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HIV/AIDS and drug use in Burma/Myanmar*

*"Funding for AIDS programmes should be exempted from a boycott as, whatever political side one is on, it is the population that is ultimately affected. And the AIDS epidemic is not limited by time or geography and will intensify problems for any future regime and possibly neighbouring countries... Increased aid, de-politicisation and acknowledgement of the epidemic by all players are essential for further prevention."*¹

The increasing number of injecting drug users (IDUs) and the growing HIV/AIDS epidemic in Burma presents one of the most serious health threats to the population in the country, and also to the region at large. Infection rates among IDUs in Burma are among the highest in the world.

UNAIDS has warned that Burma is close to the tipping point, where the critical mass of infection becomes so great that the epidemic is self-sustaining in the general population, even in the event of a significant reduction in risk behaviour in the most vulnerable sub-populations, such as IDUs.

Yet while the need for an adequate and immediate response to the public health crisis in Burma is clear, a number of factors have limited the scope and effectiveness of humanitarian assistance in the country, which has strong socio-economic impacts on people's lives.

The military government, the State Peace and Development Council (SPDC), has imposed several new restrictions on the operations of UN agencies and international NGOs in the country. Furthermore, a number of international donors oppose giving humanitarian aid to Burma, mainly for political reasons. A major blow to efforts to avert the HIV/AIDS epidemic was the decision of the Global Fund to terminate its grants agreements to Burma.

RECOMMENDATIONS

- All stakeholders involved should acknowledge the HIV/AIDS epidemic and the need for harm reduction policies. It is key for all sides to de-politicise HIV/AIDS.
- The international community needs to make a firm commitment to stem the HIV/AIDS epidemic in Burma and should ensure sufficient and long-term financial support for HIV/AIDS and harm reduction programmes.
- The government of Burma/Myanmar should provide adequate conditions for humanitarian aid to take place and ensure unhindered access for international aid agencies to local communities. The space for initial harm reduction initiatives is encouraging but needs to be scaled up in order to be effective.
- Local community-based organisations in Burma should be able to participate in the debate about international humanitarian aid to Burma. In particular, people living with HIV/AIDS, and drug users or organisations that represent them, should be consulted in discussions and decision-making processes about the funding for programmes on HIV/AIDS

* In 1989, the military government changed the official name of the country from Burma to Myanmar. Using either 'Burma' or 'Myanmar' has since become a highly politicised issue. The UN system uses Myanmar, but for the sake of consistency we have chosen to use Burma, which is the way the country is referred to in the large majority of English language press and other publications. For background information see: Transnational Institute, *Drugs and Conflict in Burma (Myanmar); Dilemmas for Policy Responses*, Drugs & Conflict Debate Paper No.9, Amsterdam, December 2003.

Opium, Heroin, and 'Crazy Medicine'

Although opium cultivation has decreased significantly in recent years, Burma remains the second largest producer of illicit opium in the world, after Afghanistan.² As an opium producing country, Burma has traditionally known opium use, including for medicinal purposes. Most of the opium is cultivated in Shan State, and to a lesser extent in Kachin State. For many ethnic minority communities opium is the only viable cash crop in their impoverished regions.

In the last two decades the number of drug users in Burma has grown dramatically, and drug use in the country has changed from smoking opium to smoking and injecting heroin. This is partly because heroin has become widely available, is pure, has a more instant effect, and is easy to consume. Heroin is currently the dominant drug used in Kachin State, Northern Shan State and in the large cities. Opium is mostly used in Eastern and Southern Shan State and in Kayah State.

Furthermore, since the mid-1990s the production of Amphetamine Type Stimulants (ATS) has seen a significant increase. Methamphetamine is mainly produced in the border regions of Shan State, from where it is exported to Thailand and China. Methamphetamine tablets are mainly consumed in neighbouring countries, especially Thailand, where they are better known as 'yaba' or 'crazy medicine', but their use has also spread to Burma, and they are now easily available in big cities like Rangoon and Mandalay. Recently, the use of an injected form of methamphetamine has been reported in Thailand.

Official government figures listed 66,076 registered drug users in 1998 and 86,537 in 1999.³ However, it is likely that the real numbers are significantly higher. Although reliable figures are not available, international NGOs put the number of drug users in Burma at between 300,000 and 500,000. Among them, there are an estimated 150,000 to 250,000 IDUs, based on a conservative estimate that 50% of all drug users are IDUs.⁴

Most of the opium, heroin and ATS produced in Burma are exported from Shan State to China, Thailand and Laos. In 2003 the government reported the seizure of about 1,300 kilos of opium and 560 kilos of heroin, with

75% of these seizures in Shan State.⁵ Precursor chemicals, such as acetic anhydride for heroin and ephedrine for methamphetamine, are not produced in Burma. These are all illegally imported from Thailand, China, and, more recently, also from India.

The Public Health Crisis in Burma: A Silent Emergency

More than fifty years of civil war and decades of military rule and government mismanagement have caused great suffering for the peoples of Burma, especially for ethnic minority groups, in whose areas most of the fighting has taken place. Burma is in the midst of a deep political, economic and social crisis. Compared to the defence budget, government spending on health and education remains extremely low. The public health sector is hugely under-funded and under-resourced.

Many people in Burma still die of preventable or curable illnesses. The general health situation in Burma compares unfavourably to other countries in the region. The number of doctors per capita is extremely low. An international NGO estimated that in one area there were only 4-5 doctors to serve about 500,000 people. Only one-third of the country has access to clean water and proper sanitation. Burma has one of the highest rates in Asia of infant mortality, maternal

1. *Fighting AIDS in Burma*, Letters to the Editor, Dr. Frank Smithuis, MSF Holland, Bangkok Post, 25 November 2000.

2. Opium production in Burma decreased from around 1,800 tons in 1996 to just over 300 tons in 2005, partly because of a number of opium bans, which have had an immediate and profound impact on the livelihoods of opium poppy farmers due to a lack of sufficient alternative income opportunities. See: Transnational Institute (TNI), *Downward Spiral: Banning Opium in Burma and Afghanistan*, Drugs & Conflict Debate Paper No.12, Amsterdam, June 2005, and: UNODC, *Myanmar Opium Survey 2005*, November 2005.

3. Police Col. Hkam Awng, Joint Secretary Central Committee for Drug Abuse Control (CCDAC), *Country Paper on Suppression of Narcotics Drugs*, Third Session of Seminar on Understanding Myanmar, 27 January 2004, Yangon.

