**HIV Prevention and Harm Reduction Project among Drug (Injecting) Users**

**Project number: MMR073**

**3DF Project**

**April 2007 to December 2011**

**CARE Myanmar**

**End of Project Evaluation Report**

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AIDS Acquired Immune Deficiency Syndrome

ANTF Anti-Narcotics Task Force

ART Anti-Retroviral Treatment

ARV Anti-Retroviral

ASEAN Association of South East Asian Nations

BCC Behavior Change Communication

BI Burnet Institute

CBT Cognitive Behavior Therapy

CCDAC Central Committee for Drug Abuse Control

DIC Drop In Centre

DOH Department of Health

DSW Department of Social Welfare

DTC Drug Treatment Centre

EOP End of Project

EU European Union

FGCC Family care Giver Group

FGD Focus Group Discussions

HAARP HIV AIDS Asia Region Project

HIV Human Immunodeficiency Virus

IDU Injecting Drug User

IEC Information, Education, Communication

INGO International Non-Governmental Organization

IP Implementing Partner

MANA Myanmar Anti-Narcotics Association

MMT Methadone Maintenance Treatment

MOH Ministry of Health

MOHA Ministry of Home Affairs

NAP National AIDS Program

NDNM National Drug User Group

NSP Needle and Syringe Program

OI Opportunistic Infections

PAD Public Administration Department

PCM Project Coordinating Meeting

PLWHA People Living with HIV/AIDS

PRODOC Project Document

PWID People Who Inject Drugs

PWUD People Who Use Drugs

RLF Revolving Loan Fund

SHG Self Help Group

STI Sexually Transmitted Infections

SWD Social Welfare Department

TB Tuberculosis

TOT Training of Trainers

UNAIDS United National Program on AIDS

UNODC United Nations Office on Drugs and Crime

VCCT Voluntary Confidential Counseling and Testing

VSWA Volunteer Social Workers Association

WG Working Group

WHO World Health Organization

**Executive Summary**

**Introduction**

This report is the documentation of the findings and recommendations of evaluation team from technical staff of Burnet Institute Myanmar office. The evaluation team conducted the end of project evaluation focused on reflection and learning of the CARE Myanmar Harm Reduction Program as a whole as well as the relevancy and sustainability of behavior change in following the end of the project in December 2011. In addition, this review process mobilized the various stakeholders to understand taking action informed by this social learning process, which helped to facilitate the capacity development of key stakeholders to engage in all steps of a learning cycle; from assessment of project progress to reflection as well as generation of lessons learned.

The method used in this evaluation was designed within the frame of the descriptions made in TOR between CARE-Myanmar and Burnet-Myanmar. Project description documents, end of project(Reducing Injecting Drug Use and its Harmful Consequences in the Union of Myanmar-G-54) report and technical progress reports to 3DF were reviewed first and data collection methods were designed after target population in the review process was identified. The participatory approach was used in this evaluation process. Key informant interviews were made with senior and field management level staff, community leader and law enforcement personnel. A couple of Focus Group Discussions were made with targeted beneficiaries in a place that can assure data accountability. Evaluation workshop was conducted in reflection manner with the rest of the stakes holders; CARE project staff and peer educators from four project sites, project staff from MANA and HAARP in Mandalay, and representatives from NAP, DTC, CCDAC, social warfare and local police force.

The evaluation team would like to acknowledge CARE Myanmar as they were willing and able to provide all the necessary documents and reports that are supportive to the evaluation. In addition, Focus Group Discussions, in-depth interviews and evaluation workshop were conducted smoothly and effectively unless the supports from CARE Myanmar were not effective and efficient.

However, the evaluators had no chance to have direct observation in the field by which CARE activities were implementing due to limited budget and ending of the project months ago. Furthermore, we could not invite sufficient number of staff and peer educators from Kalay and Tamu field offices to evaluation workshop and in-depth interviews due to this budget limitation.

**Key findings**

* This 3DF project had a good start as it was the continuation of previous G-54 project with well trained and experienced staff. This project’s goal and objectives were set up based on the recommendations of G-54 end of project evaluation and informal situation analysis with key stakeholders including people who use drugs and project staff.
* The project log frame and the activities created enabling environment for behavior change of people who use drugs especially for people who inject drugs as it targeted not only to reach people who use drugs but also to reach the family members and general community through artist and theatre performer, Pwe troopers, police personnel. Project activities of CARE tried to meet most of the needs of people who use drugs particularly to people who inject drugs through Outreach and DIC activities combined with referral to other health care services for ART, methadone and drug detoxification, and social welfare services for rehabilitation.
* Outreach and DIC activities included health education session; about HIV and other blood born viruses transmission, safer sex and safer injection, overdose management, peer educ**a**tion, drug counseling, family counseling, VCCT , and methadone counseling; condom distribution, NSP and IEC distribution.
* However, rehabilitation services and drug treatment facilities including methadone program in Kalay and Tamu areas were the area of demand by peers and staff as these facilities were not existed form the government sector leading to unavailability of these facilities. Some peers and staff expressed that rehabilitation is one of supportive areas for process of behavior change in the field of harm reduction and demand reduction.
* It was learnt that methadone clients were using diazepam and heroin, and drinking alcohol in order to get high from multiple drugs. This behavior was spreading among old and new methadone clients, which was very much concerns from government officials, local community leaders, peer leaders and project staff.
* CARE harm reduction project also facilitated the enabling environment for behavior change and improving social reintegration through integrated approach with school support and OVC project to children of target population, income generation and livelihood project apart from harm reduction implementations.
* The staff capacity development was formulated through annual capacity development plan, cross visits to other project sites and internal sharing sessions of their attended trainings, technical support from CARE health adviser and some senior staff during their field trips and in quarterly meetings, and attending relevant workshops and trainings on Harm Reduction organized by other organizations: UNODC, NAP, Burnet Institute Myanmar, and HAARP. These efforts produced a number of recognized harm reduction staff from CARE in Myanmar in early period. However, due to lack of technical staff focusing mainly on Harm Reduction in the final years of the project, there is insufficient technical support to field level Harm Reduction staff.
* The Coordination and collaboration with government officials including high ranking officers from government including police, DOH and MOH at national level as well as township level was enhanced by the relationship building through formal as well as informal communication before 2010, which yielded the good recognition of CARE in Myanmar harm reduction field.
* Moreover, coordination mechanism among township level harm reduction implementing organizations had been established in Mandalay and Lashio, which resulted proper hand over of people who use drugs to other harm reduction organization in these areas. CARE in Mandalay provided technical and field level supports to MANA and HAARP in an initial phase of their projects resulted in an increase of local coverage to people who use drugs.
* The most significant contribution of CARE harm reduction project was training of trainers to Anti-Narcotic Task Force (ANTF) and prison department staff to improve HIV awareness and harm reduction concepts which gave an understanding of ANTF personnel upon harm reduction. However, we could not have a chance to glance the outcome of the contribution to prison.
* CARE’s another innovative approach was awareness activity among theatre performers in collaboration with Thabin Association, representative of Pwe Troupes and influential artists by producing HIV/AIDS prevention educational scripts for the general community in Pyay, Ayeyarwaddy, Mandalay and Mawlamyaing. The outcomes of these activities were not clearly visible in this evaluation.
* According to narrative reports, problem of long process of MOU lead the cessation of prison and police health education and awareness raising activities which had significantly affected the leading role of CARE in very difficult closed setting harm reduction interventions.
* CARE also paid particular attention to gather and response clients’ feedback through peers and community facilitators by doing monthly report meeting and quarterly review process. These feedbacks were incorporated in their next year project activities. The activity created a space for the beneficiaries to express their needs and to participate in the project.
* CARE project formed Family Care Giver Groups (FCGG) comprised of wives of CARE’s people who use drugs to provide support to their husbands by doing home base care using Home Based care kits provided by CARE, and sharing knowledge about health related issues, developing household income generation activities. FCGGs in Kalay, Tamu and Lashio who were still actively participating and functioning in their activities even after end of the project. However, FCGG in Mandalay was found out that it was not functional at the end of project with lack of support from project itself.
* The group members of SHG and PWUDs actively participated and shared their knowledge in monthly meetings at CARE DICs about home based care, prevention of HIV/AIDS, Dengue Hemorrhagic Fever, malaria, diarrhea, nutrition, personal hygiene, STIs, managing the side effects of ART, and peer education.
* According to the narrative reports and self-reported stories of CARE Harm Reduction Project, people who use drugs’ level of knowledge has increased and changed in practices of safer behaviors such as increased use of condoms, avoiding sharing of drug injecting paraphernalia and gradual decrease in use of drugs. When knowledge assessment questionnaires were developed and asked to peers and beneficiaries in evaluation workshop, they could correctly response 78% of the basic knowledge about drugs and HIV that need to know. In addition, the behavior and attitude of shooting gallery owners and injectors was also changed by willingness to provide or arrange needles and syringes from outside when CARE project staff could not provide enough needles and syringes due to shortage. Clients go to shooting galleries where new needles and syringes are available showing the fact that the compliance to use disposable needles and syringes is higher than expected. However, some have to share needles and syringes during police crackdown period when new needles and syringes are harder to get access; which may affect expected outcome of reducing transmission of HIV and other blood borne virus infections.
* According to interviews, workshop and self-reported stories, behavior change among CARE’s beneficiaries was significant. On the other hand, creating enabling environment is essential for sustainability of these changes. Since after second year of CARE harm reduction project, multiple strategies of phase out plan were worked out. These provided capacity building of family care giver group, self-help group and peer educators, awareness and advocacy meeting targeting community leaders, religious leaders, authorities and families to facilitate sustained enabling environment for behavior change, and meetings with local CBO, NGO and INGO together to discuss about hand over of clients and referral of project activities to other harm reduction services after end of CARE project. After that, CARE managed well on a smooth hand over of beneficiaries and activities to other harm reduction partners in Lashio and Mandalay, but it could not hand over the activities to others in Kalay and Tamu as there were no harm reduction partners in these areas.
* Peer educators and beneficiaries confidently expressed their commitment to disperse their attained knowledge and skills to other new comers and PWUDs not yet reached by the project during FGDs and evaluation workshop.
* According to people who inject drugs, there is leakage problem during pull back and mixing with blood in disposable needles and syringes, distributed by the project and procured internationally through 3DF.That was one of the lessons learnt for logistic management of the 3DF. In addition, delay to respond on that issue by 3DF till nearly end of the project. It was eventually end up with donation of these needles and syringes to MSI in Mandalay at the end of the project as these syringes have no problem in ordinary clinical use.
* Gender focused harm reduction activities were considered in the initial stage of this project with findings from 3DF Technical Progress Report (Jan – June 2008), but such gender focused harm reduction interventions were not identified in the subsequent donor progress reports, and feedbacks from CARE project staff and clients during the evaluation process. However, gender advisor of CARE Myanmar made an effort to increase awareness of gender issues by doing awareness workshops and trainings.

**List of recommendations**

* There should be whole package of comprehensive prevention, care and support services of harm reduction interventions fully covered in future CARE’s harm reduction project with continuing its integrated approach with OVC, income generation, livelihood and rehabilitation to create better enabling environment for behavior change of people who use drugs especially people who inject drugs.
* Coordination mechanism among local harm reduction implementers in project was well established and this practice should be continued in future project implementation.
* Poly drug use among methadone clients should be addressed properly with engagement of government, NGOs, clients and their families. Accessibility to MMT in terms of quality as well as geographical area is very demanding issue in harm reduction. CARE should raise an issue upon decentralization of MMT in Drug User working group to accelerate the methadone accessibility.
* Close setting harm reduction services should be prioritized in future CARE’s harm reduction project, a big gap in current harm reduction intervention in Myanmar, which is CARE’s one of the success areas.
* Feed-back mechanism should be continued in all steps of project cycle management of future projects to strengthen the program by listening to the voices of the beneficiaries.
* Rehabilitation is one of the forgotten areas for enabling environment of behavior change in the field of harm reduction and demand reduction. CARE should consider more advocacies to donors and concerned government departments in next drug related projects as this is a needing area to improve.
* Advocate to donor agencies and government including Country Coordination Mechanism through Drug User Working Group to consider increasing funding in harm reduction interventions as it was the effective approach in mitigation of negative consequences of drug use including HIV transmission.
* It’s advisable to 3DF logistic team to make sure to meet the quality of paraphernalia for safer injection practices and to response effectively.
* There is a need in effort on sustainability of self-help groups in terms of empowerment of people who use drugs for longer term behavior change as well as harm reduction interventions, although peers have willingness to work for their peers.
* Gender oriented services including DICs should be considered in future projects as the double hidden nature of female people who use drugs increase their vulnerability to HIV transmission and discrimination. This issue also highlighted the need of size estimation of female people who use drugs as well as male drugs user in Myanmar.
* There should be considerations from donors to allocate some funding to compensate CARE activities in Kalay and Tamu areas.

**Back ground**

Myanmar is one of the countries that are on the brink of affect by HIV epidemic. Among the high risk populations, people who inject drugs possess the highest prevalence of HIV in Myanmar. It is believed to be concentrated in large cities and the northern and eastern regions, where large scale production and movement of illicit drugs occurs. Although the sentinel surveillance data indicated that Myanmar’s HIV epidemic peaked in 2000–2001 and then started declining, the overall HIV prevalence among adult general population was estimated about 0.535 in 2011which reduced from 0.7% in 2005.

In the most recent HIV sentinel–surveillance survey of 2011,9.4% of female sex workers (FSW), 21.9% of people who inject drugs (IDUs) and 7.8% of men who have sex with men (MSM) were HIV infected. While the overall HIV prevalence has begun to decline, Myanmar remains vulnerable to the continuing spread of HIV due to social factors such as poverty, population mobility, HIV-associated stigma and the limited capacity of the health systems to scale-up services.

The current nationally agreed estimate for the size of the IDU population is 75,000 [range 60,000-90,000].It has been reported that the total number of people who use drugs is likely to be between 300,000 and 400,000. Injection practices may be more common in areas where availability of drugs becomes scarce or expensive, due to injection providing a higher impact from a smaller quantity of drug.

CARE’s HIV prevention and Harm Reduction project for people who use drugs and people who inject drugs (DU and IDU) was implemented with the support from 3 Diseases Fund (3DF) at four townships – Mandalay, Lashio, Tamu and Kalay from April 2007 to December 2011. Drop in centers (DIC), outreach activities and Primary Health Care services are carried out by project staff and peer educators in all four townships in order to reduce drug related harm among people who use drugs.

**Project Goal**

To reduce HIV transmission and HIV-related morbidity and mortality among DU/IDUs and police through a targeted HIV prevention and harm reduction program

***Purpose 1***

To reduce the risk of HIV transmission and HIV-related morbidity and mortality among DU/IDUs through a targeted HIV prevention and harm reduction program

***Purpose 2***

To improve knowledge on HIV prevention and harm reduction, and promote positive attitudes towards DU/IDUs and PLHAs among police personnel

***Purpose 3***

To reduce the risk of HIV infection and promote harm reduction among the general community

**Key strategies to achieve the specific objective are:**

* Building stakeholder trust for sustainable project implementation
* Creation of enabling environment for these marginalized beneficiaries by establishing drop in centers (DIC), Self Help Groups (SHGs) and Family Care Giver Groups (FCGs)
* Organizing Health Education on HIV transmission and Life Skill session through formal education by project staff and peer approach
* Raising awareness about HIV transmission and Drug related harms among community through booth show and PWE Troopers.

