

GENDER ASSESSMENT OF THE NATIONAL HIV RESPONSE IN MYANMAR

WORKING TOWARDS A GENDER HIV SENSITIVE RESPONSE



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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CBO	Community Based Organization
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Sero-surveillance Survey
IEC	Information, Education and Communication
MMT	Methadone Maintenance Therapy
MSM	Men who have sex with men
NGO	Non-governmental Organization
NSPAW	National Strategic Plan for the Advancement of Women
OVC	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PWID	People who Inject Drugs
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization



Executive Summary

The HIV epidemic in Myanmar is characterised as concentrated, with high prevalence of HIV among key affected populations – sex workers, men who have sex with men, and people who inject drugs – including young people aged 15 to 24 years within the key affected populations. Consequently, it is prudent to include key affected populations in the analysis of gender in the national HIV response. Approximately 37 per cent of people living with HIV in Myanmar are women. The 2012 HIV Sentinel Sero-surveillance survey (HSS) indicated that HIV prevalence among female sex workers was as high as 15 per cent in Patheingyi, compared to the national prevalence of 0.47 per cent among the general population.ⁱ

The Gender Assessment of the National HIV Response in Myanmar was commissioned by UNAIDS Myanmar to inform the mid-term review of the National Strategic Plan on HIV and AIDS 2011–2015. The assessment was conducted in November and December 2013 with the following process:

1. Identification of a Gender Assessment Core Team, ensuring representation of diverse constituencies
2. Desk review and pre-populating UNAIDS Gender Assessment Tool, with a focus on key epidemiological data
3. Meeting of Gender Assessment Core Team to conduct a first level analysis (28 November 2013)
4. A national Gender Assessment Workshop in Yangon (4–5 December 2013), ensuring representation of women, key affected populations, government, civil society and development partners
5. Finalisation of the Gender Assessment Report and development of key recommendations for inclusion in the National Strategic Plan.

The gender assessment brought together a wide range of partners, including representation of government sectors, development partners including donors, and civil society (National AIDS Programme, Department of Social Welfare, CCDAC, Myanmar Positive Women's Group; networks of men who have sex with men, female sex workers, transgender people; United Nations and other gender and HIV experts).

Using the UNAIDS Gender Assessment Tool, key gaps in the HIV response were identified. The *What Works for Women and Girls: Evidence for HIV/AIDS Interventions* resource was then used to propose gender-responsive interventions. The outputs were validated by national stakeholders at the Gender Assessment Workshop, which also identified gaps, built consensus on priorities and made recommendations for Myanmar.

The Gender Assessment Workshop was a consultative process and used group discussions that were guided by the gap analysis summary, derived from examination of data in the pre-populated Gender Assessment Tool. The tool incorporated national epidemiological data, and information on the social, cultural, economic and political context, and current HIV policy and programme response in Myanmar.

The gender assessment revealed that gender norms and constructs of masculinity and femininity in Myanmar impede effective HIV prevention, treatment, care and support interventions. The assessment findings came at an opportune time for consideration in the revision of the National Strategic Plan on HIV and AIDS. For Myanmar, this will be the first time that gender sensitive programmes and interventions are prioritised in the National Strategic Plan on HIV and AIDS, including:

- Creating multi-sectoral programmes to prevent and respond to gender-based violence;
- Creating specific approaches for women who inject drugs where there is high burden of injecting drug use among men and women; and
- Developing legislation to prohibit discrimination against people living with HIV including women and transgender persons.

This report presents the findings and recommendations that emerged from the gender assessment. Through the implementation of these recommendations, more effective, gender responsive HIV programmes can be achieved. Recommendations marked with an asterisk are based on *What Works for Women and Girls* (www.whatworksforwomen.org).

အဓိက ကိစ္စရပ်များနှင့် ဦးစားပေး အကြံပြုချက်များ အကျဉ်းချုပ်

မြန်မာနိုင်ငံတွင် အိပ်ချ်အိုင်စီကူးစက်ပြန့်ပွားမှုသည် လိင်လုပ်သားများ၊ ယောက်ျားချင်းလိင်ဆက်ဆံသူများ၊ မူးယစ်ဆေးထိုးသွင်းသူများ စသည့်လူအုပ်စုများတွင် အဓိကဖြစ်ပေါ်နေပြီး အဆိုပါအုပ်စုများထဲတွင် အသက် ၁၅ နှစ်မှ ၂၄ နှစ်အကြား လူငယ်များလည်း အပါအဝင်ဖြစ်သည်။ ထို့ကြောင့်အမျိုးသားအဆင့် အိပ်ချ်အိုင်စီ/အေအိုင်ဒီအက်စ်ရောဂါ ကာကွယ်ကုသရေးလုပ်ငန်းများတွင် ကျား-မ လူမှုရေးရာ ဆန်းစစ်ချက် ပြုလုပ်ရာ၌ အဆိုပါလူအုပ်စုများကို ထည့်သွင်းစဉ်းစားသင့်ပါသည်။ မြန်မာနိုင်ငံတွင် အိပ်ချ်အိုင်စီဖြစ်ပွားနေသူ ၃၇ ရာခိုင်နှုန်းခန့်မှာ အမျိုးသမီးများဖြစ်ပါသည်။ ၂၀၁၂ HIV Sentinel Sero-surveillance Survey (HSS) ၌ ပုသိမ်ရှိ အမျိုးသမီးလိင်လုပ်သားများတွင် အိပ်ချ်အိုင်စီဦးပိုးရှိသူ ၁၅ ရာခိုင်နှုန်း ရှိနေကြောင်း တွေ့ရပါသည်။ ၎င်းသည် တစ်နိုင်ငံလုံးရှိ အိပ်ချ်အိုင်စီ ဖြစ်ပွားနှုန်းဖြစ်သည့် ၀.၄၇ ရာခိုင်နှုန်းနှင့် နှိုင်းယှဉ်သော်၊ အမျိုးအစားအရ များပြားသည်ကို တွေ့မြင်နိုင်ပါသည်။

UNAIDS မြန်မာသည် ကျန်းမာရေးဦးစီးဌာန၊ အမျိုးသား ခုခံကျ/ကာလသားရောဂါတိုက်ဖျက်ရေး စီမံချက်၏ ၂၀၁၁-၂၀၁၅ အမျိုးသား မဟာဗျူဟာစီမံကိန်း ကာလအလယ် ပြန်လည်သုံးသပ်မှုတွင် အသုံးပြုရန် အဆိုပါ ကျား-မ လူမှုရေးရာဆန်းစစ်ချက်ကို အောက်ပါအတိုင်း အဆင့်ဆင့်ပြုလုပ်ခဲ့ပါသည်။

၁။ အုပ်စုအသီးသီးမှ ကိုယ်စားပြုသူများ ပါဝင်စေလျက် ကျား-မလူမှုရေးရာအခန်းကဏ္ဍ ဆန်းစစ်ချက် အခြေခံအစုအဖွဲ့ကို ဖွဲ့စည်းခြင်း၊

၂။ သက်ဆိုင်ရာ စာအုပ်စာတမ်းများကို သုံးသပ်ခြင်းနှင့် ဆန်းစစ်ရာတွင် အသုံးပြုမည့် နည်းစနစ်များတွင် အရေးပါသော ကူးစက်ရောဂါဆိုင်ရာ အခြေခံအချက်အလက်များကို ကြိုတင် ထည့်သွင်းခြင်း၊

၃။ ပထမအဆင့် ဆန်းစစ်လေ့လာချက်ပြုလုပ်ရန် အခြေခံအစုအဖွဲ့အစည်းအဝေးကို ၂၈-၁၁-၂၀၁၃ တွင် ပြုလုပ်ခြင်း၊

၄။ အမျိုးသမီးများ၊ အဓိကထိခိုက်ခံစားရသော လူအုပ်စုများ၊ နိုင်ငံတော်အစိုးရ၊ အရပ်ဘက် လူမှုအဖွဲ့အစည်း များနှင့် ဖွံ့ဖြိုးရေးမိတ်ဖက်အဖွဲ့အစည်းများ ကိုယ်စားပြုပါဝင်လျက် အမျိုးသားအဆင့် ကျား-မ လူမှုရေးရာ အခန်းကဏ္ဍ ဆန်းစစ်ချက် အလုပ်ရုံဆွေးနွေးပွဲကို ရန်ကုန်မြို့တွင် (၄-၁၂-၂၀၁၃ မှ ၅-၁၂-၂၀၁၃ အထိ) ကျင်းပပြုလုပ်ခြင်း၊

၅။ ကျား-မ အခန်းကဏ္ဍ အကဲဖြတ်ချက် အစီရင်ခံစာကို အပြီးသတ်ပြုစုခြင်းနှင့် အမျိုးသား မဟာဗျူဟာစီမံကိန်း တွင် ထည့်သွင်းရန် အဓိကအကြံပြုချက်များ ရေးဆွဲခြင်း၊

ကျား-မအခန်းကဏ္ဍ အကဲဖြတ်ချက်ပြုလုပ်ရာတွင် မိတ်ဖက်အဖွဲ့အစည်းအများအပြား ပါဝင်ခဲ့ပါသည်။ ၎င်းတို့မှာ အစိုးရဌာနများ (ခုခံကျ/ကာလသားရောဂါတိုက်ဖျက်ရေးစီမံချက်၊ လူမှုဝန်ထမ်းဦးစီးဌာန၊ မူးယစ်ဆေးဝါးနှင့် စိတ်ကိုပြောင်းလဲစေသော ဆေးဝါးများအန္တရာယ် တားဆီးကာကွယ်ရေးဗဟိုအဖွဲ့)၊ အလှူရှင် အဖွဲ့အစည်းများ၊ ကုလသမဂ္ဂအဖွဲ့အစည်းများ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်များ၊ အရပ်ဘက်လူမှုအဖွဲ့အစည်းများ (အိပ်ချ်အိုင်စီဦးပိုးဖြင့် အသက်ရှင်နေထိုင်သူ အမျိုးသမီးများကွန်ရက်၊ ယောက်ျားချင်းလိင်ဆက်ဆံသူများကွန်ရက်၊ အမျိုးသမီး လိင်လုပ်သားများကွန်ရက်၊ ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ ပြောင်းလဲခံယူနေထိုင်သူများကွန်ရက်) နှင့် အခြားကျား-မ လူမှုရေးရာအခန်းကဏ္ဍ နှင့် အိပ်ချ်အိုင်စီ ကျွမ်းကျင်သူများ ကိုယ်စားပြုပါဝင်ခဲ့ကြပါသည်။

UNAIDS ၏ ကျား-မ လူမှုရေးရာအခန်းကဏ္ဍ ဆန်းစစ်ချက်နည်းစနစ်ကို အသုံးပြုလျက် အိပ်ချ်အိုင်စီ/အေအိုင်ဒီအက်စ်ရောဂါ ကာကွယ်ကုသရေးလုပ်ငန်းများတွင် အဓိကအရေးပါသော လိုအပ်ချက်များကို ဖော်ထုတ်ခဲ့

ပါသည်။ ထို့နောက် ကျား-မ လူမှုရေးရာ အခန်းကဏ္ဍအလိုက် လိုအပ်သော လုပ်ဆောင်မှုများကို အဆိုပြုနိုင်ရန် အတွက် What Works for Women and Girls: Evidence for HIV/AIDS Interventions ဟူသော စာအုပ်စာတမ်းများကို ရည်ညွှန်းအသုံးပြုခဲ့ပါသည်။ နိုင်ငံရှိ ကဏ္ဍစုံမှပုဂ္ဂိုလ်များက ထွက်ပေါ်လာသော ရလဒ်များကို ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍ ဆန်းစစ်ချက် အလုပ်ရုံဆွေးနွေးပွဲတွင် စိစစ်အတည်ပြုခဲ့ပါသည်။ အလုပ်ရုံဆွေးနွေးပွဲ၌ လိုအပ်ချက်များ ဖော်ထုတ်ခြင်း၊ ဦးစားပေးမှုများကိုဆောင်ရွက်ရန် အားလုံးသဘောတူ အတည်ပြုခြင်း၊ မြန်မာနိုင်ငံအတွက် အကြံပြုချက်များ ပြုလုပ်ခြင်း တို့ကိုလည်း ဆောင်ရွက်ခဲ့ကြပါသည်။

ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍဆန်းစစ်ချက် အလုပ်ရုံဆွေးနွေးပွဲသည် တိုင်ပင်ဆွေးနွေးသော လုပ်ငန်းစဉ် တစ်ရပ်ဖြစ်ပြီး အုပ်စုလိုက် ဆွေးနွေးခြင်းနည်းလမ်းကို အသုံးပြုခဲ့ပါသည်။ ထိုဆွေးနွေးပွဲတွင် ကျား-မ လူမှုရေးရာ အခန်းကဏ္ဍအကျဉ်းချုပ်ချက် နည်းစနစ်ရှိ အချက်အလက်များကို စစ်ဆေးရာမှ ရရှိလာသော လိုအပ်ချက် ဆန်းစစ်လေ့လာမှု အကျဉ်းချုပ်ကို လမ်းညွှန်အဖြစ် အသုံးပြုခဲ့သည်။ အဆိုပါ အကျဉ်းချုပ်နည်းစနစ်တွင် အမျိုးသားအဆင့်ရောဂါဆိုင်ရာ အချက်အလက်များ၊ လူမှုရေးနှင့် ယဉ်ကျေးမှု၊ စီးပွားရေး နှင့် နိုင်ငံရေးဆက်စပ် အခြေအနေများ၊ မြန်မာနိုင်ငံ၏ လက်ရှိ အိပ်ချ်အိုင်စီဗီဇနှင့် လုပ်ငန်းအစီအစဉ် ဆောင်ရွက်မှုတို့ကို ထည့်သွင်း စဉ်းစားခဲ့ပါသည်။

မြန်မာနိုင်ငံတွင် ကျား-မ အခန်းကဏ္ဍ စံနှုန်းများ၊ ယောက်ျားပီသမှုနှင့် မိန်းမပီသမှု အယူအဆ သဘောထား များသည် အိပ်ချ်အိုင်စီဗီ တားဆီးကာကွယ်ရေး၊ ကုသရေး၊ ပြုစုစောင့်ရှောက်ရေးနှင့် ပံ့ပိုးမှုပေးရေး ထိရောက်စွာ ဆောင်ရွက်မှုများကို အဟန့်အတားပြုနေကြောင်း ဆန်းစစ်ချက်အရ တွေ့ရှိရပါသည်။ ယင်းဆန်းစစ်မှုမှ တွေ့ရှိချက်များသည် အိပ်ချ်အိုင်စီဗီ/အေအိုင်ဒီအက်စ်ရောဂါ အမျိုးသားအဆင့် မဟာဗျူဟာ စီမံကိန်းကို ပြန်လည် ပြင်ဆင်ရာ၌ ထည့်သွင်းစဉ်းစားနိုင်ရန် အချိန်မီ ထွက်ပေါ်လာခဲ့ပါသည်။

ခုခံအားကျဆင်းမှု ကူးစက်ရောဂါဆိုင်ရာ အမျိုးသားမဟာဗျူဟာစီမံကိန်းတွင် အောက်ပါအချက်အလက်များအပါအဝင် ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍ ကို ထည့်သွင်းစဉ်းစားသော လုပ်ငန်းအစီအစဉ်များနှင့် ဆောင်ရွက်မှုများအား ဦးစားပေးအလိုက် သတ်မှတ်ခြင်း သည် မြန်မာနိုင်ငံအဖို့ ပထမဆုံးအကြိမ်ဖြစ်ပါသည်။ ၎င်းတို့မှာ ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍအခြေပြု အကြမ်းဖက်မှုကို တားဆီးကာကွယ်ရန်နှင့် တုန့်ပြန်ဆောင်ရွက်ရန် အခန်းကဏ္ဍစုံ ပါဝင်သည့် လုပ်ငန်းအစီအစဉ် များကိုရေးဆွဲခြင်း၊ အမျိုးသားနှင့် အမျိုးသမီးများအကြား မူးယစ်ဆေးဝါးထိုးသွင်း အသုံးပြုမှု မြင့်မားသောနေရာ များတွင်မူးယစ်ဆေးဝါးထိုးသွင်းသည့် အမျိုးသမီးများအတွက် သီးသန့်ကာကွယ်ရေးလုပ်ငန်းများ လုပ်ဆောင် ပေးခြင်း၊အမျိုးသမီးများနှင့် လိင်ပြောင်းထားသူများအပါအဝင် အိပ်ချ်အိုင်စီဗီဗိုးဖြင့် နေထိုင်သူများကို ခွဲခြား ဆက်ဆံခြင်းအား တားမြစ်ပိတ်ပင်သည့် ဥပဒေများကို ရေးဆွဲခြင်း၊ ကျား-မ လူမှုရေးရာ အခန်းကဏ္ဍ အကျဉ်းချုပ်မှ ထွက်ပေါ်လာသော တွေ့ရှိချက်များနှင့် အကြံပြုချက်များကို ဤအစီရင်ခံစာတွင် တင်ပြထား ပါသည်။ ဤအကြံပြုချက်များကို အကောင်အထည်ဖော်ခြင်းဖြင့် ပိုမိုထိရောက်ပြီး ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍကို ထည့်သွင်းစဉ်းစားသော အိပ်ချ်အိုင်စီဗီ လုပ်ငန်းဆောင်ရွက်မှုအစီအစဉ်များ ဖြစ်ပေါ်လာမည်။ (ကြယ်ပွင့်ပြထားသော အကြံပြုချက်များမှာ *What Works for Women and Girls* (www.whatworksforwomen.org) အပေါ် အခြေခံထားပါသည်။)

၁။ အမျိုးသမီးများ၊ မိန်းကလေးငယ်များနှင့် အိတ်ချ်အိုင်စီဝှိ ပိုးရှိသော အမျိုးသမီးများ

အမျိုးသမီးများအနေဖြင့် ကာကွယ်စောင့်ရှောက်မှု ခံယူရရှိပြီး ကျန်းမာရေးအတွက် ကောင်းမွန်သော အပြုအမူများ လုပ်ဆောင်နိုင်ရန် လိုအပ်သောအသိပညာနှင့် ကျွမ်းကျင်မှုများကို ယောကျ်ားများနှင့် တန်းတူ ရယူအသုံးပြုနိုင်မှု မရှိခြင်းမှာ တစ်စိတ်တစ်ဒေသ အားဖြင့် ကျား-မလူမှုရေးရာ နှင့် ယဉ်ကျေးမှု စံနှုန်းများကြောင့် ဖြစ်ပါသည်။ လျှို့ဝှက်လက်ထပ်ထားခြင်း၊ လိင်အပျော်အပါးလိုက်စားခြင်း၊ အရက်သောက်ခြင်းနှင့် မူးယစ်ဆေးဝါး သုံးစွဲခြင်း ကဲ့သို့သော အန္တရာယ်များပြားသည့် အပြုအမူများကို အမျိုးသားများက ပြုလုပ်လျှင် လက်သင့်ခံသော်လည်း လိင်မှုကိစ္စဆိုင်ရာ ကျန်းမာရေးနှင့် အခွင့်အရေးများကို သိရှိရန် လုပ်ဆောင်သော အမျိုးသမီးများနှင့် မိန်းကလေးများကိုမူ လိင်ကိစ္စ ရှုပ်ပွေသည်၊ လော်လီသည်၊ မိန်းမကောင်းမဟုတ်ဟု ရှုမြင်ခြင်းများ ရှိပါသည်။ အမျိုးသမီးများအနေဖြင့် ယုံကြည်စိတ်ချမှုကို ချိုးဖောက်သည့် ဖြစ်ရပ်များတွင်လည်း ကုစားမှု ရရှိနိုင်သည့် အန္တရာယ်ကင်းရှင်းသော လမ်းကြောင်း မရှိကြပါ။ သမီးရည်းစားဘဝ၊ အဆွေခင်ပွန်းဘဝ အဖြစ် လိင်မှုကိစ္စ ဆက်ဆံရေးများတွင် အကြမ်းဖက်ခံရမှုမှ ဥပဒေအရ အကာအကွယ်ပေးမှု မရရှိပါ။ ပြုစုစောင့်ရှောက်မှုနှင့် ပံ့ပိုးမှုပံ့ဆောင်မှုများတွင် ယေဘုယျအားဖြင့် လူ့အခွင့်အရေး ရှုထောင့်မှ ရှုမြင်ခြင်းမပါဝင်ပါ။

အကြံပြုချက်များ

- ၁။ အိတ်ချ်အိုင်စီဝှိ ပိုးရှိသော အမျိုးသမီးများနှင့် အိတ်ချ်အိုင်စီဝှိ ပိုးကူးစက်ခံရနိုင်သည့် အန္တရာယ် ရှိသော အမျိုးသမီးများထံ ရောဂါကာကွယ်ရေးလုပ်ငန်းများ လက်လှမ်းမီ ရောက်ရှိရေးအတွက် ရပ်ရွာထဲအထိ လုပ်ငန်းများတိုးချဲ့ရန်နှင့် အချင်းချင်း ပညာပေးရေးတို့ဖြင့် ဘက်စုံ တားဆီးကာကွယ်ရေးကို တိုးချဲ့ ဆောင်ရွက်ရန်။
- ၂။ အိတ်ချ်အိုင်စီဝှိ တားဆီးကာကွယ်ရေး၊ ကုသရေး၊ ပြုစုစောင့်ရှောက်ရေး တို့နှင့် စပ်လျဉ်း၍ ကျား-မ လူမှုရေးရာ အခန်းကဏ္ဍနှင့် ပတ်သက်သည့် အန္တရာယ်ရှိသော စံနှုန်းများကို လျှော့ချရန်အတွက် ရပ်ရွာပြည်သူလူထုအား ကျား-မ လူမှုရေးရာ သဘာဝတရားမူဝါဒစံနှုန်းများအကြောင်းကို သင်တန်းပေးရန်။
- ၃။ အကာအကွယ် မပါရှိဘဲ လိင်ဆက်ဆံခြင်းကို လျှော့ချရန်အတွက်လိုအပ်သော သတင်းအချက်အလက် များနှင့် ကျွမ်းကျင်မှုများတည်ဆောက်ရေးအတွက် ပံ့ပိုးပေး ရန်။

၂။ မိခင်မှသန္ဓေသားသို့ရောဂါကူးစက်မှုကာကွယ်ရေးလုပ်ငန်းနှင့် အိတ်ချ်အိုင်စီဝှိ အနှစ်ရောဂါဒဏ်ကို တနည်းနည်း

ဖြင့်ခံစားနေရသောကလေးသူငယ်များ၊မိဘမဲ့ကလေးများ (PMTCT နှင့် OVC)

