National Strategic Framework on Health and Drugs

A Comprehensive Approach to Address Health, Social and Legal Consequences of Drug Use in Myanmar

2020

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FOREWORD

The challenges and consequences of illicit drug use on the health and well-being of the population, particularly the youth population, are leading health and development concerns for Myanmar. For this purpose, the Ministry of Health and Sports calls for a reinvigorated multi-sector response coordinated through the Central Committee for Drug Abuse Control (CCDAC) involving multiple sectors: health, social welfare, education, home affairs and information sectors.

The National Strategic Framework (NSF) on Health and Drugs (2020) represents such an effort to define a holistic response which addresses health, social and legal aspects of drug use. The strategic directions encompassed under this framework, among others, are (i) prevention of drug use among young people, (ii) reduction of risk and harm for people who use illicit drugs with a priority focus on people who inject drugs, (iii) provision of voluntary and evidence-informed drug treatment options for problematic drug users, (iv)ensuring possibilities at rehabilitation and social integration for those in need of such services, and (v) continuing work on national policy and legal reform that favors a 'public health' and the 'rights to services' approach, particularly for those communities experiencing the consequences of socio-economic hardships, fragile security situation and having limited access to health and social services.

Notwithstanding the individual, family and socio-economic consequences of the current trend of illicit drug use in the country, there is an increasing consensus on the need to place a social protection of people at the center of such a comprehensive response. It is, therefore, imperative that the Government of Myanmar, civil society organizations and community representatives across the country focus on those who are vulnerable to and experiencing the disproportionate negative impact of drug use.

I do appreciate the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS), in partnership with UNODC and WHO. The additional strategic contribution of UNESCO, UNICEF and UNFPA as well as others, will be essential to implement the recommended action plan under the National Strategic Framework on Health and Drugs. This ambitious plan of action would provide the framework and impetus towards reaching the relevant Sustainable Development Goals (SDG) in 2030.

Last, but not the least, I would like to express my gratitude to all the partner organizations who had provided financial, strategic and advocacy support for the development of this NSF, including the Access to Health Fund. This is the product of the insight and knowledge of a range of resource persons, experts, community networks, civil society organizations, government officials and Development Partners. Working together under this framework, we can hopefully galvanize commitment, as well as human and financial resources needed to reach these goals.

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10. 11. 20

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ACRONYMS

ADB	Asian Development Bank
AEM	AIDS Epidemic Model
AHEAD	Association for Health Adolescent Development
AHRN	Asian Harm Reduction Network
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ASEAN	Association of Southeast Asian Nations
ATS	Amphetamine-type stimulants
CBO	Community-based organization
CBT	Community based treatment
CCDAC	Central Committee for Drug Abuse Control
CSO	Civil society organization
DDTRU	Drug Dependency Treatment and Research Unit
DIC	Drop-in centre
DPAG	Drug Policy Advocacy Group
DTC	Drug Treatment Centre
FSW	Female sex worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B
HCV	Hepatitis C
HIV	Human immunodeficiency virus
HTS	HIV testing services
IBBS	Integrated Biological and Behavioural Survey
ICAP	ICAP at Columbia University
IEC	Information, education and communication
INCB	International Narcotics Control Board
INGO	International nongovernmental organization
KPSC	Key population service centre
MANA	Myanmar Anti-Narcotics Association
MDM	Médecins du Monde
MHSCC	Myanmar Health Sector Coordinating Committee
MMT	Methadone maintenance therapy
MOE	Ministry of Education
MOHA	Ministry of Home Affairs
MOHS	Ministry of Health and Sports

MOU	Memorandum of understanding
MSF-H	Médecins sans Frontières - Holland
MSM	Men who have sex with men
MSSY	MANA's Silver Star Youths
MSWRR	Ministry of Social Welfare, Relief and Resettlement
MYET	MANA's Youth Empowerment Teams
NAP	National AIDS Programme
NDNM	National Drug Users Network Myanmar
NFPE	Non-formal Primary Education Programme
NGO	Nongovernmental organization
NPS	New psychoactive substances
NSF	National Strategic Framework
NSP	Needle and syringe programme
N/S	Needle and syringe
NSP III	National Strategic Plan on HIV and AIDS 2016–2020
OST	Opioid substitution therapy
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PWID	People who inject drugs
PWUD	People who use drugs
SAP	Subregional Action Plan
SARA	Substance Abuse Research Association
SD	Strategic direction
SDG	Sustainable Development Goals
SOP	Standard operating procedures
STI	Sexually transmitted infection
TB	Tuberculosis
TSG	Technical Support Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
UNOPS	United Nations Office for Project Services
USAID	United States Agency for International Development
WHO	World Health Organization
3MDG	Three Millennium Development Goal Fund

EXECUTIVE SUMMARY

Despite reported reduction in opium cultivation, drug use continues to be a major public health concern in Myanmar. A sizeable domestic market for the consumption of opium, heroin, and more recently methamphetamine, has also developed over the past decades, resulting in major health, social and economic harms for people who use drugs, their families and the community at large. Kachin State, Shan State North and Sagaing Region have been particularly affected by major HIV, tuberculosis (TB), viral hepatitis and overdose epidemics, due to the high prevalence of injecting drug use in these States and Regions . A large proportion of people who use drugs live in remote border areas and conflict affected zones, which are hard to reach and where health services are not always available. Drug use and its consequences, however, is a concern across the country.

In response to these challenges, under the leadership of the Ministry of Health and Sports (MOHS), and in cooperation with the Ministry of Home Affairs (MOHA) and the Ministry of Social Welfare, Relief and Resettlement, UNAIDS coordinated the development of the National Strategic Framework (NSF) on Health and Drugs with the objective to respond more effectively to the interconnected health, social and legal consequences associated with the use of illicit substances in Myanmar.[i] The process was informed by an extensive review of published literature and the consultation of a broad range of stakeholders (the list of key informants is provided in Annex 1).

The NSF on Health and Drugs identifies five strategic directions to facilitate the adoption and scale-up of innovative and high-impact interventions and support the mobilisation of required resources and capacities

1) Primary prevention of drug use, especially young people who have not yet started to experiment or use drugs;
2) Harm reduction for people who already use and/or inject drugs;
3) Voluntary and evidence-based drug treatment for people who experience problematic drug use or are dependent on drugs;
4) Rehabilitation and social reintegration;
5) Laws, policies and enabling environment.

[i] This Framework adopts the UNODC definition of (illicit) drug (Reference: United Nations Office on Drugs and Crime. Terminology and Information on Drugs. Third Edition. United Nations. New York, 2016). In the context of international drug control, “drug” means any of the substances in Schedule I and II of the 1961 Convention, whether natural or synthetic. In Myanmar, the main (illicit) drugs of choice are heroin, methamphetamines and opium. In addition, the use of marijuana and misuse of tranquilizers is reported. While alcohol and tobacco, which are licit substances, have a significant impact on mortality and morbidity of people globally, and in Myanmar, addressing health and social consequences of alcohol and tobacco use are outside the remit of this Framework.

For each of the five strategic directions, the document provides a summary of the available global evidence and a brief overview of programmes and projects implemented in the country, identifies the main gaps and barriers, and proposes a set of priority interventions.

The NSF on Health and Drugs complements and is fully aligned with existing national policies, plans and strategies as well as with relevant international and regional declarations, resolutions and commitments adopted by the Government of Myanmar. The scope of the NSF does not include supply reduction, drug control or alternative development.

Strategic direction 1: Primary prevention of drug use

Prevention of drug use is a public health approach aimed to address risk factors that make individuals vulnerable to experimentation or initiation of drug use. Primary prevention encompasses any activity focused on preventing or delaying the initiation of drug use and the potential transition to problematic drug use. Drug prevention interventions are typically implemented in a variety of settings, including family, school, health sector, workplace, community, media, sports and leisure facilities.

The evidence base for the effectiveness of primary prevention of drug use is relatively recent and limited in scope, as compared, for instance, to the wealth of evidence on the effectiveness of harm reduction interventions for people who have already initiated drug use.

School-based interventions based on a combination of social competence and social influence approaches and life-skills education are considered most effective to prevent initial use of illicit drugs among adolescents. In contrast, some other approaches that have been commonly used in schools, including in Myanmar, have not proved to be highly effective in preventing drug use. These notably include knowledge-focused approaches or provision of general information about drugs, talks by former users or police as “drug educators” in schools, fear-arousal approaches and shocking images (e.g., posters), or random drug-testing of students in schools.

Media campaigns have also been widely used for the prevention of illicit drug use among the youth. Yet, their effectiveness in deterring drug use has not been clearly established and they do not seem to have a direct influence on drug use related behaviours. Likewise, and despite the popularity of using sportand other leisure time activities (nightlife, festivals, etc.) for drug prevention, very few studies have actually assessed their effectiveness in preventing drug use.

In practice, many activities that are currently used around the world and labelled as drug prevention are not evidence-based. It is therefore critical that drug prevention interventions use tools and materials that are context-specific and rooted in evidence. As importantly, it is essential to strengthen the knowledge, skills and competences of drug prevention practitioners and policymakers in order to build a critical mass of professional drug prevention specialists who are better equipped to deliver relevant and effective interventions.

In Myanmar, a range of initiatives have been developed and implemented by the Government, United Nations agencies and local organisations to prevent drug use among youth, notably via the dissemination of information in schools and the organisation of awareness-raising events about drugs and the harms associated with drug use.

Although the effectiveness or cost-effectiveness of these interventions have never been evaluated, a review of the literature and observations from key informants and stakeholders involved in drug-use prevention have allowed to identify the following important gaps:

- A lack of overarching strategy on prevention of drug use, combined with very limited funding support and a shortage of skilled staff and human resources to provide evidence-based drug prevention programmes in schools and to other relevant audiences;
- An over-reliance of current interventions and projects on methods that have proved ineffective to prevent drug use, and in particular the use of didactic learning and materials with an exclusive focus on harms associated with drug use, its negative impact on the "moral character" and "just say no to drugs" messages;
- The absence of mechanisms to monitor and evaluate current interventions, resulting in a lack of scientific evidence to demonstrate their effectiveness.

In order to address these challenges and enhance the effectiveness of drug prevention interventions in Myanmar, the following priorities have been identified:

1. Prevent the initiation of drug use through evidence-informed and targeted drug prevention interventions, implemented at different levels.
2. Develop a cadre of drug-use prevention professionals equipped with state-of-the-art knowledge and skills to design, implement and evaluate evidence-informed drug prevention interventions in schools, workplace and community.
3. Raise awareness among youth and general population of the harmful consequences associated with drug use, through well-designed targeted media campaigns that are rooted in evidence and research.
4. Build the evidence base to inform, plan, implement and evaluate future policies and programmes on drug-use prevention.

Strategic direction 2: Harm reduction

Harm reduction refers to policies, programmes and practices that aim to reduce the adverse health, social and economic consequences of drug use without necessarily reducing drug consumption. It is a human-centred approach that prioritises the health, well-being and dignity of individuals and communities affected by drug use. Harm reduction policies and practices are pragmatic, cost-effective and evidence informed. An overwhelming body of evidence shows that harm reduction is effective to reduce the spread of blood-borne viruses such as HIV, hepatitis B and C, but also to reduce risks of overdoses, drug dependence, improve social well-being and employment rates of people who use drugs, and reduce drug related crime.

The harm reduction comprehensive package for people who inject drugs (PWID) is composed of ten interventions that include: needles and syringes programmes (NSP); HIV testing services (HTS); antiretroviral therapy (ART); opioid substitution therapy (OST); prevention and treatment of sexually transmitted infections (STIs); condom programmes; focused information, education and communication (IEC); prevention, vaccination, diagnosis and treatment of viral hepatitis; prevention diagnosis and treatment of TB; and opioid overdose management with naloxone. Harm reduction, however, encompasses other interventions that can, for instance, aim to prevent the initiation of injection among people who already use drugs but do not inject—such as “break the cycle”.

In Myanmar, harm reduction was endorsed by the Central Committee for Drug Abuse Control (CCDAC) and the MOHS more than a decade ago. The provision of harm reduction services for PWID was set as a priority in both the National Strategic Plan on HIV and AIDS 2016–2020 (NSP III) and in the National Drug Control Policy. Since the initiation of harm reduction in the mid-2000s, the number of PWID accessing services has significantly increased. Nevertheless, a large number of drug users remain unreached, especially in remote areas and conflict affected zones.

A broad range of government bodies, international and local nongovernmental organisations (NGOs), drug user networks and community-based organisations (CBOs) as well as development partners and United Nations agencies have been actively involved in the harm reduction response in the country. Considerable progress and impressive achievements have been accomplished over the past decade, reflected in the increased number of harm reduction projects implemented by international and local NGOs; the growing involvement and leadership shown by the government sector; and the increased commitment by development partners, donors and supporting agencies to support services for PWID.

Expansion of service delivery in the areas of needles and syringes programmes (NSP), methadone maintenance therapy (MMT), HTS, ART, STI, hepatitis and TB has been dramatic, both in terms of geographic coverage and population served, reaching PWID and people who use drugs (PWUD) that earlier received no harm reduction interventions.

To provide a few examples, the number of needles and syringes distributed nationwide has increased considerably from 210,000 in 2003 to 35.1 million in 2019, while the number of PWID accessing HTS and MMT services increased 13-fold and 12-fold respectively since 2011. The provision of certain HIV prevention and treatment services in prison has also improved in recent years, notably following MOHS (National AIDS Programme and National TB Programme) and MOHA (Prison Department) combined efforts to improve health in prisons—although MMT is yet to become available.

Despite this progress, HIV incidence among PWID is not falling as rapidly as might be expected. After a slow but decreasing trend since harm reduction programmes started in early 2000, HIV prevalence among PWID has recently bounced back from 23.1% in 2014 to 34.9% in 2017 (IBBS).

Stakeholders involved in the NSF development process, particularly those representing people who use/inject drugs and service providers, identified a variety of challenges that hinder efforts to address HIV among PWID. These notably include:

- An insufficient programmatic coverage of key harm reduction/HIV prevention interventions, especially NSP, OST and ART, to achieve a measurable impact on the HIV epidemic among PWID, and limited availability of and access to specific services for ATS and female users, to post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), overdose management (naloxone), and hepatitis C treatment;
- A shortage of human resources and capacity of main actors to provide services on a larger scale, combined with a heavy reliance of existing harm reduction services on international support and a still limited role played in the response by the community of people who use drugs;
- Difficulties to clearly monitor and keep track of coverage and assess the impact of existing interventions.

In order to address these gaps and enhance the effectiveness of harm reduction interventions in Myanmar, the following priorities have been identified:

1. Increase programmatic coverage of comprehensive harm reduction and related HIV and health services and develop innovative approaches and service delivery models for all people who use drugs, with a focus on PWID; especially in remote and conflict affected areas.[ii]
2. Build the capacity and rationalise the workforce to maximise/optimise the harm reduction response in Myanmar.
3. Enhance sustainability of HIV prevention and harm reduction services in the prospect of reduced international funding.
4. Strengthen the evidence base on the current epidemic situation and response for PWUD and PWID in Myanmar to better inform planning, implementation and evaluation of HIV and harm reduction programmes.

[ii] When reference is made to PWID in the logframe it is also intended to include sexual partners in the plan/ intervention

Strategic direction 3: Evidence-based drug dependence treatment

Drug dependence is recognised as a complex, multifactorial health disorder characterised by a chronic and relapsing nature with social causes and consequences. The combination of voluntary, evidence-based pharmacological and psychosocial interventions generally offer the best and most cost-effective results to support the recovery of people who are dependent on drugs. Drug dependence treatment services encompass wide-ranging interventions, including community-based outreach services and harm reduction, medication-assisted detoxification, opioid substitution therapy, HIV services and psychological support and reintegration services.

The provision of community-based treatment services is considered the most cost-effective approach to support people affected by drug use and dependence. Located in the community, comprehensive services taking into account different needs (health, housing, family, education, employment) are offered primarily on an outpatient basis, thus resulting in minimum disruption of family, employment and social life. In order to qualify as community-based services, participation in treatment must be informed and voluntary, and services offered must respect human rights and dignity and accept relapse as part of the process.

Drug dependence treatment services in Myanmar are provided under the supervision of the Drug Dependency Treatment and Research Unit (DDTRU) of the MOHS. Services consist of medication-assisted detoxification provided at major Drug Treatment Centres and Drug Dependence Treatment Hospitals (DTC and DDTH) and MMT since 2006.

The number of methadone dispensing sites and patients enrolled into the programme has increased significantly after 2011 to reach approximately 20,000 patients on MMT at the end of 2019. Despite progress, coverage remains relatively low at 21% of all estimated PWID enrolled in MMT, falling short from achieving both the target set in the NSP III of 32,000 PWID receiving MMT by 2020 and the 40% coverage required to effectively address problematic drug use and reverse or stabilise an HIV epidemic among PWID.

Community-based treatment is still in its infancy in Myanmar. The United Nations Office on Drugs and Crime (UNODC) recently translated into Myanmar language and adapted to the country context a Guidance Document and a Training Toolkit for the provision of community-based services initially developed for Southeast Asia region. Community-based treatment services are currently being piloted in two townships (Kalay and Wutho in Sagaing Region) in partnership with key ministries including MOHA, MOHS, the Department of Social Welfare, as well as the National Drug Users Network in Myanmar.

Despite significant progress made in expanding access to and utilisation of drug treatment services, especially MMT, many important challenges and gaps remain. Key informants involved in the NSF development process identified the following barriers that reduce the effectiveness of the drug dependence treatment programme in Myanmar:

- Low coverage of MMT services and challenges including many steps for registration process, long induction period, long distance to travel for many patients to the closest MMT centre, difficulties to access take-home doses, unavailability of MMT services in prison, unavailability of methadone dispensing sites in remote and conflict affected areas;
- Extremely limited access to community-based voluntary drug dependence treatment services;
- Reliance of MMT programmes on international support and inadequacy of financial and human resources of DDTRU to meet the needs and cope with the required expansion of the methadone programme;
- Limited availability of updated, reliable and comprehensive data about existing drug treatment services in Myanmar.

In order to address these gaps and enhance the effectiveness of evidence-based drug treatment in Myanmar, the following priorities have been identified:

1. Expand coverage of voluntary evidence-based drug dependence treatment and develop innovative approaches and service delivery models for all people who use drugs.
2. Build the capacity and streamline the workforce to increase efficiency of drug treatment services.
3. Ensure the sustainability of the drug treatment response through strengthened coordination and collaboration across sectors and stakeholders and domestic funding mobilisation.
4. Strengthen the evidence base on the response to drug use and drug dependence in Myanmar to better inform planning, implementation and evaluation of drug treatment programmes.

Strategic direction 4: Rehabilitation and social reintegration

The World Health Organisation (WHO) has defined rehabilitation in the context of harmful drug use as a process aimed to support the achievement of optimal health, psychological functioning, and social well-being. Rehabilitation, recovery-support and social reintegration form an integral part of evidence-based drug dependence treatment services, alongside outreach, screening and brief interventions, inpatient and outpatient treatment, medical and psychosocial treatment (including treatment of comorbidities) as well as long-term residential treatment. Services usually complement pharmacological and psychotherapy support and can include relapse prevention, participation in self-help groups, housing, residence in a therapeutic community or halfway house, education and vocational trainings, and employment interventions.

It is crucial that services always be voluntary and based on the informed consent from the patient. In 2012, twelve United Nations entities issued a joint statement calling on States to close compulsory drug detention and rehabilitation centres and replace them with voluntary, rights-based and evidence-informed programmes in the community that are consistent with international human rights standards and the UNODC and WHO Principles of Drug Dependence Treatment.

Rehabilitation approaches that prove effective, both in residential and outpatient settings, include a mix of psychosocial interventions (e.g., psychotherapies such as cognitive behavioural therapy, motivational interviewing and contingency management) and social interventions (e.g., employment programmes, vocational training and legal advice).

Factors and activities that can contribute to fostering social reintegration and recovery from substance use disorders include strengthening individuals' resilience and self-confidence to manage daily challenges and stress; a supportive social network that supports the stability of recovery; stable accommodation; meaningful work with appreciation in the workplace; meaningful involvement in political, humanitarian or spiritual activities providing a stronger purpose in life; participation in educational and vocational pursuits, including volunteering or community involvement; remediation of legal and financial problems; and active involvement in self-help, religious or other support groups.

In 2019, there were nine Social Rehabilitation Centres and three Youth Correction Centres by the new Department of Rehabilitation under the Ministry of Social Welfare, Relief and Resettlement. Some centres were, however, not fully operational due to a variety of reasons, such as a lack of funding, the small number of "trainees" or the security situation. In addition, some social rehabilitation activities are conducted at the Drug Treatment Centres in Yangon, Kengtung and Myitkyina.

Government efforts are complemented by programmes and initiatives implemented by UNODC, MANA and MYET, including literacy and vocational trainings, relapse prevention meetings and small-scale income generation programmes.

Finally, numerous rehabilitation centres operated by faith-based organisations, ethnic armed organisations (EAOs) and civil society organisations have opened in recent years; these initiatives, however, are usually not coordinated with the Government, lack technical and operational support and expertise.

Key informants involved in the NSF development process have identified the following gaps and challenges limiting the effectiveness of existing rehabilitation programmes:

- Gaps along the continuum of care, treatment, and rehabilitation and social reintegration, notably due to limited collaboration between the MOHS and the Ministry of Social Welfare, Relief and Resettlement;

- Limits pertaining to the financial accessibility of rehabilitation services for people who use drugs in need of such services, limited financial and skilled human resources in these centres, the irrelevance of certain vocational trainings and the overall lack of evidence-based information associated with outcome measures, and notably relapse following the completion of the programme;
- Concerns relating to violations of human rights and a lack of evidence-based services in some of the rehabilitation centres operated by faith-based organisations and other groups in the community.

In order to address these gaps and enhance the effectiveness of rehabilitation and social reintegration services in Myanmar, the following priorities have been identified:

1. Improve recovery support for people with problematic drug use through voluntary and evidence-based rehabilitation programmes at community level, in line with WHO and UNODC standards.
2. Promote social and economic reintegration of people with problematic drug use, through voluntary and evidence-informed social integration initiatives at community level, in line with international standards.
3. Strengthen the role and technical capacity of the Ministry of Social Welfare, Relief and Resettlement in planning, management and evaluation of rehabilitation and social reintegration services.

Strategic direction 5: Laws, policies and enabling environment

Laws and policies are generally understood to have a significant influence on the health of a population. This is particularly true for laws and policies on drugs: the criminalisation of drug use and people who use drugs has a direct impact on whether and how people who use drugs can access health and social services, such as drug prevention, harm reduction, drug treatment, rehabilitation and social integration services. In this context, criminalisation negatively affects the health of people who inject and use drugs, increasing their vulnerability to HIV and other STIs and hindering access to vital prevention, treatment and care services.

The Government of Myanmar has adopted the three United Nations Conventions on Drugs. In April 2016, it also adopted the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem (UNGASS on Drugs) in which Member States expressed their commitment to address all facets of the drug problem in a comprehensive and balanced manner.

Over the past few years, there has been a growing call for ending the war on drugs. Organisations such the Global Commission on HIV and the Law and the Global Commission on Drug Policy have highlighted how repressive laws and aggressive enforcement actions were creating barriers to effective HIV prevention, treatment and care, calling on countries to decriminalise drug use and possession for personal use, repeal punitive laws and replace them with laws that promote public health, and in particular, effective HIV responses.

In Myanmar, a legal reform process resulted in the amendments of the Excise Act (1917) in December 2015 and of 1993 Narcotic Drugs and Psychotropic Substances Law in February 2018. Key changes included the removal of the compulsory registration of people who use drugs, expanded provisions on rehabilitation and community services, and an explicit inclusion of harm reduction approach in the mandate of CCDAC. The country also adopted its first National Drug Control Policy in February 2018, which clearly prioritises public health over repression, recommends to decriminalise drug use and promotes respect for human rights. Although the Policy is not a legally binding document, it nonetheless reflects a growing multisectoral consensus for adopting a more balanced, integrated and public health-oriented approach to address drug problems in Myanmar.

In spite of these positive developments, important legal and policy barriers continue to exist and have been identified by key informants as impediments to the scale-up of a more effective response to challenges posed by problematic drug use in Myanmar, including HIV:

- People who use drugs remain exposed to constant risks of arrest and long-term imprisonment, notably due to the use of Section 16 (sub-section c) of 1993 Law on the possession of small amounts of drugs for personal use, and continue to face significant stigma, discrimination and other violations of human rights as a result;
- Punitive laws, policies and policing practices hinder people who use drugs' access to vital HIV and health services, contributing to the spread of HIV and other blood-borne and sexually transmitted diseases.

In order to address these serious challenges and facilitate the emergence of a more enabling environment to address drug-related issues in Myanmar, the following priorities have been identified:

1. Ensure drug laws and policies are in line with public health and rights-based approaches.
2. Increase awareness about HIV and drug dependence among general public and specific stakeholders, to create an enabling environment for implementation of comprehensive harm reduction services.
3. Strengthen community mobilisation and technical capacity of networks and CBOs to better respond to the needs of people who use and inject drugs.
4. Identify and address policy barriers to an enabling environment for effective HIV response among people who use/inject drugs.

INTRODUCTION

Rationale for the development of the National Strategic Framework on Health and Drugs

Past and the present: cultivation, trade and consumption of drugs in Myanmar

Myanmar has a long history in the cultivation, trade and consumption of drugs. The cultivation of opium poppy was documented in Myanmar in 1736; cultivation in the north-eastern part of the country is believed to have been originally introduced by Chinese traders from the neighbouring province of Yunnan.[1] Opium use and production became widespread in the 19th century with the development of the international opium trade during British colonial rule.[2] The greatest expansion of the opium trade in the border region was reported in the early 1950s during the National Chinese (Kuomintang) troop invasion of the country, considered as the "darkest period" in Myanmar's drug history.[3]

Myanmar was the world's leading opium producer in the 1970s and 1980s.[4] Since the 1990s, it has become the second largest opium growing country after Afghanistan,[5] accounting for 5% of global opium production in 2017.[6] In recent years, a rapid expansion in the production, trafficking and use of synthetic drugs such as methamphetamine has also been observed in the South-East Asia Region.[7]

Drug-related harms to health and society in Myanmar

Ongoing supply and easy availability of drugs has resulted in major adverse health, social and economic consequences for people who inject drugs (PWID) and, increasingly, people who use amphetamine-type stimulants (ATS), their families and the community at large. In Kachin State and northern Shan State, where opium is illegally available, PWID are affected by a broad spectrum of adverse health issues, including HIV, tuberculosis and viral hepatitis. A large proportion of people who use drugs (PWUD) live in remote border areas and conflict affected zones, which are hard to reach and where health services are not always available.

Against this backdrop, considerable challenges remain to achieving the desired health impact and to reaching the Fast Track targets set by the country in the National Strategic Plan (NSP III) for HIV 2016–2020 and towards the Sustainable Development Goal of 'ending the AIDS epidemic' by 2030.

Given the magnitude of the problem, the Ministry of Health and Sports, jointly with other government bodies including the Ministry of Home Affairs, Ministry of Social Welfare, Relief and Resettlement, as well as with local and international nongovernmental organizations, representatives of National Drug Users Network in Myanmar, development partners and United Nations agencies, acknowledged the need for a comprehensive approach to address the interconnected health, social and legal consequences of drug use in Myanmar. This requires adapting and scaling up innovative strategies and high-impact interventions as well as mobilizing more resources and capacities.

The National Strategic Framework (NSF) on Health and Drugs aims to effectively respond to the intertwined challenges associated with the use of illicit substances,[iii] through a multipronged evidence-based approach that is aligned with existing national policies, plans and strategies as well as with relevant international and regional declarations, resolutions and commitments adopted by the Government of Myanmar.

