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Situational Analysis on Drug Use, HIV and the Response in Myanmar:

Looking Forward

June 2015

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Acknowledgements

Great appreciation is expressed to all those from CCDAC, Ministry of Health/National AIDS Programme, international and national NGOs, people living with HIV and representatives of drug users networks, UN agencies and representatives of development partners, who actively participated in this Situational Analysis. By providing their valuable time and important insights during the interviews and meetings, they greatly enriched an understanding of drug use, HIV and the response in Myanmar and reminded us why services to reduce the harms to key populations at higher risk of HIV infection should promote dignity and respect.

Gary Reid, international consultant, conducted the Situation Assessment on Drug Use and HIV in Myanmar. The completion of this report would have been highly compromised and incomplete if not for the diligent and focused efforts of the national consultant, Dr Sai Lone Tip.

UNAIDS provided financial and technical support for this assessment. Thanks to the team at UNAIDS Myanmar Country Office for their technical guidance and management support to the national review and the development of this report.

Deep gratitude is extended to the 3MDG Fund for the financial contribution for the conduct of this assessment and the printing of this report.

Abbreviations

AHRN	Asian Harm Reduction Network
ART	Antiretroviral Therapy
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CCDAC	Central Committee for Drug Abuse Control
DP	Development Partner
DTC	Drug Treatment Centre
DIC	Drop-in Centre
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
IEC	Information, education and communication
MANA	Myanmar Anti Narcotic Association
MDM	Médecins du Monde
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non-Governmental Organization
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PLHIV	People living with HIV
PWID	People who inject drugs
PWUD	People who use drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis
SARA	Substance Abuse Research Association
SC	Save the Children
SOP	Standard Operating Procedures
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNOPS	United Nations Office for Project Services
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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HIV in Myanmar in 2014 at a glance

- 200,000[a] people aged 15 and above living with HIV
- National HIV prevalence: 0.54%[a]
- 8,300[a] new infections. 39% of new infections were among people who inject drugs[a]
- HIV prevalence among PWID: 28.3%[b]

[a] HIV Estimates and Projections. Asian Epidemiological Model. Myanmar. December 2014 (draft)

[b] 2014 Integrated Biological-Behavioural Surveillance (IBBS) survey among PWID

မြန်မာနိုင်ငံသည် အိတ်ချ်အိုင်ဗွီကူးစက်ရောဂါ၏ ဆိုးကျိုးကိုအဆိုးရွားဆုံးခံစားနေရသော အာရှနိုင်ငံများအနက် တစ်နိုင်ငံဖြစ်သည်။ မြန်မာနိုင်ငံတွင် အိတ်ချ်အိုင်ဗွီရောဂါပိုးကူးစက်ခံထားရသော ပထမဦးဆုံးလူနာကို ၁၉၈၈ ခုနှစ်၌ စမ်းသပ်တွေ့ရှိခဲ့ပြီး အေအိုင်ဒီအက်စ်ရောဂါကို မူးယစ်ဆေးဝါးထိုးသူ တစ်ဦးတွင် ၁၉၉၁[i] ခုနှစ်၌ ပထမဦးဆုံး တွေ့ရှိခဲ့သည်။ ၂၀၁၃ ခုနှစ်မှတ်တမ်းများအရ မြန်မာနိုင်ငံတွင် တွေ့ရှိရသော အိတ်ချ်အိုင်ဗွီ ကူးစက်မှုအသစ် အားလုံး၏ ၃၂%မှာ မသန့်ရှင်းသောဆေးထိုးပစ္စည်းကိရိယာများကို အသုံးပြုခြင်းကြောင့်ဖြစ်သည်ဟု ခန့်မှန်းထား ကြသည်။[ii]

၂၀၁၃ ခုနှစ်မှတ်တမ်းများအရ အသက် (၁၅) နှစ်အထက်အရွယ်ရောက်သူများတွင် အိတ်ချ်အိုင်ဗွီဖြစ်ပွားမှုမှာ လျော့နည်းလာသည်(၀.၄၉%)[iii] ဟုဆိုသော်လည်း မူးယစ်ဆေးဝါးထိုးသူများအကြား ရောဂါဖြစ်ပွားမှုမှာ မြင့်မားနေ ဆဲဖြစ်ပြီး ၂၀၁၃ ခုနှစ်တွင် ၁၈.၇% ရှိကာ မြန်မာနိုင်ငံဒေသအသီးသီးတွင် ၅.၄% မှ ၃၅.၅% အထိရှိသည်။[iv] မူးယစ်ဆေးဝါးထိုးသူများ၏ လိုအပ်ချက်များကို ဦးတည်ဖြေရှင်းပေးနိုင်ရေးအတွက် အန္တရာယ်လျော့ချရေးလုပ်ငန်း များကို တရားဝင်အသိအမှတ်ပြုခံရပြီး အကောင်အထည်ဖော်လုပ်ကိုင်လာခဲ့သည်မှာ ဆယ်စုနှစ်ကျော်ရှိခဲ့ပြီဖြစ် သည်။ ထိုသို့တိုးချဲ့လုပ်ကိုင်နေသော်လည်းပဲ မူးယစ်ဆေးဝါးထိုးသူအများအပြားသည် အထူးသဖြင့် မူးယစ်ဆေးထိုး သွင်းသုံးစွဲနှုန်းမြင့်မားသော ဝေးလံခေါင်ဖျားသည့် (သို့မဟုတ်) ပဋိပက္ခများ ဖြစ်ပွားနေသည့်ဒေသများတွင် အိတ်ချ် အိုင်ဗွီကာကွယ်ရေးလုပ်ငန်းများနှင့် ကျန်းမာရေးဝန်ဆောင်မှုများကို မရရှိနေသေးကြောင်းတွေ့ရှိနေရသည်။

မူးယစ်ဆေးဝါးသုံးစွဲခြင်း၊ အိတ်ချ်အိုင်ဗွီနှင့် မြန်မာနိုင်ငံရှိဝန်ဆောင်မှုလုပ်ငန်းများကို ပိုမိုနားလည်စေရန် အခြေ အနေဆန်းစစ်မှုတစ်ရပ်ကို အတိုင်ပင်ခံနှစ်ဦး (နိုင်ငံခြားသားနှင့် နိုင်ငံသား) မှပြုလုပ်ခဲ့ပါသည်။ အစည်းအဝေးများ နှင့် တွေ့ဆုံမေးမြန်းခြင်းများကို အကျိုးတူပူးပေါင်းလုပ်ဆောင်လျက်ရှိသောအဖွဲ့အစည်းများ - အစိုးရဌာနများ (အထူးသဖြင့် ကျန်းမာရေးနှင့် ဥပဒေအကောင်အထည်ဖော်ဆောင်လျက်ရှိသောဌာနများ)၊ ကုလသမဂ္ဂဌာနေ လက်အောက်ခံအဖွဲ့အစည်းများ၊ ဖွံ့ဖြိုးရေးမိတ်ဖက်များ၊ နိုင်ငံတကာနှင့်ပြည်တွင်းရှိ အစိုးရမဟုတ်သောအဖွဲ့ အစည်းများ (INGOs နှင့် NGOs) နှင့် လူထုအခြေပြုအဖွဲ့အစည်းများ - ကို ကိုယ်စားပြုသည့် အဓိကသတင်း အချက်အလက်ပေးနိုင်သူ စုစုပေါင်း (၅၈) ဦးဖြင့်ပြုလုပ်ခဲ့ပါသည်။ ၂၀၁၄ ခုနှစ်၊ မတ်လမှ မေလအတွင်း ရက် သတ္တပတ် (၅) ပတ်ကျော်တွင် အစည်းအဝေး များနှင့်တွေ့ဆုံမေးမြန်းခြင်းများကို လားရှိုး၊ မန္တလေး၊ မြစ်ကြီးနား၊ နောင်မွန်ရွာ၊ နေပြည်တော်၊ စစ်ကိုင်း၊ သိန္နီ၊ ဝိုင်းမော် နှင့်ရန်ကုန်တို့တွင် လုပ်ဆောင်ခဲ့ပါသည်။

t"dl owif;tcsuf vuf ay;Edkifol rsm; t m; awGU&Sd&r;jrefcif;rS&&Sdaom awGU&Sdcsufrsm;

tEÅ&m,f avQmha&;vkyfief;t m; oabm;vnfcif;ESifh vkyfief;aqmif&Gufcsuf wdk;wufrIrsm;

အန္တရာယ်လျှော့ချရေးလုပ်ငန်း(Harm Reduction) နှင့်ပတ်သက်သော အခြေခံသဘောတရားဆိုင်ရာ စည်းမျဉ်းစည်းကမ်းမှာ မူးယစ်ဆေးဝါးထိုးသူများအကြား အိတ်ချ်အိုင်ဗွီကူးစက်ပျံ့ပွားမှုလျှော့ချရန် ဦးတည်ထားသော လုပ်ငန်းများဖြစ်သည်ဟူ၍ နားလည်သဘော ပေါက်ထားကြပါသည်။ သို့ရာတွင် ဘေးအန္တရာယ်လျှော့ချရေး အတွေးအခေါ်နှင့်ပတ်သက်ပြီး ပို၍ပြည့်ပြည့်စုံစုံ၊ ကျယ်ကျယ်ပြန့်ပြန့် နားလည်မှုမှာအများအားဖြင့် နည်းပါးနေသေးကြောင်းတွေ့ရှိရသည်။ တွေ့ဆုံမေးမြန်းခဲ့သူများအနက် မူးယစ်ဆေးဝါးထိုးသူများအတွက်သာဖြစ်သော ပြီးပြည့်စုံသောဝန်ဆောင်မှု (Comprehensive Package) တွင်ပါဝင်သော လုပ်ငန်း (၉) မျိုးအား ပြောပြနိုင်သောသူမှာ ထက်ဝက်အောက်သာရှိပါသည်။ အများစု (အထူးသဖြင့် ဝန်ဆောင်မှုများပေးအပ်နေသောသူများ) မှာလုပ်ငန်း (၅) မျိုးကိုသာ အနည်းဆုံးပြောပြနိုင်ခဲ့သည်။ ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်ဖြန့်ဝေခြင်းနှင့် သိမ်းဆည်းပေးခြင်းအစီအစဉ် (NSP) နှင့် မက်သဒုံးအစားထိုး တိုက်ကျွေးခြင်း (MMT) တို့မှာအများဆုံး ဖြေဆိုသောလုပ်ငန်းများဖြစ်ပြီး မူးယစ်ဆေးဝါးထိုးသူများအကြား လိင်မှ တဆင့်ကူးစက်တတ်သောရောဂါများ (STI) ကာကွယ်ခြင်းနှင့် ကုသခြင်းမှာ အနည်းဆုံးဖြေဆိုသော လုပ်ငန်းဖြစ်သည်။

စိန်ခေါ်မှုအများအပြားကြားမှပင် မြန်မာနိုင်ငံသည် အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများကို စတင်လုပ်ကိုင်ပြီး အကောင်အထည်ဖော်ခဲ့ရာ လွန်ခဲ့သောဆယ်စုနှစ်ကျော်ကာလအတွင်း တိုးတက်မှုများကိုအဆင့်အဆင့် တွေ့ရှိလာရပါသည်။ ယင်းကို နိုင်ငံတကာနှင့်ပြည်တွင်းရှိအစိုးရမဟုတ်သော အဖွဲ့အစည်းများမှ လုပ်ကိုင်သောအန္တရာယ်လျှော့ချရေးစီမံကိန်းနေရာများ အရေအတွက်တိုးပွားလာခြင်းနှင့် မူးယစ်ဆေးဝါးထိုးသူများအတွက် ဝန်ဆောင်မှုများလုပ်ဆောင်ရန် ဖွံ့ဖြိုးရေးမိတ်ဖက်များမှပိုမိုကတိကဝတ်ထားလာခြင်းတို့က ထင်ဟပ်ပြသနေပါသည်။ သို့သော်ငြားလည်း အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများမှာ ထိခိုက်လွယ်သောအကြောင်းအရာတစ်ခု ဖြစ်နေနိုင်သေးပါသည်။ လိုအပ်သည့် ဝန်ဆောင်မှုအမျိုးအစားများနှင့် ပတ်သက်၍လည်း သဘောထားကွဲလွဲမှုများ ရှိနေသေးသည်။ မူးယစ်ဆေးဝါးသုံးစွဲသူများ၏ လိုအပ်ချက်များအတွက် ဝန်ဆောင်မှုများပေးရာ၌ အထူးဂရုစိုက် လုပ်ဆောင်ရန် လိုအပ်သည်။ တိုက်ရိုက်ပါဝင်ခြင်းမရှိသူများမှ မကြာခဏနားလည်မှုလွဲမှားမှုများ ဖြစ်ပေါ်နေသေးကြောင်းကိုလည်း တွေ့ရပါသည်။

t"dlatmifjrifrIrsm;

ကျန်းမာရေး၊ တရားဥပဒေရေးရာနှင့် မူးယစ်ဆေးဝါးနှိမ်နင်းရေးကဏ္ဍများ၏ နှစ်ပေါင်းများစွာကြိုးပမ်းအားထုတ်မှုများကြောင့် အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများနှင့် ပတ်သက်၍ နိုင်ငံတော်အစိုးရ၏အားပေးထောက်ခံမှုများပိုမိုနိုင်မာလာသည်ကို တွေ့လာရပါသည်။ မြန်မာနိုင်ငံရှိအန္တရာယ်လျှော့ချရေးလုပ်ငန်းများမှာ အတိုင်းအတာတစ်ခုအထိ ထိရောက်မှုရှိလာပြီး ဝန်ဆောင်မှုများမှာလည်းလိုအပ်နေသူများထံသို့ ပိုမိုရောက်ရှိနေသည်ကိုတွေ့ရသည်။ မူးယစ် ဆေးဝါးသုံးစွဲခြင်းဖြင့် HIV ကူးစက်ပျံ့ပွားမှုတို့ကို ဦးတည်ဖြေရှင်းရာတွင် ကြိုးပမ်းမှု တစိတ်တပိုင်းအနေဖြင့် ပါဝင်သော အန္တရာယ်လျှော့ချရေးဝန်ဆောင်မှုများသည် စဉ်ဆက်မပြတ်အိတ်ချ်အိုင်ဗွီဖြစ်ပွားနှုန်းစောင့်ကြည့်လေ့လာခြင်းစစ်တမ်း (HSS) တွင် ဖော်ပြထားသကဲ့သို့ မူးယစ်ဆေးထိုးသူများအကြား HIV ကူးစက်နှုန်းကျဆင်းမှုကို ပံ့ပိုးပေးကြောင်း အဓိကသတင်းအချက်အလက်ပေးသူများမှ သုံးသပ်ကြသည်။ အန္တရာယ်လျှော့ချရေးဝန်ဆောင်

မှုများ မရှိသေးသောလွန်ခဲ့သောနှစ်ပေါင်းများစွာက မူးယစ်ဆေးဝါးထိုးသူအများအပြားသည် ဆေးလွန်ခြင်း (သို့ မဟုတ်) အိတ်ချ်အိုင်ဗွီနှင့်၎င်းနှင့် ဆက်စပ်သော ပြင်းထန်ရောဂါများကို မကုသနိုင်ခြင်းကြောင့် သေဆုံးကြရသည်။ ၂၀၁၁ ခုနှစ် တွင် မူးယစ်ဆေးဝါးထိုးသူများအကြား အိတ်ချ်အိုင်ဗွီဖြစ်ပွားမှုမှာ ၄၁% ရှိသော်လည်း ၂၀၁၃ ခုနှစ်တွင် ၁၈.၇% သို့ကျဆင်းလာခဲ့သည်။[v] လွှမ်းခြုံမှုမှာမလုံလောက်သေးသော်လည်း ယခုအခါ တွင် အန္တရာယ်လျှော့ချရေး ဝန်ဆောင်မှုများသည် နေရာဒေသအသစ်များ၊ ယခင်ကဤလုပ်ငန်းကို လက်မခံသော ဒေသများ၊ ဝန်ဆောင်မှုများ မရရှိနေသေးသည့် မူးယစ်ဆေးဝါးထိုးသူများထံသို့ စတင် ချဉ်းနင်းဝင်ရောက် နေလျက်ရှိသည်။

၂၀၁၃ ခုနှစ်တွင် ဆေးထိုးအပ်နှင့်ဆေးထိုးပြွန်ပေါင်း (၁၁) သန်းကျော်ကိုဖြန့်ဖြူးခဲ့သည်။ သန့်ရှင်းသောဆေးထိုးအပ် နှင့် ဆေးထိုးပြွန်များသည် အိတ်ချ်အိုင်ဗွီကူးစက်မှုကိုဟန့်တားရာတွင် ထိရောက်မှုရှိကြောင်းသက်သေအထောက် အထားများရှိနေသော်လည်း မြန်မာနိုင်ငံတွင် အကြောင်းအချက်များစွာ (အောက်တွင်အသေးစိတ်ဖော်ပြထားပါ သည်) ကြောင့်ဆေးထိုးအပ်၊ ဆေးထိုးပြွန်ဖြန့်ဝေခြင်းနှင့်သိမ်းဆည်းပေးခြင်းအစီအစဉ်များ (NSP) ကို အတိုင်း အတာတစ်ခုထိ တိုးချဲ့လုပ်ကိုင်နိုင်ခြင်းမရှိသေးပေ။ မက်သဒုံးအစားထိုး တိုက်ကျွေးခြင်း (MMT) လုပ်ငန်းကိုကျယ် ကျယ်ပြန့်ပြန့်ထောက်ခံကြပြီး လုပ်ငန်းအကောင်အထည်ဖော်ရေးအတွက် နိုင်ငံရေးအရကတိကဝတ်ထားရှိမှုများ မှာလည်း ခိုင်မာသည်ကိုတွေ့ရသည်။ ၂၀၁၁ခုနှစ်တွင် MMT ဝန်ဆောင်မှုပေးနေသောစီမံကိန်းနေရာ (၁၄) ခုရှိပြီး ဝန်ဆောင်မှုရရှိသူပေါင်း (၁,၆၃၇) ဦး[vi] ရှိသည်။ ၂၀၁၃ ခုနှစ်တွင်စီမံကိန်းနေရာ (၂၈) နေရာဖြစ်လာပြီး ဝန်ဆောင်မှုရရှိသူပေါင်း (၄,၃၉၇) ဦး[vii] ရှိလာသည်။ ၂၀၁၄ခုနှစ် ဇူလိုင်လတွင်မူ MMT ဝန်ဆောင်မှုပေးနေသော စီမံကိန်းနေရာပေါင်း (၃၅) နေရာနှင့် ဝန်ဆောင်မှုရရှိသူပေါင်း (၆,၈၆၈) ဦး[viii] ရှိနေပြီဖြစ်သည်။

