A STUDY ON DRUG RELATED HARM REDUCTION PROGRAMME IN MYANMAR (2002 - 2010)

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Abstract

To reduce the transmission of virus amongst injecting drug users and, to prevent drug misuse and adoption of risky life styles and behaviors among youth clusters in Myanmar, the harm reduction programme starts initiating in early 2000, but the coverage cab grasp only 15% of population. Indirectly inherited colonial Myanmar drug laws, public health policies and less sophisticated infrastructure not only correct drug misuse behavior with few punitive components but also creates these less aware of public health essence. Booming of jade, gold mining business and trans-border trade after 1996 has made trafficking of drugs and precursor chemicals. Peace keeping agreements with armed ethnic minorities generally reduce cottage industries converting raw into heroin and stimulants. Slow but effective advocacy could pave players expand their services and in order to sustain the services, the initial community commitment and participation at various levels of interventions is needed. As injecting drug use is cross cutting issue over sex work, social dysfunction, poverty, migration, border trade, there has been initiatives from various organizations in programme, planning and decision making. To enhance and to facilitate in a systematic way, it is necessary to focus on right to carefully focus on right based perspectives of these beneficiaries.

KEY WORDS: Supply reduction, Demand reduction, Harm **reduction,** Drug **demand reduction**

Introduction

Harm reduction is the reducing harms associated with drug use to individuals and the community. Individual who abused drug becomes drug addiction. Now, the drug addicted people are survivor of the HIV epidemic who created the socio-economic problems amongst their community.

Drug addiction is a chronic relapsing medical disorder with co-morbidity. It is simply the medical condition where client is in need of initial detoxification therapy to get rid of craving and withdrawal arising deep from central nervous system. Long-term follow up and leverage of other physiological functions is main prime of medical specialists including psychiatrists. Range of options should be made available for clients accessing the services. Clients should be able to choose the services they like or services should meet diverse and sophisticated need of clients such as poly drug use, alcohol use, underlying liver diseases and

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other associated problems, mental disorders, deficient occupational and communication skills, society outcasts and social-marital problems. But in Myanmar, it focuses on abstinence and drug free lifestyle. Drug related laws in many Asian countries composed in part of incarcerating drug users, put them in long queue of waiting in lock ups, painful cold turkey detoxification, make them unable to access medical and psychiatric consultations, spend their sentence in prisons where there is no HIV and drug education facilities, marginalize them with the stigma of registration in the society and bore their esteem in lengthy correction process. First and second time drug users have no grace period from being arrested and put under lawsuit.

As injecting drugs and getting HIV and other blood borne viruses transmitted are linked, current Asian laws somehow push drug users underground. Reusing and sharing needles, syringes or other equipment for preparation and injecting drugs represents highly sufficient way of HIV transmission. It is noted that more than 110 countries have faced HIV epidemics associated with injecting drug use[3]. Therefore, interventions aiming at reducing risky behaviors such as sharing of needles and unprotected sex will degrade injecting drug use, the main driver of HIV epidemic in Asian countries.

While most developing countries in Asia rely on external resources to curb the menace of drugs and HIV and accept the nonparallel projects and programs, sustainability is the question that community and society at large have to answer. Extensive dialogue with decision makers advocates flexible policy changes, and review of regulations causes the enabling environment for public campaigns. Longitudinal research tells that therapeutic communities where most of ex-users work for betterment of drug users at an array of services bearing the scenario that project beneficiaries should speak out for the right of themselves, serve as strong role models and activists to influence bodies such as parliamentarians, to get into international network of them and to build self capacity to each other. It has been evident that strengthening the capacity of affected population is the best way to remove stigma in society. It also makes rest of their life meaningful and use this instrumental force to design future programs in the global setting.

The direction of study goes to review advocacy, intervention and impact of drug related harm reduction programs in Myanmar and services used for drug users, client perspectives over range of services, and negotiation process with Global Fund coming into Myanmar 2011.

