

NATIONAL HIV LEGAL REVIEW REPORT

REVIEW OF MYANMAR'S LEGAL FRAMEWORK
AND ITS EFFECT ON ACCESS TO HEALTH AND
HIV SERVICES FOR PEOPLE LIVING WITH HIV
AND KEY AFFECTED POPULATIONS

September 2014



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Final Report

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Glossary of Acronyms and Terms

3DF	Three Diseases Fund
3N	National NGOs Alliance on HIV/AIDS
AHRN	Asian Harm Reduction Network
ART	Antiretroviral therapy
ARV	Antiretroviral
ASEAN	Association of South East Asian Nations
AZG	ArtsenZonderGrenzen (MSF – Holland)
BI-MM	Burnet Institute – Myanmar
CCDAC	Central Committee for Drug Abuse Control
ESCAP	Economic and Social Commission for Asia and the Pacific
ILO	International Labour Organization
INGO	International Non-governmental Organization
MBCA	Myanmar Business Coalition on AIDS
M-CCM	Myanmar Country Coordinating Mechanism
MDM	Médecins du Monde
MMCWA	Myanmar Maternal and Child Welfare Association
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MPG	Myanmar Positive Group
MRCS	Myanmar Red Cross Society
MSF-H	Médecins Sans Frontières - Holland
MSI	Marie Stopes International
MSM	Men who have sex with men
NAP	National AIDS Programme
NGO	Non-governmental organization
NSP II	Myanmar National Strategic Plan on HIV and AIDS 2011-2015
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PGK	PyiGyiKhin
PLHIV	People living with HIV
PMCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PWID	People who inject drugs
PWUD	People who use drugs
SOP	Standard operating procedure
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TB	Tuberculosis
TRIPS	Trade-related Aspects of Intellectual Property Rights
TSG	Technical and Strategy Group
UMFCCI	Union of Myanmar Federation of Chambers of Commerce and Industry
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counselling and Testing
VTW	Vocational Training for Women
WHO	World Health Organization

The term 'key populations' is used in this report to refer to people living with HIV, sex workers and their clients, MSM, transgender people, and people who use or inject drugs.

Executive Summary of Recommendations

This report presents the key findings and recommendations of the review of Myanmar's legal framework and its impact on access to health and HIV prevention and treatment services for people living with HIV and key populations.

This review was conducted through a partnership of UNAIDS, UNDP and Pyoe Pin in the period August – December 2013, in consultation with the National AIDS Programme.

The review involved the following steps:

- Literature review;
- Consultation meetings with NGOs, people living with HIV and key populations;
- A National Legal Review Meeting, convened in Naypyitaw on 25–26 November 2013;
- Analysis of all inputs to define key recommendations;
- Finalization of the report.

The literature review, consultations and National Legal Review Meeting identified key areas requiring action, including in relation to:

- Law and policy reform priorities;
- Police practices;
- Access to legal aid services, legal literacy and legal empowerment programmes; and
- Capacity building.

It is recognised that law reform is a long-term strategy and that much can be achieved in advance of law reform, for example through policy innovation, capacity building and partnerships between organizations representing key populations and law enforcement bodies to promote a shared understanding of HIV prevention objectives and approaches.

Recommendations

To support a more enabling legal and policy environment for HIV responses, it is recommended that the Government of Myanmar in partnership with key populations, donors, United Nations partners including UNAIDS and its cosponsors consider the following actions.

1. People living with HIV

The Government of Myanmar should:

1. Introduce a law and supporting policies prohibiting discrimination on the grounds of HIV status in health care, employment, and the provision of education and other services, and providing accessible complaints procedures and meaningful remedies such as compensation, admission to school, reinstatement of employment, and disciplinary sanctions for violations.
2. Allocate a specific budget and monitoring and evaluation framework for stigma and discrimination interventions in the National Strategic Plan for HIV/AIDS (2011-2016).

Health care

3. Establish a legal right for all people to access the means of protection from HIV including prevention information, condoms and clean needles and syringes.
4. Introduce provisions prohibiting non-consensual HIV testing and providing confidentiality protections for people living with HIV (this can be inserted in the Prevention and Control of Communicable Diseases Law 1995 or a new HIV law).
5. Remove AIDS from the category of Principal Epidemic Disease in the Prevention and Control of Communicable Diseases Law 1995 (Section 14 of this Law gives MoH discretion to quarantine people with a Principal Epidemic Disease which is defined to include AIDS as well as plague)
6. Ensure people living with HIV have access to complaints procedures for breach of confidentiality, non-consensual testing or other problems in delivery of health care services.
7. Strengthen the legal and policy framework for provision of care, support, treatment and impact mitigation services:
 - a. Provide access to a minimum package of HIV services under a comprehensive continuum of care framework.
 - b. Implement monitoring and evaluation systems that include community feedback on service quality. A responsive mechanism should be established for feedback on quality of services implemented by public, private and NGO sectors and that provides a process for people to seek redress for any violation of rights or malpractice.
8. Quality standards/Standard Operating Procedures should address HIV-related health service provision in both public and private sectors, including police jails, prisons, and detention/rehabilitation centres.

Employment

9. Require public and private sector workplaces to develop workplace policies on HIV that address non-discrimination and confidentiality, prohibit mandatory HIV testing of employees or applicants for employment and dismissal on the grounds of HIV status, and provide access or referral to VCCT and other health services. Where workplace HIV policies have been introduced, a system for monitoring and evaluation of compliance with non-discrimination requirements and other obligations should be implemented.

Prisoners living with HIV

10. The provision of the Prisons Act 1894 and/or the regulations and guidance under the Act should be strengthened to ensure non-discriminatory treatment of prisoners living with HIV and uninterrupted access to essential medicines. The Ministry of Home Affairs (MoHA) and Ministry of Health (MoH) should ensure a system for uninterrupted provision of antiretroviral therapy (ART) and opportunistic infection (OI) medicines to prisoners and people in police detention.
11. The Myanmar Police Force should take action to ensure medicines can be provided to people in police detention as part of prisoners' rights to health, without incentive payments of any kind.
12. Training and capacity building on HIV, harm reduction and human rights should be conducted for personnel responsible for the welfare and health of prisoners.

2. Sex workers

The Government should review the *Suppression of Prostitution Act 1949*. This review should consider the international evidence of the public health benefits of alternative legislative approaches to sex work, including models of health and safety regulation and decriminalization. To ensure sex workers are not driven underground and away from health services, legislative models should avoid punitive or compulsory measures such as compulsory testing and compulsory rehabilitation. The Government should consider the following amendments:

1. The Act should be re-titled to remove reference to 'suppression of prostitution' and instead emphasise 'protection of the rights of sex workers', including violence protection, and access to condoms and confidential health services for HIV and STI prevention, testing and treatment.
2. Include in the Act a supportive framework for implementation of the 100% Targeted Condom Programme to prevent sexual transmission of HIV and other STIs.
3. Include in the Act violence protection provisions for sex workers.
4. Remove penalties for soliciting (Section 3). If a penalty is to be imposed for sex work, this should be a fine rather than a custodial sentence.
5. Remove the offence of 'reputation' (kyawzaw) (Section 7).
6. End the practice of detaining sex workers in rehabilitation centres. Attendance at rehabilitation or vocational training centres should be voluntary rather than compulsory.

In advance of the review of the Suppression of Prostitution Act 1949, the following measures should be taken:

Police instructions

7. The Directive to police to not use condoms as evidence of prostitution offences should be revised, updated and widely disseminated. In addition to not using condoms as evidence in court, police should be directed to not search for condoms when arresting sex workers and not harass sex workers, accuse sex workers of offences or arrest sex workers based only on the finding of condoms on their person or premises.
8. The Directive should be promoted and enforced to ensure police comply with instructions prohibiting the use of condoms as evidence for prosecution or as a basis of arrest or harassment.
9. Police instructions should prohibit use of the 'reputation' offence (kyawzaw) and public order offences (such as loitering at night) against sex workers unless exceptional circumstances exist, and should prohibit the police practice of entrapment of sex workers using people who pretend to be clients.

Police responsibilities

10. Collaboration between MoH and the MoHA/Myanmar Police Force should be strengthened to support effective implementation of HIV prevention among sex workers including 100% targeted condom promotion.
11. If antiretroviral (ARV) drugs or OI medicines are found on a detained sex worker during a police search, these medicines should be returned to the sex worker

and police should help the sex worker to inform a peer educator, family member or service provider to arrange continuation of treatment. Police should be trained to recognize ARV and OI medicines, and to understand the role of these medicines in treatment and prevention.

Vocational training

12. The existing VTW Centres should be remodelled as voluntary centres that provide trainings for skills that are marketable and relevant to running a small business. There should be creation of employment opportunities for sex workers who want to find alternative viable livelihoods.

Legal aid

13. Legal aid services should be available to sex workers for representation in violence protection cases and complaints against police or health care services.

Health and HIV services

14. Health service policies should support non-discriminatory services that respect the human right to health of everyone including sex workers and ensure provision of sex worker-friendly health services including HIV, STI and reproductive health and family planning services to reduce maternal morbidity and mortality.
15. ART eligibility criteria should be relaxed so that mobile sex workers are referred to the nearest ART provider, and have flexibility to refill their ART prescription from any ART distribution site.

3. People who inject drugs (PWID)

Criminal laws and police abuses

1. The possession of needles and syringes should be decriminalized (*Myanmar Excise Act 1917*, Sections 13 and 33). The *Excise Act* should be amended to provide exceptions for distribution and possession of needles and syringes for harm reduction purposes.
2. Partnerships between the Central Committee for Drug Abuse Control (CCDAC), Myanmar Police Force, MoH, NGOs, and community networks to support harm reduction service provision need to be revitalized and local arrangements between police, NGOs and PWID communities need to be established to facilitate needle and syringe programmes.
3. The Directive by Police Headquarters (2001) not to arrest people for possession of needles and syringes should be promoted to police at all levels and strictly followed.
4. The MoHA/Myanmar Police Force should issue updated directives or police instructions prohibiting the use of needles and syringes as evidence for prosecution or as a basis of arrest or harassment. Police instructions should also prohibit police harassment of PWID attending or in the vicinity of drop-in centres or other sources of clean needles and syringes. Law enforcement efforts should focus on drug manufacturing, sale and supply, not use.
5. The Narcotics Law should be amended to include specific provisions on harm reduction services including MMT, needle and syringe programmes, and peer education and outreach.

6. Harm reduction should be a standard part of the police curriculum. Sensitization and advocacy should aim to educate police of the public health reasons for providing clean needles and syringes, peer education and MMT to PWID.

Registration of drug users

7. The system of compulsory registration of drug users should be phased out because it is stigmatizing, drives PWID away from services and fails to effectively address relapse. Instead, voluntary community-based treatment options should be provided.
8. While the current drug registration system remains in place, the law should treat registered drug users who are undergoing treatment leniently if they have a relapse during treatment. Police should take a health-oriented view to encourage more drug users to come forward to access counselling and treatment for drug use, VCCT and HIV prevention information. Police instructions should direct that a registered drug user not be charged with a criminal offence due to relapse.
9. If the registration system continues, registration for drug treatment should only be under the MoH and the personal information should be confidential and used solely for the purpose of treatment, not for police monitoring or criminal prosecution. This will encourage people who use drugs to register early for treatment and receive VCCT and HIV prevention education and services.

Prisons and detention centres

10. A prison MMT programme should be established. Procedures should ensure continued access to MMT for people in police detention or prison.
11. Treatment and rehabilitation services should be offered to people convicted of drug use or possession offences so as to divert people who use drugs from the prison system.
12. Rehabilitation centres for drug users should be offered as a voluntary option and include effective evidence-based services for drug treatment and counselling in addition to physical, psychosocial and livelihood rehabilitation.

Health care services

13. Community-based voluntary drug treatment services should be expanded. The National MMT Guideline should be fully implemented. Access to MMT and quality drug treatment counselling services should be expanded.
14. PWID should not be denied access to ART only on the grounds that they have not registered as drug users or undergone MMT initiation.
15. Drug use should be taken out of the criminal context and a new law and national policy for drug use should be developed that promotes harm reduction and treats drug dependence as a health condition.
16. Procedures and import restrictions under the National Drug Law 1992 and Narcotics Law require urgent revision to allow expanded access to effective pain relief drugs for people undergoing withdrawal from drugs.

4. MSM and transgender people

Criminal offences and police abuses

1. Section 377 of the *Penal Code* should be repealed or amended as it violates human rights to privacy and equality, fuels stigma and discrimination against MSM and transgender people, encourages abuses by the police and impedes HIV prevention and treatment efforts. Section 377 should not apply to consensual sexual conduct between adults in private.
2. The police should be trained on the harmful impacts of law enforcement practices that interfere with HIV prevention. Police should support health promotion efforts to promote condom use instead of harassing MSM and transgender people for possession of condoms when they are searched during investigation or arrest.
3. Police instructions should direct police not to enforce public order offences (e.g. loitering after dark) against MSM and transgender people unless they are implicated in genuine criminal activities.

Protective laws and policies

4. Laws and policies should prohibit stigma and discrimination against MSM and transgender people in health care, education and employment. Disciplinary action should be taken against persons who commit acts of discrimination.
5. The law should enable transgender people to change their legal gender on identity and registration documents. One option is to enable transgender people to identify as a 'third gender' on legal documents, with equal rights as enjoyed by other citizens.

Capacity building and inclusion in NSP II

6. NSP II should recognize the sexual orientation and gender identity rights of MSM and transgender people as a fundamental principle of effective HIV prevention.
7. MSM and transgender voices should be heard through representation at national health coordinating and decision-making bodies to ensure interventions are tailored to their specific needs.
8. NSP II should support comprehensive responses to the needs of MSM and transgender people including action against stigma and discrimination in delivery of health services, and sensitization and training of health personnel to increase access to VCCT and sexual health services. Health care workers should be sensitized to the needs and human rights of MSM and transgender people.

5. Women and girls

1. Violence protection laws and policies should address the needs of women and girls to be protected from violence in domestic and non-domestic contexts (e.g. sex workers). Marital rape should be criminalized.
2. Laws and policies should prohibit discrimination on the grounds of gender in the delivery of health and HIV services.
3. Policies should ensure gender-sensitive HIV services including the right of HIV-positive women to PMCT services, family planning and reproductive health services. Women and girls should have the right to decide on their family planning and reproductive health choices without any coercion. Health care workers should receive training on the reproductive rights of women and girls living with HIV.

4. Widows should be provided with access to information about their legal rights to inheritance and legal aid services so that inheritance rights can be enforced.
5. Social protection policies should address the specific needs of women and girls living with and affected by HIV, female sex workers, females who use drugs or who are in prisons or detention centres.

6. Children and young people

1. The *Child Law 1993* should be updated to ensure compliance with the Convention on the Rights of the Child and enforced to ensure orphans and vulnerable children (OVC) have access to protection, guardianship, care and support. Orphans, street children and other vulnerable children should be cared for by the State in an appropriate setting (either community or institution based) and educated to their full potential. Regulations and guidelines should be established on procedures for HIV-positive children and children from HIV-affected households including orphans to access health, education, protection and care including shelter.
2. Children should be provided with education about their rights so that they can demand fulfilment of their rights including the right to health, and the voices of children and young people should be heard in policy-making processes.
3. The Government should ensure systems are in place to support all OVC including children in HIV-affected households to have birth registration, household registration and a National Registration Card.
4. The MoH should issue Guidance confirming that sexual and reproductive health services including HIV and STI testing can be provided to young people who are 12 years or older without parental consent, if they are assessed by the health care provider to be sufficiently mature.
5. Policies on HIV prevention, care and support should include specific provisions for young key affected populations including young MSM and transgender people, young female sex workers and young people who use drugs, as well as young internal and foreign migrants.
6. The Ministry of Education should issue a policy prohibiting discrimination against children living with HIV by public or private schools.
7. The MoH should revise the ART eligibility criteria to remove the requirement that an HIV-negative adult is available to provide treatment adherence support to the child. An HIV-positive parent should be sufficient to provide adherence support to the child. MoH policy should guarantee the uninterrupted supply of ARVs in child formulations to ensure treatment efficacy and prevent unwanted side effects.

7. Patents law and access to medicines

The Government of Myanmar should:

1. Ensure that TRIPS flexibilities including compulsory licensing and parallel importing are fully addressed in the new patents law so that access to medicines is not restricted when Myanmar commences recognition of pharmaceutical patents;
2. Consider extending the date of exclusion of pharmaceutical products from patent protection until 1 July 2021, unless Myanmar graduates from Least Developed Country status before that date; and

3. Not agree to enter trade or investment agreements that impose 'TRIPS-plus' requirements that could restrict future access to generic medicines.

8. Cross-cutting priorities

1. Capacity building is required to strengthen the role of lawyers, police, judges, health-care workers and parliamentarians in supporting human rights-based HIV responses. Each of these actors needs to understand the public health and human rights rationale for developing protective legal frameworks for people living with HIV and key populations. It is particularly important to provide training for police on HIV and human rights to address police abuses and to ensure that police act to protect and promote the rights of key populations.
2. The Government and donors should support community legal empowerment and 'access to justice' programmes that provide key populations with expanded access to free legal information, advice and representation, paralegal services, legal and human rights education, legal advice hotlines and access to rapid response teams to address incidents of violence or other serious rights violations. Key populations should be made aware of their rights and responsibilities and empowered to demand justice if their rights are violated.
3. Key populations should have access to independent and confidential complaints procedures if they experience harassment, extortion, unfair treatment or violence from the police, prison guards or other law enforcement officials.
4. The capacity of the National Human Rights Commission to address HIV-related complaints should be strengthened. Staff of the Commission should be trained on HIV-related human rights issues and the nature of rights violations commonly experienced by key populations.

ဤအစီအရင်ခံစာတွင် မြန်မာနိုင်ငံဥပဒေရေးရာမူဘောင်အားပြန်လည်သုံးသပ်ခြင်းမှရရှိလာသော အဓိကတွေ့ရှိချက်များ၊ အကြံပြုချက်များနှင့် အိတ်ချ်အိုင်စီပိုးရှိနေသူများ၊ အဓိကဦးတည်အုပ်စုများ အိတ်ချ်အိုင်စီတားဆီးကာကွယ်ရေး၊ ကုသရေးဝန်ဆောင်မှုများအသုံးပြုခြင်းအပေါ်၌ အဆိုပါမူဘောင်၏အကျိုးသက်ရောက်နေပုံများ စသည်တို့ကို ဖော်ပြထားသည်။

ဤပြန်လည်သုံးသပ်ခြင်းကို အမျိုးသားခုခံကျ/ကာလသားတိုက်ဖျက်ရေးစီမံချက် (NAP) နှင့် တိုင်ပင်ဆွေးနွေးကာ UNAIDS၊ ကုလသမဂ္ဂဖွံ့ဖြိုးရေးအစီအစဉ် (UNDP) နှင့် ပျိုးပင် စသည့်အဖွဲ့များမှ (၂၀၁၃) ခုနှစ် ဩဂုတ်လမှ ဒီဇင်ဘာလအတွင်းတွင် ပူးပေါင်းလုပ်ဆောင်ခဲ့သည်။

ပြန်လည်သုံးသပ်ရာတွင် အောက်ဖော်ပြပါအဆင့်များပါဝင်ပါသည်။

- စာအုပ်စာတမ်းများ ပြန်လည်လေ့လာသုံးသပ်ခြင်း၊
- အစိုးရမဟုတ်သောအဖွဲ့များ၊ အိတ်ချ်အိုင်စီပိုးရှိသူများ၊ အဓိကဦးတည်အုပ်စုများနှင့် တိုင်ပင်ဆွေးနွေးသော အစည်းအဝေးများ၊
- (၂၀၁၃)ခုနှစ်၊ နိုဝင်ဘာ (၂၅) ရက် နှင့် (၂၆) ရက်နေ့များတွင်နေပြည်တော်၌ကျင်းပပြုလုပ်ခဲ့သော အမျိုးသားအဆင့်ဥပဒေရေးရာပြန်လည်သုံးသပ်သည့်အစည်းအဝေး၊
- အဓိကအကြံပြုချက်များကို သတ်မှတ်ထုတ်ဖော်ရန်အတွက် ရရှိလာသောအချက်အလက်များအားလုံးကို ခွဲခြမ်းစိတ်ဖြာခြင်းနှင့်
- အစီရင်ခံစာအား အပြီးသတ်ခြင်း။

စာအုပ်စာတမ်းများ ပြန်လည်လေ့လာသုံးသပ်ခြင်း၊ တိုင်ပင်ဆွေးနွေးခြင်းများနှင့် အမျိုးသားအဆင့်ဥပဒေရေးရာ ပြန်လည်သုံးသပ်ခြင်း အစည်းအဝေးစသည်တို့တွင် လုပ်ငန်းလုပ်ဆောင်ရန်လိုအပ်သော အဓိကကဏ္ဍများကို ဖော်ထုတ်ထားပြီး ယင်းတို့တွင်အောက်ပါတို့နှင့်ဆက်စပ်နေသော လုပ်ငန်းများပါဝင်သည်။

- ဥပဒေနှင့် မူဝါဒပေါ်လစီပြုပြင်ပြောင်းလဲရေးဦးစားပေးများ၊
- ရဲလုပ်ထုံးလုပ်နည်းများ၊
- ဥပဒေရေးရာအကူအညီများ၊ ဥပဒေရေးရာအသိပညာနှင့် ဥပဒေရေးရာစွမ်းဆောင်ရည်မြှင့်တင်သည့် လုပ်ငန်းများနှင့်
- စွမ်းဆောင်ရည်တည်ဆောက်ခြင်း။

ဥပဒေရေးရာပြုပြင်ပြောင်းလဲရေးမှာ ရေရှည်လုပ်ဆောင်ရမည့်နည်းဗျူဟာတစ်ရပ်ဖြစ်ကြောင်းနှင့် ပြုပြင်ပြောင်းလဲမှုများ မလုပ်ဆောင်မှီ ဆောင်ရွက်နိုင်သည့်လုပ်ငန်းများစွာရှိနေကြောင်း လက်ခံထားပါသည်။ ဥပမာ - အိတ်ချ်အိုင်စီ ကာကွယ်တားဆီးရေးဆိုင်ရာဦးတည်ချက်များနှင့် လုပ်ငန်းလုပ်ဆောင်ပုံများအား တူညီစွာနားလည်သဘောပေါက်စေရန် မူဝါဒပေါ်လစီဖော်ထုတ်ခြင်း၊ စွမ်းဆောင်ရည်တည်ဆောက်ခြင်းနှင့် အဓိကဦးတည်အုပ်စုများကို ကိုယ်စားပြုသောအဖွဲ့အစည်းများနှင့် ဥပဒေအကောင်အထည်ဖော်ပေးရမည့်အဖွဲ့အစည်းများ မိတ်ဖက်ပူးပေါင်းလုပ်ဆောင်ခြင်း စသည်တို့အားဖြင့်လုပ်ဆောင်သွားမည်။

အကြံပြုချက်များ

အိတ်ချ်အိုင်စီတုံ့ပြန်မှုလုပ်ငန်းများအတွက် တရားဥပဒေ၊ မူဝါဒပေါ်လစီနှင့်ပတ်သက်သော ပိုမိုအခွင့်အလမ်းသာသည့် ပတ်ဝန်းကျင်တစ်ရပ်ဖန်တီးပေးရန် နိုင်ငံတော်အစိုးရအနေဖြင့် အဓိကဦးတည်အုပ်စုများ၊ အလှူရှင်များ၊ UNAIDS အပါအဝင်ကုလသမဂ္ဂမိတ်ဖက်များနှင့်၎င်းတို့၏ပူးတွဲအလှူရှင်များစသူတို့နှင့်မိတ်ဖက်ပြီး အောက်ဖော်ပြပါလုပ်ငန်းများကို ထည့်သွင်းစဉ်းစားသွားရန် အကြံပြုလိုက်ရပါသည်။

၁။ အိတ်ချ်အိုင်စီပိုးရှိနေသူများ

နိုင်ငံတော်အစိုးရအနေဖြင့်

- (၁) ကျန်းမာရေးစောင့်ရှောက်မှု၊ အလုပ်အကိုင်၊ ပညာရေးနှင့် အခြားသောဝန်ဆောင်မှုများတွင် အိတ်ချ်အိုင်စီပိုးရှိနေခြင်းကိုအကြောင်းပြု၍ ခွဲခြားဆက်ဆံခြင်းကို တားမြစ်ပေးသည့်ဥပဒေတစ်ရပ်နှင့် အထောက်အပံ့ပေးသည့်မူဝါဒပေါ်လစီများကို မိတ်ဆက်ကျင့်သုံးသင့်သည်။ ထို့ပြင်မကျေနပ်ချက်များကို အလွယ်တကူတိုင်ကြားနိုင်သော လုပ်ထုံးလုပ်နည်းများအားပံ့ပိုးပေးခြင်း၊ နစ်နာကြေးပေးခြင်း၊ ကျောင်းဝင်ခွင့်ပြုခြင်း၊ အလုပ်အကိုင်ပြန်လည်ခန့်အပ်ခြင်း၊ သတ်မှတ်ထားသည့်မူဝါဒများကိုချိုးဖောက်သူများအား စည်းကမ်းတကျပြစ်ဒဏ်ပေးခြင်း စသောအဓိပ္ပါယ်ရှိသည့် ဖြေရှင်းနည်းများကိုလည်းအသုံးပြုသင့်သည်။
- (၂) အိတ်ချ်အိုင်စီ/ အေအိုင်ဒီအက်စ် အမျိုးသားအဆင့်မဟာဗျူဟာစီမံကိန်း (၂၀၁၁-၂၀၁၆) ပါ ကဲ့ရဲ့ရှုတ်ချခြင်း၊ ခွဲခြားနှိမ်ချဆက်ဆံခြင်းများကိုတိုက်ဖျက်သောလုပ်ငန်းများအတွက် စောင့်ကြည့်လေ့လာခြင်း၊ ပြန်လည်သုံးသပ်ခြင်းမူဘောင်များနှင့် ရသုံးမှန်းချေငွေစာရင်း (budget) သီးသန့် သတ်မှတ်ပေးသင့်သည်။

ကျန်းမာရေးစောင့်ရှောက်မှု

- (၃) ရောဂါကာကွယ်တားဆီးရေးသတင်းအချက်အလက်များ၊ ကွန်ဒုံး၊ သန့်ရှင်းသောဆေးထိုးအပ်နှင့်မြွန်စသည်တို့အပါအဝင် အိတ်ချ်အိုင်စီပိုးကူးစက်မခံရအောင်ကာကွယ်သောနည်းလမ်းများကို နိုင်ငံသားအားလုံးလက်လှမ်းမီနိုင်ရန် ဥပဒေရေးရာရပိုင်ခွင့်တစ်ရပ်ထူထောင်ပေးသင့်သည်။
- (၄) ကာယကံရှင်၏သဘောတူခွင့်ပြုချက်မပါဘဲအိတ်ချ်အိုင်စီပိုးရှိမရှိစစ်ဆေးခြင်းကို တားမြစ်ခြင်း၊ အိတ်ချ်အိုင်စီပိုးရှိသူများအတွက်လျှို့ဝှက်ထိန်းသိမ်းပေးခြင်း စသောဝန်ဆောင်မှုများကို စတင်လုပ်ဆောင်သင့်သည်။ (ယင်းကို ၁၉၉၅ ကူးစက်ရောဂါများတားဆီးကာကွယ်ရေးနှင့်ထိန်းချုပ်ရေးဥပဒေ သို့မဟုတ် အိတ်ချ်အိုင်စီဥပဒေသစ် တွင်ထည့်သွင်းနိုင်သည်။)
- (၅) ၁၉၉၅ ကူးစက်ရောဂါများတားဆီးကာကွယ်ရေးနှင့်ထိန်းချုပ်ရေးဥပဒေတွင် အေအိုင်ဒီအက်စ်ကို အဓိကကပ်ရောဂါအမျိုးအစားမှ ပယ်ဖျက်သင့်သည်။ (ယင်းဥပဒေ၏ အပိုဒ် (၁၄) သည် အဓိကကပ်ရောဂါဖြစ်ပွားနေသူများကိုသီးခြားထားရှိရန် ကျန်းမာရေးဝန်ကြီးဌာနအားလုပ်ပိုင်ခွင့်ပေးအပ်ထားသည်။ အဓိကကပ်ရောဂါတွင် အေအိုင်ဒီအက်စ်နှင့် ပလိပ်ရောဂါတို့ပါဝင်ပါသည်။)
- (၆) လျှို့ဝှက်ထိန်းသိမ်းအပ်သောအရာများကို ပေါက်ကြားစေခြင်း၊ ကာယကံရှင်၏သဘောတူခွင့်ပြုချက်မပါဘဲ အိတ်ချ်အိုင်စီပိုးရှိမရှိစစ်ဆေးခြင်း (သို့မဟုတ်) ကျန်းမာရေးစောင့်ရှောက်မှုခံယူရာတွင်ကြုံတွေ့ရသော အခြားပြဿနာများအားတိုင်ကြားနိုင်သည့်နည်းလမ်းများကို အိတ်ချ်အိုင်စီပိုးရှိသူများအသုံးပြုနိုင်အောင်ဆောင်ရွက်ပေးသင့်သည်။

- (၇) ကျန်းမာရေးစောင့်ရှောက်မှုပေးခြင်း၊ အထောက်အပံ့ပေးခြင်း၊ ကုသခြင်း၊ ဆိုးကျိုးသက်ရောက်မှုနည်းပါးစေခြင်း စသည့်ဝန်ဆောင်မှုများဆိုင်ရာ ဥပဒေရေးရာမူဝါဒဘောင်များကို အားဖြည့်သင့်သည်။
- (က) ပြည့်စုံလုံလောက်သောစဉ်ဆက်မပြတ်ကျန်းမာရေးစောင့်ရှောက်မှုဘောင်အတွင်းတွင် အိတ်ချ်အိုင်စီနှင့်ပတ်သက်သော အနည်းဆုံးရသင့်ရထိုက်သည့်ဝန်ဆောင်မှုများကို လက်လှမ်းမှီအသုံးပြုနိုင်စေရန်ဆောင်ရွက်ပေးခြင်း၊
- (ခ) ဝန်ဆောင်မှုအရည်အသွေးအပေါ်ပြည်သူလူထုမှ တုံ့ပြန်အကြံပြုနိုင်သည့် စောင့်ကြည့်လေ့လာခြင်းနှင့် ပြန်လည်သုံးသပ်ခြင်းစနစ်များတည်ဆောက်ခြင်း။ အစိုးရ၊ ပုဂ္ဂလိက၊ အစိုးရမဟုတ်သောအဖွဲ့များ၏ ဝန်ဆောင်မှုအရည်အသွေးများနှင့်စပ်လျဉ်း၍ ပြည်သူတို့၏အကြံပြုချက်များကို လိုလိုလားလားပြန်လည်တုံ့ပြန်ပေးသည့်နည်းလမ်းများထူထောင်သင့်သည်။ ပြည်သူလူထုအနေဖြင့် ရပိုင်ခွင့်များချိုးဖောက်ခံရပါက (သို့မဟုတ်) မသမာမှုများတွေ့ကြုံပါက ပြန်လည်ထိန်းညှိပေးမည့်နည်းလမ်းများကိုရှာဖွေတတ်စေရန် ယင်းစနစ်ကဖော်ဆောင်ပေးမည်။
- (ဂ) အချုပ်ခန်းများ၊ အကျဉ်းထောင်များ၊ ထိန်းသိမ်းရေး/ ပြန်လည်ထူထောင်ရေးစခန်းများအပါအဝင် အစိုးရနှင့်ပုဂ္ဂလိကကဏ္ဍနှစ်ရပ်လုံးရှိ အိတ်ချ်အိုင်စီနှင့်ဆက်စပ်နေသော ကျန်းမာရေးဝန်ဆောင်မှုများကို အရည်အသွေးစံနှုန်းများ/စံသတ်မှတ်ထားသောလုပ်ထုံးလုပ်နည်းများနှင့်အညီဦးတည်လုပ်ဆောင်သင့်သည်။

အလုပ်အကိုင်

- (၈) ခွဲခြားနှိမ်ချဆက်ဆံမှုမရှိဘဲအတွင်းရေးလျှို့ဝှက်ထိန်းသိမ်းပေးခြင်း၊ ဝန်ထမ်းများ/ အလုပ်လျှောက်သူများအား အိတ်ချ်အိုင်စီပိုးရှိမရှိမဖြစ်မနေစစ်ဆေးခြင်းနှင့် ပိုးရှိပါကအလုပ်မှထုတ်ပယ်ခြင်းအား တားမြစ်ခြင်းနှင့် မိမိဆန္ဒအလျောက်လျှို့ဝှက်စွာနှစ်သိမ့်ဆွေးနွေးအတိုင်ပင်ခံခြင်း၊ သွေးစစ်ဆေးခံခြင်း (VCCT) နှင့် အခြားသော ကျန်းမာရေးဝန်ဆောင်မှုများအသုံးပြုနိုင်ခြင်း (သို့မဟုတ်) ယင်းတို့အတွက်ညွှန်းပြုခြင်းစသော လုပ်ငန်းခွင်မူဝါဒပေါ်လစီများကို အစိုးရနှင့်ပုဂ္ဂလိကကဏ္ဍနှစ်ရပ်လုံးတွင် ဖော်ထုတ်ရန်လိုအပ်သည်။ အိတ်ချ်အိုင်စီနှင့်ပတ်သက်သော လုပ်ငန်းခွင်မူဝါဒပေါ်လစီများကို စတင်အကောင်အထည်ဖော်ရာ၌ ခွဲခြားဆက်ဆံမှုမပြုရေး သတ်မှတ်ချက်များ၊ အခြားသောတာဝန်ဝတ္တရားများအားလေးစားလိုက်နာမှုရှိမရှိ စောင့်ကြည့်စစ်ဆေးသော၊ ပြန်လည်သုံးသပ်သောစနစ်ကိုလည်း ထူထောင်သင့်သည်။

အိတ်ချ်အိုင်စီပိုးရှိနေသောအကျဉ်းသားများ

- (၉) အိတ်ချ်အိုင်စီပိုးရှိနေသောအကျဉ်းသားများအား ခွဲခြားဆက်ဆံမှုမပြုရေးနှင့် အရေးကြီးဆေးဝါးများကို စဉ်ဆက်မပြတ်ရရှိနိုင်ရေးအတွက် ၁၈၉၄ အကျဉ်းထောင်များအက်ဥပဒေပါ စည်းမျဉ်းစည်းကမ်းများနှင့် လမ်းညွှန်မှုများကိုလည်း ပြန်လည်သုံးသပ်သင့်သည်။ အကျဉ်းသားများ၊ ထိန်းသိမ်းရေးစခန်းတွင်ရှိသူများ အေအာရ်တီဆေး (ART) နှင့် အခွင့်အရေးယူဝင်ရောက်လာသောရောဂါများ (OI) အတွက်ဆေးဝါးများကို စဉ်ဆက်မပြတ်ရရှိစေရန် ပြည်ထဲရေးဝန်ကြီးဌာန (MoHA) နှင့် ကျန်းမာရေးဝန်ကြီးဌာန (MoH) တို့မှ ဆောင်ရွက်ပေးသင့်သည်။
- (၁၀) အကျဉ်းသားများ၏ကျန်းမာရေးနှင့်ဆိုင်သောရပိုင်ခွင့်တစ်ရပ်အနေဖြင့် ရဲထိန်းသိမ်းရေးစခန်းများတွင် ရှိနေသူများသည် လာဘ်ပေးမှုများပြုလုပ်ရန်မလိုအပ်ဘဲ ဆေးဝါးများရရှိနိုင်ရန် မြန်မာနိုင်ငံရဲတပ်ဖွဲ့မှ ဆောင်ရွက်ပေးသင့်သည်။

- (၁၁) အကျဉ်းသားများ၏ ပြန်လည်ထူထောင်ရေးနှင့်ကျန်းမာရေးအား တာဝန်ယူရသော ဝန်ထမ်းများအတွက် အိတ်ချ်အိုင်စီ၊ ဘေးအန္တရာယ်လျှော့ချရေး (Harm Reduction) နှင့် လူ့အခွင့်အရေးစသည်တို့နှင့် ပတ်သက်သော သင်တန်းများ၊ စွမ်းဆောင်ရည်တည်ဆောက်ပေးခြင်းများ ပြုလုပ်သင့်သည်။

၂။ လိင်လုပ်သားများ

နိုင်ငံတော်အစိုးရသည် ၁၉၄၉ ပြည့်တန်ဆာပပျောက်ရေးအက်ဥပဒေ ကိုပြန်လည်သုံးသပ်သင့်သည်။ ပြန်လည် သုံးသပ်ရာတွင် ကျန်းမာရေး၊ ဘေးကင်းလုံခြုံရေးစည်းမျဉ်းစည်းကမ်းများထည့်သွင်းစဉ်းစားထားသော၊ လိင် လုပ်ငန်းကိုပြစ်မှုအဖြစ်မသတ်မှတ်ထားသော စံနမူနာပုံစံများအပါအဝင် အခြားသောဥပဒေနည်းလမ်းများအသုံးပြုခြင်း ကြောင့် ပြည်သူ့ကျန်းမာရေးအကျိုးကျေးဇူးများရရှိနေသည့် အပြည်ပြည်ဆိုင်ရာသက်သေအထောက်အထားများကို ထည့်သွင်းစဉ်းစားသင့်သည်။ လိင်လုပ်သားများအား ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများမှ ပလုပ်ခံထားရခြင်းမျိုး မဖြစ်စေရန် ဥပဒေပြုစံပုံစံများတွင် ပြစ်ဒဏ်ချမှတ်ခြင်း (သို့မဟုတ်) မဖြစ်မနေ သွေးစစ်ခြင်းနှင့် ပြန်လည်ထူထောင်ရေး စခန်းများသို့ပို့ခြင်း စသည့်လုပ်ငန်းများကိုရှောင်ရှားသင့်သည်။ နိုင်ငံတော်အစိုးရအနေဖြင့်အောက်ပါပြင်ဆင်မှုများကို ထည့်သွင်းစဉ်းစားသင့်သည်။

- (၁) အက်ဥပဒေခေါင်းစဉ်ပါ “ပြည့်တန်ဆာပပျောက်ရေး” ဟူသောအသုံးအနှုန်းအား ပြန်လည်ပြင်ဆင်ပြီး ယင်းအစား အကြမ်းဖက်ခံရမှုများမှကာကွယ်ခြင်း၊ ကွန်ဒုံးနှင့် အိတ်ချ်အိုင်စီ၊ လိင်မှတဆင့်ကူးစက်သော ရောဂါများစစ်ဆေးရန်၊ ကုသခံရန်အတွက် အတွင်းရေးလျှို့ဝှက်သောကျန်းမာရေးဝန်ဆောင်မှုများကို အသုံးပြုနိုင်ခြင်း စသည်တို့ပါဝင်သော “လိင်လုပ်သားများ၏အခွင့်အရေးများကိုကာကွယ်စောင့်ရှောက်ရေး” ပေါ်တွင် အလေးပေးလုပ်ဆောင်သင့်သည်။
- (၂) အိတ်ချ်အိုင်စီအပါအဝင် အခြားလိင်မှတဆင့်ကူးစက်တတ်သောရောဂါများ ကူးစက်ခံရခြင်းမှကာကွယ်ရန် ၁၀၀ ရာနှုန်း ကွန်ဒုံးအသုံးပြုခြင်းစီမံချက်အကောင်အထည်ဖော်ရေးအထောက်အကူပြုမှုဘောင် (100% Targeted Condom Programme) ကို အက်ဥပဒေတွင် ထည့်သွင်းသင့်သည်။
- (၃) လိင်လုပ်သားများအကြမ်းဖက်ခံရခြင်းမှကာကွယ်စောင့်ရှောက်ရေး ပြဌာန်းချက်များကိုလည်း အက်ဥပဒေ တွင် ထည့်သွင်းသင့်သည်။
- (၄) ပြည့်တန်ဆာကိစ္စအလို့ငှာမြူဆွယ်သွေးဆောင်ခြင်းအတွက်ပြစ်ဒဏ်ချမှတ်ခြင်း (ပုဒ်မ ၃) ကိုပယ်ဖျက်သင့် သည်။ ပြစ်ဒဏ်ချမှတ်ရမည်ဆိုပါက ဖမ်းဆီးထိန်းသိမ်းခြင်းပြစ်ဒဏ်မျိုးမဟုတ်ဘဲ ငွေဒဏ်သာဖြစ်သင့်သည်။
- (၅) နာမည်ကျော်စောမှုကို ထိခိုက်စေခြင်း (ပုဒ်မ ၇) ကိုလည်းပယ်ဖျက်သင့်သည်။
- (၆) ပြန်လည်ထူထောင်ရေးစခန်းများတွင် လိင်လုပ်သားများအား ထိန်းသိမ်းထားသောအလေ့အကျင့်များကို အဆုံးသတ်သင့်သည်။ ပြန်လည်ထူထောင်ရေးစခန်း (သို့မဟုတ်) အသက်မွေးဝမ်းကျောင်းသင်တန်း များတွင် တက်ရောက်ခြင်းသည် မိမိဆန္ဒအလျောက်သာဖြစ်သင့်သည်။

၁၉၄၉ ပြည့်တန်ဆာပပျောက်ရေးအက်ဥပဒေကိုပြန်လည်မသုံးသပ်မှီ အောက်ပါလုပ်ငန်းများကိုလုပ်ဆောင်သင့်သည်။

ရဲဌာနများအားညွှန်ကြားချက်များ

- (၇) ကွန်ဒုံးအားလိင်လုပ်ငန်းလုပ်ကိုင်ခြင်း၏သက်သေအဖြစ်အသုံးပြုဖမ်းဆီးရန် ညွှန်ကြားထားချက်များ ကို ပြန်လည်ပြင်ဆင်ပြီး ကျယ်ကျယ်ပြန့်ပြန့်ဖြန့်ဝေသင့်သည်။ တရားခွင်တွင် ကွန်ဒုံးအားသက်သေအဖြစ် အသုံးမပြုသင့်သည့်အပြင် လိင်လုပ်သားများကိုဖမ်းဆီးရာတွင် ကွန်ဒုံးများမရှာဖွေရန်၊ လိင်လုပ်သားများအား

အနှောင့်အယှက်မပေးရန်၊ ကွန်ဒိုမင်္ဂလင်တို့ရှိခြင်း (သို့မဟုတ်) အနီးတဝိုက်တွင်တွေ့ရှိခြင်း တစ်ခုတည်းဖြင့် ပြစ်မှုကျူးလွန်သည်ဟုမစွပ်စွဲရန် (သို့မဟုတ်) ဖမ်းဆီးခြင်းမပြုလုပ်ရန် ရဲဝန်ထမ်းများအား ညွှန်ကြားထားသင့်သည်။

- (၈) လိင်လုပ်သားများအား ပြစ်ဒဏ်ချမှတ်ရာတွင် (သို့မဟုတ်) ဖမ်းဆီးရာတွင် (သို့မဟုတ်) အနှောင့်အယှက်ပေးရာတွင် ကွန်ဒိုမင်္ဂလင်အသုံးပြုရန် ညွှန်ကြားထားချက်များအပေါ် ရဲများလိုက်နာစေရန် ကြပ်ကြပ်မတ်မတ် ဆောင်ရွက်သင့်သည်။
- (၉) ခြွင်းချက်ရှိသောအခြေအနေများမှအပ နာမည်ကျော်စောမှုကိုထိခိုက်စေခြင်းနှင့် လူထုငြိမ်ဝပ်ပိပြားရေးကို ထိခိုက်စေခြင်း (ညာအချိန်တွင်ယောင်လည်လည်ဖြင့်မှောင်ရိပ်ခိုခြင်း) ပုဒ်မများကိုအသုံးပြု၍ လိင်လုပ်သားများအားဖမ်းဆီးခြင်းကိုရှောင်ရှားရန် ညွှန်ကြားထားသင့်သည်။ ရဲများအနေဖြင့် လိင်လုပ်သားနှင့် ပျော်ပါးလိုသူများအဖြစ်ဟန်ဆောင်ကာ လိင်လုပ်သားများအားထောင်ချောက်ဆင်ဖမ်းဆီးမှုများကိုလည်း တားမြစ်သင့်သည်။

