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# Drugs, AIDS, and PLA in Myanmar/Burma

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## Summary

World Concern pioneered Participatory Learning and Action (PLA) work amongst drug users in northern Myanmar/Burma, in a difficult and disabling environment. For socially excluded people, we advocate the attempted use of PLA to reduce the damage of the participants' oppressions, whilst recognising that compromises will need to be made.

## Introduction

A worldwide debate continues about the most effective ways to intervene with drug-using populations. There is now a growing knowledge of the complexity of these issues and acceptance that the issue needs to be tackled at many levels in society (Pennington, 1999). In this paper we explore the use of PLA in an extremely disabling environment where there is little capacity to develop a multifaceted approach. The prevailing intervention paradigms can be summarised as follows.

## Demand reduction

Prevention of drug use in southeast Asia has tended to focus on extreme deterrence, coupled with large-scale abstinence and 'healthy living' initiatives, often with a heavy emphasis on religion, morality, and victim blaming. The more positive end of this spectrum is still heavily weighted towards Information, Education, and Communication (IEC) approaches, which

tend to do little to change behaviour despite improving knowledge levels.

## Supply reduction

Interdiction absorbs a large proportion of funds relating to drugs in Southeast Asia. Thailand and China's long, porous borders with Myanmar and Lao PDR place their police and military most frequently in the firing line. Numerous cross-border initiatives, often supported by the USA and the United Nations international Drug Control Programme (UNDCP) have come unstuck in the local political and insurgent mire of the Mekong sub-region, not least in Myanmar's Shan States area.

## Harm reduction

Some of the most celebrated examples of harm-reduction approaches amongst drug users come from Asia. These include opiate substitution and needle and syringe exchange in New Delhi by an Indian NGO called Sharan. For street-based drug users, a number of drop-in-centres (DICs) also feature on the Asian drug scene, including IKHLAS in Kuala Lumpur.

## Drug user treatment

For many years, Sahara House in New Delhi has been a Therapeutic Community (TC). Examples of TCs are growing throughout Asia. Structured, expensive, professional led,

substance abuse clinics also exist particularly for those drug users in families at the upper end of the income spectrum – including Yayasan Harapan in Bogor (Indonesia). More widespread, and prevalent throughout Southeast Asia, are the low-cost, often income-generating, Christian drug rehabilitation centres focused around religious conversion. Around three such centres existed in Burma/Myanmar at the time of the PLA project but provided a limited referral route for a handful of the PLA clients. Some herbal-based detoxification is available on a limited scale but generally does little to prevent relapse. Also, perhaps inappropriately termed ‘rehabilitation’ are the vast government drug user internment camps in Asia, pre-eminently found in Malaysia, but also found to varying degrees of benefit and abuse in other countries of South East Asia.

### A new paradigm – participatory development

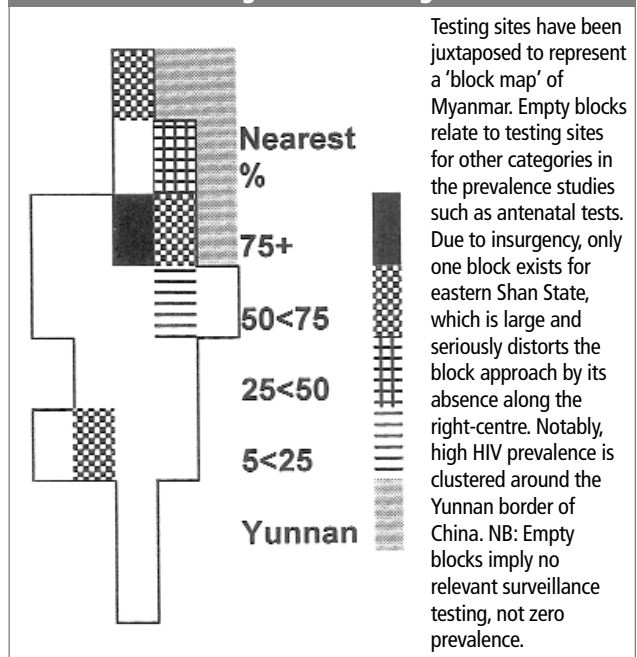
Drug using populations are generally socially excluded, whatever the economic and political structures of the country in which they live. Within the available literature on the application of PLA, there is no discussion of the use of PLA with drug using populations, although there has been some related work. Wallerstein and Bernstein (1988) report an empowering education against substance use project for adolescents in New Mexico. One of the authors (Townsend, 2001) reported preliminary results of using PLA with prisoners with HIV/AIDS in Malaysia, most of whom had a heavy drug use history, and brought this experience to bear in the Myanmar project. There has also been unpublished documentation of attempts in the United Kingdom to work with intravenous drug users in a probation hostel (Levine, 2000; Chambers, 2000).

