ACRONYMS - MYANMAR

3D Fund	Three Diseases Fund
ACCORD	ASEAN and China Cooperative Operations in Response to Dangerous Drug
ARHP	Asia Regional HIV/AIDS Project
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
CBOs	Community Based Organizations
CCDAC	Central Committee for Drug Abuse Control (Myanmar)
DIC	Drop-in Centre
DTCs	Drug Treatment Centres
DU	Drug User
FHAM	Fund for HIV/AIDS Myanmar
GoM	Government of Myanmar
LOP	Lashio Outreach Project
IDU	Injecting Drug User
INGO	International Non-Governmental Organization
IEC	Information Education and Communication
M&E	Monitoring and Evaluation
MANA	Myanmar Anti-Narcotics Association
MIS	Management Information System
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MOP	Muse Outreach Project
Myanmar	Union of Myanmar
NAP	National AIDS Program
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime (formerly UNDCP)
WHO	World Health Organization

1. National Program Support

	Ministry / Agency Responsible	Systems / Frameworks In Place (List Relevant Items)	
		Existing	**Gaps**
Political Commitment	Ministry of National Planning and Economic Development Ministry of Health and National AIDS Program (NAP) Drug control remains the mandate of the Central Committee for Drug Abuse Control (CCDAC)	The political environment in Myanmar remains authoritarian and constrained. • Methadone programs are piloted for the first time and IDU is openly acknowledged as a major cause of HIV transmission and as such "reducing HIV related risk, vulnerability and impact among drug users" is identified in the highest priority group in the National Strategic Plan for HIV[5]. • International organizations are experiencing a transition period whereby coordination responsibilities for all international involvement in harm reduction activities have been moved from the Ministry of Home Affairs to the Ministry of Health. • CCDAC is a multi-sectoral committee chaired by the Minister of Home Affairs, the ministry responsible for law enforcement. CCDAC has been the champion of harm reduction in Myanmar over the past decade and is an essential agency both at national, regional and local levels due to its structure of working groups and the 21 Special Anti-Narcotic Squads employed throughout the country. CCDAC continues to support harm reduction including programming and advocating for policy changes which affect harm reduction and resource mobilisation. • UNODC maintains an Agreement with the Ministry of Home Affairs	The Ministry of National Planning and Economic Development are currently revising 'Guidelines for UN agencies, International organisations and NGOs/INGOs on Cooperation Programme in Myanmar'. These guidelines threaten increased politicization of committees and working groups at the township level and may limit access and mobility to project sites in future.

Myanmar – United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific Baseline Assessment Dec 2006

Donor Commitment	The Fund for HIV AIDS Myanmar (FHAM) is the major donor of harm reduction activities in Myanmar. European Commission AusAID - Asia Regional HIV/AIDS Project (ARHP)	Overall, donor commitment to Myanmar is low in comparison to the region, given foreign policy constraints on engagement with Myanmar and the EU Common Position. No new funding was made available in 2006. • FHAM: About US$ 3-5 million of the $US 21.3 million is spent on harm reduction programs • EC: US$ 1.1 million (end in 2007) • AusAID: US$ 590,000 (end in 2007 with the likelihood of extension)	The termination of the Global Fund in 2006 has left a significant gap with regard to funding infectious diseases control (including harm reduction interventions) in Myanmar. However US$ 99.5 million has been pledged by Britain, Australia, the Netherlands, Norway, Sweden and the European Commission for the proposed 3 Diseases Fund which will go some way to address this gap.
Costed National Strategy	Managed by the Ministry of Health under the auspices of the National AIDS Program with UNAIDS counterpart support.	Operational Plan for HIV: • Estimated total budget: April 2006-Mar 2007 US$ 34 million April 2007-Mar 2008 US$ 41 million • IDU component estimated budget: April 2006-Mar 2007 US$ 2.88 million April 2007-Mar 2008 US$ 4.57 million	
Legal Environment	CCDAC	• Party to the 1961, 1971, and 1988 UN conventions • Most important law relating to drug use: *Myanmar Psychotropic Substance Law of* 1993. Enforces the illegality of drug use and the compulsory registration of all drug users. Upon registration drug users are subject to 6 weeks compulsory detoxification. Drug users who do not register face a 5 year prison sentence. • CCDAC are strongly advocating for the repeal of the 1914 *Needle and Syringe Possession Law* as well as the need to modify the system of compulsory registration. • CCDAC also plans to engage in a major legal review of the current drug sentencing system (project suspended under FHAM, but likely to continue) with the proposed idea of introducing diversion sentencing. However several concerns have been raised about the current model being proposed by CCDAC.	Significant gaps exist with regard to the legal environment in Myanmar. Due to the difficult political environment it is unlikely that significant changes could be made, and even if they could, their impact would be minimal due to corruption and lack of infrastructure. It remains extremely important to monitor the proposed changes to the sentencing laws and ensure that CCDAC's interpretation of diversion does not subject drug users to more harm. It remains illegal to carry a syringe in Myanmar.

