

Optimizing HIV Services for Key Populations in Public-Sector Clinics in Myanmar

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Abstract

Key populations, ie, female sex workers, men who have sex with men, transgender people, people who inject drugs, and people in prisons and other closed settings, experience stigma, discrimination, and structural barriers when accessing HIV prevention and care. Public health facilities in Myanmar became increasingly involved in HIV service delivery, leading to an urgent need for healthcare workers to provide client-centred, key population-friendly services. Between July 2017–June 2018, the Myanmar Ministry of Health and Sports and National AIDS Programme collaborated with ICAP at Columbia University and the US Centers for Disease Control and Prevention to implement a quasi-experimental, multicomponent intervention including healthcare worker sensitization training with pre- and post- knowledge assessments, healthcare worker and client satisfaction surveys, and structural changes. We observed modest improvements among healthcare workers (n = 50) in knowledge assessments. Classification of clients into key population groups increased and fewer clients were classified as low risk. Key population clients reported favourable perceptions of the quality and confidentiality of care through self-administered surveys. Our findings suggest public health facilities can deliver HIV services that are valued by key population clients.

Keywords

HIV/AIDS, key populations, Myanmar, stigma, discrimination, healthcare workers

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Introduction

Despite advances in HIV prevention and treatment services, key populations (KPs) continue to be disproportionately affected by HIV. Globally, KPs accounted for 62% of new adult HIV infections in 2019.¹ In 2019, Myanmar's HIV prevalence estimates were highest among KPs, with 19% of people who inject drugs (PWID), 8% of men who have sex with men (MSM), 8% of female sex workers (FSWs), and 4% of prisoners being HIV-positive in comparison with the national HIV prevalence of less than 1% among adults aged 15 to 49.^{2,3} In 2016, there were 11,129 new HIV infections in Myanmar, most of which were among key populations.⁴ Specifically, 3200 (29%) new infections were among PWID, 2717 (24%) were among clients of FSWs, 1277 (11%) were among MSM, and 598 (5%) were among FSW.⁴ Myanmar's HIV epidemic is concentrated in five regions which account for 75% of people living

with HIV.⁵ Yangon, the largest city in Myanmar, has an HIV prevalence of less than 1% among adults and contributes the most to Myanmar's national HIV incidence and prevalence; Yangon accounts for 26% of the national HIV prevalence.⁴

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The majority of new HIV infections there occur among MSM, clients of FSWs, and female partners of KPs.⁵ In Yangon, the HIV prevalence among some KPs, such as MSM (28%) and FSWs (17%), is higher than the national average.^{6,7}

KPs are subject to increased stigma and discrimination, and face structural barriers when accessing HIV prevention and HIV care.^{8,9} Healthcare workers (HCW) are responsible for providing KP-friendly services; however, they may have limited knowledge about or be engaged in stigmatizing or discriminatory practices towards KPs. The impact of this stigma and discrimination from HCWs has been documented in the literature and can delay or prevent KPs from accessing HIV testing, treatment, and prevention services.⁹⁻¹³ In response to the need for more KP-friendly HCWs, KP sensitization trainings have been implemented in countries where KPs face stigma and discrimination.¹⁴⁻¹⁷ These trainings have been shown to reduce stigma and discrimination against KPs by increasing knowledge, challenging negative stereotypes, and enhancing skills among HCWs to enable the provision of quality, tailored healthcare services.^{15,16} In Myanmar, non-governmental organizations (NGOs) have traditionally served KP clients.^{18,19} However, beginning in 2016, government-run public health facilities became increasingly involved in HIV service delivery. Thousands of HIV care patients were gradually transferred from NGOs to public health facilities in alignment with the National AIDS Programme's private to public antiretroviral therapy (ART) transition plan toward long term country ownership and sustainability of the HIV response in Myanmar.

Given the transition of KPs to public health facilities in Myanmar, there was an urgent need to prepare HCWs and public health facilities to provide client-centred, KP-friendly services. We implemented KP sensitization training combined with structural changes within public health facilities, then assessed the acceptability and feasibility of this intervention package.