ရဲဌာနများ၏တာဝန်ဝတ္တရားများ

- (၁၀) ၁၀၀ ရာနှုန်း ကွန်ဒိုမင်္ဂလင်အသုံးပြုရေးလုပ်ငန်းများ အပါအဝင် အိတ်ချ်အိုင်စီ ကာကွယ်တားဆီးရေး လုပ်ငန်းများ ထိရောက်စွာအကောင်အထည်ဖော်နိုင်ရန် ကျန်းမာရေးဝန်ကြီးဌာန၊ ပြည်ထဲရေးဝန်ကြီးဌာနတို့နှင့် ပူးပေါင်းကာ မြန်မာနိုင်ငံရဲတပ်ဖွဲ့အား အားဖြည့်ပေးသင့်သည်။
- (၁၁) ရဲဝန်ထမ်းများအနေဖြင့် ထိန်းသိမ်းထားသောလိင်လုပ်သားတစ်ယောက်ကိုရှာဖွေရာတွင် အေအာရ်တီဆေး (သို့မဟုတ်) OI ဆေးများ တွေ့ရှိပါက ယင်းဆေးများကိုအဆိုပါလိင်လုပ်သားထံသို့ ပြန်လည်ပေးအပ်ပြီး သက်တူရွယ်တူပညာပေးသူ၊ မိသားစုဝင် (သို့မဟုတ်) ဝန်ဆောင်မှုပေးသူများကို အကြောင်းကြားနိုင်ရန် ကူညီကာ ကုသမှုများဆက်လက်ရရှိစေရန် စီစဉ်ပေးသင့်သည်။ အေအာရ်တီဆေးနှင့် OI ဆေးများကို တွေ့မြင်လျှင်သိရှိစေရန်နှင့် ကုသရေး၊ ကာကွယ်တားဆီးရေးတို့ရှိ ယင်းဆေးဝါးများ၏အခန်းကဏ္ဍကို နားလည်သဘောပေါက်စေရန် ရဲဝန်ထမ်းများအားလေ့ကျင့်သင်ကြားပေးသင့်သည်။

အသက်မွေးဝမ်းကျောင်းသင်တန်း

- (၁၂) အမျိုးသမီးများအတွက်အသက်မွေးဝမ်းကျောင်းသင်တန်းများ (VTW) ကိုလည်း အသေးစားစီးပွားရေး လုပ်ငန်းများလုပ်ဆောင်နိုင်ရန် ဆီလျော်မှုရှိသော၊ ဈေးကွက်ဝင်ဆံ့သော ကျွမ်းကျင်မှုများလေ့ကျင့်သင်ကြားပေးသည့် မိမိဆန္ဒအလျောက်တက်ရောက်နိုင်သော သင်တန်းများအဖြစ်ပြန်လည်ပြင်ဆင်သင့်သည်။ အခြားသောအသက်မွေးဝမ်းကျောင်းလုပ်ငန်းများသို့ ပြောင်းရွှေ့လုပ်ကိုင်လိုသော လိင်လုပ်သားများအတွက် အလုပ်အကိုင်အခွင့်အလမ်းများကိုလည်း ဖန်တီးပေးသင့်သည်။

တရားဥပဒေရေးရာအကူအညီ

- (၁၃) အကြမ်းဖက်ခံရခြင်းမှကာကွယ်ပေးသည့် အမှုကိစ္စများနှင့် ရဲ (သို့မဟုတ်) ကျန်းမာရေးဝန်ဆောင်မှုများကို တိုင်ကြားခြင်း စသည့်တို့တွင် လိင်လုပ်သားများကိုယ်စားလိုက်ပါဆောင်ရွက်ပေးသော တရားဥပဒေရေးရာ အကူအညီပေးသည့် ဝန်ဆောင်မှုများ ရှိသင့်သည်။

ကျန်းမာရေးနှင့် အိတ်ချ်အိုင်ဗီဝန်ဆောင်မှုများ

- (၁၄) ကျန်းမာရေးဝန်ဆောင်မှုမူဝါဒပေါ်လစီများသည် လိင်လုပ်သားများအပါအဝင် လူသားတိုင်း၏ ကျန်းမာရေးဆိုင်ရာအခွင့်အရေးများကိုလေးစားမှုရှိသော ခွဲခြားဆက်ဆံမှုမရှိသည့် ဝန်ဆောင်မှုများကို ပံ့ပိုးပေးနေရမည်။ မိခင်ရောဂါဖြစ်ပွားနှုန်းနှင့် သေဆုံးနှုန်းကျဆင်းစေရန် အိတ်ချ်အိုင်ဗီ၊ လိင်မှတစ်ဆင့်ကူးစက်သောရောဂါများ၊ မျိုးဆက်ပွားကျန်းမာရေးနှင့် မိသားစုစီမံကိန်းဝန်ဆောင်မှုများအပါအဝင် ကျန်းမာရေးဝန်ဆောင်မှုများကို လိင်လုပ်သားများပါအသုံးပြုနိုင်ရန် လုပ်ဆောင်သင့်သည်။
- (၁၅) နေရာအတည်တကျမရှိသော လိင်လုပ်သားများအား အနီးဆုံးအေအာရ်တီ (ART) ရရှိနိုင်သောနေရာများသို့ ညွှန်းပို့နိုင်ရန် နှင့် မည်သည့်ဆေးဖြန့်ဝေသည့်နေရာမှမဆို ညွှန်းဆိုထားသည့်ဆေးညွှန်းအတိုင်း ဆေးထုတ်ယူနိုင်ရန် အေအာရ်တီရရှိနိုင်သောစံနှုန်းများ (ART) ကို ဖြေလျှော့ပေးသင့်သည်။

၃။ မူးယစ်ဆေးအကြောတွင်း ထိုးသွင်းသူများ (PWID)

ပြစ်မှုဆိုင်ရာဥပဒေများနှင့်ရဲဝန်ထမ်းများ၏ တလွဲအသုံးချမှုများ

- (၁) ဆေးထိုးအပ်နှင့်ဆေးထိုးပြွန် ပိုင်ဆိုင်မှုကိုပြစ်မှုအဖြစ်သတ်မှတ်ခြင်း (၁၉၁၇ မြန်မာနိုင်ငံငယ်မျိုးအက်ဥပဒေအပိုဒ် ၁၃ နှင့် ၃၃) အားပယ်ဖျက်သင့်သည်။ မူးယစ်ဆေးဝါးအကြောတွင်းထိုးသွင်းသုံးစွဲခြင်းနှင့် ဆက်နွှယ်သော ကျန်းမာရေး၊ စီးပွားရေး၊ လူမှုရေးဘေးအန္တရာယ်များလျော့ချရန် (Harm Reduction) ဟူသောရည်ရွယ်ချက်များဖြင့် ဆေးထိုးအပ်နှင့်ပြွန်များပိုင်ဆိုင်ခြင်း၊ ဖြန့်ချိခြင်းကို ခြွင်းချက်အနေဖြင့်ထားရှိရန် ယစ်မျိုးအက်ဥပဒေကို ပြင်ဆင်သင့်သည်။
- (၂) ဘေးအန္တရာယ်လျော့ချရေးဝန်ဆောင်မှုများအား ထောက်ပံ့ရန် မူးယစ်ဆေးဝါးအလွဲသုံးစားမှု ဗဟိုကော်မတီ (CCDAC)၊ မြန်မာနိုင်ငံရဲတပ်ဖွဲ့၊ ကျန်းမာရေးဝန်ကြီးဌာန၊ အစိုးရမဟုတ်သောအဖွဲ့အစည်းများနှင့် လူထုကွန်ယက်များ မိတ်ဖက်လုပ်ဆောင်ခြင်းကို အသက်ပြန်သွင်းသင့်သည်။ ဆေးထိုးအပ်၊ ဆေးထိုးပြွန် လဲလှယ်ခြင်းလုပ်ငန်းများလုပ်ဆောင်ရန် ရဲဝန်ထမ်းများ၊ အစိုးရမဟုတ်သောအဖွဲ့အစည်းများနှင့် မူးယစ်ဆေးအကြောတွင်း ထိုးသွင်းသုံးစွဲသူလူထုအကြား ဒေသတွင်းကြိုတင်ပြင်ဆင်မှုများလုပ်ဆောင်သင့်သည်။
- (၃) ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်လက်ဝယ်တွေ့ရှိရုံဖြင့် မဖမ်းဆီးရန်ညွှန်ကြားထားသော ရဲဌာနချုပ်၏ညွှန်ကြားချက် (၂၀၁၁) ကို နေရာအဆင့်အားလုံးရှိရဲဝန်ထမ်းများသိရှိရန်နှင့် တိကျစွာလိုက်နာရန် တွန်းအားပေးသင့်သည်။
- (၄) ပြည်ထဲရေးဝန်ကြီးဌာန/ မြန်မာနိုင်ငံရဲတပ်ဖွဲ့အနေဖြင့် ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်များအား သက်သေအဖြစ် အသုံးပြုပြီးတရားစွဲဆိုခြင်း (သို့မဟုတ်) ဖမ်းဆီးနှောင့်ယှက်ခြင်းကိုတားမြစ်ထားသည့် ပြန်လည်ပြင်ဆင်ထားသောလမ်းညွှန်ချက်များ (သို့မဟုတ်) ရဲဝန်ထမ်းညွှန်ကြားချက်များကို ထုတ်ပြန်သင့်သည်။ မူးယစ်ဆေးသုံးစွဲသူများနားခိုရာစင်တာများ (DIC)၊ ယင်းတို့အနီးတဝိုက်နှင့် သန့်ရှင်းသောဆေးထိုးအပ်၊ ဆေးထိုးပြွန်များရရှိနိုင်သော အခြားနေရာများရှိ PWID များအား ဖမ်းဆီးနှောင့်ယှက်ခြင်းမပြုရန် ရဲညွှန်ကြားချက်များတွင် ထည့်သွင်းထားသင့်သည်။ ဥပဒေအရအရေးယူဆောင်ရွက်ခြင်းများမှာ မူးယစ်ဆေးဝါးသုံးစွဲမှုအပေါ်တွင် မဟုတ်ဘဲ ထုတ်လုပ်ခြင်း၊ ရောင်းချခြင်းနှင့် ဖြန့်ဖြူးခြင်းတို့အပေါ်တွင် အာရုံစိုက်သင့်သည်။
- (၅) မူးယစ်ဆေးအစားထိုး မက်သာဒုံးတိုက်ကျွေးခြင်း (MMT)၊ ဆေးထိုးအပ်/ပြွန်လဲလှယ်ပေးခြင်းလုပ်ငန်းများ၊ သက်တူရွယ်တူပညာပေးခြင်းနှင့် လိုအပ်နေသူများထံသွားရောက်အကူအညီပေးခြင်း စသည်တို့ပါဝင်သော

ဘေးအန္တရာယ်လျော့ချခြင်းဆိုင်ရာ သီးခြားလုပ်ငန်းများပါဝင်ရန် မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေသော ဆေးဝါးများဆိုင်ရာဥပဒေကိုပြင်ဆင်သင့်သည်။

- (၆) ဘေးအန္တရာယ်လျော့ချခြင်းသည် ရဲသင်ရိုးညွှန်းတမ်း၏ စံအစိတ်အပိုင်းတစ်ခုဖြစ်သင့်သည်။ သန့်ရှင်းသော ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်များပေးခြင်း၊ သက်တူရွယ်တူပညာပေးခြင်း၊ မူးယစ်ဆေးအစားထိုးမက်သာခုံး တိုက်ကျွေးခြင်း (MMT) လုပ်ငန်းများလုပ်ဆောင်ခြင်းနှင့်စပ်လျဉ်း၍ ပြည်သူ့ကျန်းမာရေးဆိုင်ရာ အကြောင်း ပြချက်များကို ရဲများအားသင်ကြားပေးရာ၌ထည့်သွင်းသွားရန် အသိအမြင်ဖွင့်တိုက်တွန်းနှိုးဆော် သင့်သည်။

မူးယစ်ဆေးသုံးစွဲသူများကို မှတ်တမ်းသွင်းခြင်း

- (၇) မူးယစ်ဆေးသုံးစွဲသူများကို မဖြစ်မနေမှတ်ပုံတင်ရသည့်စနစ်ကို ပယ်ဖျက်သင့်သည်။ အဘယ်ကြောင့် ဆိုသော် ထိုသို့ပြုလုပ်ခြင်းမှာ ခွဲခြားသတ်မှတ်ရာရောက်ခြင်း၊ PWID များအား ဝန်ဆောင်မှုများ၏ အဝေးသို့ တွန်းပို့ရာရောက်ခြင်း၊ မူးယစ်ဆေးပြန်လည်သုံးစွဲခြင်းကို ထိရောက်စွာမဖြေရှင်းနိုင်ခြင်း တို့ကြောင့် ဖြစ်သည်။ ယင်းအစား မိမိဆန္ဒအလျောက်ရွေးချယ်နိုင်သော လူထုအခြေပြုကုသမှုနည်းလမ်းများဖြင့် ပံ့ပိုးပေးသင့်သည်။
- (၈) မူးယစ်ဆေးသုံးစွဲသူများအားမှတ်ပုံတင်သည့်စနစ်ကို ဆက်လက်လုပ်ဆောင်နေစဉ်ကာလအတွင်း ဆေးကုသ မှုခံယူနေသော မှတ်ပုံတင်ပြီးသားဆေးသုံးစွဲသူများ မူးယစ်ဆေးပြန်လည်သုံးစွဲပါက ဥပဒေအရ သက်ညှာစွာ စဉ်းစားပေးသင့်သည်။ ရဲဝန်ထမ်းများအနေဖြင့်လည်း မူးယစ်ဆေးသုံးစွဲခြင်းနှင့်ပတ်သက်ပြီး တိုင်ပင် ဆွေးနွေးခြင်းနှင့် ကုသမှုခံယူခြင်း၊ မိမိဆန္ဒအလျောက် လျှို့ဝှက်စွာ နှစ်သိမ့်ဆွေးနွေးအတိုင်ပင်ခံပြီး သွေးစစ်ခြင်း (VCCT) နှင့် အိတ်ချ်အိုင်စီကာကွယ်ရေးသတင်းအချက်အလက်များအတွက် ဆေးသုံးစွဲသူများ ပိုမိုရှေ့ထွက်ရဲလာစေရန် ကျန်းမာရေးရှုထောင့်မှနေ၍ အားပေးသင့်သည်။ မှတ်ပုံတင်ထားသော ဆေးသုံးစွဲသူများ ဆေးပြန်လည်သုံးစွဲခြင်းကို ပြစ်မှုတစ်ရပ်အဖြစ်အရေးမယူရန် ရဲညွှန်ကြားချက်များတွင် ဖော်ပြထားသင့်သည်။
- (၉) မှတ်ပုံတင်သည့်စနစ်ဆက်လက်ရှိနေမည်ဆိုပါက ဆေးကုသမှုခံရန်မှတ်ပုံတင်ခြင်းကို ကျန်းမာရေးဝန်ကြီး ဌာန လက်အောက်တွင်သာထားရှိသင့်သည်။ ကိုယ်ရေးအချက်အလက်များကို လျှို့ဝှက်ထိန်းသိမ်းထားပြီး ယင်းတို့ကို ရဲများမှစောင့်ကြပ်ကြည့်ရှုရန်နှင့် ဖမ်းဆီးအရေးယူရန်အတွက်မဟုတ်ဘဲ ဆေးကုသရန် အတွက်သာ သုံးရမည်။ ယင်းက ကုသမှုခံယူခြင်း၊ VCCT၊ အိတ်ချ်အိုင်စီကာကွယ်ရေးပညာပေးခြင်းနှင့် ဝန်ဆောင်မှုများရရှိရေးအတွက် ဆေးသုံးစွဲသူများ စောလျင်စွာမှတ်ပုံတင်ရန် အားပေးရာရောက်မည်။

အကျဉ်းထောင်များနှင့် ထိန်းသိမ်းရေးစခန်းများ

- (၁၀) အကျဉ်းထောင် MMT လုပ်ငန်းများကိုလည်း လုပ်ဆောင်သင့်သည်။ ရဲဌာနထိန်းသိမ်းရေးစခန်း (သို့မဟုတ်) အကျဉ်းထောင်များတွင် မက်သာခုံးစဉ်ဆက်မပြတ်ရရှိနေစေရန် လုပ်ထုံးလုပ်နည်းများတွင်ထည့်သွင်းထား သင့်သည်။
- (၁၁) မူးယစ်ဆေးသုံးစွဲခြင်း (သို့မဟုတ်) လက်ဝယ်တွေ့ရှိခြင်းကြောင့် ပြစ်ဒဏ်ကျခံနေရသူများအတွက် ကုသရေး နှင့် ပြန်လည်ထူထောင်ရေးဝန်ဆောင်မှုများပေးသင့်သည်။ သို့မှသာ ဆေးသုံးစွဲသူများအား ထောင်စနစ်မှ လမ်းလွှဲပေးနိုင်မည်။
- (၁၂) ပြန်လည်ထူထောင်ရေးစခန်းများသို့ သွားခြင်း၊ မသွားခြင်းနှင့် ပတ်သက်၍လည်း မူးယစ်ဆေးသုံးစွဲသူများ မိမိဆန္ဒအလျောက် ရွေးချယ်နိုင်ရမည်။ အဆိုပါစခန်းများ၏ဝန်ဆောင်မှုများတွင် ရုပ်ပိုင်းဆိုင်ရာ၊ လူမှုစိတ်ပိုင်း ဆိုင်ရာ၊ အသက်မွေးဝမ်းကျောင်းဆိုင်ရာ ပြန်လည်ထူထောင်ရေးတို့အပြင် နှစ်သိမ့်ဆွေးနွေး အတိုင်ပင်ခံခြင်း

နှင့် ဆေးကုသမှုခံယူရန်အတွက် သက်သေသာကေအခြေပြုထိရောက်သည့် ဝန်ဆောင်မှုများ ပေါင်းစပ်ပါဝင်သင့်သည်။

ကျန်းမာရေးဝန်ဆောင်မှုများ

- (၁၃) လူထုအခြေပြု မိမိဆန္ဒအလျောက်ဆေးကုသမှုခံယူသည့် ဝန်ဆောင်မှုများကို ပိုမိုချဲ့ထွင်သင့်သည်။ အမျိုးသားအဆင့် မူးယစ်ဆေးအစားထိုး မက်သာဒုံးတိုက်ကျွေးခြင်း (MMT) လမ်းညွှန်ချက်ကို ပြည့်ပြည့်ဝဝ အကောင်အထည်ဖော်သင့်သည်။ MMT ကိုလက်လှမ်းမှီနိုင်ရေးနှင့် ဆေးကုသမှုခံယူရေးအတွက် လိုအပ်သော အရည်အသွေးမြင့်နှစ်သိမ့်ဆွေးနွေးအတိုင်ပင်ခံခြင်းဝန်ဆောင်မှုများကို ချဲ့ထွင်သင့်သည်။
- (၁၄) မူးယစ်ဆေးအသုံးပြုသူအဖြစ်မှတ်ပုံတင်မထားခြင်း (သို့မဟုတ်) MMT ကုသမှုမစတင်ရသေးခြင်း စသော အကြောင်းပြချက်များဖြင့် PWID များအား အေအာရ်တီကုသမှုပေးရန် ငြင်းဆိုခြင်းမပြုလုပ်သင့်ပါ။
- (၁၅) မူးယစ်ဆေးသုံးစွဲခြင်းကို ပြစ်မှုအဖြစ်သတ်မှတ်ခြင်းမပယ်ဖျက်သင့်ပြီး ဘေးအန္တရာယ်လျော့ချခြင်းကို အားပေးသော၊ ဆေးစွဲနေခြင်းကို ကျန်းမာရေးအခြေအနေတစ်ရပ်အနေဖြင့်ကုသပေးသော မူးယစ်ဆေးသုံးစွဲခြင်းဆိုင်ရာ ဥပဒေသစ်နှင့် အမျိုးသားအဆင့်မူဝါဒများအား ဖော်ထုတ်သင့်သည်။
- (၁၆) ဆေးဖြတ်ခြင်းကြောင့်ဖြစ်ပေါ်လာသော နာကျင်မှုများကို ထိရောက်စွာကုသနိုင်မည့် ဆေးဝါးများအား လက်လှမ်းမှီရန် ၁၉၉၂ အမျိုးသားဆေးဝါးဥပဒေနှင့် မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေသောဆေးဝါးများ ဆိုင်ရာဥပဒေပါ လုပ်ထုံးလုပ်နည်းများနှင့် သွင်းကုန်ကန့်သတ်ချက်များကို အရေးပေါ်ပြင်ဆင်သင့်သည်။

၄။ အမျိုးသားချင်းလိင်တူဆက်ဆံသူများ (MSM) နှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူနေထိုင်သူများ (TG)

ပြစ်မှုဆိုင်ရာကျူးလွန်မှုများနှင့်ရဲဝန်ထမ်းများ၏ တလွဲအသုံးချမှုများ

- (၁) ပြစ်မှုဆိုင်ရာဥပဒေ ပုဒ်မ ၃၇၇ သည် ကိုယ်ရေးကိုယ်တာလွတ်လပ်မှုနှင့် ညီတူညီမျှရှိမှုစသော လူ့အခွင့်အရေးများကို ချိုးဖောက်နေခြင်း၊ အမျိုးသားချင်းလိင်တူဆက်ဆံသူများ (MSM) နှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ ပြောင်းလဲခံယူနေထိုင်သူများ (TG) ကို ခွဲခြားနှိမ်ချဆက်ဆံသည့်သဘော ပိုမိုသက်ရောက်နေခြင်း၊ ရဲဝန်ထမ်းများ၏ တလွဲအသုံးချမှုများကိုလည်း အားပေးရာရောက်နေခြင်းနှင့် အိတ်ချ်အိုင်စီ ကာကွယ်တားဆီးရေး၊ ကုသရေး ကြိုးပမ်းမှုများကိုနှောင့်နှေးကြန့်ကြာစေခြင်း စသည်တို့ကြောင့် ရုတ်သိမ်းခြင်း (သို့မဟုတ်) ပြောင်းလဲပြင်ဆင်ခြင်းပြုလုပ်သင့်သည်။ ပုဒ်မ ၃၇၇ ကို အရွယ်ရောက်ပြီးသူများအကြား ဆိတ်ကွယ်ရာတွင် သဘောတူညီမှု ရယူပြီးလိင်ဆက်ဆံခြင်းမျိုးအတွက် အသုံးမပြုသင့်ပေ။
- (၂) အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေးလုပ်ငန်းများကို အဟန့်အတားဖြစ်စေနိုင်သောဥပဒေအရအရေးယူဆောင်ရွက်ခြင်းများ၏ အန္တရာယ်ဖြစ်စေနိုင်သည့် သက်ရောက်မှုများနှင့်စပ်လျဉ်း၍ ရဲဝန်ထမ်းများအား လေ့ကျင့်သင်ကြားပေးသင့်သည်။ ရဲဝန်ထမ်းများအနေဖြင့် MSM များ၊ TG များအားစစ်ဆေးစဉ် (သို့မဟုတ်) ဖမ်းဆီးစဉ်တွင် ကွန်ဒုံးလက်ဝယ်ထားရှိခြင်းအတွက် အနှောင့်အယှက်ပေးမည့်အစား ကွန်ဒုံးအသုံးပြုခြင်းကို အားပေးသောကျန်းမာရေးမြှင့်တင်သည့်လုပ်ငန်းများကို ပံ့ပိုး သင့်သည်။
- (၃) MSM များနှင့် TGများကို အမှန်တကယ်ပြစ်မှုကျူးလွန်ခြင်းမရှိဘဲ (ဥပမာ ညအချိန်တွင်ယောင်လည်လည်ဖြင့် မှောင်ရိပ်ခိုခြင်းကြောင့်) လူထုငြိမ်ဝပ်ပိပြားရေးကို ထိခိုက်စေသည်ဟူ၍ အရေးယူဖမ်းဆီးခြင်းမျိုးမပြုလုပ်ရန် ရဲညွှန်ကြားချက်များတွင် ညွှန်ကြားထားသင့်သည်။

အကာအကွယ်ပေးနိုင်သည့်ဥပဒေများနှင့် မူဝါဒပေါ်လစီများ

- (၄) ကျန်းမာရေးစောင့်ရှောက်မှု၊ ပညာသင်ကြားရေး၊ အလုပ်အကိုင်စသည့် ကဏ္ဍများတွင် MSM များနှင့် TG များအား ခွဲခြားနှိမ်ချဆက်ဆံခြင်းကို ဥပဒေများနှင့်မူဝါဒပေါ်လစီများဖြင့်တားမြစ်သင့်သည်။ ထိုလုပ်ရပ်များ ကျူးလွန်သူများကိုလည်း စည်းကမ်းတကျအရေးယူ အပြစ်ပေးသင့်သည်။
- (၅) TG များကို မှတ်ပုံတင်နှင့်မှတ်တမ်းစာရွက်စာတမ်းများတွင် ကျား၊ မ ဟူ၍ တရားဝင်ပြောင်းလဲရန် ဥပဒေကခွင့်ပြုသင့်သည်။ ရွေးချယ်နိုင်သောနည်းလမ်းတစ်ခုမှာ အဆိုပါလိင် ပြောင်းလဲထားသူများအတွက် တရားဝင်စာရွက်စာတမ်းများတွင် “တတိယလိင်” အုပ်စုအမျိုးအစား သတ်မှတ်၍ အခြားသော နိုင်ငံသားများနှင့်တန်းတူညီမျှ အခွင့်အရေးခံစားခွင့်ပေးနိုင်သည်။

စွမ်းဆောင်ရည်တည်ဆောက်ခြင်းနှင့် အမျိုးသားအဆင့်မဟာဗျူဟာစီမံကိန်း ၂ တွင်ပါဝင်ခြင်း

- (၆) အမျိုးသားအဆင့်မဟာဗျူဟာစီမံကိန်း ၂ တွင် MSM များနှင့် TG များ၏ လိင်စိတ်ခံယူမှုဝိသေသလက္ခဏာ (sexual orientation rights) နှင့် လိင်ဝိသေသခံယူမှု (gender identity rights) တို့နှင့်ပတ်သက်သော အခွင့်အရေးများကို အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေး၏ ထိရောက်သော အခြေခံစည်းမျဉ်း တစ်ခုအဖြစ် အသိအမှတ်ပြုသင့်သည်။
- (၇) လုပ်ငန်းဆောင်ရွက်ချက်များကို MSM များနှင့် TG များ၏ သီးခြား လိုအပ်ချက်များနှင့်ကိုက်ညီစေရန် အမျိုးသားအဆင့်ကျန်းမာရေးဆိုင်ရာ ပူးပေါင်းဆောင်ရွက်ခြင်းနှင့် ဆုံးဖြတ်ချက်ချသည့်နေရာများတွင် ၎င်းတို့အားကိုယ်စားပြုပါဝင်စေခြင်းဖြင့် ၎င်းတို့၏အသံကို နားထောင် သင့်သည်။
- (၈) အမျိုးသားအဆင့်မဟာဗျူဟာစီမံကိန်း ၂ တွင် MSM များနှင့် TG များ၏ လိုအပ်ချက်များကို ပြည့်စုံလုံလောက်သည့်တုံ့ပြန်မှုများ (ကျန်းမာရေးဝန်ဆောင်မှုများပေးရာတွင် ခွဲခြားနှိမ်ချ ဆက်ဆံခြင်းကို တိုက်ဖျက်သည့်လုပ်ငန်းများ၊ VCCT နှင့် လိင်ကျန်းမာရေးဝန်ဆောင်မှုများကို ပိုမို လက်လှမ်းမီရန် ကျန်းမာရေးဝန်ထမ်းများအား အမြင်ဖွင့်ပေးခြင်း၊ သင်တန်းများပေးခြင်း) ဖြင့် ပံ့ပိုးအားပေး သင့်သည်။ ကျန်းမာရေးလုပ်သားများအနေဖြင့် MSM များနှင့် TG များ၏ လိုအပ်ချက်များ၊ လူ့အခွင့်အရေးများနှင့် အကျွမ်းတဝင်ရှိသင့်သည်။

၅။ အမျိုးသမီးများနှင့် မိန်းကလေးများ

- (၁) အကြမ်းဖက်မှုကာကွယ်တားဆီးရေးဥပဒေနှင့်မူဝါဒများအနေဖြင့် အိမ်တွင်းနှင့်နေအိမ်ပြင်ပ (ဥပမာ လိင်လုပ်သားများ) အကြမ်းဖက်ခံရခြင်းများမှ အမျိုးသမီးနှင့်မိန်းကလေးများ ကာကွယ်စောင့်ရှောက်မှုရရှိရန် ၎င်းတို့၏လိုအပ်ချက်များကို ဦးတည်သင့်သည်။ အိမ်ထောင်ဖက်မှ မုဒိန်းကျင့်ခြင်းကိုလည်း ပြစ်မှုအဖြစ် သတ်မှတ်သင့်သည်။
- (၂) ကျန်းမာရေးနှင့် အိတ်ချ်အိုင်စီဝန်ဆောင်မှုများပေးရာတွင် အမျိုးသားဖြစ်ခြင်း (သို့မဟုတ်) အမျိုးသမီးဖြစ်ခြင်း ကြောင့် ခွဲခြားနှိမ်ချဆက်ဆံခြင်းကို ဥပဒေများ၊ မူဝါဒပေါ်လစီများမှ ဟန့်တားပေးသင့်သည်။
- (၃) အိတ်ချ်အိုင်စီပိုးရှိသောအမျိုးသမီးများ PMCT (မိခင်မှသန္ဓေသားသို့ အိတ်ချ်အိုင်စီပိုးကူးစက်ခြင်းကို ကာကွယ်တားဆီးရေး)၊ မိသားစုစီမံကိန်း၊ မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများအားအသုံးပြုခွင့် အပါအဝင် ကျားမလူမှုရေးရာအသိအမြင်ရှိသောအိတ်ချ်အိုင်စီဝန်ဆောင်မှုများဖြစ်နေစေရန် မူဝါဒများချမှတ် သင့်သည်။ အမျိုးသမီးနှင့်မိန်းကလေးများအနေဖြင့် တစ်စုံတစ်ဦး၏ဖိအားပေးတိုက်တွန်းခြင်းမခံရဘဲ

မိသားစုစီမံကိန်း၊ မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာရွေးချယ်မှုများကို ကိုယ်တိုင်ဆုံးဖြတ်ပိုင်ခွင့်ရှိသင့်သည်။ ကျန်းမာရေးလုပ်သားများအနေဖြင့်လည်း အိတ်ချ်အိုင်စီပိုးရှိနေသော အမျိုးသမီးများနှင့်မိန်းကလေးများ၏ မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာအခွင့်အရေးများနှင့်ပတ်သက်၍ သင်တန်းများရရှိထားသင့်သည်။

- (၄) မုဆိုးမများကိုလည်း အမွေဆက်ခံခြင်းဆိုင်ရာ တရားဝင်အခွင့်အရေးများ၊ တရားဥပဒေရေးရာ အကူအညီများနှင့်ပတ်သက်သော သတင်းအချက်အလက်များအား လက်လှမ်းမှီစေရန် ဆောင်ရွက်ပေးထား သင့်သည်။ သို့မှသာ အမွေဆက်ခံခြင်းဆိုင်ရာ အခွင့်အရေးများကို အားဖြည့်ပေးရာရောက်မည်။
- (၅) လူမှုရေးအရကာကွယ်စောင့်ရှောက်ရေးမူဝါဒပေါ်လစီများသည် အိတ်ချ်အိုင်စီပိုးရှိနေသော/ အိတ်ချ်အိုင်စီပိုး ကြောင့် ထိခိုက်ခံစားနေရသော အမျိုးသမီးများနှင့်မိန်းကလေးများ၊ အမျိုးသမီးလိင်လုပ်သားများ၊ မူးယစ်ဆေး သုံးစွဲသောအမျိုးသမီးများ (သို့မဟုတ်) အကျဉ်းထောင်များ၊ ထိန်းသိမ်းရေးစခန်းများရှိ အမျိုးသမီးများ၏ သီးခြားလိုအပ်ချက်များကို ဦးတည်သင့်သည်။

၆။ ကလေးသူငယ်နှင့် လူရွယ်များ

- (၁) ၁၉၉၃ ကလေးသူငယ်ဥပဒေကို ကလေးသူငယ်အခွင့်အရေးများဆိုင်ရာကွန်ဗင်းရှင်းနှင့်အညီ ဖြည့်စွက် ပြင်ဆင်ပြီး မိဘမဲ့နှင့် ထိခိုက်လွယ်ကလေးသူငယ်များ (OVC) အနေဖြင့် ကာကွယ်စောင့်ရှောက်မှု၊ အုပ်ထိန်းမှု၊ ပြုစုစောင့်ရှောက်မှုနှင့်ပံ့ပိုးမှုများရရှိစေရန် ဥပဒေကိုအားဖြည့်သင့်သည်။ မိဘမဲ့များ၊ လမ်းပေါ်မှ ကလေးများနှင့် အခြားထိခိုက်လွယ်ကလေးသူငယ်များကို သင့်လျော်သောပတ်ဝန်းကျင် (လူထု အခြေပြု သို့မဟုတ် အဖွဲ့အစည်းအခြေပြု) ဖြင့် နိုင်ငံတော်မှစောင့်ရှောက်ပေးပြီး ကလေးများ၏ကိုယ်စွမ်းရှိသရွေ့ ပညာသင်ကြားပေးသင့်သည်။ မိဘမဲ့ကလေးများအပါအဝင် အိတ်ချ်အိုင်စီပိုးရှိသောကလေးများနှင့် အိတ်ချ်အိုင်စီပိုးကြောင့်ထိခိုက်ခံစားနေရသောအိမ်ထောင်စုများရှိကလေးများအနေဖြင့် ကျန်းမာရေး၊ ပညာရေး၊ နားခိုစရာအပါအဝင် ကာကွယ်စောင့်ရှောက်ရေးနှင့်ပြုစုရေး စသည့်ဝန်ဆောင်မှုများကို လက်လှမ်းမှီ အသုံးပြုနိုင်ရန် သက်ဆိုင်ရာလုပ်ထုံးလုပ်နည်းများနှင့်ပတ်သက်ပြီး စည်းမျဉ်းစည်းကမ်းများ၊ လမ်းညွှန်များ ချမှတ်သင့်သည်။
- (၂) ကလေးသူငယ်များကို မိမိတို့၏အခွင့်အရေးများနှင့်ပတ်သက်ပြီး ပညာသင်ကြားပေးရမည်။ သို့မှသာ ကျန်းမာရေးဆိုင်ရာအခွင့်အရေးများအပါအဝင် မိမိတို့၏အခွင့်အရေးများအပြည့်အဝရရှိရန် တောင်းဆိုတတ် လာမည်။ မူဝါဒချမှတ်သည့်ဖြစ်စဉ်များတွင်လည်း ကလေးသူငယ်နှင့်လူငယ်များ၏အသံကို နားထောင်သင့် သည်။
- (၃) အိတ်ချ်အိုင်စီပိုးကြောင့် ထိခိုက်ခံစားနေရသောအိမ်ထောင်စုများရှိကလေးများအပါအဝင် OVC ကလေးများ အားလုံး မွေးစာရင်း၊ အိမ်ထောင်စုစာရင်းနှင့်နိုင်ငံသားစိစစ်ရေးကဒ်များ ရရှိရန်ထောက်ကူပေးသော စနစ်များ ပုံမှန်လည်ပတ်နေရန် နိုင်ငံတော်မှလုပ်ဆောင်သင့်သည်။
- (၄) အသက်(၁၂)နှစ်နှင့်အထက်ရှိသောလူငယ်လူရွယ်များအား ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူမှ လုံလောက် သောရင့်ကျက်မှုရှိသည်ဟု အကဲဖြတ်လျှင် မိဘသဘောတူခွင့်ပြုချက်ယူစရာမလိုဘဲ အိတ်ချ်အိုင်စီပိုးနှင့် လိင်မှ တဆင့်ကူးစက်တတ်သောရောဂါများစစ်ဆေးခြင်း အပါအဝင် လိင်နှင့်မျိုးဆက်ပွားကျန်းမာရေး ဝန်ဆောင်မှု ပေးနိုင်ကြောင်း အတည်ပြုသည့်လမ်းညွှန်ချက်ကို ကျန်းမာရေးဝန်ကြီးဌာနမှ ထုတ်ပြန်သင့်သည်။

- (၅) အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေး၊ ပြုစုစောင့်ရှောက်ရေးနှင့် ပံ့ပိုးကူညီရေးဆိုင်ရာ မူဝါဒများတွင် ငယ်ရွယ်သော MSMများနှင့် TGများ၊ လိင်လုပ်သားအမျိုးသမီးငယ်များ၊ မူးယစ် ဆေးစွဲနေသောလူငယ်များ၊ ဒေသတစ်ခုနှင့်တစ်ခုကြားပြောင်းရွှေ့နေသော၊ နိုင်ငံရပ်ခြားသို့ရွှေ့ပြောင်းသွားလာ လုပ်ကိုင်လျက်ရှိသော လူငယ်များစသူတို့အပါအဝင် အဓိကထိခိုက်ခံစားနေရသောလူငယ်များအတွက် သီးခြားလုပ်ငန်းများ ပါဝင် သင့်သည်။
- (၆) ပညာရေးဝန်ကြီးဌာနအနေဖြင့် အစိုးရကျောင်းများ (သို့မဟုတ်) ပုဂ္ဂလိကကျောင်းများတွင် အိတ်ချ်အိုင်စီပိုး ရှိနေသောကလေးများအား ခွဲခြားဆက်ဆံမှုကို ဟန့်တားပေးနိုင်သောမူဝါဒများ ချမှတ်ပေးသင့်ပါသည်။
- (၇) ကျန်းမာရေးဝန်ကြီးဌာနအနေဖြင့် အေအာရ်တီ(ART)ရယူရန်စံနှုန်းများကို ပြန်လည်ပြင်ဆင်ပြီး အိတ်ချ်အိုင်စီ ရောဂါပိုးရှိသောကလေးတစ်ယောက် ကုသမှုအတိုင်းလိုက်နာရန် ရောဂါပိုးမရှိသော အရွယ်ရောက်သူတစ်ဦး မှပံ့ပိုးပေးရမည်ဟူသောလိုအပ်ချက်ကိုပယ်ဖျက်သင့်သည်။ အဆိုပါပံ့ပိုးမှုကို ရောဂါပိုးရှိသောမိဘမှ ပေးလျှင်လည်း လုံလောက်ပါသည်။ ဆေးကုသရာတွင် ထိရောက်မှုရှိပြီး အကျိုးများရန်၊ မလိုလားအပ်သော ဘေးထွက်ဆိုးကျိုးများကိုကာကွယ်ရန် ကလေးဆေးညွှန်းအေအာရ်တီဆေးကို စဉ်ဆက်မပြတ်ရရှိနိုင်အောင် ကျန်းမာရေးဝန်ကြီးဌာနမူဝါဒများက အာမခံချက်ပေးသင့်ပါသည်။

၇။ မူပိုင်ခွင့်ဥပဒေနှင့် ဆေးဝါးများလက်လှမ်းမီမှု

မြန်မာနိုင်ငံတော်အစိုးရအနေဖြင့်

- (၁) မဖြစ်မနေလိုင်စင်ပြုလုပ်ခြင်း၊ စင်ပြိုင်ပို့ကုန်တင်သွင်းခြင်းတို့ အပါအဝင် ကုန်သွယ်ခြင်းဆိုင်ရာ ဉာဏပစ္စည်း မူပိုင်ခွင့်ဥပဒေ (TRIPS) ၏ ဖြေလျှော့မှုများကို မူပိုင်ခွင့်ဥပဒေသစ်တွင် ပြည့်ပြည့်ဝဝ ဦးတည်ကိုင်တွယ် သင့်သည်။ သို့မှသာ မြန်မာနိုင်ငံတွင် ဆေးဝါးမူပိုင်ခွင့်များကို စတင်အသိအမှတ်ပြုရာ၌ ဆေးဝါးများကို အခက်အခဲမရှိဘဲ ရရှိသုံးစွဲနိုင်မည်ဖြစ်သည်။
- (၂) မြန်မာနိုင်ငံအနေဖြင့် ၂၀၂၁ခုနှစ် ဇူလိုင်လ ၁ ရက်နေ့မတိုင်မီအချိန်အထိ ဖွံ့ဖြိုးမှုအနိမ့်ဆုံးနိုင်ငံများစာရင်းမှ ပယ်ဖျက်မခံရသေးပါက ဆေးဝါးထုတ်ကုန်များအား မူပိုင်ခွင့်စောင့်ရှောက်မှုချန်လှပ်ထားမည့် အချိန်ကာလ ကို ထိုနေ့ (၂၀၂၁ ဇူလိုင်လ ၁ ရက်) အထိ တိုးမြှင့်ရန်စဉ်းစားထားသင့်သည်။
- (၃) အမှတ်တံဆိပ်မပါဘဲဈေးနှုန်းသက်သာစွာထုတ်လုပ်သောဆေးဝါးများ နောင်အခါတွင်ရယူအသုံးပြုနိုင်မှုကို အကန့်အသတ်ဖြစ်စေနိုင်မည့် “TRIPS-plus” လိုအပ်ချက်များပြဌာန်းထားသော ကုန်သွယ်မှု (သို့မဟုတ်) ရင်းနှီးမြှုပ်နှံမှု သဘောတူညီချက်များကိုလည်း မချုပ်ဆိုသင့်ပေ။

၈။ ကဏ္ဍအားလုံးနှင့်သက်ဆိုင်နေသော ဦးစားပေးများ

- (၁) လူ့အခွင့်အရေးအခြေပြု အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများကို အထောက်အပံ့ဖြစ်စေအံ့သောငှါ ရှေ့နေများ၊ ရဲများ၊ တရားသူကြီးများ၊ ကျန်းမာရေးလုပ်သားများနှင့် ပါလီမန်အမတ်များ၏အခန်းကဏ္ဍကို အားကောင်းစေရန် စွမ်းဆောင်ရည်တည်ဆောက်ခြင်းလုပ်ငန်းများလိုအပ်ပါသည်။ ၎င်းတို့တစ်ဦးတစ်ယောက်ချင်းစီအနေဖြင့် အိတ်ချ်အိုင်စီပိုးရှိသူများနှင့် အဓိကဦးတည်အုပ်စုများအတွက် အကာအကွယ်ပေးနိုင်မည့် ဥပဒေရေးရာ မူဘောင်များ ပေါ်ထွက်လာစေရေးအတွက် ပြည်သူ့ကျန်းမာရေးနှင့် လူ့အခွင့်အရေးဆိုင်ရာ သဘောတရား များကို နားလည်သဘောပေါက်ရန်လိုအပ်သည်။ ရဲဝန်ထမ်းများ၏အနိုင်ကျင့်သောအပြုအမူများကို

ဖြေရှင်းနိုင်ရန်၊ အဓိကဦးတည်အုပ်စုများ၏ ရပိုင်ခွင့်များကို ရဲများမှကာကွယ်ပေးရန်နှင့်အားပေးမြှင့်တင်ရန် ရဲဝန်ထမ်းများအား အိတ်ချ်အိုင်စီနှင့် လူ့အခွင့်အရေးဆိုင်ရာသင်တန်းများပေးရမည်။

- (၂) နိုင်ငံတော်အစိုးရနှင့်အလှူရှင်များအနေဖြင့် လူထုအခြေပြုဥပဒေရေးရာစွမ်းဆောင်ရည်မြှင့်တင်ခြင်း နှင့် တရားမျှတမှုကိုလက်လှမ်းမှီအောင်ဆောင်ရွက်ပေးသော လုပ်ငန်းများကို ပံ့ပိုးပေးသင့်သည်။ ယင်းတို့တွင် အခမဲ့ဥပဒေသတင်းအချက်အလက်များ၊ ဥပဒေရေးရာအကြံဉာဏ်နှင့် ကိုယ်စားပြုပေးခြင်းများ၊ ဥပဒေ အထောက်အကူဝန်ဆောင်မှုများ၊ ဥပဒေနှင့်လူ့အခွင့်အရေးဆိုင်ရာအသိပညာများ၊ ဥပဒေအကြံပြုချက်များ အတွက် အချိန်မရွေးခေါ်ဆိုနိုင်သော တယ်လီဖုန်းများ၊ အကြမ်းဖက်မှုများနှင့်အခြားသော ပြင်းထန်သည့် အခွင့်အရေးချိုးဖောက်မှုများကို လျင်မြန်စွာတုံ့ပြန်ဆောင်ရွက်ပေးနိုင်သည့်အဖွဲ့များ စသည်တို့ကို အဓိက ဦးတည်အုပ်စုများအနေဖြင့် ကျယ်ကျယ်ပြန့်ပြန့်အသုံးပြုနိုင်ရန် ပံ့ပိုးပေးခြင်းများပါဝင်သည်။ အဓိက ဦးတည်အုပ်စုများကိုလည်း ၎င်းတို့၏အခွင့်အရေးများနှင့်တာဝန်ဝတ္တရားများအား သိရှိရန်အမြင်ဖွင့်ပေး ရမည် ဖြစ်ပြီး အကယ်၍အခွင့်အရေးချိုးဖောက်ခံရပါက တရားမျှတမှုကိုတောင်းဆိုတတ်ရန် စွမ်းဆောင်ရည် မြှင့်တင်ပေးရမည်။
- (၃) အဓိက ဦးတည်အုပ်စုများအနေဖြင့်လည်း ရဲများ၊ ထောင်မှူးများ (သို့မဟုတ်) အခြားသော တရားဥပဒေ ဆိုင်ရာဝန်ထမ်းများမှ နှောင့်ယှက်ခြင်း၊ ခြိမ်းခြောက်ငွေညှစ်ခြင်း၊ မမျှမတဆက်ဆံခြင်း (သို့မဟုတ်) အကြမ်းဖက်ခြင်းများပြုလုပ်လာပါက လွတ်လွတ်လပ်လပ်လျှို့ဝှက်တိုင်ကြားနိုင်သော နည်းလမ်းများကို အသုံးပြုနိုင်ရမည်။
- (၄) အိတ်ချ်အိုင်စီနှင့်ဆက်နွှယ်နေသော တိုင်ကြားမှုများကိုဖြေရှင်းနိုင်ရန် အမျိုးသားအဆင့်လူ့အခွင့်အရေး ကော်မရှင်၏စွမ်းဆောင်ရည်ကိုလည်း အားပြည့်သင့်သည်။ ကော်မရှင်ဝန်ထမ်းများကို အိတ်ချ်အိုင်စီနှင့် နီးနွှယ်သောလူ့အခွင့်အရေးပြဿနာများ၊ အဓိကဦးတည်အုပ်စုများ တွေ့ကြုံရလေ့ရှိသော အခွင့်အရေး ချိုးဖောက်ခံရမှုများ၏ သဘောသဘာဝများနှင့်ပတ်သက်၍လည်း လေ့ကျင့်သင်ကြားထားပေးသင့်သည်။

1. Introduction

1.1 Objectives and methodology of the review

This review of Myanmar's legal framework and its effect on access to health and HIV services for people living with HIV and key affected populations was conducted through a partnership of UNAIDS, UNDP and Pyoe Pin in the period August–December 2013.

