

Myanmar

Country Review December 2011

MYANMAR AT A GLANCE

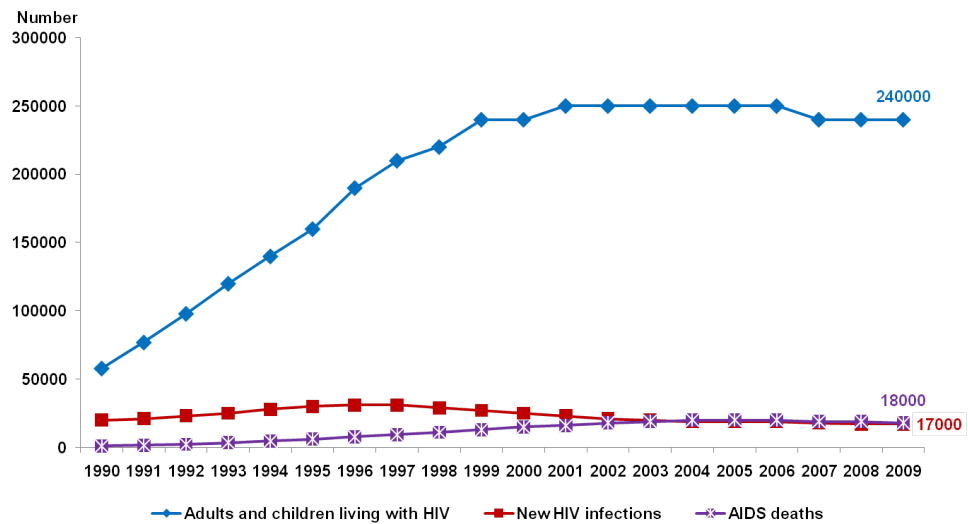
Total population (in thousands)	50,496 (2010) ¹
Annual population growth rate	1.0% (2010-2015) ¹
Population aged 15-49 (thousands)	27,314 (2010) ²
Percentage of population in urban areas	34% (2010) ³
Crude birth rate (births per 1,000 population)	20.5 (2008) ⁴
Under-5 mortality rate (per 1,000 live births)	122 (2008) ⁵
Human development index (HDI) – Rank/Value	132/0.451 (2010) ⁶
Life expectancy at birth (years)	62.7 (2010) ⁶
Adult literacy rate	91.9% (2005-2008) ⁶
Ratio of girls to boys in primary and secondary education (%)	99 (2006) ⁴
GDP per capita (PPP, \$US)	N/A
Per capita total health expenditure (Int.\$)	21 (2007) ⁵



HIV EPIDEMIOLOGY AND TRENDS

Myanmar detected its first case of HIV in 1988 and is still experiencing a concentrated HIV epidemic. Surveillance data and epidemiological models suggest a decreasing trend in HIV prevalence in the general population aged 15-49 from 0.8% in 2001 to 0.6% in 2009 – still the third highest among countries in the South-East Asian Region.⁷ The estimated number of people living with HIV in 2009 was 240,000 [160,000 – 320,000]⁷ (Fig. 1).

Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

By December 2008, a total of 77,088 HIV/AIDS cumulative cases (among blood donors and hospital patients) had been reported to the Ministry of Health. 2,038 HIV/AIDS cases were reported in 2008. The male to female ratio has decreased from almost 8 to 1 in 1994 to 2.4 to 1 in 2008⁸, showing a shift in the characteristic of the epidemic as well as the increasing vulnerability of women. This shift can be explained by the relatively successful reduction of HIV transmission between sex workers and their male clients; however, this still leaves a pool of HIV infected men who were infected earlier and could potentially transmit the virus to their spouses.

Surveillance system:

- HIV Sentinel Surveillance (HSS) since 1991
- STI Surveillance based on passive reporting by government health services (MOPH)
- Very limited behavioural surveillance survey (BSS) carried out in 2003, more comprehensive in 2008 among female sex workers (FSWs), injecting drug users (IDUs) and out-of-school youth
- Integrated Biological and Behavioural Surveillance (IBBS) conducted among men who have sex with men (MSM) in 2009 (to be published)
- Injecting drug users have been part of HIV surveillance since 1991.
- Despite the fact that HIV surveillance is conducted annually, given the geographical distribution and epidemiological diversity of Myanmar, there are limitations to the extent the data is representative at the national level. Furthermore, there is a scarcity of behavioural research and surveys on key affected populations. Surveys in key affected populations such as sex workers or IDUs have been conducted; however, these studies have not been repeated in order to measure trends in behaviour over time.⁹

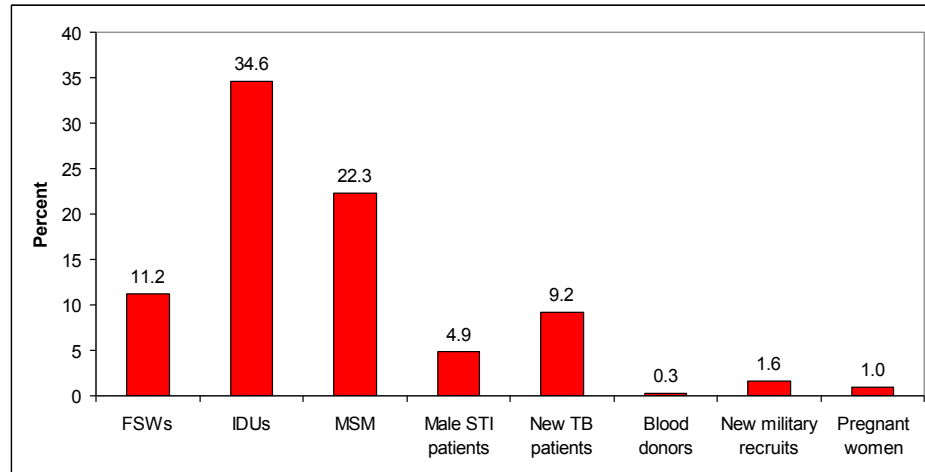
WHO IS AT RISK OF HIV IN MYANMAR?

The HIV Sentinel Surveillance (HSS) system was established in 1991 and carried out biannually until 1999. Since then, annual surveillance has been conducted since 2000 with eight populations selected as sentinel groups. In HSS 2009, sentinel groups for low risk populations are pregnant women attending antenatal clinics (ANC), blood donors, military recruits, new tuberculosis patients and male STI patients while the sentinel groups for key affected populations are injecting drug users (IDUs), men who have sex with men (MSM), female sex workers (FSWs).¹⁰

Key Sentinel Populations

Figure 2 shows findings from the 2009 sentinel surveillance. HIV prevalence is highest among IDUs (34.6%), followed by MSM (22.3%), FSWS (11.2%), newly diagnosed TB patients (9.2%), male STI patients (4.9%), new military recruits (1.6%), pregnant women (1.0%) and blood donors (0.3%).¹⁰

