Myanmar Country Brief

HIV and Key Affected Women and Girls

Key affected women and girls include:

- Female sex workers
- Female drug users
- Female spouses/intimate partners of men with high-risk behaviours
- Women and girls living with HIV
- Women and girls in HIV-affected households
- Female migrant workers who may be vulnerable to HIV due to conditions by which they migrate

Percentage of total adults living with HIV who are women:

37%

Estimated number of women living with HIV (aged 15+):

77,000

Most new HIV infections among women are among female sex workers and the female intimate partners (usually wives) of male clients of sex workers.

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About the Country Briefs

- These country briefs synthesize some of the current available data and evidence on key affected women and girls into one, easy-to-read report. For the first time, available data and research on national AIDS responses as it specifically relates to key affected women and girls were collated and carefully reviewed together, to improve understanding of women and girls most at risk of, and most affected by, HIV in the region. In doing so, the aim of the briefs is to increase understanding of the specific needs of key affected women and girls in ASEAN Member States and to support national efforts to ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls, in all their diversity. The briefs were developed in response to requests from partners at the regional and national level to assist them in prioritizing which women and girls to comprehensively target in national AIDS responses.

- A consistent approach has been applied in order to produce an off-the-shelf analysis of HIV and key affected women and girls which synthesizes information from disparate national sources. While multiple data sources have been used to compile each brief, country progress reporting on HIV and AIDS is widely cited. Each of the briefs includes an overview of the following as it specifically relates to key affected women and girls in the context of the national AIDS response:

  - Epidemiology
  - Modes of transmission
  - Social and economic vulnerabilities
  - Access to information
  - Access to services
  - Legal and policy environment
  - Current international and regional policy guidelines
  - Information gaps
  - Recommendations

From the cover page

Percentage of total adults living with HIV who are women: 37%[1]

1 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

Estimated number of women living with HIV (aged 15+): 77,000[2]

2 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

Most new HIV infections among women are among female sex workers and the female intimate partners (usually wives) of male clients of sex workers.[3]

3 Roberts. J., *Gender Review of the Myanmar National Strategic Plan on HIV 2006 – 2010*. 2009. p. 10.

EPIDEMIOLOGY

- The HIV epidemic in Myanmar is concentrated, with HIV transmission primarily occurring in high-risk sexual contacts between sex workers and their clients, men who have sex with men and the sexual partners of these sub-populations. In addition, there is a high level of HIV transmission among injecting drug users through use of contaminated injecting equipment, with sexual transmission to partners.[4]
- In 2011, the substantial proportion of new infections occurred among low-risk women, i.e. partners of men with high-risk behaviours, though the annual number of new infections is estimated to be declining.[5]
- Estimated HIV prevalence among young women aged 15-24 is 0.3%.[6]
- Myanmar is one of the few countries in Asia able to report HIV prevalence in key populations by age, and surveillance data has shown high HIV prevalence among female sex workers in young women under the age of 25.[7]
- The male to female ratio has decreased from almost 8 to 1 in 1994 to 2.4 to 1 in 2008, showing a steady increase in the proportion of women being infected.[8]

MODES OF TRANSMISSION

Sexual transmission

- Surveillance data from 2011 showed HIV prevalence in the sentinel groups at 9.4% in female sex workers.[9]
- HIV prevalence among female sex workers has declined from 18.4% in 2008 to 9.4% in 2011. The decline in prevalence among young female sex workers has slowed in recent years and seems even to have stabilized.[10]
- Condom use is higher among female sex workers than other key affected populations. However, condom use at last sex with a regular partner was much lower - as reported by only 55% of female sex workers in Mandalay and 62% in Yangon.[11]
- Many men who have sex with men (MSM) also have sex with women and a significant proportion of MSM are either already married or expect to conform to social expectations and become married.[12]

Injecting drug use

- HIV prevalence among injecting drug users (IDU) in Myanmar is 21.9%, reduced from 34% in 2009.[13]

Vertical transmission

- Estimated HIV prevalence among pregnant women in 2011 was 0.9% (0.4% in 15-19 age group and 0.7% in 20-24 age group).[14]
- HIV prevalence among pregnant women was higher (1%) in urban areas compared to those living in rural areas (0.7%).[15]
- 13% of infants born to HIV-positive mothers are infected with HIV.[16]

