

HIV and AIDS in Myanmar



Myanmar (2019)

240,000 people living with HIV

0.7% adult HIV prevalence (ages 15-49)

10,000 new HIV infections

7,700 AIDS-related deaths

77% adults on antiretroviral treatment*

73% children on antiretroviral treatment*

*All adults/children living with HIV

Source: UNAIDS Data 2020

KEY POINTS

- Although sustained and focused efforts to reach key populations have led to major reductions in HIV infections between 2010 and 2017, Myanmar continues to display a high incidence of new HIV infections.
- People who inject drugs are the group most affected by HIV in Myanmar. This is largely due to the endemic use of drugs, which are farmed, manufactured and distributed, in the northern regions of the country.
- Although access to HIV treatment is expanding, the country's low financial investment in public health appears to be a major barrier to the success of HIV programmes.

Explore this page to find out more about [populations most affected by HIV in Myanmar](#), [testing and counselling](#), [prevention programmes](#), [antiretroviral treatment availability](#), [civil society's role](#), [HIV and TB coinfection](#), [barriers to the response](#), [funding](#) and [the future of HIV in Myanmar](#).

Around 240,000 people were living with HIV in Myanmar (Burma) in 2019. In the same year, an estimated 7,700 people died from AIDS-related illnesses.¹ The increased antiretroviral treatment coverage has seen the number of people dying of AIDS-related illnesses fall by a third between 2010-2018. The number of new HIV infections has also fallen by a similar proportion during this time.²

After [Thailand](#), Myanmar has the second-highest HIV prevalence³ in Southeast Asia at 0.7%.⁴ Myanmar is one of 35 countries that together account for 90% of new infections globally. The

severity of the country's HIV epidemic resulted in UNAIDS classifying it as a 'fast-track' country in 2014 in order to help catalyse the rapid scale-up of its HIV prevention, testing and treatment programmes, although progress in these areas has been uneven.⁵

In 2018, Myanmar reported 10,000 new infections.⁶ Although this number remains steady compared to the years before, observations show the annual rate of infections is no longer declining at the same rate it did between 2000 and 2010.⁷

Although official testing, treatment and viral suppression target data for UNAIDS' 90-90-90 targets is incomplete, current estimates suggest around 76% of all people living with HIV in Myanmar were on treatment as of 2019. Of those on treatment, 95% are virally suppressed, equivalent to 72% of all people living with HIV.⁸

Myanmar's HIV epidemic is concentrated among certain key populations, most notably [people who inject drugs](#) (sometimes referred to as PWID), but also [men who have sex with men](#) (sometimes referred to as MSM), [transgender people](#) and [sex workers](#). More than 70% of new infections in the country each year occur among these groups.⁹ Approximately 65% of all key populations are estimated to be living in five regions and states (Mandalay, Yangon, Sagaing, Kachin and Shan North), largely in urban areas, which is where the majority of new infections occur.¹⁰

MYANMAR Progress towards 90 90 90 targets (all ages)



Source: UNAIDS Data 2020

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Key affected populations in Myanmar

People who inject drugs (PWID)

In 2018, 93,000 people in Myanmar were estimated to inject drugs, 19% of whom were living with HIV. This makes people who inject drugs the population group most affected by HIV in the country.¹¹

Analysis suggests that HIV infection occurs at an early age among people who inject drugs in Myanmar, with 17% of injecting drug users under the age of 25 testing positive. These findings have bolstered the case for developing more youth-targeted programmes.¹³

Although urban areas in Myanmar report the highest HIV prevalence rates in the country, prevalence is also high in the more rural northern and north-eastern areas where injectable opium is produced and its use is endemic.¹⁴ Distribution of drugs from this region has also 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.¹⁵

Only around a third (34%) of people who inject drugs have access to HIV prevention programmes. As a result, under a quarter of injecting drug users (22%) are estimated to use condoms and only a third (28%) of people who inject drugs who are HIV positive are aware of their status.¹⁶

Men who have sex with men (MSM)

In 2018, 6.4% of gay men and other men who have sex with men in Myanmar were estimated to be living with HIV.¹⁷