This study focuses on the activities of harm reduction in Myanmar from 2002 to 2010. Superficial touch is onto parallel government ground in drug treatment and rehabilitation. Law enforcement activities are mentioned where relevant to HIV-related services, and supply reduction in terms of drug related seizures is looked just to reflect the

[3] National Harm Reduction Review, 2010 May 22

area of drug consumption. Rehabilitation data is listed in order to complete range of services available in country.

Although the aims of study are offered to drug users, client perspectives over range of services, Asian setting of compulsory centers, tailoring services which are noncompulsory and peer based, new dimension of Civil Society involvement, it only was able to incorporate baby steps on development in the light of Global Fund in negotiation process coming into Myanmar 2011.

The weakness of description lies at lack of connection and linkages at official procedures such as registration at drug treatment centers, remand and waiting at police lock ups, registration and deregistration, urine and blood testing of clients, collaboration between medical and law enforcement officials, revisiting Township management structures and analysis of operational status and national budget for drug related sector.

Harm Reduction Programme in South East Asia Setting

Injecting drug use is global phenomenon identified in 148 countries. WHO estimated that there are 15.9 million people with injecting drug (PWID) people who inject drugs. Globally, up to 10% of all HIV infections are linked with injecting of drugs and up to 3.3 million PWID are living with HIV[4].

By responding to epidemic stemming from injecting drugs, countries in South East Asia generated range of public health plans. Since the 1990s the majorities of countries in the South East Asia region have experienced a significant injecting drug use problem, accompanied by explosive rates of HIV at the some sites. The governments have increasingly been to implement various harm reduction interventions to reduce the HIV prevalence and address the health needs of PWID. In the most of these countries with a high and medium burden of illicit drug injecting and PWID are either HIV infected or have a potential for being infected. The South East Asia countries reviewed are Bangladesh, India, Indonesia, Myanmar, Nepal and Thailand.

PWID are primarily concentrated in urban settings. High-risk behaviors are consistently found among PWID. Significantly high rate of sharing injecting equipment are mostly widespread. Unsafe sex among PWID is common and inconsistent condom use with a permanent partner, a casual partner or a female sex worker is widespread. Condom use with a regular sexual partner tends to be low compared to other sexual partners. Sexual relations with female sex workers are common in South East Aisa.

Injecting drug use has significantly contributed to the spread of HIV in Indonesia, Myanmar, Nepal and northeast India. In 2008,HIV prevalence among PWID is mostly high but varies widely among countries: Bangladesh (7%); India (9.19%); Indonesia (52%); Myanmar (37.5%); and Thailand (48%).[5] Wide variations of HIV prevalence within

[4] World Health Organisation Report-2000

[5] Meeting minute, Constitution of National Drug User Network, 2009 Dec 9

countries can be found, for example, **in Myanmar** (Myitkyina 54% and Taunggyi 12.5%) and in India (Manipur 28.65% and Ut'tar Pradesh 2.64%)[6]. HIV prevalence among PWID has remained consistently high in Indonesia, India, Thailand and Myanmar/ while it is rising in Bangladesh, and declining in Nepal. Many PWID are currently incarcerated and at risk of becoming HIV infected in closed settings.

Each country has drug control legislation to address drug use issues and has policy linked to national HIV strategic plans in which prevention, care and treatment of PWID are overall given a priority, to varying degrees. In recent years the policy environment has changed substantially, so that harm reduction interventions are increasingly viewed with understanding and greater acceptance.

Harm reduction interventions as a means to address HIV among PWID are increasingly accepted as the appropriate public health model for PWID. This is despite, at times, the criminalization of drug use overshadowing HIV prevention efforts for PWID.

Needle and syringe programmes (NSP) are found in all countries reviewed. Despite an overall expansion of NSP and an overall increase in the number of needles and syringes distributed, coverage of NSP was mostly low: less than a third of PWID are reached by NSP at least once over a 12 month period in South East Asia.