SOCIAL AND ECONOMIC VULNERABILITIES

- Women and girls may be particularly susceptible to infection owing to gender-specific norms. The persistence of unequal power relations between women and men and the inferior status of women and girls hamper the ability of women and girls to negotiate safe sexual practices and increase their vulnerability to infection.[17]
- Taking a proactive role in negotiating safer sex is very difficult because women are not expected to be sexually experienced, nor are they expected to demand anything sexually from their husband/partner/client. They do not expect this of themselves and nor is it expected by men.[18]
- Focus group discussions with HIV-positive women have indicated that stigma and discrimination has a major impact on their health, their psychological and economic wellbeing and on the ability of their children to receive an education. Domestic violence and suicide have also been reported among women living with HIV as a consequence of their HIV status.[19]
- There appears to be few social support systems or services available to women who have experienced violence and reports indicate that incidences of domestic violence go largely unreported.[20]
- Married women living with HIV report that their husbands were very reluctant to have an HIV test, and that men also found it difficult to change their behaviour.[21]
- A 2005 study conducted in Eastern parts of Myanmar found that the socio-economic impact of AIDS disproportionately affects the daily life of women because they have lower social and economic status and, as a result, have limited decision making power and limited capacity to cope with the effect of HIV on their life and their children's lives.[22]
- Often, by the time a woman living with HIV in a household gets sick the productive family assets are gone, the family is already living with stigma and discrimination and so families struggle both socially and economically. There are some reports of assets being taken when women are widowed or sick, either by debt collectors, family members or others.[23]
- Impact mitigation targets identify orphans but do not address the differing needs, vulnerabilities or school participation rates of boys and girls.[24]

- Females who inject drugs are more likely than male injecting drug users to be stigmatized by society because their activities are considered to be doubly deviant. It is generally considered that drug injecting violates social norms of behaviour, and many feel that drug injecting by females is even worse, as it diverges from the traditional expectations of women as wives, mothers, daughters and nurturers of families. Because of this stigma, females are more likely to conceal their drug injecting behaviour.[25]
- Some female sex workers report that they raise their primary concern – poverty – and advocate for job training and placement programmes and alternative employment options that generate a living wage whenever the opportunity arises. NGOs, which operate within a limited humanitarian response mandate and have limited resources, are often unable to respond.[26]

ACCESS TO INFORMATION

- In a 2008 behavioural survey conducted among out-of-school youth, 54% of female respondents had ever seen a condom and only 30% of female respondents knew where to obtain a condom.[27]
- Women from key populations (e.g., female sex workers and female drug users) find it difficult to discuss their risk behaviour and get effective sexual and reproductive health care and information. The main reasons for this relate to a high level of discomfort talking about sex, and fear of stigma and discrimination.[28]
- Programmes for female sex workers have greatly expanded over the last years. The targeted prevention programmes operate through drop-in centres as well as outreach programmes. The programmes provide access to information and services including condoms, STI screening, HIV counselling and testing. With the increasing coverage of these prevention programmes, there is a need to identify overlaps between different service providers. This will require improved coordination, information sharing and joint evaluation as well as research.[29]
- There are still few programmes targeting clients of sex workers other than condom provision through social marketing and some work in hotspots where behaviour change messages are provided. The reach of sexual partners of clients as well as regular partners is not known, but it is likely to be low.[30]
- Efforts to encourage men to recognize their role in and take responsibility for reducing the transmission of HIV are not always tackled overtly in behaviour change messaging.[31]

