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Independent evaluation of

UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar (MMR J63)

and

Reducing the Spread of HIV/AIDS among Drug Users through the HAARP Country Flexible Programme in Myanmar (MMR J69)

in Myanmar

Independent Evaluation Unit

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EXECUTIVE SUMMARY

Projects MMR J63 and MMR J69, funded by the donor organizations and managed and technically supported by UNODC aim to improve harm reduction efforts in several geographical locations in Myanmar that are particularly adversely affected by injection drug use, HIV, and related problems, including Yangon and Mandalay Divisions, and Shan and Kachin states.

Important contributions of the evaluated projects include the establishment and support of a small infrastructure of drop-in centers (DICs), education, outreach, and advocacy efforts in their respective catchment areas. These harm reduction efforts are accepted and well received by the local communities, local and national government agencies, and the police and anti-narcotic enforcement authorities at the local and national levels.

The services offered in these DICs, additional harm reduction efforts conducted through outreach, advocacy, and educational activities conducted by the staff of these centers contribute to the reduction of risky needle sharing practices among injection drug users, help to improve knowledge about risks associated with drug use among beneficiaries, contribute to reducing stigmatization of drug users, and help disseminate information about harmful consequences of drug use and about effective HIV prevention strategies among the reached communities.

The evaluation found that these projects were successfully established and operate in particularly difficult political, economic, social, and sometimes challenging environmental contexts. During their lifespan and despite initial implementation barriers, the harm reduction efforts implemented in the evaluated projects continued to reach increasing numbers of beneficiaries, and made significant progress toward reaching all planned goals or outputs. These successes stem from dedication, sustained efforts, and strong motivations by all individuals who were in the past and who are currently involved in provision of important harm reduction services in these projects.

As per projects design, the evaluated DICs provide protected space where drug users, their partners, and sometimes their family members can rest, socialize, receive snacks (coffee, tea, small meals), or have access to sanitation and clean water. The DICs also offer limited medical care for minor ailments, provide basic informational sessions on issues related to drug use, harm reduction through safer injection practices, prevention of blood borne and infectious diseases, safe sexual practices, and sometimes other issues that are broadly related to drug use and HIV prevention. These centers also engage in active referral efforts to support and enable access to drug treatment programs (methadone treatment and detoxification programs), diagnosis and treatment of sexually transmitted diseases, voluntary counseling and testing, and medical HIV care. The evaluated DICs not only provide information about these external services, but sometimes offer transportation and financial assistance to reduce costs, barriers, and burdens of accessing the external services by the beneficiaries/clients of the DICs.

While these harm reduction projects provide important, valuable, and necessary services, it is difficult to evaluate accurately their effectiveness in reaching the originally designated targets and goals. Changes in HIV prevalence rates, originally proposed as objective measures of efficacy and effectiveness of these projects, cannot be used as reliable indicators directly linking the potential impact of the implemented harm reduction services and the actual reductions HIV infection rates in areas or regions where such services are implemented. More direct and more reliable efficacy indicators would include the HIV incidence rates and behavioral changes among the reached

populations. Currently, no reliable data on HIV incidence rates and only very limited data on behavioral changes among the reached populations are available in Myanmar.

The current harm reduction services implemented and disseminated through the evaluated projects reach a relatively small section of highly visible and impoverished drug users (DUs) and injection drug users (IDUs) in the country and they cater mostly to individuals who are most severely afflicted by injection drug use and related problems. However, these services constitute an important first step and an opportune springboard toward much necessary expansion and improvements in availability, coverage, impact and overall quality of future harm reduction, treatment, and prevention efforts in Myanmar.

The evaluated projects have not reached self-sustainability and will require ongoing funding support from foreign donor organizations to continue to exist and function. Myanmar national and local governments, community organizations, and local businesses recognize the importance of provision of such services and are supportive of continuing and expanding harm reduction and other efforts targeting the reduction of drug use and the curtailment of the spread of HIV in the country. However, financial support for the existing or future projects and services targeting such goals does not exist locally. If the current and future projects and services do not receive continuing funding and technical support from UNODC and the donor organizations they will cease to exist within a short period of time and the current achievements or progress will be lost. Discontinuation of these services may have severe adverse consequences for the current beneficiaries and the local communities affected by drug use, HIV, and related problems.

The evaluated projects either reached the originally planned numerical outputs, or made great progress toward achieving their overall goals. However, despite strong motivation, dedication, and ongoing efforts of all staff of the evaluated projects, the evaluation team identified several areas where improvements can and should be implemented immediately. Additionally, there are a few areas of greater concern representing potentially significant problems and challenges. They will require more careful assessment and consideration of a broad range of potential solutions.

In order to further advance the progress toward reduction of drug use, HIV, and related problems in Myanmar it is critically necessary to support the expansion of evidence based harm reduction, as well as improvement and expansion of treatment, and other prevention services.

To become more efficacious, current and future efforts and services would need to target a broader population of drug users, would need to expand the scope of the offered services and projects, and would need to substantially strengthen their overall quality of delivery of these important projects, services, and efforts.

Additionally, UNODC should increase support and efforts to develop local expertise and resources to collect valid, reliable, and detailed data on a broad range of epidemiological and behavioral trends related to drug use and HIV problems in Myanmar. Future projects should rely more extensively on reliable baseline assessments during their design and should include a broad range of valid performance indicators, including quality control measures in addition to quantitative outputs assessments.

The findings included in this report are based on multiple data, information, and evidence collected during the desk review and during the site visits. The evaluation tools and techniques included structured individual interviews, structured group discussions, focus group discussions, participatory observation and shadowing of DIC's staff and outreach workers, interviews, focus groups and discussions with active drug users and drug dealers. The evaluation team also conducted group discussions with community representatives, local activists, and representatives from various branches of Myanmar government. The evaluation team also reviewed available and pertinent project related documentation and materials, conducted face-to-face and telephone interviews with relevant stakeholders, and visited selected projects' sites in Myanmar.

During the desk review, the evaluation team reviewed all available and relevant documents including documents describing the initial projects plans, original proposals, and budgets; the initial and interim progress reports, including reports from earlier field evaluations conducted by the staff who have worked on the projects and by other evaluators; available financial reports; technical documents and guidelines developed or employed within the scope of the projects; other documents containing descriptions of interventions conducted within the projects; the team also reviewed research data and epidemiological evidence collected within the projects, as well as additional available publications, and research and epidemiological reports pertaining to drug use and HIV situation in Myanmar.

During the field visits, the evaluation team conducted participatory observation and rapid appraisal of implemented services and activities, and conducted face-to-face structured interviews with a broad representation of the projects staff, beneficiaries/clients (drug users and their partners or family members), as well as with smaller samples of representatives from the local communities where the project related interventions and services are carried out (e.g., local community leaders, local police, non-drug using peers and neighbors of the DICs).

Despite extensive and careful planning, the evaluation of the projects MMR J63 and MMR J69 in Myanmar faced important limitations including limited time allotted for the entire evaluation process and some restrictive regulations or laws that precluded the evaluation team's visits at health care, educational, and social resources in the local communities that provide the same, overlapping, or ancillary services to those implemented by the evaluated projects. Additionally, the funding for the project MMR J63 has ended recently, and therefore current activities at the project sites may not fully represent the activities that were undertaken in the past.

However, notwithstanding these limitations, the sites selected for the field visits were representative of diverse settings and geographical locations where the evaluated projects are implemented: the visited sites included DICs in all covered states, except the Kachin state; and the visited sites were located in urban and rural areas of varying population sizes. The individuals, both the staff and the beneficiaries/clients, reached by the evaluation team also represent a broad range of important characteristics. The evaluators were able to interview representatives of all positions/functions within the visited DICs, including staff members with long histories of their involvement in the implementation of the evaluated projects. The evaluators were also able to conduct interviews with beneficiaries/clients of different gender, age, ethnicity; active and recovered drug users; clients with long and short histories of receiving services at the evaluated DICs; clients who are HIV positive and who are HIV negative; as well as spouses, partners, and family members of drug users.

SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

Findings[1]: problems and issues identified	Evidence (sources that substantiate findings)	Recommendations[2]
Longstanding presence and a positive image among government officials in Myanmar gives UNODC a competitive advantage	Interviews with stakeholders, community representatives, members of various branches of the government.	UNODC should increase advocacy efforts to further positively affect the laws and public health policies related to drug use and HIV-AIDS problems. In addition to narcotic control agencies, healthcare, education, and welfare branches of Myanmar government should be institutionally engaged.
Ongoing financial support of existing efforts, as well as expansion and improvement of future harm reduction efforts in Myanmar is critically necessary. The evaluated projects have not reached self-sustainability and no financial support exists at the national or local levels.	Interviews with stakeholders, UNODC staff, national and local government representatives, community representatives.	Increase efforts to identify and engage potential donors at both international and local arenas. Continue to raise awareness of needs among DU and IDU population and their partners
The evaluated projects used the allocated funds as planned and either reached most of the planned outputs or made significant progress toward reaching such goals despite funding and procurement delays, difficulties and delays in recruitment and hiring, relatively high turnover of the hired professional staff, as well as challenging political and social environment.	Desk review, interviews with stakeholders, UNODC staff, field visits, participatory observations and appraisal, interviews with field project staff and beneficiaries.	Experiences and lessons learned during implementation of the evaluated projects, considering particularly challenging political, social, and economic environment should be documented and shared/publicized to benefit future harm reduction efforts.
The evaluated MMR J63 and	Desk review, interviews with	Future harm reduction projects in

[1] A finding uses evidence from data collection to allow for a factual statement. Findings are based on a triangulation of the data collected.

[2] Recommendations are proposals aimed at enhancing the effectiveness, quality, or efficiency of a project/programme; at redesigning the objectives; and/or at the reallocation of resources. For accuracy and credibility, recommendations should be the logical implications of the findings and conclusions.

MM J69 projects were conceived, planned, and initiated during mid-2000s and they target injection drug users who are mostly injecting heroin and/or other opiates (e.g., opium, morphine, pharmaceutically produced opiate medications). Drug use patterns have changed considerably since then in Asia and in Myanmar. Currently many opiate dependent drug injecting individuals in the region are poly-substance users, with some proportion of them injecting opiates and other drugs (e.g., benzodiazepines, and amphetamine type stimulants).	stakeholders, Interviews with beneficiaries/clients, participatory observation at drug use venues.	Myanmar need to increase their efforts to target a broader representation of drug users and include services designed for poly-substance and non-injection drug users.
Accumulation of local service capacity, professional expertise, and sustained behavior changes among IDUs resulting from the implemented projects may be limited.	Interviews with beneficiaries/clients, participatory observation at drug use venues.	Increase efforts to build local expertise and service capacity. Focus future projects on implementing services and interventions that have a better chance of resulting in sustained behavioral and attitudinal changes among IDUs in Myanmar.
Epidemiological data on HIV prevalence among at risk populations in Myanmar is limited, not highly reliable, and cannot be used as strong indicators of the evaluated projects efficacy, effectiveness, or impact of the evaluated projects.	Desk review, interviews with stakeholders, review of data collection capabilities and procedures at the field operations.	Data on changes in behavioral risks, (e.g., rates of injection equipment sharing, unsafe sex practices, and on patterns of drug use behaviors) and reliable estimates of changes in HIV incidence in the respective catchment areas are better indicators of the evaluated projects efficacy, effectiveness, or impact. Additionally, data on the quality of provided services should be used as an important performance indicator. UNODC should increase efforts to support development of local expertise and resources to obtain valid and reliable data on a broad range of epidemiological and behavioral data on drug use and HIV in Myanmar.
Currently implemented progress monitoring and outcome measures focus on numerical benchmarks,	Desk review, interviews with staff of UNODC and visited field DICs, participatory observations and appraisal	Supplement quantitative and numerical performance and outcome measures with expanded and improved methods to

outputs, and outcomes with limited quality control measures or qualitative evaluation or appraisal of implemented services.	during field visits.	monitor and evaluate the quality of services and interventions.
Population of beneficiaries reached by the implemented projects represents a limited range of DUs and IDUs in the projects' catchment areas and in Myanmar. Female DUs and IDUs are likely to be underrepresented in the populations of beneficiaries reached by the evaluated projects.	Desk review, interviews with beneficiaries, staff, and community representatives, site visits to active IDU sites, participatory observations of services delivered at visited sites.	Extend and improve outreach efforts outside highly visible drug use venues, and expand the scope and improve quality of services offered at DICs. Improve and expand collection of data on patterns of drug use and drug use behaviors among broader populations of DUs and IDUs, including important subgroups (e.g., female drug users, youths).
Current DICs infrastructure, staff, and resources are not fully utilized. Administrative resources and efforts often outweigh resources allocated to directly benefit clients.	Field visits, participatory observations and appraisal, Interviews with staff and beneficiaries.	Better reallocation of available space, staff resources, and increased provision of additional on-site services could improve efficiency and cost effectiveness of the current and future projects.
Computerized system and data base (DAISY) developed and implemented to track and report key outputs of the projects (e.g., number unique individuals reached) is not used as the primary entry, tracking, and monitoring tool at the DICs. Personally identifiable and sensitive information is stored and transmitted without sufficient protective measures. DIC's staff is not sufficiently trained in the use of the DAISY system.	Interviews with UNODC management and DIC staff field observations of system utilization and reporting procedures.	Improve the understanding of the system and practical utilization skills of the field staff through additional training. Improve functionality and data content of the system. Improve security and confidentiality of information stored and transmitted through the system, or eliminate personally identifiable information from reports transmitted through unsecure communication channels.
High proportion of current NSP services is provided without direct and sufficient contact with IDUs or in environments not strongly supportive of effective communication or counseling. Delivery of clean injection equipment, educational materials, condoms, and behavioral interventions is often removed from DICs and sometimes delegated to individuals who are not highly capable, not trained, or who	Desk review, participatory observation, interviews with staff, beneficiaries, volunteers, peers, active drug users and individuals involved in drug trade.	Carefully reevaluate current NSP distribution practices. Develop plans to expand onsite provision of NSP services through existing DICs involving extended face-to-face contact, communication, and counseling. Gradually replace contentious distribution practices with evidence based, locally feasible, safe, culturally appropriate, and effective harm reduction efforts,

