UNAIDS

Situational Analysis of the HIV Response among Men who have Sex with Men and Transgender Persons in Myanmar

December 2015

Situational Analysis of the HIV Response among Men who have Sex with Men and Transgender Persons in Myanmar

UNAIDS

Table of Contents

Acknowledgements

Great appreciation is expressed to all those from the National AIDS Programme (NAP), Ministry of Health, Ministry of Home Affairs, International and National Non-Government Organisations (NGOs), development partners and United Nations (UN) agencies, and to the people living with HIV (PLHIV), and representatives of men who have sex with men (MSM) and transgender communities, who actively participated in this situational analysis by providing their valuable time and important insights during the interviews and discussions, and during the Seminar on Responding to Sexual Diversity: Collaboration for HIV Response among MSM and Transgender Persons (TG) in Myanmar, which was held in Yangon on 12-13 March 2015.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) provided financial and technical support for this assessment. Thanks to the team at UNAIDS Country Office Myanmar for their technical guidance and management support throughout the review and the development of this report.

Abbreviations

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BSS	Behavioural Surveillance Survey
CBO	Community-based organisation
CCDAC	Central Committee for Drug Abuse Control
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human immunodeficiency virus
HCT	HIV counselling and testing
HSS	HIV Sentinel Sero-Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
INGO	International non-government organisation
KP	Key population
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MDM	Médecins Du Monde
MSI	Marie Stopes International
MSF-CH	Médecins Sans Frontières - Switzerland
MSF-Holland	Médecins Sans Frontières – Holland
MSM	Men who have sex with men
NAP	National AIDS Programme
NGO	Non-government organisation
NSP	National Strategic Plan
PLHIV	People living with HIV
PSE	Population size estimate
PSI	Population Services International
PU-AMI	Première Urgence – AIDE Médicale Internationale
PWID	People who inject drugs
STI	Sexually transmitted infection
TB	Tuberculosis
SOGI	Sexual orientation and gender identity
SOP	Standard operating procedure
SRH	Sexual and reproductive health
TB	Tuberculosis

TOP	Targeted outreach programme
TWG	Technical working group
UIC	Unique identifier code
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNOPS	United Nations Office for Project Services
WHO	World Health Organisation
3MDG Fund	Three Millennium Development Goal Fund

အကြောင်းအရာအကျဉ်းချုပ်

HIV activities at Taung Pyone Festival *(Source - MDM)*

Fashion Show at World AIDS Day Celebration *(Source - MDM)*

အကြောင်းအရာအကျဉ်းချုပ်

မြန်မာနိုင်ငံသည် အိပ်ချ်အိုင်ဗွီကူးစက်ရောဂါကို အပြင်းထန်ဆုံးခံရသော အာရှနိုင်ငံများတွင် ပါဝင်ပါသည်။ ၂၀၁၄ ခုနှစ်တွင် အသက် ၁၅နှစ်နှင့်အထက် အိပ်ချ်အိုင်ဗွီရောဂါပိုးရှိနေသူအရေအတွက် ၂၀၀၀၀၀ ခန့်[1] ရှိသည်ဟု ခန့်မှန်းထားသည်။ မြန်မာနိုင်ငံသည် အာရှနှင့်ပစိဖိတ်ဒေသတွင် အိန္ဒိယ၊ တရုတ်၊ ထိုင်း၊ အင်ဒိုနီးရှားနှင့် ဗီယက်နမ်နိုင်ငံများပြီးလျှင် ဆဋ္ဌမမြောက်ရောဂါဖြစ်ပွားမှု အများဆုံးနိုင်ငံလည်း ဖြစ်သည်။[2]

မြန်မာနိုင်ငံ၌ HIV ရောဂါပထမဆုံးဖြစ်ပွားသူကို ၁၉၈၈ ခုနှစ်တွင် စတင်တွေ့ရှိခဲ့ပြီး ၁၉၉၁ ခုနှစ်တွင် ခုခံအား ကျဆင်းမှုရောဂါ (AIDS) ဖြစ်ပွားသောသူကို စတင်တွေ့ရှိအစီရင်ခံခဲ့သည်။ အဆိုပါရောဂါသည် အဓိက ထိခိုက်ခံစားသူလူအုပ်စုများဖြစ်သော မူးယစ်ဆေးထိုးသူများ၊ အမျိုးသမီးလိင်လုပ်သားများ နှင့် ၄င်းတို့နှင့် လိင်ဆက်ဆံဘက်များ၊ အမျိုးသားလိင်တူဆက်ဆံသူများ (Men who have sex with men-MSM) နှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ ပြောင်းလဲခံယူနေထိုင်သူ (Transgender-TG) များတွင် အဖြစ်များလျက်ရှိပါသည်။ အစိုးရဌာနများ၊ ပြည်တွင်းနှင့် ပြည်ပအစိုးရမဟုတ်သော အဖွဲ့အစည်းများ (INGO and NGO)၊ လူထုအခြေပြုအဖွဲ့အစည်းများ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်အဖွဲ့များမှ ဖော်ပြပါ MSM နှင့် TG များအတွင်း HIV ဖြစ်ပွားမှုလျော့ကျရေး ဝိုင်းဝန်းလုပ်ဆောင်နေသော်လည်း ထိုအုပ်စုများတွင် ရောဂါဖြစ်ပွားမှုနှုန်း မြင့်မားလျက်ရှိနေသေးသည်။ ၂၀၁၄ ခုနှစ်၌ MSM နှင့် TG များအတွင်း HIV ပျံ့နှံ့မှုနှုန်း ၆.၆% ရှိသည်။

မြန်မာနိုင်ငံတွင် အမျိုးသားအချင်းချင်းချစ်ခင်စုံမက်ခြင်းအပေါ် အလွန်အထင်အမြင်သေးသည့်အပြင် ထိုသို့ လိင်တူဆက်ဆံခြင်းသည်လည်း ရာဇဝတ်ပြစ်မှုကျူးလွန်ခြင်းလည်းမည်ပါသည်။ ဤအချက်ကြောင့် MSM နှင့် TG များသည် ထိရှလွယ်သူများဖြစ်ပြီး ရောဂါကာကွယ်တားဆီးမှုနှင့် စည်းရုံးမှုပြုလုပ်ရန် ခက်ခဲစေပါသည်။ MSM များသည် ၄င်းတို့၏ လိင်မှုဆိုင်ရာကိစ္စရပ်များကို မိသားစုဂင်များနှင့် မိတ်ဆွေများမသိရှိစေလိုပေ။ ထို့ပြင် လူအထင်သေးခံရခြင်း၊ ခွဲခြားဆက်ဆံခြင်းနှင့် ဖိနှိပ်ခြင်းတို့ကို ကြောက်ရွံ့၍ HIV ရောဂါဝန်ဆောင်မှုများကို လက်လှမ်းယူခြင်းမရှိကြပေ။ လူသိမခံလိုသော MSM များသည် ကာလသားရောဂါကုဆေးခန်းများ သို့မဟုတ် အထွေထွေရောဂါကုဆရာဝန်များထံ၌သာ ဆေးကုသလေ့ရှိသည်။ မိမိဖာသာကုသခြင်းမျိုးလည်းရှိသည်။ ထိုသို့ပြုလုပ်

ခြင်းသည် မိမိ၏ကိစ္စရပ်များကို လူမသိအောင်ဖုံးကွယ်နိုင်သည်ဟု ယူဆကြသည်။ ဤအခြေအနေမျိုးတွင် HIV နှင့် လိင်မှတဆင့်ကူးစက်သောရောဂါများ (STI) နှင့် ပတ်သက်သော သတင်းအချက်အလက်များနှင့် လုပ်ငန်းဝန်ဆောင်မှုများအား ရရှိကြမည်မဟုတ်ပေ။

သို့ဖြစ်၍ လူသိမခံလိုသော MSM များ၏ လိုအပ်ချက်များကို အရေးယူဆောင်ရွက်သည့် ပိုမိုထိရောက်သော HIVကာကွယ်ရေး၊ကုသရေးနှင့် ပြုစုစောင့်ရှောက်ရေးလုပ်ငန်းအစီ အစဉ်များလိုအပ်ပါသည်။ TG များမှာလည်း လိင်ပိုင်းဆိုင်ရာအကြမ်းဖက်မှုနှင့် HIVကူးစက်ဖြစ်ပွားမှုတွင် ထိခိုက်လွယ်အားနည်းသူများဖြစ်သဖြင့် ၎င်းတို့၏ လိုအပ်ချက်များကို ဖြည့်ဆည်းမည့်လုပ်ငန်းအစီအစဉ်များ အရေးတကြီးလိုအပ်လျက်ရှိပေသည်။

မြန်မာနိုင်ငံတွင် MSM များနှင့် TG များအကြား HIV အခြေအနေအပေါ် ပိုမိုသိရှိနားလည်စေရန် ပကတိအခြေအနေလေ့လာသုံးသပ်ချက်တစ်ရပ်ကို မြန်မာနိုင်ငံ UNAIDS ရုံးမှ ဆောင်ရွက်ခဲ့ပါသည်။ ထိုလေ့လာသုံးသပ်မှုပြုလုပ်ရာ၌ MSM များနှင့် ဆက်နွယ်ပတ်သက်သူများအပြင် MSM များအကြား HIV တိုက်ဖျက်ရေးလုပ်ငန်းဆောင်ရွက်နေသော ကျန်းမာရေးနှင့် ဥပဒေဖေါ်ဆောင်ရေးအရာရှိများ၊ ပြည်တွင်းနှင့်ပြည်ပ အစိုးရမဟုတ်သော အဖွဲ့အစည်းများ၊ လူထုအခြေပြု လူမှုအဖွဲ့အစည်းများမှ ကိုယ်စားလှယ်များ၊ လူထုအခြေပြု လူမှုကွန်ယက်များ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်အဖွဲ့များ၊ ကုလသမဂ္ဂအဖွဲ့အစည်းများမှ သက်ဆိုင်သူများ အသီးသီးအား တွေ့ဆုံမေးမြန်းခဲ့ပါသည်။ သက်ဆိုင်ရာ အဖွဲ့အစည်းမှ လူပေါင်း ၇၀ ခန့်ကို လေ့လာသုံးသပ်မှုအတွက် တွေ့ဆုံမေးမြန်းဆွေးနွေးခဲ့ပြီး ရရှိလာသောရလဒ်များကို သုံးသပ်ခြင်းဖြင့် မြန်မာနိုင်ငံတွင် MSM များနှင့် TG များ၏ လက်ရှိအခြေအနေ၊ HIV ရောဂါဝန်ဆောင်မှုလုပ်ငန်းနှင့် ပတ်သက်သော တုံ့ပြန်မှုအခြေအနေများကို ပိုမိုနားလည်ခဲ့သည်။

တွေ့ရှိချက်များ

အောင်မြင်မှုများနှင့် ဆောင်ရွက်ချက်များ

MSM များနှင့် TG များတွင် ကွန်ဒုံးနှင့်ချောဆီကို ပိုမိုအသုံးပြုခြင်းဖြင့် လိင်မှတဆင့်ကူးဆက်သော ရောဂါများကို ကာကွယ်ခြင်းသည် HIV ရောဂါဆိုင်ရာ အမျိုးသားအဆင့် တုံ့ပြန်ဆောင်ရွက်ချက်တွင် အရေးပါဆဲဖြစ်သည်။ အထူးသဖြင့် MSM နှင့် TG များပြားသည့် မြို့ပြနေရာများ၌ HIV ကာကွယ်ရေး သတင်းအချက်အလက်များ၊ ပစ္စည်းများဖြန့်ဝေခြင်းနှင့် အဆိုပါ ပစ္စည်းများအား တိုးမြင့်သုံးစွဲခြင်းလုပ်ငန်းများသည် အစိုးရမဟုတ်သော အဖွဲ့အစည်းများနှင့် လူထုအခြေပြု လူမှုအဖွဲ့အစည်းတို့၏ HIV ကာကွယ်တားဆီးရေးလုပ်ငန်းများတွင် အဓိကကျသော လုပ်ဆောင်ချက်ဖြစ်သည်။ သို့ရာတွင် နောက်ဆုံးသတင်းအချက်အလက်များ မရရှိနိုင်ခြင်းကြောင့် တိုးတက်မှုအခြေအနေနှင့် ရလဒ်များကို တိုင်းတာရန် ခက်ခဲသည်။[၀] IBBS (Integrated Biological and Behavioural Surveillance) ၂၀၁၀ ခုနှစ် အစီရင်ခံစာအရ တွေ့ဆုံမေးမြန်းခဲ့သော MSM များ၏ ၈၁.၅% သည် နောက်ဆုံးအကြိမ် လိင်ဆက်ဆံမှုတွင် ကွန်ဒုံး အသုံးပြုကြောင်း ဖြေဆိုခဲ့သည်။ သို့သော်လည်း မေးမြန်းသူ သဘောကျစေရန် အင်တာဗျူးဖြေဆိုသူများက ကွန်ဒုံးအသုံးပြုကြောင်းကို ပိုမိုဖြေဆိုခြင်းမျိုးလည်း ရှိနိုင်ပေသည်။ ကွန်ဒုံးအသုံးပြုမှုနှင့် စပ်လျဉ်း၍ ၂၀၁၅ခုနှစ် အမျိုးသားအဆင့် လျာထားချက်မှာ ၈၆%ဖြစ်ပါ သည်။

[၀] A new IBBS and population size estimates among MSM and TG are being carried out in 2015 by NAP with partners and results are expected to be issued in early 2016.

HIV စစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း (HCT) ဖြင့် MSM များနှင့် TG များသည် ၎င်းတို့အခြေအနေကို သိရှိစေနိုင်ပြီး HIV ရောဂါပိုးတွေ့ရှိလျှင် ARV ကုထုံးကို စောစီးလျင်မြန်စွာ လက်လှမ်းမှီ ရယူနိုင်ခြင်းဖြင့် ရောဂါကူးစက်ပျံ့ပွားမှုကို ကာကွယ်နိုင်ပေမည်။ HCT ဝန်ဆောင်မှုရယူသော MSM များနှင့် TG များသည် ၂၀၁၂ ခုနှစ်တွင် ၁၂၆၉၄ ဦးမှ ၂၀၁၃ ခုနှစ်တွင် ၁၇၄၇၂ ဦးသို့ မြင့်မားလာခဲ့သည်။ ထိုသို့ HCT ဝန်ဆောင်မှု ရယူသော MSM နှင့် TG အရေအတွက်များပြားလာခြင်းသည် အားတက်ဖွယ်ဖြစ်သော်လည်း ဝန်ဆောင်မှုရယူသည့် လူဦးရေအချိုးအဆကို HCT ဝန်ဆောင်မှုပေးသောဌာနများရှိ ကိန်းဂဏန်းဖြင့် အတည်ပြု၍ မရပေ။ HCT ဝန်ဆောင်မှုပေးသောဌာနများသို့ လာရောက်သည့်လူနာများကို လူအုပ်စုအလိုက် MSM များ သို့မဟုတ် TG များ အုပ်စုဟု ခွဲခြားစာရင်းပြုစုထားခြင်းမရှိပေ။

၂၀၁၃ ခုနှစ်တွင် အမျိုးသားခုခံအားကျဆင်းမှုကူးစက်ရောဂါ တိုက်ဖျက်ရေးစီမံချက် (National AIDS Programme) မှ ဗဟိုထိန်းချုပ်မှုဖြေလျှော့ခြင်းဖြင့် ART ကုထုံးနှင့် HTC ဝန်ဆောင်မှုကို လူအများပိုမိုလက်လှမ်းမှီ ရရှိစေခဲ့သည်။ ယခုအခါ HCT ဝန်ဆောင်မှုကို မြို့နယ်(၉၀)ကျော်တွင် ရယူနိုင်ပါသည်။

ကျန်းမာရေးဝန်ကြီးဌာန၏ ကျန်းမာရေးဝန်ဆောင်မှုများ တိုးချဲ့ခြင်းအပြင် မြန်မာပြည်အနှံ့အပြားရှိ ပုဂ္ဂလိက၊ INGO/NGO နှင့် လူထုအခြေပြုဝန်ဆောင်မှုနေရာများတွင် HTC ကို ရယူနိုင်ပါသည်။ ရောဂါစစ်ဆေးသူ များပြားလာစေရန်နှင့် ဆေးကုသမှုခံယူသူ တိုးပွားလာစေရန် ရည်ရွယ်၍ လူထုအခြေပြု ရောဂါရှာဖွေစစ်ဆေးခြင်းကို စတင်ဆောင်ရွက်ရန် ယေဘူယျသဘောတူထားကြပြီးဖြစ်သည်။ ဗဟိုထိန်းချုပ်မှုဖြေလျှော့ခြင်းဖြင့် ဝန်ဆောင်မှုပေးသူများသည် MSM များနှင့် TG များ စုဝေးရာနေရာများသို့ ရွှေ့လျား HCT ဝန်ဆောင်မှုများပေးစေခြင်းစသည့် နည်းလမ်းသစ်များကို အသုံးပြုလာကြပါသည်။

မြန်မာနိုင်ငံတွင် MSM ကွန်ယက်နှင့် ကိုယ့်အားကိုယ်ကိုးအဖွဲ့များ ထူထောင်ခြင်းသည် HIV ရောဂါအပေါ် အမျိုးသားအဆင့် တုံ့ပြန်ဆောင်ရွက်ရာတွင် အရပ်ဖက်လူမှုအဖွဲ့အစည်းများ၏ ပါဝင်လုပ်ဆောင်မှုကို မြင့်မားစေပါသည်။ ထိုကွန်ယက်များနှင့် ကိုယ့်အားကိုယ်ကိုးအဖွဲ့များသည် အားကောင်းလာပြီး မူဝါဒရေးရာ ဆွေးနွေးပွဲများတွင် ပါဝင်၍ မိမိတို့၏ နယ်မြေရှိ အဓိကကိစ္စရပ်များကို တင်ပြဆွေးနွေးခွင့်ရလာကြသည်။ တစ်ချိန်တည်း၌ အစိုးရနှင့် အစိုးရမဟုတ်သော အဖွဲ့အစည်းများသည် HIV ရောဂါဆိုင်ရာ မူဝါဒများနှင့် လုပ်ငန်းအစီအစဉ် ရေးဆွဲရာ၌ MSM များနှင့် TG များ ပါဝင်လာစေခဲ့သည်။ သို့ဖြစ်၍ MSM များနှင့် TG များ လုပ်ငန်း အစီအစဉ်များကို ရေးဆွဲရာတွင်လည်းကောင်း၊ အကောင်အထည်ဖော်ရာတွင်လည်းကောင်း၊ စောင့်ကြည့်လေ့လာခြင်းနှင့် သုံးသပ်ခြင်းများကိုပါဝင်စေလျက် ၎င်းတို့၏ လိုအပ်ချက်များနှင့် ကိုက်ညီသည့်ဝန်ဆောင်မှုများရရှိစေရန် ပါဝင်ဆွေးနွေးစေခဲ့ပါသည်။

မြန်မာနိုင်ငံ၌ MSM များနှင့် TG များအပေါ် HIV ရောဂါတုံ့ပြန်ဆောင်ရွက်မှု လုပ်ငန်းတိုးချဲ့လုပ်ကိုင်ရာတွင် တွေ့ရသောအခက်အခဲအတားအဆီးများ

မြန်မာနိုင်ငံ၌ MSM များနှင့် TG များအတွက် HIV ကာကွယ်ရေး၊ ကုသရေးနှင့် စောင့်ရှောက်ရေးဝန်ဆောင်မှုများပေးရာတွင် တွေ့ရသော အခက်အခဲအတားအဆီးများကို ဖော်ပြအပ်ပါသည်။

- ပြစ်မှုဆိုင်ရာ ဥပဒေပုဒ်မ (၃၇၇)၊ တနည်းအားဖြင့် ဓမ္မတာမဟုတ်သော ကာမဆက်ဆံခြင်းသည် ပြစ်မှုမြောက်သည်။ မြန်မာနိုင်ငံတဝှမ်း လိင်တူဆက်ဆံခြင်းကို ရာဇဝတ်မြောက် ပြစ်ဒဏ်ပေးခြင်းသည် MSM များနှင့် TG များ HIV ရောဂါကာကွယ်ရေးဆိုင်ရာ ဝန်ဆောင်မှုများကို အများနည်းတူ ပေါ်ပေါ်ထင်ထင်ရယူရန် ဟန့်တားမှုဖြစ်စေပါသည်။ ရန်ကုန်မြို့ ၁၈၉၉ ခုနှစ် ပုလိပ်အက်ဥပဒေ ပုဒ်မ၃၀ (ယ)

နှင့် ၁၉၄၅ခုနှစ် ပုလိပ်အက်ဥပဒေ ပုဒ်မ ၃၅ (ဃ) တို့မှာ (အရပ်သုံးစကားဖြင့် 'မှောင်ရိပ်ခိုခြင်း') ပုလိပ် (ရဲ) မှ ဖမ်းဆီးမိန့်မပါဘဲ ဖမ်းဆီးနိုင်ခွင့် ရှိပေသည်။

- MSMများသည် တစ်သားတည်းကျသော အစုအဖွဲ့မဟုတ်သဖြင့် သတ်မှတ်ဂန်ဆောင်မှုပုံစံများသည် ထိုလူအားလုံး၏ လိုအပ်ချက်များကို ပြည့်မီအောင် မဖြည့်ဆည်းနိုင်ခဲ့ပါ။ အထူးသဖြင့် လိင်တူခြင်းချစ်ခင်စုံမက်သည်ကို မသိစေလိုသူများဖြစ်နေသောကြောင့် ဖြစ်သည်။ MSM အများအပြားမှာ လူအထင်အမြင်သေးခြင်း၊ ဂန်ထမ်းများမှ ခွဲခြားဆက်ဆံခြင်းတို့ကို ကြောက်ရွံ့ခြင်းအပြင် ၄င်းတို့အတွက် သီးသန့်ဦးတည်သည့် ဂန်ဆောင်မှုအစီအစဉ်များကို ရယူခြင်းဖြင့် လိင်တူခြင်းချစ်ခင်စုံမက်သည့် အလေ့အထများ မတော်တဆပေါ် သွားမည်ကို စိုးရိမ်ခြင်းကြောင့် ဂန်ဆောင်မှုရယူရန် ဂန်လေးကြသည်။
- လက်ရှိ MSM များနှင့် TG များ၏ အမှုအကျင့်နှင့် လူဦးရေခန့်မှန်းချက်ဆိုင်ရာ သတင်းအချက်အလက်များ (PSE) မှာ လက်ရှိအချိန်နှင့် မကိုက်ညီတော့ပါ။ ၂၀၁၅ ခုနှစ်အတွက် အဆိုပါ IBBS နှင့် PSE သတင်းအချက်အလက်များကို ပြုစုဆဲဖြစ်၍ ၂၀၁၆ ခုနှစ် နှစ်ဦးပိုင်း၌ ထုတ်ပြန်နိုင်ပါမည်။
- စီမံကိန်းလုပ်ငန်းများ၏ ဝန်ဆောင်မှုရယူသော MSM/TG များမှာ တခါတရံ ထပ်ပမံရေတွက် စာရင်းသွင်းထားခြင်းမျိုးလည်းဖြစ်နိုင်သည်။ နိုင်ငံတကာတွင် အသုံးပြုသော UIC စနစ်(ဝန်ဆောင်မှုရယူသူများအား ကိုယ်ပိုင်နံပါတ်ပေးပြီး စာရင်းသွင်းခြင်း၊ လူဦးရေထပ်ခြင်းကို ကာကွယ်) ကို မြန်မာနိုင်ငံတွင် အသုံးပြုခြင်း မရှိသေးပါ။ စစ်တမ်းကောက်ယူရာတွင် ဂန်ဆောင်မှု အမျိုးအစားအပေါ် မူတည်ပြီး အသုံးပြုခဲ့သူများ ၄င်းတို့ရရှိခဲ့သော ဂန်ဆောင်မှုများကို မှတ်သားရာတွင် အခက်အခဲရှိနေဆဲပင်ဖြစ်သည်။
- အမျိုးသားအဆင့် စီမံကိန်းတွင် MSM များအတွက် လုပ်ငန်းလျာထားချက်များ ပါ၀င်သော်လည်း MSM များနှင့် TG များ၏ လိင်ဆက်ဆံဘက် အမျိုးသမီးများထံ HIV ရောဂါမကူးစက်စေရန် ကာကွယ်ရေးလုပ်ငန်းများရောက်ရှိရေး လျာထားချက်လုပ်ငန်းစဉ်များ အားနည်းနေသေးသည်။ လွန်ခဲ့သောနှစ် အနည်းငယ်အတွင်း အမျိုးသမီးအဖော်များ အနည်းအကျဉ်းကိုသာ ဂန်ဆောင်မှုပေးနိုင်ခဲ့ကြောင်း နှစ်စဉ်အစီရင်ခံစာတွင် ဖော်ပြထားသည်။
- နည်းပညာပိုင်းနှင့် အုပ်ချုပ်မှုပိုင်းဆိုင်ရာ ကျွမ်းကျင်ဂန်ထမ်းများကို အလုပ်မထွက်ရန် ထိန်းသိမ်းရန်မှာ အရေးစီအားလုံးအတွက် ခက်ခဲသောကိစ္စရပ်ပင် ဖြစ်ပါသည်။ ဂန်ထမ်းများ၏ အလုပ်ထွက်နှုန်းမြင့်မားမှုကြောင့် စွမ်းရည်မြှင့်တင်မှုသင်တန်းများ အစဉ်ပြုလုပ်ရပြီး အရေးစီများအတွင်းနှင့် အရေးစီများ အချင်းချင်း၌ အဖွဲ့အစည်းဆိုင်ရာ လုပ်ငန်းအစဉ်အဆက် သိမှီသူ (Institutional Memory) မရှိတော့ပါ။