Methods

Description of Intervention

Between July 2017–June 2018, the Myanmar Ministry of Health and Sports and National AIDS Programme collaborated with ICAP at Columbia University and the US Centers for Disease Control and Prevention (CDC) to implement a multi-component intervention to optimize HIV services for KPs in five selected public health facilities in Yangon region, Myanmar. Public health facilities in Yangon were AIDS/STD clinics that were either connected to a hospital or were stand-alone urban health centres under the Myanmar Ministry of Health and Sports. Each AIDS/STD clinic was led by National AIDS Programme team leaders and a Regional Officer based in Latha, who oversaw overall management of all National AIDS Programme AIDS/STD clinics in Yangon Region. The intervention consisted of a two-day sensitization training for HCWs providing HIV services in these health

facilities along with a set of five health facility structural changes designed to improve the experience of KPs seeking HIV testing services or HIV care. Health facilities were selected in collaboration with the National AIDS Programme based on HIV prevalence in the geographic area; availability of HIV testing; ART initiation and maintenance services; and potential attendance by KPs, including clients referred from NGOs.

Sensitization training materials were adapted from a CDC training package and included discussion panels with representatives from networks of people living with HIV (PLHIV) and KPs in Myanmar.²⁰ The aim of the training was to sensitize HCWs to provide HIV testing services, counselling, HIV care, and other HIV-related services to KPs in a non-stigmatizing and competent manner. Adaptations were made to fit the local context—such as expanding the training to address stigmatization of PLHIV more broadly—and included training on how to identify clients as KP members and to document delivery of services using standard national tools.

Project collaborators and representatives from networks of PLHIV and KPs identified five structural changes that were implemented at each participating health facilities under the project to improve the experience of KP clients accessing services. These interventions included: 1) assignment and training of KP peers to serve as counsellors and outreach workers; 2) establishment and conduct of quarterly community meetings between KPs and HCWs to discuss challenges around access to and quality of HIV services for KPs; 3) introduction of separate counselling rooms and/or partitioned clinic areas for KP clients and/or installation of noise fans to allow for private and confidential HIV testing services; 4) introduction of suggestion forms and installation of suggestion boxes to collect client feedback on health facility services; and 5) improved signage within health facilities to ease navigation to HIV and STD service points within the clinics. A timeline of study-related activities is displayed in Figure 1.

KP counsellors and outreach workers received 3-day trainings on topics including HIV, counselling skills, the role of peer educators, conduct of HIV testing, antiretroviral treatment and adherence, working with KP groups, stigma and discrimination, and recording and reporting client information. Outreach workers received additional training on outreach, demand generation for HIV prevention and testing, and linkage to services. KP counsellors were peers and were responsible for greeting KP clients at health facilities and providing HIV pre/post-test counselling and ART adherence counselling to KP clients. KP peer outreach workers were responsible for hotspot outreach to KPs throughout Yangon to provide HIV education and information on services, and peer navigation to services at public health facilities. The aim of this intervention also included increasing awareness of the provision of HIV services at public health facilities, minimizing fear among KP clients accessing public health facilities, and facilitating non-stigmatizing services.

HCWs from public health facilities were encouraged by National AIDS Programme team leads to attend community

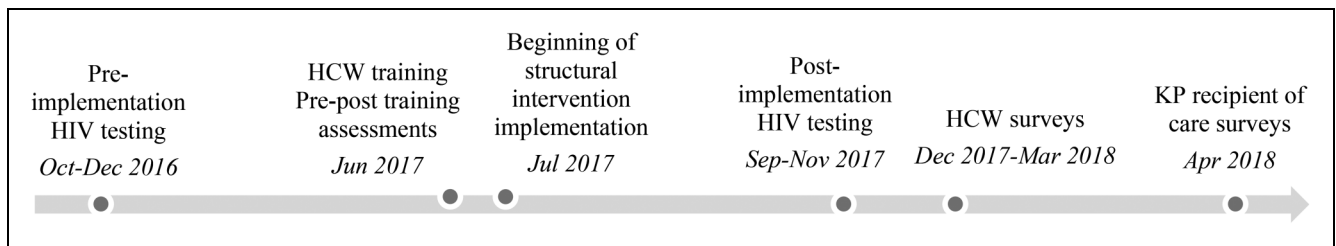


Figure 1. Timeline of study-related activities.

meetings in which they facilitated with the assistance of KP peer counsellors and ICAP project coordinators. These meetings were held quarterly at health facilities with KP clients and community members and were advertised via informational flyers posted at each of the health facilities. At the meetings, KP clients and community members and HCWs were given the opportunity to share their health facility experiences and ask questions of National AIDS Programme team leads. National AIDS Programme team leads would also address the patient feedback that was collected from the suggestion box at each of the health facilities. In addition, ICAP project staff and KP community leaders facilitated monthly project check-ins to improve awareness among the meeting attendees of KP-related health issues and provide opportunities for attendees to ask questions.