may have strong conflicts of interests preventing them from provision of high quality or adequate services benefiting IDUs.		including provision of safe injection equipment, education and information, and high quality interventions that directly and unequivocally benefit IDUs in Myanmar.
Current medication assisted symptomatic treatments of drug withdrawals offered at visited DICs are not in line with modern, medical good medical practice standards.	Desk review, field visits, review of medical protocols, implemented standards, medical records, and medication supplies. Interviews with medical personnel of visited DICs and the beneficiaries.	Review and revise current medical protocols and treatment recommendations, in particular, review and revise protocols concerning dispensation of take home doses of benzodiazepines and other psychoactive medications. Better train and supervise medical personnel. Improve comprehensiveness and quality of medical records.
Outreach work is often performed in high risk environments while safety procedures and protocols (e.g., concerning accidental needle stick) are either not fully implemented or not carefully and strictly followed.	Participatory observation and appraisal during field visits. Interviews with outreach workers and management staff of the visited DICs.	Establish improved ongoing training and supervision protocols, implement and monitor more extensive safety protocols. Engage outreach workers and the staff of DICs in developing improved, effective safety protocols (e.g., via focus groups) to better protect them from work related risks.
Current harm reduction messages and interventions misleadingly emphasize that injecting drugs with clean needles and syringes is 100% safe. Distributed clean injection sets do not routinely include disinfecting swabs, and filtering or cooking implements. Needles and syringes distributed to IDS not always meet their preferences. Non-injection drug use methods and effective ways of eliminating drug use are not extensively promoted.	Interviews with staff, outreach workers, peer volunteers, beneficiaries, other active drug users, and their families. Participatory review of provided interventions, review of educational and training materials.	Extend and improve harm reduction messages to include all risks associated with injecting street drugs, to introduce safer (non-injection) drug use methods and effective ways of reducing or eliminating illicit drug use. Improve training of DICs' staff, including, counselors, and employed and voluntary outreach workers. Review and revise informational and educational materials provided to clients. Reevaluate and improve current guidelines regarding injection sets distributed in current and future UNODC projects. Collect more detailed information on types, qualities, and characteristics of street level drugs, local drug use patterns and related behaviors to better inform

		development of more effective harm reduction interventions, messages, and informational and educational materials.

I. INTRODUCTION

Background and context

The Republic of the Union of Myanmar has an estimated population of about 55 million. The country is divided into 17 states and regions, 65 districts and 325 townships. For over fifty years, it has been subject to repeated political and economic crises, which have left Myanmar on the margin of the international community. Ranked 32nd among 50 least developed nations on the basis of the HDI, most of its population lives in conditions of poverty with scarce access to health services. This is particularly true for the North Eastern regions of the country where the two UNODC projects MMR J69 and J63 deploy their resources.

On the basis of public health importance, potential socioeconomic impact, and political importance, HIV/AIDS is ranked as a disease of first priority3 in the country. In terms of the country's overall disease burden4, HIV/AIDS is estimated to contribute 4.3%; and, has been estimated to be responsible for 4% of all deaths5. In 2009 the country had an estimated 238,000 people living with HIV6, of which approximately 74,000 met the criteria7 for needing antiretroviral therapy (ART). Of these, however, only around 21,000 currently receive ART8.

Although the overall national prevalence of HIV is estimated at below 1%, prevalence continues to remain very high among populations engaging in risky behaviors, particularly injecting drug users. The official consensus estimate of IDU population size is 75,000 (range 60,000 – 90,000),9

UNODC is responsible for coordinating illicit drug control strategies on a global level. The organization is entrusted with the responsibility for coordinating and providing effective leadership for all United Nations drug control activities. UNODC's main priorities are governed by the various United Nations Drug Control Conventions and UNODC is a co-sponsor of, since 1999, the Joint UN Programme on HIV/AIDS (UNAIDS) and, as such, has been designated the Convening UN Agency in the UNAIDS Global Division of Labour for the thematic area entitled "Protecting drug users from becoming infected with HIV and ensure access to comprehensive HIV services for people in prisons and other closed settings".

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[3] Myanmar Ministry of Health, *Health in Myanmar*, Naypyitaw, 2009.

[4] Overall disease burden is expressed in disability adjusted life years (DALY).

[5] World Health Organisation, *Global Burden of Disease: 2004 Update*, Geneva, 2008.

[6] National AIDS Programme, *HIV Estimates and Projections for Myanmar: 2008-2015*, Naypyitaw, 2010. UNAIDS records a figure of 240,000 (range 160,000 – 370,000).

[7] According to the World Health Organisation CD4 threshold of <200. Employing WHO's forthcoming increased CD4 threshold of <350 would significantly increase the estimated population in need of ART.

[8] *Myanmar National Strategic Plan on HIV and AIDS, 2011-2015*, draft for clearance, 21 October 2010.

[9] It is likely that this figure is an under-estimate as this IDU population size estimate is based on a consensus figure. See *Myanmar National Strategic Plan on HIV and AIDS, 2011-2015*, draft for clearance, 21 October 2010; and, National AIDS Programme, *HIV Sentinel Surveillance Survey*, Naypyitaw, 2009.

In order to support Myanmar's efforts more directly in developing and expanding the availability of and access to evidence-based harm reduction services for male and female drug users, including improving co-ordination and support from law enforcement, the UNODC projects MMR/J63 and MMR/J69 were developed and implemented. These projects both fall under the UNODC Regional Programme Framework for East Asia and the Pacific, thematic area 2 (Health and Development), and are aligned to that Framework's sub-programme 5 (HIV/AIDS). The Regional Programme Framework forms the basis within which all UNODC regional programming is developed and implemented.

Also, the two projects were designed in line with UNODC Myanmar Strategic Programme Framework (SPF) (2004-2007) Objective 2: *"By 2008, to have reduced significantly the spread of HIV/AIDS through injecting drug use in targeted intervention areas"*

The results of these two HIV projects are measured against global UNAIDS Unified Budget and Workplan (UBW) indicators, common regional indicators under the regional HIV sub-programme and UNODC SPF indicators and contribute to UNODC overall results in the region and country,.

The current evaluation of these two projects is linked also to a forthcoming global HIV programme evaluation within UNODC, and in this regard the evaluation of these two projects should be seen as a case study to be incorporated into the global in-depth evaluation exercise.

MMR/J63, UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar

The project J63 was funded by the Three Diseases Fund (3DF) and has undergone a final evaluation as per UNODC Evaluation Policy and Standards through the present evaluation report.

The 3DF in brief

Seven donors compose the Three Diseases Fund: Denmark, Great Britain, the European Commission, the Netherlands, Sweden, Norway and Australia. It aims to reduce the burden of HIV and AIDS, tuberculosis (TB) and malaria in Myanmar with over $100 million worth of grants awarded to dozens of implementing partners. As part of its identified priorities, the 3DF has provided gap-filling support to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF) Principal Recipients until their programs are fully functioning.

In 2003 the European Commission (EC) established a bilateral program of EUR 5 million to support HIV/AIDS projects jointly with other donors under the UN Joint Program for HIV/AIDS in Myanmar. At the same time Great Britain, Sweden, Norway and the Netherlands also provided support through the Fund for HIV/AIDS in Myanmar (FHAM). This support was aligned with the MoH's National AIDS Program. The Mid Term Review of the Joint Program and FHAM in 2005 identified two main weaknesses. On the one hand, the impact and the scope of all interventions were not sufficiently targeted to the needs of the most at-risk populations. On the other hand, there was a potential risk of conflict of interest within the FHAM funding system. No donor involvement in fund direction and decision-making was taking place and this strongly compromised its integrity in terms of partnerships within Myanmar and in terms of transparency with fund recipients. In

addition, international sanctions further prevented funds to be channeled through such a mechanism. As a consequence, the FHAM donors sought to replace the fund with a mechanism that addressed these weaknesses and took account of the presence of the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis (GFATM). The donors sought to develop the new Three Diseases Fund to respond to the funding gap left by the GFATM and the FHAM by 2006. With the active involvement of MoH, the UN facilitating agencies and Implementing Partners, a MoU with UNOPS was signed. The donors committed an initial $100m to cover the first five years of the 3DF.

The 3DF governance framework and institutional arrangements were designed to take account of the criticisms of the FHAM by separating national planning processes from fund allocation decisions. By continuing the concept of Technical Working Groups for each disease through new Technical and Strategic Groups (TSGs), involving all implementing partners (IPs) and facilitated by UN agencies, MoH planning processes for the three diseases would be reinforced and supported. The 3DF donors and staff would not be involved in the planning processes for the national plans for each disease but would allocate 3DF resources based on the priorities of the national plans. The intention was that national planning, led by MoH, would be strengthened and that 3DF assessment of the priorities in the plan would lead to independent fund allocation that reinforced service delivery by international NGOs, UN agencies, national NGOs and local civil society actors. In line with the EU Common Position, the 3DF would support activities of the MoH and other line Ministries through decentralized cooperation with local civilian administrations. In order to centralize all efforts, remain accountable and transparent, and best address the three diseases, the 3DF was established as a competitive fund, providing resources for activities in line with the national strategies but the process was operating in parallel with, but not directly relating to, the planning arrangements.

MMR J63 in brief

MMR J63 is a successor project of a former harm reduction project which started in 2003 with the support of funding from the Fund for HIV/AIDS in Myanmar (FHAM), and continued with funding support from the Three Diseases Fund (3DF) in 2007. The project was implemented in four townships in Northern Shan State and one township in the Eastern Shan State. The project is implemented in a partnership approach with international NGOs, national NGOs and other community-based organizations.

The J63 project document was signed in 2007 by the Central Committee for Drug Abuse Control (CCDAC) of the Ministry of Home Affairs (MoHA) and UNODC in light of the urgent need to improve the availability of and access to harm reduction services for drug users and their sexual partners in Myanmar. The project J63 was a continuation of an earlier project (MMR/G43) implemented by UNODC from 2004 to April 2007. Following the launch of the 3DF in Myanmar, the current project J63 was created in order to continue the earlier project's intervention activities and services. This continuation of services was designed to be done in a partnership approach with the Myanmar Business Coalition on AIDS (MBCA), Marie Stopes International (MSI), Township Project Management Committees (TPMCs) and three Community Based Organizations (CBOs). The project was implemented in four townships in northern Shan State and one township in eastern Shan State. J63 was developed with a duration of 4.5 years (April 2007 to December 2011), and with a budget of US$ 3,324,800.

The overall objective of the project was to assist the Myanmar Government to achieve significant and measurable reductions in the incidence of HIV among injecting drug users (IDUs) in the project townships, and to increase awareness and correct knowledge about drug-related HIV infection and

positively change drug-use behavior and health-seeking practices among drug users, injecting drug users, their sexual partners, and other 'at risk' populations.

Broadly specified aims of the project were described as: 1) scaling up of and making outreach services comprehensive and effective in five project townships; 2) increasing access to prevention to "at risk" mobile transport workers; 3) increasing access to quality VCT, STIs diagnosis and treatment; 4) increasing involvement of the PLWHs, self-help groups; and 5) building necessary local and Community based Organization (CBO) capacities. Planned service elements and sub-components to be offered in the J63 project included: Drop in Centers (DIC) with outpatient service; Outreach to the DUs and IDUs (prevention, risk reduction and health protection); Targeted prevention, awareness, advocacy and enabling environment; Income generating skills, socio-economic-livelihood support; VCCT and STIs diagnosis and treatment; MMT and drug treatment; Drug treatment in the community; Care and services to the PLHAs; Follow ups, home visits, care and services in the community; Referral to providers of specialist services; and Township level coordination, communication, networking.[10]

MMR J69 Reducing the Spread of HIV/AIDS among Drug Users through the HAARP Country Flexible Programme in Myanmar

The project MMR J69 was funded by AusAid and has undergone, through the present evaluation, a mid-term evaluation as per UNODC Evaluation Policy and Standards.