လက်ရှိမူးယစ်ဆေးဝါးသုံးနေသူများအတွက် အေအာတီ (ART) ဆေးပေးခြင်း၊ အိတ်ချ်အိုင်ဗွီပိုးရှိနေသော မူးယစ် ဆေးဝါးထိုးသူများအတွက် ၂၄ နာရီ ကျန်းမာရေးစောင့်ရှောက်မှုပေးခြင်း (လားရှိုး) နှင့် MMT ဝန်ဆောင်မှု အသုံး ပြုသူများ ဆေးစဉ်ဆက်မပြတ်အသုံးပြုနိုင်ရန် ကြိုပို့ဝန်ဆောင်မှုများ ပံ့ပိုးပေးခြင်းစသည်တို့ အပါအဝင် မူးယစ်ဆေး ဝါးထိုးသူများအတွက် လုပ်ငန်းအသစ်များစွာကို အောင်မြင်စွာအကောင်အထည်ဖော်နိုင်ခဲ့သည်မှာ နှစ်ပေါင်းများစွာ ရှိခဲ့ပြီ ဖြစ်ပါသည်။ အရပ်ဘက်လူ့အဖွဲ့အစည်းများ၏ ပါဝင်မှုကိုလည်းတွေ့လာရပြီး မူးယစ်ဆေးဝါးသုံးစွဲသူများ ကွန်ရက်နှင့် ဘဝတူကူညီသည့်အဖွဲ့များလည်း ပေါ်ထွက်လာခဲ့သည်။ ၎င်းတို့မှာ ပိုမိုအားကောင်းလာကြပြီး ၎င်း တို့၏ စိတ်ဝင်စားမှုများနှင့် အရေးကိစ္စများကို ပိုမိုပွင့်လင်းစွာဖော်ပြလာကြသည်။ နိုင်ငံရေးနှင့် ဥပဒေရေးရာပတ် ဝန်းကျင်မှာလည်း အပြောင်းအလဲဖြစ်ရန်အတွက် အခြေအနေကောင်းများဖန်တီးပေးနေပြီး မူးယစ်ဆေးဝါးသုံးစွဲ သူများအပေါ် အနုတ်သဘော သက်ရောက်နေသော ဥပဒေရေးရာအဟန့်အတားများကို ပြောင်းလဲပြင်ဆင်ရန် အခွင့်အလမ်းများ ပိုမိုရရှိလာနိုင်သည့် အခြေအနေများရှိနေသည်။ အန္တရာယ်လျှော့ချရေးအတွက် ဖွံ့ဖြိုးရေးမိတ် ဖက်များ၏ အထောက်အပံ့များ ပိုမိုရရှိလာခြင်းကလည်း မူးယစ်ဆေးဝါးသုံးစွဲသူများအတွက် အိတ်ချ်အိုင်ဗွီကာ ကွယ်ရေးဆိုင်ရာ လုပ်ငန်းများနှင့် ဝန်ဆောင်မှုများ တိုးချဲ့လုပ်ကိုင်နိုင်ရန်အားပေးလျက်ရှိသည်။

tEÅm , fav Ûmba&;vkyfief;rsm; twGuf t"dupdefac:rI rsm;ESifh [efYwm;rsm;

မြန်မာနိုင်ငံတွင် အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများ တိုးချဲ့လုပ်ဆောင်ရာ၌ အောက်ပါစိန်ခေါ်မှုများမှာ အဟန့်အ တား ဖြစ်လျက်ရှိပါသည် -

- လက်ရှိတည်ဆဲဥပဒေများအဖြစ်အသုံးပြုနေသော ၁၉၁၇ မြန်မာနိုင်ငံယစ်မျိုးအက်ဥပဒေ (ဆေးထိုး အပ်လက်ဝယ်ထားရှိခြင်းအား တရားမဝင်အဖြစ်သတ်မှတ်ခြင်း) နှင့် ၁၉၉၃ မူးယစ်ဆေးဝါးနှင့် စိတ်ကို ပြောင်းလဲစေသောဆေးဝါးများဆိုင်ရာဥပဒေ (ဆေးဖြတ်ရန်အတွက် မဖြစ်မနေစာရင်းသွင်းရန် လို အပ်ခြင်းနှင့် ထိုသို့မဟုတ်ပါက ပစ်ဒဏ်ပေးအကျဉ်းချခြင်း) တို့သည် အန္တရာယ်လျှော့ချရေးလုပ်ငန်း များ၏ ထိရောက်မှုကိုအားနည်းစေပါသည်။

- အန္တရာယ်လျော့ချရေးလုပ်ငန်းများ၌ ကျွမ်းကျင်မှုရှိသော ဝန်ဆောင်မှုပေးသူအရေအတွက်မှာ မူးယစ်ဆေးဝါးထိုးသူအရေအတွက်နှင့် မျှတလောက်အောင် ရှိမနေပေ။ အန္တရာယ်လျော့ချရေးလုပ်ငန်းများကို နှစ်ပေါင်းများစွာလုပ်ကိုင်လာကြသော အဖွဲ့အစည်းများမှာလည်း မူးယစ်ဆေးဝါးထိုးသူများ၏ လိုအပ်ချက်များအားလုံးကို တုန့်ပြန်ဆောင်ရွက်ပေးရာ၌ ရှိရင်းစွဲအရင်းအမြစ်များထက် ပို၍ ကြိုးပမ်းအားထုတ်နေကြရသည်။ အတွေ့အကြုံနည်းသော၊ နည်းပညာနှင့် လုပ်ငန်းလည်ပတ်မှုစွမ်းရည်နည်းပါးသော အဖွဲ့အစည်းများအနေဖြင့်မူ ထိရောက်သောတုံ့ပြန်မှုလုပ်ငန်းများ လုပ်ဆောင်ရာတွင် ၎င်းတို့၏ အရည်အသွေးများကို ပြည့်ပြည့်ဝဝအသုံးမချနိုင်ပေ။ အလျှော့ရှင်များထံမှာလည်း ငွေကြေးအထောက် အပံ့ရရှိနိုင်သော အခွင့်အရေးလည်း နည်းပါးပါသည်။

  ယေဘုယျအားဖြင့်ဆိုရလျှင် မူးယစ်ဆေးဝါးထိုးသူများအတွက် လုံလောက်သောဝန်ဆောင်မှုများ တိုးချဲ့ပေးအပ်နိုင်ရန် အဖွဲ့အစည်းဆိုင်ရာစွမ်းဆောင်ရည်များ လုံလောက်မှုမရှိသည့်အပြင် ကျွမ်းကျင်သော လူစွမ်းအားအရင်းအမြစ်မှာလည်း နည်းပါးလျက်ရှိနေပါသေးသည်။

- မြန်မာနိုင်ငံတွင် မူးယစ်ဆေးဝါးသုံးစွဲမှုမှာ နယ်စပ်ဒေသနှင့်ပဋိပက္ခဖြစ်ပွားသောဒေသများ (ကချင်၊ ရှမ်း စသည့်) တွင် အများဆုံးဖြစ်သည်။ မူးယစ်ဆေးဝါးထိုးသူအများအပြားမှာ ပထဝီအနေအထားအရ သီးသန့် ဖြစ်နေသော (သို့မဟုတ်) သွားလာရန်ကန့်သတ်ခြင်းခံထားရသော ဒေသများတွင် နေထိုင်ကြပြီး ရလဒ်အားဖြင့် အန္တရာယ်လျော့ချရေးဝန်ဆောင်မှုများကို အကန့်အသတ်ဖြင့်သာ လက်ခံရရှိပါသည်။

- ရဲဝန်ထမ်းများမှစီမံချက်အရ ဖမ်းဆီးမှုများ များပြားလာခြင်းကြောင့် မူးယစ်ဆေးဝါးထိုးသူများအတွက် ပေးအပ်နေသော ဝန်ဆောင်မှုများအဆက်ပြတ်သွားစေခြင်း၊ (အချို့သောဒေသများတွင်) ဆေးထိုးပစ္စည်းများ စည်းကမ်းမဲ့စွန့်ပစ်မှုပိုမိုများလာခြင်း၊ ဆေးထိုးအပ်/ဆေးထိုးပြွန်များကို ပြန်လည်အပ်နှံမှု လျော့ကျသွားခြင်းနှင့် ယင်းစွန့်ပစ်ပစ္စည်းများကို ထိန်းသိမ်းရခက်ခဲခြင်း၊ မူးယစ်ဆေးဝါးထိုးသူများအကြားတွင်လည်း အဖမ်းခံရမည်ကိုစိုးရွံ့ခြင်းက (အမှန်တကယ်ဖမ်းဆီးမှုများ ရှိသကဲ့သို့ အဖမ်းခံရမည်ဟုတွေးထင်ယူဆထားသူများလည်းရှိသည်) ဝန်ဆောင်မှုများအသုံးပြုရာတွင်အဟန့်အတားဖြစ်စေခြင်းစသည်တို့ကိုဖြစ်ပေါ်စေသည်။ ဥပဒေကို အကောင်အထည်ဖော်သောအဖွဲ့အစည်းများအကြား အန္တရာယ်လျော့ချရေးလုပ်ငန်းအား နားလည်သဘောပေါက်မှုမှာ ယေဘုယျအားဖြင့် ဗဟိုအဆင့်တွင် နားလည်မှုပိုမိုရှိသော်လည်း အောက်ခြေအဆင့်တွင်မူ ရှင်းလင်းမှုမရှိနေသေးသည့်အတွက် ရပ်ရွာလူထုအဆင့်အန္တရယ်လျော့ချရေးလုပ်ငန်းများအဖို့ အခြေအနေမပေးသောပတ်ဝန်းကျင်ကိုဖြစ်ပေါ်စေသည်။ မူးယစ်ဆေးဝါးသုံးစွဲသူများအားခွဲခြားဆက်ဆံခြင်း၊ နှိမ်ချပြောဆိုခြင်းများကို လူအများစုအကြားတွင် အများအပြားတွေ့နေရဆဲဖြစ်ပြီး မူးယစ်ဆေးစွဲခြင်းအား ကျန်းမာရေးပြဿနာတစ်ရပ်အဖြစ် နားလည်သဘောပေါက်မှုမှာ အလွန်နည်းပါးသည်။ အကျိုးဆက်အားဖြင့် မူးယစ်ဆေးစွဲနေသူများအား ၎င်းတို့၏ သီးခြားလိုအပ်ချက်များအတွက် ကျန်းမာရေးစောင့်ရှောက်မှုလိုအပ်နေသူများအဖြစ် မမြင်ကြဘဲ ပြစ်မှုကျူးလွန်သူများအဖြစ်သာ မြင်လေ့ရှိပါသည်။

- NSP၊ MMT၊ အိတ်ဝ်အိုင်ဗွီစစ်ဆေးခြင်းနှင့်နစ်သိမ့်ဆွေးနွေးခြင်း (HTC)၊ ART (အေအာဗီ)၊ TB (တီဘီ) နှင့် လိင်မှတဆင့်ကူးစက်တတ်သောရောဂါများ(STI) စသည့်ကဏ္ဍများ၌ ဝန်ဆောင်မှုများတိုးချဲ့ လုပ်ကိုင်လျက်ရှိသော်လည်း စိန်ခေါ်မှုများစွာရှိနေသေးသည်။ NSP နှင့်ပတ်သက်၍ အနုတ်သဘောဆောင်သော အယူအဆများမှာပျံ့နှံ့လျက်ရှိသည်။ MMT လုပ်ငန်းကို တိုးချဲ့လုပ်ကိုင်နိုင်ပြီဖြစ်သော်လည်း (ဆေးအချိန်အဆမလုံလောက်ခြင်း၊ ဆေးကိုအိမ်သို့ ယူဆောင်ရန် ခက်ခဲနေခြင်း၊ ဝန်ဆောင်မှုအသုံးပြုသူများအား လိုက်လံကြည့်ရှုစောင့်ရှောက်မှု နည်းပါးခြင်းကဲ့သို့သော) စိန်ခေါ်

မှု အချို့ရှိနေသေးသည်။ အိတ်ချ်အိုင်ဗွီစစ်ဆေးခြင်းနှင့် နှစ်သိမ့်ဆွေးနွေးခြင်းအတွက် လာရောက်သော မူးယစ်ဆေးဝါးထိုးသူအနည်းငယ်သာရှိသောကြောင့် ၎င်းတို့၏ အိတ်ချ်အိုင်ဗွီ အခြေအနေကို ယေဘုယျအားဖြင့်မသိရှိရပေ။ ART လိုအပ်လျက်ရှိသော အိတ်ချ်အိုင်ဗွီပိုးရှိသည့် မူးယစ်ဆေးဝါးထိုးသူများအနက် အများအပြားမှာ ခွဲခြားနှိမ်ချပြောဆိုမှုများနှင့် ၎င်းတို့အပေါ် ဆေးပုံမှန်သောက်မည် မသောက်မည်ကို ယုံကြည်မှုများမရှိသောကြောင့် တချို့မှာ ART မရရှိဘဲဖြစ် နေသေးသည်။ မူးယစ်ဆေးဝါးထိုးသူများအကြား၌ဖြစ်ပေါ်နေသော အသည်းရောင် အသားဝါဘီနှင့် စီရောဂါများနှင့် ပတ်သက်သော ကျန်းမာရေးပြဿနာများ ဖြေရှင်းပေးနိုင်မှုမှာ အားနည်းနေသေးသည်။ မူးယစ်ဆေးဝါးသုံးစွဲသူများသည်ကနဦးအနေဖြင့် ဆေးဖြတ်ခြင်းတစ်ခုတည်းကိုသာပြုလုပ်ကြပြီး ပြန်လည်ထူထောင်ရေးကုသမှုများကို ရရှိခဲလှသည်။ ဆေးဖြတ်ပြီး သူအများစုမှာလည်း မကြာသောအချိန်အတွင်းတွင် ဆေးပြန်လည်သုံးစွဲတတ်ကြသည်သာဖြစ်သည်။

- ဤလုပ်ငန်းများ၊ အကြောင်းအရာများနှင့်ပတ်သက်သော နည်းပညာလမ်းညွှန်များ၊ အကျဉ်းချုပ်စာစောင်များနှင့်စံချိန်စံနှုန်းဆိုင်ရာလုပ်ထုံးလုပ်နည်းလက်စွဲများရှိမနေခြင်းကအန္တရာယ်လျှော့ချရေးလုပ်ငန်းများတွင်လုပ်ကိုင်နေကြသောသူအားလုံး၏ ကောင်းမွန်သောပတ်ဝန်းကျင်အခြေအနေ ဖြစ်ပေါ်ရေးအတွက် Advocacy အသိပေးထောက်ခံဆွေးနွေးမှုများ၊ နည်းပညာစွမ်းရည်နှင့် ပူးပေါင်းလုပ်ဆောင်မှုများကိုအားနည်းစေသည်။အန္တရာယ်လျှော့ချရေးလုပ်ငန်းအားပြည်သူ့ကျန်းမာရေးလုပ်ငန်းတစ်ရပ်အဖြစ်ရှုမြင်ပြီးအကောင်းဆုံးရလဒ်များရရှိရေးအတွက်ကဏ္ဍပေါင်းစုံပူးပေါင်းလုပ်ဆောင်ရန် လိုအပ်ပါသည်။ ထို့ပြင် ကျန်းမာရေးနှင့် ဥပဒေရေးရာကဏ္ဍများအကြား ချိတ်ဆက်လုပ်ဆောင်ခြင်းမှာလည်း ကြီးမားသောတိုးတက်မှုများအတွက် အခွင့်အလမ်းတစ်ခုဖြစ်စေပါသည်။ မူးယစ်ဆေးဝါးသုံးစွဲသူများမှာ အများအားဖြင့် ဖမ်းဆီးထိန်းချုပ်ခံထားရပြီး အချို့မှာအိတ်ချ်အိုင်ဗွီပိုးရှိနေသူများဖြစ်ပါသည်။ သို့ရာတွင် ART နှင့်အခြားသောကျန်းမာရေးဆိုင်ရာစောင့်ရှောက်မှု လိုအပ်နေသောအကျဉ်းသားများအတွက် ကြိုးပမ်းဆောင်ရွက်ပေးမှုများမှာ အနည်းငယ်သာ ရှိနေပါသေးသည်။

a&Sukfvkyfaqmif&rnfhvkyfief;rsm;twGuf cGif;vrf;omaomywf0ef;usif ESifh wjyefaqmif&Gufrlt m;aumif;ap&ef aqmif&Gufcif;

၁၉၁၇ မြန်မာနိုင်ငံယစ်မျိုးအက်ဥပဒေ နှင့် ၁၉၉၃ မူးယစ်ဆေးဝါးနှင့် စိတ်ကိုပြောင်းလဲစေသော ဆေးဝါးများဆိုင်ရာဥပဒေတို့ကို ဥပဒေလမ်းကြောင်းအရပြောင်းလဲပြင်ဆင်ရန်မှာ များစွာအချိန်ယူရဦးမည်ဖြစ်သည်။ သို့ရာတွင် ဆုံးဖြတ်ချက်ချနိုင်သူများ (သို့မဟုတ်) အဓိကကျသူများအား တိုက်တွန်းနှိုးဆော်ရေးအတွက် အားထုတ်ကြိုးပမ်းမှုများဆက်လက်ပြုလုပ်နေရန်မှာ လွန်စွာအရေးကြီးပါသည်။ အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများအား တရားဝင်ထောက်ခံမှုများပေါ်ထွက်နေပြီဖြစ်ရာ ယင်းက အမှန်တကယ်လိုအပ်သော၊ လက်တွေ့ကျသော ဥပဒေရေးရာပြုပြင်ပြောင်းလဲမှုများကို လက်တွေ့ကျကျခွင့်ပြုသွားဖွယ်ရှိပါသည်။

အန္တရာယ်လျှော့ချရေးလုပ်ငန်းအတွက် အခွင့်အလမ်းသာသော ပတ်ဝန်းကျင်တစ်ရပ်ဖြစ်ရန် ဥပဒေအကောင်အထည်ဖော်နေသူများသည် သတင်းအချက်အလက်များပြည့်ပြည့်စုံစုံရရှိပြီး ၎င်းတို့၏ အပြုသဘောဆောင်သောပါဝင်မှုမျိုးများ လိုအပ်ပါသည်။ ယင်းတို့ကို လက်ရှိအရေးကိစ္စများအပေါ် ပိုမိုနားလည်သဘောပေါက်စေရန် ၎င်းတို့အဖွဲ့ဝင်များကို သင်တန်းပေးခြင်းနှင့် အသိအမြင်ဖွင့်ဆွေးနွေးတင်ပြခြင်းများအား ပြုလုပ်ပေးသင့်ပါသည်။ လုပ်ငန်းအကောင်အထည်ဖော်ဆောင်ရန်အလားအလာရှိသော အခြားအဖွဲ့အစည်းအသစ်များကိုလည်း ဖေါ်ထုတ်ရန်လိုအပ်ပြီး တုံ့ပြန်မှုများအားကောင်းစေရန် ကျွမ်းကျင်မှုပြည့်ဝသော လူ့စွမ်းအားအရင်းအမြစ်များ မွေးထုတ်ထားနိုင်ရေးအတွက် အန္တရာယ်လျှော့ချခြင်းလုပ်ငန်းနှင့် ပတ်သက်သောအသိပညာနှင့် သင်တန်းများတိုးမြှင့်ပေးအပ်သွား

