DRUGS AND HIV/AIDS
Country Programme (2009-2010)
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Drug Demand Reduction, Drugs and HIV/AIDS Unit
December 2008

Yangon, 2008
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The boundaries, names and designations used in all maps in this book do not imply official endorsement or acceptance by the United Nations.

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ATS: Amphetamine-type stimulants (ATS) are a group of substances comprising synthetic stimulants including amphetamine, methamphetamine, methcathinone and ecstasy-group substances (e.g. MDMA and its analogues). In various sections of this report, amphetamine and methamphetamine are also referred to as "amphetamines-group substances".

In cases where countries report to UNODC without indicating the specific ATS they are referring to, the term “non-specified amphetamines” is used. Tablets that are marketed to contain an ecstasy-group substance, but may actually contain a variety of other substances, are referred to as “ecstasy”.

Terms: Since there is some scientific and legal ambiguity about the distinctions between drug "use", "misuse" and "abuse", this publication uses the neutral terms, drug "use" or "consumption".

Currency: References to dollars ($) denote United States dollars unless otherwise indicated.

Map: The boundaries and names shown and the designations used on maps do not imply official endorsement or acceptance by the United Nations.

In various sections, this report uses a number of regional designations. These are not official designations. They are defined as follows:

East and South East Asia: Brunei Darussalam; Cambodia; China; Hong Kong, China; Macau, China; Taiwan Province of China; Indonesia; Japan; Republic of Korea; Lao People’s Democratic Republic; Malaysia; Mongolia; Myanmar; Philippines; Singapore; Thailand; and Viet Nam

Greater Mekong Sub-region (GMS): Cambodia, Lao People’s Democratic Republic, Myanmar, Thailand, Viet Nam and bordering provinces of China

North East Asia: Japan, Philippines and Republic of Korea

Southern Archipelago: Brunei Darussalam, Indonesia, Malaysia and Singapore

South Asia: Bangladesh, India, Maldives, Nepal and Sri Lanka

Central Asia and countries of the Caucasus: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

The following abbreviations have been used in this publication:

- 3DF: 3 Diseases Fund
- ACC: Administrative Committee on Coordination
- AHRN: Asian Harm Reduction Network
- AIDS: acquired immune deficiency syndrome
- APMG: AIDS Projects Management Group
- APO: annual plan of operations
- ART: antiretroviral therapy
- ATS: amphetamine-type stimulants
- AusAID: Australian Agency for International Development
- AZG: Médecins Sans Frontières Holland
- BI: Burnet Institute
- CARE: CARE International
- CBO: community based organization
- CFP: Country Flexible Programme (country level element of HAARP)
- COMYA: UNODC Country Office Myanmar
- CSO: Central Statistical Organization
- DU: drug user
- EC: European Commission
- FBO: faith based organization
- FO: field office
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
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<tbody>
<tr>
<td>CCDAC</td>
<td>Central Committee for Drug Abuse Control</td>
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<tr>
<td>HAARP</td>
<td>HIV/AIDS Asia Regional Programme (AusAID supported)</td>
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<tr>
<td>HCCF</td>
<td>HAARP Coordination and Consultation Forum</td>
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<tr>
<td>HDI</td>
<td>human development index</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>HQ</td>
<td>headquarters</td>
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<tr>
<td>IAC</td>
<td>International AIDS Conference</td>
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<td>ICAAP</td>
<td>International Congress on AIDS in Asia and the Pacific</td>
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<tr>
<td>ICPA</td>
<td>International Congress of Prison Administrators</td>
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<tr>
<td>IDU</td>
<td>injecting drug user</td>
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<tr>
<td>IHRA</td>
<td>International Harm Reduction Association</td>
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<td>IHRC</td>
<td>International Harm Reduction Conference</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>INGO</td>
<td>international nongovernmental organization</td>
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<tr>
<td>JAMA</td>
<td>Journal of American Medical Association</td>
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<td>MANA</td>
<td>Myanmar Anti-Narcotics Association</td>
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<td>MBC</td>
<td>Myanmar Baptist Convention</td>
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<td>MBCA</td>
<td>Myanmar Business Coalition on AIDS</td>
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<td>MCC</td>
<td>Myanmar Council of Churches</td>
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<td>MdM</td>
<td>Médecins du Monde</td>
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<td>MDMA</td>
<td>3,4-methylenedioxymethamphetamine</td>
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<td>MMT</td>
<td>methadone maintenance treatment</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MPG</td>
<td>Myanmar Positive Group</td>
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<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
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<td>NAP</td>
<td>National AIDS Control Programme, Department of Health, Ministry of Health</td>
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<tr>
<td>NATALA</td>
<td>Ministry of Progress of Border Areas and National Races and Development Affairs</td>
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<tr>
<td>NDARC</td>
<td>National Drug and Alcohol Research Centre</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<tr>
<td>PLHIV</td>
<td>people living with HIV</td>
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<td>PSI</td>
<td>Population Services International</td>
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<tr>
<td>PVHT</td>
<td>people vulnerable to human trafficking</td>
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<td>SARA</td>
<td>Substance Abuse Research Association</td>
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<tr>
<td>SHG</td>
<td>self help group</td>
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<tr>
<td>SPF</td>
<td>Strategic Programme Framework</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infections</td>
</tr>
<tr>
<td>ToR</td>
<td>terms of reference</td>
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<tr>
<td>TSG</td>
<td>Technical Strategic Group</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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</tbody>
</table>
UNICEF  United Nations Children’s Fund
UNODC  United Nations Office on Drugs and Crime
UNOPS  United Nations Office for Project Services
UNSD  United Nations Statistics Division
UNTG  UN Expanded Theme Group on HIV/AIDS
VSWA  Voluntary Social Worker Association
VCT  voluntary counselling and testing
VCCT  voluntary confidential counselling and testing
WB  World Bank
WC  World Concern
WFP  World Food Programme
WHO  World Health Organization
YET  Youth Empowerment Team

Weights and measurements

mt  metric ton
mg  milligram
Activities, UNODC Myanmar, 2008

Activities
- Police TOT training
- Prison TOT training
- Drop-in center

Data Source: UNODC Myanmar. Place-name sources: Myanmar Information Management Service/UNODC. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
The use of contaminated needles and syringes by drug users accounts for 10.0 per cent of global HIV infections and 30.0 per cent of those outside of Sub-Saharan Africa.
The United Nations Office on Drugs and Crime (formerly the Office for Drug Control and Crime Prevention) was set up in 1997, combining the United Nations Centre for International Crime Prevention and the United Nations International Drug Control Programme. It was established by the Secretary-General of the United Nations to enable the organization to focus and enhance its capacity to address the interrelated issues of drug control, crime prevention and international terrorism in all its forms. The mandate of the Office derives from several conventions and General Assembly resolutions, and the Office’s technical cooperation programme aims to help improve the capacity of governments to execute those international commitments. The Office is headed by an Executive Director, appointed by the Secretary-General, and is co-located with the United Nations Office in Vienna. The Executive Director also serves as the Director-General.

The present Drugs and HIV/AIDS Country Programme is informed by international development agendas such as the Millennium Development Goals, as well as the United Nations General Assembly Special Session on AIDS, and it is based on the National Strategic and Operation Plan on AIDS in Myanmar. It also takes account of the priorities of the UNODC Country Office constituents, as expressed in consultations held with them. The programme details the policies, strategies and results required to realize progress towards achieving its universal access targets for HIV prevention, treatment and care services among injecting drug users, in institutionalized populations and for people who have been trafficked or are at risk of being trafficked.

This publication reflects the strategic planning of UNODC Country Office Myanmar Drug Demand Reduction, Drugs and HIV/AIDS Unit cooperation activities with Myanmar for the period 2009-2010. Reflecting the constituents’ as well as the UNODC Country Office Myanmar assessment of past cooperation, the Programme aims at ensuring greater synergies and stronger coherence of UNODC Country Office Myanmar support to Myanmar and thus contributes to achieving impact and sustainable outcomes.

The UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme was developed through a participatory process based on extensive consultations with all relevant stakeholders, including UNODC Global HIV/AIDS teams based in Vienna and around the world, the UNODC Regional Centre for East Asia and the Pacific based in Bangkok, and with staff of the UNODC Country Office Myanmar Drugs and HIV/AIDS Team, United Nations sister agencies, Government of Myanmar ministries/agencies, international nongovernmental organizations (INGOs), nongovernmental organizations (NGOs), non-profit organizations (NPOs), community based organizations (CBOs), faith based organizations (FBOs), academic and research institutions, self help groups (SHGs), injecting drug users (IDUs), people living with HIV (PLHIVs) and private sector partners located in Yangon as well as in the regions.

The Drugs and HIV/AIDS Country Programme consists of a narrative part outlining the context, the strategy and a work plan that details the interventions. This publication is expected to evolve over time, benefiting from practitioners’ experience and feedback.
1. Overview

1.1. Background

The United Nations Office on Drugs and Crime (UNODC) mandates, derived largely from related United Nations (UN) conventions, protocols and resolutions of the General Assembly, are aimed at assisting Member States to effectively cope with the effects of illicit drugs, crime and terrorism. These mandates also cover primary prevention of drug use, drug dependence treatment and rehabilitation, sustainable livelihoods and supply reduction, as well as crime prevention and criminal justice. By extension, transnational organized crime, anti-trafficking, law enforcement, criminal justice reform, anti-corruption, anti-money laundering and terrorism prevention represent components of the mandates.

Taking into account the potential for further spread of human immunodeficiency virus (HIV), UNODC adheres to principles of equality and human rights that support the provision of HIV education, prevention, treatment and care to all, regardless of whether they use or have used illicit drugs, whether they are (or have been) in prison, their occupation or their sexual orientation.

Global information from the World Drug Report 2008 indicates that 4.8 per cent of the adult population globally (15 to 64 years old) used an illicit drug in the preceding 12 months. The monthly prevalence of illicit drug use was 2.6 per cent, while some 0.6 per cent report problematic, i.e. severely dependent, drug use (UNODC, 2008). If global estimates are applied to East Asia and the Pacific, it would suggest that this region includes over 66 million illicit drug users, of whom 36 million could be termed regular users (monthly) and over 8 million users would require drug dependence treatment (UNODC, 2008).

In his preface to the World Drug Report 2008, the Executive Director, Mr. Antonio Maria Costa, noting UNODC policy, calls for progress in three key areas:
• To put public health back at the centre of drug control efforts, balancing the way funds are spent to ensure that demand and the adverse health and social consequences of drug use are reduced;
• To place drug control in the larger context of crime prevention; and
• To uphold human rights and human dignity.

Agencies need accurate and reliable population estimates and qualitative information on the populations most vulnerable to HIV infection if they are to succeed in developing and delivering effective national HIV programmes. Unfortunately, they face considerable challenges in this task because of poor, or often unavailable, data. The 2007 Reference Group to the UN on HIV and Injecting Drug Users noted the following problems with data and its use (Mathers, B., et al, 2008):
• No verifiable estimates of the number of injecting drug users in most of the countries that reported their incidence;
• No published data on whether injecting drug use actually occurred, even though it was reported;
• A lack of consistency in definitions of injecting drug use;
• “Registration” being the only measure of numbers of injecting drug users;
• Definitions of “registration” lacking consistency, ranging from treatment to arrest counts; and
• Samples of limited geographical coverage (making national estimates difficult).

Consequently, HIV incidence and prevalence data in this key population at higher risk is problematic because the denominator itself is unreliable. Crucial qualitative data on the extent of drug use, drugs used, settings for drug use, modes of use, and the relationship between drug use and unsafe sexual behaviour is similarly limited.

A further complication arises because, while it is the use of contaminated injecting equipment that can result in HIV and other blood-borne infections, there is evidence that HIV risk is higher when people first begin injecting (Macquarie University, 1991), suggesting that prevention messages are needed before risk behaviour commences. Data on populations “at risk” of IDU is practically inexistent.
The use of contaminated needles and syringes by drug users accounts for 10.0 per cent of global HIV infections and 30.0 per cent of those outside of Sub-Saharan Africa. East Asia and the Pacific, which account for almost one third of the world’s population, include a number of countries where the use of contaminated needles and syringes by drug users continues to drive the HIV epidemic, including China (42.0 per cent of new infections in 2007), Indonesia (46.0 per cent), Malaysia (65.0 per cent), Viet Nam (44.0 per cent) and Myanmar (HIV prevalence is highest among drug users, at 43.0 per cent [WHO, 2006]). Other countries have concentrated epidemics among drug users and this community continues to report high HIV prevalence, but reliable data on HIV infection among drug users is still insufficient.

1.2. Institutionalized Population

Institutionalized populations covered by this country programme include a range of facilities that limit individual freedom. These include prisons, remand centres, police lock-ups, juvenile detention facilities and compulsory drug treatment centres. Levels of HIV infection tend to be higher in such settings, as do rates for other infectious diseases such as tuberculosis and hepatitis. For example, 28.4 per cent of the estimated 88,000 prisoners in Viet Nam and 20.0 per cent of the 100,000 prisoners in Indonesia are HIV positive. In China and Malaysia, reported HIV prevalence among prisoners is lower, at 4.0 per cent. However, in China this translates to over 60,000 prisoners living with HIV or acquired immune deficiency syndrome (AIDS). The Government of Viet Nam reports HIV prevalence ranging between 40.0 and 50.0 per cent among residents of rehabilitation centres, and that there are between 18,000 and 22,600 people living with HIV in such centres (UNGA S Vietnam, 2008). In Myanmar, 5,951 prisoners out of an estimated 62,300 were reached by health education in 2006 (Ministry of Health, 2006e). The Prison Department under the Ministry of Home Affairs indicated that bleaches have been provided within the prison for prevention of HIV and used for the purpose of making safe and clean water (Ministry of Home Affairs, 2008).

Communicable diseases represent a threat to the health of both inmates and staff. The generally accepted principle that prisons and prisoners remain part of the broader community means that the health threat of HIV within prisons, and the health threat outside of prisons, are inextricably linked (UNODC, 2006), necessitating a coordinated response across community and institutionalized populations. This must include drug dependence treatment centres and services. In the South East Asian region it would appear that the predominant approach to the provision of drug dependence treatment is through compulsory centres. There is no comprehensive mapping or assessment of these centres (UNODC, 2006), but relapse rates are reportedly high, bringing into question their effectiveness and cost-effectiveness (UNODC, 2002; UNODC, 2002a; UNODC, 2003).
1.3. Human Trafficking

Among victims of human trafficking, those trafficked for the purpose of sexual exploitation are, by the form of their ongoing exploitation, most exposed to the risk of HIV/AIDS. All trafficked persons, including those trafficked for forced labour, are, however, vulnerable to HIV/AIDS for similar reasons, including unsafe sex with multiple partners, injecting drug use (voluntary or forced), self-harm and unsafe medical and/or surgical treatment. People who have been trafficked do not, generally, declare their status, the problem is rather that the United Nations definition has not trickled down to the country level and that the status of victim is not clearly understood by victims, enforcement agencies and the society at large. Due, in part, to the clandestine nature of the crime, as well as a lack of awareness of the issue amongst victims, enforcement agencies and society at large, most trafficked persons are never identified as such by themselves, law enforcement and immigration officials, or by non-government organizations (NGO) and other civil society groups, throughout their trafficking experience. Because of this, most services and information aimed at preventing HIV/AIDS often do not reach trafficked persons. A safe mobility strategy should tailor components addressing HIV prevention, treatment and care for delivery at each stage of the trafficking process. Estimates of the number of people trafficked for the purpose of sexual exploitation globally vary from 700,000 to over 4 million annually. Migration in general is often linked to the spread of HIV pandemic for a number of social reasons (Pkhakadze, 2002).

1.4. UNODC Strategy

The UNODC Drugs and HIV/AIDS Country Programme response for Myanmar is in line with UNODC’s approved overarching strategy (United Nations, 2007b) and will contribute to the achievement of security and justice for all by making the world safer from crime, drugs and terrorism, as described in the UNODC mandate. The UNODC Drugs and HIV/AIDS Country Programme enhances UNODC’s comparative advantage in providing a multilateral response to the HIV/AIDS epidemic as it affects injecting drug users and those in institutionalized populations as described in the strategy for the period 2008-2011 for the UNODC in Result area 3.3 (United Nations, 2007b) – HIV/AIDS prevention and care (as related to injecting drug users [IDUs], prison settings [institutionalized populations] and trafficking in human beings), which comes under Theme 3: Prevention, treatment and reintegration and alternative development.