Figure 2: HIV prevalence among sentinel populations, 2009

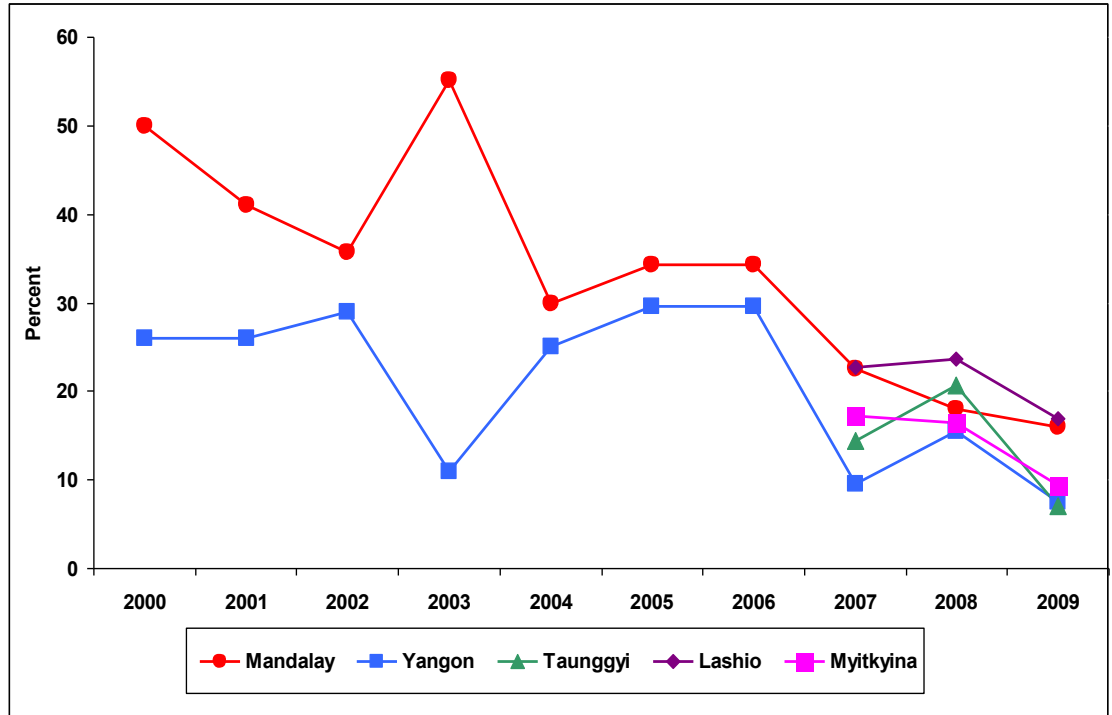


Source: HIV Sentinel Sero-surveillance Survey, 2009

Evidence from the annual sentinel surveillance revealed that IDUs, MSM and sex workers are at risk of exposure to HIV. Moreover, the National Strategic Plan (2011-2015) re-confirms the need for targeted prevention interventions to those at highest risk of HIV transmission, notably female sex workers and their clients, IDUs, MSM, and the regular sexual partners of these key affected populations. However, gradient of the epidemic is also impacting general low-risk populations most probably due to husband-to-wife transmission and turnover of high-risk populations such as ex-IDU, ex-FSWs and ex-clients of FSWs.¹¹

HIV prevalence is particularly high in a few specific geographical areas – each with varying trends. In 2009, HIV positivity rate among female sex workers appeared to fall in all sentinel sites. From Figure 3, Yangon and Mandalay, being the sentinel sites for decades, a significant continuous decline in prevalence was seen since 2007. This may be explained by a couple of reasons, getting better coordination with partners in sample collection leads to more representativeness of the collected sample, turning over of the FSW and catching the newly recruited group or the actual declines in HIV prevalence with the intensive Targeted Condom Promotion (TCP) program in place for a long time.

Figure 3: Trends of HIV prevalence among FSWs, selected sentinel sites, 2000-2009



Sources: HIV Sentinel Sero-surveillance Surveys, 2000-2009

Among pregnant women attending ANC, HIV prevalence was highest in Yangon at 4% followed by Mandalay at 2.5%, Meiktila at 2.3%, Patheingyi at 1.8% and was 1.5% in both Muse and Myitkyina.¹⁰

Migrants and mobile population

Many people from Myanmar are increasingly on the move for social, economic, political, humanitarian, and environmental reasons and they have to live far away from home in pursuit of an improved quality of life and a more promising future. Migrants and the mobile population encompass Myanmar migrant workers in neighbouring countries and mobile workers such as truck drivers, seafarers, and miners.

A majority of migrants and mobile people migrate to Thailand through leaky border points in Shan state, Kayah State, and the Tanintharye division. According to the latest 2010 official figures from the Ministry of Labor Thailand, more than 85% of the registered migrants in Thailand are Myanmar nationals. In fact¹², this figure is probably a severe underestimate as the vast majority are working as illegal migrants. Migrants are vulnerable to HIV infection and according to sentinel HIV sero-surveillance in Ranong, Thailand in 2005, HIV infection among Myanmar migrant fishermen, pregnant women and migrant female sex workers were 5%, 2%, and 21% respectively.¹³ Again, in 2008, UNRTF (Regional Task Force on Mobility and HIV vulnerability) estimated that HIV infection among Myanmar migrant fishermen in Thailand was as high as 9%.¹⁴ Unfortunately, these migrants rarely know their HIV status and occasionally go back home to family and unknowingly spread the infection to their partners.

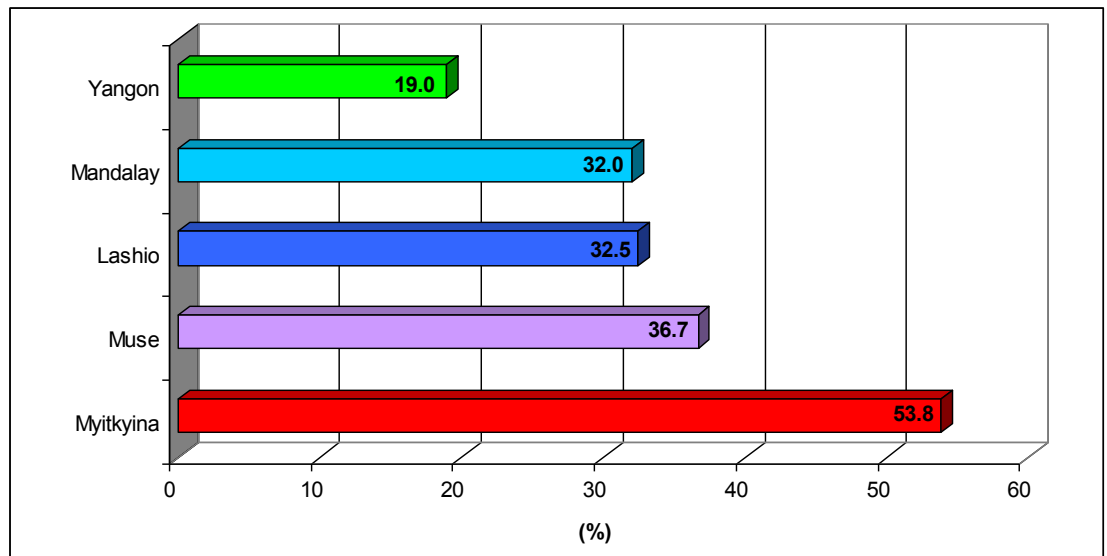
Key populations at higher risk

Injecting Drug Users

Although opium cultivation has decreased significantly in recent years, Myanmar remains the second largest producer of illicit opium in Asia, after Afghanistan and illegal drug use is rampant along with the practice of injecting drug use. Heroin abuse predominates in the Kachin State, in the Northern Shan State, and in the large cities – with an estimated 60,000 to 90,000 injecting drug users nationwide.⁹

The emergence of the HIV epidemic in Myanmar is thought to be linked closely to injecting drug use. Indeed, HIV infection among IDUs in Myanmar remains one of the highest in the world. HIV prevalence among IDUs peaked at an alarmingly high 74% in 1993.¹⁵ Though IDU prevalence declined sharply between 2001 and 2004, there was a gradual increase in the following years and it stabilized at around 40% in 2005 and 2006. Findings from the 2009 HSS show that overall HIV prevalence among IDUs was 34.6%, however this figure varies greatly depending on geographical distribution. The prevalence in Yangon was 19%, whereas it is 53.8% in Myitkyina (capital of Kachin state) (Fig. 4).¹⁰ The findings highlight that HIV prevalence among IDUs is higher in economic and trade zones of opium such as Mandalay, Lashio, Muse and Myitkyina.