ရှေ့ဆက်လုပ်ဆောင်ရမည့်လုပ်ငန်းများအတွက် အခွင့်အလမ်းသာသော ပတ်ဝန်းကျင်နှင့် တုံ့ပြန်ဆောင်ရွက်မှုအားကောင်းစေရန်ဆောင်ရွက်ခြင်း

ပြစ်မှုဆိုင်ရာဥပဒေပုဒ်မ (၃၇၇)နှင့် အခြားပြစ်ဒဏ်များနှင့် စပ်လျဉ်း၍ဥပဒေရေးရာပြောင်းလဲမှုများပြုလုပ်ရန်အတွက် အဓိကဆုံးဖြတ်ချက် ချမှတ်နိုင်သောသူများနှင့် ဆွေးနွေးတိုင်ပင်မှုများ အစဉ်အမြဲလုပ်ဆောင်ရန် အလွန်အရေးကြီးပါသည်။ ဥပဒေရေးရာ ပြောင်းလဲမှုပြုလုပ်နိုင်ရန် ဥပဒေဖော်ဆောင်ရေးအရာရှိများနှင့် အဓိကဆုံးဖြတ်ချက်ချမှတ်သူများအဖို့ မြန်မာနိုင်ငံရှိ MSM များနှင့် TG များနှင့် စပ်လျဉ်းသည့်ကိစ္စရပ်များကို ကောင်းစွာနားလည်၍ သတင်းအချက်အလက်များ အမြဲရရှိနေရန် လိုအပ်ပါသည်။

လူသိမခံလိုသော MSM များသည် ကျန်းမာရေးနှင့် HIV ရောဂါကာကွယ်ရေးဂန်ဆောင်မှုများ ၄င်းတို့ထံရောက်ရှိစေမည့် နည်းဗျူဟာသစ်များ လိုအပ်ပါသည်။ HCT ဝန်ဆောင်မှု၊ ပြုစုစောင့်ရှောက်ရေးနှင့် ကုသရေးဂန်ဆောင်

မှုများတွင် အသုံးပြုရန် ဝန်ဆောင်မှုပုံစံသစ်များကို ဖွေရှာရန် လိုအပ်ပါသည်။ ယင်းပုံစံသစ်များတွင် အမျိုးသားသီးသန့်ဆေးခန်းများ၊ နယ်လှည့်ဆေးခန်းများအပါအဝင် ပုဂ္ဂလိက ဆေးခန်းလုပ်ကိုင်သူများမှတဆင့် ဝန်ဆောင်မှုများ တိုးမြှင့်ရရှိရေးတို့ဖြစ်ပါသည်။ ဤဆေးခန်းများမှ HCT နှင့် STI ကူးစက်ရောဂါများဆိုင်ရာ ဝန်ဆောင်မှုများ၊ တီဘီရောဂါစစ်ဆေးမှုနှင့် ကုသမှု၊ ART ဆေးပေးဝေခြင်းစသည့် ဝန်ဆောင်မှုများကိုပေးမည်ဖြစ်ပါသည်။ အမျိုးသားများနှင့် လိင်မှုဆိုင်ရာကျန်းမာရေးကို အဓိကထားသော ဆေးခန်းများမှတဆင့် ထိုဝန်ဆောင်မှုများကို ကျယ်ပြန့်စွာ လုပ်ဆောင်ပေးမည်ဖြစ်သည်။

ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူများသည် MSM များနှင့် TG များအတွက် သီးသန့်ကျန်းမာရေးလိုအပ်ချက်များကို နားလည်၍ ဗဟုသုတလည်းပြည့်စုံရပါမည်။ အထူးသဖြင့် လိင်အင်္ဂါစမ်းသပ်မှုနှင့် ဓါတ်ခွဲစစ်ဆေးရန်အတွက် နမူနာယူခြင်းသည် လူနာများအတွက် အဆင်မပြေမှုနှင့် စိတ်အနှောင့်အယှက်များ ဖြစ်ပေါ်စေပါသည်။ MSM များအတွက် သတ်မှတ်ဝန်ဆောင်မှုများ (Standard Package of Services) ထားရှိရန်နှင့် TG များအတွက်လည်း ထိုသို့ထားရှိရန် လိုအပ်ကြောင်း ဖွံ့ဖြိုးမှုမိတ်ဖက်အဖွဲ့အစည်းများမှ နားလည်လက်ခံထားကြပါသည်။

ယခုအခါ အင်တာနက်ကို ပိုမိုအသုံးပြုလာနိုင်သဖြင့် HIV ရောဂါကာကွယ်ရေး သတင်းအချက်အလက်များနှင့် လွှဲပြောင်းမှုများကို ဂက်ဆိုင်အခြေပြု လူမှုသတင်းမီဒီယာများမှရရှိရန် အသုံးပြုနိုင်ပါသည်။ ထိုနည်းတူစွာပုဂ္ဂလိက ကဏ္ဍသတင်းဆက်သွယ်ရေးကုမ္ပဏီများနှင့် ပူးပေါင်း၍ စာတိုပေးပို့ခြင်း၊ အရေးပေါ် Hotline ဝန်ဆောင်မှုများ၊ စမတ်ဖုန်းလုပ်ဆောင်ချက်များကို သုံးစွဲ၍ HIV ရောဂါဆိုင်ရာသတင်းအချက်အလက်များကို ခွဲခြားဆက်ဆံမှုအတွက် စိုးရိမ်ရန်မလိုဘဲ အသုံးပြုနိုင်ပါသည်။

စမတ်ဖုန်းအက်ပ်လီကေးရှင်းများဖြင့် MSM များနှင့် TG များကို ရှာဖွေဖော်ထုတ်နိုင်ပြီး ၎င်းတို့နှင့် အနီးဆုံးဝန်ဆောင်မှုများနှင့် ချိတ်ဆက်ပေးနိုင်မည်ဖြစ်သည်။ ထိုသို့ ဝန်ဆောင်မှုပေးရန် အခွင့်အရေးများရှိသည့်အလျောက် အွန်လိုင်းဝန်ဆောင်မှုပေးရာ၌ သတ်မှတ်စံများရှိရန် လိုအပ်ပြီး ဝန်ဆောင်မှုပေးနေစဉ်နှင့် အသုံးပြုခြင်းကို စောင့်ကြည့်လေ့လာစဉ် အသုံးပြုသူများ၏ လွတ်လပ်မှုနှင့် ကိုယ်ရေးလုံခြုံမှုရှိစေမည့် နည်းလမ်းများလည်း ရှိရန်လိုအပ်ပါသည်။

အကြံပြုချက်များ

မြန်မာနိုင်ငံရှိ MSM နှင့် TG ကြား အိတ်ချ်အိုင်ဗွီ ကြိုတင်ကာကွယ်ခြင်း၊ ကုသခြင်းနှင့် စောင့်ရှောက်ခြင်းလုပ်ငန်းများအတွက် အခွင့်အလမ်းသာသော ပတ်ဝန်းကျင်ဖြစ်စေရန် ပံ့ပိုးပေးခြင်း

- မူဝါဒပိုင်းဆုံးဖြတ်ချက် ချမှတ်သူများနှင့်လည်းကောင်း၊ သင့်လျော်သော အဓိကကျသူများနှင့် လက်တွဲခြင်းဖြင့် လည်းကောင်း၊ အမြဲတစေ တိုက်တွန်းဆွေးနွေးကာ ပြစ်မှုဆိုင်ရာဥပဒေပုဒ်မ (၃၇၇)၊ ရန်ကုန်ပုလိပ်အက်ဥပဒေ ၁၈၉၉ ခုနှစ်ပါပုဒ်မ ၃၀ (ဃ) နှင့် ရန်ကုန်ပုလိပ်အက်ဥပဒေ ၁၉၄၅ ခုနှစ် ပါပုဒ်မ ၃၅ (ဃ) တို့ကို ပြောင်းလဲစေရန် ကြိုးပမ်းရပါမည်။ အကြောင်းမှာ ထိုဥပဒေနှင့် အက်ဥပဒေပုဒ်မများသည် လူအခွင့်အရေးကို ချိုးဖောက်ပြီး အထင်အမြင်သေးမှု နှင့် ခွဲခြားဆက်ဆံမှုတို့ကို တိုးပွားစေလျက် HCT နှင့် HIV ပြုစုစောင့်ရှောက်ရေးနှင့် ကုသရေးဝန်ဆောင်မှုများပါဝင်မည့် ကျန်းမာရေးစောင့်ရှောက်မှုကို အဟန့်အတားဖြစ်စေပါသည်။ လိင်တူဆက်ဆံသည့် အမူအကျင့်ကို ရာဇဝတ်မှု ကျူးလွန်သည့်အဖြစ်မှ ဖယ်ရှားရန်နှင့် အမျိုးသားအချင်းချင်းဆက်ဆံခြင်းနှင့် အမျိုးသမီးအချင်းချင်းဆက်ဆံခြင်းအတွက် ပြစ်ဒဏ်များကို လျော့ချရန်အတွက် အသိပေးဆွေးနွေးစည်းရုံးရန် ကြိုးပမ်းရပါမည်။

- MSM နှင့် TG များကို HIV ရောဂါကာကွယ်ရေး၊ ကုသရေး၊ ပြုစုစောင့်ရှောက်ရေးနှင့်အတူ လူတစ်ဦးချင်း ကျား-မဘဝအပေါ် ခံယူချက်များနှင့် လိင်မှုဆိုင်ရာကွဲပြားခြားနားချက်များကို အများပြည်သူမှ သိရှိ နားလည်ခြင်း မြင့်မားလာစေရန် အခါအားလျော်စွာ အသိပညာပေးလုပ်ငန်းများကို တိုးမြင့်ရန်၊ ကျန်းမာ ရေးဂန်ဆောင်မှုပေးသူများ၊ ဥပဒေဖော်ဆောင်ရေးအရာရှိများနှင့် ရပ်ရွာအနှံ့သွားရောက်သော လက်ကမ်းဂန်ဆောင်မှုပေးသည့် ဂန်ထမ်းများအတွက် ရည်ရွယ်လျာထားသည့် သင်တန်းများကို တိုးမြှင့်ဆောင်ရွက်ရန်
  - ဥပဒေထိန်းသိမ်းသူများအတွက် အသိပညာပေး အလုပ်ရုံဆွေးနွေးပွဲများ ကျင်းပ၍ MSM နှင့် TG များအတွက် HIV ရောဂါကာကွယ်ရေး၊ ကုသရေးနှင့် ပြုစုစောင့်ရှောက်ရေး၏ အရေးကြီးပုံကို လည်းကောင်း၊ ကန့်သတ်ထားသော ဥပဒေပုဒ်မများနှင့် ရဲတို့၏ ကိုင်တွယ်ဆောင်ရွက်မှုများက ကျန်းမာရေးဂန်ဆောင်မှုပေးရာ၌ အဟန့်အတားဖြစ်စေနိုင်ကြောင်းကိုလည်းကောင်း ရှင်းလင်းဆွေးနွေးရန်
  - ဆေးပညာနှင့်သုနာပြု သင်တန်းဆိုင်ရာ သင်ရိုးညွှန်းတမ်းများ၌ MSM နှင့် TG အပြင် အခြားဦးတည်အုပ်စုများနှင့် ကိုက်ညီသော အကြောင်းအရာများကို ထည့်သွင်းနိုင်ရေးအတွက် ပြန်လည်သုံးသပ်နိုင်သည့် အခွင့်အလမ်းများရှာဖွေရန်
- စာနယ်ဇင်းနှင့်သတင်းသမားများအား LGBTI (labian, Gay, Bisexual, Transgender, Intersex) များ၏ အရေးကိစ္စများနှင့် ပတ်သက်၍ ဝေဖန်ဘက်လိုက်မှုမရှိသော သတင်းများကို အားပေးသောအမြင်များ ရရှိအောင်ပြုလုပ်ပေးပြီး အမျိုးသားချင်းလိင်တူချစ်သူများနှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူ နေထိုင်သူများအပေါ် အပြုသဘောဆောင်သောပုံရိပ်များ တိုးပွားလာစေရန် အနုပညာဖျော်ဖြေရေးကဏ္ဍများနှင့် တွဲဖက်လုပ်ကိုင်သင့်သည်။

အဖွဲ့ဝင်များ၏ လိုအပ်ချက်များကို ပိုမိုဖြေရှင်းနိုင်ရန်အတွက် ကွန်ရက်များနှင့် လူထုအခြေပြုအဖွဲ့အစည်းများ၏ နည်းပညာဆိုင်ရာစွမ်းဆောင်ရည်မြှင့်တင်ပေးရန်လိုအပ်သည်။

- အမျိုးသားအဆင့် အိတ်ဝှိုင်ဒိုတုံ့ပြန်မှုလုပ်ငန်းများတွင် MSM နှင့် TG များ အဓိပ္ပာယ်ရှိရှိပါဝင်နိုင်ရန် ငွေကြေးနှင့်နည်းပညာ ဆိုင်ရာပံ့ပိုးမှုကိုတိုးမြင့်သင့်သည်။ ငွေကြေးနှင့်စီမံချက်စီမံခန့်ခွဲခြင်း၊ စောင့်ကြည့်လေ့လာခြင်းနှင့်ပြန်လည် သုံးသပ်ခြင်းတို့အပြင် လူအခွင့်အရေးဆိုင်ရာ ကျား/မ အခြေပြုနည်းများကဲ့သို့သော ခေါင်းစဉ်များ အပါအဂင် များစွာသောနည်းပညာပိုင်းဆိုင်ရာနယ်ပယ်များရှိ ဗဟုသုတနှင့် ကျွမ်းကျင်မှုများတည်ဆောက်ပေးခြင်းအားဖြင့် MSM များ ကွန်ရက်နှင့် လူထုအခြေပြု အဖွဲ့အစည်းများအကြား ခေါင်းဆောင်မှုနှင့် အဖွဲ့အစည်းဆိုင်ရာဖွံ့ဖြိုးရေးကို ပိုမိုအားကောင်းစေနိုင်သည်။ အခြေခံအားဖြင့် MSM ကွန်ရက်သည် ၄င်းတို့၏ အဖွဲ့ဂင်များ ဥပဒေရေးရာ အကူအညီများရယူနိုင်ရန်၊ ကျန်းမာရေးဝန်ဆောင်မှုများထံလမ်းညွှန်ပေးရန်၊ ဝင်ငွေရလုပ်ငန်းများနှင့် MSM နှင့် TG တို့၏ အခွင့်အရေးများအတွက် တိုက်တွန်းနှိုးဆော်ရန်နှင့် အကာအကွယ်ပေးရန် အရည်အသွေးပြည့်ဝနေသင့်သည်။
- MSM ကွန်ရက်ကို မူဂါဒများချမှတ်ရာတွင်ပါဂင်စေခြင်း - MSM များအနေဖြင့် အိတ်ဝှိုင်ဒိုတုံ့ပြန်မှုလုပ်ငန်းများ တိုးတက်အောင်ဆောင်ရွက်ရာတွင် ကနဦးဆွေးနွေးမှုများနှင့် ဆုံးဖြတ်ချက်များ၊ အထူးသဖြင့် ဥပဒေပြုပြင်ပြောင်းလဲရေးနှင့် အိတ်ဝှိုင်ဒိုစီမံချက်များရေးဆွဲပြင်ဆင်ခြင်းတို့တွင် ပါဂင်သင့်ပါသည်။

MSM နှင့် TG များအတွက် HIV ရောဂါဆိုင်ရာ ဝန်ဆောင်မှုတိုးချဲ့ခြင်းနှင့် ကျွမ်းကျင်နည်းညာပိုင်း စွမ်းအားမြှင့်တင်ရန်

- MSM နှင့် TG များအား ဂေဖန်ရှုံ့ချမှုနှင့် ခွဲခြားဆက်ဆံမှုကင်းသောဂန်ဆောင်မှု တိုးမြှင့်နိုင်ရန် စီမံကိန်းလုပ်ငန်းဆောင်ရွက်သော မိတ်ဖက်အဖွဲ့များအား မြန်မာနိုင်ငံတွင် ကျား-မ ရေးရာကိစ္စများ၊ လိင်မှုဆိုင်ရာ ကိစ္စများနှင့် အမျိုးသားများ၏ လိင်မှုအမူအကျင့်များနှင့်စပ်လျဉ်း၍ နည်းပညာပိုင်းကျွမ်းကျင်မှုနှင့် သိရှိနားလည်မှုမြှင့်တင်ရန်။ MSM များအတွက် ရည်ရွယ်သော ဂန်ဆောင်မှုအစီအစဉ်ကို ၎င်းတို့၏ သီးခြားကျန်းမာရေးဆိုင်ရာလိုအပ်ချက်များနှင့် ကိုက်ညီအောင် စီမံလုပ်ဆောင်ရန် လိုအပ်သည်။
    - အစိုးရနှင့် ပုဂ္ဂလိကဂန်ဆောင်မှုပေးသူများအားMSM နှင့် TG များကို နှစ်သိမ့်ဆွေးနွေးမှုပေးနိုင်ရန် သင်တန်းများပေးခြင်း၊ ထိုသင်တန်းများ၌ MSM နှင့် TG များအပေါ် အထင်အမြင်သေးခြင်းနှင့် ခွဲခြားဆက်ဆံခြင်းကို မည်သို့ကိုင်တွယ်ဆောင်ရွက်ရမည်ကို ထောက်ကူလမ်းညွှန်ပေးခြင်းတို့ ပါဂင်ရပါမည်
    - Anal/Oral/Penile/Neo-Vaginal Sex စသည့် လိင်ဆက်ဆံမှုအမျိုးမျိုးပြုကျင့်သည့် MSM နှင့် TG များ၏ ကျန်းမာရေးလိုအပ်ချက်များနှင့် စပ်လျဉ်း၍ HIV နှင့် STI ဆေးခန်းများရှိ ကျန်းမာရေးဂန်ထမ်းများအား လေ့ကျင့်သင်ကြားပေးရန်
- လူထုအခြေပြုလူမှုအဖွဲ့အစည်းများ၏ နည်းပညာပိုင်းကျွမ်းကျင်မှုစွမ်းရည်ဖွံ့ဖြိုးစေပြီး လူထုအတွင်း ကွန်ယက်များအကြားလွှဲပြောင်းမှုစနစ်များနှင့် HCT နှင့် ကုသရေး ဂန်ဆောင်မှုများ အင်အားမြှင့်တင်ရန်
- တိုက်တွန်းနှိုးဆော်ရေးလုပ်ငန်းများ အားကောင်းလာစေရန်နှင့် MSM နှင့် TG တို့အတွက် အိတ်ဝှိုင်အိုင်ဒီဂန်ဆောင်မှုများအားကောင်းစေရန် နည်းပညာဆိုင်ရာ စာစောင်များ၊ စာတမ်းများ ပြုစုထုတ်ဝေရန်
    - HIV ရောဂါစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း အမျိုးသားအဆင့် လမ်းညွှန်ချက်များကို အပြီးသတ်လုပ်ဆောင်ရန်
    - HCT, HIV ရောဂါပြုစုစောင့်ရှောက်ရေးနှင့် ကုသရေးဂန်ဆောင်မှုများအတွက် သတ်မှတ်ထားသော လုပ်ထုံးလုပ်နည်း (Standard Operating Procedures) များရေးဆွဲခြင်း၊ ဖော်ပြပါလျာထား အုပ်စုဂင်များထဲ သွားရောက်၍လည်းကောင်း၊ အွန်လိုင်းမှလည်းကောင်း၊ ဘဂတူအချင်းချင်းမှလည်းကောင်း အသိပညာပေးခြင်း၊ ၎င်းတို့အတွက် သီးခြားလုပ်ငန်းစီမံချက်များကို စောင့်ကြည့်လေ့လာခြင်းနှင့် သုံးသပ်ခြင်းများပြုလုပ်ရန်
    - အမျိုးသားခုခံအားကျဆင်းမှုရောဂါတိုက်ဖျက်ရေးစီမံချက် (National AIDS Program) ၏ HCT သင်ရိုးညွှန်းတမ်း၌ MSM နှင့် TG များ၏ သီးခြားလိုအပ်ချက်များအတွက် ဂန်ဆောင်မှုပေးရန် သင်ခန်းစာများ ထည့်သွင်းသင့်သည်။ သင်ရိုးညွှန်းတမ်းများ၌ MSM၊ TG များနှင့် အခြားအုပ်စုများအတွက် အန္တရာယ်ဖြစ်နိုင်ခြေနှင့် ထိခိုက်လွယ်မှုများ၊ စိတ်ဓါတ်မြင့်တင်ရေးဆွေးနွေးမှုများ၊ HIV နှင့် STI စစ်ဆေးချက်ရလဒ်များအား ဆွေးနွေးခြင်း၊ ၎င်းတို့၏ အဖော်များသို့ လိင်မှုဆိုင်ရာ အမူအကျင့်များကို အသိပေးခြင်းတို့ပါဂင်ရပါမည်။