အိတ်ချ်အိုင်စီဝှိ ကူးစက်နေသော ကိုယ်ဝန်ဆောင် အမျိုးသမီးများအား အေအာစီ ဆေးဝါးများ တိုက်ကျွေပြီး ရင်သွေးငယ်များသို့ရောဂါကူးစက်မှုကြိုတင်ကာကွယ်ရေးလုပ်ငန်းများသည် လျာထားချက် ပြည့်မီခဲ့သော်လည်း¹ ကိုယ်ဝန်ဆောင် အမျိုးသမီး များအကြား အိတ်ချ်အိုင်စီဝှိပိုး သွေးစစ်ခြင်းကို လက်ခံမှုမှာ နိမ့်ကျနေဆဲ ဖြစ်ပါသည်။ မမွေးဖွားမီနှင့် မွေးဖွားပြီး ဆေးခန်းသို့လာရောက်ပြသရန်ပျက်ကွက်မှု နှုန်းထားမှာလည်း မြင့်မားနေဆဲ ဖြစ်ပါသည်။ ရောဂါကာကွယ်ရေး ဝန်ဆောင်မှု ရယူအသုံးပြုရန် လိုအပ်နေသော အမျိုးသမီး အချို့ထံသို့လည်း လက်လှမ်းမီ ရောက်ရှိခြင်းမရှိပါ။ ဥပမာ မြို့ရွာ အေးချမ်းမှုမရှိ သော နယ်မြေဒေသများ၊ မိမိနေရပ်ကိုစွန့်ခွာပြီး ဒုက္ခသည်စခန်းများတွင် နေထိုင်ရသော အမျိုးသမီးများ၊ ဆင်းရဲနွမ်းပါးသော အမျိုးသမီးများ၊ လမ်းပေါ်တွင်

¹တိုးတက်မှု အစီရင်ခံစာ ၂၀၁၂ခုနှစ်

နေထိုင်ရသော အမျိုးသမီးများနှင့် ကျန်းမာရေးဝန်ဆောင်မှုပေးရာသို့ သွားရောက်ရန် လမ်းစရိတ် မတတ်နိုင်သူများ ပါဝင်ပါသည်။

ကိုယ်ဝန်ဆောင်ခြင်းကို "အမျိုးသမီးကိစ္စ"ဟု ရှုမြင်ကြပါသည်။ အမျိုးသမီးတစ်ဦးသည် ကိုယ်ဝန်ဆောင်စဉ် မိမိမှာ အိတ်ချ်အိုင်စီပိုးရှိနေကြောင်း တွေ့ရှိရပါက စွန့်ပစ်ခံရခြင်း၊ အကြမ်းဖက်ခံရခြင်းနှင့် ဆင်းရဲနွမ်းပါးခြင်း ကဲ့သို့သော ဆိုးကျိုးများကိုဖြစ်ပေါ်စေနိုင်ပါသည်။ အချို့အမျိုးသမီးများသည် ဆေးရုံတွင် ခွဲခြားနှိမ်ချဆက်ဆံ ခြင်း ခံရမည်ကို စိုးရိမ်ခြင်းကြောင့်လည်း ဆေးမစစ်ကြပါ။ ယင်းသို့သော စိုးရိမ်စိတ်ကြောင့်ပင် အိတ်ချ်အိုင်စီပိုးရှိ နေသော အမျိုးသမီးများသည် မမွေးဖွားမီကိုယ်ဝန် ပြုစုစောင့်ရှောက်မှု ဝန်ဆောင်မှုများကို ရယူခြင်း မပြုကြပါ။

အကြံပြုချက်များ

- ၁။ အိတ်ချ်အိုင်စီပိုးရှိနေသော သော အမျိုးသမီးများကို ပြုစုစောင့်ရှောက်ရေးအား အထူးသဖြင့် အဓိကထားလျက် လုံခြုံစိတ်ချရသော မိခင်ဘဝစီမံကိန်းလုပ်ငန်းများတွင် အမျိုးသားများပါဝင်လာရေး အားပေး မြှင့်တင်သည့် အစီအစဉ်များကို ထည့်သွင်းဆောင်ရွက်ရန်။
- ၂။ လင်မယားနှစ်ယောက်အနက် တစ်ယောက်တွင် အိတ်ချ်အိုင်စီပိုးရှိပြီး ကျန်တစ်ယောက်တွင် ရောဂါပိုးမရှိ သည့် စုံတွဲများအတွက် ကိုယ်ဝန်ဆောင်မီ ရွေးချယ်နိုင်မည့် နည်းလမ်းများကို ဖြည့်ဆည်း အကြံပေးရန်၊ နည်းလမ်းများတွင် အချိန်ကာလသတ်မှတ်၍ အကာအကွယ်မပါရှိဘဲ လိင်ဆက်ဆံခြင်း၊ အိတ်ချ်အိုင်စီပိုး ရှိနေသူသည် ကုသမှုခံယူပြီး လအတန်ကြာ ဆေးမှန်မှန်သောက်ပြီးသည်အထိ ကိုယ်ဝန်ဆောင်ခြင်းကို ရွှေ့ဆိုင်းထားခြင်းတို့ ပါဝင်ပါသည်။ အိတ်ချ်အိုင်စီပိုးရှိနေသော အမျိုးသမီးအနေဖြင့် အိတ်ချ်အိုင်စီပိုး မရှိ သော အမျိုးသားလက်တွဲဖော် နှင့် ကလေးငယ်တို့ကို ရောဂါကူးစက်မည့် အန္တရာယ်အနည်းပါးဆုံး ဖြစ်စေ ရန် သုက်ရည်ကို ကိုယ်တိုင်ထည့်သွင်းနိုင်ပါသည်။*
- ၃။ အမျိုးသမီးများ၊ မိန်းကလေးများနှင့် လိင်ပြောင်း ထားသူများအတွက်စီမံကိန်းလုပ်ငန်းများတွင် (အတွင်းရေး လျှို့ဝှက်ထားရှိပေးခြင်း အပါအဝင်) ကျား-မလူမှုရေးရာအခန်းကဏ္ဍများကို ထည့်သွင်းစဉ်းစားခြင်း ဆိုင်ရာသင်တန်းများကို ကျန်းမာရေးဝန်ထမ်းများ အားပေးရန်။

၃။ အမျိုးသားများနှင့် ယောက်ျားသဘာဝ

ယေဘုယျအားဖြင့်အမျိုးသားများသည် အမျိုးသမီးများနှင့် နှိုင်းယှဉ်ပါက အိတ်ချ်အိုင်စီအကြောင်း အသိပညာနှင့် သိမြင်နားလည်မှု ပိုမိုမြင့်မားပါသည်။ သို့သော် ထိုသို့ ပိုမို မြင့်မားခြင်းကြောင့် ရောဂါမကူးစက်အောင် အကာအကွယ်ရယူသော အပြုအမူများ ပြုမူမည်ဟု ယတိပြတ် မဆိုနိုင်ပါ။ အိတ်ချ်အိုင်စီ ပိုးရှိနေသော အမျိုးသားများသည် မိမိတို့မှာ အိတ်ချ်အိုင်စီပိုးရှိနေပြီဟု မသိသော အချိန်နှင့် သွေးစစ်မှုခံယူသော အချိန်အကြားတွင်လည်းကောင်း၊ သွေးစစ်ရလဒ် သိရှိရသော အချိန်နှင့် အိတ်ချ်အိုင်စီပိုးရှိနေကြောင်း မိမိ၏ကိုယ်ထုတ်ဖော်အသိပေးသော အချိန် အကြားတွင်လည်းကောင်း၊ အချိန်ကာလတစ်ခု ကြန့်ကြာမှုရှိကြောင်း ထုတ်ဖော်ပြောကြားကြပါသည်။ ကျား-မ လူမှုရေးရာအခန်းကဏ္ဍ စံနှုန်းများကြောင့် အမျိုးသားများသည် အမျိုးသမီး လက်တွဲဖော်များနှင့် ကိုယ်ရေးကိုယ်တာ ရင်းနှီးမှု ကိစ္စရပ်များ၊ မိသားစု အစီအစဉ်ရေးဆွဲ (သားဆက်ခြား)ရေး ကိစ္စရပ်များနှင့် လိင်ဆက်ဆံမှု ကိစ္စရပ်များကို ဆွေးနွေးရာတွင်လုံလောက်သောကျွမ်းကျင်မှုများ မရှိကြပါ။

အကြံပြုချက်များ

- ၁။ စုံတွဲများအားအချင်းချင်း ဆွေးနွေးစေရန်နှင့် နှစ်သိမ့်ဆွေးနွေးအကြံ ပေးမှုကို ခံယူလာစေရန် တိုက်တွန်း အားပေးရေးအတွက် ဝန်ဆောင်မှု ပေးသူများကို လေ့ကျင့်သင်တန်းပေးရန်၊ အဆိုပါသင်တန်း များတွင် ကျား-မ အခြေပြု အကြမ်းဖက်မှုကို ရှောင်ရှားနိုင်ရန်၊ အိတ်ချ်အိုင်စီပိုး သွေးစစ်ဆေးမှု ခံယူခြင်းနှင့် သွေးအဖြေကို ကိုယ့်လင်မယားချင်းထုတ်ဖော်ပြောသည့်စုံတွဲ အရေအတွက် တိုးမြှင့်လာစေရန် နည်းလမ်းများ အပါအဝင် လေ့ကျင့်သင်တန်းပေးရန် ဖြစ်ပါသည်။*
- ၂။ ကိုယ်ဝန်စောင့်ရှောက်စဉ်ကာလနှစ်သိမ့်ဆွေးနွေး အကြံပေးခြင်းကို ကူညီပံ့ပိုးပေးရန်၊ ထိုသို့ဆောင်ရွက်ခြင်း ဖြင့် အိမ်ထောင်ဖက်များအကြား ဆွေးနွေးတိုင်ပင်မှု မြင့်မားလာစေရန်နှင့် ကွန်ဒုံးသုံးစွဲခြင်းအပါအဝင် ရောဂါ ကာကွယ်ရေး အပြုအမူများ တိုးမြှင့်လာစေရန်။ *

၄။ လိင်လုပ်သားများ(ပြည့်တန်ဆာများ)

ကွန်ဒုံးအသုံးပြုမှုနှင့် လိင်အပျော်အပါးလိုက်စားခြင်းတို့အကြား ဆက်စပ်မှုမှာ မြင့်မားပါသည်။ ထို့ကြောင့် ကွန်ဒုံး အသုံးပြုသူများကို ခွဲခြားဆက်ဆံ ခြင်း သို့မဟုတ် အပျော်အပါးလိုက်စားသူများအဖြစ် ရှုမြင်ခံရပါသည်။ ပြည့်တန်ဆာအိမ်များနှင့် ဖျော်ဖြေရေးနေရာဌာန(ဥပမာ-ကေတီစွီ) ပိုင်ရှင်များသည် လိင်လုပ်သား (ပြည့်တန်ဆာ) များထံမှ ကွန်ဒုံးများကို သိမ်းယူလေ့ ရှိပါသည်။ ရဲကလည်း ကွန်ဒုံးလက်ဝယ် ရှိခြင်းကို လိင်(ပြည့်တန်ဆာ)လုပ်ငန်း လုပ်ကိုင်သည့် သက်သေအထောက်အထားအဖြစ် ယူဆနေဆဲ ဖြစ်ပါသည်။ ဌာနတွင်းညွှန်ကြားချက်အရ တားမြစ်ထားသော်လည်း ကွန်ဒုံးလက်ဝယ် ရှိခြင်းကြောင့် ဖမ်းဆီးမှုများ ပြုလုပ်နေဆဲ ဖြစ်ပါသည်။ ရပ်ရွာထဲတွင် တာဝန်ထမ်းဆောင်လျက်ရှိသောဝန်ထမ်းများသည် လိင်မှုကိစ္စ လုပ်ငန်း လုပ်ကိုင်နေသည့် အချို့သောနေရာများတွင် ကွန်ဒုံးများ ဖြန့်ဝေခွင့် မရကြပါ။ အိတ်ချ်အိုင်စီပိုးရှိသော လိင်လုပ်သားများကို အလုပ်ရှင်များက အလုပ်မှ ဖြုတ်ပစ်ပါသည်။ ရလဒ်အားဖြင့် ၎င်းတို့သည် ဆင်းရဲနွမ်းပါးကြပြီး မတရား ပြုမူခံရခြင်း၊ အာဟာရ ချို့တဲ့ခြင်း နှင့် အခွင့်အရေးယူ ဝင်ရောက်လာသော ကူးစက်ရောဂါများ ဖြစ်ပွားခြင်းတို့ကို ကြုံတွေ့ရမည့် အန္တရာယ် ပိုများလာပါသည်။ ခွဲခြားနှိမ်ချဆက်ဆံခြင်းကြောင့် လိင်လုပ်သားများအနေဖြင့် အေအာစီ ဆေးဝါးများနှင့် လိင်မှုကိစ္စ နှင့် မျိုးပွားကျန်းမာရေးဆိုင်ရာ ဝန်ဆောင်မှုများ ရယူအသုံးပြုနိုင်မှုကို လည်းအဟန့်အတား ဖြစ်စေပါသည်။ အိတ်ချ်အိုင်စီပိုးရှိသော လိင်လုပ်သားများ ဖမ်းဆီးခံရသောအခါ ရမန်ယူထားစဉ် သို့မဟုတ် ထောင်ဒဏ်ကျခံနေရစဉ် အေအာစီ ဆေးဝါးများကို ဆက်လက်၍ မရယူနိုင်ခြင်း သို့မဟုတ် မသောက်သုံးနိုင်ခြင်းများ ဖြစ်နိုင်ပါသည်။ ထိုအခါ ဆေးယဉ်ပါးခြင်း ဖြစ်လာနိုင်သည့် အန္တရာယ် ပေါ်ပေါက်လာပါသည်။

အကြံပြုချက်များ

- ၁။ သက်တူရွယ်တူချင်း ပညာပေးသူများအတွက် သင်တန်းပေးခြင်းဆိုင်ရာ သင်ရိုးညွှန်းတမ်းများကို ပြန်လည်သုံးသပ်ခြင်းနှင့် စံအဖြစ်သတ်မှတ်ထားသော သင်ရိုးညွှန်းတမ်းပြုစုရန်၊ အဆိုပါ သင်ရိုးညွှန်းတမ်း များတွင် ရပ်ရွာပြည်သူလူထုကို နှိုးဆော်စည်းရုံးခြင်း၊ လိင်မှုကိစ္စ နှင့် မျိုးဆက်ပွားကျန်းမာရေး ဝန်ဆောင်မှုများ၊ ဥပဒေပိုင်း ပံ့ပိုးမှုပေးခြင်းနှင့် ကျား-မ လူမှုရေးအခန်းကဏ္ဍ အခြေပြု အကြမ်းဖက်မှုများ အကြောင်း ပါဝင်စေရန်။
- ၂။ လူ့အခွင့်အရေးဆိုင်ရာကိစ္စများနှင့် မတရားပြု ခြင်း မခံရအောင် လိင်လုပ်သားများကို လေ့ကျင့် သင်တန်းပေးရန်။

၃။ ပြည်ထဲရေးဝန်ကြီးဌာနမှ ဥပဒေအရာရှိများနှင့် မူဝါဒချမှတ်သူများအား သက်ဆိုင်ရာကိစ္စများအကြောင်း လေ့ကျင့်သင်တန်းပေးရန် (ဥပမာ ရောဂါပိုးကူးစက်မှုအန္တရာယ်အဓိကရှိသော လူအုပ်စုများပါဝင် လျက် အလုပ်ရုံဆွေးနွေးပွဲများ၊ လေ့လာရေးခရီးစဉ်များ၊ စကားပိုင်းများပြုလုပ်ခြင်း)။

၅။ အမျိုးသားချင်း လိင်ဆက်ဆံသူ (MSM) များနှင့် လိင်ပြောင်းထားသူများ

အမျိုးသားချင်း လိင်ဆက်ဆံခြင်းကို ပြစ်မှုဆိုင်ရာ ဥပဒေ (ရာဇသတ်ကြီး) ပုဒ်မ ၃၇၇ အရ လက်တွေ့တွင် ပြစ်မှုအဖြစ် သတ်မှတ်ထားပါသည်။ အမျိုးသားချင်း လိင်ဆက်ဆံသူ (MSM) များနှင့် လိင်ပြောင်းထားသူများ ကလည်း မိမိတို့ကို ရဲက အခြား ပြဋ္ဌာန်းဥပဒေများကို အသုံးပြု၍ အနှောင့်အယှက်ပေးသည်ဟု ဆိုကြပါသည်။ လိင်တူဆက်ဆံသည့် အပြုအမူကို ပြစ်မှုအဖြစ် သတ်မှတ်ခြင်းမှာအရိုးစွဲနေသော ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍနှင့် ယောကျ်ား တစ်ယောက်အဖြစ်သတ်မှတ်သည့် စံနှုန်းများကြောင့် ပိုမိုဆိုးဝါးလာပြီး MSM များအတွက် အန္တရာယ် ကျရောက်နိုင်မှုနှင့် အိတ်ချ်အိုင်စီပိုးကူးစက်ခံရနိုင်မှုကို ပိုမိုများပြားစေပါသည်။ MSM များ(အပုန်းများ)သည်အများ အားဖြင့် အိမ်ထောင်ရှိကြပြီး ကွန်ခုံးကို ဝယ်ယူအသုံးပြုရန်လည်းကောင်း၊ မိမိတို့တွင် အိတ်ချ်အိုင်စီပိုး ရှိမရှိကို စစ်ဆေး ဖော်ထုတ်ရန်လည်းကောင်း တွန့်ဆုတ်သည်ဟု ယူဆကြပါသည်။ MSM များတွင် လိင်ဆက်ဆံဘက် ယောကျ်ားရေး မိန်းမပါအများ အပြားရှိနိုင်ပါသည်။ အသက်ကြီးသော MSM များသည် အသက်ငယ်သော MSM များထက် လိင်ဆက်ဆံမှုကို ပိုမို၍ မကြာခဏ လိုက်စားလေ့ ရှိသည်ဟု ယူဆကြပါသည်။ လိင်ပြောင်းထားသူများ အကြားတွင်လည်း အလားတူပင် ဖြစ်ပါသည်။ လိင်ပြောင်းထားသူများမှာ ရုပ်သွင်အားဖြင့် ပိုမို၍ သိလွယ်ခြင်းကြောင့် ခွဲခြားဆက်ဆံမှု ကို ပိုမိုကြုံတွေ့ရပါသည်။

အကြံပြုချက်များ

- ၁။ MSM နှင့် လိင်ပြောင်းထားသူများဆိုင်ရာ အချက်အလက်များကို ခွဲခြားဖော်ပြရန်၊ MSMများကို အဓိကထားသော ဝန်ဆောင်မှုများအပြင် လိင်ပြောင်းထားသူများကို ဦးတည်ရည်ရွယ်သည့် ဝန်ဆောင်မှုများ ကိုလည်း ဖြည့်ဆည်း ပေးရန်၊ တစ်နေရာမှတစ်နေရာသို့ ရွှေ့ပြောင်းသွားလာနေထိုင်လာသော MSM များနှင့် လိင်ပြောင်းထားသူများ အပါအဝင် MSM(အပုန်းများ) များနှင့် လိင်ပြောင်းထားသူများထံ ရောက်ရှိနိုင်မည့် ဆန်းသစ် တီထွင်သော ရောဂါတားဆီးကာကွယ်ရေး အစီအစဉ်များ ရေးဆွဲရန် (အပြုအမူပြောင်းလဲရေးဆိုင်ရာ ဆက်သွယ်ပြောဆိုခြင်း (BCC)၊ သတင်းအချက်အလက် ပညာပေးခြင်းနှင့် ဆက်သွယ်ပြောဆိုခြင်း (IEC)၊ အင်တာနက် အခြေပြု ပညာပေးရေးလုပ်ငန်းများ အပါအဝင် စံသတ်မှတ်ထားသော ဝန်ဆောင်မှုများ ဖော်ထုတ်ရန်။
- ၂။ ပြစ်မှုဆိုင်ရာဥပဒေ (ရာဇသတ်ကြီး) ပုဒ်မ ၃၇၇ ကို ပြန်လည်သုံးသပ်ခြင်းနှင့် အိတ်ချ်အိုင်စီ ပိုးရှိနေသူများ နှင့် ရောဂါကူးစက်ခံရနိုင်မှု အန္တရာယ်အဓိကရှိသော လူအုပ်စုများကို အကာအကွယ်ပေးသော ဥပဒေသစ်များကို ရေးဆွဲဖို့ စဉ်းစားရန်။

၆။ မူးယစ်ဆေးဝါးကိုထိုးသွင်းသူများ (People Who Inject Drugs - PWID)

အသက်၊ ကျား-မ နှင့် သုံးစွဲသော မူးယစ်ဆေးဝါး အမျိုးအစား (ထိုးသွင်းသုံးစွဲခြင်း နှင့် အခြားနည်းဖြင့် သုံးစွဲခြင်း) အလိုက် ခွဲခြားသတ်မှတ်ပြီး မူးယစ်ဆေးဝါးသုံးစွဲသူအရေအတွက် စုစုပေါင်း ခန့်မှန်းချက်များ ပြုလုပ်ရန် အချက်အလက်များ ကို စုဆောင်းရယူရာတွင် လစ်ဟာချက်များ ရှိပါသည်။ မူးယစ်ဆေးဝါးကို ထိုးသွင်းသော အမျိုးသမီးများနှင့် မိန်းကလေးများအကြောင်း အချက်အလက်များမှာ မရှိသလောက် နည်းပါးပါသည်။ မူးယစ်ဆေးဝါးကို ထိုးသွင်းသုံးစွဲသော အမျိုးသမီးများသည် လူသိရှင်ကြားဖြစ်ပြီး ခွဲခြားဆက်ဆံခံရခြင်း ဖြစ်ပွားမည်ကို

စိုးရွံ့ခြင်း၊ ကိုယ်တိုင် ခွဲခြားသတ်မှတ်နေထိုင်ခြင်း၊ မိမိကိုယ်ကို လွန်စွာ ရှက်စဖွယ်ဟု ယူဆခြင်း၊ မိသားစုကို ပြုစုစောင့်ရှောက်ရသည့် သူများဖြစ်နေခြင်းတို့ကြောင့် ဝန်ဆောင်မှုများကို မရယူဘဲ နေတတ်ကြ လေရာ ၎င်းတို့ထံ လက်လှမ်းမီ ရောက်ရှိရေးမှာ စိန်ခေါ်မှု အခက်အခဲ တစ်ရပ် ဖြစ်ပါသည်။ ရလဒ်အားဖြင့် မူးယစ်ဆေးဝါး ထိုးသွင်းသော အမျိုးသမီးများသည် လိင်မှုကိစ္စ နှင့် မျိုးဆက်ပွားကျန်းမာရေး၊ ရောဂါကူးစက်ခံရနိုင်မှုအန္တရာယ် လျော့ချရေးနှင့် အိတ်ချ်အိုင်စီကုသမှုဝန်ဆောင်မှုများကို ရယူခြင်း မရှိကြပါ။ ယခုအခါ မက်သနိုးဖြင့် အစားထိုးကုသမှု methadone maintenance therapy (MMT) ခံယူသူ ၁.၄%သာလျှင် အမျိုးသမီးများ ဖြစ်ပါသည်။ လိင်လုပ်ငန်း လုပ်ကိုင်ခြင်း (အမျိုးသမီးများနှင့် လိင်ပြောင်းထားသူများ) နှင့် မူးယစ် ဆေးဝါး ထိုးသွင်းအသုံးပြုခြင်း အပါအဝင် အိတ်ချ်အိုင်စီ ကူးစက်ဖြစ်ပွားနိုင်သည့် အကြောင်းအချက်အများ ဆက်စပ်နေပုံကို လေ့လာချက်များ မပြုလုပ် ရသေးပါ။