ရန်လည်း လိုအပ်ပါသည်။ အန္တရာယ်လျော့ချရေးဆိုင်ရာ အသေးစိတ်အချက်အလက်များကို ပိုမိုသိရှိလာစေရန်နှင့် ဆေးစွဲခြင်းအား ကျန်းမာရေးပြဿနာတစ်ရပ်အဖြစ်မြင်လာစေရန် အသိအမြင်ဗဟုသုတမြှင့်တင်ရေးလုပ်ငန်းများ လုပ်ဆောင်ပေးခြင်းဖြင့် ၎င်းကိစ္စများအပေါ် အထောက်အပံ့များ ပိုမိုဖြစ်ပေါ်စေနိုင်ပြီး နားလည်မှုများလည်း ပိုမို တိုးပွားလာစေနိုင်မည်ဖြစ်သည်။ လူထုအခြေပြု အဖွဲ့အစည်းများနှင့် မူးယစ်ဆေးဝါးသုံးစွဲသူများကွန်ရက်များအား နည်းပညာစွမ်းဆောင်ရည်များတည်ဆောက်ပေးခြင်းသည် ၎င်းတို့အားစွမ်းရည်မြှင့်တင်ပေးရာကျပြီး ကျန်းမာရေး ဆိုင်ရာအခွင့်အရေးများ ရရှိနိုင်ရေးအတွက် ၎င်းတို့ဆောင်ရွက်နေသော တိုက်တွန်းနှိုးဆော်ခြင်းလုပ်ငန်းများကို အထောက်အကူဖြစ်စေပါသည်။

သင်ထောက်ကူပစ္စည်းများအားလုံးသည် မြန်မာနိုင်ငံယဉ်ကျေးမှုဓလေ့ထုံးတမ်းအစဉ်အလာများနှင့် လိုက်လျော ညီထွေရှိရမည့်အပြင် လက်တွေ့ကျရမည်ဖြစ်ပြီး လိုအပ်ပါက ဒေသဘာသာစကားများသို့ ဆီလျော်အောင် ပြန် ဆိုထားရမည်ဖြစ်သည်။ အဆိုပါသင်ထောက်ကူများကို အချိန်ကာလကြာမြင့်စွာအသုံးပြုခြင်းအားဖြင့် မူးယစ် ဆေးဝါးသုံးစွဲခြင်းနှင့် အိတ်ချ်အိုင်ဗွီရောဂါပိုးတို့နှင့်ပတ်သက်သော ဒေသဗဟုသုတများနှင့် ယင်းတို့ကိုအထောက် အကူဖြစ်စေမည့် စွမ်းဆောင်ရည်များကို တည်ဆောက်ပေးနိုင်မည်ဖြစ်သည်။ သင့်လျော်သော ပံ့ပိုးမှုနှင့် လမ်းညွှန် မှုများသည် စဉ်ဆက်မပြတ်သင်ယူလေ့လာခြင်းနှင့် အသိပညာတည်ဆောက်ခြင်းတို့အတွက် ရေရှည်ပံ့ပိုးမှုများ ကိုဖြစ်စေသည်။ အရေးကိစ္စအသစ်နှင့် စိန်ခေါ်မှုအသစ်များ ဖြစ်ပေါ်လာပါက ထိုကိစ္စရပ်များကို မိမိတို့ကိုယ်ပိုင် ဖြစ်သည်/မိမိတို့နှင့်သက်ဆိုင်သည်ဟူသောစိတ်ခါတ်ဖြင့် ဖြေရှင်းနိုင်မည်။

အန္တရာယ်လျော့ချရေးလုပ်ငန်းများကို ပံ့ပိုးပေးနိုင်ရေးအတွက် လုပ်ဆောင်လျက်ရှိသော အသိပေးထောက်ခံ ဆွေးနွေးမှုများတွင် အိတ်ချ်အိုင်ဗွီနှင့်ဆက်စပ်နေသောပြဿနာရပ်များအား လူအခွင့်အရေး၊ လူတိုင်းကိုလွှမ်းခြုံ နိုင်သော ကျန်းမာရေးUHC ၊ လူမှုရေး၊ စီးပွားရေးနှင့် ပို၍ကျယ်ပြန့်သော လူအသိုင်းအဝိုင်းဆိုင်ရာအရေးကိစ္စများ အဖြစ် ကျယ်ပြန့်စွာရှုမြင်ရန်လိုအပ်ပါသည်။ ဤသို့လုပ်ဆောင်ခြင်းသည် ငွေကြေးထောက်ပံ့မှု ကတိကဝတ်များကို အားကောင်းစေရာရောက်ပြီး အန္တရာယ်လျော့ချရေးလုပ်ငန်းများ ရေရှည် တည်တံ့နိုင်ရေးအတွက်သေချာစေမည် ဖြစ်ပါသည်။

tkuljyHcsufsm;

အဓိကအကြောင်းအရာအလိုက်အကြံပြုချက်များမှာ အောက်ပါအတိုင်းဖြစ်ပါသည် -

tcGifvrfomaomywDefusif

- အန္တရာယ်လျော့ချရေးလုပ်ငန်းများအပေါ် နားလည်သဘောပေါက်မှုများတိုးပွားစေရေးအတွက်အခွင့် အလမ်းသာသောပတ်ဝန်းကျင်တစ်ရပ်ဖန်တီးသွားရန် ဥပဒေအကောင်အထည်ဖော်သူများနှင့် လူထု ခေါင်းဆောင်များအား တိုက်တွန်းနှိုးဆော်သည့်ကြိုးပမ်းမှုများနှင့် သင်တန်းအခွင့်အလမ်းများတွင် ပါ ဝင်ခြင်းဖြင့်တိုးမြှင့်လုပ်ဆောင်ရန်။
- အချို့သောဥပဒေများ (၁၉၁၇ ယစ်မျိုးအက်ဥပဒေ နှင့် ၁၉၉၃ မူးယစ်ဆေးဝါးနှင့်စိတ်ကိုပြောင်းလဲ စေသော ဆေးဝါးများဆိုင်ရာဥပဒေ) ကို ပြောင်းလဲပြင်ဆင်ရေးအတွက် ဆုံးဖြတ်ချက်ချသူများ၊ သင့် လျော်သောအဓိကကျသူများနှင့်လက်တွဲရန်၊ လက်ရှိလုပ်ဆောင်နေသော ပြောဆိုဆွေးနွေးမှုများ၊ တိုက်တွန်းနှိုးဆော်မှုများကို ဆက်လက်လုပ်ဆောင်ရန်။ တစ်ချိန်တည်းမှာပင် မူးယစ်ဆေးဝါးသုံး စွဲသူများအတွက် ပြည်သူ့ကျန်းမာရေးတုံ့ပြန်ဆောင်ရွက်မှုများ တိုးမြှင့်လုပ်ဆောင်နိုင်ရန် မူဝါဒနှင့် အလေ့အကျင့်များကို ခိုင်မာအောင် လုပ်ဆောင်ရန်။

- အန္တရာယ်လျှော့ချရေးလုပ်ငန်းများ အားကောင်းစေရေးအတွက် ကျန်းမာရေးနှင့်ဥပဒေရေးရာကဏ္ဍများ အကြားသတင်းအချက်အလက်ဖလှယ်ခြင်းနှင့် ကဏ္ဍပေါင်းစုံပူးပေါင်းလုပ်ဆောင်ခြင်းတို့ကို တိုးမြှင့်လုပ်ဆောင်ရန်။

Oefaqmifrsm;ESifhaefxrfrsm;

- နည်းပညာပိုင်းအရကျွမ်းကျင်မှုရှိသော ဝန်ဆောင်မှုပေးသည့် အဖွဲ့အစည်းအရေအတွက်များပြားလာစေရန်လုပ်ဆောင်ပြီး အန္တရာယ်လျှော့ချရေးဝန်ဆောင်မှုများနှင့် ပတ်သက်သော ကျွမ်းကျင်မှုပြည့်ဝသည့် လူ့စွမ်းအားအရင်းအမြစ်များ ပေါ်ထွက်လာရေးကိုသေချာအောင်ဆောင်ရွက်ရန်။
- မူးယစ်ဆေးဝါးထိုးသူများအတွက် NSP၊ MMT၊ HCT၊ ART၊ TB နှင့် STI ကုသမှုဆိုင်ရာ ဝန်ဆောင်မှုများ တိုးချဲ့နိုင်ရန်နှင့် လွှမ်းခြုံမှုတိုးမြှင့်နိုင်ရန်ဆက်လက်လုပ်ဆောင်ပါ။ မူးယစ်ဆေးဝါးထိုးသူများအကြား အသည်းရောင်အသားဝါရောဂါနှင့် ပတ်သက်သော အကြောင်းအရာများနှင့် ရောဂါကာကွယ်ရေး၊ ကာကွယ်ဆေးထိုးရေး၊ ရောဂါရှာဖွေဖော်ထုတ်ရေးနှင့် ကုသရေးတို့၏ အရေးပါပုံတို့ကို အသိပညာပေးမြှင့်တင်ဆောင်ရွက်ရန်။
- မူးယစ်ဆေးဖြတ်သည့်လုပ်ငန်းများနှင့် ဆေးစွဲသူပြန်လည်ထူထောင်ရေးစခန်းများ၏ ဆက်စပ်မှုကို ပိုမိုအားကောင်းအောင်ဆောင်ရွက်ရန်။ တဆက်တည်းမှာပင် မူးယစ်ဆေးစွဲခြင်းအား ကုသပေးသော လုပ်ငန်းများအားလုံးကို ပိုမိုကောင်းမွန်စေရေးအား လုပ်ဆောင်ရန်။

owiftcsuft vuESifh[kbkv

- မူးယစ်ဆေးဝါးသုံးစွဲသူများအား ရာဇဝတ်ကျူးလွန်သူများအဖြစ်သတ်မှတ်ခြင်း၊ ခွဲခြားဆက်ဆံခြင်းနှင့် နှိမ်ချပြောဆိုခြင်း လျော့နည်းလာစေရန် ဆေးစွဲခြင်းကို ဥပဒေအရကိုင်တွယ်ဆောင်ရွက်ရမည့် ပြဿနာတစ်ခုအစား ပြည်သူ့ကျန်းမာရေးပြဿနာတစ်ရပ်အဖြစ် ရှုမြင်နားလည်လာစေရန်ဆောင်ရွက်ရန်။
- အန္တရာယ်လျှော့ချရေးလုပ်ငန်းအား အကောင်အထည်ဖော်နေသောမိတ်ဖက်များ၊ အစိုးရနှင့် သတင်းမီဒီယာ အပါအဝင်အခြားသက်ဆိုင်ရာအဖွဲ့အစည်းများအတွက် အသိပေးထောက်ခံ ဆွေးနွေးသည့် ကြိုးပမ်းမှုများ၊ နည်းပညာ စွမ်းရည်နှင့်ဗဟုသုတများတိုးပွားလာစေရန် နည်းပညာစာစောင်များ၊ အကျဉ်းချုပ်စာစောင်များနှင့် အန္တရာယ်လျှော့ချခြင်းဆိုင်ရာသင်တန်းလမ်းညွှန်များ ဖော်ထုတ်ပြုစုရန်။

ukefusp&wfvkdftusp&dEdkifxdaomufESifha&&SdEkdifwnfwHh

- ဖွံ့ဖြိုးရေးမိတ်ဖက်များ အချင်းချင်းသတင်းအချက်အလက်များ လုံလောက်စွာဝေမျှခြင်းသည် လုပ်ငန်းများ မထပ်စေဘဲ အရင်းအမြစ်များကိုအကျိုးရှိရှိအသုံးချသွားစေနိုင်ပါသည်။
- တုံ့ပြန်မှုများအားကောင်းစေရန်နှင့် အန္တရာယ်လျှော့ချရေးစီမံချက်များအတွက် ကုန်ကျစရိတ်အလိုက် အကျိုးရှိမှု၊ ထိရောက်မှုနှင့်ရေရှည်တည်တံ့မှုရှိစေရန် ယခုဆန်းစစ်မှုတွင်တွေ့ရှိထားသော အဟန့်အတားများနှင့်လစ်ဟာမှုများကို သုတေသနများထပ်မံလုပ်ဆောင်ပါ။

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- အသည်းရောင်အသားဝါဘီနှင့် စီရောဂါများဆိုင်ရာ အသိပညာပေးခြင်းအပါအဝင် အိတ်ချ်အိုင်ဗွီ နှင့်တီဘီ ကာကွယ်ရေး၊ ကုသရေးနှင့်အထောက်အပံ့များအကြောင်း ပိုမိုသိရှိစေရန် အသိပေးနှိုး ဆော်မှု များကိုတိုးမြှင့်လုပ်ဆောင်ပါ။ အချုပ်ခံထားရသူများ၊ ထောင်သွင်းအကျဉ်းချခံထားရသူများ MMT ကုထုံးယူနေပါက ဆေးစဉ်ဆက်မပြတ်ရရှိနိုင်ရေးအတွက် ဆောင်ရွက်ပါ။ တဆက်တည်းမှာပင် ထိန်းသိမ်းရေးစခန်းများ၊အကျဉ်းထောင်များ၌ MMT ကုထုံးများပေးခြင်းကို စမ်းသပ်လုပ်ဆောင်ပါ။

Village level Advocacy, Tagaung village, Kinewoon village, Kawlin (MANA)

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i Thwe M. HIV/AIDS education and prevention in Myanmar.AIDS Education and Prevention, 2004, 16 (Supplement A): 170-177.

ii Myanmar's HIV estimates data submission for global AIDS report 2014.

iii Ibid

iv HIV sentinel sero-surveillance data (HSS 2013), National AIDS Programme, Ministry of Health, 2014. [To be published]

v Ibid

vi Global AIDS response progress report Myanmar (2010-2011). Naypyitaw, National AIDS Programme, Ministry of Health, 2012.

vii Global AIDS response progress report Myanmar (2012-2013). Naypyitaw, National AIDS Programme, Ministry of Health, 2014.

viii Dr Hla Htay, Program Manager, National Drug Abuse Control Program, personal communication, MMT meeting at WHO, 2014 August 22.

Executive Summary

HIV in Myanmar in 2014 at a glance

- 200,000[a] people aged 15 and above living with HIV
- National HIV prevalence: 0.54%[a]
- 8,300[a] new infections. 39% of new infections were among people who inject drugs[a]
- HIV prevalence among PWID: 28.3%[b]

[a] HIV Estimates and Projections. Asian Epidemiological Model. Myanmar. December 2014 (draft)

[b] 2014 Integrated Biological-Behavioural Surveillance (IBBS) survey among PWID

Myanmar is one of the countries most severely hit by the HIV epidemic in Asia. The first case of HIV infection was detected in Myanmar in 1988 and the first AIDS case, an injecting drug user, was reported in 1991.[1] The use of contaminated injecting equipment is estimated to account for 32% of all new HIV infections in 2013 in Myanmar.[2]

Although HIV prevalence among adults aged 15 and above is relatively low (0.49%)[3] in 2013, it still remains unacceptably high among people who inject drugs (PWID). In 2013, it was 18.7%, with a range of 5.4% to 35.5% in different parts of Myanmar.[4] A harm reduction response to address the needs of PWID has been officially recognized and operational for over a decade. Despite the expansion of harm reduction services, many PWID still do not receive HIV prevention interventions and health services,especially in remote and conflict areas where there are high levels of injecting drug use.

To improve understanding of drug use, HIV and the response in Myanmar, a comprehensive situation assessment was undertaken by two consultants (international and national). Meetings and interviews took place with a total of 58 key informants representing broad-ranging stakeholder bodies: Government bodies (primarily health and law enforcement sectors), development partners, international and national non-governmental organizations (INGOs and NGOs), community based organizations and United Nations agencies. Over five weeks between March and May 2014, meetings and interviews were conducted in Lashio, Mandalay, Myitkyina, Naung Mon Village, Nay Pyi Taw, Sagaing, Theinni, Wine Maw and Yangon.

Findings of key informant interviews

Understanding of harm reduction and progress of support towards the response

The fundamental theoretical principles of harm reduction were understood with a focus on reducing the spread of HIV among PWID. However, a more comprehensive and broader understanding of the harm reduction concept was often limited. Less than half of those interviewed named all nine interventions in the comprehensive package specific for PWID, but the majority (specifically among those implementing services) identified at least five interventions. Needle and syringe programmes (NSP) and methadone maintenance therapy (MMT) were the most commonly cited, whereas the prevention and treatment of sexually transmitted infections (STI) among PWID was the least mentioned.

Despite the many challenges, Myanmar has witnessed incremental and steady progress over the past decade towards adopting and supporting harm reduction. This was reflected in the increased number of harm reduction intervention sites operated by international and national non-governmental organizations, and the increasing commitment by development partners to support and expand services for PWID. Yet it was commonly acknowledged that the harm reduction response can still remain a sensitive topic, can divide opinions over the types of interventions required, and was often misunderstood by those not directly involved in servicing the needs of drug users.

Major successes and achievements

Many years of advocacy efforts by the health, law enforcement and drug control sectors, have seen a strengthening of government approval towards harm reduction. Harm reduction interventions in Myanmar have been shown to work in some extent where services reach those who need them. Unfortunately, where harm reduction services were not available over the years, many PWID also died from overdose or as a consequence of advanced untreated HIV infection. In 2001, HIV prevalence among PWID was 41%, decreasing to 18.7% in 2013.[5] Coverage still remains inadequate, but services have started entering new and sensitive geographical areas, reaching PWID that had not yet received harm reduction services.

In 2013, over 11 million needles and syringes were distributed. Despite their proven efficacy in preventing HIV transmission, needle and syringe programmes are still not optimally scaled-up in Myanmar due to a number of factors (detailed below). The methadone maintenance therapy (MMT) programme is widely supported, accompanied by a strengthening of political commitment for implementation. In 2011, there were 14 sites with 1,637[6] clients receiving MMT. The number

of MMT sites increased to 28 in 2013, serving 4,397 clients.[7] By July 2014, there were 35 sites serving 6,868[i] clients.

Over the years, a range of successful innovations have been implemented for PWID, including provision of antiretroviral therapy (ART) for active drug users, 24-hour health care services for HIV-positive PWID (in Lashio), and offering transport services to assist those receiving MMT to remain adherent. Civil society engagement and formation of drug user networks and support groups have emerged, which are becoming increasingly pro-active and expressing their concerns and issues more openly. The political and legal environment appears more conducive for change and there were potentially more viable opportunities to amend legal barriers that negatively impact upon the lives of drug users. Increased development partner support for harm reduction has allowed the expansion of HIV interventions and services for drug users.

Major challenges and barriers toward support for harm reduction

In Myanmar, the following challenges act as barriers for scaling up the harm reduction response:

- The Burma Excise Act (1917) (specific to illegal possession of hypodermic needles) and the Narcotic Drugs and Psychotropic Substances Law (1993) (requiring legal mandatory registration for drug treatment or face imprisonment) remain in place, undermining the strengthening of harm reduction interventions.

- There is an insufficient number of implementing service providers skilled in harm reduction to match the magnitude of injecting drug use. Organizations with a long history in harm reduction have been increasingly stretched to respond to the needs of PWID. Those with less experience and lacking technical and operational capacity were more likely to be compromised in their ability to provide an effective response in the field. They were also less likely to receive financial support from donors.

  Overall there was a general shortfall of organizational capacity to deliver sufficient services to PWID to scale, coupled with a shortage of human resources sufficiently skilled to deliver various services.

- The drug use epidemic in Myanmar is most severe in border and conflict areas (Kachin, Shan, etc.). A large number of PWID are geographically isolated or located in sensitive parts of the country in which access is restricted, and as a result only a limited range of harm reduction services can be provided.

[i] Dr Hla Htay, Program Manager, National Drug Abuse Control Program, personal communication, MMT meeting at WHO, 2014 August 22.

- A reported increase in police crackdowns has led to disruption of service delivery, an increase in discarded injecting equipment (in some areas), a decrease in the number of returned needles and syringes, associated difficulties of waste management, and fear (real or perceived) of arrest among PWID, which can obstruct access to services. Understanding of harm reduction was generally better at the central level of law enforcement but at the field level it was often less clear, which contributed toward a less conducive environment for harm reduction in a community setting. Drug users remain highly stigmatized and discriminated against by the majority of people, and drug dependency as a health issue was rarely understood. As a consequence, those that were drug dependent were commonly viewed as criminals rather than as people requiring health services to address their specific needs.

