Country Case Study, Literature Reviews, and Discussions with CBOs:

MYANMAR

The ongoing government transitions from military-led to democratic form of governance is a key factor that affects the overall health systems in Myanmar.
The decentralization in the implementation of health programs is stil at its early stage and adoption to these transition may take time. The Asia-Pacific Observatory on Health Systems Review (2014) described Myanmar's health system as a "pluralistic mix of public and private systems both in financing and provision". There is still much to improve in terms of the improvement in adequate managerial capacity and proactive mind-setting among health workers at the local settings as the decentralization progresses. The national insurance framework in Myanmar also needs more improvement pre-pandemic. No comprehensive health insurance was documented as of 2014 health systems report. Employee-employer insurance scheme is being followed while the government covers for the health programs management. The insurance schemes only covers less than 1% of the population. In the same health systems review, very few households across the country have heard about voluntary health insurance contributions. Despite expression of support in the health insurance contribution schemes, citizens and health workers/ community members verbalized their concerns that majority of the people in Myanmar are poor and may not afford the health insurance contributions.

HIV is among the top 5 causes of disability adjusted life years (DALY), along with lower respiratory tract infections, tuberculosis, and diarrheal diseases in 2010. Awareness campaigns and implementation programs for the aforementioned DALY are under the Department of Health (DOH), which also the lead government agency that manages all other public health activities through different national programs and implementations in partnership with development partners, civil service organizations, and community-based organizations. Due to lack of employment opportunities within the country, migration becomes common among the citizens and this exposes the citizens to risks of acquiring malaria, drug use, and sexually-transmitted infections such as HIV. In 2019, there are about 240,000 people living with HIV in Myanmar, with 10,000 new infections. Among the key populations affected, people who inject drugs (PWID) are most vulnerable, and studies suggested that they contracted HIV at an early age as shown by 17% among them were diagnosed at 25 years or younger. Aside from PWID, men who have sex with men (MSM) are also greatly affected. Stigma and discrimination among gay men and MSM contributes to the low intake of HIV testing as shown by only 52.4% among them knew their HIV-positive status in 2017. Same-sex behaviors are still criminalized by existing laws in Myanmar despite the relatively visible LGBT community. Documented violence and persecution against LGBT people in Myanmar prompted the recommendation to repeal punitive Section 377 of the Penal Code.

The initial discussion with CBOs revealed several impacts of COVID-19 on HIV care and services. Travel restrictions in different provinces and townships of Myanmar, as well as the closure of national borders, pose a threat to ARV procurement and accessibility of HIV services, resulting to disruptions in ARV distributions and/or delays in ART initiation among newly-diagnosed PLHIV. This increases their risk for acquiring opportunistic infections or rate in treatment cascade fallouts.

Among the key populations, people who inject drugs (PWID) are the most affected. Because of community and health center lockdowns in several townships, access to methadone therapy and sexual health services for PWID are deranged. Aside from PWID, sex workers also face layers of economic struggles due to closures of several entertainment industries and tourist areas. Because of these underlying challenges, the CBOs in Myanmar are currently collaborating with the Local Resource Centre (LRC) in providing emergency assistance for the aforementioned population.

Even before the pandemic, young key populations were already at higher risk of acquiring HIV and other STIs due to poor access to HIV and sexual health services. The inaccessibility of HIV/STI prevention and treatment among the young MSM may be attributed to the stigma and discrimination against this group. The existing laws that criminalizes same-sex behavior could be one of the underlying factors for this external and internal stigma among the young key population. As claimed by one of the CBOs, self-stigma and internalized homophobia prevents PLHIV from getting their ARV supply from the nearest treatment facilities. Strategies to increase HIV testing which include mobile and community based screening are currently in place yet web-based and online support are not yet well-established.