The objectives of the National Legal Review were:

1. To review the existing legal environment (including laws and related policies, law enforcement practices and access to justice) and its impact on HIV responses in Myanmar; and
2. To propose specific recommendations to improve the legal environment for HIV responses for consideration by the Government of Myanmar, United Nations agencies and civil society partners.

The review involved the following steps:

1. A literature review was conducted that considered relevant laws, policies, peer reviewed articles and press reports. The findings of the literature review have been integrated into this report.
2. Consultation meetings were held with NGOs and community network¹as follows:
 - NGO consultation in Yangon on 23 October 2013 with 21 representatives from international and local NGOs;
 - Community consultation in Yangon from 2–3 September 2013 with participation of 40 individuals representing key populations and national networks of key population groups;
 - Community consultation in Mawlamyine from 15–17 September 2013 with participation of 38 individuals representing key populations and self-help groups of key populations from Mon, Tanintharyi and Kayin states, and Bago region; and
 - Community consultation in Yangon from 4–6 October 2013 with participation of 47 individuals representing key populations and self-help groups of key populations from Mandalay, Sagaing, Magway, Bago regions, and Shan (North), Shan (South) and Kachin states.
 - Summaries of these consultations are contained in Annex VI.
3. A National Legal Review Meeting of 93 participants was convened in Naypyitaw on 25–26 November 2013. Participants included government, Supreme Court, parliamentarians, community networks, NGOs and United Nations agencies (see Annex V).
4. Analysis was conducted of all inputs to prepare a draft report with key recommendations.
5. Finalization of the report.

This report also includes conclusions from a Roadmap Workshop convened by UNAIDS in May 2014 that describes the next steps to implement priority recommendations (see 10.5).

1.2 Rationale, background and context

The National Legal Review was conducted to support the Government of Myanmar in meeting its international commitments, in particular:

- The commitments made at the High-Level Meeting on HIV/AIDS as set out in the *United Nations General Assembly Political Declaration on HIV/AIDS* (2011), which commits States to reviewing laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV;²
- The Millennium Development Goals (MDGs), which commit States to support universal access to HIV services (MDG6); and
- Resolutions of the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), which commit States to conduct national reviews of HIV-related laws and policies.³ ESCAP *Resolution 66/10* of 2010 commits States to "ground universal access in human rights and undertake measures to address stigma and discrimination, as well as policy and legal barriers to effective HIV responses, in particular with regard to key affected populations". ESCAP *Resolution 67/9* of 2011 commits States to "a review of national laws, policies and practices to enable full achievement of universal access with a view to eliminating discrimination against people at risk of infection or living with HIV, in particular key affected populations".

The National Legal Review also supports the Government of Myanmar in strengthening implementation of the *Myanmar National Strategic Plan on HIV and AIDS 2011–2015* (NSP II). Guiding Principles of NSP II include the protection of the human rights of people living with HIV and those vulnerable to HIV, and the creation of a favourable legal and policy context. A cross-cutting priority of NSP II is creation of a favourable environment for reducing stigma and discrimination. The findings of the National Legal Review will contribute to the mid-term review of the NSP II and inform the priorities of the National Strategic Plan III. The National Legal Review was informed by the principle of human rights, which is described in NSP II as follows:

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. In particular, it has also become increasingly clear that:

- National and local responses will not produce intended results without the full engagement and participation of those affected by HIV, particularly people living with HIV;
- The human rights of women, young people, and children must be protected if they are to withstand the impact of HIV;
- The human rights of marginalized groups (sex workers, people who use drugs, men who have sex with men, prisoners) must be fulfilled for the response to HIV to be effective;
- Supportive frameworks of policy and law are essential to an effective HIV response.⁴

In formulating recommendations, regard was had to the United Nations *International Guidelines on HIV/AIDS and Human Rights*,⁵ and the recommendations of the Report of the Global Commission on HIV and the Law (2012).⁶

2. People living with HIV



2.1 Context

The Department of Medical Research (Lower Myanmar), the Burnet Institute and the Myanmar Positive Group conducted a survey of people living with HIV in 2012 to explore the effect of HIV on socio-economic status including experiences of discrimination. The survey found that: the majority of people living with HIV report discrimination from society at large, are prohibited from collective work in wards and are barred from employment in food manufacturing; 39.2 per cent reported being treated negatively in their own neighbourhoods; and many people living with HIV have been subject to discrimination at their workplaces. The study found that people living with HIV have to cope with significant workplace discrimination, with many employers firing workers known to be HIV-positive, whereas 22.5 per cent said they had been denied employment due to their condition. Some changed their workplace because of hostility from co-workers. Eleven per cent of people who moved home did so because of social discrimination. People stayed away from the funerals of those with HIV and it was difficult to arrange cremations.⁷

Another survey of 324 people living with HIV in Myanmar conducted in 2009 as part of the People Living with HIV Stigma Index also revealed a high level of stigma and discrimination. Among the nine Asian countries where the survey was conducted, Myanmar ranked first in the prevalence of incidents such as exclusion from social gatherings and activities (31 per cent); being gossiped about (78 per cent); verbal insults, harassment, and threats (45 per cent); and physical assaults (16 per cent). Some 15 per cent reported to have been forced to change or unable to rent places of residence due to their HIV status, and 27 per cent lost employment or other form of income in the past 12 months. Among those who lost their jobs, 57 per cent attributed the reason to discrimination or a combination of discrimination and poor health.⁸

Human rights laws and policies

There are no HIV-specific protective laws in Myanmar or laws that specifically address the human rights aspects of HIV. There are no laws that specifically:

- Protect people living with HIV from discrimination in employment, health care, education or other areas of life;
- Protect people living with HIV from breach of confidentiality or non-consensual HIV testing;
- Define the rights of people living with HIV to treatment and care including antiretroviral therapy (ART) and treatments for opportunistic infections (OIs); or
- Define the rights of people living with HIV and key populations to prevention including condoms, lubricant, needles and syringes, opioid substitution therapy (OST), or HIV-related information and education.

There are some general human rights protections in the 2008 *Constitution of the Union of Myanmar*. Article 367 of the Constitution provides: "every citizen shall, in accord with the health policy laid down by the Union, have the right to health care." In theory, people living with HIV can complain to government that this constitutional right has been breached if access to essential medicines such as ART is denied, given that ART availability is supported by national policy.

People living with HIV may submit a complaint to the Myanmar National Human Rights Commission if fundamental rights (e.g. right to life or to privacy) are violated.⁹ There are also constitutional provisions prohibiting discrimination by the government on the grounds of 'status' and requiring equal opportunity in employment and equality before the law.¹⁰ However, it is unclear how these general constitutional rights would be applied in relation to violations of the rights of people living with HIV. Further, the Myanmar Human Rights Commission has limited resources and its powers to resolve individual complaints are limited. A Bill clarifying the powers and mandate of the National Human Rights Commission has been drafted, but it is yet to be considered by parliament.

An anti-discrimination agreement was signed jointly in 2012 by the Ministry of Health, the Union of Myanmar Federation of Chambers of Commerce and Industry, UNAIDS and the Myanmar Business Coalition on AIDS. The agreement commits 72 employers to provide safe workplaces with policies that prohibit HIV-related discrimination with support from the business community in Myanmar. Although this was a positive step, it is unclear how compliance with the agreement is being monitored.

Public health law

The *Prevention and Control of Communicable Diseases Law 1995* defines AIDS to be a disease in the same category as cholera, plague and dengue haemorrhagic fever, which are collectively described as 'principal epidemic diseases' (see text of the law, Annex III). As a result of this categorization, sweeping public health powers (such as powers to make compulsory orders and impose quarantine) apply to AIDS. These provisions include powers to issue orders restricting the rights of the person living with AIDS to leave and return to the person's home, residential quarters, village or township and orders to place the person under quarantine for medical examination. The Act requires revision to ensure compliance with the *International Guidelines on HIV/AIDS and Human Rights*, which recommend that States should reform public health laws to ensure that provisions applicable to casually transmitted diseases are not inappropriately applied to HIV and that they are consistent with international human rights obligations. The Guidelines recommend that public health legislation should ensure that people are not subjected to coercive measures such as isolation, detention or quarantine on the basis of their HIV status.¹¹

Penal Code

Section 269 of the *Penal Code 1860* creates a criminal offence for transmission of life-threatening infection. This provision could be used to prosecute people living with HIV who transmit disease to others. There are no reports of any person with HIV being charged with this offence in Myanmar. It should be noted that the Global Commission on HIV and the Law recommended that cases of malicious and intentional HIV transmission be addressed under general criminal provisions (such as existing provisions of the *Penal Code*), rather than creating new HIV-specific offences. The Global Commission recommended that law enforcement authorities should not prosecute people in cases of HIV exposure where no intentional or malicious HIV transmission has been proven to take place. Invoking criminal laws in cases of adult private consensual sexual activity is disproportionate and counterproductive to enhancing public health.¹²

Prisons Act

The *Prisons Act 1894-1909* Chapter VIII establishes rights of prisoners to request to see a medical officer and the obligation of the prison authorities to provide a hospital or proper place for the reception of sick prisoners.

2.2 Issues raised during consultations and the National Review Meeting

Stigma and discrimination are reportedly widespread in employment, education and the provision of health services.

Workplace issues

Participants of consultations reported that pre-employment testing for HIV and hepatitis B is required by many employers, with no provision for pre- or post-test counselling. Some employees are not given sufficient leave to enable them to access health services. Forms of workplace discrimination include denial of application for a position, bypassing for promotion and dismissal. Some people living with HIV report denial of workplace entitlements such as medical pension. Participants of consultations provided examples of people living with HIV who were excluded from employment as teachers, bank employees, hotel employees, private hospital employees and people in food handling roles. Applicants for positions abroad such as domestic helpers are often required to submit to an HIV test and denied employment if the test result is positive.

Participants suggested that the welfare of people living with HIV would be improved if the Ministry of Labour made special provision for health insurance rights for employees living with HIV.

The Union of Myanmar Federation of Chambers of Commerce and Industry (UMFCCI) has signed an agreement with UNAIDS on workplace policies. In 2012, many private sector employers signed the United Nations Global Compact, which requires action on human rights. UMFCCI have an important role in ensuring promotion of and compliance with the United Nations Global Compact and action on HIV in the workplace. Participants stressed the importance of active monitoring of compliance. Without a monitoring or evaluation system it is difficult to assess whether voluntary agreements to develop anti-discrimination workplace policies have been effective.

Although some voluntary workplace agreements have been entered into, it is not mandatory for employers to have an HIV workplace policy that addresses discrimination. Concerns were raised that even some companies such as private hospitals that have signed agreements or commitments to address HIV-related discrimination in the workplace still permit discriminatory practices to occur. Another example is the testing of taxi drivers. Transport authorities in different States/Regions apply varying testing policies so it is still reported in some places that taxi drivers are required to be tested for HIV and if they test positive are denied their taxi driver's licence.

Access to comprehensive and quality HIV treatment and care

Participants were of the view that people living with HIV require improved access to a comprehensive and quality package of services under a continuum of care model. Selection of eligible patients for ART is sometimes hastily done in order to meet treatment targets, which can result in lack of informed consent. There is poor quality of HIV counselling, treatment and care services in public health facilities because of lack of infrastructure and a high staff / patient ratio. Access to OI medicines is inadequate, leading to sickness and unnecessary deaths. Even in Yangon hospitals, OI medicines except Septrin (an essential antibiotic to protect against OIs) are not available free of charge. Participants outside Yangon area complained that even Septrin is occasionally unavailable.

Centralization of HIV treatment services, the government's limited health budget and geographical limitation of NGOs restricts access to ART and OI medicines. There is no systematic nationwide quality assurance system to monitor and assess quality of HIV services.

Conditions at treatment sites are generally poor with overcrowded waiting areas, poor lighting and ventilation, lack of privacy and space for counselling, and long waiting times. There is inadequate attention to the needs of patients for privacy and confidentiality when attending clinics. This deters some people from attending clinics due to fear of disclosure. People living with HIV are often segregated from other patients in public hospitals. Confidentiality of HIV status is often not respected by nurses and other health care workers. Disclosure of HIV status leads to stigma and discrimination from their own family and community.

In health care settings, the practice of testing patients for HIV and hepatitis B and C without informed consent or counselling is commonplace. Discrimination in health care settings takes many forms including additional fees, segregation and denial of services.

There are many accounts of people being refused care or receiving substandard care in hospitals. For example, an HIV-positive pregnant woman was placed next to the toilet when she was admitted for delivery of her baby, and HIV-positive sex workers have been attended to last when they sought care for post-abortion complications. Private hospitals charge HIV patients double the fees of other patients. In public hospitals, HIV patients are segregated from other patients. People living with HIV who have to attend hospital to seek care for health problems other than HIV care frequently face discrimination, for example, the denial of surgical

operations. Denial of surgical operations is unreasonable and discriminatory because use of infection control procedures prevents HIV transmission to health care workers.

High-level Ministry of Health instructions, directives and Standard Operating Procedures should underscore the legal rights of all citizens to health care (as established by the 2008 Constitution, Article 367) and address quality of HIV treatment and care, including the importance of addressing stigma, discrimination and confidentiality in health care settings. Disciplinary action should be taken when instructions or standards are breached.

In response to reports of some private hospitals refusing to admit HIV-positive patients, the MoH issued a directive that if a patient wishes to be in hospital, that patient can stay in hospital even though the doctors are of the opinion that the patient need not be in hospital. Although the directive does not specifically refer to HIV, the reason for the directive was to prevent hospitals refusing treatment to HIV patients. However, HIV patients are often still segregated from other patients.

Peer-to-peer education and peer counselling are very effective in HIV prevention. Stigma and discrimination occurs in health services in part because the involvement of people living with HIV themselves in delivering HIV services is inadequate. Provision of support to people living with HIV to engage more effectively in planning and delivering HIV-related services can help reduce stigma and discrimination. Similarly, to ensure HIV-related health care services provide quality care it is important to have a monitoring and evaluation system for the services that involve people living with HIV.

Mobile populations face particular problems. In the past, MSF and the MoH National AIDS Programme (NAP) had provided six-month supplies of ARV medicines for migrant workers from Myanmar who were working in Thailand. However, currently only a supply for two or three months is available. It is difficult for migrant workers to return frequently for their appointment and medicines. However, this issue has been addressed by the Thai Government with a new policy to provide ARV medicines to all those residing in Thailand, including migrant workers from neighbouring countries.

Prisoners' rights

There is a need for systematic referral linkages to ensure uninterrupted treatment for people living with HIV in prison or police detention, and upon release from prison or police detention.

Security regulations of the prison department require transporting of prisoners out of the prison to access health services. This is a major deterrent for HIV-positive prisoners to access HIV-related health services because they have to inform their HIV status to access these services and they fear breach of confidentiality and discrimination by other prisoners and prison officials. Participants suggested that this barrier could be reduced if prison doctors were trained and equipped to provide HIV care, and given permission to provide HIV-related health services.

Some HIV-positive prisoners are held separately from other prisoners, at Kyar Ni Kan in Mandalay and Toon Tae Baung Taw Gyoke in Yangon.

Access to justice

Participants noted that people living with HIV require improved access to legal aid services and information about their rights so they can assert their rights through the courts or negotiate resolution of complaints with the assistance of a lawyer. The Myanmar Legal Aid Network (MLAW) is a good example of collaboration among lawyers to provide legal aid services although the focus and expertise of MLAW is on issues other than HIV.

Impact mitigation services for people living with HIV and their families

Although NSP II mentions impact mitigation as a key strategy, implementation falls short in areas of psychosocial, economic and nutritional support for people living with HIV and impact mitigation for orphans and vulnerable children.

2.3 Recommendations

The Government of Myanmar should:

1. Introduce a law and supporting policies prohibiting discrimination on the grounds of HIV status in health care, employment, and the provision of education and other services, and providing accessible complaints procedures and meaningful remedies such as compensation, admission to school, reinstatement of employment, and disciplinary sanctions for violations.
2. Allocate a specific budget for stigma and discrimination interventions in the NSP.

Health care

3. Establish a legal right for all people to access the means of protection from HIV including prevention information, condoms and clean needles and syringes.
4. Introduce provisions prohibiting non-consensual HIV testing and providing confidentiality protections for people living with HIV (this can be inserted in the Prevention and Control of Communicable Diseases Law 1995 or a new HIV law).
5. Remove AIDS from the category of Principal Epidemic Disease in the Prevention and Control of Communicable Diseases Law 1995.
6. Ensure people living with HIV have access to complaints procedures for breach of confidentiality, non-consensual testing or other problems in delivery of health care services.
7. Strengthen the legal and policy framework for provisions of care, support, treatment and impact mitigation services:
 - a. Provide access to a minimum package of HIV services under a comprehensive continuum of care framework.
 - b. Implement monitoring and evaluation systems that include community feedback on service quality. A responsive mechanism should be established for feedback on quality of services implemented by public, private and NGO sectors and to seek redress for any violation of rights or malpractice.
 - c. Quality standards / Standard Operating Procedures should address HIV-related health service provision in both public and private sectors, including jails, prisons, and detention/rehabilitation centres.

Employment

8. Require public and private sector workplaces to develop workplace policies on HIV that address non-discrimination and confidentiality, prohibit mandatory HIV testing of employees or applicants for employment, and provide access or referral to VCCT and other health services. Where workplace HIV policies have been introduced, a system for monitoring and evaluation of compliance with non-discrimination requirements and other obligations should be implemented.

Prisoners living with HIV

9. The provision of the *Prisons Act 1894* and/or the regulations and guidance under the Act should be strengthened to ensure non-discriminatory treatment of prisoners living with HIV and uninterrupted access to essential medicines. MoHA and MoH should ensure a system for uninterrupted provision of ART and OI medicines to prisoners and people in police detention.

10. The Myanmar Police Force should take action to ensure medicines can be provided to people in police detention as part of prisoners' rights to health, without incentive payments of any kind.
11. Training and capacity building on HIV, harm reduction and human rights should be conducted for personnel responsible for the welfare of prisoners.

3. Sex workers¹³



3.1 Context

The *Suppression of Prostitution Act 1949* provides offences for:

- Soliciting;¹⁴
- Living on the earnings of prostitution;
- Procuring persons to engage in prostitution;¹⁵
- Owning or managing a brothel, or renting premises for use as a brothel;¹⁶
- Aiding and abetting prostitution.

Penalties for soliciting include imprisonment for between one year and three years, and female sex workers may be detained in a “prescribed centre”.¹⁷ Soliciting is defined very widely to include the conduct of sex workers in public or private places that seeks to attract clients.¹⁸

Section 7 of the *Suppression of Prostitution Act 1949* enables police to arrest sex workers merely on the basis of their reputation for illegal conduct (*kyawzaw*).

The Ministry of Home Affairs issued an Administrative Order in 2000 directing police not to use condoms as evidence in prosecutions of sex workers.¹⁹

The *Law Amending the Suppression of Prostitution Act 1949* was enacted in 1998 to broaden the definition of a brothel to include any place used habitually for sex work. This was in response to new sex work businesses being established at massage parlours and beauty parlours.

Public order offences that may be applied to sex workers include Section 268 of the *Penal Code 1860* (public nuisance), Section 35 of the *Police Act 1945* (loitering) and Section 30 of the *Rangoon Police Act 1899* (loitering, in relation to conduct in Yangon). Under these laws, police have wide powers to detain persons loitering after dark (see Annex III).

A magistrate or judge may make an order under the *Code of Criminal Procedure* requiring a sex worker to stay away from specified areas and to attend the police station each day for a given period.²⁰

There is no law against buying sex. However, the loitering offence could be used against clients.

The *Child Law 1993* provides that it is an offence punishable with imprisonment for a term that may extend to two years and/or a fine for a person to permit a child under the person's guardianship to live with or to consort with a person who earns a livelihood by prostitution.²¹

Myanmar is a signatory to the *Convention on Elimination of all forms of Discrimination Against Women*, which prohibits the trafficking and exploitation of women for any purpose.²² Myanmar has enacted the *Anti-Trafficking in Persons Law 2005* to protect women from trafficking including for the purpose of sexual exploitation.

Law enforcement issues

There were reportedly 1,956 people prosecuted for prostitution in 2011, and 3,226 cases in 2012.²³ There are reports of police harassment of sex workers and police seeking payment of bribes to secure release of arrested sex workers.²⁴

According to the Yangon-based NGO Targeted Outreach Program (TOP), law enforcement practices under the *Suppression of Prostitution Act* and lower socioeconomic status of women in Myanmar contribute to high levels of stigma and discrimination against female sex workers. This in turn hinders their access to HIV prevention, treatment and social protection services.²⁵

It is reported that sex workers face widespread discrimination and abuse, and some are required to pay up to two thirds of their income to police:

Many opt to use middlemen, such as madams or pimps, to navigate the corrupted elements of Burma's police force. But this option is not open to transgender sex workers, who face additional stigma and legal obstacles due to the criminalisation of homosexuality. Those who refuse or are unable to bribe the police face arrest and incarceration, sometimes in so-called "rehabilitation centres" intended to reform immoral behaviour. But while prostitution is a criminal offence, buying sex is not, which leaves sex workers largely at the mercy of their clients. Cases of rape and sexual assault are a daily occurrence. "Because clients know that sex work is criminal, they can be violent or refuse to use a condom and the sex worker can't say no," says Thu Thu. To make matters worse, police often use condoms as evidence of prostitution, even though the government formally banned the practice.²⁶

The police have a duty to report monthly statistics of arrests. Sex workers are relatively easy targets for arrest. It has been reported that in the final two months of the calendar year, more sex workers are arrested as police try to improve yearly figures.²⁷

Sex work occurs in increasingly diverse settings. Law enforcement efforts have led to closure of most brothels over the last decade and continue to target street-based work. An independent team reported the following to the Ministry of Health in 2005:

The law and its enforcement greatly influence the organization of sex work. Over recent years, the number of brothels has decreased and their operations are more transient and clandestine, to avoid police action. As a result, there is an increasing shift from brothel-based to indirect sex work, and most commercial sexual services in Myanmar are now provided in informal settings such as karaoke bars, nightclubs, hotels and guesthouses. Our impression is that most sex workers have chosen this occupation, as part of their limited livelihood options. All types of sex workers are extremely mobile, moving regularly between establishments and townships, and frequently switching

categories. This implies a relative freedom of movement across geographical boundaries and across different sex work settings. This also signals some ability to negotiate terms of contract with entertainment establishment owners. We have not received reports that trafficking is a major issue in Myanmar, though prostitution of under-age girls is practised.²⁸

In 2008 it was reported that numerous brothels based in guesthouses were appearing in Yangon. The police and local authorities license guesthouses. According to reports, a licensed guesthouse owner generally pays neighbourhood police annual 'levies' ranging from 300,000 kyat to 1 million kyat. The money buys advance warnings from the local police if superior officers have planned a raid.²⁹

A study on the impact of law, policy and enforcement practices on sex work, which drew from interviews conducted in Yangon, Mandalay and Patheingyi in 2011, made the following observations:

Female and transgender sex workers in Myanmar are subject to extortion, arrest and incarceration which is continual and systematic. Female sex workers can reduce their chances of arrest by working in a venue for a boss who provides protection from police but who may exploit or abuse them. Transgender sex workers do not have that option and are therefore even more exposed to the cycle of extortion, arrest and jail.

Sex workers[] HIV vulnerability is driven by lack of access to safe workplaces and lack of access to services. All health care other than ARVs for HIV and TB antibiotics must be paid for so poverty is a significant barrier to accessing services... the key legal barriers are the laws and enforcement procedures that prevent sex workers from earning, retaining and managing their money.

Violence also contributes to vulnerability. Rape and violence associated with arrest drives sex workers into various forms of employment where they are less vulnerable to police violence but in which none of the protections and rights of legal workers apply...

Sex workers who do not have identification cards have difficulty accessing services, travelling, securing accommodation and changing occupation...³⁰

The law is ostensibly vigorously enforced. Police are clearly under instructions to operate a zero tolerance policy towards brothels and street work and there is some evidence that they have quotas of arrests to fill. There are times when sex workers cannot bribe their way out of arrest but can get charges reduced by informing on other sex workers or third parties leading to their arrest as well...³¹

Law enforcement is linked to both lack of access to services and to lack of access to safe workplaces.

Unprotected sex, when it happens, occurs at the behest of police, clients or sex venue bosses whose power over sex workers is entrenched by the law and by a justice system that sex workers say is indifferent to justice and human rights.³²

Violence clearly emerged as routine and most sex workers experience it as a constant threat. It also contributes to vulnerability in a range of direct and indirect ways. For example rape presents a direct threat to all sex workers mental and physical health.³³

In 2011, the government announced a ban on massage parlours and restrictions on

restaurants and karaoke lounges in Naypyitaw. Restaurants and karaoke lounges were ordered to install transparent glass in their rooms and beauty parlours were required to install adequate lighting.³⁴

It has been reported that compliance with the Order prohibiting use of condoms as evidence of sex work is inconsistent.³⁵ There continue to be reports of police arresting sex workers who are found with condoms in their possession. A press report quoted a sex worker as follows:³⁶

We bribe local policemen so we can work. When other police come they call us and warn us that there will be a raid and to hide. We pay them a monthly fee between 30 – 50 US dollars, sometimes it's 150 [US] dollars. We have to give them whatever they ask. I never carry condoms because if they see the condom they know that I am a sex worker.

Interviews conducted at three sites in 2011 found that the practice of condom confiscation 'has declined to different extents in each site...(but) has not been entirely eliminated.'³⁷

A behaviour surveillance survey conducted in 2008 found that 36 per cent of female sex workers in Yangon and 37 per cent in Mandalay gave money earned from their last client to a madam, pimp or police officer.³⁸

Some sex workers reportedly pay protection money to corrupted elements in the police force. Some sex workers also report sexual exploitation and violence perpetrated by police.³⁹

In 2010 there were press reports of sex workers arrested who were selling sex to the military.⁴⁰ The 2006 review of the National AIDS Programme noted that in some localities the military are a major source of clients for sex workers:⁴¹

A behavioural assessment is done with all new recruits in order to better understand and address risk behaviours. It was reported that young servicemen in isolated postings were especially vulnerable and at high risk to HIV, and were routinely clients of sex workers.

100% Targeted Condom Programme (TCP)

The 100% TCP commenced in 2001 and has expanded to 170 townships. A WHO review of the National AIDS Programme described the 100% TCP as follows:⁴²

The main activities include advocacy, training of township staff, formation of condom core groups, geo-social mapping, condom distribution and programme monitoring... The review teams were informed in several townships that the police force supports 100% TCP by active participation in the [condom core groups].

Sex workers undergo regular physical and serological check-ups, including [syphilis] testing. HIV testing is reported to be voluntary. They did not have to carry a card indicating whether they had complied with check-up requirements or the result of tests...

A key barrier to effective implementation of the programme is the continued disruption caused by police arrests of sex workers. INGOs reported that this happens particularly towards the end of the month when the police have to meet their monthly targets as part of the programme to control sex work. At that time, attendance by sex workers to drop-in centres declined. In one district, stakeholders and the divisional AIDS/STD officer reported that sex workers are harder to access now due to (a) the shift of sex work from brothels to other entertainment establishments and freelance work; and (b) the continual movement of sex workers due to police activity and migration. The divisional AIDS/STD officer estimated that consistent condom use in entertainment establishments was less than 50 per cent in that state/division.

The 2010 UNGASS Country Report of the Ministry of Health stated:⁴³

The Ministry of Health is in full support of prevention programmes for groups with high risk of HIV transmission. However, the law enforcement agencies in the areas where the services are provided are not always fully aware of prevention programmes. The 100% Targeted Condom Programme of the National AIDS Programme will continue to address this through advocacy with local authorities including law enforcement.

3.2 Issues raised during consultations and the National Review Meeting

Confiscation of condoms

Police harassment of sex workers when they find condoms on them or in their premises is an on-going problem that deters sex workers from carrying condoms. Condoms are important both for HIV prevention and contraception. Most police in large towns comply with the government Directive in that they do not submit condoms as evidence in court.

However, not all local police in the field are fully aware of the Directive and in what context it was issued.

The Directive is of limited assistance to sex workers because police continue to use possession of condoms as a basis of harassment. As a result, freelance sex workers who commonly carry six or seven condoms with them discard the condoms if they see the police coming. There is therefore a need for a more comprehensive police instruction that prohibits police from interfering with the right of all persons to carry condoms for HIV prevention or contraception, as well as prohibiting use of condoms as evidence of prostitution offences in court proceedings.

Harassment, violence and other police abuses

Arrests of sex workers generally occur under provisions of the *Prostitution Suppression Act 1949* relating to soliciting or selling sex (Sections 3(a), 3(b)) or having a reputation of being a prostitute (Section 7). Section 5(2) of the *Prostitution Suppression Act* prohibits certain conduct that promotes prostitution. Sex workers raised concerns that this Section could be used by police to prevent sex workers meeting as a group either for safer sex, HIV and other health education or self-help group activities or simply for socialization as they can be construed as exchanging information to encourage sex work. Police sometimes have used peer education meetings as opportunities to identify sex work places and subsequently arrest sex workers. Sex worker representatives at the consultations raised the concern that peer educators should be able to conduct group peer education sessions at the sex work places without worrying about police monitoring, harassment or arrest. Sex workers reported one case in which police shadowed peer educators as they were working, and then later raided the premises and arrested the sex workers. Since then, no sex work venue in the area wants to have peer educators come to their place.

Sex workers are also commonly charged or threatened with arrest for the public order offence of loitering after dark (*Police Act* and *Rangoon Police Act*) and less commonly for public nuisance (Section 268 of *Myanmar Penal Code*). Abuse of the laws by the police is reported as common especially in relation to arrest under Section 35 of the *Police Act* (loitering) and Section 54 (arrest without warrant) of the *Code of Criminal Procedure*. Section 34(7) of the *Police Act* (causing disorder by drunkenness) is also sometimes used to charge sex workers.

Reported examples of police abuses include:

- Extortion of bribes to reduce the charge to a lesser offence, or release without charge. Police abuses include verbally and physically abusing sex workers to confess to the crime of soliciting and extortion of bribes either from sex workers or pimps to either reduce the charge to one with a lighter sentence or release the sex workers.
- In some cases, police have threatened a sex worker with arrest unless she provides free sexual services for several days to a visiting police officer or official.
- Police use entrapment methods to secure arrests, such as undercover police who pretend to be clients seeking the services of sex workers. Undercover police then arrest the sex workers during or after exchange of sex for cash. Manipulation of evidence by the police has also been experienced.
- Sex workers reported not being able to practise safe sex and use condoms when they encounter clients who are police as they do not have the same bargaining power as they have with other types of clients. Police have the power to arrest and shut down their sex work businesses.
- Sex workers have been denied the right to inform either family members or a lawyer of their arrest.
- Charges of being 'suspected of prostitution' are brought arbitrarily. The offence of having a 'reputation as a prostitute' is applied arbitrarily against people who are no longer practising sex work (*Prostitution Suppression Act* Section 7, *Kyawzaw*). Arrest for reputation as sex worker enables the police to harass current or former sex workers any time and in any place as they see fit. Section 7 also inhibits sex workers from openly participating as sex workers in HIV prevention activities as they worry about becoming known or associated with the reputation of 'sex workers'.
- A quota system operates within the police department and some police target sex workers to fulfil arrest quotas. Police engage in periodic crackdowns targeting sex workers. No peer education sessions can be conducted during these periods. Peer educators are afraid to meet with other sex workers for peer education and condom distribution purposes at their street or brothel workplace at night.

Sex workers are reluctant to challenge police abuses because they worry about further aggravating the police. Sex workers generally lack awareness about their arrest rights, which leaves them vulnerable to the vagaries of the local police. Many sex workers do not know their rights and have little or no legal literacy, which makes them an easy prey to police intimidation and harassment.

Sex workers who experience violence including rape by their clients are not confident to report such incidents to police for fear that no action will be taken or they will be charged with prostitution offences.

Police often change the section of the law under which sex workers are charged, so as to rely on charges that are easiest to prove, such as loitering after dark. At the court, sex workers are often prosecuted based on flimsy evidence. Accounts of biased practices by the magistrates or judges in the court regarding cases of prostitution are also common.

In some locations, public order measures constrain health promotion. Rules that require permission from several government offices for gatherings of people for health related activities create obstacles. Local authorities should aim to encourage wider health education among sex workers and other key populations to prevent HIV more effectively.

The application of criminal laws against sex workers fuels stigma and discrimination against sex workers, acts as a deterrent for them to seek HIV information and health services, and fosters a clandestine sex work environment.

CWC and Sex Worker Rehabilitation detention facilities

There are two types of detention centres (apart from prisons) where sex workers may be held. The Centre for Women's Care (CWC) is a special centre established for HIV-positive female prisoners in Yangon (Toon Tae Baung Taw Gyoke) and Mandalay (Kyar Ni Kan). CWC is a quasi-prison facility under the Ministry of Home Affairs operated as a collaboration between the Department of Prisons, Department of Health and Department of Social Welfare. CWC is regarded by some as a preferable alternative to a prison. However, it is also regarded as stigmatizing and a form of discrimination by some sex workers. Sex workers who are sent to prison are tested for HIV and may be sent to a CWC if found HIV-positive. However, there is inconsistency between prisons as to whether women have the opportunity to be transferred to CWC. For example, HIV-positive sex workers who are sentenced to Mandalay Oh-Bo prison are said to be transferred to CWC but that practice is not common across all prisons e.g. HIV-positive sex workers from Shwe Bo prison are not transferred to CWC.

The other type of facility is the Vocational Training Centre for Women (VTW Centre), which focuses on sex worker rehabilitation. Sex workers are sent to VTW centres prior to their release from prison. Vocational training offered to women is usually literacy skills, knitting and basket making rather than more marketable skills. There are VTW centres in Yangon and Mandalay.

Police detention

When sex workers are held in police detention or jail awaiting a bail decision or the outcome of their court case, personal belongings including ARVs are confiscated and can only be retrieved by a family member. Since in most cases their families do not know they are sex workers, this is often not an option. Even if sex workers are willing to contact their family, they are often refused a phone call. HIV-positive sex workers commonly miss at least two to three days of doses of ARVs while in police detention. It is reported that payments of financial incentives to police are required: when sex worker peer educators want to send ARV and OI medicines; food, other medicines and basic items to sex workers in jail (the more important and urgent the item, the larger the payment) Sometimes payment is also required to maintain confidentiality of HIV status of sex workers.

Sex workers are often reluctant to disclose their positive HIV status when in prison for fear of discrimination by prison personnel and other inmates due to their HIV-positive status in addition to being a sex worker. Some prisons require HIV testing of all persons who are serving sentences for a prostitution offence and there is little or no pre- and post-test counselling. Some are offered voluntary testing.

Prisons

Access to any form of health care services in prisons is limited and these are often of poor quality. All prisoners have a range of general health care needs that are exacerbated by poor prison conditions. Prisoners living with HIV have additional health care needs. Tuberculosis (TB) spreads easily in prison conditions and TB-HIV co-infection is a particular problem for prisoners. When HIV-positive sex workers on ART are sentenced to prison, a peer educator may be able to liaise with the NGO or government ART provider and the prison doctor to arrange for continuation of ART. Peer educators refill the prescription at the clinic and deliver the medicines to the prison doctor, who then provides the sex workers with their medication. In some cases, an NGO or government service provider and the prison doctor directly cooperate to continue the ARV supply. If sex workers are found to be HIV-positive

and needing ART during imprisonment, prison doctors also make referrals to outside service providers. However, these systems are not operating in smaller prisons (e.g. Shwe Bo) and prison staff do not allow visitors to bring in medicines or peers to send ARV medicines for their friends.

Workplace conditions

Many sex workers at community consultations argued that the law should treat them as workers with employment rights, rather than as prostitutes, and that the government should recognize sex work as an occupation or profession so that sex workers can enjoy workplace health and safety rights and protection from exploitation.

Employment conditions for sex workers are sometimes exploitative. Exploitation of their earnings by the brothel owners is reportedly fuelled by the police practice of asking for a fee for protection or permission to run the business. The owners of sex work establishments sometimes restrict movement of sex workers. Many places have rules restricting sex workers from leaving the premises for more than an hour per day. If the sex worker does not return during that hour, she has to pay a hefty fine, which is taken out of her pay by the owners. This makes it very difficult for peer educators to encourage the sex workers to go for regular testing or treatment.

Some residential quarter authorities refuse to issue an overnight guest permit if they know or suspect a woman to be a sex worker. This practice of not giving an overnight permit is more common in smaller cities and towns where sex workers are easily identifiable. Many sex workers do not have a National Registration Card, which is required to apply for an overnight guest permit. When the local authorities conduct the check of a residence, sex workers can be fined and/or arrested if found without a valid overnight guest permit.

Health care services

Sex workers experience discrimination, poor quality of care, insensitivity and lack of confidentiality at public health facilities such as hospitals and STI services which makes them reluctant to attend health services. The *Suppression of Prostitution Act 1949* and the threat of arrest further inhibit female sex workers to come forward for family planning, reproductive health, and HIV services.

Examples of sex worker complaints relating to health care include:

- Access to sex worker-friendly services, peer counsellors and other service providers vary greatly, depending on the personality and attitude of regional NAP/STD officer. Sex workers report poor confidentiality standards at the hospitals, segregation of HIV-positive patients in a different residential quarter (ward), and brash and insensitive approach of health staff.
- Sex workers experience rude and condescending behaviour of service providers when they seek treatment for STI or reproductive tract conditions. Fear of judgmental attitudes and discriminatory behaviour from health care providers inhibits sex workers from openly discussing their STI symptoms and their occupation, leading to ineffective investigation and treatment of STIs.
- There is usually no peer counsellor and inadequate privacy and space for counselling at township hospitals and STD team premises. Poor confidentiality standards at the hospitals, segregation of HIV-positive patients in a different ward, brash and insensitive approach of health staff in trying to reach out to partners of HIV-positive sex workers for HIV testing act as barriers to access treatment and care at most public hospitals and clinics.
- Discrimination by ART treatment counsellors towards sex workers.
- Health care workers insist that the sex worker bring the husband to the health facility if the sex worker seeks post-abortion care, thus encouraging sex

workers to stay away from the health facilities when they need to deal with an unwanted pregnancy or pregnancy arising out of rape.

- If female sex workers attempt to undergo abortion for unwanted pregnancy, they can face criminal charges under Section 312 of the *Penal Code* for illegal abortion. Abortion is not legal in the case of rape unless the abortion is necessary to save the mother's life. There are very limited opportunities for sex workers to access safe abortion services for unwanted pregnancies that often happen as a consequence of sexual violence.
- Confidentiality is not respected at STI services. Some sex workers do not want to go to STI clinics for HIV testing or ART because sometimes police officers also attend the same place for their tests. Sex workers avoid attending health services because of the concern that the police will find out they are sex workers and HIV-positive.

ART eligibility requirements are difficult for many sex workers to fulfil because they require documentation such as Household Registration (form 10) and endorsement from the residential ward authority (vouching that this person is living in the ward), and require a family member to act as treatment supporter. Participants were concerned that ART eligibility criteria need to be more flexible, taking into account recommendations of the national ART assessment conducted in 2013. Health care providers are reluctant to prescribe ART to sex workers due to the mobility associated with their work, which means they are living away from their native place and family. The need to go for frequent appointments for counselling before initiating ART is also a challenge for many establishment-based sex workers who have very limited amount of time off from their employers or pimps. In many cases it is not a realistic option to disclose the reason why they need to go frequently to a clinic, due to the lack of confidentiality and negative repercussions of disclosure of HIV status on their work and income.

Access to justice

Participants noted the importance of a fair process to address police abuses and other unlawful conduct affecting the rights of sex workers, and that free legal aid services for sex workers (e.g. similar to Equal Project) should be made available in other areas outside Yangon. Sex workers should be educated on their arrest rights and the laws protecting women against physical and verbal assault (e.g. Section 354 and 509 of the *Penal Code*). There are no dedicated services to provide welfare and legal support to sex workers who experience violence. Focal department or civil society organizations should be identified, trained and sensitized to handle such complaints so that sex workers can seek justice without fear of discrimination because of their occupation.

Legislative models for sex work legislation

At the national review meeting, a representative of UNFPA presented different international models for sex work legislation, including criminalization, decriminalization and regulation. Data from Australia was presented indicating that decriminalization had delivered greater public health benefits than criminalization or regulation. To assess whether different legal models have an impact on the delivery of health promotion services to sex workers, researchers compared health promotion programmes in three cities. The study concluded that the decriminalization of sex work is associated with better coverage of health promotion programmes for sex workers.⁴⁴ Other countries in the region have introduced various models of regulation of the sex industry. Thailand and the Philippines have introduced health regulations relating to condom availability, STI testing and peer education for entertainment venues. Indonesia and Singapore have designated 'red light' areas where sex work is tolerated and regulated by local government.⁴⁵

3.3 Recommendations

The Government should review the *Suppression of Prostitution Act 1949*. This review should consider the international evidence of the public health benefits of alternative legislative approaches to sex work, including models of health and safety regulation and decriminalization. To ensure sex workers are not driven underground and away from health services, legislative models should avoid punitive or compulsory measures such as compulsory testing and compulsory rehabilitation.