Opioid substitution therapy (OST) programmes offering methadone and buprenorphine, or sometimes both, are found in all countries. Yet, the numbers of PWID having access to and availability of OST remains very low (less than 5%) and considerably less than those able to secure clean injecting equipment.

Overall coverage of harm reduction interventions as part of a comprehensive package of services has increased compared to previous years. But the majority of PWID do not receive services to meet their general health needs. The overall number of PWID who are also HIV-infected and able to access antiretroviral therapy is small, despite the fact that in some countries PWID have the highest rates of HIV prevalence.

Policy Environment

The Narcotic drugs and Psychotropic Substance Law (1993) replaced the previous law and established the Central Committee for Drug Abuse Control (CCDAC), which is chaired by the Minister of Home Affairs and consists of representatives from the relevant ministries and government departments including the national police, customs, military intelligence and army. The CCDAC has comprised of 27 anti-narcotic task forces throughout the country. The main function of the committee is to formulate policies on all aspects of drug control.

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[6] Hla Htay et al, 5 years follow up study of post treatment and rehabilitation, 2003 Myanmar Medical Conference

A drug user who fails to register at the place prescribed by the Ministry of Health or at a medical center recognized by the government for this purpose or who fails to abide by the directives issued by the Ministry of Health for medical treatment shall be punished with imprisonment for a term which may extend from a minimum of three years to a maximum of five years.

Drug users in Myanmar are required to register with the government and can be prosecuted if they did not do so. Drug control remains the mandate of the CCDAC, which has only implemented harm reduction in Myanmar over the past decade, assisting in resource mobilization, supporting programs and advocating for policy changes where these impede harm reduction.

An old law that has not yet been replaced is the Burma Excise Act (1917) which regulates the provision of needles and syringes. Possession of syringes and needles without a granted license is liable to punishment of up to six months imprisonment or a fine up to 1000 kyat or both. Needle and syringe programs (NSPs) are still hampered by legal constraints, which also cause misunderstandings regarding their effectiveness in HIV/AIDS prevention among various stakeholders. Under current legislation, drug use in Myanmar remains a judicial rather than a health problem.

Amendment and relaxation of laws that is called Alternating Sentencing through legal review workshops were participated by lawyers, advocates, law enforcement officials, health officials in 1993 and 2010. Discussion focused at creating flexibility at current drug related laws and rooms for grace period for drug users. Following recommendations were made in March 2010 which is to be submitted to Cabinet.

Overview of HIV Situation

Myanmar has the third-highest HIV burden of people living with HIV and AIDS in the South East Asia Region after India and Thailand, with an estimated 240 000 (range 160 000-370 000) as of 2007.[7] The HIV epidemic in Myanmar is driven by a combination of injecting drug use and sex work. It occurs especially in large cities and the north and east regions because of large-scale production and movement of illicit drugs.

Injecting drug use has significantly contributed to the spread of HIV/AIDS accounted for about 30% of total infections in the country. Sentinel surveillance data indicate that Myanmar's HIV epidemic peaked in 2000-2001 and then started declined but remains vulnerable to the continuing spread of HIV due to social factors such as poverty, population mobility, HIV-associated stigma and the limited capacity of the health systems to scale-up services. The overall adult HIV prevalence is estimated to be 0.7% but populations with high-risk behaviors are disproportionately affected. In the most recent HIV sentinel-

[7] Hla Htay et al, 5 years follow up study of post treatment and rehabilitation, 2003 Myanmar Medical Conference.

surveillance survey of 2008, 18.38% of FSW, 37.5% of PWID and 28.8% of men who have sex with men (MSM) were infected.

Overview of Drug Use Situation

Opium use and production happen as a long history in Myanmar. Currently, it continues to be the second-largest producer of poppy opium in the world, after Afghanistan. However, the trend of using pattern has changed from opium to heroin and opiates are still the preferred category of drugs consumed by 2003-2004, Amphathemine Type Stimulant (ATS) were ranked as the third-most serious drug of abuse in Myanmar after heroin and opium. Although Heroin is commonly administered through injection and no official estimates of the number of drug users due to problems in collecting independent data in Myanmar, it has been reported that numbers is likely to be between 300 000 and 400 000. The current nationally agreed estimate for the size of the PWID is 75 000 (range 60 000-90 000). This translates into a 0.23% prevalence of drug injecting in the male adult population-one of the highest in Asia after China, Malaysia, Thailand and Viet Nam.