Figure 4: HIV prevalence among IDUs by sentinel site, 2009



Source: HIV Sentinel Sero-surveillance Survey, 2009

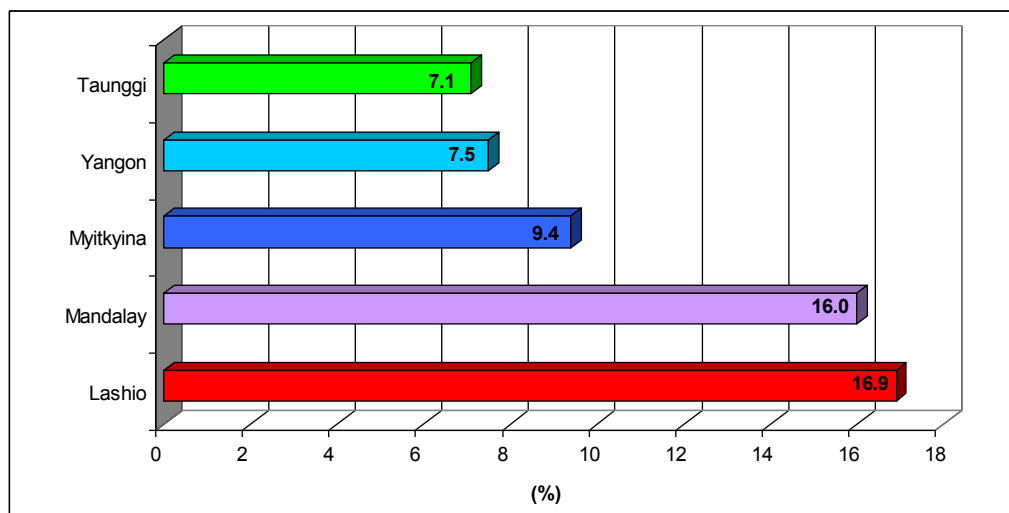
A recent (2009) study among 217 drug users - 74% of whom were IDUs - found that those using used syringes were at a fivefold greater risk of getting HIV as compared to those using disposable syringes at their first injection.¹⁶ Most of the respondents (99%) knew about the Needle and Syringe Exchange Programme and found it easy to get syringes from the programme; most (91%) claimed that they would not be inclined to use more drugs if they were given free syringes.

Female sex workers and their clients

The estimated population of sex workers in 2008 was between 40,000 and 80,000 and the population of their clients between 840,000 and 1,400,000.⁹ The primary types of sex work reported include direct, brothel-based work as well as various indirect types of sex work involving work in massage parlours, karaoke bars and guesthouses. Indirect sex workers are considered highly mobile and are often hidden, as they are not operating in brothels but rather are street-based or work in entertainment establishments.¹⁷ Anecdotal evidence suggests that direct sex workers are also highly mobile within the country and are concentrated in identifiable areas, particularly those fostering migration such as in mining areas or along border sites. In terms of numbers, it is assumed that the largest numbers of sex workers are to be found in Mandalay and Yangon. However, a conclusive and reliable size estimate is not available.

According to the findings from the annual HSS, HIV prevalence among sex workers was higher than 30% from 2000-2006 (except 2004) but has trended downward to 15.6% in 2007, 18.4% in 2008 and 11.2% in 2009. This sharp decline might be due to a change in number of sentinel sites, sample sizes and the selection of participants. Until 2006, the sample size for sentinel surveillance was around 200 and only two sites were sampled, Yangon and Mandalay. In 2007, surveillance was extended to six sentinel sites. As of 2008, HSS was conducted in 5 sites with an intended sample size of 200 per site. In 2009, HIV prevalence among FSWs ranged by site from 7.5% in Yangon to 16.9% in Lashio (Fig. 5).¹⁰

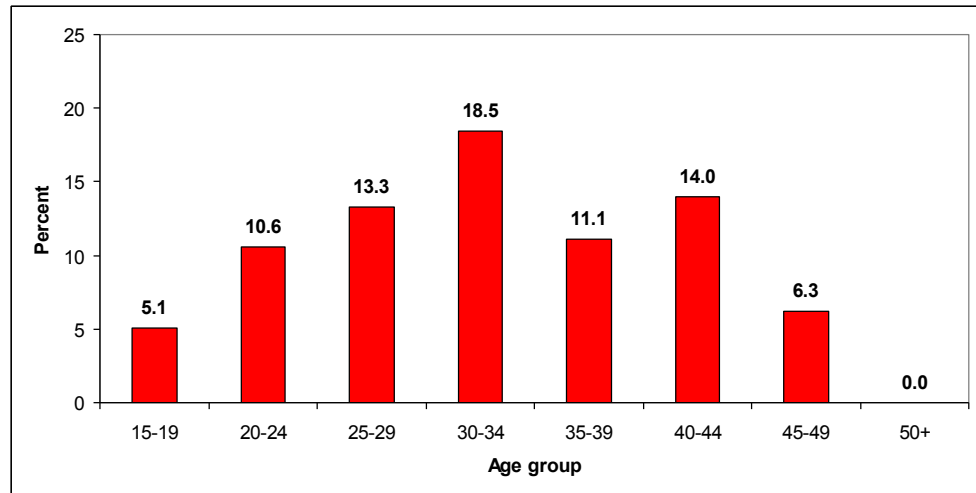
Figure 5: HIV prevalence among female sex workers, selected cities, 2009



Source: HIV Sentinel Sero-surveillance Survey, 2009

Figure 6 shows HIV prevalence among FSW by age groups in 2009. The 20-29 year age group had the highest prevalence at 18.5%, slightly down from 24.1% in 2007. Notably, HIV prevalence was substantially lower among 15-19 year olds at 5.1% in 2009 as compared to 10.7% in 2007, which would seem to indicate a lowered incidence among FSWs.¹⁰

Figure 6: HIV prevalence among female sex workers by age group, 2009



Source: HIV Sentinel Sero-surveillance Survey, 2009

FSWs become involved in sex work at a young age in Myanmar. In fact, 6% in Mandalay and 7% in Yangon are commercially sexually exploited children between the ages of 14-16 upon initiation. Another 18.4% in Mandalay and 11% in Yangon are between the ages of 17-19.¹⁸

In 2008, the mean number of clients in the last week reported by FSWs was 7 in Yangon and 15 in Mandalay.¹⁸ FSWs' sexual networking with other key populations at higher risk and the general population is of concern given the overlapping vulnerability factors involved. In 2008, the percentage of male IDUs having had sex with a paid partner in the last six months was 9% in Lashio, 31% in Myitkyina, 42% in Yangon and 48% in Mandalay.¹⁸ Moreover, the percentage of male out-of-school youth (aged 15-24 years) reporting sex with commercial partners in 2007 ranged from 3% in Monywa, 4% in Lashio, 5% in both Mandalay and Meiktila and 15% in Yangon.¹⁹

