



UNAIDS

**SITUATIONAL ANALYSIS
OF THE HIV RESPONSE AMONG
SEX WORKERS
IN MYANMAR**

April 2016

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Table of Contents

Acknowledgements	7
Acronyms and abbreviations	8
အကြောင်းအရာအကျဉ်းချုပ်	11
Executive summary	27
Foreword	41
1. Introduction	43
1.1 Objectives of the situational analysis	46
1.2 Key definitions	46
1.3 Modes of sex work	47
1.4 Limitations to the Situational Analysis	47
2. Literature review: the HIV epidemic among sex workers in Myanmar and the national response	51
2.1 Methodology of literature review	53
2.2 Overview of the HIV epidemic among sex workers and their clients in Myanmar	53
2.2.1 HIV prevalence among female sex workers in Myanmar by geographic region	55
2.2.2 HIV prevalence among clients of FSW in Myanmar	56
2.2.3 TB and TB-HIV co-infection rates among sex workers	57
2.3 HIV risk and vulnerability among sex workers	57
2.3.1 Police harassment, punitive laws, policies and practices	58
2.3.1.1 Common laws in Myanmar that impact on HIV vulnerability among sex workers	58
2.3.2 Violence against sex workers	59
2.3.3 Migration, mobility and sex work	60
2.3.4 Service barriers due to stigma and discrimination	61
2.3.5 Knowledge of HIV risk and service availability	62

2.3.6	Condom use	63
2.3.7	Child victims of sexual exploitation and young people involved in sex work	64
2.4	Policy and Programme Response	65
2.4.1	Myanmar National Strategic Plan on HIV and AIDS 2011–2016	66
2.4.1.1	NSP II Strategic Objective 1: HIV Prevention	66
2.4.1.2	NSP II Strategic Objective 2: HIV treatment, care and support	67
2.4.1.3	NSP II Strategic Objective 3: Community-based approaches for PLHIV	69
2.4.1.4	NSP II: Cross cutting interventions	70
2.4.2	Coverage of HIV prevention programmes targeting sex workers and their clients	72
2.4.3	The national response to sex workers, the legal and policy environment	74
2.5	Financing of HIV programmes in Myanmar	75
2.5.1	National investment	75
2.5.2	Funding commitments for HIV, sex workers and their clients	76
2.5.3	Development partner investment	77
2.5.4	Funding gaps	78
3.	Qualitative analysis: findings from key informant interviews and focus group discussions	79
3.1	Methodology of qualitative analysis	82
3.1.1	Data collection	82
3.1.2	Analysis	82
3.2	Successes and achievements of the national HIV response	83
3.2.1	Acceptance of HIV prevention as a public health intervention for sex workers	83
3.2.2	Declining HIV prevalence	85
3.2.3	Expansion of health services for sex workers	86
3.2.4	The rise of civil society	87
3.2.5	Rising opportunities for legal and policy reform	89
3.2.6	Funding opportunities for HIV prevention and treatment programmes	91
3.3	Challenges and barriers to an effective HIV response among sex workers	92
3.3.1	Legislation, policy and practice	92
3.3.2	Stigma and discrimination	98
3.3.3	Limited reach of HIV and integrated health services	100
3.3.4	Reliance on INGOs due to limited local capacity	102
3.3.5	Risk behaviours associated with sex work	102
3.3.6	Barriers to accessing health services	104
3.3.7	Issues with data collection and management	104
3.3.8	Mobility, migration and trafficking	105

3.3.9	Barriers toward economic emancipation and support for sex workers and their families	106
4.	Discussion and Recommendations	107
	Bibliography	123
	Endnotes	130
Annex 1:	Detailed list of key informants	115
Annex 2:	Question guide for key informant interviews and focus group discussions	118
FIGURES:		
Figure 1:	Trends of HIV prevalence among key populations, 2006-2014	54
Figure 2:	HIV prevalence among female sex workers and their clients in Myanmar, disaggregated by age	56
Figure 3:	Prevention interventions in 2012-2013 (in US\$) [Analysis of GFATM HIV spending, 2012-2013]	77
Figure 4:	Analysis of GFATM HIV spending, 2012-2013	78
TABLES:		
Table 1:	HIV prevalence among FSW by geographic region, 2013-2014	55
Table 2:	Estimated mode of transmission for new cases of HIV infection, 2010–2014	57
Table 3:	FSW and their clients programme data, 2010-2013	73

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Abbreviations

3ILPMS	Three Interlinked Patient Monitoring Systems
3MDG Fund	Three Millennium Development Goal Fund
AIDS	Acquired immune deficiency syndrome
AMA	Aye Myanmar Association (National Sex Workers Network)
APCOM	Asia Pacific Coalition on Male Sexual Health
ART	Antiretroviral therapy
BSS	Behavioural Surveillance Survey
CBO	Community-based organisation
DfID	Department for International Development
DIC	Drop-in-centre
FGD	Focus group discussion
FSW	Female sex worker
GARPR	Global AIDS Response Progress Report
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B virus
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HIV-TSG	HIV Technical and Strategy Group
HSS	HIV Sentinel Sero-Surveillance
IBBS/PSE	Integrated Biological and Behavioural Surveillance/Population Size Estimation
INGO	International non-government organisation
IOM	International Organisation for Migration
MCH	Maternal and child health
M-HSCC	Myanmar Health Sector Coordinating Committee
MOH	Ministry of Health
MSM	Men who have sex with men
NAP	National AIDS Programme
NGO	Non-government organisation
NRC	National Registration Card
NSP	National Strategic Plan
NSP II	Myanmar National Strategic Plan on HIV and AIDS 2011–2016
PEPFAR	United States President's Emergency Plan for AIDS Relief
PGK	Pyi Gyi Khin

PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PWID	People who inject drugs
SI & ME TWG	Strategic Information and Monitoring and Evaluation Technical Working Group
SMS	Short Message Service
SOP	Standard operating procedure
STI	Sexually transmitted infection
SWiM	Sex Workers in Myanmar
TB	Tuberculosis
TRaC	Tracking results continuously
UIC	Unique identifier code
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UHC	Universal health coverage
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organisation

အကြောင်းအရာအကျဉ်းချုပ်



Seminar on "Collaboration for HIV Response with Sex Workers in Myanmar". (Source - UNAIDS)



Outreach activities (Source - TOP, PSI)



Micro Finance Training (Source - SWiM)

အကြောင်းအရာအကျဉ်းချုပ်

မြန်မာနိုင်ငံသည် ခုခံအားကျဆင်းမှုရောဂါ၏ ရိုက်ခတ်မှုဒဏ်ကို ပြင်းထန်စွာခံစားခဲ့ရသော အရှေ့တောင်အာရှနိုင်ငံများထဲမှ နိုင်ငံတစ်နိုင်ငံဖြစ်ပါသည်။ အသက်(၁၅) နှစ်နှင့်အထက်အုပ်စုအတွင်း အိတ်ချ်အိုင်စီပိုးရှိနေသူများမှာ (၂၀၁၄) ခုနှစ်တွင် ခန့်မှန်းလူဦးရေ (၂) သိန်းခန့်^၁ ရှိပြီး မြန်မာနိုင်ငံသည် အိန္ဒိယ၊ တရုတ်၊ ထိုင်း၊ အင်ဒိုနီးရှားနှင့် ဗီယက်နမ်^၂ နိုင်ငံများပြီးနောက် အရှေ့တောင်အာရှနှင့် ပစိဖိတ်ဒေသတွင် အိတ်ချ်အိုင်စီပိုးရောဂါခံစားနေရသူအများဆုံးရှိသည့် ဆဌမမြောက်နိုင်ငံဖြစ်သည်။ မြန်မာနိုင်ငံတွင် ပထမဦးဆုံးအိတ်ချ်အိုင်စီပိုးကို (၁၉၈၈) ခုနှစ်နှင့် ပထမဆုံးအေအိုင်ဒီအက်စ်ရောဂါဖြစ်ပွားသူကို (၁၉၉၁)^၃ ခုနှစ် တွင် စတင်တွေ့ရှိခဲ့ပြီးနောက်တွင် ခုခံအားကျဆင်းမှုရောဂါ ကပ်ရောဂါအသွင်ဖြစ်ပွားမှုသည် အဓိကလူအုပ်စုများဖြစ်သော မူးယစ်ဆေးဝါးသုံးစွဲသူများ (PWID)၊ အမျိုးသမီးလိင်လုပ်သားများ (FSW)၊ အမျိုးသားချင်းလိင်ဆက်ဆံသူများ (MSM) နှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူနေထိုင်သူများ (TG) စသူတို့အပေါ်တွင် ဆက်လက်တည်ရှိနေခဲ့သည်။

(၂၀၁၀) ခုနှစ်တွင် အမျိုးသမီးလိင်လုပ်သားများ (အသက် ၁၅နှစ်မှ ၄၉နှစ်အတွင်း) အရေအတွက်သည် ခုနှစ်သောင်းခန့်နှင့် ၎င်းတို့၏ဝန်ဆောင်မှု ရရှိသူများအရေအတွက်သည် ရှစ်သိန်းသုံးသောင်းခန့်ရှိမည်ဟု ခန့်မှန်းထားခဲ့သည်။ (၁၉၉၆) ခုနှစ်မှ (၂၀၀၆) ခုနှစ်အထိ အမျိုးသမီးလိင်လုပ်သားများကြား အိတ်ချ်အိုင်စီပိုးရောဂါပိုး ဖြစ်ပွားမှုသည် (၂၀) ရာခိုင်နှုန်းအထက်တွင်ရှိနေဆဲဖြစ်ပြီး (၂၀၀၀) ခုနှစ်တွင် (၃၈) ရာခိုင်နှုန်း^၄ ဖြင့် ဖြစ်ပွားမှုအမြင့်ဆုံးအဖြစ်မှတ်တမ်းတင်ထားသည်။ အဓိကထိခိုက်ခံစားနေရသောအုပ်စုများအတွက် သီးသန့်ဦးတည်ထားသော ကာကွယ်ရေး ဝန်ဆောင်မှုများတိုးမြှင့်ရန် ကျန်းမာရေးဝန်ကြီးဌာနနှင့် အမျိုးသားခုခံအားကျဆင်းမှုကူးစက်ရောဂါတိုက်ဖျက်ရေးစီမံချက် (NAP) တို့၏ဦးဆောင်မှုနှင့်ကတိကဝတ်ထားရှိမှုတို့ကြောင့် HIV ကာကွယ်မှုလုပ်ငန်းများ အရှိန်အဟုန်တိုးမြှင့်လာသည်။ သို့သော် အမျိုးသမီးလိင်လုပ်သားများကြားတွင် (၂၀၁၄)^၆ ခုနှစ် တွင် (၆.၃) ရာခိုင်နှုန်းရှိကာ ဖြစ်ပွားမှုမြင့်မားနေဆဲဖြစ်ပြီး ထိရောက်သောကာကွယ်ရေးလုပ်ဆောင်မှုများ ဆက်လက်လိုအပ်နေသည်ကို ဖော်ပြနေသည်။

အမျိုးသမီးလိင်လုပ်သားများထံမှ ဝန်ဆောင်မှုရရှိသူများကြား အိတ်ချ်အိုင်စီပိုးဖြစ်ပွားမှုမှာလည်း ယေဘုယျ အမျိုးသားများထက်မြင့်မားလျက်ရှိသည်။ အမျိုးသမီးလိင်လုပ်သားများထံမှ ဝန်ဆောင်မှုရယူသူများ၏ ရောဂါ ဖြစ်ပွားမှုကို ခန့်မှန်းရန်အတွက် ဆေးရုံဆေးခန်းများသို့ လိင်မှတစ်ဆင့်ကူးစက်တတ်သောရောဂါများ (STI) လာ ရောက်ပြသသော အမျိုးသားလူနာများ၏ ရောဂါဖြစ်ပွားမှုစာရင်းများကို အသုံးပြုပါသည်။^၇ (၂၀၁၄) ခုနှစ်၊ အိတ်ချ် အိုင်စီရောဂါပိုး ကူးစက်ပျံ့ပွားမှုစောင့်ကြည့်လေ့လာရေးစာတမ်း (HSS) ၌ လိင်မှတစ်ဆင့်ကူးစက်တတ်သော ရောဂါများ ခံစားနေရသည့် အမျိုးသားလူနာများ၏ (၄) ရာခိုင်နှုန်းသည် အိတ်ချ်အိုင်စီပိုးရှိသူများဖြစ်ကြောင်း တွေ့ ရပြီး အရွယ်ရောက်ပြီးသော အမျိုးသားလူနာများကြား အိတ်ချ်အိုင်စီပိုး ဖြစ်ပွားမှုမှာ (၀.၇၅)ဖြစ်သည်။^၈

အစိုးရအဖွဲ့အစည်းများ၊ နိုင်ငံတကာနှင့် ပြည်တွင်းမှ အစိုးရမဟုတ်သော အဖွဲ့အစည်းများ၊ လူထုအခြေပြုအဖွဲ့ အစည်းများ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်များနှင့် ကုလသမဂ္ဂအဖွဲ့အစည်းများ၏ ပူးပေါင်းအားထုတ်မှုများရှိသော်လည်း လူ တန်းစားခွဲခြားခြင်းနှင့်နိမ့်ချဆက်ဆံခြင်းများ၊ ဆိုးရွားသောဥပဒေရေးရာ ပတ်ဝန်းကျင်နှင့် ဆင်းရဲမွဲတေမှုစသည့် အတားအဆီးများကြောင့် လိင်လုပ်သားများသည် အိတ်ချ်အိုင်စီပိုးဝန်ဆောင်မှုများရယူနိုင်ရန် အခက်အခဲများနှင့် ရင်ဆိုင်နေရဆဲဖြစ်ပါသည်။ ထိုလူမှုရေး၊ ဥပဒေနှင့် စီးပွားရေးနှင့်ပတ်သတ်သော အကြောင်းအရင်းများသည် လိင်လုပ်သားများ အိတ်ချ်အိုင်စီပိုးနှင့် အခြားလိင်မှတစ်ဆင့်ကူးစက်တတ်သော ရောဂါများကူးစက်ခံရခြင်းကို အဓိက အဆုံးအဖြတ်ပေးသောအရာများဖြစ်ပါသည်။ လိင်လုပ်သားများနေ့စဉ် ကြုံတွေ့နေရသော ညဉ့်ပန်းနှိပ်စက်မှုနှင့် အကြမ်းဖက်မှုများသည်လည်း ၎င်းတို့အား အိတ်ချ်အိုင်စီပိုးကာကွယ်ရေး လုပ်ငန်းများအပါအဝင် ကျန်းမာရေးစီမံချက် များနှင့် ဝေးရာသို့တွန်းပို့ပေးနေသကဲ့သို့ဖြစ်နေသည်။

ထိုနည်းတူစွာ အမျိုးသားနှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲခံယူနေထိုင်သူလိင်လုပ်သား ခန့်မှန်းအရေအ တွက်နှင့် ၎င်းတို့အကြား အိတ်ချ်အိုင်စီပိုးဖြစ်ပွားမှုအပါအဝင်လိင်လုပ်ငန်းနှင့်ပတ်သတ်သော အချက်အလက်များ မရှိခြင်းနှင့် နားလည်မှုနည်းပါးခြင်းတို့ကလည်း အဆိုပါ အဓိကထိခိုက်ခံစားနေရသော လူအုပ်စုများအတွက် ပြီး ပြည့်စုံသော ကာကွယ်ရေး၊ ကုသရေး၊ စောင့်ရှောက်မှုပေးခြင်းနှင့် ပံ့ပိုးပေးခြင်းစသည့်လုပ်ငန်းများ လုပ်ဆောင်ရာ တွင် စိန်ခေါ်မှုများဖြစ်ပေါ်စေခဲ့သည်။ အမျိုးသမီးလိင်လုပ်သားများ၊ အမျိုးသားချင်းလိင်တူဆက်ဆံသူများ နှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ ပြောင်းလဲခံယူနေထိုင်သူများအတွင်း ပြုလုပ်ထားသော IBBS/PSE ဟူသော လေ့လာမှုအသစ်နှစ်ရပ်မှ ရလဒ်များသည် ထိုသူများ၏ ဗဟုသုတများ၊ သဘောထားများနှင့် အမူအကျင့်များနှင့် ပတ်သက်၍ လက်ရှိအခြေအနေနှင့်ပို၍ကိုက်ညီသော အချက်အလက်များနှင့်ခွဲခြမ်းစိတ်ဖြာမှုများကို ပေးနိုင်ပါ လိမ့်မည်။

အခြေအနေဆန်းစစ်မှု၏ အခြေခံအကြောင်းအရာများနှင့် ရည်မှန်းချက်များ

လိင်လုပ်သားများအနေဖြင့် မြို့ပြများ၊ ဆင်ခြေဖုန်းဒေသများ၊ သတ္တုတွင်းဒေသများနှင့် နယ်စပ်ဒေသတစ် လျှောက်^၉တွင် အများအားဖြင့် ကျင်လည်လေ့ရှိသော်လည်း မြန်မာနိုင်ငံအတွင်းရှိ လိင်လုပ်သားအများစုမှာ ၎င်းတို့အတွက် ပို၍အကျိုးရှိနိုင်သော ဈေးကွက်အခွင့်အလမ်းများရနိုင်သည့်နေရာများ၊ သို့သပ်စွာနေထိုင်နိုင်ပြီး ဥပဒေအကြောင်းပြုနှောင့်ယှက်ခြင်းနှင့် ဖမ်းဆီးချုပ်နှောင်ခြင်းများအား ရှောင်ရှားနိုင်သောနေရာများကို လိုက်လံ ရှာဖွေကာ ရွှေ့ပြောင်းနေထိုင်လေ့ရှိသည်။^{၁၀} မြန်မာနိုင်ငံ၏ လျင်မြန်စွာပြောင်းလဲနေသော နိုင်ငံရေးနှင့် စီးပွားရေး အခြေအနေများသည် ပုန်းကွယ်နေသော (သို့မဟုတ်) ရောက်ရှိရန်ခက်ခဲသော လိင်လုပ်သားများကို နယ်စပ် ဒေသတစ်လျှောက်နှင့် သတ္တုတွင်းဒေသများကဲ့သို့သော စီးပွားရေးလမ်းကြောင်းများတစ်လျှောက်တွင်သော်လည်း ကောင်း၊ တယ်လီဖုန်းများ၊ လတ်တလောရေပန်းစားလာသော အင်တာနက်စာမျက်နှာ သို့မဟုတ် လူမှုကွန်ယက်

များမှတဆင့်သော်လည်းကောင်း ထွက်ပေါ်လာစေသည်။ အမှန်တကယ်အားဖြင့် ၎င်းတို့သည် အလွယ်တကူ သိရှိနိုင်သူများမဟုတ်သည့်အတွက် အိတ်ချ်အိုင်စီကာကွယ်ရေးစီမံချက်များသည်လည်း ၎င်းတို့ထံသို့ မရောက်ရှိနိုင်ပေ။ မြန်မာနိုင်ငံတွင် ရွှေ့ပြောင်းသွားလာသောသူများနှင့် အလွယ်တကူအသုံးပြုနိုင်သော ငွေပိုငွေလျှံရရှိနေသော သူများတိုးပွားလာသည်နှင့်အမျှ လိင်လုပ်သားများထံမှ ဝန်ဆောင်မှုရယူကြသူ အရေအတွက်မှာလည်း တိုးပွားလာသည်။ အဆိုပါ ပြောင်းလဲလာသောအခြေအနေကို ဖြေရှင်းရန်၊ အိတ်ချ်အိုင်စီ စစ်ဆေးခြင်း၊ နှစ်သိမ့်ဆွေးနွေးခြင်းများ (HCT) နှင့် အိတ်ချ်အိုင်စီကုသမှုခံယူခြင်းကို အားပေးရန်နှင့် (အမျိုးသမီး၊ အမျိုးသား၊ TG) လိင်လုပ်သားအားလုံးအတွက် သင့်လျော်၍ထိရောက်မှုရှိသောဝန်ဆောင်မှုများပေးနိုင်ရန် ဆန်းသစ်သော နည်းဗျူဟာများ (အင်တာနက်ကွန်ရက်အခြေပြ application များနှင့် လူမှုကွန်ရက်မီဒီယာများကို အသုံးပြုခြင်း) သည် အလွန်အရေးကြီးသည်။¹¹

လက်ရှိသက်သေအထောက်အထားများနှင့် ရှုထောင့်များကို တင်ပြခြင်းအားဖြင့် မူဝါဒနှင့် စီမံချက်ကဏ္ဍများတွင် အခြေအနေနှင့်လျော်ညီစွာ ပြင်ဆင်ထားသော ဦးစားပေးများသတ်မှတ်ပြီး လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများ အရှိန်အဟုန်မြှင့်ဆောင်ရွက်နိုင်ရန်အလို့ငှာ အကျိုးတူပူးပေါင်းဆောင်ရွက်နေကြသူများ အားလုံးအကြား ဆွေးနွေးပွဲများနှင့် အရေးပေါ်အရေးယူဆောင်ရွက်မှုများဖြစ်ပေါ်လာစေရန် ဤအခြေအနေဆန်းစစ်မှုက ရည်ရွယ်ပါသည်။ တိကျစွာဖော်ပြရမည်ဆိုလျှင် မြန်မာနိုင်ငံရှိလိင်လုပ်သားများအကြား အိတ်ချ်အိုင်စီတုံ့ပြန်ချက်လုပ်ငန်းများအပေါ် ပြုလုပ်ထားသော အခြေအနေဆန်းစစ်မှု၏ရည်ရွယ်ချက်များမှာ -

- ၁။ အိတ်ချ်အိုင်စီတုံ့ပြန်မှုတွင် ထွက်ပေါ်လာသော နည်းလမ်းအသစ်များအား ဆွေးနွေးရန်
- ၂။ အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများတွင် တွေ့ရှိရသော လက်ရှိစိန်ခေါ်မှုများနှင့် တိုးတက်မှုများကို မီးမောင်းထိုးပြရန်
- ၃။ လိင်လုပ်သားများ၏လိုအပ်မှုများကို ဖြေရှင်းရန်အတွက် အဓိကဦးစားပေးလုပ်ဆောင်ရမည့်အရာများကို ဖော်ထုတ်ရန်နှင့်
- ၄။ လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်စီတုံ့ပြန်မှုများ တိုးတက်စေရန် သက်ဆိုင်ရာအကြံပြုချက်များအား တင်ပြရန်တုံ့ဖြစ်ပါသည်။

နည်းစနစ်များ

ဤအစီရင်ခံစာသည် စာအုပ်စာတမ်းများအား ပြန်လည်သုံးသပ်လေ့လာခြင်း၊ (၂၀၁၅) ဧပြီတွင်ပြုလုပ်ခဲ့သော အဓိကသတင်းပေးနိုင်သူများအား မေးမြန်းချက် (၂၇) ခုနှင့် ဦးတည်အုပ်စုဖွဲ့ဆွေးနွေးခြင်း (၁၆) ခု၊ (၂၀၁၄) ခုနှစ်၊ အောက်တိုဘာတွင် ပြုလုပ်ခဲ့သောပဏာမသုတေသန စသည့်နည်းလမ်းများအားဖြင့်ပြုလုပ်ထားသော အခြေအနေဆန်းစစ်မှု၏တွေ့ရှိချက်များနှင့် အကြံပြုချက်များကို ပေါင်းစပ်ထားခြင်းဖြစ်ပါသည်။ အရည်အသွေးအခြေပြုသုတေသနကို ရန်ကုန်၊ မန္တလေး၊ မော်လမြိုင်နှင့် နေပြည်တော်¹² စသော မြန်မာနိုင်ငံရှိမြို့ကြီးလေးမြို့တွင် ပြုလုပ်ထားပါသည်။

တွေ့ရှိချက်များ

အဓိကအောင်မြင်မှုများ

မြန်မာနိုင်ငံရှိ လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်စီပိုးကာကွယ်ရေး၊ ပြုစုစောင့်ရှောက်ရေးနှင့် ကုသရေးလွှမ်းခြုံမှုများသည် လွန်ခဲ့သောဆယ်စုနှစ်အတွင်း များစွာတိုးတက်လာခဲ့ပြီး လိင်လုပ်သားများကြား အိတ်ချ်အိုင်စီပိုးဖြစ်ပွားမှုကို လျော့ကျစေခဲ့သည်။ အိတ်ချ်အိုင်စီပိုးစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း (HCT) နှင့် ART ဆေးဖြင့် ကုသခြင်းဝန်ဆောင်မှုများနှင့်ပတ်သက်၍ (၂၀၁၄) ခုနှစ်တွင် စတင်ခဲ့သော ဗဟိုချုပ်ကိုင်မှုဖြေလျှော့ပေးခြင်းသည် အဓိကထိခိုက်ခံစားနေရသော လူအုပ်စုများကြား လာမည့်နှစ်များတွင် အိတ်ချ်အိုင်စီပိုးအသစ်ကူးစက်ခံရမှု လျော့ချပေးရေးကို သံသယမရှိ အထောက်အပံ့ဖြစ်စေသည်။ ဗဟိုချုပ်ကိုင်မှုဖြေလျှော့ပေးခြင်း၏ ရလဒ်များကို အခြေအနေဆန်းစစ်ခြင်းအားဖြင့် အကဲဖြတ်ရန်စောနေသေးသော်လည်း HCT နှင့် ART ဝန်ဆောင်မှုများတွင် ထိုသို့ ချုပ်ကိုင်မှုဖြေလျှော့ပေးခြင်းသည် လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်စီပိုးကာကွယ်ရေးလုပ်ငန်းများရှိ လက်ကမ်းကူညီစောင့်ရှောက်မှုများကို တိုးတက်စေသောအချက်တစ်ချက်အဖြစ် ဆန်းစစ်မှုတွင်ပါဝင်ခဲ့သူများက ယူဆကြသည်။

အိတ်ချ်အိုင်စီအကြောင်း ပညာပေးခြင်း၊ ကွင်းဆင်းလုပ်သားအခြေပြု အသိမြှင့်တင်ရေးလုပ်ရှားမှုများ၊ ကွန်ဒုံဖြန့်ဝေခြင်း၊ အိတ်ချ်အိုင်စီအတွက် နှစ်သိမ့်ဆွေးနွေးပညာပေးခြင်းနှင့် သွေးစစ်ခြင်း၊ ကာလသားရောဂါကုသရေးဝန်ဆောင်မှုများသို့ လွှဲပို့ပေးခြင်း အစရှိသည့် အိတ်ချ်အိုင်စီကာကွယ်ရေး အစီအစဉ်များသည် လက်ရှိတွင် လိင်လုပ်သားများ [၅၄၆၄၆ ဦး (အနိမ့်ဆုံး) မှ ၇၇၀၅၉ ဦး (အမြင့်ဆုံး)]¹³ထံသို့ ရောက်ရှိနေသည်ဟု ယူဆရသည်။ အပြောင်းအလဲဖြစ်ရန် တိုက်တွန်းနှိုးဆော်ခြင်း၊ လူမှုရေးအရပံ့ပိုးမှုများ၊ ကာကွယ်ရေးဆိုင်ရာလက်ကမ်းစောင့်ရှောက် မှုများတွင် လုပ်ဆောင် နေကြသော ပြည်တွင်းလူထုအခြေပြု အဖွဲ့အစည်းအသစ်များ (CBO) ထွက်ပေါ်လာသည်နှင့်အမျှ အဆိုပါ ဝန်ဆောင်မှုလုပ်ငန်းများကိုလည်း ဆက်လက်တိုးချဲ့လျက်ရှိသည်။ သို့သော် လိင်လုပ်သားများအတွက် ကာကွယ်ရေးစီမံချက်များ၏လွှမ်းခြုံမှုမှာ တစ်စိတ်တစ်ပိုင်းမျှသာရှိနေပြီး မသေချာသော ခန့်မှန်းလူဦးရေပမာဏအပေါ် အခြေခံ ထားသည်။ FSW, MSM နှင့် TG များကြားရှိ IBBS/PSE အသစ်သည် ဤကွာဟချက်ကို ကူညီဖြည့်ဆည်းပေးမည် ဖြစ်သည်။

အထင်ရှားဆုံးတိုးတက်မှုကိုဖော်ပြရမည်ဆိုလျှင် (၂၀၁၆)ခုနှစ်အကုန်တွင်လွှမ်းခြုံမှု (၈၆)ရာခိုင်နှုန်းရှိရမည်ဟူသော အမျိုးသားအဆင့်ဦးတည်ချက်ကို ပြည့်မှီရန် အလားအလာကောင်းနေသည့် လျင်မြန်စွာတိုးတက်လုပ်ဆောင်လာသော ART ဝန်ဆောင်မှုများပင်ဖြစ်သည် (အိတ်ချ်အိုင်စီပိုးရှိနေပြီး ART ဆေးဖြင့်ကုသမှုခံယူနေသော လူကြီးနှင့်ကလေး စုစုပေါင်း ၁၁၄၄၃၇ ယောက်ရှိသည်)။ (၂၀၁၄) ခုနှစ်တွင် အိတ်ချ်အိုင်စီရောဂါပိုးရှိသောသူ (၈၅၆၂၆) ယောက်သည် ART ဆေးဖြင့် ကုသခံရန် စာရင်းပေးသွင်းခဲ့ကြသည်¹³။

