POLICY BRIEF

Increasing uptake of HIV testing and counselling among men who have sex with men and transgender persons in Myanmar

INTRODUCTION

HIV counselling and testing (HCT) is an important entry point to the HIV cascade (from prevention to treatment and care). For people who test negative, HCT provides an opportunity to put those at risk in contact with primary prevention programmes, and encourages retesting at a later stage.[1] For people who test positive, HCT services provide an essential link with treatment and care services. Early treatment of HIV with appropriate combination of antiretroviral drugs leads to a reduction in a person's HIV viral load. This improves the individual's health and ultimately their quality of life. Furthermore, evidence now shows that reducing a person's viral load to undetectable levels dramatically reduces the risk of onward transmission. As such, emerging strategies that use antiretroviral drugs, including "treatment as prevention", pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP)[i], are being globally recognised as important strategies to prevent HIV[2]. However, to ultimately benefit from antiretroviral treatment, both at an individual level and more broadly at the population level, HIV testing is of paramount importance.

KEY MESSAGES

- The criminalisation of male-to-male sex heightens HIV and other sexually transmissible infection (STI) risks and vulnerabilities, and hinders access to HIV and STI services including HCT.
- Men who have sex with men (MSM) and transgender persons (TG) are not a homogeneous group. As such, a variety of HCT service models are needed to reach the various segments of these populations.
- Stigma and discrimination remain ongoing issues at a number of service points. Targeted training of service providers is therefore needed so that MSM and TG are not discouraged from seeking HCT and high-quality prevention, treatment and care services.
- Specific guidelines on HIV prevention, treatment and care services for MSM or TG help improve the delivery of services.
- Online outreach activities can support referral to appropriate MSM or TG-friendly services, and mobile applications can provide the locations of HCT services via smartphone Global Positioning System (GPS) technologies.

[i] The National Strategic Plan (NSP III) on HIV and AIDS (2016-2020) recommends developing a model PrEP programme for populations at substantial risk of HIV infection as part of combination prevention. NSP III recommends providing PEP to all eligible people from key populations after possible exposure to HIV and following possible occupational exposure to HIV.

CHALLENGES

In Myanmar, HIV prevalence is highest among extremely stigmatised key populations, including men who have sex with men (MSM) and transgender persons (TG).

Myanmar is one of the countries in Asia hardest hit by the HIV epidemic. With an estimated 220,000[3] people aged 15 and above living with HIV (PLHIV) in 2016, Myanmar has the 6th largest number of PLHIV in the Asia and Pacific Region after India, China, Thailand, Indonesia and Viet Nam[4]. Although HIV prevalence among people aged 15 and above is 0.6%, it remains considerably high among key populations such as people who inject drugs, MSM, TG and female sex workers[5].

The proportion of new HIV infections attributed to MSM and TG went up from 7% in 2000 to 13% in 2015[6]. In 2015, the the Integrated Biological and Behavioral Surveillance (IBBS) conducted in a representative sample of the population showed a particularly high prevalence in specific areas. Over one fourth (27%) of MSM and TG who participated in the survey in Yangon, and over one fifth (22%) in Mandalay tested HIV positive, which is among the highest prevalence in specific geographical sites in the Asia region[7].

The national HIV prevalence among MSM, based on HSS and IBBS data in AEM is estimated at 11.6%.

As in other countries in Southeast Asia, many MSM and TG in Myanmar do not identify as gay or bisexual and are not accessing HIV services due to high levels of stigma and discrimination directed toward these individuals. It is estimated that 48% of MSM have been reached by HIV prevention programmes in Myanmar in 2015. Only 27% received an HIV test and post-test counselling based on the programme reported data[8].

Legal barriers negatively impact on access to HIV services and escalate HIV transmission.