The HIV-AIDS Asia Regional Program (HAARP) in brief:

The HIV/AIDS Asia Regional Program (HAARP) is the Australian Government Aid Program funded initiative committed to supporting the provision of high quality HIV prevention for injecting drug users in South East Asia.

HAARP aims to strengthen the capacity and will of governments and communities in the region to adopt effective harm reduction approaches that address HIV transmission associated with drug use, especially injecting drug use. A bidding process for the implementation of country level programs was initiated in which UNODC participated. As a consequence, UNODC started in 2007 to establish country level programs in Myanmar, Cambodia, China (some Provinces), Laos and Vietnam (3 Provinces) with a research program in the Philippines. Regional coordination and assistance are provided by the Technical Support Unit (TSU) in Bangkok, Thailand. The program will run until 2015, with a total funding of AUD$59m over the eight year period.

Australia's support for HIV prevention in South East Asia dates back to 2002 with the creation of the Asia Regional HIV/AIDS Program (ARHP). As AusAID began working with local partners in Myanmar, China and Vietnam to reduce HIV associated with drug use, fifteen harm reduction pilot projects were eventually established in Myanmar and southern China - in which a range of services are provided to IDUs to reduce HIV transmission, and in Vietnam significant training and capacity building activities took place within Vietnamese law enforcement agencies (UNODC is also in the picture in Vietnam).

Recognizing the benefits of a regional approach, HAARP was therefore designed to build upon and scale-up the work of ARHP by incorporating Cambodia, Laos and the Philippines into the regional

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10 See Project Document MMRJ63, August 15 2007 and Project Reference Manual

program. The intention was to create a framework that specifically promotes regional cooperation and addressed cross-border issues, not only among Australian activities but also among other international agencies, CSOs and NGOs, and at the same time supported the locality-specific and technical aspects of work on HIV associated with drug use within various national HIV programs. The design of MMR J69 is therefore strongly CSO and NGO focused, and includes a various range of local and national official authorities and non-official, community based actors.

HAARP comprises three elements, two at the regional level and one at the country level, which incorporates all the country programs (called Country Flexible Programs or CFPs in design). In the first element, a new Regional Technical and Coordination Unit (RTCU), subsequently renamed as Technical Support Unit (TSU) is responsible for managing regional level activities with the aim of extending the contributions of national activities towards regional level outcomes. In the second, the TSU works with relevant multilateral agencies that work on HIV and drug use in the region, as well as coordinate with other organizations to ensure complementarity and maximize effectiveness of all efforts in the area of HIV associated with drug use. For the third element (country level), the Program provides an overall technical and performance framework in which HIV and harm reduction activities can be implemented, which respond to local contextual issues and priorities. The TSU provides relevant high-level support and technical inputs as required by the respective CFPs.

No pre-determined outputs are established and the work of the TSU is a combination of innovative efforts to bring about policy and implementation improvements in HIV and Drugs across the region, shared learning and cooperation, and responsiveness to requests for technical assistance from CFPs.

The outcomes of the program at country level are expected to be: increased national and sub-national level understanding about the necessity and value of sharing information about government and community-led efforts to address drug use within HIV policies, strategies and programs; increased experience among governments and communities of initiating and managing efforts to address drug use and HIV issues; increased expertise in the practical use of approaches and methods that will assist in reducing the HIV harm associated with drug use among men and women in the respective country.

As regards the Myanmar Country Program, its aim is to reduce the transmission of HIV associated with injecting drug use. The project builds on the achievements of the preceding Asia HIV/AIDS Regional Program (ARHP), which established five Effective Approaches Project (EAP) sites. The HAARP Country Program in Myanmar is expanding and further strengthening provision of harm reduction services, and supporting the scale up of activities and expansion of sites.

The Myanmar Country Program (CP) is therefore designed to enhance the policy and legal environment in which the Burma (Myanmar) CP operates; provide, via both fixed site & outreach modalities, the expanded harm reduction services that drug users require to keep them free of risk from HIV; build community-level management capacity for management of services; strengthen Myanmar cooperation with regional initiatives to prevent HIV transmission in injecting drug users.

MMR J69 in brief:

The Country Program is managed by the UNODC Country Office in Myanmar (COMYA). UNODC implements CP activities in collaboration with the Central Committee for Drug Abuse Control (CCDAC), Ministry of Health (through the National AIDS Program - NAP), Township Committee members and NGO partners. UNODC is responsible for the development and implementation of annual work plans and budgets that are technically reviewed by the HAARP Technical Support Unit (TSU).

The CP is currently operating in 10 sites across the North East of the country. There are currently HAARP funded outreach and needle and syringe programs in the following townships: Mandalay, Lashio, Muse, Tachilek, Mogok, Myitkyina, Pyin Oo Lwin, Phakant, Taunggyi, and Yangon.

The HAARP commenced in 2007, with its specific goal and purpose being:

- Goal: To reduce the spread of HIV associated with drug use among men and women in South East Asia and China.
- Purpose: To strengthen the capacity and will of governments and communities in South East Asia and China to reduce HIV-related harm associated with drug use.

Outcomes contributing to the overall program Goal and Purpose are developed for and contained in individual Country Programmes (CP) created for each of the six HAARP country partners. The outcomes for the Myanmar CP are the following:

a. Enhanced policy and legal environment in which the Myanmar CP operates.
b. Scaled-up harm reduction services for drug users.
c. Increased community-level capacity for management of harm reduction services.
d. Strengthened involvement of Myanmar CP stakeholders in regional HAARP activities.

A three-year Myanmar CP commenced in January 2008 following a transition period from the ARHP which had been operational in five project sites in Myanmar since 2002. UNODC is the management contractor for this CP, and has been coordinating the implementation of the CP sub-components. UNODC brings to this management role the unique ability to convene and coordinate with Government and other national and international stakeholders within Myanmar on the subject of expanding availability of and access to HIV harm reduction services for injecting drug users and their sexual partners. Through the initial three-year CP UNODC has taken a strong role in directly coordinating the development and implementation of harm reduction service provision by local partners in line with established UN standards and norms. UNODC on-going field presence in support of the CP also aids in the frequent identification of systemic (and, occasionally, unique) harm reduction service delivery constraints, gaps and/ or barriers. This then enables the development by UNODC of relevant solutions generated through provision of immediate technical assistance and/or through consultation convened with input from stakeholders at the community, state, and national levels.

The design of MMR J69 specified the project's target groups as "drug users, injecting drug users, young people at "most risk" and vulnerable to drug abuse and to IDUs in the community, as well as their sexual partners." The MMR J69 project planned "to provide services to 20% of the estimated (injecting) drug users." Broadly specified project objectives aimed "to reduce HIV transmission associated with (injecting) drug use among an estimated 35,000 - 50,000 drug users including female IDUs and their sexual partners by 5% through comprehensive risk reduction and sexual and reproductive health services in 18 township sites." The project MMR J69 design documents included four primary outcomes: "1) Increased national and sub-national level understanding about the necessity and value of sharing information about governments and community led efforts to address drug use within HIV policies, strategies and programmes; 2) Increased expertise in the practical use of approaches and methods that will assist in reducing the HIV harm associated with drug use among men and women in Myanmar; 3) Increased experience among communities of initiating and managing efforts to address drug use and HIV issues; and 4) Strengthened cooperation of Myanmar in the region and plan other country specific activities." Additionally, a range of outputs associated with these outcomes was outlined (see documents Funding agreement & Concept Note 2011.pdf and MMRJ69 Final Prodoc31 Aug 2010.doc for complete description of planned outcomes and outputs).

Evaluation Methodology and Data Sources

The two evaluated projects closely relate to each other and were implemented in the same geographical areas of the country during the overlapping times. In addition to their geographical and time coinciding, both projects targeted the same populations of beneficiaries and had similar objectives addressing intertwined problems in the area of drug abuse and HIV in Myanmar. These problems are still present in the regions of Myanmar where the evaluated projects have been operating. Furthermore, because of the recent discontinuation of financial support for activities previously conducted under the umbrella of the project MMR J63, occasionally, staff of the project MMR J69 undertakes commendable efforts to address upcoming issues as they arise, without scrupulous delineation between MMR J63 and MMR J69 mandates. Therefore, it would be very difficult to describe these two so clearly overlapping projects in two separate evaluation reports. While some differences in the design and implementation of the two evaluated projects may have had important impact on their respective efficiency and effectiveness (e.g., centralized procurement requirements in MMR J63 resulted in delays and some shortcomings – they are described in the later parts of this evaluation report), separate evaluations of these two projects may also unnecessarily dilute important big picture issues and fail to inform major stakeholders and core learning partners about key lessons learnt.

The current evaluation of the projects MMR J63 and MMR J69 implemented in Myanmar is based on multiple data, information, and evidence sources. The evaluation team reviewed, discussed, and summarized all available and pertinent project related documents, conducted face-to-face and telephone interviews with relevant stakeholders, and visited selected projects' sites in Myanmar.

All information collected directly from individuals involved in planning, implementation, service provision, management, and monitoring of the evaluated projects, as well as the evidence and data obtained from all other sources or information collacted using different tools or methods were triangulated, or crosschecked against each other to improve the validity and reliability of source information before formulating the findings and recommendations included in this report. This report is the result of a triangulation of all sources of information as described in this section of the report.

During the desk review portion of the evaluation mission, the evaluation team reviewed previous progress and monitoring reports, financial reports, and a range of other relevant internal documents and published reports. Over 130 individual documents were provided to the Evaluation Team Members (Annex A includes the list of all documents reviewed by the evaluation team). The range and type of documents reviewed and analyzed during the desk review included documents describing the initial projects plans, original project proposals and budgets; the initial and interim progress reports, including reports from earlier field evaluations conducted by the staff who have worked on the projects and by other evaluators; available financial reports; technical documents and guidelines developed or employed within the scope of the projects; other documents containing descriptions of interventions conducted within the projects. The evaluation team also reviewed research data and epidemiological evidence collected within the projects, as well as additional available published evidence, research, and epidemiological reports pertaining to drug use and HIV situation in Myanmar.

Between February 18 and March 6, 2012, the evaluation team also travelled across the country collecting data and evidence at selected project sites in Yangon Division, Mandalay Division, and Shan States. During the field review, the evaluation team conducted face-to-face discussions and structured interviews with projects stakeholders (including WHO, UNAIDS, 3DF, AusAid, UNODC staff as well as beneficiaries, local authorities, community organizations, and implementing

partners), visited selected project sites, obtained information from project staff and from recipients of services in these projects; obtained information from the neighbors of these projects, and from representatives of local authorities, local and national government.

During field visits at DICs, the evaluation team also reviewed all available documentation, including the registries of clients/beneficiaries, records of their participation, records of their daily/periodical attendance, and available medical records/documentation. The team also reviewed inventories of supplies pertinent to the key services offered by the projects (e.g., inventories of needles, syringes, medications and medical supplies), and reviewed existing computerized records, data storage, and electronic data reporting systems and data transmission capabilities of each visited DIC. Additionally, the evaluation team visited one methadone dispensing center and several drug use/injection sites ("shooting galleries" or "needle parks").

The evaluation tools and techniques included structured individual interviews, structured group discussions, focus group discussions, participatory observation and shadowing of DIC's staff and outreach workers, interviews and discussions with active drug users and drug dealers. The evaluation team also conducted group discussions with community representatives, local activists, and representatives from various branches of Myanmar government. Overall, during the field visits in Myanmar, the evaluation team conducted individual or small group (2 to 3 participants), face-to-face structured interviews with over 40 individuals, and lead group discussions with over 120 additional individuals. Further information on the structured interviews and tools used can be found in Annex III.

While other data collection tools, techniques, and methods are available, face-to-face strtuctured interviews with individuals who are directly involved in planning, implementation, services provision, management, and evaluation, as well as with individuals who are directly or indirectly affected by the services and activities of the evaluated projects were selected to be the most appropriate tools to be used during the field visits. Alternative methods, such as questionnaires, surveys, tests, or quizzes would require exstensive preliminary work and pilot testing to ensure their validity, reliability, and cultural acceptability before translated versions of such instruments could be administered among samples or populations of targeted individuals. The process of developing such tools is complicated, takes long time, and often requires multistep research efforts to obtain valid and reliable results. Structured interviews, on the other hand, are more flexible, better suited and easier to adapt to local cultural contexts, can be conducted with the help of local interpreters, and are more valid, and efficient tools for a rapid apprisial in naturalistic environment. During the planning of the evaluation mission, several alternative tools and methodologies were discussed, and structured interviews were selected as the primary tools for the filed visit portion of the current evaluation.

The evaluation team also collected and reviewed copies of pertinent protocols, documents, educational materials (e.g., handouts, training materials) examples of dispensed injection equipment, other supplies, and materials, all of which were further used in triangulation of the evidence alnong with other evaluated data sources or documents. Throughout the entire evaluation process, the team collected extensive notes, conducted discussions and critical reviews of all collected evidence, and took pictures in order to fully document all fact finding activities, encounters, and evidence collected during the field visits.