အကြံပြုချက်များ

- ၁။ ရောဂါကူးစက်ခံရနိုင်မှု အန္တရာယ်ရှိသော အပြုအမူများကို ပြုလုပ်သူများ (မူးယစ်ဆေးဝါးထိုးသွင်းသူများ၊ လိင်လုပ်သားများ၊ MSM များ၊ လိင်ပြောင်းထားသူများ)၏ လိင်ဆက်ဆံဖက်များကို နှစ်သိမ့်ဆွေးနွေးအကြံပေးမှု ခံယူစေပြီး အိတ်ချ်အိုင်စီပိုး စစ်ဆေးရန် အားပေးခြင်း၊ (ရောဂါကူးစက်ခံရနိုင်မှုအန္တရာယ်လျော့ချရန်) ရပ်ထဲရွာထဲ အထိအမျိုးသမီးဝန်ထမ်းများ ရောက်ရှိရေးအတွက် အစီအစဉ်များ ထည့်သွင်းခြင်းနှင့် အိတ်ချ်အိုင်စီ ကုသမှု အကြောင်း အသိပညာနှင့် နားလည်မှု မြှင့်တင်ပေးရန်။
- ၂။ အသက်နှင့် ကျား-မ အလိုက် ခွဲခြားဖော်ပြထားသော PWID ဆိုင်ရာ အချက်အလက်များနှင့် ၎င်းတို့၏ လိင်ဆက်ဆံဖက်များဆိုင်ရာ အချက်အလက်များ ရရှိနိုင်ရေးလုပ်ဆောင်ရန်။
- ၃။ မူးယစ်ဆေးဝါးကို ထိုးသွင်းသူ အရေအတွက်များပြားသော နယ်မြေဒေသများ (ဖားကန့်၊ လားရှိုး၊ မူဆယ်၊ မြစ်ကြီးနားနှင့် ပင်လယ်ဘူး) တွင် အမျိုးသမီးများနှင့်သင့်တော်သောရောဂါကူးစက်ခံရနိုင်မှု လျော့နည်းကျဆင်းရေး အစီအစဉ်များကို ရေးဆွဲဆောင်ရွက်ရန်။

ကဏ္ဍပေါင်းစုံနှင့် သက်ဆိုင်သော အကြံပြုချက်များ

- ၁။ ကျား-မလူမှုရေးရာကဏ္ဍအလိုက် အိတ်ချ်အိုင်စီပိုး ကပ်ရောဂါ ဖြစ်ပွားမှု အခြေအနေကိုသိရှိ နားလည်နိုင်ရန်နှင့် ကျား-မ အခန်းကဏ္ဍကို ထည့်သွင်းစဉ်းစားသောမူဝါဒ နှင့် လုပ်ငန်းအစီအစဉ် ရေးဆွဲ အကောင်အထည် ဖော်ရန်အတွက် လိုအပ်သော သုတေသန လုပ်ငန်းများကို လုပ်ဆောင်ဖို့ အားပေး မြှင့်တင်ရန်၊
- ၂။ သတင်းအချက်အလက်လိုအပ်ချက် ရှိနေသည့် အောက်ပါနယ်ပယ်များတွင် လုပ်ငန်းပိုင်းဆိုင်ရာ သုတေသန လုပ်ငန်းများ လုပ်ဆောင်ရန်၊
 - (က) လိင်လုပ်သားများ၊ အိတ်ချ်အိုင်စီပိုးရှိနေသော အမျိုးသမီးများ၊ MSM များ၊ လိင်ပြောင်းထားသူများ (နှင့် လိင်တူဆက်ဆံသူ အမျိုးသမီးများ) အကြားတွင် ကျား-မလူမှုရေးရာ အခန်းကဏ္ဍ အခြေပြု အကြမ်းဖက်မှု ဖြစ်ပွားနှုန်း၊ ထိုသို့ အကြမ်းဖက်မှုတွေ့ကြုံခံစားရသူများသည် အိတ်ချ်အိုင်စီပိုး ကူးစက်ခံရမည့် အန္တရာယ် ပိုမို ကြုံတွေ့ရပါသလား။
 - (ခ) MSM နှင့် လိင်ပြောင်းထားသူ လိင်လုပ်သားများ၏ လူမှုရေး ကွန်ရက်များကို လေ့လာရန်။
 - (ဂ) မူးယစ်ဆေးဝါးကို ထိုးသွင်းသူများအနက် အမျိုးသမီးအရေအတွက် မည်မျှရှိပါသလဲ။ ၎င်းတို့သည် လူမှုအသိုင်းအဝန်းထဲသို့ ဝင်ဆန့်ရန် ခက်ခဲသူများဖြစ်ပါသလား။

- (ဃ) မြန်မာနိုင်ငံတွင် ရောဂါပိုးကူးစက်ခံရနိုင်မှု "အန္တရာယ် နည်းပါးသော" အမျိုးသမီးများ အိတ်ချ်အိုင်ဗွီပိုး မည်သို့ကူးစက်ခံရပါသလဲ။
- (င) မူးယစ်ဆေးဝါးကို ထိုးသွင်းသူ အမျိုးသားများနှင့် MSM များ၏ အမျိုးသမီး လိင်ဆက်ဆံဖက် များထံ လက်လှမ်းမီ ရောက်ရှိနိုင်မည့် နည်းလမ်းများ။

Summary of key issues and prioritised recommendations

I. Women, girls and women living with HIV

Gender and cultural norms contribute towards women having inequitable access to knowledge and skills that would protect them and reinforce good health-seeking behaviours. While it is tolerated that men can engage in high risk behaviours such as polygamous secret marriages, buying sex, and alcohol and drug abuse, women and girls are viewed as promiscuous, indecent or immoral if they seek information on sexual and reproductive health and rights. Women have no safe avenue of redress when trust is breached, including no legal protection against violence within intimate partner relationships. Care and support services in general lack a human rights perspective.

Recommendations

1. Expand comprehensive prevention through community outreach and peer education to reach HIV-positive women and women vulnerable to HIV.
2. Provide community training on gender equitable norms to reduce gender harmful norms,* in relation to HIV prevention, treatment and care.
3. Provide information and skills-building support to reduce unprotected sex.*

II. PMTCT and OVC

Although the target of providing ARV prophylaxis to HIV-positive pregnant women was reached (Progress Report 2012), the uptake of HIV testing among pregnant women is still low and loss to follow-up before and after birth is high. Some women who need access to services are not being reached, such as those in areas of civil unrest; camps for internally displaced people; and other poor or street-based women, including those who cannot afford transportation to the service sites.

Pregnancy is seen as a “woman’s issue”. If a woman finds out that she is HIV-positive during pregnancy it could lead to detrimental outcomes for her, such as abandonment, violence and poverty. Fear of stigma and discrimination in hospital settings deters women from getting tested, and deters women living with HIV from seeking antenatal care services.

Recommendations

1. Integrate programmes to promote male involvement in the safe motherhood programme, with a particular focus on the care of women living with HIV.
2. Provide pre-conception options for serodiscordant couples. Options include timed unprotected intercourse, and delayed conception until the HIV-positive partner is on treatment and adherent for a number of months. Self-insemination can minimize the risk of HIV transmission from an HIV-positive woman to her seronegative male partner and infant.*
3. Train health care workers to adopt gender sensitive approaches for women, girls and transgender persons (including ensuring confidentiality).

III. Men and masculinities

Men generally have greater knowledge and awareness of HIV compared to women, but this knowledge does not necessarily translate into protective behaviour. Men living with HIV report a lapse of time between suspecting they are HIV-positive and getting tested, and between testing HIV-positive and disclosing their positive serostatus to their wives. Gender norms contribute

towards shortcomings in the communication and interpersonal skills of males to discuss issues relating to intimacy, family planning and sexuality with their female partners.

Recommendations

1. Train providers to encourage couple dialogue and counselling, including techniques to avert gender-based violence, to increase the number of couples who receive and disclose their HIV test results.*
2. Facilitate informed and appropriate counselling during antenatal care to increase discussion between partners and increase protective behaviours, including increased condom use.*

IV. Sex workers

The link between condom use and illicit sex is high and therefore condom use may be seen as stigmatised, or confirmation of the illicitness of the activity. Brothel and entertainment venue owners confiscate condoms from sex workers and police still consider condom possession as evidence of sex work and to justify arrest despite the law prohibiting this. Outreach workers are not allowed to distribute condoms in some places where sex work occurs. HIV-positive sex workers are fired by their employers and as a result become susceptible to poverty, further increasing their vulnerability to abuse, malnutrition and opportunistic infections. Stigma and discrimination hinder sex workers' access to antiretroviral therapy (ART) and sexual and reproductive health services. HIV-positive sex workers who are arrested may not be able to access or continue ART while in remand or serving a prison sentence, which is a risk for the development of drug resistance.

Recommendations

1. Review training curriculums and develop a standardised training curriculum for peer educators to include community mobilization, sexual and reproductive health services, legal support and gender-based violence.
2. Train sex workers on human rights and redress.
3. Sensitization and training of law enforcement officials and policy makers of Ministry of Home Affairs (such as workshops, study tours, and dialogue involving key populations, officials and policy makers).

V. Men who have Sex with Men (MSM) and Transgender People

Sex between males is *de facto* criminalised under Section 377 of the country's penal code, and MSM and transgender people also report being harassed by the police under other statutes. Criminalisation of homosexual behaviour, exacerbated by strong gender and masculinity norms, further increases the risk and exposure to HIV for MSM. 'Hidden' MSM are often married and are thought to be reluctant to buy and use condoms, or to find out or disclose their HIV status. MSM may have multiple partners, both male and female. Older MSM are thought to buy sex more often than younger MSM. The same applies to older transgender persons. Transgender people are more easily identifiable by their physical appearance and are therefore subject to high levels of discrimination.

Recommendations

1. Disaggregate data for MSM and transgender persons; provide services targeted to transgender persons in addition to services focusing on MSM. Develop innovative prevention programmes to reach hidden MSM and transgender persons, including mobile MSM and transgender persons (defining a standard package of services, including BCC, IEC, web-based strategies).ⁱⁱ

2. Review Penal Code Section 377 and consider creating new (anti-discrimination) laws that are protective of people living with HIV and key affected populations.

VI. People who inject drugs

There are gaps in data collection on people who use drugs: population size estimates disaggregated by age, gender and type of drug use (injecting, non-injecting). Little is known about women and girls who inject drugs. Reaching out to women who inject drugs is a challenge, as they may not access services due to fear of public stigma and discrimination, alongside self-stigmatisation; a deep sense of personal shame; and also because they are caregivers to the family. As a result, women who inject drugs are not accessing sexual and reproductive health, harm reduction and HIV treatment services. At present, only 1.4 per cent of methadone maintenance therapy (MMT) patients are women. The interaction of multiple risk factors for HIV transmission, including sex work (female and transgender) and injecting drug use, has not been studied.

Recommendations

1. Outreach to encourage HIV counselling and testing for partners of people who engage in high risk behaviour (PWID, sex workers, MSM, transgender persons); include designing programmes that use female outreach workers (for harm reduction) and increasing HIV treatment literacy and awareness.
2. Ensure availability of age and gender disaggregated data on PWID and data on their sexual partners.
3. Develop women-friendly harm reduction programmes* in areas where there are high numbers of people who inject drugs (Hpakant, Lashio, Muse, Myitkyina and Pinlebu).

Cross-cutting recommendations

1. Promote age, sex-disaggregated data and gender sensitive research for a better understanding of the gender and HIV epidemiological situation and gender sensitive policy and programme formulation and implementation.
2. Initiate operational research in areas where there are gaps in information, such as:
 - a. What is the incidence of gender-based violence among sex workers, women living with HIV, MSM, transgender (and women who have sex with women) of those who experience gender-based violence, are they at increased risk of HIV infection?
 - b. Map social networks of MSM and transgender sex workers.
 - c. How many injecting drug users are women? Are they a “hidden population”?
 - d. How do “low risk” women in Myanmar acquire HIV?
 - e. How can we reach female partners of men who inject drugs and MSM?



Background

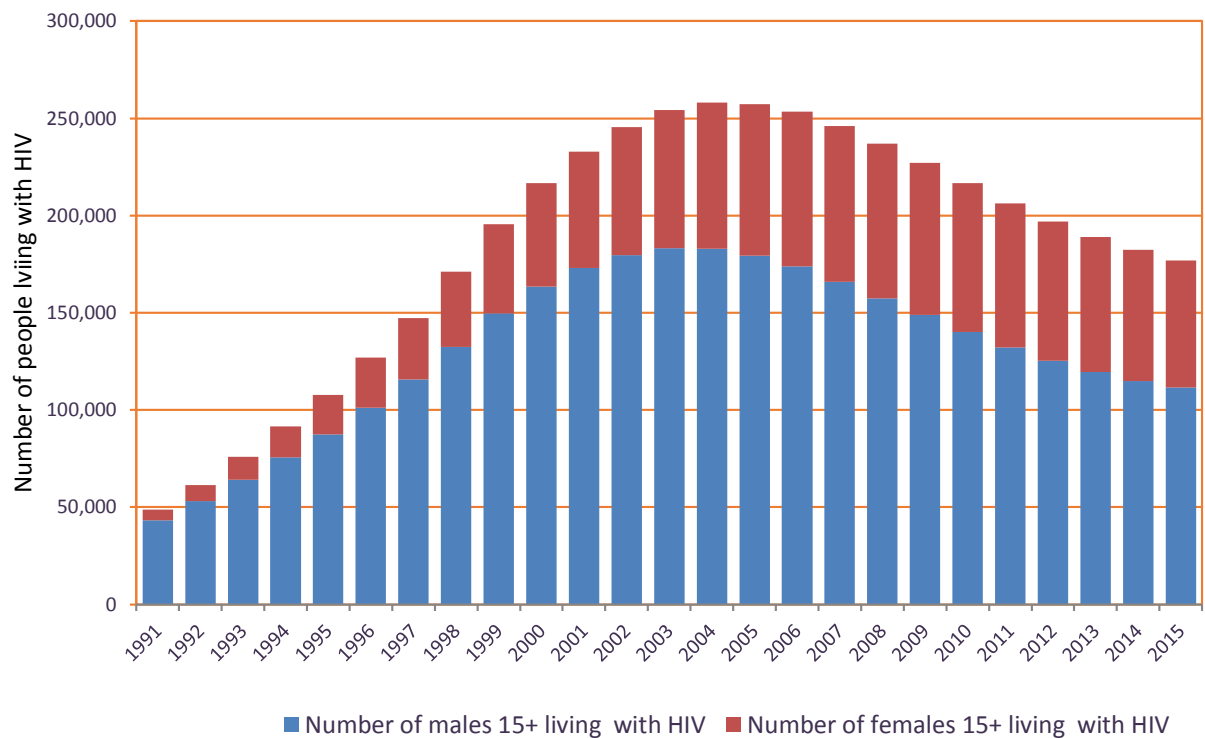
Gender equality is defined in the Myanmar National Strategic Plan on HIV and AIDS 2011–2015 as “the equal enjoyment by females and males (of all ages and sexual orientations) of rights, socially valued goods, opportunities, resources and rewards”. The World Health Organization defines gender as “socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women”.ⁱⁱⁱ

Understanding gender equality is key to understanding what makes men, women and transgender persons at risk to HIV. Gender equality has an important influence on the health knowledge and health behaviours of individuals. Gender norms – perpetuated by individuals, society, cultural and/or religious practices and reinforced by legislation and policy – contribute to disparities in the burden of ill health on all individuals.

In order to increase coverage of HIV interventions in Myanmar, it is important to understand the dimensions in which gender inequality hinders the effectiveness of existing programmes. Many questions remain unanswered. Why are women who were previously categorised as “low risk women” increasingly at risk to HIV infection? Are the needs of female and transgender persons who inject drugs adequately met in harm reduction programmes, including MMT? What do we know of young key affected populations?

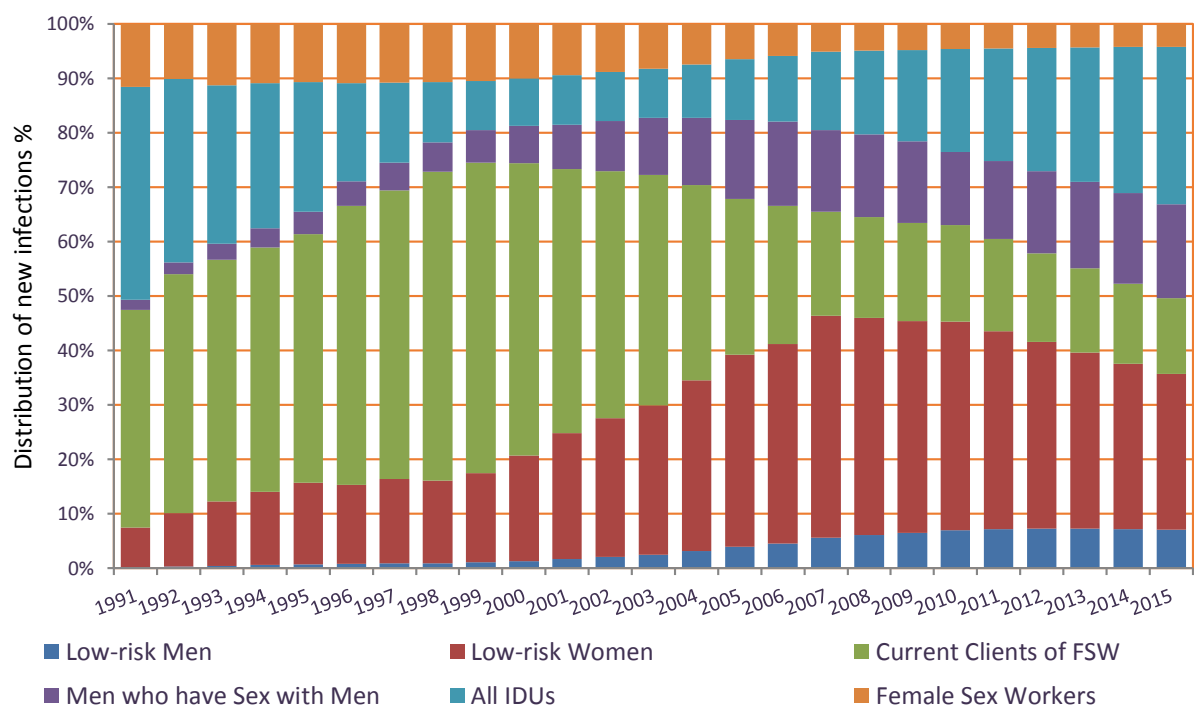
The key to successful HIV interventions is to map out ways in which the National Strategic Plan can become sufficiently gender sensitive to target and promote HIV prevention, testing and ensure equal and non-discriminatory access to antiretroviral therapy (ART).

Number of people living with HIV – Myanmar 1991-2015



Source: HIV Estimates and Projections Asian Epidemiological Model Myanmar 2010-2015

Distribution of new infections among key affected populations – Myanmar 1991-2015



The HIV epidemic in Myanmar

The HIV epidemic in Myanmar is concentrated among key populations at higher risk. There has been a downward trend in HIV prevalence in the general population, from a peak of 0.75 per cent in 2000–2001 to an estimated 0.47 per cent in 2012–2013. Approximately 37 per cent (n=76,664) of people living with HIV in Myanmar are women. The number of “low-risk” women newly infected with HIV has increased over the years ^{iv}.

Myanmar has been carrying out an annual HIV Sentinel Sero-surveillance Survey (HSS) since 1992. The 2012 survey (HSS 2012) included eight sentinel groups: pregnant women attending antenatal care clinics (ANC), new military recruits, blood donors, newly diagnosed tuberculosis (TB) patients, people who inject drugs (PWID), men who have sex with men (MSM), female sex workers (FSW) and male patients attending sexually transmitted infection (STI) clinics. In 2012, HIV prevalence was 0.7 per cent in women tested at antenatal clinics and above five per cent across key affected populations. HIV prevalence remains highest among PWID, followed by new TB patients, MSM and FSW. The median HIV prevalence among PWID was 17 per cent, ranging from 6.7 to 29 per cent depending on the survey site.^v Although the report shows that HIV prevalence among PWID is declining, use of contaminated injecting equipment remains a significant route of HIV transmission in the country.

The National AIDS Programme recognises the threat of sexual transmission of HIV to “low risk women”, i.e. wives and female sexual partners of men who inject drugs, men who are clients of sex workers and men who have sex with both men and women.^{vi}

HIV prevalence is higher in urban areas (e.g. Yangon and Mandalay) and in the northern part of the country, which has a higher concentration of people who inject drugs. HSS 2012 indicated that HIV prevalence varied significantly across sentinel sites, reaching 29 per cent among PWID in Myitkyina, and 21.3 per cent in men who have sex with men and 15 per cent in female sex workers in Patheingyi.

Getting to Zero in Myanmar

- Maintain the focus on interventions for **key populations at higher risk**
- **Scale up harm reduction** for people who inject drugs – avert more new infections than any other interventions
- Provide prevention services to 7,000 **high risk men who have sex with men (MSM)** – cut 50% new infections among this group
- Put **106,000 PLHIV on ARV** treatment by 2016 – cut 50% AIDS related deaths by 2020

Maximum impact will be achieved by prioritising interventions targeting:

1. People Who Inject Drugs (PWID)
2. Men who have sex with men (MSM)
3. Female Sex Workers (FSW)
4. Young FSW and MSM

Source: Myanmar Investment Case Report (2013)



Gender assessment of the national HIV response

The gender assessment of the national HIV response was commissioned by UNAIDS Myanmar Country Office. The assessment was undertaken concurrently with other evaluation activities for the mid-term review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015, which was carried out in January 2014.

The goal of the gender assessment is to ensure that gender equality principles and gender transformative interventions (where feasible) are incorporated into the national response to HIV at the mid-term review of National Strategic Plan on HIV and AIDS 2011–2015. The assessment was conducted with the following objectives:

1. To understand the HIV epidemic and country context from a gender perspective
2. To formulate key strategic recommendations for the country response to HIV from a gender perspective
3. To analyse and use the findings of the gender assessment to strengthen the existing HIV response, guided by international best practices.