4. The Centre for Harm Reduction & Burnett Institute, *Revisiting 'The Hidden Epidemic', A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS*, January 2002.

5. Pol.Col. Hkam Awng, Joint Secretary Central Committee for Drug Abuse Control (CCDAC), *Country Paper on Suppression of Narcotics Drugs*, Third Session of Seminar on Understanding Myanmar, 27 January 2004, Yangon.

mortality and malnutrition among children. Ethnic minority regions are worst off.⁶

"While the situation cannot yet be defined as an acute humanitarian crisis, specific aspects of suffering, particularly HIV/AIDS, tuberculosis and malaria, do constitute a humanitarian emergency," said Ibrahim Gambari, the UN Undersecretary-general for Political Affairs, in a briefing to the UN Security Council in December 2005. *"In the longer-term, deep-rooted chronic and accelerating poverty, growing insecurity and increasing political tension appear to be moving Myanmar [Burma] towards a humanitarian crisis,"* he warned.⁷

The HIV/AIDS crisis in Burma is one of the most serious health threats to the population, and also presents serious risks to neighbouring countries. Burma, Cambodia and Thailand are the countries hit hardest by the HIV/AIDS epidemic in Asia. The epidemic in Burma is the most serious as it is the only one of these three countries where the HIV infection rate continues to rise.⁸

The simultaneous spread of the HIV/AIDS epidemic and injecting heroin use in Burma has resulted in a very high HIV prevalence among IDUs. The HIV infection rate continues to rise due to high-risk behaviour among IDUs, which is still widespread in the drug injecting teashops or 'shooting galleries', not only in cities but increasingly also in rural areas. Usually only one set of needles is present, and sterilisation of injecting paraphernalia is uncommon.

Reliable data is not available, and all figures should be treated with great caution. According to an NGO report of 2002, the estimated HIV prevalence among IDUs in Burma increased from 54% in 1997 to 63% in 2000. It runs at over 90% in some areas, especially in Shan and Kachin State. According to the same study, 61% of injecting heroin users shared their needles and syringes. Unlike most other countries, IDUs in Burma often get infected with HIV soon after they start injecting drugs.⁹

In 2004, UNAIDS reported that 47% of IDUs tested HIV-positive in Myitkyina, the capital of Kachin State in northern Burma, while 60% of IDUs tested HIV-positive in Lashio in northern Shan State. In the main cities Yangon and Mandalay the HIV-prevalence rates among IDUs were 25% and 30% respec-

tively. According to the national Department of Health the HIV prevalence among IDUs nationwide was 34% in 2004.¹⁰

Another major driver of the HIV epidemic is the practice of unsafe sex, mainly through commercial sex. HIV/AIDS infection rates among sex workers are high. Data from the year 2000 shows a significant increase in infection rates among sex workers from 26% in 1999 to 38% in 2000. The same research reported that about 12% of the male clients treated at public clinics for sexually transmitted diseases were HIV positive.¹¹ UNAIDS reported that 27% of the sex workers who were tested in 2004 were found to be HIV positive.¹²

A recent study to assess the prevalence of drug use among sex workers in Kachin State found that nearly 50% were using some kind of drugs. The majority of them were taking ATS 'cocktails', and about 5-10% of them were IDUs. These IDU sex workers are a 'double high-risk' population with more complex problems, and so far no specific programme exists to address their needs.¹³

The HIV/AIDS epidemic is further fuelled by population mobility, such as in border trade; migrant worker sites such as mines and logging camps, which have a high prevalence of drug use and sex workers; and by poverty. Sexual transmission of HIV is also taking place among men having sex with men.

There is also evidence of the epidemic spreading into lower-risk groups. For example, HIV

6. Personal communication with representative of international NGO in Burma, and: Martin Smith, *Ethnic Conflict and the Challenge of Civil Society in Burma*, in: *Strengthening Civil Society in Burma; Possibilities and Dilemmas for International NGOs*, BCN/TNI (eds.), Silk-worm Books, Chiangmai 1999.

7. AP, *Burma Is Heading for Humanitarian Crisis*, UN says, Edith M. Lederer, December 17, 2005

8. UNESCO, *HIV/AIDS in the GMS*, Bulletin for Preventive Education in the Greater Mekong Subregion, Issue 1, 2004.

9. The Centre for Harm Reduction & Burnett Institute, *Revisiting 'The Hidden Epidemic', A Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS*, January 2002.

10. UNAIDS/WHO, *AIDS Epidemic Update*: December 2005, Asia.

11. International Crisis Group (ICG), *Myanmar: The HIV/AIDS Crisis*, Bangkok/Brussels, 2 April 2002.

12. UNAIDS/WHO, *AIDS Epidemic Update*: December 2005, Asia.

13. Personal communication with representative of international NGO in Burma, May 2006.

prevalence among pregnant women is rising and has now exceeded 3%. HIV prevalence among military recruits tested in Rangoon and Mandalay has also increased, as have infection rates among blood donors.¹⁴

The Tipping Point

In mid-2004, UNAIDS estimated the number of HIV-infected people at between 170,000 and 620,000. The epidemic is no longer limited to specific risk groups but has spread among all segments of the population, and UNAIDS has characterised Burma as having a 'generalised epidemic'.¹⁵ According to UNAIDS:

*"The country is close to the tipping point. This is the point at which the critical mass of infection becomes so great that the epidemic is self-sustaining in the general population, even if risk behaviour in the most vulnerable sub-populations, such as injecting drug users and sex workers, is significantly reduced."*¹⁶

The same study estimated that some 60,000 PLWHA were in immediate need of anti-retroviral treatment.¹⁷ A mid-2005 report estimated that the number of people that were receiving ARV treatment represented less than 5% of those who needed the treatment.¹⁸ There are no statistics available on the mortality rate of AIDS, but UNAIDS estimated the number of AIDS deaths among adults and children at some 20,000 in 2003.¹⁹ Given the circumstances, the number is likely to increase rapidly and according to some NGOs has already surpassed the traditional main causes of death such as malaria.²⁰

