HIV and AIDS in Myanmar

Myanmar updated August 2017

KEY POINTS:

- Myanmar currently has the second highest number of people living with HIV in the Southeast Asia region.
- Myanmar is a UNAIDS country of concern, as it continues to display a high incidence of new HIV infections, despite the implementation of prevention and treatment programmes.
- People who inject drugs are the group most affected by HIV in Myanmar. This is largely due to drugs which are farmed, manufactured and distributed in the northern regions of the country.
- The country's low financial investment in public health appears to be a major barrier to the success of HIV testing, prevention and treatment programmes.

Explore this page to find out more about populations most affected, HIV testing and counselling, prevention programmes, access to treatment, barriers to prevention and the future of HIV and AIDS in Myanmar.

Myanmar (also known as Burma) has a population of 51 million people, of which UNAIDS estimates there were 230,000 people living with HIV in 2016.¹

A further 7,800 people died from AIDS-related illnesses in the same year. Between 2000 and 2016, the number of AIDS-related deaths has fallen by an estimated 52% as a result of antiretroviral treatment coverage in Myanmar.²

After Thailand, Myanmar has the second highest number of people living with HIV in Southeast Asia and shares similar key populations of people most affected by HIV. These include men who have sex with men, male and female sex workers and people who inject drugs and their intimate partners.³

Despite a general decline in new infections across Asia, gains in some countries have been offset by rising epidemics in places such as Myanmar where funding of effective primary HIV prevention has been insufficient.⁴
As such, Myanmar is now one of 35 countries which together account for 90% of new infections globally. Myanmar had 11,000 new infections reported (approximately 30 infections per day) in 2016. Although this number of new infections remains steady compared to the year before, observations show that the annual rate of infections is no longer declining at the same rate it did between 2000 and 2010.5

New infections are mostly found in urban areas or areas where drug use is endemic. For example in the country’s largest city, Yangon (formerly known as Rangoon), there appears to be a higher rate of partner change, a higher rate of buying sex and injecting drugs, lower knowledge on HIV transmission and prevention, lower contact by outreach workers and a lower rate of condom use, all resulting in higher HIV prevalence.6

Myanmar bar chart August2017_for website.png

### Key affected populations in Myanmar

**People who inject drugs (PWID) and HIV**

In 2016, HIV prevalence among people who inject drugs (sometimes referred to as PWID) was the highest out of all of the key affected populations, with 26.3% of injecting drug users testing positive for HIV.7

In the previous year, people who inject drugs also presented the highest HIV incidence, accounting for 20–65% of adults, aged 15 to 49, testing positive for new infections.8

Additional analysis suggests that infection occurs at an early age among those who inject drugs, with 16.8% of those under the age of 25 already testing positive. These findings have bolstered the argument that the risk associated with injecting drug use and HIV vulnerability should make the case for developing more youth-targeted programmes.9

Although the burden of HIV prevalence is traditionally limited to urban towns and cities in Myanmar, injectable opium use is endemic with rates of high HIV prevalence evident in the more rural northern and north-eastern areas of the country where the drug is produced. For example, in Waingmaw in Kachin State, HIV prevalence among people who inject drugs was particularly high at
Distribution of drugs from this region also has contributed to new HIV infections developing in more remote areas of the country, providing additional challenges to expanding the coverage of harm reduction and HIV services.11

Currently, less than 50% of people who inject drugs report regular testing for HIV and less than a quarter of those asked in 2016 reported consistent condom use.12 Moreover, under 86% of people who inject drugs report using sterile injection equipment for their last injection.13

**Men who have sex with men (MSM) and HIV**

HIV prevalence (6.4%) among gay men and other men who have sex with men (sometimes referred to as MSM) has continued to remain a concern in Myanmar, with rates particularly high in many cities and urban areas such as Yangon (26.6%).14

This the highest recorded rate of prevalence for this group in the Southeast Asia region, even higher than Bangkok, Thailand (24.4%). Myanmar’s latest National Strategy Plan recognises that these rates are alarming and should present an immediate call to scale up targeted services in high burden geographical locations.15

There appears to be an increased risk of HIV infection within the most sexually active age group (25-49 year olds) where prevalence of HIV is significantly higher than average. Prevalence peaks at 25% for the 35-39 age group.16

Stigma and discrimination continues to contribute to the low levels of access to HIV services, with just 50%-75% of men who have sex with men reporting having an HIV test in 2015. Consequently, in 2016, just over half (52%) of those living with HIV knew their status.17

MSM and HIV positive people are denied equal employment opportunities and access to proper medical treatment, which in turn discourages them from safe behaviour.