The authors of a recent paper (Busza, Xakha, Ly, and Saron, 2001) discuss the application of PLA methods with commercial sex workers in Phnom Penh (Cambodia). Of particular note is their caution that PLA principles may at times seem to be compromised in such work but, ‘with vigilance and the willingness to experiment with various facilitation strategies, the potential benefits to the community are numerous and the challenges are not insurmountable’.

### The PLA project Background

The two-year Myanmar project was funded by UNDCP and implemented by World Concern. Following the arrival of one of us (Townsend) in October 1998, the IEC methodology was revised to focus on PLA approaches. UNDCP endorsed these changes and implementation began in early 1999 with the project funded until December 2000. Garrow undertook the task of strengthening the project’s evaluation by including a

**Figure 1: Burma / Myanmar HIV Sentinel Surveillance Data: Point Prevalence among Intravenous Drug Users in March 1999**



methodology review component to examine the novel use of PLA in the context of drug use.

### Project areas

The PLA component, aimed at drug using populations and people at high risk of becoming drug users, was implemented in three of Kachin State’s regional towns – Bamaw (near to the Chinese border and a major trading point), Hpakant (a jade mining town), and Hopin (a key transport intersection). Each town attracts a transitory population and has drug-taking communities.

Myanmar’s history of opiate production is well documented. In addition, the country is facing an increasing problem of amphetamine production. In Hpakant, UNDCP (1999) noted that some mine owners believed that 60% or more of their workers were regular drug users. Various approximation methods were used by the World Concern team to triangulate a possible figure for numbers of regular heroin users in Hpakant. The team concluded that there are around 60,000 smokers and 6000 injectors of opiates in a population that can oscillate from approximately 100,000 during the wet season to approximately 500,000 during the dry season.

In 2000, UNAIDS estimated that 530,000 people in Myanmar had HIV, an adult prevalence rate of 1.99%. Figure 1 illustrates the high prevalence rate of HIV amongst opiate injectors in Myanmar during March of 1999.

## Methods

Three teams (comprising a total of 12 facilitators) were trained in participatory learning methods (a very new approach for them in this context).

Participative implementation planning allowed the teams to help select appropriate PLA tools including six core ones: a personal timeline, a Venn diagram of community networks, a symptom based illness catalogue, a wealth ranking chart, a livelihood analysis, and a causal diagram for key problems. One team resided in each of three towns, each having at least one member previously resident in that town. This and the commitment of the facilitators meant that their involvement with participants often extended beyond the group work context.

Group participants encountered opportunities to join in a range of ways. Social contact was established by facilitators with each potential participant as part of the method before they were invited to join. Group sizes ranged from one to seven.

## Immediate outcomes

One of us (Garrow) conducted a participatory methodological review of the PLA component of the work in the presence of a representative of the Committee for Drug Abuse Control (CCDAC) and a staff person from a government drug treatment centre. In addition, she collaborated with an external evaluation of World Concern's overall drugs project. This evaluation was presented and fully discussed with both UNDCP and the CCDAC. With the permission of World Concern, summary findings are presented below:

- Some participants reported that they had stopped using drugs.
- Staff observations and client follow-up indicate that some participants have stopped using drugs. There is some evidence that they were more likely to be the heavy opium smokers than intravenous drug users.
- Many participants had made their first decision to change their drug use.
- Some participants had reduced their drug use. In some cases ex-clients reported that this enabled them to work. Sometimes returning to work and becoming responsible for their family again was part of an action plan that could only be achieved using this approach. One worker explained, 'I say, "It's your decision whether you slowly reduce or stop, but you must decide whether you can do it – just stop it. If you wish, it's your decision". And most of them decide to reduce in their own time'.
- Some participants began to make changes that would reduce HIV transmission. Many commented on how they

had learnt about transmission of infection and how to prevent infection. 'After discussion I use disposable syringes and separate blades to avoid AIDS'. There is evidence that the groups have served to provide education to clients, whether this be through the IEC material or the facilitator. It is possible that in the PLA group setting participants were more open to the education material.

