SITUATIONAL ANALYSIS OF THE HIV RESPONSE AMONG SEX WORKERS IN MYANMAR

April 2016
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[Analysis of GFATM HIV spending, 2012-2013]

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Acknowledgements

Great appreciation is expressed to all those from the Ministry of Home Affairs Criminal Department, National AIDS Programme, international and national non-government organisations, development partners and United Nations agencies, and to the people living with HIV and representatives of sex worker networks who actively participated in this Situational Analysis. By providing important insights during the interviews and discussions, these stakeholders greatly enriched our understanding of sex work, HIV and the response in Myanmar and reminded us why services to support key populations at higher risk of HIV infection should promote dignity and respect.

Celeste Jennings, independent consultant, completed the Situational Analysis of the HIV Response among Sex Workers in Myanmar, and Brigitte Tenni and Naanki Pasricha, independent consultants, conducted preliminary data collection and analysis.

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

Deep gratitude is extended to the Three Millennium Development Goal Fund for their financial contribution to the Situational Analysis, and to the printing of this report.
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>3ILPMS</td>
<td>Three Interlinked Patient Monitoring Systems</td>
</tr>
<tr>
<td>3MDG Fund</td>
<td>Three Millennium Development Goal Fund</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>AMA</td>
<td>Aye Myanmar Association (National Sex Workers Network)</td>
</tr>
<tr>
<td>APCOM</td>
<td>Asia Pacific Coalition on Male Sexual Health</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organisation</td>
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<tr>
<td>DfID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop-in-centre</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>FSW</td>
<td>Female sex worker</td>
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<tr>
<td>GARPR</td>
<td>Global AIDS Response Progress Report</td>
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<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B virus</td>
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<tr>
<td>HCT</td>
<td>HIV counselling and testing</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HIV-TSG</td>
<td>HIV Technical and Strategy Group</td>
</tr>
<tr>
<td>HSS</td>
<td>HIV Sentinel Sero-Surveillance</td>
</tr>
<tr>
<td>IBBS/PSE</td>
<td>Integrated Biological and Behavioural Surveillance/Population Size Estimation</td>
</tr>
<tr>
<td>INGO</td>
<td>International non-government organisation</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organisation for Migration</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and child health</td>
</tr>
<tr>
<td>M-HSCC</td>
<td>Myanmar Health Sector Coordinating Committee</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NAP</td>
<td>National AIDS Programme</td>
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<tr>
<td>NGO</td>
<td>Non-government organisation</td>
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<tr>
<td>NRC</td>
<td>National Registration Card</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<td>NSP II</td>
<td>Myanmar National Strategic Plan on HIV and AIDS 2011–2016</td>
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<tr>
<td>PEPFAR</td>
<td>United States President’s Emergency Plan for AIDS Relief</td>
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<td>PGK</td>
<td>Pyi Gyi Khin</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>SI &amp; ME TWG</td>
<td>Strategic Information and Monitoring and Evaluation Technical Working Group</td>
</tr>
<tr>
<td>SMS</td>
<td>Short Message Service</td>
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<tr>
<td>SOP</td>
<td>Standard operating procedure</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>SWiM</td>
<td>Sex Workers in Myanmar</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TRaC</td>
<td>Tracking results continuously</td>
</tr>
<tr>
<td>UIC</td>
<td>Unique identifier code</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal health coverage</td>
</tr>
<tr>
<td>UNOPS</td>
<td>United Nations Office for Project Services</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Seminar on "Collaboration for HIV Response with Sex Workers in Myanmar". (Source - UNAIDS)
Outreach activities (Source - TOP, PSI)

Micro Finance Training (Source - SWiM)
ဗိုလ်ချုပ်ရေးဦးစီးခ်ဳပ် (UNAIDS) အဖွဲ့အစည်းအဖြစ် ဖွံ့ဖြိုးမှုများအပေါ် လွေ့ခြားသော ဖော်ပြချက်ကောင်းမှုများ ဖော်ပြသည်။ ဗိုလ်ချုပ်ရေးဦးစီးခ်ဳပ် (UNAIDS) အဖွဲ့အစည်းအဖြစ် ဖွံ့ဖြိုးမှုများအပေါ် လွေ့ခြားသော ဖော်ပြချက်ကောင်းမှုများ ဖော်ပြသည်။
အမ်ိဳးသမီးလိင္လုပ္သားမ်ားထံမွ ၀န္ေဆာင္မႈရရွိသူမ်ားၾကား အိတ္ခ်္အုိင္ဗြီပုိးျဖစ္ပြားမႈမွာလည္း ေယဘုယ်အမ်ိဳးသားမ်ားထက္ျမ_insufficient_data
မှားမွတဆင့်လည်းထြက်လာစသည်။ အမွန်တကယ်အပေါ် သိရွှေ့ႏိုင်းသူများမဟုတ်သည့်အတွက် အိတ်ချုပ်အုိင်းကာကြယ်ရေးစီမံခါများသည်လည်း သိရွှေ့ႏိုင်းသူများထံသုံးမှုများကို မေရာက်ရွှေ့ႏိုင်းသူ ရှိတို့နှင့်အတွက် ဗိုလ်ချုပ်သူများရှိကြသော အထောက်အထား သူများတိုးပျော်လာသည်။ အောက်ပါ ဗိုလ်ချုပ်လာလာသောအောက်ပါအခါကို ဖော်ပြရန်၊ အိတ်ချုပ်အုိင်းကာကြယ်ဗျားဗား (HCT) နှင့် အိတ်ချုပ်အုိင်းကာကြယ်ဗျား (အမျိုးသမီး အမျိုးသား TG) ကြေးနှင့်အတွက် အထောက်အထားနှင့်ဆုံးဖြတ်မှုများကို အားလံုးအေတြဖြစ်၍ထိုးရမှုသူများ အားလံုးအေတြဖြစ်၍ထိုးရမှုသူများအတွက် အိတ်ချုပ်အုိင်းကာကြယ်ဗျားများ အရွိနှင့်အချင်းမှာမွာစီးဗျားရန်အလိုင်းငွေ့ပူးဗျားေဆာင်ရာများ အားလံုးအေတြဖြစ်၍ထိုးရမှုများျဖစ္ေပၚလာေစရန္ ဤအောက်ပါအခါဆန္းစစ္များကို ရည်ရွယ်ပါသည်။ တိက်စိုးေဖြူမည်ဆုိလွ်င္ ဗိုလ်ချုပ်ပေါန်းလျောက်လာမှုတော်မှုများအား အောက်ပါအခါဆန္းစစ္များကို အားလံုးအေတြဖြစ်၍ထိုးရမှုများမှာ -