MSM နှင့် TG အတွင်း ဝန်ဆောင်မှုများ ပိုမိုလက်လှမ်းမှီအသုံးပြုနိုင်ရန်အတွက် လက်ကမ်းစောင့်ရှောက်ပေးသော ကျန်းမာရေးဝန်ဆောင်မှုများနှင့် ဆန်းသစ်သော ဝန်ဆောင်မှုပုံစံသစ်များ စမ်းသပ်လုပ်ကိုင်ခြင်းတို့ကို တိုးမြှင့်သွားခြင်း

- MSM နှင့် TG များထဲ HIV ရောဂါကာကွယ်ရေး သတင်းအချက်အလက်များ ဖြန့်ဝေနိုင်ရန်လည်းကောင်း၊ သက်ဆိုင်သည့် ဂန်ဆောင်မှုဌာနများသို့ လွှဲပြောင်းပေးရန်လည်းကောင်း၊ လူမှုသတင်းမီဒီယာ အပါအဝင် မိုဘိုင်းဖုန်းနှင့် ဂက်ဘ်ဆိုဒ်နည်းပညာများကို အသုံးပြု လုပ်ဆောင်ရန်။ ၄င်းဂက်ဘ်ဆိုဒ်နည်းပညာများ အသုံးပြုရာတွင် သတင်းအချက်အလက်များ လုံခြုံမှုရှိစေရန် သင့်လျော်သောနည်းဗျူဟာများနှင့် လမ်းညွှန်ချက်များ သတ်မှတ်ထားရှိရန်
- လူသိမခံလိုသော MSMများအား ဆွဲဆောင်နိုင်ရန် အမျိုးသားသီးသန့်ကျန်းမာရေးဆေးခန်းများကို ထူထောင်၍ သွေးပေါင်ချိန်၊ သွေးချို သွေးတွင်းအဆီဓာတ်နှင့် ကျောက်ကပ်လုပ်ဆောင်မှုများစသည့် စစ်ဆေးမှုများ ပါဂင်သော အမျိုးသားသီးသန့်ကျန်းမာရေး ဂန်ဆောင်မှုအစီအစဉ်အား စမ်းသပ်လုပ်ဆောင်ရန်
- လက်ရှိလုပ်ဆောင်နေသော အိတ်ဝ်အိုင်ဗွီစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း၊ ART ဆေးဖြင့် ကုသပေးခြင်း၊ မျိုးဆက်ပွားကျန်းမာရေးနှင့် တီဘီရောဂါဂန်ဆောင်မှုများ ပိုမိုလက်လှမ်းမှီစေရန် ရွှေလျားကျန်းမာရေးဂန်ဆောင်မှုများ ထူထောင်သင့်သည်။ ရွှေလျားကျန်းမာရေးဂန်ဆောင်မှုများကို MSM များစုဝေးလေ့ရှိရာ အလှပြင်ဆိုင်ကဲ့သို့သော နေရာမျိုးတွင် ပေးအပ်သင့်သည်။ ထိုနည်းတူစွာပင် KP များအား သီးသန့်ဦးတည်ထားသော ဓေါင်းစီးမျိုး တပ်မထားသည့် ရွှေလျားကျန်းမာရေးဆေးခန်းများကို လူသိများ ကျော်ကြားသော ကုန်တိုက်ကြီးများ၊ ပွဲတော်များ၊ အခမ်းအနားကျင်းပရာနေရာများ စသော လူစည်ကားရာ နေရာများ၏ အနီးတဝိုက်တွင် ပြုလုပ်သင့်သည်။
- အိတ်ဝ်အိုင်ဗွီပိုး ကူးစက်ရန် အခွင့်အလမ်းများသည့် MSM များအတွက် အိတ်ဝ်အိုင်ဗွီ ရောဂါကာကွယ်တားဆီးရေး လုပ်ဆောင်ရာတွင် ရောဂါပိုးနှင့်မထိတွေ့မှီ ကြိုတင်ကာကွယ်ခြင်း (PrEP-Pre Exposure Prophylaxis) ကို ထပ်ဆောင်းဝန်ဆောင်မှုတစ်ခုအဖြစ် လုပ်ဆောင်ရန် တိုက်တွန်းနှိုးဆော်သင့်သည်။ ထိုသို့ လုပ်ဆောင်ရာတွင် MSMများ၊ အခြား KPအုပ်စုများနှင့် အရပ်ဖက်လူ့အဖွဲ့အစည်းများအား PrEP အသုံးပြုခြင်းနှင့် ပတ်သက်သည့် အထောက်အထားများ၊ သတင်းအချက်အလက်များကို သိရှိစေပြီး HIV ကာကွယ်ရေးနှင့် ကုသရေးလုပ်ငန်း ဝန်ဆောင်မှုများ၏ တစိတ်တပိုင်းတခုအဖြစ် ပါဝင်သင့်ကြောင်းကို နားလည်အောင် လုပ်ဆောင်သင့်သည်။

လက်ရှိ HIV ဖြစ်ပွားမှုနှင့် မြန်မာနိုင်ငံအတွင်းရှိ MSM နှင့် TG အတွက် သက်သေအထောက်အထားများအပေါ် အခြေခံထားသော တုံ့ပြန်မှုများ ပိုမိုအားကောင်းအောင်လုပ်ဆောင်သင့်သည်။

- MSM များစွာရှိသောနေရာ၊ လက်ရှိလုပ်ဆောင်နေသော စီမံချက်ဆိုင်ရာ ကွာဟချက်များနှင့် ဝန်ဆောင်မှုများထပ်နေသောနေရာများကို ရှာဖွေဖော်ထုတ်ရန် အဆင့်ဆင့်ပုံဖော်လေ့လာမှုများ (mapping exercise) ပြုလုပ်သင့်သည်။ mapping exercise ကို နှစ်စဉ် အမျိုးသားအဆင့်တွင် NAP မှ ဦးဆောင်ညှိနှိုင်းသင့်ပြီး ဦးစားပေးရမည့်မြို့နယ်များဖော်ထုတ်နိုင်ရန်အတွက် လုပ်ငန်းအကောင်အထည်ဖော် လုပ်ဆောင်နေသော မိတ်ဖက်များနှင့် MSM ကွန်ရက်များ ပါဝင်သင့်သည်။ ဦးတည်ချက်ခိုင်မာသောလုပ်ငန်းများဖြစ်စေရန် အတွက် ခရိုင် (သို့မဟုတ်) မြို့နယ်အဆင့်နှင့် ဒေသတွင်းလုပ်ငန်းအကောင် အထည်ဖော်သောအဆင့်

တွင် စီမံချက်ကျကျ ချိတ်ဆက်ခြင်းဖြင့် လုပ်ဆောင်သင့်သည်။

- ဘဝတူကူညီစောင့်ရှောက်သူများ လူထုအတွင်းရှိ လူအများစုထံ ဝန်ဆောင်ပေးနိုင်ရန်၊ အန္တရာယ်နှင့် ထိခိုက်မှုများကို ဆန်းစစ်နိုင်ရေး၊ လက်ကမ်းစောင့်ရှောက်ခြင်းအားဖြင့် စီမံချက်လွှမ်းခြုံမှုရရှိရေး၊ ဝန်ဆောင်မှုဦးတည်ချက်များ ပြည့်မှီမှုရှိအောင် ဆောင်ရွက်နိုင်ရေးအတွက် ဘဝတူကူညီစောင့်ရှောက်သူများ ဦးဆောင်သော လက်ကမ်းစောင့်ရှောက်မှုပေးသည့် အစီအစဉ်များတွင် အသေးစိတ်လုပ်ငန်းဆောင်တာများ ရေးဆွဲခြင်းများ[၂] မိတ်ဆက်ပေးသင့်သည်။
- နည်းဗျူဟာမြောက်အချက်အလက်များနှင့် စောင့်ကြည့်လေ့လာခြင်းနှင့်ပြန်လည်သုံးသပ်ခြင်း နည်းပညာပိုင်းဆိုင်ရာ လုပ်ဆောင်မှုအဖွဲ့ (SI & ME TWG) ၏ အကြံပြုချက်များနှင့်အညီ KP အုပ်စုများအတွင်း ကျန်းမာရေးတိုးတက်မှုကို ဆန်းစစ်တိုင်းတာရာ၌ တွေ့ရသော အခက်အခဲများကို ဖြေရှင်းသင့်သည်။ မူဂါဒချမှတ်သူများနှင့် စီမံချက်အကောင်အထည်ဖော်သူများ လိုအပ်နေသော အချက်အလက်များကို ပြန်လည်သုံးသပ်ပြီး အညွှန်းကိန်းများ အားကောင်းစေရန် အားစိုက်ထုတ်သင့်သည်။ သို့မှသာ အိတ်ချ်အိုင်ဗွီ တုံ့ပြန်မှုတစ်လျှောက် လုပ်ဆောင်ခဲ့သော တိုးတက်မှုများနှင့် ရောဂါဖြစ်ပွားများ၏ ပြောင်းလဲမှုများကို ထိထိမိမိသိရှိနိုင်မည်ဖြစ်သည်။ အထူးသဖြင့် အိတ်ချ်အိုင်ဗွီပိုး စစ်ဆေးခြင်း၊ ART ဆေးနှင့်ကုသမှုခံယူခြင်း၊ အိတ်ချ်အိုင်ဗွီနှင့် ဆက်စပ်ရောဂါများ (ဥပမာ - တီဘီရောဂါ)၊ လိင်နှင့် မျိုးဆက်ပွားကျန်းမာရေးစစ်ဆေးခြင်းနှင့်ကုသခြင်း စသည်တို့နှင့် ပတ်သက်၍ KP အုပ်စုအလိုက် ခွဲခြားသတ်မှတ်ထားသော ဝန်ဆောင်မှုဆိုင်ရာ အချက်အလက်များစုဆောင်းခြင်းကို အဓိကထားဆောင်ရွက်သင့်သည်။
- စီမံချက်အကောင်အထည်ဖော် လုပ်ဆောင်နေသူများ အသုံးပြုနိုင်ရန် အဓိကထိခိုက်ခံစားနေရသော လူအုပ်စုများအတွက် လူကျင့်ဂတ်နှင့်ကိုက်ညီပြီး လက်တွေ့ကျသော UIC စနစ်ကို ပုံဖော်ရေးဆွဲပြီး အကောင်အထည်ဖော်သင့်သည်။ ထို့ပြင် ကျန်းမာရေးဂန်ဆောင်မှုများ၏ အရည်အသွေးနှင့် အရေအတွက်ကို ဆန်းစစ် ရာတွင် အားစိုက်ထုတ်သင့်သည်။ (ဆိုလိုသည်မှာ - ဂန်ဆောင်မှုကွာဟချက်များကို ဖော်ထုတ်ခြင်း၊ ကျန်းမာရေးစောင့်ရှောက်မှု ဂန်ဆောင်မှုပေးသူများ၏ ဖော်ရွေမှု သို့မဟုတ် ခွဲခြားနိမ့်ချ ဆက်ဆံမှုကိုတိုင်းတာခြင်း၊ လူနာမှပြန်လည် အကြံပေးနိုင်သည့်အစီအစဉ်အား အကောင်အထည်ဖော်ခြင်း) တို့အပေါ် အားစိုက်သင့်ပါသည်။

သုတေသနများမှတဆင့်အမျိုးသားချင်းလိင်တူချစ်သူများနှင့်ပတ်သက်သောဗဟုသုတနှင့်သတင်းအချက်အလက်များ မြှင့်တင်ခြင်း။

- ဤလေ့လာတွေ့ရှိမှု၏ ကန့်သတ်ချက်များနှင့် ကွာဟချက်များများကို ဖြေရှင်းရန် နောက်ထပ်သုတေသနများ ဆောင်ရွက်ရန် လိုအပ်ပါသည်။ ဝန်ဆောင်မှုများ အားကောင်းစေရန် အဆိုပါတွေ့ရှိချက်များအပေါ် အခြေခံပြီး မကြာသေးမီက ပြုလုပ်ခဲ့သော IBBS/PSE မှရလဒ်များနှင့်ပေါင်းစပ်၍ လက်ရှိနှင့် အသစ်ရရှိလာမည့် အချက်အလက်များအား ခွဲခြမ်းစိတ်ဖြာခြင်း၊ ပြန်လည်စမ်းစစ်ခြင်း၊ အသုံးပြုခြင်းတို့ကို နေရာဒေသအဆင့်တိုင်း၌ မြှင့်တင် ဆောင်ရွက်သင့်သည်။ ထို့ပြင် ကိုယ်ရေးကိုယ်တာအချက်အလက်များအား လျှို့ဝှက်ထိန်းသိမ်းပေးရင်း တစ်ချိန်တည်းမှာပင် ဖွံ့ဖြိုးရေးမိတ်ဖက်များအကြား အချက်အလက်နှင့် သတင်းများအား ဝေမျှခြင်းဖြင့် MSMနှင့် TGများအတွက် အိတ်ချ်အိုင်ဗွီစီမံချက်များ၏အကျိုးရှိမှုထိရောက်

[၂] Bill and Melinda Gates Foundation. Avahan (Indian AIDS initiative). Micro-planning in peer-led outreach programs. (http://futuresgroup.com/files/publications/Microplanning_Handbook_(Web).pdf accessed 21 August 2015)

မှုနှင့်ရေရှည်တည်တံ့မှုတို့ကို တိုးတက်စေမည်ဖြစ်သည်။ အထူးသဖြင့် သုတေသနအကြောင်းအရာသည် အောက်ပါနယ်ပယ်များကို အာရုံစိုက်သင့်ပါသည် -

- MSM နှင့် TG များကို ဦးတည်ထားသော လက်ရှိစီမံချက်များ၏ အကျိုးရှိမှု၊ ကုန်ကျစရိတ်အလိုက် ထိရောက်မှု နှင့်ရေရှည်တည်တံ့မှု။
- HCT ဝန်ဆောင်မှုပုံစံသစ်များဖော်ထုတ်ပြီး အခြေအနေ/နေရာဒေသ တစ်ခုချင်းစီ၌ သင့်လျော်မှုရှိသော ပုံစံကို ဖေါ်ထုတ်နိုင်ရန်အတွက် သုတေသနများလိုအပ်ပါသည်။ MSM များ အများဆုံးအသုံးပြုသော အခြားသောဝန်ဆောင်မှုများအား ဖေါ်ထုတ်ခြင်းနှင့် ဝန်ဆောင်မှုများ၏ ကုန်ကျစရိတ်ကို ဖော်ထုတ်ခြင်းသည် ဤသုတေသန၏ အရေးကြီးသောရှုထောင့်များဖြစ်ပါသည်။
- လိင်လုပ်ငန်းလုပ်ကိုင်သူနှင့်/ သို့မဟုတ် မူးယစ်ဆေးဝါးသုံးစွဲသူ MSM နှင့် TG တို့၏ အန္တရာယ်ရှိသော အပြုအမူ များဆိုင်ရာ သုသေတနများပြုလုပ်ခြင်း
- PrPE လုပ်ဆောင်ရန် သင့်လျော်မှုရှိမရှိ ကနဦးလေ့လာမှုပြုလုပ်ရန်နှင့် MSM[၃] နှင့် TG တို့အကြားတွင် PrEP အား လက်ခံနိုင်မှု။

[၃] မြန်မာနိုင်ငံတွင်းရှိ အမျိုးသားချင်းလိင်တူချစ်သူများအကြား PrEP အားလက်ခံနိုင်မှုဆိုင်ရာ လေ့လာမှုတစ်ရပ်ကို Burnet Institute မှ ပြုလုပ်ခဲ့ပြီး တွေ့ရှိချက်များကို ၂၀၁၅ နှစ်ကုန်ပိုင်းတွင်ဖြန့်ဝေရန်ရှိပါသည်။

Executive Summary

Seminar on "Responding to Sexual Diversity: Collaboration for HIV response Among Men Who have sex with Men and Transgender People in Myanmar *(Source - UNAIDS)*

HIV awareness raising & stigma reduction event by Khittayar Swe Taw Oo-MSM CBO *(Source - Alliance)*

Executive Summary

Myanmar is one of the countries in Asia hardest hit by the HIV epidemic. With an estimated 200,000[1] people aged 15 and above living with HIV (PLHIV) in 2014, Myanmar has the 6th largest number of PLHIV in the Asia and Pacific Region after India, China, Thailand, Indonesia and Viet Nam.[2]

Since the first individual infected by HIV was identified in Myanmar in 1988 and the first AIDS case was reported in 1991,[3] the HIV epidemic has remained concentrated in specific key populations (KPs): people who inject drugs (PWID), female sex workers (FSW) and their clients, men who have sex with men (MSM) and transgender persons (TG). Despite concerted efforts between government agencies, international and local non-government organisations (NGOs), community-based organisations (CBOs) and development partners to respond to the HIV epidemic among MSM and TG, HIV prevalence among these KPs remained considerably high at 6.6% in 2014.[4]

Sex between men is highly stigmatised and also criminalised in Myanmar. This adds to the vulnerability of MSM and TG, and has often made it difficult to carry out relevant HIV prevention and awareness campaigns. MSM often do not disclose their same-sex behaviour to family and friends, and do not access HIV services for MSM for fear of stigma, discrimination and persecution. Non-disclosed MSM are more likely to seek treatment from public STI clinics or general practitioners, or to self-medicate, because they believe these options provide greater confidentiality and anonymity. In these settings, however, MSM may not be exposed to appropriate messaging and interventions for HIV and STI prevention.

More effective HIV prevention, treatment and care programmes that specifically address the needs of non-disclosed MSM are necessary. In addition, interventions that are adequately tailored to the specific needs of TG, who are particularly vulnerable to gender-based violence and HIV acquisition, are urgently required.[5]

To improve understanding of HIV among MSM and TG in Myanmar, a comprehensive situational analysis was carried out by UNAIDS Country Office in Myanmar. The analysis involved relevant stakeholders dealing with MSM and HIV issues from various sectors, including health and law enforcement officials and representatives from NGOs, CBOs, community networks, development partners and United Nations agencies. More than 70 people from various institutions were interviewed during the analysis. Analysis of the results has contributed to an improved understanding of the current situation and responses to HIV among MSM and TG in Myanmar.

Findings

Successes and achievements

Preventing sexual transmission of HIV among MSM and TG through the promotion of consistent condom and lubricant use remains an integral component of the national HIV response. The dissemination of HIV prevention information and commodities, and the promotion of their use, has been at the heart of HIV prevention activities conducted by NGOs and CBOs in Myanmar, especially in urban centres where populations of MSM and TG are concentrated. However, it is too early to assess progress and results, as up-to-date data are lacking.[i] The [unpublished] 2009 Integrated Biological and Behavioural Surveillance (IBBS) found that 81.5% of MSM surveyed, reported condom use at last sex. However, condom use is generally believed to be over-reported by respondents in order to please interviewers. The 2015 national target for this indicator is 86%.[6]

HIV counselling and testing (HCT) are equally important interventions, ensuring MSM and TG know their HIV status so they can immediately access ARV treatment if diagnosed to be HIV positive and prevent onward transmission of HIV. The number of MSM and TG enrolled in HCT services grew from 12,694 in 2012[7] to 17,472 in 2013.[8] While the growth in the number of MSM and TG accessing HCT services is encouraging, the proportion of these populations covered by HCT services cannot be established with data from testing sites. Testing sites do not systematically capture whether clients belongs to specific KPs, such as MSM or TG.

[i] A new IBBS and population size estimates among MSM and TG are being carried out in 2015 by NAP with partners and results are expected to be issued in early 2016.

In 2013, the National AIDS Programme (NAP) started efforts to decentralise antiretroviral therapy (ART) and HCT to increase access to these essential services. More than 90 townships now provide decentralised HCT services.[ix]

In addition to expansion among public services, private, NGO and community-based sites across Myanmar are now able to provide HCT. There is general commitment to introduce community-based HIV screening, which is expected to boost enrolment in testing and increase the number of people accessing treatment. Decentralisation has enabled service providers to explore innovative approaches, such as mobile/outreach HCT services to sites where MSM and TG gather.

The establishment of MSM networks and self-help groups in Myanmar has resulted in increased civil society engagement in the national HIV response. Networks and self-help groups have become increasingly pro-active, engaging in policy discussions and highlighting key issues affecting their constituents. At the same time, government and non-government entities are increasingly committed to supporting the meaningful engagement of MSM and TG in HIV policy and programming. This has enabled MSM and TG to oversee the planning, implementation, monitoring and evaluation of their own programmes and provide input into the development of services that are tailored to meet their needs.

Challenges and barriers to expanding the HIV response among MSM and TG in Myanmar

The following issues represent challenges and barriers to HIV prevention, treatment and care among MSM and TG in Myanmar:

- Penal Code, Section 377, known as the anti-sodomy law, implicitly prohibits homosexual behaviour throughout Myanmar, which creates an environment that discourages MSM and TG from accessing available services. Sections 30(d) and 35(d) of the Rangoon Police Act of 1899 and the Police Act of 1945, respectively - provisions colloquially known as “in the shadows” laws - give police the power to make arrest without a warrant.

- MSM are not a homogeneous group, yet service models are not adequately meeting the needs of these key populations, especially individuals who are not willing to disclose same-sex behaviour. Many MSM are reluctant to use available services for fear of stigma and discrimination from staff, or inadvertent disclosure of same-sex behaviour when attending MSM-focused services.

- Behavioural data and population size estimates (PSEs) for MSM and TG are out of date, but the 2015 IBBS and PSE among MSM and TG are currently being conducted and will produce data by early 2016.

- Persons reached by interventions are often double-counted. A universal unique identifier system is not yet available in Myanmar. Tracking individual clients across different services, and determining what services they have received, remains a challenge.

- Although part of the national MSM strategy, targeted interventions for reaching female sexual partners of MSM and TG with HIV prevention services are lacking. Only a very small number of female partners have been reached in recent years, as shown in annual reports.[x]

- Retention of skilled staff, both technical and administrative, is an issue for all agencies. High turnover rates have led to endless capacity building and a lack of institutional memory, both within and between agencies.

Improving the enabling environment and strengthening the HIV response for the way forward

Maintaining advocacy efforts with those in key strategic or decision-making roles remains critically important for legislative change to address Penal Code, Section 377 and other punitive laws. An enabling environment for legislative change requires well-informed and positively engaged law enforcement and key decision makers, which can be achieved through training and sensitisation of individuals to better understand the issues affecting MSM and TG in Myanmar.

New innovative strategies are needed to reach non-disclosed MSM to ensure those at risk are receiving critical health and HIV services. New models in HCT and care and treatment services need to be explored. These might include men's health clinics, mobile/outreach clinics or increased access to services through private practitioners. These clinics would provide HCT and clinical services for STI treatment, TB testing and treatment, and ART. These services would be provided through a clinic broadly targeting men and sexual health.

Health-care providers must be sensitive to, and knowledgeable about, the specific health needs of both MSM and TG. In particular, genital examination and specimen collection can sometimes be uncomfortable or upsetting for clients. The need to develop a standard package of services for MSM, and another one for TG, is already recognised by partners.

As the internet becomes more accessible, web-based and social media platforms may be utilised to provide HIV prevention information and referrals without judgmental attitudes or ridicule from service providers. Similarly, HIV information may be provided through text messaging, hotline services and smartphone applications, in partnership with private sector telecommunications companies, in non-discriminatory ways.[xii]

Smartphone applications can also help MSM and TG identify MSM and/or TG-friendly services that are geographically close to their current position. As the possibilities are explored, standards in online service provision are needed, as well as strategies, to protect client privacy and confidentiality while providing services and monitoring service usage.