The HIV/AIDS epidemic also has strong socio-economic repercussions. *"A lot of people we work with do not have access to anti-retroviral treatment",* says an international aid worker. *"Many are sick, poor, and unable to work. Most of them rely on their families. We have heard stories of people being thrown out of their house and living at cemeteries. It does happen. But in the majority of the cases the family will accept it, even reluctantly. It is just that the poverty is so widespread. With HIV/AIDS on top of it, it is really tough."*²¹

The Asian Development Bank recently warned that the epidemic in Burma is also a threat to the economy as a whole, as it decreases labour productivity, is slowing popu-

lation growth, and diminishes people's savings.²²

There is a lot of stigma surrounding people living with HIV/AIDS, and aid workers say the majority of them are not willing to be open about it. *"There are many people getting sick, so there is more discussion about HIV/AIDS. But by the time people seek help it is in a very late stage, when they are about to die."*²³

Bickering over Numbers

There has been some controversy over the magnitude of the HIV/AIDS epidemic in Burma and the number of infected people. Generally speaking, there is little reliable data and few statistics on Burma available on any issue, and all figures should be treated with great caution. Opposing sides in the political debate on Burma have used different figures to support their political positions. In reality, all numbers are estimates, often based on limited baseline surveys or anecdotal evidence. The politicising of HIV/AIDS has greatly hindered an adequate response, with both opposing sides in denial of the realities on the ground. As a medical doctor with a long-term working experience on HIV/AIDS in Burma wrote some years ago:

"AIDS in Burma has become politicised. Governments and political groups are using the AIDS epidemic as a political tool, in order to make accusations. As a consequence,

14. UNAIDS, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Myanmar, 2004 Update.*

15. UNAIDS, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Myanmar, 2004 Update.*

16. UNAIDS, Myanmar at a Glance [www.youandAIDS.org/Asia Pacific at Glance/Myanmar/](http://www.youandAIDS.org/Asia%20Pacific%20at%20Glance/Myanmar/)

17. UNAIDS, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Myanmar, 2004 Update.*

18. Joint Programme for HIV/AIDS, Myanmar 2003-2005 Mid-Term Review, draft 29 June 2005.

19. Based on low estimate of 11,000 and high estimate of 35,000. UNAIDS, *Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, Myanmar, 2004 Update.*

20. Personal communication with representative of international NGO in Burma, May 2006.

21. Interview with representative of international NGO, Rangoon, December 2005.

22. AIDS "Epidemic" harming Burma's economy, says report, The Irrawaddy, Sai Silp, December 1, 2005.

23. Interview with representative of international NGO, Rangoon, December 2005.

*the situation is either exaggerated or hidden, in order to prove each other wrong. This is counter-productive."*²⁴

Similarly, the politicising of HIV/AIDS has fed speculation about the origin and spread of HIV in Asia. A recent report suggested that various strains of HIV in Asia originated in Burma, and that these types of HIV are concentrated in key population groups, especially among sex workers and IDUs. According to the report:

*"The HIV cases and the specific HIV subtypes cluster in opium poppy-growing regions and then travel along heroin-smuggling routes across Asia... Along the Heroin routes, [Burma] may be the greatest contributor of new types of HIV in the world."*²⁵

The report sparked a reaction from UN representatives in Burma, who released a statement saying there is no definitive proof on the origin of the strains, or on the direction of their spread. They also highlight empirical evidence showing that 'importation' or origin is not the major determinant in the spread of HIV. The major factors in transmission of HIV, they argue, are indigenous risk behaviours in China, India, Burma, Vietnam, Laos and Thailand:

*"Ascribing the origin of HIV strains and their spread to one country undermines the collective effort required for an effective response, both regionally and internationally. This also alienates countries and governments and often entrenches the stigmatisation of particular vulnerable groups, thereby, further complicating efforts to stop the spread of HIV."*²⁶

International Responses to the Crisis

In Thailand and Cambodia, the resources put in to combat the HIV/AIDS epidemic by the national authorities as well as by the international community have quickly expanded. But in Burma this has not been the case. The military government has been slow to respond to the epidemic. However, in 2001 the government made a significant policy change and listed HIV/AIDS as one of the three priority diseases in the country, after malaria and TB. The need to address HIV transmission by drug use was also mentioned in the new National AIDS Program of the Ministry of Health. This provided initial space for international agencies to openly set up harm reduction projects, including

needle exchange and substitution treatment. However, HIV/AIDS among drug users in Burma remains a highly sensitive issue for the government, and there are still many limitations.

The international community has limited international development assistance to Burma for political reasons, and per capita international aid to Burma is among the lowest in the world. The question of whether, and how, the international community should channel international assistance to Burma is very politicised and has been subject to lengthy and heated debate. Critics say humanitarian aid is only supporting and legitimising the military government, and claim it is not possible to reach the target population. They also feel it is impossible to carry out adequate monitoring.

By contrast, international NGOs working in the country, supported by an increasing number of newly formed local community-based organisations, argue that it is possible to directly reach those in need with humanitarian aid, and that their presence on the ground actually increases the space for others to work in. There is also a strong feeling that it is not right to punish the poor for the failures of the government, by denying them aid at a time when the country is in the grip of an enormous humanitarian crisis.

In 2001, the heads of eight UN agencies operating in Burma stated in a letter to their headquarters that Burma was *"on the brink of a humanitarian crisis"* and called for *"a dramatic overhaul of budget allocations to Myanmar"*. *"Under these circumstances"*, they argued, *"humanitarian assistance is a moral and ethical necessity...The nature and magnitude of the humanitarian situation does not permit delaying until the political situation evolves"*.²⁷

A change of thinking has also taken place among representatives of the Burmese

24. *Fighting AIDS in Burma*, Letters to the Editor, Dr. Frank Smithuis, MSF Holland, Bangkok Post, 25 November 2000.

25. *HIV and National Security: Where Are the Links?*, Laurie Garrett, Senior Fellow for Global Health, Council on Foreign Relations, July 18, 2005.

26. Clarification on the origin and spread of HIV in Asia, Jean-Luc Lemahieu, Chair, UN Expanded Theme Groups on HIV/AIDS and Charles Petrie, UN Resident Coordinator, Yangon, 28 July 2005.