Policy Environment	CCDAC	Myanmar has faced considerable international pressure to control drug production, especially opium and heroin, within its borders. International aid has funded crop substitution and eradication in the country from the mid-1970s and has remained the central pillar to Myanmar's response to drug issues. • Myanmar's stated policy towards drugs: "15-Year Narcotic Drug Elimination Plan" (1999) The Plan will be implemented in three five-year phases using law enforcement, supply elimination and demand elimination as the major tactics. • UNODC Memorandum of Understanding (along with Cambodia, China, Laos, Thailand and Vietnam): Subregional action plan aimed at controlling precursor chemicals and reducing illicit drug use in the highlands of Southeast Asia • ACCORD "drug free ASEAN 2015" agenda • Bilateral agreements relating to drug issues with China, Laos, India, Russia, Thailand, USA and Australia • Myanmar National Strategic Plan on HIV and AIDS 2006-2010 has been endorsed by the government as of 2007. One strategic direction is Reducing HIV-related risk, vulnerability and impact among drug users	Myanmar's drug policy is focused on the elimination of drugs by 2015, with little mention of the need for harm reduction or even the recognition that this is an unachievable policy. Despite this, several key figures have been out spoken in support for harm reduction in the recent years.
M & E Systems/ Research Capacity	Governmental and Non-Governmental Organizations	• There is a structured management monitoring system in place which produces timely information, although this information could be more effective if it focused more on outcome (behaviour change and use of services) than on output (implementation of services and dissemination of materials and commodities), and could thereby be more appropriately utilized at the local level. • The Burnet Institute, Centre for Harm Reduction is currently working with other partners implementing harm reduction programs in Myanmar to develop an M&E system that will assist data collection for harm reduction indicators across the country. This system will standardize data collection nationally as well as simplify data management and reporting.	Research remains difficult to conduct in Myanmar. **Governmental research**: • A major national behavioural surveillance study (planned for 2004) remains uncompleted. • The methodology used by the Government to conduct prevalence and surveillance studies remains questionable.

			There are major gaps with regard to the conduct of **independent research**: • The government remains extremely suspicious of external agencies conducting research in the country. • Capacity to conduct well designed research remains poor (for both governmental and non-governmental organizations). • Due to a large mobile population, many internally displaced people and no-go conflict zones, it remains impossible to obtain a representative sample.
Surveillance Systems	NAP	The HIV surveillance system established in 1992 was gradually expanded as a sentinel surveillance system to which a behavioural surveillance element was added in 2003. It has produced valuable data which are used centrally for the monitoring, targeting and planning of programme activities.	No surveillance system exists with regard to drug use. A recent review of the NAP HIV surveillance system recommended the following improvements: • The HIV surveillance system should be updated to incorporate new elements, including new surveillance groups, increase coverage and allow comparison over time; • AIDS case reporting should move towards an anonymous coding system with a single identifier in order to protect confidentiality; • Procedures for flow of data from implementers to the NAP should be more clearly defined. The reporting mechanism to and from the AIDS committees, township medical officers and AIDS/STD teams should be streamlined, and