တုံ့ပြန်မှုတွင် အစိုးရအဖွဲ့ဝင်များမှ ပူးပေါင်းဆောင်ရွက်သူများ ပိုမိုပါဝင်လာရေးနှင့်စပ်လျဉ်း၍ အမျိုးသားအဆင့်မဟာဗျူဟာအကောင်အထည်ဖော်စဉ်အတွင်း ဗဟိုအဆင့်၊ မြို့နယ်အဆင့်များရှိ အစိုးရအဖွဲ့များအကြား ပူးပေါင်း လုပ်ကိုင်မှု ပိုမိုတိုးတက်လာသည်ကိုတွေ့ရပြီး ယင်းကို ရလဒ်ကောင်းတစ်ခုအဖြစ် ဤလေ့လာဆန်းစစ်မှုအတွက် သတင်းပေးသူများကို အမေးအဖြေအများစုတွင် မီးမောင်းထိုးပြခံခဲ့ရပါသည်။ ဤကဲ့သို့ ပူးပေါင်းပါဝင်မှုသည် INGO/NGO များ စီမံချက်အကောင်အထည်ဖော်ရာတွင် လမ်းညွှန်မှုပေးနေပါသည်။ အိတ်ချ်အိုင်စီလုပ်ငန်းများအတွက် နိုင်ငံတော်အသုံးစရိတ်များ တိုးမြှင့်လာသည်ကိုလည်းတွေ့ရသည်မှာ အားရစရာကောင်းလှသည် (အိတ်ချ်အိုင်စီအတွက် အသုံးစရိတ်မှာ (၂၀၁၂) ခုနှစ်တွင် (၂) ရာခိုင်နှုန်းရှိရာမှ (၂၀၁၃) ခုနှစ်

တွင် (၈) ရာခိုင်နှုန်း¹⁴)။ အဘယ်ကြောင့်ဆိုသော် ကျန်းမာရေးနှင့်အိတ်ချ်အိုင်ဗီအတွက် နိုင်ငံတော်အသုံးစရိတ်များ နှင့်ပတ်သက်၍ မြန်မာနိုင်ငံသည် အခြားသော အရှေ့တောင်အာရှနိုင်ငံ အများအပြားထက် နောက်ကျနေသေး သောကြောင့်ဖြစ်သည်။ ထို့ပြင် အပြောင်းအလဲအတွက်တိုက်တွန်းနှိုးဆော်ခြင်း၊ လူမှုရေးပံ့ပိုးမှုများနှင့် ကာကွယ် ရေးလုပ်ငန်းများတွင် လုပ်ကိုင်နေသော လိင်လုပ်သားများကွန်ရက်နှင့် ကိုယ့်အား ကိုယ်ကိုးအဖွဲ့များ ပေါ်ထွက်လာ ခြင်းကလည်း အမျိုးသားအဆင့် အိတ်ချ်အိုင်ဗီတုံ့ပြန်ရေးတွင် အရပ်ဖက်အဖွဲ့များ ပါဝင်မှုကို တိုးတက်လာစေပြီး ယင်းက လိင်လုပ်သားများနှင့်အခြားသော အဓိက ဦးတည်အုပ်စုများအတွက် တုံ့ပြန်ရေးလုပ်ငန်းများ အောင်မြင် မှု၏အခြေခံဖြစ်သည်။

အိတ်ချ်အိုင်ဗီတုံ့ပြန်ရေးလုပ်ငန်းများ ချဲ့ထွင်ရာတွင် တွေ့ရသောအဓိကစိန်ခေါ်မှုများနှင့်အတားအဆီး များ

လိင်လုပ်ငန်းများကို ပြစ်မှုအဖြစ်သတ်မှတ်ခြင်းက လိင်လုပ်သားများကို အိတ်ချ်အိုင်ဗီပိုးကူးစက်ခံရ လွယ်စေခြင်း၊ ခွဲခြားနှိမ်ချဆက်ဆံခံရခြင်း၊ ကိုယ်ထိလက်ရောက်စော်ကားမှုများနှင့် အကြမ်းဖက်မှုများခံရနိုင်ချေများစေပြီး ကပ် ရောဂါအသွင်ဆက်လက်ဖြစ်ပွားစေပါသည်။ မြန်မာနိုင်ငံတွင် ၁၉၄၉ ပြည့်တန်ဆာနှိပ်ကွပ်ရေးအက်ဥပဒေသည် ဆက်လက်တည်ရှိနေပြီး ယင်းက လိင်လုပ်သားများအားဦးတည်သော အိတ်ချ်အိုင်ဗီတုံ့ပြန်ရေးလုပ်ငန်းများအ တွက် စိန်ခေါ်မှုဖြစ်စေသည်။ လိင်လုပ်ငန်းများကို ပြစ်မှုအဖြစ်သတ်မှတ်ခြင်းက အမြဲတစေကြောက်ရွံ့နေရသော ပတ်ဝန်းကျင်ကိုဖန်တီးပေးနေသည် - ယင်းဥပဒေကို အကောင်အထည်ဖော်သော အလေ့အကျင့်များကြောင့် လိင်လုပ်သားများအနေဖြင့် မတရားသဖြင့် ငွေညှစ်ခံရခြင်း၊ အကြမ်းဖက်ခံရခြင်း၊ ဖမ်းဆီးချုပ်နှောင်ခံရခြင်းများ ကြုံတွေ့ကြရသည်။ (၂၀၁၁) ခုနှစ်¹⁵တွင် အမှုပေါင်း (၁၉၅၆) ခုမှ (၂၀၁၂) တွင် အမှုပေါင်း (၃၂၂၆) ထိ မြင့်တက်လာသည်ကို ကြည့်ခြင်းအားဖြင့် မြန်မာနိုင်ငံတွင်လိင်လုပ်သားများ ဖမ်းဆီးမှုမြင့်မားလာသည်ကို သိနိုင် ပါသည်။ ရလဒ်အနေဖြင့် လိင်လုပ်သားများသည် ပုန်းလျှိုးကွယ်လျှိုးနေကြရပြီး လုံခြုံစိတ်ချရသော လုပ်ငန်းအခြေ အနေ (မှန်ကန်သောနည်းဖြင့် ကွန်ဒုံးပုံမှန်အသုံးပြုနိုင်ခြင်း) အတွက် ညှိနှိုင်းဆွေးနွေးရန်နှင့် အိတ်ချ်အိုင်ဗီစီမံချက် များအား လက်လှမ်းမီအသုံးပြုရန်ပို၍ ခက်ခဲစေသည်။

ဤအခြေအနေဆန်းစစ်မှုတွင် ဆောင်ကြာမြိုင်အခြေပြုလိင်လုပ်သားများမှာ လွတ်လပ်စွာသွားလာခွင့် ထိန်းချုပ် ခံထားရပြီး ကွန်ဒုံး၊ အိတ်ချ်အိုင်ဗီနှင့် လိင်မှတဆင့်ကူးစက်တတ်သောရောဂါများ စစ်ဆေးခြင်း၊ ကုသခြင်းနှင့် အခြားဝန်ဆောင်မှုများအတွက် ညွှန်းပို့ခြင်း စသည်တို့ကဲ့သို့သော အမှန်တကယ်လိုအပ်သည့် ဝန်ဆောင်မှုများအား အသုံးမပြုနိုင်ဖြစ်နေသည်ဟု အများစုမှပြောကြားခဲ့သည်ကို တွေ့ရသည်။ အချို့လိင်လုပ်ငန်းအဆောင်ပိုင်ရှင် များသည် အိတ်ချ်အိုင်ဗီကာကွယ်ရေးလက်ကမ်းဝန်ဆောင်မှုများကို ငြင်းဆိုတတ်ကြပြီး အချို့မှာမူ အဆောင်ပိတ် ချိန်တွင် လက်ကမ်းကူညီမှုများကို လက်ခံကြသည်။ အရေးကြီးဆုံးအချက်မှာ လိင်လုပ်သားများသည် သင့်လျော် သော တရားရေးရာဝန်ဆောင်မှုများကို မရရှိကြချေ။ လိင်လုပ်သားများသည် မိမိကိုယ်ကို ဥပဒေနှင့် ငြိစွန်းသူများ (သို့မဟုတ်) ဥပဒေချိုးဖောက်ခံရသူများအဖြစ် မြင်နေတတ်ကြသည်။ သို့သော် မြန်မာနိုင်ငံရှိ လိင်လုပ်သားများ သည် အကြမ်းဖက်မှုများ (သို့မဟုတ်) ညှဉ်းပမ်းနှိပ်စက်မှုများ၊ အထူးသဖြင့် ပြစ်မှုကျူးလွန်သူများသည် ရဲ (သို့) ဥပဒေဖော်ဆောင်ရေးအရာရှိများဖြစ်နေလျှင် သတင်းပို့တိုင်ကြားရန် တရားရေးရာကာကွယ်မှု (သို့မဟုတ်) လုံခြုံ စိတ်ချရသောနည်းလမ်းများ ရှိမနေပေ။

Myanmar Equality နှင့် Myanmar Law Project ကဲ့သို့ လက်ရှိပေးအပ်နေသော ဝန်ဆောင်မှုများသည် လွှမ်းမိုးမှု (ရန်ကုန်နှင့် မန္တလေး) နှင့် လူ့အရင်းအမြစ်စွမ်းအားများ အကန့်အသတ်ရှိနေသည်။ လေ့လာမှုများအရ

လိင်လုပ်ငန်းအား ဆန့်ကျင်သောဥပဒေ၊ လိင်လုပ်ငန်းနှင့် ပတ်သတ်သော ခွဲခြားနှိမ်ချဆက်ဆံမှုတို့က လိင်လုပ်သားများ၏ လူ့အခွင့်အရေးများ၊ ကျန်းမာရေးနှင့် အိတ်ချ်အိုင်စီဆိုင်ရာဝန်ဆောင်မှုများရရှိနိုင်ရန် ကြိုးစားအားထုတ်ခြင်းများကို အားနည်းစေကြောင်းတွေ့ရှိရပါသည်။ သို့ဖြစ်ရာ လိင်လုပ်သားများအတွက် တရားရေးရာဝန်ဆောင်မှုများ၏ လွှမ်းခြုံမှုနှင့် ယင်းတို့ကို ရယူအသုံးပြုနိုင်မှုတို့ကို လိင်လုပ်သားအားလုံးထံသို့ ရောက်ရှိအောင် တိုးချဲ့ရန် လိုအပ်ပါသည်။

မြန်မာနိုင်ငံ၏ နိုင်ငံရေးနှင့် တရားဥပဒေရေးရာပတ်ဝန်းကျင်သည် ယခင်ကထက် ပိုမိုအထောက်အကူဖြစ်လာသည်ဟု ထင်ရဖွယ်ရှိကြောင်း ဤအခြေအနေဆန်းစစ်မှုအရ တွေ့ရပါသည်။ (၂၀၁၃) အမျိုးသားအဆင့်အိတ်ချ်အိုင်စီဥပဒေရေးရာပြန်လည်သုံးသပ်သည့်လုပ်ငန်းတွင် အဓိကထိခိုက်ခံစားနေရသော လူအုပ်စုများ၏ အိတ်ချ်အိုင်စီအန္တရာယ်နှင့် ထိခိုက်လွယ်မှုများကို တိုးပွားစေနိုင်သည့် တည်ဆဲဥပဒေများနှင့် အပြုအမူများအား ပြန်လည်သုံးသပ်ရာ၌ အစိုးရ၊ လိင်လုပ်သားများနှင့် အိတ်ချ်အိုင်စီနှင့်နေထိုင်သူများ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်များ၊ အိတ်ချ်အိုင်စီစီမံချက်အကောင်အထည်ဖော်နေသည့်မိတ်ဖက်များနှင့် ကုလသမဂ္ဂအဖွဲ့အစည်းများကြား ခိုင်မာသောပူးပေါင်း လုပ်ဆောင်အားထုတ်မှုများကို မြင်တွေ့ခဲ့ရသည်။ ပြည့်တန်ဆာနိုင်ငံကွပ်ရေးဥပဒေအပါအဝင် မြန်မာ့ဥပဒေရေးရာမူဘောင်၊ ဥပဒေများနှင့် မူဝါဒများမှ အိတ်ချ်အိုင်စီပိုးရိုနေသူများနှင့် အဓိကဦးတည်အုပ်စုများ¹⁶ ကျန်းမာရေးနှင့် အိတ်ချ်အိုင်စီဝန်ဆောင်မှုများ လက်လှမ်းမှီအသုံးပြုနိုင်မှုအပေါ် သက်ရောက်နေမှုများကို ပြန်လည်သုံးသပ်ရန် လိုအပ်ကြောင်း အကြံပြုထားပါသည်။

ထို့ပြင် နိုင်ငံတော်အစိုးရသည် ၁၉၉၃ မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲစေသော ဆေးဝါးများဆိုင်ရာဥပဒေနှင့် ၁၉၁၇ မြန်မာနိုင်ငံယစ်မျိုးအက်ဥပဒေ (အထူးသဖြင့် ဆေးထိုးအပ်ပိုင်ဆိုင်ခြင်းကို တရားမဝင်အဖြစ်သတ်မှတ်ခြင်း) ကဲ့သို့ အဓိကထိခိုက်ခံစားရသောလူအုပ်စုများနှင့် ဆက်စပ်သောဥပဒေများကို ပြင်ဆင်ရန် အစပြုလုပ်ဆောင်လာသည်ကို တွေ့ရပါသည်။ သို့သော် ဥပဒေပြုပြင်ပြောင်းလဲရေးတွင် စိန်ခေါ်မှုများနှင့် နှောင့်နှေးမှုများ ဆက်လက်တည်ရှိနေသည်။ ဥပမာအားဖြင့် (၂၀၁၅) ခုနှစ် ဇူလိုင်လတွင် ပြည်ထဲရေးဝန်ကြီးဌာနမှ ၁၉၄၉ ပြည့်တန်ဆာနိုင်ငံကွပ်ရေးအက်ဥပဒေအတွက် ပြင်ဆင်မှုများစွာကို အဆိုတင်သွင်းခဲ့ပြီး ပြည်သူလူထု၏ အမြင်များကို တောင်းခံခဲ့သော်လည်း ထိုအဆိုတင်သွင်းထားသော ပြင်ဆင်ချက်များကို အကျိုးတူပူးပေါင်းဆောင်ရွက်သူများ ပါဝင်ခြင်းမရှိဘဲ မူကြမ်းအဖြစ်ရေးဆွဲခဲ့ကြသည်။ ထို့ကြောင့် လိင်လုပ်သားများ၏ အခွင့်အရေးများနှင့် ကျန်းမာရေးလိုအပ်ချက်များကို ကာကွယ်ရန် ဤဥပဒေများကိုပြုပြင်ပြောင်းလဲရာတွင် ကြိုးပမ်းခဲ့ကြသော ပူးပေါင်း အားထုတ်ဆောင်ရွက်မှုများ ရေရှည်တည်တံ့ရန်မှာ အလွန်အရေးကြီးပါသည်။

ဥပဒေအကောင်အထည်ဖော်ခြင်းနှင့် လိင်လုပ်ငန်းကဏ္ဍနှင့်စပ်လျဉ်း၍ လက်တွေ့လုပ်ငန်းလုပ်ဆောင်သည့်အဆင့်တွင် လိင်လုပ်သားများ၏လိုအပ်ချက်များနှင့် အိတ်ချ်အိုင်စီကာကွယ်ရေးဆိုင်ရာ သင်တန်းများနှင့် အသိပညာပေးအစီအစဉ်များ ရဲအရာရှိများအတွက် အလုံအလောက်ရှိမနေသည်ကို ဤအခြေအနေဆန်းစစ်မှုက တွေ့ရှိခဲ့ပါသည်။ ဥပဒေအကောင်အထည်ဖော်သည့်ကဏ္ဍအတွင်း အဓိကဦးတည်အုပ်စုများ၏ အခွင့်အရေးများကို ထိန်းသိမ်းခြင်း၊ အကြမ်းဖက်မှုများမှအကာအကွယ်ပေးခြင်း၊ ကွန်ဒုံးအားလက်လှမ်းမှီအသုံးပြုနိုင်ခြင်းနှင့် လျှို့ဝှက်ထိန်းသိမ်းပေးသော ကျန်းမာရေးဝန်ဆောင်မှုများစသည်တို့ကို အားပေးနေသည့် အလေ့အထတစ်ခုဖြစ်နေစေရန် အဆိုပါသင်တန်းများက သေချာစေမည်ဖြစ်သည်။

စီမံကိန်းလုပ်ငန်းများနှင့်စပ်လျဉ်း၍ လက်ရှိအထင်ကရနေရာများတွင် လုပ်ငန်းလွှမ်းခြုံမှုသည် မြင့်မားလျက်ရှိပြီး အဓိကထိခိုက်ခံစားနေရသောလူအုပ်စုကြား အိတ်ချ်အိုင်စီဖြစ်ပွားမှုကျဆင်းရေးကို အတိုင်းအတာတစ်ခုအထိ ပံ့ပိုးပေးလျက်ရှိသည်။ သို့သော် လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်စီတိုက်ဖျက်ရေးစီမံချက်များ၏ လက်ကမ်းစောင့်ရှောက်ရေးလုပ်ငန်းများသည် ဦးတည်ချက်ပိုမိုခိုင်မာပြီး ဆန်းသစ်တီထွင်မှုများလိုအပ်ပါသည်။ လိင်လုပ်သားများကွန်ရက်နှင့် စီမံချက်မိတ်ဖက်များထံမှသတင်းအချက်အလက်များအရ လိင်လုပ်ငန်းဈေးကွက်အသစ်များ၊

အထူးသဖြင့် နယ်စပ်တစ်လျှောက်နှင့် သတ္တုတွင်းဒေသမြို့များနှင့် လက်ကိုင်ဖုန်း (သို့မဟုတ်) ကွန်ယက်အခြေပြု လမ်းကြောင်းများမှတစ်ဆင့် ပေါ်ထွက်လာပြီးပုန်းကွယ်နေသော (သို့မဟုတ်) တွေ့နိုင်ရန်ခက်ခဲသော လိင်လုပ် သား အရေအတွက်တိုးပွားလာကြောင်း တွေ့ရှိရပါသည်။ ဝန်ဆောင်မှုများမရှိသေးသော အဆိုပါနေရာဒေသ အသစ်များတွင် လိင်လုပ်သားများသည် ကြိုတင်ကာကွယ်ခြင်း (သို့မဟုတ်) အခြားဝန်ဆောင်မှုများထံသို့ လွှဲ ပြောင်းပေးခြင်း စသည်တို့ကို မရရှိနိုင်ပေ။ ပူတွဲကျန်းမာရေးဝန်ဆောင်မှုများ (ဥပမာ- လိင်လုပ်သားများအတွက် မိခင်နှင့်ကလေးကျန်းမာရေး၊ လိင်နှင့် မျိုးဆက်ပွားကျန်းမာရေး၊ တီဘီရောဂါ) အကြောင်းကို ဤလေ့လာဆန်းစစ် မှုတွင် သီးခြားမေးမြန်းထားခြင်းမရှိသော်လည်း ဤဝန်ဆောင်မှုများကို အသုံးပြုခြင်းမှာ အလွန်နည်းပါးနေ သေးကြောင်းဆန်းစစ်မှုတွင်ပါဝင်ခဲ့ကြသူများက တင်ပြကြပြီး ယင်းက ဤဝန်ဆောင်မှုများကို လိင်လုပ်သားများ ပိုမိုအသုံးပြုနိုင်စေရန် ၎င်းတို့အားဦးတည်သော လုပ်ဆောင်မှုများတိုးမြှင့်သွားရန်လိုအပ်ကြောင်း ဖော်ပြနေသည်။

လိင်လုပ်သားများအတွက် ကျန်းမာရေးဆိုင်ရာလွှဲပြောင်းညွှန်းပို့သည့် ကွန်ရက်များ၊ အထူးသဖြင့် လိင်လုပ်သား တစ်ဦးကို အိတ်ချ်အိုင်စီဝန်ဆောင်မှုမှ တခြားဝန်ဆောင်မှုများထံသို့ လွှဲပြောင်းပေးသည့် အခြေအနေများ (ဆိုလိုသည်မှာ အိတ်ချ်အိုင်စီမှ လိင်ပိုင်းဆိုင်ရာနှင့် မျိုးဆက်ပွားကျန်းမာရေး (သို့) တီဘီဝန်ဆောင်မှုများထံ လွှဲပြောင်းပေးခြင်း) (သို့မဟုတ်) ART ဆေးဖြင့် ကုသမှုမယူနေသော လိင်လုပ်သားကို ART ဆေးကုသမှုဌာန တစ်ခုမှ နောက်တစ်ခုသို့ လွှဲပြောင်းပေးခြင်းသည် ထိရောက်မှုမရှိဟု အများစုက ယေဘုယျအားဖြင့် လက်ခံထား ကြသည်။ လိင်လုပ်သားများ၏ ဆက်ဆံဖက်များတွင် အိတ်ချ်အိုင်စီစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း ဝန် ဆောင်မှုများ ရယူသုံးစွဲခြင်းအလွန်နည်းပါးကြောင်းကို ဆန်းစစ်မှုတွင်ပါဝင်ဖြေဆိုသူအားလုံးမှ အလေးထားပြောဆို ထားကြသည်။ ထိုသို့နည်းပါးခြင်းမှာ အဆိုပါလူစု၏ လိုအပ်ချက်နှင့်လိုက်လျောညီထွေ ပြင်ဆင်ထားသော စီမံ ချက်များမရှိခြင်းနှင့် အများအားဖြင့် လိင်လုပ်သားများ၏ ကျန်းမာရေးဝန်ဆောင်မှုများအပေါ်တွင်သာ အာရုံစိုက် ထားပြီး ထိုမှကျော်လွန်၍အသုံးပြုရန် ခွင့်ပြုထားသော ရန်ပုံငွေကန့်သတ်ချက်များကြောင့်ဖြစ်မည်ဟု သုံးသပ်ကြ သည်။

နည်းဗျူဟာမြောက်သတင်းအချက်အလက်များ၊ စောင့်ကြည့်လေ့လာခြင်းနှင့်အက်ဖြတ်ခြင်းနှင့် စပ်လျဉ်း၍ ဆိုရ လျှင် အဓိကထိခိုက်ခံစားနေရသောလူအုပ်စုများ၏ ကျန်းမာရေးတိုးတက်မှုအခြေအနေကို တိုင်းတာရာတွင် စိန်ခေါ်မှုများ ဆက်လက်ရှိနေဆဲဖြစ်ပါသည်¹⁷။ ART ဆေးရယူသူစာရင်းအချက်အလက်များတွင် လက်ရှိတွင် အဓိက ထိခိုက်ခံစားရသောလူအုပ်စုများအလိုက် ခွဲခြားထားခြင်းမရှိပေ။ ထို့အတူ လိင်ပိုင်းဆိုင်ရာနှင့် မျိုးဆက် ပွား ကျန်းမာရေး (သို့မဟုတ်) တီဘီရောဂါ ရှာဖွေရေးနှင့် ကုသရေးအချက်အလက်များသည်လည်း ခွဲခြား ထားခြင်း မရှိသောကြောင့် ဖွံ့ဖြိုးရေးနှင့်လုပ်ငန်းအကောင်အထည်ဖော်သည့် မိတ်ဖက်များအနေဖြင့် သတင်း အချက်အလက်များရရှိပြီး စီမံချက်နှင့်မူဝါဒဆိုင်ရာဆုံးဖြတ်ချက်များ ချမှတ်နိုင်ရေးအတွက် အဓိကဦးတည်အုပ်စု များ၏ ဝန်ဆောင်မှုသုံးစွဲသည့် အလေ့အထတိုးတက်မှုကို စောင့်ကြည့်လေ့လာရာတွင် အခက်တွေ့စေပါသည်။ ကျန်းမာရေးဝန်ဆောင်မှုများကို လက်လှမ်းမှီ အသုံးပြုနေသော လိင်လုပ်သားတစ်ဦးချင်းစီနှင့် အရေအတွက်ကို စောင့်ကြည့်လေ့လာပြီး ဝန်ဆောင်မှုပေးသူများအကြား တစ်ကမ္ဘာလုံးအတိုင်းအတာနှင့် စနစ်တကျပြန်လည် မျှဝေနိုင်သည့် လူတစ်ဦးချင်းအား တိကျစွာခွဲခြားမှတ်သားထားနိုင်သောစနစ် (Unique Identifier Code – UIC) မရှိခြင်းကလည်း အချက်အလက်များကောက်ယူရာတွင် အကန့်အသတ်များဖြစ်ပေါ်စေပါသည်။

အဓိကအကြောင်းအရာများအလိုက် အကြံပြုချက်များ

လိင်လုပ်သားများကို ဦးတည်သော အိတ်ချ်အိုင်စီကြိုတင်ကာကွယ်ခြင်း၊ ကုသခြင်းနှင့်စောင့်ရှောက်မှုပေးခြင်းတို့ အတွက် အခွင့်အလမ်းသာသောပတ်ဝန်းကျင် ဖန်တီးပေးခြင်း

လိင်လုပ်သားများကို အကြမ်းဖက်ခြင်း၊ လူတန်းစားခွဲခြားဆက်ဆံခြင်းတို့မှ အကာအကွယ်ပေးနိုင်ရန် လက်ရှိဥပဒေ များ ပြုပြင်ပြောင်းလဲခြင်း၊ ဥပဒေနှင့်စည်းမျဉ်းစည်းကမ်းအသစ်များဖော်ထုတ်ခြင်းတို့အတွက် တိုက်တွန်းနှိုးဆော် သင့်သည်။

- ၁၉၄၉ ပြည့်တန်ဆာနှိပ်ကွပ်ရေးအက်ဥပဒေနှင့် ၁၉၄၅ ပုလိပ်အက်ဥပဒေပုဒ်မများကို ပြုပြင်ပြောင်းလဲ ရန် လက်ရှိလုပ်ဆောင်လျက်ရှိသော ဆုံးဖြတ်ချက်ချမှတ်နိုင်သူများနှင့် ဆွေးနွေးမှုများ၊ တိုက်တွန်း နှိုးဆော် ကြိုးပမ်းအားထုတ်မှုများကို ဆက်လက်လုပ်ဆောင်သင့်သည်။ ပြုပြင်ပြောင်းလဲရန် ကြိုးပမ်း ရာတွင် ပြည်သူ့ကျန်းမာရေးစံနမူနာများ၊ ဘေးကင်းလုံခြုံမှုရှိသော စည်းမျဉ်းများ၊ လိင်လုပ်သားများ ၏ အခွင့်အရေးများကို အကာအကွယ်ပေးခြင်းများ အပါအဝင် လိင်လုပ်ငန်းတွင် အခြားသောဥပဒေ ရေးရာ ချဉ်းကပ်နည်းများအသုံးပြုခြင်း၏ အကျိုးကျေးဇူးကို ပံ့ပိုးပေးနေသော အပြည်ပြည်ဆိုင်ရာ အထောက်အထားများကို ထည့်သွင်းစဉ်းစားသင့်ပါသည်။ တိုက်တွန်းနှိုးဆော်သည့် ကြိုးပမ်းအားထုတ် မှုများတွင် လိင်လုပ်သားထုအား ပါဝင်စေရန် အလွန်အရေးကြီးပါသည်။ ဥပဒေကို ပြုပြင်ပြောင်းလဲရာ တွင်သို့ ဥပဒေကြမ်းရေးဆွဲရာတွင် ကျန်းမာရေးနှင့် လူ့အခွင့်အရေးဆိုင်ရာ အချက်အလက်များကို အခြေခံ၍ ချဉ်းကပ်ညှိနှိုင်းယူရမည်ဖြစ်ပြီး အပြစ်ပေးခြင်းထက် ကာကွယ်ရေးကို ဦးတည်နိုင်ရန် ဦးစားပေးရမည်။ ၁၉၄၉ ပြည့်တန်ဆာနှိပ်ကွပ်ရေးဥပဒေကို ပြင်ဆင်ရာ၌လည်းကောင်း၊ ပြည့်တန်ဆာ ဥပဒေမူကြမ်းတစ်ရပ်ကို ရေးဆွဲရာ၌လည်းကောင်း ၂၀၁၄ အမျိုးသားအိတ်ချ်အိုင်စီဥပဒေရေးရာပြန်လည် သုံးသပ်ခြင်းအစီရင်ခံစာတွင် အကြံပြုထားသော အချက်အလက် များကို ထည့်သွင်းစဉ်းစားရပါမည်။^{၁၈}

၁၉၄၉ ပြည့်တန်ဆာနှိပ်ကွပ်ရေးအက်ဥပဒေပြင်ဆင်ချက်မူကြမ်းအတွက် ပြည်သူလူထုထံမှ အကြံပြုချက်များ တောင်းခံခဲ့ရာ ယင်းကိုတုံ့ပြန်သည့်အနေဖြင့် ပြည်ထဲရေးဝန်ကြီးဌာနဆီသို့ (၁၉ ဩဂုတ်လ ၂၀၁၅ တွင်) ပူးပေါင်း ပေးပို့သောစာချွန်လွှာတွင် မြန်မာနိုင်ငံကုလသမဂ္ဂကျား/မရေးရာအဖွဲ့ (United Nations Gender Theme Group - UNAIDS, UNDP, UNESCO, UNFPA, UN Women နှင့် ILO) မှအဖွဲ့ဝင်များသည် လိင်လုပ်သားများ၏ကျန်းမာရေးနှင့် လူ့အခွင့်အရေးများအားမြှင့်တင်ရေးအတွက် အပြည်ပြည်ဆိုင်ရာ မူဝါဒစာစောင်များ၊ ကြေညာချက်များ၊ ကတိက ဝတ်များ၊ လမ်းညွှန်ချက်များနှင့်အညီ ပြီးပြည့်စုံသောချဉ်းကပ်နည်းကို အသုံးပြုရန် အကြံပြုထားသည်။