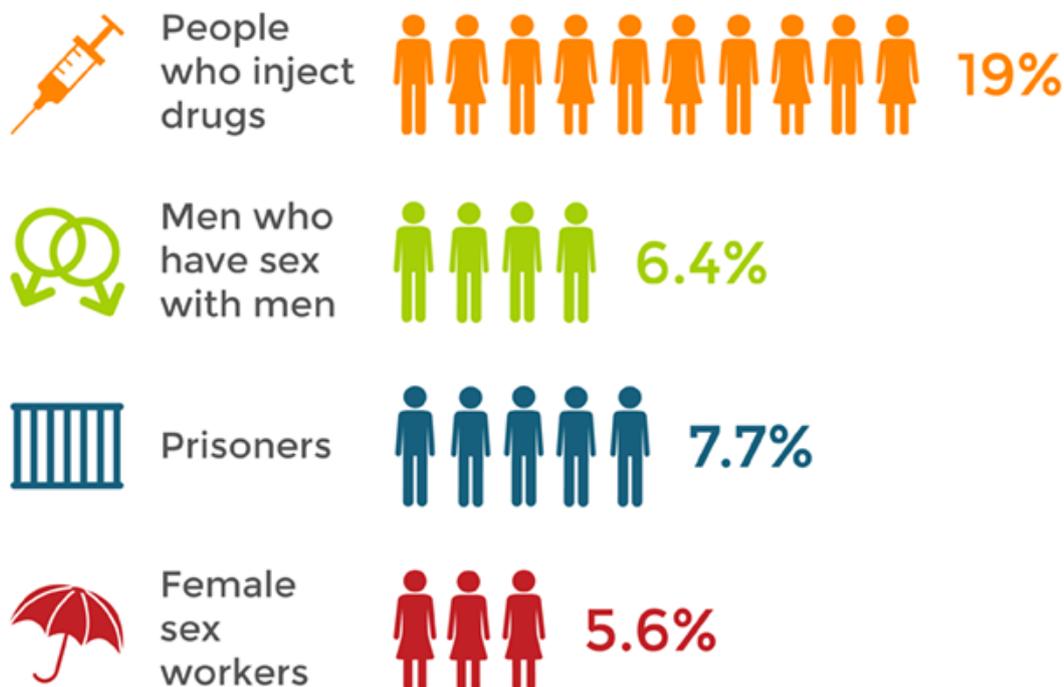
Rates are particularly high in cities and urban areas such as Yangon, where HIV prevalence is estimated to be 26.6% among this population group. This is the highest recorded prevalence rate for this group in the Southeast Asia region, even higher than Bangkok in Thailand where prevalence is estimated to be 24.4%.¹⁸

Myanmar's National Strategic Plan on HIV and AIDS 2016-2020 recognises that these rates are alarming and has presented a plan to scale up targeted services for men who have sex with men in geographical locations where HIV prevalence is high.¹⁹

Stigma and discrimination continues to contribute to low levels of access to HIV services, with between half and three quarters of men who have sex with men estimated to have taken an HIV test in 2015. Consequently, in 2017, just over half (52.4%) of men who have sex with men who were living with HIV were aware of their status.²⁰

Most recent statistics suggest 77% of men who have sex with men use condoms. 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.²¹ Although Myanmar has a relatively visible LGBT community, existing laws criminalise same-sex behaviour and keep many people hidden from the reach of healthcare providers. Moreover, a lack of legal gender-identity recognition in the country often results in transgender people being wrongly categorised as men who have sex with men and provided with inappropriate HIV services.²²

These observations have resulted in the National Strategic Plan including a more appropriate framework for effectively responding to the needs of gay men, men who have sex with men and transgender people. By 2020 the new strategy aims to reach more 'non-disclosed' men who have sex with men by expanding services through innovative social media activity, test-and-treat campaigns and proactive community-led outreach, linked to services that are friendly towards gay men, men who have sex with men and transgender people.²³



Source: UNAIDS 2018

Avert www.avert.org

Sex workers

In 2018, HIV prevalence among sex workers stood at 5.6%. Around 45% of HIV positive sex workers were aware of their status.²⁴

In Myanmar's major cities, HIV prevalence among sex workers is much higher, estimated at 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.²⁵