Evaluation and Analysis

Evaluation results include data from knowledge assessments conducted immediately before and after the KP sensitization training of HCWs from project health facilities in July 2017. Also included were data from a survey of HCWs from participating health facilities conducted between December 2017–March 2018 after training and implementation of the structural changes; data from surveys of KP clients seeking HIV testing and treatment, conducted in April 2018; and, lastly, aggregate programmatic data reported to the Myanmar Ministry of Health and Sports from HIV testing services in the five project health facilities. All survey measures were designed by the study team. Aggregate HIV testing service data from two periods were examined: a pre-intervention period, October–December 2016, and a post-intervention period, September 2017–November 2017.

HCW Training Knowledge Assessments. Identical pre- and post-test KP knowledge assessments were administered to all 50 HCWs from participating health facilities completing the two-day sensitization training (see supplemental materials). Knowledge assessment questions were multiple choice and true/false; responses were recorded by HCWs using pen and paper and were submitted to training facilitators immediately following test administration prior to, and after the sensitization training. For this analysis, we calculated the median, mean, and percent of correct answers before and after the training. An independent sample t-test was used to

compare mean numbers of correct answers pre- and post-training.

Facility HIV Testing Data. A data collector abstracted results from the paper-based, monthly aggregate data reports for HIV testing services compiled routinely by health facilities for two three-month periods, October–December 2016 (pre-implementation) and September–November 2017 (post-implementation). Abstracted data included number tested and number HIV-positive by standard classifications of HIV testing service recipients, including MSM, FSWs, PWID, partners of KPs, clients of FSWs, and clients classified as low-risk, ie, not falling into one of the previous groups. Under this analysis, we calculated descriptive statistics, including the number and percent of HIV testing service recipients tested, and found to be HIV-positive, as well as the proportion of HIV-positive health facility clients, by classification.

KP Recipient of Care Surveys. A separate acceptability survey was conducted with a convenience sample of adult (≥ 18 years) KP recipients of HIV testing service ($n = 33$) and HIV care ($n = 29$) services across the five health facilities. For the HIV testing services survey, participants were required to have received HIV testing services at a participating health facility on the day of the survey. For the HIV care survey, both newly and previously enrolled KP recipients of HIV care who received services during the project period were eligible for recruitment. Both KP surveys were anonymously self-administered in English or Burmese via audio-enabled electronic tablets. KP surveys were comprised of multiple choice and yes/no questions and various Likert scales with response options ranging from excellent to poor, strongly agree to strongly disagree, very happy to not happy, most of the time to never, and very comfortable to not at all comfortable when assessing KP satisfaction with services (see supplemental materials). Analysis of HCW and KP survey data consisted of descriptive statistics summarizing key demographic variables and variables reflecting experiences with HIV services for KPs in the participating health facilities.

Survey of HCWs. During the 4 to 7-month period after implementation of project interventions, a convenience sample of 30 HCWs at participating health facilities were recruited for a survey designed to assess acceptability of providing services to KP clients. HCWs who had been providing services to KPs

Table 1. Number tested and HIV-positive by risk classification, pre- and post- intervention, a pre-intervention period, October-December 2016, and a post-intervention period, September-November 2017

Classification of clinic clients	Pre-intervention			Post-intervention		
	Clients tested for HIV n (column %)	HIV + results n (row %)	Proportion of HIV + among health facilities (column %)	Clients tested for HIV n (column %)	HIV + results n (row%)	Proportion of HIV + among health facilities (column %)
Low Risk	339 (32%)	34 (10%)	15%	69 (6%)	15 (22%)	6%
Clients of FSW	309 (29%)	65 (21%)	28%	383 (34%)	73 (19%)	30%
Partner of KP	353 (33%)	111 (31%)	48%	393 (35%)	88 (22%)	36%
Any KP client	62 (6%)	20 (32%)	9%	279 (25%)	66 (24%)	27%
FSW	45 (4%)	15 (33%)	7%	189 (17%)	31 (16%)	13%
MSM	14 (1%)	4 (29%)	2%	74 (7%)	27 (37%)	11%
PWID	3 (0.3%)	1 (33%)	0.4%	16 (1%)	8 (50%)	3%
Total	1063 (100%)	230 (22%)	100%	1124 (100%)	242 (22%)	100%

for at least three months at each health facility were eligible for the survey. All surveys were self-administered by HCWs using pen and paper and submitted anonymously. These surveys included multiple choice, Likert scales, and yes/no questions.