The Government should consider the following amendments suggested during the national review:

1. The Act should be re-titled to remove reference to 'suppression of prostitution' and instead emphasise 'protection of the rights of sex workers', including violence protection, and access to condoms and confidential health services for HIV and STI prevention, testing and treatment.
2. Include in the Act a supportive framework for implementation of the 100% Targeted Condom Programme to prevent sexual transmission of HIV and other STIs.
3. Include in the Act violence protection provisions for sex workers.
4. Remove penalties for soliciting (Section 3). If a penalty is to be imposed for sex work, this should be a fine rather than a custodial sentence.
5. Remove the offence of 'reputation' (kyawzaw) (Section 7).
6. End the practice of detaining sex workers in rehabilitation centres. Attendance at rehabilitation or vocational training centres should be voluntary rather than compulsory.

In advance of the review of the *Suppression of Prostitution Act 1949*, the following measures should be taken:

Police instructions

1. The Directive to police to not use condoms as evidence of prostitution offences should be revised. In addition to not using condoms as evidence in court, police should be directed to not search for condoms when arresting sex workers and not harass sex workers, accuse sex workers of offences or arrest sex workers based on the finding of condoms on their person or premises.
2. The Directive should be promoted and enforced to ensure police comply with instructions prohibiting the use of condoms as evidence for prosecution or as a basis of arrest or harassment.
3. Police instructions should prohibit use of the 'reputation' offence (*kyawzaw*) and public order offences (such as loitering at night) against sex workers unless exceptional circumstances exist and should prohibit the police practice of entrapment of sex workers using people who pretend to be clients.

Police responsibilities

4. Collaboration between MoH and the MoHA/Myanmar Police Force should be strengthened to support effective implementation of HIV prevention among sex workers including 100% targeted condom promotion.
5. The Government should ensure sex workers have access to independent and confidential complaints procedures if they experience police harassment, extortion, unfair treatment or violence from the police. There should be a confidential mechanism for sex workers to report exploitation and abuses without having to share their sex work status with police.
6. If ARV or OI medicines are found on a sex worker during a police search, these medicines should be returned to the sex worker and police should help the sex worker to inform a peer educator, family member or service provider for continuation of treatment.

Vocational training

7. The existing VTW Centres should be remodelled as voluntary centres that provide training for skills that are marketable and relevant to running a small business including how to find capital, how to identify the market and how to market your product. There should be creation of employment opportunities for sex workers who want to find alternative viable livelihoods.

Legal aid

8. Legal aid services should be available to sex workers for representation in violence protection cases and complaints against police or health care services.

Health and HIV services

9. Health service policies should support non-discriminatory services that respect the human right to health of everyone including sex workers and ensure provision of sex worker-friendly health services including HIV, STI and reproductive health and family planning services to reduce maternal morbidity and mortality.
10. ART eligibility criteria should be relaxed so that mobile sex workers are referred to the nearest ART provider, and have flexibility to refill their ART prescription from any ART distribution site.

4. People who inject drugs



4.1 Context

Criminal laws

Possession of narcotic drugs is criminalized and people who inject drugs (PWID) are required to register with health authorities and undergo six weeks compulsory detoxification. The *Narcotic Drugs and Psychotropic Substances Law* of 1993 creates offences relating to drug possession, including the following offences:

- Possession, transportation, distribution and sale of materials, implements and chemicals used in the production of a narcotic drug or psychotropic substance;
- Possession, transportation, transmission and transfer of a narcotic drug or psychotropic substance.

Penalties are a minimum of five years to a maximum of ten years imprisonment and a fine.⁴⁶

Although there is no specific offence for drug use, if an arrested person's urine tests positive for drugs, the person is charged and may be sentenced to 3–5 years prison under Section 15 for failing to register or failing to abide by MoH directions regarding treatment.

The *Myanmar Excise Act 1917*⁴⁷ prohibits the possession, sale or distribution of hypodermic needles without a license. Section 33 of this Act prohibits the making, selling, possessing or use of hypodermic syringes or any other apparatus suitable for injecting any intoxicating drugs without licence. Contravention of this section is punishable with six months imprisonment and/or a fine.

Needle and syringe distribution programmes have been implemented in Myanmar for over ten years. To facilitate establishment of needle and syringe programmes, a Directive from the Myanmar Police Force Headquarters was given not to make arrests for possession of needles and syringes in 2001. However, this Directive has had a limited impact because in practice needles and syringes are confiscated by police and submitted to the courts as evidence when people are arrested for drug

possession.⁴⁸ Police continue to refer to Section 33 of the *Myanmar Excise Act* to justify confiscation of needles and syringes, although subsequent prosecutions usually proceed under the narcotics legislation.

Compulsory treatment and rehabilitation

The *Narcotic Drugs and Psychotropic Substances Law 1993* creates a system of registration and compulsory treatment of drug users. A drug user is required to register at the place prescribed by MoH or at a medical centre recognized by the Government for this purpose, to take medical treatment. MoH is required to provide programmes for medical treatment for registered drug users. A registered drug user undergoing medical treatment is required to abide by the directives issued by MoH.⁴⁹

A drug user who fails to register or who fails to attend medical treatment as required shall be punished with imprisonment for a term which may extend from a minimum of three years to a maximum of five years.⁵⁰ MoHA is required to provide for the teaching of means of livelihood as may be necessary to persons serving sentences for failing to register.⁵¹

Treatment centres for registered drug users are either Drug Treatment Centres or Hospitals under MoH. There are 26 major and 40 minor drug treatment centres. Major centres are 200 or 300 bed hospitals. Minor centres are small hospitals or centres managed by the Township Medical Officer. Services available differ depending on the location and may be detoxification alone or detoxification plus methadone maintenance therapy (MMT) services. ART is not integrated at drug treatment sites. Duration of stay varies but it is common for drug users to stay 42 days for detoxification and 14 days for MMT induction. Many people who use drugs who have not sought treatment are subject to prison sentences.

The Ministry of Social Welfare, Relief and Resettlement (MSWRR) is required to provide for rehabilitation and care of drug users, including:

- Rendering assistance and protection as may be necessary to persons undergoing medical treatment and the families dependent on them;
- Providing for rehabilitation, teaching of means of livelihood as may be necessary, resettlement and aftercare to enable persons who have undergone medical treatment to resume their normal lives;
- Conducting expertise training courses for the relevant persons in order to implement systematically and effectively the work of rehabilitation of drug users.⁵²

The MSWRR's rehabilitation centres are for people who have already undergone drug treatment at a DTC. There are seven rehabilitation centres but not all are operating due to funding constraints. Clients are required to remain for a minimum of six weeks. Services offered include sports, vocational training, counselling, meditation and arts. Costs must be covered by family members or NGOs/drug demand reduction organizations.

The MoHA and MoH also operate three youth drug rehabilitation centres for young people who use drugs who are serving prison sentences.

Methadone maintenance therapy

Methadone maintenance therapy (MMT) commenced in 2006 and in 2012 over 2,900 people were receiving MMT. MoH issued *Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar* in 2012.⁵³ The Guidelines promote harm reduction interventions as part of a comprehensive approach to addressing drug dependence. Harm reduction is described by the Guidelines as follows:

In the context of harmful use of and dependence on opioids, harm reduction means preventing the transmission of HIV and hepatitis B and C through the practice of using sterile injections, reducing injection-related injuries through safe injection techniques, and reducing engagement in illegal activities through the use of methadone and another OST called buprenorphine, which is used in some countries.

The Guidelines recommend that all dispensers be required to complete training and receive certification to confirm that they are familiar with the guidelines on the methadone programme and the principles of methadone administration.⁵⁴ The Guidelines recommend that dispensing areas should be discrete to avoid stigma and ensure confidentiality.⁵⁵ The Guidelines address dispensing in prisons and other closed settings (yet to be implemented in practice), provision of take-home medication, and the importance of peer educators and self help groups.

Law enforcement issues

Conflict is reported to occur between operational policing and the implementation of harm reduction services. Police crackdowns impede the access of outreach workers and NGOs to people who inject drugs, disrupting needle and syringe programmes and other services. Police crackdowns can result in the 'conversion' of smokers into injectors because during crackdowns the price of drugs increases, with the result that poorer users resort to injecting as a more efficient mode of administration of drugs than smoking. Advocacy with State and Division level authorities has reportedly been successful in avoiding police crackdowns at some harm reduction intervention sites.⁵⁶

A review of harm reduction in Myanmar conducted in 2010 made the following observations:⁵⁷

Mandatory registration of drug users, including those who seek to access drug treatment and MMT remains in force and is a major barrier to the utilization of drug treatment and to the organization of drug-user networks...the legal environment in Myanmar is a major obstacle to the achievement of HIV control in this population. Like most other countries in the region, the national drug laws are punitive...

Failure to register is punishable by three to five years of imprisonment. (Section 15)

Possession of three grams of heroin, 100 grams of opium, three grams of ATS, or 25 grams of cannabis is considered to be in possession of narcotic drugs and is punishable by five to ten years imprisonment. (Section 16 (c)) The Anti Narcotics Law is a constraint for HIV control given compulsory registration requires drug users to enter treatment. Because of this, many drug users and injecting drug users are driven underground for many years.

4.2 Issues raised during consultations and the National Review Meeting

Criminalization of drug possession means that PWID are viewed as criminals by society, rather than as people with health problems and complex social welfare needs. The view of PWID as criminals is widespread in society at large as well as among police and health care workers. Fundamentally, PWID would like to see the legal and policy framework for drug dependence changed so that it is primarily focused on public health and services that address individual health care and welfare needs, rather than the existing punitive criminal justice approach. Participants at community consultation argued that such a public health approach and attention to health care needs should also inform law enforcement practices.

Police abuses

PWID report police harassment and physical abuse if police find PWID carrying needles and syringes. This deters PWID from either buying or carrying needles and syringes. They report that police initially justify arrests under the *Excise Act 1917*, Section 33, which leads to later charges of drug possession under the *Narcotic Drugs and Psychotropic Substances Law 1993*.

The Directive from the Myanmar Police Force Headquarters in 2001 not to make arrests for possession of needles and syringes was regarded as a positive step towards addressing drug use as a public health problem rather than a criminal problem. However, accounts from PWID participants revealed confiscation of needles and syringes for laboratory investigations and use of needles and syringes as evidence in prosecutions is still common practice. Although possession of needles and syringes is not charged directly by the police, possession of injecting equipment leads to further investigations and drug possession charges.

Sentencing of PWID for possession when only trace evidence of drugs are found in the laboratory traps PWID in a cycle of imprisonment and drug use, without affording a reasonable opportunity to progress through treatment. Advocates for PWID argued that drug users who have registered for treatment under the law should not be prosecuted as they have admitted their health problem and are trying to seek help to overcome addiction. They pointed out that according to medical literature, relapse can happen anytime among ex-drug users or users on drug treatment.

Threat of arrest for carrying needles and syringes affects the willingness of people to work as outreach workers to distribute clean needles and syringes.

Threat of arrest for carrying syringes also hinders overdose treatment (Naloxone injection). Administration of Naloxone to PWID who have overdosed requires syringes to be available to drug users or their peer educators.

At project sites where organizations have a Memorandum of Understanding with the government to implement the harm reduction project, the local police generally tolerate needle and syringe programme outreach workers. Arrangements at the local level between police and harm reduction services were effective in some areas under MOUs entered in 2008–2009. NGO participants at the consultations proposed that these arrangements be revived.

Police harassment leads to PWID avoiding purchasing new syringes. Instead, some PWID resort to the unsafe practice of hiding used syringes at the shooting places for re-use at a later time. Police harassment and scrutiny of drop-in centres deters PWID from accessing the services provided at centres.

Police also conduct surveillance of known PWID. In a typical scenario, PWID purchase three to five new syringes per person at the market. After PWID leave the shop and use their syringes, the police arrest them under Section 33. While they send the syringes to the laboratory for chemical analysis, PWID are detained in police jail. Sometimes it takes six months for the laboratory result to be provided. If the result is positive, the charge is then changed to drug possession or failure to follow directions regarding abstinence.

Police occasionally conduct crackdowns, arresting many PWID to fulfil quotas. Police apply public order offences against PWID, particularly loitering after dark (Section 35 of the *Police Act*), drunk and disorderly (Section 47 of the *Police Act*) and behavioural bonds under the *Restriction and Bond Act 1961* (Section 5(1)). Under the *Restriction and Bond Act 1961*, if police claim they have information that a person is likely to commit a criminal offence, they can apply for bond to be placed on the

person to require the person to report to the police, to be on good behaviour and to not travel.

Conspiring or abetting the commission of a crime is an offence under Section 21 of the *Narcotics Law 1993*. Police reportedly use this offence to justify arrests for possession of drugs merely on the grounds of someone else's word. This sometimes leads to accusations from peers within the community of PWID ('finger pointing') and creates more secrecy among the drug using community. This makes it challenging to build the trust and relationships required to do outreach for harm reduction. Some police entrap drug users by cultivating a group of drug user informants, which contributes to the atmosphere of fear and secrecy.

The community consultations heard accounts of corruption including officials taking bribes, planting evidence, and using street children as informers. There were accounts of law enforcement officers targeting PWID rather than suppliers for arrest.

Section 18 of the *Narcotic Drugs and Psychotropic Substances Law 1993* is intended to provide protection against police misconduct such as taking bribes or switching or planting evidence. Usually, such a complaint is investigated and handled internally within the Myanmar Police Force and the harshest punishment is dismissal from the position or demotion. Participants were concerned that police misconduct should be taken more seriously and receive more severe penalties.

Even though the law requires mandatory registration for treatment, lack of treatment facilities means that most PWID receive prison sentences rather than proper treatment for their drug dependence.

Criminalization also reduces the capacity of PWID to be involved in decisions in relation to HIV policy and planning of services, and to participate in delivery of health and HIV services. In most areas, participation of drug users in HIV responses is minimal or non-existent and it is very difficult to reach out to drug users in the community for HIV prevention activities because of danger of disclosure to the police. It was reported that PWID were reluctant to attend consultation meetings for the National Legal Review because of concerns that disclosure of drug use history could result in arrest based merely on suspicion.

ART services

PWID report that they are denied access to ART unless they have registered as drug users and have undergone MMT initiation. Although it is not written policy, being an active user is a *de facto* disqualifier for ART. Access to treatment services is impeded due to the prejudice of health care workers regarding the reliability of PWID to adhere to treatment, and lack of PWID-targeted treatment services. The perception of PWID as criminals or potential criminals has influenced the perspective of many health care providers. As a result, discrimination against PWID is common in medical settings. Drug users are given low priority by ART providers in the public and NGO sectors. Some PWID do not disclose their drug use problem to the doctors or counsellors because of the perception that providers are prejudiced against prescribing ART for drug users. For those who disclose their drug use, they are more likely to receive ART if they are on regular methadone maintenance as providers consider it as a proxy for treatment adherence.

Methadone sites are located in areas with high levels of injecting of heroin. Many drug users in other areas cannot access methadone, which means that they are also unable to access ART (e.g. Southern Shan) because MMT initiation is considered a precondition for ART. While those users do not inject heroin, they inject other drugs such as Diazepam and this injecting behaviour facilitates transmission of HIV and other blood borne infections.

MMT services

There is an unmet need for MMT due to difficulty with registration and lack of legal protections from arrest for registered drug users, and low coverage of methadone service provision. There are an estimated 75,000 PWID in Myanmar. However there are only 28 centres prescribing methadone. Availability and quality of counselling for methadone patients is also an area of unmet need. The National MMT Guideline describes many supportive features such as proper counselling before initiating MMT and transportation allowances for drug users to come for daily dose at the centre. However in reality, there is inadequate pre-treatment counselling and no travel support for the drug users registered for treatment.

PWID also report difficulties in obtaining take-away doses of methadone for the purpose of traveling. There are very few methadone treatment centres in the country and it is very inconvenient for people to travel daily to get their daily doses. In Yangon, there are two centres for methadone treatment: Sanpya General Hospital and Ywarthangyi Hospital.

The eligibility criteria for MMT are problematic for many PWID. For example, the requirements that a PWID must live in the particular geographical location, must have household registration for that location and possess a National Registration Card are prohibitive. Many PWID do not have a National Registration Card because they come from isolated villages and cannot afford the cost involved in obtaining a card or because they are migrants. The requirement to report occupation is also a barrier to register, because confidentiality of information is often not respected and PWID risk dismissal if employers know that the employee is registered for MMT.

The proximity of MMT centres to law enforcement offices is another access barrier. Some MMT centres are located close to offices of the anti-narcotics police.

The PWID network expressed concern at consultations and the National Legal Review Meeting that registered drug users are not protected from arrest. There is little incentive to register if to do so bring drug users to the attention of police and increases the chances of arrest and imprisonment. Registered users are required to carry a treatment registration card, and are required to attend regularly for medical follow-up. The PWID network is seeking legal protection for PWID who are registered and admit themselves to treatment. The current situation is that if PWID relapse during treatment and their home is searched for evidence of possession, the person can be charged for possession if the police find even an extremely small amount (trace evidence) of drugs in used injecting paraphernalia. In this regard, there is no legal protection from punishment if a PWID relapses during their treatment.

The registration system is regarded by international NGOs as out-dated and counterproductive. Guidelines in relation to prescription of methadone are unduly restrictive and exclude NGOs from providing MMT. Guidelines require methadone to be provided at a drug treatment centre or under supervision of a psychiatrist at a township hospital. Buprenorphine as an alternative to methadone is not available due to narcotics and drug registration laws. Access to analgesics for pain management is also restricted. Access to analgesics is important for PWID undergoing withdrawal because they are more likely to share injecting equipment if they do not have access to pain killers.

The representative of the Central Committee for Drug Abuse Control (CCDAC) at the National Legal Review Meeting made the following points:

- The Government accepts that the law requires revision and the legal requirement to register (Section 15) is already being reviewed. It is expected that revision of Section 15 will mean that if a person is found by a police officer to be using drugs, the PWID will be encouraged to register for treatment and will be sent to

a hospital. The revision may also address the circumstances in which a PWID who relapses and re-offends may be sent to a rehabilitation centre or prison.

- However, lack of health infrastructure is a problem. If we find a drug user in an area where there is no hospital with a drug treatment centre, how can we send him to hospital? How can we treat him? Even if we can treat him, he will be sent back home after nine months, and then who will give aftercare? Therefore the participation of the whole community is needed.
- The Government has considered experiences of decriminalization of drug use in other countries. In a European country, the model of decriminalization involves assessment of a person who uses drugs by a board comprising a doctor, a lawyer and a police officer. After the assessment is conducted, the person is sent to a hospital to receive treatment and they are linked with community groups to help find employment. This approach requires health infrastructure and CCDAC's view is that Myanmar does not yet have sufficient infrastructure for this approach.

Access to MMT in prison or police detention

A PWID who is charged for drug possession or use usually has to spend time in police detention while the prosecution case is being prepared. Treatment for withdrawal from drugs is needed during the first few days in jail. Depending on the severity, police inform family members and may refer the user to be hospitalized under police custody. PWID typically spend two weeks in police holding cells and it is in this period that it is critically important that access to ARVs, methadone and tuberculosis antibiotics are made available without interruption.

Lack of access to methadone inside the police jail or prison is a serious problem for those who are taking MMT as they suffer from severe withdrawal symptoms. Currently there are very limited MMT services inside prisons. When a drug user is sentenced to prison, he often loses his access to MMT, even though the National MMT Guideline refers to provision of methadone in prison setting. In practice, the senior medical officer prescribing methadone will only provide a one to two week supply of methadone to the prison doctor to taper off treatment (depending on level of cooperation between the police and methadone centre). However, in many cases police do not take any initiative to arrange for MMT to be provided to PWID in their custody. Medical officers prescribing MMT can arrange to send methadone through the police if they are informed by PWID or their families about the situation. On-going access to methadone is only provided if a family member or friend takes responsibility and bears the cost of delivering the methadone to the jail. Beyond this period, there is no treatment provided from the public sector. Access to condoms is also important in prisons.

4.3 Recommendations

Criminal laws and police abuses

1. The possession of needles and syringes should be decriminalized (Myanmar Excise Act 1917, Section 33). The Myanmar Excise Act should be amended to provide exceptions for distribution and possession of needles and syringes for HIV prevention and harm reduction purposes.
2. Partnerships between CCDAC, Myanmar Police Force, MoH, UN, NGOs, and community networks to support harm reduction service provision need to be revitalized and local arrangements between police, NGOs and PWID communities to facilitate needle and syringe programmes need to be re-established.

3. The Directive by Police Headquarters (2001) not to arrest for possession of needles and syringes should be widely promoted to police at all levels and strictly followed.
4. The MoHA/Myanmar Police Force should issue updated directives or police instructions prohibiting the use of needles and syringes as evidence for prosecution or as a basis of arrest or harassment. Police instructions should also prohibit police harassment of PWID attending or in the vicinity of drop-in centres or other sources of clean needles and syringes. Law enforcement efforts should focus on drug manufacturing, sale and supply, not use.
5. The Narcotics Law should be amended to include specific provisions on harm reduction services including MMT, needle and syringe programmes, and peer education and outreach, including in detention centres and prisons.
6. Harm reduction should be a standard part of the police curriculum. Sensitization and advocacy should aim to educate police of the public health reasons for providing clean needles and syringes, peer education and MMT to PWID.

Registration of drug users

7. The system of compulsory registration of drug users should be phased out because it is stigmatizing, drives PWID underground and away from services, and fails to effectively address relapse.⁵⁸ Instead, voluntary community-based treatment options should be provided.
8. While the current drug registration system remains in place, the law should treat registered drug users who are undergoing treatment leniently if they have a relapse during treatment. Police should take a health-oriented view to encourage more drug users to come forward to access counselling and treatment for drug use, VCCT and HIV prevention information. Police instructions should direct that a registered drug user not be charged with a criminal offence due to relapse.
9. If the registration system continues, registration for drug treatment should only be under the MoH and personal information should be confidential and used solely for the purpose of treatment, not for police monitoring or criminal prosecution. This will encourage PWUD to register early for treatment and receive VCCT and HIV prevention education and services.

Prisons and detention centres

10. A prison MMT programme should be established. Procedures should ensure continued access to MMT for people in police detention or prison.
11. Treatment and rehabilitation services should be offered to people convicted of drug use or possession offences so as to divert PWUD from the prison system.
12. Rehabilitation centres for drug users should be offered as a voluntary option and include effective evidence-based services for drug treatment and counselling in addition to physical, psychosocial and livelihood rehabilitation.

Health care services

13. Community-based voluntary drug treatment services should be expanded. The National MMT Guideline should be fully implemented. Access to MMT and quality drug treatment counselling services should be expanded.
14. PWID should not be denied access to ART only on the grounds that they have not registered as drug users or undergone MMT initiation.
15. Drug use should be taken out of the criminal context and a new law and national policy for drug use should be developed that promotes harm reduction and treats drug dependence as a health condition.

Procedures and import restrictions under the National Drug Law and Narcotics Law require urgent revision to allow expanded access to effective pain relief drugs for PWUD undergoing withdrawal.

5. MSM and transgender people



5.1 Context

Criminal laws

Sodomy is criminalized by Section 377 of the *Penal Code 1860*, which defines the 'unnatural offence' of carnal intercourse against the order of nature with any man, woman or animal. The penalty for 'unnatural' sex is imprisonment for up to ten years, and a fine.

Although this offence in theory can be applied to all genders and is not restricted to sodomy between men, the offence in effect is interpreted by police as criminalizing male consensual homosexual conduct (as well as other forms of sex considered 'unnatural').⁵⁹

The *Penal Code 1860* was inherited from the British colonial era and is based on the *Indian Penal Code*. Myanmar is the only country in the Greater Mekong Sub-Region that criminalizes sex between consenting adult males. The other countries (Cambodia, Lao PDR, Thailand, Viet Nam) were not British colonies so did not inherit the 'unnatural sex' provision from the British penal code. For example, in Cambodia and Lao PDR age of consent to sex is 15 for both heterosexual and homosexual sex.⁶⁰

Protective laws

There are no specific laws addressing the legal status of transgender persons and their ability to change gender on identification documents. This contrasts with other Asian countries including Bangladesh, India, Nepal and Singapore, which provide legal recognition to transgender or 'third gender' people. There are no laws protecting MSM or transgender persons from discrimination on the grounds of sexual orientation or gender identity. For example, some cities in the Philippines prohibit discrimination on these grounds in employment and access to health care services.⁶¹

Law enforcement issues

Police use public order laws against MSM and transgender people, particularly if they are suspected of involvement in sex work.

Although the 'unnatural sex' law is rarely enforced, the existence of the offence complicates the delivery of effective HIV prevention services because it prevents community-based organizations (CBOs) from being registered with the state and discourages programme beneficiaries from accessing basic HIV services.⁶²

The existence of the offence also makes MSM and transgender people vulnerable to abuse by the police.

In 2013, an NGO (Asian Human Rights Commission) reported that police in Mandalay had been conducting an operation against MSM and transgender people who had been congregating in public places in the city:

...a group of around 20 (non-uniformed) men—some police, others local administrators or other unidentified persons—descended on the area outside the Sedona Hotel in Mandalay and assaulted a group of gay and transgender people there, pushing, hitting, handcuffing them and pulling off their garments in public before loading them on to a number of vehicles. Once in custody, police continued to abuse the group of 11 detainees, hitting and kicking them constantly, stripping them naked in the public areas of the Mandalay Regional Police headquarters, photographing them, forcing them to hop like frogs, forcing them to clean shoes and tables, to walk up and down as if on a catwalk, uttering obscenities at them, and otherwise physically and psychologically demeaning them. One of those detained said that a police officer interrogated her at length about her sexual activities and preferences, where she usually hangs out, and later tried to lure her to come back with him after leaving the police station.

Although many of those detained are later being released without charge, some have been threatened with, and others charged under, the 1945 Police Act, section 35(c), which stipulates that, "Any person found between sunset and sunrise having his face covered or otherwise disguised, who is unable to give a satisfactory account himself... may be taken into custody by any police-officer without a warrant, and shall be punishable on conviction with imprisonment for a term which may extend to three months". In one case, the details of which have been obtained by the AHRC, two accused each had to pay bribes of around 400,000 Kyat (about USD 420) to be released from a case under this section lodged by the police in the Aungmyay-thazan Township Court. They were informed that for a lesser amount of money they could be held for just one week instead of the full three-month period.

Equally disturbing is that some of those who are being released are being forced to sign pledges beforehand that they will not go to public places as before or wear women's clothing.⁶³

The police reportedly use the law to intimidate and extort bribes. In one such case in Yangon, a man who has sex with men was accused of soliciting and was arrested. Unable to pay a bribe, he was locked up and sexually assaulted by police. In another case, several MSM were arrested during the annual TaungByone festival near Mandalay, which attracts hundreds of MSM. They were eventually released without charge.⁶⁴

In 2006, a study of 828 MSM and male sex workers found that 13 per cent of MSM and 30 per cent of male sex workers reported police harassment in the past 30 days; and 15 per cent of MSM and 26 per cent of male sex workers reported being beaten or forced to have sex in the past year. Police are reported to misuse existing laws to extort money from MSM, transgender people, and sex workers.⁶⁵

In 2008, the *3rd National MSM Consultation and Capacity Building Meeting in Myanmar* reported that HIV behaviour change communication cannot be explicit

because of government censorship policies. The meeting recommended that advocacy work be done with the government and police, and that censorship rules be changed to enable provision of sexual health information. In relation to male sex workers, the meeting participants recommended that advocacy be undertaken with law enforcement agencies and personnel to reduce levels of harassment and abuse, including male-on-male rape and sexual violence.⁶⁶

5.2 Issues raised during consultations and the National Review Meeting

Police abuses

Section 377 of the *Myanmar Penal Code* in practice is only referred to by police in reference to sexual intercourse between two males, and this interpretation of the law enables the police and law enforcement officers to extort money from MSM and transgender people and commit verbal as well as physical and sexual abuse of arrested MSM and transgender people. Although actual prosecutions under Section 377 are rare (with the exception of cases involving children), the existence of this criminal offence adds to stigma and drives MSM and transgender people to live in a secretive and unprotected environment where access to HIV prevention information and opportunities to practise safer sex behaviour are constrained.

MSM and transgender participants of the consultations expressed concern that Section 377 fuels negative attitudes and behaviour towards them, makes them vulnerable to police abuses and violates their human rights to expression of sexual orientation and gender identity.

Section 377 is very well known among MSM and transgender people. As a result of fear of police abuses, MSM and transgender people either do not carry condoms or hide condoms on their person.

The 2013 incident in Mandalay of a police raid where several transgender persons and MSM were arrested and abused has made MSM and transgender people in other areas wary of similar incidents happening to them. Transgender people in particular have concerns for their safety and vulnerability to police harassment.

Transgender people experience frequent physical and verbal violence from the police.

Many transgender people rely on sex work for income due to lack of alternative livelihood options. Transgender people report that sometimes the police have unprotected and unpaid sex with transgender sex workers. The police frequently harass transgender people if they are found walking on the street after dark and they are particularly vulnerable if they are carrying condoms or suspected of engaging in sex work.

It was reported that some policemen extort money from MSM and transgender people and some require sex to be provided under threat of arrest. Section 377 is used as the basis to threaten jail if money or sex is not provided because the offence carries a heavy prison sentence. MSM and transgender people who are held in police detention are reportedly subject to harassment and assaults including sexual violence. Transgender detainees also face threats of sexual violence from other inmates and some police are said to turn a blind eye or even encourage this practice by telling the other inmates to 'teach a lesson to this *achautma*' (transgender persons).

Inside police detention and prison, there are reports of humiliating treatment such as MSM and transgender persons being forced to strip naked and dance, beaten with a rod (Nan-Bat-Dote), ridiculed while they are naked, pressured to have sex and burnt with cigarettes.

Criminal charges create difficulties for MSM and transgender people including maintaining their jobs, interruption to education, and financial hardships due to the need to pay bribes or fines. The negative experiences of MSM and transgender people with the police practices have led to mistrust in the judicial system. As a result, not many MSM and transgender people are willing to use legal aid services even when these are available (e.g. through the Equal Project).

There was disagreement during the consultations and National Legal Review Meeting as to whether Section 377 should be completely repealed, or amended so that it does not apply to consenting adults but still applies to non-consensual conduct and to protect minors.

MSM and transgender people are usually detained under Section 30(d) *Rangoon Police Act* or Section 35 of the *Police Act* for loitering or suspicious activity, or under Section 54 *Code of Criminal Procedure* which gives police the power to make an arrest without a warrant, or under Section 5(1) of the *Restriction and Bond Act 1961*.

It was also reported that if a bribe is provided to the police, the charge is reduced to Section 47 *Police Act* (public nuisance), which has a lighter penalty than other public order offences. Freedom of movement is severely affected by police enforcement of public order provisions including Section 54, Section 30 *Rangoon Police Act* and Section 35(a)-(e) *Police Act*. Threat of arrest prevents MSM and transgender people from leading a regular life and enjoying freedom of movement at all hours. Transgender people and MSM cannot go to certain areas in towns that are more frequently associated with police raids. In some towns, police selectively enforce Section 268 of the *Penal Code* (public nuisance) against MSM and transgender people.

Stigma and discrimination

MSM and transgender communities do not enjoy equal rights to education, health care and livelihoods. Participants expressed the concern that young MSM and transgender people need to be supported to understand and safely express their sexual orientation and gender identity, and require access to non-discriminatory education and health services.

Compared to more masculine MSM, transgender people face stronger stigma and discrimination both within their own families, communities, education institutions and work places. Transgender people face discrimination from a young age. Verbal teasing, abuse and harassment especially from male members of the community are a daily reality for openly homosexual and transgender people. Transgender people face discrimination in their dealings with government offices. In one example, a transgender person was snubbed several times at the immigration office when he went to renew his National Registration Card because he was wearing women's clothing and hairstyle.

In Mandalay, religious authorities reportedly placed a warning notice stating that homosexual men are not allowed on the upper level of the place of worship, where only men are allowed.

Society's attitude and behaviour towards MSM and transgender people should be non-discriminatory. Promotion of non-discrimination can be achieved through education, awareness raising, sensitizing mainstream media, and introduction of protective laws and policies. The media tend to portray MSM and transgender people in a very negative or comical way to be ridiculed, rather than as responsible and productive members of society.

The law itself is considered to be discriminatory in that there is no legal recognition of transgender or 'third gender' status. The National Registration Card, as a basic identity document for a citizen, should allow people to be photographed as they

prefer to present themselves, rather than having to revert back to a male persona to fit the 'male' description under 'sex' category. The Penal Code includes the offence of rape (Sections 375, 376) but this does not apply to sexual assault of males by males. MSM and transgender persons who are sexually assaulted by police are unable to claim rape under the Penal Code.

MSM community networks identified the need for constitutional recognition of transgender status and constitutional protections from discrimination on the grounds of sexual orientation and gender identity. It was proposed that the *Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity* (2006) should be adopted as national policy by the State.

Health services and representation in national health and HIV policy bodies

Most health services are not sensitive to the specific needs of MSM and transgender communities. Many health care workers display prejudicial attitudes and behaviours towards these communities and do not treat them with respect or dignity, including at public health facilities.

MSM and transgender communities are not represented in the governance of health service providers and do not have regular opportunities to provide inputs and feedback on the needs of their community to influence how health services are provided.

Counselling sensitive to the needs of MSM and transgender people including for voluntary and confidential HIV counselling and testing (VCCT) is not yet available across the country.

Representatives of the Myanmar MSM Network felt that the needs of MSM and transgender people are not adequately addressed by NSP II. MSM participants were critical of the content of NSP II. NSP II includes MSM only under the sexual transmission category and there are no specific targets or activities to address the wider health, human rights and social welfare needs of the MSM and transgender community. NSP II does not address the sexual orientation and gender identity rights of MSM and transgender people beyond their status as target groups for HIV prevention.

There is inadequate, visible representation of MSM and transgender people at the national level to provide feedback and influence priorities of HIV and health policy coordination and planning. It is important to provide MSM and transgender people with opportunities for official representation in the national level health coordinating and decision-making bodies.

The transgender community also face challenges when they try to become involved in implementing HIV prevention activities at local level. Transgender people face difficulties in applying for an overnight guest permit because of the way they dress and look.

Education

There is considerable pressure on MSM and transgender people to conform to the mainstream gender and sexuality norms when attending schools or colleges. Bullying or mistreatment is reported from other students as well as from teachers. Discrimination includes not being considered for scholarship opportunities abroad. Current teaching curricula do not address issues relating to sexual orientation, gender identity or stigma associated with MSM and transgender people.

Employment

Many transgender and openly gay men have limited work opportunities in the mainstream labour market because of stigma and discrimination and stereotyping of suitable work for MSM and transgender people. Openly homosexual and transgender

people often encounter financial hardship. MSM and transgender people are also constrained from expressing their sexual orientation and gender identity in workplaces due to existing gender norms and workplace regulations (e.g. dress codes for males and females).

5.3 Recommendations

Criminal offences and police abuses

1. Section 377 of the *Penal Code* should be repealed or amended as it violates human rights to privacy and equality, fuels stigma and discrimination, encourages abuses by the police, impedes HIV prevention efforts and is an obstacle to access to health care. Section 377 should not apply to consensual sexual conduct between adults in private.
2. The police should be trained on the harmful impacts of law enforcement practices that interfere with HIV prevention. Police should support health promotion efforts to promote condom use instead of harassing MSM and transgender people for possession of condoms when they are searched during investigation or arrest.
3. Police instructions should direct police not to enforce public order offences (e.g. loitering after dark) against MSM and transgender people unless they are implicated in genuinely criminal activities.

Protective laws and policies

4. Laws and policies should prohibit stigma and discrimination against MSM and transgender people in health care, education and employment. Disciplinary action should be taken against persons who commit acts of discrimination.
5. The law should enable transgender people to change their legal gender on identity and registration documents. One option is to enable transgender people to identify as a 'third gender' on legal documents, with equal rights as enjoyed by other citizens.

Capacity building and inclusion in NSP II

6. Health care workers should be sensitized to the needs and human rights of MSM and transgender people to increase access to HIV testing, treatment, and sexual health services for MSM and transgender communities.
7. NSP II should recognize the sexual orientation and gender identity rights of MSM and transgender people as a fundamental principle of effective HIV prevention.
8. NSP II should support comprehensive responses to the needs of MSM and transgender people including action against stigma and discrimination in delivery of health services, and sensitization and training of health personnel to increase access to VCCT and sexual health services.
9. MSM and transgender voices should be heard through representation at national health coordinating and decision-making bodies to ensure interventions are tailored to their specific needs.

6 Women and girls



6.1 Context

Legal and policy framework for gender and HIV

Article 22 of the *Constitution of the Union of Myanmar* (2008) states that all citizens shall be equal before the law, regardless of race, religion, status, or sex, enjoy equal opportunities, enjoy the benefits derived from his labour in proportion to his contribution in manual or mental labour and have the right to inherit according to law. Article 32A of the Constitution states that the Union shall care for mothers and children.

Myanmar has acceded to the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW) and is a signatory to the Beijing Declaration and Platform of Action.⁶⁷ However, domestic laws do not yet offer comprehensive legal protections of the rights of women and girls in general, or in the context of the specific gender issues raised by the HIV epidemic including violence protection.

NSP II is informed by the principle of gender equality, and requires that interventions be gender-sensitive and informed by gender analysis.⁶⁸

The *National Strategic Plan for the Advancement of Women (2012–2021)* is intended to implement the Beijing Declaration and Platform of Action. It includes the following actions relevant to HIV under the priority area of 'Women and Health':

- Research and surveys on the role of women in decision making for HIV prevention, care and treatment, and women's access to and utilization of HIV prevention, care and treatment services.
- To raise awareness of not only women but also men and teenagers on basic health, sexual and reproductive health, HIV and sexually transmitted infections, treatment, care and support, and to implement community-based initiatives by collaborating with women's organizations.

- To reduce and eliminate customs, superstitions and beliefs that are obstacles to women's access to, and use of basic health, sexual and reproductive health care.
- Expand rural area-oriented activities for basic health, sexual and reproductive health care, prevention, treatment, care and support of HIV/AIDS and sexually transmitted diseases.

The Government is developing a national Social Protection Strategy focused on the needs of women, children, people with disabilities and other vulnerable groups. A National Committee for the coordination of social protection is led by the Ministry of Labour and the Ministry of Social Welfare, Relief and Resettlement.

The *Penal Code* Section 312 criminalizes abortion except when it is necessary to save the woman's life. There is no exception for women who have been raped. There is a large unmet demand for modern family planning methods. Unsafe abortions are a major contributor to high maternal mortality rates.

Violence protection

Myanmar does not have a domestic violence law. The only laws concerning sexual violence are sections of the *Penal Code 1860* and provisions against sexual exploitation in the *Anti-Trafficking in Persons Law* (2005). A process is underway led by the Ministry of Social Welfare, Relief and Resettlement to develop a law on 'Anti-Violence Against Women'.

The *Penal Code* contains some provisions for crimes of violence against women including rape, abuse, and seduction and sex with under-age women. The *Penal Code* (Sections 354 and 509) addresses violence with criminal intent, and threatening a woman's dignity either by verbal or physical gestures or physical action. Trafficking or trading women for prostitution, or enticing for sexual purpose are also crimes. Spousal rape is not considered a crime unless the wife is younger than 13 years (Section 375).

Property and inheritance

For Buddhist citizens, Myanmar Customary Law applies in the areas of marriage, succession and inheritance. Traditional understandings of gender roles influence the application of Customary Law. The rights of Buddhist women to gender equality are protected by the *Buddhist Women's Special Marriage and Succession Act 1954*.

Under Myanmar Customary Law, a spouse can be automatically divorced if she/he has a sexually transmitted infection as it is considered as a sign of infidelity. A court has to decide who the injured party is, and that injured party may ask for compensation.

Muslim Law and Hindu Law are applied by the respective communities in respect of marriage, succession and inheritance.⁶⁹ The *Christian Marriage Act, Burma Divorce Act* and the *Succession Act* (regulating matters of inheritance) govern the rights of Christian women. Inheritance practices can vary according to local customary laws and in some remote areas women are denied inheritance rights.⁷⁰

6.2 Issues raised during consultations and the National Review Meeting

Financial disadvantage

Women bear the burden of care for children and HIV-affected family members. Women living with HIV are ostracized from communities and are particularly disadvantaged in finding employment. 'Low-risk' women (who typically acquire HIV from husbands who engage in high-risk behaviour) are not well served by HIV prevention, care and support services. Women living with or affected by HIV often experience financial hardship, which can be addressed by social protection.

Health care

Representatives of Myanmar Positive Women's Group raised concerns at the community consultation of key populations from Mandalay and the north⁷¹ that pregnant women face difficulties in accessing prevention of mother-to-child HIV transmission (PMCT) services outside of big cities and towns. PMCT services are not well known in some areas and women report poor quality of counselling, lack of confidentiality, and poor antenatal care due to lack of skills and interest of service providers. Participants were also concerned that insufficient funding leads to HIV-positive pregnant women having to pay prohibitively expensive delivery fees. HIV-positive pregnant women face higher delivery charges at public hospitals (either for normal or caesarean delivery) compared to negative women.

Women report stigma and discrimination by staff including midwives, nurses and other health care providers, and cleaners. Many HIV-positive pregnant women stay away from health services because of fear of breach of confidentiality and insensitive treatment by nurses and midwives. Many women deliver at home in rural and remote communities, and only find out about their HIV status when they fall sick.

HIV-positive women experience difficulties in accessing reproductive health and family planning services. There is limited information on options for free or subsidized reproductive health and family planning services for HIV-positive women to enable them to make informed health decisions. Reproductive health care providers are not well informed about universal infection control procedures and many have unreasonable fears regarding the risk of infection from providing care to patients.

There were reports from HIV positive women of cases where some of their peers were possibly pressured by counsellors, midwives, nurses and doctors not to have children, to undergo permanent sterilization or to take contraception. HIV-positive mothers are kept in a separate ward with infectious disease patients, rather than with other mothers.

Property and inheritance

Women are blamed for bringing HIV into the family and the shame associated with a stigmatized disease. In practice, the legal rights of HIV widows to inherit property from their husband are often denied. This may be because of lack of access to legal representation to ensure inheritance rights are enforced, or because customary inheritance rules are applied so as to benefit relatives of the deceased husband rather than the widow.

6.3 Recommendations

1. Violence protection laws and policies should address the needs of women and girls to be protected from violence in domestic and non-domestic contexts (e.g. sex workers). Marital rape should be criminalized.
2. Laws and policies should prohibit discrimination on the grounds of gender in the delivery of health and HIV services.
3. Policies should ensure gender-sensitive HIV services including the right of HIV-positive women to PMCT services, family planning and reproductive health services. Women and girls should have the right to decide on their family planning and reproductive health choices. Health care workers should receive training on the reproductive rights of women and girls living with HIV.
4. Widows should be provided with access to information about their legal rights to inheritance and legal aid services so that inheritance rights can be enforced.

The national Social Protection Strategy should address the specific needs of women and girls living with and affected by HIV, female sex workers, females who use drugs or who are in prisons or detention centres.

7. Children and young people



7.1 Context

A recent study of the needs of orphans and vulnerable children (OVC) in Myanmar found a high incidence of social and psychological consequences among HIV OVC. A much greater number of HIV OVC than their neighbouring children experienced family displacement from their original homes, child/sibling displacement and family dispersion. The study recommended establishment of community support programmes, creation of job opportunities to minimize social impact on affected families and provision of counselling and psychological support to HIV OVC.⁷² Another study on HIV orphans in Myanmar documented a range of adverse socioeconomic consequences such as school discontinuation, family dispersion, adverse effects on family economies, stigma and discrimination.⁷³

The *Child Law 1993* (which is currently being updated) addresses child protection and guardianship issues. The Department of Social Welfare is revising the *National Plan of Action for Children* in collaboration with UNICEF and national partners. This revision includes a section on HIV OVC.