27. Myanmar: A silent Humanitarian Crisis in the Making, letter of the UN Country Team in Myanmar to the UN Secretary-General, 30 June 2001.

community in exile. As Harn Yawnghwe, director of the Euro Burma Office in Brussels, argued in 2003:

"Many Burmese within the exiled communities will say that what is needed now, immediately, is not assistance but strong and de-

Asia embraces harm reduction

Burma does not stand alone in its endorsement of harm reduction services. Asia as a whole is shifting away from its zero-tolerant drug control approach to a more pragmatic response to injecting drug use. The only effective way to reverse the HIV/AIDS epidemic is a comprehensive package of harm reduction measures to reduce the sharing of contaminated needles among drug users, to urge them to adopt safer injection or non-injection consumption patterns, offer them treatment to reduce or end their drug use, and promotion of safe sex practices.

Low-threshold drop-in centres, alternative (non-prison) sentences and decriminalisation of drug users are essential components of the package in order to reach out to the high-risk groups. Ensuring wide availability of condoms and sterile needles and syringes, and offering substitution treatment with -orally taken - methadone or buprenorphine are the first logical and necessary steps.

*"There is overwhelming, high quality evidence of very effective, safe and cost effective harm reduction strategies to reduce the negative health and social consequences of drug injection. [...] Experience of numerous programs and projects in all regions of the world indicate that HIV/AIDS epidemics among injecting drug users can be prevented, stabilized and even reversed by timely and vigorous harm reduction strategies."*¹

China started pilot needle exchange and methadone projects back in 2000, but is now scaling up harm reduction services at high speed, opening about a hundred methadone treatment centres in the course of 2005 and aiming to provide substitution treatment to 200,000 patients by 2010. In June 2005 the Chinese Health Ministry issued new guidelines in favour of harm reduction approaches and called on local communities around the country to promote needle exchange programmes and free condoms distribution. In predominantly Muslim countries such as Iran, Afghanistan, Pakistan, Malaysia and Indonesia the pragmatic breakthrough has also become apparent. Iran has opened more than 20 methadone clinics over the past three years and established a National Harm Reduction Committee to coordinate fast implementation of country-wide drop-in centres, substitution treatment and distribution of clean injecting equipment, including in prisons.

In Indonesia a review of the highly repressive drug laws is in process and the National AIDS Commission has embraced a harm reduction approach. Malaysia started in October 2005 its first methadone treatment centre and the Health Ministry has announced for 2006 needle exchange and free condom distribution among drug users in three cities.²

The Asian Harm Reduction Network (AHRN), a region-wide information and support network, has played an important role in promoting harm reduction practices and convincing governments of the urgency to implement them. Tariq Zafar, from Pakistan and AHRN Executive Committee Chairperson, warns that though hopeful developments are underway, the extent in practice falls way short of what is needed to effectively confront the epidemic. *"We don't need cosmetic surgery. The coverage is not just poor but I'd say it's pathetic."*³

Meanwhile the war on drugs is still raging on in most Asian countries including unacceptable measures such as death penalties, mass incarceration, extreme prison sentences for simple possession for personal use, etc. Human rights are violated on a daily basis on the continent in name of the fight against drugs. Legal ambiguities and police harassment lead to contradictions in the field. Police in China or Thailand, for example, have been found to round up drug users in the vicinity of drop-in and treatment centres. Fear of arrest is mentioned by drug users in several Asian countries as the main obstacle to access clean needles.

Still, slowly but surely the balance shifts in favour of harm reduction, eroding the justification behind an ongoing repression of drug users. The rising tide in support of harm reduction in Asia has crossed its point of no return.

1. Leadership Statement on Injecting drug use and HIV/AIDS, XV International AIDS Conference in Bangkok, 11-16 July 2004.

2. For more examples of harm reduction advances in Asia, see *Harm Reduction Developments 2005*, International Harm Reduction Development. Program, Open Society Institute, April 2006; or consult the website of the Asian Harm Reduction Network (AHRN) at www.ahrn.net

3. *Is Asia at the Harm Reduction 'Tipping Point'?*, AHRNews, No. 39, August-December 2005.

terminated action to ensure that the political situation will change. They will say that without change, we would only be dealing with the symptoms and not with the root cause of the problem. However, at the same time, we cannot ignore the humanitarian need in Burma and assume that everything will work itself out once political change occurs. The list of what is wrong is endless. (...) The crisis must be tackled now if it is to be contained and if it is not to destabilise the region.”²⁸

In recent years, more funding has become available to counter the HIV/AIDS epidemic. Burma is now one of the three priority countries for the United Nations Joint Programme for HIV/AIDS (UNAIDS), and in 2002 the United Nations Expanded Theme Group on HIV/AIDS was set up to include the Burmese government, donors and INGOs. Four key priorities were identified, translated into five major components, including reducing the individual risk of HIV transmission among IDUs and their partners. In January 2003 the Fund for HIV/AIDS in Myanmar (FHAM) was created to support the Joint Programme for HIV/AIDS, with most of the funds coming from the United Kingdom.

Towards Harm Reduction?

International NGOs and the United Nations Office on Drugs and Crime (UNODC) have played an important role in advocating a more humane approach to drug users in the country. For several years, a number of international NGOs have been running projects to address HIV/AIDS among drug users. Activities related to drug use constitute 50% of the UNODC Myanmar budget; the other half is largely devoted to development programmes in opium-producing areas. It is their biggest partnership with international NGOs next to the Kokang and Wa Initiative (KOWI), an umbrella programme of NGOs and UN agencies to help poppy farmers and their families meet their basic needs without the income derived from opium.

These organisations have set up IDU intervention programmes which directly target IDUs, and include drop-in centres, needle exchange programmes, and methadone treatment centres. Apart from activities related to drug users, there are also clinics for sexually transmitted infections. These clinics provide voluntary and confidential counselling and testing. There has also been an increase in the number of patients visiting the clinics that have received HIV tests and post-test

counselling. The number of townships offering HIV tests and post-test counselling, and prevention of mother-to-child transmission, have both increased. However, all of these services are still limited and need to be scaled up in order to be effective.

Officially, the government has acknowledged the important role international agencies can play in harm reduction activities. At an ASEAN forum on the prevention of drugs and substance abuse at the end of 2004, the new Minister of Home Affairs (after the SPDC leadership change – see below) stated:

“The harm reduction initiatives, in conjunction with on-going demand reduction activities, are now being strengthened through numerous interventions of local and international NGOs throughout the country. In this connection, I can fairly say that the community outreach approach initiated by NGOs is far more effective than the institutional approach pursued by the government.”²⁹

The Minister also stated that he hoped the meeting would discuss:

“Ways and means to step up interventions in the fields of supply, demand and harm reduction; to ascertain the problems of drug abuse; and to discuss the most effective ways to identify and address the undesirable consequences of illicit drugs use.”³⁰

So even in Burma, the trend is towards harm reduction approaches, including needle exchange and substitution treatment. However, HIV/AIDS infection among drug users remains a sensitive issue for the government, and there are still many limitations.