Recommendations

Support an enabling environment for HIV prevention, treatment and care among MSM and TG in Myanmar

- Maintain on-going dialogue and advocacy efforts with decision makers, and those with appropriate connections and influence, to amend Penal Code, Section 377 and the sections 30(d) of the Rangoon Police Act of 1899 and 35(d) of the Police Act of 1945 as they violate human rights, fuels stigma and discrimination, and represent an obstacle to health care, including HCT and HIV care and treatment services. Advocate for the decriminalization of sex-same behaviour and for the reduction of the sentence for male-male sex.

- Increase advocacy efforts and training opportunities targeting health service providers, law enforcement officers and community outreach workers, as well as the wider community whenever appropriate, to strengthen understanding of gender and sexual diversity and HIV prevention, treatment and care among MSM and TG.
  - Conduct sensitisation workshops for law enforcement about the importance of HIV prevention, treatment and care among MSM, TG and other KPs, and explain how restrictive laws and/or police abuse can create barriers to accessing services.
  - Explore opportunities to review medical and nursing training curriculum to ensure inclusion of content relevant to working with MSM, TG and other KPs.

- Sensitise journalists with a view to encouraging unbiased media coverage of LGBTI issues, and work with the arts and entertainment sector to increase positive images of MSM and TG.

Strengthen technical capacity of networks and CBOs to better address the needs of their members

- Increase financial and technical support for the meaningful engagement of MSM and TG in the national HIV response. Strengthen leadership and organizational development among MSM-led networks and CBOs by supporting knowledge and skill-building in various technical areas including financial and programme management, and monitoring and evaluation,

as well as thematic topics such as human rights and gender-based approaches. Ultimately MSM networks should be competent to provide their members with support to access legal aid, referrals to health services, income generation and advocating for rights and protection of MSM and TG communities.

- Involve MSM in policy making: MSM should be involved in discussions and decisions around improving the HIV response from the outset, specifically those relating to law reform and HIV programme planning.

Expand HIV services for MSM and TG and strengthen technical capacity

- Strengthen the technical capacity and understanding of implementing partners with respect to gender, sexuality and male sexual behaviours in Myanmar with a view to promoting specialised services for MSM and TG that are free of judgment and discrimination. A standard package of services for MSM and another one for TG should be developed to match the specific health needs of both populations.
  - Provide training on MSM and TG-appropriate counselling to public and private service providers, with supportive supervision to address stigma and discrimination toward MSM and TG clients.
  - Provide training to HIV and STI clinical staff in relation to the health needs of MSM and TG who engage in anal, oral, penile or neo-vaginal sex.

- Build technical capacity for CBOs and networks of MSM and TG to strengthen the referral/cross-referral system between outreach networks and HCT and treatment services.

- Develop technical documents to enhance advocacy efforts and strengthen HIV service delivery for MSM and TG.
  - Finalize National Guidelines on HIV Counselling and Testing.
  - Develop Standard Operating Procedures (SOPs) for HCT, HIV care and treatment services, online and offline outreach and peer education, and monitoring and evaluation of interventions specific to MSM and TG.
  - Expand the NAP training curriculum on HCT to include modules specific to the provision of services for both MSM and TG. These may include modules on risks and vulnerabilities of MSM, TG and other KPs, motivational interviewing, disclosure of HIV and STI test results, and disclosure of sexual practices to partners.

Improve outreach of health services and trial innovative service delivery models to increase accessibility and use among MSM and TG.

- Use mobile and web-based technologies, including social media applications, to conduct outreach among MSM and TG, disseminate HIV prevention messages, and facilitate referral to relevant services. Ensure that on-line service provision protects the privacy, confidentiality and security of individuals, through developing appropriate strategies and guidelines.

- Pilot men's health clinics to attract non-disclosed MSM to HCT and STI treatment services within a package of men's health services, including testing relating to blood pressure, blood sugar, cholesterol and kidney function.

- Establish mobile health services to increase the flexibility of existing HCT, ART, reproductive health and TB services. Mobile services should be delivered to sites where MSM and TG gather, such as beauty salons. Similarly, mobile health clinics without banners targeting specific KPs can be set up close to community "hang out" places such as popular shopping malls, festivals, and event venues.

- Advocate for pre-exposure prophylaxis (PrEP) as an additional effective intervention option for HIV prevention for MSM at higher risk of HIV. This will require engaging MSM, other key populations and civil society with information on the evidence to support the use of PrEP as part of a comprehensive HIV prevention and treatment service.

Strengthen the evidence base on the current epidemic situation and response for MSM and TG in Myanmar.

- Organize mapping exercises at several levels to identify where MSM are concentrated, existing programmatic gaps and duplication of services. Annual high-level mapping should be coordinated by NAP at the national level and involve implementing partners and MSM networks to identify priority townships. Programmatic mapping should be carried out at district or township level and at local implementation level, to better target interventions.

- Introduce micro planning[ii] in peer-led outreach programmes and case management approaches to help peer educators to better reach the maximum number of community members, assess risk and vulnerability and ensure that programme coverage and service targets are being met through outreach.

- Address challenges in the measurement of health progress among key populations, in line with the recommendations of the Strategic Information and Monitoring & Evaluation Technical Working Group (SI & ME TWG). Data needs of policy makers and programme implementers need to be reviewed and efforts made to strengthen indicators so that they adequately capture changes in the epidemic and progress made through the HIV response. Focus should be on collecting service data, disaggregated by key population, specifically in relation to HIV testing, ART, screening and treatment of HIV-related comorbidities (e.g. TB), and sexual and reproductive health.

- Design and implement a harmonised UIC system to be used by implementing partners that is ethical and realistic for key populations. Efforts should also focus on assessing the quantity and quality of health services (i.e. identifying service gaps, measuring friendliness or stigma and discrimination from health personnel, implementing patient feedback programmes etc.).

Improve information and knowledge about MSM and TG through research

- Undertake further research to address the limitations and gaps identified in this situational analysis. Building on these findings and in conjunction with the results from the most recent IBBS/PSE, analysis, triangulation, and use of data from existing and new sources need to be promoted at all levels to strengthen the response. As well, sharing of data and information among development partners, while maintaining confidentiality and privacy, will help to improve the efficiency, effectiveness, and sustainability of HIV programmes for MSM and TG. Specifically, the research agenda should focus on the following areas:
    - Efficiency, cost-effectiveness and sustainability of existing programmes targeting MSM and TG;
    - Operations research in the development and strengthening of alternate HCT service models is needed to determine what model of service is appropriate in each setting. The identification of alternate services commonly used by MSM and costing of services are important aspects of this research;

[ii] Bill and Melinda Gates Foundation. Avahan (Indian AIDS initiative). Micro-planning in peer-led outreach programs. (http://futuresgroup.com/files/publications/Microplanning_Handbook_(Web).pdf accessed 21 August 2015)

- Overlapping risk practices of MSM and TG who also sell sex and/or also use/inject drugs and;
- Acceptability of PrEP among MSM[iii] and TG, with a view to conducting a feasibility study on piloting PrEP and increasing public demand.

[iii] Burnet Institute has conducted a study on “HIV prevention preparedness among men who have sex with men (MSM) in Myanmar: 'test and treat' and pre-exposure prophylaxis” (500 MSM surveyed in Yangon and Mandalay) whose results will be disseminated in late 2015.

1. Introduction

Health Education visit to YatanaGu Festival *(Source - MDM)*

HIV awareness session at pagoda festival *(Source - MDM)*

1. Introduction

It is estimated that as many as 50% of all new HIV infections worldwide occur in people from key populations (KPs), including men who have sex with men (MSM) and transgender persons (TG).[13] Globally, MSM are 19 times more likely to be living with HIV than the general population[14] while transgender women were some 49 times more likely to have HIV than other reproductive-age adults in the same population.[15] In Asia, same-sex behaviour is a major contributor to the HIV epidemics in several countries, including Myanmar.[16] MSM and TG face substantial barriers in accessing HIV prevention, treatment and care services, largely due to stigma, discrimination and, in some countries, the criminalisation of same-sex behaviour. These social and legal factors contribute to their vulnerability to HIV infection.

The response to the HIV epidemic among MSM and TG in Myanmar began a little more than a decade ago, while HIV prevalence among MSM and TG was first documented in the National HIV Sentinel Surveillance in 2007. But, despite concerted efforts between government agencies, international and local non-government organisations (NGOs), community-based organisations (CBOs) and development partners to respond to the HIV epidemic among MSM and TG, HIV prevalence among these KPs remains considerably high at 6.6% in 2014.[17]

Sex between men is highly stigmatised and also criminalised in Myanmar. This adds to the vulnerability of MSM and TG, and has often made it difficult to carry out relevant HIV prevention and awareness campaigns. Due to high stigma and discrimination, most MSM do not disclose their same-sex behaviour to health professionals, and thereby have limited access to appropriate HIV

prevention information and services. Accordingly, to strengthen the HIV response for MSM and TG, innovative strategies are needed to ensure these populations have access to appropriate prevention information and are linked to more effective HIV prevention, treatment and care services that specifically address the barriers to access.

1.1 Objectives of the situational analysis

The objectives of the situational analysis of the HIV response among men who have sex with men and transgender persons in Myanmar are as follows:

1. Discuss new trends emerging in the national HIV response;
2. Highlight successes and achievements, as well as current challenges, evident in the HIV response;
3. Identify key priorities to address the needs of MSM and TG in Myanmar; and
4. Provide recommended actions aimed to improve the enabling environment and strengthen the national HIV response for MSM and TG.

1.2 Key concepts and definitions

General definitions (UNAIDS Terminology Guidelines)

Gay men: The term gay can refer to same-sex sexual attraction, same-sex sexual behaviour and same-sex cultural identity. Unless individuals or groups self-identify as gay, the expression men who have sex with men should be used.

Men who have sex with men: The term men who have sex with men describes males who have sex with males, regardless of whether or not they also have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self identify as heterosexual but who have sex with other men.

Transgender: Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders. Transgender individuals may self-identify as transgender, female, male, transwoman or transman, transsexual, hijra, kathoey, waria or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways. Due to this diversity, it is important to learn and use positive local terms for transgender people, and to avoid derogatory terms.

Myanmar context

In Myanmar, sexual orientation, sexual behaviour and gender identity frameworks are particularly complex, interwoven and fragmentary. The term “MSM” is meant to describe men who engage in same-sex behaviours, and is commonly used in different settings in an attempt to move away from sexual orientation or sexual identity categories (e.g. homosexual, bisexual or heterosexual). This term however seems reductionist in the current context as it does not do justice to the diversity of sexual and gender identities in Myanmar. For instance, while the term “MSM” is frequently applied to people with transgender identities, some TG identify as women, and some experience their gender in ways that are non-binary. Furthermore, the specific needs of TG must be carefully identified and addressed within the context of HIV prevention, treatment and care.

Masculinities, male sexualities, and male-to-male sexual dynamics, are complex and need to be seen as part of a behavioural framework accommodating various and intertwined gender identities and sexual orientations and behaviours. MSM and TG in Myanmar are identified (by themselves and/or people around them) through the use of various local terms (i.e. apwint, apone and tha nge). These terms reflect distinctions made on the basis of sexual orientation and gender identity, as well as the public expression of gender identity through personal bearing, mode of dress, mannerisms, speech patterns, social behaviour and sexual interactions.

Apwint are biological males whose public and private gender identity is feminine. Apwint are sexually oriented towards men and are generally viewed as the receptive partner during sexual intercourse but they may, on occasion, also be the penetrating partner. The term apwint is applied to male-female transgender individuals, regardless of whether they have chosen to transition their biological sex.

Apone are biological males whose gender identity may be either masculine or feminine but maintain a masculine appearance in all or most spheres of life. The cultural connotation of apone is a man who is not ready to open or appear in public as a woman. Apone are also sexually oriented toward men and are typically viewed as the receptive partner in sexual intercourse. However, apone may have sex with apwint as the penetrating partner, or sex with tha nge as the penetrated partner, or with each other in a mutual sexual role exchange.

Tha nge are biological males whose gender identity is male. They have a sexual preference for apwint and apone, as well as for women, typically as the penetrative sexual partner. Tha nge would not consider themselves MSM or bisexual. As men, they can penetrate transgender persons without losing their sense of masculinity. Some tha nge also like to be penetrated, but such behaviour is kept secret.

While apwint and apone are generally associated with femininity and passivity, the newer identity of homo is gaining popularity in urban areas. Homo are biological males whose gender identity is also male, and who are attracted to other biological males. While the term homo is often seen as synonymous with apone because both groups are biological males attracted to other biological males, homo identify as men and are attracted to others with the same gender identity.

It is critical for sexual health programmes to separate sexual orientation and gender identity from sexual behaviour. In the interviews, it was apparent that a feminised gender display was often assumed to signify an individual's preferred role during sex. As we can see from the definitions above, gender identity and sexual behaviour may be discordant, demonstrating that gender identification, like sexual orientation, is not a central indicator of actual sexual practice. Assumptions about sexual behaviour should never be based on sexual orientation or gender identity. While sexual orientation and gender identity may contribute to an individual's vulnerability to HIV infection, it is ultimately the individual's sexual behaviour that places him or her at risk.

2. Methodology

Condom Promotion in Water Festival by Sar Nar Hmu Say Ta Nar-MSM CBO *(Source - Alliance)*

HIV Health Edcucation Group Session in Taung Pyone Festival-MSM CBO *(Source - Alliance)*

2. Methodology

The situational analysis consisted of two components, a literature review and consultation with stakeholders involved in the HIV response among MSM and TG in Myanmar, through key informant interviews and focus group discussions.

A total of 74 key informants from 35 stakeholder bodies, including the National AIDS Programme and the Ministry of Home Affairs were interviewed. Most organizations were represented by one or two staff in the interviews, while a few organizations had five or more representatives in the interview. Interviews were conducted in Yangon, Nay Pyi Taw, Mandalay, and Pathein between 3 to 23 November 2014. Interviews and focus group discussions were mainly conducted in English and when required, in Myanmar language with English translation provided for the international consultant. All questions raised were semi-structured, and included a series of probing questions to elicit more information on issues directly related to the experiences of key informants.

Based on the findings of the literature review, and of the interviews and discussions, a list of recommendations for an improved and expanded response to HIV among MSM and TG was drafted. This list of recommendations was discussed with representatives from government, international non-government organisations (INGOs), NGOs, CBOs, MSM and TG communities, development partners and UN agencies (see Annex 1-3 for list of those interviewed, as well as a detailed methodology).

Limitations

The recruitment of focus group discussion participants was arranged by INGOs providing drop-in centre services to MSM and TG in Myanmar. It was not always possible for the INGOs to recruit the desired number of participants (approximately eight persons) due to the scheduling of focus group discussions. In addition, representation of the broad diversity of MSM and TG was not achieved in these discussions. The majority of participants in each discussion were self-identified male-female TG or apwint. Apone were underrepresented and only present at two sites. There were no tha nge present at any of the focus group discussions.

A small number of organisations involved in the HIV response among MSM and TG in Myanmar were not able to be consulted. Despite these limitations, the rich variety of qualitative data resulting from the large number of interviews has contributed to an improved understanding of the situation and responses.

3. Literature review

HIV awareness session to MSM/TG and their partners *(Source - Pyi Gyi Khin)*

Knowledge sharing session among peer - MSM self-help group *(Source - Pyi Gyi Khin)*

3. Literature review

3.1 The HIV epidemic among MSM and TG globally, regionally and in Myanmar

3.1.1 The global HIV situation

There were an estimated 35 million people living with HIV (PLHIV) worldwide in 2013. In the same year, 2.1 million people became newly infected with the virus, down from 3.4 million in 2001. In the past three years alone, new HIV infections fell by 13%.[iv, 18] It is estimated that as many as 50% of all new infections worldwide occur in people from KPs such as people who inject drugs (PWID), MSM, TG and female sex workers (FSW).[19]

While HIV incidence is declining in most of the world, incidence among MSM appears to be rising in several regions, including in Asia and the Pacific, where this mode of transmission is a major contributor to HIV epidemics in several countries. Worldwide, MSM are 19 times more likely to be living with HIV than the general population.[20] The median HIV prevalence among MSM is 3.7% according to Global AIDS Response Progress Report (GARPR) data from 96 countries.[21] According to national GARPR reports, the highest median HIV prevalence among MSM was reported in Western and Central Africa (15%) and Eastern and Southern Africa (14%). Though somewhat lower, high levels of HIV infection were also reported among MSM in Latin America (13%), Western and Central Europe and North America (10%) the Middle East and North Africa (7%), Asia and the Pacific (6%) and the Caribbean (6%).[22]

[iv] Epidemiological surveys of MSM are limited and may not be nationally representative. Epidemiological trends among MSM vary by region.

MSM living with HIV often acquired the virus while they were quite young, with a median HIV prevalence of 4.2% for MSM under 25 years old, according to studies primarily in countries with concentrated epidemics.[23]

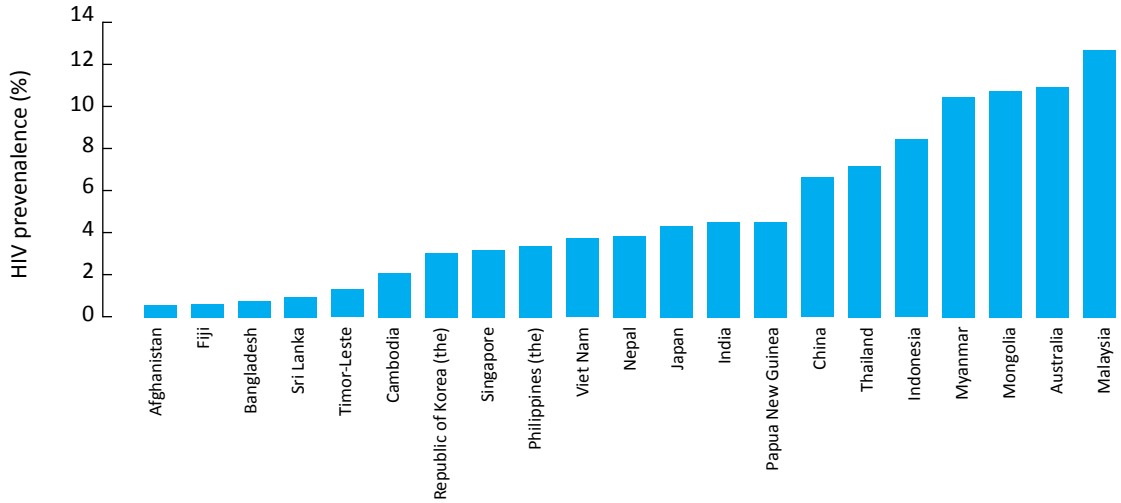
Transgender women – male-to-female TG – are particularly affected by HIV. In a recent review of the global burden of HIV among transgender women in 15 countries worldwide, the pooled HIV prevalence was 19.1%. Transgender women were 49 times more likely to have HIV than other reproductive-age adults in the general population.[24]

3.1.2 The HIV situation in Asia and the Pacific

In 2013, there were 4.8 million PLHIV and an estimated 350,000 new HIV infections in Asia and the Pacific. China, India, Indonesia, Myanmar, Thailand and Vietnam account for more than 90% of the PLHIV in the region. In most countries in Asia and the Pacific, sex workers and their clients, MSM, TG, and PWID represent the populations most affected by the epidemic. Regionally, it is estimated that 1.4% of the adult male population has sex with other men. A significant portion of these men may also have sex with women. A review of data from 2003 to 2007 among MSM in South Asia showed that 20-89% also had sex with women and 21-42% were married.[25]

According to national GARP reports, the median HIV prevalence among MSM in Asia and the Pacific was 6% in 2013.[26] National HIV prevalence among MSM in China, Indonesia, Thailand and Viet Nam was between 4–9%, while prevalence was 10% or higher in Australia, Malaysia, Mongolia and Myanmar. However, national HIV prevalence hides much larger epidemics in local areas. For example, in Bangkok, HIV prevalence among gay men and other MSM was 24.4% compared to the national HIV prevalence of 7% for this population across all of Thailand.[27]

Figure 1: HIV prevalence among gay men and other men who have sex with men across Asia and the Pacific, 2009–2013

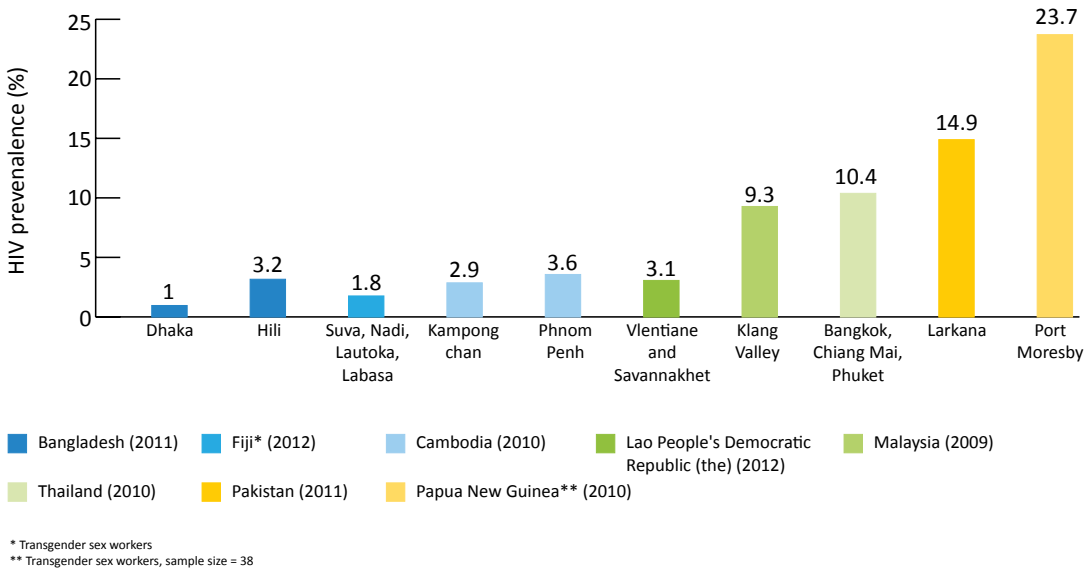


Source: Global AIDS Response Progress Reporting 2014.

Research conducted in Asia and the Pacific in 2012 suggests that the transgender population in the region is around 9–9.5 million, made up predominantly of transgender women.[28]

In most countries, the epidemiology of HIV among TG has been concealed within data collected for MSM and pose challenges to HIV responses. Epidemiological data in relation to HIV among TG are slowly emerging in the region.

Figure 2: HIV prevalence among transgender people in select cities in Asia and the Pacific, 2009–2012



Source: HIV and AIDS Data Hub for Asia Pacific (www.aidsdatahub.org), based on integrated bio-behavioural surveys reported in global AIDS response progress reports from 2012.

Similarly, data on transgender sex workers are scarce but, where available, demonstrate high HIV prevalence. For example, 31% of transgender (waria) sex workers in Jakarta tested HIV-positive as did 19% in Maharashtra, India. The epidemiology among these communities is often confounded by the fact that transgender sex workers are often over-sampled or exclusively sampled from these communities, a bias that may drive HIV estimates among this population. This underscores both the need for better data regarding transgender sex workers and for HIV programmes that address their needs.[29]

3.1.3 The HIV situation in Myanmar

In Asia, Myanmar is one of the countries hardest hit by the HIV epidemic. In 2014, the National AIDS Programme (NAP) reported an estimated 200,000 people aged 15 and above living with HIV. HIV prevalence in the general adult population in Myanmar has been declining steadily over the last decade.