**Objectives of the evaluation**

1. To facilitate the reflection and learning of the key stakeholders involved in CARE Myanmar Harm Reduction Program on the effectiveness of the program.
2. To evaluate on the relevancy, effectiveness and sustainability of behavior change in following the end of the project in December 2011

**Methodology**

Within the frame of the descriptions made in TOR between CARE-Myanmar and Burnet-Myanmar, the following data collection methods were applied in end project evaluation of harm reduction project with Participatory approach.

**1. Review of Documents**

G-54 end of project review, Project description documents, narrative project progress reports, relevant project documents and technical progress reports were reviewed.

**2. Targeted population**

All the stake holders participated in this evaluation.

1. Management level project staff and operational level CARE project staff from four project sites
2. Peer educators from four project sites
3. Project beneficiaries- People who use drugs, People who inject drugs, Methadone clients
4. Management and operational level project staff from other harm reduction project implementers from Mandalay MANA and HAARP)
5. Government officials from NAP,DTC, CCDAC, Police, PAD, SWD)
6. Local community leader

**3. Focus Group Discussions (FGD)**

Two FGDs were performed with end beneficiaries. There were ten beneficiaries per FGD and all of these FGDs were done in the premise of Social Welfare Department in Mandalay in consideration of neutrality. Here also elicitations were made on their perceptions on developmental issues of their organizations. The aim of FGD was to extract the pieces of idea and perception on CARE’s harm reduction project.

The specific FGD guide was formulated by Burnet Myanmar technical staff. The interviewees were asked to narrate their reflections on services they received or provided, if any, and their success stories working as Volunteers. They were requested to express their perceptions on achievements, lessons learnt and changes in the community due to the impact of the project and sustainability of the activities of the project.

**4. In-dept Interviews**

In-dept interviews (IDIs) were performed with experienced senior staff of CARE project –Yangon, Mandalay and Tamu, CCDAC Mandalay and local community leader from Mandalay with the criteria of who had known CARE project from start to end. The interviews were made face-to-face. Their insights into the CARE project development issues within the project area were elicited. IDI guide used for interviewees was developed by Burnet Myanmar evaluators.

**5. Workshop for reflections of the project by all the stake holders**

One-day workshop was held with **thirty five participants:** thirteen from CARE project staff from four sites, nine peers from four project sites, four project staff from HAARP and MANA, six representatives from NAP, DTC, CCDAC, social warfare and local police department.

During this workshop, quantitative questionnaires were used at the end to elicit information from peer educators. We obtained both the quantitative and qualitative data from the workshop to elicit the status and impact of the drug program and changes that had occurred in the community, Lessons learned, good practices, unexpected outcomes such as benefit, harm, social changes.

**Key findings,**

**1.Findings on project management context**

* CARE has been earned good reputation and one of the very few organizations which has established harm reduction in the country. In addition, this project was started by doing informal situation analysis on the drug network on the border area, Kalay and Tamu, where no harm reduction service were established, area between Myanmar & India. Before submission of EOI, CARE has conducted FGDs with DU/IDU and their care givers as well as police personnel and their family members in Jan 2007 and information was used for project design. This project was initiated with the continuation of harm reduction activities in project areas in Mandalay and Lashio with consideration of recommendations from G54 end of project evaluation.
* Policy and guidelines regarding standard precautions, guideline for caring TB clients, management and transport of hazardous waste or specimen as part of occupational health and safety, organizational policy for using printed materials, reporting guideline, project management guidelines for CARE staff and volunteers are in place. It was encouraging to see a wide range of policy and guidelines: standard precautions, guideline for caring TB clients, management and transport of hazardous waste or specimen, in favor of occupational health and safety. Moreover, organizational policy for using printed materials, reporting guideline, project management guidelines, TOT (training on trainers) manuals for police personnel and peer educators were in place to support project staff for carrying out project activities day to day basis. It was also found out that the project management was very effective in planning by having individual project staff work plan. Adaptability on reporting: CARE staff has a strong adaptability on reporting style to arrange timely reporting by doing direct meeting with field staff and clarification on information straight away.
* ***Log Frame development***
* The project log frame and the activities targeted people who use drugs including people who inject drugs as a primary target and also to reach the family members and general community through artist and theatre performer, Pwe troopers, police personals. Project activities of CARE tried to provide needs of people who use drugs particularly to people who inject drugs through outreach and DIC activities. CARE referred the clients to seek other health care services for ART, methadone and drug detoxification and social ware fare services for rehabilitation.
* After having reviewed on the log frame (Year 1 and 2), objectively verifiable indicators (OVI) were few to support the purpose. For example, only condom distribution was described to be objectively verifiable indicator for activities to achieve the first objective “To reduce the risk of HIV transmission and HIV-related morbidity and mortality among DU/IDUs through a targeted HIV prevention and harm reduction program”. Two more activities including provision of harm reduction interventions and behavior change interventions were provided to fulfill the first objective but any elaboration of OVIs to measure these two activities was not noted. The whole log frame and the activity plan in year one and two were focused only to measure the output level with activity based but no proper attention was paid beyond output level of the project to assess outcome and impact level in particular. These necessities were more completed with the revised log frame of Year 3-4 which was more in details with relevant indicators and activities to achieve targeted outputs, outcomes and impact levels.
* Outreach and DIC activities included health education session; about HIV and other blood born viruses transmission, safer sex and safer injection, overdose management, peer education, drug counseling, family counseling, VCCT , and methadone counseling; condom distribution, NSP and IEC distribution.
* Some peers and staff expressed that rehabilitation is one of supportive areas for process of behavior change in the field of harm reduction and demand reduction. However, rehabilitation services and drug treatment facilities including methadone program were not included in the interventions in Kalay and Tamu areas as these facilities were not provided by the government sector leading to gap in the services.
* Awareness activity among theatre performers in collaboration with Thabin Association, representative of Pwe Troupes and influential artists by producing HIV/AIDS prevention educational scripts for the general community in Pyay, Ayeyarwaddy, Mandalay and Mawlamyaing was CARE’s innovative approach in harm reduction. The outcomes of these activities were not accessible in this evaluation.
* CARE harm reduction project also integrated school support and OVC project to children of target population, income generation and livelihood project apart from harm reduction implementations to facilitate social reintegration and behavior change.
* ***Coordination and collaboration***
* According to progress reports and interviews, advocacy strategy was formulated by CARE Myanmar to have more coordination and collaboration with maximal support from high ranking government officials from Ministry of Home Affairs, Department of Health and Department of Social Welfare. The relationship and the formal as well as informal communication with ANTF and local authority were good and they were very supportive of CARE project and its activities but all of these achievements should be sustained with continuous and repeated efforts. The interviewees expressed that there was a good communication and a positive relationship had been established with ANTF, Myanmar Police force and prison officials. The benefit of this success advocacy strategy created the enabling environment for NSP. CARE staff expressed that they can do NSP without being interfered by field ANTF staff and CARE staff also paid mutual respect to them. Moreover, during the evaluation workshop, ANTF officer openly said that they ordered to their grass root level ANTF work forces not to arrest people who use drugs at ground just by possessing needles and syringes apart from suspect of involvement in drug dealing.
* CARE harm reduction project’s most significant contribution to HIV/AIDS awareness was training of trainers to ANTF and prison department staff to improve HIV knowledge and harm reduction concepts to enhance understanding of ANTF personals upon HIV and harm reduction. The outcome could not be measured given that the cessation of these activities after 2009 due to the problem of long process of MOU lead to significantly affect the leading role of CARE in very difficult closed setting harm reduction interventions.
* According to findings from reports and in-depth interviews, there was loss of continuity of coordination with some government officials such as CCDAC and local police force in Mandalay especially after 2010. This loss of continuity can affect the enabling environment for outreach activities and for people who inject drugs.
* Coordination mechanism was well established among other harm reduction implementers in Mandalay and Lashio. One of the examples was that CARE Myanmar was able to refer shooting gallery owners to HAARP to get more Needles and syringes when CARE was in case unable to provide the required needles and syringes requested by these owners. CARE helped MANA and HAARP by providing training and field visits opportunity to their staff in their project initiation.
* ***Capacity development***
* After reviewing the progress reports, a project inception workshop was held in 2009 in Yangon attended by CARE senior management staff including Program Coordinator, Assistant Program Coordinator, three Field Office Coordinators and three Senor Project Officers and similar inception workshops with their own project teams to ensure the understanding of all staff up on the project goals, objectives, outputs and indicators. The involvement of CARE staff from head office to field level offices at all levels that could not only ensure the project was running well with changing situations at field level but also they could get a sense of ownership.
* The organizational structure of CARE has been changed two times due to the restructuring process to align with the changing situations and the organization’s direction regarding technical thematic areas, and funding availability. As usual with change process loss of motivation of field level staff and loss of trained competent staff to some extent were resulted. Due to lack of technical staff focusing mainly on Harm Reduction in the final years of the project, there was insufficient technical support to field level harm reduction staff.
* It was learnt that, CARE health adviser and some senior staff provided technical support during their field visits and opportunities for project staff to attend relevant workshops and trainings on Harm Reduction organized by other organizations: UNODC, NAP, Burnet Myanmar, were provided. Then, sharing sessions were organized in regular basis in their weekly staff meeting at project offices. It was found out that cross exchange visits were organized among their project offices. (See annex 7 for list of trainings/workshops attended by CARE project staff)
* Staff capacity building was organized at monthly staff meetings in project areas and an annual capacity building plan was developed by the project team.
* CARE project staff organized a Peer Educator Working Group meeting to prepare for and finalize the PE Training of Trainers (TOT) manual and PE TOT training plan facilitated by CARE’s Health Advisor in February 2010. Following the training, the staff member participated as a co-trainer during the PEs TOT course in March 2010. This trained PEs expressed in the reflection workshop that their continued sharing of their knowledge with their peers in their respective areas. The outcome of this activity was partly observed in the FGD with beneficiaries, where the clients expressed the positive value of peer education.
* Peer educator trainings and workshops were conducted and the attending participants displayed keen interest in training due primarily to the training methods, which included singing songs, playing games, and group brain storming. These training topics were knowledge about life skills, PE, adult learning, Hepatitis B/C infections, overdose, Tuberculosis, concept of VCCT, communication skills, and transmission and prevention of HIV/AIDS and STIs. As a result, they have committed to share the knowledge gained to their friends and family. Moreover, CARE Myanmar had organized Peer Forum collaboratively with Rehabilitation Centre to share knowledge about HIV prevention and harm reduction, drug overdoses, and personal hygiene through interactive games and participatory activities. On the other hand, peers expressed their concern about disappearance of these activities after the closure of DIC in Mandalay after 2010.

**2.Findings on Relevancy of the project**

* CARE is the front runner in harm reduction project implementation in Myanmar. They have started harm reduction projects since 2003 in Mandalay. This 3DF project was the continuation of previous harm reduction projects with well trained and experienced staff. This project’s goal and objectives were set up on the recommendation of G-54 evaluation and informal situation analysis including a number of meetings with key stakeholders.
* CARE was paying particular attention to gather and response clients’ feedback. Some clients expressed during FGDs on having more opportunities to access care and support that they were difficult to get access in the past, more understanding on their current health status leading to more chances for them to live longer with better quality of life.
* It was mentioned that supports were provided for PWUD who want to stay at rehabilitation center after detoxification. However, the coverage of these activities was not efficient to meet the needs of the client due to less support and interest from the government and funding availability of CARE. Rehabilitation services and drug treatment facilities including methadone program in Kalay and Tamu areas were not existed form the government sector leading to unavailability of these facilities which were the areas of expressing concern by peers and staff. They expressed that rehabilitation is one of supportive areas for process of behavior change in the field of harm reduction and demand reduction.
* Necessary capacity development trainings and creation of income generation activities targeted PWUD self-help groups and its members were aimed to social re-integration with their families and their community. According to beneficiaries, more efforts were also needed for sustainability of these activities not only from the service providers but also from the beneficiaries and their community. School support was one of CARE Project’s activities providing support to children of PWUD in conjunction with the UNICEF funded OVC project in Mandalay. It can be seen that CARE Harm Reduction is trying to provide integrated and comprehensive services targeting not only PWUD but also their related family and the community as well.
* CARE outreach team conducted HE sessions on safer injection, drug use to promote awareness of HIV prevention and harm reduction among the drug user community and the general community according to the requests from clients and village community leaders. Request from VSWA in Mandalay: CARE had conducted HE sessions in those rehabilitation centers in May and June 2009.
* It was learnt that due to the role and function of CARE Myanmar in the response to HIV/AIDS epidemic in Myanmar, the consultant team for developing National Strategic Plan including Assistant Director from NAP, Representatives from UNAIDS visited MMT center to identify where and how coordination and referrals can be strengthened for new NSP development with participation from CARE and other harm reduction implementing organizations such as MANA and HAARP.During the evaluation workshop, attending participants; including CARE project staff, peer educators, staff from other harm reduction implementing organizations with official from government departments: NAP, DTC, ANTF and Local police force, were asked to identify a variety of drug and HIV related issues and then, prioritized with reasons of importance. The following table is the relevancy score provided by the workshop’s participants.

**Table 1: Relevancy scores out of ten given by evaluation workshop participants**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Participants** | **CARE project staff** | **Staff from other harm reduction organizations** | **Peer educators from CARE** | **Government official including health and law enforcement** |
| **Scores given(1-10)** | **6** | **7** | **7** | **5** |

* During the workshop, peer educators from CARE project put the score at seven with their views of provision of family counseling, formation of SHGs, creation of safe and resting place, provision of drugs and nutrition for needy clients and refer to other institutions for other services. CARE project staff gave the relevancy score at six out ten with the reasons of CARE have provided most of the comprehensive package of harm reduction services, but they pointed out the insufficient access to methadone maintenance program, not providing ART, lack of specific alcohol and other drug counselor in DIC and un-satisfaction on the involvement of community and, people who use drugs and their families.
* Staff from other harm reduction organizations gave the relevancy score of seven due to the good advocacy strategy and good collaboration with other harm reduction partners. On the other hand, government official including health, social warfare department and law enforcement kept the score at five due to still lacking of HIV and drug use health education among youths and teenagers, overall risks of HIV is still high, problems of MMT accessibility and poly drug use among methadone clients.