Methodology

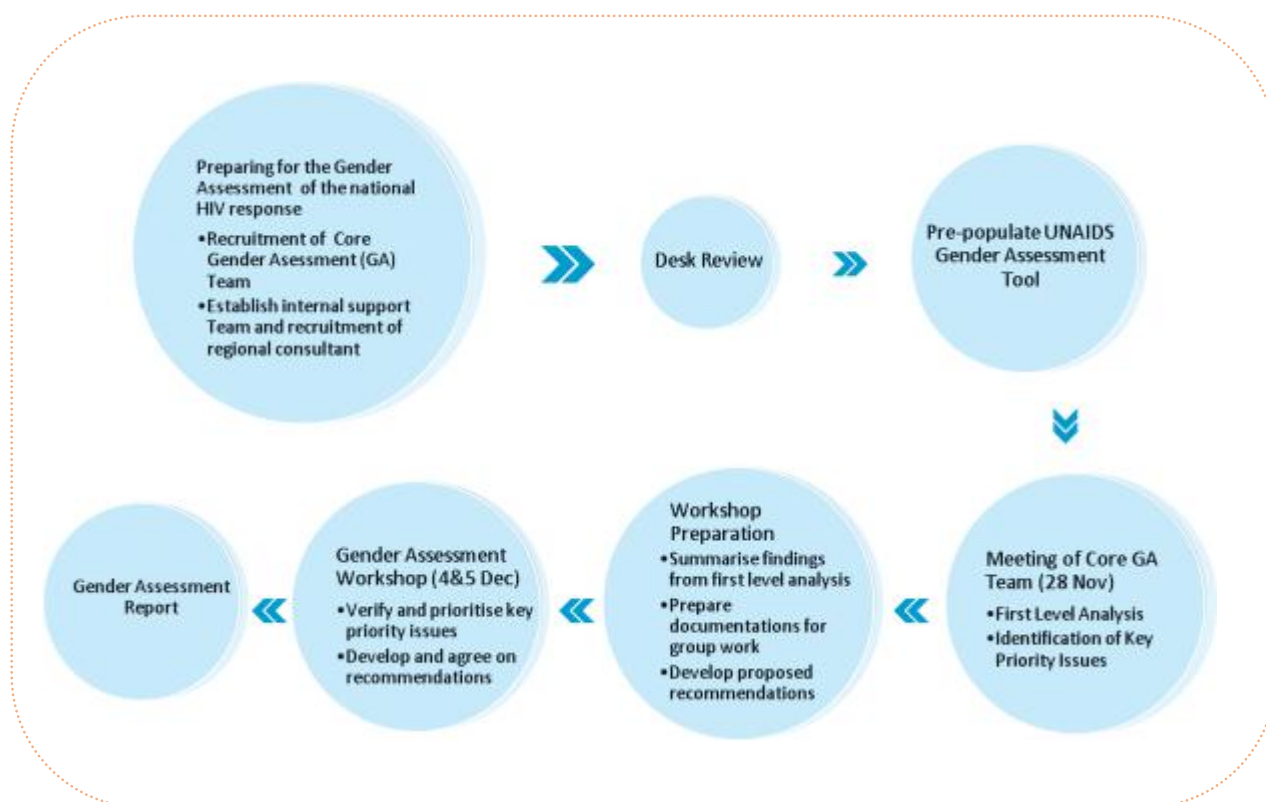


Figure 1: Process Flowchart of the Gender Assessment in Myanmar

Figure 1 illustrates the process of the gender assessment in a flowchart. The Gender Assessment Core Team met on 28 November 2013 to examine the data in the pre-populated tool and conduct first-level analysis. Aside from validating the data that had been pre-populated in the Gender Assessment Tool, the core team also provided valuable additional input to further enhance understanding of the gender perspective in HIV programming. This process eliminated the necessity to repeat the analysis of the Gender Assessment Tool during the multi-stakeholder workshop. It also afforded time for the internal support team and consultants to prepare key documents for the consultation, including summaries of key issues for each key affected population and a draft list of proposed recommendations drawn from regional best practices and the What Works for Women and Girls evidence base.

The Gender Assessment Workshop was held on 4–5 December 2013 in Yangon. Approximately 50 participants attended, representing government agencies, non-governmental organisations (both national and international) and civil society, as well as development partners including donors. Participants were divided into workgroups on: 1) women, girls, and women living with HIV, 2) PMTCT and OVC, 3) men and masculinities, 4) sex workers, 5) MSM and transgender persons, and 6) people who inject drugs.



Key issues identified in a gap analysis

A gap analysis using the Gender Assessment Tool identified a substantial number of issues, which were then summarized and consolidated in a single document for further analysis at the workshop. Recognising that it would be impractical to address all issues identified by the Gender Assessment Tool, groups representing all key populations were asked to focus on delineating issues using the following criteria:

1. Most critical issues faced by their constituents
2. Issues requiring urgent gender-sensitive interventions
3. Practical recommendations for the mid-term review of the National Strategic Plan on HIV and AIDS 2011-2015.

The following sections highlight prioritised issues identified by groups representing:

1. Women, girls, and women living with HIV
2. PMTCT and OVC
3. Men and masculinities
4. Sex workers
5. Men who have sex with men, and transgender persons
6. People who inject drugs.

I. Women, girls, and women living with HIV

The male to female ratio for new HIV cases is decreasing as the course of the epidemic progresses in Myanmar. In 1994, there were eight new cases of HIV in men for every one new case in women, but by 2008, the ratio had reduced to 2.1:1.^{vii} Various factors determine a woman's risk to HIV. Exposure to HIV may begin at a young age. According to a Behavioural Surveillance Study conducted in 2008 among out-of-school youth (n=6,954), the median age of sexual debut was reported as 19 years for males and 18 years for females. This does not take into account child marriages, which are more commonly practised in some communities. The assessment found that while there are laws to protect children against early and forced marriage, marriage of minors is permissible with parental authority (e.g. Muslim girls may be married with parental consent as early as 14 years of age). In those cases, girls are often married to men who are significantly older, with a longer history of sexual encounters.

Evidence shows that violence against women can also contribute to a higher risk of HIV infection for women.^{viii} Gender norms and constructs of femininity dictate that women are expected to be faithful, and they have no safe avenue of redress when trust is breached—including no legal protection against intimate partner violence. These norms also hinder women from having knowledge about sex and sexual health. Marital rape is not a criminal offence under the penal code, but at time of conducting the assessment it was noted that a bill is being drafted to protect women from domestic violence and to impose penalty on domestic violence. There are no anti-discrimination laws to protect the rights of citizens to fully exercise their rights to health, protection against violence, access to information and employment opportunities, particularly for people living with HIV and key affected populations.

According to available literature about gender-based violence, sexual violence and intimate partner violence in Myanmar, there are very few actual cases of survivors reporting to authorities in Myanmar, due in large part to the shortage of services available, and fears of further risks they may face by reporting what happened to them. According to reports from Women's League of Burma in January 2014, 100 cases of sexual violence have been documented in Kachin State between 2011 and 2014, but which "represent only a fraction" of the actual number.^{ix}

At present, the linkage between gender-based violence and HIV is weak and the availability of gender-based violence related services at both government and non-government service delivery points is very limited. Gender norms discourage men and women (married and unmarried) from discussing sex, and women have less power to insist on safe sex.

It was also found that there is limited synergy between the National Strategic Plan on HIV and AIDS and the National Strategic Plan for the Advancement of Women (NSPAW). The latter has

only recently been launched (2013). The NSPAW follows the Beijing Platform for Action and addresses HIV under health, and women and decision-making. There is scope for the NSPAW to also address gender equality in intimate relationships; gender equality in household decision-making; transforming concepts of masculinity that encourage sexual risk-taking and discourage health-seeking behaviours; access to economic empowerment opportunities, including through microcredit or cash transfer; gender-based stigma and discrimination against people living with HIV; and access to social services.

Recommendations

1. Expand comprehensive prevention through community outreach and peer education to reach HIV-positive women and women vulnerable to HIV.
2. Promote establishment of women- and youth-friendly health services that are conveniently located, affordable, confidential and non-judgmental.*
3. Sensitize male partners, families, and communities on sexual and reproductive health.
4. Provide continued counselling (either group or individual) and related training for those who are HIV-positive and those affected by HIV to relieve psychological distress.*
5. Train and empower women to negotiate condom use (including female condoms) and dual protection contraception.*
6. Provide community training on gender equitable norms to reduce gender harmful norms, in relation to HIV prevention, treatment, and care.*
7. Provide information and skills-building support to reduce unprotected sex.*
8. Provide health facility based peer support systems to assist newly diagnosed HIV-positive women (psychosocial, partner notification, treatment adherence, referrals to shelters).
9. Ensure access to women-friendly HIV prevention, ART, reproductive health services, HIV counselling and testing, post-exposure prophylaxis, and psychosocial support services for women who are displaced (man-made and natural disasters).
10. Ensure linkages between the National Strategic Plan on HIV and AIDS and the National Strategic Plan for the Advancement of Women (NSPAW).

II. PMTCT and OVC

HIV prevalence among pregnant women attending ANC clinics is at its lowest since 1992, according to HSS 2012, at 0.7 per cent (range 0–2 per cent across 35 sentinel sites). However, it is important to note patterns of geographical distribution in the data and investigate why the prevalence is higher in some areas than others. For example, the prevalence was highest in Yangon, which showed an increasing trend, followed by Myawaddy and Taunggyi. On the other hand, Muse showed a decline from three per cent in 2007 to 0.8 per cent in 2012.^x HSS 2009 reported that 13 per cent of infants born to HIV-positive mothers were infected with HIV.^{xi}

Although the target of providing ARV prophylaxis to HIV-positive pregnant women was reached (Progress Report 2012), the uptake of HIV testing among pregnant women is still low and loss to follow-up before and after birth is high.

Some women who need access to services are not being reached such as those in areas of civil unrest; camps for internally displaced people; and other poor or street-based women, including those who cannot afford transportation to the service sites or fees associated with health care.

Pregnancy is seen as a “woman’s issue”, a common gender and cultural norm in Asia. Male involvement during antenatal and postpartum care is not expected by both men and women and is therefore low. If a woman finds out that she is HIV-positive during pregnancy it could lead to detrimental outcomes for her, such as abandonment, violence and poverty. Social stigma attached to having HIV deters women from getting tested and fear of discrimination deters women living with HIV from seeking ANC services.

There is a prevalent belief in society that women who are HIV-positive should not have children, and one of the key concerns raised during the assessment was limited counselling support for reproductive health of HIV positive women which can result in possible pressure by health care staff for HIV-positive women to undergo sterilisation. There were few accounts of HIV-positive

women being asked to sign consent forms for sterilisation without proper counselling, before advent of PMTCT, hence depriving them from having complete information and understanding of the consequences of that decision. There were also reports of HIV-positive mothers who were prevented from breastfeeding. Representatives from the networks of people living with HIV also reported instances of severe discrimination towards HIV-positive pregnant women in hospitals, such as being placed in separate wards, or near public toilets and other public areas, even during delivery.

Recommendations - PMTCT

1. Integrate programmes to promote male involvement in the safe motherhood programme, with a particular focus on the care of women living with HIV.
2. Improve maternal health systems by strengthening components of the safe motherhood programme (or mother-baby package) to improve prevention of vertical transmission, including access for adolescent girls.
3. Strengthen peer support groups for women living with HIV.
4. Institute prevention and response for gender-based violence, giving priority to the safety and well-being of women prior to any adoption of male-friendly procedures.*
5. Promoting family planning counselling and voluntary contraceptive use as part of routine HIV services (and vice versa) to increase contraceptive use, including dual protection (i.e. condoms plus another contraceptive method).*
6. Provide pre-conception options for serodiscordant couples. Depending on feasibility in Myanmar, options include pre-exposure prophylaxis combined with timed unprotected intercourse, and delayed conception until the HIV-positive partner is on treatment and adherent for a number of months. Self-insemination can minimize the risk of HIV transmission from an HIV-positive woman to her seronegative male partner and infant.*
7. Facilitate informed and appropriate counselling during ANC to increase discussion between partners and increase protective behaviours, including condom use.*
8. Test for and treat syphilis in conjunction with HIV testing for pregnant women*
9. Initiate antiretroviral triple therapy as early in pregnancy as possible – or better yet, prior to pregnancy – for those women living with HIV who are ready to be adherent.*
10. Create community outreach for women living with HIV for early postpartum visits, to provide contraceptive counselling and services.*
11. Train health care workers to employ gender sensitive approaches for women, girls and transgender persons (including ensuring confidentiality).

Issues around orphans and vulnerable children were also extensively discussed during the consultation. Limited ARV treatment literacy, in particular for adults caring for children living with HIV, and the limited availability of paediatric ARV formulations were two key issues raised. Furthermore, for a child to be on ART, it is required that one of the parents is not HIV-positive; if both are HIV-positive, health service providers can require that a different caretaker is assigned for the child. This practice is currently being reviewed.

Recommendations – Orphans and Vulnerable Children

1. Accelerate ART access for HIV-positive parents to reduce the number of orphans.*
2. Create educational support for orphaned children to reduce risk of acquiring HIV.*
3. Create programmes to promote the importance of supporting and caring for OVC within a family environment, and offer family-centred integrated economic, health and social support to enable this.*
4. Provide community development projects, rather than a narrowly defined HIV/AIDS programme, to reduce the stigma against OVC.*
5. Provide age-appropriate sexual and reproductive health services for OVC, along with information, condom negotiation skills and condom supplies.
6. Create programmes that provide community-wide cash transfers, microenterprise opportunities, old age pensions or other targeted financial and livelihood assistance to support OVC.*

III. Men and masculinities

“Treat your sons like lords, Treat your husbands like God” – Myanmar proverb

This proverb takes effect the moment a woman enters into marriage. It elevates the status of men and boys; the culture of masculinity thrives throughout the lifetime of a Myanmar man. Gender inequality extends to the domain of education and economic empowerment, whereas within the context of risk and exposure to HIV, gender inequality justifies male dominance in sexual relations.

Gender norms and constructs of masculinity encourage men to have multiple unsafe sexual encounters and condone (transactional) sex-seeking behaviour by men. HSS 2012 reported a median HIV prevalence of 3.3 per cent in male STI patients, (range 0–14.2 per cent across sites), indicating high levels of exposure to HIV for sexually active men. It is assumed that MSM and transgender persons are also included in the male STI patient cohort.

Men generally have greater knowledge and awareness of HIV compared to women, but this knowledge does not necessarily translate into protective behaviour. Men living with HIV report a lapse of time between suspecting they are HIV-positive and getting tested, and between testing HIV-positive and disclosing their positive serostatus to their wives.^{xii}

Male involvement in reproductive health interventions is lacking. Gender norms contribute towards shortcomings in the communication and interpersonal skills of males to discuss issues relating to intimacy, family planning and sexuality with their female partners. For example, men may not understand that they have a shared responsibility to reduce unwanted pregnancy. Current services such as counselling, treatment and positive prevention are not gender sensitive.

Recommendations

1. Develop a communication strategy (short and long term) to sensitise the male population at five levels – individual, family, society, organisation and state.
2. Develop strategies to encourage and institute male involvement in targeted programmes.
3. Train providers to encourage couple dialogue and counselling, including techniques to avert gender-based violence, to increase the number of couples who receive and mutually disclose their HIV test results.
4. Facilitate informed and appropriate counselling during ANC to increase discussion between partners and increase protective behaviours, including increased condom use.*
5. Teach men and young people to provide voluntary home care assistance to ease the burden of home care for women.

IV. Sex workers

HSS 2012 reported a median HIV prevalence among sex workers of 6.4 per cent. Across the sentinel sites, HIV prevalence was highest in Patheingyi (15%) followed by Myittha (12.4%), and lowest in Pyaw (3%). HIV prevalence was found to be significantly higher among direct sex workers than indirect sex workers, at nine and 3.9 per cent respectively (with a p value of less than 0.0001).

The correlation between sex worker mobility and HIV is high. More than 50 per cent of FSW reported working in multiple townships in the 12-month period. Exposure to HIV is high within the first year of becoming a sex worker.

The link between condom use and illicit sex is high and therefore condom use may be seen as stigmatised, or confirmation of the illicitness of the activity. Brothel and entertainment venue owners confiscate condoms from sex workers and despite contrary instructions police still use condom possession as evidence of sex work and to justify arrest. Outreach workers are not allowed to distribute condoms in places where sex work occurs. HIV-positive sex workers are fired by their employers and as a result become susceptible to poverty, further increasing their vulnerability to abuse, malnutrition and opportunistic infections.

Stigma and discrimination hinder sex workers' access to ART and sexual and reproductive health services. HIV-positive sex workers who are arrested may not be able to access or continue ART while in remand or serving a prison sentence, which is a risk for the development of drug

resistance. Since abortion is illegal in Myanmar, pregnant sex workers also resort to unsafe abortions and when faced with complications they may be refused post-abortion care by service providers. Young sex workers are often refused by shopkeepers when they want to purchase condoms, and need parental permission to access healthcare services (including reproductive health and ART). There were accounts of HIV-positive young sex workers becoming homeless and dying on the streets due to malnutrition.

Recommendations

1. Provide mobile clinic services to sex workers in hard to reach areas.
2. Provide reproductive health services, PMTCT services including easy, no- or low-cost access to dual protection contraception methods (condoms plus) and counselling for sex workers.*
3. Establish programmes to reduce violence against sex workers and respond to the needs of survivors of violence (www.endvawnow.org).*
4. Create socio-economic and educational support for vulnerable children (i.e. children of female sex workers) to reduce the risk of HIV.
5. Create referral systems between sex worker CBOs, NGOs (local/international) and government services.
6. Review training curriculums and develop a standardised training curriculum for peer educators to include community mobilization, sexual and reproductive health services, legal support and support for those who experienced gender-based violence.
7. Train sex workers on human rights and redress, (promote IEC materials that include useful information such as the Police Instruction not to use condoms as evidence for arrest of sex workers and phone numbers for legal aid, shelters, etc.).
8. Strengthening of sex-worker led community based organisations for organisational development, financial management, project management, volunteer recruitment and retention.
9. Sensitization and training of law enforcement officials and policy makers of Ministry of Home Affairs (such as workshops, study tours, dialogue involving key populations, officials and policy makers).
10. Advocate and campaign for greater involvement of men (encouraging greater responsibility of male clients to use condoms). [Creative data collection processes to track commodities to clients and sex workers via peer educators]
11. Pilot training, messaging and targeted distribution of female condoms using networks of sex workers and disseminate the results of the pilot widely.

V. Men who have sex with men, and transgender persons

In many settings there is no sign of a decrease in new HIV infections among men who have sex with men, unlike for other key affected populations. The Commission on AIDS in Asia reports that if HIV prevention services do not improve their effectiveness and reach, MSM and transgender people will represent half of all new infections in the region by 2020.^{xiii} The median prevalence of HIV among MSM in HSS 2012 was 6.8 per cent, with a large variation of 3–21.3 per cent across the four sentinel sites.

One of the key issues raised during the gender assessment consultation was that there is a need for separate data on transgender persons, as currently transgender persons are included in the overall MSM population in terms of surveillance and programme data. According to a study conducted by PSI in 2008, the HIV prevalence in transgender people was around three times higher than for other MSM.^{xiv}

Sex between males is *de facto* criminalised under Section 377 of the country's penal code, and MSM and transgender people also report being harassed by the police under other statutes. Criminalisation of homosexual behaviour, exacerbated by strong gender and masculinity norms, further increases the risk of exposure to HIV for MSM. Within the wider MSM population there is a sub-population referred to as 'hidden' MSM, because they are harder to reach using HIV prevention approaches that target MSM who are more open about their sexuality. However, hidden MSM may be reachable through their peers. Hidden MSM may appear to be heterosexual and

may be married or also have sex with women. It may be important to include messages about the risk of HIV transmission to themselves and their wives and children in prevention programmes. However, there are limited opportunities to highlight sexual minority issues in mass media. Hidden MSM are thought to be reluctant to buy and use condoms, or to find out or disclose their HIV status.

Older MSM are thought to buy sex more often than younger MSM. The same applies to older transgender persons. Since they are more easily identifiable because of their appearance, transgender people are subject to high levels of discrimination. Some are concerned that if they try to negotiate condom use, their sexual partner might think them promiscuous, unclean, untrusting, or not submissive enough – which could be inconsistent with a feminised role. Men who sell sex to men may not identify as gay. Some may want to conform by having a girlfriend, so they have paid sex with other men so they can afford the relationship with their girlfriend.

There are accounts of MSM and transgender persons being subjected to gender-based violence in prison and rehabilitation centres and like other PLHIV who face detention they also have difficulty accessing ART.

Recommendations

1. Disaggregate data for MSM and transgender persons.
2. Provide services targeted to transgender persons in addition to services focusing on MSM.
3. Develop innovative prevention programmes to reach hidden MSM and transgender persons, including mobile MSM and transgender persons (defining a standard package of services, including BCC, IEC, web-based strategies).
4. Provide access to clinical and psychosocial programmes that address violence against effeminate men and transgender persons in incarceration settings (including access to condoms and other commodities).
5. Create gender-based violence prevention and response programmes that consider the needs of MSM and transgender persons including HIV prevention programmes for MSM in prisons/ closed settings.
6. Train MSM and transgender persons on human rights and redress (promote IEC materials that include useful information such as the Police Instruction refraining from arrests using condoms as evidence and phone numbers for legal aid, shelters, etc.).
7. Review Penal Code Section 377 and consider creating new (anti-discrimination) laws that are protective of people living with HIV and key affected populations.

VI. People who inject drugs

HSS 2012 reported 17 per cent HIV prevalence among people who inject drugs, with a wide range across the seven survey sites from 6.7 per cent (Taunggyi) to 29 per cent (Myitkyina). The overall trend of HIV prevalence among drug users is decreasing but it remains high. Thirty per cent of all new HIV infections in 2012 were among male injecting drug users. Exposure to HIV is high within the first year of starting to inject drugs. Harm reduction efforts need to be expanded, targeting areas with the most concentrated HIV epidemic.

Drug treatment and HIV prevention programmes are typically gender-biased towards men and poorly address the needs of women and girls who inject drugs and the female partners of men who inject drugs. In general, HIV prevention that targets women puts the responsibility on women to insist on safer sex, increasing their risk to physical and sexual abuse. Evidence shows that female injecting drug users often depend on their male partners not only to procure drugs but also to inject them, which places them “second on the needle”, thus increasing their risk of exposure to HIV and other blood-borne pathogens.^{xv}

Little is known about the number of women who inject drugs. Anecdotally, numbers of women who inject drugs are low. There are gaps in data collection on people who inject drugs, including population size estimates disaggregated by age, gender and type of drug use (injecting, non-injecting). Reaching out to women who inject drugs is a challenge as they may not access services due to self-stigmatisation, a deep sense of personal shame, and also because they are caregivers to the family. Due to stigma and discrimination, women who inject drugs are not accessing sexual

and reproductive health, harm reduction and HIV treatment services. At present, only 1.4 per cent of MMT patients are women.^{xvi}

There is no clear strategy on how to provide services and ensure access for female partners of men who inject drugs. Furthermore, the interaction of multiple risk factors for HIV transmission – including sex work (female and transgender) and injecting drug use – has not been studied.