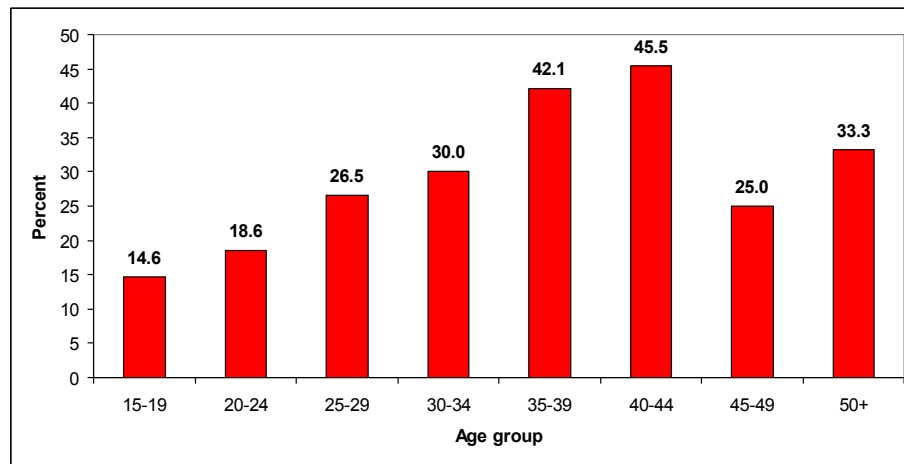
Men who have sex with men

MSM at a Glance

<p>HIV prevalence 9; 10</p>	<ul style="list-style-type: none"> • Estimated 200,000 to 280,000 MSM in Myanmar; • Overall HIV prevalence among MSM in 22.3% which is 37 times higher than the adult national HIV prevalence of 0.61%; • HIV prevalence in Yangon and Mandalay is 12.5% and 32%, respectively; • HIV prevalence among young MSM (15-24 years) is 16.9%; • The prevalence of active syphilis among MSM was 6.3% in 2009.
<p>Selected behaviors⁸; 20</p>	<ul style="list-style-type: none"> • 81.6% of MSM used a condom at last anal sex; • 53% of MSM used condoms consistently in anal sex with male paid partners and 78% in vaginal sex with female paid partners whereas 52% used condoms consistently in anal sex with casual male partners and 19% in vaginal sex with female casual partners (n=828); • 68.3% of MSM have comprehensive knowledge about HIV.
<p>National response²¹</p>	<ul style="list-style-type: none"> • MSM population is hidden and difficult to access due to discrimination and social norms but they are informally organized through local community based organizations; • There is a specific program line for prevention services for MSM in the national strategic plan; • The estimated budget for the intervention programs is 5,550,000 but there is a budget deficit of 4,500,000.

The estimated MSM population in Myanmar stands between 200,000 and 280,000.⁹ In 2009 HIV prevalence among MSM was 22.3% – 37 times higher than the adult national prevalence. In 2009, sentinel surveillance sampled MSM from two sites. Among them, HIV prevalence was 12.5% in Yangon and 32% in Mandalay. Young MSM below the age of 25 years have significantly lower HIV prevalence than their older counterparts (Fig. 7). The 40-44 year old age category had the highest prevalence among those sampled in the 2009 HSS. The prevalence of active syphilis among MSM was 6.3% in 2009.¹⁰

Figure 7: HIV prevalence among MSM by age group, 2009



Source: HIV Sentinel Sero-surveillance Survey, 2009

VULNERABILITY & KNOWLEDGE

Vulnerability factors:

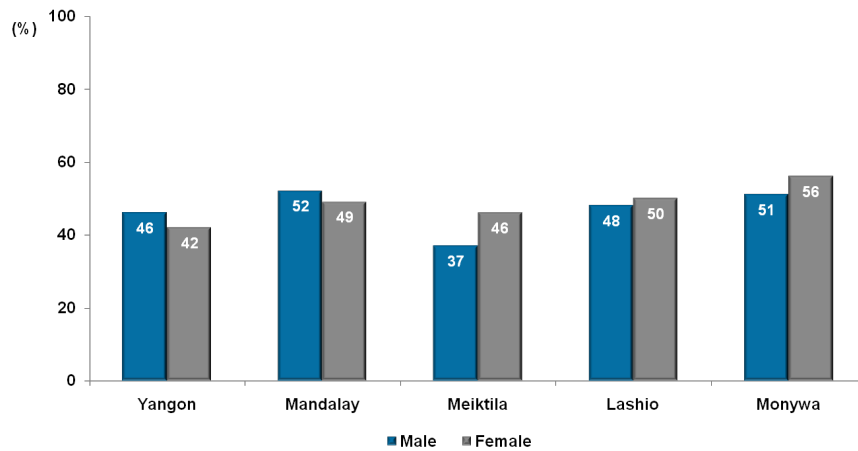
Though the country is experiencing a declining pattern of HIV prevalence, there are many hardships and obstacles in stabilizing the epidemic. Firstly, political turmoil with corresponding international pressure and sanctions from international donors poses a great hindrance to the effectiveness of HIV interventions in those areas most in need. Secondly, HIV prevalence is very high among sex workers, IDUs, and MSM. Furthermore, there is high mobility (with high numbers of internal and international migrants and a large mobile population) due to socio-economic and political hardships and yet there is a lack of nationally-coordinated HIV prevention programs for pre-departure (potential) migrants, return and circular migrants, and the mobile population in general.

Knowledge of HIV

HIV knowledge is relatively poor among young people and the general population. In a 2005 survey on knowledge of reproductive and sexual health was carried out by the Department of Health Planning and surveyed 14,400 households sampled from 86 townships.²² It was found that only half of the respondents (aged 15-49) could correctly identify the primary ways of preventing HIV transmission. Although this was an improvement on the fewer than 40% who could do so in a similar study three years earlier, it still indicates that the knowledge level is low among general population.²²

In 2008, less than half (47.5%) of out-of-school youth aged 15-24 had comprehensive knowledge about HIV – that is, were able to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.¹⁹ As shown in Figure 8, comprehensive knowledge is quite even across all surveillance sites and between sexes – ranging from 37% among young males in Meiktila to 56% among young females in Monywa.

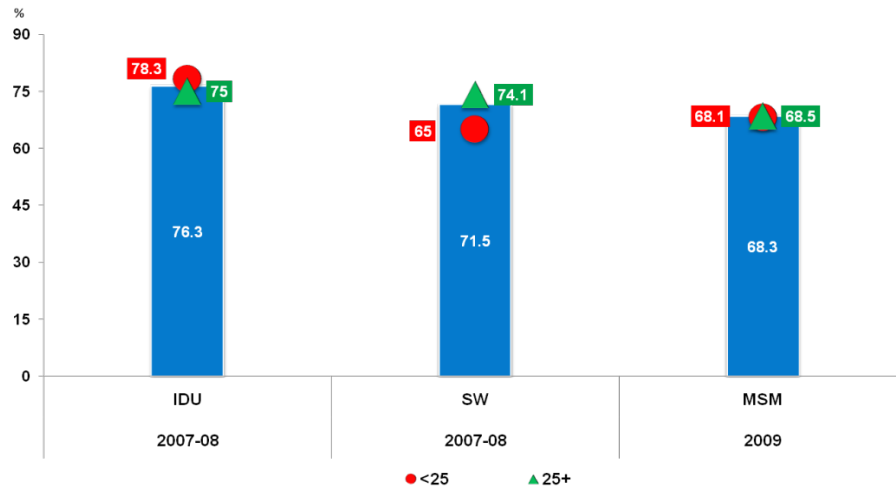
Figure 8: Percentage of out-of-school youths (15-24) with comprehensive HIV knowledge by city, 2007



