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In-depth evaluation of the

**UNODC Partnership for the Reduction of  
Injecting Drug Use, HIV/AIDS and  
Related Vulnerability in Myanmar and  
Reducing the Spread of HIV/AIDS among  
Drug Users through the HAARP Country  
Flexible Programme in Myanmar**

MMR J63 and MMR J69  
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.





# MANAGEMENT RESPONSE

The Senior Management of UNODC appreciates the efforts of the IEU and the Evaluation Team on evaluating MMR J63 (UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar) and MMR J69 (Reducing the Spread of HIV/AIDS among Drug Users through the HAARP Country Flexible Programme in Myanmar). All the recommendations of the Report will be taken into consideration by UNODC.

The Management acknowledges also the dedication of the staff of the project, the Field Office and the Regional Centre, and the support provided by the Drug Prevention and Health Branch. The Management notes that significant results have been achieved in a difficult political environment, by reaching out to the most marginalized drug users while operating with very poor public health and social assistance facilities.

One of the main messages from the evaluation report is that project activities will not be sustainable at this stage without outside financial assistance. This is due to the fact that Myanmar is a least developed country and that indeed national resources for HIV prevention will not be available in the foreseeable future. In order to contain the spread of HIV and to build basic infrastructure for service provision to drug users, UNODC will continue to advocate with bilateral and multilateral donors (for example, the Global Fund and the MDG Fund) to invest in Myanmar and with the Government authorities for a growing allocation of specific national resources.

The evaluation report stressed repeatedly the lack of basic reliable data on prevalence and incidence of HIV and drug use, at the level of monitoring project implementation and at the national level. Baseline data for national planning and measuring progress are virtually absent and are usually replaced by so-called expert opinion. UNODC will continue to work for the establishment of data systems which should feed into national and local planning exercises and serve as baseline measurement points to determine progress. Data collection systems will be gradually improved, and population size estimates be developed by the Field Office and the HIV/AIDS Section using internationally accepted indicators of incidence, prevalence and risk behaviours.

The evaluation report indicates that the results obtained by the current projects should be considered as an initial operational step, paving the way to large-scale interventions for HIV prevention, drug dependence treatment, and social protection that could be developed with the involvement of all stakeholders such as government institutions, civil society organisations, and UN partners. UNODC will continue to cooperate with these stakeholders to scale up evidence based interventions.

A major goal of the projects was to advocate for evidence-based interventions in the field of harm reduction, human rights of drug users, and appropriate pharmacological treatment, obtaining agreement to operate in line with medical standards and humanitarian health-oriented strategies. The recommendations of the evaluation report will be used to further improve the quality of services in this field, to align the interventions to the overall UNODC operations and to scale up the interventions to reach a broader coverage. They will be also used to establish large-scale sustainable interventions in the area of drug users' health care, including comprehensive harm reduction and drug dependence treatment measures. This advocacy work will aim at

mainstreaming activities in the broader public healthcare and social welfare system, and the national development plan of Myanmar.

The expansion of interventions will aim to establish further face-to-face contact with a larger number of drug users, particularly those who are not in treatment or in contact with service providers. Service provision (outreach, drop-in centres, drug dependence treatment) will be made more appealing and accessible with the purpose of motivating drug users to attend HIV prevention and drug dependence treatment programmes.

A comprehensive approach will be adopted, designing a continuum of prevention and care, including low threshold interventions, educational and vocational training, treatment of drug dependence with pharmacological and psychosocial methods, and social integration opportunities. The provision of prevention commodities and social assistance will be combined with healthy life-style communications and possible recovery perspectives. This one-stop-shop approach, where possible, will require cooperation between the HIV/AIDS sector and the prevention, treatment and rehabilitation and other social sectors.

Local and national professionals will be offered further training opportunities to improve data collection and management capacity, strategies to reach drug users, diagnostic and therapeutic interventions, and clinical case management abilities.

UNODC will propose a revision of pharmacological treatment for drug dependence in the country with extensive use of methadone in line with science-based evidence, significant reduction of the barriers to access drug dependence treatment and accurate methods to avoid diversion and abuse of prescription drugs. People using drugs other than heroin and other opiates will be, if possible and feasible, also considered in future interventions, disseminating good practice for outreach and treatment of stimulant users. The Office will develop a general communication strategy which will be in line with scientific evidence, human rights and the spirit of the Conventions.

The process to further develop operations in Myanmar will be supported by the Drug Prevention and Health Branch through the development of integrated health teams, working simultaneously on drug dependence, social protection and low threshold health interventions, particularly for HIV prevention.

# SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

<b>Findings<sup>1</sup>: problems and issues identified</b>	<b>Evidence (sources that substantiate findings)</b>	<b>Recommendations<sup>2</sup></b>
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 MM J69 projects were conceived, planned, and initiated during mid-2000s and	Desk review, interviews with stakeholders, Interviews with beneficiaries/clients, participatory observation at	Future harm reduction projects in Myanmar need to increase their efforts to target a broader representation of drug users and

<sup>1</sup> A finding uses evidence from data collection to allow for a factual statement. Findings are based on a triangulation of the data collected.

<sup>2</sup> 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.

<p>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).</p>	<p>drug use venues.</p>	<p>include services designed for poly-substance and non-injection drug users.</p>
<p>Accumulation of local service capacity, professional expertise, and sustained behavior changes among IDUs resulting from the implemented projects may be limited.</p>	<p>Interviews with beneficiaries/clients, participatory observation at drug use venues.</p>	<p>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.</p>
<p>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.</p>	<p>Desk review, interviews with stakeholders, review of data collection capabilities and procedures at the field operations.</p>	<p>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.</p>
<p>Currently implemented progress monitoring and outcome measures focus on numerical benchmarks, outputs, and outcomes with limited quality control measures or qualitative evaluation or appraisal of implemented services.</p>	<p>Desk review, interviews with staff of UNODC and visited field DICs, participatory observations and appraisal during field visits.</p>	<p>Supplement quantitative and numerical performance and outcome measures with expanded and improved methods to monitor and evaluate the quality of services and interventions.</p>
<p>Population of beneficiaries reached by the implemented projects represents a limited range of DUs and IDUs in the</p>	<p>Desk review, interviews with beneficiaries, staff, and community representatives, site visits to active IDU sites,</p>	<p>Extend and improve outreach efforts outside highly visible drug use venues, and expand the scope and improve quality of</p>