The scope of the NSF on Health and Drugs

The scope of the NSF on Health and Drugs includes the following five strategic directions:

6) Primary prevention of drug use, especially young people who have not yet started to experiment or use drugs;
7) Harm reduction for people who already use and/or inject drugs;
8) Voluntary and evidence-based drug treatment for people who experience problematic drug use or are dependent on drugs;
9) Rehabilitation and social integration;
10) Laws, policies and enabling environment.

The NSF also makes recommendations for future research to inform the development, implementation and monitoring of the response to drug-related health consequences. The scope of the NSF does not include supply reduction, drug control or alternative development.

Process for the development of the NSF

The NSF has been developed under the leadership and guidance of the Ministry of Health and Sports and with the support of the Ministry of Home Affairs and the Ministry of Social Welfare Relief and Resettlement. Its development was informed by a review of published literature and a participatory consultative process involving a broad range of stakeholders in each of the five thematic areas covered by the NSF (the list of key informants is provided in Annex 1).

Peer-reviewed databases relevant to the thematic areas were examined as well as web-based grey literature and reports published at country, regional or global level.

iii This Framework adopts the UNODC definition of (illicit) drug (Reference: United Nations Office on Drugs and Crime. Terminology and Information on Drugs. Third Edition. United Nations. New York, 2016). In the context of international drug control, "drug" means any of the substances in Schedule I and II of the 1961 Convention, whether natural or synthetic. In Myanmar, the main (illicit) drugs of choice are heroin, methamphetamines and opium. In addition, the use of marijuana and misuse of tranquilizers is reported. While alcohol and tobacco, which are licit substances, have a significant impact on mortality and morbidity of people globally, and in Myanmar, addressing health and social consequences of alcohol and tobacco use are outside the remit of this Framework.

Following the literature review, a participatory consultative process was undertaken at different stages of NSF development to:

- determine the outline and scope for the NSF;
- review the first draft of the strategy, and;
- obtain stakeholders' feedback on the advanced draft of the strategy.

Key informant interviews and discussions were conducted with stakeholders from various fields of expertise or experience relevant to each thematic area. Key informants included: policy-makers, service-providers, programme implementers, I/NGOs, representatives of people who use and inject drugs, as well as development partners and representatives and staff from United Nations agencies.

Existing forums – such as the national Myanmar Health Sector Coordinating Committee (MHSCC) and the Harm Reduction Technical Working Group under the Technical Strategy Group (TSG) on HIV – were also utilized to consult key stakeholders at critical junctures in the NSF development.

Geopolitical context of The Republic of the Union of Myanmar

Bordering the People's Republic of Bangladesh, the Republic of India, the People's Republic of China, the Lao People's Democratic Republic (Lao PDR) and Thailand, Myanmar is the second largest country in Southeast Asia in terms of land area.[8] The intersection between Lao PDR, Myanmar and Thailand is known as the 'Golden Triangle'.

Administratively, Myanmar is divided into seven states, seven regions and one union territory—Nay Pyi Taw, the capital. The seven states – Chin, Kachin, Kayah, Kayin, Mon, Rakhine and Shan – are largely populated by ethnic communities while the seven regions – Ayeyarwady, Bago, Magway, Mandalay, Sagaing, Tanintharyi, and Yangon – are predominantly populated by people of Bamar origin.[9]

The total population size is estimated to be between 48 million and over 60 million. According to the 2014 census, Myanmar has more than 51 million inhabitants, of whom two thirds live in rural areas.[10] The Government of Myanmar recognizes some 135 different ethnic groups.

Approximately one in four persons lives below the poverty line. Years of geographic, political and economic isolation combined with a relatively low level of national investment in health, have held back the development of health infrastructure, which remains limited, especially in remote areas and areas affected by internal conflicts. Household out-of-pocket payment accounts for 70% to 80% of total health expenditure.[11]

Determinants of drug use

Harmful use of drugs has been defined by WHO and UNODC as a pattern of psychoactive substance use that causes damage to physical health (e.g., acquiring HIV through use of contaminated injecting equipment) and/or mental health (e.g., depressive episodes resulting from prolonged and excessive alcohol use) and which commonly or invariably leads to serious adverse social consequences.[12]

There is no single cause for initiation of drug use and no single factor for drug dependence. Rather, drug use is a behaviour that is linked to development processes and usually begins during adolescence or young adulthood.

Many factors have been associated with an increased risk of substance use among children, young people and adults. The more risk factors (or the more acute) an individual is exposed to, the greater his or her likelihood of using drug. Of the numerous risk factors, the following appear to significantly increase the vulnerability to drug use:[13]

Figure 1. Risk factors associated with increasing vulnerability to drug use

COMMUNITY/SOCIETY

Laws and norms favourable towards drugs use
Availability
Accessibility
Extreme poverty
Anti-social behaviour in childhood

SCHOOL/EDUCATION AND PEERS

Childhood/adolescence
School failure
Low commitment to school
Not college bound
Deviant peer group
Peer attitudes towards drugs
Associating with drug-using peers
Aggression towards peers
Interpersonal alienation
Peer rejection

Young adulthood
Attending college
Substance using peers

FAMILY

Early childhood
Cold and unresponsive mother behaviour
Parental modelling of drug use

Childhood/adolescence
Permissive parenting
Parent-child conflict
Low parental warmth
Parental hostility
Harsh discipline
Child abuse/maltreatment
Parental/sibling modelling of drug use
Parental favourable attitudes towards drugs
Inadequate supervision and monitoring
Low parental involvement
Low parental aspirations for child
Lack of or inconsistent discipline

Young adulthood
Leaving home

INDIVIDUAL

Preconception
Genetic predisposition
Prenatal alcohol exposure

Early childhood
Difficult temperament

Middle childhood
Poor impulse control
Low harm avoidance
Sensation seeking
Lack of behavioural self-control regulation
Aggressiveness
Antisocial behaviour
Anxiety, depression
ADHD, hyperactivity
Early persistent problem behaviours
Early substance use

Adolescence
Behavioural disengagement coping
Negative emotionality
Conduct disorder
Favourable attitudes towards drugs
Antisocial behaviour
Rebelliousness
Early substance use

Young adulthood
Lack of commitment to conventional adult roles
Antisocial behaviour

MEDIA

Norms, e.g, advertising favourable towards drugs

Source: National Research Council and Institute of Medicine of the National Academies. Preventing mental, emotional, and behavioural disorders among young people: Progress and possibilities. Washington, DC: The National Academies Press; 2009

At the same time, protective factors contribute to preventing the initiation of drug use and helping the individual to make healthier life choices and informed decisions. They include:

- psychological and emotional well-being;
- personal and social competence;
- strong attachment to caring and effective parents;
- strong attachment to schools and community that are well resourced and organized.[14]

In addition to individual factors and interpersonal relationships such as family, peers and school, other interconnected community-level and societal factors strongly influence drug use and the way a country addresses drug-related challenges. These factors include: availability and accessibility of drugs, extreme economic deprivation, violence, and community disorganization.[15, 16]

> The vast majority of people who use drugs do not become dependent. According to UNODC, out of the total number of people who use drugs globally, just over 13% (or around 35 million) are engaged in problematic use. This means that their drug use is harmful to the point that they may experience drug dependence and require treatment.[17]
>
> Opioids, however, including heroin, remain the most harmful drug type in health terms.

Overview of health, social and legal consequences of drug use

Drug use and drug dependence are associated with multiple adverse health, social, economic and legal consequences, for individuals and society as a whole. They place an inordinate burden on national health and criminal justice systems. People who inject drugs (PWID) are among the most marginalized drug users. They experience some of the most severe health consequences associated with drug use, with a greater risk of premature death and high rates of infectious diseases such as HIV, hepatitis and tuberculosis, and increased risk of drug overdoses (both fatal and non-fatal).[18, 19]

Additionally, infectious diseases acquired through using contaminated injecting equipment further impact on those who do not inject or use drugs (for example, sexual partners) through other modes of transmission.

Global prevalence of injecting drug use and drug-related health harms

According to a joint estimate by UNAIDS, UNODC, WHO and the World Bank, 11.3 million people worldwide injected drugs in 2017. This represents 0.23% of the global population aged 15–64 years. The largest populations of PWID are in East and Southeast Asia with 28% the global total of PWID.[20] People who inject drugs are particularly vulnerable to acquiring HIV and hepatitis B and C through use of non-sterile injecting equipment.[21]

HIV among PWID globally

- The risk for PWID to acquire HIV is 22 times higher than for adults in the general population.[22]
- Nearly one in eight people who inject drugs is living with HIV (12.7%). This represents about 1.4 million PWID living with HIV worldwide.[23]
- Outside sub-Saharan Africa,[24] PWID accounted for 20% of all new HIV infections in 2015.[25]
- Of great concern is the increase by one third in the number of newly infected PWID globally, from 114,000 new infections in 2011 to 152,000 in 2015.[26]

HCV, HBV and TB among PWID globally

Coinfection with hepatitis C virus (HCV) is highly prevalent among PWID. Morbidity and mortality associated with HCV in this population are higher than the burden of disease resulting from HIV, including for people with a past history of injecting drug use (important because the health consequences might not be seen for many decades after initial infection). It is estimated that 82.4% of all HIV-positive PWID globally are also infected with HCV.[27] Hepatitis B virus (HBV) prevalence among PWID is estimated at 7.5% globally.[28]

Tuberculosis (TB) prevalence is estimated at 8% among PWID.[29] Infection with HIV dramatically increases the chance of latent TB infection progressing to active TB.[30] TB is one of the leading causes of mortality among PWUD/PWID and people living with HIV.[31]

Overlapping risk factors

Drug use can also be linked with involvement in sex work in certain contexts. Although the extent of engagement in sexual risk varies considerably among samples of PWID across countries, in general, PWID are exposed to adverse risk environment all over the world.[32]

	Globally	East and Southeast Asia
Recent sex work	**16.8%**	**19.6%**
[current or past year among all PWID in a sample, not by gender]	PWID had recently engaged in sex work	Almost one in five PWID had recently engaged in sex work
Recent sexual risk	**37.4%**	**35.8%**
[no or inconsistent condom use with casual partner / within the past month]	PWID had recently engaged in sexual risk behaviour	More than one in three PWID had recently engaged in sexual risk behaviour

Source: Degenhardt L, et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: A multistage systematic review. Lancet Global Health 2017;5(12):PE1192-E1207.

A review of published and grey literature on the evidence of injecting and non-injecting stimulant use (including ATS) and their possible link to HIV, HCV and HBV vulnerability and transmission, found that sex risk behaviour was significantly associated with stimulant use. The study, however, stressed that it was difficult to quantify the exact role of stimulant use in increasing HIV infection, although the evidence seemed to point towards a positive association between these two factors.[33]

Methamphetamine users are more likely to engage in high-risk sexual behaviours that place them at greater HIV and STI risks.[34]

Other drug-related health and social harms

In addition to infectious diseases, drug overdose and suicides are among the leading causes of death.[35] A systematic review found that nearly half (47%, range 17% to 68%) of people who use drugs who participated in the studies reviewed had experienced a non-fatal overdose at least once in their lives. Among those, 17% (range 4% to 38%) had experienced a non-fatal overdose in the past year.[36] People who survive an heroin overdose may still experience a range of health complications, including brain damage caused by oxygen deprivation, kidney failure, heart problems, seizures, nerve damage, cognitive impairment and muscle tissue breakdown.[37]

Available data also indicate an intricate relationship between substance use and mental disorders such as depression, mania or psychosis, which require specific medical attention in appropriate mental health services.[38]

People who use/inject drugs experience a wide range of social problems, including poor nutrition, homelessness, interpersonal and family-related problems, high school drop-out and unemployment. Moreover, drug dependence is rarely understood as a health issue, and drug-dependent individuals are commonly viewed as criminals rather than as people requiring health services to address their specific needs. They are highly stigmatized and discriminated against by society at large. Women who use and/or inject drugs face greater stigma and discrimination and tend to be more marginalized than male counterparts.[39] Those who engage in sex work are further criminalized, which increases their vulnerability to sexually transmitted or blood-borne infections.[40]

Human rights abuses against people who use drugs

Violation of the human rights of people who use drugs, and especially those who inject drugs, has been widely documented. It includes harassment, arbitrary arrest and incarceration, violence and ill treatment during detention, extortion, beatings and sexual abuses, among other violations.[41]

There are also reports of violence and extrajudicial killings of suspected drug offenders in the Asia region, notably in the Philippines,[42] Indonesia[43] and Bangladesh[44]. The United Nations High Commissioner for Human Rights,[45] the International Narcotics Control Board[46] as well as various United Nations human rights bodies[47] and governments[48] strongly condemned the practice of extrajudicial killings.

The cost of drug use to society

Drug use-related problems are among the main contributors to the global burden of disease and put a heavy burden on national health systems that are sometimes already overstretched. People who use drugs require a full range of health services, including prevention, diagnosis and treatment of HIV, STIs, hepatitis, and TB; medical interventions including emergency services to respond to opioid overdoses; drug treatment for those who are dependent; as well as specific services to address mental health issues.

In addition to harming personal health and accomplishments, problematic drug use negatively affects family functioning (e.g., relationships, financial security), and society at large as it also results in lost productivity. All over the world, the retention of laws and policies that criminalize and penalize people for personal use and possession of drugs even in small quantities, weighs considerably on criminal justice systems.[49] Sentences can be very harsh, with high percentages of people jailed for minor drug-related offences, contributing to the overcrowding of prisons in many countries. Large numbers of people who use drugs are also incarcerated in compulsory drug detention centres, especially in Asia and Latin America.[50]

In prisons and other closed settings such as drug detention facilities, the prevalence of HIV, HBV, HCV and TB is between two and ten times higher than in the general population.[51, 52] Despite heightened transmission risk in prisons, prevention and clinical services to address these communicable diseases appear to be rare. This places an additional burden on prison health systems, where financial resources for the provision of mainstream health services are already very limited.

> However, it is important to bear in mind that among people who do develop a dependence to drugs, the majority can be offered treatment **through low threshold, community-based services**.[53]

Prevalence and patterns of drug use in Myanmar

Despite reported reduction in opium cultivation, Myanmar remains the second largest opium growing country after Afghanistan[54]. Shan State is the main producing region of opium poppy – nearly 90% of the total opium poppy area – followed by Kachin State (9%)[55]. In these two main producer states, the area under opium poppy cultivation decreased by 12 percent between 2017 and 2018[56].

In Myanmar, the most commonly used illicit drugs include: opioids (with heroin being the primary drug of choice), amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens. The most commonly injected drug is heroin, which is injected through intravenous, intramuscular, subcutaneous and other routes.[57] Poly drug use, defined as the use of two or more psychoactive drugs in combination, is reported as frequent.[58, 59]

The estimated number of people who inject drugs has increased from 83,000 in 2015[60] to 93,000 in 2017[61]. Little is known about the extent of drug use and the number of drug users in Myanmar. In the absence of nationally representative survey data on the prevalence and patterns of drug use in the general population, information is currently derived from drug treatment centres in the public sector. For example, although data on the prevalence of ATS use is scarce, based on available information on seizures, arrests and treatment data, experts believe that methamphetamine use is on the increase in Myanmar.[62]

Information from drug treatment centres indicates that the number of people admitted for problematic drug use or drug dependence has been increasing steadily over time. Although heroin and opium users still represent the majority of admissions, the proportion of people seeking treatment for problematic use of methamphetamine, as well as for substance use disorders, keeps increasing.

In 2019 methamphetamine users accounted for nearly 8% of all new treatment admissions,[63] a three-fold increase compared to 2014. The emergence of the use of methamphetamine in crystalline form (reported by government officials for the first time in 2015) in addition to the use of methamphetamine tablets, could partly explain such increase.[64] As yet, the use of ecstasy or new psychoactive substances (NPS) has not been reported as a major problem in the country,[65] while the cultivation and use of a traditional substance, Kratom,[iv] is quite common.[66]

Overview of risk factors for HIV in Myanmar

Most recent information about HIV-related risk among people who inject drugs comes from the Integrated Biological and Behavioural Survey (IBBS) from 2018, conducted by the National AIDS Programme across 13 sites and among a sample of 6,061 PWID.[67] Data about HIV-related risks among people who do not inject drugs remains limited.

Results from the IBBS showed that, on average, people switched from drug use to injecting drug use within four years. The pace was faster in Mandalay (less than two years), Mohnyin and Myitkyina (less than three years). Approximately one quarter of IBBS respondents had been injecting drugs for one year or less. These new injectors are at very high risk for HIV: one in five neophyte injectors are getting infected in their first year of injecting and one in two and a half are infected by their second year (20% HIV prevalence among those injecting for less than one year and 40% among those injecting for more than one year 40%).

The overwhelming majority (99%) of PWID who participated in the 2018 IBBS survey reported heroin as their primary drug of injection in the last 12 months. Poly drug use through non-injecting modes was frequent with two thirds of PWID reporting using heroin, more than half using amphetamines, and over one third using opium.

Injection practices

Frequency of injection in the last month	Use of non-sterile injecting equipment
• 2–3 times a day or more for 80% of respondents • 4 or more times a day: ~12% on average (all sites), from 3.3% in Yangon to 16.3% in Kutkai	• 5.9% of PWID (across all sites) reported having used someone else's needle and syringe at last injection

[iv] Kratom is a substance derived from the Mitragyna speciosa plant which is indigenous to Southeast Asia, in particular in Malaysia, Myanmar and Thailand. It is both a stimulant and a sedative. The most frequent mode of use is making tea out of the dried leaves. It is a controlled substance in Myanmar.

Sexual relationships and practices among PWID

Around 85% of PWID who participated in the IBBS had ever had sex. The median age of first sexual intercourse was 19 years and the mean 20 years; 15.3% of respondents reported having sex with a sex worker in the past 12 months, ranging from 3.6% in Indaw to 30.2% in Hpakant.

Condom use remained very low overall: only 20% of PWID who had sex with any type of partner in the last month reported condom use at last sexual encounter.

	PWID who had sex in last 12 months	Condom use (past month)
With a regular partner	87%	68% reported **not** having used a condom with a regular partner
With a paid partner	15.3%	80% of PWID reported having used a condom with a sex worker. However, in Kalay, this proportion dropped to only one third (35%) and less than half (45.9%) in Kutkai.

Overall, 1.8% of PWID tested positive for syphilis across all IBBS sites. Yangon had the highest prevalence (5.7%), followed by Mandalay (3%), Tamu (2.6%) and Muse (2.5%).

Sexual risks among non-injecting drug users

Information about HIV-related risks among non-injecting users remains limited in contrast to what is available concerning PWID. Nevertheless, the risks associated with the concomitant use of injecting and non-injection drugs have been described in Myanmar and other countries.[68] A study conducted in 2013 among 1,183 methamphetamine users in Muse (Shan State North) found that a large proportion of them, both men and women, engaged in high-risk sexual behaviours such as inconsistent condom use and multiple sexual partners. Furthermore, 16% of the sampled individuals reported having injected methamphetamine and 21% having injecting heroin in the preceding six months. Despite overlapping HIV risk factors, only 14.7% had ever tested for HIV.[69]

Epidemiology of HIV, and coinfections with viral hepatitis and tuberculosis

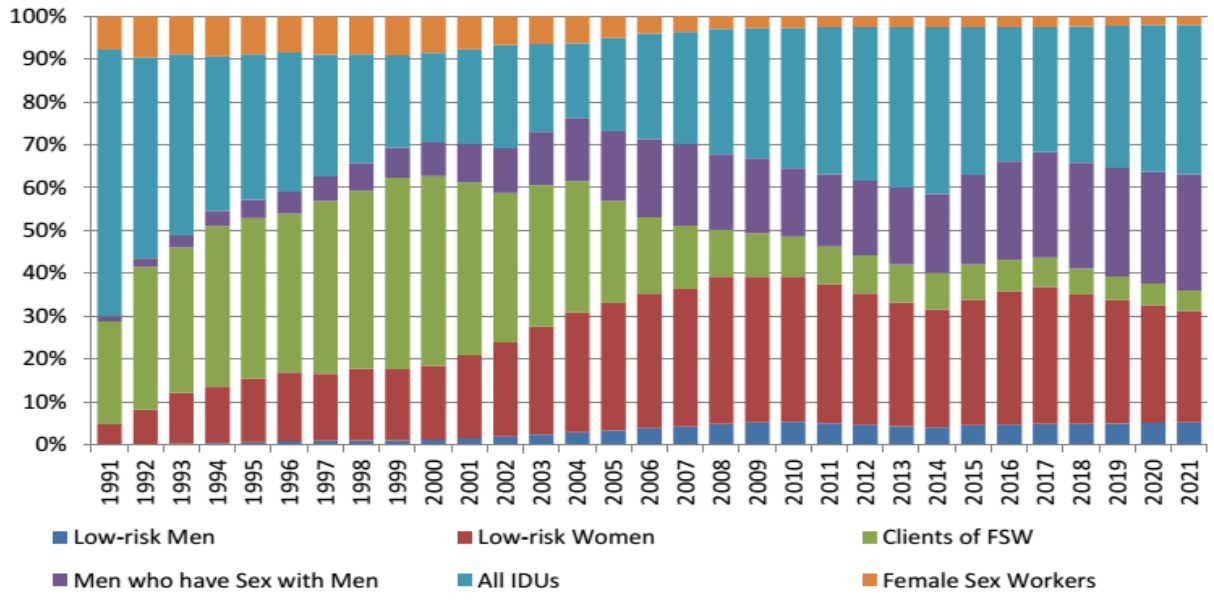
HIV at a glance in Myanmar in 2019	
Adults and children living with HIV	240,000 of which 39% are women
HIV prevalence in adults > 15 years	0.58 % (Source: AEM-Spectrum March 2020)
Adults and children newly infected	10,000
Adult and child deaths due to AIDS	7,700

Source: Global AIDS Monitoring (GAM) report and estimates, 2019, aidsinfo.unaids.org

The prevalence of HIV in the adult population (15+ years old) remains relatively low and has slowly declined in Myanmar over the last decade. However, there is notable variation across regions of the country.

The epidemic is concentrated among key populations at higher risk of HIV transmission, namely people who inject drugs, men who have sex with men, transgender individuals, people engaged in sex work, as well as the intimate partners of these key populations.

Figure 2. Distribution of new HIV infections by population group, based on AIDS epidemic model (AEM), 1991–2021



Source: Myanmar. Key facts on HIV. https://www.aidsdatahub.org/Country-Profiles/Myanmar

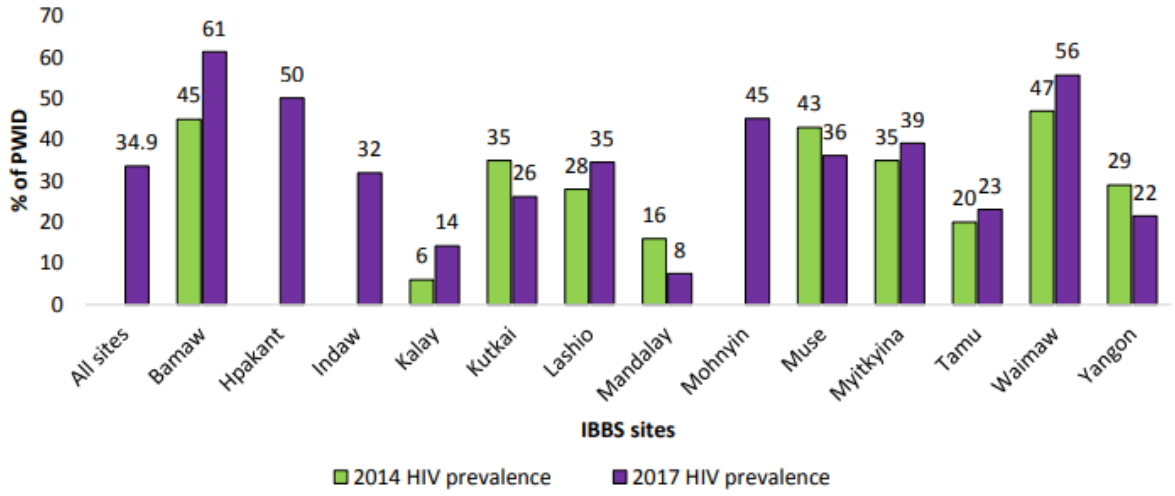
HIV prevalence among key populations at national level

At national level, HIV prevalence among PWID was estimated at 35% in the 2018 IBBS,[70] up from 28.5% in 2016.[71] It is the highest prevalence across all key populations, far ahead of the prevalence among sex workers (14.6%) and men who have sex with men (11.6%).[v] No HIV prevalence data is available for transgender individuals.

HIV prevalence among PWID across IBBS survey sites

Across the 13 IBBS survey sites, the lowest HIV prevalence among PWID was in Mandalay (7.6%) while the highest prevalence was in Bamaw (61%) in Kachin State. Injection drug use is endemic in Kachin State where 5% of the male population aged 14–49 are estimated to be PWID.[72] This is much higher than most countries. Prevalence rates above 50% were reported in Hpakant and Waimaw, and above 40% in Mohnyin (Kachin State). Six survey sites reported an increase in HIV prevalence from the 2014 IBBS (Bamaw, Kalay, Lashio, Myitkyina, Tamu and Waimaw), while four sites (Kutkai, Mandalay, Muse and Yangon) reported a reduction.

Figure 3. HIV Prevalence in 2014 vs 2017



Source: IBBS among PWID (2018)

Hepatitis B and C in general population and among PWID

Hepatitis B (HBV) and C (HCV) infections incur a substantial disease burden in Myanmar, both in the general population and among PWID. In 2015, a national seroprevalence survey, conducted in 18 study sites covering all states and regions, showed that 6.51% of the general population was infected with hepatitis B and 2.65% with hepatitis C.[73]

[v] Based on latest available data collected in 2015 for the IBBS among MSM and FSW.

The burden of viral hepatitis among PWID is considerable, as shown in the table below:

HCV	HIV/HCV coinfection	HBV	HIV/HBV coinfection
56% overall	26.8% overall	7.7% overall	3.2% overall
Ranging from 27% in Myitkyina to 84.5% in Waimaw	Ranging from 4% in Mandalay to 55% in Bamaw	The highest was in Muse, Kalay and Mohnyin at approximately 10%	Ranging from 0.5% in Mandalay to 5.7% in Hpakant

Source: IBBS 2018 among PWID[74]

Tuberculosis

Myanmar is one of the 30 highest TB burden countries in the world.[75] In 2017 alone, 132,025 cases of TB were recorded, including 8,700 confirmed cases of multidrug resistant (MDR)-TB.[76] The same year, TB incidence rate was 358 per 100,000 per year (including TB+HIV).[77]

The incidence of TB and TB–HIV coinfection among PWID is unknown. However, PWID would most likely be affected as 11% of all people living with HIV newly enrolled in HIV care in 2019 (3,915 out of a total of 35,572 patients) were detected as having active TB disease.[78]

Overview of the situation in prison

There are 46 prisons and 48 camps in Myanmar with an estimated 65,000 to 70,000 prisoners. In addition, there are up to 40,000 persons in pre-trial detention.[79] The number of persons incarcerated markedly exceeds the design capacity of the facilities that hold them, and prison populations continue to increase steadily. Nearly half of detainees nationwide are in prison for drug-related offences.[80] In some prisons, such in Myitkyina, this proportion rises to 70%–80%.[81] Overcrowded living environments increase the probability of transmission of infectious diseases, such as HIV and TB.

Prevalence among prisoners was estimated at 4.7% at national level. Significant HIV prevalence has been found among prisoners with 19,7% in Kachin, 7.4% in Mon and 6% in Sagaing, and Shan North.[82]

AIDS-related illness is the leading cause of death among prisoners and tuberculosis is the second.