---

1 Convention against Transnational Organized Crime, 2000. Accepted by Myanmar, 30 March 2004, trafficking in human beings defined as: ‘the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation’.

2 Until recently the only reports of HIV risk and HIV infections associated with human trafficking for the purpose of sexual exploitation were drawn from proxy estimates vis-à-vis sex workers; anecdotal and case histories from people assisted through “Victim and Witness Protection Programmes”; and, from people assisted by IOM and various NGOs. Among their narratives are histories of sexual assault, forced unprotected sex, often with multiple partners, and forced injecting drug use. Largely as a result of these reports, it has become received wisdom that all, or the vast majority of people trafficked for the purpose of sexual exploitation experience such abuse.

The first and to date only, robust peer-reviewed paper demonstrating epidemiological evidence for the link between Human Trafficking for the purpose of sexual exploitation and HIV/AIDS was published in the Journal of American Medical Association (JAMA) in August 2007 (Silverman et al, v208(5)). Briefly, the study examined HIV prevalence among women who had been returned to Nepal following trafficking experiences. Over one-third tested positive for HIV, and for people trafficked at age 14 or younger, almost two-thirds tested positive.
1.5. United Nations Division of Labour

Additionally, UNODC has been a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS) since 1999. In 2004 the Office established the global HIV/AIDS programme as a stand-alone initiative, and currently this programme consists of 65 advisors with a wide range of expertise, operating globally with a portfolio of over $100 million. Within the UNAIDS Technical Division of Labour (UNAIDS, 2005), the Office has the lead agency responsibility in two areas: injecting drug use and institutionalized populations. At country level, the role of the lead agency within the UNAIDS technical division of labour is to propose initiatives, enhance coordination and, where necessary, directly support implementation. The Office is also the UN coordinating agency for the HIV/AIDS response to human trafficking.

“HIV epidemics in Asia are diverse but disproportionately affect people who inject drugs, sex workers and their clients, and men who have sex with men. Myanmar is considered to have one of the most serious HIV epidemics in South East Asia. However, the spread of HIV infection across the country is heterogeneous, varying widely by geographical location.”
1.6. UNODC Drugs and HIV/AIDS Policy

UNODC’s work in relation to reducing the adverse health and social consequences of drug abuse and HIV/AIDS prevention, care and support is guided by several policy documents, which are:

- **Declaration on the Guiding Principles of Demand Reduction (UNODC, 1998)** – the publication states that activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and for society as a whole. HIV/AIDS constitutes one of the serious potential harms of drug abuse;

- **Administrative Committee on Coordination (ACC)-approved UN System Position Paper (United Nations, 2002)** – the publication recommends a comprehensive package of prevention and care for IDUs, which could include outreach services, HIV/AIDS education, condoms, drug dependency treatment (including substitution treatment and, where appropriate, rehabilitation), voluntary HIV testing/counselling and psychosocial support;

- **2001 UNGASS Declaration of Commitment on HIV/AIDS (United Nations, 2001)** – the publication sets out general targets for Member States on HIV prevention and specific targets for groups with high or increasing rates of infection, including IDUs;

- **Commission on Narcotic Drugs Resolution E/CN.7/2002/L.3/Rev.1 (United Nations, 2002)** – the publication calls “upon UNODC to continue to cooperate with the Joint United Nations Programme (UNAIDS) and other relevant United Nations entities in introducing and strengthening programmes to address HIV/AIDS”;

- **Intensifying HIV Prevention-UNAIDS Policy Position Paper (UNAIDS, 2005b)** – further to the Administrative Committee on Coordination (ACC)-approved UN System Position Paper, this policy position paper recommends a set of measures to prevent the transmission of HIV through injecting drug use, through the development of a comprehensive, integrated and effective system of measures that consists of a full range of treatment options (notably drug substitution treatment) and the implementation of harm reduction measures (through, among others, peer outreach to injecting drug users, and sterile needle and syringe programmes), voluntary confidential HIV counselling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment for sexually transmitted infections), access to primary healthcare and access to antiretroviral therapy. Such an approach must be based on promoting, protecting and respecting the human rights of drug users;

- **The Joint UNAIDS Statement on HIV Prevention and Care Strategies for Drug Users (UNAIDS, 2005c)**, which acknowledges the strong and consistent evidence that a package of harm reduction interventions significantly reduces injecting drug use and associated risk behaviours and hence prevents, halts and reverses HIV epidemics associated with injecting drug use;

- **Resolution/Political Declaration 60/262 on HIV/AIDS Adopted by the General Assembly in June 2006 (United Nations, 2006)** reiterated the urgent need to scale up activities significantly towards the goal of universal access to comprehensive HIV prevention programmes, treatment, care and support by 2010;

- **Technical Support on AIDS: Division of Labour of UN Organizations in Myanmar against Globally Defined Areas of Work protocol (Ministry of Health, 2006a)**; and

- **UNODC globally and in Myanmar has the mandate of “prevention of transmission of HIV among injecting drug users and in prisons” (UNAIDS, 2005)**.

The UNODC Drugs and HIV/AIDS Country Programme will further promote those policies in Myanmar.
1.7. HIV/AIDS Situation in Myanmar

Myanmar’s estimated population in 2005 was 54.3 million people (Central Statistical Organization, 2005), while some experts believe the real figure is between 43.0 and 51.0 million (AIDS Project Management Group, 2005), 46.4 [United Nations, 2007], 48.0 [United Nations, 2006a], 48.8 [United Nations, 2007a], 50.5 [UNAIDS, 2008], 51.0 [UNSD, 2008]). The estimates of population growth rate (PGR) in the country also vary from 0.9 to 2.02 depending on the source (0.9 per cent [United Nations, 2007a], 1.1 per cent [UNAIDS, 2008], 2.02 per cent [Central Statistical Organization, 2005]). Life expectancy at birth in the country is 62.9 years for women (United Nations, 2007a) and 57.4 years for men (United Nations, 2007a). The Myanmar Human Development Index (HDI) is 0.6, and the country is ranked 130th – while neighbouring Bangladesh is ranked 137th, China 81st, India 126th, Lao People’s Democratic Republic 133rd and Thailand 74th (United Nations, 2007a).

HIV epidemics in Asia are diverse but disproportionately affect people who inject drugs, sex workers and their clients, and men who have sex with men. Myanmar is considered to have one of the most serious HIV epidemics in South East Asia (UNAIDS, 2007). However, the spread of HIV infection across the country is heterogeneous, varying widely by geographical location. In Tanintharyi Division, for instance, HIV is the single leading cause of mortality (for 3.2 per cent of patients in 2005 [Ministry of Health, 2006c]). In Pyay and Hpa-an respectively, 5.0 per cent and 7.5 per cent of pregnant women tested HIV positive in 2003, while 50.0 per cent to 85.0 per cent of IDUs tested in Yangon and Mandalay in 2003 were HIV positive (WHO, 2008). Prevalence also varies among population sub-groups: HIV prevalence among male clients of STI clinics is 4.1 per cent, sex workers 32.0 per cent and injecting drug users from 41.0 per cent (Wiwat, P., 2007) to 43.2 per cent (Ministry of Health, 2007).

The national average prevalence of HIV infection among adults (15 to 49 years) is estimated from 0.67 per cent (Ministry of Health, 2007c) to 1.3 per cent (range 0.7 to 2.0 per cent, 2007) (UNAIDS, 2008), or 1.4 per cent (1993) (Baker, Bühler and Petrie, 2008). By the end of 2004, 8,921 AIDS cases were registered by the National AIDS Control Programme, Department of Health, Ministry of Health of Myanmar (WHO, 2005). The total estimated number of adults living with HIV varies from 230,000 (Ministry of Health, 2007c) to 338,911 (WHO, 2007) or 360,000 (UNAIDS, 2006c) depending on the source.