			• Programme-related information, including surveillance data should be analysed systematically and disseminated promptly among stakeholders, especially at the local level. All partners should be encouraged to contribute to a standardized management information system.
Multi-sectoral Involvement	Government CCDAC UN INGOs	• CCDAC is a multi-sectoral committee chaired by the Minister of Home Affairs, with the head of the Myanmar Police Force serving as secretary to the Committee. • Within the harm reduction field, government, UN and INGOs work cooperatively to address township level responses. Model Township Project Steering Committees involving health, law enforcement, UN, INGO and local NGO stakeholders have successfully demonstrated the ability to work multi-sectorally but it is unrealistic to expect such a participatory process at a national or central level. • The 2006-2010 National Strategic Plan for HIV/AIDS outlines "Institutional arrangements" for the implementation of the National Strategic Plan. A National Coordinating body oversees policy guidance and identification of external support and is represented by several government ministries, UN, INGO and donor organizations. • The Technical and Strategy Group for HIV/AIDS draws upon expertise from across the public health sector, professional associations, INGOs and UN agencies.	Community based organizations and local NGOs are not represented in any of the key coordinating structures for the new National Strategic Plan for HIV/AIDS. Civil society participation is represented only by government-nominated NGOs.
Law enforcement involvement	CCDAC is the main body responsible for drug related law enforcement in Myanmar.	Law enforcement resources are primarily focused on drug seizures, arrests and crop eradication. • With the recent introduction of harm reduction in Myanmar, CCDAC has advocated that law enforcement agencies relax certain laws that contradict some harm reduction services in several pilot zones.	Conflict between operational policing and the implementation of harm reduction remains a considerable problem in Myanmar. Corruption also causes problems. Capacity of operational police to understand HR issues is low and presents barriers for implementation.

		• Under the control of CCDAC, Working Committees for Crop Substitution, Livestock Breeding, Treatment, Rehabilitation, Educating the Children and Youth, Law Enforcement, Public Relations, and Precursor Control have been formed. • CCDAC has Regional Committees for drug abuse control at a State/Divisional, District, Township, Ward and Village level. • CCDAC oversees 21 Special Anti-Narcotic Squads deployed throughout the country and relies in part on military, police and customs personnel to execute law enforcement duties. • CCDAC is also playing a lead role in training new law enforcement recruits in harm reduction and together with the Burnet Institute and the Asia Regional HIV/AIDS Project (ARHP) is developing a specific law enforcement and harm reduction curriculum. • CARE Myanmar is also working with "uniformed services" on basic HIV and AIDS prevention.	
Involvement of IDUs in Response	Involvement of drug users in harm reduction programs is limited.	• Some programs have recently employed current drug users as outreach workers or needle patrols but still face considerable opposition to this from authorities. • Two drug users were recently invited to participate in the development of the new National HIV plan; however their involvement was considered token.	• No formal drug user organizations exist in Myanmar. Due to the current political and legal environment in Myanmar it would be difficult for a drug user organization to form. • Efforts need to be maintained by those in 'safe' positions to continue to advocate for the rights of drug users and continue to push for their involvement in all levels of the response.
Capacity building	Myanmar Anti Narcotics Association (MANA) International Organizations (Burnet Institute, International HIV/AIDS Alliance)	MANA is the only local agency implementing harm reduction. All other programs are implemented by international organizations. Some projects have been able to successfully engage with government groups. However, this has remained problematic at best, and in some cases impossible.	• While several government agencies were identified as playing a role in responding to the harms associated with drug use in the country (e.g. Ministries of Education, Social Affairs, Home Affairs and Health,

		Where partnership agreements are in place between INGOs and local NGOs there is a great opportunity for long term capacity development linked with organisational development. Only one INGO currently takes this approach to capacity development.	other Government organizations e.g. the Myanmar Women's Affairs Federation), engaging with these groups has proven difficult. • UN agencies are best placed in Myanmar to work with identified counterpart agencies in an attempt to build capacity. Other specialist INGOs could be sub-contracted to assist this process. • MANA claim their capacity to respond still remains low and they encourage assistance to help them with what they do in HR.