No formal mapping or size estimation of high-risk group populations is available to describe the geographical distribution of PWID. However, based on observational and ethnographic-type data, it appears to roughly reflect the drug production centers and trafficking routes in the country. The largest concentrations are to be in the northern (Kachin) and eastern (Shan) states that share borders with China, Laos and Thailand (Golden Triangle).

It has been reported that PWID population in Yangon is mostly underground, where heroin is limited, and due to the high cost. However, use of tranquilizers was common in Yangon and 69% of all PWID in Yangon injected their tranquilizers. In Mandalay the population of PWID is considered to be large and young and heroin is also expensive and less readily available.

In Lashio (Shan State) and Myitkyina (Kachin State), PWID has easy access to inexpensive heroin, but the size of PWID population is not clear. The majority of poppy opium is grown in the Shan state while heroin and amphetamines are manufactured and then trafficked across the China and Thailand border areas. It has been reported that in recent years precious gem-mining areas within the Shan and Kachin states have employed approximately 500 000 seasonal male migrant laborers who were known to engaged in high levels of both drug use and commercial sex.

The data from the drug treatment centers is likely that only a small proportion of the total drug users in Myanmar are registered due to the inadequate capacity at these facilities and only a few systemic studies are available. Injecting practices may be more common in areas where availability of drugs becomes scarce or expensive, due to injection providing a higher impact from a smaller quantity of drug.

Most information about sharing practices among PWID is derived from field observations. Sharing behavior appeared more common among long-term injectors compared

with those starters. The most recent information on injecting risk behaviors is available from the National Behavioral Surveillance Survey (BSS) 2007-2008 of PWID from four cities. While needle and syringe sharing is a moderately high in Yangon rather than Myitkyina and Lashio, and relatively low in Mandalay. That may suggest an overall higher level of potential for transmission among PWID networks.

Limited information on the sexual risk behavior of PWID included in some baseline assessments from implementers of harm reduction programmes. But the sexual activity is strongly associated with use of type of drugs. In the cities, more than a third of PWID having sex while under the influence of amphetamines.

HIV prevalence among PWID peaked in the early 1990s at over 70% before beginning a slow, but steady declined during 2005-2006. However, sentinel surveillance data clearly show HIV prevalence was currently still too high among PWID in the all locations and provided sufficient evidence for the need for prevention programmes.

Some situation assessments noted that a particularly high level of HIV infection among new drug injectors. The high level of HIV prevalence among PWID is due to sharing of equipment is reported, are consistent with high rates of transmission among PWID overall. In addition, the high proportion of PWID who report having paid and casual sex is an important area. Migrant workers, particularly miners, are more vulnerable to developing injecting drug use habits and returning to their home and sparking local epidemics. This is already a cause for concern and that has moved much beyond a core PWID group.

Available Interventions

HIV epidemic among PWID has been well established since the mid-1990s, with HIV prevalence levels reaching some of the highest in the world at that time. The government recognized the role of the injecting drug use in the spread of the epidemic and has expressed explicit policy support for harm reduction in national policy documents. Reducing HIV-related risk, vulnerability and impact among drug users is one of the main priorities within the National Strategic Plan on HIV/AIDS (2006-2010). Harm reduction as HIV prevention interventions such as NSPs, opioid substitution therapy, condom promotion, outreach, and peer education efforts have increased, but it is not yet comprehensive and the scale of response has yet to match the magnitude of the problem.

Treatment of Drug Dependence

A range of treatment services is available for drug users, including detoxification, counseling, rehabilitation, methadone maintenance and after-care.