All individual face-to-face interviews with the staff and beneficiaries/clients of the visited DICs and projects were conducted under the explicit conditions of confidentiality and privacy and focused on activities, events, situations, and encounters of these individuals. All information and evidence obtained in these interviews is therefore based on firsthand and direct knowledge and experiences. Because the visited and evaluated projects are relatively small – they typically employ one manager, one medical officer, one nurse, one counselor, a few outreach workers, and a few

additional staff – and because the evaluation team interviewed a relatively small number of beneficiaries/clients, the evaluation team is facing a responsibility to maintain confidentiality of the information sources while reporting on the mission/evaluation findings. Therefore, despite the fact that the team collected detailed notes and other detailed evidence, the level of the identifying details (names, functions, positions, individual characteristics, and locations) associated with the evidence supporting the findings included in this report will be limited in order to maintain the confidentiality of all individuals that provided the team with the valuable information and evidence.

The evaluation team was composed of one lead evaluator, one national consultant, and one staff member of the UNODC Independent Evaluation Unit. Additionally, during the initial portion of the visit, two external observers (and as such not part of the evaluation team) from AusAID accompanied the evaluation team: one staff member of the AusAid Bangkok Office joined the evaluation team during the first five days of Yangon visits and meetings, another staff member from AusAid Yangon Office joined the evaluation team during the remaining 1 day in Yangon and during the visit in Mandalay). Because of the timeframe proposed by the travel itinerary and the amount of data collection that had to take place, the team adopted a flexible approach and was splitting on several occasions. Prior to separated visits, meetings, or discussions, the lead evaluator and the evaluation team members developed detailed plans and clear instructions regarding evaluation activities during split visits and daily briefings were held among the team to keep all members informed of all information gathered and all observations collected at all times.

Challenges and limitations

Evaluating active projects or services, such as social support, health care, or educational programs implemented in the real world settings, poses important challenges. In order to observe projects, services, and activities as they are truly implemented without disrupting their ability to provide such services, and in order to ensure high reliability and objectivity/representativeness of the collected data and evidence, it is necessary to minimize the impact of the evaluation process on the day-to-day activities within the evaluated projects. In case of evaluating active programs and services implemented within a context of a delicate balance between opposing and supporting opinions, attitudes, and interests the challenge and the responsibility is even greater.

The evaluation team took efforts to minimize the size and visibility of the visiting entourage (e.g., limiting the number of observers, removing traveling vehicles from the visiting sites), to minimize disruption in day-to-day activities or service delivery at the visited sites (e.g., discouraging long presentations or conferences at the sites, discouraging inviting additional visitors from the communities, encouraging clients/beneficiaries to enter the projects and to receive services as usual despite our presence). These efforts were not always successful. Some of the DICs were visited during weekends (the staff and clients had to be invited especially for the evaluation team visit), and because of traditional cultural local norms which often dictate additional preparations and special treatment of guests/visitors, efforts were taken to host and inform the team and such efforts may have limited the ability to perform work as usual in the visited locations.

In order to maintain objectivity and a neutral, non-judgmental attitude toward evaluated projects, the evaluation team also paid careful attention to not point out or expose deficiencies while collecting evidence pertaining to the effectiveness, efficacy, or impact of the evaluated services and projects, and successful efforts were not to make recommendations or suggestions based on immediate findings or observations during the evaluation process.

Despite extensive and careful planning, the evaluation of the projects MMR J63 and MMR J69 in Myanmar faced important limitations. These limitations include the limited time allotted for the entire evaluation process and consequently limited time that could be allocated to spend at each of

the visited projects sites. Additionally, the funding for the project MMR J63 has ended recently, and therefore current activities at the project sites may not fully represent the activities that were undertaken in the past. Moreover, due to various regulations, laws, travel difficulties and restrictions, and ongoing unrest or military conflict in the Kachin state, the evaluation team had a limited freedom of movement and was not able to visit all sites where the projects MMR J63 and MMR J69 were implemented. The team was also not able to visit other health care, educational, and social resources in the local communities that provide the same, overlapping, or ancillary services. For similar reasons, all site visits had to be planned and scheduled well in advance limiting the evaluation's team ability to sample or select the locations to be visited during the mission.

Despite these limitations, the sites selected for the field visits were representative of diverse settings and geographical locations where the evaluated projects are implemented: the visited sites included DICs in all covered states, except the Kachin state; and the visited sites were located in urban and rural areas of varying population sizes. The individuals, both the staff and the beneficiaries/clients, reached by the evaluation team also represent a broad range of important characteristics. The evaluators were able to interview representatives of all positions/functions within the visited DICs, including staff members with long histories of their involvement in the implementation of the evaluated projects. The evaluators were also able to conduct interviews with beneficiaries/clients of different gender, age, ethnicity; active and recovered drug users; clients with long and short histories of receiving services at the evaluated DICs; clients who are HIV positive and who are HIV negative; as well as spouses, partners, and family members of drug users.

In addition, despite understandable and socially and culturally appropriate efforts of DICs' staff to prepare, summarize, and present to the team their own views of the achievements and challenges faced during the delivery of the services and interventions implemented within the scope of the evaluated projects, the evaluation team was able to reach beyond the prepared presentations and was able to collect reliable independent information, data, and evidence pertaining to the relevance, effectiveness, efficiency, impact, sustainability and the overall quality of the evaluated projects and services.

The evaluation team has not encountered any evidence of active deception, misrepresentation of achievements or information, fabrication of evidence, or active efforts to interfere or obstruct our efforts to collect data or evidence. All staff members and beneficiaries/clients reached by the evaluation team were collaborative, engaged, and supportive of our efforts.

II. EVALUATION FINDINGS

The Terms of Reference for the current evaluation of the projects MMR J63 and MMR J69 implemented in Myanmar included a broad range of evaluation areas and specific questions pertaining to the overall design of the projects, their relevance, efficiency, effectiveness, impact, partnerships and cooperation, and sustainability. Answers to the majority of these questions are included in the descriptive summary of the evaluation findings below.

Design

The review of background epidemiological information on the drug use and HIV situation in Myanmar included in the design and in plans for the evaluated projects, as well as information available from other published sources (including reports by UNODC and WHO) indicates that most background and epidemiological estimates on Myanmar drug and HIV situation before the onset of these projects was based on expert opinions, case studies, or at best on small sample research, rather than on reliable epidemiological evidence. It is important to note that such sources are seldom highly accurate, and that a significant bias in either direction (underestimates and overestimates) could be introduced to the assessment needs based on such sources. While the lack of reliable epidemiological information from Myanmar it is understandable considering the general political, economic, and social context, it is also important to understand that this lack of reliable baseline information was a significant implementation challenge and a limitation in assessing accomplishments of the evaluated projects.

Based on the desk review and on additional data collected during the field visits portion of the mission, the evaluation team found that the goals, aims, and outputs of the two evaluated projects while intuitively important and potentially beneficial to the targeted populations in Myanmar were not specified in terms of clear, achievable, and measurable outcomes or performance indicators that can be directly linked to the interventions or services implemented within the scope of the evaluated projects.

The design plans and protocols of the two evaluated projects proposed reductions in HIV prevalence rates as one of the key objective outcomes. However, if a significant/substantial reduction of HIV prevalence in a country over a relatively short period of time (several years) is truly achieved, the interpretation of such an outcome poses significant challenges. Becoming infected with HIV is a terminal event (currently there are no means/treatments reversing HIV infection status from positive to negative), the prevalence of HIV infection in a population can only be reduced through processes involving substantial mortality of the already infected individuals along with a diminishing rate of the new infections. It is not likely that in the Myanmar context a dramatic reduction of HIV prevalence could be achieved over a short time period, nor should it be expected, projected, or anticipated as a result of the two projects under evaluation. The incidence rate, or the number of newly detected infections, could be a better, more accurate measure of progress in combating the spread of a disease. However, a precise and reliable measurement of HIV incidence rate requires a well-established network of healthcare facilities and a sophisticated epidemiological surveillance system, both of which were not, and currently are still not, available in Myanmar and most other countries.

Education about transmission means and routes, interventions to reduce behavioral risks, medical treatment of already infected individuals, effective treatment of substance abusing or dependent individuals, evidence based harm reduction measures and initiatives, and implementation of interventions aimed at improving life opportunities for at-risk individuals are most often cited as

important factors contributing to reductions in intertwined drug use and HIV problems. Well defined outcomes measuring achievements in such efforts could also serve as reliable performance measures in future efforts.

Other goals of the projects included in their initial design/proposal documents aimed to broadly improve harm reduction efforts in Myanmar and were described as efforts to "increase, enhance, scale-up, support, nurture," etc. existing and future efforts in this arena. However, these important goals were not associated with clearly measurable indicators. Future proposals should provide detailed, well defined, and measurable outcomes/outputs for all significant aims and goals of the planned projects.

Objectives and outputs specified in the design of the evaluated projects included numerical indicators of the numbers of clients/beneficiaries reached by these projects, the numbers of clients referred to other services (e.g., methadone treatment, HIV treatment, voluntary counseling and testing), and the numbers of clean injection equipment distributed to IDUs in the projects catchment areas. Despite initial implementation barriers and difficult political, economic, social, and sometimes challenging environmental contexts in which the evaluated projects operate, due to dedication, sustained efforts, and strong motivations by all individuals who were in the past and who are currently involved in provision of important harm reduction services in these projects, the evaluated projects continued to reach increasing numbers of beneficiaries and were able to distribute a steadily increasing number of needles, syringes, and condoms in their respective catchment areas.

In summary, the evaluated projects specified a range of numerical outcomes and outputs intended to measure overall performance (e.g., the numbers of clients/beneficiaries reached by these projects, the numbers of clients referred to other services, and the numbers of clean injection equipment distributed). On the other hand, less attention has been given in the design and during the implementation of the evaluated projects to measuring behavioral change (e.g., reductions in the rates of needle sharing, injection drug use, and unsafe sexual practices) among the targeted populations, or to measuring the quality of services and interventions.

Consequently, current performance monitoring and reporting protocols implemented in the evaluated projects focus on numerical benchmark indicators with only limited efforts directed towards assessing, evaluating, and reporting on the quality of services and interventions. The current evaluation mission, by combining document and protocols review with participatory field visits gave a unique opportunity to better evaluate actual field implementation, scope, and quality of services and interventions within the evaluated MMR J63 and MMR J69 harm reduction projects.

Relevance

The overall goals and objectives of the evaluated projects aimed at important social and public health care problems existing in Myanmar during the planning and design phases of the projects. The evaluated projects are also well aligned with Myanmar national HIV/AIDS strategic plans, the strategic plans of the donor organizations, as well as UNODC global mandate and regional programme objectives. Also, the two projects were drafted in line with the UNODC Myanmar Strategic Programme Framework, 2004-2007 Objective 2: "By 2008, to have reduced significantly the spread of HIV/AIDS through injecting drug use in targeted intervention areas".

While the evaluated projects contributed to reaching some progress in achieving goals outlined in Myanmar national strategic plans (see National Strategic Plan for HIV/AIDS in Myanmar, Progress report 2010), illicit drug use and HIV transmission remain to be important and challenging

problems in Myanmar. Building upon achievements of the implemented projects, continuation and expansion of harm reduction services and interventions, and ongoing technical and financial support facilitated by UNODC is necessary to sustain or enhance the progress toward reaching the goals and objectives outlined in Myanmar future strategic HIV/AIDS goals.

The services offered through DICs established and supported by the evaluated projects and additional harm reduction efforts conducted through outreach, advocacy, and educational activities conducted by the staff of these centers contribute to the reduction of risky needle sharing practices among injection drug users, help to improve knowledge about risks associated with drug use among all reached beneficiaries, contribute to reducing stigmatization of drug users, and help disseminate information about harmful consequences of drug use and about effective HIV prevention strategies in the reached communities.

The evaluated MMR J63 and MMR J69 harm reduction projects and the services implemented and delivered in these projects were designed to target injection drug users who are mostly injecting heroin and/or other opiates (e.g., opium, morphine, pharmaceutically produced opiate medications). While the majority of IDUs were likely to be primary heroin or opiate injectors during the time when the evaluated MMR J63 and MM J69 projects were conceived, planned, and initiated (during mid 2000s), the patterns and trends in drug use in Asia and in Myanmar have changed considerably since then.

Extensive epidemiological and other research data collected in Asia over the past several years shows that while abuse of heroin and other opiates has somewhat stabilized, new trends and new illicit drugs emerged rapidly in the region. In the countries surrounding Myanmar, including China, Thailand, Malaysia, abuse of amphetamine type stimulants (ATS) increased significantly in recent years and many opiate dependent individuals in the region are poly-substance users, with some proportion of them injecting both opiates and ATS drugs.[11]

These new trends pose significant challenges to the traditional harm reduction efforts. While there is a growing body of evidence that ATS abuse is a significant risk factor for HIV transmission, the precise understanding of means and ways that ATS abuse contributes to the spread of HIV are not yet fully uncovered. It is reasonable to assume that ATS risks include increased sexual stimulation/desire and impaired decision making resulting in higher rates of unsafe sex practices and potentially higher rates of unsafe injection practices among ATS abusers. Future harm reduction projects in Myanmar need to increase their efforts to target a broader representation of drug users and include/expand services designed for poly-substance and non-injection drug users.