Drugs treatment orientated towards abstinence and substitution therapy has only recently been considered on a pilot basis. The penalties for drug use are strict, as the government has criminalised addiction. The 1993 Narcotics Drugs and Psychotropic Substances Law requires drug addicts to regis-

28. Harn Yawngghwe, from his speech ‘Possibilities and dilemma’s of humanitarian assistance to Burma’ delivered at the Burma Day 2003: Political and humanitarian options for the international community, October 8 2003 Brussels/Belgium.

29. Statement made by Major-General Maung Oo, Minister for Home Affairs and Chairman of the Central Committee for Drug Abuse Control at the 14th IFNGO ASEAN NGOs Workshop on Prevention of Drugs and Substance Abuse, 2 December 2004.

30. Ibid.

ter themselves with government medical facilities to undergo treatment and rehabilitation. Failure to register, or being unsuccessful in treatment, is punishable with three to five years' imprisonment. It is estimated that the number of drug users sent to prison is high. According to CCDAC, 22,168 unregistered drugs addicts were arrested in the period from 1988 to the end of 2003. HIV continues to be transmitted in prisons through medical and non-medical injecting. In the mid-1990s, reading materials about HIV transmission were forbidden for prisoners. The present situation is not known.

The capacity and facilities at the government drug treatment centres, set up following the introduction of legislation that made drug treatment compulsorily for addicts, are insufficient, and this has also driven many drug users underground. Those who leave or do not seek treatment risk being arrested and sent to prison.

Needle exchange programmes run by international agencies have expanded but remain controversial in Burma. As in many other countries, more pragmatic thinking on drugs policies apparently started among people in the law enforcement sector first, and not those in the health sector. However, there are indications that the Ministry of Health has recently become more open to harm reduction activities.

Law enforcement activities restrict access to services provided by NGOs for addicts, which in effect forces drug users to go underground and places them beyond reach. INGO access to high-risk behaviour IDUs, such as those in the so-called 'shooting galleries', remains sensitive.

Among the legal obstacles is the Burma Excise Code of 1905, which prohibits the making, selling, possessing or use of a hypodermic needle without licence. In 2001 an order was given not to implement this regulation, but it is unclear how this is put into practice.

Police crackdowns not only decrease NGO access to IDUs, disrupting needle exchange and other services, but also result in the 'conversion' of more smokers into injectors. During police crackdowns, the price of drugs (both smokeable and injectable) increases, with many poorer smokers resorting to injecting, since it is more potent and requires a smaller quantity of the drug to give them the 'high'.³¹

Recent Political Developments

Although rumours about a power struggle within the SPDC leadership were rife for many years, the removal and arrest of Prime Minister and head of Military Intelligence (MI) Lt. General Khin Nyunt in October 2004 still caught most observers by surprise. Officially Lt. General Khin Nyunt was 'permitted to resign on medical grounds,' but the SPDC issued a lengthy statement with allegations of corruption by him and the MI.³² Khin Nyunt was seen as no.3 in the military hierarchy, after SPDC Chairman and Minister of Defence Senior General Than Shwe and SPDC Vice-chairman and Army Commander Vice-senior General Maung Aye. At present Senior General Than Shwe is seen as being in full control of the SPDC.

Khin Nyunt was the main architect of the cease-fire agreements with some 17 armed groups. He was the main contact for these cease-fire groups in the government, and initially there was wide speculation as to how the truces would be affected. However, the SPDC was quick to stress that the leadership change would not affect the cease-fire agreements, the 'seven step roadmap to democracy' including the National Convention, or its foreign policy.³³

Following Khin Nyunt's arrest, the once powerful Military Intelligence was purged and dismantled, and many of its members were arrested. The purge continued for some weeks, not only limited to the MI, but also to others who were associated with Khin Nyunt or his policies. Many government officials felt insecure about their own position and kept a low profile, and avoided having to make any decision that could potentially be seen as controversial.

This has also greatly hindered the ability of UN agencies and international NGOs to work in the country. It led to huge delays for international organisations in getting travel permits for international staff to visit projects in the field, and to get import licenses

31. Personal communication with representative of international NGO in Burma, May 2006.

32. Complete explanation on the developments in the country given by General Thura Shwe Mann (Member of the State Peace and Development Council) and Lt. General Soe Win (Prime Minister) at Zeyar Thiri Hall 24 October 2004, and explanation by Secretary-1, Lt. General Thein Sein, Chairman of the National Convention Convening Commission, 22 October 2004.

33. Ibid.

for medicines. There was almost no access to high-ranking government officials.

Since the leadership change, the space for humanitarian assistance in Burma has shrunk. Within the regime, it was Khin Nyunt and his associates who were keen to develop relations with international NGOs and UN agencies, and sign MOUs with them. They advocated letting international organisations work in sensitive border areas, and largely formulated the government's policy towards NGOs. They were also the main contact for international organisations in the government.

Access to the government further deteriorated when it moved to the new capital at Pyinmana, a provincial town some 400 kilometres north of Rangoon. The official name of the new capital is 'Pyinmana Nay Pyi Daw', which translates as 'Pyinmana the Royal City'. Various theories have been suggested to explain the move to the centre of the country. Possible motives include the thought that it would make any potential attack by the US more difficult; that it would allow for better control over regional commanders and ethnic minority armed groups; or that moving civil servants away from the population would help to avoid civic unrest. Another explanation given by some analysts is that SPDC chairman Than Shwe hopes to create his own dynasty, building a new royal city in the tradition of old Burmese kingdoms.³⁴

The move started in late 2005, with civil servants often being given only very short notice to pack and move. The facilities at the new capital are reportedly not ready, and the ministries that have moved have become further isolated. UN agencies and foreign embassies have found it much more difficult to communicate with their counterpart ministries after the move.