Adolescent sexual health

Myanmar's *Strategic Plan for Reproductive Health (2008–2013)* states the goal of the attainment of a better quality of life by improved reproductive health status of women, men, adolescents and youths. The Plan supports provision of contraceptives and reproductive health services to unmarried persons and adolescents.⁷⁴

The *National Strategic Plan for Adolescent Health and Development in Myanmar 2009–2013* states: "Unmarried girls and young women are especially vulnerable to unwanted pregnancies because currently the services are not targeted to them and are limited to married women". To encourage young people to access services:

...service environments and health staff attitudes need to be adolescent friendly. Providing services alone is not sufficient to increase access and utilization. It is necessary to create demand among young people by both informing them that comfortable and convenient services are available and ensuring they understand the benefit of such services...Existing primary health

care services are to be reoriented with introduction in a phased way [of] adolescent friendly standardized service package...⁷⁵

The *Myanmar National Plan of Action for Children 2006–2015*⁷⁶ addresses HIV as follows:

Prevention and Control of HIV/AIDS and Care of People Living with HIV/AIDS

Activities such as dissemination of relevant health information regarding HIV/AIDS to adolescent boys and girls, provision of reproductive health services, voluntary testing for HIV/AIDS and counselling, and prevention of mother to child transmission will be carried out. Activities will also include establishment of youth friendly services for capacity building of health personnel and the community, surveillance of risk behaviour, counselling and care for people with risky behaviour, and for people who are at risk of getting HIV/AIDS.

Age of consent issues

The age of consent to sex is 14 years for females (Section 375, *Penal Code*). There is no specific age restriction on males engaging in sex. Sodomy is prohibited for all ages.

There is no specific law or policy defining the age at which a young person can obtain an HIV test independently, without their parent's consent. It is important to clarify the legal age of capacity to independently request an HIV test, because young people who are at risk of HIV may be reluctant to test because of fear that their sexual or drug use conduct will be disclosed to their family. The United Nations Committee on the Rights of the Child issued a General Comment in 2013 recommending that countries consider allowing children to consent to HIV testing and education and guidance on sexual health.⁷⁷ In other countries of Asia and the Pacific, laws or policies have been developed to clarify the age when young people can access HIV testing without parental consent. For example, in Viet Nam it is 16, Lao PDR 14, Nepal 14 and Papua New Guinea 13 years.⁷⁸

The *Child Law 1993* defines a child as under 16 years of age (this is currently under revision with the intent to raise the age to 18 so as to be consistent with the Convention on the Rights of the Child). The *Child Law 1993* states:

Every child who is capable of expressing his or her own views in accordance with his age and maturity has the right to express his own views in matters concerning children. The views of the child shall be given due weight in accordance with his age and maturity, by those concerned.⁷⁹

Section 89 of the *Penal Code* states that a guardian may consent to medical treatment for a person under 12 years of age.⁸⁰ Reading the provisions of the *Penal Code* and the *Child Law* together suggests that persons over 12 years may exercise their own independent right to consent to testing or treatment, if they are of sufficient maturity to understand the nature and implications of the test or treatment. However there are no official guidelines confirming this interpretation. Account also needs to be taken of the *Majority Act*. No minor can enter into a legal contract until 18 years, which is the legal age of majority (*Majority Act*).⁸¹ Some medical practitioners may take the view that they should not test or treat a person under 18 years without parental consent. This points to the need for guidance to clarify the legal rights of children between the age of 12 and 18 years to consent to medical treatment independent of their parents.

People under the age of 18 require parental consent to marry. Most marriages are conducted under religious laws.⁸²

There are no age restrictions for access to methadone or needles and syringes.⁸³ In practice, professional norms determine whether a minor can access HIV testing independent of their parents / guardians. These vary across the country.⁸⁴

There are no specific laws regarding the rights of minors to privacy or confidentiality of medical records or other personal information disclosed to health care workers. Information regarding a minor's health status or behaviours may be disclosed to parents at the discretion of health care workers.

7.2 Issues raised during consultations and the National Review Meeting

Child protection

Participants of the Mawlamyine community consultation raised concerns that there are very few care and support options for orphans and vulnerable children of HIV. According to participants, there are no government-run services for HIV orphans. Services are provided by small local civil society, self-help and religious groups. Such services have very limited resources and face constant risk of discontinuation due to lack of funds.

Participants of the Mandalay and northern areas community consultation noted that the burden of caring for OVC usually falls to relatives or other community members who are often already struggling with their own financial issues. Participants shared the common challenge of not having a functioning guardianship system or other formal state mechanism to tackle this issue in many communities across the country. Lack of appropriate guardianship arrangement for orphans is a common problem. The *Child Law* exists for adoption and guardianship of orphans. However the law is not evenly enforced and many OVC lose their identity and links to their family and relatives. Although street children are the responsibility of the State under the law, most street children lack any support or care. Cases of neglect in caring for HIV orphans are common.

Children of sex workers who are sentenced to prison, and who have no other family members to look after them often must rely on the goodwill of other sex worker families or local humanitarian groups or religious leaders for assistance and care. There is no formal mechanism or support from the government offered either at the court or throughout the legal process for the children of sex workers.

OVC experience stigma and discrimination from the community. Many HIV orphans work as scavengers on the street or long hours at tea shops for less than a minimum wage.

Participants were of the view that parents and the wider community should receive education on the rights of children and the laws protecting their rights, and that civil society organizations and local authorities should work together to raise awareness about the rights of children in the communities, especially targeting parents and guardians. There is currently no effective representation at the national level for raising the child protection, treatment, care and support issues of OVC.

National registration

Many OVC are unable to obtain a National Registration Card (NRC) when they come of age because they are unable to supply the information required for the NRC application. The NRC is required to obtain access to services from the State, to attend school, travel freely within or outside the country and to apply for employment. Household registration is also important for accessing services. Children who have lost both parents face difficulties in obtaining an NRC.

Treatment and care for children living with HIV

ART eligibility criteria require one or two HIV-negative adults to supervise the child's treatment in addition to the child's HIV-positive parents. HIV-positive orphans without any guardian or care taker cannot access ART, because an adult care taker or guardian is regarded as necessary to ensure the child is adhering to treatment and monitoring side effects.

The lack of free OI medicines in public hospitals is a problem for children who cannot afford the cost of treatments. ART medicines are generally not yet available in child formulations in Myanmar. Breaking the adult pill into a child's dose is common practice with no guarantee of the correct dosage. The National Guideline on treatment of HIV infection among children is not consistently implemented.

Education

Access to education can be difficult for children from HIV-affected households, regardless of their own HIV status. They experience discrimination from teachers and other students. Children living with HIV face problems in obtaining leave to go for health appointments, and they may be more frequently absent from school due to their health conditions. Private schools generally refuse to accept HIV-positive children as their students. The main reason for this is ignorance about the lack of HIV transmission risk through casual contact. The Ministry of Education does not have law, policy or directives on this issue yet. Discrimination experienced in private schools includes being forced to move schools, denial for school admission, and refusal to give sick leave to children who need to attend HIV treatment centres. Many parents do not want their children to play with children of sex workers or children suspected of having HIV. Teachers ask HIV-positive children of sex workers to sit at the back of the class or not to play with other children. The children of sex workers are discriminated against in schools to the point that these children no longer want to attend school and some drop out.

7.3 Recommendations

1. The *Child Law 1993* should be updated and enforced to ensure OVC have access to protection, guardianship, care and support. Orphans, street children and other vulnerable children should be cared for by the State in an appropriate setting (either community or institution based) and educated to their full potential. Regulations and guidelines should be established on procedures for HIV-positive children and children from HIV-affected households including orphans to access health, education, protection and care including shelter.
2. Children should be provided with education about their rights so that they can demand fulfilment of their rights including the right to health, and the voices of children and young people should be heard in policy-making processes.
3. The Government should ensure systems are in place to support all OVC including children in HIV-affected households to have birth registration, household registration and a National Registration Card.
4. The Ministry of Health should issue Guidance confirming that sexual and reproductive health services including HIV and STI testing can be provided to young people who are 12 years or older without parental consent, if they are assessed by the health care provider to be sufficiently mature.
5. Policies on HIV prevention, care and support should include specific provisions for young key affected populations including young MSM and transgender people, young female sex workers and young PWUD as well as young internal and foreign migrants.
6. The Ministry of Education should issue a policy prohibiting discrimination against children living with HIV by public or private schools.
7. The MoH should revise the ART eligibility criteria to remove the requirement that an HIV-negative adult be available to provide treatment adherence support to the child. An HIV-positive parent should be sufficient to provide adherence support to the child. MoH policy should guarantee the uninterrupted supply of ARVs in child formulations to ensure treatment efficacy and prevent unwanted side effects.

8. Patents and access to generic medicines



8.1 Context

Myanmar does not manufacture antiretroviral drugs (ARVs) and relies on imported ARVs. Generic versions of patented ARVs are imported mainly from India. The ongoing supply of affordable generic ARVs may be restricted if Myanmar:

- Introduces a new patent law that fails to include adequate flexibilities regarding supply of medicines for public health purposes; or
- Enters into trade or investment agreements with other countries that restrict access to generic medicines.

Myanmar does not currently have an operational system for recognizing or enforcing pharmaceutical patents. The introduction of a patents system is planned in the near future and will lead to cost increases for new medicines marketed in Myanmar during the twenty-year patent term. The proposed

new patent law will provide a monopoly to the patent holder for twenty years, which means that the pharmaceutical company that owns the patent for a drug can determine the price of the patented drug during the twenty-year patent term. This has particular relevance to third-line ARVs and new ARVs that come on the market. It also has relevance to new drugs for other diseases for which many people living with HIV require treatment, such as hepatitis C, cancers and opportunistic infections such as tuberculosis.

The World Intellectual Property Organization (WIPO) website states as follows:⁸⁵

In Myanmar, there is presently no law or at least no law in operation on patents and industrial designs. This means that production, (commercial) use and trade in goods is possible without permission of the people/companies who may hold the patents or design rights outside Myanmar... Having repealed the Patent and Design Act of 1945, the only law relating to patents and designs still in force is the Burma Patents and Designs (Emergency Provisions) Act 1946... nothing has been applicable since the replacement of the substantive Act of 1945.

With regard to pharmaceutical products, the national Drug Law has been promulgated since October 1992 and notifications were issued in August 1993 pertaining to drug registration, drug manufacturing, importing, selling and distribution, labelling and advertisements... However, these laws do not include

patenting in the field of pharmaceutical process and products. Therefore, it is currently not possible to apply for patent and design registration in Myanmar. Drafting the new legislation for patents... to come into line with the TRIPS Agreement has been carried out by the Attorney General's Office in cooperation with Ministry of Science and Technology. However, patent protection in the pharmaceutical area may not be possible at least until the year 2016.

Under the World Trade Organization's (WTO) *Agreement on Trade Related Aspects of International Property Rights* (TRIPS), least developed countries (LDCs) are not required to have patent laws in place that comply with TRIPS until July 2021.⁸⁶ Myanmar is regarded as an LDC by WTO. Therefore, WTO does not require Myanmar to introduce or enforce patent protections for pharmaceutical products until 2021. Although a patent law may be introduced before 2021, to enable importing of generic medicines to continue, a decision could be reached not to enforce patents that relate to pharmaceuticals until 2021.

The TRIPS Agreement allows countries to take measures to ensure that the approach taken to implementing TRIPS requirements in domestic laws does not interfere with public health objectives. These are known as 'TRIPS flexibilities'. The WTO *Doha Declaration on TRIPS and Public Health* (2001) affirms the right of poor countries to make full use of TRIPS flexibilities to protect public health and to enhance access to essential medicines.

To ensure ongoing access to generic medicines, it is important that any new national patent law incorporates mechanisms to allow the Government to exercise TRIPS flexibilities such as compulsory licensing, parallel importing, and a mechanism to import generic versions of patented medicines.

A Core Working Group has been established to ensure TRIPS flexibilities are included in the new draft patents law. Members of the group include concerned Ministries (Ministry of Science and Technology, Ministry of Health, Ministry of Information and Ministry of Commerce), United Nations agencies (UNDP, UNAIDS, UNICEF and WHO), NGOs, civil society and a law firm. A national consultation meeting with all stakeholders including Ministries, United Nations agencies, NGOs and civil society was held in December, 2012. The Core Working Group meeting for TRIPS flexibilities was convened in August 2013 and an information session for parliamentarians was convened in October 2013. In 2014, upon receipt of the current draft of the Patent Section, UNAIDS on behalf of the Core Working Group organized a technical review of the draft law. Subsequently, the Core Working Group then relayed the comments from the review to the Ministry of Science and Technology.

8.2 Issues raised during consultations and the National Review Meeting

The drafting of the new law on patents is underway and it is understood that the Government is keen to introduce the law soon because it will encourage foreign investment in the economy. The need for flexibilities to be included in Myanmar's new patents legislation was confirmed during the National Legal Review Meeting. Discussions focused on the need to ensure the law maximizes access to affordable generic medicines through compulsory licensing and avoids TRIPS-plus provisions. Regard should be had to transitional periods for enforcing TRIPS that apply to Least Developed Countries.

8.3 Recommendations

The Government of Myanmar should:

1. Ensure that TRIPS flexibilities including compulsory licensing and parallel importing are fully addressed in the new patents law so that access to medicines is not restricted when Myanmar commences recognition of pharmaceutical patents.
2. Consider extending the date of exclusion of pharmaceutical products from patent protection until 1 July 2021, unless Myanmar graduates from Least Developed Country status before that date.
3. Not agree to enter trade or investment agreements that impose 'TRIPS-plus' requirements that could restrict future access to generic medicines.

9. Cross-cutting issues



The literature review, consultations and National Legal Review Meeting identified key areas requiring action, including in relation to:

- Law and policy reform priorities;
- Police practices;
- Capacity building; and
- Access to justice, through legal aid services, legal literacy and legal empowerment programmes.

Law and policy reform

Most of the key laws that affect the rights of people living with HIV and key populations are old laws from the nineteenth and mid-twentieth century that need to be updated to reflect contemporary social contexts and the realities of the HIV epidemic. Some laws date back to the British colonial era (such as the *Penal Code 1860*, *Prisons Act 1894*, *Rangoon Police Act 1899* and *Myanmar Excise Act 1917*). There was interest from some parliamentarians attending the National Legal Review Meeting in developing a new national HIV law for Myanmar. Several countries in the region have enacted comprehensive national HIV laws that address the human rights and public health aspects of the HIV epidemic in one piece of legislation (e.g. China, Cambodia, Fiji, Lao PDR, Mongolia, Papua New Guinea, the Philippines and Viet Nam).⁸⁷ India and Nepal are also considering comprehensive HIV/AIDS Bills. In considering law reform options, other approaches also require consideration, such as inclusion of HIV within general laws and policies relating to human rights, public health, gender equality and social protection.

It should be recognised that law reform is a long-term strategy. Myanmar is currently undergoing a period of significant change with multiple laws and diverse areas of social and economic policy undergoing significant reforms concurrently. It may be several years before laws relating to people living with HIV and key

populations are given priority in parliament. However, much can be achieved in advance of law reform, for example through policy innovation, capacity building and partnerships between community-based organizations and law enforcement bodies to promote a shared understanding of how a rights-based approach supports HIV prevention objectives.

Police practices

A major theme arising from consultations was the difficulties created by police conduct that impedes HIV prevention efforts. Punitive police practices that were reported included harassment, extortion and arbitrary detention, which deter key populations from accessing the means of HIV prevention (condoms and clean needles and syringes) and drive key populations underground and away from services. Police instructions require updating to address the role of police in supporting HIV prevention with key populations. This can occur immediately while also pursuing the longer-term objective of reforming the laws on sex work, drug use and homosexual conduct.

Capacity building

Consultations identified the need for capacity building of the justice sector and health care workers in HIV and human rights. Myanmar should consider examples of good practice in capacity building from other countries in the region, for example:⁸⁸

- In Thailand, a sex worker-led organization (SWING) has delivered HIV training to police cadets and works in partnership with tourist police to improve responses to violence directed at sex workers.
- The PoroSapot project in Papua New Guinea delivers sensitization to police on HIV and human rights using MSM and sex workers as educators. In 2011, the project reached over 500 police in three provinces.
- India's Human Rights Law Network convened a National Judicial Colloquium on HIV/AIDS and the Law in 2007, which brought together over 50 judges from the various High Courts and the Supreme Court of India.
- People living with HIV networks in India have worked with medical associations to train health care workers to reduce stigma and discrimination in health care settings.

Legal aid, legal empowerment and access to justice

Lessons from the existing legal aid services provided by NGOs such as the Equal Project, MDM and Myanmar Legal Aid Network (MLAW) can be applied to inform approaches to reaching communities with legal services, including paralegal services and human rights education. Consultations confirmed the need for policy and guidance to be developed that strengthens the legal aid system to address HIV-related issues including police abuses, discrimination and violence protection for key populations.

Recommendations

1. Capacity building is required to strengthen the role of lawyers, police, judges, health-care workers and parliamentarians in supporting human rights-based HIV responses. Each of these actors needs to understand the public health and human rights rationale for developing protective legal frameworks for people living with HIV and key populations. It is particularly important to provide training for police on HIV and human rights to address police abuses and to ensure that police act to protect and promote the rights of key populations.

2. The Government and donors should support community legal empowerment and 'access to justice' programmes that provide key populations with expanded access to free legal information, advice and representation, paralegal services, legal and human rights education, legal advice hotlines and access to rapid response teams to address incidents of violence or other serious rights violations. Key populations should be made aware of their rights and empowered to demand justice if their rights are violated.
3. Key populations should have access to independent and confidential complaints procedures if they experience harassment, extortion, unfair treatment or violence from the police, prison guards or other law enforcement officials.

The capacity of the National Human Rights Commission to address HIV-related complaints should be strengthened. Staff of the Commission should be trained on HIV-related human rights issues and the nature of rights violations commonly experienced by key populations.

10 Options for the way forward



10.1 Mechanisms for defining priorities and on-going planning

Mechanisms at the national level need to be established to agree priorities and strategies to drive forward the legal and human rights agenda for HIV. These should be located within the existing architecture of the national HIV response (e.g. a Working Group of the Technical and Strategy Group for HIV of the Myanmar Health Sector Coordinating Committee) and within parliamentary committee processes. For parliamentarians, at the beginning of 2014, a separate joint Parliament and Community Network Consortium Committee on HIV and Human Rights has been established. In addition the Parliamentary Committees on Population and Social Development, Rule of Law, and Human Rights may be appropriate bodies for discussion of HIV issues.

10.2 Immediate priorities: 2014–2015

A manageable number of priorities should be identified where progress could be achieved within a two-year period. For example, the following issues could be pursued, with progress monitored by a national committee with government, civil society and United Nations representation:

Law reform

Possession of needles and syringes

MoH should give immediate priority to amendment of the *Excise Act 1917* to decriminalize possession of needles and syringes to support the scale-up of the national needle and syringe programme.

Patents Bill

A Patents Bill was drafted in 2013 and is due to be considered by parliament in 2014. A 2013 WTO decision sets the deadline for Least Developed Countries (LDCs) such as Myanmar to comply with TRIPS as 2021. Myanmar could maximize access to ARVs and other medicines by delaying commencement of patent provisions relating to pharmaceuticals until 2021. NAP should be actively monitoring progress of the Patents Bill including the commencement date for provisions relating to pharmaceuticals to ensure that all TRIPS flexibilities are incorporated in the draft.⁸⁹

Policy reform

National guidance on non-discrimination and confidentiality

NAP (preferably in partnership with the Myanmar National Human Rights Commission) should develop guidance on non-discrimination on the grounds of HIV status and confidentiality of HIV status for endorsement by relevant sectors e.g. MoH and the ministries responsible for education and employment. Initially this guidance could focus on the priority areas of health care, employment, and the provision of education. Other issues such as insurance, finance, funerals and housing could be addressed at a later stage.

Although such guidance would not by itself be legally binding, it could provide a clear indication of conduct considered acceptable by government. The government could direct all public sector bodies to comply with the guidelines and also encourage private sector bodies and professional associations to endorse the guidelines. The relevant public sector agencies could also be required to report within a given period on measures taken to establish a process to enable people living with HIV to lodge complaints if guidelines are breached, and options for making responsibilities legally enforceable. For example, sectors could examine options for integrating non-discrimination and confidentiality obligations into regulations governing school education, regulations that address rights of employees in the public service, regulations governing ethical conduct or licensing of registered health care workers, and legislation or regulations on the mandate of the National Human Rights Commission.

ARV eligibility criteria

ARV eligibility criteria reportedly disadvantage PWID, mobile populations (including sex workers), and children, either through the wording of the criteria or the way the criteria are understood and enforced. To address concerns, NAP should clarify that:

- PWID should not be denied access to ART only on the grounds that they have not registered as drug users or undergone MMT initiation. This is particularly an issue for PWID seeking access to ART in areas where no MMT programme exists.
- Children with HIV should not need to be supervised by an HIV-negative parent to be able to access ARVs. Criteria should permit the adult who provides treatment support to the child to be HIV-positive. The presence of an HIV-positive parent should be sufficient to provide support to ensure the child adheres to treatment regimens.

- Mobile populations (including sex workers) should have a right to refill their ART prescription at any ART distribution site in Myanmar.

Access to medicines for people in police detention or prisons

Procedures should be established to ensure continued access to ARVs, medicines for OIs (particularly TB), and MMT for people in police detention or prison. MoH and MoHA should collaborate to ensure police instructions are issued and enforced to address access to treatments and MMT while in police custody, and to ensure that a prison MMT programme is established consistent with the national MMT Guidelines.

Reproductive health rights of positive women

NAP should issue guidelines for health care workers which stresses the rights of HIV-positive women to family planning and reproductive health choices and for health care workers to provide counselling, information and support to HIV positive women to make their own choices.

Law enforcement

Policing of key populations

Interventions should be designed to address the role of police in supporting HIV prevention with key populations in specific 'hotspot' localities. This will require national and local level leadership from within the Myanmar Police Force, and a willingness to work through partnership approaches involving local health authorities, key populations and local police at township level. Activities could include:

- Revision and updating of police instructions: A comprehensive instruction relating to HIV prevention and policing of all key populations could be developed. Police instructions need to address:
 - Not harassing/arresting sex workers, MSM and transgender people for carrying condoms;
 - Not harassing/arresting PWID or peer educators for carrying needles and syringes;
 - Not arbitrarily enforcing public order offences, Section 377 of the Penal Code or prostitution offences to harass or extort money from key populations;
 - Not interfering with HIV prevention delivered through peer education and outreach; and
 - Ensuring access to ARVs, OI medicines and methadone for people after arrest.
- Pilot sites could be selected with a focus on epidemic hotspots to monitor how police instructions are enforced. This may involve reviving local arrangements that were in place for needle and syringe programmes and extending this model to other key populations. For example, this could require health authorities working with local law enforcement bodies in the following activities:
 - Convening of regular coordination meetings of representatives of police, the local health authority, local HIV NGOs and key populations. The objective of these meetings would be to strengthen coordination of responses to HIV prevention among key populations in each district or township.
 - Lessons learned from evaluation of pilot sites could be used to inform a scaled-up 'national police-community HIV partnership' programme.

Capacity building

Implementation of the new laws, policies and police instructions described above will require targeted capacity building efforts. For example, police will need to be trained on new or updated police instructions that require them to work in partnership with health authorities to support needle and syringe programmes and condom distribution efforts. Training of health care workers will be important to ensure new policies on non-discrimination, confidentiality, reproductive rights and ARV eligibility/access are understood and applied. Resources should also be available to enable community networks to educate people living with HIV and other key populations about their rights under these new policies.

Access to justice

Ensuring that existing legal aid services are maintained is an immediate priority. Lessons learned from initiatives to reach key populations (e.g. the Equal Project) need to be systematically assessed to guide expansion of legal services. Low-cost models such as training of paralegal advice workers should be expanded.

10.3 The longer-term agenda

Law reform

The review identified the need for a range of new laws to be enacted (e.g. anti-discrimination and confidentiality laws to protect people living with HIV and key populations, laws on informed consent to HIV testing, legal recognition of transgender status, and a new law on patents). The review also identified existing provisions of laws that should be reviewed and amended / repealed to support HIV responses, including provisions in the *Suppression of Prostitution Act 1949*, *Narcotics Law*, *Penal Code*, *Prevention and Control of Communicable Diseases Law*, *Prisons Act* and the *Excise Act 1917*. It may take a decade or more to address all issues through parliament. However, some laws may already be subject to reform processes, so intervention to ensure HIV-related factors are taken into account may be feasible in the next one to two years. For example, the Patents Bill and a National Human Rights Commission Bill are currently being drafted and some aspects of the narcotics legislation are also undergoing review.

Anti-discrimination legislation

A national law prohibiting discrimination on the grounds of HIV status (particularly in employment, health care and education) should be an overarching priority for government, but it is unclear how or when an opportunity to introduce such a law will arise in parliament. Possibilities for anti-discrimination legislation include:

- A provision in the National Human Rights Commission Bill or regulations that clarify that the Commission has a mandate to accept complaints for HIV-related discrimination;
- A provision in a new law on disability discrimination;
- Inclusion of non-discrimination provisions in the *Labour Law* or *Penal Code* that extend to health status and disability generally, or HIV status specifically;
- A general provision in the Constitution relating to non-discrimination on the grounds of health status and/or disability, which is defined to include HIV, or a general provision on the right to health;
- Enactment of a stand-alone national HIV law.

Comprehensive national HIV law and other laws affecting key populations

The National Legal Review identified the option of enacting a comprehensive rights-based national HIV law following the models of other countries such as Cambodia, Viet Nam and Lao PDR. However, this is probably a long-term project for Myanmar noting that it is an ambitious undertaking and other countries such as Nepal, India and Pakistan have been discussing HIV Bills for five to ten years with little progress. Parliamentarians should also consider other models for achieving rights-based law reform such as the inclusion of rights to confidentiality and consensual HIV testing in the Communicable Disease Law or a new general health law, rather than enacting a new HIV-specific law for which it may be difficult to garner support.

For these and other legislative enactments / amendments (such as reform of the laws on prostitution, narcotics and 'unnatural sex' and introduction of legal recognition of 'third gender' status) it may take some years before an opportunity for parliamentary action arises without undue risk of a backlash potentially resulting in a more punitive outcome for key populations. At this stage it is important that parliamentarians and officials are equipped to identify opportunities for proposing changes to relevant legislation as they arise, so they can intervene with proposals in an informed and timely manner. For example, opportunities are likely to arise for revising the *Penal Code* in coming years. Parliamentarians and the NAP should be fully briefed to make the public health and human rights case for amendment of Section 377 of the *Penal Code*, enabling HIV prevention interventions to reach MSM.

Law enforcement

The longer-term law enforcement agenda should focus on enforcement of the new protective laws introduced to advance the rights of people living with HIV and key populations. Enforcement may require intervention of police or prosecutors in the case of serious violations of rights. The Myanmar National Human Rights Commission may have a role in providing redress for some rights violations. Other cases may be more appropriately dealt with through establishing new administrative mechanisms for handling complaints. Processes for addressing complaints of rights violations need to be developed that are low cost, accessible, speedy and confidential. This is a priority particularly in the health care sector. For example, hospitals could establish patient complaints offices to receive and respond to complaints of discrimination or breach of confidentiality of HIV status. Developing mechanisms to address health care complaints is a broader health systems issue that goes beyond HIV and will need to be sustainable for the long term.

Capacity building

Capacity building also requires long-term investments. Communities will need to be educated about their rights under the new laws and policies that are introduced. Integrating HIV-related issues into the curriculum for police training and law schools would ensure improved understanding of the role of the law and law enforcement in providing an enabling environment for HIV responses. This should include education about the importance of harm reduction approaches in addressing HIV acquired through injecting drug use.

Judges would benefit from opportunities to learn from their peers. In India, judicial training on HIV-related issues has been provided and national meetings have been held on HIV-related issues for the judiciary. A similar approach could be considered in Myanmar. The *Judicial Handbook on HIV, Human Rights and the Law* published in 2013 by UNAIDS could be translated into Myanmar language and used as a resource for training.

Capacity development of parliamentarians may include study tours (e.g. to observe how community-based models of harm reduction operate in Malaysia) or attendance at regional events such as HIV-related meetings of the Asian Forum of Parliamentarians on Population and Development (AFPPD). AFPPD provides a range

of resources and access to a regional network of parliamentarians interested in human rights and HIV.

Access to justice

Provision of legal services to people living with HIV and key populations needs to be part of the broader effort to establish a sustainable legal aid system for low-income populations in Myanmar. This will require engaging the mainstream legal profession on HIV-related human rights issues, for example through the Bar Council, and potentially also international law firms with an interest in providing pro bono services such as DLA Piper. International legal assistance may also be available for specific issues such as litigation to challenge controversial laws such as Section 377 from legal and human rights NGOs such as the Human Dignity Trust. It should be a longer-term objective to include HIV in clinical legal education models that use the law departments of Myanmar's universities to train students to provide paralegal support for marginalized populations.

10.4 Indicators of success

Actions to improve the legal and policy environment for HIV responses

Issue	Examples of indicators of success for priority actions
Leadership and coordination	<p>Multi-sectoral HIV legal and human rights working group established / number of meetings held.</p> <p>Parliamentary Committee identified / established for MPs on HIV-related laws / no. of meetings held.</p>
Police conduct affecting HIV prevention among key populations	<p>Comprehensive police instruction on HIV prevention and policing of key populations developed and disseminated.</p> <p>No. of police / health care workers trained on effective approaches to HIV prevention with key populations, harm reduction and sensitization to needs of key populations.</p> <p>Number of pilot sites identified for police-community partnership initiative.</p> <p>Number of coordination meetings of police, the local health authority, local HIV NGO and key populations at pilot sites.</p>
Discrimination and confidentiality	<p>National guidance on non-discrimination and confidentiality in employment developed and disseminated.</p> <p>National guidance on non-discrimination and confidentiality in health care developed and disseminated.</p> <p>National guidance on non-discrimination and confidentiality in education developed and disseminated.</p> <p>Processes established to enable people living with HIV to lodge complaints if guidance is breached in contexts of: (i) public sector employment; (ii) public hospitals / clinics (iii) public schools.</p>
ART eligibility criteria	<p>NAP instruction / directive issued clarifying that PWID should not be denied access to ART only on the grounds that they have not registered as drug users or undergone MMT initiation.</p> <p>NAP instruction / directive issued clarifying that supervision by an HIV-positive parent satisfies eligibility criteria for a child to be able to access ARVs.</p> <p>NAP instruction / directive issued clarifying that mobile populations have a right to access and refill their ART prescription at any ART distribution site in Myanmar.</p>

Issue	Examples of indicators of success for priority actions
Positive women's reproductive rights	NAP guidelines issued stressing right of HIV positive women to access family planning and reproductive health services for health care workers to provide counselling, information and options for HIV positive women.
Possession of needles and syringes	Amendment of the <i>Excise Act 1917 Section 33</i> to decriminalize possession of needles and syringes.
Access to medicines and Patents Law	The Patents Bill includes TRIPS flexibilities including compulsory licensing and maximum transitional period for pharmaceuticals as allowed by WTO.
Decriminalization of consensual sex between males	The need for Section 377 to be amended / repealed to support HIV prevention with MSM is raised with the Attorney General to be considered in <i>Penal Code</i> reviews / law reform processes.

10.5 Development of a roadmap to guide future actions

In May 2014, a Workshop was convened by UNAIDS to agree a draft Roadmap of short, medium and long-term priorities to improve the legal environment. Workshop participants were drawn from the Human Rights and Gender Working Group that was established in 2014 as a working Group of the HIV Technical and Strategy Group of the Myanmar Health Sector Coordination Committee. On the basis of these discussions the following table was prepared to guide the work of the Human Rights and Gender Working Group.

Draft roadmap of actions to improve the legal environment

Issue	Short term 2014-2015	Medium term 2015-2017	Long term By 2020
1. HIV Law <ul style="list-style-type: none"> • Discrimination • Confidentiality • Consent to testing • HIV prevention 	<p>Assess political risks. Conduct consultations on scope of draft HIV Law.</p> <p>Engage technical assistance from legal drafters.</p> <p>Parliament debates and passes HIV Law.</p>	<p>Community education on rights and responsibilities under the HIV Law.</p> <p>Mechanisms established to receive complaints.</p> <p>Legal aid services for PLHIV expanded.</p>	<p>Implementation and enforcement of HIV Law.</p> <p>Sustainable legal aid services available for PLHIV and key populations</p>
2. Police HIV instructions: <ul style="list-style-type: none"> • Condoms • Syringes • Police harassment • Access to ARVs & methadone 	<p>Consultations with community and Myanmar Police Force. Proposal put to MoHA.</p>	<p>Mechanisms established to monitor compliance at hotspots. Mechanisms established to receive complaints. Legal aid services for key populations expanded.</p>	<p>Monitor / update</p>
3. MoH Guidance or Directives <ul style="list-style-type: none"> • Discrimination • Confidentiality • Consent • Universal ARV access • Reproductive health rights 	<p>Collation of case studies to demonstrate problems. Consultations with community and health care workers. Proposal put to MoH.</p>	<p>Guidance / directives promoted systematically to health care workers and key populations.</p> <p>Complaint mechanism established at hospitals / clinics to address violations.</p>	<p>Monitor / update</p>
4. Excise Act	<p>Engage relevant government department on alternative approaches to regulating quacks. Draft amendment to repeal sections criminalizing possession of syringes (Sections 13, 33). Advocate for rapid passage through parliament.</p>	<p>Ensure Myanmar Police Force are aware of the amendments. Link this amendment to police instructions on syringes.</p>	

Issue	Short term 2014-2015	Medium term 2015-2017	Long term By 2020
5. Patents Bill	Obtain copy of most recent version of the Bill. Review TRIPS flexibilities and transitional periods that apply to medicines. Engage with MoH to propose amendments to Ministry of Science and Technology. Provide briefings to parliamentarians.		
6. Ministry of Labour Guidance or Directives <ul style="list-style-type: none"> • Discrimination • Confidentiality • No compulsory testing 		Consultations with community and employers, MBCA, UMFCCI. Proposal for Guidance put to Ministry of Labour. Make representations to licensing authorities regarding HIV testing of drivers. Link these actions with consultations on draft HIV Law.	
7. Ministry of Education Guidance or Directives <ul style="list-style-type: none"> • Discrimination • Confidentiality • No compulsory testing 		Consultations with community and teachers / schools. Proposal put to MoE. Link this with consultations on draft HIV Law.	
8. Prostitution Suppression Act <ul style="list-style-type: none"> • Reform to address workplace health promotion and violence protection measures 		Consultations with sex workers, community, police Link this reform to Police Instructions.	Sex Work law introduced

Issue	Short term 2014-2015	Medium term 2015-2017	Long term By 2020
9. Narcotics Act	Review proposed reforms to registration requirements being considered by Attorney General.	Propose the Act be amended to include harm reduction provisions relating to needle and syringe programmes and opioid substitution therapy. Propose decriminalization of possession of small quantities of drugs for personal use. Link this reform to Police Instructions	New Narcotics Act introduced
10. Penal Code Section 377		Propose amendment of 377 to restrict its application to assaults on minors and other sexual assaults. Link this reform to Police Instructions.	377 amended or repealed
11. Communicable Diseases Law 1995		Revise and update to remove AIDS from quarantine provisions that apply to plague and cholera etc	
12. Prisons Act 1894-1909, Prisons health care regulations		Revise and update to ensure rights of uninterrupted access to HIV prevention, ARVs, opioid substitution therapy.	Compliance with Act and Regulations actively monitored

၁၀ ရှေ့ဆက်လုပ်ဆောင်ရန် ရွေးချယ်နိုင်သောနည်းလမ်းများ

၁၀.၁ ဦးစားပေးလုပ်ငန်းများဖော်ထုတ်ရန်နှင့်စဉ်ဆက်မပြတ်လုပ်ငန်းအစီအစဉ်ရေးဆွဲရန် လုပ်ထုံးလုပ်နည်းများ

အိတ်ချ်အိုင်စီဆိုင်ရာ ဥပဒေရေးရာနှင့် လူ့အခွင့်အရေးလုပ်ငန်းစဉ်များ ရှေ့ဆက်လုပ်ဆောင်နိုင်ရေးအတွက် ဦးစားပေးလုပ်ငန်းများ၊ နည်းဗျူဟာများနှင့်ပတ်သက်ပြီးသဘောတူညီမှုရရှိရန် အမျိုးသားအဆင့်လုပ်ထုံးလုပ်နည်းများ တည်ထောင်ရန်လိုအပ်ပါသည်။ ယင်းတို့သည် လက်ရှိ အမျိုးသားအဆင့်အိတ်ချ်အိုင်စီတုံ့ပြန်မှု (ဥပမာ မြန်မာနိုင်ငံ ကျန်းမာရေးကဏ္ဍ ညှိနှိုင်းပေါင်းစပ်ဆောင်ရွက်ရေးကော်မတီ MHSCC ၏ အိတ်ချ်အိုင်စီဆိုင်ရာ နည်းပညာနှင့် နည်းဗျူဟာအဖွဲ့ TSG-HIV Working Group) နှင့် ပါလီမန်လွှတ်တော်ကော်မတီ၏ လုပ်ငန်းစဉ်များအတွင်းတွင် ပါဝင်နေသင့်သည်။ ၂၀၁၄ နှစ်ဆန်းပိုင်းတွင် အိတ်ချ်အိုင်စီနှင့်လူ့အခွင့်အရေးဆိုင်ရာ လွှတ်တော်နှင့်ရပ်ရွာလူထု ကွန်ရက်ပူးတွဲကော်မတီ (Joint Parliament and Community Network Consortium Committee on HIV and Human Rights) ဟူသော သီးသန့်အဖွဲ့တစ်ဖွဲ့ကို လွှတ်တော်အမတ်များအတွက်တည်ထောင်ခဲ့ပါသည်။ ထို့ပြင် လူဦးရေနှင့်လူမှုရေးဖွံ့ဖြိုးတိုးတက်မှု၊ တရားဥပဒေစိုးမိုးရေးနှင့် လူ့အခွင့်အရေးဆိုင်ရာလွှတ်တော်ကော်မတီများသည် အိတ်ချ်အိုင်စီပြဿနာရပ်များဆွေးနွေးရန်အတွက် သင့်လျော်သော အဖွဲ့အစည်းများဖြစ်နိုင်ပါသည်။

၁၀.၂ လက်ငင်းဦးစားပေးလုပ်ငန်းများ ၂၀၁၄-၂၀၁၅

နှစ်နှစ်တာကာလအတွင်း တိုးတက်မှုများရရှိနိုင်ရန် နိုင်ငံခြားနှင့်လုပ်ကိုင်နိုင်မည့်ဦးစားပေးလုပ်ငန်းများကို ရှာဖွေဖော်ထုတ်ရန်လိုအပ်ပါသည်။ ဥပမာ အောက်ပါလုပ်ငန်းစဉ်များကိုဦးတည်လုပ်ဆောင်နိုင်ပြီး တိုးတက်မှုကို အစိုးရ၊ အရပ်ဖက်လူ့အဖွဲ့အစည်းနှင့် ကုလသမဂ္ဂကိုယ်စားလှယ်များပါဝင်သော အမျိုးသားအဆင့်ကော်မတီမှ စောင့်ကြည့်လေ့လာနိုင်သည်။ -

ဥပဒေပြုပြင်ပြောင်းလဲရေး

ဆေးထိုးအပ်နှင့်ဆေးထိုးပြွန်များလက်ဝယ်ရှိခြင်း

ကျန်းမာရေးဝန်ကြီးဌာနသည် အမျိုးသားအဆင့်ဆေးထိုးအပ်နှင့်ဆေးထိုးပြွန်လဲလှယ်ရေးလုပ်ငန်းစဉ်များအရှိန်အဟုန်မြှင့်ဆောင်ရွက်ခြင်းကိုပံ့ပိုးသည့်အနေဖြင့် ဆေးထိုးအပ်နှင့်ဆေးထိုးပြွန်များလက်ဝယ်တွေ့ရှိခြင်းအား ပြစ်မှုအဖြစ် မသတ်မှတ်တော့ရန် ၁၉၁၇ ယစ်မျိုးအက်ဥပဒေပြင်ဆင်ရေးကို လက်ငင်းဦးစားပေးအဖြစ် ဆောင်ရွက်သင့်ပါသည်။

မူပိုင်ခွင့်ဥပဒေမူကြမ်း

မူပိုင်ခွင့်ဥပဒေမူကြမ်းကို ၂၀၁၃ ခုနှစ်က ရေးဆွဲခဲ့ပြီး ၂၀၁၄ ခုနှစ်တွင် လွှတ်တော်၌ဦးစားဆွေးနွေးရန် ဖြစ်ပါသည်။ မြန်မာနိုင်ငံကဲ့သို့သော ဖွံ့ဖြိုးမှုအနည်းဆုံးနိုင်ငံများ (LDCs) ကုန်သွယ်ခြင်းဆိုင်ရာ ဉာဏပစ္စည်းမူပိုင်ခွင့်ဥပဒေ (TRIPS) ကို ၂၀၂၁ နောက်ဆုံးထား၍လိုက်နာရန် ၂၀၁၃ WTO ဆုံးဖြတ်ချက်ကသတ်မှတ်ထားပါသည်။ မြန်မာနိုင်ငံအနေဖြင့် ဆေးဝါးများဆိုင်ရာမူပိုင်ခွင့်ပြဌာန်းချက်များစတင်ခြင်းကို ၂၀၂၁ ခုနှစ်အထိဆိုင်းငံ့ထားခြင်းအားဖြင့် အေအာရ်ဗီ (ARV) နှင့် အခြားဆေးဝါးများလက်လှမ်းမီအသုံးပြုနိုင်ခြင်းကို အမြင့်မားဆုံးဖြစ်အောင် ဆောင်ရွက်ထားနိုင်ပါသည်။ TRIPS ဖြေလျှော့မှုများ ဥပဒေမူကြမ်း^၁တွင်ပါဝင်မှုရှိနေစေရန် ဆေးဝါးနှင့် သက်ဆိုင်သော ပြဌာန်းချက်များ

^၁ ဆေးဝါးများဆိုင်ရာအကူးအပြောင်းကာလအပေါ် ၇၆ ၂၀၁၃ WTO ဆုံးဖြတ်ချက်၏သက်ရောက်မှုများသည် WTO ၏ ဆက်လက်ရှင်းလင်းထုတ်ပြန်ချက်များနှင့် သက်ဆိုင်အကျိုးဝင်နေနိုင်သည်။ LDC နိုင်ငံများအနေဖြင့် TRIPS ကိုလိုက်နာရမည့် မူပိုင်ခွင့် ဥပဒေများကို ၂၀၂၁

စတင်အသက်ဝင်မည့်နေ့စွဲအပါအဝင် မူပိုင်ခွင့်ဥပဒေမူကြမ်း၏တိုးတက်မှုကို အမျိုးသားခုခံကျ/ကာလသား တိုက်ဖျက်ရေးစီမံချက် (NAP) မှ စဉ်ဆက်မပြတ်စောင့်ကြည့်လေ့လာသင့်သည်။

မူဝါဒပြုပြင်ပြောင်းလဲရေး

ခွဲခြားနှိမ်ချဆက်ဆံမှုမပြုရေးနှင့် လျှို့ဝှက်ထိန်းသိမ်းရေးဆိုင်ရာအမျိုးသားအဆင့်လမ်းညွှန်ချက်