- *Thet Mon Phyo, Programme Manager at The Help, Myanmar*18

Most recent statistics record 77% of gay men and other men who have sex with men reporting condom use with their last male partner. However, male-to-male sexual dynamics are complex in Myanmar, and risk behaviours can vary between self-categorised groups of men who have sex with men.19

A 2012 study found that those who identified as Ah Chawk Ma (broadly feminine gender presentation) who were more likely to be the receptive partner of anal sex also reported having more sexual partners, less consistent condom use, and more frequent history of STIs compared to those described as Tha Ngwe (broadly masculine gender presentation).20

Although Myanmar has a relatively visible LGBT community, existing laws which criminalise same sex behaviour in Myanmar keep many people hidden from the reach of healthcare service providers. Moreover, a lack of legal gender identity recognition in the country often means that transgender people are wrongly categorised as men who have sex with men and are commonly not offered the appropriate link to targeted HIV services.21

These observations have informed the country’s National Strategic Plan to develop a more appropriate future framework for effective responses to intertwined gender identities, sexual
orientations and behaviours. By 2020 the new strategy aims to reach more ‘non-disclosed’ men who have sex with men by expanding services through innovative social media, test-and-treat campaigns and proactive community-led outreach linked to services which are friendly towards men who have sex with men and transgender persons.22

**Sex workers and HIV**

HIV prevalence among female sex workers was over 5% in just three (Indonesia, Malaysia and Myanmar) of the 21 countries that provided data in the 2015 UNAIDs report.23

In Myanmar’s major cities, HIV prevalence was much higher - 24.6% and 13.7% in Yangon and Mandalay respectively - representing some of the highest HIV prevalence locations in the Southeast Asia and Pacific region.24

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**Case study: Risk behaviours of female sex workers in major cities in Myanmar**

In 2013, 200 female sex workers were interviewed as part of a study to determine risk behaviours associated with HIV prevalence in high-burden cities.

Unlike other studies which show that a lack of sexual health knowledge is linked with inconsistent condom use, almost everyone in this study (99%) had previous knowledge of STIs and HIV.

However, while there were varied methods of contraceptives used, only 11.5% of the participants consistently used condoms to protect themselves from infection.

Results from the interviews also showed that those who had a low income, those who had regular partners who refused to use condoms, and that respondents who did not have access to HIV counselling were all at a much higher risk of being HIV-positive. As a result, 18.4% of participants who were tested were shown to be HIV-positive.25

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**Migrants and HIV**

Myanmar is home to over 100 different ethnic groups and shares its borders with two of the most populated countries in the world, India and China, in addition to Bangladesh, Laos and Thailand.

The 2014 census estimated that over 11 million residents have migrated internally or externally. Some critics are now concerned that increasingly open borders make Myanmar more vulnerable to HIV incidence with an increase of migrants coming from bordering high prevalence countries.26

As HIV testing is not a condition for entry, work or residence in Myanmar there is not much comprehensive information available on HIV prevalence or risk behaviours associated with the migrant population. Nevertheless, in 2014, the IOM data project did find that 18% of people identifying as migrants in Mon and Kayin states were HIV positive - although it is difficult to assess if the point of infection happened within country.27

However, it is broadly assumed that migrants might face residency and social restrictions that limit their access to HIV programming services, as well as other general forms of healthcare.28

Since 2014, HIV awareness campaigns specifically targeting large migrant populations have been created to address this issue.29 The current National Strategy Plan for HIV also proposes developing specific packages for people near transit points in addition to cross-border referral mechanisms and agreements to strengthen access to health services in destination countries.30
HIV testing and counselling (HTC) in Myanmar

Across the country the rate of HIV testing for the general population was last recorded at 11.3% in 2007, with specific testing rates varying among key affected population groups. However, in 2014 the estimated testing coverage for key affected populations specifically was still far from optimal with only 34% accessing testing services.

Unfortunately, there has been no new behavioural data on HIV testing among the general population since 2007. As such, there is an urgent need for strengthening the involvement of community networks in the planning and monitoring of testing services.

Myanmar’s most recent National Strategic Plan, launched in 2016, aims to promote early HIV testing and counselling in line with WHO recommendations, and to close the testing gap by prioritising townships with a high epidemic burden and by centralising the provision of HIV counselling and testing to become a local public health sector concern.