- Expansion of service delivery in the areas of NSP, MMT, HIV counselling and testing (HCT), ART, tuberculosis and STI was underway but various challenges remain. Highly negative perceptions towards NSP prevail, and although MMT was expanding, a range of challenges existed (such as inadequate dosing, difficulty accessing take-home doses and low follow-up of clients). Too few PWID present for HCT, thus HIV status commonly remains unknown, and among HIV-positive PWID in need of ART, many were not provided treatment, often due to ongoing stigma and distrust of their adherence capacity. Many issues surrounding hepatitis B and C among PWID remain largely unaddressed. Drug treatment was primarily restricted to detoxification and rarely did drug users receive drug rehabilitation treatment. The majority of those completing detoxification relapse.

- A lack of technical guidelines, briefing papers and various standard operating procedures manuals covering a range of interventions and topics diminishes the advocacy efforts, technical capacity and collective, cohesive response among all those working in the area of harm reduction. Harm reduction as a public health intervention requires a multi-sector approach to achieve the best outcomes, yet linkages between the health and law enforcement sectors have scope for greater improvement. Drug users were often incarcerated and some were known to be HIV-positive. However, limited efforts were made to improve the health of prisoners that required ART and assistance with other health issues.

Enabling environment and strengthening the response for the way forward

Legislative change to address the Burma Excise Act (1917) and Narcotic Drugs and Psychotropic Substances Law (1993) could take years, but maintaining advocacy efforts with those in decision making or key influencing roles remains critically important. Official support for harm reduction exists, which realistically could allow for the desired legal changes and amendments.

An enabling environment for harm reduction requires well informed and positively engaged law enforcement, which can be achieved through training and sensitization of their members to better understand the issues.

A pro-active search for potential other implementing organizations is required and there is a need to increase education and training on various aspects of harm reduction to build a pool of skilled human resources to strengthen the response. A systematic and focused awareness-raising programme to improve insights about harm reduction and drug dependency as a health issue would contribute towards a more supportive and improved understanding of the issues. Building technical capacity for community based organizations and networks of drug users would enhance empowerment that could assist in their advocacy efforts towards securing health based rights.

All educational materials developed need to be practical, appropriately translated into local languages when and where needed, and suited to the cultural context of Myanmar. These educational materials over time would build up the local knowledge and capacity to respond to drug use and HIV. Appropriate support and guidance would improve local ownership to sustain ongoing training and educational development as new issues and challenges emerged.

Ongoing advocacy efforts in support of harm reduction need to include the issue of HIV within the broader context of human rights, universal health care and various social, economic and larger structural issues. This approach would likely contribute towards a strengthening of the financial commitment and ensure the harm reduction response was sustained for the long term.

Recommendations

Thematic based recommendations are as follows:

Enabling environment

- Increase advocacy efforts and training opportunities for greater inclusion of law enforcement and community leaders to improve the enabling environment to enhance and strengthen understanding of the harm reduction response.

- Maintain ongoing dialogue and advocacy efforts with decision makers, and those that have appropriate connections and influence to amend specific laws (Excise Act 1917 and Narcotic Drugs and Psychotropic Substances Law 1993), as well as strengthen policy and practice to improve the public health response for drug users.

- Improve multi-sector collaborations and exchange information between health and law enforcement sectors to strengthen the harm reduction response.

Services and staff

- Increase the number of technically strong implementing service providers, and ensure the development of skilled human resources in harm reduction services.

- Continue to expand and increase coverage in service delivery of NSP, MMT, HCT, ART, TB and STI treatment to PWID. Raise the profile and importance of prevention, vaccination, diagnosis and treatment for viral hepatitis among PWID.

- Explore and improve linkages between detoxification programmes and drug rehabilitation centres, as well as overall improvement in drug dependence treatment.

Information and knowledge

- Improve understanding of drug dependency as a health issue that requires a public health response rather than a law enforcement response, to reduce criminalization, stigma and discrimination of drug users.

- Develop technical documents, briefing papers and a harm reduction training curriculum to enhance advocacy efforts, technical capacity and improve knowledge for harm reduction implementing partners and other appropriate agencies, including government and media.

Cost efficiency, effectiveness and sustainability

- Improve overall response and prevent overlapping of activities by ensuring greater efficiency of available resources through increased sharing of information among development partners.

- Undertake further research to address limitations and gaps identified in the situation analysis to strengthen the response and improve efficiency, effectiveness and sustainability of harm reduction programmes.

Closed settings

- Increase advocacy efforts to raise profile and encouragement of HIV and TB prevention, treatment and support, including initiating awareness on hepatitis Band hepatitis C, and ensure uninterrupted MMT for those incarcerated when receiving treatment, as well as piloting of MMT in closed settings.

1. Literature Review

Health Education at the Drop-In Centre (MDM)

1.1 Introduction

Myanmar has a long history in the production, trade and use of drugs. In contemporary times these issues still exist and drug use has resulted in various adverse health, social and economic consequences. For over two decades people who inject drugs (PWID) have been harshly affected by the HIV epidemic, and in 2013 HIV prevalence among PWID was 18.7%.[8] Despite the legal framework that criminalizes drug use behaviour, there is a growing and expanding comprehensive response to address the needs of PWID, which has gained strength with each passing year. Many more drug users are being contacted and receiving a variety of harm reduction services with measurable results. However, available data does highlight that the majority of drug users are still not receiving HIV prevention interventions. Despite the various challenges, evidence shows harm reduction does work in the Myanmar context. With ongoing broad ranging support, a strengthening of the response to drug use and HIV issues should follow.

1.2 Past and the present: cultivation, trade and consumption of drugs

The cultivation, trade and consumption of drugs in Myanmar have a long history, with records describing opium being transported and used in Myanmar in the late 16th century. The cultivation

of opium in the north-eastern part of the country is believed to have been introduced by Chinese traders from Yunnan province; cultivation of the opium poppy was documented in Myanmar in 1736. Before colonisation by the British in 1852, opium use was not widespread.[9, 10] In 1878, the Opium Act made it illegal for any Burmese to smoke opium, which could only be sold to registered addicts, most of whom were Chinese.[11, 12] By 1906, the trading of opium was declared illegal but this had minimal impact. By 1930, there were an estimated 100,000 opium addicts in the country. Several decades later heroin appeared and by the late 1980s there were an estimated 30,000 heroin users: in the early 1990s this dramatically increased to an estimated 160,000.[13, 14]

Opium cultivation had been declining since the mid-1990s, but in 2013 higher yields and increased cultivation witnessed opium production increase by 26%, the highest since official assessments began in 2002. Today Myanmar remains the largest opium poppy growing country in southeast Asia and the second largest global producer after Afghanistan.[15]

Since the late 1990s Myanmar has also become a major source of amphetamine-type stimulants (specifically methamphetamine pills and crystalline methamphetamine), of which the majority is manufactured in Shan State. Large amounts of methamphetamines are primarily trafficked to Thailand, China, Vietnam and Cambodia. The use of methamphetamines has become increasingly widespread in Myanmar and more so in urban settings.[16]

Official data on the number of drug users in Myanmar are not available, but estimates of 300,000 to 400,000 are reported:[17] in 2007 an estimated 75,000 people who inject drugs (PWID) was reported.[18] An Integrated Biological Behavioural Surveillance/Population Size Estimation targeting PWID is underway in 2014 and its results will be available in 2015. The largest concentrations of PWID are believed to be in the northern (Kachin) and eastern (Shan) states that share borders with China, Laos and Thailand[19] but populations of PWID are identified in various regions of the country.

1.3 HIV and other blood borne viruses among people who inject drugs

The first HIV-positive individual was identified in Myanmar in 1988 and the first AIDS case, an injecting drug user, was reported in 1991.[20] HIV prevalence in Myanmar among the general adult population, aged more than 15 years, was estimated to be 0.49% in 2013: there were an estimated 184,965 adults living with HIV in 2013.[21] Among key populations, HIV prevalence in 2013 was considerably higher: 10.4% among men who have sex with men (MSM) and 8.1% among female sex workers.[22] Among PWID, the national HIV prevalence was 18.7% in 2013, with prevalence of 35.5% in Myitkyina and 20% in Lashio.[23]

HIV sentinel sero-surveillance over the past two decades has seen a marked slow-but-steady decline in HIV prevalence among PWID: from 1992–2000 HIV prevalence remained above 50%, followed by slow but decreasing trends.[24] Despite this progress, new HIV infections through injecting drug use are projected to make up an increasing proportion of all new HIV infections: in 2013, the use of contaminated injecting equipment was estimated to account for 32% of all new HIV infections in Myanmar and by 2015, PWID will account for the largest proportion of new infections, in the absence of an increase in targeted interventions.[25]

PWID are also at high risk of hepatitis B virus (HBV) and hepatitis C virus (HCV) infections. In 2009 the mid-range prevalence of HBsAg (earliest indicator of acute hepatitis B) and anti-HCV (highlights exposure to the virus) among PWID worldwide was 9% and 79% respectively.[26] Studies on HIV/HCV coinfection show that HIV accelerates the progression of HCV disease and mortality, particularly in the absence of antiretroviral therapy.[27, 28] Chronic HCV infection is independently associated with a 50% increase in mortality among patients with HIV.[29]

In 2007, a study among PWID undertaken at various sites in Myanmar highlighted a widespread epidemic of HBV (HBsAg rapid test) and HCV (anti-HCV rapid test): prevalence of 8% and 74% (Yangon); 12% and 87% (Myitkyina); 11% and 88% (Moegaung); 3% and 93% (Bamaw) and 8% and 66% (Mandalay) respectively.[30]

In Myanmar a cross-sectional analysis of HIV-positive patients (that included adult males and females, MSM, female sex workers, blood transfusion recipients and PWID) enrolled in the Integrated HIV Care Programme from May 2005 to April 2012 found that among PWID the prevalence of HBV and HCV co-infection was 10.2 % and 47%. Among the different groups, PWID had the highest risk of being co-infected with hepatitis C.[31]

1.4 Risk behaviours among PWID

In the mid-1990s it was reported that many injecting drug users had their first injection from a professional injector and that these injectors were used by drug users when they were away from their home area. Many professional injectors worked in a drug injecting tea shop or 'shooting gallery' where for a fee, a drug user was administered heroin. The risk of HIV in such environments was high as sterilisation of various injecting paraphernalia was rarely a consideration. These circumstances contributed considerably to the explosive HIV epidemic among PWID during this time.[32, 33, 34] The introduction over the past decade of HIV prevention programmes targeting PWID has resulted in a marked improvement in reducing unsafe injecting practices, though not completely. Most information and insights about sharing practices among PWID largely derive from field observations, programmatic experience of NGOs or drug treatment centre staff who work with PWID.

The last published national behavioural surveillance survey (BSS) among PWID was conducted in 2007-2008. The survey found sharing of injecting equipment at last injection ranged from 31% in Yangon, 22% in Myitkyina and 19% in Lashio: sharing injecting equipment most commonly occurred with a friend. Plain water was the material most commonly used to clean injecting equipment.

Buying sex was more common in some parts of the country than others: Mandalay (48%), Yangon (41%), Myitkyina (31%) and Lashio (9%). Among those that bought sex, condom use at last sex with a partner was highest in Lashio (87%) and lowest in Mandalay (46%).[35]

The overlap between male injecting drug users and sex workers increases the potential to accelerate the spread of HIV. A new Integrated Biological-Behavioural Surveillance (IBBS) survey will provide more up-to-date information on PWID in 2015. A study conducted among HIV-positive PWID in Shan State near the border with Thailand found that those who shared syringes were almost five times more likely to become infected with HIV compared to those that did not share syringes for the first time. The same study found that those who were illiterate and from an ethnic minority background had a higher risk of being infected with HIV.[36]

1.5 Laws, policy and practice

Introduced during British colonial era and still in place is the Burma Excise Act of 1917, which prohibits the making, selling, possession, distribution or use of a hypodermic needle without a licence.[37] With an uncontrolled HIV epidemic among PWID, in 2001, a verbal instruction from the Myanmar Police Force Headquarters was given to avoid making arrests for possession of hypodermic needles. However, it has been reported that this directive has had limited impact in practice, as needles and syringes are confiscated by police and submitted to courts as evidence that individuals are in possession of drugs or needles and syringes.[38, 39] Maintaining this law is in conflict with current NSP endorsed in the revised Myanmar National Strategic Plan on HIV and AIDS 2011–2016, to prevent needle sharing and promote safer injecting practices among PWID.[40]

A review of the Burma Excise Act (1917) was conducted in 2009[41] but no amendment followed. In late 2013, a National Legal Review Meeting with broad ranging participation of government, Supreme Court, parliamentarians, community networks, non-governmental organizations and United Nations (UN) agencies recommended that the Burma Excise Act (1917) be amended to provide exceptions for distribution and possession of needles and syringes for harm reduction purposes. In addition, it was recommended that the Directive by Police Headquarters not to arrest people in possession of needles and syringes be promoted to police stations at all levels, and that the use of needles and syringes as evidence for prosecution should be prohibited.[42] The Narcotic Drugs and Psychotropic Substances Law (1993) outlines offences relating to drug possession and illicit drug use. This same law creates a system for registration and compulsory treatment for those using

drugs. Under Section 15, failure to register or not abiding by the Ministry of Health directions regarding medical treatment can result in imprisonment for minimum of three to maximum of five years.[43] A review of the Narcotic Drugs and Psychoactive Substances Law (1993) took place in 2009 to propose amending Section 15 concerning drug user registration and reducing the severity of punishment, but changes did not follow.[44] The National Legal Review Meeting in 2013 recommended compulsory registration of drug users should be phased out due to the adverse consequences of stigmatization and of the failure to effectively address relapse. As an alternative, voluntary community-based approach was recommended.[45]

2. Global response for people who inject drugs

Cane Competition at Drop-In Center (AHRN)

2.1 Support for comprehensive response to achieve best results

People who inject drugs are highly vulnerable to HIV and have multiple health issues. In 2012, WHO, UNODC and UNAIDS released a revised document: *'Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users'.*[46] Within the Technical Guide a Comprehensive Package is presented with the endorsement of WHO, UNAIDS, UNODC, the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund to Fight AIDS, Tuberculosis and Malaria, The United States President's Emergency Plan For AIDS Relief, and various other eminent institutions and agencies.[47, 48] There are a total of nine interventions within the Comprehensive Package. Each intervention is strongly supported by scientific evidence that shows its efficacy of not only preventing HIV among PWID but also reducing a range of adverse health consequences associated with drug use.[49, 50] A comprehensive approach produces better results for reducing the spread of HIV compared to any single intervention alone, which has only limited impact. In low and middle income countries, implementing all nine interventions can be challenging but it is important to note various interventions found in the comprehensive package

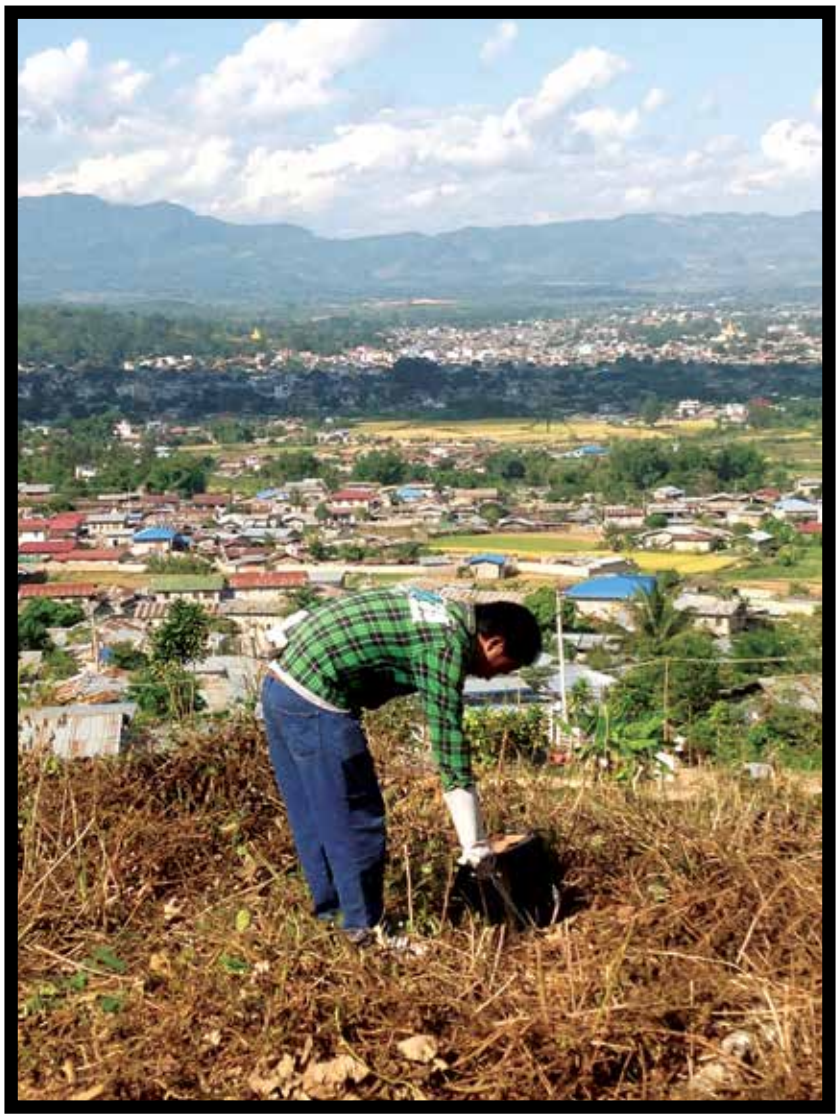
are not drug-user-specific and often function as services applicable to the wider community.

In order to successfully address HIV among PWID, it has been recommended by WHO, UNAIDS and UNODC that countries should prioritize implementing needle and syringe programmes and evidence-based drug dependence treatment, specifically opioid substitution therapy.

