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Female sex work in Yangon, Myanmar

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Abstract. ***Background:*** Myanmar (Burma), with an upper estimate of 400 000 people living with HIV/AIDS, faces a dangerous and potentially devastating epidemic. Female sex workers in the country are one of the most affected populations, with high prevalence rates of both HIV and sexually transmitted infections (STIs). ***Methods:*** A qualitative study was undertaken in Yangon at the end of 2002 to investigate the social and demographic features contributing to the transmission of HIV among female sex workers in urban Myanmar. Twenty-seven key informants from the government, non-government organisations (NGOs), international non-government organisations (INGOs), private sector and the United Nations system agencies and 25 women currently working in the sex trade were interviewed. ***Results:*** The sex trade in Yangon is rapidly growing and is characterised by a high degree of complexity. The number of female sex workers is estimated to be between 5000 and 10 000 and there are ∼100 brothels operating in various townships around the city. Nearly one-third of the women in the study reported previous imprisonment for offences related to sex work as well as fear of harassment, sexual exploitation, violence and gang rape. Almost half reported using condoms with clients at all times. Contradicting views exist as to the level of awareness about STIs and HIV among Yangon sex workers, with the majority never having been tested for HIV. Only one-quarter of women were regular patients of the limited number of STI clinics operated by INGOs. ***Conclusions:*** Female sex workers in Myanmar remain a highly marginalised group almost inaccessible due to a variety of legal, political, cultural and social factors and are particularly vulnerable to HIV and STIs. It is important to encourage partnerships between INGOs by promoting service coordination and information sharing to increase the availability of services for sex workers and to build political support for an unpopular cause.

Additional keywords: Burma, HIV, Myanmar, sex work.

Introduction

Decades of a military-dominated regime, economic decline and political instability in Myanmar have transformed a vibrant country into one of the most underdeveloped in the world.[1] In its 'World Health Report 2000', the World Health Organization[2] ranked Burma second last of 191 countries in terms of overall health system performance. There are high rates of maternal and child mortality and morbidity and infectious diseases such as tuberculosis and malaria are widespread.

By far, one of the most serious health problems in Myanmar is the rapid spread of HIV/AIDS. Myanmar has one of Asia's most severe generalised epidemics. There are very high prevalence and incidence rates, which continue to rise.[3,4] The United Nations Programme on HIV and AIDS (UNAIDS)[5] reported the following HIV rates for 2001: sexually transmitted infection (STI) patients (20.5%), commercial sex workers (33.5%), blood donors (1.1%), new military recruits (2.2%) and pregnant women (2.2%). UNAIDS[6] estimated that, by the end of 2001, between 180 000 and 400 000 people were living with HIV infection in Myanmar.

Information about the dynamic sex trade in Myanmar is limited but growing, with at least one typology of sex workers having been developed.[7] A 100% condom use programme developed with the National AIDS Programme, UNAIDS Southeast Asia Pacific Intercountry group, UNAIDS Myanmar and the World Health Organization Myanmar office was implemented in late 2000. This programme's implementation demonstrated that it was essential to understand the contexts of sex work and condom use at the programme sites. As has been demonstrated throughout the global HIV experience, mapping sex work behaviour, including risk venues, is crucial to the development of meaningful or effective programmes to reduce STI and HIV prevalence in sex workers.[8,9]

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This study investigated the social and demographic features contributing to the transmission of HIV among female sex workers in urban Myanmar and sought to:

- Describe the sex trade in Yangon
- Describe the sex workers' commercial sexual behaviour and their working environment
- Describe women's perceptions about HIV/STIs and access to health services

Although the small sample size limits the generality of the findings, the study highlights some critical issues conducive to the spread of HIV/STIs among female sex workers in urban Myanmar. This study has attempted to raise international awareness about the desperate plight of women in the sex trade who are particularly susceptible to HIV infection because of persecution and their inequitable and unjust social position.

Methods

Myanmar is inhabited by an estimated 48 million people representing 135 ethnic groups, the largest being Bamar, Chin, Kachin, Kayah, Kayin, Mon, Rakhine and Shan. The dominant religion of the country is Theravada Buddhism (89.2%). Since 1988, the country has been ruled by a military government. Yangon, formerly Rangoon (population ~4.3 million), is the transportation hub of the country and its commercial and industrial centre.