Recommendations

1. Outreach to encourage HIV counselling and testing for partners of people who engage in high risk behaviour (PWID, sex workers, MSM, transgender persons).
2. Ensure availability of age and gender disaggregated data on PWID and data on their sexual partners.
3. Where there are large numbers of women who inject drugs, design programmes that use female outreach workers (for harm reduction) and increase treatment literacy and awareness for women who inject drugs. Train women who inject drugs to serve as peers to reach other women with information on prevention, harm reduction, and sexual and reproductive health.
4. Review MMT guidelines and provide MMT in appropriate dosages that reduce the likelihood of PWID continuing to inject drugs.
5. Ensure that harm reduction programmes address the needs of women (where relevant), including sessions for couples to increase condom use and safe injection practices.
6. Create an incentive system for peer support for access to clean needles, adherence to MMT and adherence to ART (particularly considering the needs of women and transgender persons).
7. Strengthen linkages between ART and MMT programmes.

Cross-cutting interventions for all key affected populations

The assessment also identified cross-cutting issues, which are applicable to all key affected populations (and in particular to young people in the key affected populations) and in some instances to the general population. For example, the issue of sex, sexuality and gender education in both formal and non-formal learning settings remains a sensitive subject matter. From a legal perspective, there are no age restrictions on accessing HIV and sexual and reproductive health and rights (SRHR) services and commodities. However, in practice there are barriers that impede young women, men, and key affected populations from accessing such services and commodities to the same extent (and under the same conditions) as adults. A recurring issue that emerged from the assessment is the lack of awareness and support from law enforcement agencies for HIV programmes targeting key affected populations, which hinders the effectiveness of outreach programmes implemented by non-governmental organisations.

Recommendations

1. Develop a gender-sensitive sex education curriculum that adheres to UNESCO standards (UNESCO, 2009a and b).*
2. Promote establishment of key affected population friendly (non-judgemental) STI clinics, where needed.*
3. Increase employment opportunities, microfinance, or small-scale income-generating activities to reduce risk behaviours.*
4. Ensure youth-friendly condom distribution.
5. Train teachers to conduct age-appropriate sexuality education.*
6. Provide clinical services that are youth-friendly, conveniently located, affordable, confidential and non-judgmental for young people.*
7. Sensitization and training of law enforcement officials and policy makers of the Ministry of Home Affairs (workshops, study tours, and dialogue involving key populations, officials and policy makers).

Strategic information, monitoring & evaluation and research

The most noticeable gap found in the review of the HIV epidemiological data was the absence of data disaggregation by age and gender. Disaggregated data will facilitate a better understanding of gender in the HIV epidemiological situation. Another key issue raised was the need for data on transgender persons, as this is currently included under MSM data (as mentioned in the MSM and transgender section, above).

Recommendations

1. Ensure availability of age and gender disaggregated data for prevention, treatment, OVC. Disaggregate data by age categories 0–10, 11–17, 18–24, 25–45. Separate data on transgender persons from the MSM data category.

Additional research

To enhance future planning of gender sensitive HIV interventions, additional research is recommended to better understand gaps and needs in the response to HIV, in particular for hidden and mobile populations. The following research questions and issues were discussed and agreed by workshop participants as critical areas for additional research:

Recommendations

1. What is the incidence of gender-based violence among sex workers, women living with HIV, MSM, transgender persons (and women who have sex with women)? Are those who experience gender-based violence at increased risk of HIV infection?
2. Map social networks of MSM and transgender sex workers.
3. Assess effectiveness and gender sensitivity of drug treatment programmes in Myanmar.
4. How many injecting drug users are women? Are they a “hidden population”?
5. How do “low risk women” in Myanmar acquire HIV?
6. How to reach female partners of men who inject drugs and MSM?
7. Map the risk behaviours of men in conflict environments.
8. Men, mobility and risk behaviours.

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Annex 1

Participant List of Gender and HIV Assessment Workshop

4 – 5, December 2013

Summit Parkview Hotel

1. Dr Myo Thant (National AIDS Programme)
2. Dr Tin Tin Mar (National AIDS Programme)
3. Police Major Win Ko Ko (CCDAC)
4. Ms Khin Than Win (DEPT)
5. Mr Kyaw Zay Yar (National Drug User Network Myanmar)
6. Mr Myo Myint Naung (National Drug User Network Myanmar)
7. Dr Yu Yu Aung (UNESCO)
8. Ms Hnin Hnin Yu (Sex Workers in Myanmar Network)
9. Dr Kyaw Htin Soe (UNHCR)
10. Saw San Oo (aka) Sammy (Alliance Myanmar)
11. Ms Jean D'Cunha (UN Women)
12. Mr Chit Ko Ko (Lotus)
13. Dr Myo Win Tin (Merlin)
14. Mr Kyaw Sit Naing (CRB)
15. Ms Khin Khin Mon (Myanmar Positive Women Network)
16. Ms Hnin Si Wai (National NGOs Network on HIV/AIDS)
17. Mr Aung Myo Min (MDM)
18. Ms Sandar Moe (Sex Workers in Myanmar Network)
19. Ms Htwe Htwe Myint (Myanmar Positive Women Network)
20. Dr Htin Kyaw (MANA)
21. Ms Zin Win Mar (Sex Workers in Myanmar Network)
22. Mr Ikuma Nozaki (JICA)
23. Mr Nay Lin (Myanmar MSM Network)
24. Ms Tha Zin (Myanmar MSM Network)
25. Ms Khin Khin Win (Myanmar Interfaith Network on HIV/AIDS)
26. Mr Myo Kyaw Lynn (Myanmar Positive Group)
27. Mr Swe San Oo (National NGOs Network on HIV/AIDS)
28. Dr May Thu Ne Win (UNOPS)
29. Ms Zar Chi Htwe (MSI)
30. Ms Mary Aung (MDM)
31. Mr Win Min (National Drug User Network Myanmar)
32. Dr Nwe Ni Myint (Alliance Myanmar)
33. Dr Kyi Zaw Win (Pyi Gyi Khin)
34. Mr Kyaw Min Tun (Myanmar MSM Network)
35. Mr Wai Phyo (Myanmar Positive Group)
36. Ms Khin Mar Kyway (PSI)
37. Ms The Chit Su (MCUM)
38. Benjamin (MCUM)
39. Ms April Snow (Myanmar MSM Network)

40. Dr Sanda Thant (UNDP)
41. Mr Maung Maung (FAO)
42. Ms Nang Si Phong (Ratana Metta)
43. Ms Nan Cherry (Myanmar Interfaith Network on HIV/AIDS)
44. Dr Win Mar (UNDP)
45. Ms Hnin Thandar Win (Myanmar Positive Women Network)
46. Dr Maung Maung Sein (UNODC)
47. Mr Si Thu Aung (National Drug User Network Myanmar)
48. Ms Wynt Yi Khaing (Myanmar Positive Group)
49. Mr Kyaw Thu (National Drug User Network Myanmar)
50. Mr Htoo Wint Kyaw (Myanmar Positive Group)
51. Ms Pansy Tun Thein (Local Resource Center)
52. Mr Nay Oo Lwin (PSI)
53. Mr Tun Aung Kyaw (Myanmar Positive Group)
54. Soe San (Kings and Queens)
55. Aw Zar Moe (Kings and Queens)
56. Dr Nay Win Ko Ko (Burnet Institute)
57. Dr Kyaw Myint Tun (IOM)
58. Dr Peter Wilson (Merlin)
59. Ms Hnin Kalayar Kyaw (Burnet Institute)
60. Ms Dominique Chambless (UNAIDS)
61. Ms Jacquie Cheung (UNAIDS)



Extracted from Gender Assessment Tool for National HIV Responses

STAGE 2

Knowing the HIV epidemic and context in the country

Step 1 • HIV Prevalence, Incidence and Behavioural Information

Question 1. What is the latest prevalence rate of HIV, disaggregated by sex and age, in the general population?

HIV Prevalence rate [2012]				
	Total population	Male	Female	Trans
Overall	206,873	130,209	76,664	-
0–14	9,839	4,993	4,846	-
15 and above (no other age desegregated data is available)	197,034	125,216	71,818	

1.1 Please specify the trend over time in prevalence data (disaggregated by sex and age).

Obs.: Consider presenting the trend in a graph as Annex, if available

Description

There is a downward trend in HIV prevalence among the general population, from a peak in 2000-2001 of 0.75 to the 2012-2013 estimate of 0.47. HIV prevalence has fallen concurrently with incidence. As well, the difference in prevalence based on gender has started to level off; approximately 37% of people living with HIV (PLHIV) in Myanmar are women. Refer to the graph in **Appendix 1**.

HIV prevalence is estimated to be below 1% among women tested at antenatal clinics and above 5% among one or more of the Key Affected Populations (KAPs). Myanmar has been carrying out the annual HIV Sentinel Sero-surveillance Survey (HSS) since 1992. The survey includes 8 targeted sentinel groups: Pregnant Women attending the antenatal clinics (ANC), New Military Recruits, Blood Donors, newly diagnosed TB patients, People who inject drugs (PWID), Men who have Sex with Men (MSM), Female Sex Workers (FSW) and Male patients attending sexually transmitted infection (STI) clinic.

HIV prevalence remains highest among PWIDs followed by new TB patients, MSM and FSW. The mean prevalence amongst people who inject drugs is 17%, ranging from 6.7% to 29%. Although the report shows that IDU prevalence is declining, this percentage is still alarming and represents a major threat to the health system in Myanmar. The use of non-sterile needles and syringes and other injecting drug equipment remains a critical factor exacerbating the HIV epidemic among PWID and transmission to their

sexual partners. The National AIDS Programme recognises the threat of sexual HIV transmission to "low risk women", i.e. wives and sexual partners of men who inject drugs, men who are clients of sex workers and men who have sex with men and women.

Question 2. What is the latest national HIV incidence rate, disaggregated by sex and age, in the general population?

Incidence [2012]	Total	Female	Male
0–14	400*	No data	No data
15 and above (no other age desegregated data is available)	7,696	2,986	4,710

*Data from PMTCT programme, 2012

Question 3: Have population size estimations for key populations been performed?¹

Key Population	Size estimation performed (yes/no)	If yes, when was the latest estimation performed? (year)	If yes, what was the size estimation?
a) Men who have sex with men	No*	2008 IBBS	224,000
b) People who inject drugs	No*	2008 BBS	75,000
c) Sex workers	No*	2008 BBS	60,000
d) Comments	<p>* The population size estimates reported above are based on Behavioural Surveillance Surveys (BSS) and the Integrated Biological and Behavioural Surveillance (IBBS) conducted in 2008. Transgendered persons are included within MSM population size estimates. Other population groups surveyed include out-of-school youth (15-24 years) and truckers.</p> <p>BSS are conducted every 3-4 years to monitor risk and preventive behaviour, knowledge of HIV transmission and prevention, and service exposure and coverage. IBBS combines HIV sero-surveillance with behavioural surveillance. The National AID Programme with the assistance of UNAIDS will conduct a national population size estimate of key population (MSM, PWID, FSW) in 2013/2014.</p>		

Question 4: What is the prevalence rate of HIV in key populations? Disaggregated by sex and age, if available.

HIV Prevalence rate [2012]							
	Overall	Female	Male	<25yrs		≥25yrs	
				F	M	F	M

^A Separate data on transgender and transsexual people are not available as they are included in MSM data

¹ See Appendix 3. Special 2013 GARPR questionnaire, available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

IDU	18.0%	- ^B	18.0%	-	13.7%	-	18.7%
Sex workers	7.1	7.1%	- ^C	6.9%	-	6.6%	-
Transgender ^A	-	-	-	-	-	-	-
MSM	8.9	-	8.9%	-	6.4	-	16.3
Male STI patients	4.1%						
New Military Recruits	1%						
New TB patients	9.6%						

^B Limited data available on female injecting drug users

^C Limited data available on male sex workers

Sentinel Group	# tested for HIV	# HIV positive	sero positive (%)	Range			95%CI
				Minimum (%)	Median (%)	Maximum (%)	
Male STI patients	5,034	204	4.1%	0%	3.3%	14.2%	3.5%-4.6%
FSW	1,784	126	7.1%	3%	6.4%	15%	5.9%-8.3%
PWID	1,217	219	18%	6.7%	17%	29%	15.8%-20.2%
MSM	763	68	8.9%	3%	6.8%	21.3%	6.9%-10.9%
Pregnant Women	13,995	102	0.7%	0%	0.8%	2%	0.6%-0.9%
New Military Recruits	732	7	1%	0.6%	0.9%	13.3%	0.3%-1.7%
New TB patients	3,296	317	9.6%	0.9%	10%	19%	8.7%-10.7%
Blood Donors	30,584	44	0.14%	0%	0.08%	0.74%	0.1%-0.19%

Figure 1: HIV prevalence among sentinel populations, HSS 2012

4.1 Please specify the trend over time in prevalence data in key populations (disaggregated by sex and age).

There is a downward trend in prevalence among key affected populations. Refer to the graph in **Appendix 1**. While all groups show declining or stable trends, the absolute values remain high, with HIV prevalence highest among PWID.

Question 5. If a *modes of transmission* study² has been undertaken, what are the modes of HIV transmission for women, girls, men, boys, and transgender persons?

² A modes of transmission study determines the way a given population acquired HIV (sexual transmission, vertical transmission, infected needle, or infected blood transfusion.) For more information, see http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/guidelines/JC2427_ModelingNewHIVInfectionsbyModesofTransmission_en.pdf

No formal study has been undertaken at time of assessment. However, the most common modes of HIV transmission are via: sex work; discordant couples (husband to wife and vice versa); casual heterosexual sex (non-commercial); sex between men (including transgender and male sex workers); needle sharing; and mother-to-child transmission.

Question 6. Are there any locations of higher incidence (e.g. rural, urban, or specific geographic locations)? Provide information by general population and key population if available.

Myanmar has a concentrated HIV epidemic, with prevalence higher in urban areas (e.g. Yangon and Mandalay) and in the northern part of the country, which has a high concentration of people who inject drugs. The 2012 HIV Sentinel Sero-Surveillance (HSS) survey indicated that prevalence rates vary significantly across sentinel sites, from as high as 29% among PWID in Myitkyina (northern Myanmar) and 21.3% in MSM and 15% in FSW in Patheingyi (southern Myanmar).

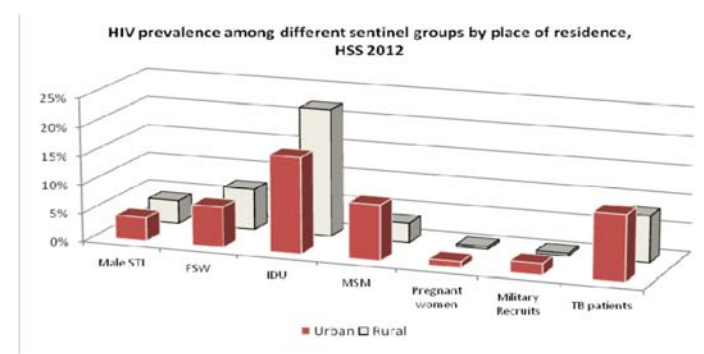


Figure 2: HIV prevalence in different sentinel groups by residence, HSS 2012

Question 7. What is the percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission?³

Disaggregated by sex (female, male), age, and key populations, if available.

Young people: knowledge about HIV and prevention				Key populations
Age	Total	Female	Male	
15–19	45.32%	46.34%	44.34%	N/A
20–24	49.67	48.71	50.67	N/A

³ See GARPR 1.1., http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

[GARPR 2012] – no data for young key affected populations

7.1 What is the percentage of young women, men and transgender that have knowledge of whether a person can reduce the risk of getting HIV by using a condom every time they have sex?

Young people: knowledge about HIV and prevention			
Age	Total	Male	Female
15–19	82.49%	81.00%	83.92%
20–24	84.83	85.99	83.71

[GARPR 2012] – no data for young key affected populations

7.2 If available, what is the trend in knowledge and access over the past 5 to 10 years? (disaggregated by sex and age).

Data not available.

Question 8: What is the percentage of women and men aged 15–49

Multiple sexual partnerships			
Age group	Total	Female	Male
15–19	0.61%	0.00%	1.22%
20–24	5.57	0.42	10.83
25–49	8.58	0.33	17.15

[GARPR 2012]

8.1. What is the percentage of women and men aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse?⁴

Condom use at last sex among people with multiple sexual partnerships			
	Total	Female	Male
15–19	66.67	-	66.67%
20–24	67.92	-	70.59
25–49	39.07	-	39.86

[GARPR 2012]

8.2. If available, what is the trend in knowledge and access over the past 5 to 10 years? (Disaggregated by sex and age).

Data not available.

Question 9. Does the country have data on unwanted pregnancy among unmarried adolescents? If so, please record here.

Data not available.

⁴ See GARPR 1.4.
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/GARPR_2013_guidelines_en.pdf

9.1. Do the country policies and programmes link prevention of unwanted pregnancies and HIV prevention?

No - there is no formal link between the prevention of unwanted pregnancies and HIV in the national policies and programmes of Myanmar.

Question 10. Is there data available on intimate partner violence (IPV), including sexual violence? If yes, please describe and if possible, include age-disaggregated data.

Lack of data available – studies conducted have been limited in scale and scope. UNDP and UNFPA have recently conducted a study on Sex Work and Violence. This study has not yet been published.

Questions 11. Has the country collected data on stigma and discrimination toward people living with HIV e.g. through the stigma index⁵ Please include data disaggregated by sex and age, where available.

Myanmar participated in the 2011 roll-out of the PLHIV Stigma Index in Asia and the Pacific region (alongside eight other countries). Myanmar Positive Group (MPG) carried out the field work to collect data to develop the PLHIV Stigma Index in Myanmar. Refer to **Appendix 2** for data highlights.

Summary of Key Issues

- age and gender disaggregated data is required for better understanding of gender and HIV epidemiological situation
- separate transgendered persons from MSM data – 2008 PSI study shows that HIV prevalence amongst transgendered persons are 3 times higher than MSM
- need to capture data on young key affected populations. ie. PWID, SW, MSM and TG < 24 years
- more information needed on women who inject drugs – population size estimates, mapping of multiple risk factors and other determinants of health
- growing number of sero-conversion amongst wives and partners of men who inject drugs, clients of sex workers who are otherwise low risk women
- population size estimates for all key affected populations are needed (note: PSI is of the opinion that current population size estimates of MSM and SW are low - MSM could be as high as 400,000 and SW up to 80,000)
- data required on male sex workers and migration (or mobility), as well as regional disparities and data trends over time
- due to the illegality of abortion in Myanmar, there is limited data on unwanted pregnancy. It is reported that almost 5% of pregnancies end in abortion⁶, unsafe abortion is an issue of unmet needs for reproductive health and family planning

Add data from 2013 journal articles and if available, preliminary findings from UNDP and UNFPA report on SW and violence.

⁵ The *People Living with HIV Stigma Index* provides a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. More information at www.stigmaindex.org

⁶ Report on Situation Analysis of Population and Development, Reproductive Health and Gender in Myanmar, UNFPA, July 2010

Step 2

Social, Cultural, and Economic Factors

Please refer to women, men, and transgender people, disaggregated by age, if possible, when answering questions below.

Question 1. What socio-cultural norms and practices may contribute to increasing the risk of HIV transmission among women and girls, men and boys, and transgender persons?

1.1 In which way do they contribute to higher risk of HIV transmission? Be specific, based on evidence.

Socio-cultural norms and practices in Myanmar that may contribute to increasing the risk of HIV transmission among the **general population** include the following (but are not limited to):

- HIV related stigma that remains widespread and plays a major role in fuelling HIV infection (by hindering openness and seeking HIV testing) and in putting people with HIV into unnecessary hostile situations.
- Within marriage, the husband and wife usually do not use a condom when engaging in sexual intercourse, even if the wife suspects that there is risk of HIV transmission. The use of a condom would signify mistrust or unfaithfulness and is usually associated with sex work.
- Although it is not commonly practiced and may be socially frowned upon in certain areas, polygamy (for men) is permitted under Myanmar customary law; the reverse (i.e. a woman having more than one husband) is not socially acceptable or practised. "Secret marriages" are common among older men and younger women. Age disparate relationships are also common among transgendered persons and their regular intimate partners, whom are often much younger.
- Sex and sexuality are taboo subjects; these are considered private matters and are not discussed. Women and girls are viewed as promiscuous/indecent or immoral if they seek information (i.e. from family members, friends, health facilities, or other external parties) on these matters and other related subjects including HIV prevention. The lack of knowledge on sexual health contributes to risk of HIV transmission.
- Myanmar society places high value on the virginity (purity) of females. This discourages women from seeking sexual and reproductive health information and services, including STI treatment and VCCT, contributing to the higher risk of HIV transmission.
- Myanmar society also places high value on masculinity. Men are expected, to a certain degree, to demonstrate their masculinity through male-associated behaviours such as the high consumption of alcohol, drug use, and engaging in sexual acts (including sex with sex workers). These actions may result in the higher risk of HIV transmission.
- Sexual debut among boys (as young as aged 13ys) in Myanmar with sex workers are common practice.
- Pregnant women who are HIV positive are viewed as a dishonour to their family and are subject to stigma and discrimination by the general community. As such, pregnant women who test positive or who suspect they may be HIV positive will avoid seeking treatment. This results in a higher risk of mother-to-child transmission of HIV.

1.2 Does the country have any data on **age disparate** sexual relationships between older men and younger women? If available, also add any data on age disparate and, sexual relationships between older men and younger men.

	Age disparate
Women	
15–19	No data available.
20–24	

Question 2. Are there socio-cultural norms and practices that contribute to the risk of HIV transmission among other key populations? If yes, what are these norms and practices?

2.1 In which way do they contribute to higher risk of HIV transmission? Be specific, based on evidence.

Socio-cultural norms and practices in Myanmar that may contribute to increasing the risk of HIV transmission among **key populations** include the following (but are not limited to):

- Stigma, discrimination, and violence against sex workers – in particular female sex workers – are highly prevalent in Myanmar. General society condones the maltreatment of sex workers because commercial sex work is illegal and viewed as immoral. As a result, FSW may decide not to obtain HIV prevention and treatment services to avoid being subject to abuse.
- Condom use in sex is generally associated with sex work. However, sex workers, in particular FSW, may not be able to negotiate condom use with their clients due to the economic power imbalance. This results in the lack of control by the FSW over decision-making; FSW may feel the pressure to engage in sex without a condom in order to earn an income.
- Police harassment of FSW is common and generally accepted by society since sex work is illegal. Although the policy of condom possession as a liability of sex work was abolished, FSW are still threatened with arrest and subject to bribery. As a result, FSW may opt to not carry condoms in order to avoid police harassment, which leads to increased risk of HIV transmission.
- Within MSM culture and practice, some older MSM prefer to not use condoms when having sex with younger MSM (for increased pleasure etc.), resulting in higher transmission risk. Generally, age disparate intimate relationships amongst MSM are uncommon. However, male sex workers seek older male clientele for economic benefits.
- The value placed on masculinity results in low tolerance towards men who engage in male to male sex. MSM in these institutions remain hidden and are highly vulnerable to sexual violence and unsafe sexual behaviours.
- Transgendered persons are subject to stigma and discrimination more so than MSM, based on their appearance. This may result in transgender people avoiding seeking HIV prevention and treatment services for fear of mistreatment by service providers or other patients.
- It is common for transgendered persons to engage in long term intimate partnerships with younger men. Unlike women who are in secret marriages with older men, these young men gain economic benefits from their relationships with older transgendered persons.
- For people who inject drugs, women who inject drugs are more marginalised than male IDUs, and are subject to greater stigma and discrimination. Service providers are not sensitised to providing clinical and

support services for women who inject drugs. Women injectors self-stigmatise more so than men, which becomes a deterrent to health seeking behaviours.