- Significant improvements to the 'enabling environment' occurred as people in the community became familiar with the nature of the PLA processes.
- Others in the community began to work with drug users in a less judgmental way.
- Community 'gatekeepers' changed their attitudes towards drug users.
- The unconditional concern by workers for them was reported by many participants as being new and significant in their conceptualisation/perception of themselves and their worth.
- Collaboration with other projects improved.
- Staff developed sustainable skills in management and implementation.

## Longer-term outcomes

Follow-up for a highly migrant drug using community is not an easy prospect. This was expected and the project was less interested in short term behaviour change, than in promoting the cycling through of a longer-term behaviour change spiral (Parnell and Benton, 1999). The project showed that a large percentage of participants had made significant progress through this spiral (around two-thirds planned a simple but significant and achievable action plan on the foundation of detailed personal and contextual analyses undertaken by the PLA process). Theoretically, longer-term behaviour change can be expected to have been accelerated by the work.

Staff were surprised to hear that some former participants were informally initiating and conducting PLA groups of their own. However, these anecdotes hint at the power of consciousness-raising in setting the scene for internally driven behaviour change. It reinforces the importance of one of the project's key positions arising out of this work: PLA work should not be considered merely a method (and subject to short-term evaluation of limited indicators) but an operational philosophy.

Lastly, without access to appropriate rehabilitation opportunities, it is unreasonable to expect much in the way of drug-use behaviour change. Knowing their own constraints, staff were in some ways grateful that as a method for imbuing people with abilities to change their lifestyle contexts, the use

of PLA was not necessarily required to be directed at the narrower goal of short-term drug use prevention.

### Conclusions

The work this paper represents is in most ways experimental. There has been insufficient validation of the use of PLA methods amongst extremely socially excluded groups and project staff have not been able to do much more than benchmark a process which can be built on. The choice and development of the particular PLA tools employed with Myanmar's drug users was in many ways arbitrary. While there was a positive response to most of the tools, we did not test a wide range of PLA tools for their utility and may through evaluation be able to improve the scope and scale of tools.

It can be argued that the success of PLA is not merely in its outcomes, but also in its implementation. The process is, in and of itself, empowering. Secondly, PLA always enables its participants to look realistically at their environmental limitations.

PLA and its associated techniques, on the back of Paulo Freire's work in the 1960s and 1970s, have perpetually emphasised the necessity of group action following consci-

entisation (Freire, 1972). The extent to which this is possible will be largely determined by the perceived risks facing those who are already excluded from mainstream society.

Lastly, funding and other constraints in the Myanmar context forced the project to offer the PLA work almost without reference to a viable drug user support environment. Staff were virtually unable to provide opportunities for drug users to benefit from any other drug related interventions. Some could legitimately ask if the work unfairly raised expectations. We would argue that project staff were not necessarily setting out to prevent drug use. Conscientisation involves a recognition of unresolved (and at times irresolvable) paradoxes as a prerequisite to internally motivated change. It also stimulates participants to find ways to change for themselves.

Ultimately, it may be that PLA work with people under extreme social exclusion must of necessity be carried out in a compromised fashion, if it is not to backfire on people already without social power. The task then is to explore the features of PLA work, which can bring sufficient relief to its participants to justify its taking place. On the other hand, some would argue that conscientisation is a human right and worth doing even under the most difficult circumstances.

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#### NOTES

'Ditch' Townsend is Southeast Asia director of The Leprosy Mission International and was drugs/AIDS technical advisor for World Concern in Myanmar during the work reported here (1998–2000).

Anne Garrow was a researcher at the International Health Unit of Macfarlane Burnet Centre for Medical Research in Melbourne, Australia at the time that this article was written. Opinions or statements expressed in this article reflect the views of the contributors and do not represent the official policy of the organisations mentioned, unless so stated.

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