysis documenting enhanced outreach programming on behalf of the Mission, through primary data collection and analysis of secondary data and project reporting.
- Provide remote support for development of Mission staff position description classification packages.
Major Tasks & Activities
What major tasks will the consult(s) be expected to implement

Component (a) Documentation of Enhanced Outreach

This task is to trace the adoption and amplification process of the Enhanced Outreach methodology developed by PEPFAR, assess the extent to which adoption and amplification has occurred and its contribution to the national HIV/AIDS response, and provide actionable recommendations to USAID/Burma regarding how to successfully incubate and scale new approaches.

- How and to what extent have PEPFAR-supported enhanced outreach innovations been adopted and scaled up by Global Fund and 3MDG projects? What factors enabled, and what factors inhibited, scale up?
- What is the quantifiable value of USAID contribution and leverage of other resources through innovation?
- What lessons learned can be adopted to future donor-supported efforts to develop and scale innovations for reaching 90-90-90 targets in Myanmar?

This is expected to involve two to three weeks of field work including visits to GF PR and 3MDG program offices and, HIV Program sites in Yangon, and Mandalay; key informant interviews with stakeholders at all sites, partners in Yangon, and government counterparts in Nay Pyi Taw.

XI. DELIVERABLES & MILESTONES
List all deliverables in the table below. Provide estimated timelines and deliverable deadline for each.

<table>
<thead>
<tr>
<th>Deliverables</th>
<th>Timelines/Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Kick-off call with Mission and lead consultants for Enhanced Outreach activity</td>
<td>TBD</td>
</tr>
<tr>
<td>2 Draft data collection and analysis plan submitted to Mission</td>
<td>March 1, 2019</td>
</tr>
<tr>
<td>3 Final data collection and analysis plan</td>
<td>March 6, 2019</td>
</tr>
<tr>
<td>4 In-country field work and report writing</td>
<td>March 7 – March 22</td>
</tr>
<tr>
<td>5 Debriefing with Mission and TOP</td>
<td>a/o March 26</td>
</tr>
<tr>
<td>6 Draft report</td>
<td>April 19, 2019</td>
</tr>
<tr>
<td>7 Final report</td>
<td>June 15, 2019</td>
</tr>
<tr>
<td>8 FSN-12 classification and approval package</td>
<td>TBD or as agreed with Mission POC</td>
</tr>
<tr>
<td>9 TB position description and approval package</td>
<td>TBD or as agreed with Mission POC</td>
</tr>
<tr>
<td>10 1-2 Position Classifications (TBD)</td>
<td>TBD or as agreed with Mission POC</td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval: _____ Up to 10 Business days
XII. STAFFING

Consultant(s) Needed: □ Individual Consultant □ Team of ___ # of Consultants (estimated)

They will be joined with up to two staff from USAID/Washington and USAID/Burma.

Consultant 1 Title: Lead HIV Program Expert (International)

Roles & Responsibilities: In collaboration with the USAID Mission, this person will be responsible for the overall documentation of Enhanced Outreach and Innovate-Adapt-Amplify, including the data collection and analysis plan, management of any local consultants associated with this activity, and production of the final debrief and report.

Qualifications: The senior HIV program expert should have significant experience with HIV programming in developing countries, with particular emphasis on key populations such as Female Sex Workers, Men who have Sex with Men (MSM) and Transgender (TG) populations. Experience in Asia and experience with PEPFAR programming are strongly preferred. Knowledge of the Global Fund, PEPFAR and international best practices for HIV diagnosis, care and treatment are required. Demonstrated strong writing skills are essential, and s/he must be able to lead a team that includes USAID staff and Myanmar nationals.

Consultant 2

HIV Program Technical Specialist or Evaluation Specialist (Local): This consultant will work in partnership with the Lead HIV Program Expert to support the overall design and execution of Enhanced Outreach documentation. S/he will serve as a liaison and linkage to key counterparts and experts among stakeholder organizations and the Ministry of Health and Sports and provide vital understanding of the Myanmar context.

Qualifications: The local technical consultant should have mid- to senior-level qualifications and experience in HIV Programming or in public health program evaluation and/or operations research (at the discretion of GH Pro and the lead consultant). Must be fluent in English and Burmese and have strong English writing skills.

Consultant 3

Logistics/Program Coordination and Note Taker (Local): If needed, at discretion of GH Pro, this consultant will work closely with consultants 1 and 2 to support field logistics including booking appointments with key stakeholders, arranging transport, etc.