The research design was exploratory and cross-sectional and involved the collection of predominantly qualitative data from 27 key informants and 25 female sex workers.

Twenty-seven key informants with knowledge of the sex industry in Myanmar and Yangon were identified and interviewed. Key informants included staff of international non-government organisations (INGOs) and the UN system agencies as well as clients of sex workers, a broker and ex-pimps. These key informants were located utilising a snowball sampling technique. Information obtained in these interviews proved to be invaluable in terms of expanding the researcher's knowledge about the nature of the sex industry in Myanmar, its political, economic and legal environment as well as the country's health system and the operation of INGOs and UN agencies.

These key informants also facilitated contact with 25 female sex workers who were willing to participate in the study. Approximately half of the sample of female sex workers was recruited with the assistance of three INGOs working with women living in one of the impoverished townships on the outskirts of Yangon. Since half the volunteering sex workers had already had contact with these agencies and had some HIV education, this introduced some bias to the sample of sex workers. A short questionnaire to elicit demographic information was utilised followed by semi-structured interviews using a combination of open- and closed-ended questions. In addition, one focus group with six of the female sex workers was conducted.

The field research was completed for a research project for the Master of International Health programme at Curtin University. It was conducted by the first author and took place over two months (October and December 2002) with a follow-up visit in December 2003. For over 12 years, the first author has been involved in planning, developing, implementing, monitoring and evaluating HIV/STI prevention and education strategies for high-risk, vulnerable populations, such as sex workers, injecting drug users and indigenous people.

Consent was obtained from all participants. Verbal permission was also requested for audio taping of interviews. Informal approval for the research was provided by the INGO that supported the researcher, with formal approval provided by the Human Research and Ethics Committee of Curtin University, Western Australia.

In view of the clandestine and illegal nature of the sex industry in Myanmar, a flexible approach was adopted at all times to ensure the safety and wellbeing of participants. This included the participants' preferences for venues and suitable timing of interviews. Most interviews and the focus group were conducted in karaoke bars. Other interviews took place in motels, teashops and in offices of INGOs. Participants were requested to use pseudonyms so that they could not be identified. All interviews and the focus group were conducted with the assistance of three qualified bilingual research assistants/interpreters. All were Myanmar nationals and fluent in English.

Available data were also gathered through records and documentation of the Myanmar Governments' departments and some selected INGOs operating in Yangon. The researcher was also invited to the sex workers' workshop organised by an INGO, which provided him with further information on women's experiences and their plans and hopes for the future.

The analysis of the demographic data was performed using simple descriptive statistics. The qualitative data obtained via semi-structured interviews and the focus group were rigorously analysed in accordance with the constant comparative method.[10]

Results

Essentially, sources of data fell into three areas: the profiles of the informants and interviewed sex workers, a description of Yangon's sex industry and analysis of the HIV/AIDS and STIs situation in the sex trade.

Profiles of key informants and the sex workers in the study

Key informants

In Myanmar, several key stakeholder groups are actively involved in HIV/AIDS prevention and control. These agencies represent the government, the local and religious NGOs, INGOs, the private sector and the United Nations system. INGOs include agencies such as CARE, World Vision, Population Services International, Association Francois Xavier Bagnoud Foundation, Médecins Sans Frontieres (Holland), Médecins du Monde, World Concern, Marie Stopes International and Save the Children Fund (UK).

Of the 27 key informants in the study, 19 were involved in several of the above agencies and two were connected to the private sector. Key informants also included three local clients of sex workers, one broker and two ex-pimps. The broker was a Myanmar male involved in supplying sex workers to predominantly local guests of Yangon's downtown inexpensive hotels and motels. The two ex-pimps were middle-aged Myanmar women who had worked as sex workers in the past. Both women were employed by two distinct INGOs, the first as a female sex worker peer educator and the second in a welfare support capacity.

Sex workers

With the exception of one, all women in the study were sex workers currently working in the sex trade. Seventeen women worked as freelance sex workers with a broker, four worked independently on the streets and three were brothel-based.