Sex work is criminalised in Myanmar and so presents a major obstacle to scaling up HIV and other essential healthcare services for this group. Sex worker networks and civil society organisations report police-related violence and abuse towards sex workers, something that deters many sex workers from accessing HIV services, including HIV testing and lifesaving antiretroviral treatment. Incarceration can cause sex workers living with HIV to disrupt treatment, which can result in drug resistance, treatment failure and the progression to advanced HIV infection or AIDS.²⁶

The criminalisation of sex work also worsens stigma and discrimination towards them, which also drives sex workers away from healthcare services.²⁷

Young people

In 2018, young people (aged 15-24 years) accounted for 26% of new infections in the region but a higher proportion in Myanmar at around 55%.²⁸

Because Myanmar's HIV epidemic is concentrated among certain groups, 15 to 24-year-olds from

these key populations are most affected. For example, HIV prevalence among young men who have sex with men is five times that of the general population. Social norms concerning same-sex relationships and the criminalisation of homosexuality, coupled with taboos regarding young people's sexuality, combine to result in poor access to essential HIV services and information.²⁹

As a result of a lack of access to HIV and sexual health services, young people from key populations are at high risk of acquiring HIV and other STIs. A study with young female sex workers and young men who have sex with men based in Yangon and Mandalay found 30% had a sexually transmitted infection (STI) and around 40% had accessed treatment. Those that sought treatment did so from NGO-run clinics rather than public health facilities as they were seen as more welcoming. Adolescent men who have sex with men and brothel-based young sex workers were found to be the least likely to access any form of sexual health service. ³⁰

Migrants

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 last census (2014) estimated that over 11 million residents (approximately 20% of the population) have migrated internally or externally.³¹ Some critics are concerned that increasingly open borders make Myanmar more vulnerable to HIV incidence with the increase of migrants coming from bordering high-prevalence countries.³²

As HIV testing is not a condition for entry, work or residence in Myanmar, there is little comprehensive information available on HIV prevalence or risk behaviours associated with the migrant population. Nevertheless, in 2014, the UN's International Organization for Migration's data project found 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 the country.³³ 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 forms of healthcare.³⁴

Since 2014, HIV awareness campaigns that target large migrant populations have been created to address these issues.³⁵ NSP III 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.³⁶

Since August 2017 almost a million Rohingya people have migrated to neighbouring Bangladesh, fleeing from mass atrocities in Myanmar, their homeland. Most are now living in the Cox's Bazar district of Bangladesh where they are particularly vulnerable to HIV and other STIs due to multiple and overlapping forms of discrimination and abuse.³⁷ Sexual violence and exploitation is common and the area is also a drug trafficking route, meaning heroin is widely available, all of which increases people's vulnerability to HIV. As of March 2019, around 320 in the Cox's Bazar refugee camp had been diagnosed with HIV and it is likely more people are living with HIV but are undiagnosed. Of those diagnosed, 277 are on treatment and 19 have died.³⁸

HIV testing and counselling (HTC) in Myanmar

There has been no new behavioural data on HIV testing among the general population in Myanmar since 2007 when it was recorded at 11.3%.³⁹ As such, there is an urgent need to strengthen the

involvement of community networks in the planning and monitoring of testing services.[40](#)

The National Strategic Plan aims to promote early HIV testing and counselling, in line with World Health Organization (WHO) recommendations. It also aims to close the testing gap by prioritising high HIV prevalence areas and decentralising HIV counselling and testing so that it is provided by the local public health sector.[41](#)

Current strategies to increase HIV testing include mobile and community-based testing in places where people from key populations can be found, working with people from key populations to become peer educators, who then link other people from their communities to NGO-run testing and treatment services.[42](#) Provider-initiated HIV testing, whereby medical professionals offer HIV testing to patients who they deem to be at risk, has also been integrated into general practices, antenatal clinics and tuberculosis services.[43](#)

HIV self-testing is not yet widely available but a self-testing policy is being developed, and a handful of self-testing trials focusing on transgender women and men who have sex with men have been conducted.[44](#)

CASE STUDY: Attitudes towards self-testing for out-of-reach key affected populations in Myanmar

A 2017 study by the Johns Hopkins University School of Public Health and the International HIV/AIDS Alliance in Myanmar conducted focus groups and in-depth interviews with transgender women and gay men in Myanmar to examine their attitudes towards HIV self-testing.