Although HIV prevalence among people aged 15 and above was 0.54%[30] in 2014, it remained considerably high among specific populations such as PWID (23%[v]), MSM (6.6%) and FSW (6.3%).[31]

In 2013, HIV prevalence was estimated at 10.4% in MSM aged 15 and above, up from 7.8% in 2011. Data suggest that younger MSM (aged 15–24 years) are at high risk with HIV prevalence fluctuating from 7.1% in 2010 to 4.5% in 2012 to 8.8% in 2013.[32] However, this HIV Sentinel Sero-Surveillance (HSS) data must be considered with caution because they largely reflect the situation of people who are in contact with services as HSS is carried out at health facilities.

More representative data are needed to analyse the situation among KPs at large. Community- based IBBS surveys and populations size estimates (PSEs) were completed by the Ministry of Health among PWID in 2014 and will be conducted among MSM, TG and FSW in 2015. The results of these latter surveys are expected in early 2016.

The current PSE for MSM is 240,000.[33] The estimated number of TG is not available. One of the key issues raised during the 2014 consultation on the Gender Assessment of the National HIV Response in Myanmar was that there was a need for separate data on TG, as TG were included in the MSM population in terms of surveillance and programme data. According to a study conducted by the INGO Population Services International (PSI) in 2008, HIV prevalence among TG was around three times higher than prevalence among MSM.[34] Furthermore, it is not appropriate to refer to TG as MSM as some TG identify as women, and some experience their gender in ways that are non-binary.

3.2 HIV risk factors and vulnerabilities among MSM and TG

Structural and legal factors, such as those related to stigma and discrimination, violence based on sexual orientation and gender identity, and the criminalization of same-sex sexual practices, contribute to hindering access to HIV prevention, treatment and care services among MSM and TG, which results in their being disproportionately affected by HIV in all countries and in all settings. These disproportionate risks reflect both sexual and other high-risk behaviours common among members of MSM and transgender communities and specific legal and social issues that increase their vulnerability.

[v] Data collected by the IBBS among PWID at 16 sites in 2014 found HIV prevalence in this group to be 28.3% (National AIDS Programme. Global AIDS response progress report Myanmar: January 2014 – December 2014, 2015)

3.2.1 Sexual and other high-risk behaviours

HIV transmission through unprotected anal intercourse is more efficient than through vaginal intercourse without a condom. Identified individual-level risks for HIV infection among MSM include unprotected receptive anal intercourse and a high number of male sexual partners. Some MSM may engage in more than one high-risk behaviour, such as selling sex or injecting drugs, and these populations are more likely to have higher rates of HIV infection than those with only one type of risk factor.[35]

Within the global context, adolescent and young MSM are at even higher-risk of HIV infection.[36] Low risk perception among young MSM and high levels of multi-partner sex fuelled by the use of amphetamine-type substances create the conditions for low condom use, even when people are aware of the risks.[37] Policy and legal barriers related to the age of consent often prevent adolescent MSM from accessing health services, including HCT.[38]

Risks for HIV infection among TG include unprotected receptive anal intercourse and/or unprotected neo-vaginal intercourse. Some TG may also inject drugs or hormones for gender affirmation. The sharing of injecting equipment places them not only at high-risk for HIV infection, but also for other blood-borne pathogens, such as hepatitis B and C.

TG who engage in sex work are especially at risk of HIV infection. In 2008, a systematic review and meta-analysis of 25 studies among 6,405 participants recruited from 14 countries compared an overall HIV prevalence among transgender sex workers (23.7%) and transgender non-sex workers (14.7%). Country reports suggest that HIV prevalence for transgender sex workers is, on average, nine times higher than for cisgender[vi] female sex workers, and three times higher than for cisgender male sex workers.[39]

In addition to individual-level risk behaviours, globally HIV transmission among MSM and TG is driven by network-level factors, including the size of an individual's sexual network, the efficiency of HIV transmission through unprotected receptive anal or neo-vaginal intercourse, the sexual role versatility of MSM and TG, and the high proportion of new infections due to onward transmission of recent and acute infections. All of these factors are likely affected by the proportion of untested and untreated PLHIV in the Asia and Pacific region.[40]

[vi] The term "cisgender" is used to refer to a person whose gender identity corresponds with the sex they were assigned at birth.

3.2.2 Stigma, discrimination and social exclusion

Stigma and discrimination contribute to HIV risk among MSM and TG around the world, and hinder the availability, access and uptake of HIV prevention, testing and treatment services among these populations. Studies have linked HIV-related stigma with delayed HIV testing and counselling, non-disclosure to partners and poor engagement with HIV services.[41]

Increasing access to prevention programming, culturally sensitive HCT and antiretroviral therapy (ART) for MSM is an urgent global health priority. Fewer than one in 10 MSM may be receiving a basic package of HIV prevention interventions, and MSM often have extremely limited access to HIV prevention commodities, such as condoms, water-based lubricants, HIV education and support for sexual risk reduction. Current levels of HIV testing, standing below 55% in all regions, are insufficient to link MSM to care in sufficient numbers to effectively reduce HIV transmission. TG also face stigma and ill treatment, including refusal of care, harassment, verbal abuse and violence in health-care settings.[42] Despite evidence of heightened HIV vulnerabilities and risks, resulting in high HIV prevalence among TG, the coverage of HIV prevention programmes among this population remains poor across all regions, including Asia and the Pacific.[43] Moreover, stigma and discrimination in the health system, alongside limited expertise with respect to HIV prevention, treatment and care among TG, deter individuals from using services.

Social exclusion also contributes to TG's increased vulnerability to HIV infection. Globally, many TG lack legal recognition of their affirmed gender and therefore lack papers that reflect their gender identity. Without appropriate identity papers, TG are excluded from education, employment, and appropriate health care. Evidence suggests that, in some settings, a significant proportion of young TG engage in sex work due to the lack of other opportunities. Social exclusion affects their self-perception and sense of self-worth, and may contribute to depression, anxiety, drug and alcohol use, self-harm and suicide.[44]

In Myanmar, many MSM and TG face discrimination from family, friends, teachers, classmates, peers and employers due to their sexual orientation or gender identity. Families are sometimes more concerned about the reputation of the family than the safety of the family member. Friendships might suddenly stop if one's sexual orientation or gender identity were suspected, and MSM and TG might be prohibited by their family members from socialising with other gay or transgender individuals. MSM and TG sometimes receive instruction from family members on how they should change their behaviour, including changing their style of dress, who they socialise with, how they portray their gender and who they are oriented to sexually.

In school, TG might be prevented from dressing in accordance with their gender and/or might be verbally denigrated by teachers, classmates, or professors. Entering the monkhood might be prohibited and finding employment might be difficult, even if well qualified. Being discriminated against often leads to self-censorship and to publicly repressed identity.[45] It is little wonder that MSM and TG are reluctant to attend health services where they will be asked to disclose their most intimate details.

3.2.3 Sexual orientation and gender identity (SOGI) and violence

High levels of physical, psychological and sexual violence against MSM and TG have been reported worldwide, including extortion, humiliation, discrimination and physical violence (such as rape) based on SOGI.[46] However, reported rates of violence against MSM and TG are likely to be underreported, especially where same-sex behaviours are a criminal offence.

The mid-term reviews of United Nations 2011 Political Declaration on HIV and AIDS targets and elimination commitments in Asia and the Pacific highlighted how gender-based violence, including the threat or fear of violence, makes MSM and TG, in addition to women and girls, more vulnerable to HIV and other sexually transmitted infections (STIs). The violence is often sexual, and reports of rape and sexual coercion are common. Vulnerability may be linked to a variety of factors, ranging from physical trauma that increases the risk of HIV infection to complexities around negotiating safer sex. Within the regional context, two key perpetrators of violence against MSM and TG were found to be health workers and police officers. Legal protections for MSM and TG are often limited or completely lacking in Asia and the Pacific due to the criminalisation of male-to-male sex.[47]

In Myanmar, MSM and TG have reported that verbal harassment and threats by the police are a common experience, both in public and in detention. Threats to "out" a person as gay or transgender to family and community members, threats of violence, and threats of longer prison sentences have reportedly been used as methods of coercion by police to elicit bribes and confessions to crimes that were not committed by the MSM and TG held for questioning. Verbal abuse is reportedly often accompanied by physical abuse, such as kicking, beating with a wooden stick, torture and being forced to strip. Those who are visibly transgender are said to be at higher risk for verbal and physical harassment, including head shaving, and subject to sexual abuse – forced stripping, fondling, slapping or squeezing of breasts, forced oral sex and anal intercourse (rape), including gang rape. Physical and sexual abuse may also be perpetrated by friends and family members.[48]

3.2.4 Criminalisation of same-sex relations

There are 38 UN member states in Asia and the Pacific of which 18, including Myanmar criminalise same-sex relations.[49] The country still retains the colonial legacy of its Penal Code, which is based on the Indian Penal Code of 1860. Section 377 of the 1860 Penal Code, inherited from British colonial rule, states that:

> ***Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term, which may extend to ten years, and shall also be liable to fine.[50]***

Although the phrase "carnal intercourse against the order of nature" is not defined clearly in the Code, similar provisions in other former British colonies have been interpreted to encompass oral and anal sex.[51] The lack of reference to force or involuntariness has been taken to mean that the law applies to adult sexual conduct, public or private, regardless of whether the conduct is consensual, coerced or forced. Male consensual homosexual conduct is in effect interpreted as "unnatural," the penalty for which can be imprisonment for up to 10 years, and a fine.[52]

Section 377 contributes to an environment of limited social acceptance for MSM and TG. Although the law is rarely enforced, the existence of the offence remains a critical barrier to the delivery of effective HIV prevention, treatment and care services because it prevents CBOs from being registered with the state and discourages MSM and TG from accessing services. Section 377 further adds to stigma and drives MSM and TG to live in a secretive and unprotected environment where access to HIV services and commodities is constrained by the need to disclose same-sex behaviour. Moreover, behaviour change communication materials cannot be explicit because of government censorship policies.[53]

Section 377 however, is the only statute that offers protection from same-sex rape and child sexual abuse. The law serves as both a tool of protection and a tool of discrimination. The solution would be to enact laws that protect people from all types of sexual assault and abuse, regardless of the sexual orientation of the victim and perpetrator, and to enact laws specifically for the protection of children.[54] In addition to Section 377, police have used public order laws against MSM and TG in Myanmar. MSM and TG are usually detained under Section 30(d) Rangoon Police Act of 1899 or Section 35, Police Act of 1945 for loitering or suspicious activity, or under Section 54 Code of Criminal Procedure, which gives police the power to make arrest without a warrant.[55]

The Rangoon Police Act allows for the punishment of "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," while the Police Act of 1945 echoes these words without the specification of "between sunset and sunrise." The wording is thus vague enough to enable police to target anybody they deem suspicious or undesirable. Their maximum prison term of three months is less severe than Section 377's 10-year penalty. People arrested under these laws usually comply out of fear of escalating the charges to Section 377.[56]

If the arrested person resists or protests during arrest, the police might then threaten to charge them with a violation of Section 377. It has also been reported that some police officers extort money from MSM and TG, 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 Section 377 carries a heavy prison sentence. MSM and TG may also face harassment and assaults, including sexual violence, while in police detention.[57]

Documented incidents of abuse of MSM and TG vary in detail, but they exhibit recurring patterns: MSM and TG are usually arrested at public venues popular among their community, or when they are walking or standing on the streets at night. The laws are known colloquially as "in the shadows" laws.[58]

3.3 HIV prevention, treatment and care among MSM and TG in Myanmar

The World Health Organisation (WHO) has introduced the Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, bringing together all existing WHO guidance relevant to KPs. The guidelines include a comprehensive package of interventions and critical strategies for strengthening the enabling environment required for successful implementation of HIV prevention, treatment and care programmes for KPs.

THE COMPREHENSIVE PACKAGE

a) Essential health sector interventions

1. Comprehensive condom and lubricant programming
2. Harm reduction interventions for substance use (in particular needle and syringe programmes and opioid substitution therapy)
3. Behavioural interventions
4. HIV counselling and testing
5. HIV treatment and care
6. Sexual and reproductive health interventions
7. Prevention and management of co-infections and other co-morbidities, including viral hepatitis, tuberculosis and mental health conditions

b) Essential strategies for an enabling environment

1. Supportive legislation, policy and financial commitment, including decriminalisation of certain behaviours of key populations
2. Addressing stigma and discrimination
3. Community empowerment
4. Addressing violence against people from key populations

Source: World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.

The comprehensive package will be used to guide the review of HIV prevention, treatment and care among MSM and TG in Myanmar.

3.3.1 Essential health sector interventions

"Health services should be made available, accessible and acceptable to [key populations], based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health."[59]

Behavioural interventions

In Myanmar, the 2009 IBBS found that 69.1% of respondents had been reached with HIV prevention programmes.[vii] Behavioural surveillance data are yet to measure progress made through the scale-up of interventions targeting MSM and TG. Data from routine monitoring have shown that the number of MSM and TG reached by prevention interventions decreased between 2010 and 2012.[60]

The mid-term review (MTR) of the NSP II suggested that this decrease in coverage was primarily due to changes in monitoring and reporting. To avoid double or multiple counting of people reached by a given service, stricter head counts were required. The largest numbers of MSM and TG reached by prevention interventions were in Yangon and Mandalay.[61]

In 2013, the total number of MSM reached by HIV programmes was 82,363 (high estimate[viii]). After adjustment to eliminate double counting, the "low" figure was 44,343 MSM reached.[62] Both figures (high and low) indicate an increase in the number of MSM reached with HIV prevention activities compared to the figures reported in 2012, and 68,067 (high)[63] and 32,905 (low) (see table below).

Table 1: MSM and their regular female sexual partners programme data, 2010–2013

Indicator	Size estimate	Baseline 2010	Target 2012	Results 2013	Target 2013	Results 2013
# of MSM reached by a package of behaviour change communication and STI prevention/treatment	240,000	High: 79,522 Low: 54,863	70,000	High: 68,067 Low: 32,905	75,000	High: 82,363 Low: 44,363
# of female sexual partners of MSM and clients reached with HIV prevention programmes		NA	2,813	263	3,375	504

Source: Progress Reports 2012 and 2013: National Strategic Plan on HIV/AIDS in Myanmar

[vii] According to the definition of GARP indicator 1.11 Percentage of individuals answering "yes" to both questions: "Do you know where you can go if you wish to have an HIV test?" and "In the last twelve months, have you been given condoms?"

[viii] Double counting of individuals reached by services can occur where there is more than one organisation providing services in the same geographical area. The "low" figure is the number of individuals reached by the organisation reported to have reached the largest number of individuals in each township. The "high" figure is the total number of individuals reached by all organisations.

It is important to also reach the sexual partners (including clients of sex workers) of both MSM and TG to prevent onward transmission and ensure that infected partners are linked with appropriate treatment and care. Clear strategies for reaching female sexual partners of MSM and TG with HIV prevention programmes are lacking. Only 263 female partners of a target of 2,813, or 9.3%, were reached in 2012.[64] In 2013, 14.9% or 504 of a targeted 3,375 regular female partners were reached.[65]

Comprehensive condom and lubricant programming

Condom programming is an integral component of effective HIV prevention. When used correctly and consistently, condoms remain one of the most effective technologies available to prevent sexual transmission of HIV. In the 2009 IBBS among MSM, the use of a condom at last anal sex with a male partner was reported by 81.5% of respondents.[66] However, condom use is generally believed to be over-reported by respondents in order to please interviewers.

In 2013, more than 18 million of condoms were sold through social marketing and more than 21 million were distributed for free in Myanmar (to general population and all key populations).[67]

HIV counselling and testing

In Myanmar, most MSM are reluctant to disclose their same-sex behaviour while accessing public services, out of fear of stigma and discrimination, and will not risk being exposed by attending HIV services that specifically target MSM.[68]

The 2009 IBBS among MSM found that, in Yangon, the percentage of MSM and TG who had received an HIV test in the past 12 months and knew their results was 47.6%.[69] Routine monitoring data show that HIV testing among MSM and TG increased by 83% between 2010 and 2012, but the testing rate among MSM and TG is still far lower than the target set in the revised NSP II of 55% by 2015.[70]

Table 2: MSM and their regular female sexual partners programme data, 2010–2013

Output/coverage targets	Size estimate	Baseline 2010	Target 2011	Results 2011	Target 2012	Results 2012	Target 2013	Results 2013
MSM receiving HIV test and post-test counselling VCCT	240,000	6,932	16,250	12,535	17,500	12,694	18,750	17,472

Source: National AIDS Programme. Progress Reports 2011, 2012, 2013: National strategic plan on HIV/AIDS in Myanmar

During 2013, the NAP launched a decentralised HCT plan and more than 90 townships started providing decentralised HCT services. According to the plan, almost all townships across the country will be delivering HCT by 2016. In the context of decentralisation of testing and treatment and the introduction of rapid HIV tests, more NGOs will be trained to provide HCT on a much larger scale and also in hard-to reach areas of the country.[71] The decentralisation of HCT should facilitate achievement of testing targets and allow different models of services provision, such as mobile outreach for HCT. However, much remains to be done to address stigma and discrimination in health facilities, and in communities at large, in order to reach non-disclosed MSM.[72]

Treatment, care and support

ART is provided in Myanmar by the NAP and by international and local NGOs. In 2007, the number of PLHIV receiving ART was 11,000. At the end of 2014, 85,626 persons were receiving ART.[73] This represented 69.7%[ix] of all those in need of treatment, as specified in national treatment guidelines.

The exact number of MSM and TG who are eligible to receive ART is not known. The number of MSM and TG receiving ART is also unknown as routine monitoring data of this kind are fragmentary.[x] There is also no universal unique identifier system that allows tracking of MSM, TG and other KPs across different prevention, treatment and care services.

Prevention and management of co-infections and other co-morbidities

Within Myanmar, MSM and TG are frequently co-infected with HIV, viral hepatitis, tuberculosis and/or other infectious diseases. Mental health conditions are also common among these populations. Integrated services provide the opportunity for patient-centred prevention, care and treatment for the multitude of issues affecting MSM and TG. In addition, integrated services facilitate better communication and care. Thus, according to the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, service delivery for MSM, TG and other KAPs should be integrated wherever feasible. When this is not possible, the guidelines recommend strong links among health services working with KAPs are established and maintained.[74]

[ix] In 2013, the nationally approved treatment protocol (following WHO/UNAIDS standards) stipulated that all PLHIV with CD4 cell count of less than or equal to 350 were eligible to receive ART free of charge. In 2013, 69.7% represents the percentage of patients on ART against the universe of need of ART services (122,860 in need of ART).

[x] HCT clients are not systematically identified as belonging to a particular KP.

Prevention, diagnosis and treatment of tuberculosis

In Asia and the Pacific, almost all countries report a lack of robust routine monitoring systems despite having tuberculosis (TB) and HIV committees. Collaboration between HIV and TB programmes has so far been limited, even if they are both located within health ministries.[75]

The 2012 target of (2,752) TB patients testing positive for HIV and starting ART in the National Strategic Plan was exceeded by 262 per cent (7,152) so the 2015 target of 6,836 has already been surpassed.[76] HIV testing is available in the TB clinics of TB-HIV townships[xi] and TB testing is available in ART service centres. Once diagnosed with TB, HIV-positive patients are referred to National Tuberculosis Programme service providers. Similarly, TB patients diagnosed with HIV are referred to NAP service providers.[77]

In Myanmar, data on TB testing are not disaggregated by sexual orientation or gender identity. Therefore, the number of MSM and TG with TB is unknown, as is their HIV testing rate. The rate of TB testing among HIV positive MSM and TG is also unknown.

Prevention, vaccination, diagnosis and treatment for viral hepatitis

Hepatitis B (HBV) and hepatitis C (HCV) disproportionally affect KPs as a result of sexual transmission and sharing of needles, syringes and ancillary injecting equipment. Among those living with HIV who are co-infected with hepatitis B or C, liver disease progresses more rapidly and mortality is greater than among those with hepatitis B or C who are not living with HIV.[78]

National prevalence of hepatitis B and C among MSM and TG in Myanmar is unknown. The 2015 IBBS among MSM and TG will perform hepatitis B and C testing. A national prevalence survey on hepatitis B and C was initiated in May 2015 to assess the magnitude of the problem among the general population. The findings of this survey carried out by the Department of Medical Research and the Department of Public Health should be available by the end of 2015.

A study conducted by Médecins du Monde in Myanmar from January 2005 to December 2013 screened FSW, MSM and PWID for hepatitis B and C during enrolment in ART. Hepatitis B vaccination was offered to patients who were eligible. The percentage of patients co-infected with HBV and with HCV is described in the tables below.

[xi] Townships where HIV and TB services are integrated.

Table 3: Patients coinfected with HIV and HBV

Key Population	Co-infected HIV/HBV
MSM (n=591)	15.2%
PWID (n=573)	14%
FSW (n=400)	10.3%

Table 4: Patients coinfected with HIV and HCV

Key Population	Co-infected HIV/HCV
MSM (n=580)	5.7%
PWID (n=571)	59.7%
FSW (n=382)	9.2%

It was concluded that hepatitis B and C co-infections were common among KPs and that prevention and treatment of viral hepatitis should be assessable and linked with HIV prevention and care programs.[79]

The extent to which hepatitis B vaccination is offered to MSM and TG in Myanmar is unknown but can be assumed to be low. There is currently no vaccine for hepatitis C.

In a survey conducted by WHO in 2012, the Government of Myanmar reported that publically funded treatment of hepatitis B and C was available, though information was not provided on who was eligible for it.[80] However, the National guidelines, a core package for HIV prevention amongst key populations in Myanmar states that, due to prohibitively high costs, hepatitis C treatment is not yet available in public settings in Myanmar, though limited numbers of HIV-hepatitis C co-infected patients are accessing treatment through the private sector. One INGO is planning to pilot treatment for a small number of co-infected patients.

The Ministry of Health is in the process of developing clinical guidelines and standard operational procedures for hepatitis C with the technical assistance of the Clinton Health Access Initiative (CHAI) and the National Liver Foundation with the aim to provide hepatitis C treatment at lower cost by the end of 2015.[81]

Mental health

In addition to being disproportionately burdened by HIV, MSM, TG and other KPs experience higher rates of depression, anxiety, smoking, harmful alcohol use and alcohol dependence, other substance use and suicide as a result of chronic stress, social isolation, violence and disconnection from a range of health and support services.[82] WHO has recommended that routine screening and management for mental health disorders (particularly depression and psychosocial stress) be provided to people from KPs who are living with HIV, in order to optimise health outcomes and improve adherence to ART.

Regional averages of data collected in 2008-2012 for the Stigma Index of People Living with HIV in Asia and the Pacific revealed that 61% of respondents reported feeling ashamed because of their HIV status and 23% had felt suicidal because they were living with HIV.[83] While these data are not specific to MSM and TG, these populations may be at higher risk of suicide because of the "double stigma" associated with HIV and with same-sex behaviour.

The social exclusion experienced by some MSM and TG may affect their self-perception and sense of worth and may contribute to depression, anxiety, drug and alcohol use, self-harm and suicide.[84]

3.3.2 Building an enabling environment

Supportive legislation

"Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from [KPs]"[85]

There has been some progress in addressing stigma, discrimination and punitive laws that undermine AIDS responses in Asia and the Pacific. This has included significantly improved strategic information on stigma and on legal and policy barriers, the implementation of key programmes that reduce stigma and discrimination and increase access to justice, and reform of laws and policies that impede effective responses.[86]

In Myanmar, the results of the MTR of the NSP have been used to update and improve the strategic plan. For example, recognising that the HIV response will not be successful without a supportive, enabling environment, more emphasis was placed on important cross-cutting issues such as gender, human rights and legal issues.[87] A comprehensive legal review was carried out in 2013 as part of the MTR of the NSP, and concluded that there were still many laws that hampered the national

response to HIV. Although diminishing, stigma and discrimination against PLHIV and KPs persist. Behaviours of KPs remain illegal, and FSW, MSM, TG and PWID are still harassed and arrested.[88] Awareness has been heightened through important documents, such as the National HIV Legal Review Report and Facing 377: Discrimination and Human Rights Abuses Against Transgender, Gay and Bisexual Men in Myanmar.