ACCESS TO SERVICES

- By the end of 2011, antiretroviral (ART) coverage was 43.8% (40,128 persons) for all adults and children. Women and girls constituted 44% of those receiving ART in 2011.[32]
- Voluntary and confidential testing for HIV continues to be low. There has been hardly any reported growth since 2008. There are still only a handful of non-governmental organizations that can provide the full range of testing services. This is considered an important impediment to accessing testing services, since many providers cannot give same day or same session results.[33]
- Despite increases in service availability and uptake in recent years, overall coverage is still low in terms of the proportion of the key populations reached by services. This is especially true for men who have sex with men, and injecting drug users as well as their long-term sexual partners.[34]
- Female sex workers reported that some entertainment venue managers do not like to have condoms on display or easily available. Reasons for this are related to not wanting to bear the cost, not wanting to be seen openly as 'sex on premises venues' and not wanting to give the impression that staff are 'unsafe'. Barriers to consistent condom use are reported as monetary incentives and the perception of the client by the sex worker.[35]
- The number of reported female drug users in Myanmar is limited. Around 9% of the people who inject drugs contacted through outreach were female, while only 4% of individuals accessing drop-in centres were female.[36]
- A prominent reason why female injecting drug users do not reach available IDU/DU services is the fact that these services are mostly not gender responsive and thus the specific needs of female injecting drug users are not met. Harm reduction staff, outreach workers and peers tend to be male, and activities taking place in drop-in centres are often male orientated.[37]
- The prevention of mother-to-child transmission of HIV (PMTCT) services has reached a relatively large part of the country. The number of women choosing to access the service has risen continually. The services are constrained by a relatively low attendance to antenatal care (ANC) services in rural areas and a considerable loss to follow before and after birth. However, enrolment of clinically eligible pregnant women in ART programmes has increased substantially.[38]

- In 2010, the number of women accessing antenatal care services who received pre-test HIV counselling was 539,728. The number of women who accepted HIV testing and received the test results with post-test counselling increased, reaching a total of 250,938 women.[39]
- In 2011, a total of 3,003 pregnant women were reported as having received PMTCT services from Government and NGO service providers. Of those, 2,097 received a two-drug combination to prevent HIV transmission. A total of 906 women were reported as being on ARV treatment during delivery.[40]
- Some HIV-positive women report being told by healthcare workers that it is too dangerous to have children; they are selfish if they place children at risk; and they do not deserve to have children. However, with no access to social safety nets and cultural norms that expect women to become mothers and bear several children, many HIV affected couples are likely to continue to have children.[41]
- Reports indicate that among married men and women where one or both partners are HIV-positive, men's access to treatment is prioritised because they usually get sick first and because they are the main breadwinner, the family decision maker and the most powerful and respected member of the family. Some women report that when they found they had been infected with HIV by their husbands they chose to leave the marriage, and this was partly due to their desire to access treatment for themselves.[42]
- The shortage of staff at all levels poses serious challenges to the scale up of service delivery in the public health sector, including service delivery to women and girls. There is not yet a policy and tradition of shifting non-specialized medical tasks to other health workers or to specifically trained lay persons (such as women living with HIV).[43]

LEGAL AND POLICY ENVIRONMENT

- Laws which criminalize behaviour of groups who are most at risk (sex workers, men who have sex with men and people who use drugs) remain in place. This may lead to incidents of harassment of key affected populations which discourages effective and open interventions with these populations.[44]
- Sex work is illegal in Myanmar.[45]
- A substantial proportion of female sex workers, (34% in Yangon, and 16% in Mandalay), report being afraid of being caught with condoms by authorities and said they did not carry condoms for that reason. While it is not illegal to carry a condom, women report that the police sometimes use this as evidence that a woman is doing sex work (which is illegal) and extort money from them. Independent or street based sex workers are reported to be more vulnerable to this.[46]
- Under the Narcotic Drugs and Psychotropic Substances Law (1993), possession of narcotic drugs is illegal while no specific offence is made for consumption. Drug users are mandated to register with a government identified facility for treatment and non-compliance with medical treatment results in penal consequences, namely imprisonment from three to five years. According to the Central Committee for Drug Abuse Control there were 69,547 registered drug users as of June 2008. Sex-disaggregated data on the number of female registered drug users is not available but it is reported that the majority of those in national drug treatment centres are male (94.9%).[47]
- The Government of the Union of Myanmar recognized the role of injecting drug use in the spread of the HIV epidemic early on and has expressed explicit policy support for harm reduction in national policy documents. Reducing HIV related risk, vulnerability and impact among drug users was one of the main priorities within The National Strategic Plan (NSP) on HIV/AIDS (2006-2010).[48]
- There is currently very little research or analysis of how HIV or related laws and policies affect women in Myanmar.[49]
- Current policies and legislation may not adequately take into account gender-specific vulnerabilities or adequately protect the rights of women and girls affected by HIV/AIDS.[50]