The confidentiality and privacy that comes with self-testing for HIV were seen as significant benefits by both groups. People taking part in the study saw self-testing as a way to avoid uncertainty and worry about who will be there when seeking facility-based HIV testing, as it can be done at home. The fact that self-testing is conducted through a saliva-based test and is therefore pain-free was also seen as an advantage.

Although participants were generally optimistic about self-testing some concerns were raised, particularly around the lack of counselling associated with self-testing. They feared this might lead to poor mental health outcomes among those who test positive, which could prevent them from disclosing their status and linking to care.

The fact that self-testing is conducted orally also raised concerns. Participants highlighted how this may lead people to incorrectly believe that saliva can transmit HIV, which could further stigmatise people living with HIV. The use of community education, peer networks, social media and mass media to inform people about self-testing was suggested by participants as a way to combat this.

Concerns around the introduction of compulsory self-testing by employers or others in positions of power, which could result in further stigma, were also raised.[45](#)

HIV prevention programmes in Myanmar

Myanmar's National Strategic Plan sets the target of reaching 90% of sex workers, men who have sex with men, people who inject drugs, prisoners and migrants with combination prevention services by 2020. Unfortunately, current data suggests this target will be missed.⁴⁶

The strategy sets out a number of key focus areas to reduce new infections:

- expanding combination prevention interventions for priority populations
- maximising HIV testing and linkages to treatment for priority populations
- integrating service delivery into maternal and child health and sexual and reproductive health
- providing pre-exposure prophylaxis (PrEP) for at-risk populations
- working towards the elimination of mother-to-child transmission of HIV.⁴⁷ A number of these focus areas are examined in more detail below.

Harm reduction

Research consistently shows that [harm reduction programmes](#), such as [needle and syringe exchange programmes](#) (NSPs) and [opioid substitution therapy](#), are the most effective way of reducing the spread of HIV among people who inject drugs.^{48 49}

Myanmar has one of the best NSPs in the region, and has increased the number of needle and syringe exchanges available in recent years. In 2018, around 270 NSP sites were operating in the country⁵⁰, providing an average of 350 clean needles and syringes for every person who injects drugs. As a result, the use of sterile injecting equipment is high, with around 90% of people who inject drugs reporting that they used clean equipment at last injection.⁵¹

However, because the scale of drug use in Myanmar is particularly extensive, existing harm reduction services are failing to meet the escalating demand by people who inject drugs.⁵² In particular, OST sites need to be scaled up. Currently only around 50 OST sites are in operation, reaching around 17% of people who inject drugs.^{53 54}

The government has recognised the need to scale up its commitment to strengthening harm reduction services, allocating 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 in 2016.⁵⁵ However, critics suggest that this sum will not be enough to curtail the growing dependency on drug use within the country.⁵⁶