၁. အိတ်ချုပ်အုိင်းကာကြယ်ဗျားများတြင် ထြက်လာစသော နည်းလမ်းအသစ္များအား ဖော်ပြရန်

၂. အိတ်ချုပ်အုိင်းကာကြယ်ဗျားများတြင် လိုင်စာများ နှင့် တိုးတက်များကို မီးေမာင်းထုံးေပရန်

၃. ဗိုလ်ချုပ်များ၏လူမျိုးများကို ဖော်ပြရန်အထောက်အထားများကို အားလံုးအေတြဖြစ်၍ထိုးရမှုများကို ဖော်ပြရန်

၄. ဗိုလ်ချုပ်များအတွက် အိတ်ချုပ်အုိင်းကာကြယ်ဗျားများ တိုုးတက်စသော သက္ဆိုင်ရာအားလံုးအေတြဖြစ်၍ထိုးရမှုများအား ဖော်ပြရန်

ဖော်ပြပါပြီးမှာ အတွက်၎င်း၏နှစ်ထုတ်ဝေမှုကို ဖော်ပြရန် အပေါ်တွင် အားလံုးအေတြဖြစ်၍ထိုးရမှုများကို ပေါင်းစပ်ထားရှိသည်။ အရည်အေဖာ့်ေတာ်မှုကို ရန္ကုန္၊ မႏၲေလး၊ ဗိုလ်မာေါးစေသာ ဗိုလ်ချုပ်ေလးများအား ပေါင်းစပ်ထားပါသည်။
 STL့စ္ဆုိင္ခ်က္မ်ားအားလောက်ခြင်းမ်ားအတြက္ အိတ္ခ်္အုိင္ဗီြအေၾကာင္း ပညာေပးျခင္း၊ ကြင္းဆင္းလုပ္သားအေျချပဳ အသိျမႇင့္တင္ေရးလႈပ္ရွားမႈမ်ား၊ ကြန္ဒံုျဖန္႔ေ၀ျခင္း၊ အိပ္ခ်္အိုင္ဗီြအတြက္ ႏွစ္သိမ့္ေဆြးေႏြးပညာေပးျခင္းႏွင့္ ေသြးစစ္ျခင္း၊ ကာလသသားေရာဂါကုသေရး၀န္ေဆာင္မႈမ်ားသို႔ လႊဲပို႔ေပးျခင္း အစရွိသည့္ အိတ္ခ်္အိုင္ဗီြကာကြယ္ေရး အစီအစဥ္မ်ားသည္ လက္ရွိတြင္ လိင္လုပ္သားမ်ား 

[၅၄၆၄၆ ဦး (အနိမ့္ဆံုး) မွ ၇၇၀၅၉ ဦး (အျမင့္ဆံုး)]