However, still more needs to be done to advocate for acceptance and justice for these populations, and for the adoption of a public health approach to community protection.

Addressing violence against MSM and TG

In mid-term reviews of the United Nations 2011 Political Declaration on HIV and AIDS targets and elimination commitments, most countries in Asia and the Pacific reported signs of progress in relation to the prevention of violence against KPs, citing efforts to address gender inequalities through the development of national laws, strategies, programmes, mechanisms and assessments related to gender, gender-based violence, health and human rights. However, few countries have HIV policies or programmes that prioritise gender equality and address the full range of vulnerabilities faced by women, men and TG through gender-sensitive programmes.

In Myanmar, the Core Package for HIV Prevention amongst Key Populations suggests that, to address violence against members of KPs, particularly gender-based violence against women and TG, service providers can document incidents of violence and provide and/or refer individuals to appropriate services, where available, including health care, emergency contraception, post-exposure prophylaxis, diagnosis and treatment of STIs, counselling, legal assistance, psychosocial support and shelter.[89]

4. Analysis of key informant interviews and focus group discussions

Peer educator provided Health Education Session at Drop-in-Centre *(Source - Top Centre-PSI)*

HIV and STI knowledge sharing session among peers *(Source - Top Centre-PSI)*

4. Analysis of key informant interviews and focus group discussions

The HIV response among MSM, TG and their partners in Myanmar is still in its first decade. While overall programme coverage has exceeded targets, a large population of non-disclosed MSM has not been duly reached. Through an extensive set of interviews with key informants, and focus group discussions with community members, a fuller understanding of the response was developed. Findings from the interviews and discussions encompassed recent successes and achievements, as well as challenges and barriers, in the response to HIV among MSM and TG in Myanmar. In addition, respondents suggested strategies for improving the enabling environment and further strengthening the HIV response among these populations.

4.1 Successes and achievements

Key informants identified many successes and achievements in their own work and in the national HIV response more broadly. The most frequently mentioned successes and achievements are mentioned here:

4.1.1 Establishment of services in a restrictive environment

According to key informants, one of the primary reasons for delayed progress in the national response to HIV among MSM and TG is the highly restrictive legal environment. Although Penal Code, Section 377 is rarely enforced, it is alleged to complicate the delivery of effective HIV prevention interventions. In spite of this restrictive and uncertain environment, drop-in centres

were established to provide safe spaces for MSM, TG and other KPs to gather and to access important HIV prevention and STI treatment services.

> ***"At the time, it was quite an accomplishment to set up drop-in centres to serve as safe spaces and educational centres for key populations. No one was confident [of success] at that time but now many of the centres have been in operation for more than 10 years with more and more services added." (INGO source)***

Today most drop-in centres offer outreach and peer education, HCT services, targeted prevention media, condom distribution, and STI treatment, among other services.

> ***"The drop-in centre provides a safe space to meet friends, ask questions on health, get food and condoms, and have the freedom to be yourself. There is also group entertainment, clinical services, and free Wi-Fi service." (Community source)***

4.1.2 Declining HIV prevalence among MSM

Many key informants acknowledged that HIV programming among MSM and TG in Myanmar had shown results. Prevention information through outreach and peer education, expanded access to HCT and treatment, and the distribution of more than 30 million condoms across the country was cited as having contributed to declining HIV prevalence among MSM.

> ***"HIV prevalence among MSM has declined in a big way since 2007. Although it has not stayed at its lowest level, it has remained at about 10%. This provides some evidence for us that the interventions being implemented are having an effect. Of course we would like to see the prevalence fall below 5%." (Government source).***

4.1.3 Decentralisation of HIV testing, treatment and care

Key informants from service provision agencies remarked that the NAP launched a decentralised HCT plan in 2013, accompanied by an expansion of ART provision by a larger number of public, private, NGO and community-based sites across Myanmar. Decentralisation had provided an opportunity for them to explore innovative approaches to HCT. Some service providers were planning mobile/outreach services to sites where MSM and TG gathered, including counselling and testing at TG-friendly salons.

> ***"Previously, the MoH controlled everything. Decentralisation of HCT services has allowed more people to know their status and access treatment." (Development partner)***

> ***"Decentralisation has led to new HCT and ART centres in new areas of the country. Since it began, the number of MSM receiving an HIV test has increased by 25%. INGOs are also providing comprehensive 'one-stop' services to this group." (Government source)***

> ***"There is now greater access to HCT, follow-up testing and ART, as well as other services such as nutritional support, TB and STI treatment." (CBO source)***

> ***"Decentralisation of HCT has allowed some NGOs and CBOs to provide services as long as they have a NAP-trained counsellor, lab and test kits. NGOs and CBOs are only able to provide HIV screening tests and must refer clients to public services for confirmation testing. Some INGOs with higher capacity are providing comprehensive one-stop services, from HCT services with confirmed results to the provision of ART." (UN source)***

4.1.4 Public health advocacy and condoms

While outreach services, peer education programmes and access to clinical services had provided greater access to condoms, respondents said MSM and TG were previously reluctant to carry them because law enforcement personnel used condoms as evidence of sex work or intention to do sex work. Advocacy by NAP to the law enforcement sector on the importance of condom use in the prevention of HIV and other STIs, as well as education for the Myanmar Police Force on HIV prevention, helped to change this position. The Ministry of Home Affairs issued an unpublished internal directive in 2001 instructing police not to use possession of condoms as evidence of sex work or intention to engage in sex work.[90]

> ***"Instructions were given to the police forces at the State and Division level that persons should not be arrested for carrying condoms. The carrying of condoms is not evidence of sex work." (Government source)***

> ***"Arrests are still made but for other reasons. We have not heard of any recent arrests for carrying condoms." (Community source)***

Although some community members said MSM and TG were still concerned that carrying condoms might lead to questioning or harassment by police, making them reluctant to do so, participants in focus group discussions in Mandalay, Pathein, and Yangon acknowledged that they had not heard of any recent arrests for carrying condoms.

4.1.5 Emergence of MSM and TG networks and self-help groups

Respondents noted that the establishment of MSM and TG networks and self-help groups in Myanmar had resulted in increased civil society engagement in the national HIV response. They said networks and self-help groups had become increasingly proactive, engaging in policy discussions and highlighting key issues affecting their constituents. Key informants also observed government and non-government entities were increasingly committed to supporting the meaningful engagement of MSM and TG in HIV policy and programming.

> ***"The Myanmar MSM Network has representation on the Joint Parliament and Community Committee on HIV and Human Rights. MSM can now voice concerns over [Penal Code, Section] 377 and be heard." (NGO source)***

4.2 Challenges and barriers to expanding the HIV response among MSM and TG in Myanmar

In addition to identifying successes and achievements, key informants and community members identified challenges and barriers that impacted adversely upon the response to HIV among MSM and TG in Myanmar. Themes most commonly raised by respondents are as follows:

4.2.1 Legislation, policy and practice

Penal Code, Section 377, which implicitly prohibits homosexual behaviour throughout Myanmar was said to create an environment that discouraged MSM and TG from accessing available services. Although Parliament is currently reviewing many laws, respondents felt there was little political will to either abolish or amend the law.

> ***"Penal Code, Section 377 and social attitudes permeate decision making. Politicians want to get re-elected so they are unwilling to take up disliked causes." (UN source)***

Since the law has been rarely used in court, there have been mixed arguments on whether or not it is necessary to amend or abolish it. Little political will exists among law enforcement to change the law, and parts of the law are still necessary to protect others, especially children.

> ***"What happens between consenting adults in private is of no concern to the police. Law enforcement cannot take action based on reports from community or family members. Only direct evidence can be considered grounds for arrest. However, reports of underage or coerced sex must be investigated." (Government source)***

Some key informants mistakenly conflated the issue of same-sex relations between consenting adults with the issue of child sexual abuse.

> ***"There is a counter argument that the law protects children from sexual molestation and paedophiles and the recruitment of young MSM." (INGO Source)***

Others maintained the existence of Section 377 made MSM and TG more compliant in interactions with the police and less likely to report police abuse or the payment of fines. Key informants said the law also discouraged MSM and TG from accessing available services.

"The law [Penal Code, Section 377] is still there and can be used at any time" (NGO source)

"[Penal Code, Section] 377 is like a black shadow that follows MSM all the time." (Community source)

4.2.2 Attracting non-disclosed MSM to services

According to respondents, not all MSM and TG feel comfortable using the HIV-related services that are available to them. Stigma and discrimination from service providers and community members prevent some MSM and TG from using services. Some people worry that their same-sex behaviour will be disclosed to the community just by attending services that are known to target MSM. As a result, some choose to attend mainstream health services where they may not receive targeted prevention information.

Government clinics were said to be the primary provider of HCT services to the general public. However, according to respondents, MSM and TG face stigma and discrimination from government services providers, as well as gaps in understanding about same-sex behaviour and the medical service needs of MSM and TG. When non-disclosed MSM attend government services, respondents said they were unlikely to disclose their same-sex behaviour.

"Public services are not friendly to youth or to MSM. They provide no privacy and raise fears that confidentiality will not be assured." (NGO source)

"Counselling is limited at government services. When it is available, staff often display a blaming attitude. Physicians do not understand MSM service needs." (NGO source)

"Government hospitals are the worst places for services. They are not very professional, even in rural areas. In urban settings, MSM never receive a full body exam[xii]." (Community source)

[xii] The meaning here is that MSM never receive a thorough examination – oral, penile and anal – for STI.

An alternative to the government clinical services are the drop-in centres. Drop-in centres for MSM were first set up in 2004 to provide health services in stigma and discrimination-free zones. But key barriers for many MSM in accessing drop-in centre services include the service hours, which are generally 9:00am-4:00pm Monday to Friday, and the fear of being identified as MSM just by attending services.

> ***"Services are generally offered Monday to Friday only, which limits access to services for people who work." (NGO source)***

> ***"MSM focused services can be a barrier. Many MSM do not want to attend this type of service because they do not want to be identified as MSM." (NGO source)***

> ***"My friends do not want to come here. They are afraid that someone they know will see them and word will spread within the community that they are MSM or transgender." (Community source)***

> ***"Some of the services are very good, but the location of the services with communities creates a lack of privacy. Transportation to and from the services can be difficult. Clients notice the stigmatising looks of community members as they walk to the centre." (Community source)***

Over the years, more and more services have been provided through the drop-in centres. Key informants provided examples of information, training, and social and cultural services for MSM and TG. However, there was growing concern that HIV prevention and related services were no longer the focus of the drop-in centres, and that new models in HIV service provision were needed.

> ***"Centres set up for prevention have become 'safe spaces' and have taken on other agendas, such as 'rights advocacy' so that focus on HIV prevention has been lost. A shake-up in services is needed." (Development partner source)***

> ***"DIC have served their purpose. New models for HIV services are needed." (INGO source)***

A number of respondents involved in outreach and peer education disclosed that MSM and TG who were unwilling to attend drop-in centres were sometimes referred to sexual and reproductive health (SRH) services and private clinics for testing and/or treatment of STIs. INGO SRH services and a number of clinics in the Sun Quality Health Network[xiii] were considered MSM and TG friendly. However, respondents noted most private clinics did not offer counselling services. Therefore, appropriate HIV prevention and harm reduction messages were not always communicated to MSM and TG because detailed risk assessments were not conducted.

> ***"MSM clients may access SRH services but still feel uncomfortable about disclosing same-sex behaviour. Service providers are also hesitant to investigate whether a client engages in same-sex behaviour." (INGO source)***

> ***"There are four to five private clinics in Yangon that are considered MSM friendly, but they do not yet provide counselling services. Same-sex behaviour may not be revealed nor appropriate prevention discussed." (INGO source)***

4.2.3 Technical capacity and retention of staff

Key informants commented that the retention of skilled staff, both technical and administrative, was an issue for all agencies. Trained staff could often find better positions at other organisations or in the private sector.

> ***"High turnover leads to endless capacity building and lack of institutional memory." (Development partner source)***

> ***"There is a high turnover among medical staff. It is difficult to compete with other agencies with more funding." (INGO source)***

[xiii] The Sun Quality Health Network is a franchise of licensed private sector general practitioners and community health care workers that serve low-income clients. Services include newborn and pediatric care, family planning, post-abortion care and HIV, TB, STI and malaria services.

> ***"CBOs have the highest rate of turnover among staff. There is a continuous need to build skills in financial management, monitoring and evaluation, general data management and report writing, as well as the necessary skills for outreach and peer education." (INGO source)***

Some of the turnover has been attributed to stigma among staff toward KPs.

> ***"Stigma among own medical staff is also a factor." (INGO source)***

Turnover was identified as a problem within organisations, and as a barrier to good working relationships between organisations. Key informants said good working relationships might be established between the government sector and the NGO/CBO sector, but when staff move to other positions, the process of relationship building must begin again.

> ***"Turnover is a problem in the police force, CBOs, NGOs and local authorities. There are floating populations on all sides. There needs to be a mechanism to provide information on good practices to successors." (Government source)***

4.2.4 Guidelines and standard operating procedures

National HCT guidelines

Some key informants voiced concerns that, while there was considerable support for decentralisation of HCT services, the national guidelines on HCT services had yet to be finalised. They explained that these guidelines were needed for advocacy to policy makers and for setting standards for service providers.

> ***"The guidelines are necessary for advocacy when you need to speak to decision makers who don't understand the need for, or the process of, HIV counselling and testing and treatment services." (NGO source)***

> ***"Finalised national guidelines for HCT might help in getting public services to improve their services for key populations." (NGO source)***

As the decentralisation of services continues, respondents said the guidelines could be useful in developing HIV counselling, testing and referral services and policies, not only in traditional service settings (e.g. drop-in centres, STI clinics and private physicians' offices) but also in non- traditional settings, such as mobile clinical services, which are being planned by several agencies to provide access to services for KPs. The guidelines could be especially important in providing strategies for the identification of non-disclosed MSM through detailed clinical risk assessment. Guidelines are also important in the development of standard operating procedures (SOPs) and quality assurance/ quality control systems.

> ***"The National AIDS Programme has been planning to conduct periodic quality assurance assessments and quality control of testing. Without the national guidelines, core SOPs that are needed to do these assessments may not yet be identified." (INGO source)***

Guidance for outreach and peer education

Key informants suggested that guidelines and/or SOPs were also needed for outreach and peer education, including referral to HCT and/or treatment services, and monitoring and evaluation specific to programmes targeting MSM and TG.

> ***"While some services have very well developed SOPs and quality assurance/ monitoring and evaluation plans, others have no clear criteria for services." (UN source)***

> ***"CBOs and self-help groups often lack SOPs and may find them too complicated." (NGO source)***

Use of social media and web-based applications

Myanmar is currently seeing rapid growth in mobile phone ownership, and internet connectivity. As opportunities are explored to use online media platforms, such as Facebook, for HIV prevention messaging and for follow-up testing, treatment and care, key informants said standards in online service provision were needed in order to protect client privacy and confidentiality. Currently, links to clients are made through existing friendship networks.

> ***"Facebook is used as a tool for outreach. Initial links are made through existing members' friendship networks. The campaign site makes a request to be added as a friend or linked to the user as a discussion group. Information on HIV, STI and referral to services are provided as well as answers to questions." (CBO source)***

While using friendship networks may present opportunities to reach out and provide important HIV prevention information and referrals to MSM and TG, service providers must ensure personal information is not inadvertently divulged to these networks. Clients need to be informed of appropriate steps in linking and using online services to assure confidentiality and anonymity. Social media has also presented greater opportunities for sexual partnering among MSM and TG.

> ***"Sex partnering among MSM and TG is changing. From personal face-to-face encounters, there is a switch to social media, 'sexting', and chat rooms." (INGO source)***

> ***"Sex work contacts are now being made through social media channels." (Community source)***

But there is still little understanding of how sexual risk behaviours among MSM and TG may be facilitated by the nature of these applications, the way they are used, and the process by which sexual pairing occurs via these applications and how prevention messaging may be provided. Key informants from a few different CBOs described how they are providing prevention messaging: They log onto sexual partnering sites and "chat up" site visitors before revealing their intentions to provide prevention education.

> ***"I log onto different sites and show interest in one of the guys online. I then find out what types of sex the guy likes to have and then provide information about HIV risk from each behaviour." (CBO source)***

Outreach workers posing as potential sex partners in order to make contact and exchange messages with individual users before revealing their true purpose online raises a number of ethical concerns. One online outreach worker said that sometimes the "clients" would ask for more information but, at other times, they would fall silent or even "block" the outreach worker from contacting them. Clear SOPs, including a code of ethics, are necessary to protect the outreach worker and client and the integrity of the organisation conducting the intervention.

4.2.5 Multi-sector collaboration

Some key informants believed multi-sector collaboration in relation to HIV prevention among MSM and TG was working well. They noted discussions on MSM and TG programming were scheduled within the meeting agendas of the Technical Working Group (TWG) on STI. Yet, other key informants expressed concern that there was insufficient discussion and attention given to the needs of MSM, TG and other KPs. According to these respondents meetings were too infrequent or not well attended enough to achieve desired outcomes.

> ***"There is no sub-working group for MSM and specific donor to support MSM networks." (UN source)***

> ***"There is no focal person at the National AIDS Programme for key affected populations." (UN source)***

> ***"The STI TWG should be sufficient. If special issues need to be discussed, then workshops with a clear agenda and strong leadership may be sufficient." (INGO source)***

Key informants acknowledged the technical support and strong leadership of UNAIDS on issues related to MSM and TG.

4.2.6 Monitoring and reporting

NGOs and CBOs reported large numbers of MSM and TG being reached through outreach and peer education, but said multiple outreach workers sometimes reached the same individuals. Attempts are reportedly being made to reduce double-counting by establishing zones of work for agencies working in the same community. Key informants acknowledged that clients might still be double-counted as they move from one zone to another, and that the comparison of client registration logbooks is difficult without clear identifiers for each client.

> ***"Zones for work help reduce double-counting. But every Friday, all peers must check for redundancy by comparing logbooks." (NGO source)***

Even with intensive screening of contacts, key informants said it might still be difficult to determine the number of clients reached, how many of these clients were attending services and how many times they were attending each service.

> ***"The numbers of MSM reached are counted but not necessarily linked to any positive action – testing, condom use and treatment." (Development partner source)***

A unique identifier code (UIC), whereby each client is given a unique identification number, was recommended by some key informants to track clients and improve monitoring across services.

> ***"A UIC system would be an improvement in the outreach record system and reduce double-counting. It will make it easier to know how many people have been reached, how many have attended services, and how many are receiving treatment. The codes can be linked for all activities and services." (INGO source)***

Some INGO and NGO service providers in Myanmar are already using a code system to track clients through their own services. However, these systems are generally incompatible with systems set up by other NGOs. Some attempts have been made to establish a standardised UIC based on the UIC system in neighbouring Thailand.

> ***"We have made attempts to develop a unique identifier system in Myanmar, using client initials and birthdates, but it proved very difficult due to the duplication and similarity of names, and many clients are unsure of their birthdates." (INGO source)***

Thus, tracking an individual across different services, and determining what services this person has received, remains a challenge.

4.2.7 Development partners requirements and funding

A few key informants voiced concerns that funding was primarily targeted towards existing services, especially for treatment and care, and not towards innovative new strategies for prevention, such as mobile clinical services.

> ***"New models are needed for reaching MSM and TG for prevention but most of the funding is going toward ART." (Development partner source)***

> ***"Funding often restricts innovation. Sometimes services need to go to the community but funding restrictions may prevent this." (INGO source)***

A number of NGOs and CBOs recognised that adolescent MSM and TG needed to have access to HIV prevention messages and services due to early sexual debut, but said they were constrained by age restrictions on funding, even though the legal age of consent was 16.

> ***"Work is based on donor requirements. Adults 18 and above are targeted while those under 18 present some difficulties. Young MSM and TG need more attention." (NGO source)***

Key informants noted several CBOs and self-help groups were not officially recognised by the state and therefore had difficulty accessing technical support and funding. The organisations and groups were said to be involved in health outreach although little was known of their operations because they fell outside capacity building, monitoring, and reporting networks.

> ***"Self-help groups lack support and funding. They want to be effective in their work and be provided training as well." (NGO source)***

4.3 Improving the enabling environment and strengthening the HIV response for the way forward

4.3.1 Legislation, policy and practice

The Myanmar Parliament is currently reviewing many laws, including Penal Code, Section 377. Both HIV and human rights agencies have been intensifying advocacy efforts to have the law revoked or amended. Key informants acknowledged that the process of legislative change can take many years but, from a human rights and public health standpoint, felt on-going dialogue and advocacy efforts must continue with decision-makers and others that have appropriate connections and influence.

> ***"In spite of the difficulty, legal reform is needed. Agencies concerned need to work with line ministries (e.g. Home Affairs) to repeal or amend 377. It would be better to do away with legislation that affects the public health response." (Government source)***

Some key informants pointed out that there was concern that a repeal of Section 377 could inflame opposition among fundamentalist and nationalist groups that consider homosexuality incompatible with Myanmar culture. Developing broad social support was suggested as one way to counter this opposition.

> ***"Advocacy efforts should target respected community leaders, such as the township medical officer, who is the chairperson of the Myanmar Medical Association at the township level, to promote reform from both sides." (UN source)***

4.3.2 Targeted information, education and communication

Outreach and peer education

According to respondents, offline outreach and peer education is still considered the most important channel for reaching MSM and TG outside of Yangon and other major cities, although regular capacity building is required.

> ***"Peer outreach is the most effective way to reach MSM at this time. Capacity building on how to approach MSM and refer them to services is needed." (NGO source)***

Some of the key informants shared specific ideas regarding the types of capacity building that might be helpful for outreach and peer education workers.

> ***"Trainings to build outreach capacity need to include skills development in addition to important key messages. Skills in communication, motivational interviewing, and how to assess the clients' needs would be particularly useful." (CBO source)***

> ***"Peer educators need training on how to effectively create demand for condoms." (Development partner source)***

> ***"Peer outreach workers need training that promotes acceptance of the broad diversity of MSM and TG." (INGO source)***

Innovative strategies using mobile and web-based technologies

Although it will take time for emerging mobile and web-based technologies to become available nationwide and accepted as an outreach channel, key informants from all sectors suggested that they should be utilised, where appropriate, to provide access to MSM and TG-friendly services.

> *"Providing or having access to information on health, HIV prevention and human rights through mobile phone applications and web-based interventions would be very useful. Applications could also identify testing sites for those who want to get tested." (UN source)*

> *"Awareness campaigns can be conducted through social media. Facebook allows our staff to provide quality responses to user questions." (Community source)*

> *"Messages about prevention and adherence, and reminders about appointments, could be provided through smartphone applications, SMS or voice messaging." (INGO source)*

Some of the frequently accessed sexual partnering sites identified by interview participants provide opportunities to link users to HIV prevention information and HCT services. Some of these sites offer country-specific (or perhaps even location specific), time-limited pop-up banners that can provide HIV prevention messages and links to other application pages that discuss the benefits of HIV testing and locations where testing is available. While some of the sites may charge a fee for these services, others provide advertising space and banners free of charge for non-profit organisations. At least one web-based platform has a web-page for "health support", which lists organisations in different countries that may be contacted for information and referrals. One site even lists a code of ethics for health supporters. Opportunities to partner with these sites should be explored.