Qualifications: S/he must be fluent in English and Burmese and have demonstrated experience documenting discussions and decision points and providing logistical support; and good organizational skills.

Consultant 4:

Title: Public Health Programs Advisor (international)

Roles & Responsibilities: This consultant will provide expert support to the USAID/Burma Mission for development of new position descriptions, caging and approval documents for new Mission positions.

Qualifications: Public health expert with demonstrated experience in USAID program management and caging of personnel positions required.
**GH Pro Program Manager**

Roles and Responsibilities: Provide overall management of the activities, recruitment of consultants, editing of final reports, serving as content editor as needed. Support to be provided remotely, as needed.

**XIII. Staffing Level of Effort (LOE) Matrix Instructions:**
This LOE Matrix can help you estimate the LOE of each consultant attached to this assignment. If you are unsure, GH Pro can assist you to complete this table.

- a) For each column, replace the label "Title" with the actual position title of consultant needed for this activity.
- b) Enter Row labels for each activity, task and deliverable needed to implement this activity.
- c) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- d) At the bottom of the table total the LOE days for each consultant title.

Level of Effort in days for each Consultant attached to this assignment- ESTIMATED (Will be revised)

<table>
<thead>
<tr>
<th>Activity /Task / Deliverable</th>
<th>Estimated Consultants LOE (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lead HIV Program Expert</td>
</tr>
<tr>
<td>Component A: Enhanced Outreach</td>
<td></td>
</tr>
<tr>
<td>1 Kick-off call with Mission and lead consultants for Enhanced Outreach activity</td>
<td>0.5</td>
</tr>
<tr>
<td>2 Draft data collection and analysis plan submitted to Mission</td>
<td>3</td>
</tr>
<tr>
<td>3 Respond to USAID feedback and finalize data collection and analysis plan</td>
<td>1.5</td>
</tr>
<tr>
<td>4 Preparation for field work</td>
<td>1</td>
</tr>
<tr>
<td>5 In-country field work and report writing, and debriefing in-country, including in-country air travel to Nay Pyi Taw, Mandalay, and Kachin. Local travel in Yangon as well.</td>
<td>18</td>
</tr>
</tbody>
</table>
### Activity /Task / Deliverable
List each activity, task and deliverable expected

<table>
<thead>
<tr>
<th>Activity /Task / Deliverable</th>
<th>Lead HIV Program Expert</th>
<th>Local, HIV Program Technical Specialist/ Evaluation Specialist</th>
<th>Logistics Coordinator/ Note Taker</th>
<th>Public Health Programs Advisor</th>
<th>GH Pro PM</th>
<th>USAID/ Myanmar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft report and submit to Mission</td>
<td>5</td>
<td>5</td>
<td></td>
<td>1</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Respond to USAID comments on draft report</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final report submission</td>
<td></td>
<td>0.5</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Component a subtotal</strong></td>
<td>32</td>
<td>32</td>
<td>21.5</td>
<td>0</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Prepare FSN care package &amp; respond to Mission comments</td>
<td>2</td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare PSC TB care package &amp; respond to Mission comments</td>
<td>3</td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2 Position Classifications (TBD)</td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Component a subtotal</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total LOE</strong></td>
<td>32</td>
<td>32</td>
<td>21.5</td>
<td>10</td>
<td>5</td>
<td>11</td>
</tr>
</tbody>
</table>

If overseas, is a 6-day work week permitted?  
☐ Yes  ☑ No

### XIV. LOGISTICS

**Visa Requirements**

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

- A business visa on arrival is required for expatriate travel to Burma and can be facilitated by the Mission; processing time is 5-8 weeks, and validity is 8 weeks maximum.

**List recommended/required type of Visa for entry into counties where consultant(s) will work**

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>☐ Tourist</td>
</tr>
</tbody>
</table>

**Clearances & Other Requirements**

**Note:** Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.
GH Pro can obtain **Secret Security Clearances** and **Facility Access (FA)** for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking **approximately 6 months** to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant’s travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for **additional lodging** and M&E to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- [ ] USAID Facility Access
  
  Specify who will require Facility Access: ________________________________

- [ ] Electronic County Clearance (ECC) (International travelers only)
  
  □ High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)
  
  □ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

- [ ] GH Pro workspace
  
  Specify who will require workspace at GH Pro: ________________________________

- [ ] Travel - other than posting (specify): Travel for lead international consultant to Myanmar; in-country travel for consultants 1-3 in Yangon, and Mandalay.