ထံသို႔ ေရာက္ရွိေနသည္ဟု ယူဆရသည္။ အေျပာင္းအလဲျဖစ္ရန္ တိုက္တြန္းႏိႈးေဆာ္ျခင္း၊ လူမႈေရးအရပံ့ပိုးမႈမ်ား၊ ကာကြယ္ေရးဆိုင္ရာလက္ကမ္းေစာင့္ေရွာက္ မႈမ်ားတြင္ လုပ္ေဆာင္ ေနၾကေသာ ျပည္တြင္းလူထုအေျချပဳ အဖြဲ႔အစည္းအသစ္မ်ား (CBO) ထြက္ေပၚလာသည္ႏွင့္အမွ် အဆိုပါ ဝန္ေဆာင္မႈလုပ္ငန္းမ်ားကိုလည္း ဆက္လက္တိုးခ်ဲ႕လ်က္ရွိသည္။ သုိ႕ေသာ္ လိင္လုပ္သားမ်ားအတြက္ ကာကြယ္ေရးစီမံခ်က္မ်ား၏လႊမ္းၿခံဳမႈမွာ တစ္စိတ္တစ္ပိုင္းမွ်သာရွိေနၿပီး မေသခ်ာေသာခန္႔မွန္းလူဦးေရပမာဏအေပၚ အေျခခံ ထားသည္။ FSW, MSM ႏွင့္ TG မ်ားၾကားရွိ IBBS/PSE အသစ္သည္ ဤကြာဟခ်က္ကို ကူညီျဖည့္ဆည္းေပးမည္ျဖစ္သည္။ အထင္ရွားဆံုးတုိးတက္မႈကိုေဖာ္ျပရမည္ဆုိလွ်င္ (၂၀၁၆) ခုႏွစ္အကုန္တြင္ လႊမ္းၿခံဳမႈ (၈၆) ရာခိုင္ႏႈန္းရွိရမည္ဟူေသာအမ်ိဳးသားအဆင့္ဦးတည္ခ်က္ကို ျပည့္မွီရန္ အလားအလာေကာင္းေနသည့္ လ်င္ျမန္စြာတိုးတက္လုပ္ေဆာင္လာေသာ ART ဝန္ေဆာင္မႈမ်ားပင္ျဖစ္သည္ (အိတ္ခ်္အိုင္ဗြီပုိးရွိေနျပီး ART ေဆးျဖင့္ကုသမႈခံယူေနေသာ လူၾကီးႏွင့္ကေလး စုစုေပါင္း ၁၁၄၄၃၇ ေယာက္ရွိသည္)။ (၂၀၁၄) ခုႏွစ္တြင္ အိတ္ခ်္အိုင္ဗြီ၀န္ေဆာင္မႈမ်ားရွိေသာသူ (၈၅၆၂၆) ေယာက္သည္ ART ေဆးျဖင့္ ကုသခံရန္ စာရင္းေပးသြင္းခဲ႔ၾကသည္။
ဆက်လက်တည်ရွေး ယင်းက လိင္လုပ္သားမ်ားအားဦးတည္ေသာ အိတ္ခ်္အုိင္ဗီတံ႔ုျပန္ေရးလုပ္ငန္းမ်ားအလိင္လုပ္ငန္းမ်ားကို ျပစ္မႈအျဖစ္သတ္မွတ္ျခင္းက လိင္လုပ္သားမ်ားကို အိတ္ခ်္အုိင္ဗီပုိးကူးစက္ခံရ လြယ္ေစျခင္း၊တြင္ (၈) ရာခုိင္ႏႈန္း UNAIDS ျခင္းကလည္း အမ်ိဳးသားအဆင့္ အိတ္ခ်္အိုင္ဗီြတံု႔ျပန္ေရးတြင္ အရပ္ဖက္အဖြဲ႕မ်ား ပါဝင္မႈကို တိုးတက္လာေစၿပီး ေရးလုပ္ငန္းမ်ားတြင္ လုပ္ကိုင္ေနေသာ လိင္လုပ္သားမ်ားကြန္ရက္ႏွင့္ ကိုယ့္အား ကိုယ္ကိုးအဖြဲ႕မ်ား ေပၚထြက္လာေသာေၾကာင့္ျဖစ္သည္။ ထို႔ျပင္ အေျပာင္းအလဲအတြက္တိုက္တြန္းႏိႈးေဆာ္ျခင္း၊ လူမႈေရးပံ့ပိုးမႈမ်ားႏွင့္ ကာကြယ္လႊမ္းျခံဳမႈ (ရန္ကုန္ႏွင့္ မႏၲေလး) ႏွင့္ လူ႔အရင္းအျမစ္စြမ္းအားမ်ား အကန္႔အသတ္ရွိေနသည္။ ေလ့လာမႈမ်ားအရ ᥥပေဒေဖၚေဆာင္ေရးအရာရွိမ်ားျဖစ္ေနလွ်င္ သတင္းပုိ႔တုိင္ၾကားရန္ တရားေရးရာကာကြယ္မႈ (သို႔မဟုတ္) လံုၿခံဳ သည္ အၾကမ္းဖက္မႈမ်ား (သို႔မဟုတ္) ညွဥ္းပမ္းႏွိပ္စက္မႈမ်ား၊ အထူးသျဖင့္ ျပစ္မႈက်ဴးလြန္သူမ်ားသည္ ရဲ (သို႔) ေသာ တရားေရးရာ၀န္ေဆာင္မႈမ်ားကို မရရွိၾကေခ်။ လိင္လုပ္သားမ်ားသည္ မိမိကုိယ္ကို ဥပေဒႏွင့္ ျငိစြန္းသူမ်ားအသံုးမျပဳႏိုင္ျဖစ္ေနသည္ဟု အမ်ားစုမွေျပာၾကားခဲ့သည္ကို ေတြ႕ခဲ့ရသည္။ အခ်ိဳ႕လိင္လုပ္ငန္းအေဆာင္ပိုင္ရွင္ အျခားဝန္ေဆာင္မႈမ်ားအတြက္ ညႊန္းပို႔ျခင္း စသည္တုိ႔ကဲ့သို႔ေသာ အမွန္တကယ္လိုအပ္သည့္ ဝန္ေဆာင္မႈမ်ားအား ျမင့္တက္လာသည္ကို ၾကည့္ျခင္းအားျဖင့္ ျမန္မာႏုိင္ငံတြင္လိင္လုပ္သားမ်ား ဖမ္းဆီးမႈျမင့္မားလာသည္ကို သိႏုိင္တြင္ အမႈေပါင္း (၁၉၅၆) ခုမွ (၂၀၁၂) တြင္ အမႈေပါင္း (၃၂၂၆) ထိ

Myanmar Equality နော် Myanmar Law Project ေျာ် ကုမ္မဏီစွဲးကြီးအဖွဲ့အစည်း၏ ဗုဒ္ဓေရာ (ရုိမတရာအဖွဲ့) နော် ဗုဒ္ဓေရာအဖွဲ့အစည်း၏ အကျဉ်းဝင်မှု့ေရာ အကျဉ်းဝင်မှု့ေရာ
ပြုလုပ်ခွင်းမှာ အာေ၀ရာစီးဥပုဒ်အဖြဲ႔များအတွက် လိင်လုပ်ငန်းသည် ဖော်ပြခြင်းနှင့်အကြမ်းဖက်များ၏စီမံချက်များကြောင့် လုပ်ရေးအာေစီးကြက်များ၊ ရေးဇူးကြည်းများသည် သိပ္ပံတစ်ပါတီများမှာ ဗျူးကိုးနှစ်ခန့် စီးပြည်သူထောင်းလျက်ရှိသည်။ လိင်လုပ်သူများကြောင့် အကြမ်းဖက်များမှာ ဆုံးသစ်နာများကို ရှာဖွေကြသည်။ သုံးသပ်သောမှာ အပြည်အစုံအလုပ်များ၏ အဓိကအထောက်ခံစားရောက်ရောက်သောလူများအတွက် အထောက်အကူတစ်ခုအထိအဆင့်တွင် အပြည်ပြည်ဆိုင်ရာအလုပ်များကိုနှုန်းရေးဦးစီးသည်။