(ဖြစ်နိုင်ပါက မြန်မာနိုင်ငံအမျိုးသားလူ့အခွင့်အရေးကော်မရှင် (Myanmar National Human Rights Commission) နှင့် မိတ်ဖက်ဖွဲ့ကာ) အမျိုးသားခုခံကျ/ကာလသား တိုက်ဖျက်ရေးစီမံချက် NAP အနေဖြင့် အိတ်ချ်အိုင်စီပိုးရိုခြင်းကို အကြောင်းပြု၍ ခွဲခြားနှိမ်ချဆက်ဆံမှုမပြုရေးနှင့် ပိုးရိုခြင်းကိုလျှို့ဝှက်ထိန်းသိမ်းပေးရေး လမ်းညွှန်များထုတ်ဖော်သင့်သည်။ ယင်းကို တာဝန်ရှိသောသက်ဆိုင်ရာဝန်ကြီးဌာနများ ဥပမာ ကျန်းမာရေး၊ ပညာရေးနှင့် အလုပ်သမားဝန်ကြီး တို့မှထောက်ခံအတည်ပြုပေးသင့်သည်။ အဆိုပါလမ်းညွှန်ချက်သည် ကျန်းမာရေးစောင့်ရှောက်မှု၊ အလုပ်အကိုင် အခွင့်အလမ်း၊ ပညာသင်ကြားရေး အစရှိသော ဦးစားပေးကဏ္ဍများကို ဦးစွာအာရုံစိုက်သင့်သည်။ အာမခံ၊ ဘဏ္ဍာရေး၊ နာရေးနှင့် အိုးအိမ်ကဲ့သို့သော အခြားအရေးကိစ္စများကို နောက်ပိုင်းတွင် ဦးတည်လုပ်ဆောင် နိုင်ပါသည်။

အဆိုပါလမ်းညွှန်ချက်များသည် ဥပဒေအရချည်နှောင်မှုများမရှိသော်လည်း နိုင်ငံတော်မှလက်ခံနိုင်ဖွယ်ရှိသော ရှင်းလင်းသည့်ဖော်ပြချက်များပါဝင်ရန်လိုအပ်သည်။ နိုင်ငံတော်အစိုးရအနေဖြင့် အများပြည်သူကဏ္ဍအဖွဲ့အစည်းများ အားလုံးကို လမ်းညွှန်ချက်အတိုင်းလိုက်နာဆောင်ရွက်ရန် ညွှန်ကြားပေးနိုင်ပြီး ပုဂ္ဂလိကကဏ္ဍအဖွဲ့အစည်းများနှင့် ပညာရှင်အစည်းအရုံးများကိုလည်း လမ်းညွှန်ချက်များအားအတည်ပြုထောက်ခံရန် အားပေးအားမြှောက်ပြုလုပ်နိုင် သည်။ လမ်းညွှန်ချက်များကိုချိုးဖောက်ပါက အိတ်ချ်အိုင်စီပိုးရိုသူများအနေဖြင့် တိုင်ကြားနိုင်သောလုပ်ငန်းစဉ် တည်ထောင်ရေးနှင့် အရေးယူဆောင်ရွက်ပေးရမည့်တာဝန်များကို ဥပဒေအကြောင်းအရ အားဖြည့်ပေးသော နည်းလမ်းများဖော်ထုတ်ရေး စသည့်ဆောင်ရွက်ချက်များနှင့်ပတ်သက်၍ သက်ဆိုင်ရာအများပြည်သူကဏ္ဍ အဖွဲ့အစည်းများကလည်း သတ်မှတ်ထားသောအချိန်ကာလအတွင်း အဆိုပါဆောင်ရွက်ချက်များကို သတင်းပေးပို့ရန် လိုသည်။ ဥပမာ ကျောင်းပညာရေးကိုလွှမ်းမိုးနေသောစည်းမျဉ်းများ၊ အစိုးရဝန်ထမ်းများ၏ အခွင့်အရေးများကို ဦးတည်ထားသော စည်းမျဉ်းများ၊ ကျန်းမာရေးဝန်ထမ်းများ၏ ကျင့်ဝတ် (သို့မဟုတ်) မှတ်ပုံတင်ခြင်းကို လွှမ်းမိုးနေ သောစည်းမျဉ်းများ၊ အမျိုးသားလူ့အခွင့်အရေးကော်မရှင်၏ အခွင့်အာဏာနှင့်ပတ်သက်သော ဥပဒေပြဌာန်းချက်များ (သို့မဟုတ်) စည်းမျဉ်းများတွင် ခွဲခြားဆက်ဆံမှုမပြုရေး၊ လျှို့ဝှက်ထိန်းသိမ်းရေးစည်းမျဉ်းများအား ပေါင်းစပ်ထည့်သွင်း နိုင်မည့်နည်းလမ်းများကို ရှာဖွေဖော်ထုတ်နိုင်သည်။

အေအာရ်ဗီ (ARV) ရယူရန်စံနှုန်းများ

အေအာရ်ဗီ (ARV) ရယူရန်စံနှုန်းများသည် သုံးနှုန်းထားသောစကားလုံးများကြောင့်သော်လည်းကောင်း၊ စံနှုန်းများကို နားလည်သဘောပေါက်ပုံနှင့် အားဖြည့်ပြဌာန်းထားသည့်ပုံစံတို့ကြောင့်သော်လည်းကောင်း မူးယစ်ဆေးအကြောတွင်း ထိုးသွင်းသူများ (PWID)၊ လိင်လုပ်သားများ အပါအဝင် ပြောင်းရွှေ့သွားလာနေသောသူများ၊ ကလေးသူငယ်များ

ခုနှစ်မတိုင်ခင်အထိ ပြဌာန်းရန် မလိုသေးကြောင်း WTO သည် ၂၀၁၃ ဇွန်တွင် သဘောတူညီမှုရရှိခဲ့ပါသည်။ အစောပိုင်း WTO ညွှန်ကြားချက်တွင် LDC များအနေဖြင့် ဆေးဝါးမူပိုင်ခွင့်ကို ၂၀၁၆ ခုနှစ်နောက်ဆုံးထား၍ ဥပဒေအရအသိအမှတ်ပြုရန်လိုအပ်ကြောင်းဖော်ပြထားသည်။ WTO ထံမှ တိကျသော ထပ်မံရှင်းလင်းချက်များ လိုအပ်မည်ဖြစ်သော်လည်း လက်ရှိ WTO ဆုံးဖြတ်ချက်သည် နောက်ဆုံးသတ်မှတ်ချိန် ၂၀၁၆ ခုနှစ်ကို ၂၀၂၁ ခုနှစ်အထိသက်တမ်းတိုးပေးလိုက်သည်ဟု အချို့သော သုံးသပ်သူများမှ နားလည်ထားကြသည်။ <http://www.ip-watch.org/2013/08/02/what-does-wto-extension-for-lcds-to-enforce-ip-mean-for-pharmaceuticals/> တွင်ကြည့်ပါ။

အတွက် ဆိုးကျိုးများသက်ရောက်နေစေသည်ဟု သိရပါသည်။ အဆိုပါစိုးရိမ်ပူပန်မှုများကိုပြေလျော့စေရန် အမျိုးသားခုခံကျ/ကာလသား တိုက်ဖျက်ရေးစီမံချက် NAP အနေဖြင့် အောက်ပါတို့ကိုရှင်းလင်းဖော်ပြသင့်သည်။

- မူးယစ်ဆေးအသုံးပြုသူအဖြစ်မှတ်ပုံတင်ထားခြင်း (သို့မဟုတ်) မူးယစ်ဆေးအစားထိုး မက်သာဒုံး တိုက်ကျွေးခြင်း MMT ကုသမှုမစတင်ရသေးခြင်းစသော အကြောင်းပြချက်များဖြင့် PWID များအား အေအာရ်တီကုသမှုပေးရန်ငြင်းဆိုခြင်းမပြုလုပ်သင့်ပါ။ MMT စီမံချက်မရှိသောဒေသများတွင် အေအာရ်တီ ရယူလိုသော PWID များအတွက် ဤအချက်မှာ အရေးကြီးသောပြဿနာတစ်ရပ်ဖြစ်ပါသည်။
- အိတ်ချ်အိုင်စီပိုးရှိသောကလေးများအနေဖြင့်လည်း အေအာရ်စီ (ARV) ရယူရန်အတွက် ပိုးမရှိသောမိဘမှ ကြီးကြပ်ရမည်ဆိုသည်မှာလည်းဖြစ်သင့်ပါ။ အိတ်ချ်အိုင်စီပိုးရှိနေသော အရွယ်ရောက်ပြီးသူမှ ကလေးအား ကုသရေးစောင့်ရှောက်မှုပေးခြင်းကို စံနှုန်းများက ခွင့်ပြုသင့်သည်။ ကုထုံးများအတိုင်း ကလေးငယ် လိုက်နာစေရေးအတွက် လိုအပ်သောပံ့ပိုးမှုများပေးရန် အိတ်ချ်အိုင်စီပိုးရှိသောမိဘတစ်ဦးဦးရှိနေခြင်းသည် လုံလောက်သင့်ပါသည်။
- (ပြည့်တန်ဆာများအပါအဝင်) တစ်နေရာမှတစ်နေရာရွှေ့ပြောင်းသွားလာနေရသူများအနေဖြင့် မည်သည့် အေအာရ်တီ ART ဆေးဖြန့်ဝေသည့်နေရာမှမဆို ညွှန်းဆိုထားသည့်ဆေးညွှန်းအတိုင်း ဆေးထုတ်ယူနိုင်ရန် အခွင့်အရေးရရှိသင့်ပါသည်။

ရဲထိန်းသိမ်းရေးဌာနများနှင့်အကျဉ်းထောင်များ၌ရှိသောသူများ ဆေးဝါးများလက်လှမ်းမီအသုံးပြုနိုင်မှု

ရဲထိန်းသိမ်းရေးဌာနများနှင့်အကျဉ်းထောင်များ၌ရှိသောသူများ အေအာရ်စီ၊ OI (အထူးသဖြင့် တီဘီ) အတွက်ဆေးဝါး များ၊ MMT စသည်တို့စဉ်ဆက်မပြတ်ရရှိနေစေရန် လုပ်ထုံးလုပ်နည်းများထူထောင်သင့်သည်။ ရဲအချုပ်ခန်းများတွင် ရှိနေစဉ် ဆေးကုသမှုနှင့် MMT ကိုလက်လှမ်းမီအသုံးပြုနိုင်ရေးအတွက် ရဲညွှန်ကြားထားချက်များထုတ်ပြန်ရန်နှင့် ယင်းတို့ကိုအားကောင်းစေရန် ကျန်းမာရေးဝန်ကြီးဌာနနှင့်ပြည်ထဲရေးဝန်ကြီးဌာနတို့ ပူးပေါင်းဆောင်ရွက်သင့်သည်။ အကျဉ်းထောင် MMT စီမံချက်ကို အမျိုးသားအဆင့် MMT လမ်းညွှန်ချက်များနှင့်လျော်ညီစွာ ထူထောင်နိုင်ရန်လည်း လုပ်ဆောင်သင့်ပါသည်။

အိတ်ချ်အိုင်စီပိုးရှိသောအမျိုးသမီးများ၏ မျိုးဆက်ပွားကျန်းမာရေးရပိုင်ခွင့်များ

အမျိုးသားခုခံကျ/ကာလသား တိုက်ဖျက်ရေးစီမံချက် NAP အနေဖြင့် ကျန်းမာရေးလုပ်သားများအတွက်လမ်းညွှန်ကို ထုတ်ပြန်သင့်သည်။ ယင်းတွင် အိတ်ချ်အိုင်စီပိုး ရှိသောအမျိုးသမီးများ၏ မိသားစုစီမံကိန်းနှင့် မျိုးဆက်ပွားကျန်းမာရေးရွေးချယ်စရာများဆိုင်ရာ အခွင့်အရေးများကို အလေးပေးဖော်ပြသင့်ပြီး ကျန်းမာရေးလုပ်သားများ နှစ်သိမ့်ဆွေးနွေးအကြံပေးသည့် သတင်းအချက်အလက်များ ပေးနိုင်ရန်၊ အိတ်ချ်အိုင်စီပိုးရှိသောအမျိုးသမီးများကို ကိုယ်ပိုင်ရွေးချယ်မှုများ ပြုလုပ်နိုင်အောင် ပံ့ပိုးပေးနိုင်ရန် စသည်တို့လည်းပါဝင်သင့်သည်။

ဥပဒေအရအရေးယူဆောင်ရွက်ခြင်း

အဓိကဦးတည်အုပ်စုများကိုထိန်းသိမ်းကြပ်မတ်စောင့်ရှောက်ပေးခြင်း

ရောဂါအဖြစ်များသောနေရာများတွင်နေထိုင်သော အဓိကဦးတည်အုပ်စုများအတွက် အိတ်ချ်အိုင်စီကာကွယ်တားဆီး ရေးပံ့ပိုးမှုများပေးရာ၌ ပါဝင်နေသောရဲများ၏အခန်းကဏ္ဍကိုဦးတည်ပြီး လုပ်ငန်းအစီအစဉ်များရေးဆွဲသင့်ပါသည်။ ဤသို့လုပ်ဆောင်ရာတွင် မြန်မာနိုင်ငံ ရဲတပ်ဖွဲ့အတွင်းမှ အမျိုးသားအဆင့်၊ ဒေသအဆင့် ခေါင်းဆောင်မှုများ

ပါဝင်ရန်လိုအပ်သည်။ ထို့ပြင် ဒေသကျန်းမာရေးအာဏာပိုင်များ၊ အဓိကဦးတည်အုပ်စုများ၊ မြို့နယ်အဆင့်ရှိ ဒေသရဲဝန်ထမ်းများနှင့်လည်း ပူးပေါင်းဆောင်ရွက်လိုစိတ်ရှိရပါမည်။ လုပ်ငန်းများတွင် အောက်ပါတို့ ပါဝင်ပါသည်။

- ရဲဝန်ထမ်းညွှန်ကြားချက်များအား ပြန်လည်သုံးသပ်ခြင်းနှင့်ပြင်ဆင်မွမ်းမံခြင်း - အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေး၊ အဓိကဦးတည်အုပ်စုများအားလုံးကို ထိန်းသိမ်းကြပ်မတ်စောင့်ရှောက်ပေးရေးဆိုင်ရာ ဘက်စုံညွှန်ကြားချက်များကို ဖော်ထုတ်နိုင်သည်။ ရဲညွှန်ကြားချက်များတွင် အောက်ပါတို့ကိုဖြေရှင်းပေးသင့်ပါသည်။
 - ကွန်ဗုံးကိုင်ဆောင်ထားခြင်းအတွက် လိင်လုပ်သားများ၊ အမျိုးသားချင်းလိင်တူဆက်ဆံသူများနှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူနေထိုင်သူများအား အနှောင့်အယှက်ပေးခြင်း၊ ဖမ်းဆီးခြင်းမလုပ်ရန်
 - ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်များကိုင်ဆောင်ထားခြင်းအတွက် PWID များ (သို့မဟုတ်) သက်တူရွယ်တူပညာပေးသူများအား အနှောင့်အယှက်ပေးခြင်း၊ ဖမ်းဆီးခြင်းမလုပ်ရန်
 - အဓိကဦးတည်အုပ်စုများအား အနှောင့်အယှက်ပေးရန် (သို့မဟုတ်) ခြိမ်းခြောက်ငွေညစ်ရန် အလို့ငှာ အများပြည်သူငြိမ်ဝပ်ပိပြားရေးဆိုင်ရာ ပြစ်မှုများ၊ ပြစ်မှုဆိုင်ရာဥပဒေ ပုဒ်မ ၃၇၇ (သို့မဟုတ်) လိင်လုပ်သားပြစ်မှုများဖြင့် တစ်ဖက်သတ်အရေးယူခြင်းမပြုရန်
 - သက်တူရွယ်တူပညာပေးခြင်းနှင့် လိုအပ်နေသူများထံသွားရောက်အကူအညီပေးခြင်း နည်းလမ်းများမှတစ်ဆင့်လုပ်ဆောင်နေသော အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေးလုပ်ငန်းများကို ဝင်ရောက်နှောင့်ယှက်ခြင်း မပြုရန်
 - အဖမ်းဆီးခံရသူများ အဖမ်းဆီးခံရပြီးနောက် အေအာရီစီဆေးများ၊ OI ဆေးများ၊ မက်သာဒုံးစသည်တို့ဆက်လက်ရရှိနေစေရန်
- ရဲညွှန်ကြားချက်များအား မည်ကဲ့သို့အားဖြည့်ဆောင်ရွက်နေသည်ကို စောင့်ကြပ်ကြည့်ရှုရန် ရောဂါအဖြစ်များသောနေရာဒေသများကို အာရုံထားလျက် လုပ်ငန်းစဉ်သစ်လုပ်ဆောင်ရန်ရွေးချယ်နိုင်သည်။ ဒေသအတွင်း ကိုယ်ပိုင်အစီအစဉ်ဖြင့်လုပ်ဆောင်နေသော ဆေးထိုးပြွန်နှင့်အပ်များလဲလှယ်သည့် လက်ရှိစီမံချက်များအားပြန်လည်အသက်သွင်းခြင်းနှင့် အဆိုပါစံနမူနာကိုအခြားသောအဓိကဦးတည်အုပ်စုများထံသို့ တိုးချဲ့လုပ်ကိုင်ခြင်းများပါဝင်သည်။ ဥပမာအားဖြင့် ထိုသို့လုပ်ဆောင်နိုင်ရန် အောက်ပါလုပ်ငန်းများတွင် ကျန်းမာရေးအာဏာပိုင်များနှင့် ဒေသတွင်းရှိဥပဒေအကောင်အထည်ဖော်သူများ ပူးပေါင်းဆောင်ရွက်ရန် လိုသည်။
 - ရဲများ၊ ဒေသကျန်းမာရေးအာဏာပိုင်များ၊ အိတ်ချ်အိုင်စီလုပ်ငန်းလုပ်ကိုင်နေသော အစိုးရမဟုတ်သည့် ဒေသအဖွဲ့အစည်းများနှင့် အဓိကဦးတည်အုပ်စုများ စသည်တို့မှကိုယ်စားလှယ်များ ပါဝင်သော ပေါင်းစပ်ညှိနှိုင်းရေးအစည်းအဝေးများပုံမှန်ကျင်းပခြင်း။ အဆိုပါအစည်းအဝေးများ ၏ ရည်ရွယ်ချက်မှာ ခရိုင် (သို့မဟုတ်) မြို့နယ်တစ်ခုချင်းစီရှိ အဓိကဦးတည်အုပ်စုများအတွက် အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေးတုံ့ပြန်မှုများ ပေါင်းစပ်ညှိနှိုင်းခြင်းကို အားကောင်းစေရန် ဖြစ်သည်။
 - စမ်းသပ်ဒေသများပြန်လည်သုံးသပ်ခြင်းမှရရှိလာသောသင်ခန်းစာများကို အမျိုးသားအဆင့် ရဲလူထု အိတ်ချ်အိုင်စီဆိုင်ရာမိတ်ဖက်လုပ်ဆောင်ခြင်းစီမံချက် တိုးမြှင့်လုပ်ဆောင်ရာတွင် သတင်းအချက်အလက်အဖြစ်အသုံးပြုနိုင်သည်။

စွမ်းဆောင်ရည်တည်ဆောက်ခြင်း

အထက်ဖော်ပြပါ ဥပဒေအသစ်များ၊ မူဝါဒအသစ်များနှင့် ရဲညွှန်ကြားချက်အသစ်များကို အကောင်အထည်ဖော်ရန် အတွက် ဦးတည်ချက်ရှိရှိ စွမ်းဆောင်ရည်တည်ဆောက်သွားရန်လိုအပ်သည်။ ဥပမာ ဆေးထိုးအပ်၊ ဆေးထိုးပြွန် စီမံချက်နှင့် ကွန်ဒိုမင်္ဂဒ်ဝေသည့်လုပ်ငန်းများကို ရဲနှင့်ကျန်းမာရေးအာဏာပိုင်များ ပူးပေါင်းပံ့ပိုးသွားရန် ညွှန်ကြားထားသော ရဲညွှန်ကြားချက်အသစ် (သို့မဟုတ်) မွမ်းမံချက်များနှင့်ပတ်သက်၍ ရဲများအား သင်တန်းပေးရန်လိုအပ်သည်။ ခွဲခြားဆက်ဆံမှုမပြုရေး၊ လျှို့ဝှက်ထိန်းသိမ်းရေး၊ မျိုးဆက်ပွားကျန်းမာရေးဆိုင်ရာအခွင့်အရေးများ၊ ARV ရယူနိုင်သော စံနှုန်းသတ်မှတ်ချက်များ/ လက်လှမ်းမှီမှု စသည်တို့နှင့်ပတ်သက်သော မူဝါဒအသစ်များကို နားလည်နေကြောင်း၊ လိုက်လံလုပ်ဆောင်နေကြောင်း သေချာစေရန် ကျန်းမာရေးလုပ်သားများအား သင်တန်းပေးခြင်းမှာလည်း အရေးကြီးပါသည်။ အိတ်ချ်အိုင်စီပိုးရှိသူများနှင့် အခြားအဓိကကျသောဦးတည်အုပ်စုများအား အဆိုပါမူဝါဒအသစ်များတွင်ပါဝင်သော ၎င်းတို့၏ အခွင့်အရေးများနှင့် ပတ်သက်၍ ပညာပေးနိုင်ရန် လူထုကွန်ယက်များအတွက်လည်း အရင်းအမြစ်များရရှိနိုင်ရမည်ဖြစ်ပါသည်။

တရားမျှတမှုကိုလက်လှမ်းမီခြင်း

ရှိရင်း ဥပဒေရေးရာအကူအညီပေးသည့်ဝန်ဆောင်မှုများကို ဆက်လက်ထိန်းသိမ်းရေးမှာ လက်ငင်း ဦးစားပေးလုပ်ငန်းတစ်ရပ်ဖြစ်ပါသည်။ အဆိုပါဝန်ဆောင်မှုများတိုးချဲ့ရာတွင်လမ်းညွှန်မှုရရှိရန် အဓိကဦးတည်အုပ်စုများထံသို့ လက်လှမ်းမှီရောက်ရှိနိုင်ရေးအတွက်လုပ်ဆောင်နေသောလုပ်ငန်းများ (ဥပမာ - Equal စီမံကိန်း) မှ သင်ခန်းစာများကို စနစ်တကျပြန်လည် ဆန်းစစ်သင့်ပါသည်။ ဥပဒေအထောက်အကူဝန်ဆောင်မှုများပေးသောဝန်ထမ်းများအား သင်တန်းပေးခြင်းကဲ့သို့သော အကုန်အကျသက်သာသည့် လုပ်ငန်းများကို တိုးချဲ့သင့်ပါသည်။

၁၀.၃ ရေရှည်လုပ်ငန်းစဉ်များ

ဥပဒေပြုပြင်ပြောင်းလဲရေး

ဥပဒေအသစ်များ (ဥပမာ အိတ်ချ်အိုင်စီပိုးရှိသူများနှင့် အဓိကဦးတည်အုပ်စုများအား ကာကွယ်ရန် ခွဲခြားဆက်ဆံမှုမပြုရေးနှင့် လျှို့ဝှက်ထိန်းသိမ်းရေးဥပဒေ၊ အိတ်ချ်အိုင်စီပိုးစစ်ဆေးရာတွင် သတင်းအချက်အလက်ပေးပြီး သဘောတူညီမှုရယူခြင်းဥပဒေ၊ ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူနေထိုင်သူများအား ဥပဒေအရအသိအမှတ်ပြုရေးနှင့် မူပိုင်ခွင့် ဥပဒေသစ်) ပြဌာန်းထုတ်ပြန်ရန်လိုအပ်နေကြောင်းကို ပြန်လည်သုံးသပ်ခြင်းတွင် တွေ့ရှိခဲ့ရပါသည်။ ၁၉၄၉ ပြည့်တန်ဆာပပျောက်ရေးအက်ဥပဒေ၊ မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေတတ်သောဆေးဝါးများဆိုင်ရာဥပဒေ၊ ပြစ်မှုဆိုင်ရာဥပဒေ၊ ကူးစက်ရောဂါများ တားဆီးကာကွယ်ရေးနှင့်ထိန်းချုပ်ရေးဥပဒေ၊ အကျဉ်းထောင်များအက်ဥပဒေ၊ ၁၉၁၇ ယစ်မျိုးအက်ဥပဒေ စသည်တို့အပါအဝင် လက်ရှိ ထုတ်ပြန်ထားသောဥပဒေများကိုလည်း အိတ်ချ်အိုင်စီပိုးတုံ့ပြန်မှုလုပ်ငန်းစဉ်များအား အထောက်အကူဖြစ်စေရန် ပြန်လည်ပြင်ဆင်မွမ်းမံသင့်ကြောင်း တွေ့ရှိခဲ့ပါသည်။ လွှတ်တော်မှတစ်ဆင့်အဆိုပါကိစ္စရပ်များအားလုံးကို ဖြေရှင်း ဆောင်ရွက်ရန်အတွက် ဆယ်စုနှစ် (သို့မဟုတ်) ထိုထက်ပို၍လိုအပ်နိုင်ပါသည်။ သို့ရာတွင် အချို့ဥပဒေများသည် ပြုပြင်ပြောင်းလဲရေးလုပ်ငန်းစဉ်များ ဖြတ်သန်းပြီးဖြစ်ပါသည်။ ထို့ကြောင့် အိတ်ချ်အိုင်စီပိုးနှင့်သက်ဆိုင်သော အချက်အလက်များပါဝင်သည့်လုပ်ငန်းများကို လာမည့်တစ်နှစ်၊ နှစ်နှစ်အတွင်းတွင် ထည့်သွင်းစဉ်းစားသွားလျှင် ဖြစ်နိုင်ချေရှိပါသည်။ ဥပမာ လက်ရှိအခြေအနေတွင် မူပိုင်ခွင့်ဥပဒေနှင့် အမျိုးသားအဆင့်လူ့အခွင့်အရေးကော်မရှင် ဥပဒေတို့မှာ မူကြမ်းရေးဆွဲပြီးဖြစ်ပြီး မူးယစ်ဆေးဝါးနှင့် စိတ်ကိုပြောင်းလဲစေတတ်သောဆေးဝါးများဆိုင်ရာဥပဒေ၏ အချို့သောရှုထောင့်များမှာ ပြန်လည်သုံးသပ်နေဆဲ ဖြစ်ပါသည်။

ခွဲခြားဆက်ဆံမှုမပြုရေးဥပဒေ

(အထူးသဖြင့် အလုပ်အကိုင်အခွင့်အလမ်း၊ ကျန်းမာရေးစောင့်ရှောက်မှုနှင့် ပညာသင်ယူရေးတို့တွင်) အိတ်ချ်အိုင်စီပိုး ရှိခြင်းကိုအခြေခံ၍ ခွဲခြားဆက်ဆံခြင်းကိုတားမြစ်ထားသည့် အမျိုးသားအဆင့်ဥပဒေမှာ နိုင်ငံတော်၏ ကဏ္ဍအားလုံး နှင့်သက်ဆိုင်နေသော ဦးစားပေးတစ်ရပ်ဖြစ်သင့်ပါသည်။ သို့ရာတွင် ထိုကဲ့သို့သောဥပဒေတစ်ရပ်ကို လွှတ်တော် အတွင်းမိတ်ဆက်ဆွေးနွေးရန် အခွင့်အလမ်းမည်ကဲ့သို့ (သို့မဟုတ်) မည်သည့်အချိန်တွင်ပေါ်ပေါက်လာမည် ဆိုသည်မှာ မရှင်းလင်းသေးသောကိစ္စတစ်ရပ်ဖြစ်ပါသည်။ ခွဲခြားဆက်ဆံမှုမပြုရေးဥပဒေပြဌာန်းရာတွင် အောက်ပါတို့ ပါဝင်ပါသည်။

- အမျိုးသားအဆင့်လူ့အခွင့်အရေးကော်မရှင်သည် အိတ်ချ်အိုင်စီနှင့်ဆက်နွှယ်နေသော ခွဲခြားဆက်ဆံမှုများကို တိုင်ကြားလာပါက ယင်းတို့ကိုလက်ခံဖြေရှင်းပေးရန် ကတိကဝတ်ရှိသည်ဟူသော ရှင်းလင်းချက်ကို ကော်မရှင်ဥပဒေမူကြမ်း (သို့မဟုတ်) စည်းမျဉ်းစည်းကမ်းတွင် ထည့်သွင်းဖော်ပြခြင်း။
- မသန်စွမ်းသူများအားခွဲခြားဆက်ဆံခြင်းနှင့်ပတ်သက်၍ ဥပဒေသစ်ပြဌာန်းချက်။
- အလုပ်သမားဥပဒေ (သို့မဟုတ်) ပြစ်မှုဆိုင်ရာဥပဒေတွင် ခွဲခြားဆက်ဆံမှုမပြုရေးပြဌာန်းချက်ကို ထည့်သွင်းခြင်း၊ ယင်းတွင် ယေဘုယျအားဖြင့် ကျန်းမာရေးအခြေအနေ၊ မသန်စွမ်းမှုတို့အပေါ်မူတည်၍ ခွဲခြားဆက်ဆံမှုမပြုရေး (သို့မဟုတ်) တိတိကျကျအားဖြင့် အိတ်ချ်အိုင်စီပိုးရှိနေခြင်းကြောင့် ခွဲခြားဆက်ဆံမှု မပြုရေး စသည်တို့အထိထည့်သွင်းဖော်ပြခြင်း။
- ကျန်းမာရေးအခြေအနေနှင့်/သို့မဟုတ် မသန်စွမ်းမှုတို့အပေါ်မူတည်၍ခွဲခြားဆက်ဆံမှုမပြုရေး နှင့်ပတ်သက် သော အခြေခံဥပဒေအထွေထွေပြဌာန်းချက်၊ ယင်းတွင်အိတ်ချ်အိုင်စီပါဝင်သည်ဟု အဓိပ္ပါယ်ဖွင့်ဆိုထားရ မည်။ သို့တည်းမဟုတ် ကျန်းမာရေးဆိုင်ရာအခွင့်အရေးနှင့်ပတ်သက်သော အထွေထွေပြဌာန်းချက်။
- သီးသန့်အမျိုးသားအဆင့်အိတ်ချ်အိုင်စီဥပဒေပြဌာန်းအတည်ပြုခြင်း။

ပြီးပြည့်စုံသောအမျိုးသားအဆင့် အိတ်ချ်အိုင်စီဥပဒေနှင့် အဓိကဦးတည်အုပ်စုများအား သက်ရောက်နေသောအခြား ဥပဒေများ

ကမ္ဘောဒီးယား၊ ဗီယက်နမ်နှင့် လာအိုပြည်သူ့ဒီမိုကရက်တစ်သမ္မတနိုင်ငံ စသောအခြားနိုင်ငံများမှစံနမူနာကိုယူ၍ လူ့အခွင့်အရေးအခြေပြု ပြီးပြည့်စုံသောအမျိုးသားအဆင့်အိတ်ချ်အိုင်စီဥပဒေ ပြဌာန်းအတည်ပြုရန်နည်းလမ်းကို အမျိုးသားအဆင့်ဥပဒေပြန်လည်သုံးသပ်ခြင်းတွင် ရှာဖွေဖော်ထုတ်ခဲ့ပါသည်။ ဤသည်မှာ မြန်မာနိုင်ငံအတွက် အလွန် ရည်မှန်းချက်ကြီးမားသောလုပ်ရပ်ဖြစ်ပြီး ရေရှည်ပြုလုပ်ရမည့်စီမံကိန်းတစ်ရပ်လည်းဖြစ်ပါသည်။ နီပေါ၊ အိန္ဒိယ၊ ပါကစ္စတန်စသော အခြားနိုင်ငံများတွင် အိတ်ချ်အိုင်စီဥပဒေမူကြမ်းနှင့်ပတ်သက်၍ ဆွေးနွေးလာသည်မှာ (၅) နှစ်တာ ကာလမှ (၁၀) နှစ်တာကာလအထိကြာမြင့်နေပြီဖြစ်သော်လည်း တိုးတက်မှုအနည်းငယ်သာရှိနေသည်။ လူ့အခွင့်အရေးအခြေပြု ဥပဒေပြုပြင်ပြောင်းလဲရေးအတွက် လွှတ်တော်အမတ်များအနေဖြင့် ထောက်ခံမှုရရှိရန် ခက်ခဲနိုင်သော သီးသန့်အိတ်ချ်အိုင်စီဥပဒေကိုပြဌာန်းမည့်အစား ကူးစက်ရောဂါများတားဆီးကာကွယ်ရေးနှင့် ထိန်းချုပ်ရေးဥပဒေ (သို့မဟုတ်) အထွေထွေကျန်းမာရေးဥပဒေသစ်တွင် လျှို့ဝှက်ထိန်းသိမ်းခြင်းဆိုင်ရာ အခွင့်အရေး များနှင့် ကာယကံရှင်သဘောတူညီချက်ဖြင့် အိတ်ချ်အိုင်စီ ပိုးစစ်ဆေးခြင်းဆိုင်ရာ အခွင့်အရေးများထည့်သွင်းခြင်း ကဲ့သို့သော အခြားစံနမူနာများကိုလည်း ထည့်သွင်းစဉ်းစား သွားသင့်ပါသည်။

အထက်ဖော်ပြပါဥပဒေများနှင့် (ပြည့်တန်ဆာပပျောက်ရေးဥပဒေ၊ မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေသော ဆေးဝါးများဆိုင်ရာဥပဒေ၊ သဘာဝအတိုင်းမဟုတ်သော လိင်ဆက်ဆံခြင်း၊ “တတိယလိင်” အမျိုးအစားကို

တရားဝင်အသိအမှတ်ပြုရေး စသည့်) အခြားသောဥပဒေများ ပြဌာန်း/ ပြင်ဆင်ရာ၌ လွှတ်တော်တွင်လွန်ကဲသော တုံ့ပြန်မှုများမရှိဘဲလုပ်ဆောင်နိုင်မည့်အခွင့်အရေးများရရှိနိုင်ရန် နှစ်ပေါင်းများစွာ ကြာမြင့်သွားနိုင်သည်။ ယင်းက အဓိကဦးတည်အုပ်စုများအတွက် ပိုမိုဆိုးရွားပြင်းထန်သောရလဒ်များ ဖြစ်လာနိုင်ချေရှိသည်။ ဤအခြေအနေတွင် လွှတ်တော်အမတ်များနှင့်အရာရှိများအနေဖြင့် အခွင့်အလမ်းများ ပေါ်ပေါက်လာပါက သက်ဆိုင်ရာဥပဒေ ပြောင်းလဲ ပြင်ဆင်ရန်အတွက် အဆိုပြုနိုင်မည့်ယင်းအခွင့်အလမ်းကို သိရှိနိုင်သောစွမ်းဆောင်ရည်များရှိနေရန် အရေးကြီး ပါသည်။ သို့မှသာ အဆိုပြုချက်များကို သတင်းအချက်အလက်ပြည့်ပြည့်စုံစုံဖြင့် အချိန်မှီတင်သွင်းဆောင်ရွက် နိုင်မည်ဖြစ်သည်။ ဥပမာ လာမည့်နှစ်များတွင် ပြစ်မှုဆိုင်ရာဥပဒေအား ပြန်လည်ဆန်းစစ်ရန်အခွင့်အလမ်းများ ပေါ်ပေါက်လာနိုင်ချေရှိသည်။ လွှတ်တော်အမတ်များနှင့် အမျိုးသားခုခံကျ/ကာလသား တိုက်ဖျက်ရေးစီမံချက် NAP တို့အနေဖြင့် ပြစ်မှုဆိုင်ရာဥပဒေ ပုဒ်မ ၃၇၇ ကိုပြင်ဆင်ရန် ပြည်သူ့ကျန်းမာရေးနှင့် လူ့အခွင့်အရေးဆိုင်ရာ ကိစ္စရပ်များကို ပြည့်ပြည့်ဝဝ အသေးစိတ်သိရှိထားသင့်သည်။ သို့မှသာ အိတ်ချ်အိုင်စီကာကွယ်ရေးလုပ်ငန်းများသည် MSM များထံသို့ ရောက်ရှိနိုင်မည်ဖြစ်သည်။

ဥပဒေအရအရေးယူဆောင်ရွက်ခြင်း

ရေရှည် ဥပဒေအရအရေးယူဆောင်ရွက်ခြင်းလုပ်ငန်းများသည် အိတ်ချ်အိုင်စီပိုးရိုသူများနှင့် အဓိကဦးတည်အုပ်စုများ၏ အခွင့်အရေးများကိုတိုးမြှင့်ပေးရန်ပြဌာန်းထားသော အကာအကွယ်ပေးရေးဥပဒေသစ်များအတိုင်း လိုက်နာဆောင်ရွက် ရန် အာရုံစိုက်သင့်ပါသည်။ ထိုသို့လုပ်ဆောင်ရာတွင် အခွင့်အရေးများကိုကြီးလေးစွာမျိုးဖောက်ပါက ရဲ (သို့မဟုတ်) တရားလိုရှေ့နေများ၏ ကြားဝင်ဆောင်ရွက်မှုများ လိုအပ်ကောင်းလိုအပ်လိမ့်မည်ဖြစ်သည်။ အချို့သောအခွင့်အရေး ချိုးဖောက်မှုများကို ဖြေရှင်းပေးရာတွင် မြန်မာနိုင်ငံအမျိုးသားအဆင့်လူ့အခွင့်အရေးကော်မရှင်၏အခန်းကဏ္ဍလည်း ပါဝင်နိုင်ပါသည်။ အခြားသောအမှုကိစ္စများအတွက်မူ တိုင်ကြားချက်များကိုတွယ်ဖြေရှင်းပေးရန် အုပ်ချုပ်မှုပုံစံအသစ် တည်ထောင်ခြင်းအားဖြင့် ယင်းတို့ကိုပိုမိုသင့်လျော်စွာဖြေရှင်းပေးနိုင်မည်ဖြစ်သည်။ အခွင့်အရေးချိုးဖောက်မှုများအား တိုင်ကြားလာပါက ဖြေရှင်းပေးသောလုပ်ငန်းစဉ်များသည် အဖိုးအနည်းရန်၊ လက်လှမ်းမီရန်၊ မြန်ဆန်မှုရှိရန်၊ လျှို့ဝှက်ထိန်းသိမ်းမှုရှိရန် လိုအပ်သည်။ အထူးသဖြင့်ကျန်းမာရေးကဏ္ဍတွင် ဤလုပ်ငန်းသည် ဦးစားပေးတစ်ရပ် ဖြစ်သည်။ ဥပမာ ဆေးရုံများတွင် ခွဲခြားဆက်ဆံခြင်း၊ အိတ်ချ်အိုင်စီပိုးရိုခြင်းဆိုင်ရာ လျှို့ဝှက်ထိန်းသိမ်းအပ်သော အကြောင်းအချက်များပေါက်ကြားခြင်းစသည်တို့အတွက် လူနာများ၏ မကျေနပ်ချက်များကို တိုင်ကြားနိုင်သော ရုံးခန်းများ တည်ထောင်ပေးနိုင်သည်။ ကျန်းမာရေးစောင့်ရှောက်မှုနှင့်ပတ်သက်သောတိုင်ကြားချက်များကို ဖြေရှင်းပေး မည့်လုပ်ငန်းများ တည်ထောင်ခြင်းမှာ ကျန်းမာရေးစနစ်၏ကျယ်ပြန့်သောအရေးကိစ္စတစ်ရပ်ဖြစ်သည်။ ယင်းသည် အိတ်ချ်အိုင်စီပိုးရိုသူက ကဏ္ဍတစ်ခုထက်ပိုပြီးရေရှည်တည်တံ့ရန်လည်းလိုပါသည်။

စွမ်းဆောင်ရည်တည်ဆောက်ခြင်း

စွမ်းဆောင်ရည်တည်ဆောက်ရာတွင်လည်း ရေရှည်ရင်းနှီးမြှုပ်နှံမှုများလိုအပ်ပါသည်။ ပြဌာန်းထားသော ဥပဒေများ၊ မူဝါဒများအောက်ရှိ မိမိတို့၏အခွင့်အရေးများနှင့်ပတ်သက်၍ လူထုအားအသိပညာပေးရန်လိုအပ်ပါသည်။ ရဲသင်တန်းများနှင့် ဥပဒေကျောင်းများရှိ သင်ရိုးညွှန်းတမ်းများတွင် အိတ်ချ်အိုင်စီနှင့်ဆက်နွှယ်နေသော ပြဿနာရပ် များအကြောင်းကို ထည့်သွင်းသင်ကြားပေးခြင်းဖြင့် အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများအတွက် အခွင့်အလမ်းသာသော ပတ်ဝန်းကျင်ဖန်တီးပေးရာတွင်ရှိသော ဥပဒေနှင့်ဥပဒေအရ အရေးယူဆောင်ရွက်ခြင်းတို့၏အခန်းကဏ္ဍကို နားလည်မှု တိုးစေမည်ဖြစ်သည်။ ယင်းတွင် မူးယစ်ဆေးထိုးခြင်းမှ အိတ်ချ်အိုင်စီကူးစက်ခံရခြင်းကို ကာကွယ်ပေးမည့် အန္တရာယ် လျော့ချရေးနည်းလမ်းများ၏ အရေးပါပုံကို အသိပညာပေးခြင်းများလည်းပါဝင်သင့်သည်။

တရားသူကြီးများအနေဖြင့်လည်း အချင်းချင်းထံမှလေ့လာသင်ယူနိုင်မည့်အခွင့်အရေးများရရှိပါက ပိုမိုအကျိုးဖြစ်ထွန်းနိုင်ပါသည်။ အိန္ဒိယတွင် တရားသူကြီးများအတွက် အိတ်ချ်အိုင်စီနှင့်ဆက်နွယ်သောအရေးကိစ္စများနှင့်ပတ်သက်သည့် တရားရေးသင်တန်းပေးခြင်း၊ အမျိုးသားအဆင့်ဆွေးနွေးပွဲများကျင်းပခြင်း စသည်တို့လုပ်ဆောင်ကြပါသည်။ မြန်မာနိုင်ငံတွင်လည်း အလားတူနည်းလမ်းများကို အသုံးပြုနိုင်ပါသည်။ ၂၀၁၃ ခုနှစ်တွင် UNAIDS ကထုတ်ဝေခဲ့သော အိတ်ချ်အိုင်စီ၊ လူ့အခွင့်အရေးနှင့် ဥပဒေဆိုင်ရာတရားစီရင်ရေးလက်စွဲစာအုပ်ကို မြန်မာပြန်ဆိုပြီး သင်တန်းအရင်းအမြစ်တစ်ခုအနေဖြင့် အသုံးပြုနိုင်ပါသည်။

လွှတ်တော်အမတ်များအား စွမ်းဆောင်ရည်ဖွံ့ဖြိုးအောင်လုပ်ဆောင်ရာတွင် လေ့လာရေးခရီးစဉ်များ (ဥပမာ မလေးရှားနိုင်ငံတွင် လူထုအခြေပြုအန္တရာယ်လျှော့ချခြင်းလုပ်ငန်းများမည်ကဲ့သို့ ဆောင်ရွက်နေသည်ကို လေ့လာရန်) သို့မဟုတ် လူဦးရေနှင့်ဖွံ့ဖြိုးရေးဆိုင်ရာလွှတ်တော်ကိုယ်စားလှယ်များ အာရှဖိုရမ် AFPPD ၏ အိတ်ချ်အိုင်စီဆိုင်ရာ အစည်းအဝေးများ စသော ဒေသအဆင့်အခမ်းအနားများသို့တက်ရောက်ခြင်း စသည်တို့ပါဝင်နိုင်ပါသည်။ AFPPD သည် လူ့အခွင့်အရေးနှင့်အိတ်ချ်အိုင်စီလုပ်ငန်းများအား စိတ်ဝင်စားသော လွှတ်တော်ကိုယ်စားလှယ်များအတွက် အရင်းအမြစ်များစွာနှင့် ဒေသအဆင့်ကွန်ယက်များကို လက်လှမ်းမီနိုင်ရန် ပံ့ပိုးမှုများပေးလျက်ရှိပါသည်။