2. Barriers to Scale Up

Key Area	Barriers to Scale Up	Key Actors / Facilitators	Plans to Address Barriers
1. Political commitment	1.1 Support for harm reduction from MoH and NAP 1.2 Gaining local support to implement harm reduction. Often political commitment will be given at a central level but then blocked at a local/regional level depending on the local political power dynamics. 1.3 The distinction and roles between the NAP and CCDAC with regard to enforcement, health and harm reduction need to be clarified.	MoH NAP CCDAC	CCDAC is currently undertaking a review of their structure and how they can streamline communication between local, regional and central departments.
2. Community commitment	2.1 Drug use remains a highly stigmatized behaviour 2.2 Limited opportunity for civil society to mobilise		Several INGOs have recognized the importance of engaging with civil society with regard to health issues. The government is also recognizing the importance of engaging with civil society, reflected by the increased exposure these groups were given during the national strategic planning process.
3. Legislative/ policy	3.1 The NS possession laws; The Burma Excise Act 1917 Section 13 and Section 33. 3.3 Compulsory registration of drug users laws A.3.1 Narcotic Drugs and Psychotropic Substances Law Chapter 5. Section 9 & 10: Chapter 8, Section 15 & 16	CCDAC Ministry of Home Affairs	The international community must watch these attempts closely and ensure that changes to the legislation (especially with regard to diversion) do not increase the harms to drug users. CCDAC is playing an important role in attempting to reform some major legal barriers to harm reduction.
4. Comprehensive Services	4.1 Scaling up (mainstreaming): Services to drug users remain isolated “specialist” services. Harm reduction and support for drug users need to be mainstreamed into existing health services.	MoH NAP CCDAC UNODC INGOs	

	4.2 Drugs and development (crop eradication): While several programs address the economic and social impacts of opium eradication, no projects are working with community members who also use drugs.		
	4.3 Need to look beyond IDU: ATS users and people at risk of injecting (e.g. opium and heroin smokers)		
5. Resources	5.1 Donor commitment to Myanmar is low in comparison to the region.	Government International Donors	
6. Affected community involvement	6.1 Political and legal environment makes the involvement of drug users very difficult.		
7. Commodities			
8. Scaling up plans	8.1 Permission and access to new sites	CCDAC, UN INGOs	Advocacy continues
9. Capacity Building	9.1 Lack of local organizations engaged in harm reduction		

3. Program Implementation[1,2]

Estimated IDU Population: 60,000[5]
Due to problems in collecting independent data in Myanmar, estimating the number of drug users is difficult. According to Government records there were 63,149 registered drug users in Myanmar in 2002 (Central Committee for Drug Abuse Control, 2002). However it is openly held that the number of drug users in Myanmar is significantly higher than reflected by the drug registry. While CCDAC has no official estimate of the number of drug users in the country, they suggest that based on reports from registered drug users about the number of drug using associates who are not registered, the total number of drug users is likely to be between 300,000 - 400,000 (United Nations Office of Drug Control, 2004).
Similarly, estimates about the number of IDU vary greatly between reports. A figure falling between 90,000 and 300,000 seems most likely (Aceijas *et al.*, 2006[3]; Reid & Costigan, 2002[4]).

Service Coverage: 5-10%

	Available Data (note, UNODC data is for Jan-Jun 06) LOP= Lashio Outreach Project MOP = Muse Outreach Project (in partnership with MANA)							**NSP coverage**
		NGOs (Number)	Govt. Health Services (Number)	# Clients Accessing Services	Needle / Syringe Distribution (Number) (B)	# Condoms Distributed	# of IEC Materials Distributed	
Outreach		NGOs - 2 in Lashio - 1 in Muse - 1 in Tachilek INGOs - 5 in Lashio - 2 in Mytkyina - 1 in Mandala - 1 Muse UNODC - 1 in Lashio - 1 in Theinni	0	7,500 LOP 220	1,161,000 (outreach +DIC) LOP 58627 MOP 24269	148,000 (outreach +DIC) LOP 25239 MOP 6812	26534 (UNODC outreach + DIC) LOP 29267 (outreach and DIC)	

Drop-in Centres		18 (in Lashio, Muse, Mytkyina, Ubiet Tachilek & Mandalay)	0	4,000 LOP 4760 (DUs and families)				
VCT		2 NGO officially, (+ 1 unofficially)	122 service points total (govt and NGO)	LOP 48 MOP 45				Scale up to 10,500 IDU by 3/09
Linkage to HIV Care and Support		As such Care & Support is not there; CBOs are involved in faith based interventions	0 STI Teams are planning to start ARV as selected sites	10,000 in general population unknown for DUs				Scale up to 25,000 in general population by 3/09
ARV		5 (INGO)	45 STI teams	2479 in general population. Not available to current drug users.				
Primary Health Care		6 NGO + UNODC (16 sites)	0	LOP 1100 MOP 1185				
Needle and Syringe Programs		6 NGO + UNODC (2 sites)	0	6,500				
Substitution Programs		1 NGO (in cooperation with DTC)	4 Drug treatment centres	160				Scale up to 2000 by 3/09