ထိန်းသိမ်းချင်ရာ ကျင်းမားများနှင့် အာေလ့အထတ်ချင်း၀င်းများကို အာေနေသည် ထိက်အပွဲေဖားခင်း၊ အကြမ်းဖက်များကို ပြန်လာခင်း၊ လူဌားအာေလံလွမ်းများကို အရေးပါသည်။ ဥပေဒအေကာင်အထည်းအဖြွဲးများ အဓိကဦးတည်အုပ်စုများ၏ အခြင့်အေရးများကို ပြည်ထောင်စုပေါ်ပေါက်ဦးစီးသို့ အခြေခံမှုေျပာင်းပေါ်သည် အဆင့်တွင် လိင်လုပ်သူများ၏ လုပ်ဆောင်ချက်များ၊ အိတ်ခုိင်ဗျူးများလုံးရာအရာရှိများအတွက် အလွှေ့အကြောင်းဒီမှားပြောင်းမှုကြောင့်ခံရသည်။

လိင်လုပ်ငန်းမှာ လိင်လုပ်သူများ၏ စီမံချက်များ၊ အိတ်ခုိင်ဗျူးများမှာ ဗျူးသူလူများကိုအဆင့်တွင် လေးလာ့စ်တားလုပ်ရေးလုပ်ဆောင်သည် လေးလာ့စ်တားမှားပြောင်းမှုကြောင့်ခံရသည်။ ဥပေဒအေကာင်အထည်းအဖြွဲးများကို ဗျူးထောင်စုပေါ်ပေါက်ဦးစီးသို့ အခြေခံမှုေျပာင်းပေါ်သည် အဓိကဦးတည်အုပ်စုများ၏ အခြင့်အေရးများကို ပြည်ထောင်စုပေါ်ပေါက်ဦးစီးသို့ အခြေခံမှုေျပာင်းပေါ်သည်။

ထိန်းသိမ်းချင်ရာ ကျင်းမားများနှင့် အာေလ့အထတ်ချင်း၀င်းများကို အာေနေသည် ထိက်အပွဲေဖားခင်း၊ အကြမ်းဖက်များကို ပြန်လာခင်း၊ လူဌားအာေလံလွမ်းများကို အရေးပါသည်။ ဥပေဒအေကာင်အထည်းအဖြွဲးများ အဓိကဦးတည်အုပ်စုများ၏ အခြင့်အေရးများကို ပြည်ထောင်စုပေါ်ပေါက်ဦးစီးသို့ အခြေခံမှုေျပာင်းပေါ်သည် အဓိကဦးတည်အုပ်စုများ၏ အခြင့်အေရးများကို ပြည်ထောင်စုပေါ်ပေါက်ဦးစီးသို့ အခြေခံမှုေျပာင်းပေါ်သည်။
မရွိခင်ကလည်း အချက်အလက်များကိုယူရာတွင် အကန်အသတ်များဖူးပါသည်။

ထဲခြေ မရွိသေကာင်ဖြစ်သောစီမံခန်းနှင့်လုပ်ငန်းအကောင်အထည်ဖူးသည် မိတ်ဖက်များအနေဖြင့် သတင်းပြောင်းမှု (သို့မဟုတ်) ART ရွေးချယ်ရာ ရွေးချယ်ရာ အချက်အလက်များသည်လည်း ခြားများအဓိကထိခုံချုံစားရာလူအဖျီစုများအလိုက် ခြားများထားခင်မရွိပါ။ ထိုအတွက် လိင်ပုံဆိုင်ရာနှင့်မ်ိဳးဆက်စိန်ချမှုများ ဆက်လက်ရွေးချယ်ပါသည်

လွေ့အဓိကထိခုံချုံစားရာလူအဖျီစုများ၏ ကျောင်းသားတုံးတက်မှုအောက်ကို တိုင်းတာရာတွင် နည်းဗျားဗျာသတင်းအချက်အလက်များ၊ စွန်းလာပါသည်။ ထိုမွေက်ာ္လွန်၍အသံးျပဳရန် ခြင့်ျပဳမထားျခင်များျဖစ္မည်ဟု သုံးသပ္ခ်က်များမရွိခင်ခြင်းနှင့်အမ်ားအားဖြင့် လိင်လုပ်သားများ၏ ကျောင်းသားစွာမိမိစွာအောင် လိင်းတိုးတက်မှုများ (သို့မဟုတ်) ART စွာမိမိစွာအောင် တိုင်းကြီးထားပါသည်။ ပူတဲ့ကျောင်းသားတိုးတက်မှုများ (ဥပမာ - လိင်လုပ်သားများအတွက် 19
အဓိကအေကာင္းအရာမ်ားအလုိက္ အၾကံျပဳခ်က္မ်ားလိင္လုပ္သားမ်ားကို ဦးတည္ေသာ အိတ္ခ်္အုိင္ဗြီၾကိဳတင္ကာကြယ္ျခင္း၊ ကုသျခင္းႏွင့္ေစာင့္ေရွာက္မႈေပးျခင္းတို႔အတြက္ အခြင့္အလမ္းသာေသာပတ္၀န္းက်င္ ဖန္တီးေပးျခင္းလိင္လုပ္သားမ်ားကို အၾကမ္းဖက္ျခင္း၊ လူတန္းစာခြဲျခားဆက္ဆံျခင္းတို႔မွ အကာအကြယ္ေပးႏိႈင္ရန္ လက္ရွိဥပေဒမ်ား ျပဳျပင္ေျပာင္းလဲျခင္း၊ ဥပေဒႏွင့္စည္းမ်ဥ္းစည္းကမ္းအသစ္မ်ားေဖာ္ထုတ္ျခင္းတို႔အတြက္ တိုက္တြန္းႏိႈးေဆာ္သင့္သည္။