**3.Findings on effectiveness**

* Progress reports of CARE said that baseline assessment survey with PWUDs, ex-users, prison staff, local doctors and traditional healers, pharmacy staff, sex workers and their pimps in February 2008. According to this survey, one third of PWIDs had experience sharing of N/S and one third of male respondents having sex without condom at all.
* There were recommendations from this baseline assessment: increase efforts to access female people who use drugs (often illiterate), ensuring IDUs access to NSEP, community misunderstanding about NSEP, and the negative attitudes of health and police personnel towards DUs/IDUs. Among these recommendations, follow up activities to make female who use drugs be accessible to harm reduction services were not done properly.
* Some clients said that they brought their own lunch boxes to stay at DIC for the whole day, regular methadone meeting with MMT clients and other IDUs interested in this program, some parents brought their addicted sons to come to DIC to access knowledge and health services. It was shown that what CARE has created her DIC as a user friendly and safe space for PWUDs. However, the clients in FGD opened up their grief feeling of mourning these DICs after closure in 2010.
* According to interviewees, Community feedback mechanism was in existence with regular feedback provided to senior management staff by peers and community facilitator monthly. After taking into consideration of relevant feedbacks, CARE made changes in program deliverables as necessary and also used in annual planning process. Moreover, CARE explored on the background reason of negative feedback received from community, found out the suitable way of solution and gave the chance for the community to discuss in detail and gave explanation.
* CARE organized and formed Family Care Giver Groups (FCGG), mostly comprised of wives of the registered people who use drugs in all four project areas since the inception of the project to provide support to their husbands in improving their health, developing household income generation activities, conducting Home Based Care for family members and friends using the Home Based Care kits provided by CARE, and sharing knowledge about health related issues. It was found to be FCGGs in Kalay, Tamu and Lashio who were still actively participating and functioning in their activities even after the project. However, FCGG in Mandalay is said to be not functional at the end of project due to lack of support from the project.
* Monthly meetings were conducted at the CARE DICs and staff shared knowledge with family CARE giver groups about home based care, prevention of HIV/AIDS, Dengue Hemorrhagic fever, malaria, diarrhea, nutrition, personal hygiene, STIs, managing the side effects of ART, and peer education.
* **BCC**
* According to the narrative report of CARE Harm Reduction Project, drug user’s level of knowledge has increased and behavior change in relation to harm reduction is becoming increased by observing through informal interviews, counseling, and PHC checks: Peer Education approach is the most effective in reaching to hidden population like people who use drugs especially to people who inject drugs.
* According to case study, Focused Group Discussions and Most Significant Changes techniques, it was observed that changes in practices and increase in safer behaviors such as increased use of condoms, avoiding sharing of paraphernalia and gradual decrease in use of drugs. Another favoring factor was due to education about safer injection techniques and safe disposal of needles and syringes to shooting gallery’s helpers by project staff.
* According to interviews with CARE staff, approximately 90% of the clients of Mandalay site avoided in their needle sharing behavior and they even did not use already opened needles and syringes. If there were not enough needles and syringes provided by CARE to shooting gallery owners, these people who use drugs buy from outside market or shooting gallery owners who will arrange to buy needles and syringes from outside. Clients will go to shooting galleries where new needles and syringes are available showing the fact that the compliance to use disposable needles and syringes is increased. However, some have to share needles and syringes during police crackdown period when new needles and syringes are less available.
* However, end line survey on BCC was not done. So that, the qualitative improvement in these outcome indicator of behavior changes could not be shown. These changes can only be relied on qualitative; self-reported-case study, MSC stories and interviews.
* The table below described the perspectives of attending participants at the evaluation workshop on the effectiveness of CARE harm reduction project.

**Table 2: Effectiveness scores out of ten given by evaluation workshop participants**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Participants** | **CARE project staff** | **Staff from other harm reduction organizations** | **Peer educators from CARE** | **Government official including health and law enforcement** |
| **Scores given(1-10)** | **7** | **7** | **7** | **5** |

* According the findings from the workshop, staff from other harm reduction partners kept the score at seven with the reasons of nearly 90 percent of clients using disposable needles and syringes, but they also not satisfied by poly drug use of methadone clients.. In addition, CARE project staff put the score at seven with their views of increased personal hygiene of the clients, reduced risk behaviors of HIV transmission and reduced risks of over dose. They also pointed out the insufficient access to methadone maintenance treatment program, not providing ART, rehabilitation in all project sites,
* Moreover, government official including health, social warfare department and law enforcement gave the effectiveness score five out ten and the reasons behind are poly drug use problem among the methadone users, high on relapse rate and drug related crimes. On the other hand, peers from CARE gave the effectiveness score of seven due to their satisfaction on supporting on reducing their risk behavior and creating enabling environment for social reintegration, but they don’t have much satisfaction on condom use and, aggressive and agile behavior of their peers.

**4. Findings on sustainability of BCC**

* CARE has set up the phase out plan in each and every project site. Since May 2010, interventions have been focused on outreach activities and support, and providing capacity building of family care giver group, self-help group and peer educator as part of its exit strategy. The integrated approach was also targeting community leaders, religious leaders, authorities and family to facilitate sustained enabling environment for behavior change.
* Project staff met with local CBO, NGO and INGO together to discuss about hand over of clients and referral of project activities to other harm reduction services after end of CARE project. In Mandalay CARE patients and activities were handed over to HAARP, MANA, Treat Net and rehabilitation center. In Lashio CARE patients and activities were also handed over to AHRN. MSI, MNMA, Community support foundation (one of the CBOs) accepted to continue supports to CARE patients in Kalay & Tamu. CARE also compensated some community facilitators in continuing project to ease the phase out process.
* CARE’s peer education strategy is also the effective way to reaching the people who use drugs as the peers share the same life experience and can be seen as credible sources of information for behavior change. The aim of peer education is to change behavior by working at two levels: the individual level by modifying knowledge, attitudes and behavior & skills, and the group level by modifying norms, values & beliefs. Peer educators support others in their peer group to make informed and responsible decisions for HIV prevention, safer injecting drug practices, condom use, knowing their HIV status etc. Moreover, peer education approach is also a way to empower people; it offers them the opportunity to participate in activities that affect them and to access the information and services they need to maintain and promote their health.
* According to findings from FGDs and evaluation workshop, peer educators are slowly becoming socially accepted because of their improved lifestyles and changing behaviors. Some have stopped using drugs and become active community members. They share that this is due to support from project staff have made frequent home visits to the peer educators and continued to motivate them to carry out their peer education, which they share they are keen to do. The following is a quote of the peer on the feeling of peer education which showed the positive result of peer strategy from the perspective of behavior change; *“Previously, I served as volunteer for CARE without knowing the true meaning of ‘peer’ and the importance of peer education. Now [because of the training] I no longer view myself as a beneficiary of CARE. Instead I regard myself as a peer from CARE and that I have the responsibility to carry out HIV prevention and harm reduction education with others. After receiving the peer training from CARE I have more confidence in conducting in peer education. Moreover, I know well what I can do for my friends and others and that is providing health education, counseling and referrals. ”*
* Another strategy was undertaking of income generation activities and networking with other SHGs, providing information related to funding support to SHGs and NGOs to strengthen the capacity of SHGs, FCGGs to sustain the safer behavior and their activities after end of project. During FGDs and evaluation workshop, Peer educators and beneficiaries confidently expressed their commitment to disperse their attained knowledge and skills to other new comers and PWUDs not yet reached by the project.
* In addition, according to the clients in FGD, clients prefer going to shooting galleries where new needles and syringes are available showing the fact that the compliance to use disposable needles and syringes. However, some have to share needles and syringes during police crackdown period when new needles and syringes are hard to get access; which may affect the expected outcome of reducing transmission of HIV and other blood borne virus infections.
* According to reports and interviews, behavior and attitude of shooting gallery owners and injectors was also changed by willingness to provide or arrange needles and syringes from outside when CARE project staff could not provide enough needles and syringes due to shortage.
* The table below described the perspectives of attending participants at the evaluation workshop on the sustainability of CARE harm reduction project.

**Table 3: Sustainability of behavior change scores given by evaluation workshop participants**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Participants** | **CARE project staff** | **Staff from other harm reduction organizations** | **Peer educators from CARE** | **Government official including health and law enforcement** |
| **Scores given(1-10)** | **5** | **7** | **6** | **6** |

* Among the workshop participants, CARE project staff gave the Sustainability of behavior change score five out of ten with the reasons of inadequate strengthening of PEs and SHGs, worried on the functioning of income generation and sustainability of FCGG, but they have level of satisfaction over existing hand over and referral of clients to other partners providing services and good networking. Peer educators from CARE project put the score at six with their views of PE from organized SHGs will distribute knowledge on health and bad consequences of drug use to new generation, they have referral & networks to help people who use drugs to stop using drugs and help in solving their problems.
* In addition, government official including health, social warfare department and law enforcement kept the score at six with their suggestion on lacking group therapy and behavior modification techniques. On the other hand, staff from other harm reduction organizations gave the relevancy score of seven due to their satisfaction on psychosocial supports to social reintegration of clients by CARE. They suggested to have more psychosocial supports to clients for their behavior change and to provide more supports including follow up to crease methadone accessibility.
* Peers and beneficiaries were assessed their knowledge and practice by asking questionnaires in evaluation workshop and they could correctly response 78% of the basic knowledge about drugs and HIV that they need to know.

**Unexpected outcomes (Positive and Negative)**

* There was cessation of police related HIV and Harm Reduction activities due to a letter from Central Committee of Drug Abuse Control in 3rd of April 2008 in which it was mentioned that CARE Myanmar did not have Memorandum of Understanding with Ministry of Home Affairs resulted from the misunderstanding during the discussion between new Director General from ministry of health and Director General of MOHA. According to reports, the situation will be reviewed by CCDAC once CARE has received a new MOU from the MOH. It was shown that legality of organizations is important and Harm Reduction as well as HIV/AIDS related activity was still sensitive in nature among uniformed services personnel.
* Despite the fact that many people who use drugs are aware of the risks in sharing needles and syringes, there is still fear to use and handle needles and syringes due to the fear of existing law for possessing injecting equipment. On the other hand, police are saying that they have never arrested people who use drugs with needles and syringes. It’s still in a process to amend the law on possession of needles and syringes. Another contrasting issue is a community leader emphasized on the fact that some people who use drugs are exploiting of the relaxation of the current law by the authority in which they bring along the needles and syringes openly in public places.
* Lack of clarity on procurement policies and subsequent implementation of strict policies on the procurement of medicines and medical supplies, and delay in procurement of drugs challenged on service provision. (drugs arrived only in Jun 2008 to Kalay and Tamu)
* Some experienced staff from CARE project, who lost their job during organization restructure to adapt the program, were working in other harm reduction services. The rest were wandering in other fields of NGOs and business sector, which was a hall mark of drawback for momentum of CARE Myanmar’s harm reduction services in Myanmar.

**Lessons learned and good practices**

* ***Effective Advocacy strategy***
* CARE had set up an effective advocacy strategy for different level of government officials including high ranking officers from police, Department of Health and Ministry of Health at national level as well as township level.
* Anti-Narcotic Task Force (ANTF) personals did not make any restriction and they were very supportive to CARE activities and showed proper acknowledgement on what they have been doing. One example is despite the fact that ANTF patrol team accidentally faced CARE staff during their outreach activities in the field, these police personnel did not prohibit on staffs NSEP activities. Open and trusted communications with ANTF, Myanmar police force, prison department and township SPDC’s president led to proper recognition and needed support to CARE project activities.
* The relationship and the formal as well as informal communication with ANTF and local authority are good and they are very supportive of CARE project and its activities but all of these achievements should be sustained with continuous and repeated efforts.
* ***Coordination and Collaboration***
* There is a coordination mechanism among harm reduction implementing organizations in all project areas but the coordination is sporadic and irregular with local authority including officials from government departments such as CCDAC, DSW, DOH, NAP, DTC and local police force in Mandalay especially after 2010.
* CARE’s strategy to collaborate with Thabin Association, Representative of Pwe Troupes and influential artists in Harm Reduction Project was innovative and effective. Pwe troupes performed HIV/AIDS prevention educational scripts for the general community in Pyay, Ayeyawaddy and Mawlamyaing. First workshop on arts creation was organized in Yangon in October 2008 with 8 artists to develop and produce IEC booklets for HIV prevention and harm reduction with the participation of artists and DU/IDUS.
* CARE Myanmar has an advantage of having a wider program that is focusing on health and development arenas. That facilitated CARE Myanmar in Kalay and Tamu to have strengthened coordinated and collaborated response in the outbreak of Dengue Hemorrhagic Fever in these areas.
* To have a collaborative effort from the private and public sector, CARE Myanmar had provided a training on Harm Reduction for general practitioners working in private clinics, medical doctors from government general hospitals and medical college with purpose to conceptualize to enhance understanding on Harm Reduction and drug related issues.
* CARE Myanmar provided helping hands to other Harm Reduction implementing organizations like Myanmar Anti-Narcotics Association (MANA) in their project initiation by giving on-job training to their outreach team in Mandalay. In addition to this, CARE helped HIV/AIDS Asia Regional Project in their outreach activities by providing information on mapping and sharing injecting sites and shooting galleries for effective implementation of Harm Reduction activities.
* ***Community mobilization through key stakes holders***
* CARE has strong strategies to mobilize the community and in addition the staff had strong advocacy, collaborating and coordinating skills. By utilizing these skills, they had conducted the mobilization activities through engaging in public events like Shan New Year festival, World AIDS day and drug abuse control day with booth show. Condoms and IEC materials were distributed during the events. Moreover, they raised community awareness by performing a number of health education sessions during the events.
* Training of Trainer to law enforcement sector enhanced the trust building and created a space for doing project activities in prisons during the initial period of CARE Myanmar Harm Reduction project. Having Project maturity in the late years of the project period led to desensitization and understanding of harm reduction strategy by community knowing that there are a number of options like safer sex and safer injection practices to tackle drug use and drug related problems. Integrated and longer term project addressing health needs, social problems and livelihood also increased the level of the community acceptance and its participation.
* **Family care giver groups -**In addition to formation and development of self-help groups, nutrition program, livelihood program and OVC program with school support of CARE Myanmar facilitate the gaining of community and family trust, addressing health and social needs of people who use drugs with ultimate aim for sustainability of their behavior change. Gaining community acceptance and involvement through awareness raising effort of CARE Project enhance social reintegration of people who use drugs which is un-denial to the fact that these people who use drugs are not staying all the time in drop in centers.
* CARE staff trained SHG members to conduct health education sessions using flip charts, and helped them to review some health education topics during the monthly SHG meetings; adherence counseling for peer counselors from IHC in collaboration with NAP in Lashio for the sustainability of behavior changes even after the ending of Car Myanmar Harm Reduction Project
* This is a quote from one of the peer educators who elaborate his progress from beneficiary level to service provision for his peers that show the effectiveness of community mobilization strategized by CARE Myanmar: *“I was discriminated against by my family and neighbors because I was a drug user and sent to prison. After being released I contacted CARE and received counseling and health education many times, which really helped to relieve my stress. I also developed an interest in peer activities through CARE. I then became a SHG member and peer educator after receiving a peer education training, and started to share HIV prevention and harm reduction knowledge to my friends, gave counseling, did referrals to service providers and distributed condoms. Now most of my friends and families ask me for my help and consult me about their problems related with drug use and HIV/AIDS*”, said by a peer educator who had tried to demolish stigma and discrimination imposed by the community with support from CARE Myanmar Harm Reduction Project.
* ***Involvements of key stakes holders in the services***
* CARE project staff had succeeded to convince shooting gallery owners and its assistants for distribution of disposable needle and syringe along with condoms which have strong influence on behavior change process as they could be assumed as one of the gate keepers in the process to create enabling environment for drug uses in using these injecting paraphernalia for safer injecting and sexual behaviors. Repeated health education sessions were provided by CARE outreach workers to shooting gallery assistants in order to increase the use of gloves when recollecting the used needles and syringes as they did not want to use these gloves due to the reason that all of them are already infected with HIV.
* In the needle syringe exchange program, some shooting gallery owners committed to buy necessary needles and syringes from outside market when the supply of these injecting equipment were not meeting their usage. It was encouraging to see the understanding and involvement of shooting gallery owners in the behavior change process despite the fact that they had to spend their own money for the safety of people who use drugs. On the other hand, it was inevitable that the project itself was not in a position to provide adequate amount of needles and syringes.