တရားမျှတမှုကိုလက်လှမ်းမီခြင်း

အိတ်ချ်အိုင်စီပိုမိုရရှိသူများနှင့် အဓိကဦးတည်အုပ်စုများအား ဥပဒေရေးရာဝန်ဆောင်မှုများပေးခြင်းမှာ မြန်မာနိုင်ငံအတွင်းရှိ ဝင်ငွေနည်းပါးသောလူထုအတွက် ရေရှည်တည်တံ့သောဥပဒေရေးရာအထောက်အပံ့စနစ်တစ်ရပ် တည်ထောင်ရန်ကျယ်ကျယ်ပြန့်ပြန့်ကြိုးပမ်းနေမှုများ၏ တစ်စိတ်တစ်ဒေသဖြစ်သင့်ပါသည်။ ထိုသို့လုပ်ဆောင်ရာတွင် အိတ်ချ်အိုင်စီနှင့် ဆက်နွယ်နေသော လူ့အခွင့်အရေးကိစ္စရပ်များတွင် လက်ရှိလုပ်ကိုင်နေသော တရားရေးပညာရှင်များနှင့်ချိတ်ဆက်ရန်လိုသည်။ ဥပမာ တရားရေးဝန်ထမ်းများမှတစ်ဆင့်၊ ဖြစ်နိုင်ပါက DLA Piper ကဲ့သို့သော မိမိဆန္ဒအလျောက်အခမဲ့ဝန်ဆောင်မှုများပေးရန် စိတ်ဝင်စားသည့် အပြည်ပြည်ဆိုင်ရာဥပဒေအဖွဲ့အစည်းများမှတစ်ဆင့်၊ ပုဒ်မ ၃၇၇ ကဲ့သို့သောအငြင်းပွားဖွယ်ဥပဒေများအား စိန်ခေါ်ဆန်းစစ်ရန် Human Dignity Trust ကဲ့သို့သော ဥပဒေနှင့်လူ့အခွင့်အရေးဆိုင်ရာ အစိုးရမဟုတ်သောအဖွဲ့အစည်းများ (NGOs) မှ နိုင်ငံတကာဥပဒေရေးရာ အကူအညီများ ရနိုင်ပါသည်။ မြန်မာနိုင်ငံတကာသိုလ်များရှိ ဥပဒေရေးရာဌာနများတွင်အသုံးပြုသော ဥပဒေရေးရာသင်ကြားမှုပုံစံများတွင်အိတ်ချ်အိုင်စီကဏ္ဍကိုထည့်သွင်းပြီး ကျောင်းသားများ အပစ်ပယ်ခံလူထုကို ဥပဒေအထောက်အကူဝန်ဆောင်မှုများ ပေးနိုင်အောင်သင်ကြားပေးရေးမှာ ရေရှည်ရည်မှန်းချက်တစ်ရပ်ဖြစ်သင့်ပါသည်။

၁၀.၄ အောင်မြင်မှု၏ညွှန်းကိန်းများ

အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများအတွက် ဥပဒေနှင့်မူဝါဒပတ်ဝန်းကျင်တိုးတက်စေရေးဆောင်ရွက်ချက်များ

အကြောင်းကိစ္စ	ဦးစားပေးလုပ်ငန်းများအတွက် အောင်မြင်မှုညွှန်းကိန်းဥပမာများ
ခေါင်းဆောင်မှုနှင့် ပူးပေါင်းညှိနှိုင်းဆောင်ရွက်မှု	ကဏ္ဍပေါင်းစုံ အိတ်ချ်အိုင်စီဥပဒေရေးရာနှင့် လူ့အခွင့်အရေးအတွက် စိတ်တူကိုယ်တူဆောင်ရွက်သူများအဖွဲ့ တည်ထောင်ပြီးခြင်း/ ကျင်းပပြုလုပ်ပြီးသော အစည်းအဝေးအရေအတွက် အိတ်ချ်အိုင်စီဆိုင်ရာ ဥပဒေများနှင့်ပတ်သက်၍ လွှတ်တော်ကိုယ်စားလှယ်များအတွက် လွှတ်တော်ကော်မတီ သတ်မှတ်ပြီးခြင်း/ တည်ထောင်ပြီးခြင်း/ ကျင်းပပြုလုပ်ပြီးသော အစည်းအဝေးအရေအတွက်
အဓိကဦးတည်အုပ်စုများအကြား	အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေးနှင့် အဓိကဦးတည်အုပ်စုများကို ထိန်းသိမ်းကြပ်မတ်စောင့်ရှောက်ရေးအတွက် ပြည့်စုံနားလည်လွယ်သောရဲညွှန်ကြားချက်များ ဖော်ထုတ်ပြီးစီးခြင်း၊

အကြောင်းကိစ္စ	ဦးစားပေးလုပ်ငန်းများအတွက် အောင်မြင်မှုညွှန်းကိန်းဥပမာများ
အိတ်ချ်အိုင်စီ ကာကွယ်ရေးကို သက်ရောက်နေသော ရဲလုပ်ဆောင်မှုများ	<p>ဖြန့်ဝေပြီးခြင်း</p> <p>အဓိကဦးတည်အုပ်စုများအတွက် အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေး၊ ဘေးအန္တရာယ် လျော့ချရေး၊ ၎င်းတို့၏လိုအပ်ချက်များအား သိမြင်လာအောင်ပြုလုပ်ရေးဆိုင်ရာ ထိရောက်သောလုပ်ငန်းလုပ်ဆောင်ပုံများနှင့်ပတ်သက်၍သင်တန်းပေးပြီးသော ရဲ/ ကျန်းမာရေးဝန်ထမ်းအရေအတွက်</p> <p>ရဲ-လူထု မိတ်ဖက်လုပ်ဆောင်သောလုပ်ငန်းများအတွက် ရှာဖွေဖော်ထုတ်ထားသော စမ်းသပ်လုပ်ငန်းလုပ်ဆောင်မည့်နေရာအရေအတွက်</p> <p>လုပ်ငန်းစမ်းသပ်ဒေသများရှိ ရဲ၊ ဒေသကျန်းမာရေးအာဏာပိုင်၊ ဒေသတွင်းအိတ်ချ်အိုင်စီ လုပ်ငန်းလုပ်ဆောင်နေသော အစိုးရမဟုတ်သောအဖွဲ့အစည်းနှင့်အဓိကဦးတည်အုပ်စု များ ပါဝင်သော ပူးပေါင်းညှိနှိုင်း ဆောင်ရွက်ရေးအစည်းအဝေးအရေအတွက်</p>
ခွဲခြားဆက်ဆံရေးနှင့် လျှို့ဝှက်ထိန်းသိမ်းရေး	<p>အလုပ်အကိုင်ခန့်အပ်ရာတွင် ခွဲခြားဆက်ဆံမှုမပြုရေး၊ လျှို့ဝှက်ထိန်းသိမ်းရေး ဆိုင်ရာ အမျိုးသားအဆင့်လမ်းညွှန်ချက်များ ဖော်ထုတ်ပြီးစီးခြင်းနှင့်ဖြန့်ဝေပြီးခြင်း</p> <p>ကျန်းမာရေးစောင့်ရှောက်ရာတွင် ခွဲခြားဆက်ဆံမှုမပြုရေး၊ လျှို့ဝှက်ထိန်းသိမ်းရေး ဆိုင်ရာ အမျိုးသားအဆင့်လမ်းညွှန်ချက်များ ဖော်ထုတ်ပြီးစီးခြင်းနှင့်ဖြန့်ဝေပြီးခြင်း</p> <p>ပညာသင်ကြားရာတွင် ခွဲခြားဆက်ဆံမှုမပြုရေး၊ လျှို့ဝှက်ထိန်းသိမ်းရေး ဆိုင်ရာ အမျိုးသားအဆင့်လမ်းညွှန်ချက်များ ဖော်ထုတ်ပြီးစီးခြင်းနှင့်ဖြန့်ဝေပြီးခြင်း</p> <p>(၁) အစိုးရအလုပ်အကိုင်၊ (၂) အစိုးရဆေးရုံ၊ ဆေးခန်းများ၊ (၃) အစိုးရကျောင်းများ စသည့်နေရာများတွင် လမ်းညွှန်ချက်များချိုးဖောက်ပါက အိတ်ချ်အိုင်စီပိုးရှိသူများ အနေဖြင့် တိုင်ကြားနိုင်ရန်လုပ်ငန်းစဉ်များတည်ထောင်ပြီးစီးခြင်း</p>
အေအာရ်တီ ART ရရှိနိုင်သောစံနှုန်းများ	<p>မူးယစ်ဆေးအသုံးပြုသူအဖြစ်မှတ်ပုံတင်ထားခြင်း (သို့မဟုတ်) မူးယစ်ဆေးအစားထိုး မက်သာဒုံး တိုက်ကျွေးခြင်း MMT ကုသမှုစတင်ရသေးခြင်းစသော အကြောင်းပြချက် များဖြင့် PWID များအား အေအာရ်တီကုသမှုပေးရန်ငြင်းဆိုခြင်းမပြုလုပ်သင့်ကြောင်း ရှင်းလင်းထားသော NAP ညွှန်ကြားချက်/ လမ်းညွှန်ချက်ထုတ်ပြန်ပြီးခြင်း</p> <p>အိတ်ချ်အိုင်စီပိုးရှိနေသောမိဘတစ်ဦး၏ကြပ်မတ်မှုသည် ကလေးတစ်ဦး ARV ဆေး ရယူရန် လုံလောက်သောစံနှုန်းဖြစ်ကြောင်း ရှင်းလင်းထားသော NAP ညွှန်ကြားချက်/ လမ်းညွှန်ချက်ထုတ်ပြန်ပြီးခြင်း</p> <p>တစ်နေရာမှတစ်နေရာရွှေ့ပြောင်းသွားလာနေရသူများအနေဖြင့် မြန်မာနိုင်ငံအတွင်းရှိ မည်သည့် အေအာရ်တီ ART ဆေးဖြန့်ဝေသည့်နေရာမှမဆို ညွှန်းဆိုထားသည့် ဆေးညွှန်းအတိုင်း ဆေးထုတ်ယူနိုင်ရန် အခွင့်အရေးရရှိသင့်ကြောင်းရှင်းလင်းထားသော NAP ညွှန်ကြားချက်/ လမ်းညွှန်ချက်ထုတ်ပြန်ပြီးခြင်း</p>
အကျဉ်းကျခံနေရသူများ နှင့်ထိန်းသိမ်းခံထားရ သူများ၏အခွင့်အရေးများ	<p>ရဲထိန်းသိမ်းခံထားရသူများ အေအာရ်တီဆေးများ ARVs၊ OIs (အထူးသဖြင့် အဆုတ်ရောဂါ TB) ဆေးများ၊ မက်သာဒုံး စသည်တို့ကိုစဉ်ဆက်မပြတ်ရရှိနိုင်သော လုပ်ထုံးလုပ်နည်းများ တည်ထောင်ပြီးစီးခြင်း</p> <p>အကျဉ်းကျခံနေရသူများ အေအာရ်တီဆေးများ ARVs၊ OIs (အထူးသဖြင့် တီဘီ) ဆေးများ၊ မက်သာဒုံး စသည်တို့ကိုစဉ်ဆက်မပြတ်ရရှိနိုင်သော လုပ်ထုံးလုပ်နည်းများ တည်ထောင်ပြီးစီးခြင်း</p>
အိတ်ချ်အိုင်စီပိုးရှိသော အမျိုးသမီးများ၏ မျိုးဆက်ပွားကျန်းမာရေး ဆိုင်ရာအခွင့်အရေးများ	<p>အိတ်ချ်အိုင်စီပိုးရှိသော အမျိုးသမီးများ မိသားစုစီမံကိန်း၊ မျိုးဆက်ပွားကျန်းမာရေး ဝန်ဆောင်မှုများ အသုံးပြုပိုင်ခွင့်နှင့် ၎င်းတို့အတွက် ကျန်းမာရေးဝန်ထမ်းမှ နှစ်သိမ့်ဆွေးနွေး အတိုင်ပင်ခံရန်၊ သတင်းအချက်အလက်ပေးရန်၊ နည်းလမ်းများပေးရန် အလေးပေးဖော်ပြထားသော NAP လမ်းညွှန်ချက်များ ထုတ်ပြန်ပြီးခြင်း</p>

အကြောင်းကိစ္စ	ဦးစားပေးလုပ်ငန်းများအတွက် အောင်မြင်မှုညွှန်းကိန်းဥပမာများ
ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်များလက်ဝယ်ထားရှိခြင်း	ဆေးထိုးအပ်များ၊ ဆေးထိုးပြွန်များလက်ဝယ်တွေ့ရှိခြင်းကို ပြစ်မှုအဖြစ်မသတ်မှတ်ရန် ၁၉၁၇ ယစ်မျိုးအက်ဥပဒေ ပုဒ်မ ၃၃ ကိုပြင်ဆင်ခြင်း
ဆေးဝါးများလက်လှမ်းမှီမှုနှင့် မူပိုင်ခွင့်ဥပဒေ	မဖြစ်မနေလိုစင်ပြုလုပ်ခြင်း၊ WTO မှခွင့်ပြုထားသည့်အတိုင်း ဆေးဝါးမူပိုင်ခွင့် အကူးအပြောင်းကာလကို အကြာမြင့်ဆုံးဖြစ်အောင်ဆောင်ရွက်ခြင်းစသည့် TRIPS ဖြေလျှော့မှုများပါဝင်သည့် မူပိုင်ခွင့်ဥပဒေမူကြမ်း
အမျိုးသားအချင်းချင်း သဘောတူညီမှုဖြင့် လိင်ဆက်ဆံခြင်းကို ပြစ်မှုအဖြစ်မသတ်မှတ်ရေး	MSM များအတွက် အိတ်ချ်အိုင်စီကာကွယ်တားဆီးရေးကို ပံ့ပိုးပေးရန် ပုဒ်မ ၃၇၇ ကို ပြင်ဆင်ရန်/ ရုတ်သိမ်းရန်လိုကြောင်း ပြစ်မှုဆိုင်ရာဥပဒေပြန်လည်သုံးသပ်ခြင်း/ ဥပဒေပြုပြင်ပြောင်းလဲခြင်းဖြစ်စဉ်များတွင် ထည့်သွင်းစဉ်းစားနိုင်ရန် ရှေ့နေချုပ်အား တင်ပြခြင်း

၁၀.၅ အနာဂတ်လုပ်ငန်းဆောင်ရွက်ချက်များကိုလမ်းညွှန်မှုပေးမည့် လမ်းပြမြေပုံဖော်ထုတ်ခြင်း

၂၀၁၄ မေလတွင် UNAIDS မှကြီးမှူး၍အလုပ်ရုံဆွေးနွေးပွဲတစ်ခု ကျင်းပခဲ့ပြီး ဥပဒေရေးရာပတ်ဝန်းကျင် တိုးတက်ကောင်းမွန်ရန်အတွက် ကာလတို၊ အလယ်အလတ်ကာလ၊ ကာလရှည် ဦးစားပေးလုပ်ငန်းများအတွက် လမ်းပြမြေပုံမူကြမ်းတစ်ရပ်ကို သဘောတူညီမှုရယူခဲ့ပါသည်။ ဆွေးနွေးပွဲတွင်ပါဝင်သူများမှာ မြန်မာနိုင်ငံ ကျန်းမာရေး ကဏ္ဍညှိနှိုင်းပေါင်းစပ်ဆောင်ရွက်ရေးကော်မတီ (MHSCC) ၏ အိတ်ချ်အိုင်စီဆိုင်ရာ နည်းပညာနှင့် နည်းဗျူဟာအဖွဲ့ (HIV-TSG) အနေဖြင့် ၂၀၁၄ ခုနှစ်တွင် ဖွဲ့စည်းတည်ထောင်ခဲ့သော လူ့အခွင့်အရေးနှင့် ကျားမလူမှုရေးရာ (ဂျင်ဒါ) ဆောင်ရွက်သူအဖွဲ့ဝင်များဖြစ်ပါသည်။ လူ့အခွင့်အရေးနှင့် ကျားမလူမှုရေးရာဂျင်ဒါဆောင်ရွက်သူအဖွဲ့များ၏ လုပ်ငန်း ကို လမ်းညွှန်မှုပေးနိုင်ရန်အတွက် အဆိုပါဆွေးနွေးချက်များကို အခြေခံ၍ အောက်ပါဇယားကို ပြင်ဆင်ခဲ့ပါသည်။

ဥပဒေပတ်ဝန်းကျင်တိုးတက်ကောင်းမွန်စေရေး လုပ်ငန်းဆောင်ရွက်ချက်များ၏လမ်းပြမြေပုံ မူကြမ်း

အကြောင်းကိစ္စ	ကာလတို ၂၀၁၄-၂၀၁၅	အလယ်အလတ် ကာလ ၂၀၁၅-၂၀၁၇	ကာလရှည် ၂၀၂၀ ထက် နောက်ကျော့
၁။ HIV ဥပဒေ <ul style="list-style-type: none"> ခွဲခြားဆက်ဆံမှု လျှို့ဝှက်ထိန်းသိမ်းခြင်း သဘောတူညီမှုရယူပြီး သွေးစစ်ခြင်း HIV ကာကွယ်ရေး 	<p>နိုင်ငံရေးအခြေအနေကို ဆန်းစစ်ခြင်း။</p> <p>HIV ဥပဒေမူကြမ်း၏ နယ်ပယ်ကို တိုင်ပင်ဆွေးနွေးခြင်း။</p> <p>ဥပဒေမူကြမ်းရေးဆွဲသူများထံမှ နည်းပညာအကူအညီယူခြင်း။</p> <p>လွှတ်တော်တွင် HIV ဥပဒေကိုဆွေးနွေးခြင်းနှင့်အတည်ပြုခြင်း။</p>	<p>HIV ဥပဒေပါ အခွင့်အရေးများနှင့် တာဝန်များကို လူထုအား ပညာပေးခြင်း။</p> <p>တိုင်ကြားချက်များကို လက်ခံရန်နည်းလမ်းတည်ထောင်ခြင်း။</p> <p>HIV ပိုးရှိသူများ အတွက် ဥပဒေအကူ အညီဝန်ဆောင်မှုများ တိုးချဲ့ခြင်း။</p>	<p>HIV ဥပဒေအား အကောင်အထည်ဖော်ခြင်းနှင့် အကျိုးသက်ရောက်မှု ရှိစေခြင်း။</p> <p>HIV ပိုးရှိသူများနှင့် အဓိကဦးတည်အုပ်စု အတွက် ရေရှည် တည်တံ့သော ဥပဒေအကူအညီ ဝန်ဆောင်မှုများ ရရှိစေခြင်း။</p>
၂။ HIV ဆိုင်ရာရဲညွှန်ကြားချက်များ <ul style="list-style-type: none"> ကွန်ဒိုများ ဆေးထိုးပြွန်များ ရဲဝန်ထမ်းများ၏နှောင့်ယှက်မှု ARV နှင့် မက်သာဒုံးရရှိမှု 	<p>လူထု၊ မြန်မာနိုင်ငံရဲတပ်ဖွဲ့နှင့် တိုင်ပင်ဆွေးနွေးခြင်း။</p> <p>အဆိုတင်သွင်းလွှာကို ပြည်ထဲရေးဝန်ကြီးဌာနသို့ပေးပို့ခြင်း။</p>	<p>အရေးပါသောနေရာ များတွင် ညွှန်ကြားချက်များကို လိုက်နာမှုရှိမရှိ စောင့်ကြည့်လေ့လာ ရန် နည်းလမ်းများ တည်ထောင်ခြင်း။</p> <p>တိုင်ကြားမှုများကို လက်ခံသော နည်းလမ်းများ တည်ထောင်ခြင်း။</p> <p>အဓိကဦးတည်အုပ်စုအတွက် ဥပဒေအကူ အညီဝန်ဆောင်မှုများ တိုးချဲ့ခြင်း။</p>	<p>စောင့်ကြည့်လေ့လာ ခြင်း/ မွမ်းမံပြင်ဆင် ခြင်း။</p>
၃။ ကျန်းမာရေးဝန်ကြီးဌာနလမ်းညွှန် (သို့မဟုတ်) ညွှန်ကြားချက်များ <ul style="list-style-type: none"> ခွဲခြားဆက်ဆံမှု လျှို့ဝှက်ထိန်းသိမ်းခြင်း သဘောတူညီမှုရယူခြင်း ပြီးပြည့်စုံသော ARV ရရှိမှု မျိုးဆက်ပွားကျန်းမာရေး ရပိုင်ခွင့်များ 	<p>ပြဿနာများကို ဖော်ပြနိုင်ရန် ဖြစ်ရပ်လေ့လာချက်များကို စုစည်းခြင်း။</p> <p>လူထု၊ ကျန်းမာရေး လုပ်သားများနှင့် တိုင်ပင်ဆွေးနွေးခြင်း။</p> <p>အဆိုတင်သွင်းလွှာကို ကျန်းမာရေးဝန်ကြီးဌာနသို့ပေးပို့ခြင်း။</p>	<p>ကျန်းမာရေးလုပ်သားများနှင့် အဓိကဦးတည်အုပ်စုများထံသို့ ရောက်ရှိရန် လမ်းညွှန်ချက်များကို စနစ်တကျ မြှင့်တင်ခြင်း။</p> <p>ညွှန်ကြားချက် ချိုးဖောက်မှုများအား ဖြေရှင်းရန် ဆေးရုံ/ဆေးခန်းများတွင် မကျေနပ်ချက်များကို တိုင်ကြားနိုင်သော အစီအစဉ်များ။</p>	<p>စောင့်ကြည့်လေ့လာ ခြင်း/ မွမ်းမံပြင်ဆင် ခြင်း။</p>

အကြောင်းကိစ္စ	ကာလတို ၂၀၁၄-၂၀၁၅	အလယ်အလတ် ကာလ ၂၀၁၅-၂၀၁၇	ကာလရှည် ၂၀၂၀ ထက် နောက်ကျသော်
၄။ ယစ်မျိုးအက်ဥပဒေ	ရမ်းကုများကို စည်းကမ်းထိန်းချုပ် ရာတွင် သုံးနိုင်သော အခြားနည်းလမ်းများ နှင့်ပတ်သက်၍ သက်ဆိုင်ရာအစိုးရ ဌာနများနှင့်ချိတ်ဆက် လုပ်ဆောင်ခြင်း။ ဆေးထိုးပြန်လက်ဝယ် ကိုင်ဆောင်ခြင်းကို ပြစ်မှုအဖြစ်သတ်မှတ် သော ပုဒ်မ ၁၃၊ ၃၃ ကိုရုတ်သိမ်းရန် ဥပဒေ ကြမ်းပြင်ဆင်ခြင်း။ လွှတ်တော်တွင် လျင်မြန်စွာ အတည်ပြု နိုင်ရန် တိုက်တွန်း နှိုးဆော်ခြင်း။	ပြင်ဆင်ချက်များကို ရဲများသိရှိစေရန် လုပ်ဆောင်ခြင်း၊ ဤပြင်ဆင်ချက်ကို ဆေးထိုးပြန်ဆိုင်ရာ ရဲညွှန်ကြားချက်များ နှင့် ချိတ်ဆက်ခြင်း။	
၅။ မူပိုင်ခွင့် ဥပဒေမူကြမ်း	ဥပဒေအခြေခံဆုံး မူကြမ်းကိုရယူခြင်း၊ TRIPS ဖြေလျော့မှုများနှင့် ဆေးဝါးများနှင့် ပတ်သက်သော အကူး အပြောင်း ကာလကို ပြန်လည်သုံးသပ်ခြင်း။ သိပ္ပံနှင့်နည်းပညာဌာန သို့ပြင်ဆင်မှုများ အဆိုတင်သွင်းရန် ကျန်းမာရေးဝန်ကြီး ဌာနနှင့်ပူးပေါင်း ဆောင်ရွက်ခြင်း။ လွှတ်တော်ကိုယ်စားလှယ်များအား အသေးစိတ်ရှင်းလင်း တင်ပြခြင်း။		
၆။ အလုပ်သမားဝန်ကြီးဌာန လမ်းညွှန်ချက် (သို့မဟုတ်) ညွှန်ကြားချက်များ <ul style="list-style-type: none"> ခွဲခြားဆက်ဆံမှု လျှို့ဝှက်ထိန်းသိမ်းခြင်း မဖြစ်မနေသွေးစစ်ဆေးခြင်း မပြုလုပ်ရေး 		လူထု၊ အလုပ်ရှင်များ၊ MBCA, UMFCCI တို့နှင့် တိုင်ပင် ဆွေးနွေးခြင်း။ လမ်းညွှန်ချက် အဆိုတင်သွင်းလွှာကို အလုပ်သမားဝန်ကြီး ဌာနသို့တင်သွင်းခြင်း။ ယာဉ်မောင်းများအား HIV စစ်ဆေးခြင်းနှင့် ပတ်သက်၍ လိုင်စင်ထုတ်ပေးသောအာဏာပိုင်များထံ တင်ပြကန့်ကွက်ခြင်း။ အဆိုပါ လုပ်ဆောင် ချက်များကို HIV ဥပဒေကြမ်းဆိုင်ရာ တိုင်ပင်ဆွေးနွေးမှုများနှင့် ချိတ်ဆက် လုပ်ဆောင်ခြင်း။	

အကြောင်းကိစ္စ	ကာလတို ၂၀၁၄-၂၀၁၅	အလယ်အလတ် ကာလ ၂၀၁၅-၂၀၁၇	ကာလရှည် ၂၀၂၀ ထက် နောက်ကျသော
၇။ ပညာရေး ဝန်ကြီးဌာန လမ်းညွှန်ချက် (သို့မဟုတ်) ညွှန်ကြားချက်များ <ul style="list-style-type: none"> ခွဲခြားဆက်ဆံမှု လျှို့ဝှက်ထိန်းသိမ်းခြင်း မဖြစ်မနေသွေးစစ်ဆေးခြင်း မပြုလုပ်ရေး 		လူထု၊ ဆရာ/မများ၊ ကျောင်းများနှင့် တိုင်ပင်ဆွေးနွေးခြင်း။ အဆိုတင်သွင်းလွှာကို ပညာရေးဝန်ကြီးဌာနသို့တင်သွင်းခြင်း။ ယင်းကို HIV ဥပဒေကြမ်းဆိုင်ရာ တိုင်ပင်ဆွေးနွေးမှုများနှင့် ချိတ်ဆက် လုပ်ဆောင်ခြင်း။	
၈။ ပြည့်တန်ဆာပျောက်ရေး အက်ဥပဒေ <ul style="list-style-type: none"> အလုပ်ခွင်ကျန်းမာရေးမြှင့်တင် ခြင်း၊ အကြမ်းဖက်မှုကာကွယ်ခြင်းလုပ်ငန်းများဆောင်ရွက်ရန် ပြုပြင်ပြောင်းလဲခြင်း။ 		လိင်လုပ်သားများ၊ လူထု၊ ရဲများနှင့် တိုင်ပင်ဆွေးနွေးခြင်း။ အဆိုပါပြုပြင် ပြောင်းလဲမှုကို ရဲညွှန်ကြားချက်များ နှင့် ချိတ်ဆက်ခြင်း။	လိင်လုပ်ငန်းဥပဒေ မိတ်ဆက်ခြင်း။
၉။ မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေသောဆေးဝါးများဆိုင်ရာအက်ဥပဒေ	ရှေ့နေချုပ်က စဉ်းစားလျက်ရှိသော မှတ်ပုံတင်ခြင်းဆိုင်ရာ လိုအပ်ချက်များနှင့် ပတ်သက်၍ အဆိုတင်သွင်းထားသောပြုပြင်ပြောင်းလဲ ရေးများကို ပြန်လည်သုံးသပ်ခြင်း။	အက်ဥပဒေပြင်ဆင်ရာတွင် ဆေးထိုးအပ်၊ ပြွန်စီမံချက်ဆိုင်ရာ ဘေးအန္တရာယ် လျော့ချရေးပြဌာန်းချက်များ၊ မူးယစ်ဆေး အစားထိုးကုသခြင်း ပြဌာန်းချက်များပါဝင် စေရန် အဆို တင်သွင်းခြင်း။ မိမိအသုံးပြုရန် မူးယစ်ဆေးနွယ်ဝင် ဆေးအနည်းငယ် လက်ဝယ်ထားရှိခြင်းကို ပြစ်မှုအဖြစ် မသတ်မှတ်ရန် အဆိုတင်သွင်းခြင်း။ အဆိုပါပြုပြင် ပြောင်းလဲမှုကို ရဲညွှန်ကြားချက်များ နှင့် ချိတ်ဆက်ခြင်း။	မူးယစ်ဆေးဝါးနှင့် စိတ်ကိုပြောင်းလဲစေသောဆေးဝါးများဆိုင်ရာအက်ဥပဒေ သစ် မိတ်ဆက်ခြင်း။

အကြောင်းကိစ္စ	ကာလတို ၂၀၁၄-၂၀၁၅	အလယ်အလတ် ကာလ ၂၀၁၅-၂၀၁၇	ကာလရှည် ၂၀၂၀ ထက် နောက်မကျဘဲ
၁၀။ ပြစ်မှုဆိုင်ရာဥပဒေ ပုဒ်မ ၃၇၇		အရွယ်မရောက်သူကို ကိုယ်ထိလက်ရောက် ကျူးလွန်မှုများနှင့် အခြားသော လိင်ပိုင်းဆိုင်ရာ ကိုယ်ထိလက်ရောက် ကျူးလွန်မှုများတွင် ပုဒ်မ ၃၇၇ သက်ရောက်မှုကို ကန့်သတ်ရန် ပုဒ်မ ၃၇၇ ပြင်ဆင်ရေး အဆိုပြုခြင်း အဆိုပါပြုပြင် ပြောင်းလဲမှုကို ရဲညွှန်ကြားချက်များ နှင့် ချိတ်ဆက်ခြင်း။	ပုဒ်မ ၃၇၇ ပြင်ဆင်ပြောင်းလဲခြင်း (သို့မဟုတ်) ရုတ်သိမ်းခြင်း။
၁၁။ ၁၉၉၅ ကူးစက်ရောဂါများတားဆီး ကာကွယ်ရေးနှင့်ထိန်းချုပ်ရေးဥပဒေ		AIDS ရောဂါကို ပလိပ်ရောဂါ၊ ကာလဝမ်းရောဂါ စသည်တို့ နည်းတူ သီးသန့်ထိန်းချုပ်ထား ရန်ပြဌာန်းထားခြင်းမှ ဖယ်ရှားရန် ဥပဒေကို ပြင်ဆင်ခြင်း၊ မွမ်းမံခြင်း။	
၁၂။ ၁၉၉၄-၁၉၀၉ အကျဉ်းထောင် အက်ဥပဒေ၊ အကျဉ်းထောင်ကျန်းမာရေး စောင့်ရှောက်မှုစည်းမျဉ်းစည်းကမ်းများ		HIV ကာကွယ်ရေး၊ ARVs၊ မူးယစ်ဆေး အစားထိုးကုသမှု စသည်တို့ကို စဉ်ဆက် မပြတ် လက်လှမ်းမီ ရရှိနိုင်သော အခွင့် အရေးများ ပါဝင်နေ စေရန် ဥပဒေကို ပြင်ဆင်ခြင်း၊ မွမ်းမံခြင်း။	အက်ဥပဒေနှင့် စည်းမျဉ်းစည်းကမ်း များကိုလိုက်နာမှုရှိမရှိ တက်ကြွစွာ စောင့်ကြည့် လေ့လာခြင်း။

Annex I

Stakeholder Mapping

This is provided as initial guidance only and is not intended to be a definitive or exhaustive list. It represents the notes of a discussion on Day 2 of the National Legal Review Meeting.

Priority	Stakeholders
1. Criminal laws, police and prisons Police training Review of laws & police manuals / instructions <ul style="list-style-type: none"> • Prostitution Act • Penal Code • Excise Act • Narcotics Act • Police Acts 	MoHA: Prisons Department, CCDAC, Myanmar Police Force Attorney General's Office Ministry of Health MDM AHRN MANA SARA MPG & Community networks UNODC, UNDP
2. Legal aid Legal advice Legal representation Community legal education Paralegal support	Attorney General's Office Ministry of Home Affairs National Human Rights Commission Equal Project Justice Centre, Myanmar Legal Aid Network (MLAW) Youth Legal Clinic Myanmar Lawyer Network UNDP Pyoe Pin
3. Health care rights Protective laws: discrimination, privacy Quality standards, SOPs Professional guidance Education of health care workers Regulation of health care professions	Ministry of Health NAP Union Parliament Health Committee Myanmar Health Sector Coordinating Committee Myanmar Medical Association State, Division and Township medical officers under DOH responsible for ART MPG & Community networks WHO, UNAIDS INGOs and local NGOs providing health care ICRC
4. Employment rights Protective laws / regulations Workplace policies	Ministry of Labour, Employment and Social Security Ministry of Health Occupational Health Department UMFCCI Myanmar Business Coalition on AIDS MPG & Community networks UNDP, UNAIDS
5. Women's rights Violence protection Social protection Positive women's reproductive rights	National Committee for Women Affairs Ministry of Social Welfare and Resulttand Gender Equality Network (GEN) UN Women, UNFPA Women's Organization Network (WON) INGOs providing RH services e.g. MSI, Alliance MPG & Community networks

6. Young people's rights Schools / Education Consent to HIV testing, sexual health services	Ministry of Education Ministry of Social Welfare and Resulttand MOH NAP Myanmar Youth Stars UNESCO, UNFPA, UNICEF INGOs, Save the Children MRCS RatanaMetta SARA
7. Children's rights Orphans, guardianship, access to treatment & care National registration Social protection Paediatric treatment and care	Department of Social Welfare Population and Social Development Committee Department of Immigration MMWCA Maternal & Child Welfare Assn. UNICEF INGOs: Save the Children
8. Patents Law & treatment access	Ministry of Science and Technology 7 Networks TRIPS Working Group INGOs: AIDS, Alliance, MSF-H UNAIDS, WHO, UNICEF, UNDP

Annex II

Selected references

Laws

Burma Excise Act 1917

Child Law 1993

Narcotics and Psychotropic Substances Act 1993

Prevention and Control of Communicable Diseases Law 1995

Penal Code 1860

Police Act 1945

Prisons Act 1894

Rangoon Police Act 1899

Suppression of Prostitution Act 1949

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Annex III

Text of relevant legislative provisions

These extracts are from most the recent available English translations of the legislation. However, please note that the text may have been subject to subsequent amendments.

Prevention and Control of Communicable Diseases Law 1995

AIDS is defined as a 'Principal Epidemic Disease'

The head of the household or any member of the household shall report immediately to the nearest health department or hospital when (outbreak of a Principal Epidemic Disease) occurs.

1. Traditional medicine practitioners, health assistants and doctors shall report immediately to the nearest health department or hospital if a case of Principal Epidemic Disease is found during practice.
2. In order to prevent and control the spread of a Principal Epidemic Disease, the Health Officer may undertake the following measures:-
 - (a) investigation of a patient or any other person required;
 - (b) medical examination;
 - (c) causing laboratory investigation of stool, urine, sputum and blood samples he carried out;
 - (d) causing investigation by injection he carried out;
 - (e) carrying out other necessary investigations.
12. The Health Officer has the right to do laboratory investigation of any food, water and other necessary materials.
13. The Health Officer shall report immediately the source to the relevant Department of Health of the Principal Epidemic Disease.
14. An organization or an officer on whom power is conferred by the Ministry of Health may issue a prohibitive order or a restrictive order in respect of the following matters:-
 - (a) right of the person suffering from Principal Epidemic Disease to leave and return to his house;
 - (b) right of people living in the house, ward, village or township infected by Principal Epidemic Disease to leave and return thereto;
 - (c) right of people from outside to enter the house, 'ward, village or township infected by Principal Epidemic Disease;
 - (d) if there is a person suffering from Principal Epidemic Disease among those people arriving by train, motor vehicle, aircraft, vessel or any other vehicle, right of such person put under quarantine up to a period necessary for medical examination, to leave and return thereto;
 - (e) when an outbreak of Principal Epidemic Disease occurs during the time of fair and festival, right of the public to visit the site and right to continue the festival.

17. The head of the household or any member of the household who fails to comply with the provision of section 9 or any traditional medicine practitioner, health assistant or doctor who fails to comply with provision of section 10 shall, on conviction be punished with imprisonment for a term which may extend to one month or with fine which may extend to kyats 5000 or with both.

18. Whoever violates the prohibitive or restrictive order issued by the relevant organization or officer under section 14 shall, on conviction he punished with imprisonment for a term which may extend to six months or with a fine which may extend to kyats 10,000 or both.

20. Prevention, control of the spread and necessary investigations in respect of AIDS shall be carried out in accordance with the orders and directives issued specifically by the Ministry of Health.

Penal Code 1860

Offences affecting the public health etc.

269. Whoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease dangerous to life shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.

Unnatural Offences

377. Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with transportation for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

Myanmar Excise Act 1917

13. No person shall make, sell, possess or use--

(i) any hypodermic syringe, or

(ii) any other apparatus suitable for injecting any intoxicating drug, except under

and in accordance with the conditions of a licence granted under this Act :

Provided that this prohibition shall not apply to:

(a) a medical practitioner,

(b) a veterinary practitioner,

(c) a person who possesses or uses any such syringe or apparatus on the prescription of a medical practitioner.

33. Whoever, in contravention of section 13, makes, sells, possesses or uses

(a) any hypodermic syringe, or

(b) any other apparatus suitable for injecting any intoxicating drug,

shall be punishable with imprisonment for a term which may extend to six months, or with fine which may extend to one thousand rupees, or with both,

Police Act 1945

35. (b) Any reputed thief found between sunset and sunrise remaining or loitering in anybazaar, street, road, yard, thoroughfare or other place, who is unable to give a satisfactoryaccount of himself ;

(c) any person found between sunset and sunrise having his face covered or otherwise

disguised, who is unable to give a satisfactory account himself;

(d) any person found within the precincts of any dwelling-house other building whatsoever, or in any back-drainage space, on board any vessel, without being able satisfactorily to account for his presence therein may be taken into custody by any police-officer without a warrant, and shall be punishable on conviction with imprisonment for a term which may extend to three months.

Rangoon Police Act 1899

Provisions against Thieves and Vagabonds.

30. (d) any person found between sunset and sunrise, within the precincts of any dwelling-house or other building whatsoever, or on board any vessel, without being able satisfactorily to account for his presence therein... may be taken into custody by any police-officer without a warrant, and shall be liable to imprisonment which may extend to three months.

43(C). Whoever, in any street, thoroughfare or place of public resort, —

(a) loiters for the purpose of prostitution ; or

(b) solicits any person to the commission of immorality, shall be punishable with fine which may extend to fifty rupees or with imprisonment which may extend to eight days.

Narcotics and Psychotropic Substances Law 1993

15. A drug user who fails to register at the place prescribed by the Ministry of Health or at a medical centre recognised by the Government for purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of 3 years to a maximum of 5 years.

16. Whoever is guilty of any of the following acts shall, on conviction be punished with imprisonment for a term which may extend from a minimum of 5 years to a maximum of 10 years and may also be liable to a fine:...(c) possession, transportation, transmission and transfer of a narcotic drug or psychotropic substance.

Child Law 1993 (extracts)

8. The State recognizes that every child has the right to survival, development, protection and care and to achieve active participation within the community.

(a) Every child has the inherent right to life;

(b) The parents or guardian shall register the birth of the child in accordance with law.

10. Every child shall have the right to citizenship in accordance with the provisions of the existing law.

11 (a) Maintenance, custody and care of children, cultivating and promoting the all-round physical, intellectual and moral development of the child shall be the primary responsibility of parents or guardian;

12. Every child: (a) shall have the right to live with and be brought up by both parents or any one parent if they are alive;

13. (a) Every child who is capable of expressing his or her own views in accordance with his age and maturity has the right to express his own views in matters concerning children;

(b) The views of the child shall be given due weight in accordance with his age and maturity, by those concerned;

(c) The child shall be given the opportunity of making a complaint, being heard and defended in the relevant Government department, organization or court either personally or through a representative, in accordance with law, in respect of his rights.

Every child shall, irrespective of race, religion, status, culture, birth or, sex:

(a) be equal before the law; (b) be given equal opportunities.

Every child-

(a) has the right to freedom of speech and expression in accordance with law;

(b) has the right to freedom of thought and conscience and to freely profess any religion;

(c) has the right to participate in organizations relating to the child, social organizations or religious organizations permitted under the law.

16. (a) In order that every child shall not be subjected to arbitrary infringement of his honour, personal freedom and security, relevant Government departments and organizations shall provide protection and care in accordance with law;

(b) Security of the property of every child shall be protected by law.

19. (a) Every child has the right to enjoy health facilities provided by the State;

(b) The Ministry of Health shall: -

(i) lay down and carry out measures for the survival of the child, immunization of child, breastfeeding of the child, family planning, adequate nutrition for the child, elimination of iodine deficiency disease, school health and family health;

(ii) lay down and carry out appropriate measures for the gradual abolition traditional practices prejudicial to the health of the child;

(iii) carry out measures to minimize the child mortality rate and to maximize the population of healthy children.

20. (a) Every child shall: -

(i) have opportunities of acquiring education;

(ii) have the right to acquire free basic education (primary level) at schools opened by the State.