<p>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.</p>	<p>participatory observations of services delivered at visited sites.</p>	<p>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).</p>
<p>Current DICs infrastructure, staff, and resources are not fully utilized. Administrative resources and efforts often outweigh resources allocated to directly benefit clients.</p>	<p>Field visits, participatory observations and appraisal, Interviews with staff and beneficiaries.</p>	<p>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.</p>
<p>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.</p>	<p>Interviews with UNODC management and DIC staff field observations of system utilization and reporting procedures.</p>	<p>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.</p>
<p>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 may have strong conflicts of interests preventing them from provision of high quality or adequate services benefiting IDUs.</p>	<p>Desk review, participatory observation, interviews with staff, beneficiaries, volunteers, peers, active drug users and individuals involved in drug trade.</p>	<p>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, including provision of safe injection equipment, education and information, and high quality interventions that directly and unequivocally benefit IDUs in Myanmar.</p>
<p>Current medication assisted symptomatic treatments of drug withdrawals offered at visited DICs are not in line with modern, medical good medical practice standards.</p>	<p>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.</p>	<p>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</p>

		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 priority<sup>3</sup> in the country. In terms of the country's overall disease burden<sup>4</sup>, HIV/AIDS is estimated to contribute 4.3%; and, has been estimated to be responsible for 4% of all deaths<sup>5</sup>. In 2009 the country had an estimated 238,000 people living with HIV<sup>6</sup>, of which approximately 74,000 met the criteria<sup>7</sup> for needing antiretroviral therapy (ART). Of these, however, only around 21,000 currently receive ART<sup>8</sup>.

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),<sup>9</sup>

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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<sup>3</sup> Myanmar Ministry of Health, Health in Myanmar, Naypyitaw, 2009.

<sup>4</sup> Overall disease burden is expressed in disability adjusted life years (DALY).

<sup>5</sup> World Health Organisation, Global Burden of Disease: 2004 Update, Geneva, 2008.

<sup>6</sup> 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).

<sup>7</sup> 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.

<sup>8</sup> Myanmar National Strategic Plan on HIV and AIDS, 2011-2015, draft for clearance, 21 October 2010.

<sup>9</sup> 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 Work plan (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



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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.<sup>10</sup>

## 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

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<sup>10</sup> See Project Document MMRJ63, August 15 2007 and Project Reference Manual

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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 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 (RTCUC) 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:

(a) Goal: To reduce the spread of HIV associated with drug use among men and women in South East Asia and China.

(b) 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

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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 collected 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 structured 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 extensive 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 appraisal 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.

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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 along 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



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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

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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.<sup>11</sup>

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

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<sup>11</sup> See UNODC’s 2011 Global ATS Assessment; Myanmar Situation Assessment on Amphetamine-Type Stimulants, December 2010.

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 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 living 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.

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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 centre; 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



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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 or 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 inpatient 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 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<sup>12</sup>

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

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<sup>12</sup> For more information on this, please see “A study on estimated HIV incidence among IDUs and its association with harm reduction services in Lashio, Northern Shan State” Substance Abuse Research Association (SARA)”.

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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 only very limited data on behavioral changes among the reached populations are available in Myanmar; a situation similar 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/procuring 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

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(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 temporarily 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.

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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 heel 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 evaluated 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 trained 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.

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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 from 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

Project no. & title: MMR/J63: UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar.  
MMR/J69: Reducing the Spread of HIV/AIDS Among Drug Users Through the HAARP Country Flexible Programme in Myanmar.

Evaluation starting date: February 2012

Evaluation team: One international consultant, and two national consultants

Evaluation duration: 40 days (comprising desk review, field visits, Vienna visits, and home-based work).

### Background information

Project numbers: MMR J63, and MMRJ69

Project titles: J63: UNODC Partnership for the Reduction of Injecting Drug Use, HIV/AIDS and Related Vulnerability in Myanmar.  
J69: Reducing the Spread of HIV/AIDS Among Drug Users Through the HAARP Country Flexible Programme in Myanmar.

Duration: J63: May 2007- June 2012  
J69: March 2008- Dec 2012

Location: 12 Townships in 2 States and 2 Divisions

Linkages to Country Programme Health and Development

Linkages to Regional Programme Sub-programme pillar (5) HIV/AIDS, under Health and Development Thematic pillar

Linkages to Thematic Programme Health and Development

Executing Agency: UNODC, Myanmar

Partner Organizations: (a) Township Project Management Committees (TPMCs);  
(b) Marie Stopes International (MSI);  
(c) National Drug and Alcohol Research Center (NDARC);  
(d) Substance Abuse Research Association (SARA);  
(e) Myanmar Baptist Convention (MBC);  
(f) Myanmar Council of Churches (MCC);  
(g) Myanmar Business Coalition on AIDS (MBCA);  
(h) and three Community Based Organizations (CBOs):  
(i) *Oasis- PLHIV group*;  
(ii) *Youth Empowerment Team (YET)*;  
(ii) *Voluntary Social Workers Association (VSWA)*.

Total Approved Budgets: MMRJ 63: \$US 3,395,739  
MMRJ 69: \$US 4,734,118

Donors:	J69: Australia J63: Three Diseases Fund (3DF), comprising Australia, Denmark, the European Commission, the Netherlands, Norway, Sweden, and the United Kingdom.
Project Manager/Coordinator:	Dr. Htwe Kyu
Type of evaluation:	J63: Terminal evaluation. J69: Midterm evaluation.
Time period covered by the evaluation:	J63: May 2007- Present J69: Mar 2008- Present
Geographical coverage of the evaluation:	Yangon, Mandalay, Lashio, Muse and Tachileik.
Core Learning Partners <sup>13</sup> (entities)	National AIDS Programme (NAP); Drug Treatment Centre, Department of Health; Central Committee for Drug Abuse Control (CCDAC); AusAID; National Drug User Network of Myanmar (NDNM).

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<sup>13</sup> The Core Learning Partnership (CLP) encourages a participatory evaluation approach by allowing its members to participate in and provide feedback on key steps of the evaluation process. CLP members are the key stakeholders of the subject evaluated (project, programme, policy etc.) who have an interest in the evaluation. The CLP works closely with the Evaluation Manager to guide the evaluation process. The list of CLP members is to be found in Annex 3.