**Cross cutting issue: Gender Mainstreaming**

* Gender awareness raising meeting was conducted with family care giver groups in Mandalay in May 2010. Based on the request to receive more information, project staff provided informal gender trainings during meetings to 35 family care givers, which include topics on sex and gender, gender roles, gender bias, and gender stereotyping. Gender advisor in CARE project also participated in quarterly reviews to ensure to address gender issues.
* The number of female people who use drugs receiving harm reduction services was under reported throughout the period of the project. Actually, gender focused harm reduction activities was considered in the initial stage of this project but there was no proper or concrete efforts for female people who use drugs made accessible to these services. Having reviewed on the DIC attendance rate, male to female attendance ration is extremely wide: 280:5 leading to raise concerns and questions over women friendly DIC.

**Limitations of project**

* Due to security reason and insurgents fighting in border area like Tamu near Myanmar-Indian border, the authority were hesitate to endorse CARE project which resulted that the project implementation especially the out-reach program was delayed as planned in Tamu.
* There was a cessation of police related HIV and Harm Reduction activities due to a letter from Central Committee of Drug Abuse Control in 3rd of April 2008 in which it was mentioned that Care Myanmar did not have Memorandum of Understanding with Ministry of Home Affair. It was shown that legality of organizations is important and Harm Reduction as well as HIV/AIDS related activity was still sensitive in nature among uniformed services personnel.
* Delayed communications between Yangon office and mainly Kalay and Tamu offices were due to unreliable and un-trustful communication channels: landline, internet connection. And the budge was not enough to finance to establish better internet connection in these field offices.
* There was a strong demand of methadone in Kalay and Tamu but there is no MMT center and CARE should work with UNODC and other HR organizations to advocate MOH/DOH for setting up MMT center in these places.
* As a non-medical organization, Care project initially focused on awareness raising and then gave a minor ailments treatment with home based care and refer to DTC for drug treatment and detoxification. At the same time, there were many limitations in the project budget to provide support for referral services to Drug Treatment Centre and Methadone Maintenance Treatment program.
* 3DF procurement policies based on National guidelines for treatment of HIV/AIDS and OIs did not allow purchasing basic medicines like ibuprofen and amoxicillin which also had significant impact on quality of life for people who use drugs.
* Problems with distributed 2 CC N/S: poor quality and lack of rubber piston in the syringe leading to blood backflow and leakage from syringes when injecting users made a mixing (Gallery owner needed to buy usable good quality N/S from outside and problematic in the long term) Although they reported about this issue to 3DF since 2nd half of 2009, there was no response and action taken on this particular issue until the end of the project. All of these syringes were now donated to Maries Stopes International (MSI) and local organizations after getting the approval from 3DF as these syringes have no problem in ordinary clinical use.
* Funding constraint was the only main reason to reduce human resources and project activities as most of them described.
* High dropout rate of the peer educators compared to the starting years of the project which was due to some PE were being detoxed, some were arrested, some were kept in prison for drug related crimes and were seasonal migrant workers.
* Increase in number of IDUs in Tamu due to increasing mobile and migrant population and some non-Myanmar IDUs from the Indian side of the border who want services from CARE leading to stretching of CARE services with this limited funding availability. On the other hand, although shooting galleries are assessable in Indian side across the border, there are no shooting galleries in Myanmar side, which was also one of the limitations in doing effective safer injecting practices.
* Project reviews were also not done properly through participatory learning approach with the involvement of peers and people who use drugs. However, they organized FGDs with targeted communities for development of IEC/BCC materials for I/DUs and the general communities. Some concerns were raised for producing IEC materials only in Burmese though people in the project areas are speaking 3 different languages: Myanmar, Chinese, Chin.
* Though it was mentioned to provide information on the exit strategy to all the staff at field level when the project was ending, IDIs conducted with some senior field level staff had not talked about the exit strategy. Funding constraint was the only main reason to reduce human resources and project activities as most of them described.
* **Recommendations from group works of evaluation workshop;**
* Counselor not only trained in general counseling but also trained in drug counseling and MMT counseling should be recruited to provide counseling services as specific counseling which is critical to provide effective psychosocial support. Field project staff and beneficiaries mentioned about the requirement of dedicated counselors providing proper counseling services for people who use drugs and their families as counseling is one of the important psychosocial supports to reduce their stress and enhance their behavior change process.
* Methadone center is still not available in Kalay and Tamu which is a tremendous stagnation for people who use drugs who want to change their injecting drug use behaviors in safer way. The majority of the workshop attendants were hoping Care Myanmar to take the leading role to advocate setting up of methadone center at the community level.
* People who use drugs are facing difficulties to get access to Methadone Maintenance Therapy despite the fact of the availability of Methadone center in their hometown. The overburden expense and the need to stay for long period in Drug Treatment Centre are barriers for people who use drugs who want to enroll in MMT. With the ending of Harm Reduction project carried out by Care Myanmar, peer educators are overwhelmingly saying that it’s a major issue for them to get access to MMT. There is also a need to relax inclusion criteria such as having consent of guardians, having household register and to be native. People who use drugs on MMT are in increasing trend to use other drugs which is ending them into poly drug use. Harm Reduction organizations including Care Myanmar are in need to consider solving out poly drug use issues especially among methadone clients. Because of increasing poly drug use, community acceptance upon MMT is unsatisfactory. CARE should encourage DTC and other harm reduction partners to do more community awareness of MMT, poly drug use problem and more effort to solve out undesirable perception of the community upon MMT.
* Peer educators mentioned their desire to increase availability of DICs for the purpose of recreation, resting and safety place, lower drug use and crimes, information sharing, access to primary care health services and medical treatment, enabling environment for behavior change and social reintegration. There are needs to do more effective follow-up, support and after care services for Methadone clients and detoxed clients. Combined efforts of harm reduction organizations and government health facilities including rehabilitation centers, drug treatment centers and methadone center, are in need to build up to meet the needs of people who use drugs including female users.
* Until now, it’s very few in number of Local organizations addressing issues of people who use drugs in the country. People who use drugs are trying their best to form and run self-help groups to provide needed services for them but the development and functioning of these SHGs are limited within the timeframe of a particular project. For sustainability purpose, SHG is the key to have continuous provision of harm reduction services. At present, it’s encouraging to see formation of National Drug User Network in Myanmar (NDNM) and the existing SHGs in Care Myanmar’s Harm Reduction project should be advised to continue linkage with this national level drug user network for further support.

**Conclusions and Recommendations for CARE Myanmar**

* Comprehensive prevention, care and support services of harm reduction interventions should be fully covered in future CARE’s harm reduction project with continuing its integrated approach with OVC, income generation, livelihood and rehabilitation to create better enabling environment for behavior change of people who use drugs especially people who inject drugs. CARE’s integrated approach was very successful in terms of advocacy as well as community mobilization and community acceptance. Providing ART, STI screening and hepatitis screening among people who inject drugs in DIC and methadone dispensing in cooperation with government sector would be added values to increase accessibility of CARE project by people who use drugs.
* Coordination mechanism among local harm reduction implementers in project was well established and this practice should be continued in future project implementation. The coordination mechanism favors better collaboration as well as improves in service area coverage through avoiding service overlapping. This mechanism will also allow the better quality service provision in order to fulfill the needs of the beneficiaries as well as the related community.
* Care should address poly drug use among methadone clients by involving in evidence based advocacy targeting more accessible MMT program.
* Close setting harm reduction services should be prioritized in future CARE’s harm reduction project, which is one of the important gaps in current harm reduction intervention in Myanmar. CARE started awareness raising activities to prison authorities as training of trainer approach. The long process of MOU and system change in MOU process leads to halt of this program in this area. There should be another package of advocacy strategy with director general of prison department and MOHA to reprocess the MOU with them, if CARE decides to work in this area.
* Feed-back mechanism should be continued in all steps of project cycle management of future projects to strengthen the program by listening to the voices of the beneficiaries. CARE has used the participatory approach since the beginning of the project. CARE included the voices of beneficiaries in their monthly reports and tried to response it timely which was clearly visible in a case of syringe leakage problem by providing needle and syringe available in order to continue accessible to NSP. CARE should also response the client feedback in their next project activities to facilitate the client’s behavior change process.
* Rehabilitation is one of the forgotten areas for enabling environment of behavior change in the field of harm reduction and demand reduction. Clients of CARE project expressed their concern on their needs on rehabilitation especially from the clients in Kalay and Tamu. The evaluation team has witnessed the various resource needs of current rehabilitation center. More advocacies to donors and concerned government departments are needed not only to improve this sector but also to create the enabling environment of behavior change of the clients.
* Advocate to donor agencies and government including Country Coordination Mechanism through Drug User Working Group using evidence based tools to consider increasing funding in harm reduction interventions as it was the effective approach in mitigation of negative consequences of drug use including HIV transmission.
* It’s advisable to 3DF logistic team to make sure to meet the quality of paraphernalia for safer injection practices and to response effectively. The purchase of injecting equipment should be discussed and tested with local beneficiaries before making mass order. The clients expressed their unpleased experience about it in their interview.
* There is a need in effort on sustainability of self-help groups in terms of empowerment of people who use drugs for longer term behavior change as well as harm reduction interventions, although peers have willingness to work for their peers. The evaluation team witnessed the willingness of peers to organize SHG and also witnessed about the ongoing contribution of mother of one of the peers in helping homeless and helpless clients. The peers in FGD wanted a support from NGOs to strengthen their capacities to run their self-help group by themselves.
* Gender oriented services including DICs should be considered in future CARE’s projects. Female clients are usually double hidden in nature as they stigmatized themselves and also discrimination of people around them, which increases their vulnerability to HIV transmission. In fact, there is scarcity of information on magnitude of people who use drugs both male and female.
* There should be effort from CARE Myanmar to advocate donors for allocating of some funding to compensate CARE activities in Kalay and Tamu areas. Cessation of harm reduction activities in these areas hugely affects the sustainability of behavior change of PWID as well as reducing HIV prevalence among PWIDs. Funding constraints was the main factor in stopping harm reduction intervention in these areas.

**Conclusions and Recommendations for other harm reduction partners**

* There is no precise and updated information on magnitude of people who use drugs including female. The in-depth problem of female who use drugs was also not properly addressed in Myanmar. This issue also highlighted the needs of size estimation of female who use drugs as well as male who use drugs in Myanmar.
* Poly drug use among methadone clients should be addressed properly with engagement of government, NGOs, clients and their family. The workshop participants worried that the increasing poly drug use is leading to negative impact upon the community acceptance on MMT. CARE should encourage DTC and other harm reduction partners to do more community awareness of MMT, poly drug use problem and more effort to solve out un-desirable perception of the community upon MMT.
* Accessibility to MMT in terms of quality as well as coverage of the program is a big gap in harm reduction in Myanmar. We need to go faster on this issue by doing evidence based advocacy targeting more accessible community based MMT program. CARE should be inclusive in the movement towards decentralization of MMT to accelerate the accessibility to methadone program.

More effective follow-up, support and after care services for Methadone clients and detoxed clients can be established by doing combined efforts of peers, harm reduction organizations and government facilities including rehabilitation centers, drug treatment centers and methadone center to build up to meet the needs of people who use drugs including female users.**Annex1-A: Lists of persons/organizations interviewed**

* Dr. Kyaw Hlaing, Health Technical Advisor, CARE Myanmar
* Dr. Aung Thant. Assistant Project Coordinator, CARE MyanmarDaw Ei Shwe Yee Win, Field Office Coordinator
* Dr. Thiha Htun, Senior Program Officer, Mandalay Field office
* Daw Hla Hla San, Program Officer, CARE Project- Tamu
* Police Captain, U De De Yaw Han, CCDAC, Northern Office, Mandalay
* U Myint Soe, Community leader, Aung May Thar Zan, Mandalay
* Beneficiaries from CARE Myanmar project, Mandalay

**Annex1-B: List of participants in Workshop**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No.** | **Name** | **Position** | **G** | **Organization** |
| 1 | Dr. Su Su Naing | Team Leader | F | AIDS/STD Team (Mandalay) |
| 2 | Dr. Moe Thant | Senior Technical Officer | M | Burnet Myanmar |
| 3 | Dr. Hla Htay | Senior Technical Officer | M | Burnet Myanmar |
| 4 | Kyaw Win Hlaing | Peer Educator | M | CARE Project (Kalay) |
| 5 | Ko Tun Yee | Peer Educator | M | CARE Project (Kalay) |
| 6 | Ban Swee Oak | Community Facilitator | M | CARE Project (Kalay) |
| 7 | Ko Tin Mg Htwe | Peer Educator | M | CARE Project (Lashio) |
| 8 | Ko Sai Kyaw Aye | Peer Educator | M | CARE Project (Lashio) |
| 9 | Sai Lao Tun | Community Facilitator | M | CARE Project (Lashio) |
| 10 | Phyo Wai Kyaw | Community Facilitator | M | CARE Project (Lashio) |
| 11 | Soe Moe Aung | Program Officer | M | CARE Project (Mandalay) |
| 12 | Nay Lin | Peer Educator | M | CARE Project (Mandalay) |
| 13 | Ma Nandar Aung | Peer Educator | F | CARE Project (Mandalay) |
| 14 | Ko Kyi Soe | Peer Educator | M | CARE Project (Mandalay) |
| 15 | Han Zar Chi | Community Facilitator | F | CARE Project (Mandalay) |
| 16 | Kyaw Zin Thet | Community Facilitator | M | CARE Project (Mandalay) |
| 17 | Ko Thaw Zin | Community Facilitator | M | CARE Project (Mandalay) |
| 18 | Ma Khine Sandi Kyaw | Community Facilitator | F | CARE Project (Mandalay) |
| 19 | Ma Nan Kyein Khan | Community Facilitator | F | CARE Project (Mandalay) |
| 20 | Ko Ko Chan Myae | Community Facilitator | M | CARE Project (Mandalay) |
| 21 | Daw Hla Hla San | Program Officer | F | CARE Project (Tamu) |
| 22 | Ma Khin Hnin Thet | Community Facilitator | F | CARE Project (Tamu) |
| 23 | Neng Nei Ling | Community Facilitator | F | CARE Project (Tamu) |
| 24 | Ko Bwe Muu | Peer Educator | M | CARE Project (Tamu) |
| 25 | On Za Mang | Community Facilitator | M | CARE Project (Tamu) |
| 26 | Ko Htwe | Peer Educator | M | CARE Project (Tamu) |
| 27 | Yan Nain | Outreach Worker | M | EAP (Mandalay) |
| 28 | Toe Toe Aung | Outreach Supervisor | M | MANA (Mandalay) |
| 29 | Ma Ei Phyu Win | Counselor | F | MANA (Mandalay) |
| 30 | Captain Win Oo | Team Leader of ANTF | M | Mandalay ANTF (Northern) |
| 31 | Captain Than Tun | Team Leader of ANTF | M | Mandalay ANTF (Southern) |
| 32 | Captain Tun Tun Oo | Chief Administrator | M | Mandalay Division Police Office |
| 33 | Dr. Kyaw San Hlaing | Medical Officer | M | Mandalay DTC |
| 34 | U Khin Htun | Manager | M | Social & Rehabilitation Centre (Mandalay) |