- အသိအမှတ်ပြုခြင်းနှင့် လိုက်နာဆောင်ရွက်ခြင်း။ ကွန်ဒုံးများကို လိင်လုပ်ငန်း၏သက်သေအဖြစ် အသုံးမပြုရန်ဟူသော ပြည်ထဲရေးဝန်ကြီးဌာနမှ အုပ်ချုပ်ရေးဆိုင်ရာအမိန့် (၂၀၁၀) အကောင်အထည် ဖော်ဆောင်ခြင်းကို ပိုမိုအားကောင်းစေရန်ဆောင်ရွက်သင့်သည်။
- လိင်လုပ်သားများကို အကြမ်းဖက်မှု၊ ခွဲခြားနှိမ်ချဆက်ဆံမှုများမှကာကွယ်ရန် ဥပဒေများနှင့် စည်းမျဉ်း စည်းကမ်းများ ဖော်ဆောင်သင့်သည်။ ယင်းနှင့်အတူ လိင်လုပ်သားများ အလျော်အစား ရနိုင်ရေးအတွက်

ဥပဒေရေးရာအထောက်အပံ့များနှင့် ကိုယ်စားပြုမှုများရှိသင့်သည်။ လိင်လုပ်သားများအပါအဝင် အဓိက ထိခိုက်ခံစားနေရသောလူအုပ်စုများအတွက် ဥပဒေအရ အကူအညီပေးနိုင်ရန် ရန်ပုံငွေတိုးမြှင့်ခြင်းနှင့် ဥပဒေရေးရာအခွင့်အလမ်းများ ရရှိစေနိုင်ရန် လုပ်ဆောင်သင့်သည်။ လိင်လုပ်သားများ မိမိတို့၏ အခွင့်အရေးကို ကောင်းစွာတတ်သိနားလည်နိုင်ရန်နှင့် တရားမျှတမှုကို လက်လှမ်းမှီအသုံးပြုနိုင်ရန် (၂၄) နာရီလုံး အလွယ်တကူ ဆက်သွယ်အကူအညီရယူနိုင်သော ဖုန်းများ ထားရှိသင့်သည်။

အခွင့်အလမ်းသာသောပတ်ဝန်းကျင်တစ်ရပ်ဖန်တီးနိုင်ရေးနှင့် ပြစ်ဒဏ်မှလွတ်မြောက်နေခြင်းများကို အဆုံးသတ် ရန် ဥပဒေအကောင်အထည်ဖော်ဆောင်နေသော အဖွဲ့များနှင့် ကျန်းမာရေးဝန်ဆောင်မှုပေးသူများအနေဖြင့် လိင်လုပ်ငန်းနှင့်ဆက်စပ်နေသော အရေးကိစ္စရပ်များကို ပိုမိုနားလည်အောင်ဆောင်ရွက်သင့်သည်။

- လိင်လုပ်သားများနှင့် ၎င်းတို့၏ ဖောက်သည်များအတွက် အိတ်ချ်အိုင်ဗွီရောဂါနှင့် လိင်မှတစ်ဆင့်ကူးစက် တတ်သောရောဂါများဆိုင်ရာ လုပ်ငန်းအစီအစဉ်များဆောင်ရွက်ရာတွင် လက်တွေ့လုပ်ကိုင်နေသော ရဲဝန်ထမ်းများကို သင်တန်းပို့ချရပါမည်။ ထိုသင်တန်းသည် လိင်လုပ်သားများအတွင်း ပြည်သူ့ကျန်းမာ ရေးလုပ်ငန်း၏ ရည်မှန်းချက်များ၊ အိတ်ချ်အိုင်ဗွီရောဂါတုန့်ပြန်ဆောင်ရွက်မှုများတွင် ဘဝတူပညာပေး သူများနှင့် လက်ကမ်းဝန်ဆောင်မှုပေးသောလုပ်သားများ၏ အရေးပါမှုကို အလေးပေးသင်ကြားပေးသင့် ပါသည်။ ဤသင်တန်းမှ အိတ်ချ်အိုင်ဗွီနှင့် လိင်မှတစ်ဆင့်ကူးစက်တတ်သောရောဂါများ ကာကွယ်တားဆီး ရေးလုပ်ငန်းများအား ထောက်ပံ့သည့် ရဲဝန်ထမ်းများ၏ စွမ်းဆောင်ရည်ကောင်းများကို အသိအမှတ်ပြု သည့် စနစ်မျိုးအား မိတ်ဆက်ပေးခြင်းကိုလည်း အဓိကထားဆောင်ရွက်သင့်သည်။ ထို့ပြင် သင်တန်း များတွင် ဖမ်းဆီးအကျဉ်းချခံရသော လိင်လုပ်သားများအား ဂုဏ်သိက္ခာရှိစွာပြုမူ ဆက်ဆံသင့်သည်။ ယင်းသင်တန်းများကို လုပ်ငန်းနယ်ပယ်၌ ကျွမ်းကျင်၍ အတွေ့အကြုံရှိသော ဥပဒေဖော်ဆောင်ရေး ဝန်ထမ်းများက ပါဝင်သင်ကြားပေးပါက အကောင်းဆုံး ဖြစ်ပေလိမ့်မည်။ အမျိုးသမီးရဲဝန်ထမ်းများကို သင်တန်းပို့ချသူနှင့် သင်တန်းသားများအဖြစ် ဗဟိုပြုခြင်းဖြင့် အမျိုးသမီးလိင်လုပ်သားများနှင့် ပတ်သက် သည့် ကိစ္စများအား ပိုမိုကောင်းမွန်စွာ ချဉ်းကပ်ဖြေရှင်း ပေးနိုင်ပါမည်။
- ရဲဝန်ထမ်းများ၏လုပ်ဆောင်ချက်ကို အကဲဖြတ်ရာတွင် လိင်လုပ်သားများ (အမျိုးသမီးများ၊ အမျိုးသားများ၊ ဆန့်ကျင်ဘက် လိင်ကဲ့သို့ ပြောင်းလဲခံယူနေထိုင်သူများ) အား သတ်မှတ်အရေအတွက်အရ ဖမ်းဆီးရမှု ပေါ်တည်ပြီး ဆုံးဖြတ်ခြင်းကို ပယ်ဖျက်သင့်သည်။ ၎င်းအစား လိင်လုပ်သားများ၏ လုံခြုံမှုနှင့် အခွင့်အ ရေးများ ကာကွယ်စောင့်ရှောက်မှုအပါအဝင် ပြည်သူ့ကျန်းမာရေးလုပ်ငန်းများ မြှင့်တင်ရေးတွင် ပူးပေါင်း ပါဝင်စေနိုင်သော အဖွဲ့အစည်းဆိုင်ရာ မြှင့်တင်နိုင်ရေးအတွက် ရဲဝန်ထမ်းများ၏ လုပ်ဆောင်ချက်ကို အကဲဖြတ်စောင့်ကြည့်လေ့လာခြင်းဆိုင်ရာမူဘောင်များကို ဖော်ထုတ်သင့်သည်။ အဆိုပါ မူဘောင်တွင် လိင်လုပ်သားများအတွင်း အိတ်ချ်အိုင်ဗွီနှင့် လိင်မှတစ်ဆင့် ကူးစက်တတ်သောရောဂါများ ကာကွယ်ရေး အစီအစဉ်များကို ပံ့ပိုးရာတွင် ရဲဝန်ထမ်းများ၏ စွမ်းဆောင်မှုကောင်းများကို တရားဝင်အသိအမှတ်ပြုခြင်း ကဲ့သို့ သော လုပ်ငန်းဆောင်တာများ ပါဝင်သင့်သည်။
- လိင်မှုဆိုင်ရာ အကြမ်းဖက်ခံရသူများနှင့် အကြမ်းဖက်မှုမှ အသက်ရှင်ကျန်ရစ်သူများအတွက် ထိရောက် စွာ တုန့်ပြန်ပေးနိုင်ရန်နှင့် စုံစမ်းစစ်ဆေးရေးတွင် အရည်အသွေးပြည့်မည်စွာ လုပ်ဆောင်နိုင်ရန်အတွက် နယ်မြေဒေသရှိ ရဲဝန်ထမ်းများ၊ တရားစီရင်ရေးနှင့် တရားဥပဒေဖော်ဆောင်ရေးဌာနများအား စွမ်းရည် မြှင့်သင်တန်းများတွင် ကျား-မရေးရာအခြေပြုသော အကြမ်းဖက်မှု၊ မျိုးဆက်ပွားကျန်းမာရေးနှင့် အိတ်ချ်

အိုင်စီစီ စသည့်ခေါင်းစဉ်များ ထည့်သွင်း သင်ကြားသင့်သည်။ ဤသည် လိင်လုပ်သားများ ၎င်းတို့အပေါ် အခြားသူများမှ ကျူးလွန်သောပြစ်မှုများကို ဖမ်းဆီးမှု၊ ခြိမ်းခြောက်မှုနှင့် ကြောက်ရွံ့မှုကင်းစွာ တိုင်ကြား နိုင်ရန် တွန်းအားပေးရာလည်း ရောက်ပါသည်။ ရဲဝန်ထမ်းများနှင့် အခြားအစိုးရ ဝန်ထမ်းများအပါအဝင် မည်သူမဆို လိင်လုပ်သားများအပေါ် အကြမ်းဖက်ညှဉ်းပန်းမှုပြုလုပ်မှုကို တိုင်ကြားလာပါက ဆိုင်းငံ့ခြင်း မရှိဘဲ တရားမျှတစွာစစ်ဆေးနိုင်ရန် စောင့်ကြည့်လေ့လာမှုစနစ်ကောင်းတစ်ခု ဖော်ဆောင်သင့်ပါသည်။ အမျိုးသမီးရဲဝန်ထမ်းများကိုလည်း ပိုမိုခန့်အပ်ပြီး လိင်လုပ်သားများ၏ လိုအပ်ချက်များကို ပိုမိုဖြည့် ဆည်းနိုင်ရန်နှင့် တိုင်ကြားချက်များကို မျှမျှတတတိုင်တွယ်ဖြေရှင်းပေးနိုင်ရန် လေ့ကျင့်သင်ကြားပေးသင့် ပါသည်။

- **မီးမောင်းထိုးခြင်း။** ။လိင်လုပ်သားများအတွင်း အိတ်ချ်အိုင်စီရောဂါ ကာကွယ်ရေး၊ ကုသရေးနှင့် ပြုစုစောင့်ရှောက်ရေးတွင် မူဝါဒကောင်းများနှင့် ရဲဝန်ထမ်းများ၏ ကောင်းမွန်သောလုပ်ဆောင်မှု အလေ့ အထကောင်းများကို စံနမူနာအဖြစ် အလေးပေးမီးမောင်းထိုးပြခြင်း။ ထိုစံနမူနာများကို မြန်မာနိုင်ငံရှိ ဥပဒေဖော်ဆောင်ရေးနှင့် လိင်လုပ်သားရေးရာဆောင်ရွက်သည့် အဖွဲ့အစည်းများထံ ဖြန့်ဝေရပါမည်။ ထို့ပြင် ဒေသဆိုင်ရာကျန်းမာရေးအထောက်အကူပြု ဆက်သွယ်ရေးအရာရှိလို ရာထူးမျိုးကိုလည်း ဖြစ် နိုင်သောနေရာများတွင် ခန့်အပ်ထားသင့်သည်။ ၎င်းသည် လိင်မှုဆိုင်ရာ ဥပဒေရေးရာပြဿနာများ ပေါ် ပေါက်လာပါက တာဝန်ခံအနေဖြင့် ကူညီဖြေရှင်းပေးရမည့်အပြင် အိတ်ချ်အိုင်စီရောဂါနှင့်ပတ်သက်ပြီး ထိခိုက်လွယ်အုပ်စုများအတွက် ဥပဒေဖော်ဆောင်ရေးဘက်မှ လုပ်ဆောင်သော အလေ့အထကောင်း များကို လုပ်ဖော်ကိုင်ဖက်အရာရှိများထံမျှဝေပြီး လမ်းညွှန်ခြင်းများ အကြံပေးခြင်းများလည်း ပြုလုပ်နိုင် သည်။ ထိုကျန်းမာရေးအထောက် အကူပြုဆက်သွယ်ရေးအရာရှိ၏ အဓိကလုပ်ငန်းတာဝန်သည် အဓိ ကထိခိုက်ခံစားနေရသောဦးတည်အုပ်စုများကို အကြမ်းဖက်မှုနှင့် လူ့အခွင့်အရေး ချိုးဖောက်မှုများမှ ကာကွယ်ရန်နှင့် ကွန်ဒိုအပါအဝင် ကျန်းမာရေးဝန်ဆောင်မှုများကို လက်လှမ်းယူနိုင်ရန်အတွက် ပံ့ပိုး ကူညီခြင်း တို့ဖြစ်ပါသည်။
- **ပြစ်ဒဏ်ပယ်ဖျက်ခြင်း။** ။ လိင်လုပ်သားများအား ပြစ်ဒဏ်ပေးခြင်းနှင့် ၎င်းတို့ရသင့်ရထိုက်သော တရားမျှတမှု၊ နစ်နာမှုအတွက် လျစ်လျူရှုထားခြင်းကို အဆုံးသတ်ရပါမည်။ လိင်လုပ်သားများအပေါ် အကြမ်းဖက်မှု ကျူးလွန် သူများအား ပြစ်ဒဏ်များနှင့် စည်းကမ်းပိုင်းအရေးယူမှုများကို ပြုလုပ်ရပါမည်။
- လိင်လုပ်သားများအား ခွဲခြားနှိမ်ချဆက်ဆံမှုမပြုဘဲ အရည်အသွေးမီကျန်းမာရေးဝန်ဆောင်မှုများပေးအပ် နေစေရေးအတွက် လိင်လုပ်သားများ၏ လိုအပ်ချက်နှင့်ပတ်သက်၍ ရဲဝန်ထမ်းများအား သင်တန်းပေး သည့်နည်းတူ အစိုးရ၊ ပုဂ္ဂလိကပိုင်နှင့် အစိုးရမဟုတ်သောအဖွဲ့အစည်းများရှိ ကျန်းမာရေးဝန်ဆောင် မှုပေးနေသူများကိုလည်း သင်တန်းများပေးသင့်သည်။

လိင်လုပ်သားများ၏လိုအပ်ချက်များကို ပို၍ကောင်းမွန်စွာတုံ့ပြန်နိုင်ရန် လူထုအခြေပြုအဖွဲ့များ နှင့် ကွန်ရက်များ၏ နည်းပညာပိုင်းဆိုင်ရာစွမ်းဆောင်ရည်များအား ခိုင်မာစေခြင်း

- ဘဏ္ဍာရေးနှင့် လုပ်ငန်းစီမံခန့်ခွဲမှု၊ စောင့်ကြည့်လေ့လာခြင်းနှင့် အကဲဖြတ်ခြင်း၊ အဓိကကဏ္ဍရပ်များ ဖြစ်သော လူ့အခွင့်အရေးနှင့် ကျား/မရေးရာအခြေခံသော ချဉ်းကပ်နည်းများအပါအဝင် အမျိုးမျိုးသော နည်းပညာပိုင်းဆိုင်ရာနယ်ပယ်များတွင် စွမ်းဆောင်ရည်မြှင့်တင်ခြင်းနှင့် ဗဟုသုတများ ပံ့ပိုးဖြည့်စွက်ပေး ခြင်းတို့ဖြင့် လိင်လုပ်သားများ ဦးဆောင်သော ကွန်ရက်များနှင့် CBO များအကြား ခေါင်းဆောင်မှု

နည်းပညာနှင့် အဖွဲ့အစည်းပိုင်းဆိုင်ရာ ဖွံ့ဖြိုးမှုများ တိုးမြှင့်ပေးသင့်သည်။ အန္တိမအနေဖြင့် လိင်လုပ်သား ကွန်ရက်များမှာ လိင်လုပ်သားများအား ဥပဒေရေးရာ အကူအညီများ ရရှိအောင်ပံ့ပိုးပေးခြင်း၊ ကျန်းမာရေး ဝန်ဆောင်မှုများထံသို့ လွှဲပြောင်းပေးခြင်း ကလေးသူငယ်စောင့်ရှောက်ရေး၊ ဝင်ငွေရလုပ်ငန်းများနှင့် လိင် လုပ်သားများ၏အခွင့်အရေးနှင့် ၎င်းတို့ကို ကာကွယ်စောင့်ရှောက်ရန်အတွက် တိုက်တွန်းနှိုးဆော်ခြင်း စသည်တို့ လုပ်ဆောင်နိုင်လောက်သော အရည်အချင်းများရှိသင့်ပါသည်။

- မူဝါဒများချမှတ်ရာတွင် လိင်လုပ်သားများအား ပါဝင်စေသင့်သည်။ လိင်လုပ်သားများသည် အိတ်ချ်အိုင်စီတို့ တုံ့ပြန်မှုများမြှင့်တင်ရန်အတွက် ဆွေးနွေးမှုများနှင့်ဆုံးဖြတ်ချက်များ ချမှတ်ခြင်း၊ အထူးသဖြင့် ဥပဒေပြုပြင် ပြောင်းလဲရေးနှင့် အိတ်ချ်အိုင်စီစီမံချက်လုပ်ငန်းများ ပြင်ဆင်ရေးဆွဲခြင်းတို့တွင် အစကတည်းက ပါဝင် သင့်သည်။
- လိင်လုပ်သားများ ကာကွယ်ရေးနှင့်ကျန်းမာရေးဝန်ဆောင်မှုများကို ပို၍လက်လှမ်းမှီအသုံးပြုနိုင်ရန် လိင် လုပ်သားများ၏ လိုအပ်ချက်များအကြောင်းနှင့်ပတ်သက်သော အမြင်ဖွင့်သင်ခန်းစာများအားဖြင့် ဆောင် ကြာမြိုင်အဆောင်ပိုင်ရှင်များကို အိတ်ချ်အိုင်စီတုံ့ပြန်ရေးလုပ်ငန်းများတွင် ပူးပေါင်းပါဝင်စေသင့်သည်။

လိင်လုပ်သားများအနေဖြင့် ဝန်ဆောင်မှုများပို၍ လက်လှမ်းမှီရန်နှင့် အသုံးပြုနိုင်ရန်အတွက် ကျန်းမာရေးဝန်ဆောင် မှုများ လက်ကမ်းစောင့်ရှောက်မှုပေးခြင်းနှင့် ဆန်းသစ်သော ဝန်ဆောင်မှုပေးအပ်သည့်ပုံစံများ စမ်းသပ်လုပ်ကိုင် နေခြင်းတို့ကို တိုးမြှင့်သွားရန် လိုအပ်သည်။

- ဝန်ဆောင်မှုများရောက်ရှိရန်ခက်ခဲသော လိင်လုပ်သားများထံသို့ ဝန်ဆောင်မှုရောက်ရှိနိုင်ရန်နှင့် လွှမ်းခြုံ မှုများ တိုးချဲ့ရန်နှင့် စောင့်ကြည့်လေ့လာခြင်းနှင့်အက်ဖြတ်ခြင်းအပါအဝင် လက်ကိုင်ဖုန်းနှင့် အင်တာနက် ကွန်ရက် အခြေပြုလုပ်ငန်းများ ဖော်ထုတ်ပြီး စမ်းသပ်လုပ်ဆောင်သင့်သည်။ လုပ်ငန်းအကောင်အထည် ဖော်မိတ်ဖက်များအနေဖြင့် လိင်လုပ်သားများ အမှုအကျင့်ပြောင်းလဲခြင်းဆိုင်ရာ ဝန်ဆောင်မှု၊ ကွန်ဒုံး အသုံးပြုမှု၊ HCT နှင့် ကုသရေးဝန်ဆောင်မှုများ အသုံးပြုမှုတိုးပွားလာစေရန် အင်တာနက်၊ လူမှုရေး ကွန်ရက်နှင့် လက်ကိုင်ဖုန်း အက်ပ်လီကေးရှင်း (Mobile Application) တို့ကို အလေးပေးပြီး ၎င်းတို့၏ ဆက်သွယ်ရေး နည်းဗျူဟာများတွင် ထည့်သွင်းထားသင့်သည်။ လိင်လုပ်သားများကိုလည်း အဆိုပါ ဝန်ဆောင်မှုများနှင့် လိုအပ်သလို ချိတ်ဆက်ပေးထားသင့်သည်။ ဥပမာဆိုရသော် မိုဘိုင်းဖုန်းစာတို ပေးပို့မှုနည်းပညာ (SMS)၊ အပြန်အလှန်ပြောဆိုနိုင်သော Chat အက်ပ်လီကေးရှင်း (viber, Line စသည်) နှင့် လူမှုကွန်ရက် (Facebook စသည်) များသည် လုံခြုံစိတ်ချရသောခြေအနေများ (virtual safe spaces) ဖန်တီးရန် အထူးသင့်လျော်နိုင်ပါသည်။ ဤတွင်အချက်အလက်များ ထိန်းသိမ်းခြင်းနှင့် ကိုယ်ရေးအချက်အလက်များ လျှို့ဝှက်ထိန်းသိမ်းထားခြင်းများသည်လည်း အရေးကြီးပါသည်။
- အိတ်ချ်အိုင်စီပိုးကူးစက်ရန် အခွင့်အလမ်းများသည့် လိင်လုပ်သားများနှင့် အခြား ထိခိုက်ခံစားနေရသော လူအုပ်စုများအတွက် အိတ်ချ်အိုင်စီ ကာကွယ်တားဆီးရေးလုပ်ဆောင်ရာတွင် ရောဂါပိုးနှင့် မထိတွေ့မှီ ကြိုတင်ကာကွယ်ခြင်း (Pre-exposure prophylaxis-PrEP) ကိုထိရောက်မှုရှိသောထပ်ဆောင်းကာကွယ်မှု နည်းလမ်းတစ်ခုအဖြစ် သိမြင်ရန် တိုက်တွန်းနှိုးဆော်သင့်သည်။ ထိုသို့လုပ်ဆောင်ရန် လိင်လုပ်သားများ၊ အခြားအဓိကထိခိုက်ခံစားနေရသော လူအုပ်စုများနှင့် အရပ်ဖက်လူ့အဖွဲ့အစည်းများအား ပြီးပြည့်စုံသော ကာကွယ်ရေးနှင့် ကုသရေးဝန်ဆောင်မှုများ၏ တစ်စိတ်တစ်ပိုင်းဖြစ်သော PrEP အသုံးပြုခြင်းကို ပံ့ပိုးပေးမည့် အထောက်အထားများပါသည့် သတင်းအချက်အလက်များမျှဝေပြီး ပူးပေါင်းပါဝင်စေရန် လိုအပ်သည်။

- လက်ရှိလုပ်ဆောင်နေသော အိတ်ချ်အိုင်စီစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်း၊ ART ဆေးဖြင့်ကုသပေးခြင်း၊ မျိုးဆက်ပွားကျန်းမာရေးနှင့် တီဘီရောဂါဝန်ဆောင်မှုများ၏ လိုက်လျောညီထွေရှိမှု၊ ပြုလွယ်ပြင်လွယ်မှုတို့ကို မြှင့်တင်ပေးရန် ရွေ့လျားကျန်းမာရေးဝန်ဆောင်မှုများ ထူထောင်သင့်သည်။ ရွေ့လျားကျန်းမာရေးဝန်ဆောင်မှုများကို လိင်လုပ်သားများနှင့် ၎င်းတို့ထံမှဝန်ဆောင်မှုရရှိသူများ စုဝေးရာနေရာများတွင် ပေးအပ်သင့်သည်။ (လိင်လုပ်ငန်းတည်ရှိသောနေရာများ သို့မဟုတ် စုဝေးနေရာရှိသော နေရာများ)
- လိင်လုပ်သားများ ထိရောက်ပြီးအချိန်မှီကုသပြုစောင့်ရှောက်မှုနှင့် အရည်အသွေးရှိသော ကျန်းမာရေးဝန်ဆောင်မှုများရရှိစေရန် လွှဲပြောင်းညွှန်းပို့သည့် ကွန်ရက်များကို ပိုမိုအားကောင်းအောင် လုပ်ဆောင်သင့်သည်။ လွှဲပြောင်းညွှန်းပို့သည့် ကွန်ရက်များနှင့်ပတ်သက်၍ လိင်လုပ်သားများဦးဆောင်သော ကွန်ယက်များ၊ လူထုအခြေပြုအဖွဲ့အစည်းများ(CBOs) နှင့်အစိုးရ၊ ပုဂ္ဂလိကနှင့် အစိုးရမဟုတ်သော အဖွဲ့အစည်းကဏ္ဍများမှ ဝန်ဆောင်မှုပေးအပ်သူများအကြား ညှိနှိုင်းဆောင်ရွက်မှုများပြုလုပ်သင့်သည်။
- ဖမ်းဆီးခြင်းခံရသော အိတ်ချ်အိုင်စီပိုးရှိနေသည့် လိင်လုပ်သားများသည်လည်း ART ဆေး ဆက်လက်ရရှိရေး၊ အခွင့်အရေးယူဝင်ရောက်လာသောရောဂါများ ရှာဖွေစစ်ဆေးခြင်း၊ ရောဂါဖော်ထုတ်ခြင်း၊ ကုသခြင်း တို့အပါအဝင် သင့်လျော်သော ကျန်းမာရေးဝန်ဆောင်မှုများ ရရှိနေအောင် ဆောင်ရွက်ပေးသင့်သည်။

လက်ရှိရောဂါဖြစ်ပွားမှုနှင့် မြန်မာနိုင်ငံအတွင်းရှိ လိင်လုပ်သားများအတွက် ကျန်းမာရေးဝန်ဆောင်မှုပေးနေမှုအပေါ် သက်သေအထောက်အထားကိုအခြေပြုသော တုံ့ပြန်မှုများ ပိုမိုအားကောင်းလာအောင် လုပ်ဆောင်သင့်သည်။

- လိင်လုပ်သားများ များစွာရှိသောနေရာ၊ လက်ရှိစီမံချက်ဆိုင်ရာ ကွာဟချက်များနှင့် ဝန်ဆောင်မှုများ ထပ်နေသောနေရာများကို ရှာဖွေဖော်ထုတ်ရန် အဆင့်အသီးသီးတွင် ဝန်ဆောင်မှုများချိတ်ဆက်ပြသည့် လေ့ကျင့်ခန်းများ (mapping exercise) ပြုလုပ်သင့်သည်။ နှစ်စဉ် လုပ်ငန်းများ ချိတ်ဆက်ကြည့်ခြင်းကို အမျိုးသားအဆင့်အပြင် ဒေသအဆင့်တွင် NAP မှ ဦးဆောင်ညှိနှိုင်းသင့်ပြီး ဦးစားပေးရမည့် မြို့နယ်များကိုဖော်ထုတ်နိုင်ရန်အတွက် လုပ်ငန်းအကောင်အထည်ဖော်နေသော မိတ်ဖက်များနှင့် လိင်လုပ်သားများ ကွန်ရက်များနှင့် ပူးပေါင်းလုပ်ဆောင်သင့်သည်။ အဆိုပါလေ့ကျင့်ခန်းအပြီးတွင် ပို၍ဦးတည်ချက်ရှိသော လုပ်ငန်းများဖြစ်စေရန် စီမံချက်ဆိုင်ရာချိတ်ဆက်ခြင်းကို ခရိုင် (သို့မဟုတ်) မြို့နယ်အဆင့်နှင့်လုပ်ငန်းအကောင်အထည်ဖော်သောအဆင့်တို့တွင် လုပ်ဆောင်သင့်သည်။ လိင်လုပ်သားများသည် ရွှေ့ပြောင်းသွားလာမှုများခြင်း၊ နိုင်ငံအတွင်းနှင့် လိင်လုပ်ငန်းများ တည်ရှိရာနေရာများအတွင်း တစ်နေရာမှတစ်နေရာသို့ သွားလာလေ့ရှိခြင်းတို့ကြောင့် ချိတ်ဆက်လေ့ကျင့်ခန်းများပြုလုပ်ခြင်းဖြင့် ပြောင်းလဲနေသော အခြေအနေများကို ပြန်လည်သုံးသပ်နိုင်ပြီး ၎င်းတို့အတွက် အိတ်ချ်အိုင်စီဝန်ဆောင်မှုများ၏ ဦးတည်ချက်များကိုလည်း ပြန်လည်ပြင်ဆင်နိုင်မည်ဖြစ်သည်။
- ဘဝတူကူညီစောင့်ရှောက်ပညာပေးသူများအနေဖြင့် လိင်လုပ်သားအရေအတွက်အများဆုံးထံသို့ ရောက်ရှိနိုင်ရေး၊ အန္တရာယ်နှင့်ထိခိုက်လွယ်မှုများကို ဆန်းစစ်နိုင်ရေး၊ လက်ကမ်းစောင့်ရှောက်ခြင်းအားဖြင့် စီမံချက် လွှမ်းမိုးမှုနှင့် ဝန်ဆောင်မှုဦးတည်ချက်များ ပြည့်မှီစေရေးအတွက် လိင်လုပ်သားများဦးဆောင်သော လက်ကမ်းစောင့်ရှောက်သည့် အစီအစဉ်များတွင် အသေးစိတ်အစီအစဉ်ရေးဆွဲပြင်ဆင်ခြင်းများ¹⁹ကို စတင်မိတ်ဆက်ပေးသင့်သည်။
- Strategic information and Monitoring and evaluation technical working group (SI and