• ၁၉၄၉ ျပည့္တန္ဆာႏွိပ္ကြပ္ေရးအက္ဥပေဒႏွင့္ ၁၉၄၅ ပုလိပ္အက္ဥပေဒပုဒ္မမ်ားကို ျပဳျပင္ေျပာင္းလဲရန္ လက္ရွိလုပ္ေဆာင္လ်က္ရွိေသာ ဆံုးျဖတ္ခ်က္ခ်မွတ္ႏိႈင္း၊ ေဆြးေႏြးမႈမ်ား၊ တိုက္တြန္းႏိႈးေဆာ္ႀကိဳးပမ္းအားထုတ္မႈမ်ားကို ဆက္လက္လုပ္ေဆာင္သင့္သည္။ ျပဳျပင္ေျပာင္းလဲရန္ႀကိဳးပမ္းရာတြင္ ျပည္သူ႔က်န္းမာေရးစံနမူနာမ်ား၊ ေဘးကင္းလံုၿခံဳမႈရွိေသာ စည္းမ်ဥ္းမ်ား၊ လိင္လုပ္သားမ်ား၏ အခြင့္အေရးမ်ားကို အကာအကြယ္ေပးျခင္းမ်ား အပါအဝင္ လိင္လုပ္ငန္းတြင္ အျခားေသာဥပေဒေရးရာ ခ်ဥ္းကပ္နည္းမ်ားအသံုျပဳျခင္း၏ အက်ိဳးေက်းဇူးကို ပံ့ပိုးေပးေနေသာ အျပည္ျပည္ဆုိင္ရာအေထာက္အထားမ်ားကို ထည့္သြင္းစဥ္းစားသင့္ပါသည္။ တိုက္တြန္းႏိႈးေဆာ္သည့္ႀကိဳးပမ္းအားထုတ္မႈမ်ားတြင္ လိင္လုပ္သားထုအား ပါဝင္ေစရန္ အလြန္အေရးႀကီးပါသည္။ ဥပေဒကို ျပဳျပင္ေျပာင္းလဲရာတြင္သို႔ ဥပေဒၾကမ္းေရးဆြဲရာတြင္ က်န္းမာေရးႏွင့္ လူ႕အခြင့္အေရးဆိုင္ရာ အခ်က္အလက္မ်ားကို အေျခခံ၍ ခ်ည္းကပ္ညႇိႏိႈင္းယူရမည္ျဖစ္ျပီး အျပစ္ေပးျခင္းထက္ ကာကြယ္ေရးကို ဦးတည္ႏိႈင္ရန္ ဦးစားေပးရမည္။ ၁၉၄၉ ျပည့္တန္ဆာႏွိပ္ကြပ္ေရးဥပေဒကို ျပင္ဆင္ရာ၌လည္းေကာင္း၊ ျပည့္တန္ဆာ ဥပေဒမူၾကမ္းတစ္ရပ္ကို ေရးဆြဲရာ၌လည္းေကာင္း ၂၀၁၄ အမ်ိဳးသား အိတ္ခ်္အိုင္ဗြီဥပေဒေရးရာ ျပန္လည္သံုးသပ္ျခင္းအစီရင္ခံစာတြင္ အၾကံျပဳထားေသာ အခ်က္အလက္ မ်ားကို ထည့္သြင္းစဥ္းစားရပါမည္။
အေးချဲအဖွဲ့အစည်းအတွက် အသုံးပြုနိုင်သော လိုအပ်ချက်များကို ကျင်းပရာရှိများကို အခြေခံပေးပါက ပိုမိုကြားမြန်စိုးမြန်စိုးပါ။

• တစ်ရပ်စီးရေးအဖွဲ့အစည်းအတွက် လိုအပ်ချက်များကို အသုံးပြုခြင်းနှင့် လိုအပ်ချက်များကို စီစဉ်ခြင်းဖြင့် အဖွဲ့အစည်းများသည် ပြုလုပ်ခြင်းကို လိုအပ်သည်။

• လူမှုများ တွေ့ရှိခြင်းကို မဖော်ပြထားသော လိုအပ်ချက်များကို အဖွဲ့အစည်းများသည် သတိပေးခြင်း ကျင်းပရာရှိများကို အသုံးပြုခြင်းကို လိုအပ်သည်။

• လိုအပ်ချက်များကို အဖွဲ့အစည်းများကို မဖော်ပြထားသော လိုအပ်ချက်များကို အသုံးပြုခြင်းကို စီစဉ်ခြင်းဖြင့် အဖွဲ့အစည်းများသည် ပြုလုပ်ခြင်းကို လိုအပ်သည်။

• လိုအပ်ချက်များကို အဖွဲ့အစည်းများကို မဖော်ပြထားသော လိုအပ်ချက်များကို အသုံးပြုခြင်းကို စီစဉ်ခြင်းဖြင့် အဖွဲ့အစည်းများသည် ပြုလုပ်ခြင်းကို လိုအပ်သည်။
စီးပွားရေးစီးပါဝင်အောင် စီးပွားရေးစီမံခန့်ခွဲမှု ပြည်သူများ အကဲဖြတ်အောင်လုပ်ဆောင်ကို ကြိုးစားရွယ်စောင်းပါသည်။ ထိုက်နိုင်ငံအောက်ပါ အကူညီးပြုသူများကို အကူအညီလောက်လုပ်နေသည်။ အိမ်ခေါင်းအုပ်စီးရာဝန်ထမ်းများအား ပြုလုပ်ကြသောအချက်များအား လိုအပ်ချက်များစွာ ပြုလုပ်မှုအလုပ်သားများ လိုအပ်ချက်များကို အိမ်ခေါင်းမှန်ကန် ပြုလုပ်ပါမည်။ လိုအပ်ချက်များကို အုပ်စီးရာဝန်ထမ်းများအား ပြုလုပ်ကြသောအချက်များအား လိုအပ်ချက်များစွာ ပြုလုပ်မှုအလုပ်သားများ လိုအပ်ချက်များကို အိမ်ခေါင်းမှန်ကန် ပြုလုပ်ပါမည်။