3 The average annual per cent change in the population, resulting from a surplus (or deficit) of births over deaths and the balance of migrants entering and leaving a country. The rate may be positive or negative.
4 The Commission on AIDS in Asia concluded that 75 per cent or more of new infections were occurring among these most vulnerable populations. Report of the Commission on AIDS in Asia, 2008 (p. 31).
5 Some experts believe that Myanmar is a high HIV prevalence country (Reid, Costigan, 2002) with a generalized/concentrated epidemic (APMG, 2005) among drug users (as in China, Indonesia, Malaysia and Viet Nam). Reliable data is not available, and all figures should be treated with great caution. (Generalized: HIV prevalence more than 1 per cent among antenatal women. Concentrated: HIV prevalence more than 5 per cent in high risk groups but below 1 per cent in antenatal women. Low level epidemic: HIV prevalence less than 5 per cent in high risk groups and less than 1 per cent in antenatal women.)
6 The estimation workshop held in Mandalay in August 2007, with the Myanmar Government, UN, INGOs and NGOs. The results estimate that 242,000 adults and children were living with HIV in Myanmar at the end of 2007 (or 0.67 per cent, within a range of 0.5 per cent to 0.9 per cent).
It is also estimated that in 2007 13,000 new infections among adults occurred, while the annual number of AIDS deaths was 24,000 persons (Ministry of Health, 2007c). The number of children living with HIV in Myanmar is estimated at 6,000 (Ministry of Health, 2007c). Out of 73,000 adults in need of ART (Ministry of Health, 2007c), only 6,476 received ART in 2006, of which 63.0 per cent were male and 4.8 per cent were children under 13 years of age (Ministry of Health, 2007b). AIDS has already reduced life expectancy in Myanmar, although by a relatively small margin. It is estimated that life expectancy in Myanmar in 2005 was 1.7 years lower than it would have been in the absence of an AIDS epidemic. As a point of comparison, life expectancy was reduced by three years in Cambodia and one year in India and Thailand (Commission on AIDS in Asia, 2008).

As in other countries of the region, the HIV epidemic in Myanmar is driven mostly by heterosexual transmission (approximately 65.0 per cent [Ministry of Health, 2005] or 68.0 per cent [WHO, 2005]) and injecting drug use (26.0 per cent in 2003 [MOH, 2005]; 30.0 per cent [WHO, 2005] to 42.5 per cent [Ministry of Health, 2006a] in 2005; or 43.24 per cent in 2005, 34.2 per cent in 2004 and 48 per cent in 2003 [Central Committee for Drug Abuse Control, 2008]). The epidemic in Myanmar is showing signs of a decline along with Cambodia and Thailand (UNAIDS, 2007), with HIV prevalence among pregnant women at antenatal clinics having dropped from 2.2 per cent in 2000 to 1.5 per cent in 2006 (Ministry of Health, 2007). Despite the overall decline in prevalence, the elevated prevalence of HIV among key populations at higher risk is of concern (UNAIDS, 2007).

1.8. IDU and DU Situation in the Country

Despite years of decreases, Myanmar still is the second largest opium poppy grower in the world after Afghanistan. However, its share of global opium poppy cultivation fell from 63 per cent in 1998 to only 11 per cent in 2006 and 5 per cent in 2007. This large proportional decline was caused by a decrease of opium poppy cultivation in Myanmar in combination with a large increase in Afghanistan, which accounted for over 92 per cent of global opium production (UNODC, 2006a; UNODC, 2006b; UNODC, 2008).

The drug user population in Myanmar is estimated between 60,000 (Mathers, B., et al, 2008) and 300,000-400,000 (UNODC, 2004). The estimated injecting drug user population varies from 90,000 (Mathers, B., et al, 2008); to 150,000-250,000 (Centre for Harm Reduction, Burnett Institute, 2002), or 90,000 to 300,000 (Aceijas, C., et al, 2004). According to the CCDAC, there were 63,149 registered drug users (accumulated number of registered drug addicts who seek treatment in drug treatment centres, or DTCs) in Myanmar in 2002 (Central Committee for Drug Abuse Control, 2002), and the number rose to 69,547 from February 1974 to June 2008 (Central Committee for Drug Abuse Control, 2008) as reported from major drug treatment centres around the country. In 1989, data from Bhamo in Kachin State recorded astounding epidemiological data of HIV prevalence among IDUs of 96.7 per cent (Reid, G., and G. Costigan, 2002).

The latest (2007) available data from the HIV sentinel sero-surveillance report provided by the NAP in July 2008 stated that HIV prevalence among IDUs was 29.2 per cent (ranging from 25.3 per cent to 32.1 per cent) with the highest HIV prevalence in Lashio (48.5 per cent) followed by Mandalay (38 per cent), Myitkyina (30.8 per cent), Muse (30 per cent), Taunggyi (9.1 per cent) and Yangon (6.5 per cent) (Ministry of Health, 2008).

7 Life expectancy at birth measures the average number of years that a newborn child would live if mortality rates remained constant throughout his or her lifetime.
Earlier estimates of HIV prevalence among injecting drug users in Myanmar vary between 26.0 per cent (Ministry of Health, 2005), 30.0 per cent (WHO, 2005; UNAIDS, 2004), 34.4 per cent (Ministry of Health, 2006d), 41.0 per cent (Wiwat, P., 2007), 42.5 per cent (Ministry of Health, 2006a), 42.6 per cent (Mathers, B., et al, 2008), 43.2 per cent (Ministry of Health, 2007), 29.2 per cent (ranging from 26.3 to 32.1 per cent), to a range of 50.0 to 90.0 per cent (Birgin, R., 2004) depending on the source. Irrespective of the source, it is one of the highest in the world. Data from 2003 indicates that between 50.0 per cent and 85.0 per cent (WHO, 2008) of IDUs tested in Yangon and Mandalay were HIV positive, while data from Lashio indicates that between 36.0 per cent (UNAIDS, 2006a) and 60.0 per cent (Commission on AIDS in Asia, 2008) of drug users were found to be HIV positive.

The CCDAC survey in 2002 highlighted that the most commonly used drugs in Myanmar are opium (54.0 per cent), heroin (36.0 per cent)8 and methamphetamines (16.0 per cent). UNAIDS in 2005 indicated that less than 5.0 per cent (UNAIDS, 2005f) of the IDU population nationwide is covered by harm reduction activities, but lack of reliable data on the number of IDUs was (and is) still an issue. The report states that "there has been an insufficient impact on the HIV epidemic in this group [IDUs] in spite of the increased involvement of donors and NGOs in recent years" (UNAIDS, 2005f). The latest available data (2006) from the NAP indicates that out of 60,000 IDUs estimated in 2006, 11,500 were reached by harm reduction programmes, 4,375 accessed voluntary confidential counselling and testing (VCCT), and 300 were on methadone maintenance treatment (MMT), while two million needles were distributed to IDUs in the country (Ministry of Health, 2006e). The report also highlights four key achievements in 2006: a) an increased number of drop-in centres (DIC), up to 19; b) a continuing increase in the number of IDUs reached by harm reduction services; c) the successful start and expansion of MMT; and d) the growth of needle and syringe exchanges in the country (Ministry of Health, 2006e).

The number of reported female drug users in Myanmar is limited. NAP data indicates that out of 4,048 drug users reached in DICs in 2006, only 178 were female, and out of 3,957 drug users reached by outreach activities, only 150 were female (Ministry of Health, 2006e). Females who inject drugs are more likely than male injecting drug users to be stigmatized by society because their activities are considered to be doubly deviant: It is generally considered that drug injecting violates social norms of behaviour, and many feel that drug injecting by females is even worse, as it diverges from the traditional expectations of women as wives, mothers, daughters and nurturers of families. Because of this stigma, females are more likely to conceal their drug injecting behaviour. A prominent reason why female injecting drug users do not reach available IDU/DU services is the fact that these services are mostly not gender responsive and thus the specific needs of female injecting drug users are not met.

The UNODC Country Office Myanmar and its partners have used multiple approaches to drugs and HIV-related matters. Up to 2008, more than 30,000 IDUs/DU users have visited 12 UNODC-operated drop-in centres in Shan and Kachin states, out of 24 in the country operated by INGOs and NGO/NPO partners. Over 122,000 youth have participated in drug demand reduction activities in youth centres, almost 150,000 educational materials have been distributed and approximately 6,000 injecting drug users have received treatment through outreach services. These results indicate that the mitigation and reduction of drug use, HIV and their harmful consequences in Myanmar is possible.