The interviews with the staff of visited DICs' indicated that drug use in Myanmar is virtually limited to the "shooting galleries" or "needle parks." Therefore, virtually all harm reduction efforts implemented by the visited DICs are targeting such places and the individuals who frequent such places or supply drugs in those locations. On the other hand, the interviews with active drug users and their families indicated that drug users often use drugs at home, at other private locations (small private parties), at entertainment venues, and other places. The current harm reduction efforts in Myanmar rarely reach drug users that are not highly visible and who do not frequently aggregate or use drugs in "shooting galleries" or "needle parks." For example, females account for only a very small fraction of current beneficiaries/clients of the evaluated DICs. This problem has been noted by the DICs' staff and recognized in several earlier evaluation visits. Some efforts to increase the number of female drug users participating in current harm reduction projects have been

[11] See UNODC's 2011 Global ATS Assessment; Myanmar Situation Assessment on Amphetamine-Type Stimulants, December 2010.

made (e.g., in several of visited DICs female friendly environment have been created/designated, typically in a form of a separate room called "female corner").

Currently there is no reliable epidemiological evidence regarding the estimated size or proportion of females among all drug users in Myanmar. During the interviews with female clients of the DICs and during visits to active drug use sites, the evaluation team learned that female drug users in the visited areas of Myanmar very rarely utilize such places and they mostly use drugs at home. Reaching a higher proportion female IDUs, especially those who do not use drugs in the "shooting galleries" or "needle parks" will require more extensive targeted outreach efforts and provision of services that are attractive, desirable, or beneficial to female drug users.

Presently, all of the visited DICs are marked and advertised by large, highly visible banners. While acknowledging donors supporting harm reduction services, openness and visibility of these centers can help reduce stigmatization of drug users and people leaving with HIV, significant numbers of drug using individuals may prefer not to become highly visible and labeled because of receiving help or support at these currently broadly advertised venues. In other countries, harm reduction organizations frequently use a low profile approach using smaller and less obvious signs, or using non-interpretable acronyms to acknowledge the donors and to mark locations where important harm reduction and other services are provided to drug users, their partners, and their families.

Efficiency

The evaluated projects used the allocated funds as planned and either reached most of the planned outputs or made significant progress toward reaching such goals despite funding and procurement delays, difficulties and delays in recruitment and hiring, and relatively high turnover of the hired professional staff. All visited sites were fully functional and operating as described in the proposals and previous evaluation reports. Most services designed/planned for the evaluated projects are fully implemented and offered to beneficiaries of the visited DICs. Due to discontinuation of funding for the project MMR J63, diagnosis and treatment of sexually transmitted diseases is no longer offered, and some sites scaled back or discontinued home visit based services. Despite some recent shortage of staff (e.g., some of the visited DICs do not have a medical officer, or a counselor – these positions were filled in the past), for the most part, the visited DICs have sufficient staff to perform their planned/designated activities. In most of the visited locations, the evaluation team also found additional volunteer force (recovered drug users, peer support groups, community activists, other unpaid volunteers) supplementing the paid personnel. All staff members and volunteers at the visited DICs showed a great degree of commitment, dedication, and enthusiasm for their important and difficult work. The visited DICs are very well integrated and accepted by their surrounding communities. In one location we were able to interview a couple of immediate neighbors of the DIC, and both of these interviews indicated that despite some minor inconveniences and nuisances (e.g., pieces of laundry or other small household items missing occasionally), they are welcoming and accepting the presence of the DIC in their neighborhood.

All visited DICs are relatively easy to reach by either public transport or by other available means of transportation (walking, or motorbike ride) and are located in close proximity to the areas with high concentration of drug users. They have ample space and sufficient infrastructure to perform the planned harm reduction activities and to provide services as outlined in the scopes of the evaluated projects. One of the visited DICs, in Mandalay, has a limited office space and therefore conducting confidential/private interviews with clients/beneficiaries is a challenge there. In other DICs, some of the available space could also be reassigned from administrative or office functions to service delivery functions, supporting potential future expansion of services offered.

All visited DICs provide a range of onsite services (e.g., shelter, sanitation, recreational space, limited health care, periodical informational sessions, they provide clean injection equipment, condoms, information, and educational activities), outreach services and activities (e.g., contact with new drug users and other potential beneficiaries, dispensation of clean injection equipment and condoms, dispensation of educational materials, assistance in referrals to and engagement with external services, home visits), and to a lesser extent advocacy activities (e.g., informational and training sessions for law and drug enforcement personnel and for community members).

All visited DICs are sufficiently equipped with office equipment (e.g., desks, telephones, printers, chairs, storage cabinets), computers (some of these computers while still functional are relatively outdated), and other functional or recreational equipment (kitchen space and some rudimentary equipment, ping-pong tables, TVs, stereos). On the other hand, the infrastructure, staff, and resources of the visited DICs are underutilized. Cost effectiveness of the future projects could be improved by extending and improving utilization of existing staff and infrastructure resources.

The computerized DAISY system was contracted, developed, and disseminated in response to previous evaluation recommendations concerning improvements in counting and reporting the number of unique individuals reached by the services and interventions implemented within the scope of the MMR J63 and MMR J69 projects. The evaluation team closely examined the DAISY and other computerized systems and records in all of the visited DICs. The collected evidence (direct observations of DAISY field utilization and interviews with the staff of Yangon office managing the database and information collected through DAISY) suggests that the implementation of the DAISY system improved somewhat the accounting and reporting practices, but did not eliminate all problems with inaccurate counting of unique individuals receiving services at the evaluated DICs while created additional workload burden for the staff of the DICs.

In all visited locations, the primary registration, daily monitoring, and the primary sources of day to day reporting consist of paper records. The primary registration of clients is notebook based. It contains the most detailed information about all clients of the DICs including their names, contact information, and some additional rudimentary information about their drug use history and living situation. The secondary, day-to-day accounting of visitors and of the number of distributed coffee packs and meals consists of numerical ID based paper logs. Once per week - sometimes less frequently - the paper records are entered into the computerized DAISY system. The sole purpose of this activity, as reported to the evaluation team by the staff in charge of it in all visited DIC's, is to enable the reporting of the numbers to the central office in Yangon. The local DIC staff does not recognize the DAISY system as a useful tool in day-to-day operations. For most of them, using it is an additional burden and a challenge. Interviewed DIC staff reported that the provided DAISY training was short with limited practical or hands-on components and that they did not acquire sufficient skills to use this system efficiently. DAISY training efforts are also challenged by the staff turnover preventing continuity and transmission of skills and experiences.

The DAISY system could become a potentially useful data collection tool if data collection procedures implemented at the local DICs and the review and utilization of collected data by the Yangon office were improved. It was observed at several locations that the client screening form is often left incomplete or unfinished at the data collection and data entry point (DIC), and when all the reports from all DICs are collated at the Yangon office, only minimal quality control or completeness review is conducted. Additionally, due to the implemented data collection strategies, all clients under the age of 18 are collapsed into one category without a possibility to provide detailed information on drug use and risk behaviors of the youth, another target group. Ability to record exact age of the young clients would improve comprehensiveness and utility of the collected information. An improved, shorter, and more focused form would result in a better completion rate and accumulation of information that could be used in gradual improvement of the implemented

harm reduction services. Additionally, a feedback on quality and completeness of the transmitted data could, over time, improve the quality and the ultimate utility of the collected data.

The evaluation team also discovered that data transmission and reporting between the local DICs and the central office in Yangon is conducted using standard, commercial email agents (Yahoo, Gmail). These email systems are not secure and should not be used to communicate confidential or sensitive information. The transmitted data include names, addresses, phone numbers, and other personal information on individuals who are contact persons for the DIC clients (no names of the clients themselves are stored in the computerized system) and that the transmitted files are not encrypted or protected. The electronic service records, as well as transmission or reporting and communication procedures should be revised, improved, and updated to meet better security standards and to better prevent a possibility potential confidentiality breaches.

Current lateral communication channels among different local DICs are limited. As a result, useful solutions, experiences, discoveries, and problem solving skills developed at one of the DICs are not communicated to other DICs, limiting accumulation of locally collected information, practical knowledge, skills, or successful solutions to commonly encountered problems. In one of the DICs, the staff learned about specific needle preferences among drug users and responded to this information by changing the type of needles supplied with the clean injection kit. This type of information has not been communicated in reports sent to the central office in Yangon and therefore it has not been evaluated and further disseminated among all other DICs.

Similarly, there are insufficient lateral communication channels among different UNODC services currently operating in Myanmar. For example, one of the visited DICs is located in a very close proximity to a TREATNET center, however, the UNODC staff in Yangon has very limited familiarity with the TREATNET resources.

Partnerships and cooperation

During the meeting with the representatives of various branches of the Myanmar government (Ministries of Health, Education, Social Welfare, the National AIDS Program, the Narcotic Enforcement Agency and the Police), the evaluation team learned that many individual members of the government are supportive of evidence based, medical, social, and legal efforts to improve drug use and HIV situation in Myanmar. They understand the rationale behind such efforts and they view the initial implementation efforts as signs of good progress. They are also generally supportive of continuing expansion and improvement of these initial efforts and they are in favor of receiving continuing financial support from foreign organizations. In their opinions, UNODC is recognized by the government and the society in Myanmar as a reliable partner to help them obtain comprehensive and politically neutral support from foreign organizations and to facilitate and technically support future implementation efforts.

Services and interventions implemented within the scope of the MMR J63 and MMR J69 projects included active referral of drug users to methadone treatment, detoxification treatment, antiretroviral treatment, and voluntary counseling and testing. Generally, these goals have been reached only with a very limited success by the evaluated projects. For the most part, the reasons for not achieving planned goals or benchmarks are not related to the performance deficiencies of the evaluated projects of failures of the implementation efforts and are external to the evaluated projects. The implementation of methadone treatment programs in Myanmar created serious bottlenecks in the ability of these projects to attract and enroll sufficient number of patients. The requirement for the initial impatient stabilization (between 14 and 45 days) creates a significant barrier for potential patients to enter these projects. While both the inpatient stabilization and later outpatient dispensation of methadone are offered without direct costs to patients, transportation

costs (hospitals offering initial inpatient stabilization are not easily reachable in some of the visited locations), the cost of food during the inpatient stabilization, and potential disruption of employment during the initiation period create significant financial burdens that prevent many potential patients from entering methadone treatment. Additional barriers to improving the impact of methadone treatment on drug use situation in Myanmar consist of limited capacities of the inpatient facilities (only a few patients can be admitted at any given time) and the lack of any additional ancillary services. The current methadone dispensing centers in Myanmar dispense daily methadone doses during a few hours each day and do not provide any additional counseling or supportive services.

Based on interviews with active methadone patients and on the review of the clinical records of methadone treatment program, the evaluation team learned that these projects offer take-home doses of methadone. Reports from methadone patients and DICs' staff illustrate that take-home doses without careful evaluation and monitoring can result in dangerous abuse and misuse of the methadone medication. For example, the evaluation team learned that methadone patients stock their take-home doses while using street heroin, and occasionally use the "saved" medication to double up their daily doses resulting in very high daily methadone intake (e.g., 2x150 mg per day). In one of the visited DICs, staff members reported that about an 80 years old female was recently brought to this DIC for an overdose treatment due to her ingestion of methadone stored in the home refrigerator.

During interviews conducted with medical doctors overseeing the implementation of methadone projects in Myanmar or currently supervising methadone dispensation centers, they reported that they were offered a limited training before being assigned the roles of addiction specialists: the implementation of methadone treatment in Myanmar was preceded by a study tour for 12 invited doctors to visit the methadone system in Hong Kong. Recently, there was a shortage of methadone medication (two months in 2010). During that time, in at least one of the affected clinics, the medication protocol was altered and half of the daily methadone dose for all patients was substituted by additional "equivalent" (4x the volume) dose of opium tincture in the evening. While this creative solution represents a well-intended fix for a real life problem, there is no scientific evidence pointing to clear advantages for the patients resulting from such substitutions. .

Generally, methadone dispensation centers do not employ any measures of health outcome monitoring or evaluation of their efficacy. No urine testing for illicit drug use is performed, and no evaluations of functional or health status are routinely conducted among the patients. Evaluation of medical records from the methadone centers also revealed other problems with the field implementation of this treatment. For example, patients frequently miss long periods of medication and are given the last ingested dose upon their return to the clinic. Based on safe medical practices principles, their first dose after missing three or more days of methadone should be reduced, and they should restart the induction dosing protocol of methadone upon the return.