ME TWG) ၏ အကြံပြုချက်များနှင့်အညီ အဓိကထိခိုက်ခံစားရသော လူအုပ်စုများအတွင်း ကျန်းမာရေး တိုးတက်မှုကို တိုင်းတာရာ၌ တွေ့ရသော စိန်ခေါ်မှုများအား ဖြေရှင်းသင့်သည်။ မူဝါဒချမှတ်သူများနှင့် စီမံချက်အကောင်အထည်ဖော်သူများ လိုအပ်နေသော အချက်အလက်များကို ပြန်လည်သုံးသပ်ပြီး အညွှန်းကိန်းများ အားကောင်းစေရန် အားစိုက်ထုတ်သင့်သည်။ သို့မှသာ ရောဂါဖြစ်ပွားပြောင်းလဲမှုနှင့် အိတ်ချ်အိုင်ဗွီတုံ့ပြန်မှုတစ်လျှောက် လုပ်ဆောင်ခဲ့သော တိုးတက်မှုများကို အလုံအလောက်သိရှိနိုင်မည်ဖြစ်သည်။ အထူးသဖြင့် အိတ်ချ်အိုင်ဗွီပိုးစစ်ဆေးခြင်း၊ ART ဆေးနှင့် ကုသမှုခံယူခြင်း၊ အိတ်ချ်အိုင်ဗွီနှင့်ဆက်စပ်ရောဂါများ (ဥပမာ - တီဘီရောဂါ)၊ လိင်နှင့် မျိုးဆက်ပွားကျန်းမာရေးအတွက် စစ်ဆေးခြင်းနှင့် ကုသခြင်းစသည်တို့နှင့် ပတ်သက်၍ အဓိကထိခိုက်ခံစားနေရသော ဦးတည်အုပ်စုများအလိုက် အချက်အလက်များ ခွဲခြားမှတ်သားထားခြင်းကို အာရုံစိုက်သင့်သည်။

အဆိုပါဝန်ဆောင်မှုများ အသုံးပြုသူအရေအတွက် တိုးပွားလာစေရန်နှင့် မတူညီသောဝန်ဆောင်မှုများ တစ်လျှောက် ၎င်းတို့အား စောင့်ကြပ်ကြည့်ရှုနိုင်ရန် SI and ME TWG အနေဖြင့် HIV TSG မှ ဦးစားပေးကာကွယ်ရေးလုပ်ငန်းများ ၂၀၁၅-၂၀၁၆ တွင် အကြံပြုထားသည့်အတိုင်း လုပ်ငန်းအကောင်အထည်ဖော်မိတ်ဖက်များ အသုံးပြုနိုင်သောလူ့ကျင့်ဝတ်နှင့်ကိုက်ညီပြီး အဓိကထိခိုက်ခံစားနေရသူများအတွက် လက်တွေ့ကျကျကိုက်ညီသော UIC စနစ်တစ်ခုပုံဖော်ရေးဆွဲပြီး အကောင်အထည်ဖော်သင့်သည်။ ထို့ပြင် ကျန်းမာရေးဝန်ဆောင်မှုများ၏ အရေအတွက်နှင့် အရည်အသွေး (ဆိုလိုသည်မှာ - ဝန်ဆောင်မှုကွာဟချက်များကို ဖော်ထုတ်ခြင်း၊ ကျန်းမာရေးစောင့်ရှောက်မှုဝန်ဆောင်မှုပေးသူ၏ဖော်ရွေမှု သို့မဟုတ် ခွဲခြားနှိမ်ချဆက်ဆံမှုကိုတိုင်းတာခြင်း၊ လူနာမှတုံ့ပြန်အကြံပေးသည့်အစီအစဉ်အား အကောင်အထည်ဖော်ခြင်း) ကို ဆန်းစစ်ရာတွင် အာရုံစိုက်လုပ်ဆောင်သင့်သည်။

သုတေသနများမှတစ်ဆင့် လိင်လုပ်သားများနှင့်ပတ်သက်သော ဗဟုသုတနှင့် သတင်းအချက်အလက်များ မြှင့်တင်သင့်သည်။

- ဤဆန်းစစ်လေ့လာမှုတွင် ဖော်ထုတ်တွေ့ရှိခဲ့သော ကန့်သတ်ချက်များနှင့် ကွာဟချက်များများကို ဖြေရှင်းရန် နောက်ထပ်သုတေသနများဆောင်ရွက်ရန်လိုအပ်ပါသည်။ ဤတွေ့ရှိချက်များနှင့်အတူ မကြာသေးမှီက ပြုလုပ်ခဲ့သော IBBS/PSE မှ ရလဒ်များနှင့်ပေါင်းစပ်၍ လက်ရှိနှင့် အသစ်ရရှိလာမည့် အချက်အလက်များအား ခွဲခြမ်းစိတ်ဖြာခြင်း၊ ပြန်လည်စစ်ဆေးခြင်း၊ အသုံးပြုခြင်းတို့ကို နေရာဒေသအဆင့်တိုင်း၌ မြှင့်တင်ဆောင်ရွက်သင့်သည်။

ထို့ပြင် ကိုယ်ရေးကိုယ်တာအချက်အလက်များအား လျှို့ဝှက်ထိန်းသိမ်းပေးပြီး တစ်ချိန်တည်းမှာပင် ဂွံ့ဖြိုးရေး မိတ်ဖက်များအကြား အချက်အလက်နှင့် သတင်းများအားဝေမျှခြင်းဖြင့် လိင်လုပ်သားများအတွက် အိတ်ချ်အိုင်ဗွီစီမံချက်များ၏ အကျိုးရှိမှု၊ ထိရောက်မှုနှင့်ရေရှည်တည်တံ့မှုတို့ကို အထောက်အပံ့ဖြစ်စေမည်ဖြစ်သည်။ အထူးသဖြင့် သုတေသနအကြောင်းအရာသည် အောက်ပါနယ်ပယ်များကို အာရုံစိုက်သင့်ပါသည် -

- o လိင်လုပ်သားများကို ဦးတည်ထားသော လက်ရှိစီမံချက်များ၏ အကျိုးရှိမှု၊ ကုန်ကျစရိတ်အလိုက် ထိရောက်မှုနှင့် ရေရှည်တည်တံ့မှု။
- o ကျယ်ပျံ့လာသော ဈေးကွက်တစ်မျိုးဖြစ်သည့် ဖုန်းနှင့်အင်တာနက်မှတစ်ဆင့် လိင်လုပ်ငန်း လုပ်

ဆောင်ခြင်းများ ပြုလုပ်နေသောသူများ၏ အခြေအနေနှင့်လိုအပ်ချက်များကို ဆန်းစစ်ခြင်း။

- o (လူကုန်ကူးမှုအပါအဝင်) အိတ်ချ်အိုင်စီ၊ လိင်လုပ်သားများ၏ လှုပ်ရှားသွားလာမှုနှင့် ရွှေ့ပြောင်းသွားလာမှုတို့အကြားရှိ အပြန်အလှန်ဆက်စပ်မှု။
- o မြန်မာပြည်ရှိ ငယ်ရွယ်သောလိင်လုပ်သားများနှင့် ၎င်းတို့၏ အိတ်ချ်အိုင်စီကူးစက်ခံရနိုင်ချေအား ဖော်ထုတ်ခြင်း။
- o အမျိုးသားလိင်လုပ်သားများနှင့် ဆန့်ကျင်ဘက်လိင်ကဲ့သို့ပြောင်းလဲနေထိုင်သူ (MSM and TG) လိင်လုပ်သားများ၏ လိုအပ်ချက်များ
- o လိင်လုပ်သားများကြား PrEP လက်ခံနိုင်မှုအား လေ့လာစမ်းစစ်ချက်လုပ်ဆောင်ရန် လူထု၏ လိုအပ်မှု တိုးတက်လာစေရန်နှင့် PrEP ကို စမ်းသပ်လုပ်ဆောင်နိုင်ရန် ရည်ရွယ်သည်



Executive Summary



16 Days Activities (Source - SWiM)



Brthel based health education session and STI mobile activity (Source - MDM)



Community Health Education Session (Source - PU-AMI)



Health Education in Outreach (Source - Pyi Gyi Khin)

Executive Summary

Myanmar is one of the countries in Asia hardest hit by the HIV epidemic. With an estimated 200,000¹ 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 HIV case was identified in Myanmar in 1988 and the first AIDS case was reported in 1991³, the HIV epidemic has remained concentrated in key populations: people who inject drugs (PWID), female sex workers (FSW), and men who have sex with men (MSM) and transgender persons (TG).

In 2010, the size of the FSW population was estimated at around 70,000 (aged between 15-49) and their clients at 830,000.⁴ From 1996 to 2006, HIV prevalence among FSW remained above 20%, with the highest prevalence reported in 2000, at 38%.⁵ Through the leadership and commitment of the Ministry of Health and National AIDS Programme (NAP), targeted prevention services for key populations were scaled-up. However, HIV prevalence among FSW remains considerably high at 6.3% in 2014⁶, confirming the continuing need for effective prevention efforts.

HIV prevalence among clients of FSW is also higher than in the general male population. Prevalence recorded among male patients visiting health services to seek care for sexually transmitted infections (STI) is commonly used as a proxy to estimate prevalence among male clients of FSW.⁷ In 2014, the HIV Sentinel Sero-Surveillance Survey (HSS) found 4% of male STI patients were HIV-positive, while HIV prevalence among adult male population was 0.75%.⁸

Despite concerted efforts between government agencies, international and local non-governmental organizations, community-based organizations, development partners and UN agencies, sex workers still face substantial barriers in accessing HIV services, largely due to stigma and discrimination, a punitive legal environment, and poverty. These social, legal, and economic factors are key determinants of their risk of acquiring HIV and other STI. The direct risk of violence and abuse that sex workers encounter daily also drives sex workers underground, away from health programmes, including HIV prevention efforts.

As well, the lack of data and understanding around sex work, including on the estimated number of male and transgender sex workers and their HIV prevalence, serves to make the provision of comprehensive HIV prevention, treatment, care and support for this key population particularly challenging. Results of the two new integrated Bio-Behavioural Surveillance Survey and Population Size Estimation (IBBS/PSE) among FSW and MSM and transgender persons will provide more up-to-date data and analysis of knowledge, attitudes and behaviours of female, transgender and male sex workers.

Rationale and objectives for the situational analysis

Although usually concentrated in cities and urban areas, mining areas, or along the country borders⁹, most sex workers within Myanmar are highly mobile as they migrate to seek more lucrative market-driven work opportunities, maintain anonymity, and avoid law enforcement harassment and arrests.¹⁰ The rapidly changing political and economic landscape in Myanmar has created an emergence of "hard-to-reach" sex workers in economic corridors such as border areas and mining towns, or via telephone and more recently web-based or social media channels; assumedly, as they are anonymous, these sex workers are not being reached by HIV prevention programmes. The number of clients of sex workers has risen with the increasing number of people in Myanmar who are now mobile and have extra disposable income. Innovative strategies (utilizing web-based applications and social media) are imperative to address these new trends, encourage greater HIV counselling and testing (HCT) and uptake of HIV treatment, and provide relevant and effective services for all sex workers (female, transgender and male sex workers).¹¹

Through presenting current evidence and perspectives, this situational analysis is intended to stimulate discussion and urgent action among all HIV stakeholders to accelerate the HIV response for sex workers, with updated priority setting in policy and programme areas. Specifically, objectives of the Situational Analysis on the HIV Response for Sex workers in Myanmar were to:

1. Discuss new trends emerging in the HIV response;
2. Highlight progress and current challenges evident in the HIV response;

3. Identify key priorities to address needs of sex workers; and,
4. Present corresponding recommendations to improve the HIV response for sex workers.

Methodology

This report consolidates findings and recommendations from the situational analysis which was conducted through a literature review, 27 semi-structured key informant interviews (KII), and 16 focus group discussions (FGD) in April 2015, with preliminary research carried out in October 2014. Qualitative research was undertaken in four cities across Myanmar in Yangon, Mandalay, Mawlamyine and Nay Pyi Taw.¹²

Findings

Major successes and achievements

Coverage of HIV prevention, care and treatment for sex workers in Myanmar has seen a vast increase over the last decade which, to some extent, has contributed towards the declining HIV prevalence among sex workers. Decentralisation of HIV counselling and testing (HCT) and antiretroviral treatment (ART) services, which was initiated in 2013, will over the coming few years undoubtedly contribute to reducing new HIV infections among key populations. The decentralisation of HCT and ART services was perceived by respondents as improving outreach to sex workers in HIV prevention programming, although it was too early in the decentralisation process for the situational analysis to determine evidence of this.

It is estimated that between 54646 and 77059 (high and low figure)¹³ of sex workers are currently being reached through HIV prevention programmes including HIV education, awareness raising activities through outreach, condom distribution, and referral to HIV counselling and testing (HCT) and sexually transmitted infections (STI) services. Expansion of these services is continuing, with an increase of new and emerging local community-based organizations (CBO) working in advocacy, social support and prevention outreach interventions. However coverage of prevention programmes for sex workers remains partial and based on uncertain population size estimates. The new IBBS/PSE among FSW, MSM and transgender persons will help fill this gap.

The most notable expansion to date, is the rapid scale up of ART services which is well positioned to meet the national target of 86% coverage by the end of 2016 (114,437 adults and children living with HIV on ART). In 2014, 85,626 PLHIV were registered for ART services.¹⁴

With regard to **increased engagement among government stakeholders in the response**, intergovernmental engagement has progressed at central and township levels during the implementation of the National Strategic Plan, which was highlighted as an achievement during most informant interviews for this situational analysis. Such engagement has guided INGOs/NGOs in programme implementation. There is rising public expenditure for HIV programming (from 2% of total HIV spending in 2012 to 8% in 2013¹⁵) which is an encouraging trend as Myanmar still lags behind many countries in the region with regards to its level of public expenditure for health and HIV. Also, the establishment of sex worker networks and self-help groups in Myanmar working in advocacy, social support and prevention has resulted in increased civil society engagement in the national HIV response, which is fundamental to the success of the response for sex workers and other key populations.

Major challenges and barriers in expanding the HIV response

Criminalization of sex work exposes sex workers to HIV vulnerability, discrimination, harassment and violence - perpetuating the epidemic. In Myanmar, the Suppression of Prostitution Act (1949) remains in effect and presents challenges to the HIV response for sex workers. Criminalization of sex work creates a culture of fear; law enforcement practices often result in sex workers experiencing extortion, violence, arrest and incarceration. Myanmar has seen an increase in arrests of sex workers from 1,956 cases in 2011, to 3,226 in 2012.¹⁶ As a result, sex workers are driven underground, where it is harder to negotiate safer work conditions (such as the correct and consistent use of condoms), and to access HIV programmes. These factors place sex workers in an extremely vulnerable situation.

The situational analysis found that most **brothel-based sex workers consistently report mobility restrictions** and cannot access much-needed services such as condom provision, HIV and STI testing, and treatment and referral to other services. Some venue owners refuse HIV prevention outreach services, whilst others allow outreach when the brothel is closed. **Of great concern is that sex workers lack access to appropriate legal services.** Sex workers often find themselves in conflict with the law and/or victims of violations of the law. Despite this, sex workers in Myanmar currently have no legal protection or safe mechanism to report acts of violence or abuse, particularly if the perpetrator is police or law enforcement officials.

The services that do exist, such as Myanmar Equality and Myanmar Law Project, have limited coverage (Yangon and Mandalay) and human resource capacity. Studies have shown that the laws against sex work, as well as the **stigma and discrimination** associated with sex work, undermine sex workers' human rights and programming efforts to ensure access to health and HIV-related services. As such, coverage and access to legal services for sex workers need to be expanded to

reach all sex workers.

The situational analysis found that the political and legal environments in Myanmar appear to be more conducive than previously. The 2013 National HIV Legal Review process saw strong collaborative efforts among Government, sex worker and people living with HIV (PLHIV) communities, development partners, HIV programme implementing partners and UN agencies on the review of existing laws and practices that increase vulnerability and HIV risk of key populations. It was recommended that Myanmar's legal framework, laws, and policies, including The Suppression of Prostitution Act, be reviewed for its effects on access to health and HIV services for PLHIV and key populations.¹⁷

In addition, the Government recently started to amend laws pertaining to key populations, such as the Narcotic Drugs and Psychotropic Substances Law of 1993 and the Burma Excise Act of 1917 (specific to the illegal possession of hypodermic needles). However, there continues to be **challenges and delays with legal reform**. For example, in July 2015, the Ministry of Home Affairs proposed several amendments to the Suppression of Prostitution Act of 1949 and although they called for public comments, the proposed amendments were drafted without involving stakeholders. Therefore, it is imperative that collaborative efforts to reform these laws are sustained, to protect the rights and health needs of sex workers.

Related to law enforcement and sex work, the situational analysis found that there is **inadequate training and sensitization programmes for police personnel** at the operational level on the needs of sex workers and HIV prevention. Such training will ensure the culture within the law enforcement sector encourages upholding the rights of key populations, protection against violence, and supporting access to condoms and confidential health services.

With regard to programming, coverage within existing well-known locations for sex work is high which, to some extent, has contributed to declining HIV prevalence among this key population. However, **outreach to sex workers in HIV programmes needs stronger focus and greater innovation**. Information from sex workers networks and programme partners indicates that there are new sex work markets, especially in border areas and mining towns and via mobile phone or web-based channels, with an increase of sex workers who are "hard-to-reach". In these new areas where programmes are not yet established, sex workers are not accessing prevention or referral services. Although data on integrated health services [e.g. maternal and child health, sexual and reproductive health, and tuberculosis (TB)] for sex workers is currently not captured, most respondents in the situational analysis believed the uptake of these services is very low, which also indicates a need to improve targeting sex workers to attend these services.

Health referral networks for sex workers were generally perceived by most respondents to be ineffective, particularly in the instance where a sex worker is referred from an HIV service to an integrated service (i.e. referred from an HIV to sexual and reproductive health or TB service), or a sex worker ART patient is referred and transferred from one ART site to another. All respondents emphasized there is very low uptake of HCT services for partners of sex workers; it was perceived that the low uptake stems from a lack of programmes tailored to needs of these populations, arising from the limited programme funding to stretch beyond focusing primarily on sex workers for health services.

For **strategic information and monitoring and evaluation**, challenges continue in the measurement of health progress of key populations.¹⁸ ART treatment data is currently not disaggregated by key population, nor is sexual and reproductive health or TB screening and treatment, which makes it difficult for development and implementing partners to track progress of service uptake by key populations to help inform programme and policy decision-making. The absence of a unique identifier code (UIC) which is universally and systematically shared across service providers to track the number of individual sex workers accessing health services also continues to impose limitations to data collection.

Key Thematic Recommendations:

Enabling environment for HIV prevention, treatment and care targeting sex workers

Advocate for the reforms of existing laws and establish new laws and regulations to protect sex workers from violence, stigma and discrimination.

- **Maintain on-going dialogue and advocacy efforts with decision-makers to reform the Suppression of Prostitution Act 1949 and sections of the Police Act 1945.** Reform efforts should consider international evidence supporting the benefits of alternative legislative approaches to sex work, including models of public health and safety regulation and the protection of human rights of sex workers. The involvement of sex worker communities in advocacy efforts is essential. Amending or drafting a new law that is based on health and human rights approaches and is protective rather than punitive is of high priority. Amendments to the Suppression of Prostitution Act 1949 or the drafting of a new law on sex work should take into consideration recommendations outlined in the 2014 National HIV Legal Review Report.¹⁹

In a joint letter sent to the Ministry of Home Affairs (dated 19 August 2015) responding to a call for public comments to the draft amendments of the Suppression of Prostitution Act of 1949, the

members of the United Nations Gender Theme Group in Myanmar (UNAIDS, UNDP, UNESCO, UNFPA, UN Women, and ILO), recommended taking a comprehensive approach towards improving health and human rights of sex workers in line with international policy documents, declarations, commitments, and guidelines.

- **Endorse and reinforce** the implementation of the Ministry of Home Affairs administrative order (2000) not to use condoms as evidence of sex work.²⁰
- **Establish laws and regulations to protect sex workers from violence, stigma and discrimination.** This should be accompanied by legal support and representation for sex workers to seek redress. Increased funding for legal aid programmes and pro bono legal services for key populations, including sex workers should be made available. A hotline number should be established to strengthen sex workers' access to justice, and knowledge of their rights.

Increase understanding of issues pertaining to sex-work among law enforcement agencies and health care service providers to promote an enabling environment and end impunity

- **Provide training for operational police (with a focus on female police officers) on how best to support HIV and STI programming for sex workers.** Such training should instil an understanding of the public health goals of such programming, and the importance of peer educators and outreach workers in providing essential services as a part of the HIV response. Central to this training should be the introduction of a system that recognises the good work undertaken by police who support HIV and STI prevention programming. Further, training of police and prison staff should be conducted regularly to ensure sex workers are treated with dignity and respect. These trainings will be best provided by law enforcement officers with experience and expertise in this area. Focusing on female police officers, as trainers and trainees, will help with outreach to female sex workers.
- **Remove sex workers (female, transgender and male) from the arrest quotas** as a method to appraise police performance and develop a system that reframes police performance monitoring frameworks to strengthen attention and institutional support for the protective role that police can play in promoting public health including, safety and rights of sex workers. Such a framework may include formal recognition of the good work undertaken by police who provide support for HIV and STI prevention programmes among sex workers.
- **Strengthen the capacity of local operational police, the judiciary and other law enforcement agencies** to effectively respond to cases of sexual violence and to undertake investigations by enhancing their training to include topics on gender-based violence, reproductive health

and HIV. A systematic monitoring system should be developed and implemented to ensure all allegations and reports of violence against sex workers, including those perpetrated by police and other state officials, are promptly and impartially investigated. More female police officers should be recruited and trained to better meet the needs of sex workers and respond to their complaints.

- **Highlight examples of good policy and practice undertaken by police in support of HIV prevention, treatment and care among sex workers** and disseminate these examples to law enforcement and other organizations working on sex work issues in Myanmar. In support, local “health support liaison officers” from police should be established, whenever possible, to serve as a focal point for key populations, and to provide guidance to fellow officers on best practice law enforcement responses to communities vulnerable to HIV. The mandate of the health support liaison officer should be to support key populations by protecting them from violence and rights violations and ensuring access to health services and tools, including condoms.
- **End impunity** and the denial of sex workers' right to justice and redress. Impose penalties and disciplinary measures to those carrying out violence against sex workers.
- Similar to training for operational police, **provide training to health care service providers from public, private and NGO sectors** on the needs of sex workers to ensure that inclusive quality health services are delivered to sex workers without stigma and discrimination.

Strengthen technical capacity of networks and CBOs to better respond to the needs of sex workers.

- **Increase leadership and organizational development among sex worker-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, sex workers networks should be competent to provide their members with support to access legal aid, referrals to health services, child support, income generation and advocating for rights and protection of sex workers.
- **Involve sex workers in policy making;** sex workers 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.

- **Engage brothel owners in the HIV response** among sex workers through awareness-raising sessions about the needs of sex workers to improve their access to prevention and health services.

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

- **Develop and implement mobile and web-based activities to expand service coverage and reach of "hard-to-reach" sex workers.** Implementing partners should include in their targeted communications strategy a focus on internet, social media and mobile applications as platforms for increasing the demand for condoms, HCT and treatment services among sex workers. In this instance, mobile phone SMS technology, instant chat applications such as Viber and Line, and social media networks such as Facebook, may be particularly relevant. Ensuring confidentiality and protection of data is essential.
- **Advocate for pre-exposure prophylaxis (PrEP)** as an additional effective intervention option for HIV prevention for sex workers and other key populations at higher risk of HIV. This will require engaging sex workers, 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.
- **Establish mobile health services to increase the flexibility of existing HCT, ART, reproductive health and TB services.** Mobile services should be delivered where sex workers and their clients are located (i.e. at venues and in other areas where sex work takes place).
- **Strengthen referral networks to ensure sex workers receive effective, timely case management and quality health services.** Referral networks should be coordinated among sex worker-led CBOs and service providers from public, private and NGO sectors.
- **Ensure that sex workers living with HIV who are incarcerated have access to appropriate health services,** including uninterrupted access to ART, and screening, diagnosis and treatment of opportunistic infections.

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

- **Organize mapping exercises at several levels to identify where sex workers are concentrated, existing programmatic gaps and duplication of services.** Annual high-level mapping should be coordinated by NAP at the national and subnational levels and involve implementing partners and sex workers 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. Given that sex workers are highly mobile, moving across geographical areas and sex work venues, mapping will help to evaluate how the situation is changing and re-orient targeting of HIV services for sex workers.
- **Introduce micro planning²¹ 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.

To increase the number of people accessing services and monitoring them across different services, the SI & ME TWG should steer a process to design and implement a harmonised UIC system to be used by implementing partners that is ethical and realistic for key populations as per the HIV TSG Recommendations of Priority Prevention Interventions 2015-2016. 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 sex workers 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 sex workers. Specifically, the research agenda should focus on the following areas:

- o Efficiency, cost-effectiveness and sustainability of existing programmes targeting sex workers;
- o Situational and needs assessment of people selling sex over the phone and internet, which is an expanding practice and market;
- o Correlation between HIV, mobility and migration of sex workers (including trafficking);
- o Identification of young sex workers in Myanmar and their vulnerability to HIV;
- o Specific needs of transgender and male sex workers; and
- o Acceptability of PrEP among sex workers, with a view to conducting a feasibility study on piloting PrEP and increasing public demand.



Provide Medical Care and Treatment (Source - TOP, PSI)





Recreational activities: Beauty parlor for sex workers at MDM drop-in-centre (*Source - MDM*)



Counselling and psychological support (*Source - TOP, PSI*)

Foreword

To enhance the understanding of sex workers, HIV and the response in Myanmar, a situational analysis was undertaken by an independent consultant, on behalf of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Country Office in Myanmar, in April 2015, with preliminary data collection undertaken by two other independent consultants in late 2014. The report has been structured to include combined quantitative and qualitative analysis of data, which relates to HIV prevention among sex workers in Myanmar. Multiple data collection elements and data sources were used to strengthen confidence in the findings and provided a richer substance upon which conclusions were drawn in the Discussion and Recommendations section of this report.

1. Introduction



SWiM annual meeting (Source - SWiM)



Coordination meeting (Source - AMA)



Education Training for Sex Worker (Source - AMA)



Organizing special event day at SWiM drop-in-centre (Source - SWiM)

1. Introduction

Sex workers have been among the populations most affected by HIV since the beginning of the epidemic more than 30 years ago. HIV prevalence is considerably higher among sex workers than in the general population. Globally, female sex workers (FSW) are 13.5 times more likely to be living with HIV than all other women, including in hyper-endemic countries.²² In Asia, the risk of HIV is 29 times greater for FSW than for women of a similar age who are not sex workers.²³ Sex workers face substantial barriers in accessing prevention, treatment and care services, largely due to stigma and discrimination, punitive legal environments, and client and police-related violence and abuses. These social, legal and economic factors contribute to their high risk of acquiring HIV and other sexually transmitted infections (STIs).

Although much progress has been made over the past decade in reducing HIV prevalence, Myanmar continues to experience an epidemic where sex workers remain one of the populations most affected by HIV. From 1996 to 2006, HIV prevalence among FSW remained above 20% (peaking at 38% in 2000²⁴). Although HIV prevalence among FSW has seen a steady decline since 2008, it remains high at 6.3% in 2014.²⁵ There is no accurate measurement of HIV prevalence among clients of sex workers, given difficulties identifying and reaching this population. Therefore clients are not included in annual HSS, although male patients of STI health services are used as a proxy for HIV prevalence among clients of sex workers. In 2014, it was estimated 4% of clients of sex workers were living with HIV,²⁶ while HIV prevalence among the adult male population was 0.75 in 2014.²⁷

Despite the legal framework that criminalises sex work in Myanmar, there is a growing and expanding response to the needs of sex workers. Coverage within existing programme locations is high which, to some extent, has contributed to declining HIV prevalence among this key population.

However, information from sex worker networks and programme partners indicates that Myanmar's rapidly changing political and economic landscape has created new sex work markets, especially in border areas and mining towns and via mobile and web-based technologies, with an increase in the number of sex workers who are "hard-to-reach". In these new areas where programmes are not yet established, sex workers are not accessing prevention or referral services.

With the expansion of this pool of sex workers, and the high mobility of sex workers in general, innovative strategies are indispensable to address these new challenges and strengthen the HIV response for all sex workers (including female, male and transgender sex workers).²⁸

1.1 Objectives of the situational analysis

The objectives of the Situational Analysis of the HIV Response among Sex Workers in Myanmar were to:

1. Discuss new trends emerging in the HIV response;
2. Highlight progress and current challenges evident in the HIV response;
3. Identify key priorities to address the needs of sex workers and;
4. Present corresponding recommendations on a way forward to improve the HIV response for sex workers.

1.2 Key definitions

Working definitions of "sex worker" and "client of sex worker"

For the purposes of this situational analysis, the term "sex worker" is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults over the age of 18 and young people over the age of 18, who receive money or goods in exchange for sexual services, either regularly or occasionally.²⁹ A client of a sex worker is defined as a person who procures sexual services from a sex worker through payment in the form of money or goods.

When discussing prevalence and incidence of HIV among sex workers throughout this report, reference will be made to FSW as epidemiological data available at national and global levels currently

only captures the situation of females. There are some sections within this report, however, that will distinctively highlight issues pertinent to sex workers of all genders, including female, male and transgender sex workers. The HIV response among sex workers in Myanmar is inclusive of all gender identities.