Comprehensive package for people who inject drugs – nine interventions

- Needle and syringe programmes (NSP)
- Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
- HIV Counselling and Testing (HCT)
- Antiretroviral therapy (ART)
- Prevention and treatment of sexually transmitted infections (STI)
- Condom programming for PWID and their sexual partners
- Targeted information, education and communication (IEC) for PWID and their sexual partners
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis (TB)

3. Myanmar response for people who inject drugs



Outreach Needle Collection in Lashio (AHRN)

3.1 Needle and syringe programmes

The exact year when NSP started to operate in Myanmar for the distribution of sterile needles and syringes to address the HIV epidemic among PWID cannot be confirmed. However, it was likely these activities commenced unofficially in the mid -1990s, on a small scale and with limited reach. Since its inception, implementation of NSP in Myanmar has been the responsibility of international and local non-governmental organizations, and needles and syringes are distributed primarily through outreach workers and drop-in centres. Since 2003, the number of needles and syringes distributed nationwide was officially recorded, with a slow increase until 2007, followed by a marked steady rise: in 2003 it was 210,000 and in 2012 it was 8,667,544. In 2013, needle and syringe distribution increased, reaching 11,045,607. [51]

Currently the majority of needles and syringes are distributed in Kachin State. A target of 25 million needles and syringes has been set for distribution for 2015 and 30 million for 2016.[52] Challenges remain as the total number of needles and syringes that need to be distributed annually is estimated to be 75 million.[53]

The estimated average number of needles and syringes distributed per injecting drug user per year through NSP was 118 in 2011[54], increasing

to 147 in 2013.[55] As per the WHO, UNAIDS, UNODC technical guide for PWID, a mid-range possible target for distribution of needles and syringes with impact on HIV transmission was 100–200 per PWID per year.[56] In 2012, the number of NSP sites (including pharmacy sites providing no-cost needles and syringes) was reported as 50 sites.[57]

With increased distribution of needles and syringes, the challenges of waste management do surface. A review conducted in 2013 identified that needle collection rates were between 66 and 90% at three drop-in centres (DIC). However, it was also reported that as a result of community anger over discarded needles and syringes at a drop-in centre in Myitkyina, the service was closed down for 12 months.[58] Globally NSP remain the most controversial of all the HIV prevention interventions, largely due to the perception that distribution of needles and syringes encourages drug use. In fact, NSP do not encourage the uptake of drug use, and there is no evidence of major unintended negative consequences of NSP, such as initiation of injecting among people who have not injected previously, or an increase in injecting.[59]

3.2 Opioid substitution therapy

In Myanmar the OST of choice is methadone. The methadone maintenance therapy (MMT) programme is under the responsibility of the National Drug Abuse Control Program, Ministry of Health. The MMT programme commenced in early 2006 and enrolled 260 people in that year. Since 2006 there has been a steady increase: in 2011, 1,637 clients were registered to receive MMT. Registrations increased considerably. In 2013, there were 4,397 MMT clients, representing a 50% increase, compared to 2012. A target of 10,000 clients on MMT has been set for 2016.[60]

During 2006–2010, there were 10 MMT sites increasing to 28 sites by late 2013. In July 2014, there were 6,868 clients currently receiving MMT of which 94 were female. Nineteen per cent of patients dropped out of MMT from January–September 2013.[61] In late 2013, a review of the MMT programme was undertaken and identified a range of challenges: inconvenient operational hours; long distance to travel for MMT clients; lengthy registration process; ongoing injecting among a significant number of clients; long induction period; and lack of confidentiality.[62]

3.3 HIV Counselling and Testing

In Myanmar, the number of PWID that receive HCT is generally low but improves when there is established connection with a service specific to their needs. The Behavioural Surveillance Survey (BSS) 2007-2008 found that in Lashio, Mandalay, Myitkyina and Yangon, the percentage of PWID who had received an HIV test in the past 12 months and knew their results was only 27.3%. Around 50% of PWID reported ever having an HIV test.[63]

Access to Methadone at Station Hospital, Nanpaung village, Lashio (MANA)

In 2010, a study conducted in Lashio among PWID found that approximately 77% of participants had ever tested for HIV. PWID who have received drug treatment were more likely to have tested for HIV.[64]

3.4 Antiretroviral therapy

In 2007, the number of people living with HIV (PLHIV) under ART was 11,000. By the end of 2013 this had increased to 67,643 which represented 54% of all those in need of treatment as specified in national treatment guidelines.[65] The exact number of PWID who are eligible for and receive ART is not known, as ART data by key population groups is not routinely collected. However, the perception is that the number is low. Research shows that PWID can successfully receive treatment and receive the same benefits as others on ART.[66] However, research has shown that PWID experience more barriers to accessing ART for various reasons.[67] There is a commonly held perception that HIV-positive PWID will be poor candidates for ART due to inability to adhere to ART regimes and procedures. At the same time, there are also studies that show that with tailored HIV care for PWID, provision of ART can be successful.[68] Another study also showed that HIV-positive PWID can achieve the same levels of adherence as PLHIV without a history of drug use.[69] In Myanmar, Médecins du Monde (MDM) have been collecting data on ART provision for PWID since 2007 and with impressive results.[ii]

[ii] Data on number of those that cease drug use or remain using drugs after initiation of ART was not collected.

Table 1. Retention and survival rate among PWID receiving ART in MDM sites of Myitkyina, Moegaung and Hopin, 2007–2013 (MDM)

Time period	6 months	12 months	24 months
Total number who received ART	424	375	323
Total number on treatment and alive	392	336	263
Percentage	92.5%	89.6%	81.4%

Table 2. PWID receiving ART in MDM sites of Myitkyina, Moegaung and Hopin, and PWID receiving ART and methadone in Moegaung and Hopin, December 2013 (MDM)

December 2013	Myitkyina, Moegaung and Hopin sites	Myitkyina site	Moegaung and Hopin sites
PWID receiving ART	263	95	168
PWID receiving ART and methadone	N/A	N/A	67
Percentage	N/A	N/A	39.9%

Treatment outcomes have generally improved over the years, mostly as a result of improvements in the treatments available such as MMT. It can be assumed retention and survival outcomes for PWID on ART will continue to improve.[iii]

3.5 Condom programming for PWID and their sexual partners

The BSS 2007-08 found that condom use among PWID varied considerably depending on type of sexual partner. An example of this was among PWID in Yangon, where 14% of PWID who had sex with casual partners (no payment for sex) used a condom at the last time, compared to 60% who used condoms with their last paid partner.[70] The new IBBS of PWID will also collect more up-to-date information on the pattern of condom use of PWID. The importance of condom programming for PWID is acknowledged by harm reduction implementing partners, with condom distribution a key HIV intervention activity.

[iii] Médecins du Monde. ART among people that use drugs. 2014 [unpublished data].

3.6 Prevention and treatment of sexually transmitted infections

Current data on prevention and treatment of STIs among PWID is not yet available. The BSS of 2007-08 does however identify that among the respondents a substantial proportion reported a urethral discharge or genital ulcer in the last 12 months (a range of 9% to 13% had discharge; and 8% to 15% had an ulcer).[71]

Syphilis testing, as part of HIV sentinel sero-surveillance in 2013, shows that among PWID, the prevalence of syphilis (VDRL+) ranged from 0% in Mandalay, Muse, Myitkyina, and Yangon to 3.3% in Tachileik.[72]

3.7 Targeted information, education and communication for PWID and their sexual partners

Information, education and communication (IEC) materials are widely produced by most if not all implementing service providers from the international and national non-governmental sector. The IEC topics covered are broad ranging and include basic information about HIV and AIDS and modes of HIV transmission, safer injecting practices, drug overdose, STIs, and MMT to name but some. An inventory of all IEC materials produced by the majority of implementing service providers has been undertaken. It is unclear to what extent IEC materials are shared among the various implementing service providers at a national level. A national resource centre for harm reduction does not exist.

3.8 Prevention, vaccination, diagnosis and treatment for viral hepatitis

An epidemic of hepatitis C virus (HCV) and to a lesser extent hepatitis B virus (HBV) was identified among PWID in Myanmar.[73] The common co-infection of HIV and HCV among many PWID has serious adverse medical consequences.[74] HCV is highly infectious, much more so than HIV, and unlike hepatitis B, there is currently no vaccine to prevent HCV infection. To what extent HBV vaccination is offered to PWID in Myanmar is unknown but can be assumed to be low. Testing and diagnosis of HCV among PWID in Myanmar are rare, largely due to lack of facilities and budgets to undertake these tasks. Some implementing partners do provide information and education to PWID about the transmission and risk of HCV but knowledge about HBV and HCV among PWID is assumed to be low. For PWID who have HCV and need assistance, treatment is often a complex challenge – prohibitively expensive and beyond their reach.

In 2014, Médecins Sans Frontières (MSF) - Holland announced plans to provide 80 HIV/HCV co-infected patients with treatment in 2015 and 2016 in cooperation with Myanmar Positive Group (MPG), through UNITAID funding. The drug to treat HCV that was selected was Sofosbuvir.[75] Depending on the HCV genotype, the period of treatment can vary between 24 and 48 weeks. The current cost of treatment ranges between US$5,000 and US$10,000.

3.9 Prevention, diagnosis and treatment of tuberculosis

Cumulative data from 2011 and 2012 show that the number of tuberculosis (TB) patients testing positive for HIV and starting ART was 12,887. This number significantly exceeded the 2015 target of 7,216 patients.[76] In 2013, the number of HIV-TB co-infected patients who initiated ART was 3,987, against a national target of 3,323.[77] The number of PWID with TB infection and their HIV testing rate was unknown.

3.10 Issues of coverage

There has been a significant increase in the number of PWID reached by HIV prevention programmes either through outreach or drop-in centres (DIC) in recent years. In 2012, 17,623 PWID were reached by outreach, higher than the target of 12,500 people; 18,781 PWID were reached through DIC, lower than target of 28,000 people [see Table 3].[78] In the same period, the number of people that use drugs (PWUD) reached by outreach was 6,774 and through DIC was 7,509.[79] The frequency of service provider contacts with PWID and PWUD is unknown. With a population size estimate of 75,000 PWID, coverage rates remain low. Still, the potential for double counting of the number of PWID and PWUD reached by outreach and DIC cannot be dismissed. While there is no formal population size estimate of the number of female drug users, it is presumed to be a small number. They face greater stigma and discrimination and tend to be more marginalized than male injecting drug users. Efforts are needed to ensure that women who use drugs can properly access harm reduction services and that their specific needs are met (linkage with Prevention of Mother-to-Child Transmission, family planning, sexual and reproductive health, post-abortion care, nutrition and child support services, gender-based violence response, and legal services).[80]

Table 3. PWID reached by outreach and drop-in centres (DIC) 2011–2012, AHRN, MANA, MDM, MSF-Holland, NAP, UNODC and SARA[81, 82]

	2011	2012
PWID reached by DIC	14,956	18,781
PWID reached by outreach	15,297	17,623

4. Analysis of key informant interviews

Conducting advocacy to community members on harm reduction (SARA)

4.1 Introduction

As highlighted in the literature review, the HIV epidemic among PWID is now entering its third decade and for more than a decade a harm reduction response to tackle this issue has begun to produce good results. However, as mentioned above, overall programme coverage remains low and there is still much more to be done to lower the HIV prevalence among PWID, and to ensure ongoing strengthening of the response. To enhance a greater understanding of the current situation, an extensive series of interviews was conducted with those representing various stakeholders in different parts of the country. The findings from the key informants identified and articulated core issues that range from understanding of the harm reduction concept, the successes and achievements, the challenges and barriers, and a way forward to strengthen an enabling environment, which will further improve the response.

4.2 Methodology

A total of 58 key informants – representing broad-ranging stakeholders from Government entities, development partners, international and national non-government organizations, community based organizations and UN agencies were interviewed. Interviews were conducted over a duration of five weeks from March to May

2014 in Lashio, Mandalay, Myitkyina, Naung Mon Village, Nay Pyi Taw, Sagaing, Theinni, Waingmaw, and Yangon. Interviews were mainly conducted in English and when required, in Myanmar language with English translation provided for the international consultant. All questions raised were semi-structured, and included a series of probing questions to elicit more information on issues directly related to the experiences of key informants (see Annex 1 and 2 for list of those interviewed, as well as a detailed methodology).

4.3 Understanding about harm reduction and HIV prevention interventions

Harm reduction as a concept related to drug use is not new to Myanmar. Official dialogue about harm reduction, accompanied by various degrees of support and service provision for PWID, enters its second decade. Despite the various challenges from within the health and law enforcement sectors, as well as within the wider community, the public health principles of harm reduction have gained incremental positive understanding and recognition as a valuable approach to address the HIV epidemic among PWID. All key informants understand the fundamental theoretical principles of harm reduction to address various adverse medical consequences of injecting drugs, with prominence towards averting HIV transmission. All spoke of the varying degree of the physical and psycho-social costs to the individual but only a few raised the issue of the detrimental impact on the drug user's family and on the wider community. Some key informants commented upon the adverse economic consequences of drug dependency among PWID and their family, and one person raised the loss of education opportunities that results from drug dependency.

> **'Harm reduction is to reduce any harm: health, social and economic. Different types of consequences that are caused due to drug use. We are looking at the individual first and the community at large.' (NGO source)**

> **'Provide services to reduce harms related to drug use. We cannot say or tell people to stop what they want to do, what they are doing. But we can inform them about the drug use issue and about HIV.' (Development partner source)**

> **'Harm reduction is innocent and it is good for the general public. It prevents harm of the drugs to the user, it prevents the spread of HIV and also a way of managing drug related crime.' (Government source)**

Key informants generally acknowledged that not all drug users are able to cease drug use and as a result, a range of interventions should be available to address their multiple health needs. Less than half of the key informants were able to name all nine interventions of the comprehensive package specific for PWID, with the majority of respondents identifying at least five of the nine interventions. Generally the five most commonly nominated interventions include: needle and syringe

programmes (NSP); opioid substitution therapy (OST) with specific mention of methadone maintenance therapy (MMT); HIV counselling and testing (HCT); antiretroviral therapy (ART) and; condom distribution. The other recommended interventions were mentioned by less than half of the respondents: prevention of sexually transmitted infections (STI) was the least mentioned.

Many mentioned outreach as an intervention though this is not considered a part of the comprehensive package as it is viewed as a modality for delivering a specific service, rather than a service *per se*. Income generating schemes and vocational education skill development were expressed by around ten respondents, while some raised concerns of the need for drug overdose management and the importance of *Naloxone* [iv] to address potential drug use fatalities.

> **'A lot of drug users come here due to overdose. In 2013 we had a total of 34 overdose cases and three died due to very late presentation. With the others we were able to give them naloxone.' (NGO source)**

A few key informants commented on the importance of an enabling environment and the need for collaborations to strengthen the impact of harm reduction interventions.

> **'[Harm reduction] activities should be collaborative and involve the non-health sector such as community, law enforcement [and] they need to involve the drug users.' (NGO source)**

4.4 State of progress to the adoption and/or support of harm reduction

Despite the many challenges, Myanmar has witnessed an incremental and steady progress over the past decade towards adopting and supporting harm reduction. This is reflected in the increased number of harm reduction intervention sites established by the international and local non-governmental organizations (NGOs); the government sector involvement; and a commitment by the development partners to support and expand services for PWID. A few NGOs addressing the needs of PWID in Myanmar have been operating for over a decade. Their longevity of involvement has seen a maturing and refined understanding of the various issues to meet the needs of PWID specific to the Myanmar context. With increased development partner support, these same NGOs have not only generally accelerated and expanded their service reach, but also increased efforts to broaden the range of health and social services, when and where feasible, for PWID.

[iv] Naloxone is accepted as a safe medicine with no misuse potential and minimal side effects. It is a highly effective antidote to drug overdoses involving heroin, opium and prescription opioids. Naloxone is mostly administered intramuscularly, but can also be injected intravenously. It works within two to eight minutes to restore breathing, and the patient will quickly regain consciousness. Naloxone is low-cost and is included in the World Health Organization's List of Essential Medications.

Some other NGOs are fairly recent to harm reduction implementation or soon to embark upon servicing PWID at an operational level and remain in their infancy stage, or as described by one key informant 'adolescence' stage. Key informants from UN agencies are keen in their support for harm reduction from a personal perspective. However, they acknowledged from an organizational level full expansion and progress of support towards harm reduction is either curtailed due to financial limitation or harm reduction remains sensitive and misunderstood, with discrimination towards drug users still highly prevalent. Key informants from government acknowledge a slow but growing progress towards support for harm reduction ranging from scale-up of methadone sites to a desire for law reform for a more health-centric approach to dealing with drug users.

> ***'We want to go in a different and new direction in Myanmar such as initiating ART for active drugs users. We piloted it and it worked.' (NGO source)***

> ***'Still only half way in terms of support of harm reduction and there is a long way to go. It is based more on misunderstanding of the concept [harm reduction] and acceptance within the country. We believe that if we push too much it will break down [the progress] and then we cannot repair the damage.' (UN source)***

'We have submitted our proposal to Attorney General Office in 2013 aiming to decriminalize drug users. We do not want the drug user who is not involved in drug trafficking to be sent to prison. We have requested to change sections in the 1993 law from compulsory registration to voluntary.' (Government source)

'For the implementation we are in our infancy but we have strong theoretical background. We have close collaboration with our partners, [and] carried out mentoring and field visits.' (NGO source)

Provision of Primary Health Care Services in Outreach Field, Tangyan (MANA)

5. Successes and achievements

Recreational activities at the Drop-In Centre, painting (MDM)

5.1 Acceptance of harm reduction as public health intervention for PWID

Following many years of advocacy efforts with the health, law enforcement and drug control sectors, official government acceptance and understanding of harm reduction – including a range of health interventions targeting PWID – has increased. Unlike most countries of the world, the concept of harm reduction in Myanmar was first understood, supported and embraced for its pragmatism by the law enforcement sector, specifically the Central Committee for Drug Abuse Control (CCDAC) in 2003-2004. The Ministry of Health (MoH) at the time hesitated and disagreed on the need to provide harm reduction services. However, after one to two years the MoH approved and endorsed the interventions of harm reduction. Historically, the initial transformative changes in policy within CCDAC were directly linked to educational and site visit opportunities to other countries tackling drug use and HIV. When piloting of harm reduction interventions in Myanmar proved successful and compatible to the local context, they soon became the catalyst to expand similar services targeting PWID in other parts of the country.

'We liked the idea [harm reduction] so much. We were losing the battle with drug use and HIV and there was a need to control the problem.' (Government source)

Since the early days, there has been considerable advancement in scaling up harm reduction programmes in Myanmar, even though there are difficulties and at times the pace of change seems too slow. With increasing acceptance of harm reduction services, an increasing number of drug users came forward to connect with outreach workers and NGOs operating drop-in centres – seeking health and psycho-social assistance, and to utilize the recreational facilities.

'There are more harm reduction services for drug users and they are more open to seek the services. Before they were very hidden and did not like to be exposed.' (NGO source)

'Arresting them and putting them into prison does not solve the problem. Drug users still have addiction problems and go back to drug use. Harm reduction is a suitable intervention to minimize risks among drug users.' (Government source)

5.2 Impact of Harm Reduction Programmes

Many key informants acknowledge that harm reduction programmes in Myanmar have been shown to work in some extent where services reach those who need them. However, epidemic modelling projections estimated that new HIV infections through injecting drug use will make up an increasing proportion of all new HIV infections.

'We have seen a real difference in HIV rates among PWID in our area that receive harm reduction services and an area that does not. Lashio Township area HIV prevalence was around 25% [for those PWID coming to our DIC for HIV testing 2005-2013] and in Hsipaw Township, area receiving no harm reduction service, HIV prevalence was around 68% [for those PWID coming from Hsipaw to our DIC for HIV testing 2005-2013].' (NGO source)

5.3 Expansion of services throughout the country

While it is widely accepted that harm reduction programme coverage remains inadequate[v] key informants commented that expansion of services is underway, entering new geographical areas throughout the country – sometimes highly sensitive, such as mining and border areas – and connecting with a range of PWID (such as rural migrants and miners) that earlier received no harm reduction interventions.

'In Sagaing Division there were no harm reduction activities and no harm reduction partners working there. Now they have methadone centres and some partners are going to implement harm reduction activities.' (UN source)

Methadone dispensing (MDM)

[v] HIV prevention coverage for PWID in Myanmar is reported as 30% and is the lowest among all other key affected populations (UNAIDS. Myanmar's HIV Investment Case. 2013)

5.4 Growing acceptance of methadone maintenance therapy

The MMT programme was first introduced in 2006 and experienced various challenges and barriers that hampered expansion along the way. Some key informants commented on a recent rise in political commitment towards MMT, accompanied by open dialogue, support, and flexibility, as well as wider acceptance by drug users and community members. This cumulative and growing support has been a central factor for the rise in enrolment numbers and increase in new MMT sites. In 2011, 1,637 patients received MMT from 14 sites[vi], and as of July 2014, 6,868 patients received MMT from 35 sites. The target for 2016 is 10,000 patients receiving MMT.