The National Convention, the SPDC's vehicle for political reform, has convened on and off since its inception in 1993. It was adjourned again in April 2006, and the SPDC has announced it will commence again by the end of the year. The political impasse remains, as opposition leader Aung San Suu Kyi is still under house arrest and the dialogue process between her and the SPDC, initiated at the end of 2000 and facilitated by Malaysian diplomat Tan Sri Razali Ismael, the UN Secretary-General's special envoy for Burma, seems to have come to a definitive end. Pressure on fellow party members of the opposition National League for Democracy

(NLD) increased in 2006, with some members being forced to resign by the government. The SPDC has also threatened to declare the party 'an unlawful association', which would further marginalise it.³⁵

Meanwhile, there has been increasing pressure on ethnic minority groups. The temporary ceasefire agreement between the SPDC and the Karen National Union (KNU) seems to have come to an end after a major new government offensive against the KNU. The Burmese army launched a military campaign in northern Karen State, the largest since 1997. The offensive has already displaced over 10,000 Karen civilians.³⁶

Pressure from the government on the ceasefire groups has also increased. A number of them have been disarmed. The arrest of a number of prominent Shan leaders in February 2005 is a further sign of increased pressure on ethnic minority organisations.

During ceasefire negotiations, the SPDC told the armed groups to wait until the National Convention had finalised the new constitution, and a new government had been formed, for a political agreement. However, until now none of the proposals of the ceasefire groups, who attend the National Convention, have been met. The intensified pressure on the ceasefire groups could potentially lead to a renewal of hostilities. This could lead to further fragmentation and instability in the country, and a growing space for illegal activities, including drug trafficking, logging, other black market trading, gambling, and human trafficking. All these factors will also have a negative impact on humanitarian work in these areas.

New Restrictions on NGOs

At a meeting in February 2006 the Minister of Planning presented UN Agencies and international NGOs with new guidelines for humanitarian aid. These guidelines, if implemented, will impose new restrictions on their operations. According to the document:

"It is clearly observed that there are many [programmes] that will benefit both sides

34. Larry Jagan, *Uneasy Lies the Crown in Myanmar*, Asia Times, April 4, 2006.

35. *NLD Under New Threat*, April 27, 2006, Irrawaddy, Yeni.

36. *UN Must Act to end Attacks on Karen*, Human Rights Watch, New York, May 3, 2006.

and contribute to the well being of the communities in Myanmar. It is also observed that UN Agencies, international NGOs and [local NGOs] which have been providing assistance for the socio-economic development of Myanmar should be systematically coordinated and guided so as to achieve more effective and efficient outcomes. Myanmar welcomes the assistance being provided by these organisations. Myanmar side will cooperate and give support for the successful implementation of these cooperation programmes and projects."³⁷

There are three serious problems with the new guidelines. First of all the document starts off by listing the political objectives of the SPDC. This politicises humanitarian action, and will most likely be opposed by UN agencies and international NGOs. Secondly, there are some serious concerns over the establishment of the control mechanism for humanitarian action at the sub-nation level by local authorities. Furthermore, it is extremely unlikely that the requirement that all national staff can only be selected from a list of candidates provided by the government will be accepted by international organisations and their donors.

The UN has made clear that the international community cannot accept the regulations as they currently stand. These new guidelines from the government, if implemented, could effectively put an end to humanitarian aid to Burma. It is, as yet, unclear how the government will respond.

Amidst increasingly difficult circumstances, two international NGOs ceased operations in the country in early 2006. In February the authorities closed the office of the Centre for Humanitarian Dialogue. The organisation's representative played an important role as mediator between opposition leader Aung San Suu Kyi and the military government. He was also the de-facto local representative for Razali Ismail, the former UN special envoy to Burma, and for the International Labour Organization and the UN Special Rapporteur on the situation of human rights in Burma. The organisation hopes that the closure of its office is only temporary, and that the authorities will re-consider their position in the near future.³⁸

In March 2006 Medecins Sans Frontieres (MSF) France left the country "*because of unacceptable conditions imposed by the authorities on how to provide relief to people*

living in war-affected areas".³⁹ Since 2001, MSF-France had been implementing a malaria treatment project in Mon and Karen State. After the removal of Khin Nyunt at the end of 2004, new travel restrictions on MSF staff and government pressure on local health authorities not to work with MSF-France reduced access to the population. MSF-Holland and MSF-Switzerland continue to work in Burma.

The Termination of the Global Fund

A major blow to efforts to combat the HIV/AIDS epidemic was the decision in August 2005 of the Global Fund for HIV/AIDS, TB and malaria to end its grants agreements to Burma, citing new travel restrictions imposed on international NGOs.⁴⁰ The Global Fund would have contributed 98.5 million dollars over five years to combat AIDS, malaria and tuberculosis in Burma. The UNPD was the principal recipient of the Global Fund.

The move has angered many NGO workers in Burma. They argue that after intensive lobby by US-based advocacy groups, the US government has, for political reasons, imposed restrictions on the Global Fund that would make implementation impossible.

"If this is seen as the impossibility of providing humanitarian aid to Burma this will be a major setback to wider humanitarian action in Burma," says the UN Resident Representative in Burma Charles Petrie. *"It is possible to implement humanitarian operations in Burma. It is complicated, necessitates tremendous efforts and time, and it is that level of flexibility that the Global Fund private public partnership was not able to accommodate, and led to the decision to terminate."*⁴¹

At the end of 2004, three US Senators had called on the Global Fund to "*cease additional funding for Burma and other state*

37. Ministry of National Planning and Economic Development, *Guidelines for UN Agencies, International Organisations and NGOs / INGOs on Cooperation Programme in Myanmar*, February 2006.

38. *Myanmar Junta Forces out International Mediator with Suu Kyi ties*, March 3, 2006 Agence France Presse.

39. *Prevented from Working, the French Section of MSF Leaves Myanmar*, March 30, 2006, Reuters.

40. *The Global Fund Terminates Grants to Myanmar*, Global Fund, 19 August 2005.