Source: Behavioral Surveillance Survey (BSS) among Out-of-School Youth, 2008

According to the 2008 Behavioural Surveillance Survey (BSS) among IDUs and FSWs and the 2009 Integrated Biological and Behavioural Surveillance (IBBS) among MSM, the percentage of these key affected populations who have comprehensive HIV knowledge ranged from 68.3% among MSM to 71.5% among FSWs and 76.3% among IDUs (Fig. 9).^{8; 18}

Figure 9: Percentage of key affected populations with comprehensive HIV knowledge by age group, 2007 - 2009



Source: Behavioral Surveillance Survey (BSS) among IDUs and FSWs, 2008 and IBBS, 2009, cited in UNGASS Country Progress Report, 2010

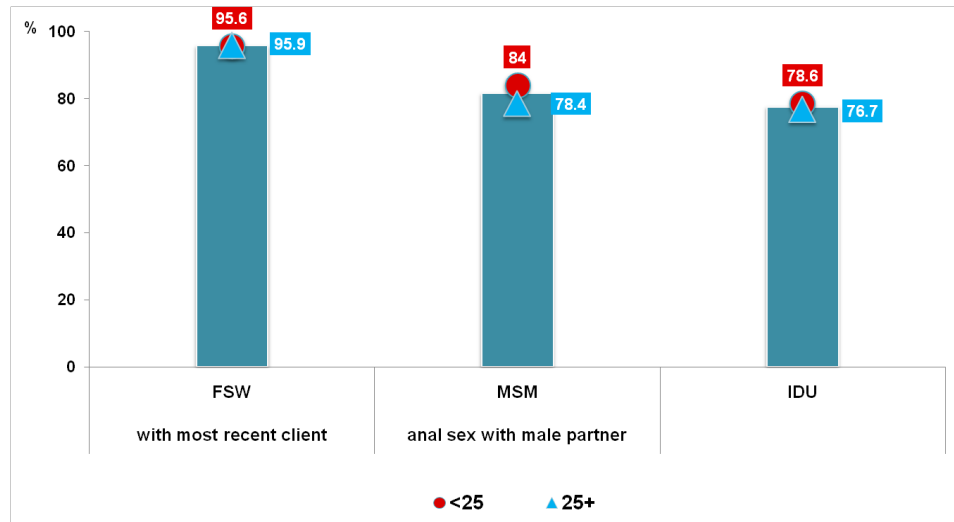
IDUs have relatively good knowledge about where to get new needles, with 100% of IDUs in Yangon and Mandalay having this knowledge, together with 99% in Lashio and, to a lesser extent, 78% in Myitkyina.¹⁸ In terms IDUs who knew where to get condoms, 93% in Lashio, 95% in Yangon, 97% in Myitkyina and 100% in Mandalay had this knowledge.¹⁸ Similarly high numbers of FSWs knew where to get condoms: 93% in Yangon and 97% in Mandalay.¹⁸

RISK BEHAVIOURS

Condom use

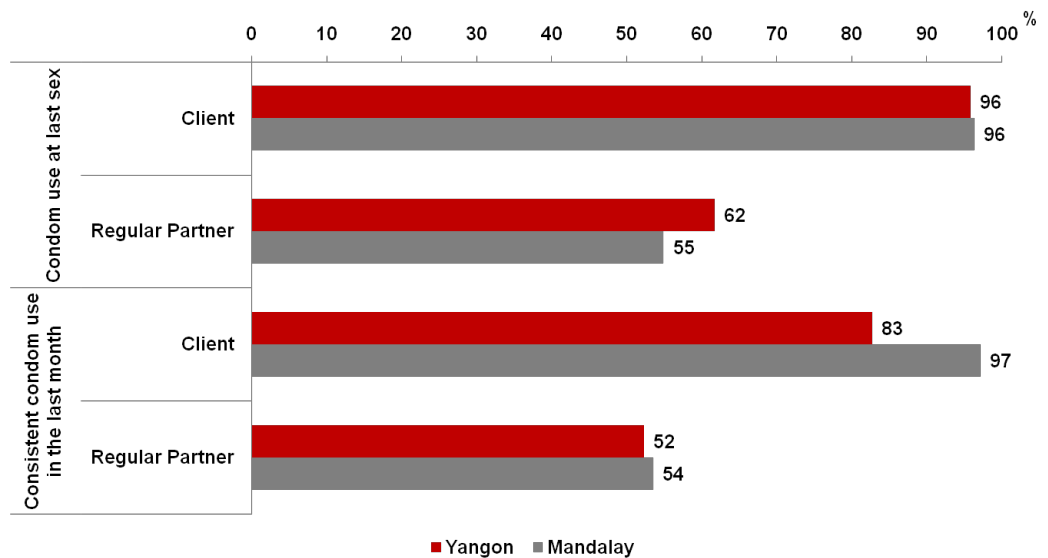
Condom use is much higher among FSWs than other key affected populations (Fig. 10). In 2008, 96% of FSWs used a condom with their most recent client. However, condom use at last sex with a regular partner was much lower - as reported by only 55% of FSWs in Mandalay and 62% in Yangon (Fig. 11).¹⁸ Moreover, consistent condom use was more variable: 97% of FSWs in Mandalay and 83% in Yangon reported using condoms consistently with clients in the last month. Meanwhile, 54% and 52% reported consistent condom use with a regular partner in Mandalay and Yangon, respectively.¹⁸

Figure 10: Percentage of key affected populations who used a condom at last sex by age group, 2007 – 2009



Source: Behavioral Surveillance Survey (BSS) among IDUs and FSWs, 2008 and IBBS, 2009, cited in UNGASS Country Progress Report, 2010

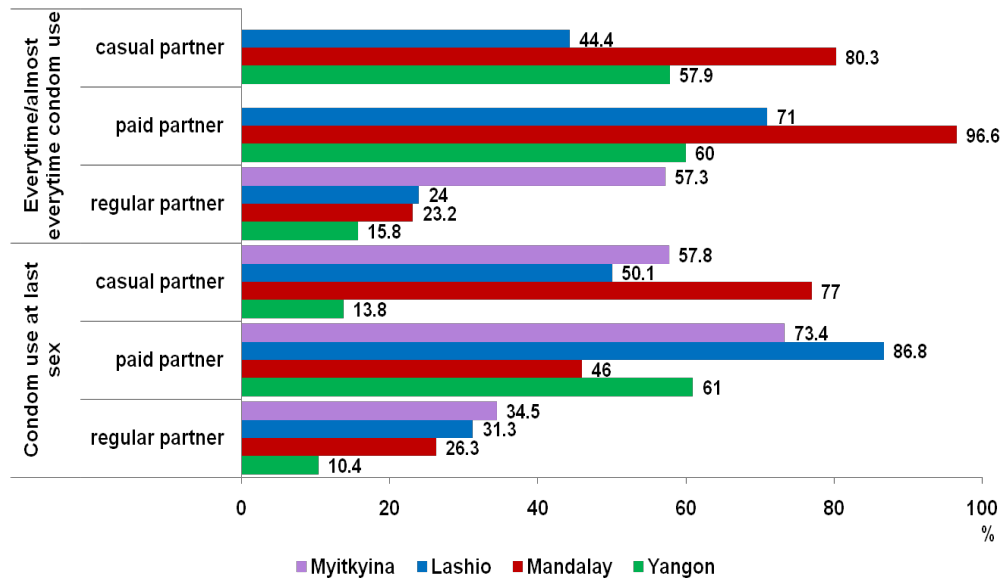
Figure 11: Percentage of condom use among female sex workers with different types of sexual partners, 2007-2008



Source: Behavioral Surveillance Survey (BSS) among Injecting Drug Users and Female Sex Workers, 2008

In 2008, 77.6% of IDUs used a condom at last sex.¹⁸ Similar to what was observed among FSWs, IDUs generally use condoms (at last sex and consistently) more often with paid partners than with casual or regular partners (Fig. 12).