Alignment of the NSF with international and regional resolutions and declarations

Commitment at international level

In an effort to address the adverse effects of drug use and drug dependence, including the spread of HIV and other infectious diseases, the Government of Myanmar adopted a series of global and regional resolutions. The NSF on Health and Drugs complies with these commitments.

2015–The Sustainable Development Agenda
Myanmar adopts the 2030 Agenda for Sustainable Development Goals (SDG) and the 17 Sustainable Development Goals.[83] The NSF on Health and Drugs is aligned with Goal 3 "Ensure healthy lives and promote well-being for all at all ages", and especially with sub-goals: • 3.3 "By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases"; • 3.5 "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" and; • 3.8 "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[84]
2016
UNGASS Outcome Document
The Government of Myanmar adopts the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem[85] reaffirming its determination to address the drug problem through: • "Promoting the health, welfare and well-being of all individuals, families, communities and society as a whole, and facilitating healthy lifestyles through effective, comprehensive, scientific evidence-based demand reduction initiatives at all levels, covering, in accordance with national legislation and the three international drug control conventions, prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration measures, as well as initiatives and measures aimed at minimizing the adverse public health and social consequences of drug abuse" The Government also reiterates its commitment to: • "Ending, by 2030, the epidemics of AIDS and tuberculosis, as well as to combating viral hepatitis and other communicable diseases, inter alia, among people who use drugs, including people who inject drugs".

Political Declaration on HIV and AIDS
Myanmar adopts the United Nations Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030.[86] This declaration adopted in June 2016 in New York, calls on Member States to expand access to a comprehensive package of HIV prevention, treatment and care services for people who inject drugs, as outlined by WHO, UNODC and UNAIDS in 2012.[87]
UNAIDS 2016–2021 Fast-Track Strategy
Myanmar is also committed to achieving the fast-track targets set out in UNAIDS 2016–2021 Strategy on the Fast-Track to end AIDS.[88] In that regard, Target 6 is, among other targets, particularly relevant to the NSF on Health and Drugs: • "90% of key populations, including sex workers, men who have sex with men, people who inject drugs, transgender people and prisoners, as well as migrants, have access to HIV combination prevention services" and other related targets.

Commitments at regional level

At regional level, Myanmar adopts the 2016 Association of Southeast Asian Nations (ASEAN) Declaration on HIV and AIDS.[89] In this declaration, ASEAN Member States commit to "scale-up and strengthen the coverage, reach and quality of a continuum of comprehensive integrated packages of prevention, testing, treatment, care and support services for key affected populations in priority geographic areas according to national legislation, priorities and evidence about the epidemic in each ASEAN Member State".

Specifically, the ASEAN Declaration calls for Member States to scale up "Combination of prevention interventions, tailored for each key affected population taking into consideration the religious and cultural sensitivities of the community, that may include peer- and outreach-based education, healthy sexual relationship, condoms, pre-exposure prophylaxis for those at higher risk, HIV and STI testing, STI treatment, combat hepatitis B and C, measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication assisted therapy programmes and injecting equipment programmes, and access to appropriate interventions for people in prisons and other custodial settings".

The Government of Myanmar is also a party to the Mekong Memorandum of Understanding (MoU) on Drug Control[90] which aims to address illicit drug production, trafficking and use. The NSF on Health and Drugs is closely aligned with one of its four thematic areas: i) "Drugs and health" of the tenth revision of the Sub-regional Action Plan (SAP) (2017–2019) of the MoU process. The section on Drugs and health reads as follows in the SAP: "The trend of increased drug use, and the burden to public health and the social welfare of citizens and communities, can be reversed through stronger cooperation on drugs and health, and through more balanced, holistic and evidence-based drug policies".

Alignment of the NSF with national policies, strategies and plans

The NSF on Health and Drugs is also aligned with key national policies, strategies and plans relevant to drugs, health and HIV.

Alignment with national drug control policies

In 2018, the Myanmar 1993 Narcotic Drugs and Psychotropic Substances Law was amended. Despite positive steps towards shifting from a punitive to a public health approach, some areas of concern remain (discussed later in this document). Meanwhile, a new National Drug Control Policy[91] was developed by the Central Committee for Drug Abuse Control (CCDAC)/Ministry of Home Affairs, in cooperation with other Government bodies as well as I/NGOs and United Nations agencies. This new policy includes health and social policy responses with a view to addressing drug challenges through a more health-focused and people-oriented approach.

Most of the strategic directions that are reflected in the NSF on Health and Drugs directly complement some of the priority areas set in the National Drug Control Policy:

Complementary areas	
NSF on Health and Drugs	**National Drug Control Policy**
1) Primary prevention of drug use 2) Harm reduction 3) Voluntary and evidence-based drug dependence treatment 4) Rehabilitation and social reintegration	The following thematic areas are included under the overall priority area "Demand and Harm Reduction": • Prevention • Harm Reduction • Treatment, rehabilitation and reintegration

Drug-related laws and policies are discussed under Strategic Direction 5 of the NSF.

The NSF on Health and Drugs is also closely aligned with some of the objectives of the CCDAC National Strategic Plan on Drug Control that was developed in 2018–2019. Both strategic documents provide a framework which is based on public health and human rights for responding to the issues of drugs.

Alignment with national health policies

Addressing the adverse health outcomes associated with drug use is one of the top priorities of the Ministry of Health and Sports, as highlighted in the following key documents:

- The Myanmar National Health Plan (2017–2021);[92]
- The National Strategic Plan on HIV and AIDS (2016–2020);[93] and
- The Myanmar National Strategic Plan on Viral Hepatitis (2016–2020).[94]

The current National Health Policy of Myanmar dates from 1993, before the HIV epidemic started to spread in the country, and there is a plan to review this policy.

While the National Health Policy does not directly mention drug use and HIV, the Myanmar National Health Plan (2017–2021) acknowledges that "It is important to note some population groups may have special needs when it comes to health care (e.g., disabled, adolescents, pregnant teenagers, drug users, transgender…)". It stresses that: "while these special needs will have to be addressed and barriers to utilisation for these groups will need to be removed, the complexity involved in doing so, deserves more in-depth analysis and special attention".

The strategic objectives of the NSF on Health and Drugs are closely aligned with the overall objectives and specific targets, relating to addressing HIV among people who inject drugs, that were set out in the National Strategic Plan (NSP III) on HIV and AIDS 2016–2020, including the following targets pertaining to HIV prevention among PWID:

- 90% of priority populations [including PWID] reached by HIV prevention programmes;
- 90% condom use among priority populations [including PWID] at last sex;
- 30 million needles and syringes distributed to PWID (providing approximately 360 clean needles per year per PWID);
- 32,000 PWID receiving methadone maintenance therapy (MMT) or oral substitution therapy (OST), of whom 85% of individuals receive MMT for at least six months;
- 90% of those reached with prevention programmes tested and know their status, including children and young people;
- 90% of people from priority populations received a test in the last 12 months and know their results;
- 75% reduction of new infections.

The NSP III subnational HIV operational plans, developed throughout 2018–2019, focus on the states and regions with the highest number of HIV infections among key populations, including PWID. These operational plans set out a full range of actions to tackle health risks and the adverse effects associated with drug use, in Kachin, Shan North, Sagaing and Yangon.

The NSF on Health and Drugs also aims at harnessing synergies between the national response to HIV and the response to viral hepatitis, based on the strategic directions outlined in both National Strategic Plans.

Alignment with national youth policies

The NSF on Health and Drugs is cognizant of the need to prevent drug use young people and protect youth from the potential harms associated with drug use, as outlined in the National Youth Policy (2017), developed collectively by the Ministry of Health and Sports (MOHS), the Ministry of Social Welfare, Relief and Resettlement (MSWRR), the Ministry of Education (MOE), youth representatives, United Nations agencies and other relevant agencies.[95] All strategic directions (SD) of the NSF are aligned with the National Youth Policy, especially SD 1 on primary prevention of drug use, and other SDs on harm reduction, drug dependence treatment, and rehabilitation and social integration.

The NSF on Health and Drugs is also aligned with the Myanmar Five-Year Strategic Plan for Young People's Health (2016–2020),[96] developed by MOHS, parts of which relate to reducing the HIV risk and vulnerability of young people who use drugs.

Additionally, the Myanmar National Comprehensive School Health Strategic Plan (2017–2022),[97] developed by MOHS in collaboration with MOE, provides a strategic framework to "promote physical, mental and social health of entire students and promote healthy behaviour to prevent communicable and non-communicable diseases as well as determinants of health and risk factors to prevent diseases through comprehensive health promoting school approach". It includes the provision of basic health services and education in order to "prevent alcohol and substance abuse (2.1.2)" and of basic health promotion package to "prevent HIV, TB" and other communicable diseases (2.3.3) – consistent with the objectives of the NSF (especially SD 1 and SD 2).

Alignment with development partners' priorities

In 2018, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) redirected some unspent funds to scale up harm reduction interventions for PWID and their intimate partners, particularly in states and regions with a high burden of HIV and drug use. Likewise, the new multilateral Access to Health Funds focuses its efforts on the two states with the most severe burden: Kachin and Shan North. Financial support is provided to the MOHS and to I/NGOS with a view to comprehensively addressing drug-related harms (including the risk of HIV and hepatitis transmission).

Since August 2017, the USAID HIV Flagship (UHF) Project supported intervention for HIV prevention, testing, treatment and care among people who inject drugs in Kachin State, Shan State North and Sagaing Region, focusing on innovative service delivery models and approaches to enhance access to harm reduction services.

Relevant sectors and ministries

Several ministries share responsibility for the health and welfare of people who are affected by drug use and drug dependence. The line ministries are:

Ministry of Health and Sports

The primary goals of the MOHS are to: i) enable every citizen to attain full life expectancy and enjoy longevity of life and; ii) ensure that every citizen is free from diseases.[98] In terms of organizational structure, the National AIDS Programme (NAP) is responsible for the design, implementation, monitoring and evaluation of the HIV prevention, treatment and care programme (including harm reduction) while the Drug Dependency Treatment and Research Unit (DDTRU)[vi] oversees the drug dependence treatment programme, including the methadone maintenance therapy (MMT) programme.

Ministry of Social Welfare, Relief and Resettlement

The Department of Social Welfare, within the MSWRR, is responsible for providing "ex-drug addicts" and other vulnerable people, such as "children and their families, youth, women, person with disabilities, elderly, and people who are faced with social problems",[99] with prevention, protection and rehabilitation programmes.

Ministry of Home Affairs

The MOHA, has the primary responsibility for: i) ensuring national security; ii) strengthening law enforcement; iii) maintaining community peace and tranquillity, and iv) providing social services for the people. Within the MOHA, the Central Committee for Drug Abuse Control, (CCDAC) was constituted in 1976 to implement drug eradication interventions. Since then, the CCDAC has been reconstituted several times, including in 2016. The CCDAC is the entity responsible for the development of national drug policy and strategy. Within the MOHA, the Prisons Department is tasked with eight duties[100] including the provision of health care for inmates. Thus, the Prisons Department has a critical role in addressing adverse health consequences of drug use, considering that nearly half of the estimated 65,000-70,000 prisoners are serving sentences for drug related offences.[101]

[vi] The NAP is under the Department of Public Health; the DDTRU is under the Department of Medical Services

Ministry of Education

The MOE is the main provider of education and training in Myanmar, especially in the areas of basic education, teacher education and higher education. The main responsibility of the MOE is to implement education plans laid down by the government to achieve educational objectives prescribed in the education policy and education Acts.[102] The Myanmar National Comprehensive School Health Strategic Plan, developed by the MOHS in cooperation with the MOE, outlines a set of activities aimed at preventing HIV and drug use among the youth (see above under the section on **'Alignment with national youth policies'**).

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The following section presents **Strategic Direction 1** of the NSF on Health and Drugs on **Primary prevention of drug use**. After introducing the concept, this section provides a summary of the global evidence on the effectiveness of drug use prevention interventions, as well as a brief overview of programmes and projects implemented in Myanmar. It also identifies gaps and barriers and proposes a strategic framework for enhancing prevention of drug use in the country.
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STRATEGIC DIRECTION 1. PRIMARY PREVENTION OF DRUG USE

Definition and introduction

There is no single cause for initiating drug use and no single factor that determines whether a person will become dependent on drugs. The likelihood of developing drug dependence differs from person to person and depends on internal and external factors that have been described earlier in this document [refer to Introduction; Determinants of drug use].

It is important to bear in mind that drug use does not systematically lead to dependence and that only around 13% of people who used drugs globally were engaged in problematic use.

> **Prevention of drug use** is a public health approach which aims to address risk factors that render individuals vulnerable to experimentation or initiation of drug use. Prevention approaches are traditionally classified into primary, secondary and tertiary prevention strategies. Primary prevention "encompasses any activity focused on preventing or delaying the initiation of drug use and the potential transition to problem drug use".[103]

In view of the harmful effects of problematic drug use, the importance of preventing drug use is considered a global priority.

- **The Preamble of the International Drug Control Conventions** states that "The Parties (…) concerned with the health and welfare of mankind" acknowledge the importance of preventing and treating substance use disorders. Thus, preventing drug use is one of the key provisions of these conventions that aim to protect the health of people from the adverse consequences of illicit drugs use while ensuring availability of controlled substances for scientific and medical purposes, such as using morphine for pain control.[104]
- In 2015, by adopting the **Sustainable Development Goals**, Member States committed to "Strengthen[ing] the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol".[vii]

[vii] Sustainable Development Goal Target 3.5.3. under Goal 3. "Ensure healthy lives and promote well-being for all at all ages"

Drug prevention interventions can be proposed at different life stages (during the prenatal and infancy period, early childhood, middle childhood, early adolescence, adolescence and adulthood) and implemented in a variety of settings, including family, school, health sector, workplace, community, media, sports and leisure facilities.[105]

Prevention programmes can be tailored for different target groups, such as: i) the general population at average risk (universal prevention interventions); ii) groups that are at increased risk (selective prevention interventions); and iii) individuals that are particularly at risk (indicated prevention interventions), including people who have started experimenting with drugs and who are at higher risk of progressing to problematic drug use.[106]

Effectiveness of prevention of drug use: global evidence

The evidence base for the effectiveness of primary prevention of drug use is relatively recent and limited in scope, as compared, for instance, to the wealth of evidence on the effectiveness of harm reduction interventions for people who have already initiated drug use.[107]

Although people usually start using drugs during adolescence and young adulthood, at least half of adolescents never experiment with illicit drugs.[108] Available evidence shows that drug prevention interventions obtain greater impact when they are implemented at earlier ages than adolescence and act both at the individual level and on the developmental contexts within which individuals evolve.[109]

School-based interventions based on a combination of social competence and social influence approaches are most likely to be effective in preventing illicit drug use.[110] An overview of 22 systematic reviews found small but consistent positive preventive effects for this kind of intervention both in the short and longer term (one year after the intervention).[111] Life-skills education in schools was also considered as an effective approach to preventing initial use of illicit drugs among adolescents.[112, 113]

In contrast, some approaches that have been very much used in schools have not proved to be effective in preventing drug use.[114]

Interventions that do not work

- Random drug-testing of students in schools;[115, 116]
- Knowledge-focused approaches/Provision of general information about drugs;[117]
- Fear arousal approaches and shocking images (e.g., posters);[118]
- Talks by former users or police as "drug educators" in schools;[119]
- Peer mentoring schemes that are not evidence-based;[120]
- Programmes that focus solely on boosting self-esteem.[121]

Drug prevention interventions can also be implemented at community level. They encompass multiple components, including mobilization of a wide range of stakeholders such as young people, parents, teachers, community leaders and religious leaders, among others.

Media campaigns have been widely used for the prevention of illicit drug use among the youth. Yet, their effectiveness in deterring drug use has not been clearly established and they do not seem to have a direct influence on drug use related behaviours.[122] Therefore, the researchers concluded that "the available evidence does not allow conclusions about the effect of media campaigns on illicit drug use among young people" and "that further studies are needed".

Likewise, despite the popularity of using sport and other leisure time activities (nightlife, festivals…) for drug prevention,[123] there is a dearth of studies assessing the effectiveness of such activities.[124]

Research studies show that the use of alcohol and tobacco usually precedes drug use,[125, 126, 127] suggesting that efforts to prevent their use are also relevant to drug use prevention. Public policies affecting the price of alcoholic beverages and therefore making them less affordable had significant effect on alcohol-related morbidity and mortality as well as on other drug use.[128] Increasing the minimum legal drinking age was also found to be effective in decreasing drinking and related harmful effects among youths, as well as alcohol related accidents.[129]

Concerns and recommendations regarding drug prevention interventions

- "Many activities labelled as drug prevention are not evidence-based, their coverage is limited and their quality unknown at best";
- Therefore, it is critical that countries "move away from a model in which prevention of drug use is delivered by isolated but well-intentioned individuals who improvise in delivering interventions";
- Drug prevention interventions should systematically use tools and materials that are context-specific and rooted in evidence;
- As importantly, it is essential to strengthen the knowledge, skills and competences of drug prevention practitioners and policymakers in order to build a critical mass of professional drug prevention specialists who are equipped to deliver relevant interventions.[130]

Prevention of drug use in Myanmar

The National Drug Control Policy of the Republic of the Union of Myanmar recommends taking a "health-based approach with a focus on prevention to deter the initiation of drug use, target individuals at high risk of drug use, and reduce harm to individuals, families and the community from drug use".[131] Through the implementation of this new policy, the Government of Myanmar is committed to designing and setting up strategies, programmes, projects and activities that are guided by global and regional evidence and best practices, including in the sphere of drug prevention.

At governmental level, the Ministry of Education (MOE) is responsible for raising awareness about the harms associated with drug use among youth and students in schools, universities and colleges, as well as out of school.

The Central Committee for Drug Abuse Control (CCDAC) is responsible for all drug-related matters, including primary prevention of drug use. There are 11 Working Sectors within the CCDAC, of which the Students and Youth Education Sector and the Mass Media Sector are involved in the primary prevention of drug use.

The objectives of the Students and Youth Education Sector are to i) promote the awareness that preventive health is better than curative health, ii) disseminate knowledge on the "danger of narcotic drugs" through life-skills curriculum at all school levels; and iii) provide appropriate knowledge and skills to adopt healthy lifestyles.

Life-skills education is a core subject at primary level, and it is also taught at lower and upper secondary levels as a "co-curriculum" subject. Topics covered in the life-skills lessons include: 'Drug and Disease', 'Causes and Effects of Drug Use', 'Disease Prevention', 'Nutrition' and 'HIV/AIDS'. As part of the curriculum reforms, it is also planned to include life-skills education as a core subject in the curricula for lower and upper secondary levels.

The 'Mass Media Sector' committee has conducted awareness-raising on drugs through a variety of approaches, including distribution of periodicals and educational books, radio talks, cartoons, poems, educational songs and talks, photo-exhibitions, stories and plays, editorials, articles, and interviews, as well as posters and pamphlets, among other activities.[132]

Joint initiatives between government, United Nations agencies and local organizations

Collaboration in the area of drugs between the Government of Myanmar and the United Nations dates back to 1972, when the Chairman of the International Narcotics Control Board (INCB) and the Special Representative of the Secretary-General in charge of the United Nations Fund for Drug Abuse Control (UNFDAC) visited Myanmar to hold initial discussions on how the United Nations could support the Government's efforts to respond to drug-related challenges.

The Government, United Nations agencies and local organizations have joined forces to prevent drug use through developing a range of initiatives. For example, Non-Formal Primary Education (NFPE) programmes, which targeted out-of-school children aged 10–14, have been implemented by the MOE in collaboration with UNICEF and NGOs in 103 townships. Areas of learning included: 'Healthy Living, Diseases, Social Skills, Environment' (level I) and 'Healthy Living, Diseases, Social Skills, Drug and HIV/AIDS, Reproductive, Health, Disaster' (level II).

UNODC Country Programme (2014–2017, extended until December 2019) includes a subprogramme on 'Drugs and Health', whose overall objective is to increase access to evidence-based prevention, treatment and care services for drug use and HIV. Activities include:

- capacity development for drug prevention and treatment responses; development/ adaptation of national standards, tools and guidelines for drug use prevention, and drug dependence treatment, care and rehabilitation;
- strengthening of government systems and human resources for programming;
- strengthening the delivery and monitoring of evidence-based drug use prevention and drug dependence treatment interventions, and;
- facilitating their mainstreaming into health and social welfare systems; as well as support to expansion of quality low-threshold MMT programme.

National NGOs have also taken an active part in the prevention of drug use in Myanmar. For instance, the Substance Abuse Research Association (SARA) has developed a range of initiatives including: early childhood interventions and parenting skills training; life-skills training for youth and other school-based activities aimed to prevent or delay the initiation of illicit drug use.

SARA used mass media to raise awareness about drugs in the community and contributed to strengthening local coordination mechanisms through helping districts and townships develop their own strategic plans. SARA is also planning to establish Youth Resource Centres in townships where the NGO already operates and to continue sensitizing communities via mass media, Facebook, radio broadcasting, as well as a webpage.

Myanmar Anti-Narcotics Association (MANA) has been part of the response to drug use since the 1990s. Its initial focus was on demand reduction through advocacy and awareness raising activities about drugs and drug education programmes primarily targeting young people. MANA was established and registered as an NGO in 1994, and has branches at regional, state, district and township levels.

Through its 'Silver Stars Youth' (MSSY) initiative, MANA has provided education about drugs to schoolchildren and general youth population since 1999. MSSY activities include the dissemination of 'anti-drug messages' among youths by means of 'anti-drug health talks' and puppet shows.[133] MSSY has also organized drug awareness-raising events and conducted training of trainers (ToT) for staff of community-based organizations. In addition, MANA has established 'Youth Empowerment Teams' (MYET) at local level to reach out to children and youth, both in-school and out-of-school, with education on drugs. MYET members also assist those who want to quit drugs by facilitating referrals to treatment as well as through organizing counselling sessions, home visits and 'gathering meetings'.

The Association for Healthy Adolescent Development (AHEAD) was established in 2014. This local NGO started with a teen volunteer programme, which initially aimed to train volunteers both on sexual and reproductive health and risks associated with drug use. However, given the limited number of organizations involved in the primary prevention of drug use, AHEAD has recently decided to focus increased attention on this area. In the Yangon office, 17 volunteers use social media platforms to educate young people about drugs, health, sexual and reproductive health, online safety and nutrition.

The 'Drugs and Alcohol Facts Week', organized in Yangon, Mandalay, Mawlamyine and Taunggyi, mobilizes youth volunteers to talk about drugs in schools and communities. AHEAD also organizes conferences on 'Youth and Drugs' to increase youth participation in drug prevention through skills-building activities and panel sessions. In the near future, AHEAD plans to support the MOE in developing a school policy on preventing drug use. Another objective is to work closely with parents and community leaders to engage them further in the prevention of drug use.

AHEAD is also planning to adapt the 'Project Towards No Drug Abuse' to the Myanmar context. This project, developed by the University of Southern California, aims to reduce harms among youths who have already started using drugs.

Challenges and gaps in drug use prevention

Drug prevention efforts in Myanmar have mainly consisted in raising awareness of the general public about drugs and the harms associated with drug use, and disseminating youth information in schools. Evaluating the effectiveness or cost-effectiveness of drug prevention interventions and projects goes beyond the scope of the NSF on Health and Drugs. Nevertheless, based on the literature review and the observations from key informants and stakeholders involved in drug-use prevention, the following gaps have been identified.

Policy, funding and human resources capacity:

- Despite the magnitude of the drug use problem in Myanmar, there is no specific National Strategy on Prevention of Drug Use.
- Funding support for drug prevention – both domestic and international – remains extremely limited.
- There is a limited number of skilled staff coupled with a shortage of human resources to provide evidence-based drug prevention programmes in schools and to other relevant audiences.

Project/intervention design and approach:

- With a few exceptions, the design of drug prevention interventions and projects has not been informed by behavioural theories, such as the Theory of Planned Behaviour Change[134] nor international principles of drug prevention or other best practices.
- Awareness-raising and education about drugs, using printed and audiovisual media, have mostly focused on conveying the message that people should not use drugs because of the harms associated with drug use and its negative impact on the "moral character". Yet, it appears that these information, education and communication materials were developed without the involvement of affected people, whether they use alcohol, methamphetamine, opium or heroin, or the engagement of former users.
- Overall, drug prevention initiatives were described as not holistic enough. Healthy lifestyle approaches were rarely used to prepare individuals to take positive actions to change behaviours, make informed decisions, and promote health and safety.

- The Life Skills education initiative in schools was reported to be focused on "didactic learning" for large groups of students, as opposed to actual skills-building of young people, which is the intended objective of the life-skills education approach, and is learner-focused and based on participatory teaching/learning methods.

Data, monitoring and evaluation:

- The lack of reliable local data on the pattern and scale of drug use in Myanmar makes it challenging to design drug use prevention interventions that are tailored to the needs of youths and rooted in evidence. Likewise, there is no scientific evidence to demonstrate the effectiveness of current interventions. Evidence is largely anecdotal.
- Little has been done to properly monitor and evaluate the effectiveness of such interventions. For instance, few interventions have used pre- and post-intervention tests/questionnaires to measure the knowledge that participants gained or the skills they developed.
- Among the described interventions, none seem to have included long-term follow-up of cohorts; for instance, students exposed to a specific intervention, to measure its potential effect in terms of preventing or delaying the initiation of drug use. Similarly, none of the interventions have included a comparison/control group to allow comparison and understand the effect of a specific intervention.

RECOMMENDATIONS FOR THE STRATEGIC DIRECTION 1

SD1.1 Prevent the initiation of drug use through evidence-informed and targeted drug prevention interventions, implemented at different levels

Objectives	Main activities	Responsible sectors	Potential Partners
O1.1.1 – Develop and implement a coordinated, multisectoral response for the prevention of drug use that is grounded in evidence and facilitating the mainstreaming of drug prevention interventions into health and social welfare systems	• Develop a multisectoral National Strategy on Prevention of Drug Use and a multisectoral coordination mechanism at both national and subnational levels, in coordination with relevant sectors. The Strategy will be informed by the findings and recommendations of formative research(es) (refer to SD1.4-O1.4.2) and the lessons learned from implementation of drug prevention interventions (refer to O1.1.2, O1.1.3 and O1.4.1) • Establish an intersectoral/interministerial committee to support resource mobilization, ensure implementation and provide oversight to the multisectoral National Strategy on Prevention of Drug Use	Ministry of Health and Sports (MOHS); Ministry of Education; Ministry of Information; Ministry of Labour; relevant CCDAC Sectors	UN
O1.1.2 – Increase availability of and access to community-based drug prevention interventions, in areas with high burden of drug use	• In states/regions heavily affected by drug use and HIV, design, implement and evaluate evidence-informed[viii] community-based interventions aimed to prevent drug use, in all townships/villages categorized as 'high burden' • Involve all relevant stakeholders in the design, monitoring and evaluation of community-based drug prevention interventions, including PWUD, youth representatives, members from CSOs, teachers, parents, community and religious leaders	MOHS; Ministry of Education; Ministry of Information, Ministry of Labour, relevant CCDAC Sectors, local authorities	UN Community leaders/ CSO PWUD, youth representatives (from schools and universities)

[viii] Evidence-informed refers to drug use prevention interventions that are in line with International Standards on Drug Use Prevention. Second Updated Edition. WHO & UNODC, 2014.