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8 In this publication the term “opioid use/user” is utilized to refer to any form, level and pattern of non-medical use of opioids, including occasional and prolonged consumption.
Opium poppy has been cultivated in Myanmar for more than a century. Farmers have traditionally relied on its cultivation to offset rice deficits and to purchase basic goods. Opium has also been used as a painkiller and to alleviate the symptoms associated with diarrhoea, cough and other ailments. Additionally, the use of opium as medicine is often exacerbated by the lack of access to healthcare services. In recent years, there has been a trend away from the traditional smoking of opium to injecting heroin. Moreover, the use of amphetamine-type stimulants (ATS), especially by young people, is rapidly increasing (UNODC, 2008a). ATS is a primary drug of abuse for 11.80 per cent of persons treated for drug problems in Myanmar (UNODC, 2008). The World Drugs Report 2008 indicates that the largest national ATS seizures in 2006 were reported from Saudi Arabia (26 per cent), the USA (15 per cent), China (13 per cent), Myanmar (6 per cent), the UK (5 per cent), Oman and the Netherlands (4 per cent each), and Australia and Indonesia (3 per cent each) (UNODC, 2008). Most ATS seized in Myanmar are in the form of methamphetamine tablets9. In 2006, as a result of a focused law enforcement campaign, tablet seizures topped 19 million, contributing to the total of 2.8 mt of ATS reportedly seized, three times the largest amount previously reported to UNODC by the Union of Myanmar (UNODC, 2008a).

1.9. Legal Environment

Myanmar has signed seven internationally binding conventions related to drugs and crime:

- Agreement Concerning the Suppression of the Manufacture of Internal Trade in and Use of Prepared Opium, 1925;
- International Opium Convention and Protocol, 1925;
- Protocol Bringing under International Control Drugs Outside the Scope of the Convention, 1931;
- Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs and Protocol of Signature, 1931;
- Single Convention on Narcotic Drugs, 1961;
- Convention on Psychotropic Substances, 1971;
- United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988; and

9 Methamphetamine tablets produced in Myanmar are assumed to contain 30 mg of active ingredient. Reports for 2007 suggest declines in tablets seized.

Myanmar also adopted several laws and regulations related to drugs and AIDS:

- Narcotic Drugs and Psychotropic Substances Law, January 27, 1993;
- Order Relating to Illicit Crop, January 28, 1993;
- Order of Chemical Used in Production of Narcotic Drug, January 28, 1993; and the January 28, 1993; April 20, 1993; and April 21, 1994 amendments;
- Order Relating to Narcotic Drugs and Psychotropic Substances, January 2, 1996;
- Order of chemical used in production of Narcotic Drug, September 20, 1996;
- A sodomy law for male-male sex remains on the statute books of Myanmar.\(^\text{10}\)

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\(^{10}\) Along with eleven countries in the region: Bangladesh, Bhutan, India, the Lao People’s Democratic Republic, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Singapore and Sri Lanka (Sanders, 2006).
1.10. Myanmar National Drugs and HIV/AIDS Strategy

The National Strategic Plan (NSP) on HIV/AIDS (2006-2010) was the first in Myanmar developed with contributions from all stakeholders (Ministry of Health, 2006b). In the NSP, the drug user population is identified as one of the four population groups with the highest priority for intervention. The NSP Third Strategic Direction, “Reducing HIV-related risk, vulnerability and impact among drug users”, is the highest priority. The Fifth Strategic Direction, “Reducing HIV-related risk, vulnerability and impact among institutionalized populations”, and Sixth Strategic Direction, “Reducing HIV-related risk, vulnerability and impact among mobile populations”, are high priorities of the NSP. In fact, the Government of Myanmar has declared that stopping the spread of HIV is one of its top national priorities. UNODC Country Office Myanmar is working together with other UN agencies, government counterparts and NGOs/NPOs to achieve this goal.

UNODC Country Office Myanmar is currently working in nine townships out of the NSP’s 29 townships prioritized for drug use by the Technical Strategy Group (TSG) in 2007 (Ministry of Health, 2006b) through its holistic approach to drugs by focusing on both harm reduction and demand reduction, and through partnership with civil society groups in providing a comprehensive package of care for drug users. UNODC Country Office Myanmar has been responding to the AIDS epidemic in Myanmar in accordance with the NSP.

1.11. UNODC Country Office Myanmar Strategy

UNODC Country Office Myanmar Strategic Programme Framework (SPF), 2004-2007 Objective 2 is as follows: “By 2008, to have reduced significantly the spread of HIV/AIDS through injecting drug use in targeted intervention areas”. It is currently implementing SPF targets: No. 12, No. 13, No. 14, No. 15, No. 16 and UNODC Country Office Myanmar Country Programme (2008-2011) strategic Objective 2.3.2. “To have reduced significantly the spread of HIV/AIDS through injecting drug use in targeted intervention areas” through two main projects:
UNODC Project for reducing the spread of HIV/AIDS among drug users through the HIV/AIDS Asia Regional Project – Country Flexible Programme for Myanmar TDMRJ69 (2008-2011) [Donor: AusAID]: UNODC Country Office Myanmar, in partnership with international/local nongovernmental organizations and community groups, namely Marie Stopes International, National Drugs and Alcohol Research Centre, Myanmar Council of Churches, Myanmar Baptist Convention, Substance Abuse Research Association and Township Project Management Committees, has been providing drugs and HIV-related prevention, care and support, harm reduction and improving access of clients to local facilities covering 2,000 injecting drug users/drug users (IDUs/DUs), sexual partners and youth at risk in five priority townships in northern and eastern Shan States of the Union of Myanmar.

UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar TDMRJ63 (2007-2010) [Donor: 3 Diseases Fund]: UNODC Country Office Myanmar, in partnership with international and local nongovernmental organizations, community based organizations (CBOs) and local groups, namely Marie Stopes International, Myanmar Business Coalition on AIDS, Oasis (a self help group for PLHIVs), Voluntary Social Workers Association and Youth Empowerment Team, and Township Project Management Committees, has been implementing behaviour change and service delivering activities with IDUs/DUs, sexual partners and “key populations at higher risk” like road transport workers in five priority townships in northern and eastern Shan States of Myanmar. Through the strategies of high risk behaviour change, targeted beneficiary responsive services provision, empowerment of the DUs and IDUs, inclusion of PLHIVs, CBOs and local institutions, and building of an enabling environment, the project has reached 2000 beneficiaries.

The total budget of the UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme secured programme portfolio (see Table 1) amounts to $1,722,220 for 2009 and $1,795,700 for 2010.

<table>
<thead>
<tr>
<th>Table 1. Programme Portfolio</th>
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<tbody>
<tr>
<td><strong>Project Number and Title</strong></td>
</tr>
<tr>
<td>MMRJ69: Reducing the spread of HIV/AIDS among drug users through the HAARP – Country Flexible Programme for Myanmar*</td>
</tr>
<tr>
<td>MMRJ63: UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar**</td>
</tr>
<tr>
<td>Sub Total</td>
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</table>

*AusAID has demonstrated their interest in funding the HAARP-CFP programme in Myanmar for eight years.
** The 3 Diseases Fund pledge has been secured until 2009. The 3 Diseases Fund pledged $100 million over five years (2007-2011) in Myanmar and the contracts are renewable for each year.
2.1. Scope of the Programme

This Drugs and HIV/AIDS Country Programme’s main entry point is the prevention of HIV transmission among drug users, particularly injecting drug users. However, it addresses the three areas for which UNODC has lead agency responsibility within the Joint UN Programme on HIV and AIDS (UNAIDS): drug users, institutionalized populations and human trafficking.

In these areas, the prevention measures needed to respond to HIV effectively have involved significant challenges for individuals, communities, the Government of Myanmar (local/state and central level) and the UN system. HIV prevention has required:

- Individuals to change their behaviour;
- Communities to discuss issues of sexuality and drug use;
- The health system to become more responsive to client needs, to review priorities and to find ways to work with other sectors in delivering programmes; and
- The Government of Myanmar and multilateral agencies to develop new approaches to planning and funding programme development.