Monitoring and reporting important health statistics from the methadone treatment system in Myanmar could also be considerably improved. Currently WHO reported that about 1,600 patients receive methadone in all methadone centers in Myanmar. However, important stakeholders such as UNAIDS, Ministry of Health, and UNODC staff indicated that this number could represent the cumulative number of methadone patients ever receiving methadone since the onset of this program in 2005 with some number of methadone patients entering the methadone system multiple times, inflating the cumulative number. Based on field reports, the dropout rate from the methadone programs is reportedly high and the evaluation team was not able to obtain a reliable number of currently enrolled and active methadone patients in Myanmar.

Currently, several NGO organizations that specialize in providing support and assistance to selected risk groups (e.g., MSM, sex workers, IDUs) took upon themselves the task of collecting some basic

epidemiological data from these populations. The data collected by these NGOs is then shared with other organizations in order to come up with estimates using models and extrapolations. However, most of these NGOs do not have sufficient expertise and capabilities to reliably collect prevalence, incidence, or other epidemiological data from the difficult to reach populations. Additional technical assistance and support provided by UNODC to the NGOs involved in collection of epidemiological and surveillance data could potentially improve the overall quality of epidemiological models and the reliability of data on illicit drug use and HIV problems in Myanmar.

In several visited DICs the rate of HIV infection among IDUs served by these projects was estimated, derived, or calculated based on the number of volunteers referred to HIV testing who tested HIV positive in any given year. For example, in a DIC that has a census of about 5,000 beneficiaries/clients, less than 1,000 were voluntarily referred and tested for HIV, and for about 300 of them the test was positive. Consequently, it was reported that in the year 2010 at this particular location "HIV prevalence among IDUs was 30%." Such a method of estimation is likely to be severely biased.

Small efforts were undertaken to collect better epidemiological evidence and within a scope of the project MMR J69 a seroconversion study was initiated. Briefly, in this study, a small number (less than 300) of individuals was initially tested and the individuals who tested negative were followed for 3 months. About half of them were reached and retested at the 3 month follow-up. The investigators concluded that the HIV incidence rate at this location is "low." This study was severely flawed: the proposed sample size was too small to evaluate the incidence rate; an appropriately powered study would require a sample size tenfold larger, with substantially longer follow up periods, and the follow-up completion rates of about 90% or higher to collect reliable data. The evaluation team was also not able to obtain full description of the study design, the methods of selection and enrollment of study participants, or assessments and instruments used in this study[12]

In general, the evaluation team found that available epidemiological data contained factual and statistical errors and it should be interpreted with great caution, taking into consideration the data collection context and details of employed methodologies. The source information and/or underlying data collected by NGOs during their field work that is later used to build epidemiological models and estimates of the trends are often not highly precise, accurate, or reliable. Therefore the resulting estimates are not likely to be highly reliable and should not be interpreted as valid indicators of past and current trends or as reliable or useful indicators of the efficacy and impact of the harm reduction efforts implemented in Myanmar.

Effectiveness

Harm reduction programs implemented by the evaluated projects provide important, valuable, and necessary services. However, it is difficult to evaluate accurately their effectiveness in reaching the originally planned aims and goals. Changes in HIV prevalence rates, originally proposed as the main objective measures of effectiveness, cannot be used as reliable indicators directly linking the potential impact of the implemented harm reduction services and the actual reductions HIV infection rates in areas or regions where these services are implemented. More direct and more reliable effectiveness indicators should include the HIV incidence rates and indicators of behavioral changes among the reached populations. Currently, no reliable data on HIV incidence rates and

[12] For more information on this, please see "A study on estimated HIV incidence among IDUs and it's association with harm reduction services in Lashio, Northern Shan State" Substance Abuse Research Association (SARA)".

only very limited data on behavioral changes among the reached populations are available in Myanmar; a situation similiar to other countries.

On the other hand, most of the specified and targeted numerical outputs were either achieved, or a significant progress toward achieving them has been made. One of the areas where numerical targets have not been fully reached includes the number of clients referred to external services (e.g., methadone treatment, HIV treatment, or voluntary counseling and testing).

It is important to note that these targets are missed not due to performance deficiencies of the evaluated projects, but due to external barriers and factors related to how these external services are implemented and operating in Myanmar.

Harm reduction efforts currently implemented in visited DICs do not (or rarely) include information about safer drug use methods (e.g., smoking/chasing, nasal insufflation/snorting/sniffing). The evaluation team was not able to obtain reliable information about the quality or purity of the street drugs at the visited locations. Reported and observed injection practices (rapid dissolution of heroin in cold water) indicate a high purity of street heroin in some locations in Myanmar. However, it is also possible that heroin is mixed with other substances to aid rapid dissolution in cold water inside syringes. At the same time, pure heroin has a higher burning point and is not suitable for chasing or smoking, but may be sufficiently pure for nasal insufflation (snorting/sniffing). Local quality or purity of street drugs often affects the local drug use practices. Obtaining reliable information, including laboratory testing of street samples, collection of detailed information from DUs and IDUs on drug use patterns, specific behaviors, and preferences, would be useful for better understanding of the local, street level, economic forces that often strongly influence drug use behaviors of DUs and IDUs. Consequently, more effective harm reduction efforts could be formulated and effectively implemented. Currently, such detailed and reliable information is not collected in the implemented projects.

Some of the problems with dispensing clean injection equipment that does not meet local drug users' preferences are related to purchasing/procuring practices selected by the donor organizations. In one of the visited DICs, the evaluation team discovered unusually large quantities of stored syringes and needles. Upon further investigation, the staff explained that due to the purchasing/procurring requirements of the donor organization (3DF) these needles and syringes were purchased in bulk at the onset of the project. As it turned out later, these syringes (2ml) are not liked or wanted by the local IDUs. Despite difficulties in dispensing them, the DIC staff continues their efforts to distribute them.

The same centralized procuring/purchasing policies and the resulting long cycle of ordering and delivery of typically large quantities of supplies is partially responsible for shortages of medications experienced by the visited DICs. In several of the visited locations, the evaluation team discovered shortages of medications that were needed for the planned treatment regimens that are delivered at the DICs, some of the medications stocked at the visited DICs were also significantly past their expiration dates. Of particular concern is the severe shortage of medications used to treat heroin/opiate overdose. Two of the visited locations had a very small supply of Naloxone (one or two ampoules), and in one of the visited DICs Naloxone stock was long expired (many years past the expiration date).

Impact

In all visited DICs the primary distribution of clean injection equipment, condoms, and, to a lesser extent, of educational and informational materials is conducted through outreach work. Only a small number of beneficiaries receive NSP services via individual, face to face contact at the DICs. All visited DICs also implemented a method of distributing clean injection equipment and

recollecting used needles and syringes via unattended boxes installed on the outside of the DICs' premises. Such a method of distribution minimizes access barriers for some IDUs, offers 24 hour access to clean needles and syringes, and can help the projects to distribute larger numbers of needles and syringes. At the same time, this passive delivery of NSP services limits possibilities for face-to-face contacts with IDUs, removes important opportunities for delivery of interventions targeting behavioral change or delivery of information about available support resources or services, and complicates the accounting of unique clients reached by such a distribution scheme. The number of unique individuals reached by the harm reduction services implemented in the evaluated projects has been one of the key outcome/output measures selected as an important indicator of the services' efficacy, effectiveness, and impact. However, the number of individuals who utilize the unattended boxes and their patterns of utilization of such a service (e.g., numbers and characteristics of individuals, numbers of needles and syringes taken and/or returned by each individual) are unknown.

Based on earlier reports and evaluations of the MMR J63 and MMR J69 projects, initial efforts to dispense clean injection equipment to a significantly large number of IDUs through face-to-face contacts at the DICs were not highly successful. The reason often cited for these difficulties includes the legal prohibition on carrying needles and syringes by individuals who do not have medical condition to justify possession of such equipment. Although in Myanmar needles and syringes can be purchased in pharmacies without prescription, suspected drug using individuals can, and have been, arrested and prosecuted for carrying/possession of injection equipment. In well intended and often creative efforts to distribute as large as possible numbers of clean injection equipment to IDUs who need such equipment to protect themselves from the dangers of HIV and other infectious diseases, all visited DICs came up with methods of NSP delivery primarily via outreach activities.

During individual face-to-face interviews with outreach workers and DIC managers describing their own daily activities and duties, and based on shadowing of outreach workers and DIC managers during their field work, the evaluation team learned that in most of the visited DICs the outreach workers deliver injection equipment, condoms, and educational/informational materials (either in individually pre-packed sets or in bulk) to the injection sites ("shooting galleries" or "needle parks"). At those sites, they either distribute needles and syringes directly to the IDUs that are present at these sites, or they leave these supplies and materials with individuals tending or guarding the "shooting galleries" or "needle parks." In some of the visited locations, the responsibilities for packaging, distribution, and the education of the end users (IDUs) on safe injection practices and safe disposal of used equipment are passed onto the "volunteer workforce" including active drug users and drug dealers.

Distribution practices implemented in one of the visited DICs involve distribution of injection equipment directly to the large-scale drug dealers (between 300 and 1200 needles and syringes delivered per day) and distribution of condoms to owners/mangers/agents ("pimps") of illegal commercial sex venues. Based on interviews with outreach workers and DIC managers, in this model of NSP distribution, drug dealers and commercial sex agents send information to the DICs (telephone calls, text messages) about the number of requested injection sets and condoms. Consequently, the outreach workers deliver the requested supplies to each of the collaborating venues (only selected drug dealing and commercial venues are collaborating with currently active DICs). Based on interviews with outreach workers and active drug users, the evaluation team learned that some drug dealers pre-load syringes received from the outreach workers with heroin and sell the preloaded injection equipment to IDUs at their venues.

The review by the evaluation team of medical protocols, procedures, medication supplies, and medical records at visited DICs show that during a symptomatic treatment of drug withdrawals drug users frequently receive multiday take-home regimens of combinations of medications, including

Tramadol, Haloperidol, Clonidine, Diazepam (or other benzodiazepines). The goal is to help them alleviate unpleasant symptoms or to support their efforts to temporary abstain or reduce their drug use. These combinations of medications have analgesic, antipsychotic, sedative, and hypnotic effects, and they depress or slow down the body's functions. When properly used, they are able to relieve pain, calm anxiety, or to induce sleep. While it is understandable that drug users desire, request, and like to receive such medications, these medications carry a serious abuse potential and if misused or combined with illicit drugs, they can cause severe health problems, including overdose or death.

The formula charts that are present at most of the visited DICs include progressively increasing doses of these combined medications and consist of 10 progressive levels. During interviews with nursing personnel at the visited DICs, dispensation of medications included at the second or third formulaic levels resulted on several occasions in severe sedation of patients ("they slept all day"). Formulas above level 4 have never or rarely been used - a good indication that the staff of the DICs is aware of potentially harmful consequences of these medications. The current protocols and guidelines regarding outpatient medication treatment of drug withdrawal symptoms should be carefully reevaluated by medically trained and experienced experts to better evaluate risks and benefits of application of such formulas at the outpatient settings without close expert medical supervision and close follow up and monitoring of patients receiving such treatments. Revised, improved, and safer guidelines concerning such treatments should be developed and disseminated to the DICs.

Interviews with drug users and peer groups at the visited DICs, interviews with active drug users at the "shooting galleries" or "needle parks," the evaluation team field visits and observations of drug users at the visited "shooting galleries" or "needle parks" indicate that a substantial proportion of DUs and IDUs (clients/beneficiaries of the DICs) in Myanmar are poly-substance users actively using both opiates and stimulant drugs. During a visit to one of the active drug use venues in Shan state, the lead evaluator observed that individuals congregating at this location inject, smoke, and ingest orally a broad range of substances including heroin, opium, crystal meth, amphetamine pills, and alcohol. The overall atmosphere of this "drug use park" is characterized by high levels of intoxication, physical and verbal excitation, interpersonal tension, and verbal and physical conflicts, with many individuals showing signs of emotional distress. At the same time, it was observed that many drug users present at this place carry weapons. Provision of clean injection equipment, condoms, educational materials, and useful or important information in such settings pose significant challenges, and the presence of outreach workers or counselors in such venues may be associated with considerable personal risks to them. More extensive training of field workers on safety procedures and on methods of handling potential conflict, disputes, and acts of aggression could improve both their work effectiveness and reduce potential risks to their safety.

Field visits and face-to-face interviews with the staff members of DICs indicate that many of them lack skills to effectively reach and to communicate with individuals who are shy, not very open or trusting, who are withdrawn, depressed, or emotionally disturbed and that DICs' staff members have not been sufficiently trained in communication techniques that enhance and facilitate communication exchanges about sensitive topics, information, or situations. The evaluation team also observed that not enough attention is paid to issues of confidentiality, privacy, and mutual respect. All of such skills could significantly increase the DICs' staff members' ability to obtain more reliable information about and from the beneficiaries/clients. The staff of the DICs recognizes the importance of open and trusting communication and at the same time recognizes their own limitations in achieving good levels of communication with their clients. Many DICs implemented suggestion boxes and message boards as means of receiving anonymous messages from their clients about important issues, complaints, or potential improvements to the services offered by the visited DICs. In some instances these passive methods of communication resulted in obtaining valuable feedback or information from the clients. However, improving face-to-face

communication skills would result in faster and more significant improvements in the overall efficacy and impact of services and programs offered by the evaluated DICs.