The mean age of this study population was 24 years and all women were above the legal age of consent for sex (16 years for females in Myanmar). Their socio-demographic characteristics are presented in Table 1. The majority of women were of Bamar ethnic background.

The attained levels of education were low, with over a half of the sample having no education or an incomplete primary education. Only one woman had completed a year of study at university. Of the women in the study, most were single (never married, divorced or widowed).

Eighteen women had no children, one had one child, two had two children and one had four children. Most of the women derived their income exclusively from the sex trade. Others complemented their daytime jobs with sex work.

Table 1. Socio-demographic characteristics of female sex workers in the study

Characteristic	Number
Total	25
Age (years)	
17–20	10
21–25	8
26+	7
Ethnicity	
Bamar	22
Bamar-Karenni	2
Shan	1
Place of birth	
Yangon	6
Rest of Myanmar	19
Religion	
Buddhist	22
Muslim	3
Education (years)	
No education	4
1–4	10
5–8	9
9+	2
Marital status	
Never married	9
Married	6
Divorced/separated	8
Widowed	2
Monthly income (in US$[A])	
No regular income	4
<10	6
11–30	7
31–60	5
100–150	3

[A] In November 2002, the black market value of US$1.00 was ~1000 kyat.

The sex trade in Yangon

There was a strong consensus among key INGO and UN informants that the sex trade is rapidly growing in Yangon. Informants were of the view that it is also characterised by mobility and a high degree of complexity. Due to its criminal nature, the industry is constantly evolving, with the operators often resorting to somewhat ingenious methods of concealing their activities. Some sex establishments, for example, are disguised as tailoring or beautician training schools. Sex workers can sometimes be found in both Buddhist pagodas and Hindu temples, seeking both rest and refuge.

Enumeration of sex-service establishments is problematic. Brothels, nightclubs and karaoke places are mushrooming around the city, only to be closed soon after opening or moved to other townships by the law enforcement officers. Given the limited tourism industry, there are a surprisingly large number of recently established motels, guesthouses and inexpensive hotels in Yangon. Their real business purpose is deemed to be suspicious by many and unlikely to be for the flagging tourism industry. A broker, for example, commented 'nowadays, if someone opens a new guesthouse it is perceived by people as opening a brothel'.

One of the agencies approached in the study estimated that there are around 100 brothels spread around the city in various townships. There are ~20 brothels in Hlaingthaya, 17 in South and North Dagon, eight in Thingangyun, 27 in Okkalapa and several in Thuwana. The researcher's observations confirm the views of sex workers that Yangon's brothels are often not more than dilapidated shacks with limited or no privacy. Some have partitions separating rooms and there are often large gaps between partitions and the floor area.

Accurately estimating the number of sex workers currently operating in Yangon is impossible, with key informants from INGOs reporting the total number of female sex workers to be between 5000 and 10 000. An informant, with access to government records, indicated that the government estimates 20 000 female sex workers for the whole of Myanmar. Various INGOs argue that the numbers could be much higher.

Nearly one-third of the women in the study reported being previously imprisoned for offences related to sex work. Duration of imprisonment ranged from 15 days to three years. The women reported that, if arrested, they may be released for a bribe or if they exchange sex. Bribes for release range from 50 000 to 100 000 kyat (US$50.00–US$100.00). Most women need to get a loan to repay this amount, forcing them to return to selling sex. Many of them are re-arrested soon after their release.

Life on the outside is equally harsh. Most sex workers must pay protection money to some corrupted elements in the police force. This widespread acceptance of bribes comes as no surprise given the minimal wages of public servants. Bribes are paid in cash or goods, such as bags of rice. Interviewed women stated that they live in fear of being arrested and experience various forms of harassment from law enforcement officers. Sexual exploitation and violence perpetrated by police, often off duty, was also described by several of the women.

Towards a more detailed typology

This study allowed for the expansion of Uhrig's[7] classification of sex workers in Myanmar. A 'new' typology of sex workers is presented in Table 2 and contains nine groups or categories of female sex workers. These categories were identified by the key informants and confirmed by the researcher's observations. The process of identifying them was difficult owing to the complexity of the trade, obscure management boundaries and the women's fluctuating association with different control systems.