- Men, women and transgendered persons in prison and rehabilitation centres do not have access to HIV and STI prevention health commodities. Incidence of violence, rape (including gang rapes) are common, particularly for effeminate men and transgendered persons. People living with HIV and people who inject drugs do not have access to ART, harm reduction programmes and MMT. There are also harmful practices which increase risk to HIV transmission such as tattooing.
- There is a cross cutting issue of drugs and alcohol use among sex workers, their clients, young key affected populations, transgendered persons and MSM which have not been explored but regional evidence shows a strong correlation of increased risk to sexual transmission of HIV with alcohol and drug use.

Question 3. What socio-cultural norms and practices may contribute to *gender differences* in any of the issues described above (knowledge, condom use, stigma, discrimination, early or unwanted pregnancy)?

3.1 In which way do they contribute to higher risk of HIV transmission? Be specific, based on evidence.

- Gender norms and masculinity, combined with low levels of knowledge are key factors to HIV risk. Sex education is not available in schools. Among the general population, the inequality of gender relations between men and women are age old values and vary from rural and urban settings, ethnic groups and religious beliefs. By default, women are expected to have low knowledge of sex and sexual health.
- For married women, condom negotiation is difficult and leads to perceived infidelity, sex work and violence. Furthermore, married women are unable to negotiate for family planning with their spouses which leads to unwanted pregnancies with no option for safe abortion. Rape in the context marriage is not protected by law.
- Men are generally better informed due to wider social networks, social acceptance and expectation that men will seek knowledge due to their roles as leaders in the community (i.e. knowledge is power). Correspondingly, men will have greater access than women to HIV prevention and treatment services.
- Similarly within key affected population groups, MSM and male IDUs are less hidden, stigmatised and marginalised than female sex workers and female who inject drugs, transgendered persons. Consequently, male key affected populations are less difficult to reach out to and enrolled into HIV related services.
- Transgendered persons in Myanmar have few employment options, hence sex work among these population is common.
- Incarcerated populations, regardless of gender are at high risk of HIV due to harmful practices and exposure to violence. Sub populations of these group, like MSM and transgendered persons are at higher risk due to their sexual identity.

Question 4. What are the factors or social determinants, such as economic vulnerability, alcohol or chemical dependence, multiple sex partners et al, that contribute to maintaining these practices and behaviours, according to available data? Please inform it based on a) individual, b) community and c) society levels.

- Men – gender norms and masculinity, leading to acceptable high risk behaviours
- Women – gender norms and inequality, leading to unequal power relation, low health seeking behaviour and increased vulnerability
- Sex workers – criminalisation, hidden, self-stigma and exposure to violence
- Men who have sex with men – criminalisation (sodomy act), multiple partners as social norms, marginalisation
- Transgendered persons – socially unaccepted, limited employment opportunities, exposure to violence, limited family and social support, severe marginalisation
- Young key affected populations – lack access to education, sexual health services and prevention commodities, economically disadvantaged.
- Other Cross cutting issues identified include drugs and alcohol, access to sexual reproductive health, education, support services including social welfare.

YOU HAVE NOW REACHED THE END OF STEP 2. PLEASE PROCEED TO STEP 3. YOU WILL BE ASKED TO ANALYSE STEP 2 JOINTLY WITH STEP 3.

Step 3

Legal and political factors

Question 1. Is there any legal framework or policy that may impact directly women and girls, men and boys, and key populations in relation to HIV?

Please tick box, if yes

- ☐ Criminalization of HIV transmission or exposure, including vertical (mother to child) transmission (as per Human rights law database)
- ☐ Criminalization of sexual orientation and/or gender identity (as per Human rights law database)
- ☒ Criminalization of drug use (as per Human rights law database)
- ☒ Criminalization of sex work (as per Human rights law database)
- ☐ Denial of access of young people (below 18 years old) to condoms or sexual and reproductive health services
- ☐ Denial of comprehensive sexuality education below 18 years of age
- ☒ Non-recognition of sexual or gender based violence within marriage
- ☐ Denial of inheritance and/or property rights to women
- ☐ HIV-related travel restrictions
- ☒ Early and forced child marriage practices
- ☐ Polygamous marriages

Add others, as relevant.

Please elaborate.

- According to Section 376 of the Myanmar Penal Code (1860), spousal rape is not considered a criminal act (unless the female is under 14 years of age).

- There is no age restriction on the access to condoms or SRH services. However, adolescents (especially females) may not have the knowledge/awareness to access contraceptives and SRH services. As well, due to socio-cultural pressures, adolescents may be fearful of accessing such services due to the associated stigma (shame).
- Both sex work (prostitution) and sex with a minor are criminal acts under the Myanmar Penal Code (1860); however, there exists underage female sex workers.
- Child laws protect against early and forced child marriage practices, however, marriage of minors is permissible with parental authority (e.g. Muslim females may marry with parental consent if 14 years of age and older). There is no legal age restriction on marriage for men and boys; as long as a boy is considered to have reached maturity (puberty) and has the capacity, he is eligible to marry.

Question 2. Are there legal frameworks that specifically protect the rights of people living with HIV, women and girls, and other key populations in the country in terms of:

Please tick boxes, if yes

- ☐ Family and Property law (marriage, cohabitation, separation, divorce, child custody, property, inheritance, etc.)
- ☐ Rights under national law regarding access to healthcare (health services, access to information about health, ART, condoms, pre-exposure prophylaxis and post-exposure prophylaxis. etc.)
- ☐ Legal frameworks regarding sexual and reproductive rights
- ☐ Laws ensuring comprehensive sexuality education, non-stigmatizing and non-discriminatory education
- ☐ Labour relations and social security legislation
- ☒ Laws ensuring voluntary-nature and confidentiality of HIV services, such as testing and counselling
- ☐ Criminalisation of intimate partner violence
- ☒ Criminalisation of early and forced marriage
- ☐ Gender Identity laws
- ☐ Migrant rights

Please add others considered, as relevant.

- The Myanmar Penal Code (1860) does not contain a clause specifically on the criminalisation of intimate partner violence (IPV). However, for women, IPV cases could fall under Section 376 *Punishment for Rape* or charges related to assault.

Question 3. Are there indications that these laws are not implemented comprehensively and impartially, e.g. for women and men, for transgender, for key populations, for people living with HIV? Please specify.

Despite the existence of protective laws for citizens of Myanmar, there are indications that these laws are not implemented comprehensively and legal recourse are denied to marginalised populations and those without economic means to litigate for legal redress.

For example, if a person living with HIV is arrested and placed in detention, he or she will need to receive the authorisation from the prison medical officer to take ART. This compromises treatment adherence.

Female sex workers are more exposure to harassment, police arrest and violence in detention compared to male sex workers. Incidence of extortion are reportedly high.

Question 4. Are the existing laws and policies translated into equal access to services for women, girls, men, boys and key populations, in terms of:

Please tick box, if yes

- ☒ Sexual and Reproductive health and rights services
- ☒ Information about health services available
- ☐ Commodities for HIV prevention (male and female condoms, harm reduction practices)
- ☒ Pre-Exposure Prophylaxis (PrEP)
- ☒ Post-Exposure Prophylaxis (PEP)
- ☒ Psychosocial support for people living with HIV
- ☒ Comprehensive sexuality education
- ☐ Social protection
- ☒ Education
- ☒ Labour

Please add others as relevant

There are no laws which protects people living with HIV from discrimination against those living with HIV, including workplace policies. In addition, confidentiality of one's HIV status is not well safeguarded in spaces where service are provided.

Note that the above services are legally accessible for women, girls, men, boys, and key populations, but may differ in practice (due to socio-cultural norms and practices, stigma and discrimination etc.).

Question 5. Does the government, both executive and legislative branches, work toward implementing the international treaties and declarations the country is a signatory of? Please, give examples of laws approved and services provided according to the commitments signed in the 2011 Political Declaration on HIV/AIDS, the Beijing Declaration, and the Convention on the Elimination of All Forms of Discrimination against Women – CEDAW.⁷

Myanmar is a signatory to CEDAW (1997) and is committed to international policy initiatives including the 2011 Political Declaration on HIV/AIDS and the Beijing Declaration. Although the Government has worked (and continues to work) toward implementing the international treaties and declarations, the efforts have produced mixed results and are in general, are not comprehensive in scope and scale.

The recently launched National Strategic Plan for the Advancement of Women (2013-2022) (NSPAW) demonstrates the Government's increasing commitment to addressing gender equality in Myanmar. However, the NSPAW has no corresponding budget, which limits its effectiveness.

As noted, Myanmar ratified CEDAW in 1997, but the 2008 Constitution does not quite conform to it. For example, Chapter 8 of the Constitution includes a prohibition of discrimination "based on race, birth, religion,

⁷ Further information regarding these conventions and declarations can be found in the Glossary of the Guide.

and sex” in appointing or assigning duties to civil services personnel, but it also states that “nothing shall prevent appointment of men to the positions that are naturally suitable for men only.”

Also, although the National Strategic Plan on HIV and AIDS (2011-2015) includes Gender as a Guiding Principle, the activity area interventions do not explicitly address the gender-related issues, including gender-based violence, that impact the effectiveness of the national HIV response.

Question 6. Is there any indication of discriminatory or coercive practices in health care settings that may impact access and utilization of HIV-related services by women living with HIV, including those from key and marginalised populations?

Please tick box, if yes

- ☒ Coerced family planning
- ☒ Coerced abortion
- ☒ Forced sterilization
- ☒ Stigma against women living with HIV
- ☒ Discrimination against transgender women
- ☒ Stigma and discrimination against drug users
- ☐ Denial of access to contraception and abortion, where legal*

- Myanmar is signatory to the 1994 International Conference on Population and Development (ICPD)
- There are ongoing surveys being conducted in townships concerning CEDAW
- It has been reported that women living with HIV are counselled for sterilisation. There is not enough evidence to demonstrate if this is commonly practiced by healthcare providers or the result of inadequate quality counselling, as women are not given options.
- Gender sensitive training including sexuality and violence are not available nor targeted to law enforcement officers and healthcare workers.
- Abortion is illegal in Myanmar

Question 7. Are there indications of discriminatory practices by the judiciary and law enforcement personnel (including the Police) that may prevent women, girls, or any other key or marginalised population from accessing their rights? If so, please describe.

- Limited to no legal rights for sex workers and people who inject drugs since sex work and use of narcotics are illegal. As a result, these population groups essentially have no legal recourse and there are very few organisations in Myanmar that provide legal support. Equal Project is a local NGO that provides legal assistance to key affected populations.
- Female sex workers, people who inject drugs, men who have sex with men and transgendered persons are viewed as “money-making machines”, ie. monetary extortion by police and harassment are common.
- Under Section 15 of the Narcotic Drugs Law, a drug user is required to register at a medical centre for treatment (e.g. MMT) or will be subject to imprisonment. However, there have been cases where police will use the medical centre registration list to target PWID for bribery.

- For PLHIV who are arrested, they may be refused ART until a medical officer grants permission (which may be delayed), which is loss of their rights to health.
- Transgender people may be subject to arrest based on their appearance (clothing) according to the Union Military Police Act, Section 35(d).
- Men who have sex with men are subject to Penal Code Section 377 which criminalises sodomy.

Question 8. What is the percentage of women in the Parliament or Congress? What is the percentage of women in the Cabinet (or Secretariat or Ministerial body)? Will find out from UNFPA

Women constitute:

- 4.3% of the People’s Assembly
- 4.9% of the National Assembly and
- 3.8% of regional and state representatives

in the newly elected Parliament of Myanmar that was convened for the first time on the 31st of January, 2011. This figure increased by 50% with the addition of 10 new women MPs after the by-elections of 1 April 2012 to the Pyithu Hluttaw (People’s Assembly).

Analysis of Key Gender Differences – Socio-cultural, Economics and Legal Context

- Gender and cultural norms contribute towards women having inequitable access to knowledge and skills which will enforce and sustain health seeking behaviours
- Sex education remains a taboo in formal education system
- Despite existing laws and the government’s commitment to international conventions, there is limited evidence that these laws are enforced to protect the rights of citizens in practice. Laws pertaining to criminalisation of sex work, men who have sex with men and people who inject drugs greatly impact on the effectiveness of HIV interventions. Anti-discriminatory laws are non-existent to protect the rights of citizens to fully exercise their rights to health, protection against violence, access to information and employment opportunities, particularly for people living with HIV and key affected populations.

STAGE 3

Knowing the country HIV response

Step 1 • Gender equality in HIV and policies and programmes

Step 1.1 • THE OVERALL HIV RESPONSE

Question 1. Which populations are addressed in the HIV national response?

Please disaggregate by age, sex, gender identity or sexual orientation, as appropriate.

The following populations are addressed in the National Strategic Plan on HIV and AIDS 2011-2015:

- Injecting drug users (people who inject drugs)
- Men who have sex with men, including transgender persons
- Female sex workers and their clients
- Male and female adult population (15+)
- Institutionalised population (prison and rehabilitation)
- Military and uniformed services
- Migrant and mobile population
- Young people

[Situation Analysis, Section 1.4]

1.1 Does the National HIV response include people with disabilities? If yes, are there specific programmes for people with disabilities in the response? Is there a difference between the way the needs of men/boys and women/girls are addressed by it?

No, the national response does not include people with disabilities; there are no references to people with disabilities living with HIV in the NSP II.

1.2 Does the national HIV response include older people, in particular older women? If yes, are there programmes to address their needs e.g. chronic care package, including cervical cancer screening.

No, the national response does not include older populations (women, men, transgenders) which have particular vulnerabilities not just to HIV but other chronic illnesses. The NSP II references elderly caregivers in the context of psychosocial, nutritional, and economic support for PLHIV, their families and communities. [Strategic Priority III, Intervention I]

Question 2. Does the HIV response recognize, plan for, and address gender issues related to:

Please tick box, if yes

- ☐ Rural/urban specificities
- ☐ Socio-economic status
- ☐ Forced and/or voluntary migration
- ☐ Early and forced marriage
- ☐ Race and ethnicity

No, the NSP II does not recognise, plan for, and address gender issues as related to the above areas. Neither does it address gender issues in areas of conflict, displaced populations, migrant and mobile populations. Early and forced marriage, race and ethnicity are also not referenced in the NSP II.

Question 3. Have issues of gender identity and sexual orientation been recognized within the HIV policy/strategy?
Yes

If yes, what is recommended in terms of HIV services regarding stigma, discrimination, and human rights?

The NSP II includes references to gender identity and sexual orientation in their recognition of MSM and transgender people as one of the key priority population groups.

However, recommended HIV services regarding stigma, discrimination, and human rights are vague (e.g. strengthening the enabling environment so that township environments are support of HIV prevention programmes and services for MSM, leading to an outcome of less stigma, discrimination, and violence against visible groups of MSM). [Strategic Priority 1, Intervention 2]

Question 4. To what extent is the national HIV response funded by domestic sources and to what extent is it from external sources?

Domestic sources ~ 4%

External sources ~ 96%

4.1. Does the national HIV response already include gender-equality interventions?
No

Question 5. Is there a formal system of accountability for the HIV response that allows civil society, UN agencies, and citizens to monitor the spending on gender equality within the HIV response? If yes, how does it work?

No, there is no formal system of accountability or monitoring of gender equality HIV response.

Although individual organisations will monitor spending on gender-related projects, there is no sector-wide mechanism to consolidate the expenditure data to provide an overall view of spending on gender equality within the HIV response.

Step 1.2 • MEANINGFUL PARTICIPATION

Question 1. Are networks and organizations of people living with HIV, women's rights, sexual and reproductive health, gender equality, youth, and other key populations' organizations e.g., gay men and other men who have sex with men (MSM), sex workers, injecting drug users (IDU), and transgender people engaged in decision-making at different stages, levels, and sectors of the country HIV response, including design and implementation of the response?

Please differentiate per constituency in responding.

There is increasing engagement of PLHIV networks and organisations, including key affected populations (MSM, FSW, PWID), in the design and implementation of HIV policies and programmes. However, involvement in decision-making, especially in the final stages of project planning and design, is still on a limited scale.

INGOs, and NGOS, engagement levels with UN agencies are relatively high and inputs from PLHIV are incorporated into all aspects of programme planning, including budgeting. For Government-only managed projects, the engagement of PLHIV is lower and primarily at the township level (i.e. with the Township Medical Officer).

With multi-sectoral/stakeholder projects, such as the annual Progress Report and review of the National Strategic Plan on HIV and AIDS, inputs from PLHIV are included since PLHIV and key affected population representatives are invited to participate in meetings and group-work discussions. However, PLHIV networks and organisations do not have a direct link with higher level Government officials.

1.1 Please document observations that are relevant from a gender perspective in the participation of civil society in the HIV response.

Women from civil society organisations feel that inputs from men are generally more accepted and welcomed, which results in men's dominating presence in meetings and discussions, making it difficult for women to provide their input. The stereotype of Myanmar women being too timid and soft-spoken is reinforced, but also perpetuated, by both men and women. It is interesting to note that representatives from sex workers organisations and networks are better able to voice their opinions due to the specificities of sex work in the context of national epidemic.

At the program implementation level, programs targeting key affected populations actively involve the communities, from recruitment of outreach workers from each target population to training of peer educators. However, it was noted that there is a large gap in technical capacities of community based organisations to conduct effective outreach and continuum of care for their constituencies.

Question 2. Are there formal mechanisms (e.g. partnership forums, joint HIV theme groups, National AIDS Councils/ Commissions, CCM that ensure the views, needs and rights of these populations are taken into account in decision-making processes in the response to HIV? If so, please describe how this is ensured, with a particular focus on gender issues, and provide examples, if possible.

The Myanmar-Health Sector Coordinating Committee (M-HSCC) is comprised of a variety of stakeholders in the health sector, including representatives of PLHIV and key affected populations. However, the M-HSCC has not yet focused specifically on gender issues.

Similarly, the Technical Strategy Group on HIV/AIDS takes into account the inputs of PLHIV and key affected populations in decision-making processes.

Question 3. What legal and policy provisions exist for these populations to access domestic and/or international funding to support the national HIV response?

Domestic funding for key population groups (i.e. NGOs, networks, CBOs, CSOs etc.) is generally not available (note: domestic HIV and AIDS spending is at 4%). National NGOs, CBOs and international NGOs are able to access international funding by submission of expressions of interests and proposal. At the local level, a memorandum of understanding (MOU) with the Ministry of Health is required to implement activities in specified areas of the country in order to access permission to operate in those areas. This applies to both national and international NGOs.

Question 4. What (legal, political, financial) provisions exist for capacity building and allocation of resources to support the participation of women, girls and transgender women in the HIV response?

Financial resources in the form of small grants are available from UN agencies, INGOs, and NGOs for capacity building to support participation in the HIV response. In 2013, the Global Fund approved a Community Systems Strengthening and Human Rights grant amounting to approximately USD 2.2 million to Alliance Myanmar and Pyi Gyi Khin. This grant will support activities for capacity building and organisational development targeting key population organisations and national networks.

Question 5. Is there any key population that is excluded – by laws, regulations or policies – from engaging in the national HIV response?

No. Although sex work and drug use are criminalised activities, those persons involved in sex work and drug use are included in the national HIV response.

Step 1.3 • COORDINATION OF GENDER EQUALITY WITHIN THE HIV RESPONSE

Question 1. Does the national HIV coordination mechanism include a dedicated focus on gender equality? If yes, please describe.

No.

1.1 Are there additional coordination mechanisms at different government sectors (gender, health, human rights, etc.) and levels for joint action on gender equality in the national HIV response? If so, please describe.

No.

Question 2. Is civil society officially included in any of the above coordination mechanisms, in particular networks of people living with HIV representatives of identified key populations and groups working on gender equality and women's rights issues?

CS participation in coordination mechanisms for gender within HIV response			
	National HIV coordination mechanism	Coordination within other sectors	Decentralized coordination mechanism
CS participation	✓	✗	✓

Representative network of people living with HIV	✓	✗	✓
Representative of groups working on gender equality and women's rights	✗	✗	✗
Add key populations as necessary			

Question 3: Are there civil society coordination mechanisms addressing HIV and gender, and if so, which constituencies are involved?

No civil society mechanisms exist at present that address HIV and gender.

Step 1.4 • GENDER EQUALITY IN THE CONCEPTUAL FRAMEWORK AND DESIGN

Question 1. What national gender equality policy/guideline provides guidance to the national HIV response?

None at present; however, an alignment of the NSP II and the National Strategic Plan for the Advancement of Women (2013-2022)(NSPAW) is planned.

One of the key priority areas of the NSPAW is Women and Health. Within that section, references are made to the need for:

- Research and surveys on
 - Women's participation in decision-making for sexual and reproductive health, including family planning;
 - Women's participation in decision-making for HIV prevention, care and treatment, and women's access to and utilisation of HIV prevention, care and treatment services;
 - Barriers to women's access and use of basic health, sexual and reproductive health care;
- Awareness raising of not only women, but also men and teenagers, on basic health, SRH, HIV, and STIs, treatment, care and support, and the implementation of community-based initiatives by collaborating with women's organisations
- Implementation of
 - Rural area oriented activities for basic health, SRH, prevention, treatment, care and support of HIV/AIDS and STIs
 - Provision of free contraception for women living poverty
 - Adolescent SRH services to prevent underage pregnancies and the transmission of STIs

[NSPAW, paragraph 9]

1.1 Is the development of the national HIV response guided by the *UNAIDS Accelerated Country Action for Women, Girls, Gender Equality and HIV*?

No.

Question 2. Does the HIV policy reflect a commitment to gender equality?

References to gender and gender equality/equity include the following (but are not limited to):

- The NSP II has the vision "to achieve a society that is free of new HIV infections and where all people regardless of gender, age or origin have access to treatment and support that enables them to live a fulfilling life." [The National Strategic Plan, Section 2.2 Vision]
- Target No 2 in the NSP II mentions gender - 80% of PLHIV, who are eligible, to receive ART regardless of gender, transmission type, age, ethnicity, and location. [Target 2]
- The NSP II also describes that "gender cuts across all interventions and implies an understanding of how social norms affect vulnerabilities of men and women and people of different sexual orientations differently and thus may require differential interventions." [Annex II, Guiding Principle 11]
- Gender equality is defined in the NSP II as "the equal enjoyment by females and males (of all ages and sexual orientations) of rights, socially valued goods, opportunities, resources and rewards." [Annex II, Guiding Principle 11]
- As well, the NSP acknowledges that "gender equality is important in relation to HIV. Women and men experience different health risks, engage in different health seeking behaviour, and usually receive different responses from health services. As power is distributed unequally, women have less access to health information, care and services, and resources to protect their health." [Annex II, Guiding Principle 11]

Question 3. Is this commitment reflected in addressing the following through the HIV response:

3.1 Inequality between women/girls (including transgender women) and men/boys?

Yes, there is written commitment but has not been adequately operationalized.