**စီးပွားရေးစီမံခန့်ခွဲမှု**

- စီးပွားရေးစီမံခန့်ခွဲမှု စီမံခန့်ခွဲမှု အကူညီးပြုသူများကို ကြိုးစားရွယ်စောင်းပါသည်။ ထိုက်နိုင်ငံအောက်ပါ အကူညီးပြုသူများကို အကူအညီလောက်လုပ်နေသည်။

- စီးပွားရေးစီမံခန့်ခွဲမှု အကူညီးပြုသူများကို အကူအညီလောက်လုပ်နေသည်။ လိုအပ်ချက်များစွာ ပြုလုပ်မှုအလုပ်သားများ လိုအပ်ချက်များကို အိမ်ခေါင်းမှန်ကန် ပြုလုပ်ပါမည်။ လိုအပ်ချက်များကို အိမ်ခေါင်းမှန်ကန် ပြုလုပ်ပါမည်။

စီးပွားရေးစီမံခန့်ခွဲမှု စီမံခန့်ခွဲမှု အကူညီးပြုသူများကို ပြုလုပ်ကြသောအချက်များအား လိုအပ်ချက်များစွာ ပြုလုပ်မှုအလုပ်သားများ လိုအပ်ချက်များကို အိမ်ခေါင်းမှန်ကန် ပြုလုပ်ပါမည်။
ဗိုလ်ချင်း: အရေးအရာအားဖြင့် လုပ်ငန်းမှု့မှုများသားများကို ပေးပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများအား ပိုင်းခြေချေပါမော်ပါတယ်။ ကိုယ်စားလှယ်များကို ကျော်လွန်မော်ပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါသည်။

• လုပ်ငန်းမှုများအား မော်ပါပါတယ်။ လုပ်ငန်းမှုများသားများကို အချက်အလက်များကို ပိုင်းခြေပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါပါတယ်။ ကိုယ်စားလှယ်များကို ကျော်လွန်မော်ပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါသည်။

• လုပ်ငန်းမှုများကို တွေ့ရှိမှုများမှာ စိတ်ပြုလာပါတယ်။ လုပ်ငန်းမှုများသားများ၏ လုပ်ငန်းမှုများမှာ အိပ်ပါပါတယ်။ ကိုယ်စားလှယ်များကို ကျော်လွန်ပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါပါတယ်။

• လုပ်ငန်းမှုများကို မော်ပါပါတယ်။ လုပ်ငန်းမှုများသားများကို မော်ပါပါတယ်။ ကိုယ်စားလှယ်များကို မော်ပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါသည်။

• လုပ်ငန်းမှုများကို မော်ပါပါတယ်။ လုပ်ငန်းမှုများသားများကို မော်ပါပါတယ်။ ကိုယ်စားလှယ်များကို မော်ပါပါတယ်။ အထူးသဖြင့် လုပ်ငန်းမှုများသားများအား ပါဝင်ရောက်ပါသည်။
• သက္ေသအေထာက္အထားကိုအေျချပဳေသာ တုံ႕ျပန္မႈမ်ား ပုိမုိအားေကာင္းလာေအာင္ လုပ္ေဆာင္သင့္သည္။

• လက္ရွိလုပ္ေဆာင္ေနေသာ အိတ္ခ်္အိုင္ဗီြြစစ္ေဆးျခင္းႏွင့္ ႏွစ္သိမ့္ေဆြးေႏြးျခင္း၊ ART ေဆးျဖင့္ကုသ

• လိင္လုပ္သားမ်ားဦးေဆာင္ေသာ ကြန္ရက္မ်ားႏွင့္ပတ္သက္၍ လိင္လုပ္သားမ်ားဦးေဆာင္ေသာ ကြန္က်န္းမာေရး၀န္ေဆာင္မႈမ်ားကို လိင္လုပ္သားမ်ားႏွင့္ ၎တိနေးေဆာင္ရြက္သူမ်ား စုေ၀းရာေနရာ ကို

• Strategic information and Monitoring and evluation technical working group (SI and
ME TWG) သည် အမြဲအမြဲမှုလုပ်ငန်းအတွက် ဖျင်သွယ်သော တိုးတက်ရေး အဖြစ် များစွာ ဒေတာအဖြစ် အာရုံစိုက်ချိုးစိုက်ပေးသော ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ် များ၊ ထို့ြင်း လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်အကြောင်း များဖြင့် အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။ အဖြစ်သာ ဖျင်သွယ်မှုများဖြင့် လိုအပ်သည်။
အဆိုဒ် ၁: ဗုဒ်အရေအတွက်တောင်းဆိုသောမူလ အားလုံးအတွက် အိမ်ရိုးလောက်မှုများ လိုအပ်သည်။

ဗုဒ် ၂: လူကုန်ကူးမြို့အပေါ် (လူထု) အိတ်ချိန်အုပ်အိုင်း၊ လိုင်လုပ်သားများ၏ လိုင်းရွားသို့လာရောက်ရာ အျပန်အလွန်ဆက်စပ်မွေးစွာကို ဆောင်ရွက်သည်။

ဗုဒ် ၃: မြန်မာနိုင်ငံရေးသားလိုင်လုပ်သားများနှင့် ၄င်းတု့်အား ဖုံးစံချင်းချချင်းချင်း (MSM and TG) လိုင်လုပ်သားများ၏ လိုအပ်ချက်များ

ဗုဒ် ၄: PrEP ကို လုပ်ဆောင်ရာ အိမ်ရိုးလောက်မှုနောက်တစ်ဆယ်ခွက်အတွက် ပါဝင်သူ လိုင်းရွားသို့လာရောက်ချင်သူများ PrEP ကို အသုံးပြုတာချင်သူများ ပေါင်းစည်းချင်း
Executive Summary

16 Days Activities (Source - SWiM)

Brithel based health education session and STI mobile activity (Source - MDM)
Executive Summary

Myanmar is one of the countries in Asia hardest hit by the HIV epidemic. With an estimated 200,000\(^1\) people aged 15 and above living with HIV (PLHIV) in 2014, Myanmar has the 6th largest number of PLHIV in the Asia and Pacific Region after India, China, Thailand, Indonesia and Viet Nam.\(^2\) Since the first HIV case was identified in Myanmar in 1988 and the first AIDS case was reported in 1991\(^3\), 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 2014\(^6\), 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 borders, 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. 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).