As can be seen from Table 2, the women's place of employment can be misleading. Generalisations about certain groups of women involved in the sex trade solely based on their occupation (e.g. masseuses and karaoke workers) are stigmatising and likely to be a superficial analysis of the situation.

The numbers of clients seen by female sex workers per night differ in various categories within the trade. Generally, women from lower socio-economic groups involved in freelance and brothel work have more clients. Some agencies suggest that street workers and brothel-based female sex workers may provide services to up to 15 clients a day and, in some extreme cases, as many as 30 clients a day. However, various INGOs in Myanmar argue that, on average, women provide services to three to five clients per night.

Clients can be as young as 12 years old. These boys are often introduced to the sex trade by older brothers, uncles or fathers as part of their sexual initiation. According to one agency, there are a growing number of anecdotal reports of young schoolgirls selling sex to their peers.

Cases of female sex workers being gang raped were also described. In these instances, women were visiting a single client and were confronted by a group of men. If they refused to have sex with the men they were also beaten. A young woman described her ordeal: 'I was forced to have sex with 12 men in an empty bus. This went on for the whole night. There were policemen around but if I cried for help I would be the only one arrested. Only half of the men used condoms. In the morning I got 1000 kyat (US$1.00)'.

Only four of the 25 women in the study worked independently, without the involvement of pimps or brokers. The majority of freelance sex workers in the study were pimp-controlled and even if pimps were not directly involved, there were other intermediaries such as rickshaw/taxi drivers, waiters or hotel staff.

There were contradicting views as to whether the trade is operated by males or females. Some informants claimed that the sex trade is controlled by men with only some pockets of the industry, such as brothels, managed by females. Others noted that there are large numbers of older females, mostly ex-sex workers, who dominate the industry.

Some pimps are reported to be ruthless and brutal, with women providing vivid descriptions of the harsh initiation process into the sex industry. Sex workers described the cruel induction rite: 'The pimp who is controlling the area will take you to a place where you will be forced to strip and dance naked before the pimp and his friends. Then you will be raped by many of them'. Pimps are territorial and any competition is swiftly dealt with. 'I worked for a couple of people', a sex worker told the researcher, 'but a rival gang drove them out of the area. I continued to work there without the gang's permission. One day they captured me and took me to the cemetery. They forced me to strip and told me to go home naked. I apologized to the men and they let me work for them.'

Sexual behaviour and condom use

All interviewed sex workers reported that they practised vaginal sexual intercourse with their customers. Most women refused oral sex and the most common reasons for refusal were: 'it is dirty, a mouth is for eating', or we pray to Buddha with our mouths'. Women sometimes gave oral sex when coerced by clients or if induced by an additional payment. Anal sex was reported to be very rare, with the anal passage considered by many women in the study as the 'unclean area'.

Several informants from INGOs and the UN agencies noted that condom use had been low 3–4 years ago, with only ~30% of sex workers using condoms consistently. However, in 2002, between 40–50% of sex workers were believed to be using condoms at all times. This proposition is consistent with data provided by the women in the study. Almost half of the sample reported using condoms with clients all the time, with the remaining of women never using condoms or using them irregularly. The women reported that they rarely purchased condoms due to the stigma associated with them and their relatively high price. Women reported asking young boys to purchase condoms for them. Some women noted that condoms were readily available at a few guesthouses, which increased their chances of negotiating condom use.

Economic need is a compelling reason to accept a client who refuses to use a condom. 'Even if a man does not want to use condoms, most women want the business', said one INGO informant. Limited negotiation skills and gender