4.3.3 Reducing stigma and discrimination

Key informants recognised that stigma and discrimination, whether real or perceived, often prevented MSM and TG from accessing HIV and STI services in private and public health care facilities. This situation is threatening the lives of many MSM and TG who do not always have access to the information they need to stay healthy. There was consensus among key informants regarding cross-cutting strategies for reducing stigma and discrimination. These have been compiled below:

- Sensitise and train public and private health care providers to offer specialised services for MSM and TG that are free of judgment and discrimination.

- Sensitise journalists with a view to encouraging unbiased media coverage of LGBTI issues and work with the arts and entertainment sector to increase positive images of MSM and TG.
- Work with MSM and TG to decrease self-stigma that may result in increased risk-taking behaviour.
- Mobilise communities to reduce discrimination against MSM and TG and normalise HIV prevention behaviours such as condom use and HIV testing.
- Build or strengthen linkages between community-based outreach and peer education workers and public and private facility-based prevention and care services to help break down stigma and eliminate discrimination.
- Sensitise police and law enforcement about the importance of HIV prevention for MSM and TG, and how restrictive laws and/or police abuse can create barriers to accessing HIV prevention and care.

Law enforcement personnel said they had previously received training on HIV from the United Nations Development Program (UNDP), and would welcome the continuation of this type of training and were open to learning more about MSM, TG and other KPs.

> ***"The Myanmar Police Force would welcome training on HIV and AIDS among key populations." (Government source)***

4.3.4 Technical capacity building

Key informants were asked to identify strategies for building capacity among service providers and other professional staff in light of the high rate of turnover identified in the previous section. The strategies recommended by key informants explored how capacity building could be institutionalised, either through the curricula of professional degree programmes or through the establishment of a technical resource centre.

> ***"The university does not have a separate curriculum for HIV or for working or communicating with key populations. In order to have a constant supply of skilled professionals, new doctors, nurses, and counsellors could be trained as part of their degree programme." (INGO source)***

The idea for a Training Learning Centre was proposed in order to build capacity among drug treatment and harm reduction practitioners in Myanmar. Development partners and UN representatives suggested that the same concept could be useful for building the capacity of practitioners working with other KPs.

> ***"A training and resource learning centre to build capacity of local implementing partners for programme scale-up has been discussed and should be considered. The centre could deliver awareness and sensitisation programmes for health care professionals, law enforcement, and community members; review and/or develop guidelines and standards related to the provision of health and educational services; and develop capacity for monitoring and evaluation of services." (UN source)***

A Training Learning Centre would likely be located at a medical or a public health university, a facility that could bring in expert agencies to provide technical support to the centre. However, a key informant from the government sector cautioned that medium or long-term planning may be needed to set up such a centre.

> ***"A lot of meetings between stakeholders will be needed to discuss where the centre will be located, who the partners will be, the staffing needs, the set-up costs, including capacity building for the centre's staff, recurrent costs and cost recovery. Then, a Memorandum of Understanding will need to be approved by the Ministry. These things will not happen overnight." (Government source)***

4.3.5 Improving service provision, innovation, and comprehensiveness

Existing services

While targeted services for MSM and TG have been available for more than 10 years, respondents noted non-disclosed MSM were largely absent from services. Many MSM did not want to be identified as engaging in same-sex behaviour, and did not want to be associated with HIV, so were disinclined to access these services. Key informants identified a number of strategies that might make existing services more attractive and accessible to this sub-population.

> ***"More one-stop services with well-trained staff that are sensitive to the needs of MSM and TG are needed." (CBO source)***

"Counselling services should be able to identify same-sex behaviour and provide appropriate prevention information during the risk assessment." (NGO source)

"Clinics in the Sun Quality Network or other private clinics are a good option for MSM-friendly services. Some clients are already being referred to some of these clinics. It would be a good idea to look at the quality of services provided and link outreach services to them." (Community source)

Key informants from the community sector also recommended extended service hours at drop-in centres so that people who work are able to access services. Key informants recommended that service hours be extended until 7pm or that clinics change their hours of service to 11am to 7pm. At least one service is already keeping extended hours, and undertaking some cost recovery:

"The QC Centre[xiv] in Hliangthayar Township has extended hours and is opened on weekends, accessible for students and people who work. There is an obvious need and some willingness to pay a nominal fee for services – 500 Kyat." (INGO source)

As well, it may be advisable to support a periodic mapping of service options friendly to MSM and TG. The mapping would help in determining the number and location of sites where prevention and treatment services friendly to MSM and TG are available; identifying sites where services available for the general population deliver friendly services to MSM and TG; identifying types of service providers and delivery channels, such as mobile services, special clinics, mainstream services and dedicated service sites; and helping to strengthen the referral/cross referral networks of peer outreach educators and services. Such mapping would also help to identify areas that currently lack such services so that drop-in centres or other health facilities may be established.

[xiv] Quality Control or QC franchise (QC) is a stand-alone HCT service established by Population Services International (PSI) Myanmar in 2005.

Alternative models of service and innovative prevention strategies

Key informants from various INGOs, NGOs, development partners and UN agencies recommended the establishment of alternative models of service. The setting up of "men's health clinics" or "men's sexual health clinics" was a common theme of discussion. These clinics would provide HCT and clinical services for STI treatment, TB testing and treatment and ART, through a clinic broadly targeting men and sexual health.

The idea of men's health clinics was presented to respondents from the community sector. These respondents thought that the services would be beneficial but questioned how they would be different from the existing drop-in centre-based services. They suggested that, if the clinic is to target non-disclosed MSM, then it should offer a broad range of services so that the clinics are not immediately identified as MSM or HIV-positive clinics.

> ***"A men's health clinic should provide comprehensive testing and treatment but also general care for coughing, headaches, skin diseases, blood group typing, cholesterol, and blood sugar among others. MSM and men in general have health needs beyond HIV testing and STI treatment." (Community source)***

> ***"Men's health clinics should provide services to all men. If they only provide services to MSM, it is only a matter of time before they are identified as MSM clinics." (Community source)***

> ***"The men's health clinic could provide a testing package for workers going overseas. Currently, this type of service is expensive. If the men's health clinic could provide services at a lower cost, it would be beneficial and attract all types of men, and men who may go to work in same-sex environments." (Community source)***

INGO and NGO informants also recommended that other alternative service models, such as mobile clinics, be considered. The mobile clinics could provide testing and treatment services to sites where MSM gather, such as beauty salons. Similarly, mobile health clinics without banners targeting specific KPs can be set up close to community "hang out" places such as popular shopping malls, festivals, and event venues. These health clinics can provide free condoms, rapid HIV tests, STI prevention information and other health services such as body mass index measurement, as well

as blood pressure and blood sugar testing. Health clinics in popular locations have been demonstrated to be a good way to offer rapid HIV tests to MSM who are not afraid or willing to attend MSM-targeted services.[xv]

Piloting pre-exposure prophylaxis (PrEP) was also considered as an additional effective intervention option for HIV prevention for MSM at higher risk of HIV. This will require engaging MSM, other key populations and civil society with information on the evidence to support the use of PrEP as part of a comprehensive HIV prevention and treatment intervention.

4.3.6 Strengthening multi-sector engagement

Development partners and UN agencies were in agreement that a sub-working group on MSM and TG was needed, but there was also caution about the difficulty of establishing a sub-working group.

> ***"A sub-working group on MSM and TG is needed to have regular discussions between partners on what needs to be done and for greater coordination of efforts." (Development partner source)***

> ***"It may be difficult to establish a sub-working group on MSM because some government people are very conservative and may not see MSM and TG as a priority." (UN source)***

To be effective, key informants suggested that meetings of the sub-working group should be regular, systematic and inclusive of all partners, namely government, international and local NGOs and community-based organisations.

> ***"Good sub-working group leadership and good coordination are essential." (UN source)***

[xv] In Indonesia, 103 people accessed HIV testing in 2 days at Teman Teman mobile clinic in a shopping mall: 51% were MSM, 28% were heterosexual men and 21% were women. 81% were first-time testers. Source: Personal communication from Dr Nittaya Phanuphak (Thai Red Cross AIDS Research Centre, Bangkok, Thailand) during the Seminar on Responding to Sexual Diversity: Collaboration for HIV Response among MSM and TG, 12-13 March 2015, Yangon, Myanmar.

5. Discussion and recommendations

Provide training to MSM/TG and sex-workers *(Source - Top Centre-PSI)*

Outreach workers training *(Source - Pyi Gyi Khin)*

5. Discussion and recommendations

The literature review, key informant interviews and focus group discussions facilitated a more comprehensive understanding of the HIV response among MSM and TG in Myanmar. Over the past decade, there have been a number of successful outcomes from targeted interventions, including increased condom use among KPs, and a decline in HIV prevalence among MSM and TG.

There is greater involvement of civil society in the national response, and more HIV prevention services targeting MSM and TG than ever before. But, as outlined by key informants and focus group members, there is an extensive list of challenges and barriers undermining the response.

In order to address these challenges, the following recommendations are put forward to strengthen existing prevention, testing, treatment and care programmes and improve the national HIV response among MSM and TG.

Support an enabling environment for HIV prevention, treatment and care among MSM and TG in Myanmar

- Maintain on-going dialogue and advocacy efforts with decision makers, and those with appropriate connections and influence, to amend Penal Code, Section 377 and the sections 30(d) of the Rangoon Police Act of 1899 and 35(d) of the Police Act of 1945 as they violate human rights, fuels stigma and discrimination, and represent an obstacle to health care, including HCT and HIV care and treatment services. Advocate for the decriminalization of sex-same behaviour and for the reduction of the sentence for male-male sex.

- Increase advocacy efforts and training opportunities targeting health service providers, law enforcement officers and community outreach workers, as well as the wider community whenever appropriate, to strengthen understanding of gender and sexual diversity and HIV prevention, treatment and care among MSM and TG.
  - o Conduct sensitisation workshops for law enforcement about the importance of HIV prevention, treatment and care among MSM, TG and other KPs, and explain how restrictive laws and/or police abuse can create barriers to accessing services.
  - o Explore opportunities to review medical and nursing training curriculum to ensure inclusion of content relevant to working with MSM, TG and other KPs.

- Sensitise journalists with a view to encouraging unbiased media coverage of LGBTI issues, and work with the arts and entertainment sector to increase positive images of MSM and TG.

Strengthen technical capacity of networks and CBOs to better address the needs of their members

- Increase financial and technical support for the meaningful engagement of MSM and TG in the national HIV response. Strengthen leadership and organizational development among MSM-led networks and CBOs by supporting knowledge and skill-building in various technical areas including financial and programme management, and monitoring and evaluation, as well as thematic topics such as human rights and gender-based approaches. Ultimately MSM networks should be competent to provide their members with support to access legal aid, referrals to health services, income generation and advocating for rights and protection of MSM and TG communities.

- Involve MSM in policy making: MSM should be involved in discussions and decisions around improving the HIV response from the outset, specifically those relating to law reform and HIV programme planning.

Expand HIV services for MSM and TG and strengthen technical capacity

- Strengthen the technical capacity and understanding of implementing partners with respect to gender, sexuality and male sexual behaviours in Myanmar with a view to promoting specialised services for MSM and TG that are free of judgment and discrimination. A standard package of services for MSM and another one for TG should be developed to match the specific health needs of both populations.
  - o Provide training on MSM and TG-appropriate counselling to public and private service providers, with supportive supervision to address stigma and discrimination toward MSM and TG clients.

- Provide training to HIV and STI clinical staff in relation to the health needs of MSM and TG who engage in anal, oral, penile or neo-vaginal sex.

- Build technical capacity for CBOs and networks of MSM and TG to strengthen the referral/cross-referral system between outreach networks and HCT and treatment services.

- Develop technical documents to enhance advocacy efforts and strengthen HIV service delivery for MSM and TG.
  - Finalize National Guidelines on HIV Counselling and Testing.
  - Develop SOPs for HCT, HIV care and treatment services, online and offline outreach and peer education, and monitoring and evaluation of interventions specific to MSM and TG.
  - Expand the NAP training curriculum on HCT to include modules specific to the provision of services for both MSM and TG. These may include modules on risks and vulnerabilities of MSM, TG and other KPs, motivational interviewing, disclosure of HIV and STI test results, and disclosure of sexual practices to partners.

Improve outreach of health services and trial innovative service delivery models to increase accessibility and use among MSM and TG

- Use mobile and web-based technologies, including social media applications, to conduct outreach among MSM and TG, disseminate HIV prevention messages, and facilitate referral to relevant services. Ensure that on-line service provision protects the privacy, confidentiality and security of individuals, through developing appropriate strategies and guidelines.

- Pilot men's health clinics to attract non-disclosed MSM to HCT and STI treatment services within a package of men's health services, including testing relating to blood pressure, blood sugar, cholesterol and kidney function.

- Establish mobile health services to increase the flexibility of existing HCT, ART, reproductive health and TB services. Mobile services should be delivered to sites where MSM and TG gather, such as beauty salons. Similarly, mobile health clinics without banners targeting specific KPs can be set up close to community "hang out" places such as popular shopping malls, festivals, and event venues.

- Advocate for pre-exposure prophylaxis (PrEP) as an additional effective intervention option for HIV prevention for MSM at higher risk of HIV. This will require engaging MSM, other key populations and civil society with information on the evidence to support the use of PrEP as part of a comprehensive HIV prevention and treatment service.

Strengthen the evidence base on the current epidemic situation and response for MSM in Myanmar.

- Organize mapping exercises at several levels to identify where MSM are concentrated, existing programmatic gaps and duplication of services. Annual high-level mapping should be coordinated by NAP at the national level and involve implementing partners and MSM networks to identify priority townships. Programmatic mapping should be carried out at district or township level and at local implementation level, to better target interventions.

- Introduce micro planning in peer-led outreach programmes to help peer educators to better reach the maximum number of community members, assess risk and vulnerability and ensure that programme coverage and service targets are being met through outreach.

- Address challenges in the measurement of health progress among key populations, in line with the recommendations of the Strategic Information and Monitoring & Evaluation Technical Working Group (SI & ME TWG). Data needs of policy makers and programme implementers need to be reviewed and efforts made to strengthen indicators so that they adequately capture changes in the epidemic and progress made through the HIV response. Focus should be on collecting service data, disaggregated by key population, specifically in relation to HIV testing, ART, screening and treatment of HIV-related comorbidities (e.g. TB), and sexual and reproductive health.

- Design and implement a harmonised UIC system to be used by implementing partners that is ethical and realistic for key populations. Efforts should also focus on assessing the quantity and quality of health services (i.e. identifying service gaps, measuring friendliness or stigma and discrimination from health personnel, implementing patient feedback programmes etc.).

Improve information and knowledge about MSM and TG through research

- Undertake further research to address the limitations and gaps identified in this situational analysis. Building on these findings and in conjunction with the results from the most recent IBBS/PSE, analysis, triangulation, and use of data from existing and new sources need to be promoted at all levels to strengthen the response. As well, sharing of data and information among development partners, while maintaining confidentiality and privacy, will help to improve the efficiency, effectiveness, and sustainability of HIV programmes for MSM. Specifically, the research agenda should focus on the following areas:
  - Efficiency, cost-effectiveness and sustainability of existing programmes targeting MSM and TG;
  - Operations research in the development and strengthening of alternate HCT service models is

needed to determine what model of service is appropriate in each setting. The identification of alternate services commonly used by MSM and costing of services are important aspects of this research;

- Overlapping risk practices of MSM and TG who also sell sex and/or also use/inject drugs and;
- Acceptability of PrEP among MSM, with a view to conducting a feasibility study on piloting PrEP and increasing public demand.

Gathering event at Top Centre *(Source - Top Centre-PSI)*

6. Conclusion

HIV testing *(Source - Top Centre-PSI)*

Seminar on "Responding to Sexual Diversity: Collaboration for HIV response Among Men Who have sex with Men and Transgender People in Myanmar *(Source - UNAIDS)*

6. Conclusion

Despite the concerted efforts of government agencies, international and local NGOs, CBOs and development partners to respond to the HIV epidemic among MSM and TG in Myanmar, many MSM and TG remain isolated from services, are reluctant to attend the services that are available, and find it difficult to disclose same-sex and HIV risk behaviours. HIV prevalence among MSM and TG is still considerably higher than among the general population, and there is potential for growth, as already observed in other countries such as China and Thailand, especially in urban areas with greater openness towards gender and sexual diversity.

With many rapid societal changes in Myanmar, new innovative approaches are needed to better address HIV among MSM and TG. As more and more people own mobile phones and have access to the internet, mobile and web-based technologies are quickly becoming the easiest way for members of MSM and TG communities to connect with each other. They also represent an important opportunity for reaching MSM and TG with HIV prevention messages and information on referral points, provided clients confidentiality and anonymity can be ensured.

Another innovative approach to HIV prevention, treatment and care among MSM can be found in the establishment of men's health services. MSM and TG communities are not a homogeneous group, so varied service models are needed to reach different segments of these populations. Models could include stand-alone men's health services, partnerships with private clinical services, and mobile community clinics.

This situation analysis identified the need for these types of services through a literature review, key informant interviews and focus group discussions with relevant stakeholders from various sectors including health care workers, law enforcement officials and representatives from NGOs, CBOs, community networks, development partners and UN agencies.

Still, there are many challenges that need to be addressed, including legal barriers such as Penal Code, Section 377. Moving forward, well-coordinated and multisectoral cooperation (between health, law enforcement and other sectors) will be critical in fostering an enabling environment for effective HIV prevention, treatment and care among MSM and TG.

It is hoped that this report will stimulate opportunities to explore and discuss how government, community, technical and development partners can work together in the best interests of the people of Myanmar and for the health and wellbeing of MSM and TG.

Annex 1: List of key informants and focus group discussion participants

	Name	Position/Function	Organisation
1.	Dr Myint Shwe	Program Manager	National AIDS Programme
2.	Police Brigadier General Kyaw Win	Joint Secretary of CCDAC cum Commander of Drug Enforcement Division	Central Committee for Drug Abuse Control (CCDAC), Ministry of Home Affairs
3.	Police Colonel Tin Aung	Head of Department (Administration) Drug Enforcement Division	CCDAC, Ministry of Home Affairs
4.	Pol Col Ohn Khaing	Director	Criminal Department, Ministry of Home Affairs
5.	Pol Col Myint Thein	Deputy Commander, DED	CCDAC, Ministry of Home Affairs
6.	Dr. Beate Scherrer	Country Programme Coordinator	Malteser International
7.	Mr. Serge Birtel	Programme Officer	Malteser International
8.	Mr. Robert Kelly	HIV/AIDS Technical Advisor	United States Agency for International Development (USAID)
9.	Dr Sid Naing	Country Director	Marie Stopes International (MSI)
10.	Dr. Liesbeth Aelbrecht	Head of Mission	Médecins Sans Frontieres, Switzerland (MSF-CH)
11.	Hla Myat Tun	Programme Officer	Colours Rainbow
12.	Kyaw Min Htun	Director	Myanmar Youth Stars
13.	Kyaw Thet Khaing	Project Officer	Myanmar Youth Stars
14.	Ms Justine Sass	Regional HIV and AIDS Adviser for Asia and the Pacific	United Nations Educational, Scientific and Cultural Organisation (UNESCO)
15.	Dr. Pyi Pyi Phyo	Programme Officer (HIV/AIDS)	UNESCO
16.	Dr. Nu Nu Aye	Public Health Officer	Three Millennium Development Goal Fund (3MDG) Fund

	Name	Position/Function	Organisation
17.	Mr. Robert Bennoun	Senior Strategic Advisor	3MDG Fund
18.	Dr. Yamin Shwesin	Monitoring and Evaluation Officer (HIV)	United Nations Office for Project Services (UNOPS) (GFATM)
19.	Thein Zaw Lwin	Public Health Officer (HIV)	UNOPS (GFATM)
20.	Thura Myint Soe	Public Health Officer	UNOPS
21.	Ms Phavady Bollen	Technical Officer (HIV/AIDS)	World Health Organisation (WHO)
22.	Dr. Ni Ni Khiang	National Programme Officer, HIV	United Nations Population Fund (UNFPA)
23.	Dr. Soe Naing	Executive Director	International HIV/AIDS Alliance
24.	Thiha Nyi Nyi	Community Officer	International HIV/AIDS Alliance
25.	Dr. Linn Htet	HIV/TB Coordinator	Médecins Sans Frontieres – Holland (MSF-Holland)
26.	Ms Parsa Sanjana	Deputy Director, Program Implementation and Management (GFATM)	Save the Children (GFATM)
27.	Dr. Myo Kyaw Lwin	Senior Programme Manager (GFATM)	Save the Children (GFATM)
28.	Dr. Myo Set Aung	Head of HIV/AIDS	Save the Children (GFATM)
29.	Dr. Phyo Win Tun	Project Medical Advisor	Premiere Urgence – AIDE Medicale Internationale (PU-AMI)
30.	Zaw Hpang	HIV Prevention Officer	PU-AMI
31.	Nan Hnin Mwe Chit	HIV Prevention Supervisor	PU-AMI
32.	Ko Win Aung	HIV Prevention Staff	PU-AMI
33.	Kyaw Kyaw Hitke	Peer Monitor	PU-AMI
34.	Aye Aye Nyein	FSW and MSM Peer Monitor	PU-AMI
35.	Mr. Dean Creer	Country Director	Consortium
36.	Dr. Khin Swe Swe	National Program Officer	Consortium

	Name	Position/Function	Organisation
37.	Zar Chi Htwe	Project Manager	Consortium/MSI
38.	U Chit	Chairperson	Lotus
39.	Ko Lin Aung	Project Manager	Lotus
40.	Ma Kyae Mone Lin	Assistant Project Manager	Lotus
41.	Ko Myo Htet	Assistant Project Manager	Lotus
42.	Thet Thet Kyi	Accountant	Lotus
43.	Nay Lin	Chairperson	Men who have sex with men (MSM) Network
44.	Ko Win Thu	Secretary	MSM Network
45.	Mr Renaud Cachia	Program Coordinator	Médecins Du Monde (MDM)
46.	Dr. Aung Si Thu	Field Coordinator	Médecins Du Monde (MDM)
47.	Mr Eamonn Murphy	Country Director	Joint United Nations Programme on HIV/AIDS (UNAIDS)
48.	Ms Nwe Zin Win	Executive Director	Pyi Gyi Khin
49.	Dr. Thwe Hnin Zin	Senior Programme Manager	Population Services International (PSI)/Targeted Outreach Programme (TOP) Center, Mandalay
50.	Dr. Zaw Nyi Nyi Kyaw	Medical Officer (MSM)	PSI/TOP Center, Mandalay
51.	Moe Zaw	Community Organiser	PSI/TOP Center, Mandalay
52.	Kyaw Thu Min Kaung	Community Worker (Peer Leader)	PSI/TOP Center, Mandalay
53.	Kyaw Zin Myat	Community Worker	PSI/TOP Center, Mandalay
54.	Myo Min Win (Casper)	Counsellor	PSI/TOP Center, Mandalay
55.	Thar Thar	Peer Worker	PSI/TOP Center, Mandalay
56.	Shin Thnat Phyo	Peer Worker	PSI/TOP Center, Mandalay
57.	Aung Ko Oo	Peer Worker	PSI/TOP Center, Mandalay
58.	Win Htun	Peer Worker	PSI/TOP Center, Mandalay

	Name	Position/Function	Organisation
59.	Ko Myint Thein	Peer Worker	PSI/TOP Center, Mandalay
60.	Shine Htet Aung	Community Facilitator	Consortium/CARE Myanmar
61.	Thin Thin	Programme Officer	Consortium/CARE Myanmar
62.	Gwan San Naw	Sexual and Reproductive Health Promoter	Consortium/MSI
63.	Daw Own Aung	Project Officer	Consortium/MSI
64.	Ma Sandar Htun	Project Officer	PSI/TOP Center, Pathein
65.	Tin Aung Cho	MSM Community Worker	PSI/TOP Center, Pathein
66.	Aung Myat Khin	Regional Field Coordinator	Consortium/MSI, Pathein
67.	Aye Thant Thant	Global Fund Supervisor	Consortium/MSI, Pathein
68.	Ma Amy Soe	Sexual and Reproductive Health Promoter	Consortium/MSI, Pathein
69.	Htet Htet	Outreach Worker	Pyi Gyi Khin, Pathein
70.	Ko Hliang Min	Outreach Worker	MSM Network, Pathein
71.	Than Naing Oo	Program Manager	PSI/TOP Center, Yangon
72.	Wut Yee Win Maung	Senior Administrative Officer	PSI/TOP Center, Yangon
73.	Aung Kyaw Moe	Community Organiser	PSI/TOP Center, Yangon
74.	Ms Anne Lancelot	Former Director, PSI Myanmar	PSI, Bangkok

Focus Group Discussions

	Organisation	Number of Participants	Position/Function
1.	PU-AMI Drop-in Center for MSM	Four participants	Peer Outreach staff and Drop-In Centre service users
2.	Médecins Du Monde	Five participants	Peer Outreach staff and Drop-In Centre service users
3.	PSI/TOP Center, Mandalay	Seven participants	Peer Outreach staff and Drop-In Centre service users
4.	PSI/TOP Center, Pathein	Four participants	Peer Outreach staff
5.	PSI/TOP Center, Yangon	Four participants	Peer Outreach staff

Annex 2: Detailed methodology

The situational analysis consisted of two components, a literature review and consultation with stakeholders involved in the HIV response among MSM and TG in Myanmar, through key informant interviews and focus group discussions. Based on the findings of the literature review, and of the interviews and discussions, a list of recommendations for an improved and expanded response to HIV among MSM and TG was drafted. This list of recommendations was discussed with representatives from government, international non-government organisations (INGOs), NGOs, CBOs, MSM and TG communities, development partners and UN agencies.