1.3 Modes of sex work

For the purpose of clarity, this report will use the following terminology for the Myanmar context:

Direct sex work/ers: sex workers whose primary mode or source of income is to sell sex. Female sex workers usually work in brothels or in the street or parks. They are increasingly mobile, often concentrated in the country's new economic hubs such as mining sites, casinos and border areas. Male and transgender direct sex workers usually sell sex in the street or in other areas such as bars and night clubs.³⁰

Indirect sex work/ers: relates to sex workers whose primary source of income is not sex work but who may sell sex when or as opportunities arise. FSW are usually employed in the entertainment sector, for example as beer promoters, karaoke singers, massage workers or hostesses, or operate through mobile and web-based applications, which are becoming more accessible in Myanmar. Male and transgender indirect sex workers usually work in massage and spa venues, and may be reached by clients through mobile and web-based applications.³¹

Sex work/ers: includes both direct and indirect sex workers regardless of their context. It is assumed that prevalence is higher among direct sex workers in brothel settings as working conditions may impede information and autonomy relating to HIV risk reduction. Venue owners or managers may fail to supply condoms on the premises because of higher rates charged for unprotected sex, and restrictions placed on workers' mobility may prevent them from accessing condoms independently.³²

1.4 Limitations to the situational analysis

Annual HSS has been conducted in Myanmar since 1991, including among key populations such as FSW. The results have been used to track trends in the national HIV epidemic, and show declines in HIV prevalence across all of the population groups involved in HSS. One limitation, however, is that because HSS is carried out at health facilities, the sample is not sufficiently representative of people who are not in contact with services. To gain a better understanding of the situation of all sex workers, an Integrated Bio-Behavioural Surveillance Survey and Population Size Estimation (IBBS/PSE), involving HIV testing and a questionnaire, has been undertaken in Myanmar in 2015.

The results will become available in early 2016. HSS data on HIV prevalence among FSW are outlined in Section 2.2 of this report.³³

The Behavioural Surveillance Survey (BSS) seeks to measure correct and consistent condom use among sex workers (defined as always or almost always using condoms in the last six months with clients). Past surveys have found high condom use rates among FSW. In 2007, condom use was reportedly very high among FSW in Mandalay (97%) and slightly lower in Yangon (83%). It is believed that these rates do not reflect the reality, possibly because respondents answer questions about consistent condom use in ways they feel will please the interviewers.³⁴ This is why the data from the 2007 BSS among FSW were triangulated with data from the BSS among the general population, where men who reported paying for sex were asked questions about condom use. Triangulation with the findings of the Tracking Results Continuously (TRaC) survey conducted by Population Services International (PSI) confirms that condom use is over-reported in the BSS.³⁵

Estimates of the size of key populations, including FSW, are necessary for advocacy as well as for planning, monitoring and evaluation of HIV prevention programmes. These populations are usually hard to reach,³⁶ which makes it difficult to determine their exact sizes. Consequently, a number of techniques are used to estimate the size of these populations. In Myanmar, population size estimations for FSW were respectively undertaken in 2010 by the National AIDS Programme (NAP) and PSI using mapping. The results were relatively coherent and the Strategic Information and Monitoring and Evaluation Technical Working Group (SI & ME TWG) reached consensus on the estimate of around 70,000 FSW. The estimate will be updated once the results of the FSW Integrated Biological and Behavioural Surveillance Survey/Population Size Estimation (IBBS/PSE) becomes available. Simultaneously, the population size estimate of men who have sex with men (MSM) and transgender persons is currently being produced.

Prevalence and behavioural data concerning female, male and transgender sex workers are limited, which makes it difficult to tailor the national HIV response to the specific needs of all sex workers. The new IBBS/PSE among FSW, MSM and transgender persons will help fill this gap. The IBBS will more systematically collect data in relation to drug use, including injecting drug use, from sex workers. The survey will also produce data that help measure stigma and discrimination experienced by sex workers, and harassment and violence of different kinds towards sex workers, including from clients, partners, public health workers and law enforcement.

Currently, the NAP does not disaggregate treatment data by key population, which makes it difficult for implementing partners to track service uptake by key population. Data on tuberculosis (TB) prevalence among sex workers are currently not available in Myanmar. The incidence of TB and TB-HIV co-infection among sex workers is also unknown. Similarly, rates of contraceptive use

are currently unknown for the sex worker population. Data related to risk behaviours linked to injecting drug use among sex workers are currently not available. Further, limited data are available on stigma and discrimination experienced by sex workers, such as from the 2010 Myanmar People Living with HIV Stigma Index. No data exist on the prevalence of sexual and physical violence, including from clients, partners and state actors.



HIV and safer sex health education session by Myittashin Sex Worker CBO (Source - Alliance)



Human Right Training (Source - AMA)



2. Literature review



Seminar on "Collaboration for HIV Response with Sex Workers in Myanmar". Opening remarked by Dr. Than Win, Deputy Director General, Department of Public Health, Ministry of Health. (Source - UNAIDS)



Seminar on "Collaboration for HIV Response with Sex Workers in Myanmar". Presentation by Dr. Htun Nyut Oo, Programme Manager, National AIDS Programme, Department of Public Health, Ministry of Health. (Source - UNAIDS)



Dissemination of the Right(s) Process Report (Source - AMA)



Participation in World AIDS Day event (Source - AMA)

2. Literature review

The HIV epidemic among sex workers in Myanmar and the national response

2.1 Methodology of literature review

A literature review was undertaken, which provided useful data and a historical perspective of the situation of sex workers in Myanmar and the HIV response. The review included peer reviewed articles and reports from government, non-government and United Nations (UN) agencies. Quantitative analysis was achieved through examination of BSS and HSS data, and review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2016 (NSP II), Mid-Term Review of the Myanmar National Strategic Plan on HIV and AIDS 2011–2015 and associated Progress Reports, 2014 Global AIDS Response Progress Report (GARPR), and HIV Estimates and Projections: Asian Epidemic Model Myanmar 2010–2015. A detailed listing of all literature reviewed during the situational analysis can be found in the Bibliography section of this report.

2.2 Overview of the HIV epidemic among sex workers and their clients in Myanmar

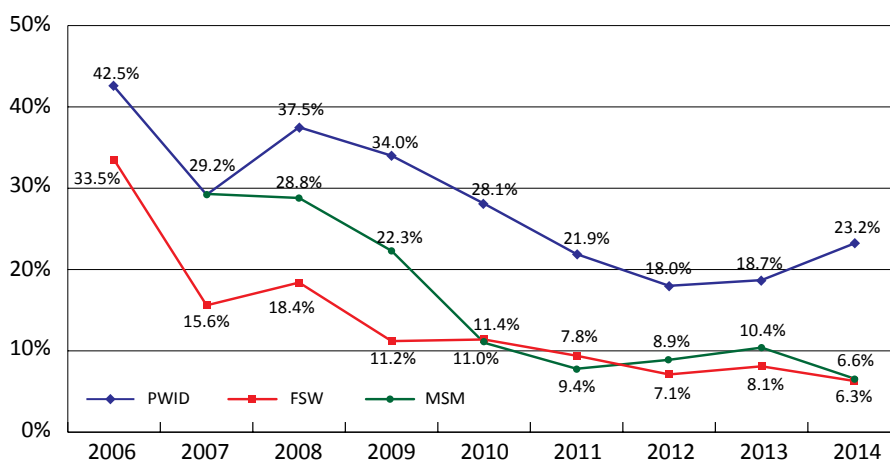
The first HIV-positive individual in Myanmar was identified in 1988 and the first case of AIDS was reported in 1991.³⁷ HIV prevalence among the general adult population in Myanmar was 0.54% in 2014.³⁸ The number of people aged 15 and above living with HIV (PLHIV) was estimated at around 200,000 of which 33% were female. An estimated 10,412 adult people died of AIDS-related illness

in the same year. Based on epidemiological modelling, the incidence of new infections has declined in recent years, but 8,000 new infections are estimated to have occurred in 2014 in adult population³⁹, confirming the continuing need for effective prevention efforts.

The HIV epidemic in Myanmar is concentrated in key populations: sex workers, people who inject drugs (PWID) and MSM. HIV transmission in Myanmar is largely driven by the use of non-sterile injecting equipment and by sexual contact. Key factors that make Myanmar vulnerable to the HIV epidemic are the large size of key populations, punitive laws that fuel stigma and discrimination, high prevalence of risk behaviours, limited coverage of effective prevention programmes, high prevalence of syphilis, population mobility and poverty.⁴⁰ Although there has been a sustained downward trend in HIV prevalence among key populations⁴¹ (as shown in the table below), it remains high in these sentinel groups.

In 2014, according to HSS data, HIV prevalence was 6.3% nationwide among the estimated 70,000⁴² FSW. Results of the two IBBS/PSE among FSW and MSM and transgender persons will provide more up-to-date data and analysis in early 2016.

Figure 1: Trends of HIV prevalence among key populations, 2006–2014



Source: National AIDS Programme. HIV Sentinel Sero-Surveillance Survey, 2006–2014

2.2.1 HIV prevalence among female sex workers in Myanmar by geographic region

HIV prevalence among FSW in Mandalay and Yangon was reportedly 7% in 2014. Pathein township in south west Myanmar, a transit town toward beach holiday destinations in Ayeyarwady Division, experiences the highest HIV prevalence among FSW in the country although it has seen a sharp decline from 24.5% in 2013 to 13% in 2014. Over the same period of time, HIV prevalence among FSW has declined from 12.5% to 10% in Myitkyina in Kachin State whilst Mandalay has seen a spike in HIV prevalence in this population from 3.5% to 7%⁴³ (see table below). These data, however, need to be treated cautiously due to the small sample sizes and current limitations experienced with population size estimations for FSW in Myanmar. More information on limitations to data and measurement can be found in the Limitations to the Situational Analysis section of this report. Such fluctuations may be related to the mobile nature of sex work, however further investigation through a rapid assessment in border areas would be able to provide better insight.

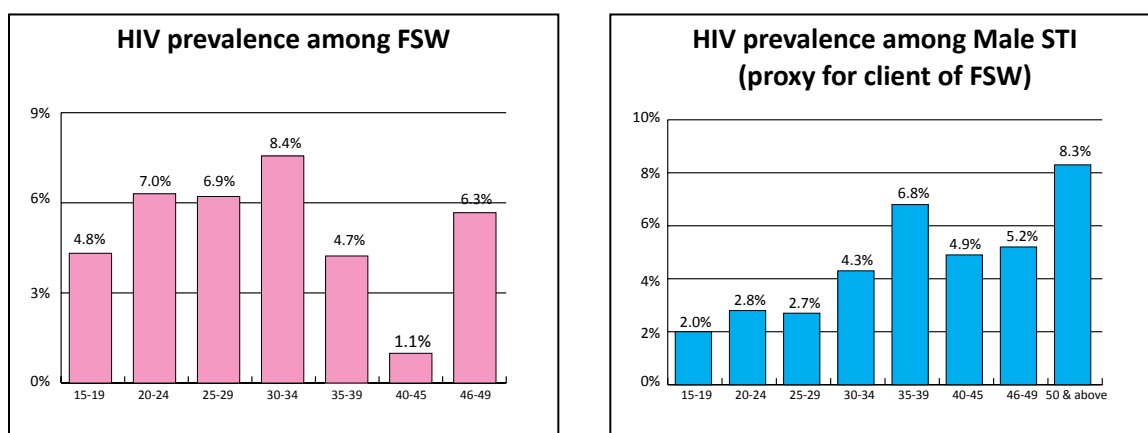
Table 1: HIV prevalence among FSW by geographic region, 2013-2014

	2013	2014
Mandalay	3.5%	7%
Mawlamyaing	3.5%	3.5%
Myitkyina	12.5%	10%
Pathein	24.5%	13%
Tachileik	7%	6.4%
Taunggyi	5.5%	6.5%
Yangon	11%	7%

Source: National AIDS Programme. HIV Sentinel Sero-Surveillance Survey, 2013-2014

2.2.2 HIV prevalence among clients of FSW in Myanmar

There are an estimated 830,000 clients of sex workers in Myanmar.⁴⁴ As clients of sex workers are difficult to reach, HIV prevalence among this population cannot be extrapolated from available data. The metric of STI prevalence among males, however, is used as a proxy for assumed HIV prevalence among male clients of FSW. In 2014, 4% of males with STIs were HIV positive so it is assumed 4% of clients of FSW were living with HIV,⁴⁵ while HIV prevalence among the adult male population was 0.75 in 2014.⁴⁶ These data, however, need to be treated cautiously due to the small sample sizes. Figure 2 below provides a breakdown of HIV prevalence by age among FSW and their clients.



Source: National AIDS Programme. HIV Sentinel Sero-Surveillance Survey, 2014

In 2014, 11% of all new HIV infections occurred through sex work, whilst most new infections (25%) occurred through sexual transmission from husband to wife. The assumption here is that newly infected male clients of sex workers are transmitting the virus to their wives (Refer to Table 1 below).⁴⁷ Rates of infection through sex work and through sexual transmission from husbands to wives (clients of sex workers to their spouses or partners),⁴⁸ are declining faster than other transmission routes, however this target group is often out of reach for HIV prevention programmes. The 2010 Myanmar People living with HIV Stigma Index reported 18% of HIV-positive male clients of sex workers had not disclosed their status to their wife or partner.⁴⁹

Table 2: Estimated mode of transmission for new cases of HIV infection, 2010–2014

Mode of transmission	2010 (%)	2014 (%)
Sex work	12	11
Needle sharing	32	39
Male–male sex	16	18
Husband to wife	31	25
Wife to husband	5	4
Casual sex (non-commercial)	3	2
Total	100	100

Source: HIV Estimates and Projections: AEM 2010-2015. 2014 (draft).

2.2.3 TB and TB-HIV co-infection rates among sex workers

TB and HIV co-infection rates among new TB patients have seen a steady decline over the past four years, from 10.4% in 2010 to 8.5% in 2014.⁵⁰ TB and TB and HIV co-infection rates among sex workers are not known as there is currently no disaggregation of data by key population. INGOs providing clinical services to sex workers in Myanmar report a low number of sex workers access TB services. Challenges with the provision of TB screening services for sex workers include a high patient non-return rate (for sputum smear follow up), and equally, retention challenges exist with adherence to TB treatment for sex workers living with TB.

2.3 HIV risk and vulnerability among sex workers

Globally, female, male and transgender sex workers are especially vulnerable to HIV infection and, at the population level, experience greater HIV risk. These risk factors and vulnerabilities are related to stigma, discrimination and social marginalisation, barriers to negotiation of consistent condom use, unsafe working conditions, arrest and detention in closed settings, and punitive laws, policies and practices. High rates of violence, including rape and forced sex, as well as alcohol and drug use in some settings, further exacerbate the situation.⁵¹

2.3.1 Police harassment, punitive laws, policies and practices

All countries in the Asia Pacific region, with the exception of New Zealand and the state of New South Wales in Australia, criminalise sex work or specific aspects of sex work. Criminalisation increases HIV risk and vulnerability among sex workers by facilitating stigma and discrimination, creating barriers to sexual health and harm reduction services, and adversely affecting the self-esteem of sex workers and their ability to make informed choices about their health.⁵² Where sex work is criminalised, sex workers have fewer legal protections and may be exploited or abused by clients, co-workers and law enforcement officials without legal recourse.⁵³ Fear of arrest may drive sex workers “underground” where it is harder to negotiate safe working conditions and consistent use of condoms. Access to HIV and other health services may also be impeded. Incarceration and compulsory detention may expose detainees to sexual assault, whilst condoms are contraband and health services (including antiretroviral medicines) are often denied, which can result in drug resistance, treatment failure and progression to advanced HIV disease.⁵⁴

A recent study examining the impact of law, policy and enforcement practices on sex work in Myanmar found sex workers experienced regular extortion, arrest and incarceration at the hands of the police.⁵⁵ In 2006, a regional study of 828 MSM and male sex workers in Myanmar found nearly 13% of MSM and 30% of male sex workers reported police harassment in the past 30 days, and 15% of MSM and 26% of male sex workers reported being beaten or forced to have sex in the past year.⁵⁶

Police sometimes misuse existing laws to extort money from MSM, transgender persons and sex workers.⁵⁷ Many sex workers do not know their rights and have little or no legal literacy, which makes them especially vulnerable to police intimidation and harassment.⁵⁸ Therefore, they are reluctant to challenge police abuses because they worry about further aggravating the police.

2.3.1.1 Common laws in Myanmar that impact on HIV vulnerability among sex workers

The laws and policies currently governing sex work in Myanmar impact greatly on HIV vulnerability among sex workers. The Suppression of Prostitution Act 1949 is the law governing prosecution for the act of prostitution. It provides offences for soliciting, living on the earnings of prostitution, procuring persons to engage in prostitution, owning or managing a brothel or renting premises for use as a brothel, and aiding and abetting prostitution.⁵⁹ Under the act, sex workers can face up to three years imprisonment or be detained in a “prescribed centre”, and individuals responsible for owning or managing sex work premises can receive up to five years imprisonment.⁶⁰ Section 7 of the Act enables police to arrest sex workers merely on the basis of their reputation.⁶¹ An

amendment to the Suppression of Prostitution Act 1949 was enacted in 1998 to broaden the definition of "brothel" to include any house, building, room, vehicle, vessel, aircraft or place habitually used for the purpose of prostitution or used with reference to any kind of business for the purpose of prostitution.

Public order offences that are known to be applied to sex workers include Section 268 (public nuisance) of the Penal Code 1860, Section 35 of the Police Act 1945 (loitering) and Section 30 of the Rangoon Police Act 1899 (loitering, in relation to conduct in Yangon). Under these laws, police have widespread powers to detain persons loitering after dark.⁶² Abuse of these laws by the police is commonly reported, especially in relation to arrest under Section 35 of the Police Act (loitering) and Section 54 (arrest without warrant) of the Code of Criminal Procedure. Section 34 (7) of the Police Act (causing disorder by drunkenness) is also sometimes used to charge sex workers.

Section 377 of the Penal Code 1860 criminalises "carnal intercourse against the order of nature". Male and transgender sex workers may be prosecuted under this law for same-sex sexual conduct.⁶³ There were reportedly 1,956 people prosecuted for prostitution in Myanmar in 2011 and 3,226 cases in 2012.⁶⁴ An increase in prosecutions have likely occurred over the past 18 months, as there are anecdotal reports of police harassment of sex workers and police seeking payment to secure release of arrested workers.⁶⁵

The Child Law 1993 states it is an offence punishable with a fine and/or imprisonment up to two years for a person to permit a child under their guardianship to live or consort with a person who earns their livelihood through prostitution.⁶⁶ Children of sex workers remain vulnerable to discrimination, which consequently restricts their access to education and health services.

2.3.2 Violence against sex workers

Recent studies demonstrate that violence, including sexual violence and coercion, are commonly experienced by sex workers in Myanmar, often at the hands of their clients or law enforcement officers.^{67, 68, 69} Available evidence from studies conducted in Myanmar and in different countries indicates sexual and physical violence against sex workers negatively impacts on their mental health and emotional wellbeing,^{70, 71, 72, 73} and can heighten their vulnerability to HIV and other STIs. Coerced sex is rarely protected and can result in injuries that increase HIV risk.⁷⁴ Furthermore, men who are sexually violent are more likely to have multiple partners and to be living with HIV and/or other STIs.^{75, 76, 77}

Where sex work is criminalised, reporting sexual and physical violence to the authorities can be difficult⁷⁸ so it often goes unchecked. The fear of violence from regular partners (husbands or

lovers) after inadvertent disclosure of sex work can also deter women from negotiating condom use with these partners and from accessing sexual health services.^{79, 80} In addition, mental health issues arising from violence can reduce the ability of sex workers to negotiate condom use and access HIV and STI services for testing and treatment.⁸¹

2.3.3 Migration, mobility and sex work

Regular migration within the country and across border areas is common for sex workers from Myanmar. Most direct sex workers are highly mobile within the country but are usually concentrated in brothels in big cities and urban areas, mining areas, or along the country's borders.⁸² The correlation between sex worker mobility and HIV is presumed to be high but further investigation should be made to provide better insight. When a sex worker arrives at a new venue or location in Myanmar or across the border, they are considered a "newcomer". Newcomers attract a higher fee for the sex worker and venue owner as they are in higher demand.⁸³ A 2007 rapid assessment of HIV vulnerability among migrant sex workers in the border towns of Myawaddy (in Myanmar) and Mae Sot (in Thailand) discussed the yearly migration of women back to Myanmar once their "newcomer" period had expired. With the savings they acquire over the year, sex workers return home, visit family and friends for an extended period of time, then return to Mae Sot to be reintroduced as a "newcomer".⁸⁴

Venue-based sex workers (operating in brothels, karaoke bars and other entertainment venues) consistently report mobility restrictions. Many places have rules restricting sex workers from leaving the premises for more than one hour at a time. If the sex worker does not return during that hour, she has to pay a hefty fine, which is taken out of her pay by the owners.⁸⁵

The trafficking of women and girls for sexual exploitation within Myanmar and across the border has not been widely researched. There are no reliable estimates of the number of persons trafficked annually, although a total of 134 trafficking cases were investigated in 2008 involving 303 victims (153 female and 50 male) and 342 traffickers prosecuted.⁸⁶ 15 cases were related to internal trafficking, but there are likely to be more cases in remote areas. Identified cases only represent a small fraction of the scale of the problem. The United Nations Children's Fund (UNICEF), for example, proposed in 2003 that 10,000 girls were being trafficked every year from Myanmar into Thai brothels alone.⁸⁷ There is a Memorandum of Understanding Between the Government of the Kingdom of Thailand and the Government of the Union of Myanmar on Cooperation To Combat Trafficking in Persons, especially Women and Children (2009).

There are few known publications that discuss instances of women or girls being entrapped or coerced and trafficked for sexual exploitation. The 2007 International Organisation for Migration

(IOM) study on mobility and HIV vulnerability in Mae Sot and Myawaddy⁸⁸ found trafficking of women and girls into Thailand was occurring, and provided qualitative case study data detailing sex workers' experiences of entrapment and forced "pay back" to migration brokers. IOM completed a second study on HIV vulnerabilities and access to HIV health-care services among key populations (i.e. FSW, MSM, PWID, as well as migrants) in Myawaddy and Kawkaik in 2015.⁸⁹ Results indicated limited HIV-related knowledge, a high prevalence of stigma towards PLHIV, and significant structural, financial, and social barriers to accessing health care. There is a gap in knowledge on adolescents, young people and children being trafficked or entrapped for sexual exploitation. Given little research has been done, further investigation should be made to assess if there is a correlation between HIV, mobility and migration (including trafficking), as a part of the national HIV response.

2.3.4 Service barriers due to stigma and discrimination

Despite decreasing HIV prevalence among sex workers in Myanmar, stigma associated with HIV, and with sex work, continues to undermine sex worker rights, including access to HIV-related services. The 2010 Myanmar People Living with HIV Stigma Index found a large number of FSW respondents had been excluded from social gatherings due to their HIV status.⁹⁰ There are also consistent reports that sex workers experience stigma and discrimination when seeking to access HIV and sexual and reproductive health services.^{91, 92, 93, 94}

A 2014 study on violence against sex workers in Yangon found stigma in healthcare settings had serious consequences for sex workers' health and wellbeing. Many of those who sought medical care encountered mistreatment from doctors, nurses and medical staff, including verbal abuse, discrimination and denial of treatment.⁹⁵ Consistent with this, the 2014 HIV Legal Review Report detailed sex worker complaints relating to discrimination in health care settings. Sex workers reportedly experienced rude and condescending behaviour from service providers when they sought treatment for STIs or reproductive tract infections.

Fear of judgemental attitudes and discriminatory behaviour inhibited sex workers from openly discussing their STI symptoms and their occupation, leading to ineffective investigation and treatment of STIs and potentially HIV. Further, the study found access to sex worker friendly services, peer counsellors and other service providers varied greatly, depending on the personality and attitude of the health care provider. Sex workers reported poor confidentiality standards in hospitals, segregation of patients living with HIV in a different ward, brash and insensitive behaviour by health staff, and discrimination by ART counsellors.⁹⁶

Evidence indicates self-stigma among sex workers is very high. In its Joint Rapid Assessment of HIV Treatment in Myanmar (September 2013), the NAP reported sex workers tended to visit INGO clinics

as they anticipated greater acceptance of their occupation and of an HIV-positive diagnosis. When sex workers enrolled in services at public facilities however, they tended to present as “general population” and did not self-identify as sex workers, which also creates challenges when measuring prevalence and treatment rates for key populations.⁹⁷

There are a number of recent studies that look at the impact of stigma and discrimination on the mental health and wellbeing of sex workers. The 2010 Myanmar People Living with HIV Stigma Index found many FSW living with HIV had low self-esteem (85%) and some felt suicidal (38%) because of their status.⁹⁸ Consistent with this, the 2014 study by UNDP and UNFPA entitled *Sex Work and Violence in Yangon, Myanmar: Understanding Factors for Safety and Protection*⁹⁹ reported 58% of all respondents¹⁰⁰ (female, male and transgender sex workers) had attempted suicide or had self-harmed.

2.3.5 Knowledge of HIV risk and service availability

A surveillance survey conducted among FSW in 2007 and other research on knowledge of HIV and risk behaviours and condom availability among sex workers in Myanmar indicate most sex workers are aware of the routes of HIV transmission and know where to access condoms.^{101, 102, 103, 104, 105} This can be partly attributed to the 100% Targeted Condom Programme, first introduced by NAP in the early 2001 in four pilot sites, to prevent HIV among FSW. Myanmar Government’s political commitment to prevent transmission of HIV among sex workers was confirmed in the first National Strategic Plan on HIV and AIDS developed in 2005.¹⁰⁶

The 2007 BSS identified a gap in knowledge among sex workers in relation to the prevention of mother-to-child transmission (PMTCT). Many women did not know that breastfeeding was associated with HIV transmission or that ART could be used to prevent mother-to-child transmission.¹⁰⁷ The 2010 Myanmar People Living with HIV Stigma Index found 70% of all sex worker respondents living with HIV reported at least one of their children was HIV-positive.¹⁰⁸ Caution should be applied when referring to these data, however, due to the small sample size of the study. Results of the two IBBS and population size estimations among FSW and MSM and transgender persons will provide more up-to-date data and analysis of knowledge, attitudes and behaviours of both female and male sex workers.

In the 2011 Knowledge, Attitude and Practices study conducted by Médecins Du Monde, health workers (particularly those from government agencies and NGOs as well as peer educators and outreach workers) were reported to be the main source of HIV-related information and knowledge among sex workers. The majority of FSW were able to name INGOs providing services including HIV testing (96.3%), voluntary counselling and testing (94.1%), condom distribution (93.6%), drop-

in-centres (91.8%), general health care (85.4%) and health talks (79.2%).¹⁰⁹

2.3.6 Condom use

Despite the widespread distribution of free or affordable condoms to FSW, there is a growing body of evidence to suggest the existence of significant barriers to condom use within the sex industry. After the Ministry of Home Affairs issued an Administrative Order in 2000, directing police not to use condoms as evidence of sex work, reports of this practise persisted at the local level.¹¹⁰ FSW were thereby disincentivised from carrying condoms for fear they would attract the attention of law enforcement.

Street-based sex workers frequently source condoms from peer educators or from betel nut sellers on the street. However, sex workers operating out of brothels or entertainment venues often report barriers to condom accessibility. Condoms are sometimes confiscated by venue owners because they do not want their businesses identified as sex work venues by the authorities. Similarly, outreach workers are often denied entry to these venues and are therefore unable to distribute condoms to employees.^{111, 112, 113}

It is unknown if condom use rates have improved in recent years. The 2007 BSS reported consistent condom use during last month among FSW was very high in Mandalay (97%) and slightly lower in Yangon (83%). However, despite high rates of reported consistent condom use, more than half of the FSW in Mandalay and Yangon reported either a genital ulcer or discharge in the last year. Caution should therefore be applied when referring to 2007 BSS data which does not seem to reflect the situation which is probably due to desirability bias (i.e. intent to please the interviewer by reporting a recommended behaviour).¹¹⁴ Still, most research conducted in recent years has found similar high rates of condom use among FSW, but this could be due to the fact that data was gathered by INGOs/NGOs among their own programme clients. It can be expected that programme clients practice safer behaviours compared to people who are not benefitting from programmes and their responses are affected more by desirability bias.

PSI conducted a behavioural study in 2013–2014 looking at correct and consistent condom use among FSW and their clients in Yangon and Mandalay. A total of 2,127 individuals were interviewed. The study found 79.8% of client respondents reported correct and consistent use of condoms with FSW in the last month. The main reasons for not using condoms were reduced sexual pleasure (39.7%), the FSW presented as “healthy and clean” (34.5%) and alcohol use (19.8%). Where FSW respondents reported not using condoms they said it was because clients refused to use them, or because there was a financial incentive associated with not using condoms.¹¹⁵

Médecins Du Monde's 2011 Knowledge, Attitude and Practices study found most FSW reported consistent condom use with clients. Only 4% reported they did not use a condom with their last client. More than 90% of all FSW said they knew how to negotiate condom use with clients. The most common reason for not using a condom was that the clients refused.¹¹⁶

However, a study conducted in 2013 among 200 individuals,¹¹⁷ which aimed to determine HIV prevalence among FSW in major cities within Myanmar, found less promising results in relation to condom use. 65% of respondents reportedly always used condoms during the past year and 67% reportedly used condoms during their last encounter with paid clients. Most respondents had one regular partner who was not their client during the period of the study (87.0%) and had regular sex with him (57.5%). Most had not used condoms during their last sexual encounter (69.6%) nor had they used condoms regularly with regular partners (27.0%) because they did not consider it necessary (86.3%).

The most common reasons given for not using condoms were that the regular "partner didn't like condoms" (Yangon: 53% and Mandalay: 44%) and that they "didn't think it was necessary to use condoms with their regular partners" (Yangon: 27%; Mandalay: 45%).¹¹⁸ These low levels of condom use indicate a continued need for targeted, rigorous HIV prevention efforts among sex workers and their clients. In this study 18.4% respondents were found to be HIV-positive.