## Justification

In the past years, HIV has killed over an estimated 25 million people across the world. There are now some 34 million people living with HIV. Even while it has produced an unprecedented response globally, HIV remains an immense public health challenge, threatening development efforts and national security.

A primary driver of the HIV epidemics in many East Asian countries has been, and continues to be, unsafe injecting practices among male and female injecting drug users (IDUs). If HIV transmission associated with injecting drug use is not addressed across East Asia in general, and within Myanmar specifically, HIV incidence among this at-risk population group will continue to increase, and subsequent transmission may expand beyond the sub-populations of injecting drug users and through their primary sexual partners to the wider national population. Evidence supporting the potential of this epidemiological transition from concentrated populations of 'higher risk' individuals to larger populations of persons of 'lower risk' is available from several East Asian countries including Vietnam, and Myanmar<sup>14</sup>.

In Myanmar, on the basis of public health importance, potential socioeconomic impact, and political importance, AIDS is ranked as a disease of first priority<sup>15</sup>. In terms of the country's overall disease burden<sup>16</sup>, HIV/AIDS is estimated to contribute 4.3%; and, has been estimated to be responsible for 4% of all deaths<sup>17</sup>. In 2009 the country had an estimated 238,000 people living with HIV<sup>18</sup>, of which approximately 74,000 met the criteria<sup>19</sup> for needing antiretroviral therapy (ART). Of these, however, only around 21,000 currently receive ART<sup>20</sup>.

Although the overall national prevalence of HIV is estimated at below 1%, prevalence continues to remain very high among populations engaging in higher frequencies of risky behaviour, particularly injecting drug users (35% prevalence, range 32-38%, CI 95%)<sup>21</sup>. The official estimate of IDU population size is 75,000 (range 60,000 – 90,000),<sup>22</sup> but even though IDU constitute a significant portion of the total population of people living with HIV in Myanmar, the number of IDU receiving ART remains disproportionately low<sup>23</sup>. Further, the availability of and access to quality HIV prevention services by IDU is limited. It is estimated that harm reduction programming reached only 8,274 individual IDU nationwide, and approximately 822 IDU are being treated in the national Methadone Maintenance Therapy (MMT) programme<sup>24</sup>. All of these figures fall well below Universal

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<sup>14</sup> National AIDS Programme, Myanmar National Strategic Plan on HIV and AIDS, 2011-2015, draft for clearance, 21 October 2010.

<sup>15</sup> Myanmar Ministry of Health, Health in Myanmar, Naypyitaw, 2009.

<sup>16</sup> Overall disease burden is expressed in disability adjusted life years (DALY).

<sup>17</sup> World Health Organisation, Global Burden of Disease: 2004 Update, Geneva, 2008.

<sup>18</sup> 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).

<sup>19</sup> 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.

<sup>20</sup> Myanmar National Strategic Plan on HIV and AIDS, 2011-2015, draft for clearance, 21 October 2010.

<sup>21</sup> National AIDS Programme, HIV Sentinel Surveillance Survey, Naypyitaw, 2009.

<sup>22</sup> 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.

<sup>23</sup> While official figures are difficult to verify, the number of IDU receiving ART is only 'a few hundred'.

<sup>24</sup> Both figures supplied by the National AIDS Programme, 2010. Few of the MMT clients are also on ART.

Access targets, and also jeopardise Myanmar's achievement of its Millennium Development Goal 6 commitment on HIV<sup>25</sup>.

There are many reasons why the HIV response among IDU in Myanmar remains inadequate. Primary reasons include inadequate funding<sup>26</sup>; a poorly resourced and equipped national health system<sup>27</sup>; a scarcity of properly trained health professionals, particularly in rural areas; national policies which are discriminatory toward drug users, and which generally embody a public security and not a public health approach; high rates of stigma and discrimination toward drug users; and, high rates of vulnerability among drug using populations caused by widespread poverty, food insecurity, and on-going security concerns, particularly in the border regions and the illicit drug production areas of East and South Shan State.

UNODC is responsible for coordinating illicit drug control strategies on a global level. The organisation 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 n. UNODC is a co-sponsor also of, most recently, the Joint UN Programme on HIV/AIDS (UNAIDS) and, as such, has been designated the Lead 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".

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. The results of these two HIV projects are measured against common regional indicators under the regional HIV sub-programme, and contribute to UNODC overall results in the region.

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.

## Work and Monitoring Plan

The HIV and AIDS Section has developed a strong communication and monitoring mechanism encompassing all UNODC HIV projects and programmes. The information flow is a Field-to-Headquarters communication through a monthly report which is sent by all staff members. The

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<sup>25</sup> United Nations Country Team in Myanmar, Myanmar's Progress on Achieving the Millennium Development Goals, unpublished paper, 2010.

<sup>26</sup> The Government annual financial contribution to the national response to HIV is estimated at approximately \$US 1.52 million. Myanmar receives one of the world's lowest rates of overseas development assistance. Even with the approval of the Global Fund Round 9 grant which contains a ceiling of \$US 153 million for HIV over five years (2011-2015), the estimated cost of Myanmar's national response to HIV over this same period is \$US 336 million (See: National AIDS Programme, Operational Plan: 2011-2015, version for clearance, 21 October 2010).

<sup>27</sup> The Government of Myanmar spends less than 1% of its GDP on health, which corresponds to less than \$US 1 per capita.

monthly report provides programmatic information, such as the major achievements, difficulties encountered, and future opportunities identified. Regular monthly global and regional conference calls and Skype connections are also held to share and discuss the most up to date information and events.

### *MMRJ69(HAARP)*

Senior national staff members of Country Program Team – Yangon take responsibility for overall M&E issue of the whole program and of individual project site (EAP) as well. Team Leader, Harm Reduction Coordinator and Health Information and Research Analysis share this task, developed M&E visit plan for each year, developed M&E tools and report format. Semi-Annual and Annual Review meetings between Yangon Programme Management Team and representatives (Project Officers and Admin & Finance Assistants) of all project sites are regularly conducted. To present current achievement against the targets for each activity, to explore technical needs in harm reduction and information and data collection, and to discuss how to resolve and reduce the difficulty and/problem met by particular project sites, especially in security and coordination with partners, are the main purposes of those review meeting.