Literature review

Peer-reviewed articles and "grey literature" pertinent to HIV prevention, treatment and care among MSM and TG, globally, regionally, and in Myanmar, were collected by UNAIDS Country Office Myanmar. Recommendations for an expanded HIV response among MSM and TG from global and regional documents were compared with the current situation in Myanmar to identify key policy and programmatic gaps.

Key informant interviews and focus group discussions

Key informant interviews were conducted with representatives from government bodies, international and national NGOs and CBOs, development partners and UN agencies in order to gain in-depth knowledge of the lives and needs of MSM and TG in Myanmar, and of current responses to HIV among these populations. An international consultant, with the assistance of UNAIDS Country Office Myanmar, identified key informants with first-hand knowledge of the topic of interest and/or experience implementing HIV interventions for MSM and TG in Myanmar. Each stakeholder was contacted through email, telephone, and/or formal invitation letter to outline the focus of the interview.

A total of 74 key informants from 35 stakeholder bodies, including the NAP and the Central Committee for Drug Abuse Control (CCDAC) were interviewed. Most organisations were represented by one or two staff members at the interviews, while a few organisations nominated five or more staff members (See Annex 1 for the list of key informants and focus group discussion participants). Interviews were conducted in Yangon, Nay Pyi Taw, Mandalay, and Pathein between 3 and 23 November 2014.

Prior to each interview, respondents were reminded about the objectives of the study. They were informed that no names would be linked to any quotes in the report, although their sector (e.g.

government, NGO, CBO, community member, development partner or UN) would be identified. If the respondent did not speak English, the interview was held in Myanmar language with the support of an interpreter. Each interview was carried-out in a private and confidential space, using a semi-structured interview guide developed by the consultant and reviewed by UNAIDS Country Office Myanmar (See Annex 3 for the interview and discussion guides). The consultant took notes during the interviews, trying to capture everything as accurately as possible. At the end of each interview, the consultant expanded his notes and included more narrative around the discussions that arose.

Five separate focus group discussions were held with MSM and TG in Yangon, Mandalay, and Pathein in order to gather vital background information on their needs and on the difficulties and challenges they had encountered. INGOs providing drop-in centre services to MSM and TG were asked to recruit between five and eight participants, either peer outreach workers or service users, for the focus group discussions.

As focus groups discussion participants arrived, they were welcomed and asked to review a consent form in Myanmar language, which explained the following:

a) the purpose of the discussion and topics to be addressed;
b) participation in the discussions was voluntary;
c) they could leave at any time without any negative repercussions;
d) a participant could refuse to answer any questions they did not feel comfortable answering;
e) the could use nicknames or pseudonyms during the discussions;
f) all discussions would be held in confidence and no names would be used in any reports;
g) the group discussions would take approximately 90 minutes; and
h) they should not discuss information shared by other participants during the focus group once they left the site.

The participants were asked to provide written consent, using a nickname or pseudonym, or they could provide verbal consent if it made them feel more comfortable. When verbal consent was given, the consultant verified the consent by signing the consent form.

Each group discussion was carried out in a space that provided visual and auditory privacy from other drop-in centre clients and staff. A semi-structured discussion guide was developed by the consultant and reviewed by UNAIDS Country Office Myanmar. Notes were taken at each focus group discussion, trying to capture everything as accurately as possible. After each discussion, the notes were immediately reviewed and expanded as appropriate. Focus group discussions were conducted in English with interpretation.

Analysis and synthesis of literature and data

A table was developed for the analysis of interview data. It consisted of five columns: the agency and sector interview subjects represented; area of work and state of progress; challenges and barriers; successes and achievements; and strategies or recommendations for improving the enabling environment and the way forward. Information from the interview summaries was then recorded in the appropriate column.

A similar table was developed for the analysis of focus group discussion data. This table, however, consisted of only four columns: location of the discussion and number of participants; challenges and barriers; successes and achievements; and strategies or recommendations for improving the enabling environment and the way forward.

A qualitative analysis was neither done on the interview data, nor the discussion data, as they were not representative samples. Instead, common themes were identified and colour coded within each column of the table. Key messages from within each theme, and from different sectors, were then identified for use in the report.

Data from key informant interviews and focus group discussions were then compared with literature review findings to identify priorities with respect to HIV prevention, treatment and care among MSM and TG in Myanmar, and synthesise recommendations for an expanded HIV response.

Limitations

The recruitment of focus group discussion participants was arranged by INGOs providing drop-in centre services to MSM and TG in Myanmar. It was not always possible for the INGOs to recruit the desired number of participants (approximately eight persons) due to the scheduling of focus group discussions.

In addition, representation of the broad diversity of MSM and TG was not achieved in these discussions. The majority of participants in each discussion were self-identified male-female TG or apwint. Apone were underrepresented and only present at two sites. There were no tha nge present at any of the focus group discussions.

A small number of organisations involved in the HIV response among MSM and TG in Myanmar were not able to be consulted. Despite these limitations, the rich variety of qualitative data resulting from the large number of interviews has contributed to an improved understanding of the situation and responses.

Annex 3: Interview and discussion guides

Key informant interview guide

1. **In your own words can you explain to me your understanding about the some of the complexities in reaching MSM and transgender populations in Myanmar?** (explore reaching hard-to-reach populations, i.e. sexual identity versus sexual practice.)

2. **Can you explain to me where you think your department/organization is (state of progress) with regards to supporting and/or implementing of various prevention interventions for these populations?** (probe about scale, expansion, sustainability, accessibility).

3. **What do you think have been the major successes or positive shifts in your department/organization that have been experienced, achieved and witnessed with regards to the adoption, support and/or implementation of HIV prevention interventions for MSM and transgender?** (expansion of interventions; wider acceptance of interventions; increased service provision; reduced stigma, etc.).

4. **What do you think are the challenges and/or barriers your department/organization currently experiences in regard to the provision and/or support of prevention programming for men who have sex with men and transgender persons?** (explore various challenges including policy, practice, coverage of programs, coordination within sector, multi-sectoral collaboration, planning of approaches, prioritizing of importance, capacity to respond (government, community), human/financial resources, technical, access/dissemination of information, widespread misunderstanding/incorrect perceptions).

5. **From your perspective and/or that of your department/organization what do you think would be the best strategies for reaching larger numbers of MSM and transgender persons, especially those hard-to-reach, are necessary to improve the response to reduce risk of HIV infection and/or access care?** (explore what actions might be necessary to initiate/promote/expand/sustain these strategies, including policy and practice to strengthen the capacity of the government and communities to respond accordingly; potential players/partners that can be encouraged to be involved in the response; thoughts on suggested strategies - men's health clinics and web-based outreach)

6. **Are there any other issues or comments you would like to tell me?**

Interview guide for law enforcement

1. Overview of role of law enforcement in dealing with the issues related to same-sex behaviour in Myanmar

Ask about:

A. In general, what is the law enforcement approach to men who have sex with men and transgender persons?
B. What is the penalty for same-sex behaviour?
   a. How would persons engaging in same-sex behaviour be identified?
   b. Are condoms considered an indicator of possible same-sex behaviour or sex work?
C. Do you receive request from the community to arrest men who have sex with men or transgender persons?
D. What is the impact of the current strategy/approach? Does it contribute to reducing the number of men who have sex with men and transgender?

2. Role of Law enforcement in HIV prevention

A. Are law enforcement agencies involved/engaged in any specific HIV prevention activities targeting men who have sex with men and transgender in Myanmar?
a. How? (ask about: potential referral to prevention services/ do operational police know where the HIV prevention services are available?)
b. In collaboration with whom? (Ask about: MSM networks? NGOs? Government departments?
c. How do these collaborations (if any) work? (ask about: any coordination mechanisms, steering committees meetings aimed to solve problems?
B. What are the main difficulties and challenges?
a. Ask about: potential conflict between complaints/requests from the community, the legal framework - which criminalizes the same-sex behavior -and the public health response (which endorses condoms programs etc.)
C. Do you know of any programs either within Myanmar or abroad where law enforcement has played a key role in HIV prevention programs?

3. Recommendations and way forward

A. How could the cooperation between law enforcement and health sectors be strengthened?
B. What do you believe are the some key strategies you would like to see in place either by law enforcement or other organisations that could improve HIV prevention amongst men who have sex with men and transgender persons?

Focus group discussion guide

1. **In your own words can you tell us why it can be difficult to reach men who have sex with men and transgender persons with HIV prevention programs and/or to encourage them to use HIV counselling and testing services?** (explore reaching hard-to-reach populations, i.e. disclosure issues, sexual identity versus sexual practice, issues of stigma, etc.)

2. **What do you see are some of the positive things happening in HIV prevention interventions for MSM and transgender persons? How have these been helpful?** (explore access, increased service provision; reduced stigma, etc.).

3. **What do you think are the challenges in regard to accessing prevention programming for men who have sex with men and transgender persons?** (explore various challenges including practice, coverage of programs, capacity to respond (government, community), human/financial resources, promotion misunderstanding/incorrect perceptions, etc.).

4. **How did you find out about the HIV prevention programs/services you have participated in?**

a. Explore: peer outreach, flyers, TV or radio, word of mouth, internet others?

5. **What do you think would be the useful strategies/ways for reaching larger numbers of MSM and transgender persons, especially those not ready to disclose sexual identities or behaviours?** (explore what actions might be necessary to assist government, NGOs and communities to respond accordingly; potential players/partners that can be encouraged to be involved in the response; thoughts on suggested strategies - men's health clinics and web-based outreach)

6. **Can you share with us what kinds of media and which channels you use to access information about HIV, sexuality issues, and health services?** (Explore TV, radio, internet, etc. Then, explore which of the media and channels would be most useful in reaching men and transgender who are not yet ready to disclose

7. **Are there any other issues or comments you would like to share with us?**

Annex 4: Literature review documents

Asia Pacific Coalition on Male Sexual Health. Concept note: transgender and positive transgender consultation, 2014.

Joint United Nations Programme on HIV/AIDS. Gap analysis and needs assessment of key HIV prevention issues in Myanmar, unpublished.

Chua LJ, Gilbert D. Sexual orientation and gender identity minorities in transition: LGBT rights and activism in Myanmar. Human Rights Quarterly, 2015, 37: 1-28.Colors Rainbow. Facing 377: discrimination and human rights abuses against transgender, gay and bisexual men in Myanmar, 2014.

Department of Medical Research and United Nations Educational, Scientific and Cultural Organisation. Multi-level risk and protective factors and HIV-related risk behaviours among young men who have sex with men (YMSM) in Myanmar, 2014.

International HIV/AIDS Alliance Myanmar. Gender, sexuality and HIV vulnerability among MSMs in 5 selected townships in Myanmar, 2012.

Joint United Nations Programme on HIV/AIDS. Gender assessment of the national HIV response in Myanmar, 2014.

Joint United Nations Programme on HIV/AIDS. The GAP Report, 2014.

Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.

Joint United Nations Programme on HIV/AIDS. Myanmar epidemiological factsheet, 2013.

Joint United Nations Programme on HIV/AIDS. Myanmar – HIV and AIDS Country Brief, 2009.

Médecins du Monde. Knowledge, attitude and practice survey in Myanmar, February 2011.

Ministry of Health. Health in Myanmar, 2012.

National AIDS Programme. HIV estimates and projections: Asian epidemiological model Myanmar 2010-2015.

National AIDS Programme. Myanmar's HIV estimates data submission for global AIDS report, 2014.

National AIDS Programme. Behavioural Surveillance Survey 2007-2008.

National AIDS Programme. Global AIDS response progress report Myanmar: January 2012-December 2013, 2014.

National AIDS Programme. Global AIDS response progress report Myanmar: January 2010-December 2011, 2012.

National AIDS Programme. Global AIDS response progress report Myanmar, online data submission, 2013.

National AIDS Programme. HIV Sentinel Sero-Surveillance survey report, 2012.

National AIDS Programme. HIV Sentinel Sero-Surveillance survey report, 2013.

National AIDS Programme. Mid-term review of the Myanmar national strategic plan on HIV and AIDS 2011-2015: consolidation report, unpublished, November 2013.

National AIDS Programme. Myanmar national monitoring and evaluation plan on HIV and AIDS 2011-2015.

National AIDS Programme. Myanmar national strategic plan on HIV and AIDS 2011–2015. National AIDS Programme. National guidelines: a core package for HIV prevention amongst key populations in Myanmar, December 2014.
National AIDS Programme. Progress report 2012: national strategic plan for HIV/AIDS in Myanmar.
National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.
National AIDS Programme. Revised national strategic plan II 2011-2016, 2014.
United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Pyoe Pin. National HIV legal review report: review of Myanmar's legal framework and its affect on access to health and HIV services for people living with HIV and key affected populations, September 2014.
World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care of key populations, July 2014.
World Health Organisation. Global update on HIV treatment 2013: results, impact and opportunities, June 2013.
World Health Organisation. Global update on the health sector response to HIV, July 20.

Annex 5: References

[1] HIV Estimates and Projections, Spectrum 5.30, May 2015.
[2] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific. UNAIDS report 2013. http://www.unaids.org/sites/default/files/media_asset/2013_HIV-Asia-Pacific_en_0.pdf.
[3] Thwe M. HIV/AIDS education and prevention in Myanmar. AIDS Education and Prevention, June 2004, 16 (3 Supplement A), p. 170-177.
[4] National AIDS Programme in Myanmar, HIV sentinel Sero-Surveillance Survey (HSS) 2014. February 2015.
[5] Joint United Nations Programme on HIV/AIDS. Gender assessment of the national HIV response in Myanmar, 2014.
[6] National AIDS Programme. Revised national strategic plan II 2011-2016, 2014.
[7] National AIDS Programme. Progress report 2012: national strategic plan for HIV/AIDS in Myanmar.
[8] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.
[9] Ibid.
[10] National AIDS Programme. HIV sentinel sero-surveillance survey report, 2013.
[11] National AIDS Programme. National guidelines: a core package for prevention of HIV amongst key populations in Myanmar, unpublished, December 2014.
[12] Joint United Nations Programme on HIV/AIDS. Gap analysis and needs assessment of key HIV prevention issues in Myanmar, unpublished.
[13] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.
[14] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014.
[15] Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic and metaanalysis. Lancet Infect Dis. 2013;13(2):214–222.
[16] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.
[17] National AIDS Programme in Myanmar, HIV sentinel Sero-Surveillance Survey (HSS) 2014. February 2015.
[18] Joint United Nations Programme on HIV/AIDS. The Gap Report 2014.
[19] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.
[20] Joint United Nations Programme on HIV/AIDS. The Gap Report 2014.
[21] Joint United Nations Programme on HIV/AIDS. Global AIDS response progress reporting 2014. Geneva. 2014 (http://www.aidsinfoonline.org)
[22] Ibid
[23] Ibid
[24] Baral SD, Poteat T, Strömdahl S, Wirtz AL, Guadamuz, TE, Beyrer C. Worldwide burden of HIV in transgender women: a systematic review and metaanalysis. Lancet Infect Dis. 2013;113(3):214–222.
[25] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014.

[26] Joint United Nations Programme on HIV/AIDS. Global AIDS response progress reporting 2014. Geneva. 2014 (http://www.aidsinfoonline.org)

[27] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014.

[28] Asia-Pacific Transgender Network and United Nations Development Programme. Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region. Bangkok, United Nations Development Programme, 2012.

[29] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.

[30] HIV Estimates and Projections, Spectrum 5.30, May 2015.

[31] National AIDS Programme in Myanmar, HIV sentinel Sero-Surveillance Survey (HSS) 2013-2014. February 2015.

[32] National AIDS Programme in Myanmar, HIV sentinel Sero-Surveillance Survey (HSS) 2010-2013. February 2015.

[33] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.

[34] Joint United Nations Programme on HIV/AIDS. Gender assessment of the national HIV response in Myanmar 2014.

[35] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.

[36] Ibid.

[37] Australian Federation of AIDS Organisations. Epidemiological overview: MSM and transgender women in Asia and the Pacific. HIV Australia, November 2013, 11(4).

[38] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2014.

[39] Operario D, Soma T, Underhill K. Sex work and HIV status among transgender women: systematic review and meta-analysis. J Acquir Immune Defic. Syndr. 2008;48(1):97–103.

[40] Beyrer C et al. Global epidemiology of HIV infection in men who have sex with men. Lancet, 28 July 2012, 380(9839):367–77.

[41] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.

[42] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014

[43] World Health Organisation, United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Asia-Pacific Transgender Network. Joint Technical Brief: HIV, Sexually Transmitted Infections and other Health Needs among Transgender People in Asia and the Pacific. Geneva, World Health Organisation, 2013.

[44] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014

[45] Colors Rainbow. Facing 377: discrimination and human rights abuses against transgender, gay and bisexual men in Myanmar, 2014.

[46] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014.

[47] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.

[48] Colors Rainbow. Facing 377: discrimination and human rights abuses against transgender, gay

and bisexual men in Myanmar, 2014.

[49] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.

[50] The Penal Code, Section 377 (1861) (Myanmar).

[51] Chua LJ, Gilbert D. Sexual orientation and gender identity minorities in transition: LGBT rights and activism in Myanmar. Human Rights Quarterly, 2015, 37, p. 1-28.

[52] United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Pyoe Pin. National HIV legal review report: review of Myanmar's legal framework and its affect on access to health and HIV services for people living with HIV and key affected populations. September 2014.

[53] Ibid

[54] Colors Rainbow. Facing 377: discrimination and human rights abuses against transgender, gay and bisexual men in Myanmar, 2014.

[55] United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Pyoe Pin. National HIV legal review report: review of Myanmar's legal framework and its affect on access to health and HIV services for people living with HIV and key affected populations. September 2014.

[56] Chua LJ, Gilbert D. Sexual orientation and gender identity minorities in transition: LGBT rights and activism in Myanmar. Human Rights Quarterly, 2015, 37.

[57] United Nations Development Programme, Joint United Nations Programme on HIV/AIDS and Pyoe Pin. National HIV legal review report: review of Myanmar's legal framework and its affect on access to health and HIV services for people living with HIV and key affected populations. September 2014.

[58] Chua LJ, Gilbert D. Sexual orientation and gender identity minorities in transition: LGBT rights and activism in Myanmar. Human Rights Quarterly, 2015, 37.

[59] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014.

[60] National AIDS Programme. Mid-term review of the Myanmar national strategic plan on HIV and AIDS 2011-2015: consolidation report, unpublished, November 2013.

[61] Ibid

[62] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.

[63] National AIDS Programme. Progress report 2012: national strategic plan for HIV/AIDS in Myanmar.

[64] Ibid

[65] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.

[66] National AIDS Programme. Integrated biological and behavioural surveillance 2009, men who have sex with men

[67] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.

[68] Joint United Nations Programme on HIV/AIDS. Gap analysis and needs assessment of key HIV prevention issues in Myanmar.

[69] National AIDS Programme. Progress report 2013: national strategic plan for HIV/AIDS in Myanmar.
[70] National AIDS Programme. Global AIDS response progress report Myanmar: January 2012-December 2013, 2014.
[71] National AIDS Programme. Mid-term review of the Myanmar national strategic plan on HIV and AIDS 2011-2015: consolidation report, unpublished, November 2013.
[72] Ibid.
[73] National AIDS Programme. Global AIDS response progress report Myanmar: January 2012-December 2013, 2014.
[74] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014.
[75] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.
[76] National AIDS Program. Mid-term review of the Myanmar national strategic plan on HIV and AIDS 2011-2015: consolidation report, unpublished, November 2013.
[77] Ibid.
[78] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014.
[79] Myint, WM et al. Hepatitis B and C co infection among the key affected populations in an ART program in Myanmar: the need for assess to treatment, poster exhibition, 20th International AIDS Conference, Melbourne, Australia, 20-25 July 2014.
[80] World Health Organisation. Global policy report on the prevention and control of viral hepatitis in WHO member states, 2013.
[81] Ministry of Health. Department of Public Health. Consultation on National Strategic Plan, National Treatment Guideline and Standard Operational Procedures for Hepatitis. Nay Pyi Taw, June 2015.
[82] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014.
[83] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.
[84] Joint United Nations Programme on HIV/AIDS. The GAP Report 2014.
[85] World Health Organisation. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, July 2014.
[86] Joint United Nations Programme on HIV/AIDS. HIV in Asia and the Pacific, 2013.
[87] National AIDS Program. Global AIDS response progress report Myanmar, 2014.
[88] Ibid.
[89] National AIDS Program. National guidelines: a core package for HIV prevention amongst key populations in Myanmar, December 2014.
[90] Williams B et al. Increase coverage of HIV and AIDS services in Myanmar. Conflict and Health, published online, March 2008, volume 2.

137/1 Than Lwin Road
Kamayut Township
Yangon, Myanmar

Tel : (+95 1) 538087, 538938, 503816, 534498, 504832
Fax : (+95 1) 503160

Web: http://unaids.org