**Annex2: Reference**

1. **Technical progress report to 3DF (May to December 2007)**
2. **Technical progress report to 3DF (January to June 2008)**
3. **Technical progress report to 3DF (July to December 2008)**
4. **Technical progress report to 3DF (January to June 2009)**
5. **Technical progress report to 3DF (July to December 2009)**
6. **Technical progress report to 3DF (January to June 2010)**
7. **Technical progress report to 3DF (July to December 2010)**
8. **Technical progress report to 3DF (January to June 2011)**
9. **Outputs from CARE end of project evaluation workshop in Mandalay (03 February 2012)**
10. **Data and information from IDIs and FGDs with CARE staff, Peers, beneficiaries, police officials and community leaders**
11. **Logical frame work of CARE HIV prevention and Harm Reduction project among Drug (injecting) users**

**Annex 3: CARE work plan vs. achievement 2007-2011**

|  |  |  |  |
| --- | --- | --- | --- |
| **Purpose 1** | **To reduce the risk of HIV transmission and HIV-related morbidity and mortality among DU/IDUs through a targeted HIV prevention and harm reduction program** | | |
| **Output 1.1** | **Provide targeted HIV prevention and harm reduction interventions to DU/IDUs, their sexual partners and families as well as access to quality treatment, care and support services for DU/IDUs** | | |
| **Activity No.** | **Activities** | **Targeted**  **(2007-2011)** | **Achieved**  **(2007-2011)** |
|
| 1.1.2 | Provide harm reduction interventions to DU/IDU through outreach activities | **2,875** | **2,837** |
| 1.1.3 | Provide harm reduction interventions to DU/IDU through Drop-in Centers | **11,240** | **8,873** |
| 1.1.4 | Needle and Syringe Exchange Program | **152,901** | **124,607** |
| 1.1.6 | Provide basic health services for DU/IDU | **3,106** | **6,166** |
| 1.1.7 | Provide referrals to appropriate medical treatment including VCCT testing, ART, treatment for serious opportunistic infections and detoxification for DU/IDU. | **1,506** | **556** |
| 1.1.8 | Conduct home based care visits to DU/IDU living with HIV/AIDS | **882** | **783** |
| 1.1.9 | Provide nutritional and psychological support to DU/IDU living with HIV/AIDS | **1,124** | **1,300** |
| 1.1.12 | Provide support to DU/IDU family members and care givers | **375** | **420** |
| 1.1.13 | Conduct Peer Educator training-reached PEs | **315** | **1829** |

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| --- | --- | --- | --- |
| **Purpose 2** | **To reduce the risk of HIV infection and promote harm reduction among the general community** | | |
| **Output 2.1** | **Increase awareness of HIV transmission, prevention and drug use among the general community, through influential artists, Pwe performers and community exhibitions** | | |
| **Activity No.** | **Activities** | **Target (2007-2011)** | **Achieved**  **(2007-2011)** |
|
| 2.1.1 | Provide health education sessions to Pwe performers | 450 | 1901 |

**Annex 4.A: Logical frame work 3DF (HIV prevention & Harm reduction) for year 1& 2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Intervention Logic** | **Activities** | **Objectively Verifiable Indicators** | **Sources & means of verification** | **Risks& Assumptions** |
| **Objective**  To reduce the risk of HIV among DU/IDU through behavior change  **Strategy**  Provision of targeted interventions to DU/IDUs, their partners and families | 1. Provision of condoms for sexually active men and women 2. Provision of harm reduction interventions 3. Behavior change interventions targeting DU/IDUs | 36,000 male condoms and 1000 female condom distributed to DU/IDUs, their partners and families | Monthly reports  Inventory records | * Target group interest remains high. * Authorities continue support for activities. |
| **Objective 2**  To provide or facilitate access to treatment, care and support for DU/IDUs and PLHAs  **Strategy**  To provide or facilitate access to treatment, care and support for DU/IDUs and PLHAs. | 1. Provision of access/referral to drug treatment in institutional settings, ART and other health services 2. Provision of general, HIV and drug abuse counseling 3. Provision of care and support for PLHAs | * + 150 DU/IDUs receive general counseling, 100 DU/IDUs receive HIV counseling, 150 receive drug abuse counseling   + 50 PLHAs receive nutritional, OI treatment and psychosocial support | DIC records & reports  Project records  HBC reports  Referral records | * Political & social context allows recognition of drug treatment services for IDUs * Availability of service providers. |
| **Objective 3**  To foster the development of an enabling environment for HIV prevention and care | 1. Facilitation of active support from key stakeholders and community leaders for the promotion of a supportive environment for implementation of effective prevention and care activities 2. Training/workshop for service providers and traditional healers in harm reduction principles and HIV prevention and CARE 3. Provision of support to DU/IDU family members and CARE givers 4. Provision of information to the general community through awareness raising activities | * 120 Key stakeholders and community leaders reached through 6 Advocacy meetings held throughout(10)Townships * 45 Service providers and traditional healers receive training and information in harm reduction and HIV prevention and care in all Townships * 45 DU/IDU family members and CARE givers involved with support groups * 1058 Community members reached through 34 Awareness raising activities conducted throughout 10 Townships | * meeting minutes * project reports | * All members are available and willing to participate in project activities according to TOR * Key stakeholders and community leaders are available to participate in the meetings and trainings. |
| **Objective 4**  To improve knowledge in HIV, drug use and related harm and promote positive attitude among police personnel and their communities.  **Strategy 1**  Develop an enabling environment for police targeted activities through advocacy and coordination  **Strategy 2**  Increase awareness and knowledge of HIV, drug use and related harm and promote positive attitudes among police personnel and their communities towards drug users. | **Activities for strategy 1**   1. Facilitation of active support from key stakeholders at national level for the promotion of a supportive environment for implementation of effective harm reduction interventions which target police personnel and their communities 2. Facilitation of active support from key stakeholders at State and Division level for the promotion of a supportive environment for implementation of effective harm reduction interventions which target police personnel and their communities 3. Facilitation of the coordination at Township level of harm reduction interventions which target police personnel and their communities   **Activities for strategy 2**   1. Provision of 'training of trainers' training for police personnel and their family members 2. Provision of health education sessions to police personnel and their family members 3. Provision of information sessions to police related communities | **Indicators for strategy 1**   * 1 Advocacy meetings conducted with 25 high ranking police officials to ensure support and approval of activities which target police and their families and communities throughout all 10 Townships * 3 Advocacy meetings conducted with 75 high ranking police officials to ensure support and approval of activities which target police and their families and communities throughout all 10 Townships * 10 Planning and coordination meetings conducted with 100 local authorities to ensure support and approval for activities which target police and their families and communities throughout 10 Townships   **Indicators for strategy 2**   * 80 police personnel and 80 Family members received ‘training of trainers. * 560 police personnel and 560 family members received health education sessions on HIV/AIDS prevention, drug use and related harm and harm reduction measures. * 5000 community members information on HIV/AIDS, drug use and related harm and harm reduction measures through 40 information sessions. | * KAP survey report * FGD & KII | * KAP survey is representing accurately. * Harm reduction knowledge and attitude scores accurately reflect what police think and influence their work. |
| **Objective 5**  To reduce the risk of HIV infection and promote harm reduction among the general community  **Strategy**  Increase awareness of HIV prevention and harm reduction among the general community | **Activities**   1. Facilitation of Workshop to provide HIV prevention and harm reduction information to influential artists, including writers, cartoonists and poets. 2. Provision of health education sessions to *Pwe* performers 3. Provision of community-based exhibitions and activities 4. Provision of condoms to targeted groups, including police, and community | * 30 influential artists received information HIV prevention and harm reduction through 1 workshop. * 150 *Pwe* performers received information on HIV prevention and harm reduction through 5 health education sessions * 7,500 community members receive information on HIV prevention and harm reduction through 5 community exhibitions. * 100,000 male condoms and 1,000 female condoms distributed to beneficiaries from targeted groups and the community | * Quarterly report * Quarterly report * Workshop report | * Supportive legal environment prevailing for activities. * Community is accepting HR intervention. * International community continuously involves in HIV/AIDS prevention and control program. * Timely permission of government. |
| **Objective 6**  To develop appropriate support materials for HIV prevention and harm reduction interventions for specific target groups and the general community | 1. Development and distribution of IEC/BCC materials to support activities targeting DU/IDUs, their partners and their families, and HIV prevention and harm reduction 2. Development and distribution of IEC/BCC materials to support activities targeting police and their families and communities 3. Facilitation of development of *Pwe* support materials | IEC/BCC materials appropriate to the needs of DU/IDUs, their partners and families distributed to 6120 project beneficiaries  IEC/BCC materials appropriate to the needs of police, and their families and communities distributed to 6120project beneficiaries  150 *Pwe* performers from 15 *Pwe* troupes received support materials which emphasize HIV prevention and harm reduction messages. | No. of developed and distributed information packages  inventory records  No. of distributed information packages. | * IEC materials timely and widely distributed. |

**Annex 4.B: Logical frame work 3DF (HIV prevention & Harm reduction) for year 3 & 4**

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| --- | --- | --- | --- | --- | --- |
| **PROJECT TITLE** | **HIV Prevention and Harm Reduction Project** | | | | |
| **GOAL** | **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** |  |
| To reduce transmission and enhance provision of treatment and care for HIV/AIDS, TB and malaria for the most in need populations | Contribute to the National Strategic Plan for HIV/AIDS to reduce transmission of HIV |  |  |  |
| **Source** | | |
| National surveillance reports  Annual national data collection | | |
| **PURPOSE** | **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** | **Assumptions** |
| To reduce the risk of HIV transmission and HIV-related morbidity and mortality among DU/IDUs through a targeted HIV prevention and harm reduction program | Contribute to the National Strategic Plan for HIV/AIDS to reduce transmission of HIV and related morbidity and mortality among DU/IDUs |  |  |  | Continued support from national/central level authorities such as CCDAC, police department and general administration; and good communication between national/central level and local authorities regarding support for program interventions.  Local authorities continue to support on-going program interventions  Target groups will be available to participate in project activities (lack of crackdowns on DU/IDU, stable security situation). |
| **Source** | | |
| National surveillance reports  Annual national data collection | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **OUTPUT 1** | **Indicator** | **Baseline + year (Dec 2009)** | **Target at the end of 2010** | | **Target at the end of April 2011** | **Assumptions** |
| Provide targeted HIV prevention and harm reduction interventions to DU/IDUs, their sexual partners and families as well as access to quality treatment, care and support services for DU/IDUs | Number of advocacy meetings held with key stakeholders and community leaders | 2 advocacy meetings held with stakeholders and community leaders | 6 advocacy meetings held with stakeholders and community leaders | |  | Due to changes in personnel at township level and to ensure continued support from authorities at different levels advocacy is required. Good communication continues between national/central level and local authorities regarding support for program interventions.  Authorities continue to support program interventions  Other key stakeholders including elders, community leaders, family members continue to support program intervention  Target groups are able to participate in project activities (lack of crackdowns on DU/IDU, stable security situation).  High degree of interest and trust by families in the project  Availability and willingness of service providers to provide care and treatment to DU/IDU and DU/IDU living with HIV/AIDS |
| **Source** | | | |
| * Reports (monthly, quarterly, annual) * Meeting minutes and outputs | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | | **Target at the end of April 2011** |
| Number of DU/IDU who have been reached at least once by any type of HIV prevention and harm reduction program | 841 DU/IDU | 1,837 DU/IDUs | | 1,855 DU/IDUs |
| **Source** | | | |
| * DIC & outreach records/reports * Referral records * Distribution reports * Client feedback data * Counseling records * FGDs reports * NSEP distribution data * Training and Health education sessions records * IEC records | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** | |
| Number of health service providers who have received training and knowledge in harm reduction and HIV care and treatment | 120 Health Service Providers | 100 Health Service Providers |  | |
| **Source** | | | |
| * Training records * Reports * Referral records | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | | **Target at the end of April 2011** | Authorities continue to support program interventions  Other key stakeholders including elders, community leaders, family members continue to support program intervention  Target groups are able to participate in project activities (lack of crackdowns on DU/IDU, stable security situation). |
| Number of needles and syringes distributed | 9,529 needles and syringes distributed | 39,838 needles and syringes distributed | | 15,000 needles and syringes distributed |
| **Source** | | | |
| * Distribution and collection records | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | | **Target at the end of April 2011** | Trained staff remains with the project, clients are willing and able to participate in counseling sessions. Target groups are able to participate in project activities (lack of crackdowns on DU/IDU, stable security situation). |
| Number of drug abuse and general counseling provided in DIC and through outreach activity | 81 counseling sessions | 366 HIV counseling  211 drug abuse  430 general | | 424 HIV counseling  267 drug abuse  472 general counseling |
| **Source** | | | |
| * Monthly reports * Counseling records | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | | **Target at the end of April 2011** | Authorities continue to support program interventions  Other key stakeholders including elders, community leaders, family members continue to support program intervention  Target groups are able to participate in project activities (lack of crackdowns on DU/IDU, stable security situation). |
| Number of nutritional and psychosocial support provided for DU/IDU | 208 provided with nutrition or psychosocial support | 207 provided with nutrition or psychosocial support | | 214 provided with nutrition or psychosocial support |
| Source | | | |
|  | | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | | **Target at the end of April 2011** | Availability and willingness of service providers to provide care and treatment to DU/IDU and DU/IDU living with HIV/AIDS |
| Number of referrals for DU/IDU to medical treatments services | 250 referred | 666 referred | | 798 referred |
| **Source** | | | |
| * Monthly reports * Referral records | | | |