In many cases these changes have come too slowly, and HIV has continued to spread when in fact the means of prevention are relatively simple – protected sex and safe drug injecting drug use.

2.2. Mission Statement

Myanmar will, by 2010, have achieved its universal access targets for HIV prevention, treatment and care services among injecting drug users, in institutionalized populations and for people who have been trafficked or are at risk of being trafficked.

2.3. Guiding Principles

- HIV prevention, treatment and care are essential in promoting, protecting and respecting human rights.
- Gender sensitivity is fundamental to ensure that policy, legislation and service provision respect human rights of all people.
- Decision making processes must include a central role for people living with HIV and for people who use drugs.
- Building supportive environments will make a critical difference in ensuring that HIV prevention programming reaches the coverage, scale and intensity required for universal access.
- A sustainable approach to HIV prevention, treatment and care is vital to achieve universal access and Millennium Development Goals.
- Legislation, policy, programmes and technical advice must be informed by evidence of what is known and proven to be effective. UNODC Country Office Myanmar’s work should also seek to bring in internationally recognised good practices to feed policy debates and strategic discussions.
- UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme will strengthen/develop partnerships with national authorities, communities, the private sector, nongovernmental agencies and other UN agencies to maximise the benefits of the Joint UN Programme on HIV/AIDS (UNAIDS).
- UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme responds to priority needs of vulnerable populations directly and through local NGOs/NPOs, CBOs and the private sector.
2.4. How We Work

The UNODC structure includes a headquarters (HQ) in Vienna, Austria, and 21 field offices (FOs). HQ provides organization-wide policy and strategic framework, management and administrative support through various substantive offices. UNODC Country Office Myanmar (COMYA) is responsible for implementing programmes and projects operations in Myanmar in consultation with the Myanmar Government.

UNODC Country Office Myanmar Drugs and HIV/AIDS Team are composed of one international staff, 15 national experts and 75 field/support staff. The Drugs and HIV/AIDS Team and Regional HIV Team in Bangkok support the Global HIV Team to achieve the objectives of the UNODC Global HIV and AIDS Programme. Those objectives are reflected in the draft Regional Framework and in this Country Programme.

UNODC Drugs and HIV/AIDS Country Programme works with all stakeholders involved: UN, Myanmar Government ministries/agencies, INGOs, NGOs/NPOs, CBOs, FBOs, SHGs, and research and academic institutions (see chapter 2.8).

2.5. What Has to Be Achieved?

Following from UN Member States’ commitment in 2006 to pursue the goal of universal access to comprehensive HIV prevention, treatment, care and support by 2010, the framework and UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme aim for:

- 80.0 per cent of injecting drug users\(^\text{11}\) to have access to clean needles and syringes;
- 80.0 per cent of injecting drug users and their sexual partners to practice safe sex;
- Drug-dependent people to have access to a range of evidence-informed drug dependence treatments;
- Injecting drug users to have access to HIV/AIDS treatments, care and psychosocial support;
- The broader community to support the provision of a comprehensive package of HIV prevention, treatment and care with drug users;
- Vulnerable communities (IDU/DI/PLHIV) to have the capacity to contribute to the programme at all levels;
- National AIDS Plan to include human resources development strategies to address HIV prevention, treatment and care with drug users;
- Government, civil society, the private sector and multilateral agencies to work as partners in the development and delivery of the comprehensive package to 80.0 per cent of drug users;
- 80.0 per cent coverage of provision of the comprehensive package within prisons and closed settings, including condoms, access to clean needles and syringes, and access to a range of evidence-informed drug dependence treatments; and
- 80.0 per cent coverage of the comprehensive package for people vulnerable to human trafficking, targeting all phases of human trafficking.

\(^{11}\) Denominator: Estimated IDU population in Myanmar 75,000 (Ministry of Health, 2007c)
2.6. Objectives and Strategies of the Country Programme

2.6.1. Coverage:

Ensure that coverage of comprehensive HIV/AIDS prevention and care services for injecting drug users/drug users, people in institutionalized populations and among actual and potential victims of human trafficking increases to 80.0 per cent by 2010.

- Provide country coordination and support between IDU/DU partners (based on the consultations) in the country.
- Strengthen/develop the capacity of the Myanmar Government to manage the provision of a comprehensive HIV prevention, treatment and care programme with drug users, in prisons and among people vulnerable to human trafficking (PVHT).
- Support the development of the necessary “enabling environment” for an evidence-informed response to HIV among drug users, in institutionalized populations and in relation to trafficking in human beings.
- Respond to priority needs of vulnerable populations directly and through local NGOs/NPOs, CBOs, FBOs, SHGs, IDUs, PLHIVs and the private sector.

2.6.2. Strategic Information:

Ensure that the Government of Myanmar, UN agencies, civil society and partners in Myanmar have access to timely strategic information and analysis in the areas of HIV prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings.

- Strengthen/develop national capacity to provide strategic information related to HIV in the areas of HIV prevention and care among injecting drug users, in institutionalized population and in relation to trafficking in human beings.
- Document and disseminate strategic information in the country.

2.6.3. Mainstreaming:

Ensure that UNODC Country Office Myanmar, Government of Myanmar, UN agencies and civil society partners incorporate HIV prevention, treatment and care into programmes or projects in the areas of HIV prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings, where possible.

- Support UNODC Country Office Myanmar staff, including Alternative Development Programme and field/partners projects staff to identify the impact of HIV/AIDS on their area and how this might be addressed. Propose technical support for the incorporation of HIV prevention in the programmes of other UN agencies and counterparts.
- Support the incorporation of HIV prevention in community sector programmes.
- Support the incorporation of HIV prevention in the programmes of the private sector.
### 2.7. The Work Plan for 2009-2010

**Objective 1:** Ensure that coverage of comprehensive HIV/AIDS prevention and care services for injecting drug users/drug users, people in institutionalized populations and among actual and potential victims of human trafficking increase to 80.0 per cent by 2010.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 1.1. Provide country coordination and support country collaboration | 1.1. Provide technical support:  
   a) UN Expanded Theme Group on HIV/AIDS (UNTG)  
   b) A Technical Strategy Group (TSG) |
| 1.1.2. Facilitate harm reduction thematic sub-group under the Technical Strategy Group headed by the NAP with technical expertise from the UN and other partners |  
1.1.3. Strengthen/develop agreements to support joint programming |
| 1.1.4. a) Conduct annual meeting of key country cosponsor representatives (Yangon and Bangkok based)  
   b) Country and regional meetings of key donors to discuss harmonisation of funding and work programmes |  
1.1.7. Meeting of national NGOs/NPOs, CBOs and SHGs to discuss country representation for drug users and their engagement in country programme development and delivery |
| 1.1.5. a) Strengthen/develop collaboration among HIV/AIDS focal points in UNODC regionally  
   b) Hold a regular team teleconference with UNODC HIV Team |  
1.1.7. Participate in key regional and global conferences: IHRC, ICAAP, ICPA, IAC, HCCE, UNODC HIV team meetings (global/regional) |
<table>
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<tr>
<th>Strategy</th>
<th>Activities</th>
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<tbody>
<tr>
<td>1.2. Develop capacity of the Myanmar Government to manage the provision of a comprehensive HIV prevention, treatment and care programme with drug users, in prisons and among people vulnerable to human trafficking (PVHT)</td>
<td>1.2.1. a) Assess national approaches and capacity to manage public sector programmes and staff development in the country including: assess existing staff training programmes used in Government departments (eg, Ministries of Justice, Home Affairs, Health, etc) and provide training based on the assessment b) Strengthen existing country mechanism to support public sector programme management capacity</td>
</tr>
<tr>
<td>1.2.2. Adapt or develop quality assurance guidelines for delivery of the comprehensive package in the country</td>
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<tr>
<td>1.3. Support the development of the required human resource capacity to deliver the programme</td>
<td>1.3.1. Assess national approaches and capacity for workforce development in government and nongovernmental sectors in Myanmar, including: a) Assess existing staff training and development programmes used in Government departments (eg, Ministries of Justice, Home Affairs, Health, etc) b) Assist country to access training resources and adapt them for local delivery</td>
</tr>
<tr>
<td>1.4. Support the development of the necessary “enabling environment” for an evidence-informed response to HIV among drug users, in institutionalized populations and in relation to trafficking in human beings</td>
<td>1.4.1. Advocate to all stakeholders involved for: a) Concurrent legislation on HIV/AIDS and drug use, criminal justice and prisons, and for alternatives to imprisonment b) Inclusion of PVHT in National HIV/AIDS Plan c) Inclusion of HIV/AIDS in national human trafficking laws and mechanisms</td>
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<td>1.4.2. Review legislation affecting the delivery of the comprehensive package in Myanmar</td>
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<tr>
<td>1.4.3. Support the development of community representation for drug users and their participation in national programmes and national policy processes</td>
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<tr>
<td>1.4.4. Identify funds for research activities to fill research gaps identified in UN TSG on HIV/AIDS and drug use</td>
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<tr>
<td>1.5. Respond to priority needs of vulnerable populations (close settings / IDUs / victims of trafficking) directly and through NGOs/NPOs, CBOs, FBO, SHGs, IDUs, PLHIVs and the private sector at the community level</td>
<td>1.5.1. a) Provide services at central, state and community level for IDUs/DUs and PLHIV's b) Provide technical assistance to NGOs/NPOs, CBOs,FBOs, SHGs, IDUs, PLHIVs and the private sector organizations through trainings, capacity building and grants c) Monitor and evaluate the central, state and community levels of assistance provided through local NGOs/NPOs, CBOs, FBOs, SHGs, IDUs, PLHIVs and private sector organizations</td>
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12 “Manage” defined as developing, implementing, monitoring and reporting on a plan to achieve agreed targets.
In this publication the term “substitution maintenance therapy” refers to treatment fulfilling the following criteria: agents used for substitution therapy have been thoroughly evaluated, treatment is administered by accredited professionals in the framework of recognized medical practice, and there is appropriate clinical monitoring.