Myanmar still retains the colonial legacy of its Penal Code, which is based on the Indian Penal Code of 1860. Section 377 of the Penal Code criminalises "carnal intercourse against the order of nature" and stipulates a penalty of imprisonment for up to ten years and a fine[9]. In addition to Section 377, police have used public order laws against MSM and TG in Myanmar. MSM and TG are usually detained under Sections 30(d) of the Rangoon Police Act of 1899 and 35(d) of the Police Act of 1945, for loitering or suspicious activity, or under Section 54 of the Code of Criminal Procedure, which gives police the power to make arrest without a warrant.[10, 11]

This contributes to an environment of limited social acceptance for MSM and TG. Although the Section 377 is rarely enforced, the existence of the offence complicates the delivery of effective HIV prevention services because it discourages programme beneficiaries from accessing basic HIV services.

MSM and TG are not a homogeneous group, yet service models are not adequately meeting the needs of these key populations, especially individuals who are not willing to disclose same-sex behaviour.

It is estimated that there are approximately 252,000[12] MSM and TG in Myanmar. There are currently a number of MSM and TG-focused service delivery models operating in the country. The longest serving model has involved mainstream international non-governmental organisations (INGOs) setting up MSM/TG clinics that provide clinical services and safe spaces for these populations to gather and support one another. The second model, which has emerged in recent years, has seen a number of INGOs and local NGOs integrating MSM and TG-friendly HCT services into their HIV prevention, treatment and care programmes. Both models require a significant population of MSM and TG who are willing to gather relatively openly. However, in Myanmar, most MSM are not willing to disclose same-sex behaviour and will not risk being exposed by attending HIV services that specifically target MSM[13].

Existing public STI and HIV services are another model. However, MSM and TG may be reluctant to use public clinics for fear of stigma and discrimination from staff. Discomfort with existing service models may lead MSM and TG to pursue self-treatment for STIs and/or seek out private providers for HIV testing and treatment, if and when they can afford it. Same-sex behaviours need not be disclosed to private providers, but at the

same time, clients may not receive appropriate HIV prevention counselling or thorough STI investigation from these providers. Opportunities for public-private partnerships can be explored to provide MSM and TG-friendly services that subscribe to quality assurance standards in service provision and are linked to treatment and care services as well as national reporting frameworks.

Guidelines for HIV testing and counselling services are yet to be released

National guidelines for HIV testing and counselling will be released in accordance with updated World Health Organisation (WHO) HCT guidelines. Such guidelines will identify ethical practice and set other standards in service provision, and may be a useful tool in reducing stigma and discrimination, especially when linked to quality assurance and quality improvement programmes for validation of clinical services.

Many health services are unprepared to address the needs of either MSM or TG.

Many service providers are unprepared to address the health needs of either MSM or TG, either because they harbour negative attitudes towards these populations or because they are unfamiliar with their unique health needs[14]. Discomfort in discussing the risk behaviours of MSM and TG may lead to non-disclosure of same-sex behaviours or risk behaviour by clients and, as a result, important sexual risk reduction information may not be provided. In Myanmar, HIV counsellors are required to receive certification following attendance at national AIDS programme (NAP) training workshops, but the availability of NAP trainers and the number of days for training are limited. Modules related to the provision of services to key populations have not yet been used[ii] as well. A number of INGOs provide supplemental training and supervision to the health workers in their service networks to fill this gap. However, most public and private sector counsellors have not yet received these supplemental training workshops. Focused trainings and continued supervision are needed to ensure that health workers provide high-quality, appropriate and culturally-sensitive services to MSM and TG.

HCT service promotion requires strengthening and diversifying.

The promotion of HCT services is largely done through peer outreach condom programmes linked to specific services but these condom programmes should not be the only gateway through which clients are referred to HCT services, treatment or other interventions[15]. In addition, some NGOs and CBOs have started to provide HIV prevention information through social media and mobile applications while encouraging MSM and TG to access HIV testing. Still, opportunities to provide anonymous links to HIV prevention and/or service websites through banners on mobile applications that facilitate encounters between MSM, TG and their partners have not been fully explored. Mobile applications that provide MSM and TG-friendly, HCT location services via smartphone GPS technology, are not yet available in Myanmar[16].