- [ ] Other (specify): ________________________________
XV. **GH Pro Roles and Responsibilities**
GH Pro will coordinate and manage the consultant or consulting team, and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for activity
- Recruit and hire consultants, with USAID POC approval
- Arrange travel and lodging for consultants to primary location of work, as needed
- Request facility access and/or country clearance (if needed)
- Review methods, work plan, reports and other deliverables as part of the quality assurance oversight
- Report production (when a report is a deliverable) – If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for Internal Distribution.

XVI. **USAID Roles and Responsibilities**
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

### USAID Roles and Responsibilities

**USAID** will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

#### Before Field Work

- **SOW.**
  - Respond to queries about the SOW and/or the assignment at large.
- **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment. GH Pro team should also work directly with PSI to provide access to all requisite background materials.
- **Local Consultants.** Upon request, assist with identification of potential local consultants, including contact information, if requested.
- **Site Visit Preparations.** GH Pro will be expected to handle all site visit preparations in coordination with PSI, including requests for Ministry meetings. If needed and as advised by PSI, USAID can provide a support letter to MOHS requesting meetings with key officials on the team’s behalf.
- **Lodgings and Travel.** Upon request, provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).
During Field Work

- **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work.
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders, where needed. Mission is willing send request letter for MOHS meetings if requested, and if advised by PSI; GH Pro will be expected to follow up and confirm meetings directly.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings, on an as-needed basis. In general, it is expected that the GH Pro team will reach out directly to partners, with support from PSI / TOP.
- **Participate in selected site visits.** Mission POC may participate in selected site visits, at the direction of USAID.

After Field Work

- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

### USAID CONTACT PERSON

<table>
<thead>
<tr>
<th></th>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td>Robert Kelly</td>
<td>Karen Cavanaugh</td>
<td>Ben Zinner</td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>HIV AIDS Advisor</td>
<td>Office Director</td>
<td>Deputy Director</td>
</tr>
<tr>
<td><strong>USAID Office/Mission</strong></td>
<td>Burma /OPH</td>
<td>Burma /OPH</td>
<td>Burma /OPH</td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td><a href="mailto:rkelly@usaid.gov">rkelly@usaid.gov</a></td>
<td><a href="mailto:kcavanaugh@usaid.gov">kcavanaugh@usaid.gov</a></td>
<td><a href="mailto:bzinner@usaid.gov">bzinner@usaid.gov</a></td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>+95-1 536509-4994</td>
<td>+95-1 536509</td>
<td>+95-1  536509</td>
</tr>
<tr>
<td><strong>Cell Phone:</strong></td>
<td>09-798-420393</td>
<td>09-541-9652</td>
<td>09-541-9589</td>
</tr>
</tbody>
</table>

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th></th>
<th>Tech Support Contact 1</th>
<th>Tech Support Contact 2</th>
<th>Tech Support Contact 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong></td>
<td>Naw Shelda</td>
<td>Ei Thu Soe Moe</td>
<td></td>
</tr>
<tr>
<td><strong>Title:</strong></td>
<td>Program Assistant</td>
<td>Administrative Assistant</td>
<td></td>
</tr>
<tr>
<td><strong>USAID Office:</strong></td>
<td>USAID/Burma OPH</td>
<td>USAID/Burma OPH</td>
<td></td>
</tr>
<tr>
<td><strong>Email:</strong></td>
<td><a href="mailto:nshelda@usaid.gov">nshelda@usaid.gov</a></td>
<td><a href="mailto:etsmoe@usaid.gov">etsmoe@usaid.gov</a></td>
<td></td>
</tr>
</tbody>
</table>
XVII. REFERENCE MATERIALS
Documents and materials needed and/or useful for consultant assignment

Briefing document on “Reaching the Right People at the Right Time: Innovations that resulted in HIV testing yield increases.”
ANNEX II. ENHANCED OUTREACH DOCUMENTATION TOOL

Innovate

- Describe the Enhanced Outreach innovations and when each were implemented?
- How does the Enhanced Outreach approach differ for each key population?
- What are the results for Enhanced Outreach?
  - What innovations are the most successful in terms of results achieved?
  - Any contextualization required?
- How were innovations identified?
- How were innovations tested?
- What are the strengths, challenges, and lessons learned during the innovation phase?