41. Interview with Charles Petrie, UN Resident Coordinator, quoted in: Tom Kramer, *Kicking the Habit*, The Irrawaddy, October 2005, Vol.13, No.10.

sponsors of terrorism", and labelled funding as "reckless":

"While we take no issue with appropriate measures to assist the Burmese people, we

are appalled that the Global Fund and the United Nations Development Programme seemingly fail to recognise that the SPDC is solely responsible for creating the myriad humanitarian crisis faced by Burma today –

US, UN and harm reduction

Developments in Asia reflect a global trend of increasing support for harm reduction approaches, which prompted the Bush administration and drug warriors in US Congress to launch a counter-attack. The US government - the biggest donor of UNODC - threatened to cut funding to the agency unless UNODC would abstain from any involvement in or expression of support for harm reduction, including needle exchange programmes.¹ US Congress maintains a ban on the use of federal funds for needle exchange, endangering the continuation of various USAID-supported programmes in Asia. Opinion-leading newspapers condemned the US pressure in their editorials in strong wordings. The New York Times on February 26 2005 referred to *"a triumph of ideology over science, logic and compassion"* and urged the Bush administration to *"call off their budding witch hunt"* against needle exchange; they *"should at least allow the rest of the world to get on with saving millions of lives."* The Washington Post one day later, under the title 'Deadly Ignorance', called on the US government *"to end this bullying flat-earthism"*.

The US pressure became a highly tense issue at the 48th session of the UN Commission on Narcotic Drugs (CND) in March 2005 in Vienna, the UN body providing policy guidance to UNODC. Delegates from around the globe stood up to defend the overwhelming evidence that harm reduction measures are effective against the spread of HIV/AIDS. In a marked shift from previous years, the European Union presented a common position on this issue, and Latin American, African and Asian countries almost unanimously showed support for harm reduction programmes. The CND session thus became an impressive demonstration of changed attitudes around the world concerning harm reduction in the HIV/AIDS context. The US maintained its moral opposition, arguing that harm reduction practices allow for drug abuse to continue and that the only answer should be to enforce abstinence.² A resolution that tried to provide UNODC with a mandate to continue providing technical support for harm reduction programmes, as UNODC Myanmar has been doing past years, could not be adopted because of US objections.

In June 2005, the issue re-appeared at the meeting of the Programme Coordinating Board of UNAIDS in Geneva. Again the US delegation initially insisted that all references to needle exchange be removed from the document. Again, the NYT devoted an editorial (27 June), referring to the US taking *"a breathtakingly dangerous step"*. Fortunately, this time the US was forced back by a unified front and reduced their opposition to the inclusion of a footnote saying that the US *"cannot be expected to fund activities inconsistent with its own national laws and policies"*.

A UNAIDS strategy on intensifying HIV prevention could be approved with the support of all member states and UN co-sponsoring agencies, that includes a clear call for the urgent expansion of harm reduction measures amongst drug injectors in countries experiencing, or at risk of, HIV epidemics.³ At the 49th CND session in March 2006, a resolution was adopted that endorsed the outcomes of the UNAIDS board meeting, thereby providing UNODC with a mandate to provide assistance in accordance with the UNAIDS guidelines.⁴

The US still did not allow to use the terms harm reduction, sterile injecting equipment or needle and syringe programmes in the text of the CND resolution, but indirectly the reference to other UN-approved documents should allow UNODC to support harm reduction projects where requested.

1. *The United Nations and Harm Reduction*, TNI Drug Policy Briefing 12, Amsterdam March 2005.

2. *The United Nations and Harm Reduction – Revisited: An Unauthorized Report on the Outcomes of the 48th CND Session*, TNI Drug Policy Briefing 13, Amsterdam April, 2005.

3. *UNAIDS & The prevention of HIV infection through injecting drug use*, Briefing Paper 9, Beckley Foundation Drug Policy Programme (BFDPP), London September 2005; and *Harm Reduction Developments 2005*, International Harm Reduction Development Program, Open Society Institute, April 2006.

4. *Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users*, Resolution 49/4, Commission on Narcotic Drugs, Report on the forty-ninth session (8 December 2005 and 13-17 March 2006), E/CN.7/2006/10.

whether an exploding HIV/AIDS rate, a ruined economy, a high rate of poverty, or a political environment marked by torture rape, intimidation and imprisonment."⁴²

Furthermore, the US Congress adopted a resolution which stipulated that US contributions to the Global Fund be withheld by any amount "expended by the Global Fund to Fight AIDS, Tuberculosis and Malaria to the State Peace and Development Council in Burma, directly or through groups and organisations affiliated with the Global Fund".⁴³

Pressure was also put on the UNDP directly, by trying to impose severe financial constraints on its operations. The UNDP's mandate restricts formal contacts with the SPDC. European donors have preferred to interpret this mandate in a flexible way, among others to allow the UNDP to carry out community development programmes as well as facilitating a response to address the HIV/AIDS crisis.

In contrast, the Washington-based lobby started to push for a more strict interpretation of the UNDP mandate. This would have led to a significant decrease of the UNDP operation's presence in Burma. The end result was that the UNDP decided that, under these circumstances, it was unable to carry out its role as principal recipient of the Global Fund.⁴⁴

Losing Hope

The withdrawal also caused some strong reactions from inside Burma. In the past, the exile community and international campaign groups have dominated the debate on international policies towards the country. Very few local actors from inside the country, who are involved in on the ground and community-based programmes, have been able to express their views in public forums and participate in international discussions on humanitarian aid to Burma.

In an unprecedented move, a group of People Living with HIV/AIDS (PLWHA) in Burma released a statement expressing deep concern over the potential withdrawal of the Global Fund from Burma:

"As people whose lives will be affected by the decision to withdraw, we would like to request the Global Fund and the Principal Recipient in Myanmar to seek alternative arrangements to safeguard the humanitarian

*elements of the programme. We would also like to request that the Global Fund and the Principal Recipient in Myanmar clearly explain the reasons and the process which have led to the consideration to withdraw".*⁴⁵

For PLWHA it is a matter of life and death: "I am afraid that the withdrawal of the Global Fund project will have an impact on my ARV treatments", says a PLWHA. "If we buy the drugs from the private sector, it costs about Kyats 40,000 (about US\$40) per month. For most people in Myanmar, this is their whole monthly income."

Furthermore, following the announcement of the withdrawal of the Global Fund, a group of well-known student leaders in Burma, who played a leading role during the 1988 demonstrations, stated that the humanitarian situation in the country was at a critical point, and called upon the international community to continue providing humanitarian aid to Burma. The group was led by Min Ko Naing who, like many other group members, had been recently released after serving a long jail term. According to Min Ko Naing:

*"The crisis of health and education in Burma is in an alarming stage, and effective measures should be taken immediately. Only international cooperation and humanitarian aid will resolve the problems effectively."*⁴⁶

The group also called on the SPDC and opposition groups to work together to meet the humanitarian needs of the country, and for the removal of government restrictions on international aid agencies.