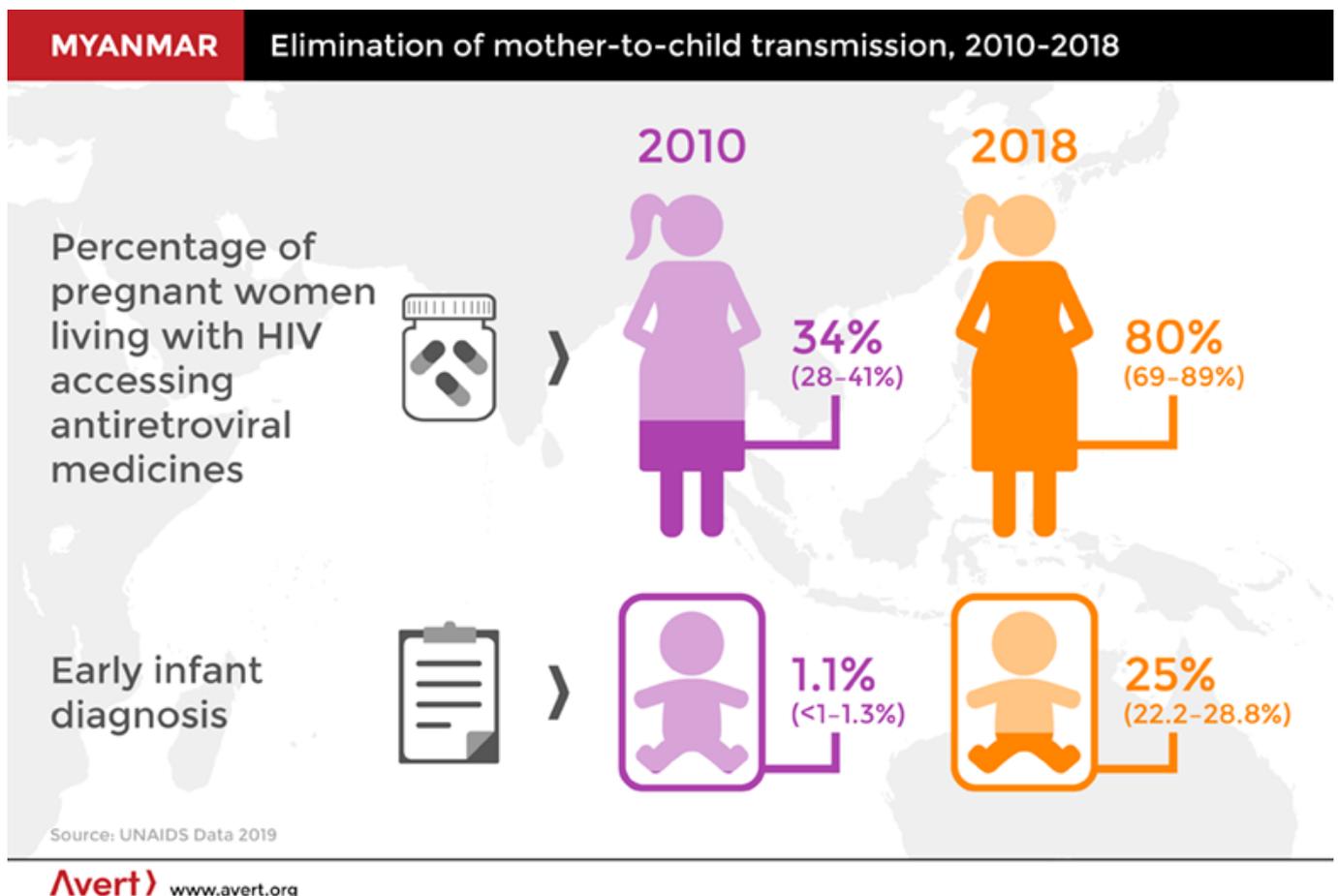
People ask us why we are helping people who use drugs, since they think these people are not good. People who use drugs are also human. If we, the community, do not change how we think and our attitudes towards them, our region and our country will not be able to develop.

- Saw Yu Htwe, AIDS Committee member in Kachin state where two out of five people who inject drugs are estimated to be living with HIV.⁵⁷

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 region.^{58 59} As a result, 95% of pregnant women took an HIV test in 2018, and 80% of those testing HIV positive accessed treatment.⁶⁰

Routine monitoring continues to be an area of weakness – as it is across most testing, prevention and treatment services in Myanmar. Only a quarter of infants who had been exposed to HIV were tested within the first six weeks of life (known as early infant diagnosis).⁶¹ 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.⁶²



Pre-exposure prophylaxis (PrEP)

Although Myanmar has included PrEP in the National Strategic Plan, the country has no PrEP programmes in place.

A 2016 study carried out to test the acceptability of PrEP among men who have sex with men in Myanmar found 39% of participants would be willing to use it, with the cost of PrEP a key barrier to access. The study also suggested that, because sex between men is illegal in Myanmar, it is unlikely that men who have sex with men would access PrEP from government-run clinics.⁶³

Antiretroviral treatment availability (ART) in Myanmar

According to UNAIDS, in 2018 70% of adults and 80% of children living with HIV in Myanmar were on antiretroviral treatment (ART).⁶⁴ It is worth noting that this figure has more than doubled (from 24% in 2012, and has seen the country achieve higher treatment coverage than the regional average (54%). As a result, the country has witnessed the number of AIDS-related deaths fall by 30% since 2010, to 7,800 in 2018 as ART coverage has expanded.⁶⁵

Despite men being more affected by HIV than women in the country, HIV positive women in Myanmar are more likely to be on treatment than their male counterparts. In 2018, 81% of all women living with HIV in the country were on treatment, compared to 63% of men.⁶⁶ This is largely due to Myanmar's successful PMTCT programme.