'MMT is more popular among PWID and there is more willingness to take MMT.' (NGO source)

'We now have townships requesting [to government health officials] to set up MMT clinics. Take-home dose is limited but it is starting. We thought this might never happen or it is impossible.' (UN source)

'Before MMT, most [PWID] were jobless and some now have resumed their jobs, some have reduced criminal behaviours and families are very happy because their children are changed after MMT. Methadone is a success and I am satisfied with the results.' (Government source)

Key informants commented that as it is a medicine, methadone is better understood and accepted. Some communities have recently requested Government to establish MMT programmes for drug users in their communities.

Additionally, MMT enrolment criteria for patients have also improved. Referrals to MMT clinics have increased; induction to MMT inside a clinical setting are no longer mandatory; and workshops and training programmes on MMT are consistently provided. Current funding for MMT is internationally sourced but future domestic funding is likely and for sustainability most encouraged, given the positive perception towards MMT by Government and communities.

'We are not sure about the funding of MMT after 2015, so we need to put some budget from the government to prevent a problem in case we will not receive the funding.' (Government source)

[vi] Global AIDS Response Progress Report Myanmar 2012. Naypyitaw, National AIDS Programme, Ministry of Health, 2012.

5.5 Needle and syringe programmes

According to key informants, sometimes against the odds, the number of NSP sites has expanded around the country and the distribution of needles and syringes has increased. With the introduction of NSP, behaviour change has been encouraged and through one-on-one or group education sessions, some key informants expressed that needle sharing has decreased and safer injecting practices have resulted in fewer incidents of abscesses among PWID. In some areas of the country some key informants spoke of a trusting and stable relationship between harm reduction service providers, 'shooting galleries', and those running the sites in carrying out NSP. With minimal interference of law enforcement, a smoother health delivery service is ensured that results in less discarded needles and syringes and reduces community concerns about NSP. However on the whole, there is agreement that the scale of success with NSP has considerable scope for improvement and does not match the current acceptance and support of MMT provided by government or increasingly by the wider community.

> **'Local ethnic community has acknowledged drug users and that they need help. The NSP is able to be implemented despite the drugs eradication policy in place.' (NGO source)**

> **'It is clear to us there is direct link of the NSP undertaken by our service and a decline in the prevalence of HIV among injecting drug users.' (NGO source)**

5.6 Implementation of diverse services for PWID

A few key informants highlighted a variety of important successful innovations to ensure services and interventions meet specific needs of PWID. These include: successful provision of ART for active drug users; introduction of a mobile clinic to undertake active case finding of tuberculosis; 24-hour health care services for PWID living with HIV; nutritional support for PLHIV with TB coinfection; free transport services to assist patients to receive routine MMT and minimize drop-out; and income generating schemes for drug users.

> **'We have a 24-hour care centre service [and] normally with government this is not allowed. We see lots of drug users with advanced stages of HIV badly in need of ART. We use a buddy system where someone who is very ill has someone to care for them. For some it was like receiving palliative care, as they are very sick.' (NGO source)**

Referring clients to MMT centre (Burnet Institute)

It is acknowledged that HCT among PWID is low but recently as a result of advocacy, decentralizing of HCT and initiated training programmes, the number of PWID receiving HCT has increased in some areas through NGO services. A few key informants also remarked that for drug users enrolled in MMT, opportunities to partake in HCT are enhanced.

5.7 Emergence of drug user groups

Formation of drug user networks and support groups has resulted in increased civil society engagement. Networks and community groups have become increasingly pro-active, expressing their concerns and issues affecting their communities much more openly. Key informants commented on a growing recognition of the importance to encourage drug user participation in forums, meetings and workshops to discuss their concerns with government officials from different sectors (including parliamentarians), NGOs, development partners and UN agencies. This is a major positive breakthrough despite the various challenges that remain. Furthermore, drug users have come together as a community to assist other drug users to develop a sense of empowerment; support other drug users with health improvement and palliative care; and to also regain a sense of dignity when many experienced abandonment by the community and family members.

'The network had 24 drug user groups in 2009 and now it has 36 drug user groups in 10 regions of Myanmar. In 2013, there were 1,800 members in the network.' (Community Based Organization (CBO) source)

'We have saved a lot of lives, helped with overdose cases, taken care of neglected and sick drug users and those that are HIV infected, and we also do home based care for drug users with HIV.' (CBO source)

5.8 Rising opportunities for potential legal and policy reforms

Despite acknowledgement of the challenges and delays associated with legal reform, a number of key informants are encouraged that the political and legal environment appear more conducive to openly put forward recommendations for review and revision, legal barriers that negatively impact upon the lives of drug users and deter them from accessing harm reduction and health services. Some key informants commented on the greater interest and explicit support among some government officials (both from health and law enforcement) not to view drug users as criminals but as those needing medical assistance. A few key informants commented that as a result of increased understanding of harm reduction and the lives of drug users in general, there have been fewer arrests of PWID in some townships. However, this is not the perception of all: others believed the opposite, commenting that the rise of police crackdowns against PWID had led to disrupted services and arrests.

'In the national legal review workshop at the end of 2013, one member from CCDAC spoke openly about decriminalization and how to treat and consider drug users. Before these issues were mainly advocated only by local and international NGOs. Now the government and parliament are interested in these issues.' (UN source)

5.9 Improved funding opportunities for harm reduction programmes

A more recent rise in development partners' support to fund harm reduction programmes has led to an expansion of activities and geographic sites. A few key informants remarked this increases opportunities for implementing partners to attend events, with specific objectives, that allowed for improved coordination and cooperation as well as sharing of information and learning from others in the field. While such initiatives are fairly recent, they do bode well for future gatherings as more implementing partners expand their coverage areas and scope of work.

6. Challenges and barriers towards adoption and support of harm reduction approaches

Seminar on responding to drug use and HIV — Chief of Police provided the opening remark (UNAIDS)

Despite the significant achievements of harm reduction programmes, key informants provided an extensive list of challenges and barriers that impact adversely upon the response to HIV prevention among PWID in general. Prominent themes most commonly raised by key informants are as follows.

6.1 Legislation, policy and practice

Although steps are underway for legal review and amendment of the Burma Excise Act (1917) (specific to possession of hypodermic needles) and the Narcotic Drugs and Psychotropic Substances Law (1993) (specifically mandatory registration for drug treatment) the fact that these laws remain in place has created an environment that directly hampers harm reduction interventions. Needle and syringe programmes (NSP) are an essential HIV prevention service for PWID but despite support in the National Strategic Plan on HIV and AIDS 2011–2015, it remains directly in conflict with an existing law. Key informants commented that the impact of the Burma Excise Act (1917) contributes to the lack of commitment, undermines support and promotes uncertainty towards NSP. The negative consequences of this law are undesirable, especially when NSP is much more difficult to market for wider acceptance than any other harm reduction intervention. The Police Department issued a Directive in 2001 to police officers not to arrest PWID in possession of needles

and syringes but some key informants commented that in reality not all police are aware of the Directive, or through rotation and reassignment to other townships, the Directive becomes forgotten. As there is no evidence of a written directive, it leads partner to believe that was only verbal directive.

'The law is not helping those with drug addiction because the MoH and doctors are hesitant to initiate the ideas of harm reduction responses…possible problems with the police may arise.' (NGO source)

'There is still an issue of arresting drug users when found with a needle in hand and this makes the user not bring back the needle. It is not supposed to happen this way but this is the truth.' (NGO source)

'The law [Burma Excise Act (1917)] is still there and can be used at any time to disrupt the delivery of services.' (NGO source)

Implementation of the law varies: some key informants from both the NGO and law enforcement sectors commented that PWID in possession of needle and syringe are not arrested solely for possession of the injecting equipment, but they would be arrested if found with drugs and needle/syringe. However, some key informants commented on a common perception among PWID that simply having needles/syringes on their person may lead to potential threatening questioning and creates genuine fear of arrest. One potential consequence can be the hazardous discarding of needles and syringes by PWID in a public area upon sighting of police officers.

Key informants commented that many drug users remain fearful to be registered for drug treatment as it stigmatizes them and contributes further towards a criminalizing of their behaviours if they relapse or do not oblige with current legal requirements. Beyond the policies of the central Government there are also some conflict areas that are controlled by insurgent groups where drug use is reportedly widespread, which have adopted a drug eradication policy. This policy has resulted in major implications for PWID who are targeted harshly for their behaviours. Such a policy has been very disruptive and seriously challenged the delivery of harm reduction services in these areas.

'For drug use the person has to register. This is bad for the individual but also for the family. The family then has a bad reputation that they have to live with. There is fear among drug users to be registered.' (Government source)

6.2 Lack of service providers, skilled human resources, technical capacity and low coverage

Despite a growing increase in donor funding towards harm reduction, there is a limited number of implementing partners skilled in harm reduction interventions to match the magnitude of need. This situation adversely impacts upon increasing the coverage of services for PWID. Some key organizations with a long history in harm reduction are increasingly stretched and have reached their maximum capacity to deliver quality services deemed necessary for their client group, despite repeated requests by development partners to scale up and cover more clients. While new implementing partners are being recruited to deliver services, some of these new partners are still lacking strong technical knowledge and equally important, organizational management capacity for field implementation. These factors are especially critical in sensitive areas where no prior harm reduction interventions have been implemented.

Key informants generally agreed there is a lack of in-country capacity to deliver sufficient services to PWID at a scale that is required at this point in time. It was also voiced by some key informants that technical capacity is lacking among some agencies including the National AIDS Programme and those under the umbrella of the United Nations system. There has been no leadership to move forward the harm reduction agenda.

> **'We are looking for other partners to get involved and the Global Fund had to call out for tenders twice as there were insufficient numbers that applied.' (Development partner source)**

> **'There is a lot more money [for harm reduction] but the capacity to absorb these new funds will be difficult.' (NGO source)**

The problems and concerns of a shortage of implementing partners in harm reduction is further compounded by insufficient human resources skilled enough to work and deliver the types of services necessary to match the health needs of PWID. Key informants commented that it is not enough to just secure staff with technical skills to work with drug users, but also needed are staff with a comprehensive skills set, including: financial management, monitoring and evaluation, general data management and report writing. This high standard requirement increases the difficulty in recruiting staff. It is acknowledged by Government representatives that services for drug users are needed but there are human resources constraints that need to be addressed.

'It is very difficult to provide monitoring and evaluation information and give financial reports on time. We need people with specialized skills and such people are not easy to find. We need skilled staff at the local level [but] educational level of the local people is limited. Staff are not able to do their job very well.'
(NGO source)

'We want to open more sites (MMT) but skilled staff are lacking.'
(Government source)

'We face turnover of staff [and] it is hard to get quality staff to be sent to project areas where there are challenges. They are hardship posts and isolating to work. There are more employment opportunities compared to the past… we cannot always recruit the type of staff we would like.' (NGO source)

6.3 Geography, mobility, sensitive areas and specific groups of PWID

There are concentrated groups of PWID in areas that are often geographically remote and isolated. Due to poor road conditions, reaching those areas with harm reduction services is difficult. PWID can also be found in areas that commonly report episodes of conflicts and insecurities, and this severely disrupts service delivery. To date, health and harm reduction services remain limited in geographic areas that are remote or sensitive due to conflict and insecurity. Lastly, some key informants also raised the mobility and migratory patterns of some PWID, which further add to the challenges of expanding harm reduction services to reach more PWID.

[There is] mobility of drugs users, such as in gold mining areas. For the mining areas we only reach drug users through outreach activities. They don't come to the DIC as they stay in the mining area, so they do not access the full package of services. Sometimes we can offer needle and syringe and some health education but that is all. They only come back to main town [where there are more services] when the mines are closed for the season. The roads to the mines are also very poor.' (NGO source)

'Drug users in mining areas often have poor injecting techniques. They don't mix heroin with water before injecting. They inject heroin directly into the vein, withdraw blood and push back the mixture into the vein. This method of injecting heroin damages the vein.' (Government source)

Some key informants voiced concerns that new young PWID and female injecting drug users are considerably much more hidden; fear exposure; are difficult to access; and are highly reluctant to seek out and attend services. Currently there is only one known service provider specifically targeting female injecting drug users with a female specific drop-in centre. Such a service comes at an additional financial cost, as it serves a small group at high risk but with multiple health and social needs.

> **'Even though there are female users they do not want to come to the DIC and get services. There are a few female injecting drug users we are aware of but they do not come forward to the service.' (NGO source)**

A few key informants voiced their concerns that funding is primarily targeted towards PWID and not adequately focused on non-injecting drug users that engage in risk behaviours associated with a rise of amphetamine-type substance use.

6.4 Police crackdowns

A number of key informants identified that in 2013 there was an increase in police crackdowns resulting in adverse consequences, including: disruption of service delivery; an increase in arrests of PWID; fear of arrest among PWID (which deters them from accessing services and attending DIC); an increase in discarded injecting equipment; and a decrease in return of needles and syringes. The reason behind the police crackdowns is not clear but some key informants suggested a range of possibilities: police needing to fulfil specific arrest quotas and follow set schedules; police officers not familiar with harm reduction interventions (due to rotation and reassignment); or the police and/or government responding to expressed concerns of the wider community to clean up the area of drug users. A few key informants commented that orders for arrests originated from local government and not from the central level, while some thought there was collaboration and communication between the two levels before police crackdowns took place. Other key informants also commented that sometimes police conduct crackdowns to target drug dealers, but often it is difficult to differentiate between drug users and drug dealers, so police end up arresting drug users even though they may have been only targeting the dealers. In conclusion, no matter what the reason for the crackdown, crackdowns lead to adverse impact on harm reduction activities.

'With police crackdowns occurring more frequently, the situation is getting worse. Drug users are dispersed, shooting galleries are dispersed and then it becomes very difficult for the service providers to find the drug users. Because they fear arrest, when drug users see police officers, they discard their needle straight away after use. Data shows that in areas where police crackdowns occur, the return rate for needle and syringe has reduced from 90% to 40%.' (NGO source)

'Drug users are put into prison and then they are not able to access ART, condoms and NSP.' (NGO source)

'We have not yet heard about the closure of a service but we know that when there is a demand from higher level authorities to arrest PWID, there is a type of obligation [by police at township or community level] to follow orders.' (NGO source)

'Police crackdowns have already happened twice in 2014, leading to more dispersal of drug users and injecting sites. There used to be four shooting sites in town and now there are none. Drug users have shifted away, difficult to find, and not even coming to DIC... could be fear of arrest by the police.' (NGO source)

6.5 Role of police and Central Committee for Drug Abuse Control

A critical component of any enabling environment is to ensure wider understanding and acceptance of harm reduction with the involvement and partnership of the police and Central Committee for Drug Abuse Control (CCDAC). As earlier reported, CCDAC have played a pivotal role in the introduction of harm reduction to Myanmar and despite some challenges along the way they have maintained a commitment to the harm reduction concept for many years. However, some key informants commented that while understanding of the harm reduction is mostly good at the higher central level in both CCDAC and law enforcement, at the field level the messages of harm reduction are generally not as clear, creating a less conducive environment for harm reduction operations. Some key informants remarked that some police officers at the field level have poor understanding of harm reduction and this may be associated with routine rotation of police officers at field level. Information dissemination and local advocacy efforts with the police are essential but require time and are a huge investment effort for service providers.

'The changing and transferring of police from one post to another requires repeated advocacy and sensitization to the new person and this requires training for the staff.' (NGO source)

'When it comes to law enforcement and responses, messages from the higher level authority are not reaching the township and grassroots level. There are always going to be strong personalities within the police that are going to dislike PWID. Perhaps there are no mechanisms in place to address issues of harm reduction and police when such personalities take a dislike of PWID' (UN source)

Between 2005 and 2012, the Central Police Academy conducted training programmes on the principles of harm reduction in which thousands of police officers participated. However, after 2012, these training opportunities ceased. Some key informants commented that this would be revived under UNODC in the future. To date, HIV-related resources for development partners to support the engagement of police and CCDAC on harm reduction activities have been limited.

6.6 Decreasing of the enabling environment

Despite an expansion of harm reduction interventions and the government officially endorsing harm reduction activities, some key informants commented that the enabling environment for harm reduction is decreasing whilst a transition to democratic processes and freedom of expression is rising. With drug users commonly viewed as criminals, a new constraint emerges when the wider community is permitted to become more vocal with local concerns; make certain demands; and scapegoat others that do not follow accepted norms of behaviour. When this is accompanied by generally misinformed opinions about PWID, it can contribute towards a less conducive environment when implementing harm reduction services. Compounding the challenges, many key informants voiced concerns that the harm reduction concept remains widely misunderstood by the wider community, many government officials and the police in general.

'Acknowledging the extent of drug use here can be seen as a failure of the administration. Cleaning up the community is popular in Myanmar at the moment. Harm reduction issue is a hard message to sell due to its complexity.' (NGO source)

'Some political authorities are following the desire of the community and using this to their own advantage in their campaign to get more votes. Some with political aspirations are expressing, as part of their campaign, an anti-drug message that impacts on servicing drug users.' (NGO source)

6.7 Waste management

Myanmar has seen an increase in the distribution of needles and syringes and a fundamental task of NSP services is to ensure recollection of used injecting equipment. However, key informants commented that at various locations, for different reasons, the return of needles and syringes has sometimes been disrupted, incidents of discarded needles have increased (commonly linked to police crackdowns), and the wider community has responded angrily to such incidents. Trust and understanding about NSP between the service providers and the wider community in some areas are under threat and have sometimes proved volatile.

The challenge is to manage the expectations of the wider community about discarded needles and syringes and move towards improvements in overall waste management to minimize further disruption of NSP services.

> **'The discarding of needles is an issue. Due to the law they [drug users] do not want to hold on to needles for a long time. They prefer to just throw them away to avoid police detection and possible arrest.' (NGO source)**

> **'We even received complaints from the community about the bad smell from incinerating [needles and syringes] and had to shift to the cemetery [to undertake this activity].' (NGO source)**

6.8 Stigma, discrimination and misunderstanding of drug dependency

Key informants widely agreed that drug users are highly stigmatized and discriminated against by majority of people and that drug dependency as a health issue is rarely understood. As a consequence, a drug user is commonly viewed as a criminal rather than as a person that requires health services that address their specific needs. Stigma and discrimination towards drug users is mostly endemic and perpetrators are those that closely interact with drug users such as public health providers, law enforcement authorities and other service providers. Many key informants agreed drug users are a population group viewed with prejudice and distrust. Despite the widespread stigma and discrimination, some key informants commented that in some areas drug users have become more open and outspoken, while in other areas many drug users fear exposure and prefer to remain hidden.