Ethical Approval and Informed Consent

Approvals for this evaluation were obtained from the Ethics Review Committee of the Department of Medical Research in Myanmar (ERC number: 016416) and the Columbia University Medical Center Institutional Review Board (protocol number: IRB-AAAR1555). This project was also reviewed by the CGH Office of the Associate Director for Science/Laboratory Science in accordance with CDC human research protection procedures and determined to be research, but CDC investigators did not interact with human subjects or have access to identifiable data or specimens for research purposes, so IRB approval was not required (CGH-HSR tracking #: 2017-244). Written informed consent was obtained from all healthcare workers and KP clients prior to survey initiation.

Results

Among the 50 HCWs completing the sensitization training, we observed a modest but statistically significant improvement between pre- and post-training assessments. The mean number of correct answers out of a maximum score of 15 increased from 7 (47% correct, 95% confidence interval (CI): 6.0-7.7) pre-training to 9 (60% correct, 95% CI: 7.8-9.4) post-training ($p < 0.003$). Prior to HCWs receiving the sensitization training and structural changes being put in place, health facilities appeared to have small proportions of KP clients and a large proportion of low-risk clients (Table 1). For example, 32% of HIV testing service clients were classified as low risk; however, after sensitization training and structural changes, 6% of clients tested were classified as low risk. After training and structural changes, health facilities reported increased

testing by KP clients and increased numbers of HIV-positive KPs diagnosed in their health facilities. During the post-intervention period, for example, the proportion of all KP clients increased from 6% to 25% and the proportion of all positive results increased from 9% to 27% among KP clients.

Comments placed in suggestion boxes addressed a range of issues, including: 1) transportation to the health facility and a request for transportation incentives; 2) long waiting times at clinics; 3) a preference for same-day HIV test results; and 4) a desire for better patient education on ART treatment. In addition, comments expressed satisfaction with counselling and peer volunteers, as well as requests that clients be treated in a kind manner by health facility staff. One comment suggested that HCWs call out clinic registration numbers, rather than client names, when summoning a client to an exam room.

Table 2 displays responses from self-administered KP surveys by HIV testing services ($n = 33$) and HIV care ($n = 29$) respondents conducted following the health facility structural changes. Most HIV testing service respondents reported being at least somewhat happy with services (91%), at least somewhat comfortable asking questions of HCWs (100%) and believed that HCWs at the facility were well-trained (100%). A lower proportion of HIV testing service respondents believed that client information is kept confidential (70%) and felt free from stigma in the waiting room (61%). None reported discrimination at the health facilities where they were surveyed. Among HIV care respondents, the majority were at least somewhat happy with services (93%), at least somewhat comfortable asking questions of doctors and nurses (100%), felt HCWs were well trained and experienced (86%), and believed sensitive information shared by patients was kept confidential (76%). A lower percentage reported feeling free from stigma in the waiting room (62%) and a few HIV care respondents reported negative experiences at the facilities, including being verbally insulted or harassed (17%), receiving sub-standard care (10%), and not being treated with respect or dignity (10%).

As shown in Table 3, the majority of HCWs ($n = 30$) participating in the survey were female (77%) and an equal number

Table 2. Participant characteristics and survey responses of KP clients receiving HIV testing services (a) and HIV care (b).