Figure 12: Percentage of condom use among male IDUs with different types of sexual partners, 2007-2008



Source: Behavioral Surveillance Survey (BSS) among Injecting Drug Users (IDUs) and Female Sex Workers (FSWs), 2008

The 2009 IBBS found that 81.6% of MSM used a condom the last time they had anal sex with a male partner.⁸ An NGO survey (unpublished, 2008) of 828 MSM and male sex workers (MSWs) found that 53% of MSM/transgenders used condoms consistently in anal sex with male paid partners and 78% in vaginal sex with female paid partners; 52% used condoms consistently in anal sex with casual male partners and 19% in vaginal sex with female casual partners.²⁰ Condom use amongst MSW (including transgenders who sell sex) were similar: 52% with one-time male clients, 48% with regular male clients; 45% with a male paid partner, 69% with a female paid partner, 43% with a casual male partner and 21% with a casual female partner.

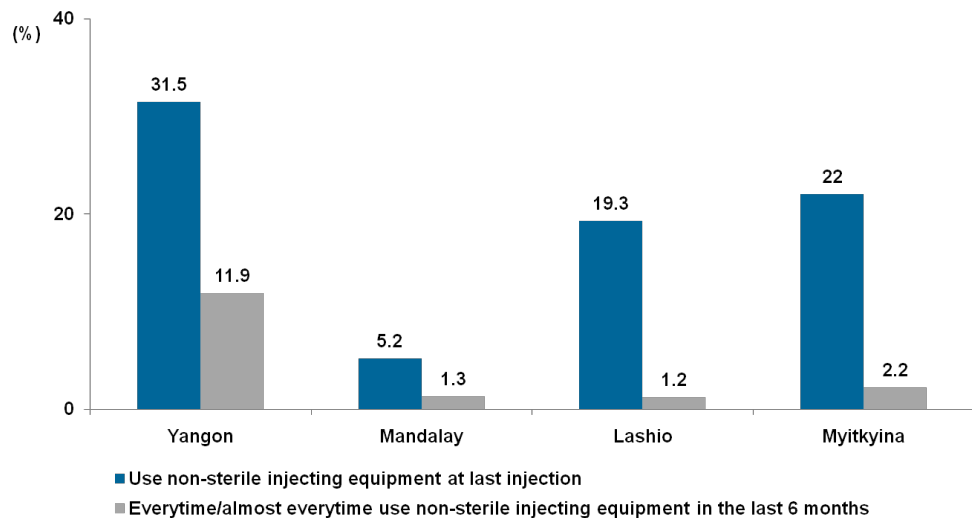
The BSS 2008 among out-of-school youth found similar patterns in condom use with causal vs. paid partners. While 90% reported condom use at last sex with a sex worker, only 52% used a condom at last sex with a casual partner.¹⁹



Injecting equipment

A significant number of IDUs sampled in the BSS 2008 reported using non-sterile injecting equipment at last injection, ranging from 5.2% in Mandalay to 31.5% in Yangon (Fig. 13).¹⁸ Moreover, 11.9% in Yangon reported using non-sterile injecting equipment every time or almost every time they injected in the last 6 months (Fig. 13).¹⁸

Figure 13: Percentage of male IDUs using non-sterile injecting equipment at last injection and in the last six months, 2007-2008



Source: Behavioral Surveillance Survey (BSS) among Injecting Drug Users (IDUs) and Female Sex Workers (FSWs), 2008

NATIONAL RESPONSE

Law and policy implementation

A number of laws are in place in Myanmar that further hinder the efficacy of HIV prevention programs given that they keep key affected populations hidden and stigmatized. Specifically, Myanmar is one of the former British colonies in Asia which still adheres to colonial laws against sodomy. Section 377 of the Myanmar Penal Code, Act 45/1860 criminalizes male-to-male sex with the penalty of transportation for life, or maximum imprisonment of 10 years.²³ Sex work is also illegal in Myanmar.²⁴

Myanmar law obliges drug users to register for treatment or face five years in prison.²⁵ In addition, registered drug users cannot carry methadone, but must be provided with the medication daily at a government identified facility.²⁶ The fact that criminalization has historically been the norm in Myanmar has complicated policy change initiatives. For example, despite the fact that the Myanmar Excise Act, 1917 prohibits the possession, sale or distribution of needles without a license, a Directive from the Myanmar Police Force Headquarters was given not to make arrests for possession of hypodermic needles. In practice, however, needles are confiscated and submitted to the courts as evidence when individuals are arrested for drug possession.²⁷

Governance

The National Health Committee was formed in 1989 and is the highest policy-making multisectoral body, giving guidance on all health related matters, including HIV and AIDS. As HIV is one of three communicable diseases (together with TB and malaria) of national priority, a high-level multisectoral National AIDS Committee chaired by the Minister of Health was formed in 1989 to oversee the National AIDS Programme (NAP).

The National Strategic Plan (2011-2015) was developed using participatory processes, with direct involvement of all sectors concerned in the national response to the HIV epidemic. Contributions were made by the Ministry of Health, several other government ministries, United Nation agencies, local NGOs, international NGOs, people living with HIV and people from vulnerable groups. The plan is comprehensive and detailed, outlining the priority target groups, prevention, care and support programs, as well as systems strengthening elements. It addresses capacity development, resource mobilization, gender and equity issues, combined with a clear scale-up and yearly operational plan. There is also a strong component of monitoring and evaluation as part of the plan.

The Country Coordinating Mechanism for AIDS, Tuberculosis and Malaria (M-CCM) oversees implementation of the National Strategic Plan, provides policy guidance and identifies appropriate external support. M-CCM is supported by one Technical Strategy Group (TSG) for each disease.

The Technical and Strategy Group (TSG) on HIV and AIDS – chaired by the Department of Health with membership drawn from government, non-governmental and UN partners and including representatives of people living with HIV – coordinates partners' activities in relation to the National Strategic Plan. Moreover, nearly 40 national and international NGOs are implementing intervention activities in Myanmar alongside government efforts and with UN support.