Table 2. 'New' typology of female sex workers in Yangon, Myanmar

Proposed name	Description	Places where clients are met	Places where sex occurs	Fee (in US$)	No. of clients	Type of Clients
Brothel-based	Pimp controlled, 2–20 sex workers on premises, some women kept off site	In a brothel	In a brothel, occasionally other locations	0.50–5.00	Up to 15	Local men
Freelance	Women from low socio-economic groups, the majority operate with a pimp or a broker such as a trishaw/taxi driver	On the streets, at bus stations, jetties and market places like Kanna-zay Thirimingalar or Bayin Naung market, the Sinmalite highway station	Low-priced guesthouses, isolated areas such as bushes, long grass, parks or vehicles (train carriages)	1.50–2.50	3–5	Local men
Nightclub-based	Some sex workers are freelance, others are pimp-controlled, may only work 2–3 nights/week	Local nightclubs (Emperor, BME, JJ's) and large international hotels (Sedona, Sofitel, Asia Plaza, the Kandawgyi Palace)	Hotels, guesthouses or client's residence	10.00–30.00 (local clubs) 40.00–100.00 (international hotels)	1	Local men, foreigners, including expatriates
Call girls	Contactable through mobile phones, bookings made directly or via a pimp	Upmarket hotels or private/service apartments	Hotels or private/service apartments	50.00–100.00	1	Wealthy local businessmen
Fashion models/singers	Women's consent to sex with clients depends on the amount of gifts and their own preferences	Restaurants/ nightclubs	Off the premises, most commonly in guesthouses, hotels or private apartments	50.00–100.00, in addition to gifts	1	Predominantly local, affluent men, some Asian businessmen
Massage-parlour-based	Women at massage parlours almost exclusively provide non-sexual services	At the massage/beauty parlour	Guesthouses, uncommonly sex on premises	>10.00	1–2	Local men
Karaoke-based	Singers/waitresses are forced to sell sex due to the very low pay	At the karaoke	Guesthouses, some establishments rent rooms	5.00–20.00	2–3	Local men
'Kyaik-kone' (if I like I'll bend)	Opportunistic sex workers with generally more power and control over who or if they go with someone	Via intermediary	Hotels, guesthouses or clients' houses	70.00–100.00 and above, in addition to gifts	Unknown	Typically a wealthy local businessman
Service-industry-based	Domestic servants, women employed in hotels, bars and golf courses	Private houses, hotels, restaurants, golf courses	Hotels, guesthouses or clients' houses	Wide-ranging	Unknown	Local men

inequalities are, of course, contributing factors. Many sex workers refuse to carry condoms because they may be used as evidence for prosecution. Interestingly, since 2001, it is no longer permissible for the possession of condoms to be used as evidence if legal action is taken against sex workers under the *Prostitution Act*. Several informants noted that despite this, there are confirmed reports that women continue to be arrested based on condom evidence. When asked, none of the women in the study were aware of the new ruling and all were convinced that the possession of condoms would lead to prosecution and imprisonment.

The broker and both ex-pimps noted that condoms are rarely used by new entrants to the industry, such as teenage girls who also tend to have less knowledge about HIV/STIs. Several informants suggested that some women refuse to use condoms, as they do not want to be perceived and treated as sex workers. All the women in the study had either never heard of or never used water-based lubricants. These women also admitted that condoms are generally not used with non-paying partners, or are used inconsistently.

Perceptions about HIV/AIDS and STIs in the sex trade

Awareness about HIV/AIDS and STIs

Contradicting views exist among key informants as to levels of awareness about HIV/AIDS and STIs among sex workers. Some informants suggested that awareness is high in Yangon with 70–80% of sex workers believed to possess a relatively adequate knowledge of HIV/AIDS. Others argued that these figures were inflated and reflect a bias in estimations derived from samples of female sex workers who have already been in contact with INGOs and were therefore better health educated.

Several INGO informants were of the view that awareness among sex workers was very low, which was evident in prevailing misconceptions held by workers, such as ‘healthy men do not carry the virus’ or ‘men with cool skin are not infected’. Some sex workers stated with conviction that HIV was transmitted through social contact such as ‘living and eating together’ as well as through sharing underwear or a ‘longyi’ (Myanmar’s traditional skirt-like garment). Half of women in the study appeared to have no knowledge of HIV/STIs.

Informants supporting the existence of high awareness conceded that, although most female sex workers have heard about HIV, there is a high degree of complacency about condom use. As one INGO informant said: ‘50% of women make their decision about condom use on the basis of a clients’ appearance and the way they speak’.

Many women in the study reported being petrified of AIDS, although the disease is still not visible in Yangon. Some of them commented that they had never seen anyone with AIDS. However, they observed that there are increasing numbers of death notices of young people who ‘must have died of AIDS because they were buried the same day’.