### *MMRJ63(3DF)*

As the regular tracking of the project progress and direction, MMRJ63 project management team collect, compile, review and feedback the monthly, quarterly and six monthly progress reports, database files, costed work plan from each project site. To complement this, regular monitoring visits were conducted to the field sites as well as identifying the issues for technical support. In addition, regular review and work planning workshops were done by J63 on basis of three times per year to review activities, revise work plan and costed work plans.

With regards to data management, the project developed database software named DAISY for J63 with unique coding system. To assess the project outcome and impact, MMRJ63 conducted regular behavioural surveys and follow up studies led by Health Information & Research Analyst of the project. To strengthen the communication and feed back mechanism, stakeholder meetings were conducted and beneficiary accountability arrangements were also set up in field projects

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

The project 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 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 Three Diseases Fund (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 main objective of the project is to assist the Myanmar Government to achieve significant and measurable results in reducing the prevalence of HIV among injecting drug users through the following outcomes:

(a) HIV prevalence among IDU in the project townships is significantly decreased.

(b) Drug users, injecting drug users, their sexual partners, and ‘at risk’ populations demonstrate increased awareness and correct knowledge about drug-related HIV infection and have positively changed their drug-use behavior and health-seeking practices.

*MMR/J69, Reducing the Spread of HIV/AIDS Among Drug Users Through the HAARP Country Flexible Programme in Myanmar.*

Between 2002 and 2007 AusAID funded the Asia Regional HIV Programme (ARHP) which was implemented in China and Vietnam, as well as Myanmar. Based on the success of this programme, AusAID developed a successor programme to the ARHP entitled the HIV/AIDS Asia Regional Programme (HAARP). HAARP is an Australian Government (AusAID) funded health program aimed at providing harm reduction to both men and women. The HAARP is an important element in Australia’s response to the growing HIV problem in the East Asian region, and this importance is demonstrated through HAARP’s expansion of its geographic scope to include Cambodia, Lao, and the Philippines. As it is regional in nature, HAARP comprises two layers of activity focussed on HIV and drug use – first, at the regional level; and second, at national levels in which its six constituent countries are involved.

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

(a) Goal: To reduce the spread of HIV associated with drug use among men and women in South East Asia and China.

(b) 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 programme Goal and Purpose are developed for and contained in individual Country Programmes (CP) created for each of the six HAARP six 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.

## Disbursement history

<i>Overall Budget (time period)</i>	<i>Total Approved Budget (time period)</i>	<i>Expenditure (31 December 2011)</i>	<i>Expenditure in % (26 October 2011)</i>
J63: \$US 3,414,400 (2007- 2011)	\$US 3,395,739	\$US 3,350,709	98.6 %
J69: \$US 4,842,346 (Mar 2008- Dec 2012)	\$US 4,816,574	\$US 3,502,786	73 %

Project MMRJ63 is funded by the Three Diseases Fund (3DF), which is a multi-donor trust fund operating in Myanmar and funded by Australia, Great Britain, European Union, Netherlands, Norway, Sweden, and Denmark. Project MMRJ69 is funded by Australia.

## Purpose of the evaluation

In compliance with the project documents, an external final evaluation for J63 and an external midterm evaluation for J69 are being initiated by UNODC. The final evaluation for J63 is to assess its results, to assess to what extent it has achieved its objectives, and to determine whether it has been relevant, efficient, and sustainable in its contribution toward its outcomes and expected impact. The midterm evaluation of J69 is to assess project interim results in relation to its objectives; and, to provide recommendations for improving project performance based on an assessment of the relevance, impact, and effectiveness as well as the various partnership/cooperation aspects of project processes and services in increasing access to services for target populations, the efficiency of current project service delivery structures, the potential sustainability of these services and their implementation structures.

The evaluation team will evaluate both projects concurrently and set them into the context of the global drug control policy and programmes of UNODC and UNODC mandates (i.e. resolutions of United Nations General Assembly, Economic and Social Council and Commission on Narcotic Drugs) as these relate to addressing HIV and AIDS. A final evaluation report will be created for J63, and a midterm evaluation report will be created for J69. These reports will be part of the in-depth evaluation of the Global HIV/AIDS Thematic Programme. Each report will include a chapter that discusses the commonalities across the projects (threads, themes, lessons learned, etc.). In addition, the evaluation team is expected to analyze joint achievements and/or gaps in delivering technical assistance under each project. The reports are expected to generate insights and questions, which will then be taken up by the in-depth evaluation, which is scheduled to take place in February-March 2012 and for which preparations have started at the end of 2011.

The evaluation findings will be discussed at the tripartite project review (TPR) meeting for each project, and published on the UNODC website. Findings will also be presented in Vienna to the Independent Evaluation Unit, the HIV/AIDS Section, and other relevant sections of UNODC Vienna.

The evaluation will seek the views and feedback also from the donors providing funding to each project, as well as from a group of Core Learning Partners (CLP). This CLP is made up of major project stakeholders, and is proposed to encourage a participatory evaluation process. Please see Annex 1 for the CLP list of Core Learning Partners (CLP) for each project. These CLP's will be consulted during the major steps of the evaluation. The evaluation will be supported also by the UNODC Independent Evaluation Unit (IEU). The IEU will provide direct support in regards to the

provision of guidelines, formats, assistance, advice and clearance on evaluation procedures and quality control of evaluation outputs. Further details on the roles and responsibilities of these and other partners to the evaluation are included in section 9 below.

## Scope of the evaluation

The period to be covered by the evaluation starts on the date when each project was launched and covers the period from this date to November 2011. For J63 the evaluation period will begin from May 2007, and for J69 the evaluation period will begin from March 2008.

The duration of the evaluation is a combined 40 days, and the evaluation will cover project field sites for both J63 and J69, including locations of geographic overlap – sites which contain service provision supported by both projects.

This evaluation will cover each project in its entirety and situate it within the Thematic Programme as well as the Regional Programme. This includes: project concept and design; implementation and management arrangements, including monitoring and evaluation; outputs, outcomes and impact(s); relevance, efficiency, and effectiveness; partnerships; coordination; and sustainability.

The evaluation will consider also the existing and/or possible synergies between the two projects and how these do or could impact on project service delivery and impact.