The NSP II notes that the national response provides support for a gender sensitive approach through the "promotion of research on gender analysis (e.g. to describe and analyse different inequalities in access to services and experience with health providers, in prevention and treatment options, needs, challenges, gaps, and opportunities to reach men and women as well as differential impact)." [Annex II, Guiding Principle 11]

3.2 Stigma and discrimination toward people living with HIV, in particular women and girls living with or affected by HIV (including transgender women) in the provision of HIV and other health services as well as the social welfare and judiciary system?

3.3 Stigma and discrimination against key populations?

Yes. Cross-cutting Intervention II also addresses stigma and discrimination against key populations (specifically FSW, MSM, PWID). Refer to Appendix 3 for an excerpt of outputs and outcomes related to creating an enabling environment for key populations to ensure that HIV interventions are effective.

[Intervention IV 2. Favourable Environment for Reducing Stigma and Discrimination, Activity Area 2]

Yes, but with no specific reference to women and girls living with or affected by HIV (including transgender women).

Strategic Priority IV: Cross-Cutting Intervention II concerns the development of a *Favourable Environment for Reducing Stigma and Discrimination*. Relevant outputs and outcomes include:

- Advice and legal support available to people living with HIV to ensure security of job, property, housing, succession, physical safety and participation to social event.
- Treatment, care and support services and community activities are more easily able to reach and support people living with HIV who might not yet know their HIV status and key populations at higher risk.

[Intervention IV 2. Favourable Environment for Reducing Stigma and Discrimination, Activity Area 1]

Question 4. Is this commitment matched with a budget to undertake and is this translated into gender sensitive and transformative initiatives and services? Please justify with examples.

No. In the accompanying Operational Plan on HIV and AIDS (2011-2015), the budget line for Strategic Priority IV: Cross-Cutting Intervention II (*Favourable Legal and Policy Context – Compassion and Understanding*) is US\$ 200,000 per fiscal year, as related to advocacy for leadership. Note that the budget amount is indicative only and may not be funded (by domestic or external resources).

Step 1.5 • GENDER EQUALITY AWARENESS AND KNOWLEDGE

Question 1. Are there indications that those involved in the HIV response, including decision makers and services providers, demonstrate awareness and knowledge of the consequences of inequality between men and women and/or the marginalization of some populations in the context of HIV? Please provide examples.

Service providers that are INGO/NGO-based generally demonstrate awareness and knowledge of the impacts of gender inequality and marginalisation of key affected populations. For example, in prevention of vertical transmission, INGO/NGO service providers have policies and procedures to encourage partner (male) involvement. Both the general population and key affected populations have access to HIV services by INGO/NGO service providers without being subject to stigma and discrimination.

However, public (Government) service providers have not adequately been capacitated on issues of gender, sexuality and gender based violence. As a result, key affected populations face stigma and discrimination in these settings. For example, MSM prefer to seek health services from clinics that are tailored to MSM rather than go to a public health facility to avoid stigma and discrimination from public health care workers.

For Government decision-makers, gender inequality and marginalisation of key affected populations are generally not acknowledged and the consensus is that both men and women, including key population groups, already have equal health rights and status.

Question 2. Does the pre-service curriculum of health care workers include sensitivity training in gender, human rights, stigma and discrimination? If yes, please tick box for the specific themes addressed?

- ☒ Human rights
- ☒ Gender equity
- ☒ Stigma and discrimination
- ☐ Gender based violence
- ☒ Sexual rights
- ☒ Sexual health
- ☒ Reproductive rights
- ☒ Reproductive health
- ☒ Voluntary counselling and testing, including for couples.

Question 3. Does the in-service curriculum (education syllabus) of health care workers delivering HIV services include sensitivity training in gender, human rights, stigma, and discrimination? If yes, what specific themes are addressed?

Overall, the curriculum of health care workers (public and NGO) include training on gender, human rights, and stigma and discrimination in the context of delivering HIV services. However, the training is not comprehensive; the topics addressed are at the awareness stage (surface level) only (e.g. definition of “gender”, “What are stigma and discrimination?” etc.). As well, even though training is provided, the concepts may not be integrated in actual practice and no practical training is provided.

3.1. How frequently do the in-service trainings happen and have they been evaluated?

Frequency of in-service trainings will depend on the organisation (public and NGO); there is no standard national requirement. For example, Marie Stopes International (MSI) Myanmar will provide training twice a year for their health care workers and there is an internal evaluation that is conducted post-trainings.

1.6 ASSESSING EXPENDITURE ALLOCATION

Question 1. Is there an accessible system of information on expenditures (national and external) on gender and on HIV, like the National AIDS Spending Assessment, in the country?

Yes, but for HIV/AIDS spending only. HIV/AIDS-related expenditures is tracked and reported in the annual Progress Report. A National AIDS Spending Assessment (NASA) is planned for 2014.

No such system of information on gender-related expenditures is currently available.

1.1 What factors influence budgeting decisions on gender and/or HIV (e.g. resources available, current priorities financed, religion, socio-cultural factors, and legal environment)?

Factors influencing budgeting decisions on gender and/or HIV include:

- Resource availability, including timing in the of release of funds (e.g. with the Global Fund grant awarded of US\$161.2 million to Myanmar for the HIV response, the grant will be provided in instalments over a four-year period)
- Competing health priorities in Myanmar that will influence how much funding (both domestic and international) is provided on gender and/or HIV issues
- Legal barriers may impede the scale-up and/or effectiveness of certain HIV interventions (e.g. MMT or needle and syringe programming)
- Surveillance data that will indicate HIV trends and hotspots (e.g. greater focus and funding should be placed on PWID to prevent an increase in HIV incidence and prevalence)

1.2 What are the challenges to the implementation of the gender and/or HIV budgets (political commitment, lack of evidence, capacity gaps, for example)?

Challenges to the implementation of gender and/or HIV budgets include (but are not limited to):

- Competing health priorities in Myanmar
- Bottlenecks in the supply and delivery chains, including insufficient human resource capacity to implement policies and programmes
- Lack of quality data
- Stigma and discrimination, which impedes outreach

Question 2. Based on the type of epidemic and the affected populations groups, are the specific needs of women, girls, men, boys, and transgender women considered in the budget allocated to the national HIV response?

The Operation Plan on HIV and AIDS has budget amounts by activity/intervention for key affected populations (FSW, MSM – including transgender, PWID, prison or rehabilitation facility populations, mobile and migrant populations, uniformed services, and out-of-school youth). The general population (of women, girls, men, and boys) are covered through mass media outreach, for which there is a budget allocated.

However, note that the “specific needs” of the populations groups may not coincide with the activities and interventions identified within the NSP II.

2.1 Is the amount allocated sufficient to meet the needs of these communities in the context of HIV? Please breakdown your response per constituency.

Insufficient data available to compare the Operational Plan budget amounts with “needed” amounts. By constituency (population group), the budget allocations (2011-2015) are as follows:

Population Group	Budget (USD in millions)
FSW	40.6
MSM	22.0
PWID	40.5
Prison or Rehabilitation	2.3
Mobile/Migrant	9.6
Uniformed Services	1.9
Youth	8.8
General	3.0

Question 3. Does the HIV response disaggregate financial data collection and reporting by sex, age and/or key populations?

Yes. Financial data is available by sex, age, and key populations, but primarily in the context of interventions.

Analysis of Gender Equality in HIV Policy

- Gender Equality in HIV policy is noted in the National Strategic and Operational Plans on HIV and AIDS and National Strategic Plan on the Advancement of Women.
- Need to consolidate key gender components in both documents and add concrete activities in the operational plans for both strategies
- Need to cost equality interventions, allocate and commit resources to the operational plans

Step 2

A comprehensive HIV response

Step 2.1 • HIV PREVENTION

Question 1. Are the following HIV prevention and supportive services generally available?

Please tick box, if yes

- ☒ Access to information about HIV
- ☒ Voluntary testing and counselling services;
- ☒ Condoms (male and female);
- ☒ Prevention of vertical transmission (also known as mother to child transmission)
- ☒ Behaviour change communication
- ☒ Male circumcision
- ☒ Drug use harm reduction measures

Please add others services, as relevant.

From a gender perspective, it may be easier for women to access HIV prevention and supportive services than men. Men generally prefer to be treated by same-sex health service providers (i.e. other men) and may be uncomfortable with receiving HIV services from female health care workers due to socio-cultural norms, including power dynamics.

Question 2. Are there gender related factors that impede women, girls, men, boys, and key populations, particularly transgender women, access, utilization and adherence to prevention services, and that should be considered and addressed?

Gender-related factors that affect access, utilization and adherence to services may include stigma, discrimination, gender-based violence, harmful gender norms in terms of power balances, masculinity and femininity; access to resources, discrimination based on gender identity, sexual orientation, age, ethnicity, or marital status. (More information found in the gender assessment tool guide.)

Please refer to which of these factors may affect diverse communities, such as young women, injecting drug users, including women who use drugs, gay and men who have sex with men, and their partners; and transgender people.

Gender norms between men and women:

- gender norms and constructs of masculinity that encourage men to have multiple unsafe sexual encounters
- gender norms and constructs of masculinity that condone (transactional) sex seeking behaviour among men
- Gender norms and constructs of femininity that ensure women are expected to be faithful to their unfaithful husbands and have no safe avenue of redress when trust is breached
- Constructs of femininity that inhibit women from having knowledge about sex and sexual health
- gender norms that discourage married men and women from discussing sex and ensure that women have less power if and when these conversations do take place
- Men living with HIV report a considerable time lapse between when they first suspected they may be at risk, when they became they aware that they are HIV-positive and when they finally told their wives.
- not enough condom use among male clients of sex workers to reduce new infections among sex workers
- economic factors that drive women into high risk work/relationships
- Power distances (men high – women low)
- men who have unsafe sex with both their wives and other men
- barriers to disclosure in married couples
- limited positive prevention, related to limited access to treatment for PLHIV
- limited access to family planning, STI and reproductive health services for PLHIV

Sex Workers

- SW are reportedly receiving health education and condom messaging, but comprehensive services that include skilled behaviour change counselling and empowerment are more limited.
- The link between condom use and illicit sex is high and therefore condom use may be seen as stigmatised, or confirmation of the illicitness of the activity.

Men who have sex with men

- Older MSM are thought to buy sex more often than younger MSM.
- Hidden MSM can pass as heterosexual, they are hard for outreach workers to find, but can be reached by others like them. They may care about the risk of HIV to themselves, their wives and children and it may be possible to exploit their desire to protect the family in prevention messaging.
- Hidden MSM are often married and are thought to be reluctant to buy and use condoms, or to know/disclose their HIV status. They may have many different partners, both male and female.
- Transgender MSM are easily identified and subject to high levels of discrimination. Condom use signals they may be promiscuous, unclean, untrusting, not submissive enough – which is inconsistent with their feminised role.
- MSM who sell sex to men may not identify as gay but rather they want to conform by having a girlfriend, so they have paid sex with other men so they can afford the relationship with the girl.

Question 3. Do prevention services respect, promote, and protect the rights of women, girls, men, boys and key populations independent of marital status, profession and age, or are there indications of violation of these, in relation to:

Please tick box, if yes

- ☒ Sexual health and rights?
- ☒ Sexual orientation?
- ☒ Gender identity?
- ☒ Reproductive health and rights?
- ☒ Voluntary testing and counselling?
- ☒ Disclosure and acceptance of their HIV status, free of discrimination?
- ☒ Access to justice and benefit of the law?
- ☒ Protection against gender harmful norms and practices?
- ☒ Addressing violence in all cases (including from partners, family, community or state)?

Question 4. What is the overall coverage of prevention of vertical transmission services?

The overall coverage of PMCT services is approximately 80% (2012 Progress Report – number of HIV-positive women who received ARV prophylaxis for PMCT).

However, the overall coverage of pregnant women who receive HIV testing and counselling (pre-and post) is low at approximately 22% (2012 Progress Report).

4.1 What is the estimated number of children born with HIV?

The percentage of infants born to HIV infected mothers that are HIV infected is 12.3% (2012 Progress Report), or approximately 442 infants (based on a denominator of 3,591 infants).

4.2 What is the overall *loss to follow-up*⁸ rate up to the end of breastfeeding phase?

Data not available.

4.3 At each stage in the process of provision of prevention of vertical transmission services, what is the coverage rate?

Coverage rate from services to prevent vertical transmission of HIV	
% of pregnant women coming to antenatal care (at least one visit)	43%
% of pregnant women accepting HIV test	59% (of those who attended antenatal care)
% of pregnant women receiving test result	85% (of those who accepted an HIV test)
% of pregnant women testing HIV positive (whether tested positive before or just tested at prenatal care)	0.7%
% of pregnant women living with HIV receiving medication to prevent vertical transmission	80%
% of pregnant women living with HIV to receive medication to prevent post-partum transmission (transmission during breastfeeding) to the infant, as per treatment approach indicated above	Data not available.

[2012 Progress Report]

4.4 Is there any insight on reasons for non-adherence from a gender perspective, and who is affected by it?

Prevention of mother-to-child transmission of HIV (PMCT) services have reached a relatively large part of the country and the number of women choosing to access the service has risen continually. However, the services are constrained by a relatively low attendance to ante-natal care services in rural areas and a considerable loss to follow before and after birth.

Reasons for non-adherence may include:

- Social stigma attached with having HIV (i.e. general society believes that women who are HIV+ should not have children);
- Discrimination by health care workers (more so in public health facilities);
- Health care staff shortages;
- ART supply shortages;
- Lack of or undermining of privacy and confidentiality (e.g. in overcrowded health care facilities);
- Lack of adherence support, which is an important part of psychosocial support services and PMCT and HIV clinical care services;
- Difficulties in accessing access health care services in rural areas (e.g. distance to the clinic, transportation costs);
- Weak social support structure at home and in the community;
- Gender inequality;
- Poverty and lack of food; and
- Incomplete or incorrect information (or lack of access to information), among others.

4.5 Discuss who is not being reached by the national programme on prevention of vertical transmission? Please exemplify or quote sources.

Persons who are not being reached with PMCT services may include:

- Women in rural areas, where it is difficult to access health facilities (e.g. distance and costs for transport and treatment);
- Women in humanitarian settings (conflict areas), including internally displaced and stateless persons;
- Women living in economic poverty, including female street youth, who are unable to afford transportation costs to a health clinic or health care fees for pre/antenatal care; and
- Adolescent girls whose families may prevent them from seeking appropriate care due to social stigma; among others.

4.6 Does the prevention of vertical transmission encourage partner involvement? If yes, what are the results? Are there indications that these programmes hinder access for women?

Partner involvement in the provision of PMCT services will depend on the situation. Partner (male) involvement is generally high if both parties are HIV positive. Similarly, for a sero-discordant couple, partner involvement is high if only the male partner is HIV positive. However, if only the female partner (who is pregnant) is HIV positive, partner involvement is generally low due to the associated social stigma (e.g. assumptions that she was unfaithful) and/or fear of telling her partner.

⁸ Loss to follow-up is the rate of disconnection between patients and treatment, in the case of vertical transmission it means babies treated at birth but that resulted in an infection, and the treatment continuation of mothers and babies.

Step 2.2 • TREATMENT

Question 1. What is the percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results?⁹

HIV testing in the general population			
[2012 Progress Report]	Total population	Female	Male
Overall	~ 0.16%*		
15–19	81,814**		
20–24			
25–49			

* Based on total population size estimate of Myanmar at 52 million (2010) per HIV Estimate and Projections AEM Model (2010–2015) (NAP)

**No disaggregation by age and gender

1.1 What is the percentage of sex workers who received an HIV test in the past 12 months and know their results?¹⁰

HIV testing in sex workers			
[2012 Progress Report]	Total population	Female	Male
Overall			
<25	60,000 *	13,968	No data available
25+			

*Age desegregated data unavailable

1.2 What is the percentage of men who have sex with men who received an HIV test in the past 12 months and know their results?¹¹

[2012]	Male
Overall	240,000
<25	12,694
25+	(5.3%)

*No disaggregation by age

1.3 What is the percentage of people who inject drugs who received an HIV test in the past 12 months and know their results?

HIV testing in people who inject drugs
--

⁹ See GARPR 1.5.

¹⁰ See GARPR 1.9

¹¹ See GARPR 1.13

[2012 Progress Report]	Total population	Female	Male
Overall	75,000	No data available	4,540
<25	No disaggregation by age. The majority of PWID are male injecting drug users and no official data is available on female IDUs.		
25+			

Question 2 What is the current treatment coverage in the country (preferably with data disaggregated by age and sex, if available)?

Treatment coverage			
[2012 Progress Report]	Total population	Female	Male
Overall			
0–14	4,033	1,922	2,111
15–19	49,676	22,315	27,361
20–24			
25–49			

Question 3. Are the treatment services equally accessible for women, men, and key populations? If not, what is limiting or impeding access related to gender?

Treatment is available for all citizens, regardless of gender. However, socio-cultural factors, as well as the related stigma and discrimination, may deter women, men, and key affected populations from accessing treatment services. The lack of support services, community self-help systems and geographical coverage of NGO activities contribute towards programme effectiveness and coverage.

Question 4. What is the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy?¹²

Twelve-month retention on antiretroviral therapy			
[GARPR 2012]	Total population	Female	Male
Overall	*	90.22	84.91
<15	93.70		
15+	86.74		

*No disaggregation by age and gender combined

4.1 Discuss who (age, sex, key population, geographical setting, socio-economic status) is affected by non-adherence and how this relates to gender?

¹² See GARPR 4.2

Insufficient data available.

However, non-adherence and loss to follow-up is more prevalent in rural areas than urban areas due to the limited health care facilities and supply of resources (e.g. health care workers, medical equipment, medication etc.).

Question 5. Do treatment services that respect, promote, and protect the rights of women, girls, men, boys and key populations independent of marital status, profession and age, or are there indications of violation of these, in relation to:

Please tick box if yes

- ☒ Sexual health?
- ☒ Sexual orientation?
- ☒ Gender identity?
- ☒ Reproductive health?
- ☐ Safe abortion?
- ☒ Voluntary testing and counselling?
- ☒ Disclosure and acceptance of their HIV status, free of stigma and discrimination?
- ☒ Access to justice and benefit of the law?
- ☒ Protection against harmful norms and practices?
- ☒ Gender based violence (including from their partners, family, community or state)?

Step 2.3 • CARE AND SUPPORT

Question 1. Are there gender factors for women, girls, men, boys, and key populations that affect utilization and adherence of these services, to be considered and addressed?

Please tick box if yes

- ☐ Home based care
- ☐ Palliative care
- ☐ Support for orphans and vulnerable children affected by HIV
- ☐ Psychosocial support for people living with HIV
- ☐ Social protection services
- ☒ Legal support services
- ☒ Sexual and reproductive health counselling

Question 2. Do care and support services respect, promote, and protect the rights of women, girls, men, boys and key populations independent of marital status, profession and age, or are there indications of violation of these, in relation to:

Please tick box if yes

- ☒ Sexual health?
- ☒ Sexual orientation?
- ☒ Gender identity?
- ☒ Reproductive health?
- ☐ Safe abortion?
- ☒ Voluntary testing and counselling?
- ☒ Disclosure and acceptance of their HIV status, free of stigma and discrimination?
- ☒ Access to justice and benefit of the law?
- ☒ Protection against harmful norms and practices?
- ☒ Gender based violence (including from their partners, family, community or state.)?

Refer to previous examples provided.

Question 3. Is there gender parity in providers of care and support at the community level? Please describe.

No. At the community level, the providers of care and support are primarily women in the roles of community health workers and midwives/ traditional birth attendants.

Question 4. Does the national HIV policy recognise the burden of care and support, and provide for mechanisms for compensation for the providers of care and support?

Yes

4.1. If yes, does it include?

- ☐ Reliable access to home-based care supplies?
- ☐ Training and support for palliative care?
- ☐ Clearly defined role and responsibilities for paid caregivers?
- ☐ Financial compensation for primary and secondary caregivers?
- ☐ Comprehensive (social and psychological) care for unpaid caregivers?
- ☐ Recognizing and addressing the burden of care on women and girls and their impacts?

Obs. 1 If possible, provide care giving information by age: women and girls for example young girls pulled out of school for care giving, (grandmothers) heading households of grandchildren, female (single) head of household.

Based on the Integrated Household Living Conditions Survey in Myanmar (2009-2010), the percentage of female-headed households is around 21%, with more female-headed households in urban areas than rural areas, and among the non-poor than poor (i.e. inverse relationship between poverty and female headship).

2.4 GENDER-BASED VIOLENCE (GBV)

Question 1. Does the national HIV and/or gender policy guide the HIV response in recognizing the link between gender-based violence and HIV, in terms of violence increasing the risk of HIV transmission, including in conflict and post-conflict situations, where relevant?

The NSP II makes one brief reference to GBV ("address gender-based violence") in the context of promoting meaningful involvement and empowerment of vulnerable groups (FSW). [Strategic Priority 1, Intervention 1]

1.1 If so, how is it addressed within HIV programmes and services?

N/A – GBV is not addressed within HIV programmes and services.

1.2 Which populations benefit from these initiatives?

N/A – GBV is not addressed within HIV programmes and services.

1.3 If not, why has it not been addressed?

Gender, gender equality, GBV, and other related matters are all relatively new considerations in Myanmar, with the majority of the population still not acknowledging gender inequality. As such, GBV has not yet been factored into the HIV response.

Question 2. Does the national HIV and/or gender policy guide the HIV response in recognizing the link between gender-based violence and HIV, in terms of violence being a consequence of HIV status, including among women living with HIV?

No. No explicit links are made between GBV and HIV in both the NSP II and the NSPAW.

2.1 If so, how is it addressed in programmes and services and which populations benefit?

N/A – The linkage of HIV and GBV is not addressed in programmes and services.

Question 3. Is there a (multi-sectoral) policy on addressing gender-based violence? If yes, does it address HIV in sectorial programmes, initiatives, or services on gender-based violence?

Yes. One example is the *Strategy for Multi-Sectoral Prevention and Response to Gender-Based Violence* developed for the Rakhine humanitarian response by members of the Humanitarian Protection Working Group. The strategy and action plan include inputs from key stakeholders engaged in providing GBV services and promoting the protection of women and children (e.g. UNFPA, UNICEF, WHO, UNDP, UNHCR, Malteser, MSF, Myanmar Women and Children's Association etc). HIV is primarily addressed in the offering of post-exposure prophylaxis as part of post-rape kits.