Prevalence of HIV and STIs

All INGO and the UN-based informants agreed that HIV prevalence in the sex industry was unacceptably high. For example, one INGO estimated that among 700–1000 female sex workers operating in a township near Yangon, 350 were known to be HIV positive.

The real extent of the problem is not known because the vast majority of sex workers have never been tested for HIV. Only five women interviewed in the study reported having been tested for HIV. All claimed that their results were negative. Free HIV testing is available in some selected hospitals and usually only when active disease is suspected. Sex workers can also be tested in private clinics, but the cost usually exceeds the ability to pay.

There are limited data on the extent of STIs in Myanmar. INGOs and the UN informants reported various STI prevalence rates among female sex workers ranging, in the case of syphilis, from 40% to 50%. One INGO noted that almost 70% of sex workers had been infected with an STI (most commonly gonorrhoea, syphilis and pelvic inflammatory disease) since they commenced sex work. In one township, estimated rates were even higher, with several interviewed medical professionals indicating that close to 90% of sex workers had a history of STI infection, predominantly syphilis, gonorrhoea and trichomoniasis.

Over three-quarters of the study sample of women had either never been tested or tested infrequently for STIs. Generally, women who reported infrequent STI checkups were unable to specify their number of tests in the previous year. When asked about sexual health, sex workers reported various STI symptoms (e.g. vaginal discharge, lower abdominal pain etc.) experienced during their sex work life and provided their own interpretation of the health problem: ‘I usually get the discharge when I am weak, when I don’t get enough sleep’.

Access to and use of health services

Only six of the 25 women in the study were regular patients of STI clinics operated by INGOs. Women perceived these facilities to be reliable and friendly. Several large INGOs have implemented programmes and provide clinical outreach services to women who work in the sex industry. However, these programmes exist in a limited number of townships and only provide selected services.

Health seeking behaviour varies dramatically among sex workers in Yangon. Informants from INGOs and the UN agencies agreed that ~30% of women experiencing STI symptoms would do nothing about it due to lack of education, insufficient time and poor financial resources.

They also indicated that ~20% would resort to self-treatment based on peer or an unqualified retailer's advice and some would use traditional medicine. They suggested that ~40% of female sex workers would choose private clinics and that they would tend to be in the higher earning bracket. Less than 10% would attend government STI clinics, which are perceived to lack modern equipment and effective medications.

The reported overuse of antibiotics even for early treatment of undetected STIs was disturbing. Several sex workers told the researcher that they had been receiving regular three-monthly injections of penicillin even in the absence of any STI symptoms. Some sex workers claimed that penicillin is a 'blood-purifying drug' and has HIV preventive qualities. Contraceptives are generally rarely used, with only a small proportion of women in the study receiving monthly Depo Provera contraceptive injections in private clinics.

Discussion and recommendations

The future of the HIV epidemic among female sex workers in Myanmar is contingent upon the effectiveness of current and future preventive efforts. Largely due to the efforts of INGOs and the UN agencies, some progress in combating the spread of HIV has been achieved through condom promotion programmes and the establishment of several STI clinics. However, more needs to be done.

The future for women in the sex trade in Myanmar is, regrettably, unpromising with most female sex workers and some stakeholders being increasingly pessimistic about the prospects for genuine change. As this change is unlikely to be instigated by the government in the short term, it needs to be encouraged and promoted by the international community. The support and involvement of Myanmar people will be critical in this process.

We argue that, when feasible, an adequate political commitment must be given by the government to repeal the draconian anti-prostitution laws and replace them with national policies aimed at assisting the target population. The authorities in Myanmar must recognise that the HIV epidemic among women in the sex industry is a priority development problem. A sustained partnership must be developed between all key stakeholders, including sex industry representatives, to enable the development and implementation of integrated target-specific HIV/AIDS prevention strategies and sex workers need to be guaranteed access to basic and general health services providing non-discriminatory and high quality care. This discussion will focus on short-term and feasible recommendations.