Objectives	Main activities	Responsible sectors	Potential Partners
O1.1.3 – Enhance awareness of the consequences of drug use among youth in schools, universities and in the workplace, and enhance their decision-making ability for healthier lifestyle choices	• Conduct a comprehensive post-implementation review of school-based life skills education programmes, non-formal primary education programmes, and extended and continuous education and learning projects for out-of-school youth • Adjust programmes based on the findings/ recommendations of the review and develop interventions that are in line with international standards (refer to SD1.2-O1.2.1) • Provide training and mentoring to educational staff in charge of delivering drug prevention education to ensure that the teaching methods used are in line with life-skills quality standards (e.g. participatory skills-building approach as opposed to didactic teaching) – also refer to SD1.2-O1.2.1 • Develop guidance for school and university pertaining to the use, possession, and distribution of illicit substances. Such guidelines should emphasize prevention and non-disciplinary approach.[ix] • Establish Youth Peer Education Networks to provide peer-to-peer information and education on drugs, at schools, universities, workplaces, etc.	Ministry of Education MOHS school health team and national adolescent health programme Ministry of Social Welfare, Relief and Resettlement (out-of-school youth) Ministry of Labour (for working youth)	UN

[ix] UNODC. School-based education for drug abuse prevention. New York: United Nations; 2004. https://www.unodc.org/pdf/youthnet/handbook_school_english.pdf

SD1.2 Develop a cadre of drug use prevention professionals equipped with state-of-the-art knowledge and skills to design, implement and evaluate evidence-informed drug prevention interventions in schools, workplace and community

Objectives	Main activities	Responsible sectors	Potential Partners
O1.2.1 – Ensure the availability of a critical mass of qualified personnel to provide drug use prevention interventions in various settings and locations	• Develop training curricula on drug use prevention that are in line with international recommendations and tailored to the needs of specific audiences (students, families, community members…) and challenged settings (including among refugees and internally displaced people) • Provide ongoing in-service training for teachers, medical staff, I/NGOs, CBOs and other relevant stakeholders engaged in drug use prevention, with a focus on high burden areas Design a professional training course (at masters, bachelor, diploma and/or certificate levels) on "drugs and health studies" and incorporate such curriculum into existing university or other relevant teaching programme • Build a technical resource pool with researchers equipped with the adequate knowledge and skills to: ▸ undertake research, including evaluations on effectiveness (and cost-effectiveness) of drug prevention interventions ▸ provide training and mentorship to different audiences (teachers, I/NGOS, CBOs, etc.)	MOHS, Ministry of Education, Ministry of Information, CCDAC	UN
O1.2.2 – Promote greater engagement of people who use drugs and former users in drug use prevention, and encourage the exchange of good practices	• Involve people who use drugs and former users from the onset in the design and programming of drug use prevention interventions • Highlight and promote best-practice approaches in drug use prevention through building knowledge on both first-hand/ hands-on experiences and evidence-informed interventions with a track-record of success	Ministry of Education, Ministry of Information, CCDAC, MOHS	PWUD/PWID and former users, UN

SD1.3 Raise awareness among youth and general population of the harmful consequences associated with drug use, through well-designed, targeted media campaigns that are rooted in evidence and research

Objectives	Main activities	Responsible sectors	Potential Partners
O1.3.1 – Mobilize the media, including social media, to play an active role in the prevention of drug use and the promotion of healthy lifestyle	• Undertake a review of existing campaigns, initiatives and strategies (including printed and audiovisual materials) used by the media in Myanmar to raise awareness about drugs among the youth and the general population, and evaluate their effectiveness • Involve members of people who use drugs and former users, as well as youth and student representatives from schools and universities and young workers, in the design of targeted education and communication messages • Provide training and mentoring to the media enabling them to provide accurate, non-judgmental information/news relating to drug use; challenge and dispel misconceptions about drug use and treatment approaches among the public • Identify social influencers and champions for drug use prevention to support education and motivate young people to stay away from drugs for a healthy lifestyle • Mainstream the Information and Communication Technologies (ICTs, e.g., Internet, m-Health and social media) in drug awareness communication strategy/campaigns; use Internet, m-Health and social media to enhance audience exposure to drug prevention messages	Ministry of Information MOHS (Health Literacy Promotion Unit)	Media agencies PWUD/PWID and former users, youth representatives, UN

SD1.4 Build the evidence base to inform, plan, implement and evaluate future policies and programmes on drug use prevention

Objectives	Main activities	Responsible sectors	Potential Partners
O1.4.1 – Assess the outcomes and impact of drug prevention interventions	● Undertake a complete review of existing drug prevention interventions in Myanmar as well as an effectiveness/cost-effectiveness analysis (also refer to O1.1.2 and O1.1.3)	Ministry of Education, MOHS, CCDAC	UN
O1.4.2 – Strengthen the efficiency, effectiveness and sustainability of drug preventions interventions	● Conduct formative research(es) to address limitations and gaps identified in the review and cost-effectiveness analysis and to document the following aspects: ▸ patterns of drug use and risk factors predominant in the onset of drug use ▸ availability and accessibility of drugs for young people ▸ knowledge and attitudes towards drug use among youth ▸ availability of/accessibility to drug prevention interventions ● Develop a monitoring and evaluation framework, to implement the National Strategy on Prevention of Drug Use, track progress and measure results of interventions (also refer to SD1.1-O1.1.1)	Ministry of Education, MOHS, CCDAC	UN

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The following section presents **Strategic Direction 2** on **Harm reduction**. After introducing the concept, it provides a summary of global evidence on the effectiveness and cost-effectiveness of harm reduction, as well as an overview of programmes and projects implemented in Myanmar. This section also analyses key challenges and proposes a strategic framework for scaling up and improving the quality of harm reduction interventions.
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STRATEGIC DIRECTION 2. HARM REDUCTION

Definition and introduction

Addressing the risks and harms associated with drug use is one of the major public health challenges. In response to this global issue, harm reduction is a human-centred approach that prioritizes the health, well-being and dignity of individuals and communities affected by drug use.

What is harm reduction?

- Harm Reduction refers to "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption".[135]
- Harm reduction is a public health and human-rights-based approach that is critical to reducing the spread of blood-borne viruses such as HIV, hepatitis B and C, and other harmful health, social and economic consequences associated with the use of psychoactive substances.
- Harm reduction policies and practices are cost-effective, pragmatic, comprehensive and evidence informed.
- Harm reduction benefits people who use drugs, their families and the community.[136]

An internationally endorsed approach

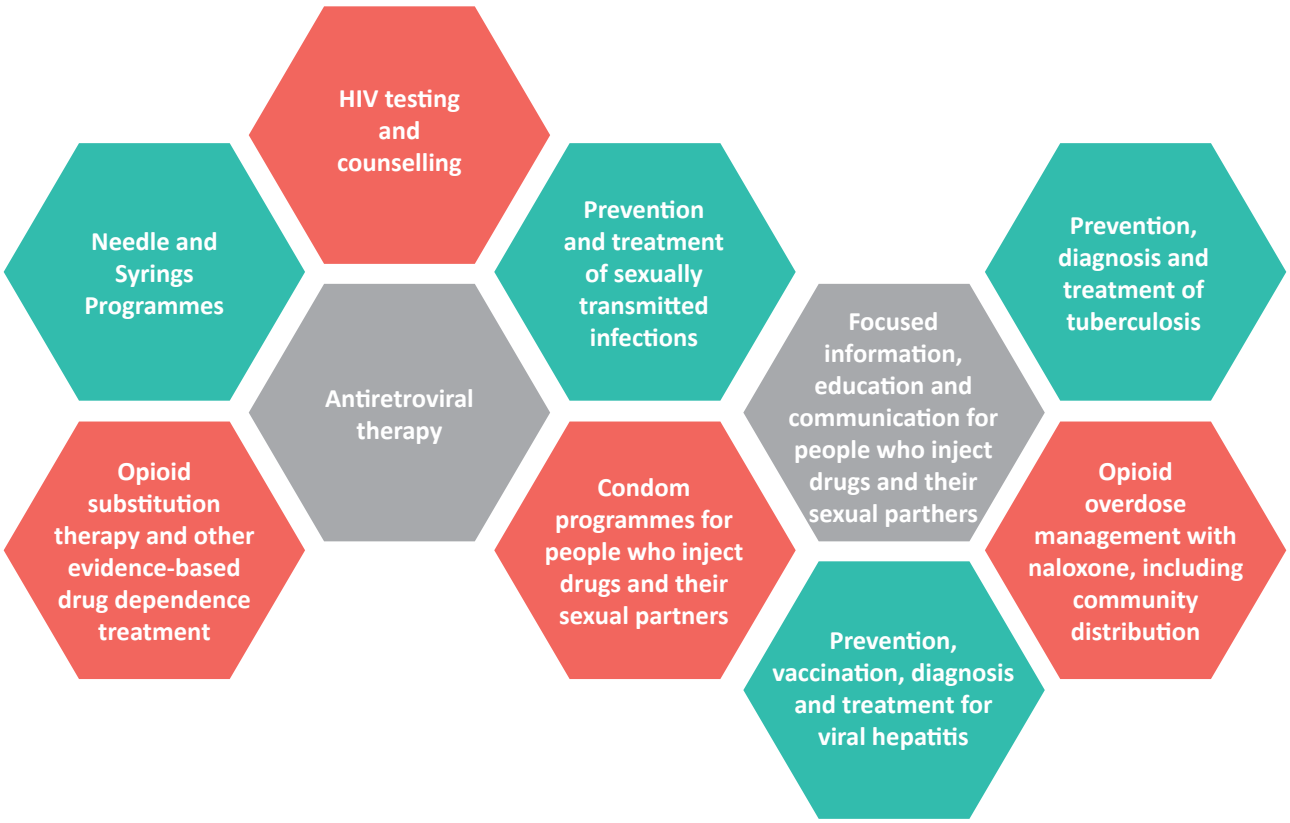
Harm reduction was originally pioneered by the United Kingdom and the Netherlands[137] to address the harmful consequences of drug use and has, since the early 1990s, become widely established as a pragmatic response to HIV epidemics associated with drug use.[138, 139]

Over the past decade, international support for this public health and rights-based approach has increased significantly and there is a growing consensus among multilateral agencies that harm reduction must be placed at the heart of the national responses to HIV, hepatitis C and drug use.[140]

The WHO, UNAIDS and UNODC have recommended the implementation and scale-up of a set of nine interventions to prevent HIV and reduce other harms associated with drug use.[141, 142] The tenth intervention (opioid overdose management with naloxone) was recommended in the WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations (2014).

The interventions included in the 'Comprehensive Package' are commonly referred to as a harm reduction approach to injecting drug use.

Figure 4. The comprehensive package of HIV prevention, treatment and care services for people who inject drugs

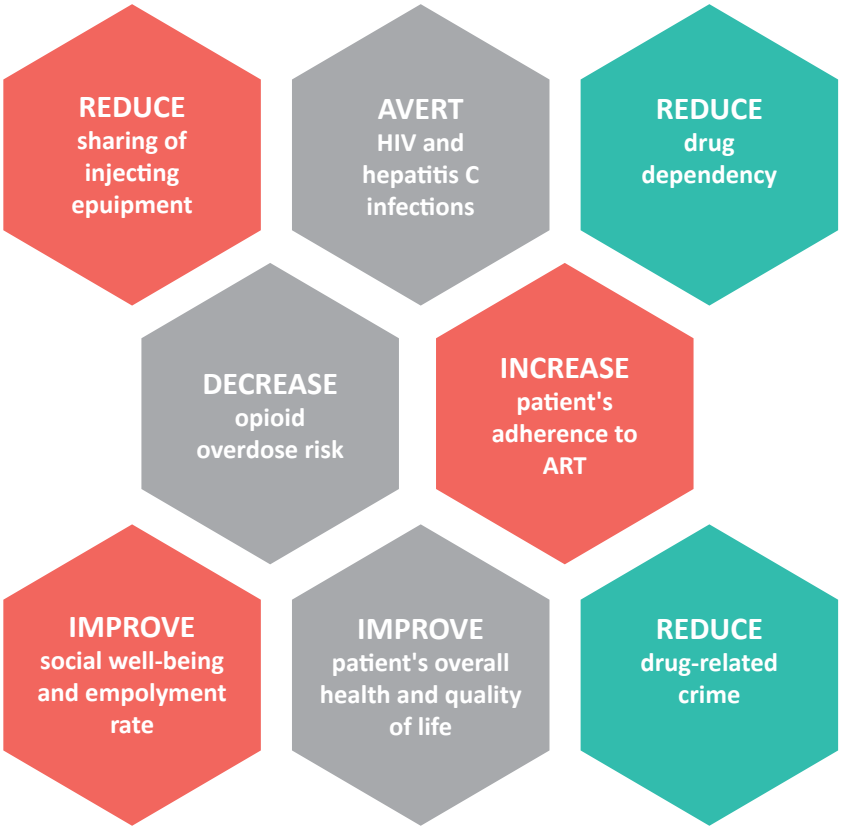


Source: UNAIDS. Do no harm: Health, human rights and people who use drugs. Geneva: UNAIDS; 2016.

Effectiveness and cost-effectiveness of harm reduction

More than three decades of research have demonstrated the effectiveness and cost-effectiveness of harm reduction in reducing the health, social and economic harms of drug use to individuals, communities and societies.[143] An overwhelming body of evidence [144, 145, 146] confirms the effectiveness of harm reduction interventions, as summarized in Figure 5.

Figure 5. Effectiveness of harm reduction interventions



Source: Source: UNAIDS. Do no harm: Health, human rights and people who use drugs. Geneva: UNAIDS; 2016.

Given the proven effectiveness of its interventions, the Comprehensive Package has been widely endorsed,[x] including in the Outcome Document of the 2016 United Nations General Assembly Special Session (UNGASS) on the World Drug Problem, which calls for governments to consider "effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other bloodborne diseases associated with drug use".[147]

Over the past decade, interventions have also been designed and implemented in various countries around the world to prevent the initiation of injection drug use. These interventions targets drug users who have not yet or have recently started injecting.

[x] By WHO, UNAIDS, UNODC, the United Nations General Assembly, the United Nations Economic and Social Council, the United Nations Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States President's Emergency Plan for AIDS Relief (PEPFAR).

Preventing injection drug use initiation

Since the early 2000s, major research studies have been conducted to expand the scientific understanding of the risk factors that influence injection initiation. This growing body of evidence has allowed development of behavioural interventions and structural approaches to prevent injection initiation. Experts recommend using these evidence-based initiatives alongside current high-quality harm reduction interventions to amplify existing efforts to prevent the spread of injection-related HIV and viral hepatitis transmission.[148]

The 'Break the Cycle' intervention

Break the Cycle is an intervention aiming to reduce the number of people who begin injecting. In 2011, the Break the Cycle campaign was launched in England, based on evidence that:

- People who (currently) inject drugs play an important role in other people's decision to try injecting;
- Once non-injectors have decided to inject, their request for assistance with their first injection can be persistent;[149]
- However, most people who inject disapprove of initiating others into injecting; and
- People who inject are not always aware that they may unintentionally increase the chances of someone deciding to try injecting.[150]

Against this backdrop, Break the Cycle targets people who inject drugs and encourages them to prevent non-injectors from starting to inject drugs. The intervention engages PWID in one-on-one education and training sessions to help them better realize how injecting in front of non-injectors can potentially influence their desire to initiate injection. It also equips them with strategies to refuse initiation requests.[151]

After receiving this intervention, injection in the presence of non-injectors was halved and the number of PWID who assisted with a first injection was significantly reduced.[152]

Break the Cycle has been adapted and used in a range of countries including Scotland, Ireland, USA, Australia, Kyrgyzstan, Uzbekistan and Viet Nam, as behavioural surveys have also confirmed that the conditions surrounding initiation frequently arise in similar ways in other countries. In Canada, Break the Cycle was adapted into 'Change the Cycle', a peer-delivered one-session intervention focusing on both injection initiation prevention and safer injection training for active PWID. This intervention was found to significantly reduce the proportion of PWID speaking positively about injection to non-injectors or offering to initiate non-injectors. The total number of initiations performed by participants also decreased significantly.[153]

Other interventions have also sought to directly target non-injectors to prevent or delay the initiation of injection drug use. For instance, an intervention, consisting of a four-session group-based social learning programme, tested the impact of a peer-based behavioural intervention among heroin sniffers. The intervention was conclusively linked with a reduced likelihood of subsequent injecting initiation.[154]

For better effectiveness, interventions aimed at preventing transitions into injecting should simultaneously address the following needs:

1) prevent people who do not inject from seeking out injecting; and

2) Prevent PWID from initiating others into this behaviour.

Addressing health consequences of drug use in Myanmar

Despite an overall decrease in the number of new HIV infections in Myanmar since the mid-2000s, that decline has slowed in recent years. There is also evidence that HIV infection has moved over time from high-risk groups to other vulnerable populations or, in some locations, to the general population, through unprotected sex. Since 2010–2011, an overall and steady increase in HIV infections among women has been observed, although incidence rates remain lower than for men.[155]

From 1992 to 2001, HIV prevalence among PWID population at national level remained above 40%, followed by slowly decreasing trends. However, in recent years, prevalence[xi] has been on the rise again: it was estimated at 23.1% in 2014[156] and 34.9% in 2018 (IBBS).

In response to this situation, funding has recently been redirected to scale up HIV prevention and treatment services and therefore reach the Fast Track set by the country in the National Strategic Plan (NSP III) for HIV 2016–2020 and towards the Sustainable Development Goal of 'ending the AIDS epidemic' by 2030. Funding comes both from domestic sources (i.e., MOHS) and from multilateral/ bilateral resources (i.e., GFATM, 3MDG/Access to Health Fund, USAID).

Given the increased level of investment since 2014–2015 in HIV prevention for key populations, including PWID and – but to a lesser extent – other groups such as prisoners, it is critical to reflect on some important questions such as:

- What is currently done to reduce HIV transmission among PWID and address adverse health outcomes associated with drug use?
- Are existing programmes and interventions achieving the desired health impact?
- What should be done to reinforce coverage, effectiveness and impact of HIV prevention and other evidence-based services in this population?

Overview of the harm reduction response in Myanmar

The introduction of harm reduction in Myanmar

"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 (…) 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".[157]

The MOHS, in turn, formally acknowledged the need to implement harm reduction interventions and endorsed this approach more than a decade ago, around 2005–2006.

[xi] It should be noted that HIV prevalence, as a metric, has limitations. It does not reveal much about epidemic trends (e.g. how quickly HIV is or is not spreading). Data on HIV incidence among key populations is not available.

Harm reduction in Myanmar national health and drug control policies

The provision of harm reduction services for PWID has been set as a priority by the MOHS and is included both in the NSP III[158] and in the Myanmar National Strategic Plan on Viral Hepatitis 2016–2020.[159] It is also recognised as a priority in the CCDAC's National Drug Control Policy[160].

The following states and regions have the largest numbers of townships classified in "high priority" category in the NSP III[161]: Kachin, Mandalay, Shan (North), Sagaing and Yangon. In Kachin, Shan (North) and Sagaing, the epidemic is mainly driven by injecting drug use, and is fuelled by widespread availability of heroin and amphetamine-type stimulants.

The NSP III details a combination of interventions that need to be made available for people who inject drugs. They include:

Behavioural interventions	Biomedical interventions
• Strengthen demand reduction and risk reduction	• Scale up needle–syringe programmes
• Strengthen addiction/substance abuse programmes	• Scale up opioid substitution therapy (including community-based and satellite services; take-home doses)
• Support positive health, dignity and prevention	• Increase condom and lubricant use
• Link to mental health/psychosocial support	• Promote and provide frequent and regular HIV counselling and testing, strengthen screening and treatment
	• Provide prevention of mother-to-child transmission of HIV services
	• Scale up antiretroviral therapy (regardless of CD4 count)
	• Model pre-exposure prophylaxis,
	• Provide post-exposure prophylaxis
	• Provide vaccination for hepatitis B
	• Introduce and scale up overdose management (at drop-in centres and through trained peer educators and outreach workers)
	• Increase wound care

Source: NSP III on HIV and AIDS (2016–2020)

In addition, the operational manual Enhanced HIV Prevention Outreach Services in Myanmar, designed by the National AIDS Programme with the support of Save the Children and UNAIDS, provides practical guidance to HIV and harm reduction implementing partners to strengthen outreach efforts at field level.[162]

Funding for HIV and harm reduction response

In 2017, the total amount of HIV/AIDS spending in Myanmar was US$ 109.5 million, compared to US$ 39.4 million in 2012. Care and treatment accounted for the largest share of spending (48%) in 2017, followed by expenditures related to prevention (27%) including HIV prevention for PWID (13%) and prevention of sexual transmission of HIV (11%), and programme management and administration (21%).[163]

The government contribution to the HIV response has increased in absolute and in relative terms, from 2% of total HIV funding in 2012 to 19% in 2017. Despite this significant increase in public expenditure, international funds remain the major source of funding, financing 79% of total HIV spending in 2017.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is by far the largest contributor to HIV prevention services (including harm reduction) in Myanmar, provided through an HIV grant to two Principal Recipients: Save the Children and UNOPS.

Other international sources include the United States Government, various multilateral donors, including the United Nations and the Three Millennium Development Goal Fund (3MDG) (replaced in 2019 by the Access to Health Fund) a fund created to strengthen the national health system in Myanmar. Médecins sans Frontières is the biggest international not-for-profit funding source in Myanmar.

International funding is the main funding source of all programmatic areas, financing more than 80% of prevention activities. By 2017, 20% of total HIV spending was for key populations with expenditures of $14M targeted for people who inject drugs.

Figure 6. HIV prevention spending in 2017

Prevention - 2017	Total	% over Prevention	% over total HIV spending
ASC.01.01 Communication for social and behavioural change	$ 87,741	0.3%	0.1%
ASC.01.03 Voluntary counselling and testing (VCT)	$ 410,517	1.4%	0.4%
ASC.01.04 Risk-reduction for vulnerable and accessible populations	$ 523,363	1.8%	0.5%
ASC.01.05 Prevention-youth in school	$ 344,031	1.2%	0.3%
ASC.01.07 Prevention of HIV transmission aimed at people living wiht HIV (PLHIV)	$ 28,379	0.1%	0.0%
ASC.01.08 Prevention programmes for sex workers and their clients	$ 4,492,080	15.1%	4.1%
ASC.01.09 Programmes for men who have sex with men (MSM)	$ 2,856,177	9.6%	2.6%
ASC.01.10 Harm-reduction programmes for people who inject drugs (IDUs)	$14,000,727	47.1%	12.8%
ASC.01.12 Condom social marketing	$ 2,459,802	8.3%	2.2%
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	$ 780,285	2.6%	0.7%
ASC.01.17 Prevention of mother-to-child transmission (PMTCT)	$ 2,246,218	7.6%	2.1%
ASC.01.19 Blood safety	$ 213,667	0.7%	0.2%
ASC.01.98 Prevention activitites not disaggregated by intervention	$ 1,270,879	4.3%	1.2%
ASC.01 Prevention Total	**$ 29,713,865**	**100.0%**	

Source: MOHS, UNAIDS. National AIDS Spending Assessment in Myanmar (2016–2017)

Implementation of the harm reduction response in Myanmar

Since harm reduction was officially endorsed in Myanmar in the mid-2000s, this approach has gained ground over time. There has been a significant increase in the number of PWID receiving a variety of harm reduction services with measurable results. However, available data also show that a large number of people who use drugs remain unreached, especially in remote areas and conflict affected zones.

Although no large-scale study has yet been conducted to assess the effectiveness and cost-effectiveness of harm reduction interventions in Myanmar, evidence from all over the world, including Southeast Asia, shows that harm reduction not only saves lives, it also presents significant returns on investment due to averted HIV infections and subsequent health costs.

A broad range of government bodies, international and local NGOs, drug user networks and CBOs, as well as development partners and United Nations agencies are actively supporting and/or implementing the harm reduction response in Myanmar.

As of 2018, they included, among other partners:

Government: Ministry of Health and Sports (National AIDS Programme [NAP], Drug Dependency Treatment and Research Unit [DDTRU]); Ministry of Home Affairs (Central Committee for Drug Abuse Control); Ministry of Social Welfare, Relief and Resettlement

International NGOs: Alliance Myanmar, Burnet Institute, Asian Harm Reduction Network (AHRN), Medical Action Myanmar (MAM), Médecins du Monde (MDM)

Local NGOs: Myanmar Anti-Narcotics Association (MANA), Metta Development Foundation, Sao Mon, Substance Abuse Research Association (SARA)

Network/CBO: The National Drug Users Network in Myanmar (NDNM), Youth Empowerment Team, self-help groups

Development partners: GFATM, 3MDG/Access to Health Fund, USAID/ PEPFAR

Technical partners/United Nations agencies: ICAP, CPI, CDC, UNODC, UNAIDS, WHO

Additionally, the Drug Policy Advocacy Group (DPAG) offers a platform for discussions and exchanges on drug policy reform. It consists of different organizations, including representatives of people who use drugs, as well as local and international NGOs working in the field of harm reduction, and other partners.

Overview of the status of implementation of the comprehensive harm reduction package

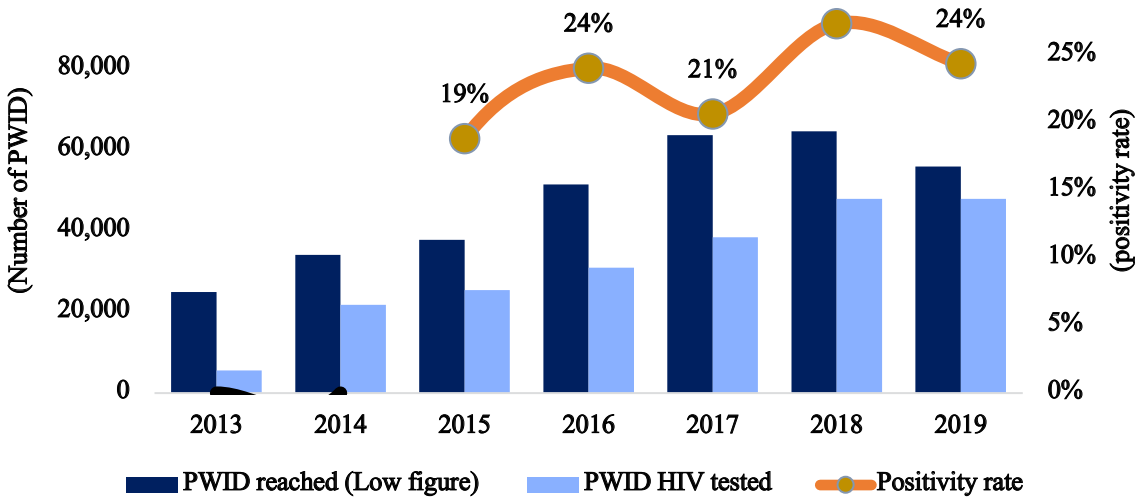
Prevention and care and treatment services to PWID are provided through outreach, drop-in centres (DIC) and drug treatment centres. HIV testing is provided by local AIDS/STI teams of the NAP, in MMT centres, as well as by INGOs and NGOS. ART is provided through a government-NGO partnership. Under NSP III, there is a plan to transform DIC to key population service centres (KPSC) and to provide outreach through NGOs linking to public sector and private service providers, in high priority townships.[164]

Coverage of HIV combination prevention programmes targeting people who inject drugs

The HIV Prevention Review Workshop in February 2019 noted that there is no common definition of coverage by outreach and some implementing partners seemed to confuse the terms 'coverage' [xii] and 'reach'.[165] In the Myanmar National Monitoring and Evaluation Plan on HIV/AIDS 2017–2020, PWID are considered 'reached' when they were provided "at least once by minimum package of HIV prevention services through interventions disaggregated by outreach and DIC during the reporting period".

As a national unique identifier system is not yet available in Myanmar, it is very difficult to estimate coverage accurately. Tracking individual clients from all key populations across different services and determining what type of services they have received, and at which frequency, remains challenging. Consequently, double counting of clients is likely.