**Objective 2: Ensure that Government, civil society and partners have access to timely strategic information and analysis in the area of HIV/AIDS prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
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</table>
| 2.1. Develop national capacity to provide strategic information related to HIV in the areas of HIV prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings | 2.1.1. a) Assess national research, monitoring and evaluation capacity  
b) Strengthen/develop country mechanism to support national research capacity building if required  
c) Ensure the dissemination of UN TSG on HIV/AIDS and drug use data |
| 2.2. Produce and disseminate strategic information in the country | 2.2.1. Collaborate with WHO, UNAIDS, NAP, CCDAC and NATALA in the continuation of the HIV Prevention and Care, Good Practice Series including substitution maintenance therapy\(^{13}\) and technical assistance on harm reduction, harm reduction review, Lashio township management model, etc. |
| 2.2.2. a) Disseminate strategic information through UNODC media and partners’ networks countrywide  
b) Strengthen/develop and maintain updated UNODC Country Office Myanmar HIV/AIDS webpage including relevant strategic information (linked with UN, INGOs, NGOs/NPOs etc.) | 2.2.3. Strengthen/develop/adapt specific HIV and AIDS policy and programmatic tools required in the country |
| 2.2.4. Develop a set of key messages for the private sector providing evidence-informed messages on HIV/AIDS and drug use |  |

\(^{13}\) In this publication the term “substitution maintenance therapy” refers to treatment fulfilling the following criteria: agents used for substitution therapy have been thoroughly evaluated, treatment is administered by accredited professionals in the framework of recognized medical practice, and there is appropriate clinical monitoring.
Objective 3: Ensure that the Government of Myanmar, UN agencies, UNODC Country Office Myanmar and civil society partners incorporate HIV prevention, treatment and care into programmes or projects in the areas of HIV/AIDS prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings where possible.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Support UNODC Country Office Myanmar staff, programmes and projects to identify the impact of HIV and AIDS on their area and how this might be addressed</td>
<td>3.1.1. a) Provide technical support to other programmes/projects staff of UNODC (Crime, Terrorism and Alternative Development) to identify the impact of HIV on their programmes/projects and to (further) integrate HIV/AIDS responses into their projects and programmes b) Support UN Cares activities/trainings in the country</td>
</tr>
<tr>
<td>3.2. Support the incorporation of HIV prevention in the programmes of other UN agencies and counterparts</td>
<td>3.2.1. a) Offer basic training on harm reduction for other relevant UN agency staff b) Consult with key UNODC partners in the areas of HIV prevention and care among injecting drug users, in institutionalized populations and in relation to trafficking in human beings to strengthen/develop plans for mainstreaming HIV/AIDS responses</td>
</tr>
<tr>
<td>3.3. Support the incorporation of HIV prevention in community sector programmes</td>
<td>3.3.1. Conduct an assessment of need and develop capacity for collaboration with key NGOs/NPOs, CBOs, FBOs and SHGs inside/outside of the HIV/AIDS sector for the integration of HIV/AIDS work related to drug use, institutionalized populations and human trafficking in their activities</td>
</tr>
<tr>
<td>3.4. Support the incorporation of HIV prevention in the programmes of the private sector</td>
<td>3.4.1. a) Conduct an assessment of need and capacity for collaboration with key private sector companies, outside of the HIV/AIDS sector, for the integration of HIV/AIDS work related to drug use, institutionalized populations and human trafficking in their activities b) Develop a set of key messages for the private sector providing evidence-informed messages on HIV/AIDS and drug use</td>
</tr>
</tbody>
</table>
2.8. Coordination and Partnership

UNODC neutrality and its institutional link between the Government Myanmar agencies and CBOs in an otherwise sensitive environment: It is a pre-condition to have Government of the Union of Myanmar approval on all activities and, especially, CCDAC support for IDU-related projects and services. Indeed, by their nature, IDU-related interventions require CBO involvement, in line with the strategy of the UNODC Country Office Myanmar that seeks to respond to priority needs of vulnerable populations directly and through local NGOs/NPOs, CBOs and the private sector. Cooperation and partnership with the following authorities and agencies are ongoing and to be reinforced by the Drugs and HIV/AIDS Country Programme:

- **Central Committee for Drug Abuse Control (CCDAC)**: UNODC Country Office Myanmar has a long-established cooperative agreement with CCDAC in joint planning and management of drug demand reduction programmes, including drug-related HIV/AIDS prevention and reduction programmes. The programme will draw on CCDAC support and facilitation capacity/mandate;

- **National AIDS Programme (NAP)**: UNODC Country Office Myanmar has a close working relationship with the NAP – the agency responsible for the coordination and management of the national response to HIV/AIDS. In particular, UNODC Country Office Myanmar works closely with NAP in relation to the crosscutting issues of harm reduction, namely voluntary counselling and testing (VCT) and methadone maintenance treatment (MMT). This collaboration and coordination will be reinforced in the programme context;

- **Ministry of Progress of Border Areas and National Races and Development Affairs (NATALA)**: UNODC Country Office Myanmar has established a cooperative agreement with NATALA in joint planning and management of drug supply reduction, including alternative livelihood development programmes and activities in the remote border areas and Special Regions of ethnic minorities. The programme will draw on NATALA support and facilitation;

- **Ministry of Health (MOH)**: UNODC Country Office Myanmar has been working with MOH on substance use treatment through MOH Drug Treatment Centres in the country for many years. This arrangement will continue;

- **UN Expanded Theme Group on HIV/AIDS (UNTG)**: UNODC Country Office Myanmar has been actively promoting issues pertaining to IDU-related HIV/AIDS and vulnerable populations and related coordination through the UNTG. From 2003 to 2006, UNODC Country Office Myanmar chaired the Harm Reduction Technical Working Group. UNODC Country Office Myanmar is playing an important advocacy role as a member of the Technical Strategy Group – a joint UNAIDS (the 10 cosponsors that make up the UNAIDS programme are UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and World Bank) and NAP/MOH national level committee overseeing the coordination of the national response; and A Technical Strategy Group, headed by the NAP with technical expertise from the UN and other partners and with several thematic sub-groups, is in place. UNODC Country Office Myanmar is leading the Sub-Committee on IDU.
Donors:

- **3 Diseases Fund (3DF)**, which includes Australia, European Commission (EC), Netherlands, Norway, Sweden and the United Kingdom (UK); and
- **AusAID** has supported drug demand reduction, HIV prevention programmes, harm reduction advocacy and implementation (a) through projects funded directly by its humanitarian assistance fund; (b) through mechanisms like Fund for HIV/AIDS in Myanmar (FHAM); and (c) currently through the Country Flexible Programme in Myanmar for which UNODC Country Office Myanmar is the management contractor.