For those on treatment, HIV treatment services are generally of good quality, with 86% of people starting ART still engaged in care after 12 months (as of 2018).⁶⁷ Overall, 92% of people on treatment were virally suppressed in 2018, meaning they are likely to be in good health and will be unable to transmit HIV to others. High levels of viral load suppression have particularly been achieved among women.⁶⁸ Due to a continued lack of access to testing and treatment for many HIV positive people, this equates to 65% of all people living with HIV in Myanmar being virally suppressed overall.⁶⁹

Nevertheless, despite improvements in treatment access, there is limited availability of viral load testing and HIV drug resistance testing for people on first-line as well as second-line ART.⁷⁰

The testing gap also creates a situation in which many people access treatment at a late stage of infection. For example, a study of around 2,600 people living with HIV in Yangon found 77% began treatment with HIV categorised at WHO stage 3 or 4.⁷¹

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 treatment. As such there have been strong arguments for a transition from private and NGO-run services to public sector delivery, with the hope of making treatment more readily available to vulnerable groups across the country.⁷²

CASE STUDY: Long-term outcomes of second-line ART in Myanmar

Second-line ART has been available in Myanmar since 2008, however until recently there has been no published data about the outcomes of patients on second-line treatment. A 2017 study followed a cohort of 824 adults and adolescents over seven years in which time 11% of patients died and the overall incidence rate of unfavourable outcomes of those who moved onto second-line treatment 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 sites 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 on making viral load monitoring routine and third-line ART drugs available for cases of virological failure.⁷³

Civil society's role and HIV in Myanmar

The legacy of military rule and restrictions on the financing and operations of civil society in Myanmar hinder efforts to provide support to people living with HIV and populations at risk of HIV. In 2018 the government increased its use of the law to arrest and imprison people for peaceful expression deemed critical of the government or military.⁷⁴

Despite this, civil society continues to grow and is playing an increasingly important part in the country's HIV response. The Myanmar Positive Group-MPG, a national network of people living with HIV, promotes networking between individuals and self-help groups, works to reduce stigma and discrimination, and advocates for peoples' rights to access treatment and quality services. In 2015, there were 177 networked self-help groups of people living with HIV; there was no update as of December 2019.

HIV and tuberculosis (TB) coinfection in Myanmar

Myanmar is one of 14 countries that carry a high burden of TB/HIV coinfection (of 30 countries globally) as well as multi-drug resistant TB and TB infection.⁷⁵

In 2018, 3,700 people with HIV died as a result of TB. In the same year, 15,000 people with HIV developed active TB, of whom 10,500 were diagnosed or notified.⁷⁶ In 2017, 12% of people beginning treatment for HIV also had active TB.⁷⁷ TB preventative therapy remains widely unavailable in Myanmar, with only 17% of people on HIV treatment accessing it as of 2017.⁷⁸

In 2016 the WHO and UNAIDS carried out an in-depth review of the status of tuberculosis and HIV coinfection in Myanmar. The key recommendations of the review, which was shared with Myanmar's Ministry of Health, focused on the importance of strengthening collaboration between HIV and TB national programmes, through improved information sharing, joint procurement and adequate deployment of human resources.

Furthermore, increasing and decentralising the number of health facilities which provide joint screenings and treatment of patients for HIV and TB at all levels of the health system (through scaling up of services and employing mobile teams, particularly in high burden areas) are central to ensuring that these diseases and coinfections are detected early, properly treated and further reduced.⁷⁹

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Barriers to the HIV response 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 HIV incidence.⁸⁰ Likewise, an analysis of countries from different regions, and with varying epidemic patterns, found that Myanmar was among the countries where funding of effective and focused primary HIV prevention was insufficient.⁸¹

Structural barriers

There are plans to move HIV treatment services to government-run facilities but as yet critical supply chain and human resource needs that would make such a transition viable have not been addressed. This means that key affected populations, such as people who inject drugs, are being left behind in terms of service reach.