a.) HIV testing services clients (n = 33)			b.) HIV care patients (n = 29)		
Respondent characteristics	n	%	Respondent characteristics	n	%
Gender			Gender		
Female	17	52%	Female	13	45%
Male	13	39%	Male	16	55%
Transgender	2	6%	Transgender	0	0%
No answer	1	3%			
Age			Age		
Median (IQR)	26 years (23-32)		Median (IQR)	33 years (24-42)	
Highest level of education completed			Highest level of education completed		
College or post-graduate	5	15%	College or post-graduate	8	28%
High school	12	36%	High school	4	14%
Middle school	9	27%	Middle school	5	17%
Less than middle/elementary	7	21%	Less than middle/elementary	12	41%
KP classification (all that apply)			KP classification (all that apply)		
Sex worker	13	39%	Sex worker	12	41%
PWID	8	24%	PWID	1	3%
MSM	6	18%	MSM	16	55%
Transgender	6	18%	Transgender	3	10%
HIV testing history at health facility			Self-reported health status		
Tested at this facility	5	15%	Excellent or very good	6	21%
Tested, but at another facility	18	55%	Good	11	38%
No prior test	10	30%	Fair or poor	12	41%
			Calendar year of HIV diagnosis		
			Current year	7	24%
			Last year	7	24%
			2 + years	15	52%
			Receiving ART	28	97%
			Missed visit(s) in past 3 months	5	17%
Experiences receiving HIV testing services			Experiences receiving HIV care		
How happy are you with the services at this clinic?			How happy are you with the services at this clinic?		
Very happy	18	55%	Very happy	11	38%
Somewhat happy	12	36%	Somewhat happy	16	55%
Not happy	0	0%	Not happy	2	7%
Don't know	2	6%			
No answer	1	3%			
How comfortable asking HCW questions?			How comfortable asking HCW questions?		
Very comfortable	24	73%	Very comfortable	19	66%
Somewhat comfortable	9	27%	Somewhat comfortable	10	35%
Not at all comfortable	0	0%	Not at all comfortable	0	0%
HCWs at this facility are well trained			HCWs at this facility are well trained and experienced		
Strongly agree or agree	33	100%	Strongly agree or agree	25	86%
Neutral	0	0%	Neutral	4	14%
Strongly disagree or disagree	0	0%	Strongly disagree or disagree	0	0%
Believe that information is kept confidential?			Believe that information is kept confidential?		
Yes	23	70%	Yes	22	76%
No	8	24%	No	6	21%
Don't know	2	6%	Don't know	1	3%
You feel safe and free from stigma in this waiting area.			You feel safe and free from stigma in this waiting area.		
Strongly agree or agree	20	61%	Strongly agree or agree	18	62%
Neutral / Don't know	5	15%	Neutral	7	24%
Strongly disagree or disagree	7	21%	Strongly disagree or disagree	4	14%
No answer	1	3%			
Experienced discrimination at this facility during current visit?			Number and % of respondents who reported the following in the past 3 months at the public health facility:		
Yes	0	0%	Was verbally insulted/harassed	5	17%
No	33	100%	Received sub-standard care	3	10%
			Was not treated with respect/dignity	3	10%
			Was gossiped about by HCW	1	3%
			Experienced discrimination	1	3%
			HCW did not keep confidentially	0	0%

Table 3. HCW participant characteristics and responses to study survey (n = 30).

	n	%
<i>HCW characteristics</i>		
Sex		
Female	23	77%
Male	7	23%
Age		
<25 years	8	27%
25 to 34 years	9	30%
35 to 44 years	5	17%
45 + years	8	27%
Cadre		
Nurse/midwife	14	47%
Lab technician	5	17%
Medical doctor	4	13%
Community counsellor	2	7%
Other*	5	17%
Years worked in current position		
< 1 year	1	3%
1 to 2 years	5	17%
3 to 5 years	11	37%
5 to 10 years	2	7%
> 10 years	11	37%
<i>Training and preparation</i>		
Sensitization training helped you to provide better care to KPs		
Agree or strongly agree	29	97%
Neutral	1	3%
Disagree or strongly disagree	0	0%
Sensitization training helped provide more welcoming environment for KPs		
Agree or strongly agree	28	93%
Neutral	2	7%
Disagree or strongly disagree	0	0%
Feel comfortable providing care for KPs		
Agree or strongly agree	24	80%
Neutral	4	13%
Disagree or strongly disagree	2	7%
Feel adequately trained and experienced to provide high quality services for KPs		
Agree or strongly agree	20	67%
Neutral**	10	33%
Disagree or strongly disagree	0	0%
<i>Attitudes and perceptions</i>		
KPs do not deserve the same quality of care as other patients		
Agree or strongly agree	1	3%
Disagree or strongly disagree	28	93%
Don't want to answer	1	3%
Witnessed discrimination in health facility in past 6 months		
Yes	10	33%
No	20	67%
What can be done to improve services for KPs (select all that apply)		
Additional training of HCW	23	77%
Revision of laws and regulations	7	23%
Special clinic hours for KPs	5	17%
Development of new policies	5	17%