3.1 If so, what are the actions, and what are the populations addressed?

From the example above, relevant actions include the distribution of post-rape kits and the provision of training for medical personnel on the clinical management of rape. The populations addressed are women and girls (although men and boys are also applicable), in particular those at internally displaced persons camps in Rakhine state.

3.2 If not, then why isn't it being addressed?

N/A

Question 4. Are there laws in place to reduce and condemn violence against women and gender-based violence?

Laws concerning sexual and gender-based violence in the Myanmar Penal Code (1860) include provisions for crimes against women including rape (Section 375-376), abuse (e.g. Section 313, Section 354, Section 509), and seduction (Section 366) and sex with underage women (i.e. less than 14 years of age). Note that spousal rape is specifically cited as an exclusion and is not considered a crime unless the wife is younger than 14 years.

Trafficking or trading women for prostitution, or enticing for sexual purpose is a crime punishable by imprisonment (e.g. Section 372-373).

No specific laws exist to address domestic violence and intimate partner violence, although there is a drafted bill on domestic violence legislation. As well, laws related to psychological aggression are limited in scope and scale.

4.1 If so, how are these upheld? If there are limitations, please describe.

The laws related to sexual and gender-based violence are upheld with fine or imprisonment for the offender, if found guilty. For example, in the case of rape, the offender will be subject to a maximum of 10 years imprisonment and a fine. However, there are a number of limitations including:

- Complicated legal action process. Refer to Appendix 4 for illustration of the legal action process to report a sexual assault incident.
- According to Section 154 of the Myanmar Code of Criminal Procedures, a First Information Report (FIR) (either written or verbal) needs to be submitted by the survivor themselves to the police in order for an investigation to be carried out.
- Socio-cultural factors, including associated stigma and discrimination, which may dissuade a person from reporting an incident. The underreporting of cases is a common occurrence in Myanmar.

Question 5. Does the HIV response address in any way (condoning) attitudes of society about violence against women and gender-based violence?

No.

Question 6. Does the HIV response address in any way (stigmatizing/condoning) attitudes of public service providers (health workers, uniformed services, teachers etc.) about violence against women and gender-based violence?

No.

6.1 If so, how does it address?

Obs. This could be done, for example, through information, education, and communication – IEC – materials, including different kinds of campaigns, training and sensitisation of healthcare workers, teachers, law enforcement personnel, media workers etc.

N/A

6.2 If not, then why?

Refer to Question 1.3 of this Section on the rationale for why gender – and correspondingly, gender-based violence – is not addressed in the national HIV response.

Question 7. Are there partnerships between government and partners, including UN agencies with women's rights, women living with HIV and/or transgender and key population organizations and networks to develop and implement programs and initiatives that address VAW and GBV in the HIV response?

Yes. Refer to Question 3 of this Section.

7.1 If not, why aren't there any?

N/A

8. If the country has a situation of humanitarian setting, is there a specific program to address gender-based violence and violence against women and girls, and its relation to HIV? Describe it.

Yes. Refer to Question 3 of this Section.

8.1 If yes, does it offer sexual and reproductive health services to women and girls, men and boys, and any specific key population in the humanitarian setting? Will check with UNFPA

SRH services offered include clinical treatment of rape survivors, and psychosocial and counselling services.

2.5 SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Question 1. Does the country have a SRHR policy (stand-alone or as part of the HIV policy) that recognizes and addresses linkages between HIV, maternal health and child health, and women's health beyond their reproductive role, as interlinked concerns? If yes, please describe them?

No. Myanmar does not have a national policy which encompasses sexual and reproductive health and rights (i.e. either as stand-alone or within the NSP II).

However, Myanmar does have a National Reproductive Policy (2002) and developed the second Five Year Strategic Plan for Reproductive Health (2009-2013).

Question 2. Which sexual and reproductive health services are available for women and girls, transgender women, men and boys, and key populations in the country? Which are not available?

SRH services available in the country include:

- SRH education and counselling
- Family planning (including birth spacing services and sterilisation)
- Contraceptives (including condom distribution)
- Pre- and antenatal care (including management of obstetric and neonatal complications and emergencies)
- Prevention and treatment of STIs, including HIV/AIDS

SRH services that are not available or are available on a limited scale include:

- Abortion-related services (e.g. prevention of abortion, management of complications resulting from unsafe abortion)
- Prevention and appropriate treatment of sub-fertility and infertility
- Adolescent sexual and reproductive health
- Prevention and management of gender-based violence

2.1 Are these SRH services integrated with HIV services?

Yes, but integration of SRH and HIV services is a recent development and is on a limited scale.

2.2 Please indicate if the available services are equally accessible by key populations, particularly transgender women, gay men and men who have sex with men.

Yes, SRH services are equally accessible by key populations, although factors such as stigma and discrimination may deter access.

No sex and age disaggregated data available on access by key populations.

2.3 Is there any indication of coercion, discrimination, and/or violence while accessing commodities or healthcare services, particularly suffered by women, girls, transgender women, gay men and boys, or other key population?

Access to services is free for all citizens. However, there are factors which contribute towards the quality of services received by people living with HIV and key affected populations.

Based on the findings of the Myanmar HIV Stigma Index, over 90% of respondents (both male and female almost equally) stated that they had never been refused health services as a result of their HIV positive status. For those who had been denied family planning services (35% total) and SRH services (20% total), there was no significant difference between male and female respondents as well as between key affected populations (FSW and PWID).

[http://www.mpgnationalnetwork.org/docs/MPG_StigmaIndex_Eng.pdf]

Question 3. Are regional and international commitments on sexual and reproductive health and rights of women and girls incorporated into the HIV response? If so, how?

No.

Question 4. What are the most common gender-related barriers and challenges for accessing integrated HIV and SRHR services and commodities in the ground?

4.1 How have these been identified?

Overall, access to integrated HIV and SRHR services and commodities is available to the general population, including key affected populations. However, as previously noted, gender-related barriers and challenges stemming from stigma and discrimination, and socio-cultural norms and practices may discourage access.

Examples include:

- With sero-discordant heterosexual couples where the female is HIV+, but the male is negative – the female may decide not to access HIV/SRH services for fear that her male partner will find out.
- Transgender people, due to their physical appearance and dress, are discriminated against and not treated with respect by service providers (in particular by public health service providers) and other patients, deterring them from accessing services.
- Men generally have greater knowledge/awareness of services such as VCCT compared to women (excluding pregnant women), resulting in higher access levels.

These examples (and many others) were identified primarily through informal discussions (e.g. among friends, within the communities).

4.2 How have they been addressed in the national strategy?

Common gender-related barriers and challenges are not explicitly addressed in the HIV response.

Question 5. Are there development partners and civil society organisations providing key services for HIV, sexual and reproductive health and rights, and gender-based violence, including violence against women and girls and key populations?

In Myanmar, development partners and CSOs providing HIV, SRHR, and GBV services include (not exhaustive):

- Association François-Xavier Bagnoud (AFXB)
- Alliance (International HIV/AIDS Alliance)
- Lotus
- Marie Stopes International (MSI) Myanmar
- Médecins Du Monde (MdM)
- Medecins Sans Frontieres- Holland (AZG)
- Myanmar Anti-Narcotics Association (MANA)
- Population Services International (PSI) Myanmar

Analysis of gender issues related to the HIV epidemic and the contextual factors.

SRH services which are not available or are available on a limited scale include:

- Abortion-related services (e.g. prevention of abortion, management of complications resulting from unsafe abortion)
- Prevention and appropriate treatment of sub-fertility and infertility
- Adolescent sexual and reproductive health
- Prevention and management of gender-based violence
- With sero-discordant heterosexual couples where the female is HIV+, but the male is negative – the female may decide not to access HIV/SRH services for fear that her male partner will reject her
- Transgender people, due to their physical appearance and dress, are discriminated against and not treated with respect by service providers (in particular by public health service providers) and other patients, deterring them from accessing services.
- Men generally have greater knowledge/awareness of services such as VCCT compared to women (excluding pregnant women), resulting in higher access levels.

Step 3

Gender considerations per community

Step 3.1 • WOMEN AND GIRLS

Question 1. Is there a national gender policy?

There is no national gender policy (as it relates to all the different types of gender). However, the National Strategic Plan for the Advancement of Women (2013-2022) (NSPAW) was recently launched in October 2013 by the Ministry of Social Welfare, Relief and Resettlement (Department of Social Welfare).

^A Not specifically related to HIV, but addressed as part of two Key Priority Areas (*Women and Livelihoods* and *Women and the Economy*)

^B *Women and Health* Paragraph 9 b)2)

^C *Women and Health* Paragraph 9

^D Also addressed as part of the Key Priority Areas *Women and Livelihoods* and *Women and the Economy*. As well, *Women and Health* Paragraph 9 references the participation of women in senior, technical and professional positions within Government Departments related to health care.

^E Not specifically related to HIV, but addressed as part of Key Priority Area *Violence Against Women*

NSPAW is based on the 12 Priority Areas of the Beijing Platform for Action and the principles of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The objectives of NSPAW are: "All women in Myanmar are empowered and able to fully enjoy their rights with the support of the Government of the Republic of the Union of Myanmar. Enabling systems, structures and practices are created for the advancement of women, gender equality, and the realisation of women's rights". [NSPAW, paragraph 5]

1.1 Does the National Gender Policy effectively address the following in relation to increased HIV vulnerability and hindering access, utilization and adherence to HIV services?

Please tick box if yes

- ☐ Gender equality in intimate relationships?
- ☐ Gender equality in household decision-making?
- ☒ Access of women and girls to financial resources (economic empowerment)? ^A
- ☒ Access of women and girls to educational opportunities, including comprehensive sexuality education? ^B
- ☐ Transforming concepts of masculinity that encourage sexual risk taking and discourage health-seeking behaviours?
- ☐ Access to economic empowerment opportunities, including through microcredits or cash transfer
- ☐ Gender-based stigma and discrimination against people living with HIV?
- ☒ Equitable access to health services including sexual and reproductive health? ^C
- ☐ Access to social services?
- ☒ Gender equality in workplace policies? ^D
- ☒ Access to legal/law enforcement institutions, in particular knowing and claiming their rights? ^E
- ☒ Access to services to address gender based violence ^E

1.2 Does the gender policy guide the HIV response, in terms of recognizing and addressing the gender aspects of the HIV epidemic and the specific HIV risks and vulnerabilities of women and girls, including from key populations? Yes/No. Please elaborate answer.

No. The NSP II and NSPAW are not aligned. NSPAW makes general reference to the HIV response, but it does not include guidance on the HIV response.

3.2 MEN AND MASCULINITIES

Question 1. Do the national HIV and/or gender policy guide the HIV response to work with men and boys to address cultural and historically constructed harmful masculinities and support them to:

No

Please tick box if yes

- ☐ Explore and address how concepts of masculinity can lead to increased risk of HIV both for them and the sexual partners, including discouraging access to HIV services, and encouraging risky sexual behaviour and gender-based violence?
- ☐ Promote positive forms of masculinity that encourage access to health?
- ☐ Acknowledge unequal power relations between men and women, boys and girls?
- ☐ Understand and respect the rights of women and girls, including those from key populations, such as men who have sex with men, LGBT population and sex workers?
- ☐ Acknowledge the stigma and discrimination faced by women and girls (including those from key populations) in many facets of life (social, economic, political and health), from domestic to labour relations?
- ☐ Address the impact of masculinity norms on women and girls, including those from key populations, such as men who have sex with men, LGBT population and sex workers, in terms of health-seeking behaviour, including HIV services; risky sexual behaviour; and gender-based violence?

Please describe how they are addressed and add other examples if applicable and relevant for replying the question.

Gender is a Guiding Principle of the NSP II, recognising that "vulnerabilities of women and men, girls and boys differ in terms of both sex and gender, and that interventions for men and women need to differ accordingly" and "as power is distributed unequally, women have less access to health information, care and services, and resources to protect their health." However, the NSP II notes that more data collection and gender analysis are required to enable a gender sensitive approach in the national response. As such, none of the actions above are addressed. [Guiding Principle 11]

Question 2. Has this resulted in national programmes or initiatives? Please provide examples.

No - None noted.

Question 3: How effective are these policies in fostering social change? Please clarify.

N/A – none noted.

3.3 KEY POPULATIONS

Question 1. Does the national gender policy and HIV policy and/or National Strategic Plan on HIV, recognize and address the specific HIV risks and vulnerabilities of key populations?

Yes, the NSP II recognises and addresses the specific HIV risks and vulnerabilities of key populations. From the Strategic Framework (Section 7.2):

NSP II gives priority to key populations most at risk of acquiring HIV infection – those identified with behaviours or situations that bring about higher than average prevalence of HIV (>5%) and who do not yet practise preventive behaviours consistently. These populations include the following:

- Female sex workers and their clients and the sexual partners of both
- Men who have high risk sex with men and their sexual partners
- People who inject drugs and their sexual partners
- Male sex workers and their clients and the sexual partners of both
- Sexual partners of people living with HIV
- Institutionalized (prison facilities, detention and rehabilitation centres) populations
- Children born to HIV-infected parents.

Note that NSPAW does not explicitly address key populations (i.e. female sex workers or female drug users etc.).

Question 2. Do the HIV policy guide programmes and initiatives for key populations, ensuring that these are?

Please tick box if yes

- ☒ Rights-based?
- ☐ Reduce gender barriers to diagnosis, treatment and care?
- ☐ Address gender-based stigma and discrimination?
- ☐ Address gender-based violence against key population?
- ☐ Empower key populations to know and claim their human rights?

One of the Guiding Principles of the NSP II is *Rights and Public Health*, recognising that “the protection of human rights, both of those vulnerable to infection and those already infected, is not only right, but also produces positive public health results against HIV.” As well, the NSP II states that “The human rights of marginalised groups (sex workers, people who use drugs, men who have sex with men, prisoners) must also be respected and fulfilled for the response to HIV to be effective.”

Rights-based intervention activities targeted at key populations include:

- For FSW – reform of Suppression of Prostitution Act 1949; creating enabling environments where programmes for FSW respect consent and confidentiality; and ensuring that condom possession is not used as a liability of sex work. [Strategic Priority 1, Intervention 1]
- For MSM – reform of laws that criminalises sex between consenting male adults (e.g. Myanmar Penal Code Section 377), and creating enabling environments that are supportive of HIV prevention programmes and services for MSM. [Strategic Priority 1, Intervention 2]
- For PWID – Enforcement of Directive 2001 from Myanmar Police Force Headquarters to not make arrests for the possess of hypodermic needles; revision of the Narcotic Law (1974) for mandatory one-

month hospitalisation of identified drug users; and in general, to amend laws that criminalise use of narcotic drugs so that obstacles to prevention and treatment programmes are removed. [Strategic Priority IV, Cross-Cutting Intervention 2]

Note that gender barriers to diagnosis, treatment and care; gender-based stigma and discrimination; gender-based violence against key populations; and empowerment of key populations to know and claim their human rights are not addressed.

3.4 YOUNG PEOPLE

Question 1. Does the country have a youth policy (stand-alone or as part of the HIV policy) or, if there is no youth-specific policy, are there regulations within the HIV and/or health framework that address the specific vulnerabilities of young people?

Myanmar does not have a stand-alone national youth policy.

As part of the NSP II, young people are identified as one of the population groups at higher of HIV infection, in particular out-of-school youth and children living on the street. The NSP II states the need for programmes and comprehensive services that are tailored and targeted by age and gender, including young key populations and youth-at-risk.

Within Strategic Priority I *Prevention of the Transmission of HIV Through Unsafe Behaviour in Sexual Contacts and Injecting Drug Use* has an intervention targeted directly at vulnerable youth – Intervention 7 (Reducing HIV-Related Risk, and Vulnerability Among Young People).

Intervention 7 references the need for youth friendly spaces and services, including access to condoms and referral to VCT and other health services; capacity building of service staff to work with youth; training of youth on life, practical, and vocational skills; youth counselling and outreach; peer support groups; and greater participation of youth in organisations and the development and implementation of programmes, among other needs.

Note that Intervention 7 is primarily applicable for out-of-school youth and children living on the street. Young key affected population groups are covered under intervention areas targeting key affected populations and mobile/migrant youth are reached through interventions targeting the general mobile/migrant population. For young people considered at low risk and vulnerability (i.e. live in stable families, attend school, live in areas of low HIV prevalence etc.), they are reached by mass media, school educational programmes, and youth clubs.

Question 2: If yes, does the policy include guidance on?

Please tick box if yes

- ☒ Access to information on HIV prevention, care and support?
- ☒ Access to HIV prevention, care and support services?
- ☒ Access to condoms?
- ☒ Access to sexuality education?
- ☒ Access to HIV testing?
- ☐ Age of consent to access condoms? ^A

- ☒ Access to information on sexual and reproductive health?
- ☒ Access to sexual and reproductive health services?
- ☒ Access to family planning?
- ☐ Access to safe abortion? ^B
- ☒ Gender equity in access?
- ☐ Protection against gender based violence? ^C
- ☐ Protection for different sexual preference? ^D
- ☐ Protection for multiple gender identity? ^E
- ☐ Age of treatment decision-making? ^F
- ☐ Age of marriage? ^G
- ☐ Parental or spousal consent to medical treatment. ^H

^A N/A – no age restriction

^B N/A – abortion is not legal

^C No reference; legal protection against general violence is referenced only

^D No reference

^E No reference

^F N/A – no legal age restriction on treatment decision-making (but in practice may differ)

^G No reference

^H No reference

Question 3. How does the policy support young people to protect them from HIV transmission, gender based violence and sexual and reproductive health, including unwanted pregnancy? Please explain.

The NSP II intervention activities targeted at young people are intended to increase individual capacity (i.e. self-awareness, self-reliance and confidence, decision-making etc.) so that they will abstain from or reduce HIV and SRH-related risk-taking behaviours, or to maintain or practice safer sexual and drug use behaviours.

Both unintended pregnancy among young people and gender-based violence against young people are not referenced.

Question 4. Does the national HIV response include programmes specifically targeting the needs and rights of young key populations? Please explain.

Yes, the needs of young key populations are targeted in the NSP II via specialised activities within the intervention areas for FSW, MSM, and PWID. However, the activities noted are not comprehensive. As well, the rights of young key populations are not explicitly referenced.

For young FSW, activities include: tailored interventions for young sex workers and integration of HIV prevention and care services with youth centres. [Strategic Priority 1, Intervention 1]

For young MSM, activities include: establishment and improvement of friendly health and other social and support services and the integration of HIV prevention and care services with youth centres. [Strategic Priority 1, Intervention 2]

For young PWID, activities include: prevention interventions specifically for youth; strengthening of drug education and HIV education for drug users and other young people; improved health settings that are friendly for drug users and youth vulnerable to drug use to seek VCCT, STI, TB, and other services; tailored health, social, and other support services for young drug users and youth vulnerable to drug use; and the integration of HIV prevention and care services with youth centres. [Strategic Priority 1, Intervention 3]

Question 5. Please indicate if these specifically available services are equally accessible by girls, young women, boys, and young men, including those from key populations.

5.1 Are young women, young men, and young transgender people able to access HIV and SRHR services and commodities under the same conditions as any adult? Please explain.

Yes. From a legal perspective, there are no age restrictions on accessing HIV and SRHR services and commodities. However, in practice, there may be barriers that impede young women, men, and key affected populations from accessing such services and commodities to the same degree (and under the same conditions) as adults.

For example, that some health clinics have a policy of providing HIV/SRH services only to persons aged 18 years and older and require registration of patients (including their age). At these clinics, young people will be able to meet with peer educators and obtain referrals for medical treatment if needed. However, this policy deters and prevents young people from obtaining needed health services.

Refer to Question 5.2 for examples of gender barriers.

5.2 Are there any gender barriers to their access? If so, which?

Yes. Gender barriers that impede access by young people to HIV/SRH services are largely based on socio-cultural norms and practices. Examples include (but are not limited to):

- Young women, especially unmarried women, are deterred from seeking HIV and SRH information and/or treatment since they will be viewed as indecent and immoral (i.e. like a sex worker).
- SRH is a taboo subject and not commonly discussed, in particular among women; it is difficult for young women to obtain SRH information from their mothers, other female relatives and family friends, or even their female peers for fear of being stigmatised and looked down upon.
- Young men in general have greater access to HIV/SRH information and services than young women since they are permitted a wider social network (by parents) and have greater mobility (i.e. they can visit health clinics without having to inform their parents).

YOU HAVE NOW REACHED THE END OF STEP 3 OF STAGE 3. PLEASE REVIEW AND ANALYSE THE MAIN GAPS IN ADDRESSING GENDER DIFFERENCES RELATED TO THE SPECIFIC COMMUNITIES. PLEASE RECALL THE EARLIER IDENTIFIED GENDER ISSUES RELATED TO THE HIV EPIDEMIC AND THE SOCIO-CULTURAL NORMS AND DETERMINANTS.

WOMEN AND GIRLS

1. NSPAW and NSP are not yet aligned to complement each other and limited reference to HIV
2. NSPAW does not address the following:
 - a. Gender equality in intimate relationships
 - b. Gender equality in household decision-making
 - c. Transforming concepts of masculinity that encourage sexual risk taking and discourage health-seeking behaviours
 - d. Access to economic empowerment opportunities, including through microcredits or cash transfer
 - e. Gender-based stigma and discrimination against people living with HIV
 - f. Access to social services

MEN AND MASCUINITIES

The national HIV and/or gender policy guide does not specifically address men and boys in respect to cultural and historically constructed harmful masculinities

KEY POPULATIONS

3. HIV policy guide programmes and initiatives for key populations does not address:
 - a. Reduction of gender barriers to diagnosis, treatment and care
 - b. gender-based stigma and discrimination
 - c. gender-based violence against key population
 - d. Empowerment of key populations to know and claim their human rights

YOUNG PEOPLE

1. HIV policy guide and initiatives for young people does not address:
 - a. Age of consent to access condoms
 - b. Access to safe termination of unwanted pregnancy
 - c. Protection against gender based violence
 - d. Protection for different sexual preference
 - e. Protection for multiple gender identity
 - f. Age of treatment decision-making
 - g. Age of marriage
 - h. Parental or spousal consent to medical treatment.
2. From a legal perspective, there are no age restrictions on accessing HIV and SRHR services and commodities. However, in practice, there are barriers that impede young women, men, and key affected

populations from accessing such services and commodities to the same degree (and under the same conditions) as adults.

3. Young women, especially unmarried women, are deterred from seeking HIV and SRH information and/or treatment since they will be viewed as indecent and immoral (i.e. like a sex worker).
4. SRH is a taboo subject and not commonly discussed, in particular among women; it is difficult for young women to obtain SRH information from their mothers, other female relatives and family friends, or even their female peers for fear of being stigmatised and looked down upon.
5. Young men in general have greater access to HIV/SRH information and services than young women since they are permitted a wider social network (by parents) and have greater mobility (i.e. they can visit health clinics without having to inform their parents).