There are six major drug treatment centers and 22 minor treatment centers under the Ministry of Health and eight rehabilitation centers, which together have provided services to around 70 000 drug users in the past decade. In 2000, UNODC established community-based treatment programmes in Northern Shan State to complement government treatment centers. By 2007, UNODC was operating five drop-in-centers (DIC) and international NGOs, such as

ARHP, MDM and local NGO- MANA were operated drop-in-centers especially in Shan and Kachin States. In 2006-2007 more than 5000 people sought treatment and support from these DIC and outreach services in these areas. Further DIC developments under these organizations were occurred up to 36 DICs currently and 15 were connected to UNODC. In 2009 there were 1059 registered drug users, the main drug of dependence was heroin, followed by opium.

Targeted Interventions

(1) Needle and Syringe Programme

The number of needles and syringes made available to PWID has been increasing steadily since 2003. In 2009, more than 5 million needles and syringes were distributed, according to the information provided at the national harm reduction review in May 2010. In 2008 there were 19 NSPs offering clean injecting equipment for PWID. The majority of PWID in the BSS (2008) mentioned pharmacies as the most common place to collect needles and syringes, followed by NGOs, then health workers and lastly drug dealers.

(2) Opioid Substitution Therapy

The opioid substitution therapy is methadone maintenance therapy (MMT) preparation started in Myanmar since 2004, but the Ministry of Health started the delivery of MMT for the treatment of PWID in 2006. In the beginning, there were four drug treatment centers used for detoxification as pilot areas. After that three more centers were opened and one additional site in Yangon at the outpatient department of hospital. In 2010, there were ten methadone dispensing centers in the country. In January 2010 the current data was 821 clients from eight sites.

The MMT programme was informally evaluated in 2007, less than 20% injected again and only occasionally; 86% showed improvement in health; and 92% reported better quality of life. The challenges were that some sites had low doses of methadone, and a prolonged duration of in-patient stabilization. Currently, the MMT programme is small with less than 1% of the estimated 75 000 PWID accessing MMT.

(3) Prison Interventions for PWID

Since around 2007 HIV health education for prisoners, prison staff and their family members in prisons were started. Also UNODC have reportedly undertaken HIV prevention training for inmates and correctional staff. But information, education and communication materials about HIV prevention were reportedly not available inside the prisons. There are no other forms of HIV prevention interventions for PWID in prisons.

(4) Access to Antiretroviral Treatment

In 2008, 15 191 PLHIV were receiving ART, but still a small proportion of those who are estimated as in need (76, 000). It is believed that ART for PWID remains away from access as is the case in the many countries in South East Asia, and there are some NGOs excluding drug users, even if they are stable on methadone.

Harm Reduction Players in Country

State Peace and Development Council has laid down guidelines on implementation of 15 years Narcotic Drugs Elimination Program. The program has started since 1999 and 2009 to 2014 is the third 5 years program.

Myanmar model focuses on abstinence and a drug free lifestyle by encouraging behavioral changes. It provides a safe environment for recovery and prepares drug user for social-reintegration. Government rehabilitation offices exist in Yangon, Mandalay, Myitkyina, Lashio, Namlatt (Banmaw), Kyaing Tong and Tachileik which run small courses on a limited budget.

The Department of Health, under the guidance of Ministry of Health, has set up a total of (26) major Drug Treatment Center (40) Subsidiary Centers and Drug Treatment Unit at three Youth Correction Center. In addition, Township Medical Officers are trained to provide registration and treatment services, if Drug Treatment Centers are not available. In National Health Plan of Myanmar, drug abuse is one of the priority diseases and 2010 was the second year of last five years plan of 15 years Narcotic Drugs Elimination Program. To achieve the Millennium Development Goal of combating HIV, proper control of drug abuse problems and their high risk behaviors will be important.

Myanmar adopted a strategy on preventing the transmission of HIV and reducing the impact by controlling injecting drug use in the National Strategic Plan for HIV and AIDS (2006-2010) and Substance Abuse Control Project of the department of health became responsible to implement this program.