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| --- | --- | --- | --- | --- | --- |
| **OUTPUT 2** | **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** | **Assumptions** |
| Increase awareness of HIV transmission, prevention and drug use among the general community, through influential artists, *Pwe* performers and community exhibitions. | Number of *Pwe* troupes who receive health education sessions and are supported to provide HIV and HR based performances | 5 *Pwe* troupes who receive health education sessions and are supported to provide HIV and HR based performances | 10 *Pwe* troupes who receive health education sessions and are supported to provide HIV and HR based performances | 10 *Pwe* troupes who receive health education sessions and are supported to provide HIV and HR based performances | Local authorities continue to support on-going program interventions  Target groups are able to participate in project activities (stable security situation).  Access to target communities to develop and pre-test IEC/BCC materials  Strong relationship with and good participation of *Pwe* troupes  Community interest in artistic works and *Pwe* performances highlighting HIV and harm reduction messages  CARE is invited to set up booths at pagoda and other festivals (eg. World AIDS Day) |
| **Source** | | |
| * Reports (monthly, quarterly, annually) * Survey/FGD with *Pwe* performers and selected audience members | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Number of community exhibitions conducted during key events eg World AIDS Day to raise community awareness | 5 community exhibitions | 13 community based exhibitions | 13 community based exhibitions |
| **Source** | | |
| * Reports (monthly, quarterly, annually) | | |
| **Indicator** | **Baseline** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Number of male condoms distributed at community events | 52,617 male condoms distributed at community exhibitions | 22,000 male condoms distributed at community exhibitions | 22,000 male condoms distributed at community exhibitions |
| **Source** | | |
| * Reports (monthly, quarterly, annually) | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **OUTPUT 3** | **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** | **Assumptions** |
| Ensure M & E activities provide opportunities to monitor, reflect and learn from project activities | # monitoring visits to field sites by CO | 2 monitoring visits | 2 | 1 | Continued support from national/central level authorities and good communication between national/central level and local authorities regarding support for program interventions.  Local authorities continue to support on-going program interventions  Target groups will be available to participate in M & E activities (lack of crackdowns on DU/IDU, stable security situation).  M & E staff are trained and able to conduct activity |
| **Source** | | |
| * Field visit reports | | |
| **Indicator** | **Baseline + year** | **Target at the end of 2010** | **Target at the end of April 2011** |
| # reflection meetings at each site | 4 | 4 | 1 |
| **Source** | | |
| * Reflection meeting minutes | | |
| **Indicator** | **Baseline** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Final evaluation documents impact and lessons learned | 0 | 0 | 1 |
| **Source** | | |
| * Evaluation report | | |

## Activities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OUTPUT 1** | **ACTIVITY 1.1** | **Target at the end of 2010** | **Target at the end of April 2011** | **Risks** |
| Provide targeted HIV prevention and harm reduction interventions to DU/IDUs, their sexual partners and families as well as access to quality treatment, care and support services for DU/IDUs | Facilitate active support from key stakeholders and community leaders for a supportive environment for prevention and care interventions targeting DU/IDU | 6 advocacy meetings held with stakeholders and community leaders | 6 advocacy meetings held with stakeholders and community leaders | Support for activity is withdrawn from national/central level authorities.  Communication challenges between national/central level and local authorities regarding support for program interventions.  Other key stakeholders including elders, community leaders, family members do not support program intervention  Target groups are no longer able to participate in project activities (due to crackdowns )on DU/IDU, stable security and security situation).  Lack of interest and trust by families in the project  Lack of availability and willingness of service providers to provide care and treatment to DU/IDU and PLHA |
| **ACTIVITY 1.2** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide harm reduction interventions to 357 DU/IDU through outreach activities | 375 DU/IDU received harm reduction intervention through the outreach activities | 383 DU/IDU received harm reduction intervention through the outreach activities |
| **ACTIVITY 1.3** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide harm reduction interventions to 1,801 DU/IDU through Drop-in Centres | 1,837 DU/IDU received harm reduction intervention through the DICs | 1,855 DU/IDU received harm reduction intervention through the DICs |
| **ACTIVITY 1.4** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide needle and syringe exchange program | 72,501 needles distributed to IDU | 87,501 needles distributed to IDU |
| **ACTIVITY 1.5** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Conduct behavior change on safe injecting and sexual behavior with DU/IDU through outreach workers and Drop-in Centres | 72 health education sessions for DU/IDU relating to safe injecting and sexual behavior and practices conducted  57,505 male condoms distributed | 84 health education sessions for DU/IDU relating to safe injecting and sexual behavior and practices conducted  67,042 male condoms distributed |
| **ACTIVITY 1.6** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide basic health services for DU/IDU | 445 DU/IDU receive basic health services at DIC | 467 DU/IDU receive basic health services at DIC |
| **ACTIVITY 1.7** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide referrals to appropriate medical treatment including VCCT testing, ART, treatment for serious opportunistic infections and detoxification for DU/IDU | 666 DU/IDU referred to appropriate health services for VCCT testing, ART, serious OI treatment, detoxification, etc. | 798 DU/IDU referred to appropriate health services for VCCT testing, ART, serious OI treatment, detoxification, etc. |
| **ACTIVITY 1.8** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Conduct home-based care visits to DU/IDU living with HIV/AIDS | Home-based care visits conducted for 262 DU/IDUs living with HIV/AIDS | Home-based care visits conducted for 295 DU/IDUs living with HIV/AIDS |
| **ACTIVITY 1.9** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide nutritional and psychological support to DU/IDU living with HIV/AIDS | 207 DU/IDU living with HIV/AIDS received nutritional and psychosocial | 214 DU/IDU living with HIV/AIDS received nutritional and psychosocial |
| **ACTIVITY 1.10** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide HIV, drug abuse and general counseling to DU/IDUs | HIV counseling for 366 DU/IDUs, drug abuse counseling for 211 DU/IDUs and general counseling for  430 DU/IDUs | HIV counseling for 424 DU/IDUs, drug abuse counseling for 267 DU/IDUs and general counseling for  472 DU/IDUs |
| **ACTIVITY 1.11** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Develop and distribute IEC/BCC materials to support activities targeting DU/IDUs, their sexual partners and families | IEC/BCC materials appropriate to the needs of DU/IDUs, their partners and families distributed to project beneficiaries | IEC/BCC materials appropriate to the needs of DU/IDUs, their partners and families distributed to project beneficiaries |
| **ACTIVITY 1.12** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide support to DU/IDU family members and care givers | Support provided to 4 family/care giver groups with 60 DU/IDU family members and caregivers participating | Support provided to 4 family/care giver groups with 60 DU/IDU family members and caregivers participating |
| **ACTIVITY 1.13** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Conduct Peer Educator training | 8 Peer Educator trainings conducted with a total of 190 Peer Educators | 8 Peer Educator trainings conducted with a total of 190 Peer Educators |
| **ACTIVITY 1.14** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Conduct training/ workshops for GPs, other service providers and traditional healers in HIV prevention and care and harm reduction principles | 6 trainings/ workshops held for a total of 150 GPs, other service providers and traditional healers | 6 trainings/ workshops held for a total of 150 GPs, other service providers and traditional healers |

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| --- | --- | --- | --- | --- |
| **OUTPUT 2** | **ACTIVITY 3.1** | **Target at the end of 2010** | **Target at the end of April 2011** | **Risks** |
| Increase awareness of HIV transmission, prevention and drug use among the general community, through influential artists, *Pwe* performers and community exhibitions. | Provide health education sessions to *Pwe* performers | 10 health education sessions conducted for 300 *Pwe* performers | 10 health education sessions conducted for 300 *Pwe* performers | Local authorities no longer provide support to on-going program interventions  Target groups are unable to participate in project activities (security situation, restrictions in access).  Access to target communities to develop and pre-test IEC/BCC materials is limited  Relationship with Pwe troupes is jeopardized  Participation of *Pwe* troupes is no longer possible due to poor relationships  Community interest in artistic works and *Pwe* performances highlighting HIV and harm reduction messages is constrained  CARE is denied opportunities to set up booths at pagoda and other festivals (eg. World AIDS Day)  Condom distribution is restricted. |
| **ACTIVITY 2.2** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Facilitate the development of Pwe support materials | 5 existing P*we* troupes receive support materials which emphasise HIV prevention and harm reduction messages. | 5 new *Pwe* troupes receive support materials which emphasise HIV prevention and harm reduction messages. |
| **ACTIVITY 2.3** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Support an artist/*Pwe* network | On-going support provided to a network of artists and Pwe performers on HIV prevention and harm reduction issues | On-going support provided to a network of artists and Pwe performers on HIV prevention and harm reduction issues |
| **ACTIVITY 2.4** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Conduct community-based exhibitions and activities | 12 community based exhibitions conducted, reaching 18,000 community members | 13 community based exhibitions conducted, reaching 19,500 community members |
| **ACTIVITY 2.5** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Provide condoms at community events | 22,000 condoms distributed | 22,000 condoms distributed |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OUTPUT 3** | **ACTIVITY 3.1** | **Target at the end of 2010** | **Target at the end of April 2011** | **Risks** |
| Ensure M & E activities provide opportunities to monitor, reflect and learn from project activities | At least 2 monitoring visits conducted by CO staff to field sites each year | 2 | 1 | Local authorities no longer provide support to on-going program interventions  Target groups are unable to participate in project activities (security situation, restrictions in access).  CO staff movements are restricted  Field level staff are unable to conduct reflection meetings due to workload  Lack of access to an independent consultant to conduct end term evaluation |
| **ACTIVITY 3.2** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Reflection meetings conducted at field level and CO level | 4 | 1 |
| **ACTIVITY 3.3** | **Target at the end of 2010** | **Target at the end of April 2011** |
| Final evaluation conducted documenting impact and lesson learned | 0 | 1 |

**Annex 5: M & E Frame work CARE**

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **(13-June-2010)** |  |  |  |  |  |  |
|  | **Indicators** | **Data Needed** | **Data Method** | **Data Source** | **Frequency of collection** | **Responsible Person** | **Dissemination and utilization** |
| **Goal :** To reduce HIV transmission and  HIV-related morbidity and mortality  among DU/IDUs through a targeted HIV prevention and harm reduction program. | % of IDUs that are  HIV infected | Total # of DU # of DU with HIV/AIDS |  | NAP progress report HSS report BSS report | Annual | NAP, PC, APC, FOC | Donor report, National Health Report |
| **Purpose 1 :** To reduce the risk of HIV transmission and HIV-related morbidity and mortality among DU/IDUs through a targeted HIV prevention and harm reduction program | % of IDU reporting the use of sterile injecting equipment the last time they injected % of IDU reporting the use of a condom the last time they had sexual intercourse (paid partner) | # of IDU reporting the use of sterile injecting equipment the last time they injected # of IDU reporting the use of a condom the last time they had sexual intercourse (paid partner) | client interview | client interview record | Bi annual ( June 2010 & March 2011) | CF, JPO, PO | Donor report |
| % of IDU who accessed DIC and/or PHC services in the last 12 months | # of IDU who accessed DIC and/or PHC services in the last 12 months | PHC record review DIC record review | Daily DIC attendance record PHC record | Monthly | CF, JPO, PO | Monthly Progress report, Donor report |
| **Output 1 :** Provide targeted HIV prevention and harm reduction  interventions to DU/IDUs, their sexual partners and families as well as access to quality treatment, care and support services for DU/IDUs | Number of advocacy meetings held with  key stakeholders and community leaders | Number of advocacy meetings | Document Review | Meeting minutes, monthly report | Semiannually | PO, SPO , FOC | Donor Report, Review Meeting, Evaluation workshop |
| Number of DU/IDU who have been reached at least once by any type of HIV prevention and harm reduction program | # of DU/IDU who have been reached at least once by any type of HIV prevention and harm reduction program | DIC & outreach records/reports review | • DIC & outreach records/reports | Semiannually | JPO, PO, SPO | Donor report, Evaluation workshop |
| Number of health service providers who have received training and knowledge in harm reduction and HIV care and treatment | # of health service providers who have received training and knowledge in harm reduction and HIV care and treatment | Document Review | • Training records• Reports • Referral records | Annually | SPO, FOC | Donor report, Evaluation workshop |
| Number of needles and syringes distributed Number of condoms distributed to DU/IDUs | # of needles and syringes distributed # of condoms distributed to DU/IDUs | Document Review | Distribution and collection record monthly report | Semiannually | CF, JPO, PO | Donor report, Evaluation workshop |
| Number of drug abuse and  general counseling provided in DIC and through outreach activity | # of drug counseling session # of general counseling session # of HIV counseling session | Document Review | counseling record, monthly report | Monthly | CF,JPO, PO | Monthly Progress report, Donor report |
| Number of nutritional and  psychosocial support provided  for DU/IDU | # of DU with HIV/AIDS who received nutritional support # of Home visits # Home Based Care | Document Review | Nutrition support record, HBC record, Home visit / follow-up record, monthly report | Monthly | CF, JPO, PO | Monthly Progress report, Donor report |
| Number of referrals for DU/IDU to medical treatments services | # of referrals for DU | Document Review | Referral record monthly report | Monthly | CF, JPO, PO | Monthly Progress report, Donor report |
| **Purpose 2 :** To reduce the risk of HIV infection and promote harm reduction among the general community | % of people in general community participating in community based events that promote harm  reduction and raise awareness of HIV | Total # of community member participating in events # of community based exhibition # of IEC distribution # of condom distribution # of participants in Quiz/ exhibition | Document Review | project report | Semiannually | CF, JPO, PO | Donor report, Evaluation workshop |
| **Output 2:** Increase awareness of HIV transmission, prevention and drug use among the general community, through influential artists, *Pwe* performers and community exhibitions**.** | Number of Pwe troupes who receive health education sessions and are supported to provide HIV and HR based performances | # of Pwe troupes who receive health education sessions and are supported to provide HIV and HR based performances # of Pwe performers received health education session | Document Review | Attendance list Pwe report , • Survey/FGD with Pwe performers and selected audience members | Annually | CF, JPO, PO | Donor report, Evaluation workshop |
| Number of community exhibitions conducted during key events for example World AIDS Day to raise community awareness | Total # of community member participating in events # of community based exhibition # of IEC distribution # of participants in Quiz/ exhibition | Document Review | project report | Semiannually | CF, JPO, PO | Donor report, Evaluation workshop |
| Number of male condoms distributed at community events | # of condom distribution | Document Review | project report | Semiannually | CF, JPO, PO | Donor report, Evaluation workshop |
| **Purpose 3 :** To determine the extent of which the project is achieving its stated purpose and goal through the activities as well as unplanned effects | % of monitoring and evaluation activities that reflect project success in meeting its purpose and contributing to the goal | # of monitoring and evaluation activities that reflect project success in meeting its purpose and contributing to the goal # of MSC stories # of success stories | MSC stories collection FGD | Monitoring reports MSC stories record  Success stories record | Semiannually | PO, SPO , FOC, APC | Donor report,  Evaluation workshop,  QPM sharing,  Annual planning |
| **Output 3 :** Ensure M & E activities provide opportunities to monitor, reflect and learn from project activities | # monitoring visits to field sites by CO | # monitoring visits to field sites  by CO | FGD | FGD record | Semiannually | APC, PC, PQT | Donor report,  Evaluation workshop,  QPM sharing,  Annual planning Marketing |
| # reflection meetings at each site | # reflection meetings at each site | Review meeting with project staff | Review meeting record | Semiannually | FOC and field team |
| Final evaluation documents impact and lessons learned | FGD result and lessons learnedChanges of project implementation | Document ReviewFGDEvaluation workshop with project staff | FGD recordReview meeting recordEvaluation findings recordSemiannual reports | Annually | PC and project staff |

**Annex 6: CARE PE manual**

**Annex 7:Annual training list of CARE harm reduction staff January- December 2009**

**Annex 8.1: IDI Guide with CARE Project management staff**

**Introduction**

CARE’s HIV prevention and Harm Reduction project for people who use drugs and people who inject drugs is implemented with the support from 3 Diseases Fund (3DF) at four townships – Mandalay, Lashio, Tamu and Kalay from April 2007 to December 2011. Drop in centres (DIC), outreach activities and Primary Health CARE services are carried out by project staff and peer educators in all four townships in order to reduce drug related harm among people who use drugs.