ACTIONS

Pilot projects for the establishment of men's health clinics to attract MSM to HIV and STI services. Marketing of HCT services should not convey the message that services are targeting the MSM community. These clinics could offer HIV prevention, testing, treatment and care services within a broader package of men’s health services, including body mass index, blood pressure, blood sugar, cholesterol, and kidney function testing. The clinics could also pilot the PrEP initiative among MSM.

Advocate for the amendment of Section 377 of the Myanmar Penal Code and of sections 30(d) the Rangoon Police Act of 1899 and 35(d) of the Police Act of 1945 as they violate human rights, fuel stigma and discrimination, and represent an obstacle to health care, including HCT and HIV care and treatment services.

Support the development of national guidelines on HCT services [expected to be available in 2015], and the review of existing counsellor training curriculum relating to key populations, based on the latest WHO HCT guidelines.

Link national guidelines on HCT services, when available, to standard operating procedures (SOPs) for HCT services and to programmes for quality assurance and quality improvement of HCT services for MSM, TG and other key populations. SOPs should take into account the specific needs of both MSM and TG.

[ii] The current training curriculum is being revised based on the upcoming national HCT guidelines.

Support quality assurance assessments of HCT services. Periodic monitoring should include activity or process/ output indicators, linked to SOPs, for counselling, laboratory, infection control, and service management and operations.

Support operations research with a view to developing and strengthening alternative HCT service models and determining what model of service is appropriate in each setting. The identification of alternative services commonly used by MSM or TG, as well as the reach and costing of services, will be important parts of this investigation.

Provide training and supervision to counsellors and clinical staff. Counsellors should be trained using curricula based on the finalised national HCT guidelines. Curricula should include sections adapted to address MSM and TG issues and concerns. Supportive supervision of all counselling and clinical staff is essential to address stigma and discrimination directed toward MSM and TG clients, and to make sure that all clients are assured of the five Cs: consent, confidentiality, counselling, correct test results, and connection and linkage to prevention, care, and treatment. NGOs and CBOs should be called upon to provide trainings on sexual orientation and gender identity to all service-related staff and volunteers, public and private.

Organize mapping exercises on a regular basis at several levels (national, district or township and at local implementation levels) to reach "hard to reach" populations and better target interventions for MSM and TG.

Enhance HIV prevention outreach to fast track the HIV response through increasing the number of MSM and TG tested and reached with services; effectively linking prevention to care and treatment and reducing 'leakage' along the HIV continuum. The referral/cross referral system between NGO, CBO outreach networks, public and private health and social services should be strengthened. Existing NGO and CBO outreach networks should continue to play an important role in informing communities about HCT services. In addition, they can provide information on the different models of services and how to access each one.

Develop online and offline outreach activities to promote access to HCT services for MSM and TG. Online service promotion of HCT for MSM and/or men's health services should be done through organisational websites and social media. Mobile applications may also be used for location-based searches of services, or for service-linked banners on popular applications for location-based searches of partners. SOPs for the development of these activities are needed. Existing NGO and CBO outreach networks can provide information on the different models of services and how to access them.

References

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[2] Ibid
[3] Myanmar HIV estimates and projection, Spectrum Version 5.4, 2016
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[5] Myanmar HIV estimates and projection, Spectrum Version 5.4, 2016
[6] Asian Epidemic Model (AEM) 2016.
[7] AIDS Data Hub for Asia/Pacific MSM. December 2015.
[8] National AIDS Programme. Progress report (draft version), Myanmar, 2015. The size of the adult MSM population was estimated at 252,000 in Myanmar in 2015, based on the IBBS /PSE; half of them were regarded as unreachable MSM. The percentage of MSM reached by prevention programmes was calculated based on reachable MSM size estimate. The percentage of MSM who received an HIV test and post-test counselling in 2015 was calculated by using programme data of 34,528 MSM receiving HCT service with new PSE.
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