Adopt

- How were partners outside of PEPFAR identified/made aware of innovations?
- Describe National AIDS Program/Government/TSG involvement. Alignment of NAP’s strategy?
- What was the process of adaptation for the Enhanced Outreach approach?
- What are some examples of how innovations were adapted for each organization? For each key population?
- What are the strengths? Challenges? Lessons learned?

Amplify

- How has Enhanced Outreach improved (or benefited) HIV programs in Myanmar?
  - What are the results of amplification?
  - What is the reach of the Enhanced Outreach approach?
- Did any new innovations spring from adapting and implementing the Enhanced Outreach approach?
- What are the strengths? Challenges? Lessons learned?
  - Factors that enabled/inhibited scale?
- What recommendations are there to replicated and incubate new, different HIV interventions?
- Can this approach be used in other sectors such as TB?
## ANNEX III. LIST OF PERSONS INTERVIEWED

<table>
<thead>
<tr>
<th>No.</th>
<th>Date and Time</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monday, March 11</td>
<td>PSI, USAID</td>
</tr>
<tr>
<td>2</td>
<td>Thursday, March 14, 2 PM</td>
<td>PSI, USAID</td>
</tr>
<tr>
<td>3</td>
<td>Friday, March 15, 3 PM</td>
<td>PSI Top</td>
</tr>
<tr>
<td>4</td>
<td>Monday, March 18, 4 PM</td>
<td>Save the Children</td>
</tr>
<tr>
<td>5</td>
<td>Tuesday, March 19, 10 AM</td>
<td>PSI Top</td>
</tr>
<tr>
<td>6</td>
<td>Wednesday, March 20</td>
<td>USAID</td>
</tr>
<tr>
<td>7</td>
<td>Thursday, March 21, 2:00 PM</td>
<td>WHO</td>
</tr>
<tr>
<td>8</td>
<td>Friday, March 22, 1:30 PM</td>
<td>UNAIDS</td>
</tr>
<tr>
<td>9</td>
<td>Friday, March 22, 3:00 PM</td>
<td>PUI</td>
</tr>
<tr>
<td>10</td>
<td>Monday, March 25, 10 AM</td>
<td>Alliance Myanmar</td>
</tr>
<tr>
<td>11</td>
<td>Monday, March, 1:00 PM</td>
<td>MDM</td>
</tr>
<tr>
<td>12</td>
<td>Tuesday, March 26, 10 AM</td>
<td>TOP center Mandalay</td>
</tr>
<tr>
<td>13</td>
<td>Tuesday, March 26, 2:00 PM</td>
<td>The Help</td>
</tr>
<tr>
<td>14</td>
<td>Tuesday, March 26, 3:30 PM</td>
<td>Yin Khat Pan</td>
</tr>
<tr>
<td>15</td>
<td>Tuesday, March 26, 5:30 PM</td>
<td>Save the Children</td>
</tr>
<tr>
<td>16</td>
<td>Thursday, March 28, 11:30 AM</td>
<td>USAID</td>
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<tr>
<td>17</td>
<td>Thursday, March 28, 3:00 PM</td>
<td>Phoenix Association</td>
</tr>
</tbody>
</table>
ANNEX IV. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