## Evaluation criteria and key evaluation questions

The evaluation will be based on the following evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability, and partnerships/coordination. The evaluation will answer key questions in each of its reports, with the understanding that these questions remain generic but are consistent with standard approaches to project evaluation. There will be an element of flexibility, as the evaluation progress, to further provide and inject additional generic questions. In this context, the overall key evaluation questions to be answered by the evaluation team for each project are as follows:

### *Project concept and design*

The evaluation will undertake to establish whether the projects' design and concept are in line with UNODC Programme and Project Document Standard Format and Guidelines, with the country's strategic priorities and expectations, as well as with the relevant Regional and Thematic Programmes. It will review the clarity, logic and coherence of the project documents; the ways in which problems are addressed by the projects and priorities were determined; the strategy adopted to address immediate objectives and planned outputs; and, whether inputs and the level of activities were appropriate and objectives and outputs achievable. It will address also whether or not learning and recommendations of relevant previous UNODC projects and programmes addressing HIV and AIDS were considered and incorporated at the design stage of the projects.

### *Implementation*

In addition, and since the UNODC Regional Programme Framework forms the basis within which all UNODC regional programming is developed and implemented, and these projects are included also as a subset within the Global HIV/AIDS Programme, the evaluation will examine the results of these two projects against the indicators under the regional HIV/AIDS sub-programme.



## *Outputs*

It will also assess whether the stated outputs have been produced, and whether/ how they contribute to the foreseen outcomes.

## *Project outcomes and indicators*

An assessment will be made of progress towards achievement of projects outcomes, objectives, and impact. If expected results have not been achieved yet, the evaluation will aim at determining why and whether progress has been made, or is being made, toward their achievement. The evaluation will also assess significant unexpected effects of the projects, their sustainability and transition strategies. In particular, the evaluation will look at the projects' contribution to human and institutional capacity development, and whether this capacity is creating - or contributing toward the creation of - conditions for sustainability. It will also assess the risk management systems and related implementation structures that have been set up for the two projects.

## *Relevance, Efficiency, Effectiveness, Impact, Sustainability, Partnerships/ Cooperation and Coordination*

The evaluation will review:

### *Relevance: Did/do the objectives of the projects match the problems and needs?*

(a) Are the projects' objectives and results (outputs, outcomes and impacts, and considering relevant indicators) clear, realistic and coherent in terms of contributing to the achievements of the UNODC Strategic Programme Framework 2008-2011, the drug demand reduction and HIV components of the UNODC Regional Programme Framework for East Asia and the Pacific, and the Thematic Programme?

(b) Do the major problems addressed under the projects still remain a problem to address? If so, why?

(c) To what extent are the projects aligned with national drug and HIV/AIDS policies and strategies?

(d) Are the projects in line with the priority areas for technical cooperation identified in these policies and strategies?

(e) To what extent does the project design incorporate gender aspects within target groups?

(f) Do/did the project interventions complement, duplicate or compete with other efforts of UNODC, the government and/or other partners in their areas of implementation in the region?

### *Effectiveness: Have the projects been successful in achieving their objectives?*

(a) Have the projects achieved, or made progress towards achieving their objectives and results (outputs, outcomes and impacts considering relevant indicators)? In particular :

(i) To which extent did they contribute to improve availability of and access to HIV/AIDS services among people suffering from drug dependence?

(ii) To which extent did they contribute to improve the policy and legal environment relevant to HIV/AIDS in the country?

(iii) To which extent did they contribute to increasing community level capacity in addressing HIV/AIDS among the target populations?

- (iv) Have HIV incidence and prevalence among people who inject drugs decreased in project township areas? If so, to which extent the observed decreases can be attributed to the two projects?
- (v) To which extent did the projects contribute to gender sensitivity in addressing HIV/AIDS among the target populations?
- (vi) To which extent did the projects contribute to increasing awareness related to HIV/AIDS among the target populations and supported to achieve positive behavioural changes, including health seeking practices amongst them?

(b) What are the projects' achievements, and if applicable, what are their deficiencies?

(c) Given the country's specific context, have the projects' work plans, logical framework matrices and monitoring systems been designed to make proper monitoring possible and effective throughout the projects cycle?

*Efficiency: How economically project resources/inputs (funds, expertise, time etc.) have been converted to results?*

(a) Have the project budgets been allocated appropriately between the outputs and spent as planned?

(b) Have projects' outputs achieved their targets (or not) according to the given inputs?

(c) What measures have been taken during the projects' planning and implementation to ensure that resources allocated are efficiently used?

(d) Are/ were the projects delivering/ delivered in line with set targets and timeframes?

(e) Do the inputs proportionally correspond to the expected deliverables in terms of workload?

*Impact: What have been positive and negative, primary and secondary, short-term and long-term effects produced by these projects' interventions - either, directly or indirectly, intended or unintended?*

(a) What were the initial provisions made to assess UNODC's contribution?

(b) What measurable contributions have the projects made with regard to HIV/AIDS programming among the national counterparts?

(c) What are the intended/unintended, positive/negative, direct/indirect, primary/ secondary technical, professional, and other relevant effects on beneficiaries?

(d) How have changes in the target group's behaviour been monitored over time?

(e) How do the different stakeholders (particularly from the Government of Myanmar, but including also implementing partners, other UN agencies, bilateral and multilateral donors) perceive the overall (a) contribution of UNODC in addressing HIV/AIDS in the country?

(f) Did the interventions have gender-specific impacts on target populations?

*Sustainability: Are there lasting benefits following the interventions such as increased self-sufficiency? What happens after the projects come to end?*

(a) To what extent will the benefits generated under these projects be sustainable? In particular, have the projects generated the following elements of sustainability as planned:

(i) Critical mass of expertise in each target area?

(ii) Diversified and integrated services?

- (iii) Responsibilities transferred to national counterparts?
- (iv) Experiences systematised, and lessons learnt and disseminated?
- (v) Policy, legal, and enabling environment?

(b) To what extent have/ could the national counterparts, beneficiaries and other partners take/n ownership of the projects' services?

(c) Are national counterparts and other partners committed to continue working towards these project objectives at the end tenure of the projects? If so, what should be continued, if not, what measures could be undertaken, or do they intend to undertake to encourage/ enable such a commitment from partners, and foster sustainability of programme impact for UNODC interventions in bridging further dialogue between national authorities?