Figure 7. Number of PWID reached by prevention program and who received HIV test and post-counselling, Myanmar (2013–2019)



Source: Progress report – IPs, NAP teams reports – NAP HTS reports – NAP and IPs

[xii] Coverage should refer to the number of times a person has received all elements of a defined package of services at the frequency set out as appropriate in guidance documents.Global Fund PRs Save the Children and UNOPS define 'reached' in their M&E guidelines as follows: KP are considered 'reached' when they have received the following package of HIV prevention services (delivered by outreach workers and/or at DIC/KPSC): HIV prevention education; Condom provision and promotion; Information on and referral for HIV testing services; Screening, diagnosis, and treatment of sexually transmitted infections. PWID include the above as well as: Safer injection practices (provision of sterile needles and syringes) and; Referral for opioid substitution therapy.

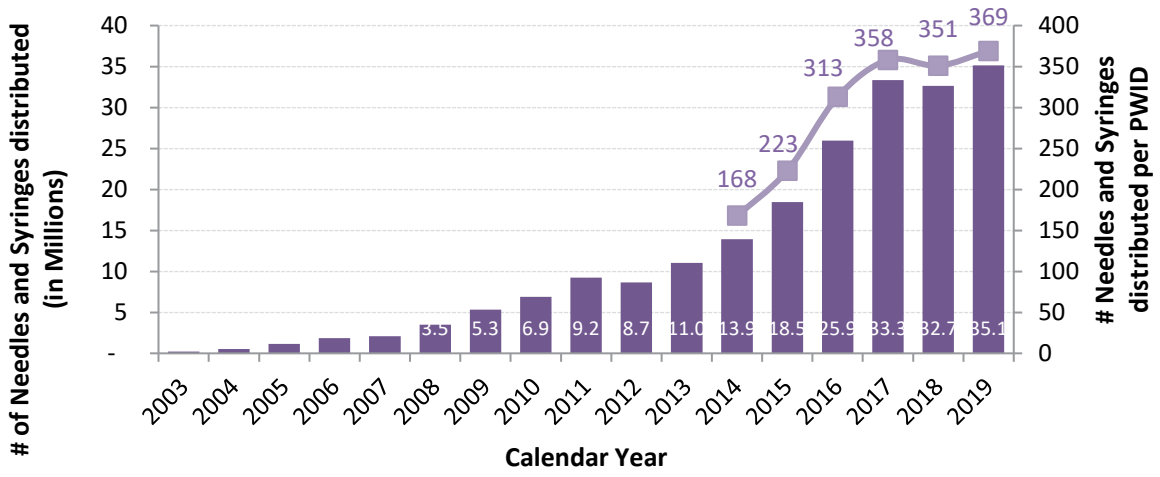
Based on 2019 programme data, 55,934[xiii] of an estimated 95,300 PWID received a package of HIV and harm reduction services. However, in the absence of a national unique identifier code (UIC), the number of PWID reached by services may be overreported despite the calculation method used to avoid double counting. According to IBBS 2018, conducted with a more representative sample of the targeted population, just over a third (34.2%)[166] of PWID were reached by prevention services, far below the 90% target by 2020.

Needle and syringe programme

The distribution of needles and syringes to address HIV among PWID has started on a limited scale in the mid-late 1990s. Since its inception, the needle and syringe programme (NSP) has been implemented by international and local NGOs, and needles and syringes are delivered primarily through outreach workers and drop-in centres.[167]

The number of needles and syringes distributed nationwide has increased considerably over the years, from 210,000 in 2003 to 35.1 million in 2019. The estimated average number of needles and syringes distributed per person who injects per year was 369 in 2019, significantly above the 200 syringes/PWID/year recommended by the WHO[168] to effectively tackle HIV in this population – a target that is considered "high" in terms of coverage.

Figure 8. Number of needles and syringes distributed (2004–2019)



Source: Draft Progress Report: 2019, PWID PSE 2014, 2017 and 2019

[xiii] Calculation based on adding up the number of PWID reached with HIV prevention services by the GFATM PRs, assuming that these PWID are unique individuals – Source: Global AIDS Monitoring (GAM) data 2019. Progress report, IPs, NAP teams reports, NAP team HTS reports, NAP and IPs.

Since the start of the programme, NSP has been implemented only by I/NGOs. In 2019, six organizations provided needles and syringes to PWID across six states/regions with high PWID population. Most needles and syringes were distributed in Kachin (about 57% of all distribution) followed by Shan North (22%), Sagaing (14%) and Mandalay (4%).[169]

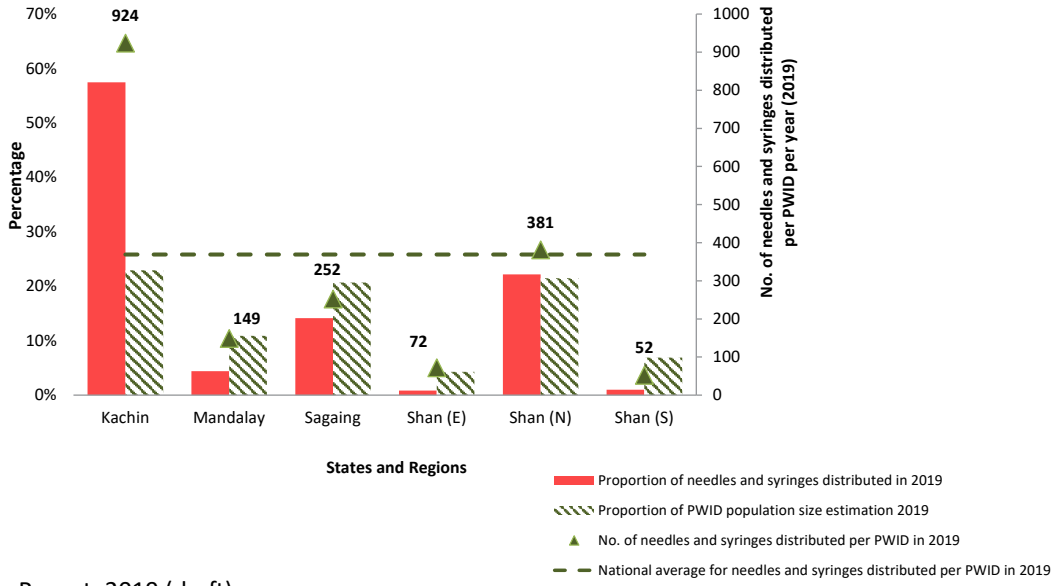
Despite impressive scale-up of NSP over the past several years, the programme keeps facing resistance at local level from law enforcement agencies and faith-based anti-narcotic drug groups in Kachin. This is mainly due to a lack of understanding of the concept of harm reduction, including the mistaken belief that the distribution of needles and syringes encourages drug use.

The NSP has not been scaled up to a level required to achieve impact in terms of controlling the HIV epidemic. A study conducted among 512 PWID, recruited through urban DIC in Yangon, Mandalay and Pyin Oo Lwin, found that almost one in five PWID (19%) had insufficient individual-level syringe coverage[xiv] in the two weeks before interview. Furthermore, insufficient NSP coverage was positively associated with syringe re-use and acquiring sterile syringes from a location other than a formal DIC.[170]

Findings from the National Key Populations Programme Review Myanmar[171] indicated that even in the five highest-burden states/regions, coverage of harm reduction programmes was far from optimal and that substantial numbers of PWID would not yet receive any harm reduction services.

As shown in Figure 9, the number of needles and syringes distributed per PWID per year in Mandalay, Sagaing, Shan East and Shan South was under or just around the recommended coverage figure. There is no NSP in Yangon.

Figure 9. Number and proportion of sterile needle/syringe distributed to PWID by state/region in 2019



Source: NAP Progress Report, 2019 (draft)

[xiv] Individual-level coverage is defined as the percentage of an individual's injecting episodes covered by a sterile syringe.

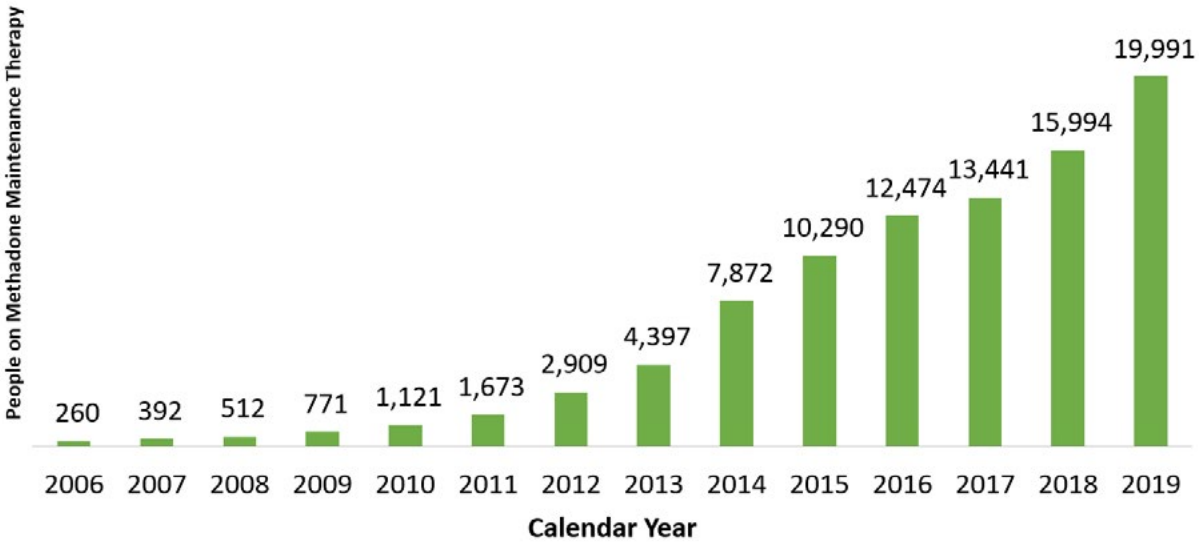
Moreover, it is estimated that in 2018 about 11,000 PWID were living the 11 states/regions where no NSP were available.[172]

Opioid substitution therapy and other evidence-based drug dependence treatment

In Myanmar, methadone is the drug used for the treatment of opioid dependence. Buprenorphine is not yet available. The methadone maintenance therapy (MMT) programme started in 2006 at three major drug treatment centres. The programme is under the responsibility of the Drug Dependency Treatment and Research Unit, Department of Medical Services, Ministry of Health and Sports.

Between 2011 and 2019, there was an almost 12-fold increase[173] in the number of MMT patients (from 1,673 patients enrolled in 13 MMT sites to 19,991 in 71 MMT centres). The NSP III aims to increase the number of PWID enrolled in MMT (or other opioid substitution therapy [OST]) to 32,000, with 85% of individuals receiving MMT/OST for at least six months by 2020.[174]

Figure 10. People on methadone maintenance therapy (2006–2019)



Source: 2019 GAM Report, 2020

An overview of the national MMT programme, as well as a description of other drug dependence treatment approaches, is presented under Strategic Direction 3: Evidence-based drug dependence treatment.

HIV testing services and antiretroviral therapy

The IBBS among PWID found that less than half (48%) of participants had ever tested for HIV and less than one in five (19%) knew their HIV-positive status, underscoring the urgent need for expanding testing coverage among PWID.[175] During key informant interviews, both the national drug users network and harm reduction implementing partners mentioned sometimes lengthy waiting times to get lab confirmation (if the preliminary test is positive), as a possible barrier to returning for an HIV test result.

The number of PWID accessing ART is unknown, as data are not disaggregated by key population. Although there is evidence to suggest that with tailored HIV care for PWID provision of ART can be successful,[176] PWID experience more barriers to accessing HIV treatment. This is notably due to a commonly held perception that PWID living with HIV will be poor candidates for ART, due to inability to adhere to ART regimens and procedures.[177]

Key informants gave various reasons to explain the gaps in access and adherence to ART for PWID living with HIV. These include experiences of withdrawal symptoms for some PWID treated with MMT due to inadequate methadone dosage during ART initiation leading to treatment dropout, as well as logistical and financial challenges to reach the nearest ART centre.

Interventions aimed at preventing sexual transmission among PWID and their sexual partners

Prevention and treatment of sexually transmitted infections, and condom programmes for PWID and their sexual partners

PWID receive STI testing and treatment both in Key Population Service Centers run by I/NGOs and in the public health system. Current data on prevention and treatment of STIs among PWID is not yet available.

The NSP III identifies the need to “Increase condom and lubricant use” and “Strengthen STI screening and treatment” as a priority intervention for PWID. This is indeed of critical importance, considering that consistent condom use is considerably low among PWID and that an increase in syphilis positivity rates has been observed according to 2018 IBBS data.

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

A large number of information, education and communication (IEC) materials on HIV and harm reduction has been developed mostly by I/NGOs, as well as CSOs, governmental actors, and United Nations agencies. They provide basic information about HIV and AIDS, safe injecting practices, drug overdose management, MMT and STIs, among other topics. Although an inventory of all materials produced has been undertaken, it is unclear to what extent IEC materials are shared among the various implementing service providers at a national level. There is no national resource centre for harm reduction.[178]

Vaccination, diagnosis and treatment of viral hepatitis

As mentioned earlier in the report, PWID are disproportionately affected by hepatitis B and C, underscoring the need to intensify efforts for prevention, vaccination (HBV), diagnosis and treatment of viral hepatitis in this population. Programmatic and technical guidance is available both at international and local levels.[179, 180, 181]

Currently, diagnosis and treatment of HCV in Myanmar is primarily conducted in centralized laboratories, tertiary hospitals and private hospitals/clinics, with a few exceptions of treatment provided at INGO clinics which rely on centralized laboratories for diagnosis.

New direct acting antivirals (DAAs) for curative treatment of HCV have dramatically changed the global treatment landscape. The simplicity of the DAAs means that HCV treatment and care can be delivered at community-based clinics, rather than solely at hospitals under the care of specialists. These drugs are well tolerated, highly effective and require only once or twice daily treatment dosages with relatively short durations (typically 12 weeks). Although developments in terms of diagnosis and treatment of HCV have become increasingly available in Myanmar, the number of PWID receiving these treatments remains very limited.

Prevention, diagnosis and treatment of tuberculosis

Despite being preventable and curable, TB is the leading cause of death among people living with HIV. In 2016, one in three HIV-related deaths were due to TB.[182] At global level, the estimated prevalence of TB among PWID is 40 times higher than in the general population.[183]

Considering the burden of disease, the WHO has developed guidelines to address TB and HIV among PWID, through the integrated delivery of a comprehensive and holistic package of care.[184]

Myanmar is among the 30 high TB burden countries in the world and among the 20 countries with the highest estimated numbers of incident TB cases; of incident TB cases among people living with HIV; and of incident MDR-TB cases.[185] The MOHS, in cooperation with various stakeholders, has developed 'The National Strategic Plan for Tuberculosis 2016–2020'[186] and a set of guidelines based on internationally accepted TB infection control standards.[187, 188]

The number of PWID with TB infection in Myanmar is currently unknown but assumed to be high.

Overdose prevention and management

Drug overdose is a major cause of preventable morbidity and mortality among people who use drugs globally.[189] In 2012 the United Nations General Assembly ratified a resolution (55/7) of the Committee on Narcotic Drugs, which called for all Member States to include overdose prevention and treatment in their national drug policies and strategies.[190] Opioids account for the majority of drug-related deaths. In most cases such deaths can be prevented by naloxone[xv] a medication that rapidly reverses the effects of an opioid overdose.[191] The prevention and management of opioid overdose is a life-saving intervention that has been added to the 'Comprehensive package of services for people who inject drugs'.[192] Technical guidance on community management of opioid overdose has been developed by WHO in 2014.[193]

In Myanmar, 16% of PWID who participated in the IBBS (2018) reported ever having an opioid overdose. The percentage was higher in Waimaw (27%) Lashio (20%), Kalay (19%), Myitkyina (19%) and Kalay (19%). Nearly three quarters of PWID indicated witnessing someone else overdosing in the past 12 months.

The NSP III acknowledges the need to address this issue and to "Introduce and scale up overdose management (at DICs, DTCs and through trained peer educators and outreach workers).[194] However, implementing service providers stressed that in practice, the possibility to effectively manage overdose with naloxone remained limited.[195] Although naloxone distribution by people who use opioids and their support networks has proved to be both effective in saving lives and cost-effective in many contexts around the world,[196] such initiatives are not yet in place in Myanmar. Harm reduction implementing partners also highlighted the necessity to develop national guidelines or SOPs for overdose management.

Harm reduction in prisons

People who use drugs and are dependent on drugs are disproportionately represented among the prison population all over the world, including in Myanmar. In view of the above, United Nations agencies have jointly developed a document to support countries in planning and implementing an effective response to HIV and AIDS in prisons and other closed settings. This comprehensive package describes 15 interventions, including the provision of needles and syringes, and of condoms, as well as access to evidence-based drug treatment and to HIV treatment, care and support.[197]

[xv] Naloxone is an opioid-receptor blocker that antagonizes the actions of opioid drugs (WHO, 2014). It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with this group of drugs. 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 WHO List of Essential Medications.

In Myanmar, prisoners are included as a priority population both in the NSP III and in the National TB Programme (NTP) of the MOHS. The National Drug Control Policy also highlights the importance of investing in prison reform (including prison management) and improving access to health services (including drug treatment services).[198]

The NSP III provides for the establishment of a comprehensive HIV package for prisoners, to better address HIV, TB, viral hepatitis and drug dependency. To date, MMT is not provided in prisons and other closed settings in Myanmar. In 2019, about 15,000 people in prison and other closed settings were reached with HIV prevention interventions. Such services can include: information on HIV, HIV testing and counselling, and hepatitis B vaccination. In 2019, around 36,000 prisoners were offered HIV testing HIV and 3,240 prisoners were on ART across 45 prisons.[199] In 2018, TB mobile teams screened over 37,000 prisoners by chest X-ray and close to 3,500 examined by sputum with 6.4% positivity. Despite these achievements, there is still a limited HIV prevention coverage in prisons and a need to improve ART initiation among HIV and HIV/TB prisoners.

In recent years, the MOHS (NAP and NTP) and MOHA (Prison Department) have combined efforts to improve health in prison settings. Multiple partners including UNODC, UNAIDS, WHO and I/NGOs contributed to this important programme. Construction and renovation of health infrastructure took place in four prisons: Insein in Yangon, Myitkyina (Kachin State), Lashio (Shan State) and Mandalay with financial and technical support from 3MDG/UNOPS.[200]

A set of SOPs was also developed and disseminated in 2018 by MOHS and MOHA to provide guidance in the provision of health services to inmates. SOPs that relate to HIV include: HIV testing and counselling; initiation of ART among those who test HIV-positive; adherence counselling and cotrimoxazole prophylaxis.[201] Despite the high number of prisoners with a history of problematic drug use, no SOP has been developed to support the delivery of substitution treatment for people who are dependent on opioids.

Moreover, the high risk of fatal overdose during the first two weeks after release from prison[202] requires ensuring stronger linkage between the prison and communities health services upon prisoner release.

Harm reduction in the context of ATS use

With an estimated 34.2 million users in 2016, amphetamine-type stimulants (ATS) are the second most widely used drugs worldwide after cannabis.

Despite a lack of reliable data in Asia, methamphetamine use is seen as one of the most worrying threats of drug use in East and Southeast Asia.[203] In recent years, several countries in the world, including Myanmar, have witnessed an increase in the use of stimulants.

However, the concept of harm reduction is still widely understood as a strategy to address the risks and harms associated with injection drug use and most harm reduction interventions are funded under the umbrella of HIV-prevention, focusing on services such as needle and syringe programmes and HIV testing and treatment.[204] Services available to ATS users are mostly limited to information sharing, brief interventions for casual and experimental users, and "crises responses" for those with acute psychiatric symptoms following ATS use.[205]

Although little is known about the prevalence of ATS use in Myanmar, data on seizures and related arrests, as well as on treatment demand, suggest that the use of methamphetamine tablets is on the rise, especially in major cities and among youth.[206] Several implementing partners have developed services for people who use drugs along with PWID, reaching around 38,000 PWUD through outreach and DIC in 2019.[207] However, there is still a lack of access to evidence-based information on ATS use, and harm reduction services for PWUD remain underdeveloped in Myanmar.[208] This situation warrants the need for extensive research to better address this additional risk factor.

In 2017, the MOHS in cooperation with WHO Myanmar developed the Guidelines for the Management of Methamphetamine Use Disorders in Myanmar.[209] These guidelines convey practical information on the adverse physical and psychological effects of ATS use and provide guidance to help various professional practitioners to better diagnose methamphetamine dependence, and reduce the risks and harms associated with ATS use, including psychosocial and therapeutic interventions, among others.[210]

- It is important to bear in mind, however, that not all people who use stimulants develop a dependence. Evidence shows that only around 11% of ATS users may become dependent and experience serious problems.[211]
- The majority of users of ATS are experimental or casual users who can benefit from counselling and harm reduction measures, aimed at preventing sexual transmission of HIV and other STIs.

Drug use among women

Women account for one third of drug users globally and make up one fifth of all people who inject drugs. In East and Southeast Asia, women account for 20.8% of the estimated number of PWID. Although they are far less likely to use cannabis, cocaine and opiates than men, women use opioids and tranquillisers for non-medical purpose at a comparable level to that of men.[212] Usually women begin using drugs at a later age than men. However, once they have initiated substance use (particularly cannabis, opioids and cocaine), they tend to increase their consumption more rapidly than men and thus may progress more rapidly to substance use disorders.

Women who inject drugs, especially young women and those who have started injecting drugs recently, are also more vulnerable than men to acquiring HIV, HCV and other blood-borne infections.[213] However, they face greater challenges in accessing services than their male counterparts. Harm reduction programmes tailored to meet their specific needs remain scarce and there is a lack of integrated drug treatment and childcare services.[214]

In many countries, a sharp increase has been observed in the rates of women being imprisoned, including for low-level drug-related offences. Between 2010 and 2014, the proportion of women sentenced for drug-related offences was two times higher than that of men (19%).[215] In prison, women have even less access than men to health-care services to address their drug use and other health conditions.

In Myanmar, as elsewhere in the world, women who inject drugs usually face higher rates of stigma and discrimination than men, which makes them reluctant to seek out and attend health services at traditional DICs.[216] Service providers specifically targeting women remain extremely limited, mostly because female PWID are presumed to be very few. However, some key informants voiced concerns that the true picture may be different as PWID female injecting drug users are considerably much more hidden.[217]

Women made up only 1.5% of the 6,061 PWID who participated in the 2018 IBBS survey. The proportion of female PWID was much higher in some areas such as Tamu (4.3%), Yangon (4%) and Muse (3.8%). Yet, women who use drugs are not specifically targeted in the NSP III. The recommended services for 'female friendly' harm reduction programmes include: BCC, NSP and OST as well as linkage with PMTCT, family planning and sexual and reproductive health, post-abortion care, nutrition and child support services, gender-based violence response, and legal services.

Challenges and gaps in harm reduction

Despite many challenges, Myanmar has made considerable progress over the past decade in adopting and supporting harm reduction. This is reflected in the increased number of harm reduction intervention sites established by international and local NGOs, the government sector involvement, and a commitment by the development partners to support services for PWID.

Expansion of service delivery in the areas of NSP, MMT, HIV counselling and testing (HCT), ART, STI, hepatitis and TB has been dramatic, both in terms of geographic coverage and population served, reaching a range of PWID (such as miners and rural migrants) and PWUD that earlier received no harm reduction interventions. Scale-up of harm reduction services for PWID along with enhanced HIV prevention outreach has translated, to a certain extent, into behaviour change and safer injecting practices.

The 2018 IBBS showed that over 90% of PWID reported the use of sterile injecting equipment at last injection, up from 86% in the 2014 IBBS. The upward trend in HIV testing among PWID is also encouraging. In 2019, 47,900 PWID accessed HIV testing services (HTS), a 13-fold increase from the 2011 figure (3,614). MMT services have been scaled up to 71 centres, serving nearly 20,000 patients, almost a 12-fold increase from 2011 (1,673).

Despite this progress, HIV incidence among PWID is not falling as rapidly as might be expected. Much remains to be done to achieve the national target of '90% of PWID reached with HIV combination prevention services' set in the NSP III and effectively address HIV in this population. The very high HIV prevalence among PWID in several townships in the northern states could be one of the reasons explaining the lack of reduction in new infections in this group. Harm reduction activities and levels of coverage that may be effective in an environment where 10% of PWID are living with HIV, may be ineffective when 40%–60% have HIV.[218]

Stakeholders involved in the NSF development process, particularly those representing people who use/inject drugs and service providers, identified a variety of challenges that hinder efforts to address HIV among PWID. Many of these reasons were echoed in the National Key Populations Program Review Myanmar.[219]

Programmatic level:

- Suboptimal programmatic coverage of key harm reduction/HIV prevention interventions, especially NSP, OST and ART, that have maximum impact on averting new HIV infections among PWID:
  - Due to geographical prioritization, substantial numbers of PWID may not be reached including in the highest-burden states, despite the widespread belief among key informants that – at least in Kachin, Shan North and Sagaing – there are likely to be PWID in all townships. In low-burden and hard-to-reach areas, harm reduction services are insufficient or inexistent.
  - The actual number of PWID being reached with comprehensive services may be lower than currently stated due to double counting in the absence of UIC (see Monitoring and evaluation). Key informants also highlighted that the PWID population size should be substantially higher, especially in Kachin.

- Needles and syringes are not distributed proportionally over the geographic areas where PWID are concentrated: e.g., in Sagaing, in eastern and southern Shan where the number of needles and syringes distributed per PWID per year was under or just around the recommended coverage figure. As an example, there is no NSP programme in Yangon.
- Education of PWID has considerable room for improvement. While safer injection practices were reported, condom use was low overall. Despite progress, uptake and frequency of HTS also remained low, with less than half of PWID who ever tested for HIV, and only 19% knowing their HIV-positive status (IBBS 2018). Scaling-up ART to reach the national target of 90% of people living with HIV on ART is dependent on people knowing their HIV status. Linkage to care and treatment, and access and adherence to ART were also reported to be insufficient among PWID.
- Although MMT services have expanded, the country is only half-way to the 2020 NSP III target of '32,000 PWID enrolled in MMT (or other OST)'

- Insufficient targeting of people who are about to start or have newly started injecting drugs. This is particularly problematic given the extremely dynamic nature of injecting drug use in Myanmar:
  - On average people switch from drug use to injecting drug use within four years (less than two years in Mandalay, IBBS 2018);
  - Approximately one quarter of PWID who participated in the 2018 IBBS had been injecting for one year or less, rising to more than half the respondents in Tamu;
  - These neophyte PWID are at high risk of HIV infection: HIV prevalence among respondents injecting for less than a year was 20% vs. 40% for those injecting for more than a year. This trend underscores the urgency of identifying and reaching PWID with HTS and targeted prevention strategies in the first year of injection drug use.
- Limited availability of harm reduction interventions to address problematic ATS use. The focus of the national response and strategic plan remains on people who inject drugs.
- Absence or limited availability of services such as post-exposure prophylaxis (PEP) for prevention failure such as condom breakage or use of non-sterile injecting equipment; pre-exposure prophylaxis (PrEP) for HIV prevention among HIV-negative PWID; life-saving interventions such as naloxone for overdose management in non-clinical contexts; and insufficient referral to other vital services (STI, TB, hepatitis, sexual and reproductive health).
- Limited access to HIV prevention, care and treatment services in prison and other closed settings and evidence-based drug dependence treatment (OST) are yet to be implemented. The continuum of care between prison and the wider community needs to be strengthened.