The leading agency is UNODC which is also main body for advocating and collaborating with the government in Myanmar. The other harm reduction players are as International NGOs such as BI MM, Care Myanmar, AHRN, MdM, AZG and as Local NGOs are MANA, SARA, MBC and MCC.

Findings and Discussion

The official prevalence of HIV amongst IDUs and general community are 37% and 0.62% respectively. It is urgent to reduce the prevalence of HIV amongst PWID as transmission of HIV from IDUs to other IDUs, sexual partners, spouse as it has been evident as reservoir spreading into general community.

Reviewing current infrastructure of drug treatment, mental health, focused intervention of National AIDS Program over risk groups, IDUs in particular identifies needs. While about 0.3% of national GDP comes to national health budget, per head allocation for concerning drug and alcohol remains negligible. The major rehabilitation centers existed in Phe Kon, Pyay and Namphatkar townships in Shan State and Bago Division of which only one is functional at the moment. Only seven drug treatment centers have been function and total capacity is about 350 beds. Those who faced with treatment and rehabilitation system served their lives with boredom into dysfunctional deregistration.

Partial opening towards international assistance 2003-2010 led to piloted harm reduction programs reaching out to roughly 15% of existing hidden population, at $20

million budget. Piloted harm reduction programs started in 2003 under the supervision of CCDAC. National AIDS Program at its operational plan identified 29 prioritized townships suitable for harm reduction. Now the programs lead to 40 drop in centers. When such pilot initiative proved that harm reduction works in Myanmar, further endeavors to scale up the program continued.

However, there are changing donor stand points. Globally, GFATM prefers to run peer-linked programme in countries where decriminalization takes place. United States government lifted the ban over needle and syringe programs in 2010 and PEPFAR (President Emergency Preparedness Fund for AIDS Response) shows strong interest to fund NSPs all over the world, although political priority still exist to allied countries.

The medical essence of drug dependency as chronic medical disorder and in most cases, mental co-morbidity is not officially recognized by legal and judicial perspectives hence institutionalize them into lock ups, custody, camping into less attractive models where government financial support could not follow as much as the legal sentence extends. Hence, more than third of prison population in Shan and Kachin States are drug related cases.

The laws making mandatory registration stigmatize people who use drug and who inject drugs (PWID) as drug users compulsory to undergo into the chain of medical treatment, referral to rehabilitation center, deregister and reintegrate into society. One study[8] denoted that those who registered at major treatment centers could not effectively deregister who face periodic follow up from social workers group up to five years after registration, about one third of population died of AIDS related symptoms and other third got into prison. One incident[9] of IDU, after being caught for keeping sample amount of heroin, was under trial for more than a year before 4 years imprisonment.

There is lack of HIV education, options of treatment and case management schemes and presence of agro-husbandry exercise leading to accusation of violation of human rights, although not true in actual setting. This all leads to current weakness of public services.

Locally, the national strategic plan 2010-14 highly recognizes the participation of affected populations such as Self Help Groups, Community Based Organizations, PLHIVs, PWIDs, MSMs, SWs, IDUs being accountable for attending meetings and participatory decision making roles. However, commitment does not extend to Ministry of Home Affairs and state or divisional military commanders. Further advocacy is necessary to make leverage so that official HIV/AIDS laws and flexible drug sentences can occur.

There has been enormous attempt by health department to run substitution therapy for drug users. The philosophy is to stabilize their nervous system signals arising from shortage of opiates hence lessen their criminal potential and HIV risk behaviors. On the practical

[8] Hla Htay et al, 5 years follow up study of post treatment and rehabilitation, 2003 Myanmar Medical Conference

[9] National Harm Reduction Review, 2010 May 22

ground, recruitment of MMT of about 1% is very less in order to see valid impact such as reduction in crime rate, increased life expectancy, Disability assisted life years and reducing further needle sharing, 2009 needles distribution, of about 5 millions translates that existing 75,000 PWIDs are using less than one needle per day while the actual need is three per day.