> **'The perception of the community is drug use is not accepted. There are posters displayed in various parts of the country 'This is a Narcotic Free Zone'. Posted in public places they have made the people perceive drug users as criminals and if they are found, they should stop using.' (UN source)**

'There is a very low knowledge on drug dependency even among the doctors. Their understanding of the issue is low.' (NGO source)

'Police have their own perception about drug users and changing this can be very difficult.' (NGO source)

'There has been no proper journalism school and when they [journalists] cover drug use issues they are mostly not well informed. The news they release could worsen the situation [drug use and criminalization].' (NGO source)

This is our fourth DIC since we started, as we needed to move due to pressure from the local community… understanding of drug users is still low.' (NGO source)

Away from prejudice – resting at the Drop-In Centre (MDM)

6.9 Service limitations: NSP, MMT, HCT, ART and hepatitis C testing

Despite a tolerance towards NSP, as mirrored by an increase in NSP sites and distribution of needles and syringes, reservations towards broad ranging support for NSP still remain firmly in place. As a consequence, coverage, distribution and availability of clean injecting equipment for PWID are often limited. Some key informants commented that communities have a perception that NSP services lead to an increase in drug use and number of drug users in the communities. As a result, communities have often attempted to close, shift or interfere with NSP operations.

> **'Some government people still do not accept NSP as they believe needle and syringes promotes the using of drugs, and this thinking can also be found within those from the religious community.' (NGO source)**

In the past two years, MMT sites have increased, as has the number of people receiving MMT. However, a number of key informants commented that as demand increases for methadone, the scale and coverage of the MMT programme still remain inadequate. A long list of challenges for MMT raised by key informants included: inadequate doses; cases of unnecessary in-patient induction (which is no longer mandatory); in-patient induction requires payment for daily food; lack of take-home doses; high daily transport costs to MMT site; large distance of MMT clinic from the patients' residences; inadequate skilled staff and resources; too many patients preventing regular follow-up; patient files displayed publicly in breach of confidentiality; limited space of clinic; complicated referral process for some patients; security issues preventing opening of sites, transport of methadone (to insecure sites); and limited options as to where and by whom methadone can be prescribed and dispensed.

> **'There is still a lot of resistance that this [methadone] should be provided at hospitals. Some psychiatrists still admit individuals to a [drug treatment] centre.' (DP source)**

> **'There is a limited number of psychiatrists in the country for MMT. The MMT clinics or satellite sites are under supervision of a psychiatrist. Sites can't be expanded unless there are adequate numbers of supervisors to supervise all the clinics. The plan is to shift the task under the township medical officer (TMO) but still the TMO will be under the supervision of a psychiatrist.' (UN source)**

> **'The cost of MMT is high because of staff costs. Costs include salaries for nurses and doctors as well as transport costs for drug users coming to the MMT clinic seven days a week. In some MMT centres, INGOs are providing their own staff for the centres… otherwise there will be no staff at the centres.' (NGO source)**

Many PWID in Myanmar have undiagnosed HIV infection and are not aware of their status. Despite some increase in PWID coming forth for HCT, and a rise in the number of PWID enrolled in MMT and receiving HCT, the majority of PWID are not aware of their HIV status.

Some key informants acknowledged that PWID who are living with HIV are not on the priority list among service providers to receive ART, partly due to ongoing stigma but also to a conviction that they will not adhere to the treatment regime. In Myanmar, while there is no data of the number of PWID receiving ART, it is widely believed to be low. Research shows that hepatitis C virus (HCV) and HIV/HCV co-infection is widespread among PWID, yet there is a general reluctance to undertake HCV testing of PWID with some key informants voicing a dilemma around identifying a medical condition for which treatment options can rarely be offered due to the prohibitive cost of hepatitis C treatment.

> **'It's a dilemma - what can we do if a drug user tests positive [for hepatitis C]. Is it ethical to test without providing treatment if the result is positive? Or is it enough to just do counselling and education; is it enough and effective? We think that by testing for HCV it allows us to understand the magnitude of the problem.'**
> **(NGO source)**

Lastly, some key informants voiced concerns that in remote areas there are limited health services (and infrastructure including equipment) available to refer PWID to, including services for diagnosing and treating STIs; detecting TB or drug detoxification and treatment.

6.10 Drug treatment

Some key informants raised the issue of the shortage of drug treatment centres (DTC) as a major challenge for those wishing to cease drug use. There has been a slight rise in the number of DTC (from 68 DTC in 2013 to 75 DTC in 2014) but this is believed inadequate to meet the demand and the estimated number of drug users. It is interesting to note that DTC primarily offer detoxification only (generally over 14 days, but sometimes longer), and it is free of charge (although food costs commonly amount to 2,000–3,000 kyats[vii] per day). While some further health assistance may be offered at drug rehabilitation programmes, in Myanmar such additional assistance is limited. Currently there are 12 drug rehabilitation centres in Myanmar: three under the responsibility of the Ministry of Home Affairs, and nine under the responsibility of the Ministry of Social Welfare, Relief and Resettlement.

[vii] At time of writing, US$1 = 960 kyats

In Myitkyina, there is a rehabilitation centre that accommodates ten people and the average stay is one month, whereas in Mandalay Region there are around 10-15 beds. International evidence shows that detoxification alone is highly unlikely to be effective in helping the majority of drug users achieve long lasting abstinence.[viii] Key informants directly working with drug users at drug treatment centres commented that the majority of drug users coming for treatment or 'around 90%' relapse post detoxification. Linkages and communications between the Ministry of Health and the Ministry of Social Welfare, Relief and Resettlement on the issues of detoxification and rehabilitation are considered to be lacking. Despite the increasing availability of methadone, there are some in the community that are still ideologically opposed to this form of treatment, as they perceive provision of methadone as moving from one drug to another, and all drug use should cease.

'Currently there are not enough treatment opportunities and drug treatment centres. Some DTC are far from the people that need them. It is possible there are 300,000 drug users in the country. If we just say we cannot give treatment and that we just do NSP and condoms you can imagine what the community will say and perceive of the service.' (NGO source)

'Rehabilitation programme is very weak with people on treatment programme relapsing soon after discharge. Many drug users want to quit but there is no psycho-social support, job opportunities or vocational training.' (NGO source)

'If patients want to go for rehabilitation we can refer them. We have only referred three or four patients for rehab in the past 12 months. Each patient can stay for two months but not all services are free.' (Government source)

6.11 Guidelines and standard operating procedures

Some key informants voiced their concerns that although there is considerable support for the expansion of harm reduction interventions, lack of technical guidelines and various standard operating procedures (SOP) diminishes the advocacy efforts, technical capacity, and collective, cohesive response among those working in the area of harm reduction. Key informants suggested the need for guidelines and/or SOPs on the following topics: harm reduction; outreach and peer education; methadone; NSP and waste management; monitoring and evaluation specific to PWID programmes; overdose management; and addressing health issues related to other drugs such as amphetamine-type substances.

[viii] UNODC. Best practices for drug addiction treatment: a review of contemporary drug treatment approaches. UNODC, Bangkok, Thailand, 2004.

'There are no proper concrete national guidelines for harm reduction in Myanmar. It is necessary for advocacy when you need to speak to people who don't understand harm reduction [and] it is important for the government.' (NGO source)

'There are no guidelines on what to monitor and thus the uniformity of what is monitored is lacking.' (UN source)

6.12 Registration of drug users groups

While there are encouraging efforts underway to assist in the registration of drug users groups, (although those with prison records are not permitted to register as a group), the process is not yet finalized. Some key informants commented that not being eligible to register hampers development within unregistered networks and limits the legitimacy of many that are most affected by drug use and HIV issues—the drug users themselves.

'… the history has been that if you have been to prison you cannot be the head of an organization and the organization cannot be registered.' (CBO source)

6.13 Multi-sector collaborations

Harm reduction as a public health intervention requires a multi-sector approach to achieve the best outcomes. There are many events, meetings and workshops in which representation from various sectors is now the norm. Some key informants believed multi-sector collaboration is working well. Yet, others voiced concerns that there is some fragmentation between and within government stakeholders undertaking specific tasks, which are considered too narrow for a comprehensive response. This approach is considered counter-productive when many issues and activities in harm reduction are highly inter-connected and overlapping. As a consequence, further efforts are required to improve collaboration between and within the sectors.

Key informants commented that power play between different sectors could have negative impact on programmes on the ground. Coordination meetings are too infrequent or not well enough facilitated to achieve good results. Key informants also expressed concerns that there are inadequate linkages between sectors (National Drug Abuse Control Program, Ministry of Health, and Ministry of Social Welfare, Relief and Resettlement) to respond to needs such as drug treatment and rehabilitation. In Myanmar's political transformation, the role of parliament is a new factor in the equation. One key informant commented that a major challenge is to balance the enthusiasm of members of parliament with their limited understanding and technical knowledge of the issues.

'Multi-sectoral collaboration remains a challenge and we need to collaborate more to solve the problems of drug prevention and control. It is a delicate and sensitive topic and organizations or the government cannot do it alone.' (Government source)

'When we conduct a workshop we would like more sectors involved so we need to create more chances for them to come. The Parliament, the ethnic group leaders, community leaders, etc. are often not present in our meetings or workshops.' (NGO source)

'People come to meetings, but still problems occur as they have their own priorities such as addressing supply reduction.' (NGO source)

6.14 Prisons

Key informants voiced their concerns of the need to provide health services to prisoners and the challenges involved. It is widely acknowledged that many drug users become incarcerated; some are living with HIV and lose access to services that they had accessed earlier, which seriously compromises their health status. In Myanmar, while there have been pilots of different programmes such as HIV awareness-raising for prison staff or provision of HIV-related services in prisons (through informal agreements), these interventions have not been scaled up nationwide and existing services have experienced disruption.

6.15 Development partners

Myanmar has seen some additional resources for harm reduction with the Three Diseases Fund (3DF), Global Fund and 3MDG Fund. However, key informants commented that there needs to be a shift in the way donors allocate resources: there needs to be flexibility in funding interventions according to the demands and needs of the specific communities and not according to a set formula to be prescribed for all project sites across the country. Key informants recommended that better coordination and harmonization of the meetings between the development partners and implementing partners would lead to more fruitful results.

'Donors do not seem to understand that there are a lot of start-up costs when setting up interventions in areas where there have been no earlier harm reduction services. As a result NGOs tend to compromise on these costs and this impacts upon the quality and capacity to deliver the service.' (UN source)

'Need to improve coordination and communications among donors… ensure activities and funding are not overlapping and ensure greater efficiency in use of money. If not it's messy for all involved.' (NGO source)

'Different donors are hiring different consultants who are doing the same things.' (NGO source)

6.16 Sustainability and predictability of funding

Some key informants voiced concerns on the difficulties of securing funds, and on the insecurities of maintaining ongoing funds to carry out operations.

'The lack of predictable, ongoing funds is one of our challenges. In the past, we were often facing situations of lack of funding. Now, funding is not consistent. It is off, on, off, on.' (NGO source)

7. Improving the enabling environment and strengthening the response for the way forward

Mobile Clinic in Kone Chan (AHRN)

7.1 Legislation, policy and practice

Procedures to amend the Burma Excise Act (1917) and the Narcotic Drugs and Psychotropic Substances Law (1993), (specifically section 15 related to mandatory registration for drug users) are underway. It is important to note there have been earlier attempts to amend the same laws, without any success. Key informants commented that legislation change can take years, but it is an important agenda item that needs to be pursued through ongoing dialogue and advocacy efforts with decision makers and those that have appropriate connections and influence. With increased focus on harm reduction interventions there is growing momentum of support that could realistically allow for legal changes and amendments in line with the nation's changing political landscape in recent times.

'Having a law that puts a person in prison for 3–5 years needs to be amended. Since three years we have been trying to amend the law. Now we are waiting comment from the Union Attorney General. After getting review from them we will then present to our Union Minister and after that the President's Office.'
(Government source)

'Needles and syringes are widely available throughout the country. People demand using disposable clean needles and syringes. From a medical point of view this is good practice. Why do we want to arrest people just because they have needle and syringe?' (Government source)

7.2 Training, education, information materials, and technical capacity building

The pool of skilled human resources for harm reduction programmes in Myanmar remains insufficient. Many key informants stressed the need to increase education and training on various aspects of harm reduction for potential new partners and all other sectors that include: legal; medical; nursing; law enforcement; policy makers as well as key players at community and township level, where harm reduction interventions take place. They also highlighted the need to identify and recruit new organizations to work on harm reduction to complement the few organizations operating in Myanmar. A systematic and focused awareness-raising programme to improve insights more broadly about drug use, harm reduction issues and drug dependency as a health issue, would contribute towards a more supportive understanding of this sensitive topic. Building the technical capacity for community based organizations and networks of drug users is also critically needed in order to empower community representatives and ensure their inclusion in forums and meetings where they will have opportunities to advocate strategically for their rights and needs.

'There is a need to strengthen the capacity of civil society from the grassroots level. Assist self-help groups among IDUs, and assist them to build their own capacity.' (NGO source)

Key informants expressed a desire for the development of a series of training packages, guidelines, standard operating procedures and various briefing papers targeted to specific audiences. All educational materials need to be practical, appropriately translated into local dialects when and where needed, and suited to the cultural context of Myanmar. These educational materials could be compiled in an information repository or resource centre and over time would build up the local knowledge and capacity to respond to the current situation. Importantly, efforts should be made to ensure that local people take ownership and, with appropriate support, sustain the ongoing training and educational development requirements as new issues and challenges emerge.

'There is a need to build a workforce for harm reduction… should develop a place where it can provide training for doctors, nurses, outreach workers, supervisors, and counsellors, and provide them with some type of certificate or diploma. Training can be provided at government centres or private centres recognized by the government. This will create efficient, professional, and better trained staff.' (NGO source)

'With training there needs to be a clear curriculum and guidelines on harm reduction that include a multi-sectoral approach. Training should include site visits and on-site practical training.' (NGO source)

'We want to have brief guidelines and reference documents, if documents are too long, people will not read them. Question and answer format is much better as here, people are busy with so many tasks that there is not enough time to read.' (UN source)

Technical agencies exist to provide guidance and strengthen capacity among organizations. Some key informants suggested that it would be worth exploring and engaging with other technical agencies to add new energy, fresh ideas and value to the current response to various drug use issues. These issues can range from prevention, treatment and psycho-social aspects, as well as community reintegration through rehabilitation and holistic support for recovering drug users.

An enabling environment for harm reduction requires a well informed and positively engaged law enforcement sector but some key informants voiced concerns that recently this has generally been lacking and needs revisiting. Even with the potential to revive police training on harm reduction issues at the Central Police Academy, among operational police at the township level such training opportunities are absent. As stated earlier, it needs to be noted that training of police at the Central Police Academy on harm reduction existed for many years but once the international funding ceased the harm reduction training programme stopped. Lessons learnt from the non-sustainability and ownership of the programme require serious reflection to avoid a potential repeat of this scenario in the future. Key informants remarked on the need to develop the technical capacity to know how to move the agenda forward and to be more visionary to ensure a greater, more sustainable response. It appears that interest within CCDAC and the law enforcement sector to re-engage on harm reduction issues exists, and should be pursued.

'The police force to be targeted would be those that have come out of the police academy and have lots of operation side policing. We need to train police at the township level. Train the police field officers and their subordinates who take the orders.' (UN source)

'We should not depend only on Police Academy. Provide training of the police force around the country where township level police can provide training of trainers and more training.' (Government source)

'Training curriculum at police academy needs to be revisited and we need to try and institutionalize the training approach so it becomes more sustainable.' (Development partner source)

7.3 Advocacy, sensitization towards harm reduction and of drug users

Many key informants commented that advocacy efforts need to be accelerated, ongoing and applied to all those that can influence the strengthening of the response. Advocacy would be targeted towards those in top leadership roles in government bodies (such as Parliamentarians, Ministry of Home Affairs, Ministry of Health, CCDAC, law enforcement, Ministry of Social Welfare, Relief and Resettlement, General Administration Department), policy makers, media workers, local religious leaders, and to the wider community in the State/Regional and township levels. Many key informants commented that advocacy and engagement at the community and local levels would promote improved understanding of the issues leading to a more sustainable outcome.

Key informants commented that misinterpretation of harm reduction principles and the comprehensive package of interventions does exist at various levels. For example, despite the existence and expansion of NSP (officially endorsed for over a decade) key informants commented that there is still persistent resistance and reservation towards NSP. Currently, this HIV intervention requires regular, routine and convincing advocacy efforts and messages to various relevant stakeholders to highlight cost effectiveness and positive health outcomes.

'We have advocated four times already with the police and we mention NSP and they are OK. We have discussed with senior monks and they approve of what we do. Some monks are aware of drug use and HIV and believe having a service for drug users is a good thing.' (NGO source)

Some key informants remarked on the need to build leadership skills and the ongoing search for 'champions of influence' (which can include high ranking government personnel) to market the concept of harm reduction and promote a more health-centric response, as opposed to criminalization of drug users. To ensure the expansion, support, commitment and endorsement for harm reduction programmes, the messages and interventions need to be socially, politically and culturally sensitive.

'Need to sell the harm reduction issues among the community more widely. Approach the message of harm reduction in a marketing kind of way. Advocacy with the correct message, which highlights the pros and cons. Need to have more spin doctors to sell the product of harm reduction, which is no easy task as it can be seen as a product that nobody really wants.' (NGO source)

'We need to meet and convince parliament speakers to understand the concept of harm reduction and commit to help in endorsing law and policy changes.' (Government source)

'We think having the harm reduction response in the national strategic plan would be enough but it is not proving to be the case. We need to advocate and communicate more at the top political level with people from MoH, MoHA, prisons department, CCDAC, parliament, and the media.' (NGO source)

Health issues in general have not held the highest priority for the government, despite the fact that the health budget in recent times has increased. Some key informants commented that HIV in general is not a high priority or is declining as a health issue of interest as other health or development issues earlier neglected are receiving more focused attention among the donor community. Against this backdrop, it is suggested that advocacy efforts will need to be more finely tuned to include the issue of HIV within the broader context of human rights, universal health care and various social, economic and larger structural issues. This approach would likely contribute towards a strengthening of the financial commitment and ensuring harm reduction responses are sustained in the long term.

'It is true the [financial] pie has become bigger but there are more slices in the pie. Health needs add to the already congested landscape among all the other needs [in the country].' (Development partner source)

7.4 Improving service provision, innovation, and comprehensiveness

Various gaps in service provision for PWID have already been identified: low rates of PWID receiving HCT; low ART enrolment among PWID living with HIV; disruption of NSP, and; various challenges to meet the growing demand for MMT. As more facilities currently offer HCT, more options need to be explored that will encourage PWID to come forth and receive HCT. Evidence from Myanmar shows that PWID can be as adherent to ART (assisted within a supportive environment) as non-drug-using individuals. Advocacy efforts that promote a supportive environment for PWID to partake in ART are required, as well as official government messages disseminated to ART centres not to withhold ART from PWID in need of ART. Adding to the improvement of services for PWID, some key informants outlined a pilot project to be implemented at five sites (Kyaukmae, Lashio, Muse, Myitkyina and Yangon) in 2014. Selected MMT clinics will be transformed into what will be termed a 'one-stop shop' facility where various services specific to PWID will be offered in one site, with linkages to other services as required.

> **'The one-stop shop will have various services including STI treatment, HCT, TB, ART, and condoms but it will not include NSP. For needles and syringes, the person can be directed to a drop-in centre.' (Development partner source)**

When NSP services get disrupted for various reasons, the impact upon PWID is profoundly negative. Whether it is because of police crackdowns, rising anger over discarded needles and syringes, or a flawed waste management system, direct and transparent communications between service provider and the wider community are of paramount importance. Key informants commented that rebuilding trust, pursuing community engagement and managing community expectations of service operations for PWID are all necessary to maintain service delivery.