Regarding condom use among children exploited for sex and young people (10-24 years) involved in sex work a study conducted in 2010 found low perceived risk with regular partners and high perceived negative consequences of condom use (such as losing money and customers, or jeopardising love and trust) presented barriers to consistent condom use.¹¹⁹

2.3.7 Child victims of sexual exploitation and young people involved in sex work

Globally, young people aged 15–24 years account for 42% of all new HIV infections among people aged 15 and older.¹²⁰ The Asia Pacific region has the second highest number of young people living with HIV, with an estimated 550,000 young PLHIV, and some 110,000 youth newly infected with HIV.¹²¹ Adolescents exploited for sex and young people who sell sex are at higher risk of HIV infection and may not have access to information and services such as HIV testing, or know their rights, which makes them vulnerable to exploitation, abuse and sex trafficking.

In Myanmar, 0.70% of young people aged 15–24 years were living with HIV in 2014.¹²² HIV prevalence among young FSW 15–24 years was 6.2%.¹²³

While adults may enter the sex industry voluntarily, children are unable to provide consent and their participation in the industry is considered exploitation. An assessment was conducted among 58 child victims of sexual exploitation and young people aged 10–24 years who were involved in the sex industry in Yangon, Mandalay and Lashio in 2010,¹²⁴ with an additional 44 key informant interviews conducted with gatekeepers (pimps/managers), influential persons (parents/senior peers), male partners (boyfriends/regular partners/husbands), private service providers and focal persons from INGOs. The study found vulnerabilities of young women and girls before entering the sex industry were multi-factorial (personal, family and environmental) and interlinked.

Common driving forces to enter the sex industry included urgent financial issues within the family, marital problems, persuasion by friends, having family members who were sex workers, and exploitation of vulnerabilities by brokers or pimps. The selling of young girls' virginities was surprisingly common at 38% of respondents, and started as young as 11 years of age. In the majority of these first sexual experiences, no condom was used. Risk behaviours were notably different with casual clients than with regular partners. Within a short period of time, young people involved in sex work regarded casual clients as regular partners and started practicing unprotected sex due to a desire for pleasure or intimacy, fear of losing their partner, and/or complexities surrounding the negotiation of condom use. Young sex workers surveyed were often victims of sexual, financial, physical and verbal abuse from clients and pimps.¹²⁵

Around the world, children and adolescents aged 10–17 years who are victims of sexual exploitation are seldom reached with life-saving prevention, treatment, protection, care or support services. Protection in this context is defined as all child and social protection interventions aiming to protect rights and provide social and economic support.¹²⁶ This represents a significant gap in the global HIV response. Further investigation should be undertaken with regard to HIV vulnerabilities among children and adolescents involved in sex work and commercial sexual exploitation in Myanmar.

2.4 Policy and Programme Response

High-level political commitment drives the national response to the HIV epidemic in Myanmar. Government is represented in all essential HIV-related committees and working groups, and meets regularly with civil society organisations, the private sector and other stakeholders.¹²⁷ The Myanmar Health Sector Coordinating Committee (M-HSCC) oversees the overall health sector, including national responses to HIV, TB, malaria, and maternal, newborn and child health. The M-HSCC is multisectoral, with broad participation from Government, international and national NGOs, development partners, the private sector and civil society.

2.4.1 Myanmar National Strategic Plan on HIV and AIDS 2011–2016

The NSP II provides an overarching strategic framework to the national HIV response in Myanmar. The implementation of the strategic plan is coordinated by the NAP and guided by the HIV Technical and Strategy Group (HIV-TSG), consisting of representatives from Government, international and national NGOs, development partners and UN agencies.

The HIV-TSG supports eight Technical Working Groups, which address specific programmatic areas. Technical Working Groups are open to representation from all stakeholders who wish to participate. Led by the NAP, the implementation of NSP II activities relevant to sex workers and their clients involves all sectors of the national HIV response. Implementation partners include the NAP, development partners, international and national NGOs, the private sector, community-based organisations and PLHIV self-help groups. In 2014, the NAP coordinated policies and activities at national and sub-national levels through 45 AIDS/STD teams throughout the country.

Currently, there are around 18 INGOs, eight local NGOs and 35 community-based organisations (CBOs) known to be implementing HIV prevention, treatment, care and support programmes. These non-government service providers make a large contribution to the national response and the provision of HIV services. In 2012 and 2013 respectively 57% and 54% of all HIV expenditure was made by INGOs.¹²⁸ With the rise of civil society and strengthening of the economy in Myanmar, there is an increased presence of local NGOs and CBOs focusing on HIV advocacy for key populations. A summary of the implementation of NSP II activities related to HIV, sex workers and their clients is provided in the coming sections. The new NSP III (2016–2020) will look to better strategically direct non-government service providers to ensure efficient and effective use of resources to maximise impact.

2.4.1.1 NSP II Strategic Objective 1: HIV Prevention

Strategic Objective 1: Reduction of HIV transmission and vulnerability particularly by people at highest risk

Objective one of the NSP II relates to HIV prevention activities as a part of the HIV response. Prevention activities targeting sex workers, their partners and clients under this objective include: condom distribution through outreach activities and commercial channels in order to increase correct and consistent condom use among sex workers and their clients, provision of mobile or static HCT services, which are either client or provider initiated, STI diagnosis and treatment, and TB screening and treatment with the aim to increase testing rates among this key population. Channels for HIV prevention service delivery are via peer-led or health worker outreach activities,

which incorporate health education and drop-in-centres that are “community-led” and supported, and clinical services available within NAP sites, NGO drop-in facilities, and the private sector.

The NAP 2013 Progress Report indicated approximately 39 million condoms were distributed through social marketing or free distribution by NAP and implementing partners. In the same year, 15,729 FSW (26% of estimated FSW population) received HIV counselling and testing (HCT) and returned to pick up their test result.¹²⁹

The decentralisation of HCT services will enable sex workers, their partners and clients greater access to these services in mobile settings, where they may have otherwise not been able to access static health services, or felt uncomfortable approaching mainstream health services with the general public. Different settings for providing mobile HCT services include: community buildings (e.g. schools, churches or administrative offices), entertainment venues, temporary structures (e.g. tents), and mobile vans.¹³⁰ Through decentralisation and scale-up, NGO partners will be able to perform an additional 6,000 HIV tests per month through approximately 600 service delivery points,¹³¹ a significant impact in the HIV response.

A critical component of HIV prevention interventions is targeted behaviour change communication. Channels include mass media condom promotion (radio, billboards and television) and interpersonal communications through outreach with health education talks and educational aids. PSI has established a telephone hotline for sex workers to access advice on health care. Few programme implementing partner organisations are applying targeted promotion via social media.

2.4.1.2 NSP II Strategic Objective 2: HIV treatment, care and support

Strategic Objective 2: Improvement of the quality and length of the life of people living with HIV through treatment, care and support

Objective two of the NSP II relates to HIV treatment, care and support activities for PLHIV. Activities under this objective targeting sex workers, their children, partners and clients include: provision of ART and adherence support, provision of prevention and treatment medications for TB and HIV co-infection and other opportunistic infections (cotrimoxazole prophylaxis), antenatal care and treatment for sex workers living with HIV who are pregnant, and provision of reproductive health services to sex workers.

2.4.1.2.1 Scale up of antiretroviral therapy

Fundamental to ART scale-up efforts is the NAP initiated ART decentralisation strategy. The impetus of decentralisation was to increase coverage of ART sites and access to treatment for PLHIV, particularly those who experience geographical or transport barriers to original ART sites. It is also intended to support intensified treatment efforts with respect to TB-HIV co-infection.

In 2014, 85,626 PLHIV were registered for ART services.¹³² This represented 69.7%¹³³ of all those in need of treatment, as specified in national treatment guidelines. Currently, the NAP does not disaggregate treatment targets or results by key population.

2.4.1.2.2 Access to ART treatment for sex workers

Health care providers are often reluctant to prescribe ART to sex workers due to the mobility associated with their work and the associated lack of personal support networks that may affect treatment adherence and retention in care. The need to attend frequent appointments for counselling before initiating ART is a challenge for many establishment-based sex workers who have very limited or no time off from work as they are restricted from their employers or pimps. In many cases, it is not a realistic option for sex workers to disclose why they need to go to a clinic, due to the lack of confidentiality and potentially negative repercussions of disclosure of HIV status on their work and income.¹³⁴

2.4.1.2.3 Antenatal care and ART for sex workers living with HIV who are pregnant

Targets and results relating to antenatal care and treatment for sex workers living with HIV who are pregnant are currently not available as the relevant NSP II indicator does not capture disaggregated data for key populations. There is growing evidence, however, that pregnant sex workers, irrespective of HIV status, experience discrimination from health providers, which in effect creates a barrier to accessing adequate antenatal care, support, and ART for PMTCT.^{135, 136, 137, 138}

2.4.1.2.4 Reproductive health services for sex workers

Globally, forced or coerced sterilisation is known to occur among female and transgender sex workers living with HIV,¹³⁹ although there are no documented cases of forced or coerced sterilisation occurring in Myanmar within NAP or NGO clinical settings. In Myanmar, sex workers reportedly experience disproportionately high rates of unintended pregnancy and abortion, as rates of condom use are considerably lower with intimate partners than with clients.¹⁴⁰ Abortion is criminalised under Myanmar's Penal Code, except when it is necessary to save the woman's life.

There is no exception for women who have been raped. As abortion is illegal, many sex workers resort to using unsafe traditional remedies and unregistered service providers to induce an abortion. Many suffer from infection and sepsis, yet are sometimes denied treatment by discriminatory health providers, although post abortion care is legal in Myanmar.¹⁴¹

The NAP promotes dual methods among sex workers (condom use to prevent HIV and other STIs and contraception to prevent unintended pregnancy), as evidence demonstrates greater efficacy of contraceptive methods other than condoms in preventing pregnancy. This is crucial in addressing high abortion rates, particularly among FSW.¹⁴² A recent study reported some shopkeepers in Myanmar refuse to sell condoms to young sex workers, and young sex workers require parental permission to access health care services such as reproductive health care and ART, resulting in unmet contraceptive needs and barriers to accessing services.¹⁴³ HIV programmes that offer outreach or drop-in-centres in safe and comfortable environments are well placed to offer integrated sexual and reproductive health services to sex workers. Addressing the unmet contraceptive needs of sex workers living with HIV is a key element of PMTCT.¹⁴⁴

2.4.1.2.5 Nutritional care and vocational training support for sex workers living with HIV

Sex workers living with HIV are eligible to receive nutritional and vocational training support, which is currently provided through some INGOs and CBOs working directly with sex workers.

2.4.1.3 NSP II Strategic Objective 3: Community-based approaches for PLHIV

Strategic Objective 3: Mitigation of the social, cultural and economic impacts of the epidemic

Objective three of the NSP II relates to community-led support activities for PLHIV. Key activities under this objective targeting sex workers, their children, partners and clients living with HIV include: support to people receiving community-based home care, support to PLHIV self-help groups, and support to HIV-related orphans and vulnerable children. The recent changing political landscape in Myanmar has seen an increase in HIV-focused CBOs and civil society organisations, which has enabled a greater platform for PLHIV-led self-help groups, and increased community home-based care services.

2.4.1.4 NSP II: Cross cutting interventions

Strategic information and monitoring and evaluation

Monitoring and reporting of results in relation to the HIV response among sex workers and their clients is undertaken in line with agreed national and global indicators. Annual progress reports track performance in relation to NSP II indicators and targets, and also analyse funding allocations and expenditure against estimated needs. In addition, annual meetings of key stakeholders are held to review progress and consider future directions. Global reports such as the GARPR and Universal Access reports are regularly produced and submitted.¹⁴⁵

The SI & ME TWG, being responsible for the oversight of measurement of NAP outcomes, prepared a thematic paper in 2013 that discussed the main achievements and challenges ahead in the strengthening of strategic information and monitoring and evaluation systems in Myanmar. The analysis concluded that good progress is being made with improving surveillance and producing updated population size estimations, developing up-to-date HIV estimates and projections, coordinating research and evaluation, and aligning and harmonizing reporting systems. The review highlighted priority actions to be undertaken in the coming years to accelerate progress.

Case reporting data

HIV case reporting data are currently not systematically compiled, although the NAP aims to revitalise the case reporting system, which will need strengthening across health facilities. A complete HIV case reporting system is capable of providing in-depth individual level data on people diagnosed with HIV, such as the date of diagnosis, mode of transmission, clinical stage, CD4 count at diagnosis, date of treatment commencement, incidence of opportunistic infections, type of treatment, and date of death.¹⁴⁶

Unique Identifier Code: Measuring uptake of STI and HIV related services

There is currently no unique identifier code (UIC) used universally across all HIV service providers to track individual clients as they access HIV and STI testing and treatment services. The SI & ME TWG is working toward developing a pilot UIC system for HIV programming. The introduction of a UIC would avoid double-counting and enable tracking of patients across the service spectrum, leading to better understanding of the dynamics of HIV in individual states/regions and nationally.

However, UICs are difficult to maintain and use effectively because (i) they rely on clients carrying their UIC number on their person at all times, and presenting it to any drop-in-centre or service

they might visit, and (ii) clients may not want to present their UIC to new services or drop-in-centres because they may want to use a different name or alias, or they may be attending a mainstream health service and not want to disclose sex work. In addition, UICs remain a challenge to integrate across all programme implementing partners due to the lack of technical capacity in synchronising data systems. If UICs are to be used in HIV programming, it is important that ethical issues are considered when capturing and managing individual case data, to ensure confidentiality, dignity and respect for key populations are upheld.

Knowledge, Attitude and Practices studies

HSS is conducted annually among FSW, PWID, MSM, newly-diagnosed TB patients, pregnant women attending antenatal care, male STI patients and military recruits. It provides useful HIV prevalence trend data for groups that access clinical services and groups at higher risk. As HSS only surveys those in contact with health services, it is not possible to generalise HIV prevalence data to the overall populations of FSW, MSM and PWID. Although the geographical coverage of HSS has expanded over time, sentinel surveillance sites implies a limited geographical representativeness. A Behavioural Surveillance Survey for sex workers was conducted in 2007-2008 by the NAP, and a comparative study was undertaken independently in 2011 by Médecins Du Monde, supported by the European Commission.

Population size estimates

A population size estimation for FSW, using mapping in a limited number of sites and the multiplier method, was conducted in 2009. The estimates and projections were updated in 2013, using a new and improved Asian Epidemiological Model. A five-year joint IBBS/PSE plan has been developed and funded. This will involve an expansion of surveillance sites. Data collection for the IBBS/PSE targeting FSW will be conducted in 2015. The IBBS will be repeated every two, three or four years to assess trends.¹⁴⁷ Male and transgender sex workers will likely be captured in surveillance of the MSM population, whereby questions will be asked to respondents related to any involvement with sex work.

Measuring the uptake of integrated services

With regard to monitoring the uptake of integrated services among key populations, assessments were carried out in 2012–2013, which led to the development of the Three Interlinked Patient Monitoring Systems (3ILPMS), which is expected to be rolled out in 2015. The 3ILPMS will provide interlinked clinical data and indicators needed to monitor several national programmes—chronic HIV care including ART and HIV drug resistance monitoring; PMTCT integrated within maternal,

newborn and child health services; TB including TB-HIV co-management; and congenital syphilis elimination.¹⁴⁸

Measuring stigma and discrimination

A People Living with HIV Stigma Index study was conducted in 2010 and a second round will be conducted in 2015, which will help determine if progress has been made. Representatives of the PLHIV network believe that while stigma has started to reduce, it is still widespread.¹⁴⁹ Current restraints and challenges related to measuring stigma and discrimination among sex workers include: a lack of resources to put in place mass communication and awareness campaigns; no formal mechanisms to report HIV-related human rights violations; and an absence of social mobilisation and community empowerment strategies.¹⁵⁰

2.4.2 Coverage of HIV prevention programmes targeting sex workers and their clients

Coverage estimates for HIV prevention programmes¹⁵¹ among sex workers and their clients are calculated based on population size estimates. There are an estimated 70,000 FSW and 830,000 male clients of FSW in Myanmar.¹⁵² The number of individual FSW reached by HIV programmes in 2013 ranged between 77,059 (high estimate)¹⁵³ and 54,646 (low estimate) (see Table 2 below). The high estimate achieved the 2013 NSP II target, while the low estimate represents 78% of the target. The number of FSW reached in 2013 was less than the number of FSW reached in the baseline year of 2010 for both the high and low estimates.¹⁵⁴ This, however, may primarily be due to measures taken to reduce multiple counting of contacts.

In 2013, the largest number of FSW was reached in Yangon (up to 36% of the total among both low and high estimates) and Mandalay (up to 16% of the total among both low and high estimates). FSW prevention services were provided in all states and regions (except Chin State) by 17 implementers (including NAP), but only at very low levels in Kayin and Kayah states.¹⁵⁵ The number of clients of sex workers reached increased by 12–26% (low and high estimates) between 2012 and 2013. In 2013, between 14,050 (high estimate) and 12,706 (low estimate) clients were reached, which equates to 9.6–10.6% of the 2013 target (132,183), or between 1.5 and 1.7% of the total estimated population of male clients of sex workers (830,000), which represents very low coverage.¹⁵⁶ More recent data will be published in forthcoming NAP Annual Progress Reports for 2014.

Table 3: FSW and their clients programme data, 2010–2013

Indicator	Population size estimate	Baseline 2010	Target 2013	Results 2013
# of FSW reached by a package of behaviour change communication and STI prevention/treatment	70,000	High: 81,185 Low: 46,395	65,000	High: 77,059 Low: 54,646
# of FSW receiving HIV testing and post-test counselling	70,000	12,107	30,000	15,729
# of clients of FSW reached with HIV prevention programmes	830,000	NA	132,183	High: 14,050 Low: 12,706
# of regular sexual partners of sex workers and clients reached with HIV prevention programmes	NA	NA	20,000	7,459

Source: National AIDS Programme. Progress Report 2013.

A recent cross-sectional study by PSI sought to determine coverage of HIV prevention services for FSW in seven cities in Myanmar (Yangon, Mandalay, Myitkyina, Monywa, Tachileik, Pyay and Bago). The study was conducted in October and November of 2010, surveying 978 sex workers from different work settings (brothel, entertainment venue and street-based).

The study found the proportion of FSW accessing HIV testing and receiving results in the last year ranged from 28% in Tachileik to 73% in Myitkyina (median for all cities surveyed: 43%). The proportion of FSW who reported visiting a drop-in-centre in the last three months ranged from 8% (Mandalay) to 67% (Pyay), with a median of 31%, and those who attended a peer educator talk ranged from 15% (Yangon) to 50% (Pyay). Recent exposure (in the last three months) to Aphaw-specific messages (condom social marketing) was high where billboards were present (97–99%), while moderate coverage was achieved with cartoons (23–84 %, median 60%) and pamphlets (36–73%, median 52%). Fewer FSW reported seeing television (10–38%, median 31%) or hearing radio messages (2–23%, median 6%). Large majority of women reported consistent condom use with clients in the last week, with only Pyay falling below 90% (88%).¹⁵⁷

Although this study does not represent coverage of HIV prevention programmes at the national level, it does provide a snapshot of coverage across seven cities, and could be used for future comparative studies and analysis to inform programming in these cities.

No evidence-informed research currently exists on programme coverage among key populations reached through social media, web-based applications or mobile phones (voice, instant chat or

short messenger service applications), although HIV services report increased use of these technologies by key populations. MSM are known to use dating mobile applications such as Grindr, as well as Facebook, and mobile phones for voice, instant chat and Short Message Service (SMS). Implementing partners report that sex workers are known to be frequent users of mobile phones (voice and SMS) and web-based instant chat applications, specifically Viber, to communicate with clients. Moreover, use of Facebook pages to promote sex services and communicate with clients is known to be increasing. This challenges HIV programmes to effectively identify, target and reach techno-savvy and "hard-to-reach" sex worker populations.

2.4.3 The national response to sex workers, the legal and policy environment

A National HIV Legal Review¹⁵⁸ assessed Myanmar's legal framework and its effect on access to health and HIV services for PLHIV and key populations, including sex workers. As a collaborative effort, meetings were held in Nay Pyi Taw in November 2013 and in May 2014 to identify issues and future legislative and policy reforms critical to the HIV response. Stakeholders included senior representatives from the Ministry of Health, Ministry of Home Affairs, Supreme Court, Attorney General's Office, Parliament, INGOs and NGOs, development partners, civil society, key populations and PLHIV networks, and UN agencies.

Key recommendations of the Legal Review called for: i) a review of the Suppression of Prostitution Act 1949, ii) consideration of international evidence regarding the public health benefits of alternative legislative approaches to sex work, including models of health and safety regulation and protection of human rights of sex workers, iii) police training on the importance of condom use to prevent HIV among sex workers, and on police responsibilities to support HIV prevention interventions among sex workers including the 100% Targeted Condom Programme, iv) the reform of vocational training centres for sex workers, v) legal aid services for sex workers who have experienced violence or wish to lodge complaints about discriminatory police or health care services, vi) sex worker-friendly health services that are free from discrimination, and vii) universal access to antiretroviral therapy (ART) for mobile sex workers and sex workers in prison and police custody.

Commitments from the Joint Committee of Parliamentarians and Community Network Consortium on Human Rights and HIV during the May 2014 meeting included "six quick wins", five of which were relevant to sex work:

1. Development of police instructions to support specific HIV prevention and treatment interventions for key populations.
2. Development of guidance on HIV-related discrimination and confidentiality in key sectors, including healthcare, education and employment.

3. Development of guidance or instructions on eligibility and universal access to ART among key populations, including PWID, children, mobile populations, sex workers and prisoners.
4. Development of guidance on the reproductive rights of women living with HIV, including guidance relating to pregnancy and PMTCT.
5. Ensuring the Patents Bill, due to be presented to parliament in 2014, includes maximum flexibilities, transitional arrangements and safeguards to ensure Myanmar is able to continue to access affordable generic medicines for public health emergencies when needed.

The sixth "quick win" relates to repealing sections of the Burma Excise Act 1917 that criminalize possession of needles and syringes for injecting drugs. Myanmar is seeing much progress toward the development of a legal framework that will help protect women against violence and HIV vulnerability. The draft law on the Prevention of Violence Against Women provides legal safeguards against violence for all women, including FSW, and is in the process of being considered for adoption. Legislation that aims to protect transgender and male sex workers from violence is yet to be developed. A law to protect the rights of PLHIV and people at risk of HIV, particularly in the health, education and employment sectors, is currently being drafted and a series of consultations and advocacy meetings with various stakeholders and communities is planned to further review and develop the draft.

Sex workers in Myanmar currently have no safe mechanism or platform to report harassment or abuses by authorities.

The Global Commission of HIV and the Law conducted a study of the risks, rights and health of people at risk of HIV, including sex workers. The Commission reviewed and analysed existing public health and legal evidence and also commissioned original analysis, resulting in the review of 680 written submissions from over 1,000 authors in 140 countries. The report presents public health, human rights and legal analysis and makes recommendations for law and policy-makers, civil society, development partners and private sector actors involved in crafting a sustainable global response to HIV.¹⁵⁹

2.5 Financing of HIV programmes in Myanmar

2.5.1 National investment

In the current climate of reform in Myanmar, there is a unique opportunity to put in place high-impact interventions, reduce inefficiencies and reallocate scarce resources to ensure maximum benefit for the people most affected by and vulnerable to HIV. Political commitment to HIV and health in

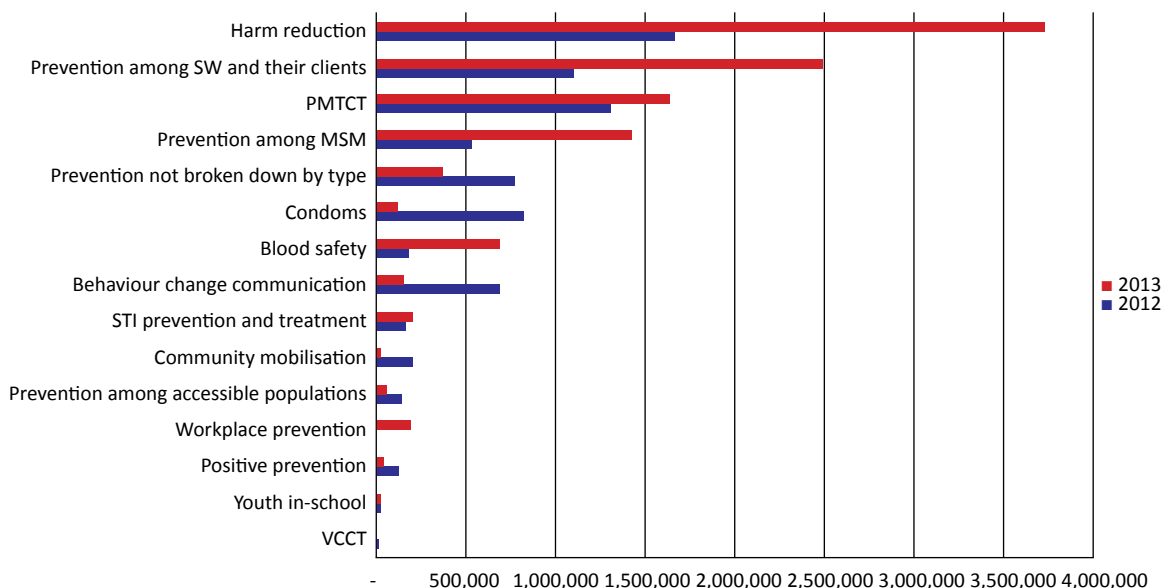
Myanmar is increasing, as reflected in increasing health expenditures. While only two per cent of GDP was allocated to health in 2012, public health expenditure increased four-fold since 2010.¹⁶⁰ It is also the first time the government has allocated a substantial amount for their HIV response. Between 2012 and 2013, the government contribution increased almost five-fold from US\$ 0.7 million to US\$ 4.1 million. As a result, in 2013, the government financed eight per cent of all HIV-related expenditure in the country. This is an encouraging increase, from less than five per cent, in just a couple of years,¹⁶¹ although much remains to be done to meet the level of public expenditure for health and HIV of many countries in the region.

Although there has been a significant increase in government expenditure, Myanmar's national response to HIV is very heavily reliant on external support. This poses a real risk to sustainability, especially in light of the global context of declining resources for health and HIV. Development of a domestic resource mobilisation strategy will need to be a priority, although this needs to be seen as a mid to long-term strategy.¹⁶² Key needs related to financing are strengthening financial absorption capacity; strengthening the capacity of the public sector to manage an increase in resources and the challenges involved in programme scale-up; and development of more robust costing and expenditure data.¹⁶³

2.5.2 Funding commitments for HIV, sex workers and their clients

Total spending on HIV and AIDS interventions in Myanmar was at US\$ 39.5 million in 2012 and increased to almost US\$ 54 million within just one year. Care and treatment accounted for the largest share of spending in 2013 (47%), followed by the expenditures related to programme management and administration strengthening (27%) and prevention (21%).¹⁶⁴ The analysis of the National AIDS Spending Assessment found that in total, prevention interventions targeting key populations (KP) represented 20% of HIV spending in the country, and 72% of all prevention spending in both years [2012-2013]. Spending on two main programmes targeting KP – harm reduction among PWID and HIV prevention among FSW and their clients – increased two-fold within the assessment period. Expenditure on HIV prevention for FSW and their clients increased within the GFATM grant's work plan as more sub-recipients (SRs) stepped in during 2013 to deliver this kind of prevention. However, available funding only covers basic services for FSW; new strategies, innovative models or pilot programmes that are required to reach those who are "hard-to-reach" are currently unfunded.

Figure 3: Prevention interventions in 2012-2013 (in US\$)

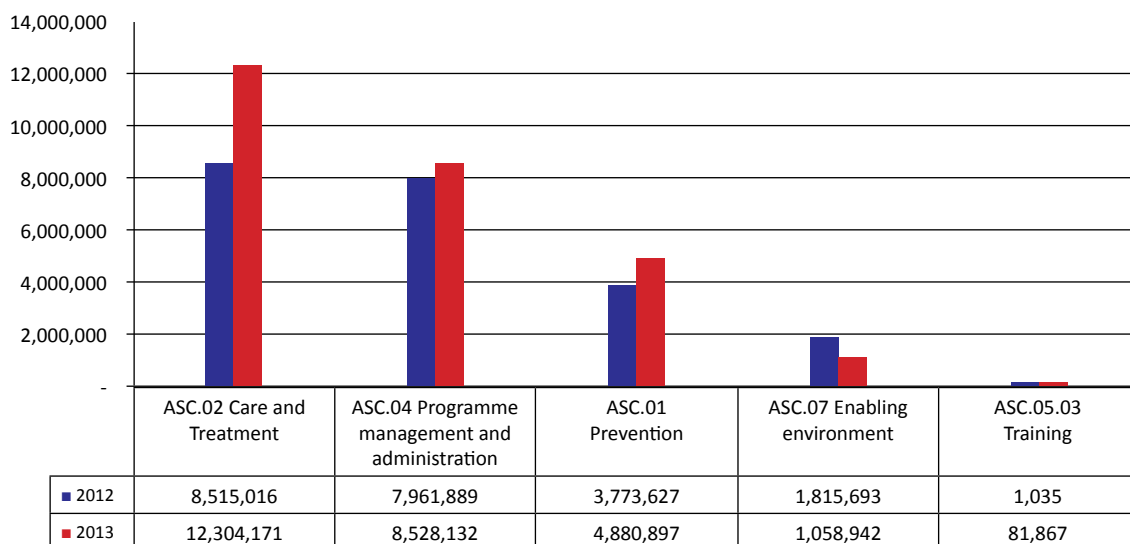


Source: UNAIDS. National AIDS Spending Assessment in Myanmar (2012-2013). March 2015

2.5.3 Development partner investment

GFATM remains the single largest financing source of the HIV response in Myanmar, covering over 50%. Over US\$ 22 million was spent in 2012 and approximately US\$ 27 million in 2013. In 2012-2013, most of the GFATM's expenditure was on care and treatment services, while 18% was spent on prevention.¹⁶⁵

In 2012-2013, 24% of total GFATM prevention spending was spent on prevention among FSW (US\$ 2 million). At the time the situational analysis was written, the future investment of GFATM beyond 2016 was not known; however it is anticipated that funding support will continue for the national HIV response.