HIV prevention programmes in Myanmar

Harm reduction services

Research consistently shows that harm reduction programmes - such as needle and syringe exchange programmes and opioid substitution therapy – are the most effective ways of reducing the spread of HIV among people who inject drugs.

However, because the scale of drug use in Myanmar is particularly extensive, existing harm reduction services are currently failing to meet the escalating demand by people who inject drugs.

For example, in response to a 2014 study which estimated that the reported re-use of needles varied from 16% in Mandalay to 63% in other areas, there were 18 million sterile needles and syringes distributed free of charge during the next year.

Despite these efforts, it was still found that the coverage of additional needles was not enough. Based on typical injecting practices involving 2-3 daily injections, around 60-90 million would be needed. So there continues to be a major gap for the 83,000 people who inject drugs in Myanmar.

The government has recognised this need to scale up their commitment to strengthening harm reduction services, and have since allocated an additional US$1 million (as part of the US$11 million domestic funding commitment towards HIV services) for methadone as a form of opioid substitution. However, critics suggest that this sum will not be enough to curtail what appears to be a growing dependency on drug use within the country.

Preventing mother-to-child transmission (PMTCT)

HIV counselling and testing services for all pregnant women have been integrated into antenatal services across the country, which presents a much more successful model of implementation compared to other countries within the Southeast Asia region.

As a result, more than 900,000 pregnant women received pre-test counselling and more than 700,000 took an HIV test and received post-test counselling during 2015. In 2015, 3,923 HIV-positive pregnant women received ART to reduce the risk of mother-to-child transmission, but only 39% of these were put on lifelong treatment (Option B+) as recommended by the WHO, with the rest only put on treatment while pregnant and breastfeeding.

In 2015, overall ART coverage among pregnant women living with HIV to prevent mother-to-child transmission was estimated to be 77%.
Routine monitoring continues to be an area of weakness - as it is across most testing, prevention and treatment services in Myanmar. Out of the 2,169 exposed infants only 801 were given an HIV test within two months of birth.44

Myanmar’s National Strategic Plan suggests that there is a critical need for better collaboration between health services to integrate early infant diagnosis into post-birth care in order to establish a fully comprehensive PMTCT cascade.45

**Antiretroviral treatment (ART) in Myanmar**

According to UNAIDS, 130,000 (55%) of all people living with HIV in Myanmar currently have access to antiretroviral treatment (ART).46

It is worth noting that this figure has more than doubled (from 24%) in 2012 (NSP), and has brought the country up to speed with the treatment rate of people living with HIV in the rest of the Southeast Asia region (41%). As a result, the country has witnessed the number of AIDS-related deaths fall by an estimated 52% as ART coverage has expanded in the last six years.47

Nevertheless, despite improvements in treatment access, Myanmar is still a high burden country with limited availability of viral load testing and HIV drug resistance testing for monitoring patients who are on first-line as well as second-line ART.48

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**Case study: Long-term outcomes of second-line ART in Myanmar**

Second line ART has been available in Myanmar since 2008, however there has been no published data about the outcomes of patients on second line treatment until recently.

A 2017 study followed a cohort of 824 adults and adolescents across seven years in which time 11% of patients died and the overall incidence rate of unfavourable outcomes of those who moved on to second-line treatments was 7.9%.

Those who fared worse on second-line treatment included patients with a history of injecting drug use, those lost to follow-up and those with a higher baseline viral load. Comparatively, patients with higher baseline CD4 counts, those who had taken first-line ART at a private clinic or received ART at decentralised cites all seemed to have a lower risk of unfavourable outcomes.

Though these results indicate relatively good long-term outcomes of patients on second line-ART treatment there was a strong emphasis made on making viral load monitoring routine, and third-line ART drugs available for cases of virological failure.49

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Historically, the majority of healthcare facilities in Myanmar have been privately funded or supported by NGOs. It is also estimated that at least 25% of people in Myanmar live below the poverty line and that those living with HIV may struggle to source the funds for necessary ARV medication.