> **'Can collection [of needles and syringes] be 100% or even 80%? Not likely, so we need to explain the situation about the function of the NSP. In some ways it's about the public relations exercise in how to address the concerns of the community.' (UN source)**

> **'Waste management problems can be a failure to provide education to the community. Not enough is being done to bring community participation to address waste management and discarded needles and syringes. Community [members] need to better understand what we are doing and why.' (NGO source)**

A few key informants expressed the need to provide a more holistic approach towards servicing the needs of PWID that can contribute towards recovery and minimize relapse – such as offering vocational training and employment opportunities. With a growing number of people stabilized on MMT,

the need to seek new options for financial independence and fulfilment becomes more pressing. Despite a growing interest among the implementing partners in this area, few have actively pursued concrete measures. A few key informants suggested that to push this agenda forward will require building technical capacity, providing professional guidance, additional funding for pilot projects, and establishing appropriate partnerships with public or private social and welfare agencies.

'Vocational training and creating job opportunities for PWID will enable them to have a regular income and avoid relapse. Provide opportunities by assisting those affected by drug use to get jobs. Assist drug users to be engaged in work and on an equal basis, not just token assistance. We can think of engaging the Ministry of Social Welfare.' (NGO source)

7.5 Strengthening multi-sector engagement

Harm reduction in Myanmar is unlikely to have progressed to where it is today if not for the multi-sector collaborations over the past decade. There are many forums, meetings and events where representatives from various sectors come together to discuss issues. Yet it was voiced by many key informants that closer working collaborations between the appropriate government departments, implementing partners, technical agencies, development partners and UN bodies dealing with drug use issues require further strengthening. This will lead to improved joint operations, as well as addressing sensitive topics such as limited HIV service delivery inside prisons for inmates.

'We all need to work closely together with all the stakeholders. The government will not be able to do this alone.' (Government source)

'MoH, NAP, MoHA, CCDAC should sit together and discuss the issues. Some meetings happen between them [but] those are infrequent. They need to be more frequent. Coordination of the response among the different stakeholders needs to be strengthened at all levels.' (NGO source)

It is not only at the higher level where collaborations can be strengthened, but also importantly at the field level, where the harm reduction interventions are being implemented. Between 2005 and 2006, township steering committee/community groups were formed in various parts of the country, which included representatives from different sectors including medical, law enforcement, general administration department and other members of the community. While it is acknowledged that some of these committees may still exist (though weakened), the majority are believed no longer to be functioning. A couple of key respondents believed that there is merit to revisit similar committees and assess their validity for the future.

'Harm reduction coordination committee meetings [were held] from 2010 till early 2014, every second month, [and] held at drug treatment hospital (DTH). Participants included DTH, INGO, NGO, state health department, administrative department, local CCDAC, police, but no community representative or religious leader. Meetings now combined with HIV coordination meeting from February 2014 with State Health Department. The meetings discuss problems and constraints such as NSP. Police always come when we invite them.' (Government source)

7.6 Providing evidence through research

With the expansion of harm reduction efforts in the country, some key informants commented that the enabling environment could be enhanced though advocacy using local evidence including scientific research and a sound monitoring and evaluation system. It was suggested that existing evidence could be widely disseminated to highlight successful harm reduction approaches. Future research projects should be supported to strengthen implementation of activities and to identify any gaps that can contribute towards an improved response overall.

'More research should be done to show the evidence of the effectiveness of harm reduction activities.' (NGO source)

Media Sensitization workshop on HIV and Human Right (UNAIDS)

8. Mapping the future: harm reduction response in Myanmar

Voluteer Peer Educator Training (MDM)

8.1 Background and recommendations

The literature review, meetings and multiple interviews with key informants from different sectors have provided the opportunity for a more comprehensive understanding of the situation of drug use, HIV and responses. Harm reduction interventions from the comprehensive package designed for PWID are officially endorsed in Myanmar as appropriate to address HIV prevention among drug users, in particular people who inject drugs. Over the past decade, there have been a number of successful outcomes from the targeted responses –importantly, contribution towards the steady decline in the HIV prevalence among PWID. However, there is scope to improve the response and reduce transmission of HIV among PWID by 50% by 2015.[ix]

Some harm reduction interventions have considerable, widespread support, such as the methadone maintenance therapy programme, whilst others such as needle and syringe programmes still remain highly sensitive and received with less enthusiasm, despite their expansion and critical role to reduce the transmission of HIV among PWID. Strengthening an enabling environment for the harm reduction response requires more involvement of law enforcement

[ix] 2011 UN General Assembly Political Declaration on HIV and AIDS target

to assist positively in the response. There is a need to re-engage with this sector, which historically over a decade ago had paved the way for a more pragmatic approach to address drug use and HIV issues, with support from the medical fraternity.

There are more harm reduction services and initiatives happening throughout the country than ever before, highlighting their support and appropriateness to the Myanmar context. However, as outlined by key informants, there is an extensive list of challenges and barriers undermining the response.

In order to address these challenges, the following thematic recommendations are strongly promoted for strengthening harm reduction programmes and improving the national response to HIV.

Understanding of drug dependency and enabling environment for harm reduction

- Increase advocacy efforts and training opportunities to all those involved in health, law enforcement and social welfare, as well as to the wider community whenever appropriate (event, seminar, media, workshop, training, campaign etc.) to improve the enabling environment, enhance greater understanding of the harm reduction response and address any police concerns associated with interventions for drug users.
    - Conduct training on harm reduction issues specifically to match the needs of law enforcement at Central Police Academy, as well as operational general police and anti-narcotics task force.
    - Develop and disseminate briefing papers to all police offices in identified common local languages that outline the role of law enforcement engagement with public health response towards prevention of HIV among drug users.
    - Document on a routine basis and collect evidence of negative implications of police crackdowns upon service delivery, including NSP, from harm reduction implementing partners.
    - Assess and explore opportunities to review medical and nursing training curriculums covering drug use issues for accuracy and key messages of drug dependency as a chronic relapsing condition that requires a medical response.
    - Engage various organizations and high profile public figures, to identify community ‘champions’ (voices from the affected community and their supporters) to assist in the dissemination of harm reduction IEC materials.
- Maintain ongoing dialogue and advocacy efforts with decision makers, and those that have appropriate connections and influence to amend specific laws (Excise Act 1917 and Narcotic Drugs and Psychotropic Substances Law 1993), as well as strengthen policy and practice to improve the public health response for drug users.

- Improve multi-sector collaborations and exchange of information between health and law enforcement sectors to strengthen harm reduction response through steering committees at township level in order to problem-solve issues and address community concerns about drug issues.

Services and staff

- Increase the number of technically strong implementing partners and ensure the development of human resources with harm reduction skills.
- Continue to expand and increase coverage in service delivery of NSP, MMT, HCT, ART, TB and STI treatment to PWID. Raise the profile and importance of prevention, vaccination, diagnosis and treatment for viral hepatitis among PWID.
    - In line with expansion of the methadone sites, increase the number of training programmes for staff working in current and new methadone dispensing sites, as well as providing opportunity for refresher training for staff after 3-5 years of service.
    - Maintain and strengthen the referral/cross referral system within MMT sites and INGOs and NGOs for ongoing methadone enrolments. Ensure that enough information about MMT services is shared with enrolled and potential clients to improve the cross referral system.
    - Promote facility based (provider initiated) and community based HCT with linkage to prevention, treatment and support services as required. Encourage HCT for PWID every 6–12 months.
    - Support equitable access to ART for HIV-positive drug users and ensure that it is incorporated as part of the comprehensive treatment and support approach. A supportive environment for HIV-positive drug users on ART should be provided to assist in adherence.
    - Offer PWID a rapid hepatitis B vaccination regimen.
    - Encourage HCV testing among PWID. Among those testing positive for HCV infection, promote screening for alcohol use and counselling to reduce moderate and high level of alcohol intake to lessen liver damage. As part of a global movement, promote ongoing advocacy for affordable HCV treatment.
    - Prioritize prevention, diagnosis and treatment of TB for all drug users.
    - Promote systematic screening for and education about STIs and raise the profile of STI among drug users.

- Strengthen and improve technical capacity of agencies that are new, or with less mature experience in harm reduction, as well as other sectors (legal; medical; nursing; law enforcement; policy makers; and key players at community and township level) through increased education, training and mentoring on various traditional (i.e. NSP and methadone) and emerging aspects of harm reduction interventions (i.e. hepatitis B & C).
- Build technical capacity for community based organizations (CBOs) and networks of drug users and identify community 'champions' to enhance their empowerment.
- Explore and improve linkages between detoxification programmes and drug rehabilitation centres, as well as overall improvement in drug dependence treatment.

Information and knowledge

- Improve understanding of drug dependency as a health issue that requires a public health response rather than a law enforcement response, to reduce criminalization, stigma and discrimination of drug users.
- Develop technical documents, briefing papers and a harm reduction training curriculum to enhance advocacy efforts, technical capacity and improve knowledge for harm reduction implementing partners and other appropriate agencies, including government and media.
    - Develop a training curriculum on harm reduction interventions targeted towards health programme managers, planners, broad-ranging health service delivery personnel, health practitioners (doctors and nurses), staff working in HIV and drug treatment and control programmes, development partners, UN agencies, INGOs and NGOs working on HIV. Conduct training programmes – ideally in government institutions or universities – to ensure local ownership and sustainability.
    - Develop the training curriculum on harm reduction for operational police, both general and anti-narcotics force teams.
    - Develop standard operational procedures for MMT; outreach and peer education; NSP and waste management; monitoring and evaluation specific to PWID.

Cost efficiency, effectiveness and sustainability

- Improve overall response and prevent overlapping of activities by ensuring greater efficiency of available resources through increased sharing of information among development partners.
- Undertake further research to address limitations and gaps identified in the situation analysis to strengthen the response and improve efficiency, effectiveness and sustainability of harm reduction programmes.

- Undertake studies to highlight the scientific evidence and essential importance of NSP to prevent the spread of HIV among PWID.
- Conduct cost-effectiveness studies:
  - To demonstrate the effectiveness of evidence-informed and rights-based approaches;
  - Of integrating methadone maintenance and antiretroviral therapy for HIV-positive drug users in Myanmar's injection-driven HIV epidemic;
  - On budget impact of Myanmar's NSP and MMT programmes in HIV prevention and treatment among PWID.

Closed settings

- Increase advocacy efforts to raise profile and encouragement of HIV and TB prevention, treatment and support, including initiating awareness on HBV and HCV, and ensure uninterrupted MMT for those incarcerated when receiving treatment, as well as piloting of MMT in closed settings.

Blood sample collection for HIV testing (MDM)

Annex 1: List of interviewees

Name	Position/Function	Organization
Dr Ko Ko Naing	Assistant Director	National AIDS Programme
Dr Hla Htay	Program Manager	National Drug Abuse Prevention and Control Program
Dr Nanda	Psychiatric	Drug Treatment Hospital, Myitkyina
Dr Tin Oo	Associate Professor, Psychiatric	Drug Treatment Hospital, Mandalay
Police Colonel Myint Aung	Head of International Relations Department	Central Committee for Drug Abuse Control (CCDAC)
Police Major Sai Thein Zaw	Police Major	Anti Narcotics Task Force, Myitkyina
Police Captain Tint Aung	Police Captain	Anti Narcotics Task Force, Lashio
U Sit Aye	Legal Advisor of President	
U Hkam Awng	Director, Myanmar Program	Centre for Social Entrepreneurship (Former CCDAC)
Mr. Eamonn Murphy	Country Director	Joint United Nations Programme on HIV/AIDS (UNAIDS)
Mr Jason Eligh	Country Director	United Nations Office on Drugs and Crime (UNODC)
Ms Phavady Bollen	Technical Officer (HIV/AIDS)	World Health Organization (WHO)
Dr Win Min Than	National Technical Officer (HIV/AIDS)	World Health Organization (WHO)
Mr Renaud Cachia	Programme Coordinator	Médecins Du Monde (MdM)
Mr Dario Devale	General Coordinator	MdM
Dr Seng Gum	Medical Officer	MdM, Myitkyina
Dr Than Min Htike	Project Manager	MdM, Moegaung
Dr Hein Thu	Project Manager	MdM, Hopin
U Thein Kywe	Peer Educator	MdM, Myitkyina

Annex 1: List of interviewees

Name	Position/Function	Organization
U C Khong Lun	Focal Peer	MdM, Myitkyina
U Zau Mai	Prevention Facilitator	MdM, Myitkyina
Mr Peter Wilson	Country Health Director	Merlin
Mr Willy De Maere	Technical Director	Asian Harm Reduction Network (AHRN)
Dr Soe Khaing Lin	Medical Coordinator	AHRN, Wine Maw
Dr Lin Aung Thu	Project Manager	AHRN, Lashio
U Thein Htay	Outreach Worker	AHRN, Lashio
U Soe Win	President	Myanmar Anti Narcotics Association
		(MANA)
U Saw Ngwe	Vice President	MANA, Yangon
Prof Khin Maung Gyi	Vice President	MANA, Yangon
Dr Pe Thet Htun	CEC	MANA, Yangon
Dr Nelly Thein	Programme Manager	MANA, Yangon
Dr U Hla Aung	Project Manager	MANA, Yangon
Dr U Htin Kyaw	Project Manager	MANA, Yangon
Dr U Maung Maung Lwin	Consultant Psychiatrist	MANA, Yangon
Dr Tin Aye Kyi	Area Manager	MANA, Mandalay
Dr Tint Swe	Area Manager	MANA, Naung Mon
Dr Gyaw Htet Doe	Technical Director	Substance Abuse Research
		Association (SARA)
Dr Zayar Soe	Harm Reduction Officer	SARA, Theinni
Ms Anne Lancelot	Director	Population Services International (PSI)
Ms Xuan PHAN	Public Health Consultant	Population Services International (PSI)
Dr Hla Htay	Senior Technical Officer	Burnet Institute, Yangon
Dr Kyaw Myo Htet	Technical Officer	Burnet Institute, Yangon
Dr Thu Wun	Area Manager	Burnet Institute, Mandalay
Daw Rosie Myint	Area Manager	Burnet Institute, Sagaing

Annex 1: List of interviewees

Name	Position/Function	Organization
Mr Li Jiayin	Programme Coordinator	Health Poverty Action
Mr Clint A Liveoak	HIV Technical Programme Manager	U.S Centers for Disease Control and Prevention
Ms Thu Van T. Dinh	Health Technical Advisor	U.S. Agency for International Development
Ms Amber Cernovs	First Secretary-Health	Australian AID
Ms Parsa Sanjana	Deputy Director (Programme Implementation and Management/GFATM)	Save the Children (GFATM)
Dr Myo Set Aung	HIV Programme Manager	Save the Children (GFATM)
Dr Htay Oung	Sr HIV Programme Coordinator	Save the Children (GFATM)
Mr Robert Bennoun	Senior Strategic Advisor	3MDG Fund
Dr Nu Nu Aye	Public Health Officer	3MDG Fund
U Kyaw Thu	Chairperson	National Drug User Network Myanmar (NDNM)
Mr Raju	Member of Better Shade	Community Based Organization -CBO (Local Drug User Network), Lashio
Mr Chin Kaw	Member of Better Shade	CBO (Local Drug User Network)
Mr Aung Kyaw Nyunt	Member of Better Shade	CBO (Local Drug User Network)
Dr Sid Naing	Country Director	Marie Stopes International
Dr Maung Maung Sein	M&E Officer (TB) (former Harm Reduction Coordinator of UNODC)	UNOPS

Annex 2: Detailed Methodology

Two UNAIDS consultants – international and national – with the assistance of the UNAIDS Country Director identified key informants and various organizations with direct or indirect links to drug use and HIV issues and harm reduction programmes in general operating throughout the country. A total of 58 key informants were met, representing five stakeholder bodies from Government bodies (including National AIDS Programme, Central Committee for Drug Abuse Control, Ministry of Home Affairs, Police Department, and Drug Treatment Hospital), international and national non-governmental organizations, development partners and UN agencies providing a range of information and answered various questions. Most organizations were represented by one to two speakers for interview while a few organizations had four to nine representatives for the interview (see Appendix 1 for list of key informants agencies/ sectors/organizations). Two field trips were conducted for further interviews and the following locations were visited: Nay Pyi Taw, Myitkyina, Wine Maw, Lashio, Sagaing, Mandalay, Naung Mon Village and Theinni (the two latter located outside of Lashio).

Interviews with key informants were conducted over five weeks from March to May 2014. Each stakeholder body was contacted through various means: telephone, email, fax, and/or formal invitation letter to outline the focus of the meeting. All were informed that their comments would contribute to the development of a strategic roadmap to guide UNAIDS but to also provide direction for harm reduction interventions in the future for Myanmar.

Interviews were conducted at various sites: participant's office, drop-in centre or identified informal setting such as coffee shop or restaurant and UNAIDS office. To ensure a more open discussion, each key informant was informed that no names would be documented with any quotes in the report but their sector – development partner, government or non-government organisation, UN source – would be identified. Request for a recording of the interview with majority of key informants was made to ease the documentation process, and verbal consent was provided. Hand written note taking and computer typing of the interviews also took place. With most government participant interviews, documentation was primarily by note taking. The majority of interviews were conducted in English and when in Myanmar language, translation was provided by the national consultant for the international consultant. Generally a transcript was produced soon after each interview. Transcripts were primarily written by the national consultant and reviewed by international consultant for accuracy with additional information added as required. Interview questions were presented by the international consultant.

All questions raised were semi-structured, and included a series of probing questions to elicit more information on issues directly related to participants' experiences. The majority of interviews took 90–120 minutes each time. The majority of key informants provided free ranging dialogue with each question but still prompting was required to explore many of the issues the questions raised. Throughout many interviews the international consultant briefly raised many points of local and Asian perspectives of harm reduction challenges and responses as part of general information sharing.

Annex 3: Question Line

1. **In your own words can you explain to me your understanding about the concept of harm reduction and can you name the harm reduction interventions – as part of the comprehensive package – to address drug use and HIV?**
   (can check if HCV is mentioned due to co-morbidity issues)

2. **Can you explain to me where you think your department/organisation/sector is (state of progress) with regards to the adoption, support and/or implementation of various harm reduction interventions since this public health approach was introduced into Myanmar?**
   (probe about still in its infancy, moving forward but cautious, accelerated pace, expansion, and so on).

3. **What do you think have been the major successes or positive shifts in your department/ organisation/sector that have been experienced, achieved and witnessed with regards to the adoption, support and/or implementation of harm reduction interventions?**
   (expansion of HR interventions; wider acceptance of interventions; increased service provisions; issues of compassion and improved understanding etc.).

4. **What do you think are the challenges and/or barriers your department/organisation/sector currently experience with regards to the adoption and/or support of harm reduction interventions?**
   (need to consider various challenges including policy, practice and legislative restrictions, coverage of programs (NSP, methadone, HIV testing, ART), waste management linked to NSP, coordination within sector, multi-sectoral collaboration, planning of approaches, prioritising of importance, capacity to respond (government, community), human/financial resources, technical, access/dissemination of information, widespread misunderstanding/incorrect perceptions about drug dependency as medical condition etc.).

5. **From your perspective and/or that of your department/organisation/sector what support or actions do you think are necessary to initiate/ promote/expand/sustain an improved enabling environment that will allow for greater implementation of a response to reduce drug related harm and HIV?**
   (explore change in policy and practice to strengthen the capacity of the government and communities to respond accordingly; where is the response need the greatest, other potential players/partners that can be encouraged to be involved in the response)

6. **Are there any other issues or comments you would like to tell me?**

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