It is evident that there is a gap between actual financial need and expended. Room to change exist at existing punitive nature of drug laws, criminalizing drug use, lack of synergy between multiple Ministries especially between Home Affairs and Health. Harm reduction projects of both local and international players are found to be donor driven, program approach intentionally ignoring the essence.

These all factors serve as constraints and limitations to attract more international funding despite the increasing political commitment, geographical interest of donors to South East Asia region.

Recommendations

It is necessary to continue advocating for involvement of drug related community, integration of optional treatment and vocational facilities and amendment of laws of illicit drugs to become flexible that will reduce medical, social, legal harms associated with drug use. As the concept of therapeutic community says problems of multiple dimension will be solved in the hands of affected community once sense of belonging and ownership ensured. This translates that lessons learnt from unnecessary evils of system will be best corrected by clients not by service providers. The service providers should support to explore competently their actual needs of client himself. It is very important that drug users work for the rights of drug users. That will only curb the HIV epidemic.

Drug law enforcement has been relatively ineffective in reducing supply, has been associated with significant unintended negative consequences and has also been cost-ineffective. Although reducing harm of illicit drugs, no effective outputs because that is significantly associated with reducing in both demand and supply. Drug use should be redefined as primarily a health and social problem with consequent funding increased to the level of the criminal justice system.

HIV preventive education and harm reduction are necessary in the closed settings as identified internationally as incubators for HIV transmission. Drug Court is the answer for delayed trial cases in the police lock ups. The number of drug users in closed settings should be reduced. Detaining drug users because of their drug use in detention centres or prisons is very expensive, has been shown to inadvertently increase the risk of HIV infection.

Over five million sterile needles and syringes were provided to injecting drug users in Myanmar in 2009. Authorities should aim to provide 30 million needles and syringes/year within five years. Authorities should develop a plan to reach this target. This plan should indicate the funding, staffing, training, logistical support and law flexibility required to

achieve the national goal agreed upon. Achieving these targets will not be possible without an enabling environment.

Opioid Substitution Therapy (OST) should be expanded to reach more drug users at risk. U$1 investment in medical interventions will reduce U$7 cost in legal settings[10]. Improving drug user access to VCT and access to ART for HIV-positive drug users who need it—including both drug users in treatment, on MMT, and active drug users—will contribute to reducing the HIV epidemic in the drug using community.

Research for determining denominators, mapping of drug users and injecting drug users, operational research on public services, collective impact studies over international projects will serve effective inputs over national planning.

Conclusion

HIV spreading among injecting drug users is now a controllable public health problem. In countries where a strong political will to resolve this problem has been demonstrated, where adequate resources have been made available, and an evidence-based, human rights-based public health response has been implemented and expanded rapidly to scale, epidemics of HIV have been brought under control within a few years. The higher the prevalence of HIV among injecting drug users when action started, the longer the delay between initial recognition of this problem and implementation of harm reduction to scale, the longer it takes and the more it costs to gain control of the epidemic.

Countries that have not followed this path, such as Russia, have paid a heavy price in health, social and economic terms. Future generations will pay huge costs. While some are quite prepared to sacrifice a population of injecting drug users to a premature and unpleasant death from HIV, it should be remembered that the price of inaction is not just the deaths of injecting drug users, but also the deaths of the many members of the general community with whom drug users have had sexual contact. Sooner or later, most communities ultimately accept the need for effective action because the price of inaction is just too high.

Myanmar was slow to take effective action. The interventions are still not at a sufficient scale to reverse the epidemic. These interventions are being expanded but at the current rate of expansion, it will still take some decades before this problem is brought under control. This response will cost the country a great deal. While the past cannot be changed, the future can. It has now been clear for about two decades that the harm reduction package of interventions is effective, safe and cost effective. One by one, all the major countries in Asia are now making the political commitment to implement harm reduction to scale. Now it is time for Myanmar to also take this step.

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