International NGOs in Burma are worried that the withdrawal of the Global Fund will lead more people to become infected with HIV. Many people in Burma still do not have a good understanding of HIV and AIDS. The majority have never had a HIV test; and many of them only realise they have AIDS at

42. Sam Brownback, United States Senator, Kansas, *Brownback, Gregg, McConnell Call on Global Fund to Cease Funding Burma*, October 5, 2004.

43. House Report 109-265 – Making Appropriations for Foreign Operations, Export Financing, and Related Programs for the Fiscal Year Ending September 30, 2006, and for other Purposes, Library of Congress.

44. Confidential correspondence, August 2005.

45. Statement of Concern, Access to Treatment for People Living With HIV/AIDS, 21 August 2005.

46. Burma's Former Students Leaders Call for Humanitarian Aid, The Irrawaddy, 7 September, 2005.

a very late stage. The Global Fund could have played an important role in supporting and scaling-up its pilot projects. International agencies therefore desperately started looking for means to compensate for the loss resulting from the Global Fund's decision.

*"When I was suddenly faced with AIDS, all the people around me were afraid and left me. Now I think only of my two sons... I was surprised to hear about ARV drugs and it gave a new hope for us", adds another PLWHA. "But now we have heard that we may lose this hope again. If there is no ARV, my two sons who have just lost their father, will lose their mother very soon. If that happens, I cannot imagine what will happen to them."*⁴⁷

In Burma, PLWHA have not had any say at all in these policies from which they stand to suffer the most. It is vital that local communities and organisations that represent them are given a voice in decision-making processes that have such a tremendous impact on their health, lives, and livelihoods.

The changing political environment and the termination of Global Fund activities has been a big blow to a decade of painstaking advocacy and diplomacy for greater acceptability of harm reduction. The aid agencies' initial strategy was to wait and see, and things have improved a lot, as travel restrictions, compulsory escorts etc. have all declined.

International NGOs believe that much can be accomplished by local level advocacy and diplomacy. Collaboration with the Department of Health for the first ever methadone substitution program is an example, with the aim being to:

*"Influence and win over the minority of positive-minded people within the set-up, facilitate un-official manoeuvres, and be able to deliver on the ground to the beneficiaries. By working together we are able to build up capacity of the health providers and improve wrong practices. This makes the interventions and investments of the international NGOs itself more sustainable."*⁴⁸

Filling the Gap: 'The 3D Fund'

There was clearly frustration among some EU countries about the withdrawal of the Global Fund from Burma, and the role of the US in this. According to European Commis-

sion Director General for External Relations Eneko Landaburu:

*"The European Commission has regretted that the Global Fund for AIDS, Tuberculosis and Malaria has ended its operations in Myanmar in 2005... We cannot simply look the other way while knowing that there are serious humanitarian and developmental problems in an important country in South-east Asia like Burma... More strategically planned assistance is needed to ensure basic services in important areas, such as health and education. Not offering it will only endanger the future of younger generations."*⁴⁹

In response to the public health crisis in Burma, and to fill the gap created by the withdrawal of the Global Fund, a number of mostly European donors decided to create a new mechanism: the Three Diseases Fund.

The fund, which quickly became known as 'The 3D Fund', is meant solely to combat malaria, TB and HIV/AIDS in Burma. Donors who have committed themselves include the European Commission, the United Kingdom, the Netherlands, Sweden, Norway, Switzerland and Australia.

The fund also fits within the mandate of the EU Common Position on Burma, which includes a number of sanctions such as a weapons embargo, a visa ban for senior SPDC members and the freezing of their assets, and a moratorium on development aid. However, the Common Position also creates space for humanitarian assistance, in particular for the fight against HIV/AIDS.

The United Nations Office for Project Services (UNOPS), which provides technical and administrative support to other UN programmes on a per-project basis, has been assigned to hold, disperse and monitor the fund. The 3D Fund should be operational by November 2006, when the Global Fund grants run out. The 3D Fund does not have the same restrictions as the Global Fund would have had.

47. We need Your Support, Statement by People Living with HIV/AIDS in reaction to the withdrawal of the Global Fund from Myanmar, 9 September 2005.

48. Personal communication with representative of international NGO in Burma, May 2006.

49. Eneko Landaburu, European Commission Director General for External Relations, *Supporting People – Assisting Transition*, Burma/Myanmar Forum, Brussels, March 29, 2006.

The European Community Humanitarian Office (ECHO) opened an office in Rangoon in October 2005, which the EU feels is a positive sign. Of the total budget of ECHO about 50% is being spent on health, with the rest going to protection, water and sanitation, and food aid.

Conclusion

The simultaneous spread of HIV/AIDS and the growing number of injecting drug users is fuelling the HIV/AIDS epidemic. Current programmes reach only a small proportion of IDUs with harm reduction interventions. There are no existing programmes available for IDUs who are sexually active to protect themselves and their sexual partners from HIV. The second major risk group are sex workers. Current programmes reach only a very small number of them, and the number of AIDS deaths among them is estimated to be high.

In order to effectively address the spiralling numbers of HIV/AIDS infected drug users, it is extremely important for all stakeholders involved to acknowledge the HIV/AIDS epidemic and the need for harm reduction policies. It is key for all sides to de-politicise HIV/AIDS.

The international community needs to make a firm international commitment to stem and reverse the HIV/AIDS epidemic in Burma. It should ensure sufficient and long-

term financial support for HIV/AIDS and harm reduction programmes.

The SPDC needs to provide adequate space for humanitarian aid to take place. The new guidelines that have been proposed by the government should be amended to ensure direct and unhindered access for international aid agencies to local communities. The space for initial harm reduction initiatives is encouraging, but needs to be scaled up in order to be effective.

Perhaps the most serious shortcoming however is the fact that local community-based organisations in Burma have not been able to participate in the debate about international humanitarian aid to Burma. In particular, in the discussions about the funding for programmes on HIV/AIDS, People Living With HIV/AIDS (PLWHA), and drug users or the organisations that represent them, have not been consulted or been able to participate in the formulation of policies and decision-making processes that have such tremendous impact on their health, livelihoods and lives.

The international community should also support and strengthen efforts by drug users and PLWHA to organise themselves. This will enable them to voice their opinion and represent their interests better at the local as well as international level. It will also contribute to civil society building and democratisation in the country.



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