Figure 4: Analysis of GFATM HIV spending, 2012-2013

Source: UNAIDS. National AIDS Spending Assessment (2012-2013). March 2015

In 2013, other large international NGOs and the UN accounted respectively for 22% and 8% of HIV-related expenditure while bilateral donors (including those contributing to the 3DF and 3MDG Fund) represented nearly 10% of the HIV financing sources in Myanmar. The 3DF and 3MDG Fund (a non-earmarked pool of predominantly bilateral organisations) financed over seven per cent of all HIV activities during 2012-2013.¹⁶⁶

2.5.4 Funding gaps

Resource needs estimates have been adjusted, following new targets set in the revised National Strategic Plan on HIV and AIDS (2011-2016) (NSP II). It is estimated that US\$ 550 million is required over six years, or roughly US\$ 110 million per year. For the year 2014, the resource needs estimated in the revised National Strategic Plan are at US\$ 116 million, with a resource gap of 61 % compared to the need. The resource gap is predominantly in prevention and in cross-cutting areas as there is inadequate commitment from donors in those areas.¹⁶⁷ Further adjustments to resource needs estimates will be made with the development of the next NSP (2016-2020) and resource gaps analysis.

3. Qualitative analysis



Education on the life of Female Comdon (Source - Alliance)



Meeting of working women self help group for saving & loan scheme (Source - Alliance)



Health education at outreach (Source - AMA)



Peer training and community health education session (Source - PU-AMI)

3. Qualitative analysis

3. Findings from key informant interviews and focus group discussions

The national HIV response among sex workers and their clients commenced in 2001 with pilot programmes and was taken to larger scale in the mid-2000s within the framework of the NSP I (2006-2010). Myanmar set up state and township AIDS committees and began targeted sex worker programmes involving information, education and communication (IEC), condom distribution, blood screening and sexual health services. These interventions helped prevent HIV transmission and reduce HIV prevalence in this key population. However, much remains to be done to strengthen the response, particularly to ensure that more sex workers access HIV testing, sexual health services and ART.¹⁶⁸

To enhance understanding of the current situation, an extensive series of key informant interviews and focus group discussions were conducted with various stakeholders in different parts of the country. Findings from these interviews and discussions identified and articulated core issues including: understandings of HIV prevention among sex workers, successes and achievements of the national HIV response, challenges and barriers to an effective response, and priorities for improving the enabling environment and strengthening the HIV response for the way forward.

3.1 Methodology of qualitative analysis

3.1.1 Data collection

The consultant, with the assistance of the UNAIDS Country Office in Myanmar, identified key informants and focus group participants, applying a purposive sampling approach. Each stakeholder was contacted through email, telephone and/or formal invitation letter to outline the focus of the proposed interview or discussion.

Qualitative methods used were 27 semi-structured key informant interviews and 16 focus group discussions. Meetings and interviews were held between October 2014 and March 2015 across the four cities of Yangon, Mandalay, Nay Pyi Taw and Mawlamyine. A total of 142 stakeholders participated in the study, specifically representatives from government, law enforcement, development partners, international and local NGOs and CBOs, and UN agencies. A detailed list of key informants is outlined in Annex 1. Analysis tools were developed including a semi-structured questionnaire for key informants and a focus group discussion (FGD) question guide, which are contained in Annex 2.

The person who managed the interview or discussion also took notes. The consultant sieved through interviews and discussions (raw data), identified themes and sub-themes, and translated excerpts, where relevant. The results of the primary qualitative data collection process are not representative, but illustrative, as the purposive sampling does not allow for representation.

3.1.2 Analysis

Data analysis consisted of a review of literature as described in the Bibliography section of this report. To optimise the usefulness of the qualitative data and encapsulate responses, an inductive analysis approach was applied. Using an inductive analysis approach, the analysis does not make use of a predetermined analysis framework but rather allows for discovering of patterns and categories in the qualitative data during the analysis process. When analysing and comparing literature, quantitative epidemiological data, and qualitative data from interviews and discussions, the focus was to identify consistencies in stakeholder perceptions and triangulate findings across these three data methods. The analysis of the qualitative data aimed to identify patterns and themes, which in essence provided validation to the situational analysis findings and recommendations.

3.2 Successes and achievements of the national HIV response

3.2.1 Acceptance of HIV prevention as a public health intervention for sex workers

Following many years of advocacy efforts with health authorities and law enforcement, government acceptance and understanding of HIV prevention as a public health intervention for sex workers and their clients has increased. Sex workers and their clients were officially recognised as key populations in the national HIV response by the Ministry of Health in the National Strategic Plan on HIV and AIDS 2006–2010. As a part of this inaugural strategy, the Ministry of Home Affairs was engaged in the implementation of the 100% Total Condom Promotion Programme, including support to Township HIV/AIDS Committee decisions at the local level.¹⁶⁹

During this time, several other government ministries were tasked with responsibilities as a part of the national HIV response. Intergovernmental engagement also increased at central and township levels during the implementation of the NSP II, which was highlighted during most key informant interviews with government, INGO and UN stakeholders. Awareness sessions on HIV among the law enforcement agencies, and advocacy efforts to promote the use of condoms are ongoing.

“We provide training at the Police Officer Training Centre on HIV awareness to our officers.”

- Government source

“Previously we were afraid to carry condoms [in Yangon] but not now as police know that they can’t arrest us for carrying a condom as proof of sex work.”

– Sex worker

According to respondents, major political and economic changes in the past couple of years have resulted in a greater ease of communication and coordination with government departments and services. This has made programme implementation easier for INGOs/NGOs. Political commitment to HIV in Myanmar is increasing which is reflected in growing expenditure for HIV and represents an encouraging trend as Myanmar still lags behind many countries in the region with regards to its level of public expenditure for health and HIV.

“The Government is now opening up, which has made it much easier to communicate and work on issues such as HIV and sex work.”

– UN source

Three respondents from different NGOs (one local and two international NGOs) reported programme staff had experienced effective collaboration with local township police in recent years. They said staff had spoken with local police about HIV prevention and the importance of safety for sex workers, including the ability to carry and use condoms without arrest. HIV awareness training targeting police and their families was also initiated by one INGO. Although this awareness programme only started a year ago, INGO staff reported a noticeable improvement in police behaviour toward sex workers in the area.

“Four times per year, our HIV programme team provided advocacy to police at the district and township levels. During this advocacy meeting, we explain the HIV programme and what we are doing, health education on the transmission of STI/HIV, and legal issues experienced by sex workers that put them at risk. We tell them not to arrest sex workers for carrying condoms as it puts them at risk. We also talk about the importance of continuing ART for sex workers who are HIV-positive and in prison.”

– INGO source

During phase II of the National Strategic Plan, trainings were provided to the police force at the central level on issues faced by sex workers that increase their HIV vulnerability, such as confiscation of condoms.

“We have trained police in sex worker issues. They now know not to arrest sex workers for carrying condoms, but now use other reasons for arrest. Also, we train prison staff and they now show some flexibility and improve their treatment of sex workers. Especially the social workers have a good relationship with sex workers.”

– UN source

3.2.2 Declining HIV prevalence

Many informants acknowledged that HIV prevention programmes in Myanmar have been a major achievement in the national response to HIV among sex workers. There was a consistent belief among key informants that HIV prevention programmes, particularly peer-led outreach and drop-in-centre modalities, have contributed to declining HIV prevalence among sex workers since 2008. Consistent with these perceptions, epidemic modelling projections estimate new HIV infections through sex work are on a steady decline. In addition, HSS data indicate a decline in HIV prevalence among sex workers from 9.4% in 2012 to 6.3% in 2014. The IBBS scheduled for 2015 will provide a more recent reflection of HIV prevalence rates. Most respondents were unsure if STI prevalence was also decreasing as there are limitations to data captured for the NAP. Some respondents felt that prevalence data were encouraging but masked the need for more community involvement of sex workers in the response.

“The reducing prevalence of HIV among sex workers is a good indicator of what we are doing, but is it enough? No, I don’t think so. This is because the sex worker community is not involved enough. We need sex workers to drive the response for inclusion and sustainability.”

– Sex worker

“We have seen a decrease in HIV prevalence among sex workers which is positive ... and policy changes have been a great improvement, but we are unsure whether the rights situation for sex workers has improved on the ground.”

– Development partner source

“We are seeing prevalence in new infections among sex workers reducing. This is a big win for Myanmar. The combined efforts of HIV prevention programmes and the scale up of ART services are likely linked to prevalence reduction.”

– NGO source

3.2.3 Expansion of health services for sex workers

Coverage of HIV prevention, treatment and care for sex workers has seen a vast increase over the last decade. According to respondents, decentralisation of HCT and ART over the coming few years will undoubtedly contribute to reducing new HIV infections among sex workers.

“[Rapid HIV testing] will benefit key populations significantly. More HIV testing means reaching ART targets as well as lowering new infection rates.”

– Development partner source

“Decentralised ART services start this year. Previously, ART services were only provided at the district level and not at the township level, which we think created barriers to access, given that many hotspots in our target area are at the township level. Decentralisation will mean the key populations congregating at the township level are now more likely to access ART services, if needed.”

– NGO source

Expansion of services to sex workers now includes more sex worker-led community-based organisations. Some informants from CBOs, INGOs and UN agencies explained the importance of community-led programmes cannot be underestimated. One CBO said sex workers accessing ART services were increasingly being supported with adherence counselling by peers.

“As FSW are very mobile, many service providers remain reluctant to provide services as they won’t be able to trace their patient for follow-up. Four years ago, availability of ART was limited so a lot of partners set eligibility criteria, which in effect excluded a lot of sex workers from accessing treatment. This is now changing because sex worker networks have become stronger, with peers available to provide adherence counselling and support to sex workers on ART.”

– CBO source

In addition to receiving health services in drop-in-centres, most sex workers who participated in focus group discussions said they appreciated the opportunity to meet with other peers, gain social support, exchange stories and experiences, and feel part of a non-judgemental community. Any reluctance to visit these services usually stemmed from the lack of autonomy of brothel and massage parlour-based workers, and the control their managers had over their time and freedom.

3.2.4 The rise of civil society

Community-based organisations and self-help groups (including sex worker networks) first began to emerge in Myanmar in 2007, and even more were established after recent political changes. Greater involvement of sex workers in the national HIV response has enabled stakeholders, including Government, to gain a better understanding of issues pertinent to this population. All key informants interviewed for the situational analysis commented that stakeholders were better placed to respond to HIV among sex workers, given there is now a better understanding of what sex workers experience and how relevant issues are linked to the HIV epidemic.

Informants from government and UN agencies commented on the increase in sex worker involvement and its significance to the national HIV response, while emphasising there was still room to increase engagement between government and civil society.

“We have seen there is more voice now for FSW to participate in different meetings right up to the national level. This is a big change and positive to say the least.”

– UN source

“We are not working formally with sex worker networks. We have met them informally during seminars and so on, but we have not had any formal engagement at this stage at the headquarter level. At the township level, we are aware that sex worker networks invite local police to meetings and police participate.”

– Government source

“It’s only a few sex workers that raise their voice, and it’s mostly the same people. We need to focus on giving space to new people to improve their capacity, so that this advocacy can grow and continue.”

– UN source

MoH requested to organize a meeting/consultation with particularly MoH staff and other key partners on the updates and to understand what will be the focus of HIV law, how this can be of benefit for people living with HIV and the community. Over the past three years, Myanmar has seen civil society groups gain leverage and access to central-level government and parliamentarians. Local NGO, Pyi Gyi Khin (PGK) was specifically tasked, as a GFATM sub-recipient, to work on the HIV and human rights component of the national HIV response. Similar to the work of the International HIV/AIDS Alliance in Myanmar, PGK works to support and build capacity among community-based organisations, self-help groups and volunteers through training, networking and fundraising. Recently, PGK was instrumental in establishing a Joint Parliamentary Committee made up of a group of parliamentarians and civil society advocates who meet at the central level to discuss matters of law reform, the goal being to create a more enabling environment for issues that matter to civil society. Seven community-led HIV-focussed organisations now represent key populations on the Joint Parliamentary Committee.¹⁷²

“Sex worker representatives from the Sex Workers in Myanmar (SWiM) network can meet with parliamentarians and chair of parliament. They have educated them about who they are, what the issues are and helped parliamentarians understand the issues.”

– INGO source

With the support of PGK, civil society is now in the process of developing a “whistleblowing” mechanism to report human rights abuses. This could potentially become a platform for sex workers to report exploitation or abuse by clients and state actors. Informants from Government and CBOs agreed that such a mechanism was needed to increase protection of sex workers. However, it was noted that scaling up efforts to build the capacity of civil society to manage such a mechanism would warrant technical and financial resource support.

“We’ve started talking about the law, HIV and human rights ... Three years ago we could not talk about human rights in Myanmar. What we are seeing here is progress.”

– UN source

“We are seeing more resources allocated to NGOs, and an increase in the capacity of community-based organisations and sex worker networks, but there is still lots of space to improve.”

– Government source

3.2.5 Rising opportunities for legal and policy reform

Despite the challenges associated with legal reform, a number of respondents said the political and legal environment in Myanmar appeared more conducive to review and revision of laws and policies that negatively impacted the lives of key populations including sex workers, and inhibited their access to health services. Strong collaboration was demonstrated among Government, civil society, implementing partners and UN agencies during the National HIV Legal Review process in 2013, which took positive steps toward reforming laws and practices that increased vulnerability and HIV risk among key populations.

It was recommended that Myanmar's legal and policy framework - including The Suppression of Prostitution Act - be reviewed to ensure access to health and HIV services for PLHIV and key populations. This is further discussed in Section 2 of this report.

“Collaborative efforts among stakeholders for the National HIV Legal Review were remarkable in coming together to address important issues relating to key populations and rights in Myanmar. All stakeholders were in agreement to move forward with reform of the Suppression of Prostitution Law, among other laws that impact on key populations. Actions that will take effect immediately were defined as ‘6 quick wins’ by meeting stakeholders.”¹⁷³

– UN source

The law on Prevention of Violence against Women which is in the process of being considered for adoption, will bring in protection of women from violence. One respondent spoke about potential collaboration between sex worker networks and the Gender Equity Network, where issues of rights abuses and violence against sex workers could be discussed at the parliamentary level. Protection of male and transgender sex workers against violence is yet to be factored into the national legal framework.

Although there is a notable willingness by parliamentarians to consider law reform issues relevant to the HIV response, three key informants said advocacy messages needed to be taken further, and discussed in Parliament, for legal reform to occur.

“It is great that issues affecting key populations are being heard by some parliamentarians, but what we are finding is they don’t always know how to help facilitate change and reform in the parliament setting. They want to, but just don’t know how to do it.”

– Sex worker and CBO source

The Government recently started to amend laws pertaining to key populations, such as the Burma Excise Act of 1917 (amended in December 2015) to repeal sections referencing the illegal possession of needles and syringes. In early 2015, wide-range consultation on amending the Narcotic Drugs and Psychotropic Substances Law of 1993 resulted in a more progressive drug law which is still to be enacted by the Parliament. However, there continues to be challenges and delays with legal reform. For example, in July 2015, the Ministry of Home Affairs proposed several amendments to the Suppression of Prostitution Act of 1949, and although public comment was invited, the proposed amendments were drafted without involving stakeholders. Therefore, it is imperative that collaborative efforts to reform these laws are sustained to protect the rights and health needs of sex workers.

At the policy level, some respondents affirmed there is now greater interest and support among government officials (within the health and law enforcement sectors) to support sex workers in gaining access to HIV prevention, treatment and care programmes.

“[The police] not only focus on law, but focus on social problems. We have to think about the social problems in [the] community. There is more open dialogue now between law enforcement and INGOs/NGOs resulting in more cooperation between partners and law enforcement – this has been very positive.”

– Government source

“We are pleased there is an increased willingness for some police authorities to receive training and advice on how to work with sex workers. Some local NGOs, in collaboration with the MoH/NAP, now provide health education to police at the township level. They discuss HIV-related challenges, such as condom use.”

– CBO source

Some respondents spoke encouragingly, with ideas for potential police-led initiatives, such as the establishment of “health support liaison officers” or “sex work focal points” within local police ranks who could help educate fellow officers on how to best protect sex workers and support HIV programming. Liaison officers could be designated and trusted individuals to whom sex workers could report crimes or issues of concern without fear of arrest or retribution. If proven effective, this initiative could be expanded across the national law enforcement network.

Not all key informants, however, perceived potential for positive engagement between the health sector and law enforcement, reiterating that police crackdowns continued to disrupt HIV services, and make life difficult for sex workers.

3.2.6 Funding opportunities for HIV prevention and treatment programmes

In recent years, Myanmar has faced a significant drop in funding for HIV prevention programmes targeting sex workers, with resources primarily supporting the scale-up of ART and decentralisation of HCT services. However, the significant injection of funding provided by the GFATM for 2013–2016 has seen a rapid scale-up of HIV prevention and treatment programmes for key populations. Expenditure on HIV prevention among FSW and their clients increased by 11% between 2012 and 2013.

A few key informants remarked how improved funding opportunities had helped Myanmar strengthen strategic information and monitoring and evaluation systems, scale up HIV treatment services, and work toward the Government’s Vision 2030 for universal health care coverage as it relates to sustainability of the national HIV response. Indeed, some development partners and UN representatives said financial responsibility for the HIV response would ultimately sit with the Ministry of Health. They said development partners would reduce their investment over time, and this should be factored into the next National Strategic Plan (III).

One key informant discussed the potential for continued support through the GFATM but, at this stage, the level of future funding is unknown. Contingent on GFATM approval, development partners informants anticipated the NAP would eventually take over the role of principal recipient. At the time of the situational analysis, it was unclear to respondents, how many additional years of funding the GFATM would provide for HIV programmes in Myanmar. One key informant from a UN agency commented on the success of the NSP II Operational Plan, and associated expenditure planning.

“Myanmar has made remarkable progress, given the limited resources it’s had [to combat HIV]. Resources are usually misspent by targeting the general community [rather than at-risk groups]. However, the country’s national strategy has included some very strong targeting.”

– UN source

Despite recent progress, respondents highlighted the need to increase financial investment in HIV prevention programmes targeting sex workers and their clients, and in new strategies, innovative models and pilot programmes designed to reach those who are "hard-to-reach".

3.3 Challenges and barriers to an effective HIV response among sex workers

3.3.1 Legislation, policy and practice

3.3.1.1 Criminalisation of sex work

As discussed in the literature review, criminalisation of sex work exposes sex workers to HIV vulnerability, discrimination, harassment and violence. Although recommendations have been put forward for legal review and amendment of the Suppression of Prostitution Act (1949), most respondents asserted existing laws created an environment that directly hindered HIV prevention interventions for sex workers.

Some of the amendments to the Suppression of Prostitution Act of 1949, drafted by the Ministry of Home Affairs in 2015, proposed to impose harsher penalties for sex workers, particularly lengthier prison sentences and larger fines.

“A FSW can get arrested one year and then get released. If the police find her one year later, even though she is not working as a sex worker, they will arrest her again. I have seen this happen.”

– NGO source

One sex worker affirmed condoms were often used as a reason for arrest, but not mentioned in court as police knew this would contravene policy. Some street-based sex workers reported they were reluctant to accept condoms from outreach workers, and felt the need to conceal them for fear of harassment from police. Similarly, one respondent commented that sex venues would not keep condoms on the premises in order to avoid attention from law enforcement.

“Beer halls and massage parlours in our area won’t dare to sell or keep condoms on site for fear of being accused of aiding sex work.”

– NGO source

Many respondents reported that police crackdowns happened periodically in response to pressure to fulfil arrest quotas. They also said sex workers were sometimes arrested during the day, when they were not working, as they were usually known to police. Then, the time of the arrest would be changed on the charge sheet if the case went to a court hearing. Some respondents affirmed they had witnessed peer workers get arrested by police, which compromises important HIV prevention outreach work.

“Crackdowns occur regularly throughout the year and during these crackdowns you can be immediately identified as a sex worker if you’re carrying condoms.”

– NGO source

“Sometimes even volunteer outreach workers are arrested when there is a police crackdown. This disrupts their outreach work which means less condoms are distributed to sex workers in the local area.”

– Sex worker

“The rules and regulations are not clear. The law is old. If you are a woman and it is dark and you are in a suspect area, you can be considered to be a sex worker and arrested, or if you have condoms in your bag, you can be arrested. This is a big challenge. There is no clear law, no clear human rights or protection for sex workers against discrimination, harassment or violence. If we are going to win the fight against HIV in Myanmar, the current laws affecting sex workers need to be changed to create a more enabling environment to protect and support their needs.”

– UN source

3.3.1.2 Police harassment of sex workers

Police harassment and intimidation of sex workers was identified as the most pressing concern for workers, and the most significant barrier to accessing HIV and sexual and reproductive health services. Street-based sex workers were purported to be the most vulnerable due to their visibility and lack of protection from pimps or managers. Some police allegedly extorted money and sexual services from sex workers. However, some sex workers reported they were still arrested after giving money and providing free sexual services to police.

“The worst problem is when the police are drunk and come to ask for money from sex workers. This is a big problem as we lose money. It is difficult to negotiate with police, especially when they are drunk. We have no power.”

– Sex worker

“During arrests, oftentimes, the client of the sex worker will not be arrested, but will be used as a witness for police to arrest the sex worker.”

– NGO source

Some respondents reported senior law enforcement officers have been known to book out a brothel for a morning or a day and demand free sexual services from resident sex workers. The brothel owners and workers have no choice but to comply with their requests.

“Police arrests make sex worker lives very difficult where sex workers face violence, harassment and sexual violence. Even brothel owners get arrested.”

– Sex worker

According to some respondents, brothels and massage parlours are often the focus of police crackdowns, although venue owners may provide money to the police, close their premises for the crackdown period and avoid the attention of law enforcement. Sex workers within these establishments tend to avoid arrest as they have some protection from brothel owners and managers who have paid money to the police.

“Brothels will pay police a large sum every month or so and will be told in advance if there is a crackdown.”

– NGO source

Many respondents reported incarceration was common for sex workers. If a sex worker is arrested and attends a court hearing, respondents said they usually ended up in prison, even if they had a good lawyer. Sex workers generally received a 1–3 year jail sentence, and relied on family for food, supplies and medication.

A few NGOs provide services for sex workers living with HIV who are in prison, but their services are limited to nutritional support, and the organisations have budget and programme quotas with regard to how many sex workers they can support within a given time frame.

“There is no organisation providing services for sex workers in jail but many staff will go to try and help sex workers in jail because they know them. It is not in their job but they feel an obligation to the sex worker.”

– NGO source

“Police should not arrest sex workers as they are working for their family’s welfare and their family will struggle without them.”

– Client of a sex worker

Despite some positive steps to raise awareness among law enforcement agencies about HIV and difficulties encountered by sex workers, the majority of respondents highlighted the urgent need for training and sensitisation programmes for police personnel at the operational level.

“We need more advocacy from [implementing] partners to inform law enforcement on the issue [of sex workers]– police are very busy and they need to be sensitised to this issue. A good example of where this has worked is harm reduction – at the time the advocacy was very good and it has resulted in this ‘de facto decriminalisation.’

– Government source

3.3.1.3 Lack of protection and legal services for sex workers

There are few legal services for sex workers in Myanmar, and those that do exist are limited in scale and geographic coverage. Funded by the United Kingdom's Department for International Development (DfID) Pyoe Pin programme, the Equal Law Project was established in 2012 and is managed by civil society groups, namely the SWiM network, the Myanmar MSM Network and the National Drug-users Network in Myanmar. The project aims to protect the human rights of people vulnerable to HIV, and to reform laws that prevent an effective response to the epidemic. Lawyers and peer paralegals are employed through the project to give legal, human rights and health education to target populations and provide representation for legal cases involving PWID, MSM and sex workers. The Equal Law Project has not yet expanded beyond Yangon and Mandalay, and plans to do so are contingent on continued funding. It was observed that Mandalay and Mawlamyine each have a legal aid service available to the general public, although these services do not have a specific focus on sex workers' issues.

When asked about legal services for key populations in Myanmar, 70% of respondents were not aware of any services for sex workers. The remaining 30%, mostly representatives from INGOs and development partners, advised there was some legal counsel offered through the Equal Law Project. Most respondents said sex workers in smaller cities needed access to education about their rights and about the legal system. Some respondents spoke of an increase in local CBOs providing basic training on legal rights to sex workers, such as Aye Myanmar Association (National Sex Workers Network), the PSI TOP programme and the SWiM network.

Most respondents, however, agreed that NGO and CBO capacity in this area needed significant development. As discussed earlier in this report, Pyi Gyi Kyin has made some progress in the establishment of a reporting mechanism enabling human rights abuses to be reported to the Joint Parliamentary Committee at the central level in Nay Pyi Taw. As well, UNAIDS Myanmar has facilitated trainings on human rights-based and gender sensitive approaches to HIV programming for participants from civil society, key populations groups and networks, I/NGOs, and the Myanmar Human Rights Commission. These trainings are intended to build the capacity of participants to organise local level trainings to disseminate the knowledge and awareness gained. Also, the Human Rights and Gender Working Group was formed based on a recommendation from the Mid-Term Review of the National Strategic Plan on HIV and AIDS (2011-2016). The working group serves as a platform for a wide-range of stakeholders to address human rights and gender-related issues in the context of the HIV response. However respondents reported that capacity development was needed at the CBO level to ensure cases were effectively referred up the reporting chain.

“No one is doing legal services. I don’t know who does this but it is needed.”

– CBO source

“Occasionally we hear some groups will provide legal services [to sex workers] but we don’t know who they are.”

– NGO source

A recurring issue raised during key informant interviews was the perceived lack of legal protection for sex workers. When asked, most respondents reported sex workers were generally unwilling to seek help or redress from police if they were a victim of violence, theft or other crime. There was the general perception that a sex worker would be arrested if she went to the police to report a crime committed against her.

“There’s nobody standing behind sex workers to protect them. They are on their own.”

– NGO source

“Law enforcement and the police are the worst problems. There is nobody who can help us when sex workers need protection from the law in instances of violence. There is no protection from the police.”

– NGO source

“I’m not sure about the law and what it says. I just know that I want to be protected from violence and intimidation but I can’t go to the police for protection.”

– Sex worker

Police perceptions differed considerably from all other respondents. When interviewed, law enforcement officers claimed procedures and practices were uniform across the country, and sex workers were no longer arrested for carrying condoms.

“It is a police officer’s duty to take action. They do not conduct raids or crackdowns but, if someone informs them of illegal sex work, then they must investigate.”

– Government source

Some officers acknowledged the current law needed to be amended, pointing out there was a provision that stated a sex worker could be “beaten”. The Literature Review from this situational analysis, however, did not locate any evidence of such wording, which implies there may be a misinterpretation of the law by some law enforcement officers.

3.3.2 Stigma and discrimination

According to respondents, stigma and discrimination continue to represent significant barriers to effective HIV responses among sex workers in Myanmar. Most respondents talked about stigma and discrimination being barriers experienced by sex workers through health services, law enforcement and their local community. It was also thought to influence sex workers’ choice of health service provider. Most respondents reported that sex workers were unlikely to access government services for fear of being identified as a sex worker and exposed to judgemental and unfriendly attitudes.

All sex workers expressed a preference for NGO service providers that were welcoming and non-judgemental, and allowed for sex workers to associate and support each other in a safe space such as a drop-in-centre. It is important to note, however, that drop-in-centres tend to attract sex workers who are lower income. According to respondents from NGOs, higher-end sex workers from nightclubs, and those who operate online or via mobile phone, rarely attend drop-in-centres.

“We like coming here [to the NGO drop-in-centre], not just because of the services but because of the social aspect and welcoming staff. We can meet other sex workers. There is no judgement from staff. They treat us very well, even buy us small gifts sometimes.”

– Sex worker

“The NAP/government HIV prevention services are available to anyone. FSW may generally be afraid to use them out fear of disclosure of their profession and being stigmatised.”

– Government source

When discussing access to health services, many sex workers and NGO staff reported sex workers were reluctant to disclose their profession to service providers due to the legal ramifications, stigma and discriminatory attitudes that might result from disclosure.

“You go to many of the drop-in-centres and many of the FSW there, especially those who work there, are quite open and self-assured. I often wonder how many other sex workers are out there who are not comfortable coming into services as they don’t want to say they are a sex worker – the stigma is too much for them to come in. Stigma blocks sex workers from getting to the services they need.”

– NGO source

“We hear a lot of cases regarding confidentiality issues around pre and post-test counselling at government sites. Most sex workers will not go there through fear of being labelled a sex worker. The stigma and discriminatory attitudes from health workers that come with that label, are feared.”

– NGO source

Service provider respondents reported a low uptake of reproductive health services among sex workers.

At times, stigma and discrimination in the wider community manifested as self-stigma. For instance, a few workers appeared accepting of negative attitudes and moral judgements toward their profession and, when asked whether sex work should be decriminalised, they said it should remain criminalised.

“Sex work is not compatible with Myanmar society and our culture. It is against our culture and should remain illegal.”

– Sex worker

However, it is important to emphasise the majority of respondents identified legislative reform, and the reduction of stigma and discrimination, as key priorities.