- Lack of harm reduction services tailored to the specific needs of women who use/inject drugs, including: sexual and reproductive health services, pre- and post-natal health care, services for women with a history of intimate partner violence or other trauma…

Funding and human resources capacity:

- Heavy reliance on external funding support, especially for harm reduction services such as NSP, prevention outreach and OST, which are critical to address HIV among PWID. Transitioning to greater reliance on domestic resources carries risks of disrupting services that are essential for PWID, hindering Myanmar's efforts to reach the goal of ending the AIDS epidemic as a public health threat by 2030 and achieve long-term sustainability of results.
- Limited number of service providers skilled in harm reduction, coupled with a shortage of human resources to provide services on a large scale. Organizations with a long history in harm reduction are increasingly overstretched to respond to the needs of PWID. NSP is exclusively provided by I/NGOS and is not integrated into the national health system.
- Community-led harm reduction initiatives remain limited. The capacity of community-based organizations willing to provide HIV and harm reduction services for people who use drugs needs strengthening.
- Likewise, despite greater involvement of networks of people who use drugs in the HIV response, there is still room to improve their inclusion in policy-making as well as in the design and delivery of HIV, health and social services for their peers.

Monitoring and evaluation and research:

- A variety of data systems (paper-based or digital) at service delivery sites and the lack of a standardized national unique identifier code (UIC) used by all service providers make it challenging to track individual clients across different services, and hence reduce the gaps across the HIV service continuum.
- The definition of 'coverage' is not clearly stated in national guidelines, leading to confusion among implementing partners and difficulties in monitoring progress and evaluating the results of harm reduction interventions among PWID.
- A review or an evaluation of the programme at national level is yet to be conducted to assess the effectiveness, cost effectiveness and impact of HIV and harm reduction interventions (such as NSP and MMT) in averting HIV new infections among PWID and saving direct health-care costs.

RECOMMENDATIONS FOR THE STRATEGIC DIRECTION 2

SD2.1 Increase programmatic coverage of comprehensive harm reduction and related HIV and health services and develop innovative approaches and service delivery models for all people who use drugs, with a focus on people who inject drugs (PWID)[xvi]

Objectives	Main activities	Responsible sectors	Potential Partners
O2.1.1 – Improve access to harm reduction services for PWUD/PWID and develop innovative service delivery approaches and models	• Expand harm reduction services (especially needle-syringe programmes and outreach) to additional townships with PWID in at least Kachin, Sagaing and Shan North states, Yangon and Mandalay, and focus on geographically hard-to-reach areas • Further integrate harm reduction interventions in both public and private health services (also refer to SD2.3-O2.3.1) • Ensure access to additional tools for HIV prevention (PEP and PrEP) and develop innovative approaches for PWID to increase linkage to care and treatment and treatment adherence support • Develop education messages further emphasizing the importance of safe practices, HIV testing and ART initiation if tested HIV-positive	NAP/MOHS	Service providers UN
O2.1.2 – Address the population of non-injectors to delay initiation/or prevent drug injection as well as the neophyte injectors to prevent escalation to drug dependence	• Develop specific behavioural and/or structural activities using short-term peer-driven interventions.[xvii] This requires involving experienced peer-educators and/or paying small allowances to previously trained active injectors and encourage them to prevent non-injectors from starting to inject (e.g., through not offering to assist them with their first injections)	NAP/MOHS	I/NGOs, CSOs, drug user networks, self-help groups UN

[xvi] When reference is made to PWID in the logframe it is also intended to include sexual partners in the plan/ intervention

[xvii] University of Connecticut. Peer-driven intervention. https://chip.uconn.edu/research/intervention-resources/peer-driven-intervention/

Objectives	Main activities	Responsible sectors	Potential Partners
	• Establish friendly services for young people and neophyte injectors and provide them with targeted messages on injecting drug use and its consequences, as well as with psychosocial support		
O2.1.3 – Develop harm reduction services tailored to the specific needs of sexual partners of PWID, and women who use/ inject drugs	• Engage in further outreach to sexual partners of PWID and to women who use /inject drugs through incorporating sexual reproductive health services, pre- and post-natal health care, services for women with a history of intimate partner violence or other trauma… into HIV and harm reduction services	NAP/MOHS	Service providers, UN
O2.1.4 – Provide PWID/PWUD who are incarcerated with the same standard of care as outside prison and other closed-settings	• Roll out the Prison Health SOPs nationwide; monitor the implementation progress and develop additional services to comply with international standards (e.g., provide access to OST in prison) • Increase access to HIV, TB, viral hepatitis and other health and drug treatment services in prison and other closed settings • Establish and implement an appropriate continuum of care between prison and the wider community	NAP/MOHS Prison Department /MOHA	Service providers, UN
O2.1.5 – Strengthen community-led interventions in remote/ border areas and conflict affected zones	• Conduct an assessment on access to HIV and health services by PWUD/PWID and subpopulations[xviii] living in remote/border areas and conflict affected zones • Develop state-level strategies and innovative service delivery models to decentralize harm reduction and address the specific needs of such populations (e.g., mobile services and voluntary community-led interventions, including overdose management by training peers and other outreach workers (also refer to O2.3.2)	NAP/DDTRU – MOHS, MOHA	NGOs and CBOs, medical staff, trained peer educators and outreach workers, Ethnic Health Organizations (EHOs) UN

[xviii] FSW, Women, children and young people; people living in remote areas, border areas and areas affected by conflicts, MSM and TG who use drugs

Objectives	Main activities	Responsible sectors	Potential Partners
O2.1.6 – Explore and address polydrug use in the Myanmar context (especially the problematic use of ATS)	• Conduct a rapid assessment/situation analysis on the use of ATS to explore the cultural and contextual factors associated with polydrug use (e.g., gendered patterns) and inform planning • Integrate specialized and complementary prevention and treatment options for ATS users into the next NSP on HIV and AIDS and other national policies, strategies and plans, where relevant • Build the capacity of relevant service providers, based on existing international and national guidelines, to better respond to the needs of ATS users (also refer to SD3.1-O3.1.4)	DDTRU/ MOHS	UN

SD2.2 Build the capacity and rationalize the workforce to maximize/optimize the harm reduction response in Myanmar

Objectives	Main activities	Responsible sectors	Potential Partners
O2.2.1 – Develop a strategic human resources (HR) plan	• Conduct a gap analysis for human resources (current staffing vs. staffing needs) to forecast the HR requirement to achieve the targets set out in the National Strategic Plan on HIV and AIDS and fast track the HIV response • Design and implement a human resources plan for pre-service recruitment, in-service professional training and task shifting to improve the efficiency of HR	NAP/MOHS	UN
O2.2.2 – Build knowledge and awareness of drug dependency and harm reduction among health workers and other relevant stakeholders	• Centre(s) of Excellence, including a resource centre and library on HIV and harm reduction, to provide a combination of theoretical and hands-on training for health care, outreach staff and other relevant stakeholders (media, police, general administration, etc.) across the country to enhance the understanding of specific needs of PWUD/PWID • Establish a platform to introduce best practices, laws/policies in response to HIV and drug use and share experiences to support national and subnational advocacy efforts	NAP/DDTRU-MOHS, CCDAC MOHA	I/NGOS and UN

SD2.3 Enhance sustainability of HIV prevention and harm reduction services in the prospect of reduced international funding

Objectives	Main activities	Responsible sectors	Potential Partners
O2.3.1 – Promote a holistic patient-centred care approach to HIV and drug dependency	• Increase availability of integrated HIV/ harm reduction/drug-treatment services into the public health sector (e.g., one-stop services) and ultimately into the Universal Health Coverage (UHC) • Develop and scale up innovative HIV and harm reduction interventions in both public and private health sectors	NAP/MOHS	UN
O2.3.2 – Increase community engagement in HIV and harm reduction to ensure that at least 30% of all service delivery by 2030 is community-led as per 2016 UN Political Declaration on Ending AIDS	• Identify and capacitate CBOs/Ethnic Health Organizations (EHOs) to implement and expand HIV and harm reduction services in hard-to-reach areas (e.g., "pairing" of an experienced harm reduction NGO with a CBO, where the experienced NGO will provide training and mentoring to the CBO) – also refer to O2.1.5 and SD5.2-O5.2.2 • Establish social contracting mechanisms (public–private partnership) to foster community engagement in service delivery	NAP/MOHS	Service providers/ EHOs, UN
O2.3.3 – Prepare the transition from international support to domestic funding for harm reduction and other HIV related services	• Mobilize domestic funding to scale up and sustain public health responses to drug use that are rooted in evidence and human rights. Prioritize funding for high-impact cost-effective and evidence-based interventions such as N/S and OST programmes • Undertake an analysis to evaluate the readiness and risks in the transition from donor to sustainable domestic funding and estimate resource needs to enable a smooth fiduciary transition. The Transition Readiness Assessment Tool[xix] that was used to guide the development of cases studies in different countries could serve as a good practice tool for Myanmar.	NAP/MOHS, Ministry of Finance and Planning	UN

[xix] http://www.harm-reduction.org/library/transition-readiness-assessment-tool-trat

Objectives	Main activities	Responsible sectors	Potential Partners
	• Diversify funding between private and public sector to meet the funding requirements and ensure that relevant ministries within the public domain have adequate fund allocations (budget) against their plan • Develop a phased transition towards a cost-effective integrated and interdisciplinary national and subnational response. This requires a domestic financing platform and/or series of mechanisms that formally support public–private partnership and hybrid financing and service delivery nationally/ subnationally - (also refer to SD3.3-O3.3.1-O3.3.2)		

SD2.4 Strengthen the evidence base on the current epidemic situation and response for PWUD and PWID in Myanmar to better inform planning, implementation and evaluation of HIV and harm reduction programmes

Objectives	Main activities	Responsible sectors	Potential Partners
O2.4.1 – Enhance understanding of the scope, effectiveness, efficiency, quality and impact of HIV and harm reduction responses among PWID in Myanmar	• Undertake periodic assessment/review of progress made in implementation of each of the critical harm reduction and HIV interventions (NSP, OST, HCT, ART), including availability and use of naloxone for overdose management[xx] for PWID, including up-to-date analysis and triangulation of available data in states and regions with higher burden of HIV and drug use • Update scale-up plans (including targets) for each core HIV prevention and treatment intervention (NSP, OST, ART) and align new targets at national/ state/region/township level, or develop a scale-up plan where such plan does not yet exist	NAP/MOHS	Harm reduction service providers and UN

[xx] National Guideline/SOP for Management of Overdose should include ease access to/ and management of Naloxone by non-medical persons.

Objectives	Main activities	Responsible sectors	Potential Partners
	● Conduct a large-scale survey on effectiveness, cost-effectiveness and impact of core HIV / harm reduction interventions (i.e., NSP, OST,[xxi] ART) to determine the health and economic outcomes and use the findings to adjust the national health response		
O2.4.2 – Reinforce the monitoring and evaluation system to reduce the gaps across the HIV service continuum and measure progress	● Refine definitions of service packages for PWUD and PWID and ensure that the national guidelines provide a clear definition of coverage for each key population including PWID/PWUD. Coverage of a defined set of services should only be recorded for each individual who has received all services in the defined package.[xxii] ● Design and implement a harmonized UIC system to be used by implementing partners that is ethical and realistic for PWUD and PWID. Efforts should also focus on assessing the quantity and quality of health services (i.e., identifying service gaps, measuring friendliness or stigma and discrimination from health personnel, implementing patient feedback programmes, etc.) ● Regular update (once in two years) PWID population size at national/regional level and validate annually (through integration to outreach approach such as microplanning) at the operational level for capturing changing trends and service coverage	NAP/MOHS	UN

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The next section presents Strategic Direction 3 on Evidence-based drug dependence treatment. After introducing the concept of drug dependence, it describes the best treatment approaches and options for people who are dependent on drugs and provides an overview of the drug treatment programme in Myanmar. This section also identifies gaps and challenges and proposes a strategic framework for scaling up and improving the quality of drug treatment services.

[xxi] The number of OST centres should be proportionate to the PWID population and be located within commuting distance.

[xxii] Recommendation from the Report of National Key Populations HIV Programme Review in Myanmar. August 2019
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STRATEGIC DIRECTION 3. EVIDENCE-BASED DRUG DEPENDENCE TREATMENT

Definitions and introduction

In the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem:

- Drug dependence is defined as a "complex, multifactorial health disorder characterized by a chronic and relapsing nature with social causes and consequences".
- It is recognized that drug dependence "can be prevented and treated through, inter alia, effective scientific evidence-based drug treatment, care and rehabilitation programmes, including community-based programmes, and strengthen capacity for aftercare for and the rehabilitation, recovery and social reintegration of individuals with substance use disorders, including, as appropriate, through assistance for effective reintegration into the labour market and other support services".[220]

People who are dependent on drugs need to have access to evidence-based and voluntary drug treatment services and other related health services that are based on their individual medical needs and grounded in human rights principles. The best and most cost-effective health results are achieved when drug dependence is addressed holistically, through the provision of comprehensive pharmacological and psychosocial interventions.

Different international blueprints and guidelines recognize the importance of providing treatment to people who are dependent on drugs:

- In the **Sustainable Development Goals**, adopted by Member States in 2015 – under the generic goal 3 on 'Health and well-being', the target 3.5 "Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" and its related indicator 3.5.1 specifically refer to this aspect: "Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders".

- In the **Outcome Document of UNGASS on Drugs**, Member States have reiterated their commitment to expanding "Treatment of drug use disorders, rehabilitation, recovery and social reintegration; prevention, treatment and care of HIV/AIDS, viral hepatitis and other blood-borne infectious diseases". This includes: "Encouraging the voluntary participation of individuals with drug use disorders in treatment programmes, with informed consent (…) and take measures to facilitate access to treatment and expand capacity".[221]
- The **Comprehensive package of HIV prevention, treatment and care services for people who inject drugs**, recommended by WHO, UNAIDS and UNODC,[222] which has also been endorsed in the Outcome Document of UNGASS on Drugs, includes the use of opioid substitution treatment and other evidence-informed drug dependence treatment.

A comprehensive and multisectoral approach to drug dependence treatment

Drug dependence can be treated effectively with low-cost medications and evidence-based psychological interventions and integrated into mainstream health and social care services, like any other disease. The diagnostic, choice of treatment and treatment plan for drug dependence need to be informed by individual clinical assessment. Co-occurring medical and mental health disorders, which are relatively common among drug-dependent individuals, also need to be assessed and treated in a holistic manner.[223]

Comprehensive drug dependence treatment services include:

- Community-based outreach services approach and harm reduction interventions (including provision of needles/syringes and condoms; overdose prevention, etc.)
- Medication-assisted detoxification, pain management and relapse-prevention programmes;
- Substitution maintenance therapy for opioid dependence;
- Voluntary testing for HIV and common infectious diseases;
- Antiretroviral therapy, including pre- and post-exposure prophylaxis, and treatment adherence support;
- Treatment of opportunistic infections (particularly TB) and coinfections (hepatitis B and C and STIs), and;
- Psychological interventions and social support for rehabilitation and reintegration into the community.

The recognition of drug dependence as a preventable and treatable multifactorial health disorder coupled with financial and technical investment in evidence-based drug dependence treatment results in economic and social gains, including a reduction in health-care spending.

Community-based treatment

Community-based treatment refers to a "specific integrated model of treatment for people affected by drug use and dependence in the community which provides a continuum of care from outreach and low threshold services, through detoxification and stabilization to aftercare and integration, including maintenance pharmacotherapy".[224] It involves the coordination of health, social and other nonspecialized services to meet the patient's needs. Strong support also needs to be given to the patient's family and the community to address drug-related problems in their complexity and ensure efficient and long-term results.

What is meant by 'community-based' treatment?

- Located in the community
- Community empowerment: mobilization of community resources and participation
- Bio-psychosocial approach
- Primarily outpatient setting
- Continuum of care
- Integrated in community health and social services

Source: UNODC. Community based treatment and care for drug use and dependence: Information brief for Southeast Asia.

There are 12 principles of community-based treatment:[225]

1. Continuum of care from outreach, basic support and harm reduction to social integration with "no wrong door" – people affected by drug use and drug dependence can access the service system at any point (e.g., community, hospital, health centres and treatment clinics);
2. Delivery of services in the community, as close as possible to where people who use drugs live;
3. Minimal disruption of social links (family, employment, social life);
4. Integrated into existing services (health, psychosocial, legal…);
5. Involve and build on community resources;
6. Participation of people who are dependent on drugs, families and the wider community in service planning and delivery;
7. Comprehensive approach – taking different needs into account (health, housing, family, education, employment) fosters acceptance and makes interventions more effective;
8. Close collaboration between civil society, the health sector and law enforcement;
9. Evidence-based interventions: providing and monitoring evidence-based interventions helps ensure that the interventions do not harm, are effective and meet appropriate standards;
10. Informed and voluntary participation in treatment;
11. Respect for human rights and dignity including confidentiality; and
12. Accepting relapse as a part of the process.

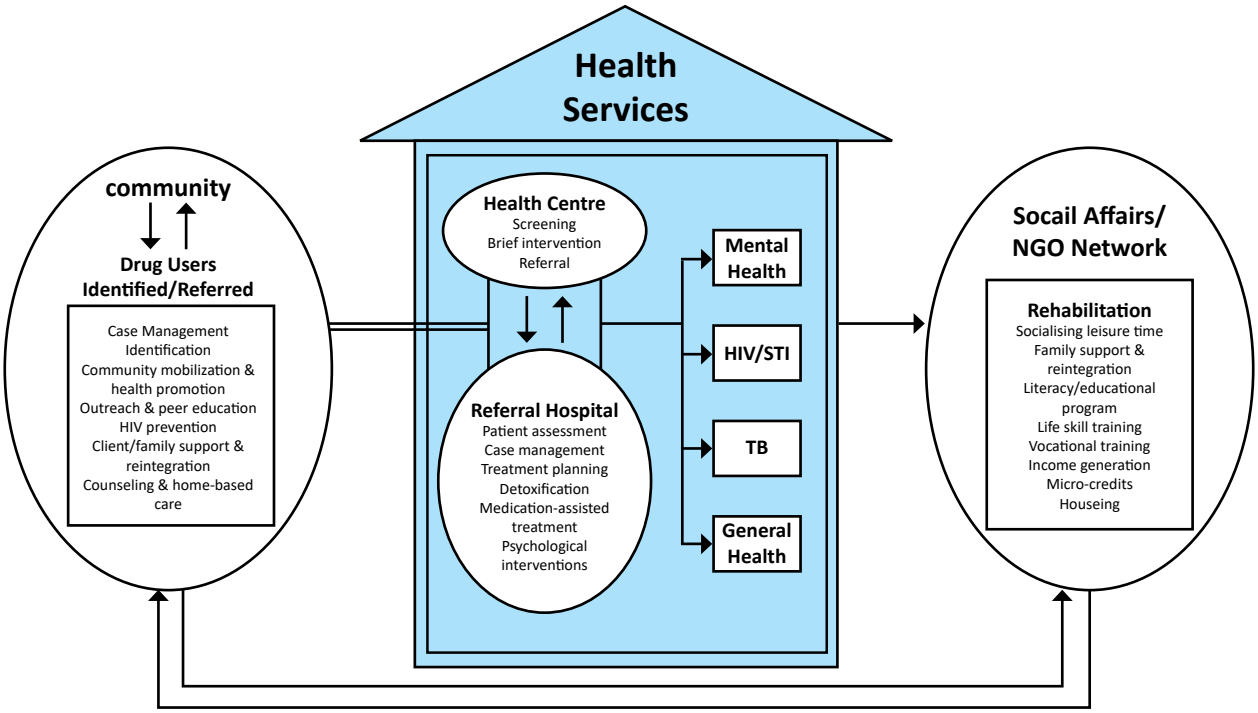
Benefits of community-based treatment

Evidence from across the world has shown that community-based treatment is the most cost-effective approach to support people affected by drug use and dependence.[226] Patients using community-based services visit the emergency room less often and have fewer hospital admissions. A significant decrease in drug-related crime was also observed.[227]

Other benefits of community-based treatment (versus residential-based services) include:

- Facilitating patients' access to treatment
- Appealing for patients
- Affordable for patients, families and the community
- Fostering patients' independence in their natural environment
- Flexibility compared to other modalities of treatment
- A focus on social integration from the beginning and community empowerment
- A less invasive approach than other treatments (e.g., residential, hospitalization, intensive treatments, custodial) which is less disrupting to family, work, and social life
- Facilitating reduction of stigma and promoting community expectation of positive outcomes.[228]

Figure 11. Model of community-based treatment



Source: UNODC Guidance for community-based treatment and care services for people affected by drug use and dependence in Southeast Asia. 2014

The service delivery model includes services in and by the community, primary health services, expert medical and psychiatric diagnosis, and services in hospitals or specialized clinics. Clients are referred to appropriate services, based on screening of drug problems, and referred back to the community for support and aftercare. This approach ensures community participation and linkages to ongoing drug use prevention and low threshold services in the community.[229]

Key components of community-based service delivery model		
Preventive education, health promotion, delivery of basic support, reintegration and rehabilitation services	Screening, counselling, primary health and referral services	Education, counselling, vocational and skills training, income generation activities, microcredit and psychosocial support
Service provider: community organizations including NGOs. • help identify people in need of care • conduct basic screening of drug problems • refer clients to primary health services	**Service provider:** health centres • refer patients to hospitals or clinics for specialized treatment of drug dependence, infectious diseases, or mental disorders	**Service provider:** Social welfare agencies and NGOs
Source: UNODC. Community based treatment and care for drug use and dependence: Information brief for Southeast Asia. 2014		

Overview of drug dependence treatment in Myanmar

'Treatment, rehabilitation and reintegration' is one of the five priority areas of work of the National Drug Control Policy. It is included under the pillar of 'Demand and Harm Reduction'.[230] This Policy stresses that expanding access to treatment is critical for the rehabilitation and reintegration of people dependent on drugs. This involves, among others, ensuring that they have the right to choose an appropriate treatment option. The National Drug Control Policy also recognizes the need to "increase in the availability and affordability of treatment options that address both mental and physical health… including community-based services for treatment of drug disorders, care and rehabilitation programmes".[231]

The 'Drug Treatment Sector', within CCDAC was reorganized in 2016, in accordance with Order 3/2016. It is chaired by the Permanent Secretary of the MOHS, and its secretary is the Director General of the Department of Medical Services. Its responsibilities are detailed in Annex 2.[232]

The Drug Treatment Sector works in partnership with relevant government departments and sectors (including rehabilitation, education, mass media information, international relations and alternative development) as well as with United Nations agencies and NGOs.

In line with the 1993 Narcotic Drugs and Psychotropic Substances Law, CCDAC also established several committees to coordinate activities in their respective sectors, including the 'Drug Treatment Committee' chaired by the Permanent Secretary of MOHS.

Drug Dependency Treatment and Research Unit

Drug dependence treatment in Myanmar falls within the overall responsibility of the MOHS. The Drug Dependency Treatment and Research Unit (DDTRU) was formed within the MOHS in 1976. It is established under the Department of Medical Services, with the goal of "protect[ing] health and well-being of the people from dangerous effects of drug use and its negative consequences".[233] Its objectives are to: i) reduce the demand for narcotic and psychotropic drugs; ii) reduce the risk of transmission of blood-borne infections among and from injecting drug users; iii) reintegrate them back to society; and iv) revitalize the existing structure of Drug Treatment Services.[234]

Its activities have evolved over time in response to the changing patterns of drug use and drug dependence. Initially, the DDTRU predominantly worked in the area of drug treatment. Since HIV emerged first among people who inject drugs, the DDTRU broadened its activities to initiate a methadone programme and provide rapid testing and vaccination for hepatitis B.[235] The DDTRU revised its objectives in 2017 in light of the evolving context of drug use and drug dependence.[xxiii]

[xxiii] The revised objectives of the DDTRU are to: 1. Improve quality of integrated, innovative and voluntary-based comprehensive drug treatment services; 2. Promote continuity of care to improve the response to the chronic and relapsing nature of drug dependency; 3. Promote and support development of community-based comprehensive drug treatment response; 4. Strengthen coordination, collaboration and capacity building to improve drug treatment service response; and 5. Strengthen and share cross cutting strategic information and research on evidence-based best practices to improve comprehensive drug treatment response.

Overview of drug treatment services in Myanmar (2019)

Major Drug Treatment Centres (DTC)	Minor DTC	MMT sites
29	**56**	**71 (in 2019)**
• State/region hospitals and district level hospitals with specialist (psychiatrist) in all states	• Township hospitals	– including 9 major DTC, 36 minor DTC, and station hospitals
Source: DDTRU		

Among the 9,644 patients newly admitted to drug treatment in 2019, the vast majority were men. Young people aged 15–24 accounted for nearly a fifth of the total.[236]

Table 1. Main drugs used by newly admitted patients (2019)

Type of drugs	Number of patients	Percentage
Heroin	8,523	88.3
Amphetamine-type stimulant	770	7.8
Opium	200	2.0
"Other" substances	131	1.35
Marijuana	20	0.2
Tranquilizers	0	0
Total	**9,644**	**100**

Source: DDTRU/MOHS. Annual Report 2019

The vast majority of patients admitted in 2017 were dependent on heroin. Among them, the majority were from Kachin State, Sagaing Region, Shan State and Mandalay Region while most of patients with problematic ATS use were from Kayin State, Mon State and Yangon Region.

Methadone maintenance therapy programme

The methadone maintenance therapy (MMT) programme was initiated in 2006 by the MOHS Department of Medical Services at three major DTCs. The number of methadone dispensing sites has increased substantially since then, based on funding availability, to reach 55 sites in 2018.

In 2014, most components of the comprehensive package of services for PWID were integrated into the MMT programme. These included: HIV testing service (HTS); antiretroviral therapy (ART); condom distribution; information, education and communication (IEC) for PWID and their sexual partners; testing and vaccination for hepatitis B; prevention, diagnosis and treatment of TB; and detection and management of STIs.[237] However, the provision of sterile injecting equipment is not available within the MMT programme. Needles and syringes are provided by I/NGOs and through pharmacies.

As of December 2019, there were 19,991 clients receiving MMT, of which 19,731 men and 260 women.[238] Despite the increase in number of sites and number of people on MMT, this indicator still did not meet the target set in NSP III of 32,000 PWID receiving MMT or oral substitution therapy (OST) by 2020.