Linkage to Rehabilitation and Detoxification		Referrals from all DTCs (16 sites)	22 (Major), 40 (Minor) DTCs 9 rehab centres	LOP 22				
Peer education programmes		6 NGOs	0					
Targeted IEC		All implementing agencies have their IEC on different themes/topics	0	LOP 5313 to IDUs 29267 to vulnerable youth, DUs and IDUs				
Plans for Scale Up				180,000 DUs by 3/09	4 million by 3/09			

Myanmar – United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS in Asia and the Pacific Baseline Assessment Dec 2006

Services in Closed Settings:

Estimated Prisoner Population: 62,300[5]

Estimated % of Drug Offenders: unknown

Service	**# of Clients Accessing Services**
Voluntary Counselling and Testing	none
Needle and Syringe Programs	none
Peer Education Programs	none
Substitution Maintenance	none
Post-release Follow-up	none
Primary Health Care	Limited availability – financial cost
Condoms	none
Total	

Workforce

Estimated Required Workforce: **NA**

	Available Data						**Standardised Training Programs in Place**	**Capacity Assessment (low/medium/high)**
	Provincial Coverage (% or Avg)	NGOs (Staff No's)	Govt. Health Services (Staff No's)	Total	Current Workforce compared to Required Workforce (%)	% of Peers in Workforce		
Service Providers								
Plans for Scale Up								

4. Gap Analysis

There is only limited support for harm reduction at all levels – central, regional, local. The Myanmar Narcotic Drugs and Psychotropic Substances Law of 1993 (Law no.1/93), the 1914 *Needle and Syringe Possession Law* and the 1917 Excise Act are problematic.

The political environment makes it difficult to effectively engage civil society and to conduct useful research and surveillance. Stigma and discrimination also present serious obstacles. Drug user organizations do not exist.

Myanmar receives less donor funding than other countries in the region. There is no service provision in prisons. IDUs do not have access to ARV.

5. Recommendations

Law enforcement

Operational police at county and district level undergo training in harm reduction. This could be done in conjunction with training staff from the police academies once the ARHP Law Enforcement Harm Reduction Curriculum has been fully integrated into the existing academy program.

CCDAC need ongoing support in mainstreaming harm reduction within their ranks as they are looking at changing their branch structure to strengthen links at community level.

Political and multi-sectoral commitment

Engage with Ministry of Health (MoH) and National AIDS Program (NAP) to emphasise the importance of NSP in HIV prevention during all workshops, seminars, and/or study tours)

Stigma and discrimination

Involve former and current drug users (where possible, appropriate and causes no harm) in a variety of roles where their experience and insight can contribute to decision making bodies at central government and provincial levels.

M & E systems

Use of a new Management Information System for harm reduction programs currently being developed and to be operating sometime in 2007 should be promoted to enable data to be collected in a coordinated manner.

A series of specific training programs on the fundamentals of monitoring and evaluation for all program management staff should be implemented

Policy Environment

Highlight and promote a comprehensive package of harm reduction approaches and interventions

Ongoing advocacy efforts with CCDAC, via UNODC, need to continue to encourage an amendment of The Myanmar Narcotic Drugs and Psychotropic Substances Law of 1993 (Law no.1/93), and the 1917 Excise Act.

6. References

[1] Hla Htay, personal communication.
[2] Siddhart Singh, personal communication.
[3] Aceijas C, Friedman SR, Cooper HL, Wiessing L, Stimson GV and Hickman M (2006). *Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution.* Sexually Transmitted Infections **82 (Supplement 3)**, iii10-iii17.
[4] Reid G and Costigan G (2002). *Revisiting "the hidden epidemic": a situation assessment of drug use in Asia in the context of HIV/AIDS.* Melbourne: Centre for Harm Reduction, Burnet Institute.
[5] Department of Health (2006). *Myanmar National Strategic Plan on HIV and AIDS 2006-2010, Draft: 28 June 2006.* Yangon, Myanmar: Department of Health. Available online at http://www.ibiblio.org/obl/docs4/MM_draft_Nat_strat_plan_on_HIV-AIDS.pdf.