The DIC staff members reporting on their past training experiences and the evaluation teams review of copies of training materials indicated that most of the training sessions have been conducted in English (Power Point presentations in English with some additional explanations in Myanmar/Burmese), they were short (up to 2 days), dense, and highly theoretical. Based on the feedback obtained from the DICs staff, their average level of comprehension allowed them to understand about 30% of the training materials, and the evaluation team observed that in most of the visited DICs, the staff members with better command of the English language showed better professional knowledge and skills. The majority of interviewed staff expressed that they would prefer the training sessions to include entire DIC team, rather than the selected few members on separate occasions, to be conducted onsite (at their respective DICs), and to be more "hands on" and practical.

The review of harm reduction messages delivered through group informational sessions, individual counseling efforts, and through other educational materials (e.g., printed handouts, posters, charts, illustrations) indicates that, generally, in the evaluated projects, injection drug use when using new needles and syringes is considered 100% safe and is frequently compared to safe sex when using a condom. In the context where most of the clients of the evaluated DICs inject drugs in highly unsanitary conditions (no running water, no sanitation, no clean surfaces to prepare injections), and where IDUs not only inject heroin but also other illicit drugs, such a strong message is misleading. HIV infection rates among IDUs in the visited areas are very high and the likelihood of dangerous infections due to non-sterile drug preparation and injection practices is further increased in immunodeficient individuals. All IDUs, but especially those who are HIV positive, need to be educated about all dangers of continuing injections of street drugs even when using clean needles and syringes.

Street drugs are not produced under high quality and safety standards, they are transported (trafficked, smuggled) into their distribution areas through highly unsanitary means, they are also often cut or mixed with other substances and adulterants increasing the dangers associated with use of chemically pure substances. In many real-life settings, it is difficult to tell what is actually in the drug that is sold locally. In most of the visited areas, IDUs employ "cold shots" (mixing street drugs with cold water, often inside the syringes). Preparations of heroin injections without boiling the water-drug mixture tend to be more dangerous while boiling the mixture kills some of the pathogenic organisms. On the other hand, boiling, and filtering the preparation requires more time and additional sterile equipment.

None of the visited DICs distributes a fully complete set of sterile injection equipment: plastic spoons were distributed inconsistently, due to interruption and delays in procurement and funding structures in only one of the visited DICs; sterile filtering materials are never included; and disinfection swabs are not always included. Different DICs also distribute different types and sizes of needles and syringes – some of them are not preferred by the local drug users, therefore it is not clear that a strong message about the safety of injections made with new equipment is unequivocally supported by the implemented distribution practices.

Shadowing of outreach workers during their fieldwork revealed that they do not wear sufficient protection while engaging in dispensing of the clean injection equipment and recollection of used and contaminated injection equipment during their fieldwork. The drug use sites ("shooting galleries" or "needle parks") where most of the outreach activities are conducted are littered with discarded, used, and contaminated needles, pieces of glass, and other sharp objects. While it is common in hot climates to wear open toe and open heal footwear ("flip flops", sandals), such footwear does not offer protection against accidental needle puncture or other injuries. The

evaluation team also learned that outreach workers (perhaps also other DIC staff) do not have health insurance coverage. The outreach workers are particularly affected by the lack of health insurance/support and are particularly vulnerable to work related health risks (e.g., they are routinely in contact with individuals who are sick, including individuals potentially transmitting infectious diseases, such as tuberculosis, viral respiratory and other infections).

While UNODC provided instructions, guidelines, and training on safety procedures, the outreach workers do not consistently follow safety guidelines and procedures and are not closely supervised in adhering to safety protocols. Many of active drug users frequenting the "shooting galleries" or "needle parks" in Myanmar carry weapons (e.g., clubs, short and long knives, machetes, firearms). In order to improve their effectiveness and beneficial impact and to improve their ability to protect themselves from potential work related dangers, the outreach workers need to receive more extensive training and close ongoing supervision on skills related to risk assessment, handling potential conflicts, aggressive, and uncontrollable behavior. Currently, such topics are not extensively covered by their training and they are not included in supervision efforts. The establishment and ongoing support and management of a network of local DICs are the primary outputs of the evalauated projects. The number of unique individuals reached by the harm reduction services implemented in the evaluated projects has been one of the key outcome/output measures selected as an important indicator of the services' efficacy, effectiveness, and impact. However, the frequent passive delivery of NSP services precludes precise estimates of the number of unique individuals who utilize such services and their individual utilization patterns (e.g., the number of individuals who utilize unattended NSP boxes and the numbers of needles and syringes taken and/or returned by each individual are unknown). In addition to complicating the accounting of unique clients or beneficiaries reached by such a distribution scheme, passive delivery of NSP services also limits possibilities for face-to-face contacts with IDUs, removes important opportunities for delivery of interventions targeting behavioral change, or delivery of information about available support resources or services, and therefore, the impact of the two projects on the reduction of the incidence of HIV/AIDS associated with drug use and the reduction of injection drug use in Myanmar is limited.

Sustainability

Interviews with stakeholders, UNODC and DICs staff, NGOs, representatives of local communities, and members of the national government indicate that the harm reduction efforts implemented by the evaluated projects are accepted and well received or welcomed by the local communities, local and national government agencies, and the police and anti-narcotic enforcement authorities at the local and national levels. However, the evaluated projects have not reached self-sustainability and financial support for the existing or future harm reduction projects and services does not exist locally. While Myanmar national and local governments, community organizations, and local businesses recognize the importance of provision of such services and are supportive of continuing and expanding harm reduction and other efforts targeting the reduction of drug use and the curtailment of the spread of HIV in the country, continuing provision of harm reduction efforts in Myanmar would require ongoing financial support from foreign and international donor organizations in the foreseeable future.

Only limited capacity building goals have been achieved by the evaluated projects. These include the establishment of the DICs infrastructure, training of their staff (although all visited DICs experience a relatively high turn over of their staff, with trainied and experienced personnel often seeking alternative employment or pursuing different professional careers), and the development and preparation of materials and service protocols. However, if the currently operating and future

harm reduction projects and services do not receive continuing funding and technical support from UNODC and the donor organizations they will likely cease to exist within a short period of time. Discontinuation of these services will not only erase the current achievements and stall the progress reached so far, but it may also have severe adverse consequences for the current beneficiaries and the local communities affected by drug use, HIV, and related problems.

III. CONCLUSIONS

Harm reduction services, interventions, and advocacy efforts supported by the MMR J63 and MMR J69 projects, funded by the donor organizations and managed and technically supported by UNODC are valuable, critically necessary, and contribute to the reduction of needle sharing practices among injection drug users, help to improve knowledge about risks associated with drug use among all reached beneficiaries, contribute to reducing stigmatization of drug users, and help disseminate information about harmful consequences of drug use and about effective HIV prevention strategies in the reached communities. The evaluated projects used the allocated funds as planned and either reached most of the planned outputs or made significant progress toward reaching such goals.

The number of clients reached (~6,000-8,000) and the number of needles and syringes distributed annually (less than 3,000,000) by the UNODC harm reduction projects implemented in Myanmar are relatively small in the context of an estimated IDU population size in the country (75,000 individuals). While other organizations in Myanmar offer similar services, considering the existing laws and barriers limiting access to safe injection equipment, education, prevention, and treatment services, the majority of IDUs in Myanmar continue to reuse and/or share contaminated injection equipment daily. Ongoing, extended, and improved efforts are critically necessary to significantly curtail problems associated with drug use and HIV in Myanmar.

The evaluated projects have not reached self-sustainability and will require ongoing funding support from foreign donor organizations to continue to exist and function. Myanmar national and local governments, community organizations, and local businesses where the services are implemented recognize the importance of provision of such services and are supportive of continuing and expanding harm reduction and other efforts targeting the reduction of drug use and the curtailment of the spread of HIV in the country.

The current evaluation found a range of achievements and several areas of necessary improvements that could potentially increase the efficiency, effectiveness, and impact of current and future harm reduction efforts in Myanmar. It is important to note that previous evaluations and field visits identified similar achievements, deficiencies, and potential areas of improvements. Specifically, the current report overlaps in several key findings and recommendations with previous reports drafted in 2011 by UNODC, by Palani Narayanan from August 2010 visit, by HAARP in its March 2010 Burma (Myanmar) Annual Review, by Mukta Sharma, HAARP, from November 2011 visit, as well as with other HAARP documents and UNODC publications (e.g., 2011 Global ATS Assessment; Myanmar Situation Assessment on Amphetamine-Type Stimulants, December 2010).

IV. RECOMMENDATIONS

This section of the report includes the evaluation team's recommendations for improvement of the relevance, efficiency, efficacy, impact, and sustainability of the projects, services, and interventions implemented through the evaluated projects.

Longstanding presence and a positive image among government officials in Myanmar gives UNODC a competitive advantage that could be used to increase advocacy efforts to stronger promote necessary changes in legal and health care aspects of Myanmar's social policies related to drug use and HIV problems. Building upon earlier achievements, UNODC should increase advocacy efforts to further positively affect the laws and public health policies related to drug use and HIV-AIDS problems, and in addition to narcotic control agencies, healthcare, education, and welfare branches of Myanmar government should be institutionally engaged.

Methadone maintenance treatment programs have a clear scientific and medical rationale, are highly efficacious when properly implemented, and are highly acceptable by the patients worldwide. The implementation of methadone programs in Myanmar, however, has not been based on internationally recognized and uniformly supported standards, does not meet good medical practice standards, and it is not likely to be highly effective. Problems with implementation of the methadone program in Myanmar illustrate areas where improved partnership, cooperation, and stronger advocacy efforts by UNODC could result in significant improvements in the overall drug use and HIV prevention situation in Myanmar. Several organizations under the UN umbrella, including WHO, UNAIDS, and UNODC, adopted and strongly support dissemination of evidence based interventions when combating drug use and related health and social problems.

Currently, several NGO organizations that specialize in providing support and assistance to selected risk groups (e.g., MSM, sex workers, IDUs) took upon themselves the task of collecting some basic epidemiological data from these populations. The data collected by these NGOs is then shared with other organizations in order to come up with estimates using models and extrapolations. However, most of these NGOs do not have sufficient expertise and capabilities to reliably collect prevalence, incidence, or other epidemiological data from the difficult to reach populations. Additional technical assistance and support provided by UNODC to the NGOs involved in collection of epidemiological and surveillance data could potentially improve the overall quality of epidemiological models and the reliability of data on illicit drug use and HIV problems in Myanmar.

The evaluated projects have not reached self-sustainability and no financial support exists at the national or local levels, therefore, ongoing financial support of existing projects and support of expanded and improved projects is critically necessary. Current political climate and international awareness of broad range of social and economic needs in Myanmar creates an opportunity for UNODC to engage potential future donors at both international and local arenas. On the other hand, an increased focus on building local expertise and professional capacity in Myanmar including better training of individuals providing harm reduction, treatment, and prevention services will result in faster accumulation of benefits and will increase the possibility of these projects and services becoming self-sustainable in the future.

Experiences and lessons learned during implementation of the evaluated projects, considering particularly challenging political, social, and economic environment should be documented and shared/publicized to benefit future harm reduction efforts. However, future harm reduction programs in Myanmar need to increase their efforts to target a broader representation of drug users, to enhance outreach efforts outside highly visible drug use venues, expand the scope and improve quality of offered services, collect better data on patterns of drug use and drug use behaviors of broader populations of DUs and IDUs, and include services designed for poly-substance and non-injection drug users.

During the field visits, the evaluation team learned that none of the visited DICs offers education or vocational training as a part of their onsite services. In a situation where many clients/beneficiaries spend considerable amount of time each day at the DICs, not offering education (e.g., improving reading and writing skills, or catching up on foral primary or high school education) and not providing useful vocational training (at one of the visited DICs a peer support group recently developed some vocational opportunities) is a lost opportunity. Extending the scope and improving the quality of the services and interventions provided though the activities of the established network of DICs may also improve utilization and cost effectiveness of the existing infrastructure, staff, and resources, and will increase the DICs' attractiveness for a broader population of IDUs and DUs, as well as increase their overall effectiveness and impact on the local problems with drug use and HIV. Additionally, current DICs infrastructure, staff, and resources may not be fully utilized. Administrative resources and efforts often outweigh resources allocated to directly benefit clients. Better reallocation of available space, staff resources, and increased provision of additional on-site services could improve efficiency and cost effectiveness of the current and future projects.

The current and the future harm reduction, treatment, and prevention efforts implemented by UNODC in Myanmar will benefit significantly and will achieve better efficacy, efficiency, and impact if greater efforts are made to achieve a better balance between monitoring and achieving the quality of services indicators and the currently employed focus on numerical output benchmarks. Incidence rate indicators, behavioral data on the scope and patterns of drug use (e.g., types and patterns of drug use behaviors) and on changes in risk behaviors (e.g., rates of injection equipment sharing and unsafe sex practices), and data on the quality of provided services could provide better indicators of the evaluated projects efficacy, performance or impact. Future harm reduction programs should supplement quantitative and numerical performance and outcome measures with expanded and improved methods to monitor and evaluate the quality of services and interventions. UNODC should support development of local expertise and resources to obtain valid and reliable data on a broad range of epidemiological and drug use indicators.