### *Partnerships/ cooperation and coordination*

(a) Who are the key stakeholders and other partners/players active in the field and what is the level and quality of cooperation with key stakeholders and other players active in the field (e.g. in terms of avoiding duplication)?

(b) What is the level of coordination between the two projects and other key stakeholders and government counterparts, and between each project and other harm reduction implementers and associated partners?

(c) Have national stakeholders, including international donors and civil society groups, been actively and meaningfully involved in developing and implementing the projects?

(d) What communication practices have been established with relevant sections and units at HQ? What is the quality of communication with HQ?

(e) Which partnerships and coordination mechanisms should be pursued, strengthened or abandoned?

### *Recommendations*

The specific findings and conclusions of the project evaluation are to be recorded. Recommendations are to be made with a view to improve the project design, management and implementation. All recommendations made should be project-specific, and concrete follow-up action should be proposed and planned for. A monitoring plan should also be established to follow-up implementation of the recommendations and taking necessary actions to improve or rectify undesired outcomes.

### *Lessons learned and best practices*

The evaluation should identify key lessons that can provide a useful basis for strengthening UNODC support to Myanmar and for improving future project performances, results and effectiveness. Through an in-depth assessment the evaluation should present and highlight features to be considered as good practice and lessons learned. It should draw lessons from unintended results, where possible; and, identify best practices that have emerged from the projects' implementation.

### *Evaluation methodology*

The evaluators will have access to all relevant documents and available staff who have worked on the projects. Based on the evaluation questions in this TOR, and prior to the field missions, the evaluators, under the direction of the Lead Evaluator, will provide a detailed description of evaluation methods and tools.

In general, a concise evaluation methodology, including the sampling strategy, will be presented by the evaluator in the inception report<sup>28</sup>. The evaluators will carry out a triangulation of findings based on the following evaluation methods and data sources:

- (a) Document review and analysis.
- (b) Face-to-face and telephone interviews with stakeholders, including key beneficiaries and players.
- (c) Field visits to selected projects' field site locations. (The evaluators will present the sampling strategy that will be applied to the selection of project sites as part of the inception report.<sup>29</sup>).
- (d) Participatory observation and rapid appraisal.
- (e) Comparative analysis with similar projects implemented in other areas.
- (f) Stakeholder feedback to the draft evaluation reports.

Based on the findings, the evaluator will prepare a draft report and submit it to the UNODC Project Manager. The draft report will be circulated for comments to the involved parties including CLP and the UNODC Independent Evaluation Unit (IEU).

In conducting the evaluation, the evaluator needs to take into account UNODC's Evaluation Policy including the Guiding principles for evaluation in the UNODC<sup>30</sup>, UNODC's evaluation report guidelines Standard format and guidelines of the UNODC for Evaluation Reports<sup>31</sup>, UNODC Guidelines for Inception Reports<sup>32</sup> as well as the United Nations Evaluation Group's Standards for Evaluation in the UN System and Norms for Evaluation in the UN system<sup>33</sup>.

After completion of the evaluation the evaluator must fill in the Evaluation Assessment Questionnaire<sup>34</sup> and submit it to the IEU.

### *Documentation*

Prior to undertaking the evaluation mission, and for ease of reference, the projects' management in Myanmar will provide the evaluation team with relevant documentation pertaining to the projects. These include the project documents, project revision documents, semi-annual and annual project progress reports, project-related mission reports, project meeting reports, and other relevant correspondence deemed necessary for the overall assessment of the current projects' status. These will also include relevant UNODC wide documentation, such as the relevant Regional and Thematic Programme, as well as the Guidance Note on UNODC Role in response to HIV and AIDS Epidemics.

### *Briefings, consultations and administrative support*

Prior to the start of the field mission, the evaluation team will meet with the UNODC IEU (in Vienna). It will visit also the UNODC Office in Myanmar for a briefing by the Country Office on the projects' management and the status of the projects' execution. The evaluation team will visit selected project sites receiving or having received assistance under each project so far. While in Myanmar the evaluators, at their discretion, may visit also other stakeholders.

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<sup>28</sup> See Annex 5.

<sup>29</sup> The sampling method with regard to site selection will be made after a careful consideration of the project sites (their accessibility, security etc.) in coordination with the project management.

<sup>30</sup> [http://www.unodc.org/documents/evaluation/Guidelines/Final\\_Evaluation\\_Policy.pdf](http://www.unodc.org/documents/evaluation/Guidelines/Final_Evaluation_Policy.pdf)

<sup>31</sup> <http://www.unodc.org/unodc/en/evaluation/about-projects-.html>

<sup>32</sup> See Annex 5.

<sup>33</sup> [http://www.unevaluation.org/normsandstandards/index.jsp?doc\\_cat\\_source\\_id=4](http://www.unevaluation.org/normsandstandards/index.jsp?doc_cat_source_id=4)

<sup>34</sup> <http://www.unodc.org/unodc/en/evaluation/about-projects-.html>

All required documentation is listed in the Annex 2, and any additional assistance as required, including travel arrangements to the projects' sites will be taken care of by the team in Myanmar. It is understood that whilst considering any views/suggestions expressed by the projects' management or any parties involved in the implementation of the projects, the evaluation team members will not act as the representatives of any party throughout the evaluation, respect confidentiality, and remain independent and impartial. The evaluation team members do not have the authority to make any commitment on behalf of the projects' parties (, i.e. UNODC, the government, and donors).

### *Evaluation report and follow-up*

There will be a debriefing meeting, held at the UNODC Office in Yangon, during which the evaluation team will present a summary of the mission's draft findings and recommendations to which CLP members will be invited. Any observations and comments received from UNODC and the national counterparts during the mission may be taken into account by the evaluation team members and reflected in the final report as appropriate, without compromising confidentiality and independence. The IEU of UNODC will provide quality assurance in accordance with the United Nations Evaluation Group (UNEG) and UNODC evaluation guidelines and standards, including comments on the draft reports and clearance of the final reports, which will be posted on the UNODC website. The evaluation team members will keep their independence and freedom of judgment in finalising the reports, and in their conclusions and recommendations.