INGOs/NGOs/NPOs/SHGs, which include the following:

- Township Project Management Committees in Lashio, Muse, Tachileik, Theinni (Hseni) and Tangyan townships;
- Asian Harm Reduction Network (AHRN);
- Burnet Institute (BI);
- CARE International;
- Marie Stopes International (MSI);
- Médecins du Monde (MdM);
- Médecins Sans Fronières Holland (AZG);
- Myanmar Anti-Narcotics Association (MANA);
- Myanmar Baptist Convention (MBC);
- Myanmar Business Coalition on AIDS (MBCA);
- Myanmar Council of Churches (MCC);
- Myanmar Positive Group (MPG)
- Oasis (a self help group for PLHIVs);
- Population Services International (PSI);
- Voluntary Social Workers Association (VSWA);
- World Concern (WC);
- Youth Empowerment Team;
- SWIFTS, and other partners.

**Academic and research Institutions:**

- Institute of Public Health, Ministry of Health, Myanmar;
- Substance Abuse Research Association (SARA); and
- National Drug and Alcohol Research Centre (NDARC).
Up to 2008, more than 30,000 IDUs/DUs have visited 12 UNODC-operated drop-in centres in Shan and Kachin states, out of 24 in the country operated by INGOs and NGO/NPO partners.
2.9. Planning, Monitoring and Evaluation

Monitoring and evaluation are an integral part of the programme strategy, to support both the development and implementation of appropriate government policies and programmes, and the planning and implementation of activities under the UNODC Drugs and HIV/AIDS Country Programme.

2.9.1. Planning and Reporting

The design of the programme is based on extensive consultations with stakeholders at national, state, division and district levels during the six months prior to submission of the UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme report to the UNODC Myanmar Country Office Management Team and to the coordination meeting on the IDU working group under TSG. A design team supported the process, consisting of the UNODC Drugs and HIV/AIDS Team in Yangon, the UNODC regional advisor in Bangkok and the UNODC HIV Team in Vienna.

An Annual Plan of Operations (APO) of the Programme will be submitted by the Programme Specialist, through the UNODC Myanmar Country Office to the coordination meeting on the IDU working group under TSG for review and endorsement before the end of each calendar year. In this plan of operations, the expected results will be specified for each of the strategic objectives as well as the required inputs. The APO will subsequently be submitted to the NAP and CCDAC.

Likewise, six-monthly progress reports will be submitted to the UNODC Myanmar Country Office Management Team for endorsement and for subsequent submission to the UNODC Myanmar Country Office Management Team for approval – including the expenditure forecast for the following six months. The Annual Plan of Operations outline 2009-2010 is based on the work plan (see chapter 2.7).

CCDAC, NAP and UNODC will meet twice a year to review and to approve progress reports (financial and technical) and the APO. These meetings are expected to be held in January/February to review the progress report of the last semester of the preceding year and to discuss and approve the annual plan; and in August/September to review/approve the progress report of the first semester of the current year, and to look at the expenditure forecast of the second semester and possible proposals for budgetary adjustments.
2.9.2. Monitoring and Evaluation

The UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme will follow existing UNODC, UNDP and UN monitoring and evaluation tools/guidelines already in place. Some documents are mandatory, such as the semi-annual and annual reports, while some other tools are for internal use (quarterly review):

- UNODC, 2005. UNODC/MI/2, 1 June 2005, Management Instruction, Financial Administration of Nationally Executed Projects (NEX);
- UNODC, 2005. UNODC/MI/2, 1 June 2005, Annex 1, Technical Guidance Note Specimen Terms of Reference for Audits of NEX or NGO Projects;
- UNODC, 2005. UNODC/MI/8/Rev. 1, 1 June 2005, Management Instruction, Field Office Administration;
- UNODC, 2005. UNODC/MI/8/Rev. 1, 1 June 2005, Annex 1, Management Instruction Instructions on Inventory Control;
Monitoring and evaluation plans for each of the activities and projects of the UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme will be made on the basis of a certain (and varying) number of indicators/outcomes decided after an extensive consultation process involving all stakeholders, including beneficiaries.

One of the first steps in planning will be to revisit the outcomes selected for evaluation. This will be done as a check to verify that the indicator/outcome is still relevant and to re-identify explicitly the key outputs, projects, activities and partners’ interventions that may have contributed to the outcome. This information will be readily available to UNODC Drugs and HIV/AIDS Team staff from regular monitoring reports and from the evaluation plan prepared by the team with consultations with partners, which details the activities and projects that are directed towards a given outcome. The outcome will be revisited every six months prior to the evaluation itself.

Technical collaboration with local research institutes and universities is expected to be necessary and beneficial with respect to monitoring and evaluation. The role of local research institutes is important to provide objective and independent information that is based on sound technical capacity. Where necessary, these institutes will be partnered with local universities to encourage sharing of information and skills.

2.9.2.1. Monitoring

In most locations, capacity to monitor programme activities is relatively limited. Successful implementation of the activities outlined in this publication requires appropriate monitoring systems and processes at the national, state, division, district and community levels. Monitoring at the community level is especially important to provide information on the impact of programme interventions on families, individuals and the functioning of communities and community governance and planning structures, and to document this impact as part of lessons learnt to be considered for policy mainstreaming.

The UNODC Drugs and HIV/AIDS Country Programme will therefore develop new tools for monitoring activities in the field. Experienced consultants will be contracted to develop an integrated set of appropriate tools for each of the programme outcomes, which will allow programme staff to track participation numbers, involvement of government and other counterparts, learning outcomes and knowledge gained. Focus will be on development of systems that allow monitoring for one component to be linked with another, so that connections can be identified. This will also be done to ensure that adjustments on one component are immediately followed up by staff working on other components. An integrated system will also allow for sharing of information and the establishment of common procedures for monitoring. It will include elements like the frequency and nature of visits, the timing of reviews and the human resources necessary to carry out the monitoring activities.

Efforts will be made to ensure that the systems to be developed are cost-effective tools, based as much as possible on already existing technology and procedures and to avoid the need for extensive training for staff on using the proposed tools. The implementation of joint monitoring and evaluation, for example through joint visits and review meetings, is expected to strengthen technical capacity among Government officials, UNODC field staff and implementing partners. Efforts will be made to involve staff of NAP and CCDAC in monitoring activities on a periodic basis. A joint monitoring schedule will be developed by the UNODC Drugs and HIV/AIDS Team with NAP and CCDAC.

Monitoring is also a tool for raising awareness that is useful for programme partners and counterparts. The results of monitoring activities can also be used as advocacy tools in efforts to obtain greater support from the Government and from the public at large for the initiatives in the fields of drug demand reduction and HIV prevention. Because of this, the programme will make available the results of monitoring and evaluation to all partners in a user-friendly format.
2.9.2.2. Evaluation

The UNODC Country Office Myanmar Drugs and HIV/AIDS Country Programme will follow closely the experiences and procedures developed by the UNODC for evaluating project activities (see chapter 2.9.2.).

As part of the evaluation, extensive consultation processes will be initiated with all stakeholders involved, including beneficiaries, to define indicators for the Country Programme that will be the basis for the baseline surveys carried out for several programme components, such as technical assistance to existing drugs and HIV/AIDS projects. Indicators will be few and carefully selected to demonstrate impact. The involvement of national and local counterparts as well as local research institutions, universities and local self help groups will be sought for these activities. Using the results of these baseline surveys, the UNODC proposes to hold annual evaluations, starting in late 2009. The results of the evaluations will be channelled to decision-makers and planning agencies involved in drafting the next strategic plans for the drug use and HIV/AIDS sectors (NAP, CCDAC). A final evaluation will be carried out at the end of the programme’s activities in 2010. The results of all evaluation activities will be documented and shared with implementing partners and relevant agencies at state and national levels.

An external tripartite (UNODC, CCDAC, NAP) mid-term (2009) and final evaluation (2010) will be conducted, for which the UNODC Drugs and HIV/AIDS Team will submit detailed Terms of Reference (ToR) to the UNODC Country Office Management Team for approval.


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