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 2013\textsuperscript{15}) 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, discriminations, 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.\textsuperscript{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.\textsuperscript{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. 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.

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

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

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:

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

Counselling and psychological support (Source - TOP, PSI)
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
SITUATIONAL ANALYSIS OF THE HIV RESPONSE AMONG SEX WORKERS IN MYANMAR

Education Training for Sex Worker (Source - AMA)

Organizing special event day at SWiM drop-in-centre (Source - SWiM)
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. In Asia, the risk of HIV is 29 times greater for FSW than for women of a similar age who are not sex workers. 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 2000). Although HIV prevalence among FSW has seen a steady decline since 2008, it remains high at 6.3% in 2014. 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, while HIV prevalence among the adult male population was 0.75 in 2014.
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 workers**: 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.

**Indirect sex workers**: 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.

**Sex workers**: 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.

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.
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 population\textsuperscript{39}, 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.\textsuperscript{40} Although there has been a sustained downward trend in HIV prevalence among key populations\textsuperscript{41} (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 70,000\textsuperscript{42} 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
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%\(^4\) (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

<table>
<thead>
<tr>
<th>Region</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandalay</td>
<td>3.5%</td>
<td>7%</td>
</tr>
<tr>
<td>Mawlamyaing</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Myitkyina</td>
<td>12.5%</td>
<td>10%</td>
</tr>
<tr>
<td>Pathein</td>
<td>24.5%</td>
<td>13%</td>
</tr>
<tr>
<td>Tachileik</td>
<td>7%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Taunggyi</td>
<td>5.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Yangon</td>
<td>11%</td>
<td>7%</td>
</tr>
</tbody>
</table>

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.

![HIV prevalence among FSW and Male STI](image)


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

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


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. 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.
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. 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. 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.

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. 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.

Police sometimes misuse existing laws to extort money from MSM, transgender persons and sex workers. 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. 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. 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. Section 7 of the Act enables police to arrest sex workers merely on the basis of their reputation.
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. 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. There were reportedly 1,956 people prosecuted for prostitution in Myanmar in 2011 and 3,226 cases in 2012. 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.

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. 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. 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, and can heighten their vulnerability to HIV and other STIs. Coerced sex is rarely protected and can result in injuries that increase HIV risk. Furthermore, men who are sexually violent are more likely to have multiple partners and to be living with HIV and/or other STIs.

Where sex work is criminalised, reporting sexual and physical violence to the authorities can be difficult 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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”.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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 Myawaddy\textsuperscript{88} 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 Kawkareik in 2015.\textsuperscript{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.\textsuperscript{90} There are also consistent reports that sex workers experience stigma and discrimination when seeking to access HIV and sexual and reproductive health services.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.  

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. Consistent with this, the 2014 study by UNDP and UNFPA entitled Sex Work and Violence in Yangon, Myanmar: Understanding Factors for Safety and Protection reported 58% of all respondents (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. 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.

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. 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. 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%).

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. 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.

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). 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.
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, 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.

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. 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. 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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{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.

\subsection*{2.4.1.2 NSP II Strategic Objective 2: HIV treatment, care and support}

\textbf{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.\textsuperscript{132} This represented 69.7\%\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{144}

\textbf{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.

\textbf{2.4.1.3 NSP II Strategic Objective 3: Community-based approaches for PLHIV}

\textbf{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. 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{150}

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

Coverage estimates for HIV prevention programmes\textsuperscript{151} 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.\textsuperscript{152} The number of individual FSW reached by HIV programmes in 2013 ranged between 77,059 (high estimate)\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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

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


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%).

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 Review 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.\footnote{159}

2.5 Finacing 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.\textsuperscript{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{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%).\textsuperscript{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$)


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 GFTAM beyond 2016 was not known; however it is anticipated that funding support will continue for the national HIV response.
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 Commod (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.”

— 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 GFTAM 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)
Outreach activities (Source - Pyl Gyi Khin)

Peer Training (Source - PU-AMI)
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:

  - Efficiency, cost-effectiveness and sustainability of existing programmes targeting sex workers;
  - Situational and needs assessment of people selling sex over the phone and internet, which is an expanding practice and market;
  - Correlation between HIV, mobility and migration of sex workers (including trafficking);
  - Identification of young sex workers in Myanmar and their vulnerability to HIV;
  - Specific needs of transgender and male sex workers; and
  - 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