<table>
<thead>
<tr>
<th>USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form,</td>
</tr>
<tr>
<td>&quot;sensitive but unclassified information,&quot; procurement sensitive and source selection information, and</td>
</tr>
<tr>
<td>information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information</td>
</tr>
<tr>
<td>which, if released, could result in harm or unfair treatment to an individual or group, or could have a</td>
</tr>
<tr>
<td>negative impact upon foreign policy or relations, or USAID’s mission.</td>
</tr>
<tr>
<td>Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration</td>
</tr>
<tr>
<td>of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:</td>
</tr>
<tr>
<td>1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to</td>
</tr>
<tr>
<td>me for compensation, monetary or otherwise. By being granted access to such Sensitive Data,</td>
</tr>
<tr>
<td>special confidence and trust has been placed in me by the United States Government, and as such it is</td>
</tr>
<tr>
<td>my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing</td>
</tr>
<tr>
<td>Sensitive Data to persons not requiring access for performance of official USAID duties.</td>
</tr>
<tr>
<td>2. Before disclosing Sensitive Data, I must determine the recipient's &quot;need to know&quot; or &quot;need to access&quot;</td>
</tr>
<tr>
<td>Sensitive Data for USAID purposes.</td>
</tr>
<tr>
<td>3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and</td>
</tr>
<tr>
<td>specifically agree not to disclose source selection information or contractor bid proposal information</td>
</tr>
<tr>
<td>to any person or entity not authorized by agency regulations to receive such information.</td>
</tr>
<tr>
<td>4. I have reviewed my employment (past, present and under consideration) and financial interests, as</td>
</tr>
<tr>
<td>well as those of my household family members, and certify that, to the best of my knowledge and</td>
</tr>
<tr>
<td>belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my</td>
</tr>
<tr>
<td>assigned duties in an impartial and objective manner.</td>
</tr>
<tr>
<td>5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if</td>
</tr>
<tr>
<td>such termination effectively negates my ability to perform my assigned duties, may lead to the</td>
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<tr>
<td>termination of my employment or other relationships with the Departments or Agencies that granted</td>
</tr>
<tr>
<td>my access.</td>
</tr>
<tr>
<td>6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or</td>
</tr>
<tr>
<td>detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any</td>
</tr>
<tr>
<td>person, firm, corporation, association, or any other entity for any reason or purpose whatsoever,</td>
</tr>
<tr>
<td>directly or indirectly, except as may be required for the benefit USAID.</td>
</tr>
<tr>
<td>7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States</td>
</tr>
<tr>
<td>criminal law, and Federally-affiliated workers (including some contract employees) who violate</td>
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<tr>
<td>privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In</td>
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<tr>
<td>particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized</td>
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<td>disclosure by government employees. There is also an exemption from the Freedom of Information</td>
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<tr>
<td>Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards</td>
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<td>that bind each government employee also prohibit unauthorized disclosure (5 CER 2635.703).</td>
</tr>
<tr>
<td>8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and</td>
</tr>
<tr>
<td>will remain the property of, or under the control of, the United States Government. I agree that I must</td>
</tr>
<tr>
<td>return all Sensitive Data which has or may come into my possession (a) upon demand by an</td>
</tr>
<tr>
<td>authorized representative of the United States Government; (b) upon the conclusion of my</td>
</tr>
<tr>
<td>employment or other relationship with the Department or Agency that last granted me access to</td>
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</tbody>
</table>

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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

__________________________
Signature

__________________________
Darrin Adams

__________________________
Name

February 28, 2019

Date

Title
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature ___________________________ Date October 14, 2018

Kyi Minn ___________________________ Title Consultant

Name ___________________________ Title Consultant
9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature  
Date 05.03.2019

Name  Dr. Thu Naing  
Title Local Logistic Coordinator  
Note taker
ANNEX V. SUMMARY BIOS OF EVALUATION TEAM

**Dee Adams, team lead,** is a global HIV technical advisor with 15 years’ experience across a variety of areas, including strategic planning and program design, research, evaluations, surveillance, capacity development, monitoring and evaluation, and data use and advocacy. Ms. Adams is most known for her contributions to research, programming, and advocacy among key populations. She has supported PEPFAR and Global Fund program improvement for key populations in 25 countries, and has lived and worked in Lesotho, Swaziland, and South Africa. She has authored and co-authored 15 peer-reviewed journal articles and co-authored global guidance documents with WHO.

**Kyi Minn, documentation specialist,** is a physician with more than 20 years’ experience working in global health, infectious diseases, nutrition, and noncommunicable disease programs in the Asia and the Pacific Region. Now a resident of Myanmar, he formerly worked at World Vision International and Nossal Institute for Global Health, the University of Melbourne. He served as a member of Civil Society Consultative Group for Health Nutrition and Population at the World Bank Group in Washington, DC. Dr. Minn is currently a Health Advisor and Global Health Consultant at Myanmar Health and Development Consortium, and has done consultancy work with Asian Development Bank; ASEAN Secretariat; DFAT/Australia; DFID; Global Affairs Canada; Global Fund to Fight AIDS, Tuberculosis and Malaria; United Nations Development Programme; USAID; and World Bank, in addition to providing technical support to local and international NGOs.

**Thu Naing, logistics specialist,** has seven years of project management and technical experience in infectious disease prevention and control programs. He also has experience in research, project monitoring, program development, and management, and has participated in project proposal and evaluation of the program. He has experience working with Community Development Association, International Organization for Migration, John Snow Inc., Global Health Program Cycle Improvement Project (GH Pro), and Karen Department of Health and Welfare. Dr. Thu Ning received a MBBS (Bachelor of Medicine, Bachelor of Surgery) and Master’s degree in Primary Health Care Management from Mahidol University, Thailand.
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