The current programmatic coverage of 21% PWID[xxiv] enrolled in MMT is far below the estimated level of coverage (40%) recommended by WHO, UNODC and UNAIDS, to modify, reduce or stop drug use and effectively prevent HIV among PWID.[239]

Table 2. MMT sites and patients at subnational level (2019)

State/region	MMT sites	Male	Female	Total
Yangon	2	647	5	652
Mandalay	6	2311	20	2331
Kachin	23	9267	157	9424
Shan	19	2230	39	2269
Sagaing	21	5276	39	5315
	71	**19,731**	**260**	**19,991**

Source: MMT programme as of December 2019

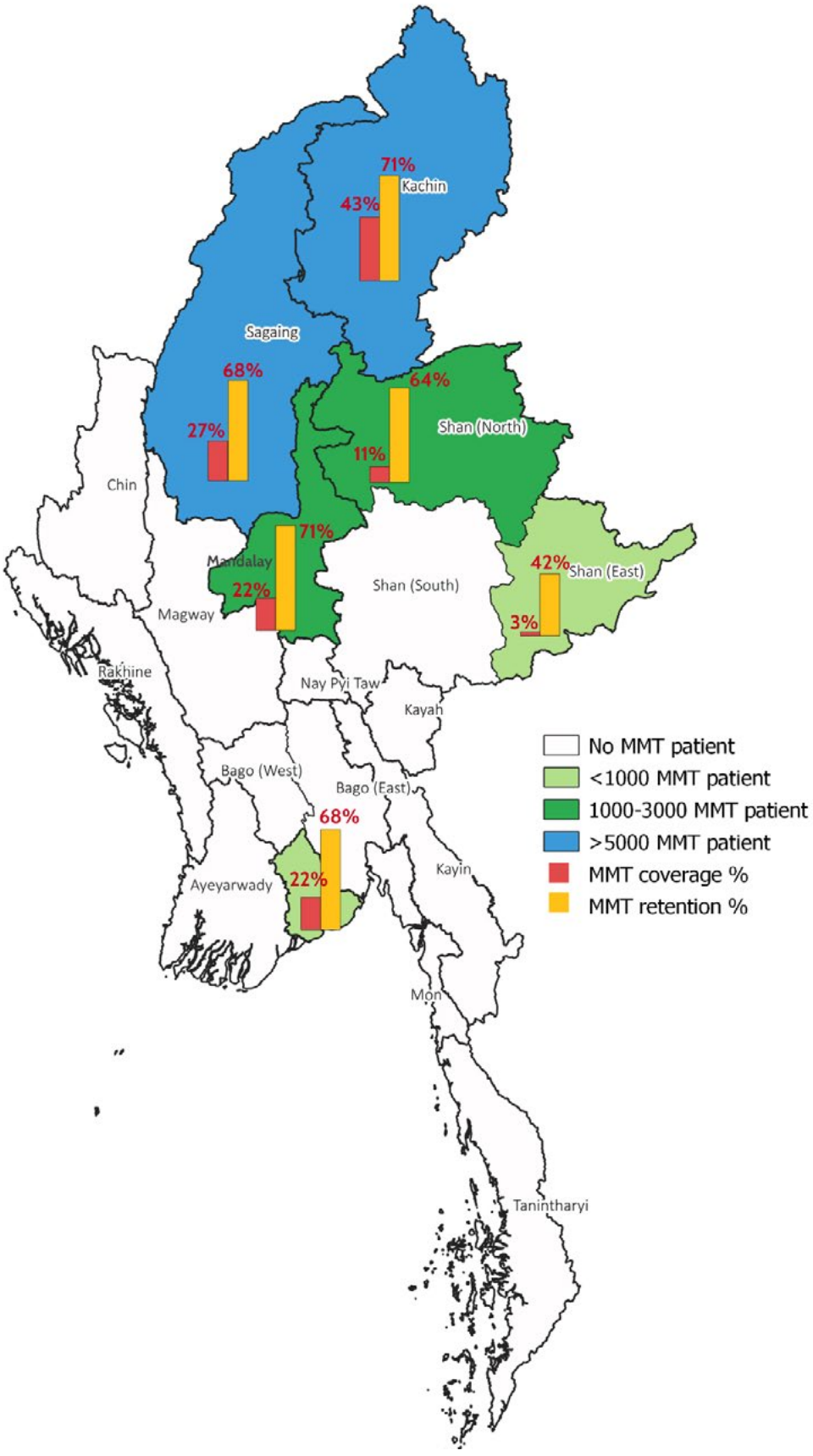
Furthermore, programme data show that MMT coverage is not proportional to the severity of the HIV epidemic among PWID. At the end of 2019, 43 % of the PWID population in Kachin were covered by MMT, 27% in Sagaing, 22 in Mandalay and Yangon. However, MMT programme coverage was only 11% in Shan North, although this area has been known for its injecting drug use driven epidemic for a long time. Only 3% of PWID were receiving MMT in Shan East and there was no MMT programme in Shan South. However, methadone clinics will open in major DTC in Shan East and Shan South in the course of 2020.

This is consistent with IBBS data showing discrepancy in the coverage of MMT across survey sites. While approximately half of PWID in Bamaw and over one third in Kalay had received MMT in the last 12 months, less than 2% of PWID in Waimaw were treated with MMT in the past year—a situation that raises concern given the high HIV prevalence among PWID this township (56%).

Furthermore, with an overall retention rate of about 69% in 2019, the MMT programme did not meet the NSP III target of 75% for MMT retention rate. However, it is important to note that in most cases, retention rates were above the global target of 60% or more of individuals retained in treatment for at least six months.[240]

[xxiv] Calculation based on number of people on MMT as of December 2019 (19,991), divided by population size estimate of 95,300 PWID (PWID PSE in 2019, based on 2017 PWID PSE and in consideration of population growth) assuming that the PWID are opioid dependent and in need of OST.

Figure 12. Map showing distribution of PWID on MMT, coverage and retention by state and region, 2019



Source: National AIDS Programme. Ministry of Health and Sports. Draft Progress report 2019

The 2012 Guidelines of Methadone Therapy and Treatment of Drug Dependence in Myanmar[241] have been updated and released in 2019. A Standard Operating Procedures for Methadone Maintenance Therapy is under development, aligned with the updated MMT Guidelines.

Given the rise in ATS use, the document Guidelines for the Management of Methamphetamine Use Disorders in Myanmar[242] was published in 2017 (also see under Strategic Direction 2).

In addition, 17 trainings, meetings and workshops were organized and completed by the DDTRU in 2018. Among the research activities, a review of the national MMT programme is currently being finalized. Other research planned includes: 'Effectiveness of Methadone Maintenance Therapy in Myanmar'; 'Harm reduction service availability and linkage for PWID among public and private service providers'; and 'HIV, hepatitis B and hepatitis C and retention in care among people who inject drugs and are placed on methadone maintenance therapy, Yangon, Myanmar'.

Community-based treatment in Myanmar

Community-based services for people affected by drug use and drug dependence are still in their very early stages in Myanmar. UNODC has developed a Guidance Document and a Training Toolkit for the provision of community-based services in Southeast Asia region, which have been translated into Myanmar language and adapted to the country context.[243]

The Government of Myanmar is committed to piloting and scaling up community-based services for people who are dependent on drugs to facilitate their reintegration into society. With this objective in mind, under the leadership and guidance of CCDAC/MOHA and the DDTRU/MOHS, in 2017 UNODC supported skills building training (a training of trainers workshop) for service providers. The objective was to build their capacity to effectively implement community-based services for PWUD/PWID.

Community-based services have been piloted in two townships (Kalay and Wutho in Sagaing Region) in partnership with key ministries including MOHA, MOHS, the Department of Social Welfare, as well as the National Drug User Network in Myanmar.

Challenges and gaps in drug dependence treatment in Myanmar

Despite significant progress made in expanding access to and utilization of drug treatment services, especially MMT, many important challenges and gaps remain. Key informants involved in the NSF development process, have identified the following barriers that impede the effectiveness of the drug dependence treatment programme in Myanmar:

Programmatic level:

- With only 21% of all estimated people dependent on opioids receiving methadone, MMT coverage falls short of the optimal level of coverage required (40%) to effectively address problematic drug use and reverse or stabilize an HIV epidemic among PWID. Moreover, the distribution of MMT services across the country is not proportional to the severity of the HIV epidemic among PWID.
- Other challenges consistently reported by informants include: many steps for registration process; long induction period and long distances to travel for many patients to the closest MMT centre. Low follow-up of MMT patients, as well as difficulty accessing take-home doses were also frequently cited as major barriers,[244] making it difficult for patients to sustain the treatment and resulting a high drop-out rate. This is consistent with findings from prior studies, including a review of the MMT programme conducted in 2013.[245, 246]
- Decentralized MMT services and satellite dispensary models remain limited, especially to reach PWID in remote areas and conflict affected zones.
- MMT is not available in prison despite the disproportionate representation of people who use drug and are dependent on drugs in closed settings.
- Community-based voluntary drug dependence treatment services are yet to be effectively implemented and scaled up. They remain inexistent for people with problematic ATS use.
- Diversion options to provide community-based treatment to people with substance use disorders as an alternative to conviction or punishment are not yet available in Myanmar. Public perception about drug use and drug dependence undermines the acceptability of such community-based services.

Funding and human resources capacity:

- During 2011–2015, the MMT programme was mostly funded from external resources, namely the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Over time, the Government has significantly increased its spending and is now a lead contributor for methadone procurement. In 2017, the MOHS spent nearly 1 million US dollars for the MMT programme. It was US$ 320,000 in 2019 while the GFATM contribution amounted to US$ 660,000. Despite this major financial commitment by the Government, funding (both domestic and international) is not sufficient to meet the MMT targets set in the NSP III. This raises concerns about the feasibility of expanding the programme to reach the level of coverage recommended to achieve the desired health impact and reach the Fast Track targets. This also raises questions about the long-term sustainability of the MMT programme.

- The DDTRU also reports difficulties in dealing with a growing number of patients as the MMT programme keeps expanding despite limited financial resources. This results in an increased workload for MMT clinical staff, which affects patient management and follow-up.[247]
- Some government facilities that have been designated as DTCs are not equipped with the required resources to provide drug dependence treatment services.

Data, monitoring and evaluation:

- Updated, reliable and comprehensive data about drug treatment services are scarce or unavailable: e.g., number and quality of drug treatment services in the country, types of treatment services provided (for heroin users, ATS users) and by which partners, in which townships… And yet these data are critical to monitor and manage health programmes as well as to inform policy decision-making and develop appropriate drug treatment services.
- It has not yet been possible to fulfil all of the responsibilities of the drug treatment sector, as detailed in the notification 3/2016 of CCDAC. For instance, "Monitoring and evaluation of implementation of drug treatment measures" is yet to be conducted.

RECOMMENDATIONS FOR THE STRATEGIC DIRECTION 3[xxv]

SD3.1 Expand coverage of voluntary evidence-based drug dependence treatment and develop innovative approaches and service delivery models for all people who use drugs[xxvi]

Objectives	Main activities	Responsible sectors	Potential Partners
O3.1.1 – Increase availability of and access to evidence-based drug treatment services	• Scale up medication-assisted treatment (MAT) and ensure that services are available in the areas where PWID are hardest hit by HIV and viral hepatitis • Establish buprenorphine programme as a public–private partnership to enhance coverage • Provide access to MAT in closed settings • Establish a specific programme to address ATS use disorder and develop evidence-based / community-based services for people with problematic ATS use (also refer to SD2.1-O2.1.6)	Department of Medical Services and DDTRU/ MOHS	UN in conjunction with I/NGOs private sector and community organizations

[xxv] The development of this logframe has been informed by i) the new National Drug Control Policy, ii) Notification 3/2016 of CCDAC which details the duties of the Drug Treatment Sector, iii) the National Strategic Framework for Comprehensive Drug Treatment (2017–2021).

[xxvi] When reference is made to PWID in the logframe it is also intended to include sexual partners in the plan/ intervention.

Objectives	Main activities	Responsible sectors	Potential Partners
O3.1.2 – Ensure that logistical and structural requirements of drug treatment centres are adequately met	• Improve the efficiency of logistics and set up a sustainable MMT supply chain management system, through developing a roadmap for MMT supply needs in the coming years • Improve the facilities and infrastructures of drug treatment centres to meet the increasing treatment demand	Department of Medical Services and DDTRU/ MOHS	UN in conjunction with I/NGOs private sector and community organizations
O3.1.3 – Prevent or delay the transition from experimental/recreational drug use to problematic drug use	• Conduct screening for drug use, brief intervention, and/or treatment referral for patients who may be at risk of developing problematic drug use at public and community-based settings	Department of Medical Services and DDTRU/ MOHS	UN in conjunction with I/NGOs private sector and community organizations
O3.1.4 – Accelerate access to decentralized evidence-based drug treatment options	• Promote community-based delivery service models for people dependent on opioids and/or with problematic ATS use. Such services should also be made available as alternatives to imprisonment for people who use drugs (also refer to SD2.1-O2.1.6) • Increase access to take-home doses of OST for stabilized adherent patients, especially those living in remote areas • Develop Standard Operating Procedure for MMT and Buprenorphine for public sector • Establish guidelines and standard procedures for the development of community-based and home-based delivery of naloxone	DDTRU/ MOHS and National Health Authorities	UN in conjunction with I/NGOs private sector and community organizations

SD3.2 Build the capacity and streamline the workforce to increase efficiency of drug treatment services

Objectives	Main activities	Responsible sectors	Potential Partners
O3.2.1 – Develop strategic workforce planning for rationalizing human resources in drug treatment centres	• Conduct a gap analysis for human resources (current staffing vs. staffing needs) to forecast the human resources requirement • Design and implement a human resources plan for pre-service recruitment, in-service professional training and task shifting (also refer to SD2.2-O2.2.1)	MOHS/ Department of Medical Services and DDTRU	UN

Objectives	Main activities	Responsible sectors	Potential Partners
O3.2.2 – Improve the capacity of health care providers to respond to the psychological and medical needs of drug dependent individuals	• Build the capacity of heath care providers through pre-service and in-service education and training programmes • Ensure that the roles and responsibilities of service providers are clearly defined and understood to better meet the needs of patients • Update the guidelines and SOPs of drug treatment services, as relevant	MOHS/ Department of Medical Services and DDTRU	UN

SD3.3 Ensure the sustainability of drug treatment response through strengthened coordination and collaboration across sectors and stakeholders and domestic funding mobilization

Objectives	Main activities	Responsible sectors	Potential Partners
O3.3.1 – Promote a holistic patient-centred care approach to drug dependency	• Further integrate drug dependency services into the public health sector, including in primary health care; as well as in the private health sector • Include drug dependency treatment as an essential component of the package of health services for Universal Health Coverage (also refer to SD2.3 – O2.3.1) • Identify and capacitate CBOs and EHOs to provide drug-treatment services, especially in remote areas/ conflict affected zones	CCDAC/ MOHA, MOHS	UN
O3.3.2 – Prepare the transition in the prospect of reduced international funding	• Mobilize domestic resources to scale up and sustain voluntary and evidence-based drug treatment services; and ensure adequate financial resources for the training of addiction professionals • Develop a financial sustainability plan for national drug dependency treatment services through multisectoral cooperation between relevant ministries, private sector I/NGOs, CBOs, EHOs, peer networks, development partners and UN agencies (also refer to SD2.3-O2.3.3)	Department of Medical Services and Public Health, other relevant Ministries MOHS	Development partners, UN

SD3.4 Strengthen the evidence base on the response to drug use and drug dependency in Myanmar to better inform planning, implementation and evaluation of drug treatment programmes

Objectives	Main activities	Responsible sectors	Potential Partners
O3.4.1 – Improve the availability, quality and use of health information, research evidence and knowledge to strengthen the response to drug dependency	• Conduct a large-scale survey on effectiveness, cost-effectiveness and impact of core HIV / harm reduction interventions (i.e., NSP, MMT, ART – also refer to SD2.4-O2.4.1). Alternatively, conduct a retrospective cohort study to evaluate health and social outcomes of MMT programme (e.g., in reducing risky behaviours and transmission of HIV and hepatitis; enhancing patients' adherence to ART; improving patients' overall health and quality of life; decreasing the death rate from overdose; decreasing drug-related crime) and use the findings for advocacy and resource mobilization • Develop the research agenda through conducting operational and implementation research/studies to fill a knowledge gap (e.g., estimate of PWUD population size); improve treatment of substance use disorders (e.g., problematic ATS use); and explore the acceptability and feasibility of new interventions/ service delivery models (e.g., community-led interventions)	MOHS/ Department of Medical Services and Department of Public Health, DDTRU	UN
O3.4.2 – Improve the surveillance system and enhance the monitoring and evaluation of drug treatment programmes	• Establish individual patient tracking mechanisms (e.g., harmonized UIC – also refer to SD2.4-O2.4.2) and a national drug use monitoring system to reduce the rates of lost-to-follow-up, and strengthen recording and reporting system • Transition to electronic-based recording and reporting system • Develop a national monitoring and evaluation framework of drug treatment centres/programmes, including the implementation of feedback mechanisms	MOHS/ Department of Medical Services and Department of Public Health, DDTRU	UN

The following section presents **STRATEGIC DIRECTION 4** on **Rehabilitation and social reintegration.** After introducing the key concepts, this section describes approaches that are considered the most effective for the rehabilitation of people with substance use disorders and provides an overview of programmes that are implemented in Myanmar. This section also identifies gaps and challenges and proposes a strategic framework for improving the quality of rehabilitation and social reintegration programmes in Myanmar.

STRATEGIC DIRECTION 4. REHABILITATION AND SOCIAL REINTEGRATION

Definitions and introduction

The WHO has defined rehabilitation, in the context of harmful drug use, as "the process by which an individual with a substance use disorder achieves an optimal state of health, psychological functioning, and social well-being".[248]

The importance of rehabilitation and aftercare services is highlighted in international reference documents:

- In the **Sustainable Development Goals** (goal 3, target 3.5, indicator 3.5.1)
- The **International Standards for the Treatment of Drug Use Disorders**, developed by WHO and UNODC in 2017,[249] define a comprehensive set of interventions that should be available, attractive and appropriate for people affected by substance use disorders, including drug dependence. Rehabilitation, recovery-support services and social reintegration form an integral part of evidence-based drug dependence treatment services, alongside outreach, screening and brief interventions,[xxvii] inpatient and outpatient treatment, medical and psychosocial treatment (including treatment of comorbidities) as well as long-term residential treatment.

- Treatment interventions, including rehabilitation and recovery services, must always be voluntary and based on the informed consent of the patient.
- In 2012, twelve United Nations entities have issued a joint statement[250] calling on States to close compulsory drug detention and rehabilitation centres and replace them with voluntary, rights-based and evidence-informed programmes in the community that are consistent with international human rights standards and the UNODC and WHO Principles of drug dependence treatment.[251]

[xxvii] Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent drug use disorders, particularly in health settings which are not specialized in the treatment of drug use disorders (i.e., primary care, emergency care, antenatal care, social welfare services, school health services).

Rehabilitation and social support services complement pharmacological and psychotherapy treatments or follow stabilization of abstinence achieved during residential or outpatient treatment. Such services aim to prevent relapse to drug use by building strength, resilience and positive emotions of patients and supporting their social reintegration into community and society. Recovery services can be implemented in a range of settings and at various stages of the disorder.

The rehabilitation process combines a variety of approaches including, to name a few:[252]

- prevention of relapse;
- participation in a mutual/self-help groups;
- housing;
- residence in a therapeutic community or half-way house;
- education and vocational training; and
- work experience.

Rehabilitation and social reintegration: global evidence

Rehabilitation approaches that prove effective, both in residential and outpatient settings, include a mix of psychosocial interventions (e.g., psychotherapies such as cognitive behavioural therapy, motivational interviewing and contingency management) and social interventions (e.g., employment programmes, vocational training and legal advice).[253] In addition, involvement in self-help groups complements psychosocial and social interventions.

The following range of factors and activities contribute to fostering social reintegration and improving the greater likelihood of recovery and stable remission from substance use disorders:

- Strengthening individuals' resilience, self-efficacy and self-confidence to manage daily challenges and stress while maintaining commitment to recovery and avoiding relapse to substance use;
- A supportive social network that can monitor the stability of recovery, abstinence from drugs and compliance with treatment;
- Stable accommodation;
- Meaningful work with appreciation in the workplace;
- Engagement with individuals and social networks of friends and workmates that have abstinence-oriented norms and are supportive of recovery goals;
- Humanitarian, social or spiritual involvement that provides a way to attribute meaning to life's stressors and develop a stronger purpose in life;

- Social participation and integration in educational and vocational pursuits, including volunteering or community involvement;
- Remediation of legal and financial problems; and
- Active involvement in self-help, religious or other support groups.[254]

Overview of rehabilitation and social integration in Myanmar

The first Drug Law (1974) of Myanmar included a chapter on drug treatment and rehabilitation. Drug dependence was defined as i) a chronic relapsing disease, and ii) a psychological and physical condition. The law stipulated that rehabilitation should follow treatment. In the section dedicated to the rehabilitation and aftercare of drug users (Chapter VI), the Narcotic Drugs and Psychotropic Substances Law (1993) gave responsibility to the Ministry of Social Welfare, Relief and Resettlement (MSWRR) for:

(a) "rendering assistance and protection as may be necessary to persons undergoing medical treatment and the families dependent on them;

(b) providing for rehabilitation, teaching of means of livelihood as may be necessary, resettlement and aftercare to enable persons who have undergone medical treatment to resume their normal lives;

(c) conducting expertise training course for the relevant persons in order to

(d) implement systematically and effectively work of rehabilitation of drug users".[255]

The importance of rehabilitation and reintegration is highlighted in the CCDAC National Drug Control Policy, under the pillar of 'Demand and Harm Reduction' (also see Strategic Direction 2 – Drug dependence treatment).

A Rehabilitation Working Committee was established in 1980 within CCDAC. In 2016, it was reformed as per order No. 3/2016 (19-9-2016). The objectives of this committee, as detailed in the Annual Report of CCDAC, are to: i) "carry out the mindset improvement of the ex-drug addicts; ii) train the ex-drug addicts to have a good relationship with their communities; iii) train the physical development of the ex-drug addicts; iv) provide the suitable vocational training and; v) train the ex-drug addicts to be part of the labour force through their accomplished vocational skills".

This committee is chaired by the Deputy Minister of the MSWRR and includes members from different government sectors (health, law enforcement, education, labour, etc.). Its secretary is the Director General of the Department of Social Welfare.

The Department of Social Welfare proposes three types of rehabilitation services: i) Centre-based rehabilitation; ii) Semi-community based rehabilitation; and iii) Community-based rehabilitation.

In 2019, there were nine Social Rehabilitation Centres and three Youth Correction Centres run by the new Department of Rehabilitation (under MSWRR).[xxviii] Some centres were not fully operational due to a variety of reasons, such as a lack of funding, the small number of "trainees" or the security situation.[256]

The following activities (as detailed in the Annual Report of CCDAC) are implemented in the Social Rehabilitation Centres:

i) Interviewing and recording the biological data of trainees;

ii) Making assessment based on the use of drugs;

iii) Mental rehabilitation, consisting of individual counselling, group counselling, family counselling, practising meditation, preventive education programme, occupational therapy and, religious therapy and recreation;

iv) Physical rehabilitation, including games, sports, physical exercises, health care services, vocational trainings as occupational therapy, preparing for reintegration into society and;

v) After-care services.

In addition, social rehabilitation activities have also been conducted on a monthly basis at the DTCs in Yangon, Kengtung and Myitkyina for a total of 471 patients.

After staying in a rehabilitation centre, individuals who are affected by drug use and substance use disorders receive aftercare aimed to facilitate their reintegration into their family and society. This support is provided by voluntary social workers under the oversight of the Department of Social Welfare. The aftercare process involves: intake interviews, discussions with the family, solving social problems, monitoring and supervision, in close collaboration with relevant rehabilitation centres. The voluntary social workers are required to regularly submit reports to the Department of Social Welfare on the progress made by the patients during the aftercare period.

According to CCDAC, a total of 278 formerly drug dependent individuals were reintegrated into society in 2016.[257] Lastly, besides providing aftercare services, the Yangon Voluntary Social Workers' Association also conducted awareness raising on drugs and HIV to a total of 42,285 persons including youth and students in 2016.

In 2016, the Department of Social Welfare spent a total of Ks 11,2087,769.88, equivalent to US$ 83,000, on rehabilitation and aftercare.[258]

[xxviii] Yangon Social Rehabilitation Centre in Yangon Region, Mandalay Social Rehabilitation Centre in Mandalay Region, Myitkyina Social Rehabilitation Centre in Kachin State, Lashio Social Rehabilitation Centre in Shan State North, Kyaing Tone Social Rehabilitation Centre in Shan State East, Tachileik Social Rehabilitation Centre in Shan State East, Namlat Social Rehabilitation, Centre (Taunggyi) in Shan State South, Myawaddy Social Rehabilitation Centre in Kayin State, Kawthaung Social Rehabilitation Centre in Tanintharyi Region, (Shwepyithar). The Youth Correction Centre (Pyi) in Western Bago Region, Shwepyiaye Youth Correction Centre (Phekon) in Shan State South and Shwepyithit Youth Correction Centre (Tema, Muse) in Shan State North were previously operated by CCDAC.

Numerous rehabilitation centres operated by faith-based organisations, Ethnic Armed Organisations (EAOs) and CSOs have opened in recent years; these initiatives, however, are usually not coordinated with the Government, lack technical and operational support and expertise. In addition, there are serious concerns that forced treatment and other violations of human rights and dignity are being committed in the name of rehabilitation.

Government efforts are complemented by programmes and initiatives implemented by various stakeholders. UNODC, for instance, carried out a range of activities in connection with rehabilitation and social integration. These included: capacity building; training of service providers and refresher trainings; development of manuals and training modules; training of government staff; establishment of a mobile team to deliver services in remote areas; setting up drop-in-centres staffed by trained volunteers and outreach workers; and follow-up counselling and support services in the communities for people formerly dependent on drugs and their families.

In addition to the above mentioned activities, UNODC has, in the past, supported literacy training in partnership with the Bureau of Education of the Ministry of Education; vocational training for former drug users (and their families) after detoxification in a community-based treatment centre; income generation programmes (e.g., rose gardens in Lashio); and approaches such as Participatory Learning Appraisal (PLA) and Stepping Stones – a gateway for former drug users and drug dependent individuals for seeking assistance.

The NGO MANA has formed Youth Empowerment Teams (MYET) at the local community level, to provide counselling to people who use drugs; facilitate their referral to drug treatment and MMT centres; and organize follow-up meetings once or twice a month to help prevent relapse. Other activities included: 'reading sessions' and experience sharing discussions. In the mid-1990s, with funding from MANA and UNODC, MYET were involved in income support programmes for people affected by drug use (e.g., setting up car washing services).

Challenges and gaps in rehabilitation and social integration approaches

Although evaluating the effectiveness or impact of past and present activities in the area of rehabilitation and social integration does not fall within the scope of the NSF, comments from key informants identified the following challenges and gaps:

- While the MOHS is responsible for the treatment of drug dependence; rehabilitation and social integration are under the MSWRR. There is a perception among stakeholders that this results in a disjointed response. Linkages along the continuum of treatment, rehabilitation and social reintegration are considered to be lacking.
- Key informants also raised concerns about the functioning and overall effectiveness of the rehabilitation centres run by the MSWRR:

- Residential rehabilitation generated substantial financial and social costs for the individuals concerned and their families, such as loss of income for patients/trainees staying in a rehabilitation centre for an extended period, and stigma related to admission to rehabilitation. It also involved operational costs for the government, including staff-related expenses, and running costs (electricity, water and sanitation, food, etc.).
- The shortage of qualified rehabilitation staff was another key concern commonly shared by interviewees; one from the MSWRR stressed that rehabilitation centres lacked permanent skilled employees, as medical doctors were assigned to this sector on a rotational basis. As a result, staff were not familiar with interacting with drug-dependent persons.
- Some patients from the highland areas found it difficult to adapt to a different climate and were unable to take part in agricultural and livestock programmes proposed in the framework of rehabilitation.
- Lack of evidence-based information associated with outcome measures (e.g., relapse after rehabilitation) made it difficult to assess the effectiveness of rehabilitation programmes.

- For all the above reasons, there was a general feeling that existing institution-based services failed to achieve the desired outcomes in terms of rehabilitation and social reintegration. There were also concerns that community and faith-based rehabilitation centres were violating human rights and not providing any evidence-based services. Therefore, some key informants recommended closing both institution-based and community-run centres permanently.