As such, there have been strong arguments for a transition from private and NGO-run services to public sector delivery with the hopes of making treatment more readily available to vulnerable groups across the country.50

**Barriers to HIV prevention in Myanmar**

**Financial barriers**
Total health expenditure in Myanmar (2-2.4% of its GDP) is among the lowest in the Southeast Asia and Western Pacific regions, which goes some way to explaining the country’s current state of HIV incidence.\textsuperscript{51}

An analysis of countries from different regions, and with different epidemic patterns, found that Myanmar was among the countries where funding of effective and focused primary HIV prevention was insufficient.\textsuperscript{52}

In 2015, the country committed US$ 11 million in domestic funding towards HIV programmes while relying on an additional US$ 71.8 million from international donors.\textsuperscript{53}

Further findings from the National AIDS Spending Assessment (NASA) indicate that while more than 20 donors provide additional financial support for healthcare in Myanmar, only a few are committed to funding HIV-specific programmes. Of these, the Global Fund currently provides around half of the existing funding towards such programmes (investing a total of US$ 266 million to date since 2009).\textsuperscript{54}

**Legal barriers for sex workers**

Sex work in Myanmar is currently illegal. Fear of prosecution, harassment and blackmail all reduce access to services such as HIV testing which, in 2016, was only accessed by 50% of sex workers in the country.\textsuperscript{55}

Until 2011, even carrying a condom could be used as circumstantial evidence if a sex worker was detained by the police.\textsuperscript{56} More recent records from 2015 still indicate that just 70-89% of sex workers reported condom use with last client.\textsuperscript{57}

One day, the police detained me and I had to pay a MMK 50,000 fine for my release next day. If I did not pay, I could be detained, sued and jailed

- *Sex worker, Myanmar*\textsuperscript{58}

Legal penalties\textsuperscript{[CH1]} for commercial sex work are just one of many social and structural barriers - alongside cultural stigma, discrimination and violence - preventing sex workers accessing necessary HIV prevention and treatment services.\textsuperscript{59}

**Stigma and discrimination**

There is currently no welfare or job support for people living with HIV in Myanmar, and many face family or community rejection as a result of their status. Stigma within communities largely appears to stem from a lack of public health education and misconceptions on how the infection is spread.

We've seen cases where if someone looking after a patient with HIV dies while the patient is unwell, other people don't want to take care of the person with HIV anymore
This stigma also persists within healthcare systems themselves, with reports of institutional neglect by nurses and doctors also being cited by patients living with HIV.

For example, in one 2015 report assessing hospital conditions of people living with HIV in Myanmar and Cambodia, it was found that some patients were relegated to segregated waiting areas and bed spaces after their status was discovered.61

The same report also discovered much more serious allegations by women living with HIV who were forced by healthcare providers into making sterilisation a condition for accessing pregnancy-related services. In one instance in the city of Yangon, they also found that one woman was sterilised without her knowledge or consent.62

The future of HIV and AIDS in Myanmar

In order to meet the UNAIDS global 90-90-90 and Fast-Track Targets, in 2014 Myanmar’s government confirmed that it would increase its HIV funding by an additional US$ 5 million – with plans to integrate more public investment in health and bring a focus on access to medicines.63

This additional commitment has brought the country’s HIV expenditure - with the additional support from international disbursements - up to US$ 84 million per year.64

It is projected that this increase in funding will enable 40,000 additional people living with HIV to access antiretroviral treatment and increase the national HIV treatment target coverage to 85%.65

Increased resources should hopefully lead to other opportunities for improvement.66 These include significantly scaling up the coverage of effective combination prevention services to people who inject drugs, the implementation of partner tracing and testing for clients of sex workers, plus increasing the uptake of timely HIV testing and counselling.67

There are also plans for the country to develop a new model for pre-exposure prophalaxis (PrEP) as a prevention method for populations at substantial risk of HIV infection. However, some critics suggest that treatment access for those living with HIV should be prioritised first before implementing new methods in prevention.68

[Myanmar is ] a country where only 60 per cent of people living with HIV can access treatment, WHO describe universal access to treatment as minimum 80 per cent coverage. It’s a heavily resource-constrained setting and there isn’t the capacity to deliver PrEP appropriately.

- Associate Professor Mark Stoové from the Burnet Institute70

An initial assessment testing the acceptability of PrEP in Myanmar during 2016 found that although 39% of men would be willing to use it, the cost of the drug was a barrier.71

The report also suggested that, because sex between men is still illegal in Myanmar, it is unlikely that PrEP would be accessed through government systems and would instead have to be administered in safer social environments by NGOs or community-led services.72

Like many other low and middle income countries, there is some way to go if Myanmar is to reach
its UNAIDs targets for ending the epidemic by 2030. However, there is some optimism that targets for reducing transmission and increasing treatment can be achieved with increased national and international funding and support.73

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