Annex IV

Agenda of the National Legal Review Meeting

National Review Meeting on the Legal Framework for the HIV Response in Myanmar		
Day 1 – November 25 (Monday)		
8:30 am – 9:00 am	Registration	
9:00 am – 9:45 am	Opening remarks Plenary Panel	Ministry of Health UNAIDS Myanmar Positive Group, Ko Myo Thant Aung
9:45 am - 10:15 am	Tea Break	
10:15 am – 10:45 am	Introduction & overview of National Legal Review	Mr John Godwin
10:45 am – 1:00 pm	Presentations from key stakeholders	Representatives of: NAP: Dr MyintShwe MSM and TG: Ko Chit Ko PLHIV: Ko Tun Aung Kyaw PWID: Ko Htoo Wint Kyaw Positive woman: Ma Hnin Thandar Win Sex worker: Ma Thiri NGO: Dr Sid Naing
1:00 pm – 2:00 pm	Lunch Break	
2:00 pm – 2:10 pm	Introduction to Group Work I: Criminal law, police and prisons	Mr John Godwin & Dr Khin Su Su Hlaing
2:10 pm – 3:15 pm	Group Work I: Key issues and recommendations relating to criminal law, police and prisons	8 groups
3:15 pm – 3:45 pm	Tea Break	
3:45 pm – 5:30 pm	Groups report back	
5:30 pm – 5:35 pm	Close session	Mr John Godwin
6:00 pm – 7:30 pm	Dinner	
Day 2 – November 26 (Tuesday)		
9:00 am – 9:15 am	Introduction to Group work II: Discrimination and access to quality treatment and care	Mr John Godwin & Dr Khin Su Su Hlaing
9:15 am – 10:30 am	Group work on issues and recommendations: Discrimination and access to quality treatment and care	8 groups
10:30 am - 11:00am	Tea Break	
11:00 am – 12:30 pm	Groups report back	
12:30 pm – 1:30 pm	Lunch Break	
1:30 pm – 2:15 pm	Plenary presentations: Patents Law and access to medicines	Mr John Godwin Dr Soe Naing
2:15 pm – 3:30 pm	Plenary presentations / discussion Women Young people	Dr Ni Ni Khaing Mr Si Thu Maung Maung Mr Naing Lin
3:30 pm – 4:00 pm	Tea break	
4:00 pm – 5:00 pm	Plenary discussion on next steps, recommendations, roles and responsibilities	Mr John Godwin & Dr Khin Su Su Hlaing
5:00 pm – 5:30 pm	Conclusion Summary of next steps UN Closing Statement	Mr John Godwin UNDP

Annex V

Participants: NGO Consultation & National Review Meeting

NGO Consultation 23 October 2013, UNAIDS Office, Yangon

No.	Name	Organization	Position Title
1	U Soe Tint	RatanaMetta Organization	Project Manager
2	U Htun Linn Oo	Alliance	Program Manager
3	Daw Kay Zin Soe	MBCA	Senior Technical Trainer
4	U Kyaw Sit Naing	Equality Myanmar	Advocacy coordinator
5	Dr Tin Thann	MRCS	Deputy HOD (Health)
6	Dr Yamin Shwesin	Save the Children	Sr. Program Coordinator
7	Dr Hla Htay	BI-MM	Senior Technical Officer
8	Dr Nyo Yamonn	Open Society Institute	Health Coordinator
9	Dr Khin Than Nwe	MMCWA	PO, PMCT project
10	Dr Hla Myo Kyaw	PSI	HIV Program Director
11	Dr Khin Nyein Chan	MSF-H	Medical Coordinator
12	Dr Myo Lwin	Pyoe Pin	Strategic Adviser
13	Dr Win Mar	UNDP	National Project Coordinator
14	Dr Nay Tun Zaw	MSI	Project Manager
15	Daw Khin Swe Swe	Consortium	NPO
16	Mr Dean Creer	Consortium	Coordinator
17	U Moe Zaw Aung	Equal Project	Program Manager
18	Mr Renaud Cachia	MDM	Program Coordinator
19	Ms Birke Herzbruch	Malteser	Country Representative
20	U Nay Oo Lwin	PSI	Program Manager
21	Mr Willy de Maere	AHRN	Technical Director

Key informant interviews

No.	Name	Organization	Position Title
1	Mr Willy de Maere	AHRN	Technical Director
2	U Tint Aung	MDM	NPO
3	U Moe Zaw Aung	Equal Project	Programme Manager

National Review Meeting on the Legal Framework for the HIV response in Myanmar

No	Person	Ministry/Department/ Organization
UN Agencies		
1	Ms Krittawawan Boonto	UNAIDS
2	Mr John Godwin	Consultant
3	Ms Jacquie Cheung	UNAIDS
4	Ms Makiko Fujita Suzanne	UNDP
5	U Maung Maung Kyaw	UNDP
6	Dr Win Mar	UNDP
7	Daw Wint Yee Nandar Lwin	UNDP
8	Daw Sandar Win	UNDP
9	Dr Khin Su Su Hlaing	UNDP
10	U Aung Swe	UNDP
11	U Brian Pe Tin Thein	UNDP
12	Dr Mya Mya Thet	UNDP
14	Dr Tint Maw	IOM
15	Dr Aung Myint Than	IOM
16	Dr Yu Yu Aung	UNESCO
17	Dr Ni Ni Khaing	UNFPA
21	Daw Nu Nu Aye	UNOPS
22	Dr Aye Aye Nyein	UNOPS
23	Dr Sai Lone Tip	WFP
24	Ms Phavady Bollen	WHO
INGO & NGO		
1	Dr Cho Cho Mar Kyaw	AFXB
2	Dr Soe Naing	Alliance
3	Dr Sai Phyo Wai Aye	Malteser
4	Dr Khin Maung Gyee	MANA
5	Mr Dario Devale	MdM
6	Dr Khin Maung Twin	Merlin
7	Dr Myo Lwin	Pyoe Pin
8	Dr Khin Nyein Chan	MSF-Holland
10	Dr Sid Naing	MSI Myanmar
11	Dr Kun Thiha	MSI Myanmar
12	Dr Hlaing Min Swe	MSI Myanmar
13	Ms Anne Lancelot	PSI Myanmar
14	Dr Soe Tint	RatanaMetta
15	Dr Gyaw Htet Doe	SARA
16	U Pyae Phyo Aung	PyiGyiKhin
17	Dr Kyi Zaw Win	PyiGyiKhin
18	Dr Sai Thet Aung	Save the Children
Bilateral Agencies		
1	Dr Ikuma Nozaki	JICA
Parliamentarians		
1	Dr Nyo Nyo Thin	MP
2	U Tin MaungOo	MP
3	U Myint Thu	MP
4	Col Htay Naing	MP
5	Dr. Aung Than	MP
6	Daw Sandar Min	MP

Community Networks		
1	U Myo Thant Aung	MPG
2	U Min San Tun	MPG
3	U Tun Aung Kyaw	MPG
4	U Zaw Min Htet	MPG
5	U Banyar Oo	MPG
6	U Moe Zaw Aung	Equal Project
7	Daw Thiri	SWiM
8	Daw Khin Cho Win	SWiM
9	Daw Zin Win Mar	SWiM
10	Daw Yadana	SWiM
11	U Htoo WintKyaw	IDU
12	U Win Min	IDU
13	U Myo Myint Naung	IDU
14	U Kyaw Zayar/U Kyaw Thu	IDU
15	Daw Thet Mon Phyo	MSM Network
16	U Erwin Kyaw Myint	MSM Network
17	U Chit Ko	MSM Network
18	Daw Thazin	MSM Network
19	Daw Htwe Htwe Myint	MPWN
20	Daw Naw She Wah	MPWN
21	Daw Hnin Thandar Win	MPWN
22	Daw Cho	MPWN
23	Daw Chaw Su	MPWN
24	Daw New Zin Win	3N
25	Daw Khin Khin Win or Daw Khawn Taung	MINA
26	U Swe San Oo	3N
27	U Tin Hlaing	3N
28	U Kyaw Nyein	MINA
29	U Thiha Kyaing	Phoenix Association
30	U Si Thu Maung Maung	Myanmar Youth Stars Network
31	U Naing Linn	Myanmar Youth Stars Network
32	Daw Kaythi Win	SW AMA network
Government		
1	Dr Soe Lwin Nyein	Ministry of Health
2	Dr Myint Shwe	Ministry of Health
3	Dr Ko Ko Naing	Ministry of Health
4	Dr Htun Myint Oo	Ministry of Health
5	Pol Col Zaw Lin Htun	Ministry of Home Affairs
6	Pol Daw Tin Tin Kyi	Ministry of Home Affairs
7	Pol May Cho Latt	Ministry of Home Affairs
8	Pol Mg Yi Yi Lay	Ministry of Home Affairs
9	Pol Lt Col Kaung San Lin	Ministry of Home Affairs
10	U Tun Oo	Ministry of Social Welfare, Relief and Resettlement
11	Daw Tin Ma Ma Hlaing	Myanmar Police Force
12	Daw Khin Thida Kyaw	Office of the Supreme Court of the Union

Annex VI

Summaries of NGO & Community Consultation Meetings

1. NGO consultation

21 participants from INGOs and local NGOs attended the meeting on 23 October 2013 in Yangon.

1. Policing of people with inject drugs

Police practices impede drug users access to needles and syringes. Intensification of police activity in the last two years means more drug users are being arrested. Ten per cent of MDM's HIV-positive drug users on ART in jail. Although possession of needles and syringes is not charged directly by the police, possession of injecting equipment leads to further investigative efforts. More rigorous enforcement of restrictions on import and use of pain relief drugs is a problem. Peer outreach workers do not face much problem with police harassment unless the peer educators are using drugs at the time of police raids of shooting galleries. Even with the availability of more funds for harm reduction, programmes are constrained to expand coverage and meet targets because of the current legal environment.

2. Sex workers and possession of condoms

Possession of condoms is less of a police concern than possession of syringes. There has not been any noticeable increase in police activity regarding condom possession or sex work. Increase in sex work business along the north-east corridor from Tachileik to Myawaddy has been noted with higher frequency of trafficking and rotation of sex workers. Anti-trafficking law is not enforced properly.

If sex workers fear carrying condoms, this concern stems more from the overall legal environment of criminalization of sex work rather than the police practice of arresting sex workers on the basis of condom possession alone. Abuses of sex workers by police and military personnel happens because of illegal status of sex work, lack of access to legal aid for sex workers and power imbalance between sex workers and law enforcement. A media and public opinion backlash from MP's proposition to legalize sex work highlights society's conservative view towards sex work and brought police attention to sex workers. In Yangon, informal sex work venues such as massage parlours and karaoke lounges have been closely scrutinized and in some cases, shut down more frequently than in the past.

3. Quality of health care in public sector

PSI & UNDP conducted a survey of MSM and transgender community. Findings indicate challenges at health facilities of double charging, stigma and discrimination. While not a written policy, current provider practice does not favour active drug users for ART, and being an active user is a *de facto* disqualifier for ART. Myanmar does not follow international guidelines on treatment of HIV-positive drug users. Referral of HIV-positive prisoners or detainees to public hospitals under MoH is a process fraught with many difficulties as the prison department cannot provide security and has to request the police department which can take considerable time with uncertain outcome. Environment, services and infrastructure at public health facilities are not client friendly.

4. How should NGOs approach advocacy on legal priorities

- Society's view on behaviours of key populations as 'Social Aberration' is not likely to change in the foreseeable future and it is unlikely that political champions will emerge before the 2015 election.

- To be sensitive to culture and context in making the case for change to laws and policies.
- Advocate to update laws and remind on Myanmar's commitment to abide by international standards.
- Support advocacy efforts led by local civil society organizations and networks, which are more meaningful and effective compared to INGO-led efforts.
- Revitalize engagement with CCDAC and Myanmar Police Force to ease the operating environment before any change in the law can be accomplished.
- Urgently revise the regulation of controlled substances under *Narcotics Law* and the *National Drug Law 1992* as it is inhumane not to make pain medication available to people in need.

5. Examples of Good Practices

- Advocacy efforts by 7 networks – awareness raising with members of parliament for the issues faced by key population groups; inputs into the draft bill on registration of associations.
- Establishing good personal relationships at local level – e.g. NGO was able to continue nutrition support to HIV-positive persons in prison because of good relationship with chief of prison.
- Promotion of corporate social responsibility work of MBCA – 72 local businesses have signed agreements on HIV which includes a non-discrimination clause for PLHIV, HIV awareness raising at work, and more engagement in community work.
- Organizing community/public events for and by key population groups.
- Regular meetings with local authorities and community leaders.
- Legal aid service for key populations – e.g. Equal Project.
- International exposure such as conference, workshop, study tour – for law enforcement, policy/law makers (e.g. UNODC organized visit for CCDAC to Vietnam, Australia for harm reduction to widen views of authorities on harm reduction and fostered evidence-based harm reduction approaches; networking established between representatives of KPs and DoH/NAP leadership)
- PGK and Alliance access Global Fund to support community networks on human rights and community feedback mechanism – the project aims to identify abuses and advocate.
- Briefing with MPs to inform the situation of PLHIV in July 2013 (what began as a personal relationship of Phoenix chairperson with one MP has been turned into an advocacy opportunity for 7 networks with 40 or so MPs). As a result of this advocacy effort, individual MPs have contacted the networks with follow-up requests for more information and offers of help.
- Equal Project is working with 3 KP groups (SW, DU, MSM) to provide legal aid services – advice and court representation (one sex worker was fully discharged after court representation).
- Equality Network provided recommendations for Human Rights Commission law in Naypyitaw (PLHIV networks might also benefit from involvement in this process to make sure HIV discrimination issues are included in this drafting. Finalization is not until end 2013).

Recommendations

- Sustain efforts to engage and sensitize law enforcement and police (e.g. CARE's police programme, UNODC's project to develop curriculum on harm reduction for police training).
- Non-discriminatory policy at national level.
- Educate and advocate the police and multi-sectoral collaboration across government ministries.

- UN/INGO/NGO should work with different stakeholders – concerned ministries, CSOs/community, MPs and the media – to advance law and policy reform issues.
- Exposure to international best practices.
- Collect voices of community to represent at national level and speak with the media.
- Set up a Working Group on legal review for HIV.
- Urge MPs to introduce laws related to health rights and provide legal protection and assistance.
- MOH should take responsibility and advocate for people's rights to access health care.
- Build civil society networks to advocate for the rights and collect evidence; set up a watchdog mechanism led by community to monitor legal environment, work with NHRC to seek redress.
- PLHIV and HIV related networks to collect testimonies and cases of HR violations to inform and influence funding and programming decisions of donors and implementing agencies.
- Donors to use evidence to inform funding and resource allocation and fill gaps where needed (e.g. international experts, capacity development of local legal experts and parliamentarians).

Community Consultations

(These are summary notes: full copies of Consultation Reports are available from 3N)

1. Yangon Community Consultation

The community consultation was conducted in Yangon from 2–3 September 2013 attended by 40 individuals representing key populations and national networks of key population groups.

1. Female sex workers

Sex workers are hesitant to attend health services because of lack of confidentiality, poor quality of care and discrimination. Access to services is restricted due to stigma and discrimination against sex workers. Health care providers are reluctant to prescribe ART to sex workers due to the mobile nature of their work. When sex workers are held in prison or police detention, they miss doses of ARVs. Lack of compliance among the local police at township level with the Administrative Order (2000) directing police not to use condoms as evidence in prosecution of sex workers: Local police still searched and used the possession of condoms as grounds for police harassment or extortion. The *Suppression of Prostitution Act 1949* and the threat of arrest inhibit sex workers to access services relating to reproductive health and HIV. Many sex workers do not have a National Registration Card. Police arbitrarily arrest women merely based on their 'reputation as a prostitute'. Laws and police practices fuel society's existing stigma and discrimination against sex workers, encourages acts of violence and fosters a clandestine sex work environment, which is counter to the health goal of HIV prevention.

By 2030, sex work should be viewed and treated like any other job. Sex work should be accepted by the society as a livelihood. The *Suppression of Prostitution Act 1949* should be abolished, so that the 100% Targeted Condom Programme can be implemented, violence against sex workers can be reduced, stigma and discrimination against sex workers can be lowered, and sex workers can confidently

access health services. If the Act is not abolished, suggestions were made for a less punitive approach to law enforcement including to reduce penalties, provide legal aid, reduce police abuses, and provide access to ART in prisons / detention. Rehabilitation centres should offer marketable skills on running a small business.

2. People who inject drugs (PWID)

Even though there is a directive from Police Force headquarters not to make arrests for possession of needles and syringes, PWID still face challenges in accessing clean needles and syringes openly and safely. Confiscation of needles for lab investigation and submission as evidence is still commonly practised by the police under Section 33 of the 1917 *Excise Act*. Law enforcement views drug users as criminals and this view has influenced the perspective of health care providers to a large extent. As a result, discrimination against drug users (injecting or otherwise) is common in medical settings. Drug users are given less priority when considering ART eligibility in both public and NGO sector. If PWID relapse during our registered treatment process, they are still charged under Section 16 for possession. The information requirement to register for methadone treatment such as household registration form (Form No.10) and occupation of drug user is a barrier to register. Drug users in prison lose access to MMT.

Section 33(d) *Excise Act* should be abolished; coverage of methadone services should be expanded and the National MMT Guideline should be fully implemented; Registration for drug treatment should only be under the Ministry of Health and information should be confidential and used solely for the purpose of treatment, not for criminal prosecution. This will encourage drug users to register early for treatment and receive VCCT and HIV prevention education and services; Section 16(c) *Narcotics Law 1993* should be amended to provide protection for a registered drug user from being charged with criminal offence due to relapse; access to comprehensive treatment services should be assured once a drug user has registered for treatment under Section 15. Prophylaxis and treatment of hepatitis B and C, and TB among drug users should also be prioritized. Drug use should be taken out of criminal context and a new law or policy for drug use should be established from the viewpoint of drug use as a health condition. Quality of drug counselling services should be improved.

3. Men who have sex with men (MSM) & Transgender (TG)

Section 377 Penal Code in practice applies only to sexual intercourse between two males, and this loose interpretation of the law enables the police and law enforcement to extort money and commit verbal as well as physical and sexual abuse on MSM & TG, and drives these people to live in a secretive and unprotected environment where access to HIV information, condoms and opportunities to practice safer sex are constrained. NSP II includes MSM only within the sexual transmission category but does not address their human rights issues, only their status as target group for HIV prevention. Participation of TG in national level coordinating bodies is not yet visible. Anti-discrimination laws and policies should be developed for sexual orientation and gender identity in education, health, work and social settings.

Section 377 of Myanmar Penal Code should be abolished as it directly violates the right of the person to express his/her own sexual orientation and gender identity in accordance with the Universal Declaration of Human Rights, fuels society's stigma and discrimination towards their community, and encourages abuses by the police; or should be amended to apply only if the act is not consensual between adults or if it is between an adult and a child. Extortion and other police abuses should be prevented. The *Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2006) should be adopted as a national policy by the State. The Constitution should address transgender identity and discrimination on grounds of sexual orientation and gender

identity. Police/law enforcement, health, education, labour etc. should be made fully aware of sexual orientation and gender identity rights. TG and MSM community should also be made aware of their rights and empowered to demand justice if their rights are not being met.

4. People living with HIV (PLHIV)

There is no specific HIV law and no mandatory HIV workplace policy in Myanmar to give protection to an HIV-positive person for his/her rights to health, education, livelihood, and a life free from stigma and discrimination. Discrimination including mandatory HIV testing is widespread. Quality of care and counselling is poor. Access to OI treatments is unreliable. An HIV law should be enacted to protect the rights of PLHIV including from discrimination, to explicitly assign the accountability for protection and ensuring their rights, and to establish a justice mechanism that provides remedies for any breach of the rights of PLHIV. Awareness should also be raised among PLHIV about their protection rights. A responsive and reliable feedback mechanism should be designed and set up for HIV-affected community to provide feedback on quality of services, service providers, programme or intervention on HIV implemented by public, private and NGO sectors; and to seek redress for any violation of their rights or malpractice. Raising awareness and capacity building of law enforcement and judiciary should occur so that they understand the human rights aspect of PLHIV and key populations affected by HIV, and the public health imperative of working together with these communities rather than suppressing them.

Other priorities include: specific implementation plan and budget for stigma and discrimination reduction; regulations and guidelines should be established on procedures for HIV-positive children and children from HIV-affected households, including orphans, to access health, education, protection and care including shelter. HIV-positive women and women affected by HIV must be assured of equal rights like any other HIV negative woman to access PMCT services, family planning and reproductive health services; and they must have the right to decide on their family planning and reproductive health choices without any coercion. Clear policies and regulations concerning the quality of health service provision in both public and private sector including jails, prisons, and detention/rehabilitation centres should be established. Workplace policy for HIV should be enforced in both private and public sector so that workers can access HIV prevention services such as health education and confidential HIV counselling and testing, and HIV-positive workers can be protected from stigma and discrimination in the workplace and dismissal or forced retirement on the ground of HIV-positive status, and have the right to access necessary health care. Human rights defenders and legal counsels for HIV-positive people, including the key affected populations, should be made available and accessible.

2. Mawlamyine Community Consultation

The Mawlamyine community consultation was conducted for three days from 15-17 September with participation of 38 individuals representing key populations and self-help groups of key populations from Mon, Tanintharyi, Kayin states, and Bago region.

1. Female sex workers

By 2030, we want our profession to be legal and sex workers to become registered professionals; to be free from stigma and discrimination and have equal rights to education, social and economic opportunities as any other citizen and equal access to health care; everyone to be treated equally in front of the law; and judiciary and

law enforcement to follow the rule of law; legal literacy and legal aid services are required.

The *Suppression of Prostitution Act* should be rewritten, but if it is not possible to repeal it entirely it should be reviewed and revised to prevent unnecessary punitive acts against sex workers. Sections 3(a), 3(b) and 7, which are the most commonly used Sections, should be reviewed and clarified to prevent varied interpretation and application by the police.

The Police Directive on not using condoms as evidence at the court for prostitution offences needs to be more comprehensive and explicit to protect sex workers against police harassment on the grounds of condom possession, as this still frequently occurs. Police practices regarding sex workers should be regulated and disciplined, e.g. abusing Code of Criminal Procedure Section 54 on arrest without warrant, detention based only on reputation without evidence of solicitation in public, not following procedures during arrest, fabricating or falsifying evidence, coercing and forcing a confession of guilt, misusing and failing to return valuable personal items upon release from jail/prison, taking bribes and manipulating the case in favour of the ones giving bribes. Liberal use by the police of loitering after dark offences of the *Police Act* should be curbed when sex workers are not committing any crime or harassing anyone in public. Having to give small bribes to the police at the jail or security personnel at the prison to send food or medicines inside jail/prison should no longer happen.

Sex worker peer educators should be able to conduct group peer education sessions at the sex work places without worrying about police harassment or arrest. Police have taken advantage of such gatherings in the past to either harass or arrest sex workers, which made it difficult for peer educators to get the trust of the sex workers.

Relaxation of ART access criteria should be done so that mobile HIV-positive sex workers are referred to the nearest ART provider outside of the initial ART site, and have flexibility to access and refill their ART prescription as they move from one place to another. For example, HIV-positive sex workers should be issued a treatment ID card that they can use to access treatment at ART service providers anywhere in the country. Jailed sex workers require continuing access to ART inside the jail. Ministry of Home Affairs as a focal for prisons department should arrange to provide PLHIV inside the prison including HIV-positive sex workers with ART adherence support. Stigma and discrimination against HIV-positive sex workers inside the prisons need to be addressed.

Sex workers should also be given an avenue to complain against irregularities and unlawful practices by the police, law enforcement and judiciary. Free legal aid services for sex workers (e.g. similar to Equal Project) should be made available in other areas outside Yangon.

There are laws and conventions to protect the rights of women such as the 2005 *Anti-trafficking in Persons Law* and CEDAW to protect the rights of women against trafficking and all forms of discrimination, including rights of sex workers to be protected from trafficking and exploitation. These laws should be fully adopted and enforced to protect the sex workers from exploitation by their employers, agents and even by persons close to law enforcement who are sometimes involved in human trafficking. Sex workers should be educated on all laws protecting women including assault provisions of the *Penal Code* and where to complain to seek redress. Focal department or civil society organization or a body should be identified, trained and sensitized to handle such complaints so that sex workers can seek justice without fearing negative repercussions on themselves because of their occupation.

2. People Who Inject Drugs and People Who Use Drugs (PWID and PWUD)

Section 33(d) *Excise Act* should be revised not to be applicable to drug users since their access to clean needles and syringes for harm reduction is being affected by this law. This law also acts against the national policy on harm reduction as described under NSP II. Directive by the Police Headquarters (2001) not to make arrest for possession of needles and syringes should be followed strictly by the local police in the spirit in which it was issued. Methadone centres should be opened more widely across the country as there are drug users who want to break their habit but are unable to do so due to lack of counselling and treatment options. Registered drug users who are undergoing treatment should be treated leniently by the law if they have a relapse during treatment and re-use drugs. Police or law enforcement should take a more health-oriented view in this regard to encourage more drug users to come forward to access counselling and treatment for drug use, VCCT and HIV prevention information. When drug users are arrested, they should not be charged for 'possession' in addition to using illicit drugs (as is currently practised by the police). They should be charged only for using and sentenced not to do a prison term but to do a treatment registration at a proper treatment facility.

3. Men who have Sex with Men (MSM) & Transgender people (TG)

The State should recognize equal rights of MSM & TG to live a life free from harassment by law enforcement and authorities, and have freedom of movement, and ultimately opportunities to become members of parliament. MSM should have equal rights and opportunities to participate in health, education, labour and social life. Section 377 of the *Penal Code* should be repealed as it violates the right of consenting adults to have sexual intercourse in privacy and creates an environment where MSM/transgender persons are seen as criminals committing abnormal acts, therefore making them fair game for harassment and abuse by the police and law enforcement and discriminatory treatment by lay people, health service providers and employers. Use of the *Police Act* loitering offences and *Code of Criminal Procedure* Section 54 to arrest MSM should no longer be practised by the police unless there is intention to commit a serious crime. Police should not abuse their power to harass and abuse gay and transgender people. Police and law enforcement should collaborate to promote condom use to prevent HIV transmission instead of harassing people for possession of condoms when they are searched during investigation or arrest. Space and opportunity should be created for more meaningful participation of MSM and transgender community in the HIV response in the country.

Rules and procedures remaining to this date from the previous military government's rule such as seeking prior permission through several government offices in order to gather people (in group of more than five persons) for health-related activities should no longer apply. Local authorities should aim to encourage wider health education among people including MSM to prevent HIV more effectively. MSM and TG should have the right to a family life like any man or woman. Non-discrimination and protective laws and policies for MSM and transgender people should be enacted. National Registration Card should recognize a right of transgender people to be photographed as he or she looks in present life rather than having to revert back to a male persona to fit the 'male' description under 'sex' category. Awareness-raising of the public on human rights of sexual minorities and sensitizing media to prevent denigrating portrayals of MSM is important.

4. People living with HIV

Stigma and discrimination in health care and work settings, families and community, and in schools are common. Workplace HIV testing is becoming more common. HIV-positive pregnant mothers delivering babies face pressure to undergo permanent sterilization and the practice of expediting the approval process for sterilization of HIV-positive women was noted. Stigma is especially strong for HIV-positive sex workers. Stigma and discrimination by health personnel especially at public facilities

including segregation should be addressed effectively and immediately. The health care providers should treat PLHIV equally to other patients. They should follow strict procedures to maintain confidentiality of patients' HIV status. Mandatory HIV testing for job applicants and in workplaces should be regulated through HIV workplace policy or guidelines to ensure proper pre-test and post-test counselling, to ensure an informed decision to test, and to prevent negative consequences for the PLHIV.

3. Third Community Consultation (Mandalay and the North)

The community consultation for key populations and self-help groups from Mandalay, Sagaing, Magway, Bago regions, and Shan (North), Shan (South) and Kachin states was conducted in Yangon from 4–6 October with participation of 47 persons.

1. Female Sex Workers

The existing Directive to police to not use condoms as evidence should be revised to say that police must not search for condoms and must not accuse prostitution because they find condoms on their body or residence. If possible, the *Prostitution Suppression Act* should be abolished or amended to that effect. If the Act is not abolished, punishment for prostitution should be lighter and only a fine instead of prison. The law should protect sex workers from police harassment or arrest if they are meeting for health education purposes. The police should protect peer educators from harassment and arrest while they are engaging in peer education activities. Police harassment, extortion and arrest of sex workers on the grounds of reputation without strong evidence should be curbed. If the police do not have evidence, sex workers should be released, instead of sentenced to one to three months of prison for loitering. Unlawful police practices should be addressed by making free legal aid services available to sex workers. There should be a confidential channel or system for sex workers to report exploitation and abuses without having to share their sex work status with police.

HIV prevention and treatment knowledge among sex workers should be promoted through expansion of sex worker-friendly services e.g. drop-in centres and peer outreach services. Peer counsellors should be made available in all health facilities offering HIV prevention and treatment. HIV and PMCT counselling and services, quality counselling and services for STI, reproductive health and family planning should be made easily available to sex workers to improve their health and reduce maternal morbidity and mortality from induced abortion. NSP II should be revised to improve sex workers' access to HIV information and treatment.

2. People Who Inject Drugs and People Who Use Drugs (PWID and PWUD)

PWID require full access to drug treatment and to be able to easily access ART and a society that does not stigmatize and discriminate PWUD. Section 33(d) *Excise Act* should be revised to add exceptions for harm reduction purposes. Police should not arrest drug users for carrying new needles and syringes under Section 33. Police should follow strictly the Directive from Police Headquarters not to arrest PWID for possession of new syringes.

Drug treatment such as MMT should be made more easily and widely available for drug users and its availability should be advertised and its use promoted through billboards so that both drug users and community members know about MMT. Police and law enforcement personnel should be fair and just: they must not plant evidence of drug use such as injecting paraphernalia or drugs during their searches; should not liberally use loitering and public order offences against PWID when they need to fill quota; when searching drug users without a warrant in a public place, police

should observe proper procedures to maintain the dignity of drug user as a person. Drug users on treatment when traveling should not be harassed by the police for carrying methadone. If necessary to question the drug users, police should respect the dignity of the person. People on methadone treatment should be allowed to live their life without harassment or scrutiny by the police and law enforcement. Police should not treat drug users as criminals or criminals-in-the-making and pull them in for questioning without due reason or evidence anytime there is a petty crime like theft in the area.

Section 15 and 16 of the *Narcotics Law* should not be applicable for people on methadone treatment and who are not engaging in selling or supplying drugs. If a drug user on methadone reuses drugs before his treatment has stabilized, instead of charging him under Section 15 and/or 16 and a prison sentence, he should be sent to treatment and a centre with MMT and counselling services. Drop-in centres for drug users should be opened in areas where PWID live. Police harassment and scrutiny of drop-in centres interferes with access to services by the drug users. Free legal education and legal aid services (e.g. Equal Project) should also be made available outside Yangon. Police should not arrest and charge a person who is on treatment for carrying and taking provider-prescribed analgesics and mood stabilizers to cope with their withdrawal symptoms. Rehabilitation centres for drug users should include effective evidence-based services for drug treatment and counselling in addition to physical, psychosocial and livelihood services.

3. Men who have Sex with Men (MSM) & Transgender (TG)

Stigma of homosexuality is stronger in small towns and rural communities compared to cities. MSM/TG face stigma and discrimination in all spectrums of their lives. MSM and TG seek equal rights under the law and in the society including to have a family and to field members of parliament, to take part in executive, judiciary and legislative bodies and in national level institutions. TG gender identity should to be recognized by the State.

NSP II should be revised to convey a strong message on recognition of sexual orientation and gender identity required to achieve HIV prevention, and strengthen programming for HIV prevention and treatment among MSM and transgender community. Sufficient budget allocation and targeting of MSM and transgender in HIV treatment provision, along with sensitizing of health personnel especially in public health facilities should be emphasized. MSM & TG should be given positions in the national level health decision-making bodies (e.g. Myanmar Health System Coordination Committee). Approaches used to health education among MSM and TG should be empowering and respect autonomy.

'Third gender' should be included in the revised Constitution. Section 377 should be abolished as there is no 'unnatural sexual act' between consenting adults, or 377 should be revised to say 'non-consensual' in the clause to make sure consensual sex in whatever form is legal and to protect men from non-consensual same sex intercourse. MSM and transgender people should also have protection under the law from sexual assault or rape as Section 375-376 protects only women against rape by men. The 'Yogyakarta principles'⁹⁰ provide a comprehensive set of principles for sexual minorities and should be adopted in Myanmar. Anti-discrimination law should address sexuality, gender identity and HIV status. The National Human Rights Commission should be strengthened in skills and resources to address MSM, TG and HIV-related complaints. Free legal aid should be made widely available so MSM and TG can seek redress against injustice and police abuses. Police Act and Police Procedures should be reviewed and revised.

School curricula should include life skills education (including human rights, civic education, sexual health, sexual orientation and gender identity, HIV prevention) as one of the main subjects in the basic education curriculum. Capacity of teachers in

life skills education should be strengthened. Degrading and stereotypical MSM descriptions in the media should be banned.

4. People living with HIV (PLHIV)

Implementation of the Continuum of Care framework should be monitored and assessed. MOH should consult with PLHIV for the most appropriate care model. Quality of health care should be improved; supply chain systems should ensure uninterrupted supply of ARVs and OI medicines in the public health sector; decentralization process should be planned carefully in advance with regard to a package of services and quality of service/care at decentralized sites; Sufficient health personnel should be assigned at the HIV treatment sites and continuous skills building and refreshing in the areas of HIV counselling, treatment and care including maintaining confidentiality; quality control of laboratory equipment and supplies should be emphasized and regular monitoring of lab quality should be done.

MOH should issue policy directives and inform various levels within the public health system to fully collaborate and support any health education activity conducted by I/LNGOs, CBOs and PLHIV groups and networks in the community. There should be a specific law against stigma and discrimination against PLHIV that includes concrete terms for compensation and punishment, and the public should be made aware of such law. The punishment such as suspension of a medical practitioner's licence, clinic licence or company licence would protect PLHIV from discrimination in health facilities and workplaces. HIV-positive women's rights to comprehensive and free health care should be promoted by policies for HIV counselling and testing, reproductive health and pregnancy care, PMCT (counselling, testing, medicines, free surgical delivery & post-delivery care), and ongoing HIV treatment for the mother. Qualified health personnel should be available especially with regard to PMCT counselling and services. Prohibition of stigma and discrimination against HIV-positive women by the health sector should be strengthened by a written policy directive and follow-up action. Government should protect the rights to access affordable medicines through TRIPS flexibilities whenever they negotiate and sign trade agreements.

Schools and education institutions should include in curricula a subject on HIV. In health care worker education, teaching should not only focus on the medical aspect but also on psychosocial aspects including counselling, confidentiality, stigma and discrimination.

Government should strengthen child protection for orphans and vulnerable children under the State's own facilities and also to monitor, regulate and support the orphanages or childcare centres in the community run by NGO/CBO and religious organizations. All HIV-positive children and children of HIV-positive parents should have access to free health services. Government should allocate more funds to ensure this. HIV-positive children and children of HIV-positive parents should have access to free education. The *Child Law* and *Convention on Rights of the Child* should be implemented to ensure the most vulnerable and orphaned children from HIV-affected households to have protection, guardianship, care and support.

End Notes

¹ Myanmar Positive Group (MPG), Myanmar Positive Women Network (MPWN), Sex Worker in Myanmar (SWiM), National Drug User Network in Myanmar (NDNM), Myanmar MSM Network (MMN), Myanmar Interfaith Network on AIDS (MINA).

² Resolution adopted by the UN General Assembly, 65/277. *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, A/65/L.77, Clause 78.

³ The Regional Framework to implement the UN *Political Declaration on HIV/AIDS* of 2011 was agreed at the 68th ESCAP meeting.

⁴ *Myanmar National Strategic Plan on HIV and AIDS 2011–2015*, p.113.

⁵ Office of the High Commission for Human Rights and UNAIDS (2006). *International Guidelines on HIV/AIDS and Human Rights*, Geneva: OHCHR and UNAIDS.

⁶ Global Commission on HIV and the Law (2012), *HIV and the Law: Risks, Rights and Health*, New York: UNDP.

⁷ Report of results of survey on *The effect of HIV/AIDS on Socio Economic Situation of HIV-Affected Households in Myanmar*. The study of 1,800 persons was conducted in 25 townships in Yangon, Mandalay, Sagaing and Tanintharyi regions and Mon and Shan states. See: HIV/AIDS discrimination on the job continues despite business sector agreement: Survey. *Eleven*, 27 September 2013, www.elevenmyanmar.com.; Survey links HIV and poverty, joblessness, *Myanmar Times*, 8 November 2012.

⁸ UNAIDS, IPPF, GNP+, ICW (2011). *People living with HIV stigma index: Asia Pacific regional analysis 2011*. Geneva: UNAIDS.

⁹ See: Government of Myanmar report to UNAIDS, *National Commitments and Policy Instrument 2012*, p.6; Myanmar National Human Rights Commission established under Notification No. 34/2011 dated 5 September 2011 of the Government of the Republic of the Union of Myanmar.

¹⁰ Articles 347-349.

¹¹ OHCHR and UNAIDS (2006), *Op cit.*, Guideline 3.

¹² Global Commission on HIV and the Law (2012), *Op cit.*, p.97.

¹³ This chapter draws from: Godwin J. (2012), *Sex work and the Law*, Bangkok: UNDP. Note that UNFPA are preparing an *HIV prevention programme package* for key populations in 2013.

¹⁴ Section 3.

¹⁵ Section 12.

¹⁶ Section 8.

¹⁷ Section 3.

¹⁸ An English language translation of the Suppression of Prostitution Act was not available. This interpretation of the meaning of ‘soliciting’ was provided in interviews with key informants.

¹⁹ Order No.1048 (1/2000), issued by Police Brigadier Zaw Win, see: Khin Ninn Lwin (2010) *Burmese sex workers dare not carry condom, fear of arrest*. <http://moemaka.org/index.php/current/news-brief/81-news/451-burmese-sex-workers-dare-not-carry-condom-fear-of-arrest>.

²⁰ *Code of Criminal Procedure* Chapter 11 enables temporary orders to be made for up to two months made in cases of nuisance, urgent orders may be made *ex parte* (in the absence of the person).

²¹ Section 66.

²² Article 6.

²³ Deputy Home Affairs Minister Brig-Gen KyawKyawTun, see: Group Calls for Overhaul of Repressive, Antiquated Prostitution Law, *The Irrawaddy*, 30 July 2013.

²⁴ Burma: For sex workers, a life of risks, *Inter Press Service*, 24 February 2010.

²⁵ UNFPA, UNAIDS, APNSW (2012) *The HIV and Sex Work Collection*, Bangkok: UNDP, p.48.

²⁶ Hindstrom H. (2012) Sex workers clamour for rights in Burma, *Democratic Voice of Burma*, see: <http://www.dvb.no/uncategorized/sex-workers-clamour-for-rights-in-a-changing-burma/25358>

²⁷ Rangoon’s Sex Workers Face Unscrupulous Police Force, *Burma Times*, 7 November 2013, see: <http://burmatimes.net/rangoons-sex-workers-face-unscrupulous-police-force/>

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- ²⁹ AungThet Wine, (2008) Sex and the (Burmese) City, *The Irrawaddy*, 16(7), July 2008.
- ³⁰ Overs C., Win K., Hawkins K., Mynt W., Shein W. (2011), *Sex work in Myanmar: the impact of law, policy and enforcement practices*, Paulo Longo Research Initiative. Michael Kirby Centre for Public Health and Human Rights, Monash University, (unpublished draft) p.6.
- ³¹ *Ibid.*, p.30.
- ³² *Ibid.*, p.30.
- ³³ *Ibid.*, p.32.
- ³⁴ Myanmar Cracks Down on Massage Parlors in Prostitution Curb Bid, *Huffington Post*, 21 March 2011.
- ³⁵ KhinNinnLwin (2010), op cit.
- ³⁶ Burmese Sex Workers Avoid Arrest with Bribes and not Carrying Condoms, *Asia Calling*, 29 August 2010
- ³⁷ Overs C., Win K., Hawkins K., Mynt W., Shein W. (2011) op cit., p.31.
- ³⁸ AIDS Data Hub (2010), *Sex work and HIV: Myanmar*, citing: Ministry of Health, Myanmar (2008) *Behavioural Surveillance Survey 2008, Injecting Drug Users and Female Sex Workers*, National AIDS Programme, July 2009.
- ³⁹ Talikowski L., Gillieatt S (2005), p.196.
- ⁴⁰ 18 sex workers produced before Maungdaw Court, *Democracy for Burma*, 27 April 2010.
- ⁴¹ Ministry of Health & WHO (2006), *Review of the Myanmar National AIDS Programme*, New Delhi: WHO SEARO p.64.
- ⁴² Ministry of Health & WHO (2006), op cit, pp. 50-51.
- ⁴³ National AIDS Programme (2010), *UNGASS Country Progress Report 2010: Union of Myanmar*, Ministry of Health, Myanmar, p.33.
- ⁴⁴ Harcourt C., O'Connor J., Egger S., et al. (2010) The decriminalization of prostitution is associated with better coverage of health promotion programs for sex workers. *Aust NZ J Public Health*, 34(5): 482-6; Donovan B., Harcourt C., Egger S. (2010) Improving the health of sex workers in NSW: maintaining success, *NSW Public Health Bulletin* 21(3-4)74-77.
- ⁴⁵ UNDP (2012) *Sex Work and the Law in Asia and the Pacific*, Bangkok: UNDP.
- ⁴⁶ Section 16.
- ⁴⁷ Burma Act V, 1917.
- ⁴⁸ HAARP (2009), *HIV/AIDS Regional Program Law and Policy Review*, HAARP & United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, p.31.
- ⁴⁹ Section 9.
- ⁵⁰ Section 15.
- ⁵¹ Section 12
- ⁵² Section 11.
- ⁵³ Ministry of Health (2012), *Guidelines on Methadone Therapy and Treatment of Drug Dependence in Myanmar*, Ministry of Health & WHO Country Office.
- ⁵⁴ *Ibid.*
- ⁵⁵ *Ibid.*, p.78.
- ⁵⁶ HAARP (2009), op cit.
- ⁵⁷ Wodak A., Burns K. (2010), *Review of Harm Reduction in Myanmar: A Report Prepared for the National AIDS Program and UNODC* p.23.
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⁶³ Asian Human Rights Commission (2013), *Statement: Burma: Police torture of gay and transgendered people*, Hong Kong: Asian Human Rights Commission.

⁶⁴ Servando K. (2013), Hope for Myanmar gays living in a secret world, *South China Morning Post*, 14 March 2013.

⁶⁵ APCOM (2012), *Country Snapshots: HIV and MSM, Myanmar*, p.3.

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⁶⁶ Khan S. (2008) *Living with Dignity – Social Justice for All*, 3rd National MSM Consultation and Capacity Building Meeting in Myanmar PSI Myanmar.

⁶⁷ United Nations, *Beijing Declaration and Platform of Action, adopted at the Fourth World Conference on Women*, 27 October 1995.

⁶⁸ *Myanmar National Strategic Plan on HIV and AIDS 2011–2015*, p.119.

⁶⁹ *State Reporting Action by State party. Response by Myanmar to the recommendations contained in the concluding observations of the Committee following the examination of the combined second and third periodic reports of Myanmar on 3 November 2008*, CEDAW, CEDAW/C/MMR/CO/3/Add.1 (2010).

⁷⁰ Myanmar's Economy Needs Human Rights Reforms, *Huffington Post*, 27 November 2013.

⁷¹ Participants of the consultation were drawn from Mandalay, Sagaing, Magway, Bago regions, and Shan (North), Shan (South) and Kachin states.

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⁷⁴ Ministry of Health. 2009. *Myanmar Strategic Plan for Reproductive Health (2008-2013)*. Yangon: Ministry of Health.

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⁷⁶ Union of Myanmar, Ministry of Social Welfare, Relief and Resettlement. National Committee on the Rights of the Child. *Myanmar National Plan of Action for Children 2006-2015*.

⁷⁷ Committee on the Rights of the Child (2013), *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, CRC/C/GC/15.

⁷⁸ UNAIDS, UNDP, UNESCO (2013) *Young people and the law in Asia and the Pacific: a review of laws and policies affecting young people's access to sexual and reproductive health and HIV services*, Bangkok: UNESCO.

⁷⁹ *Child Law 1993*, Section 13. The *Child Law* currently applies to children under 16 years. The combined Third and Fourth CRC Periodic Report states the intention to change the age of childhood to 18 years, the minimum age of criminal responsibility to 10 years and of employment to 15 years, but these changes have yet to be enacted: Ministry of National Planning and Economic Development and UNICEF (2012), *Situation Analysis of Children in Myanmar*, Nay Pyi Taw: Government of Myanmar and UNICEF, p.4.

⁸⁰ Nothing which is done in good faith for the benefit of a person under twelve years of age by consent of the guardian is an offence by reason of any harm which it may cause.

⁸¹ CEDAW, CEDAW/C/MMR/CO/3/Add.1 (2010), *Response by Myanmar to the recommendations contained in the concluding observations of the Committee following the examination of the combined second and third periodic reports of Myanmar on 3 November 2008*, Progress report submitted by Myanmar in relation to paragraphs 29 and 43 of the concluding observations of the Committee.

⁸² See: Sen B. (2001), Women and law in Burma, *Legal Issues on Burma Journal*, Burma Lawyers Council.

⁸³ Fletcher A., Krug A. (2012), Excluding youth? A global review of harm reduction services for young people, in: Stoicescu C. (ed.) (2012) *The Global State of Harm Reduction 2012: Towards an integrated response*, London: Harm Reduction International.

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⁸⁵ See World Intellectual Property Organization: <http://www.wipo.int/export/sites/www/ip-development/en/pdf/asean/myanmar.pdf>

⁸⁶ In June 2013 the WTO reached an agreement that LDCs are not required to have patents legislation in place that complies with TRIPS until 2021. An earlier WTO direction required LDCs to introduce legal recognition of pharmaceutical patents by 2016. This deadline was in effect extended to 2021 by WTO in its June 2013 decision. See: <http://www.ip-watch.org/2013/08/02/what-does-wto-extension-for-ldcs-to-enforce-ip-mean-for-pharmaceuticals/>

⁸⁷ Cambodia: *Law on the Prevention and Control of HIV/AIDS of 2002*; Fiji: *HIV/AIDS Decree 2011*; PNG: *HIV/AIDS Management and Prevention Act 2003*; Viet Nam: *Law on HIV/AIDS Prevention and Control, 2006*; Philippines: *Philippine AIDS Prevention and Control Act 1998, Revised Philippine HIV and AIDS Policy and Program Act of 2012* (House Bill 6751); Lao PDR: *Law on HIV/AIDS Control and Prevention*; Mongolia: *Law on Prevention of Human Immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome* of 2012.

⁸⁸ Examples are drawn from UNDP (2013), *Legal protections against HIV-related human rights violations: Experiences and lessons learned from national HIV laws in Asia and the Pacific*. Bangkok: UNDP, p.52.

⁸⁹ The implications of the June 2013 WTO decision on transitional periods for pharmaceuticals may be subject to further WTO clarification. In June 2013 the WTO reached an agreement that LDCs are not required to have patent legislation in place that complies with TRIPS until 2021. An earlier WTO direction required LDCs to introduce legal recognition of pharmaceutical patents by 2016. Some commentators understand the 2016 deadline to have in effect been extended to 2021 by the recent WTO decision, although specific clarification from WTO may be required. See: <http://www.ip-watch.org/2013/08/02/what-does-wto-extension-for-ldcs-to-enforce-ip-mean-for-pharmaceuticals/>

⁹⁰ *Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity*.