Policy and law

The enforcement of draconian anti-prostitution laws only perpetuates marginalisation and discrimination of women employed in the sex industry. In 1998, the *Suppression of Prostitution Act* of 1949 was amended, tightening laws to curb the growing sex trade by increasing the penalties[11] and driving the already covert industry deeper underground. The 'Plan on Prevention and Control of HIV/AIDS' released by the Myanmar Ministry of Home Affairs[12] is another example of the government's conviction that its prostitution laws are effective in preventing HIV. The document advocates, *inter alia*, various counter-productive and harsh measures such as intensified arresting of sex workers, mandatory HIV testing or seizing the assets of HIV positive sex workers in order to 'put (them) aside for their potential health problems'.[12]

The illegal status of Myanmar sex workers results in their abuse not only by pimps but also law enforcement officers and clients. There is almost no prosecution for the perpetrators of abuse or any redress opportunities for the victims. HIV/AIDS and sex work remain highly sensitive issues within the government.

However, it needs to be acknowledged that some progress has been achieved and certain key officials have recognised the magnitude of the problem. The next step is for this recognition to be translated into integrated, non-discriminatory programmes for sex workers.

It is hoped that in the near future, HIV and sex trade awareness training for the police and the justice system personnel will influence judicial practices. INGOs conducting HIV education and prevention training programmes for the members of the judicial system will no doubt encourage them to play a leading role in changing the law.

Socio-economic development

The political situation, compounded with a rapid economic decline as well as international embargos and trade restrictions, resulted in massive unemployment affecting the most vulnerable groups in the society. Wrigley[13] in his report to the UN Theme Group on HIV/AIDS, noted another important impact of displacement on people who have spent decades in social disruption and civil war leading to 'habits and practices of little or no long-term planning, focus on short-run goals, and low commitments to stability – as each of these are essentially unavailable'.

Sex work in Myanmar is, to a certain extent, entrenched in the endemic vicious cycle of poverty. The feminisation of poverty in Myanmar and the disparity between the income from commercial sex and other jobs have resulted in thousands of young women entering the sex trade. In many instances, sex work is the only viable alternative for women in the absence of employment opportunities, vocational training and welfare programmes.

HIV prevention strategies

Due to strict controls and censorship of the media, adequate and reliable information on public health matters

is infrequently provided. Populations at risk have not been identified and sex workers have not been involved in the planning, implementation and monitoring of prevention and care interventions.

At present, only a handful of INGOs work with vulnerable populations. Controls over foreign aid programmes are so rigid that many organisations decline to operate in the country. Agencies dealing with sex workers function, to a large extent, in isolation. Information sharing with other INGOs or the UN system agencies is limited and, most of the time, restricted to informal communications between staff members. Sex-work-oriented programmes are not coordinated on the national level and tend to be selective in terms of types of services provided and their geographical coverage. This is effectively crippling crucially needed HIV/AIDS prevention programmes.

HIV prevention strategies among women who work in the sex trade need to be placed in a wider context, taking into account other needs of sex workers and living conditions more generally. The limited HIV prevention interventions for sex workers in Myanmar are often aimed at reducing the risk of infection. However, issues around HIV are frequently not the highest priority for female sex workers and other problems are often more significant. Broad target-specific programmes must be implemented to address the needs of sex workers through information and education, access to a range of health, welfare and legal services as well as through skills training.

Although marginalised groups such as sex workers have often been described as 'hard to reach' they are also among those most likely to respond positively to HIV/STI prevention programmes, for example, by increasing their use of condoms with clients. A range of activities proven in other settings, such as peer education, peer support, outreach and drop-in centres need to be trialed and evaluated.

Programmes addressing the condom stigma and promoting their consistent use have been implemented and must be continued and expanded. Population Services International[14] argue that the Population Services International (Myanmar) condom social marketing intervention demonstrates that prevention programmes targeting sex workers can be effective even in a financially, politically and socially challenging setting. Research around condom use in Myanmar needs to be continued to monitor changes in attitudes towards safer sex and trends in condom usage. HIV prevention strategies also need to include sex trade management systems such as pimps and brokers because these individuals exert great influence on the behaviour and sexual health of sex workers.