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<thead>
<tr>
<th>Name</th>
<th>Position/Function</th>
<th>Organisation</th>
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<tbody>
<tr>
<td>Dr Myint Shwe</td>
<td>Programme Manager</td>
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<tr>
<td>Pol Brig General Kyaw Win</td>
<td>Joint Secretary</td>
<td>CCDAC , Ministry of Home Affairs</td>
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<tr>
<td>Pol Col Zaw Lin Htun</td>
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<td>Pol Col Own Khaing</td>
<td>Director</td>
<td>Criminal Department, Ministry of Home Affairs</td>
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<td>Pol Col Win Sein</td>
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<tr>
<td>Pol Lt Col Aye Myint Kyi</td>
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<td>Pyae Phyo Aung</td>
<td>Programme Coordinator</td>
<td>Pyi Gyi Khin</td>
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<tr>
<td>Nwe Zin Win</td>
<td>Executive Director</td>
<td>Pyi Gyi Khin</td>
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<tr>
<td>Beate Scherrer</td>
<td>Country Programme Coordinator</td>
<td>Malteser International</td>
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<tr>
<td>Dr Aye Aye Thet</td>
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<td>Dr Zin Ko Ko Lin</td>
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<td>PU-AMI</td>
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<tr>
<td>Zaw Hpang</td>
<td>HIV Prevention Officer</td>
<td>PU-AMI</td>
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<tr>
<td>Norbert Monyaarukato</td>
<td>Medical Coordinator</td>
<td>PU-AMI</td>
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<td>Dr Khin Phone Mo Mo</td>
<td>Field Coordinator</td>
<td>MDM</td>
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<tr>
<td>Thiha Nyi Nyi</td>
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<td>Hnin Hnin Yu</td>
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<td>HIV/AIDS Alliance</td>
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<td>Robert Gray</td>
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<td>Than Naing Oo</td>
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<tr>
<td>Pinky (Wut Yee Win Maung)</td>
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<td>Thae Ei Htun</td>
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<td>Dean Creer</td>
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<td>Zar Chi Htwe</td>
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<td>Representatives</td>
<td>CARE and MSI</td>
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<td>Daw Aye Aye Lwin</td>
<td>Chair</td>
<td>Myitta Shin Organization</td>
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<tr>
<td>Dr. Ohn Ohn Kyi</td>
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<td>Dr. Tun Tun Naing</td>
<td>Medical Officer</td>
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<tr>
<td>Dr Khay Mar Aung</td>
<td>Medical Advisor</td>
<td>MSF-H</td>
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<tr>
<td>Kay Thi Win</td>
<td>Chair Person</td>
<td>AMA, APNSW</td>
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<tr>
<td>Thuzar Win</td>
<td>Chair Person</td>
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<tr>
<td>Thiri</td>
<td>Secretariat</td>
<td>Sex Worker Network in Myanmar (SWiM)</td>
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<td>Dr Nu Nu Aye</td>
<td>Sr Public Health Officer</td>
<td>3 MDG</td>
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<tr>
<td>Dr Faisal Mansoor</td>
<td>Head of Project Management Unit</td>
<td>GFATM, UNOPS</td>
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<tr>
<td>Robert Kelly</td>
<td>HIV Program advisor</td>
<td>USAID</td>
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<tr>
<td>Richard Lacort</td>
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<td>Deputy Director</td>
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<td>Dr Myo Kyaw Lwin</td>
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<td>Dr Myo Set Aung</td>
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<td>Aye Aye Nwe</td>
<td>Policy Officer</td>
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## Focus Group Discussions

<table>
<thead>
<tr>
<th>Number of participants</th>
<th>Organization</th>
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<tbody>
<tr>
<td>8 Programme staff</td>
<td>TOP Center, PSI, Mandalay</td>
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<tr>
<td>10 FSW</td>
<td>TOP Center, PSI, Yangon</td>
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<tr>
<td>10 young FSW</td>
<td>TOP Center, PSI, Yangon</td>
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<tr>
<td>15 sex workers and 8 clients</td>
<td>TOP Center, PSI, Mandalay</td>
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<tr>
<td>15 sex workers</td>
<td>SWiM in Mandalay</td>
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<tr>
<td>6 sex workers</td>
<td>TOP Center, PSI, Mawlamyaing</td>
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<tr>
<td>10 Sex workers</td>
<td>Sex Worker Network in Myanmar (SWiM), Yangon</td>
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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?
  - Do you think the penalty for sex work is different depending on the type of sex work-brothel based, street based, entertainment venue based?
  - 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?
  - How (ask about: potential referral to prevention services/ do operational police know where the HIV prevention services are available?)
  - In collaboration with whom? (Ask about: sex worker networks? NGOs? Government departments?)
  - 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?
  - 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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<thead>
<tr>
<th>Author(s)</th>
<th>Title and Source</th>
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<tr>
<td>Asia Pacific Coalition on Male Sexual Health</td>
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   international and local NGOs, community-based organizations (CBO) development partners
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   The “low” figure is the number of individuals reached by the organisation reported to have reached
   the largest number of individuals in each township. The “high” figure is the total number of individuals
   reached by all organisations.
   unpublished, 2015
16 Deputy Home Affairs Minister Brig-Gen Kyaw KyawTun. Group Calls for Overhaul of Repressive
17 The HIV Legal Review Report was released in September 2014. Meetings with government, UN
   and implementing partners’, and other stakeholders in a Joint Committee were held in May 2014
   to identify priorities pertaining to HIV and the law for key populations. Six 'quick wins' were
   determined at this meeting: i) develop new police instructions to support specific HIV interventions
   for key populations; ii) develop new guidance on HIV-related discrimination and confidentiality
   in key sectors; iii) develop guidance on universal ART access; iv) develop guidance on pregnancy
   rights of HIV-positive women; v) repeal sections of the Burma Excise Act 1917 that criminalize
possession of needles and syringes for injecting drugs; and vi) ensure the Patents Bill will enable Myanmar to continue to access affordable generic medicines. Medium term priorities include the review and reform for the Suppression of Prostitution Act (1949). For more information, refer to the HIV Legal Review Report (2014), p.32 and p.43.

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The study used purposive sampling among self-identified sex workers. It involved in-depth qualitative interviews with 33 sex workers (18 female, 9 transgender and 6 male sex workers). One third of the sample involved sex workers who self-identified as living with HIV.
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168 NAP ART patient data are not disaggregated by key population. However, an assumption has been made that sex workers living with HIV have taken up ART services based on reporting by implementing partner organisations during the informant interviews held for this situational analysis. Gathering of ART patient data disaggregated by key population will enable the NAP to track the increased uptake of ART services among sex workers. It should be noted, however, that such disaggregation is dependent on sex workers accessing ART services disclosing they are a part of this key population.

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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.

174 The HIV Legal Review Report was released in September 2014. Government, UN and implementing partners’ stakeholders in a Joint Committee met in May 2014 to ascertain priorities pertaining to HIV and the law for key populations.

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