HIV prevention programmes

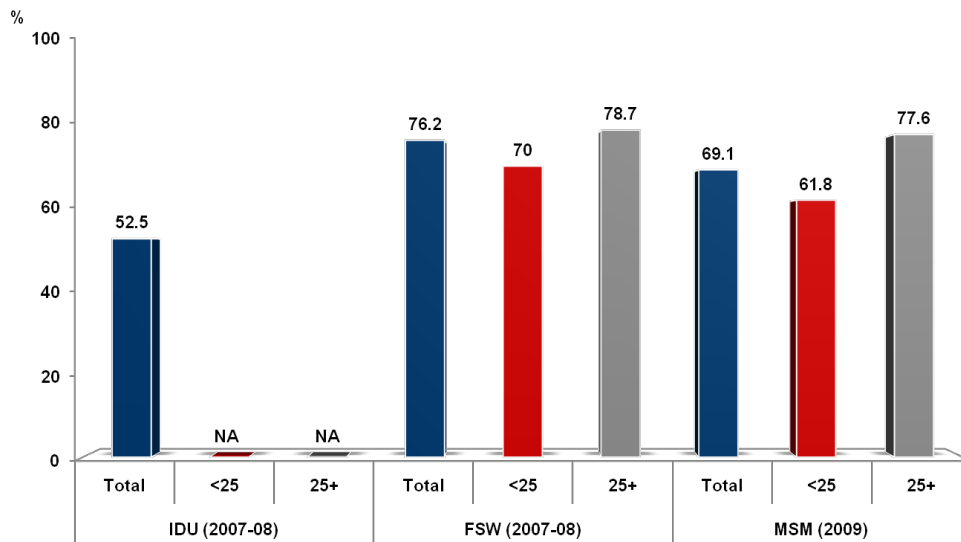
Although 100% Targeted Condom Promotion (TCP) was implemented in 154 sites in 2004, it did not cover all areas nor all types of sex work. A World Health Organization (WHO) review team observed that in some areas there was still strong resistance to admitting the existence of sex work. Key challenges in the 100% TCP implementation include the limited capacity of implementers, the lack of active partnerships with key sectors (such as the police), limited data on the quality and the effectiveness of the programme, and limited coverage. A key barrier to effective implementation of the programme is the continued disruption caused by police arrests of sex workers. International NGOs reported that this happens particularly towards the end of the month when the police have to meet their monthly targets as part of the programme to control sex work.¹⁷

A growing number of self-help groups of people living with HIV are emerging across the country, and they are beginning to organise themselves into State/Division-level networks. Most partners are able to undertake service provision using participatory approaches at the community level, through techniques emphasizing peer education and support for community-based organizations.²⁸

Progress has been made in the availability and coverage of harm reduction programmes for IDUs although stigma by the community remains and reports of neglect by some NGOs (e.g. some NGOs exclude drug users from ART, even when they are stable on methadone).¹⁷ As of 2009, there were 0.6 needle and syringe exchange programme sites per 1000 IDUs, and 67 needles/syringes were distributed per IDU per year, up from 0.2 NSEP sites/1,000 and 47 needles/syringes per IDU/year in 2008.²⁹ Methadone replacement therapy was started in 2006; there were approximately 0.1 opioid substitution therapy sites per 1000 IDUs in 2009, remaining the same as the previous year.²⁹

Indeed, the percentage of key affected populations reached with HIV prevention programs is lowest among IDUs (Fig. 14). In 2008, 52.5% of IDUs were reached in the last 12 months, compared to 76% of FSWs and 69.1% of MSM (in 2009).^{8; 18} It is important to note, however, that these levels of coverage are a marked increase from previous reports from 2005 at which time only 20% of IDUs had been reached with prevention programmes, along with 64% of FSWs and 8% of MSM. In addition, Myanmar is only behind Nepal (56%) in the region in terms of coverage for IDUs.¹⁵

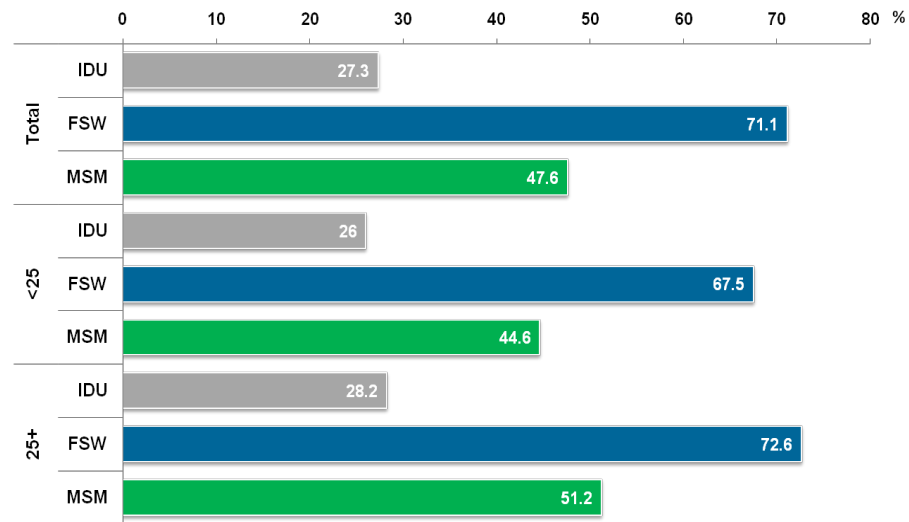
Figure 14: Percentage of key affected populations reached with HIV prevention programs in the last 12 months by age group, 2007 - 2009



Source: Behavioral Surveillance Survey among Injecting Drug Users and Female Sex Workers, 2008 and IBBS, 2009, cited in UNGASS Country Progress Report, 2010

Similar trends in HIV testing are observed among key affected populations (Fig. 15). In 2008, 27.3% of IDUs were tested in the last 12 months and knew their results, compared to 71.1% of FSWs and 47.6% of MSM (in 2009).^{8; 18}

Figure 15: Percentage of affected populations who received HIV testing in the last 12 months and knew the results, 2007 - 2009



Source: Behavioral Surveillance Survey among Injecting Drug Users and Female Sex Workers, 2008 and IBBS, 2009, cited in UNGASS Country Progress Report, 2010

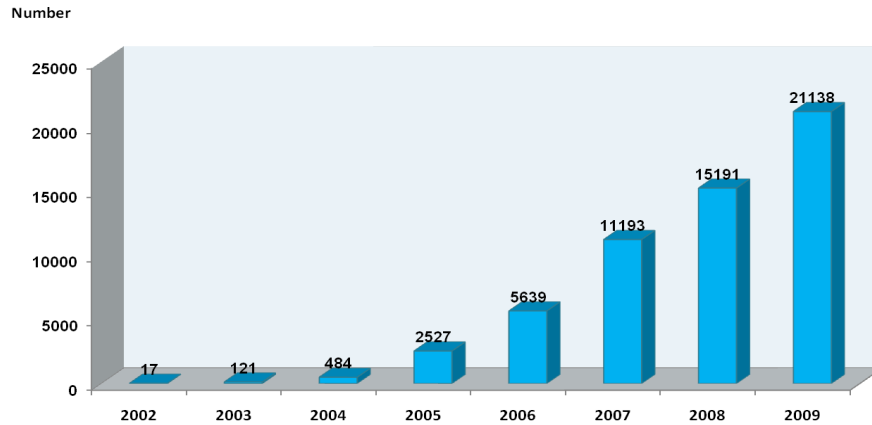
HIV testing was low among out-of-school youth in 2007. Among all respondents (n=6,954), 5.9% and 6.7% of young women and young men (aged 15-24) received an HIV test in the last 12 months and received their results, respectively.¹⁹ Comparatively, among sexually active respondents (n=3,495), 12.6% of young women and 11.7% of young men had been tested.¹⁹

Antiretroviral treatment, Prevention of Mother-to-Child Transmission

There is a continued need to scale up interventions for the Prevention of Mother-to-Child Transmission (PMTCT). In both 2008 and 2009, only 18% of pregnant women were counselled and tested for HIV, up from 11% in 2007.^{29; 30; 31} In 2009, it was estimated that between 43% and more than 95% of HIV positive pregnant women received ARVs to reduce the risk of mother-to-child transmission, an increase from 31.1% in 2008 and from between 18% and 43% in 2007.^{29; 30; 31} Data from 2009 reveal that an estimated 23% of infants born to an HIV positive mother were found to be HIV infected. Less than half (46%) of infants born to an HIV-positive mother received ARVs in 2009, up from 28% in 2008 and 22% in 2007.