The evaluated projects were conceived, planned, and initiated during mid-2000s and they target injection drug users who are mostly injecting heroin and/or other opiates (e.g., opium, morphine, pharmaceutically produced opiate medications). However, drug use patterns have changed considerably since then in Asia and in Myanmar. Currently many opiate dependent drug injecting individuals in the region are poly-substance users, with some proportion of them injecting opiates and other drugs (e.g., benzodiazepines, and amphetamine type stimulants). Future harm reduction projects in Myanmar need to increase their efforts to target a broader representation of drug users and include services designed for poly-substance and non-injection drug users.

Population of beneficiaries currently reached by the implemented projects represents a limited range of DUs and IDUs in the projects' catchment areas and in Myanmar. In particular, female DUs and IDUs may be underrepresented in the populations of beneficiaries reached by the evaluated projects. Extending and improving outreach efforts outside highly visible drug use venues, expanding the scope and improving the overall quality of services offered by DICs may help to reach and attract a broader representation of beneficiaries. Improving and expanding collection of data on patterns of drug use and drug use behaviors

among broader populations of DUs and IDUs, including important subgroups (e.g., female drug users, youths) will better inform the staff of current and future projects about the characteristics, behaviors, and specific needs of DUs and IDUs in the catchment areas.

Current NSP distribution practices need to be carefully evaluated and better monitored in the future programs. In collaboration with local stakeholders and implementing partners, UNODC management staff needs to develop plans to gradually replace contentious NDP distribution practices with evidence based, locally feasible, safe, culturally appropriate, and effective harm reduction efforts, including provision of safe injection equipment, education and information, and high quality interventions that directly and unequivocally benefit IDUs in Myanmar. Additional efforts need to be made to expand onsite provision of NSP services involving face-to-face contact, communication, and counseling.

Current medical protocols and treatment recommendations implemented in existing projects should be reviewed by medical experts. In particular, protocols concerning dispensation of take home doses of benzodiazepines and other psychoactive medications should be reviewed and revised immediately. Better training and supervision of medical personnel as well as improvements in comprehensiveness and quality of medical records are also needed.

UNODC managing staff should establish improved ongoing training and supervision protocols for all DICs' staff, including, management staff, medical and nursing staff, counselors, and employed and voluntary outreach workers. More extensive safety training and protocols as well as ongoing supervision and monitoring of field implementation of such protocol should be implemented.

While the computerized system and data base (DAISY) have been developed and implemented to improve tracking and reporting of key outputs (e.g., number unique individuals reached), this system is not used as the primary entry, tracking, and monitoring tool at the DICs. Additionally, some personally identifiable and sensitive information is stored and transmitted without sufficient protective measures. Additional training, focusing on practical utilization skills of the DICs' staff, as well as improvements in functionality and data content of the system (e.g., eliminating collection of personally identifiable information) will further improve tracking and reporting capabilities of the current and future projects.

Outreach work is often performed in high risk environments while safety procedures and protocols (e.g., concerning accidental needle stick) are either not fully implemented or not carefully and strictly followed. Improved training and supervision concerning safety protocols is necessary to better protect them from work related risks. Engaging outreach workers and the staff of DICs in developing improved, effective safety protocols will benefit from inclusion of their practical field experiences and may result in improved safety protocols that are more readily followed by the DICs' staff.

Current harm reduction messages and interventions misleadingly emphasize that injecting drugs with clean needles and syringes is 100% safe. However, distributed clean injection sets do not routinely include disinfecting swabs, and filtering or cooking implements and needles and syringes distributed to IDUs not always meet their preferences. Additionally, non-injection drug use methods and effective ways of eliminating drug use are not extensively promoted. It is necessary to extend and improve harm reduction efforts and interventions to include messages about all risks associated with injecting street drugs, to introduce safer (non-injection) drug use methods, and more extensive information about effective ways of reducing or eliminating illicit drug use. Collecting more detailed information on types, qualities, and characteristics of street level drugs, local drug use patterns and local behaviors of IDUs could inform development of more effective harm reduction interventions, messages, and improved informational and educational materials distributed to clients. Current and future harm reduction projects may benefit from

reevaluating and improve the guidelines regarding injection sets distributed and improved training of DICs' staff, including, counselors, and employed and voluntary outreach workers.

V. LESSONS LEARNED

Currently implemented services and interventions reach highly visible and impoverished drug users and injection drug users. They constitute an important first step and an opportune springboard toward much necessary expansion and improvements in availability, quality, coverage, and impact of future harm reduction, treatment, and prevention efforts in Myanmar.

Because of the lack of reliable epidemiological data on the scope of drug use and HIV problems in Myanmar at the design stage of the evaluated projects, consensus estimates and reasonable or feasible outcome indicators or numerical output benchmarks had to be selected as performance indicators of these projects. While such methods of selection of project objectives, outputs, and related performance indicators are not scientifically rigorous, they often may allow delineation of reasonably well defined objectives for the planned projects and allow to transition from planning to implementation of important activities and services. However, future projects may greatly benefit form including reliable baseline estimates in their design. Furthermore, after projects are implemented, revision and adjustments of initially estimated objectives may be possible and should be undertaken if more reliable data/information becomes available.

Introduction and implementation of the evaluated projects MMR J63 and J69 have strengthened UNODC's position in Myanmar. The currently strong positive image and competitive advantage of UNODC can be used to further advance advocacy efforts to promote important and critically necessary changes and improvements in legal, health, and social policies related to drug use and HIV problems in the country.

Some of the key findings of the present evaluation were previously reported as results of previous monitoring missions conducted by UNODC HQ personnel and evaluation visits from the donor organizations. Recommendations that were already formulated were not always implemented and not all corrective efforts were undertaken as a result of earlier findings and recommendations. UNODC should implement better mechanisms to translate evaluation reports and important recommendations into action plans to ensure better integration of evaluation findings with the ongoing implementation effort of the currently ongoing projects and into the design of future projects.

ANNEX I. TERMS OF REFERENCE OF THE EVALUATION

Will be attached when pusblished on the website.

ANNEX II. LIST OF PERSONS CONTACTED DURING THE EVALUATION

The list of interviewed persons was provided to IEU. For confidentiality purposes, it will not be further disclosed.

ANNEX III. EVALUATION TOOLS

STRUCTURED INDIVIDUAL INTERVIEWS WITH THE STAFF

Individual interviews with the staff of the evaluated projects and the visited DICs were conducted on the premises of the evaluated projects in their usual work environments, often in their own offices. All interviews started with introducing the evaluation team, the goals of the evaluation team's visit, and discussions about the overall goal of the current evaluation.

The staff members were informed that their names will not be included in reports describing information collected during the interview. They were given opportunity to ask questions about the evaluation team or the evaluation process. The interviews were not recorded verbatim, but the evaluation team took extensive notes during the interviews, and extended and completed the notes at the earliest available time based on the recollections of the interviews by the evaluation team members.

The interviewees were then asked to describe their roles and their involvement with the evaluated projects. The evaluation team then asked additional questions (primarily open ended) regarding their professional roles both within the scope of the evaluated project and before joining the project staff. The interviewees were asked to describe their typical day to day activities and responsibilities, both currently and in the past across their entire involvement/employment in the evaluated projects. The interviewees were invited to illustrate/demonstrate some of their responsibilities, to give examples of recent and past specific interactions with the clients/beneficiaries, to show records that they use to document their work (e.g., daily logs, medical history records, legers, medication and supply inventories, computerized records and reports, etc.). Some of the interviewees were also shadowed/observed during their daily activities and interactions with the current clients/beneficiaries, or during their other daily tasks (e.g., preparation of clean injection sets for distribution, outreach work and distribution of educational materials, distribution of needles, syringes, and condoms, recollection of used needles and syringes, and other interactions with the clients both at the visited DICs and during their field work).

The evaluation team asked additional questions about past and recent advocacy and educational efforts directed toward the local communities, local and national governments, collaboration with other stakeholders, NGOs, and peer groups. Sometimes, more detailed accounts of the staff activities were obtained by inviting the interviewees to give detailed accounts of the most successful, interesting, or challenging situations encountered during their work in the evaluated projects. The staff interviewees were also asked about their education, past training experiences, and future professional goals. Specifically, they were asked to provide information about their participation in formal training programs before and during their employment with the evaluated projects. Finally, they were given the opportunity to speak about their own and accomplishments and problems or challenges directly related to their work in the evaluated harm reduction project, as well as perceived impact of the projects, their current and future needs. Most of the interviews were conducted by the leader of the evaluation team. The evaluation team members were invited to ask additional questions throughout the interviews. Depending on the preference and language proficiency of the interviewed staff members, the

interviews were conducted either in English or in Burmese with sequential translation between English and Burmese to ensure that all members of the evaluation team could understand and actively participate in the interviews.

STRUCTURED INDIVIDUAL INTERVIEWS WITH CLIENTS/BENEFICIARIES

Interviews with clients/beneficiaries were conducted in settings affording privacy and confidentiality (e.g., separate rooms, or settings where the content of the interviews could not be overheard by other people). The interviews were not recorded verbatim, but the evaluation team took notes during the interviews, and created extensive/complete written records of all interviews based on the notes and immediate recollections of the interviews by the evaluation team members.

All interviews started with introducing the evaluation team, the goals of the evaluation team's visit, and explanation of the rules of confidentiality and privacy. All interviewed individuals were informed about their right to stop the interview at any point and that their names and identities would not be included in reports summarizing information obtained during the interviews. The interviewees were given opportunity to ask any clarifying questions and were asked if they want to be interviewed: all interviewed clients gave verbal informed consent to voluntarily participate in the interviews.

During the interviews, the evaluation team used primarily open ended questions to obtain information about the clients direct, first hand experiences, and opinions or preferences related to their participation in services and interventions offered through the visited DICs. The following leading questions, among others, provided structure to the interviews: "How often do you come to the DIC?" "How long have you been coming here?" "What do you do, how do you spend your time when you are here?" "What type of services do you receive from this DIC?" "How do you benefit from the services offered by the DIC?" "What did you learn by coming here?". All beneficiaries were also asked about their current patterns and the past history of illicit drug use, including injection drugs use, sources of obtaining injection equipment and drugs, their current and past recovery efforts, current and past drug treatments, and incarceration or detention histories. They were asked about their knowledge of HIV risks, their HIV status, and if applicable, their history of receiving HIV treatments. All interviewees were also asked questions pertaining to their education, current and past employment, their current living situation, overall health/medical status, and emotional/psychological well being.

Many interviewees provided additional spontaneous reports of events or interactions related to their drug use, their participation in the programs and services offered by the DICs, and their interactions with the authorities or local communities. The evaluation team also asked additional questions for clarification or confirmation of the team's understanding of the information obtained from the interviewees. The interviews lasted between 45 and 60 minutes. All interviews with clients/beneficiaries were conducted in Burmese and interpreted sequentially between Burmese and English to ensure that all members of the evaluation team understand the content of the interviews.

STRUCTURED GROUP INTERVIEWS WITH STAKEHOLDERS, IMPLEMENTING PARTNERS, COMMUNITY REPRESENTATIVES

All group interviews started with introductions of all participants and discussions of the overall goals of the current evaluation, and specific plans and goals of the evaluation team's visit. The interviews were not recorded verbatim, but the evaluation team took extensive notes during the interviews, and extended and completed the notes at the earliest available time based on the recollections of the interviews by the evaluation team members. All group meetings started with inviting the participants to share their experiences with the evaluated projects or to describe the current and past problems related to illicit drug use or HIV in the local context. Group meeting often started with presentations (PowerPoint) of the background local context, description of local efforts or implemented interventions, and outlining the accomplishments, or, sometimes, challenges. The evaluation team followed the presentation with detailed questions aimed to obtain detailed information regarding the specific local patterns and trends related to drug use and HIV, the group's information and opinions pertaining to the evaluated projects implementation efforts, their relevance, effectiveness, and impact. The groups were also invited to share their recollection of past challenges and accomplishments during the implementation of the

evaluated projects, their current and past contributions to perceived changes, their relationships to other harm reduction efforts, and the perceived current and future needs. The group participants were also invited to share their opinions and recommendations regarding potential improvements in the current and future efforts targeting drug and HIV problems in Myanmar.

Additional information on the evaluated projects, other harm reduction efforts, treatment, prevention, epidemiological assessments of drug and HIV problems, strategic current and future plans, and on a broader range of other pertinent and relevant information were obtained during discussion meetings with representatives of donor organizations and stakeholders (WHO, UNAIDS, 3DF, AusAID, representatives of the national government). These meetings were conducted following generally accepted meeting format and no tools or specific methodology were applied during these meetings. The evaluation team participated actively in those meetings and took extensive notes.

ANNEX IV. DESK REVIEW LIST

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