- To date, there is no specific law against domestic violence and the government does not maintain related statistics, which makes it difficult to judge the extent of the issue.[51]
- Women and girls in Myanmar have no right under the law to terminate pregnancy resulting from sexual violence.[52]

CURRENT INTERNATIONAL AND REGIONAL POLICY GUIDELINES

- HIV and the Law: Risks, Rights & Health (Global Commission on HIV and the Law, July 2012)[53];
- Sex Work and the Law in Asia and the Pacific (UNDP, UNFPA, UNAIDS, 2012)[54];
- UNAIDS Guidance Note on HIV and Sex Work (UNAIDS, 2009)[55];
- Agenda for accelerated country action for women, girls, gender equality and HIV (UNAIDS, 2009)[56];
- Community Innovation: Achieving sexual and reproductive health and rights for women and girls through the HIV response (UNAIDS/The ATHENA Network, 2011)[57];
- Joint UN Statement: Compulsory drug detention and rehabilitation centres (March 2012)[58].

INFORMATION GAPS

- Currently, it is not possible to easily monitor any differences in males and females access to services, coverage, access to voluntary confidential counselling and testing, HIV and TB treatment.[59]
- Sometimes data (including sex-disaggregated data) is available but it is not systematically reported nationally, analysed, used, interpreted and disseminated to inform gender sensitive programming and planning, nor is it used to set sex- specific targets.[60]
- It is not always clear to programmers and other staff how to use data specifically to improve the gender sensitivity of programmes. Usually data is used to focus on which men and women are most at risk but not to address the underlying norms and socio-cultural expectations that make people vulnerable or influence their risk behaviour.[61]

RECOMMENDATIONS

- Continued and sustained efforts to address the impact of HIV and AIDS on women and girls, as well as its social and family consequences.
- The significant proportion of married couples among those living with HIV calls for scaled up prevention services targeting spouses and female intimate partners of men living with HIV.
- HIV prevention interventions among sex workers, men who have sex with men and injecting drug users need to be scaled-up and should include a strong additional component to reach out to their long-term intimate sexual partners.
- Female intimate partners of male drug users should be included in HIV prevention efforts.
- Relatively high HIV prevalence among the 15-19 year age group of female sex workers suggests that urgent HIV prevention action is needed focused on those newly entering this population group.
- Meeting the family planning and contraception needs of key populations, whether they are HIV-positive or not, can open opportunities for addressing gender norms that make it difficult for women to ask for sexual and reproductive health information. There is also a need to integrate family planning and reproductive health into HIV treatment services and to emphasize the dual protection role of condoms.
- HIV-positive women rarely ask about family planning, so health care providers need to raise this issue routinely with both male and female patients. The links between PMTCT sites, SRH and STI services and HIV testing and treatment centres need strengthening.
- Increased, sustainable funding for positive women's groups and networks is needed alongside more meaningful involvement of women living with HIV in policy and programmatic interventions, noting the recent WHO guidance (April 2012) on couples HIV counselling and testing and the beneficial role that women living with HIV can play in delivering services and support within healthcare and community settings.
- Advocacy with the appropriate national sub- committees should be undertaken to ensure that relevant laws take into consideration the potential impact on key populations, including key affected women and girls.

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WHO ARE "KEY AFFECTED WOMEN AND GIRLS" IN ASEAN?

Depending on the circumstance and country, the following groups have been identified as key affected women and girls in ASEAN:

- Women and girls living with HIV
- Female sex workers
- Women and girls who use drugs
- Transgender women and girls
- Mobile and migrant women
- Female prisoners
- Women with disabilities
- Women in serodiscordant relationships
- Female intimate partners of men who engage in behaviours that put them at a higher risk of HIV infection
- Women and girls in HIV-affected households

The Myanmar Country Brief on HIV and Key Affected Women and Girls was developed by the Asia-Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV with support from the HIV and AIDS Data Hub for Asia Pacific and in partnership with the UNAIDS Myanmar Country Office and the Joint UN Team on AIDS in Myanmar.

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