RECOMMENDATIONS FOR THE STRATEGIC DIRECTION 4

SD4.1 Improve recovery support for people with problematic drug use through voluntary and evidence-based rehabilitation programmes at community level, in line with international standards

Objectives	Main activities	Responsible sectors	Potential partners
O4.1.1 – Analyse and assess the outcomes of existing rehabilitation and social integration programmes in sustaining recovery from drug dependence and facilitating reinsertion of into society	• Conduct a comprehensive review of existing programmes and projects aimed at promoting the rehabilitation and social integration of people affected by drug use and drug dependence. • Undertake further research (if necessary) to address limitations and gaps identified in the review and adjust the interventions/programmes according to the specific needs of people with problematic drug use	Ministry of Social Welfare, Relief and Resettlement	NDNM, UN
O4.1.2 – Increase availability and utilization of voluntary and evidence-informed rehabilitation services at community level	• Set and enforce minimum standards for the operation of existing rehabilitation centres in both public and private settings, and establish a monitoring mechanism to regularly follow up progress • Pilot voluntary and evidence-informed rehabilitation approaches to on an outpatient basis at the primary health care level, including psychosocial therapies (e.g., individual behavioural therapy and group therapy) to prevent relapse and support the rehabilitation of individuals with problematic drug use • Establish and support the functioning of mutual self-help-groups in geographic areas/township that are heavily affected by drug use and drug dependence • Gradually phase out or transition rehabilitation centres into therapeutic communities[xxix] or half-way houses[xxx] in accordance with the directions of the amended 1993 Narcotic Drugs and Psychotropic Substances Law, and the National Drug Control Policy	Ministry of Social Welfare, Relief and Resettlement	NDNM, UN

[xxix] Therapeutic community refers to a "structured environment in which individuals with psychoactive substance use disorders live in order to receive rehabilitation. Such communities are often specifically designed for drug-dependent people; they operate under strict rules, are run mainly by people who have recovered from a dependence, and are often geographically isolated. Therapeutic communities are characterized by a combination of "reality testing" (through confrontation of the individual's drug problem) and support from staff and peers. They are usually closely aligned with mutual-help groups such as Narcotics Anonymous. (Source: WHO Lexicon on Alcohol and Drug Terms, 1994).

[xxx] Halfway house is a "place of residence that acts as an intermediate stage between an inpatient and residential therapeutic programme and fully independent living in the community. The term applies to accommodation for alcohol- or drug-dependent individuals endeavouring to maintain their sobriety. There are also halfway houses for individuals with psychiatric disorders or leaving prison." (Source: WHO Lexicon on Alcohol and Drug Terms, 1994).

SD4.2 Promote social and economic reintegration of people with problematic drug use, through voluntary and evidence-informed social integration initiatives at community level, in line with international standards

Objectives	Main activities	Responsible sectors	Potential partners
O4.2.1 – Increase availability of and access to voluntary and evidence-informed social reintegration services at community level	• Develop, pilot and scale up voluntary and evidence-informed models of social reintegration, including access housing; remediation of legal and financial problems; integration in educational and vocational pursuits, including volunteering or community involvement, etc. The development of such services needs to be informed by inputs from members of the affected population, especially those who have undergone drug dependence treatment and rehabilitation in the past.	Ministry of Social Welfare, Relief and Resettlement Ministry of Labour	NDNM, UN
O4.2.2 – Encourage and ensure economic reintegration of people with problematic drug use	• Explore and pilot small-scale skill building/vocational training and job placement projects as well as income generation opportunities at community level with a view to improving employability of people with problematic drug use, including former prisoners who have been incarcerated for drug use related offences	Ministry of Social Welfare, Relief and Resettlement Ministry of Labour	UN agencies including UNODC and WHO NDNM

SD4.3 Strengthen the role and technical capacity of the Ministry of Social Welfare, Relief and Resettlement in planning, management and evaluation of rehabilitation and social reintegration services

Objectives	Main activities	Responsible sectors	Potential partners
O4.3.1 – Build the capacity of managers, administrators and other relevant staff to provide voluntary and evidence-informed rehabilitation and social reintegration services to people with problematic drug use	• Review existing training and capacity building materials pertaining to rehabilitation and social reintegration and update them and/or develop new curricula, when necessary, in line with international standards and guidance	Ministry of Social Welfare, Relief and Resettlement	NDNM, UN

Objectives	Main activities	Responsible sectors	Potential partners
	• Develop a plan, including a monitoring and evaluation component, to implement evidence-informed rehabilitation and social reintegration services and measure the results of such interventions • Train and build the capacity of relevant staff within the Ministry of Social Welfare, Relief and Resettlement on providing rehabilitation and social reintegration services to people with problematic drug use and monitoring progress	Ministry of Social Welfare, Relief and Resettlement	NDNM, UN

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The following section presents **Strategic Direction 5** on **Laws, policies and enabling environment**. After briefly describing the international conventions and covenants to which Myanmar is signatory and introducing the new approach to the war on drugs, this section examines Myanmar's legal framework and policies relating to drugs. This section also identifies key legal and policy barriers and proposes a strategic framework for fostering an enabling environment for people who use drugs to access to protect their health and other human rights.
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STRATEGIC DIRECTION 5. LAWS, POLICIES AND ENABLING ENVIRONMENT

Introduction

Laws and policies in general are understood to be a significant influence on the health of a population, and health systems often aim to promote 'Health in All Policies (HiAP),' i.e., policies that protect and promote health across sectors, such as education, social welfare, home affairs and policing, finance, and the like. This is particularly true for laws and policies on drugs: criminalization of drug use and people who use drugs has a direct impact on whether and how people who use drugs can access health and social services, such as drug prevention, harm reduction, drug treatment, rehabilitation and social integration services, as outlined in the previous sections of this strategic framework.

In this context, criminalization negatively affects the health of people who inject and use drugs, increasing their vulnerability to HIV and other STIs, and making it more challenging for them to access vital prevention, treatment and care services.

Legal and policy context and approaches

The Government of Myanmar has adopted several international conventions and covenants, including:

- The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol;
- The Convention on Psychotropic Substances of 1971;
- The United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988;
- The Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1997; and
- The Convention on the Rights of Persons with Disabilities in 2008.

In April 2016, the Government of Myanmar adopted the Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem (UNGASS on Drugs) in which Member States expressed their commitment to address all facets of the drug problem in a comprehensive and balanced manner.

These commitments include, among others:[259]

- "Consider enhancing cooperation between public health, education and law enforcement authorities when developing prevention initiatives;

- Develop and strengthen, as appropriate, the capacity of health, social and law enforcement and other criminal justice authorities to cooperate, within their mandates, in the implementation of comprehensive, integrated and balanced responses to drug abuse and drug use disorders, at all levels of government;
- Promote the inclusion in national drug policies, in accordance with national legislation and as appropriate, of elements for the prevention and treatment of drug overdose, in particular opioid overdose, including the use of opioid receptor antagonists such as naloxone to reduce drug-related mortality;
- […] Reiterate [our] commitment to respecting, protecting and promoting all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law in the development and implementation of drug policies, and we recommend the following measures:
- Promote effective supervision of drug treatment and rehabilitation facilities by competent domestic authorities to ensure adequate quality of drug treatment and rehabilitation services and to prevent any possible acts of cruel, inhuman or degrading treatment or punishment, in accordance with domestic legislation and applicable international law; and
- Promote proportionate national sentencing policies, practices and guidelines for drug-related offences whereby the severity of penalties is proportionate to the gravity of offences and whereby both mitigating and aggravating factors are considered, including the circumstances enumerated in article 3 of the 1988 Convention and other relevant and applicable international law, and in accordance with national legislation."

The 'Comprehensive package of HIV prevention, treatment and care services for people who inject drugs', recommended by WHO, UNAIDS and UNODC,[260] was also endorsed in the UNGASS on Drugs Outcome Document.

A growing call for ending the war on drugs

The international community has, time and again, expressed support for policies that provide treatment and aftercare to persons who use drugs, instead of punishing them.[261]

In 2012, the Global Commission on HIV and the Law called on countries to outlaw discrimination, repeal punitive laws, and enact protective laws to promote public health, and in particular, effective HIV responses.[262] In 2018, in a supplement updating the original report, the Commission expressed deep concern about the persistence of the war on drugs and the criminalization of drug use and people who use drugs, at global level.[263] Although a few countries and some states of the United States have decriminalized some drugs and/or the possession of small quantities for personal use, many have maintained punitive drug policies and certain countries have enforced even harsher punishments. In response, the Commission made the following recommendations:

- Do not use coercive methods or confinement during treatment for persons who use drugs;
- Repeal laws or policies that mandate total abstinence from drug use as a precondition for accessing treatment for HIV and related diseases;
- Promote alternatives to incarceration for drug use and drug-dependence offences; and
- Adopt legal protections to prevent discrimination against people who use drugs.

The same year, in a report focusing on HIV, the Global Commission on Drug Policy emphasized that "the global war on drugs was driving the pandemic", as repressive laws and aggressive enforcement actions were creating barriers to effective HIV prevention, treatment and care.[264] The report called on governments and the United Nations to "acknowledge and address the causal links between the war on drugs and the spread of HIV".

Other recommendations included: replacing criminalization and punishment with evidence-based interventions proven to reduce the negative health and social consequences of drug use; increasing investment; and scaling up such evidence-based interventions.

In 2016, the Commission issued a follow-up report re-emphasizing their recommendation to decriminalize drug use, particularly possession for personal use.[265]

The **International Guidelines on Human Rights and Drug Policy (March 2019)**,[266] highlight the measures States should undertake or refrain from undertaking in order to comply with their human rights obligations, while taking into account their concurrent obligations under the international drug control conventions. The Guidelines enlist 13 foundational principles,[267] of which Principle No. 7 is extracted below:

7. Freedom from arbitrary arrest and detention

Everyone has the right to liberty and security of the person and therefore to freedom from arbitrary arrest and detention. No one shall be deprived of liberty except on such grounds and in accordance with such procedures as are established by law. Such rights apply equally to any person known to have used drugs or suspected of drug use, as well as to anyone suspected of a drug-related offence. In accordance with this right, States shall:

i. Ensure that people are not detained solely on the basis of drug use or drug dependence.

ii. Ensure that pre-trial detention is never mandatory for drug-related charges and is imposed only in exceptional circumstances where such detention is deemed reasonable, necessary, and proportional.

In addition, States should:

iii. Guarantee that people arrested, detained, or convicted for drug-related offences can benefit from the application of noncustodial measures – such as bail or other alternatives to pre-trial detention; sentence reduction or suspension; parole; and pardon or amnesty – enjoyed by those who are arrested, detained, or convicted of other crimes.

iv. Prioritise diversion from prosecution for persons arrested for drug offences or drug-related offences of a minor nature.

v. Prioritise non-custodial measures at the sentencing and post-sentencing stages for persons charged with or convicted of drug offences or drug-related offences of a minor nature.

vi. Ensure that, where treatment is court mandated, no penalties attach to a failure to complete such treatment.

vii. Ensure that treatment for drug dependence as an alternative to incarceration is undertaken only with informed consent and where medically indicated, and under no circumstances extends beyond the period of the applicable criminal sentence.

viii. Take immediate measures to close compulsory drug detention centres where they exist, release people detained in such centres, and replace such facilities with voluntary, evidence-based care and support in the community.

Legal and policy reform in Myanmar

In recent years, there have been many efforts in the field of legal reform and policy advocacy on drugs and the health consequences associated with drug use, including HIV, in Myanmar.

In 2014, UNDP, UNAIDS and the Pyoe Pin programme published a national legal review on HIV which identified legal and policy barriers as well as opportunities for reform. The report included a comprehensive set of policy and operational recommendations aimed at shifting from repressive policies and practices towards prioritizing health and development-based approaches.[268] This advocacy document was complemented by a review of Myanmar's drug laws, released by an international NGO,[269] and by a range of initiatives engaging government, civil society, UNAIDS, UNODC, WHO and other key stakeholders to support an enabling environment for an effective response to drugs and HIV (see the next section).

A major outcome of this multi-advocacy effort was the amendment of the Excise Act (1917) by Myanmar's Parliament in December 2015, to repeal sections referencing the legal prohibition on possession of needles and syringes, a critical step towards scaling up harm reduction interventions. This was one of the 'quick wins' endorsed by the joint Parliamentarian and Community Network Consortium Committee on Human Rights and HIV as part of the legal review.[270]

Review and amendment process of the Narcotic Drugs and Psychotropic Substances Law (1993)

Myanmar's primary law on drugs is the 1993 Narcotic Drugs and Psychotropic Substances Law (hereafter referred to as 'the Drug Law'). The law defines offences and penalties, sets out provisions for rehabilitation, and provides the legal basis for the formation of the Central Committee for Drug Abuse Control (CCDAC), an interministerial coordinating body headed by the Ministry of Home Affairs.

In 2015, the Ministry of Home Affairs, through CCDAC, and with the support of UNAIDS and UNODC, organized a wide-ranging consultation to review the 1993 Drug Law and provide inputs to government on the Law's provisions. A broad range of stakeholders were engaged, including government bodies, international health and legal experts, I/NGOs, drug user networks, development partners and United Nations agencies.

This review process led to the amendment of the Drug Law, adopted by Parliament in February 2018. Key amendments to the law included:

(1) Removal of compulsory registration of people who use drugs;

(2) Shifting from a punitive to drug treatment approach with expanded provisions on rehabilitation and community services; and

(3) Explicit inclusion of harm reduction approach in the mandate of CCDAC.

Despite positive steps, there are still areas of concern. The provision regarding the death penalty for drug related offences remained in the amended law despite the recommendation to remove it. Furthermore, a provision that exempted drug users caught with small amounts of drugs for personal use, which was initially included in the draft bill, was finally removed. Hence, the amended law makes little distinction between people who use drugs, small-scale dealers and major traffickers, which raises concerns with regard to the proportionality of sentencing. The amended law also does not explicitly specify that treatment – and rehabilitation – should always remain voluntary and not coerced.[271]

Throughout 2018–2019, the (1995) rules for the amended law were being reviewed to ensure consistency with the amended Drug Law. United Nations agencies (UNAIDS, UNODC and WHO) were invited by CCDAC to attend an interministerial meeting on that matter in October 2018. UNAIDS and UNODC, in partnership with civil society organizations and other relevant stakeholders, have made recommendations to guide this review process. Key points included: reviewing quantity thresholds[xxxi] for possession; ensuring that a person should be subjected to diversionary provision rather than tried for an offence in case of personal possession; and ensuring that drug treatment was voluntary.[272]

People who use drugs are also occasionally charged with 'loitering after dark' (Section 35 of the Police Act of 1945), 'drunk and disorderly" (Section 47 of the Police Act) and 'behavioural bonds' under the Restriction and Bond Act 1961 (Section 5(1)). Under the Restriction and Bond Act 1961, if police claim they have information that a person is likely to commit a criminal offence, they can apply for bond to be placed on the person to require the person to report to the police, to be on good behaviour and not travel.[273]

Myanmar National Drug Control Policy

In February 2018, the CCDAC launched the first National Drug Control Policy, with the support of UNODC.[274] In contrast to the amended law, the policy is a broad statement of aspiration, taking a balanced, comprehensive approach in five priority areas: i) Supply Reduction and Alternative Development; ii) Demand and Harm Reduction; ii) International Cooperation; iv) Research and Analysis; and Human Rights as a cross-cutting issue.

Under the 'Demand and Harm Reduction' area, specific recommendations related to the law, policy and enabling environment were made—consistent with the priorities identified in the NSF on Health and Drugs. They include:

- Promoting an enabling environment through a favourable legal environment for implementation activities, and providing funds to promote prevention activities;

[xxxi] For further information on quantity thresholds please refer to information and publications available at https://idpc.net/

- Decriminalization of drug use;
- Capacity building for frontline providers including law enforcement officers and health care providers on harm reduction; and
- Providing training and legislative support to law enforcement and judges to promote alternatives to imprisonment of drug users.

In addition, the National Drug Control Policy outlines that the Myanmar government is committed to developing a drug control policy that respects, protects and promotes all human rights, fundamental freedoms and the inherent dignity of all individuals and the rule of law. In this regard, the policy proposes:

- Promotion of non-discriminatory access to justice, healthcare and social services: treat drug users as patients;
- Promotion of a human rights-based approach through awareness raising and education;
- Promotion of policies and criminal justice sector responses to drug use that respect human rights, including proportionate legal response mechanisms;
- Considering repealing the death sentence for drug-related offences;
- Programmes and interventions to be gender sensitive and in line with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW);
- Capacity building and support for duty-bearers; and
- Ensuring the tailoring of drug control interventions to vulnerable populations including disabled persons, children, youth and women.

While the National Drug Control Policy is not a law and therefore not a legally binding document, it represents a multisectoral consensus for adopting a balanced, integrated and public health-oriented approach to the drugs problem. The inclusion of a harm reduction both in the amended law and in the policy, and the mention of human rights in the policy, constitute positive developments. The strategic plan to implement the drug policy has been developed by the CCDAC with the support of United Nations agencies. It will serve as a guiding tool for CCDAC at state and regional level and for other related departments and sectors.

Subnational efforts

A series of efforts have been undertaken at subnational level to foster an enabling environment for addressing health, social and legal consequences of illicit drug use:

- **Dissemination of the National Drug Control Policy** by CCDAC and UNODC in the different states and regions of Myanmar.

- **Development of subnational operational plans on HIV**. The National AIDS Programme, with the support of UNAIDS and the engagement of a wide range of governmental, non-governmental and civil society organizations, led the development of subnational operational plans on HIV in Kachin State, Mandalay, Shan State North, Sagaing and Yangon. These plans provide a roadmap for concrete steps that can be taken at the state level and aim to reach populations that are most affected and in need of HIV prevention and treatment services.

  They were developed in compliance with the strategies of the NSP III, which outline new operation models prioritizing geographic areas based on epidemic burden and risk of new HIV infections by township. Specific emphasis was placed on drug use prevention, harm reduction, drug treatment and rehabilitation, as well as promoting an enabling environment through trainings on human rights and advocacy initiatives.

- Development of the Kachin State Drug Use Prevention Strategic Plan (2019–2022) between the local government and the United States State Department Bureau of International Narcotics and Law Enforcement Affairs (INL).

  The development of this plan was coordinated by the local NGO SARA in cooperation with the Kachin State CCDAC, and involved working with community and faith-based organizations over a series of workshops. Kachin State's priorities in terms of drug prevention are aligned with those described in the National Drug Control Policy: education, health promotion, social intervention, awareness-raising, and creating an enabling environment. The strategy features a strong focus on youth development for drug prevention.

Challenges and gaps in the legal and policy response to drug use

In recent years, Myanmar has made some progress in reforming legal and policies framework to move towards a less punitive and more health-focused approach to drug use and drug dependence. This was evidenced by the amendment of the Excise Act (1917); some positive provisions incorporated into the amended Drug Law; as well as the newly developed National Drug Control Policy. However, inconsistencies persist between legislation, policies and practices. Much remains to be done to ensure that the response is rooted in evidence, public health, human rights and dignity—in line with international best practices and standards.

In spite of efforts, legal and policy barriers still need to be addressed to create a more enabling environment. Key informants identified the following factors as impediments to an effective response to HIV among people who inject and use drugs:

Challenges for the protection of human rights of people who use drugs:

- Criminalization of drug use and possession of small amounts of drugs for personal use results in people who use drugs experiencing violence, arbitrary arrest and incarceration. Sentences can be very harsh, with a high percentage of people jailed for small drug-related offences, contributing to prison overcrowding.
- Alternatives to incarceration for drug use and drug-dependence offences are yet to be established.
- Criminalization of drug use, through reinforcing misconceptions about this issue, also fuels stigma and discrimination against people who use drugs, and especially people who inject drugs. As a result, drug dependence is rarely understood as a health issue and drug-dependent individuals are commonly portrayed as criminals rather than as people with a health condition requiring complex and long-term behavioural and treatment interventions.
- At local level, this translates into anti-drug operations and vigilante-type activities, primarily by faith-based institutions and other local groups publicly physically shaming and punishing people who use and inject drugs, particularly in Kachin State.
- Additionally, negative media coverage surrounding drug-related issues contributes to feeding prejudices against people who use drugs. Inflammatory reports are often followed by police crackdowns on PWID/PWUD, resulting in more hidden practices and hindered access to health services.

Challenges to health-focused drug policies and harm reduction efforts:

- Punitive laws, policies and policing practices hinder people who use drugs' access to vital HIV and health services, contributing to the spread of HIV and other blood-borne and sexually transmitted infections. Service providers express concerns that some law enforcement activities create barriers to their HIV services and deter PWID from using these programmes. In addition, police searches, detentions or other deterrents prevent outreach workers and peer educators from conducting their work.
- Community resistance to the harm reduction approach remains a significant challenge, due to limited understanding of the concept of harm reduction, in particular the distribution of sterile needles and syringes.
- The negative portrayal of drug use and people who use drugs influences the perspective of many health care providers in the public health sector. As a result, discrimination against PWID and PWUD is common in medical settings.[275]

RECOMMENDATIONS FOR STRATEGIC DIRECTION 5

SD5.1 Ensure drug laws and policies are in line with public health and rights-based approaches

Objectives	Main activities	Responsible sectors	Potential partners
O5.1.1 – Ensure that national drug laws/policies and health policies related to HIV, drug use and drug dependency complement each other and facilitate access to harm reduction programmes for PWID and PWUD	• Support the transition from a punitive to a more health-focused approach to drug use and drug dependency in the implementation of amended Narcotic Drugs and Psychotropic Substances Law and ensure that drug treatment and rehabilitation services are voluntary and evidence-informed • Promote and support the implementation of the priority area 'Demand and harm reduction' of the National Drug Control Policy and the Strategic Plan for Drug Control Policy	CCDAC/ MOHA GAD/ Union Government Office MOHS, AOG	I/NGOs CSO/ CBO, DPAG, NDNM, UN
O5.1.2 – Reform existing punitive laws and establish new laws and regulations to protect people who use drugs from violence, stigma and discrimination, and remove barriers to HIV and health services	• Carry out an assessment of implementation of existing drug legislation on a regular basis • Review laws that present obstacles to HIV prevention, treatment care and support for people who use drugs (e.g., Police Act) • Support the review of certain provisions of the amended 1993 Drug Law (e.g., the death penalty for drug-related offences) and for addressing other areas of concern (e.g., establish quantity thresholds for possession of drugs for personal use; promote diversionary measures in case of personal possession) • Maintain ongoing dialogue and advocacy efforts with decision-makers, such as the Office of the President, the Parliament and law enforcement agencies to promote human rights and health-oriented laws and policies and reaffirm Myanmar's commitment to treat people who use drugs with support and care, rather than punishment	CCDAC/ MOHA GAD/ Union Government Office MOHS, AOG	I/NGOs CSO/ CBO, DPAG, NDNM, UN

SD5.2 Increase awareness about HIV and drug dependency among general public and specific stakeholders, to create an enabling environment for implementation of comprehensive harm reduction services

Objectives	Main activities	Responsible sectors	Potential partners
O5.2.1 – Increase awareness of the role of police in reducing the impact of HIV among PWID	● Develop and implement training curricula on HIV, drug dependency and harm reduction both for the Police Academy and in-service police training ● Raise awareness among operational police and General Administration Department staff on how law enforcement activities can negatively impact the delivery of harm reduction services; and embed harm reduction in law enforcement activities	CCDAC/ MOHA GAD/ Union Government Office	I/NGOs CSO/ CBO, DPAG, NDNM, UN
O5.2.2 – Increase acceptance and support to public health-oriented approaches to drug use, at both central and community levels	● Conduct a mapping of key policy-/decision-makers and institutional influences at national and subnational levels to develop stronger ties and further engagement with members of parliament, ministries and influential people from central/local governments ● Develop an advocacy and communication strategy to promote public acceptance and support for harm reduction. This includes engaging the media to raise public awareness about HIV and harm reduction and reduce discrimination against people who use drugs. ● Sensitize community groups and faith-based organizations to the benefits of public health-oriented approaches to drug use and enhance local stakeholders' ownership, leadership and ability to develop and implement HIV and harm reduction services in the long run (also refer to SD2 O2.1.5 and O2.3.2)	NAP/MOHS CCDAC/ MOHA	DPAG, NDNM, UN
O5.2.3 – Mainstream human rights in HIV programming to reduce judgmental and discriminatory attitudes in service delivery	● Develop and implement community/patient feedback programmes (also refer to SD2.4-O2.4.2) ● Provide training to health care service providers from public, private and NGO sectors on the specific needs of PWUD/PWID to ensure that inclusive quality health services are delivered without stigma and discrimination and thus, improve adherence and treatment success	NAP/MOHS	UNAIDS

SD5.3 Strengthen community mobilization and technical capacity of networks and CBOs to better respond to the needs of people who use and inject drugs

Objectives	Main activities	Responsible sectors	Potential partners
O5.3.1 – Meaningfully engage people who use drugs in discussions and decisions around improving the HIV response from the onset, specifically those relating to law reform as well as in the design and delivery of HIV, health and social protection services	• Promote and ensure greater representation of people who use drugs in policy decision-making as well as in the planning, delivery and evaluation of harm reduction interventions • Prioritize leadership and organizational development among PWUD/PWID-led networks by providing training and capacity building, including in technical and programmatic areas	NAP/MOHS	Community networks DPAG, NDNM, self-help groups, UN
O5.3.2 – Empower people who use drugs to exercise their rights through ensuring them greater access to justice	• Raise awareness among lawyers and paralegals about HIV and drug use and sensitize them to the abuses faced by PWUD/PWID • Enhance the capacity of lawyers and paralegals to handle human rights cases and respond to legal needs of PWUD/PWID • Implement a monitoring and tracking system to collect data, including cases, to assess the scope and impact of crackdowns on the delivery and uptake of harm reduction services • Increase access to legal and paralegal services, counselling, health and social services for PWUD/PWID	NAP/MOHS	NDNM, CBO, Legal Aid organizations, lawyers, UN

SD5.4 Identify and address policy barriers to an enabling environment for effective HIV response among people who use/inject drugs

Objectives	Main activities	Responsible sectors	Potential partners
O5.4.1 – Monitor and evaluate the progress in the implementation of the national drug policy framework	• Generate data and evidence about the progress in implementation of the Amended Law, the National Drug Control Policy and other legal and policy frameworks that affect lives of people who use drugs; and draw lessons for policy advocacy and decision-making	CCDAC/ MOHA	DPAG, NDNM, self-help groups, UN

ANNEXES

Annex 1. Key informants consulted during the process of development of the National Strategic Framework on Health and Drugs

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WHO Myanmar Country Office

Dr Nang Pann Ei Kham

Coordinator

Drug Policy Advocacy Group (DPAG)

Yangon

National Drug Users Myanmar Network (NDMN)

Annex 2. Duties of the drug treatment sector according to notification 3/2016 of the Central Committee for Drug Abuse Control (CCDAC)

1. Adopting policy, goals and objectives in order to perform drug treatment measures effectively and successfully.
2. Conducting assessments and surveys such as epidemiology of drug use disorders, population size estimation for people who use drugs, integrated biological and behavioural surveys, household surveys and school surveys, etc.
3. Setting up a surveillance system on the use of narcotic drugs and psychotropic substance and its consequences.
4. Formulating and implementing plans on prevention, treatment and harm reduction activities based on findings.
5. Coordinate and collaborate with relevant departments, UN organizations, and non-governmental organizations in order to obtain necessary supports while implementing drug treatment measures.
6. Continuous learning of new therapies on emerging new psychoactive substances in addition to opium, heroin and stimulants, providing treatments accordingly and conducting research on treatment outcomes.
7. Capacity building of drug treatment professionals and create new generation of medical professionals.
8. Expanding and upgrading drug treatment centres for wider accessibility of those with drug use disorders.
9. Developing guidelines, organizing training sessions, coordinating with relevant departments for community-based drug treatment and conducting measures of implementation.
10. Formulating policy to reduce harmful consequences of drug use and implement activities.
11. Conducting awareness raising activities on risks and harms of drug use in collaboration with relevant departments.
12. Coordination with relevant departments for rehabilitation of people who use drugs after completion of drug treatment.

13. Managing with respective head of departments of medical services in Region, State, Naypyitaw Union Territory to provide close supervision and fulfilling requests submitted to them in order to implement drug treatment activities successfully.
14. Submission of progress reports to central committee occasionally.
15. Monitoring and evaluation of implementation of drug treatment measures.
16. Management and supervision of budget expenditures on drug treatment activities and managing in accordance with needs if budget contribution is from allocation of Region/State government budget.

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