As well as these limitations, service delivery and supply chains are set up to operate separately within the healthcare system. This means human resources such as community health workers and service delivery at health facilities remain distinct from one another.⁸²

Legal barriers for sex workers

Sex work in Myanmar is illegal and fear of prosecution, harassment and blackmail all reduce access to services such as HIV testing. In 2016, only 50% of sex workers in the country accessed testing.⁸³ Until 2011, even carrying a condom could be used as circumstantial evidence if a sex worker was detained by the police.⁸⁴ More recent records from 2017 indicate that around 80% of sex workers use condoms with clients.⁸⁵

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, Myanmar⁸⁶

Legal penalties for commercial sex work are just one of many social and structural barriers – alongside cultural stigma, discrimination and violence – preventing sex workers from accessing necessary HIV prevention and treatment services.⁸⁷

Same-sex sexual activity is also illegal, punishable with up to 14 years in prison.⁸⁸ In addition, a host of other laws are used to persecute people for their sexual orientation, gender identity or expression, helping to create a hostile environment for men who have sex with men and other LGBT people. Many LGBT people are further isolated by physical, verbal and sexual assault they experience at the hands of police, health workers and others in authority, as well as members of the general public, which keeps them away from essential HIV prevention, testing and treatment services.⁸⁹

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 HIV 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.

- *Soe Yadanar, Medecins Sans Frontieres (MSF)*⁹⁰

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, a 2015 report assessing hospital conditions of people living with HIV in Myanmar and Cambodia found some patients were relegated to segregated waiting areas and bed spaces after their status was discovered.⁹¹

The same report also presented more serious allegations, made 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.⁹²

The stigma surrounding HIV in Myanmar causes many HIV positive people to stay away from treatment services until their health declines. This not only increases their risk of serious illness and death, something effective antiretroviral treatment prevents, it also increases the likelihood of onward transmission.⁹³

Funding for HIV in Myanmar

Myanmar remains largely dependent on international sources to fund its HIV response.⁹⁴ Although domestic funding for HIV has increased in recent years, the country's low overall investment in public health remains a major barrier to the success of HIV testing, prevention and treatment programmes.

Historically, the private sector – through international and local NGOs – has played a major role in service delivery. Myanmar’s National Strategic Plan is focused on the development of sustainable partnerships which call for the public and private sector and communities to collaborate to design, deliver, monitor and evaluate services.

The National Strategic Plan estimated that US\$460 million was needed to fund Myanmar’s HIV response between 2016 and 2020.⁹⁵ This is a 16% decrease from the previous plan and has been achieved by reducing the number of organisations and agencies implementing HIV services.^{96 97}

The single largest financing source of the HIV response in Myanmar remains the Global Fund to Fight AIDS, Tuberculosis and Malaria. In 2017, of a total of US\$106.5 million available for the country’s HIV response, the Global Fund provided around US\$51 million. Domestic funds provided around US\$22 million (US\$20 million from public funds, US\$2 million from private sources), other international donors provided a further US\$20.5 million and the US President’s Emergency Plan for AIDS Relief (PEPAR) provided around US\$12 million.⁹⁸

Despite the reliance on external funds, international donor support for Myanmar’s HIV response is decreasing. In 2015 the Government of Australia withdrew support and in 2017 the 3MDG Fund wound up, leaving a large gap in resources for HIV prevention, particularly for people who inject drugs, one of the most key affected populations.

In 2018, the government’s increased financial commitments and management responsibility to a more integrated HIV response and a rapid expansion of services also raised concerns about how to optimise resources and bridge gaps in service quality. Successful implementation requires an increase in national resources that is beyond the capacity of the government and donor commitments.⁹⁹

The future of HIV in Myanmar

Like many other low- and middle-income countries, there is a long way to go if Myanmar is to come close to the 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.¹⁰⁰

To control the epidemic, preventing new infections among people from key populations must be prioritised. To this end, the government of Myanmar is looking to adopt new biomedical solutions, such as introducing PrEP.¹⁰¹ However, some critics suggest that treatment access for those living with HIV should be prioritised first before implementing new methods in prevention:

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

What is clear is that biomedical solutions alone will not end Myanmar's HIV epidemic. While people from key population groups remain criminalised and discriminated against they will continue to avoid publicly-run HIV services. The high proportion of new infections among young people from key population groups is also of grave concern. Unless addressed through the provision of prevention, testing and treatment services designed to meet vulnerable young people's needs, this worrying trend could see some of the gains made in recent years begin to reverse.

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