3.3.3 Limited reach of HIV and integrated health services

3.3.3.1 Insufficient investment in targeted HIV prevention programming and innovative service delivery models

Although increasing numbers of sex workers are now being reached through some form of HIV prevention programme, respondents recognised better targeting of programmes was needed to ensure service access for "hard-to-reach" populations. Most respondents referred to a sharp rise of "hard-to-reach" sex workers who were selling services through mobile and web-based technologies, such as Viber and Facebook, although real numbers of online sex workers are not known. Further investigation of the use of mobile technology and social media by sex workers is warranted to ensure effective HIV prevention interventions targeting these emerging hard-to-reach populations. A few respondents raised the issue of the changing economic landscape in Myanmar, which has presented increased opportunities and labour migration for young people who may be subject to sexual exploitation across border areas.

Most respondents emphasised the need for innovative strategies and flexible service delivery models to enable greater access to HCT, ART and integrated services (such as sexual and reproductive health and TB). Sex workers and their clients could, for example, access services in sex work venues or in other areas where sex work takes place. Some respondents discussed the benefits of introducing incentive-based programming to generate demand for health services. All service provider and development partner respondents highlighted the need to strengthen health service referral networks to ensure effective case management of sex workers, whether they were moving from one city to the other within Myanmar, or remaining in one location. This was also highlighted by implementing partners during the gap analysis conducted in early 2014.

40% of respondents highlighted that the current HIV response did not effectively target clients or partners of sex workers, or spouses of clients. INGOs reported they were reaching a very small number of clients of sex workers through HCT services in clinical settings. Due to funding constraints, however, they could only allow a sex worker to refer one partner for HCT services. Reaching spouses or partners of clients of sex workers is barely occurring, partly due to limited funding and targeting priorities (i.e. there are limited resources, so sex workers become the target priority).

3.3.3.2 Poor referral processes and limited uptake of integrated health services

Referral and linkages between different health services was perceived by many respondents as relatively weak, due to a combination of factors including the mobile nature of sex work, and the lack of structure and functionality of referral systems across service providers. This was particularly problematic for ART patient referral and transfer when a sex worker migrated to a new area.

Sex workers in Myanmar disproportionately experience unintended pregnancies and terminations, although abortion is illegal in the country. Many respondents explained sex workers would usually source a traditional birth attendant or midwife to perform a surgical abortion. Oftentimes, these “back yard” abortions lead to infection, and a subsequent hospital stay for post-abortion care. Another popular method of termination among sex workers is the use of traditional medicine to induce abortion. Respondents reported some NGOs offered counselling to sex workers who had an unintended pregnancy. However, no organisation was able to provide services for sex workers who wished to terminate the pregnancy.

“If a sex worker is less than one month pregnant, she can go to and get an abortion from a clinician doing covert services. If she is more than one month pregnant, she will go to a traditional medicine person, an unofficial person. They have so many ways to do an abortion ... sometimes they insert an iron stick ... very few FSW deliver a child. Some sex workers in their mid-20s have had more than 6 abortions.”

– NGO source

“After an abortion, [sex workers] can get very sick or get an infection, and then they must go to a general hospital. This happens often.”

– NGO, Yangon

According to sex workers and service providers, many sex workers are faced with an unintended pregnancy due to forced or coerced sex by clients or police, or through intermittent condom use, particularly with regular partners or spouse where condom negotiation is challenging. Most sex workers said other workers were reluctant to present at existing sex worker health services with an unintended pregnancy, as they knew these services could not provide terminations. This puts sex workers at great risk, as they may pursue unsafe termination practices. Through discussions with implementing partners, it is assumed sex workers in Myanmar have a low uptake of TB screening and treatment services, although this is currently not measured.

3.3.4 Reliance on INGOs due to limited local capacity

The emergence and growth of sex worker-led organisations was generally perceived to be very positive by all respondents, although most reiterated there was a lack of capacity among local NGOs and CBOs, particularly in relation to legal services for sex workers, and advocacy to central-level government and local law enforcement authorities. Fundraising, mobile HCT, and ART service provision were also areas where NGOs and CBOs lacked capacity and could benefit from intensive skills development support and resourcing.

“It is important that HIV services are provided directly by sex worker groups or CBOs, who themselves, can move to service provision. This is important for sustainability... Most of the effort lies with the international NGOs at the moment. There should be an effort amongst NGOs and INGOs (and particularly development partners) to support and build local capacity and local groups with the aim to have them involved in service delivery. This should be identified as a pillar of their programme ... It takes years, but we have to get started!”

– NGO source

Evidently, there is significant reliance on the larger, well-established INGOs in Myanmar to provide the majority of service delivery. Local NGOs and CBOs lack technical and managerial capacity to write, implement and manage grants. Many also rely on peer educators who are often not paid, which can subsequently cause a high turnover of staff and be disruptive to programming. Most respondents affirmed capacity building of local organisations was fundamental to the sustainability of HIV programming in Myanmar, given development partners cannot guarantee long-term support.

3.3.5 Risk behaviours associated with sex work

Respondents identified a number of risk behaviours associated with sex work, including complexities surrounding condom use, and drug and alcohol consumption. Respondents stated most clients were compliant with condom use (over 90%), although some offered sex workers more money to not use a condom. This behaviour, however, seems to be less common than in previous years.

“Client attitudes and behaviours are a barrier to prevention. It is difficult for a sex worker to convince a client to use a condom if he is determined not to use one. Some sex workers may then accept the client’s behaviour out of fear of losing a customer. Clients may feel that they should get the service they want because they are paying. If they don’t, there could always be the risk of violence. Poverty is the real barrier because it limits the sex worker’s choices.”

– Government source

“Most clients can be educated and persuaded of the benefits and reasons for using a condom.”

– Sex worker

“Clients from the government side use their power not to use a condom. They think they are immune from disease but they put themselves at risk if they do not use a condom.”

– Peer educator

With regard to drug and alcohol use among sex workers, respondents reported many sex workers drink alcohol, especially those working in the karaoke bars and beer halls. Some sex workers who worked in entertainment venues were encouraged to drink with clients to make the client spend more money at the venue. Intoxication is known to compromise clients’ willingness to use condoms, and sex workers’ ability to negotiate condom use.

Most respondents reported injecting drug use was not common among sex workers. Some suggested injecting drug use among sex workers may be more of an issue in Shan state and Kachin, but certainly not in Mandalay, Yangon or Mawlamyine where the situational analysis interviews took place. Injecting drug use was perceived as a very masculine behaviour.

“There is a small number of female drug users, this is related to Myanmar culture – injecting drug use is a male dominated behaviour. It is not common to even see a woman smoking.”

– NGO source

One respondent reported some sex workers use amphetamines or pharmaceuticals such as morphine to make the work easier. The price of amphetamines was said to be relatively high in some areas, so they were not commonly used. There was acknowledgement among most respondents that little data existed on drug use among sex workers in Myanmar.

3.3.6 Barriers to accessing health services

Many sex workers and NGO respondents believed street-based sex workers were more vulnerable to client and police harassment, but also more likely to access services. Most brothel-based sex workers are not allowed to leave the brothel freely, and cannot access much-needed services such as condom provision, HIV and STI testing, and treatment and referral to other services. Massage parlours and brothels are very reluctant to let their workers attend services, and are known to fine them for leaving their place of work. Some venue owners refuse HIV prevention outreach services, whilst others allow outreach when the brothel is closed.

Some respondents stated sex workers without national registration cards (NRCs) and formal identification avoided health services because they believed they would not be accepted without identification. This perception was extended to eligibility criteria for ART services. Some sex worker respondents believed sex workers who didn't have an identity card would not be allowed to access free ART. Many respondents reported it was possible for sex workers to gain access ART in prison. However this was dependent on the will of the sex worker, advocacy from an NGO, coordination with prison doctors, and availability of patient family members to deliver treatment. Some respondents commented it was problematic when HIV treatment for sex workers in prison is stopped or interrupted as they risk drug resistance and increased likelihood of opportunistic infections.

3.3.7 Issues with data collection and management

Most implementing partner and donor respondents referred to challenges currently experienced with data collection and management for HIV programmes targeting key populations. Crucial data are missing in national reporting, which makes it difficult to make an informed assessment of trends pertaining to sex worker uptake of HIV and integrated services. For instance, ART treatment data are currently not disaggregated by key population, nor is reproductive health or TB screening and treatment. One major barrier to improving the accuracy of data collection is the lack of a unique identifier code to track cases of individual sex workers accessing health services.

3.3.8 Mobility, migration and trafficking

Mobility and migration feature regularly in most sex workers' lives. INGOs/NGOs and sex worker respondents reported most sex workers moved every two or three months and sometimes more often. Respondents reported it was usually impossible to track or follow up with sex workers once they had moved. It is difficult for NGOs to link outbound migrating sex workers with services at their destination, as sex workers rarely share their travel plans. This is particularly problematic for sex workers who are on ART and require ongoing medication and adherence support.

“If sex workers move to another place, they are gone and we can’t trace them anymore. We have no way to reach them.”

– NGO source

Sex worker mobility has brought to light the lack of formal linkages and networks between services across different geographic areas. Most NGOs reported they had no formal relationships with service providers in other settings, nor were they always aware of what services were available outside their area. This has highlighted a need for greater coordination across health services. Little evidence exists in relation to trafficking within the sex industry in Myanmar, although NGOs, development partners and UN agencies have received anecdotal reports of trafficking across the Thai and Chinese borders of Shan and Kachin States, including young people and adolescents under 18 years old.

“Very young sex workers are hidden and hard-to-reach. Young women are working to capitalise on new economic opportunities. We hear this may be occurring in the border areas in the eastern part of the country.”

– Development partner source

One NGO respondent recalled how young sex workers were previously held in a KTV karaoke establishment, receiving little or no income, with their NRCs confiscated by the venue owner. Anecdotal findings of trafficking or entrapment are consistent with the IOM study on mobility and HIV vulnerability across the Myanmar Thai Border areas of Mae Sot and Myawaddy, which reported trafficking of Myanmar females into Thailand. As discussed earlier, there is a gap in knowledge regarding young people or children being trafficked or entrapped for sexual exploitation, which should be further investigated.

3.3.9 Barriers toward economic emancipation and support for sex workers and their families

All respondents uniformly agreed that sex workers in Myanmar tend to choose their line of work for economic reasons, often to escape poverty. Many of the sex workers interviewed purported to be widowed, separated or divorced. Without the economic support of a male partner, they engaged in sex work to support themselves and their families. The cost of living was a major concern for most sex workers interviewed. They said they would prefer to do other work if it were profitable and available. There was little or no option to undertake vocational training, should a sex worker wish to leave the profession to pursue other viable job options.

“All I want is to get out of this job. I want to start my own business, find a loving partner and get married.”

– Sex worker

Some sex workers spoke of struggling to support their children through school. A few CBOs are known to provide support to children of sex workers through informal and irregular playgroups or education, but it is not commonly practiced.

“The most important issue for us is financial problems. It is difficult for us to afford to send our children to school. No one is providing support to do this.”

– Sex worker



4. Discussion and recommendations



Edutainment park trip for Female Sex Workers (Source - MDM)



Police Advocacy (Source - MDM)



Peer Training (Source - PU-AMI)



Outreach activities (Source - Pyi Gyi Khin)

4. Discussion and recommendations

The literature review, key informant interviews and focus group discussions helped deepen an understanding of the current situation and response to HIV among sex workers in Myanmar. Over the past decade, Myanmar has seen a number of successful outcomes from the national HIV response; foremost, the steady decline of HIV prevalence among sex workers. There is scope, however, to improve the response and, in order to do this, innovative “game changer” approaches need to be considered. HIV programme partners need to question how they can do things differently to respond to the needs of sex workers, particularly during this transformational era where Myanmar is experiencing unprecedented political, economic and technological progress, and anticipating reduced levels of international development assistance. In order to address the identified challenges, the following recommendations are put forward to strengthen existing prevention, testing, treatment and care programmes and improve the national HIV response among sex workers.

Key Thematic Recommendations:

Enabling environment for HIV prevention, treatment and care targeting sex workers

Advocate for the reforms of existing laws and establish new laws and regulations to protect sex workers from violence, stigma and discrimination.

- **Maintain on-going dialogue and advocacy efforts with decision-makers to reform the Suppression of Prostitution Act 1949 and sections of the Police Act 1945. Reform efforts**

should consider international evidence supporting the benefits of alternative legislative approaches to sex work, including models of public health and safety regulation and the protection of human rights of sex workers. The involvement of sex worker communities in advocacy efforts is essential. Amending or drafting a new law that is based on health and human rights approaches and is protective rather than punitive is of high priority. Amendments to the Suppression of Prostitution Act 1949 or the drafting of a new law on sex work should take into consideration recommendations outlined in the 2014 National HIV Legal Review Report.

In a joint letter sent to the Ministry of Home Affairs (dated 19 August 2015) responding to a call for public comments to the draft amendments of the Suppression of Prostitution Act of 1949, the members of the United Nations Gender Theme Group in Myanmar (UNAIDS, UNDP, UNESCO, UNFPA, UN Women, and ILO), recommended taking a comprehensive approach towards improving health and human rights of sex workers in line with international policy documents, declarations, commitments, and guidelines.

- **Endorse and reinforce** the implementation of the Ministry of Home Affairs administrative order (2000) not to use condoms as evidence of sex work.
- **Establish laws and regulations to protect sex workers from violence, stigma and discrimination.** This should be accompanied by legal support and representation for sex workers to seek redress. Increased funding for legal aid programmes and pro bono legal services for key populations, including sex workers should be made available. A hotline number should be established to strengthen sex workers' access to justice, and knowledge of their rights.

Increase understanding of issues pertaining to sex-work among law enforcement agencies and health care service providers to promote an enabling environment and end impunity

- **Provide training for operational police (with a focus on female police officers) on how best to support HIV and STI programming for sex workers.** Such training should instil an understanding of the public health goals of such programming, and the importance of peer educators and outreach workers in providing essential services as a part of the HIV response. Central to this training should be the introduction of a system that recognises the good work undertaken by police who support HIV and STI prevention programming. Further, training of police and prison staff should be conducted regularly to ensure sex workers are treated with dignity and respect. These trainings will be best provided by law enforcement officers with experience and expertise in this area. Focusing on female police

officers, as trainers and trainees, will help with outreach to female sex workers.

- **Remove sex workers (female, transgender and male) from the arrest quotas** as a method to appraise police performance and develop a system that reframes police performance monitoring frameworks to strengthen attention and institutional support for the protective role that police can play in promoting public health including, safety and rights of sex workers. Such a framework may include formal recognition of the good work undertaken by police who provide support for HIV and STI prevention programmes among sex workers.
- **Strengthen the capacity of local operational police, the judiciary and other law enforcement agencies** to effectively respond to cases of sexual violence and to undertake investigations by enhancing their training to include topics on gender-based violence, reproductive health and HIV. A systematic monitoring system should be developed and implemented to ensure all allegations and reports of violence against sex workers, including those perpetrated by police and other state officials, are promptly and impartially investigated. More female police officers should be recruited and trained to better meet the needs of sex workers and respond to their complaints.
- **Highlight examples of good policy and practice undertaken by police in support of HIV prevention, treatment and care among sex workers** and disseminate these examples to law enforcement and other organizations working on sex work issues in Myanmar. In support, local “health support liaison officers” from police should be established, whenever possible, to serve as a focal point for key populations, and to provide guidance to fellow officers on best practice law enforcement responses to communities vulnerable to HIV. The mandate of the health support liaison officer should be to support key populations by protecting them from violence and rights violations and ensuring access to health services and tools, including condoms.
- **End impunity** and the denial of sex workers' right to justice and redress. Impose penalties and disciplinary measures to those carrying out violence against sex workers.
- Similar to training for operational police, **provide training to health care service providers from public, private and NGO sectors** on the needs of sex workers to ensure that inclusive quality health services are delivered to sex workers without stigma and discrimination.

Strengthen technical capacity of networks and CBOS to better respond to the needs of sex workers.

- **Increase leadership and organizational development among sex worker-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 sex workers networks should be competent to provide their members with support to access legal aid, referrals to health services, child support, income generation and advocating for rights and protection of sex workers.
- **Involve sex workers in policy making;** sex workers 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.
- **Engage brothel owners in the HIV response** among sex workers through awareness-raising sessions about the needs of sex workers to improve their access to prevention and health services.

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

- **Develop and implement mobile and web-based activities to expand service coverage and reach of "hard-to-reach" sex workers.** Implementing partners should include in their targeted communications strategy a focus on internet, social media and mobile applications as platforms for increasing the demand for condoms, HCT and treatment services among sex workers. In this instance, mobile phone SMS technology, instant chat applications such as Viber and Line, and social media networks such as Facebook, may be particularly relevant. Ensuring confidentiality and protection of data is essential.
- **Advocate for pre-exposure prophylaxis (PrEP)** as an additional effective intervention option for HIV prevention for sex workers and other key populations at higher risk of HIV. This will require engaging sex workers, 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.
- **Establish mobile health services to increase the flexibility of existing HCT, ART, reproductive health and TB services.** Mobile services should be delivered where sex workers and their clients are located (i.e. at venues or in other areas where sex work takes place).

- **Strengthen referral networks to ensure sex workers receive effective, timely case management and quality health services.** Referral networks should be coordinated among sex worker-led CBOs and service providers from public, private and NGO sectors.
- **Ensure that sex workers living with HIV who are incarcerated have access to appropriate health services,** including uninterrupted access to ART, and screening, diagnosis and treatment of opportunistic infections.

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

- **Organize mapping exercises at several levels to identify where sex workers are concentrated, existing programmatic gaps and duplication of services.**

Annual high-level mapping should be coordinated by NAP at the national and subnational levels and involve implementing partners and sex workers 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. Given that sex workers are highly mobile, moving across geographical areas and sex work venues, mapping will help to evaluate how the situation is changing and re-orient targeting of HIV services for sex workers.

- **Introduce micro planning in peer-led outreach programmes and case management approach** to help peer educators to better reach the maximum number of community members, assess risk and vulnerability, ensure that programme coverage and service targets are being met through outreach and ensure that the health and social care needs of the clients are met, through strengthened referral to specialist services.
- **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.

To increase the number of people accessing services and monitoring them across different

services, the SI & ME TWG should steer a process to design and implement a harmonised UIC system to be used by implementing partners that is ethical and realistic for key populations as per the HIV TSG Recommendations of Priority Prevention Interventions 2015-2016. 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 sex workers 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 sex workers. Specifically, the research agenda should focus on the following areas:

- o Efficiency, cost-effectiveness and sustainability of existing programmes targeting sex workers;
- o Situational and needs assessment of people selling sex over the phone and internet, which is an expanding practice and market;
- o Correlation between HIV, mobility and migration of sex workers (including trafficking);
- o Identification of young sex workers in Myanmar and their vulnerability to HIV;
- o Specific needs of transgender and male sex workers; and
- o Acceptability of PrEP among sex workers, with a view to conducting a feasibility study on piloting PrEP and increasing public demand.



Annex1: List of interviewees

Name	Position/Function	Organisation
Dr Myint Shwe	Programme Manager	National AIDS Programme
Pol Brig General Kyaw Win	Joint Secretary	CCDAC , Ministry of Home Affairs
Pol Col Zaw Lin Htun	Head of Project Management Department	CCDAC , Ministry of Home Affairs
Pol Col Own Khaing	Director	Criminal Department, Ministry of Home Affairs
Pol Col Win Sein		Criminal Department, Ministry of Home Affairs
Pol Lt Col Aye Myint Kyi	Deputy Director	Criminal Department, Ministry of Home Affairs
Pyae Phyo Aung	Programme Coordinator	Pyi Gyi Khin
Nwe Zin Win	Executive Director	Pyi Gyi Khin
Beate Scherrer	Country Programme Coordinator	Malteser International
Dr Aye Aye Thet	Country Health Coordinator	Malteser International
Dr Zin Ko Ko Lin	Country Medical Manager	PU-AMI
Zaw Hpag	HIV Prevention Officer	PU-AMI
Norbert Monyaarukato	Medical Coordinator	PU-AMI
Dr Khin Phone Mo Mo	Field Coordinator	MDM
Thiha Nyi Nyi	Programme Officer	HIV/AIDS Alliance
Hnin Hnin Yu	Programme Assistant	HIV/AIDS Alliance
Dr Saung Oo Zarni	Director	TOP Center, PSI, Yangon
Robert Gray	HIV Technical Advisor	TOP Center, PSI, Yangon
Than Naing Oo	Program Manager	TOP Center, PSI, Yangon
Pinky (Wut Yee Win Maung)	Sr Operation Manager	TOP Center, PSI, Yangon
Dr Hla Myo Kyaw	Programme Director (HIV)	PSI, Yangon
Dr.Thwe Hnin Zin	Programme Manager	TOP Center, PSI, Mandalay
Thae Ei Htun	Programme Manager	TOP Center, PSI, Mawlamyaing

Name	Position/Function	Organisation
Dean Creer	Coordinator	HIV/AIDS consortium, Yangon
Zar Chi Htwe	Programme Manager (MSI)	HIV/AIDS consortium, Yangon
Dr Khin Swe Swe	National Programme Officer	HIV/AIDS consortium, Yangon
Soe Moe Aung	Field Office Coordinator (Care)	HIV/AIDS Consortium, Mandalay
Representatives	CARE and MSI	HIV/AIDS consortium, Mawlamyaing
Daw Aye Aye Lwin	Chair	Myitta Shin Organization
Dr. Ohn Ohn Kyi	Assistant Program Manager	IOM, Mawlamyaing
Dr. Tun Tun Naing	Medical Officer	IOM, Mawlamyaing
Dr Khay Mar Aung	Medical Advisor	MSF-H
Kay Thi Win	Chair Person	AMA, APNSW
Thuzar Win	Chair Person	Sex Worker Network in Myanmar (SWiM)
Thiri	Secretariat	Sex Worker Network in Myanmar (SWiM)
Dr Nu Nu Aye	Sr Public Health Officer	3 MDG
Dr Faisal Mansoor	Head of Project Management Unit	GFATM, UNOPS
Robert Kelly	HIV Program advisor	USAID
Richard Lacort	Director	GFATM, Save the Children
Parsa Sanjana	Deputy Director	GFATM, Save the Children
Dr Myo Kyaw Lwin	Programme Manager	GFATM, Save the Children
Dr Myo Set Aung	Programme Manager (HIV)	GFATM, Save the Children
Dr Ni Ni Khaing	National Program Officer	UNFPA
Dr Win Mar	National Program Officer	UNDP
Phavody Bollen	Technical Officer (HIV/AIDS)	WHO
Eamonn Murphy	Country Director	UNAIDS
Geraldine Cazorla	HIV Prevention Advisor	UNAIDS
Aye Aye Nwe	Policy Officer	UNAIDS

Focus Group Discussions

Number of participants	Organization
8 Programme staff	TOP Center, PSI, Mandalay
10 FSW	TOP Center, PSI, Yangon
10 young FSW	TOP Center, PSI, Yangon
15 sex workers and 8 clients	TOP Center, PSI, Mandalay
15 sex workers	SWiM in Mandalay
6 sex workers	TOP Center, PSI, Mawlamyaing
10 Sex workers	Sex Worker Network in Myanmar (SWiM), Yangon



Annex 2: Question guide for key informant interviews and focus group discussions

1. Key informant interviews with law enforcement stakeholders

Issues to cover:

- Police response and attitude to sex work
- Law enforcement related programmes or collaborations with sex workers or other NGOs
- Knowledge of their role in HIV prevention programming

Question 1: Overview of role of law enforcement in dealing with the issue of sex work in Myanmar

- In general, what is the law enforcement approach to sex work?
- Does it differ from city to city/state to state etc?
- What is the penalty for sex work?
 - o Do you think the penalty for sex work is different depending on the type of sex work- brothel based, street based, entertainment venue based?
 - o What is the penalty for being in possession of condoms? Does it matter if it's a man or women?
- Are clients of sex workers arrested for engaging a sex worker?
- Do you receive request from the community to arrest sex workers?
- Do you feel the current strategy/approach is having an impact? Does it contribute to reducing the number of sex workers?

Question 2: Role of Law enforcement in HIV prevention

- Are law enforcement agencies involved/engaged in any specific HIV prevention activities targeting sex workers in Myanmar?
 - o How (ask about: potential referral to prevention services/ do operational police know where the HIV prevention services are available?)
 - o In collaboration with whom? (Ask about: sex worker networks? NGOs? Government departments?)
 - o How do these collaborations (if any) work? (ask about: any coordination mechanisms, steering committees meetings aimed to solve problems?)
- What are the main difficulties and challenges?
 - o Ask about: potential conflict between complaints/requests from the community, the legal framework - which criminalizes the sex workers -and the public health response (which endorses condoms programmes etc.)

- Do you know of any programmes either within Myanmar or abroad where law enforcement has played a key role in HIV prevention programmes?

Question 3: Recommendations and way forward

- How could the cooperation between law enforcement and health sectors be strengthened?
- 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 female sex workers?
 - a. Ask about: How could law enforcement sector play a more active role in HIV prevention among FSW (any suggestions? Ideas? Recommendations?)

2. Key informant interviews with non-government organisations and United Nations agencies

Issues to cover:

- Safety/protection from violence
- Working conditions
- Access to HIV and other services
- Law enforcement issues/incarceration/bribes
- Knowledge and information about HIV
- Sex work/injecting drug use crossover
- Priority actions to be taken /key opportunities (e.g. mobile HCT, STI and SRH services for FSW; innovative approaches to reach out to clients etc.)
- Methods of contraception and the sensitive issue of abortion

Tell me about the role your organisation plays in terms of sex workers and HIV?

Tell me about the various working conditions for sex workers? (brothel based/entertainment based/street based)- how do their needs differ in terms of HIV prevention?

What do you think are the major challenges for sex workers in Myanmar?

What services are available to sex workers? How accessible are they? What is their knowledge and understanding with regard to HIV?

What access to sex workers have to other contraception apart from condoms? What if a sex worker has an unwanted pregnancy? What are her options? What organisation would provide services relevant to her?

What are the main barriers for sex workers to protect themselves from HIV? (The law? The police? Clients' attitudes and behaviour?)

What have been the major achievements in terms of HIV programming for sex workers? Where are the major gaps? How can things improve? What key interventions need to be introduced/expanded?

Do you think many sex workers also use/inject drugs? Are there many services that cater to this cross over?

What has been the relationship between sex work and law enforcement? Do they create any problems for sex workers in terms of HIV vulnerability? Is this being addressed?

3. Focus group discussions with sex workers

Issues to cover:

- Safety/protection from violence
- Various working conditions
- Access to HIV and other services
- Law enforcement issues/incarceration/bribes
- Knowledge and information about HIV
- Sex work/injecting drug use crossover suggestions
- Priority actions to be taken /key opportunities (e.g. mobile HCT, STI and SRH services for FSW; innovative approaches to reach out to clients etc.)
- Methods of contraception and the sensitive issue of abortion

Scenario: Win Win has just started selling sex in [town]. She solicits clients from the street. She knows some women who sell sex in the same area as her.

- What do you think Win Win would know about HIV and other STIs? Where can Win Win find information about HIV and AIDS? What agencies or organisations provide the most useful services for her? Where are the gaps and what are some of the key interventions that need to be introduced/expanded?
- What do you think are her most pressing needs?
- Do you think Win Win would use contraception other than condoms? What would Win Win do if she got pregnant? What are her options?
- Where is she likely to take her clients? Do you think she would have to give money to someone else such as a pimp? Or the police?

- How does her street work differ from other types of sex work in Myanmar? Brothel based/entertainment based (indirect)? How do their work conditions differ? Who is the most vulnerable and why?
- If she got an STI where would she go to get information and treatment?
- Is her work dangerous? Why? Why not? What can she do to avoid harassment?
- Tell me about the relationship with sex workers and law enforcement
- Is it easy for Win Win to go to the police if she had been assaulted on the job? Why?/why not?
- What would make it easier for Win Win to protect herself from HIV? What are the current barriers she faces?
- How many clients do you think Win Win could see in a night? And how much money could she make?
- Do you think many sex workers like Win Win use/inject drugs? Can you tell me more about this? Can you tell me about the current HIV related services? Do they cater to sex workers who use drugs or are they separate services?

4. Focus group discussions with male clients of sex workers

Issues to cover:

- Knowledge of HIV and STIs
- Access to HIV and other services
- Attitude to and treatment of sex workers
- Law enforcement issues

Scenario: Khin is married with 2 children. When he has some spare money he will go drinking with his friends. Sometimes they visit the sex workers in [street or town]

- Where would Khin go to buy sex? What are his various options? (street based, entertainment venue based, brothel based)
- Do you think Khin would use a condom? Do you think Khin would be concerned about HIV or other STIs? Why?/why not? What would make it easier for Khin to use a condom?
- Tell me about where Khin would get his information about HIV from? What services would he access?
- What do you think are his most pressing needs?
- Tell me about the major barriers for Khin to protect himself from HIV?
- How do you think clients like Khin treat and view sex workers?
- What would be Khin's relationship with law enforcement? Would he be worried about being arrested?

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¹⁷² Seven CBOs currently advocating to government on policy reform include: Myanmar Positive Group, Women's Positive Group, Sex Workers in Myanmar, MANA, Myanmar Drug User Group, Myanmar Sex Worker Group, National NGO Network and the MSM Group.

¹⁷³ Reform of the Suppression of Prostitution Act 1949 was discussed at the symposium, and meetings were held in May 2014 for the National HIV Legal Review whereby agreement was made to

move with reform in the medium term. Six “quick wins” were determined at this meeting, and medium-term priorities include review and reform of the Suppression of Prostitution 1949. For more information, refer to the HIV Legal Review Report, 2014, p.32 and p.43.

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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>