More generally, the number of adults and children receiving ART has been increasing steadily (Fig. 16). Still, only 28.5% of adults and children with advanced HIV infection received ART in 2009, compared with 23.1% in 2008.^{29; 30} In 2009, 19,603 adults aged 15 and above (11,201 males and 8,402 females) and 1,535 children (786 males and 749 females) were receiving ART.²⁹

Figure 16: Number of adults and children receiving antiretroviral therapy, 2002 - 2009



Source: UNGASS Country Progress Report, 2010

AGE DISAGGREGATION

A highlight of Myanmar's monitoring and evaluation system is its use of age-disaggregated data. Table 1 summarizes the most recent data that has been disaggregated by age. As indicated, young people fall below average for numerous indicators (fortunately, including HIV prevalence). Some of the differences may not be significant due to small population sizes.

Table 1: Age-disaggregated data among key affected populations

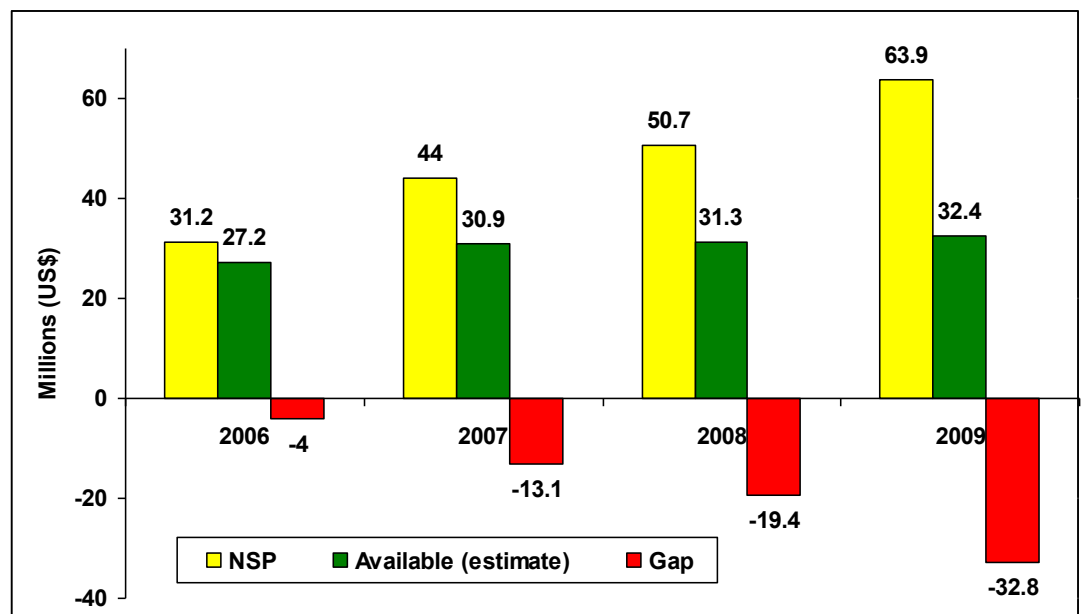
Indicator	Population	Year	<25	25+	Total	Young people fare better than average
HIV prevalence (%)	IDU (males)	2009	26.1	37.9	34.6	X
	FSW	2009	8.5	13.9	11.2	X
	MSM	2009	16.9	03.9	22.3	X
Comprehensive HIV knowledge (%)	IDU	2007-08	78.3	75	76.3	X
	FSW	2007-08	65	74.1	71.5	
	MSM	2009	68.1	68.5	68.3	
Received an HIV test in the last 12 months and know the results (%)	IDU	2008	26	28.2	27.3	
	FSW	2008	67.5	72.6	71.1	
	MSM	2009	44.6	51.2	47.6	
Reached with HIV prevention programmes (%)	FSW	2008	70	78.7	76.2	
	MSM	2009	61.8	77.6	69.1	
Used a condom with their most recent client (%)	FSW	2007-08	95.6	95.9	95.8	
Used a condom the last time they had anal sex with a male partner (%)	MSM	2009	84	78.4	81.6	X
Used a condom at last sex (%)	IDU	2007-08	78.6	76.7	77.6	X
Used sterile injecting equipment the last time they injected (%)	IDU	2007-08	83.2	78.8	80.6	X

Sources: HIV Sentinel Sero-surveillance Survey, 2009; Behavioural Surveillance Survey, Injecting Drug Users and Female Sex Workers, Myanmar, 2008; IBBS (MSM), Myanmar, 2009, cited in UNGASS Country Progress Report, 2010

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Financial resources available to the national response to HIV from both national and international sources have grown significantly in recent years. However, they are still considered insufficient, leaving the health system under-resourced given the fact that Myanmar is a donor-constrained country.¹⁷ Myanmar does not currently access resources from the World Bank or the Asian Development Bank. Myanmar did, however, receive a Global Fund Round 9 grant and projects will be implemented soon. The contribution of the government of Myanmar to the national response to AIDS was estimated at approximately US\$ 1.5 million in 2008 as compared to the US\$ 31.3 million contributed by international sources (an increase from 3.6% to 4.7% of the total).⁸ The Three Diseases Fund (3DF) provides roughly 40% of the available funding, and – while this finances critical services – the 3DF currently has insufficient funds to fuel the requisite scaling-up.²⁸ There is a significant and widening resource gap between that which is needed to carry out the National Strategic Plan and that which is actually spent (Fig. 17).

Figure 17: Resource needs as per National Strategic Plan and actual resources, 2006-2009



Source: National AIDS Programme, MoH, National Strategic Plan for HIV and AIDS in Myanmar, Progress Report 2009



ISSUES AND CHALLENGES

Though HIV prevalence in Myanmar is estimated to be declining, the sustainability of the decline will depend on a number of factors. The balance or imbalance between inhibitory and facilitation factors to the sustainability issue will be critical to contain the epidemic.

Key aggravating factors for the spread of HIV infection

- Chronic under-funding and recent conflicts in the grants environment. There is no funding support from major donors such as PEPFAR, Asian Development Bank, and World Bank;³²
- Politicized and difficult operating environment and international organizations face limitations in geographical access particularly to 'sensitive' areas (which include border areas and some critical mining sites), ability to undertake research and opportunities to dialogue with government;²⁸
- Weak public sector and insufficient multisectoral engagement from non-health government departments;
- Community organizations face considerable constraints in establishing a legal footing necessary to operate;³²
- Alarming high HIV prevalence among IDU and under-funding for harm reduction programmes;
- Lack of intervention programmes for migrants and mobile populations, though the issue of migration and mobility was addressed in National Strategic Plan.

Key inhibiting factors for the spread of HIV infection

- HIV services have expanded, with increasing coverage;
- Incremental increases in international funding (3 Disease Fund) and the establishment and expansion of services by NGOs, the UN and the government;
- The National Strategic Plan reflects international best practice, highlights the key populations at higher risk and was developed in a more participatory manner than any preceding plan.

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