Within thirteen days after the end of the mission the Evaluators will produce a draft report for each project, in English, and not exceeding 25 pages excluding annexes for each. These draft reports will be circulated for comments to UNODC Myanmar, the IEU, and by UNODC to the CLP membership in that order. The evaluation team will then incorporate any comments in their completion of the final evaluation reports. The evaluators will adhere to the UNODC format and guidelines for evaluation reports. These guidelines are attached to this TOR as Annex 4.

The Evaluators will submit the final reports to UNODC Myanmar and to the IEU 14 days after the end of the mission for final clearance.

The evaluation will be conducted within a contracted period of 40 days starting on February 16, 2012. The preliminary agenda could be revised by the Evaluators following prior consultations with the IEU and UNODC Myanmar.

An initial list of documentation related to the projects and to be provided as reference is listed in Annex 2.

### **Timeframe and deliverables**

The evaluation of the J63 and J69 projects will be carried out in 40 days beginning on February 16, 2012. The proposed allocation of time will be as follows:

- (a) 5 working days for desk reviews (home-based assignment).
- (b) 2 working days to meet with the IEU and HIV Global Programme in Vienna.
- (c) 18 working days in Myanmar (including visiting field sites).
- (d) 13 working days for writing the drafts and final evaluation reports.
- (e) 2 working days for the presentation of the draft findings upon return from mission, in Vienna HQ.

The evaluators will be briefed and debriefed on the projects by members of the IEU, the UNODC Drug Prevention and Health Branch in Vienna, and the project management team of the UNODC

Country Office in Myanmar. The latter will also provide necessary substantive and administrative support. Although the evaluators should be free to discuss all matters relevant to their assignment with the authorities concerned, the incumbents are not authorised to make any commitment on behalf of UNODC or the Government.

The evaluators will submit draft evaluation reports to the IEU, and to UNODC Myanmar. The draft reports, as agreed with UNODC, will be shared also with the CLP membership and donors for comments.

The reports will contain the draft findings, conclusions and recommendations of the evaluators, as well as a recording of the lessons learned during project implementation. Further, the evaluators will follow the instructions provided by the Evaluation Handbook of UNODC regarding the content, structure and annexes of evaluation reports. The evaluators, while considering the comments provided on the draft, will use their independent judgment in preparing the final report.

The final reports should be submitted to UNODC no later than two weeks upon completion of the field mission. The final reports will be distributed to the CLP members, CLPs and donors and, by UNODC, to relevant government authorities.

### Evaluation team composition

A three-member team of external independent evaluators will undertake the evaluation. The evaluators should not have had any previous or current involvement with the projects' idea, design or implementation. The evaluation team will be guided by the UNODC Independent Evaluation Unit, and a member of IEU will accompany the evaluation team during its fieldwork. At their discretion, a representative from the projects' donor(s) may also be included also on the mission as an observer member as long as observation does not interfere with evaluation activities and does not have an effect on evaluation outcomes. The observer is welcome to accompany the evaluation team throughout the entire process but does not have the possibility of influencing the evaluation process at any time and the observer's work/presence is not reflected in the evaluation report. The expenditures for such participation are borne by the party which has nominated the observer.

The evaluation team leader will be an international expert, and should possess a combination of technical expertise in drug control policies and programmes addressing HIV and AIDS and in evaluation. The other members of the evaluation team will be one national expert in drug control policies and programmes addressing HIV and AIDS and one in evaluation methodologies, each with a degree in the social sciences or relevant field and at least 5-7 years of proven experience in carrying out and/or planning independent evaluations, as well as on data collection and reporting. These members will work in close collaboration with the international evaluation team leader throughout the evaluation.

The evaluation team should be gender-balanced, and all members should have:

- (a) Experience in evaluation, in particular in sampling, interviewing techniques, data collection, data analysis and report writing;
- (b) Strong analytical and writing skills in English;
- (c) Experience in the area of technical assistance related drug control policies and programmes addressing HIV and AIDS
- (d) Working experience in the cultural and socio-political environment of South East Asia. Myanmar experience would be considered an asset;
- (e) Experience in evaluating similar projects.

Members of the evaluation team must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefitted from the projects under evaluation. The evaluation team consultants will be contracted by UNODC. The qualifications and responsibilities for each team member are specified in the respective job descriptions attached to these Terms of Reference as Annex 1.

## Management of evaluation process

The independent evaluation will be carried out following UNODC's evaluation policy and UNEG Norms and Standards. The evaluation team will work closely with UNODC's IEU.

### *The Independent Evaluation Unit (IEU)*

The IEU guides the quality assurance processes of this evaluation; endorses the TOR; approves the selection of the proposed evaluation team members and liaises closely with the evaluators throughout the entire evaluation process. The IEU comments on and approves the selection of evaluation consultants and the evaluation methodology, and provides methodological support throughout the evaluation. The IEU will comment on the draft reports, endorse the quality of the final reports, support the process of issuing management response, if needed, and participates in disseminating the final reports to stakeholders within and outside of UNODC. The IEU ensures a participatory evaluation process by involving Core Learning Partners during key stages of the evaluation. A member of the IEU will accompany the evaluation team during its fieldwork phase and participate actively throughout the entire evaluation process. A separate ToR will be drafted for this member in this regard.

### *Project Management Teams*

The project management teams are responsible for the provision of desk review materials to the evaluation team, reviewing the evaluation methodology liaising with Core Learning Partners, as well as reviewing the draft reports and developing an implementation plan for the evaluation recommendations.

### *Core Learning Partners*

Members of the Core Learning Partnership (CLP) are selected by the project management teams in consultation with the IEU. Members of the CLP are selected from the key stakeholder groups, including UNODC management, mentors, beneficiaries, partner organisations and donor Member States. The CLPs are asked to comment on key steps of the evaluation and act as facilitators with respect to the dissemination and application of the results and other follow-up action. A list of the projects' CLP is included in Annex 3.

### *Evaluation team*

#### *Roles and responsibilities of the Lead Evaluator*

- (a) carry out the desk review;
- (b) develop the inception report, including sample size and sampling technique;
- (c) draft the inception report and finalise the evaluation methodology incorporating relevant comments;

- (d) lead and coordinate the evaluation process and oversee the tasks of the other two evaluators;
- (e) implement quantitative tools and analyse data;
- (f) triangulate data and test rival explanations;
- (g) ensure that all aspects of the terms of reference are fulfilled;
- (h) draft an evaluation report for each project in line with the UNODC evaluation policy;
- (i) finalise the evaluation report for each project on the basis of comments received;
- (j) include a management response in each final report;
- (k) present the findings and recommendations of the evaluation at the donor briefing at the time of its annual mentors' meeting.