It will be important to encourage partnerships and develop cooperation between INGOs by promoting multi-agency service coordination and information sharing. This approach will assist in strengthening links between the agencies, both to increase the availability of expert and appropriate services for sex workers and to build political support for an unpopular cause.

Health care

Women in Myanmar suffer from a greater than ever lack of access to family planning and prenatal care, inadequate nutrition, increased maternal mortality and ineffective HIV/AIDS education.[15] The few available government health services are rudimentary and have significantly deteriorated over the last decade. Particularly, lack of equipment, lack of drugs and inadequate training for staff impede government clinics in their effort to diagnose and treat STIs. This situation is of real concern because prevention and treatment of STIs and promotion of general health are at the heart of HIV prevention.

Furthermore, there is practically no access to voluntary and free HIV counselling and testing for Myanmar people, apart from specific clinics where active disease is suspected. Paid testing is available in selected private clinics, but the costs usually exceed the average person's ability to pay.

Conversely, it is essential that health care for women in the sex trade in Myanmar does not exclusively focus on HIV/STIs because this could only perpetuate the stigmatising view that sex workers are a potential hazard to the community and a multiplier in HIV transmission. All health care services should be provided with an understanding of the specific needs of sex workers and the impact of their working conditions on health problems. The emphasis must be on general health including reproductive health, fertility counselling/treatment and nutrition. Health care programmes also need to include regular non-paying partners of female sex workers.

Because of their precarious and marginalised position, women in the sex trade have limited access to government health facilities. Even where government clinics are available, women generally distrust authorities, including health care providers, and do not use these services. This was clearly evident in the study with the majority of sex workers having infrequent or no contact with STI clinics. This situation increases the likelihood of self-medication or utilisation of traditional healers for treatment.

Careful consideration must also be given to the development of sex-worker-friendly health settings. In Myanmar, where prostitution is illegal, these distinctive facilities give the police an opportunity to apprehend sex workers, which would result in sex workers avoiding health care services. Ultimately, to ensure that health care is provided in a way that is acceptable to women in the sex industry, it is necessary to consult them and, if possible,

involve them in the design, implementation and evaluation of services.

The plight of female sex workers who are HIV positive also needs to be addressed. These women not only suffer discrimination, abandonment and expulsion from the family home but also face the grim reality of not having access to treatment and dying without proper care and support. Due to the poor state of women's health, most will succumb and die from opportunistic infections in the early stages of the illness. As antiretroviral medications are inaccessible to most people in Myanmar, it is vital that effective and realistic HIV/AIDS management strategies are applied to reduce the pain and suffering of those already infected.

Conclusion

Female sex workers in Myanmar remain a highly marginalised group almost inaccessible due to a variety of legal, political, cultural and social factors. Their reported rates of unsafe sexual practice, insufficient HIV/AIDS education, social stigmatisation, poor access to and quality of health services as well as inadequate public health programmes make them particularly vulnerable to HIV and STIs.

There is an urgent need to promote behavioural change through education and information so that people will use the condoms that are supplied, as noted by the United Nations Population Fund.[16] Aye Aye Tun and Nwe Nwe Aye[17] argue that such education is of paramount importance because of prevailing misconceptions about condom use in Myanmar.

It is imperative that sex workers are not perceived as disease vectors and be held responsible for the HIV epidemic. As seen in other countries, such views lead to further stigmatisation, scapegoating and discrimination of sex workers reinforcing a patriarchal attitude of protecting the community from HIV infection.

Instead, gender-sensitive programmes designed by and implemented for female sex workers need to be based on an acceptance and tolerance of sex work in order to make a real positive change. HIV prevention initiatives should treat all sex workers with dignity, respect and confidentiality and aim to promote their health, safety and human rights.

Due to this study's small-scale nature and brevity, it cannot expect to capture the dynamism and diversity of the sex industry in Myanmar. The researcher's intention was to identify critical challenges facing sex workers and to initiate and encourage further research in the process of contextualising their lives and ameliorating their circumstances.

It is also hoped that this newly found understanding will be put to creative use by agencies working in this field and will contribute to preventing sex workers from contracting HIV/STIs as well as help them to improve and change their lives in a sustainable way.

Conflicts of interest

None exist.

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