*Other cadres include dresser (3), investigator (1), and social worker (1)

**Neutral category includes 1 response of Don't know and 2 responses of Don't want to answer

reported between 3 to 5 years and over 10 years of experience working in their current position. The majority of HCWs reported that the sensitization training helped them provide better care (97%) and a more welcoming environment (93%) for KPs. Most HCWs (93%) reported that KPs deserve the same quality of care as other patients. A lower percentage of HCWs reported feeling adequately trained to provide high-quality services for KPs (67%). However, one-third of HCWs reported witnessing discrimination in their health facilities in the past 6 months. When asked about how services could be improved for KPs, the majority (77%) indicated that additional training of all HCWs is needed.

Discussion

Findings from this evaluation across five Myanmar public AIDS/STD clinics in urban areas, which includes a mix of peri-urban and urban settings with diverse client volumes, suggest that the introduction of a combination of structural changes and training was associated with favourable HCW attitudes towards KPs. Following the rollout of the multicomponent intervention, small samples of KPs accessing both HIV testing and HIV treatment services reported favourable perceptions of the quality and confidentiality of care provided in settings not previously considered KP-friendly or competent. Among the sample of HCWs surveyed in the intervention sites, we observed self-reported increases in their ability to provide more welcoming care to their KP clients. In fact, many HCWs surveyed one year following introduction of structural enhancements noted that sensitization training should be scaled-up to further improve HIV services for KPs in public health facilities, as one-third still observed discriminatory practices in their facilities. Given that the post-training score only increased to 60%, additional training sessions are warranted to strengthen areas of difficulty. While our evaluation relied on quasi-experimental methods, these findings provide some assurance that public health facilities can deliver HIV services that are acceptable to and valued by KP clients in Myanmar. Our findings are also encouraging for other global settings where KPs are criminalized and often either perceive or experience barriers to receiving client-centred services.

In addition to our findings suggesting that the majority KPs were happy with service delivery in public health facilities, we observed improvements in the HCWs' ability to classify KP clients and, therefore, likely deliver HIV testing services and HIV care more appropriately tailored to KP clients. The main benefit of accurate KP classification is to allow HCWs to target client-centred services that address actual risk behaviours and to offer more tailored HIV services. When clients and providers jointly break down the barriers impeding KP access to vital HIV and health services, the health of the KPs and their communities can advance.¹⁴⁻¹⁷

This program evaluation has several limitations. Firstly, we were unable to conduct an experimental study design with comparison groups, follow-up, and statistical power to assess the efficacy of the structural changes. Secondly, the identification

and classification of KPs in general, and specifically for recruitment into the KP survey, relied on self-reported information. KPs less comfortable with the public health facility settings may have been less willing to disclose the information required to allow for KP classification. This may have resulted in the exclusion of KPs with less positive views of the specific public health facility's services. Similarly, social desirability bias may have resulted in overly positive views among HCWs in the pre- and post-test surveys conducted during the sensitization training.

Conclusions

International donor support to fund community-based, often standalone, HIV prevention and treatment services for KPs is likely not sustainable over the long term. Thus, national HIV programs are incorporating the important lessons of providing truly client-centred services to ensure lifelong viral suppression for all populations. To ensure that KPs have consistent access to high quality HIV services in the long term, it is important to establish and maintain programs that actively mitigate stigma and discrimination in public health facilities. Our evaluation of a replicable, scalable model of HCW sensitivity training supported by select structural changes—such as KP peer workers, confidential spaces to provide HIV testing services, and quarterly meetings to jointly address KP and HCW concerns—were acceptable to both KP clients and HCWs. The successful introduction of KP sensitization in public health facilities in Yangon paves the way for similar structural changes to be scaled up elsewhere in Myanmar and in other countries with significant KP epidemics. For example, during and after the completion of the project, Myanmar's National AIDS Programme, in collaboration with state and regional health departments, ICAP, and KP networks, scaled the HCW training to many public health facilities who were providing ART services across the country, showing their commitment to improving stigma-free services nationally.

Declaration of Conflicting Interests

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Supplemental Material

Supplemental material for this article is available online.

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