#### *Roles and responsibilities of the evaluators*

- (a) assist the Lead Evaluator in all stages of the evaluation process, as per the respective TOR;
- (b) participate in selected missions.

#### *Roles and responsibilities of the evaluator from the IEU*

- (a) in coordination with the IEU team, provide methodological evaluation quality assurance throughout the evaluation process;
- (b) comment on all deliverables of the evaluation team;
- (c) assist the Lead Evaluator in all stages of the evaluation process;
- (d) join the planned missions and apply methodological tools.

More details are provided in the respective job descriptions an Annex 1.

### **Payment modalities**

The Evaluators will be issued consultancy contracts and paid in accordance with UNODC rules and regulations. The projects will cover all the costs related to travel of the evaluators and provide them with DSA based on the UN rates established for each location to be visited. Interpretation services will be provided by the projects. Contract payments will be made in instalments.

An initial payment will be made upon signature of the contract and will consist of an advance of 75% of the consultants' daily subsistence allowance and terminals. The balance will be paid after the travel has taken place, upon presentation of boarding passes and the completed travel claim forms.

The consultants will be paid in accordance with United Nations rules and procedures. Payment will be correlated to deliverables. Three instalments are foreseen: 25%, 25% and 50% of total fees.

The first payment of consultancy fees (25% of the total fee) will be made upon receipt of the Inception Report;

The second payment of consultancy fees (25% of the total fee) will be made upon receipt of the two draft Evaluation Reports;



The third and final payment of consultancy fees (50% of the total fee, i.e. the remainder of the fee) will be made only after completion of the respective tasks, receipt of the final reports, and their clearance by UNODC.

## ANNEX 1: Job descriptions of evaluators

### *a) Job description for the International Evaluation Consultant and Team Leader*

Post Title:	International evaluation consultant and team leader
Estimated duration:	40 working days
Starting date required:	Mid-February 2012
Duty station:	Home-based; missions to Myanmar and Vienna

### *Duties of the International Evaluation Consultant*

The International Evaluation Consultant will collaborate with, and lead a team of, two national evaluation consultants on the independent evaluation of UNODC projects MMRJ63 and MMRJ69. On the basis of the Terms of Reference s/he will carry out the following duties:

<i>Duties</i>	<i>Duration (working days)</i>	<i>Location</i>	<i>Results</i>
Desk study	5 days	Home-based	List of evaluation questions; Evaluation tools; Draft inception report. Inception report.
Interviews with staff at UNODC HQ	2 days	UNODC HQ, Vienna	
Evaluation mission: briefing, interviews and presentation of preliminary findings	18 days	Myanmar	Notes
Drafting of the evaluation report; submission to stakeholders for comments; and finalization of report	13 days	Home-based	Draft reports; Final reports.
Presentation of findings Total	2 days	UNODC Vienna	
<b>Total</b>	<b>40 days</b>		

### *Required qualifications*

The consultant should demonstrate:

- (a) extensive knowledge of, and experience in applying, qualitative and quantitative evaluation methods;
- (b) a strong record in designing and leading evaluations;
- (c) technical competence in the area under evaluation (advanced university degree or practical experience);
- (d) excellent communication and drafting skills.

### *Languages*

The consultant must have excellent English writing skills.

### *Absence of Conflict of Interest*

According to UNODC rules, the consultant must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefited from the programme/project or theme under evaluation.

### *Ethics*

The evaluators shall respect the UNEG Ethical Guidelines.

### *b) Job description for the National Evaluation Consultants (two posts)*

Post title	National Evaluation Consultant (two posts)
Estimated duration	18 working days
Starting date required	Mid-February 2012
Duty station	Home-based; field sites in Myanmar.

### *Duties of the National Evaluation Consultant*

The National Evaluation Consultant will collaborate with the International Evaluation Consultant and Team Leader on the independent evaluation of UNODC projects MMRJ63 and MMRJ69. On the basis of the Terms of Reference s/he will carry out the following duties:

<i>Duties</i>	<i>Duration (working days)</i>	<i>Location</i>	<i>Results</i>
Desk study of project documents, reports, etc and collection of additional information as required by Evaluation Team Leader. Establishment of the mission's programme; Interview guidelines in collaboration with the international consultant.	5 days	Home-based	List of evaluation questions and tools developed; Draft inception reports.
Evaluation mission: briefing and interviews.	18 days	Myanmar	Notes
Drafting of chapters of the evaluation reports in collaboration with the international consultant.	5 days	Home-based	Draft reports.
Total	28 days		

### *Required qualifications*

The consultants should always demonstrate:

- (a) knowledge of, and experience in applying, evaluation methods;
- (b) technical competence in the area under evaluation (at least one team member);
- (c) knowledge of the UN environment and possibly of UNODC;
- (d) Field experience.

### *Languages*

The national consultants must be fluent in English.

### *Absence of Conflict of Interest*

According to UNODC rules, the consultant must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefited from the programme/project or theme under evaluation.

### *Ethics*

The evaluators shall respect the UNEG Ethical Guidelines.

## 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, ledgers, 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

### General background documents

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Sharma, Mukta, Edna Oppenheimer, Tobi Saidel, Virginia Looc and Renu Garga (2009): “A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia Region”. In: AIDS 2009, Vol 23 No 00.

UNAIDS (2010): Epidemiological factsheet: Myanmar.

UNAIDS (2010): UNGASS Country Progress Report: Myanmar. January 2008 – December 2009.

UN RTF and HAARP (2010): Myanmar Country Advocacy Brief Injecting Drug Use and HIV.

UN RTF and HAARP (2009): Estimation of Resource Needs and Availability for HIV Prevention and Care among People Who Inject Drugs in Asia.

USAID (2010): HIV/AIDS Health Profile.

WHO (2010): A strategy to halt and reverse the HIV epidemic among people who inject drugs in Asia and the Pacific 2010-2015.

WHO (2010): Report on people who inject drugs in the South-East Asia Region.

WHO (2008): Operational guidelines for the management of opioid dependence in the South-East Asia Region.

WHO, UNODC and UNAIDS (2009): Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

### UNODC specific documents

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