The following goal statement of the project highlights what the project would contribute towards Myanmar’s attempts to mitigate HIV transmission and its impacts on Myanmar population: “Reduction of HIV transmission and HIV-related morbidity, disability, and social and economic impacts”. Within the overall frame of this 3DF support for the project titled To reduce HIV transmission and HIV-related morbidity and mortality among DU/IDUs and police through a targeted HIV prevention and harm reduction program covering the period 2007-2011” that we will make this discussion. You are free to express your opinions, and from ethical standpoints, making references to the names of the interviewees would be avoided to the possible extent. If necessary to make the reference by name, permission for agreement will be taken first from the interviewee. You can refrain from providing any answer that you consider you should not provide. Like in any qualitative inquiry, findings from different sources will be triangulated. I assure you that this evaluation is being made with **positivistic** and **constructivist** perspectives with the sole aim of how the endeavours of CARE in collaboration with 3DF could serve Myanmar people at risk to HIV transmission, especially those who are from the poor and the marginalized groups.

**Management**

* What is the project structure?
* Your position in the structure?
* What are your responsibilities?
* **In your opinion, is the existing project structure of CARE *appropriate* and *adequate*?**
* Clarity of Reporting Line
* Collaboration with other Programmes of CARE
* **Collaboration with Partners-other harm reduction organizations**
* **What are the added values of CARE in harm reduction interventions?**
* **Any effects of Organizational direction Change in harm reduction?**

**Staff Capacity Building**

* **Do you have staff training plan in harm reduction specific technical area?**
* **How did you plan it?( in terms of Human resource and budget aspect to assure adequacy and relevancy of the trainings)**
* **How did the CARE Myanmar project staff utilize the knowledge and skill gained from the training in the project implementation?**

**Relevance**

*Relevance*: the degree to which the organization’s objectives and activities reflect the necessities and priorities of key stakeholders.

* Did you make sure the **Need Assessments process?**
* **Is it in Participatory approach**?
* **How did you select the project objectives and activities?**
* How are **project reviews** performed? Do you have any guidelines? Did you follow up on the recommendations made by staff and beneficiaries? How did you utilize the new solutions from the mid-year and end year evaluations?

**Effectiveness**

*Effectiveness*: the degree to which the organization achieves its objectives.

* You have to submit Progress Report. Can you please tell me the positives and negatives relating to this procedure? Do you have any reporting guidelines?
* Are there any delays to accomplish the planned activities? What are the reasons for the delays? How do you solve such situations?
* Do you have quality assurance guidelines or M&E frame works?
* What are your general impressions/opinions on the effectiveness of harm reduction project of CARE at the end of the year 2011?
* Could you identify qualitative indicators for the achievements/failures?
* Are there any key lessons and best practices that can be drawn from the project? What are they?
* Can staffs plan & implement programmes? How are they performing these? What constraints are there? [Examples of Action Plan developed by staffs]
* What extent that community participated in your service provision?
* What are the significant changes in your target community? Could you please give an example?
* In your opinion, what extent of community acceptance to your project activities? How did you do advocacy for community acceptance? On what extent, community participated (SHG, FCG) in your project activities?

***[Part of effectiveness]***

* How did they contribute to the success of achieving of CARE’s Harm Reduction project for (1) Reduction of HIV transmission; (2) Care, support and treatment preparedness; (3) Mitigation of HIV impact on orphans and vulnerable children; and (4) Organizational Development?

**Efficiency**

*Efficiency*: the degree to which it generates its products using a minimum of inputs.

* What suggestions would you like to give for further improvements in the project?

**Sustainability**

*Sustainability*: sustainability of the behaviour change of clients and the community beyond the 3DF-CARE project.

I was informed that harm reduction will not continue after 3DF project, take the consideration of this point, what is your opinion as regards sustainability of the behaviour change of clients and the community in case 3DF support ends?

**Cross Cutting Issues**

What do you think the 3DF-CARE project has taken seriously into consideration of addressing Equity, Gender and Human Right Issues?

What are your opinions up on this?

How will you integrate these issues in developing future project plans?

**Is there any additional opinion and suggestion that you would like to express?**

**Annex 8.2: IDI Guide (Key Informants community leader in Mandalay)**

**Introduction**

CARE’s HIV prevention and Harm Reduction project for people who use drugs and people who inject drugs (DU and IDU) is implemented with the support from 3 Diseases Fund (3DF) at four townships – Mandalay, Lashio, Tamu and Kalay from April 2007 to December 2011. Drop in centers (DIC), outreach activities and Primary Health Care services are carried out by project staff and peer educators in all four townships in order to reduce drug related harm among people who use drugs. The following goal statement of the project highlights what the project would contribute towards Myanmar’s attempts to mitigate HIV transmission and its impacts on Myanmar population: “Reduction of HIV transmission and HIV-related morbidity, disability, and social and economic impacts”. Within the overall frame of this 3DF support for the project titled To reduce HIV transmission and HIV-related morbidity and mortality among DU/IDUs and police through a targeted HIV prevention and harm reduction program covering the period 2008-2011” that we will make this discussion. You are free to express your opinions, and from ethical standpoints, making references to the names of the interviewees would be avoided to the possible extent. If necessary to make the reference by name, permission for agreement will be taken first from the interviewee. You can refrain from providing any answer that you consider you should not provide. Like in any qualitative inquiry, findings from different sources will be triangulated. I assure you that this evaluation is being made with **positivistic** and **constructivist** perspectives with the sole aim of how the endeavors of CARE in collaboration with 3DF could serve Myanmar people at risk to HIV transmission, especially those who are from the poor and the marginalized groups.

* **General Information sharing**What is your role and responsibility in your community?
* How long have you known to CARE projects?
* Do you know what CARE projects are being implemented? What are they doing?
* What are the activities of CARE project in harm reduction?
* Did they share information about what did they do? Does what extent CARE project ask for the participation of the community?
* In your opinion, is the existing CARE project is *appropriate* and *adequate for your community’s need in term of drug related issues*? (Please mention about community perception)
* Could you please elaborate good things and bad things of the impact of CARE project within your community?
* Do you know about Self Help Groups (SHGs), Family Care Giver Groups (FCGs) and CARE Myanmar project staff? What are they doing? Collaboration with Partners-other harm reduction organization
* Any effects of reducing harm reduction activities of CARE?
* Is there any additional opinion that you would like to express?

**Annex 8.3: FGD guide Clients in Mandalay**

**Introduction**

CARE’s HIV prevention and Harm Reduction project for people who use drugs and people who inject drugs (DU and IDU) is implemented with the support from 3 Diseases Fund (3DF) at four townships – Mandalay, Lashio, Tamu and Kalay from April 2007 to December 2011. Drop in centers (DIC), outreach activities and Primary Health Care services are carried out by project staff and peer educators in all four townships in order to reduce drug related harm among people who use drugs.

The following goal statement of the project highlights what the project would contribute towards Myanmar’s attempts to mitigate HIV transmission and its impacts on Myanmar population: “Reduction of HIV transmission and HIV-related morbidity, disability, and social and economic impacts”. Within the overall frame of this 3DF support for the project titled To reduce HIV transmission and HIV-related morbidity and mortality among DU/IDUs and police through a targeted HIV prevention and harm reduction program covering the period 2008-2011” that we will make this discussion. You are free to express your opinions, and from ethical standpoints, making references to the names of the interviewees would be avoided to the possible extent. If necessary to make the reference by name, permission for agreement will be taken first from the interviewee. You can refrain from providing any answer that you consider you should not provide. Like in any qualitative inquiry, findings from different sources will be triangulated. I assure you that this evaluation is being made with **positivistic** and **constructivist** perspectives with the sole aim of how the endeavors of CARE in collaboration with 3DF could serve Myanmar people at risk to HIV transmission, especially those who are from the poor and the marginalized groups.

*Note:*

*‘We want to talk to you about your experiences of being involved in the PIP. For our purposes there are no right or wrong answers; we are genuinely interested in your perceptions & experiences of the project. However none of your responses will be able to be identified separately; we want to talk to a number of people who were involved in the project in order to get an overall impression. We are not concerned with individual assessment but rather with the project as a whole and its strengths & limitations. Essentially we want to know if it worked and if not, why not and how we might do it better in the future.’*

**Theme:**

1. Experience of sharing information with peers

**Awareness of CARE project**

* Do you aware CARE project? How did you know about CARE project?
* Do you know about the Goal and Objectives of the CARE project? If yes, can you recall and mention as much as you can
* Did you participate in this planning process?
* Did you ever heard about DIC? If not why? If yes, from where did you hear?
* Did you ever get into DIC? If not why?
* How did you access CARE services?
* How long have you been accessed to CARE services?
* What are the activities CARE had done in the project?
* What are the target populations of CARE project?

**Support**

* Did you or your friends participate in this planning process?
* What kind of information did you receive from people related from CARE project- staff, peers?
* Did you have any support from CARE DIC? Did your family also get support? How?
* What benefits have you and your family got by contacting with CARE-DIC?
* How did you get contact with other users?( network, DIC, peers, friends, ORW)

**Participation and benefits**

* Did you and your friends participate in the activities of CARE-DIC? If no why? If yes, how could you mention in which area you have been involved?
* What are the activities of user network? From where did you get support?
* Were there any training /workshop among the users? If yes, how many times during 2007-2011? Did these give benefit to you? How?
* Do you think the information gained from CARE project is useful?
* Yes No
* Can you give any examples of information you have gained?

**Satisfaction, opinion**

* How do you think that people who use drugs satisfied with the care and support given by CARE-DIC? If no /yes, why?
* Do you think that existing CARE strategies can cover the people who use drugs? Give reason.
* Did you ever participate in the meetings of CARE? If yes, please mention what meetings?
* Please feel free to discuss this matter; are there any hindrances in working with CARE?
* Do you have any plan for further collaboration? Why?
* For the further improvement, would you give your opinion?

**Putting knowledge into sustained practice**

* ***Discuss - In the last month****, how often do you*
* [Prompts: relative status, availability of equipment, whose drugs / equipment etc. ]

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How often do you and your peers** | Never | sometimes | usually | always | n/a |
| Wash hands before mixing up? |  |  |  |  |  |
| **Comments (enablers, barriers, circumstances)** | | | | | |
| Use condoms for casual sex? |  |  |  |  |  |
| **Comments (enablers, barriers, circumstances)** | | | | | |
| Use new, sterile syringes for each hit? |  |  |  |  |  |
| Comments (enablers, barriers, circumstances) | | | | | |
| Feel able to talk to others when they are using unsafely; for example: handling equipment with dirty hands, rinsing used fit in water others might use to mix with, leave used syringes lying around? |  |  |  |  |  |
| **Comments (enablers, barriers, circumstances)** | | | | | |
| Will you help someone if they experience an overdose? |  |  |  |  |  |
| **Comments (enablers, barriers, circumstances)** | | | | | |
| Give advice to a user about HIV testing? |  |  |  |  |  |
| **Comments (enablers, barriers, circumstances)** | | | | | |

**Sustainability**

Sustainability: sustainability of the behavior change of clients and the community beyond the 3DF-CARE project.

I was informed that harm reduction will not continue after 3DF project, take the consideration of this point, what is your opinion as regards sustainability of the behavior change of clients and the community in case 3DF support ends?

**Cross Cutting Issues**

What do you think the 3DF-CARE project took seriously into consideration of addressing, whenever situations allow, on Poverty, Equity, Gender and Human Right Issues in developing future project plans? What are your opinions this?

**Is there any additional opinion that you would like to express?**

Any other suggestions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Annex 8.4: Knowledge and practice questionnaires Beneficiaries**

The following questions are designed to measure how much of the information from the CARE project you remember.

atmufazmfjyygar;cGef;rsm;onf CARE\ pDrHudef;wpfckvHk;rSS owif;tcsuftvuf rnfrQoif rSwfrd onfudkprf;ppfaomar;cGef;rsm;jzpfygonf/

3 / **rSef ^ rSm; a&G;yg/ (tajz wpfckwnf;omjcpfyg**) Please answer whether you think the following statements are true or false *(Tick one)*:

***aoG;rSwqifh ul;pufaom a&m\*grsm; (Blood-Borne Viruses)***

|  |  |  |
| --- | --- | --- |
|  | rSef **True** | rSm; **False** |
| ***tonf;a&miftom;0g (pD) Hepatitis C*** |  |  |
| **tonf;a&miftom;0g (pD) onf wpfOD;rSwpfOD; qDodkY aoG; - aoG; jcif;xdawGUrI wpfckwnf;jzifhom ulpufysH YESYH aponf/**  Hepatitis C is only passed from one person to another through blood to blood contact |  |  |
| **tonf;a&miftom;0g (pD) onf vdifrSwqifhulpufaoma&m\*gjzpfonf/**  Hepatitis C is a sexually transmitted disease |  |  |
| **oifonf rl,pfaq;0g;taMumxJxdk;oGif;ypönf;rsm;tm; rQa0oHk;pGJvQif tonf;a&miftom;0g (pD) a&m\*g &&SdEdkif (odkU)jzefYa0Edkifonf/**  You can get or pass on hepatitis C through sharing injecting equipment |  |  |
| **oifonf vlwpfa,muftm; tonf;a&miftom;0g (pD) a&m\*g&Sdonf[k rsufpdESifh Munfh&Hkjzifh ajymqdkEdkifonf/**  You can tell if someone has hepatitis C by looking at them |  |  |
|  | | |
| ***tonf;a&miftom;0g (bD) Hepatitis B*** | rSef  **True** | rSm;  **False** |
| **tonf;a&miftom;0g (bD) onf wpfOD;rSwpfOD;odkY aoG; ESifh cE¨mudk,f rS xGufaom tjcm;t&nfrsm;(okwf&nf ESifh rdef;rudk,frS xGufaom t&nfrsm;) rS wqifhhysHUESYH Edkifonf/**  Hepatitis B can be passed from one person to another through blood AND other body fluids such as semen and vaginal fluids |  |  |
| **tonf;a&miftom;0g (bD) onf a&m\*g&SdolwpfOD; toHk;jyKxm;aom tdrfom tm;rQa0oHk;pGJjcif; rSwqifhh ulpufEdkif&eftcGifhtvrf;rsm;onf/**  You risk getting hepatitis B by sharing a toilet with someone who has hepatitis B |  |  |
| **tonf;a&miftom;0g (bD) onf a&m\*g&SdolwpfOD; ESifh ZGef;cuf&if; ESifh yef;uef rsm; tm;rQa0oHk;pGJjcif; rSwqifhh ulpufEdkif&eftcGifhtvrf;rsm;onf/**  You risk getting hepatitis B by sharing cutlery and plates/cups with someone who has hepatitis B |  |  |
| **oifonf tonf;a&miftom;0g (bD) tm;umuG,f aq;xdk;íMudKwifumuG,fEdkifonf/**  You can get a vaccination to protect you from hepatitis B |  |  |
| **oifonf vlwpfa,muftm; tonf;a&miftom;0g (bD) a&m\*g&Sdonf[k rsufpdESifh Munfh&Hkjzifh ajymqdkEdkifonf/**  You can tell if someone has hepatitis B by looking at them |  |  |

|  |  |  |
| --- | --- | --- |
|  | | |
| ***tdyfcsftdkifAGD******(HIV)*** | rSef **True** | rSm; **False** |
| **tdyfcsftdkifAGD onf wpfOD;rS wpfOD;odkY vdifrSwqifh om ul;pufaom a&m\*g jzpfonf/ (oifonf tyfrQa0oHk;pGJjcif;tm;jzifh rul;pufEdkifyg)**  HIV is only passed from one person to another through sex (you can’t get HIV from sharing fits) |  |  |
| tdyfcsftdkifAGD onf vdifwlqufqHolrsm;wGifom tEå&m,f&Sdygonf/  HIV is only a risk for homosexual sex |  |  |
| tdyfcsftdkifAGD &SdolwpfOD;onf tvGefvQifjrefpGmaoqHk;Edkifonf/  Someone who gets HIV will die very quickly |  |  |
| **tdyfcsftdkifAGD onfvHk;0aysmufuif;atmif ukoaomaq;r&Sdyg/**  There is no cure for HIV |  |  |
| **oifonf** tdyfcsftdkifAGD **tm;umuG,faq; xdk;í MudKwifumuG,fEdkifonf/**  You can get vaccinated to protect against HIV infection |  |  |
|  | | |
| ***oefY&Sif;a&; ESifh ydkrdkpdwfcs&aomaq;xdk;jcif; (Hygiene and Safer Injecting)*** | rSef **True** | rSm; **False** |
| **aq;xdk;&ef aq;ra&mrSDESifh taMumxJrxdk;oGif;rSD oif\vuftm; aq;aMumjcif;onfbufwD;&D;,m;ydk;rTm;rsm;0ifa&mufjcif;rSumuG,fEdkifonf/**  Washing your hands before mixing up and injecting will help prevent bacteria from entering the mix |  |  |
| **oif aq;rxdk;oGif;rSD aq;xkd;rnfhae&mtm; t&ufjyef\*Grf;jzifhokwfoifhonf/**  You should swab your injection site *before* your injection |  |  |
| **oifonf ESvHk;qDodkY OD;wnf í tjrJwrf;xdk;oGif;oifhonf/**  You should always inject towards the heart |  |  |
| **oifonf aq;xdk;jyD;aomtcg aq;xdk;onfhae&mudkk zdxm;oifhonf/**  After injection you *should* put pressure on your injection site |  |  |
|  | | |
| ***aq;vGefjcif;tm; wkefYjyefjcif; (Overdose Response/CPR)*** | rSef **True** | rSm; **False** |
| **oifonf aq;vGefjcif;tawGUtMuHK&Sdzl;olwpfOD;ESifh aeoifhonf/**  You should stay with someone who is experiencing an overdose |  |  |
| **aq;vGefaeolwpfOD;tm; a&cJa&jzifh avmif;csjcif;jzifh owdjyef&atmif vkyfEdkifonf/**  Putting an overdosed person in a cold iced bath will wake them up |  |  |
| **aq;vGefaeolwpfOD;tm; &dkufykwfjcif;? qGJqdwfjcif;jzifh owdjyef&atmif vkyfEdkifonf/**  Slapping or pinching an overdosed person will wake them up |  |  |
| **aq;vGefaeolwpfOD; tdyfaysmfoGm;ygu (yg;pyfrS a[mufoHuJhodkYtoHrsm; xGufaeaomfvnf;) 4if;\ tajctaeaumif;ygonf/**  If an overdosed person is asleep but gurgling then they are OK |  |  |

þ ar;cGef;onf þoifwef;rS &v'ftaejzifh oif\tjyKtrlajymif;vJrI ESifhyufoufygonf/ atmufazmfjyyg pmaMumif;rsm;tm; oifoabm wl ^ rwl qHk;jzwfay;yg/ (odkUr[kwf) oifwef;rwdkifcifwnf;u oifodjyD;jzpfvQif (t0dkif; 0dkif;ay;yg)

7. This question is concerned about whether your *behaviors* changed as a result of this course. State whether you agree or disagree with the following statements, or if you knew before the course *(circle 1 answer each row).*

|  |  |  |  |
| --- | --- | --- | --- |
|  | oabmwlygonf  Agree | oabmrwlyg  Disagree | uREkfyfodjyD; jzpfonf  I already knew/did this |
| uREkfyf\usef;rma&;ESifh yufoufaom qHk;jzwfcsufrsm;csrSwf&mwGifydkrdk ,HkMunfrI &Sdvmonf/  I am more confident making decisions regarding my health | 1 | 2 | 3 |
| uREkfyfonf tjcm;aq;oHk;olrsm;tm; ydkrdktEÅ&m,fuif;pGmoHk;vmap&eftm;ay; ulnDvmEdkifonf/  I encourage other people I’m using with to be safer. | 1 | 2 | 3 |
| uREkfyfonf aq;vGefjcif;tm; rnfodkY wkefUjyef&rnfudk od&Sdvmonf/  I know how to respond to an overdose | 1 | 2 | 3 |
| uREkfyfonf uREkfyf\usef;rma&;ESifh ywfoufaom tEÅ&m,frsm;udk avsmhcsEdkifcJhonf/  I take less risks regarding my health (eg. sex or drug use) | 1 | 2 | 3 |

**Annex 8.5:Knowledge and practice questionnaire for Peer Educators**

ar;cGef;wdkjzifhavhvmprf;ppfjcif;

**Particulars-** oif\udk,fa&;tcsuftvufrsm;

**1/ touf ;---ESpf** **2/ vdif usm;^r ; ---3/ ae&yf ; -----jrdKUe,f**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………

atmufazmfjyygar;cGef;rsm;onf **CARE Project** oifwef;rsm;rS rnfuJUodkUaom owif;tcsuftvufrsm;ESifU uRrf;usifrIrsm;&&Sdonfudk k qef;ppfaomar;cGef;rsm;jzpfygonf/

The following questions are designed to measure how much of knowledge and skills you gained from CARE project.

rSef ^ rSm; a&G;yg/ (tajz wpfckwnf;omjcpfyg) Please answer whether you think the following statements are true or false *(Tick one)*:

***aoG;rSwqifh ul;qufaom a&m\*grsm; (Blood-Borne Viruses)***

|  |  |  |
| --- | --- | --- |
| ***todynm*** | rSefygonf | rSm;ygonf |
| tonf;a&miftom;0g (pD) onf vdifrSwqifhomul;pufaoma&m\*gjzpfonf/ |  |  |
| oifonf rl;,pfaq;0g;taMumxJxdk;oGif;ypönf;rsm;tm; rQa0oHk;pGJ,HkrQjzifU tonf;a&miftom;0g (pD/bD) a&m\*g &&SdEdkif (odkU)jzefYa0Edkifonf/ |  |  |
| oifonf vlwpfa,muftm; (HIV) a&m\*gydk;&Sdonf[k rsufpdESifh Munfh&Hkjzifh ajymqdkEdkifygonf/ |  |  |
| tEú&m,f avQmUcsa&; vkyfief;pOfrsm;udk rl;,pfaq; okH;pGJrI avQmUcsa&; ESifU xkwfvkyfrI avQmUcsa&; tp&SdonfU vkyfief;pOfrsm;ESifU vkdufavsmnDaxGrI &SdpGm wGJzufvkyfaqmifEkdifygonf/ |  |  |
| oifonf tonf;a&miftom;0g (bD) tm;umuG,f aq;xdk;íMudKwifumuG,fEdkifonf/ |  |  |
| oif aq;rxdk;oGif;rSD aq;xkd;rnfhae&mtm; t&ufjyef\*Grf;jzifh rokwfaomfvnf; jyóem r&Sdyg/ |  |  |
| HIV ESifU umvom;a&m\*grsm; ul;pufcH&jcif;rS pdwfcs&&ef Condom tm;ESpfxyfpGyfjyD; toHk;jyKoifUonf/ |  |  |
| aq;vGefaeolwpfOD; tdyfaysmfoGm;ygu (yg;pyfrS a[mufoHuJhodkYtoHrsm; xGufaeaomfvnf;) 4if;\ tajctaepdk;&drfp&m r&Sdyg/ |  |  |
| rl;,pfaq; tvGeftuGsH ok;pGJrIaMumifU aq;vGefaeoltm; aNcrcsdK;Ncif;? qm;&nfwkdufNcif;NzifU tEú&m,fuif;pGm owdNyefvnfvmatmif jyKvkyfay;&rnf/ |  |  |
| rl;,pfaq; taMumxJ xkd;oGif;okH;pGJaeaom rdrd\ client wpfOD;u awmif;qdkvmygu pdwfcs&aom aq;xkd;oGif;okH;pGJrI Nzpfap&ef xkdoltm; wpfcgokH;aq;xkd;tyf^NyGefNzifU rdrdudk,fwkdifudk,fus xdk;oGif;ay;&rnf/ |  |  |
| rdrd\ &dyfrGeftwGif; client rsm;rS rl;,pfaq;rsm;udk a&mif;0,fazmufum;? okH;pGJrIrsm;udk wdk;wdk;wdwfwdwf vkyfaqmifaeygu rdrdtaeNzifU &dyfrGefwm0ef&Sdolrsm;tm; wifjy&rnf/ |  |  |

**oifonf atmufaz:jyygoifwef;rsm;rS rdrdwwfa&mufcJUzl;onfUoifwef;rsm;udk oufqdkif&m ay;xm;aomtwef;wpfckpDwGif trSwfNcpfay;yg/**

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| pOf | oifwef;trnf | wufa&mufcJUzl;ygonf/ | rwufa&mufcJUzl;yg/ |
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oifwwfa&mufcJUaom oifwef;rsm;rS rnfrQavUvmoif,lcJU&onfESifU yufoufNyD; oufqkdif&m eHygwfudk t0dkif;0dkif;ay;yg/

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| 1 | 2 | 3 | 4 | 5 | 6 |
| vHk;0 roif,lEkdifcJUYyg/ |  |  |  |  | trsm;qHk; oif,lEkdifcJUonf/ |

oifwwfa&mufcJUaom oifwef;rsm;rS avUvmoif,lcJU&onfrsm;udk aeUpOftvkyfwGif rnfokdUaom twkdif;twmtxd vufawGUtokH;cs vkyfaqmifEkdifcJUonfESifU yufoufNyD; oufqkdif&m eHygwfudk t0dkif;0dkif;ay;yg/

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| 1 | 2 | 3 | 4 | 5 | 6 |
| vHk;0 tokH;rcsEkdifcJUyg/ |  |  |  |  | trsm;qHk; tokH;csEkdifcJUonf/ |

oifbmaMumifU þtaNz ay;cJUonfudk taMumif;Nycsufay;yg/

oif\ tjyKtrlajymif;vJvmrIrsm;&SdcJhvQifazmfjyay;yg/ (Oyrm- tvkyftudkif? rdrd\aq;oHk;pGJaeaomyHkpHESifhyufoufíajymif;vJrIrsm; ...)

**Annex 9: Evaluation Workshop Agenda**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Running Time** | **Topics** | **Session Outlines** | **Resource Person** |
| 09:00 – 09:30 | 30 mins | Registration and Tea Break | | |
| 9:30 – 10:00 | 30 mins | Introduction | * Opening Speech by **Daw Ei Shwe Yi Win** * Introduction * Ice breaking * Objectives and Agenda Overview | Dr. Hla Htay |
| 10:00 – 10:30 | 30 mins | **Overview** of Care Drug User Project | * Brief description of the **project’s objectives and its related activities** * Clarification on expected result of the project with focus on its achievements | Daw Ei Shwe Yi Win (Care Myanmar) |
| 10:30 – 11:30 | 60 mins | Reflection on the **relevancy** of the project | * 4 different groups (Care Myanmar Staff, Peer Educators, Staff from partner organizations and other stakeholders) * [Group work](file:///D:/Users/pswai/Documents/Ma%20ESYW/MMR073%20H&HR/AppData/Local/Temp/7zO1F8A.tmp/GW-relevancy.docx) on identifying **important issues relating HIV and drug** that faced by their community particularly among People who use drugs/Injecting Drug User, why these are important, whether these issues are **addressed** in Care project. * Overall rating on relevancy of Care project by each and every group. | Dr. Moe Thant |
| 11:30 – 12:30 | 60 mins | Reflection on **the effectiveness** of the project | * 4 different groups (Care Myanmar Staff, Peer Educators, Staff from partner organizations and other stakeholders) * [Group work](file:///D:/Users/pswai/Documents/Ma%20ESYW/MMR073%20H&HR/AppData/Local/Temp/7zO1F8A.tmp/GW-effectiveness.docx) to assess the effectiveness of the services provided by Care project. | Dr. Hla Htay |
| 12:30 - 13:30 | **Lunch** | | | |
| 13:30 - 14:30 | 60 mins | Reflection on the **changes in risk behaviors of target population** | * 4 different groups (Care Myanmar Staff, Peer Educators, Staff from partner organizations and other stakeholders) * [Group work](file:///D:/Users/pswai/Documents/Ma%20ESYW/MMR073%20H&HR/AppData/Local/Temp/7zO1F8A.tmp/GW-%20BCC.docx) on **scale rating** and **reasons** to assess risk behaviors including condom use, needle sharing and drug related crimes among targeted community (People who use drugs/People who inject drugs, Police, and General Community) | Dr. Hla Htay |
| 14:30 - 15:30 | 60 mins | Reflection on the **sustainability of behavior change** | * 4 different groups (Care Myanmar Staff, Peer Educators, Staff from partner organizations and other stakeholders) * [Group work](file:///D:/Users/pswai/Documents/Ma%20ESYW/MMR073%20H&HR/AppData/Local/Temp/7zO1F8A.tmp/GW-sustainality.docx) on what kind of plans and activities need to address the sustainability of behaviors change among targeted community (People who use drugs/People who inject drugs) * What kind of plans and activities that Care have addressed the sustainability of behaviors change among targeted community (People who use drugs/People who inject drugs, Police, and General Community) | Dr. Moe Thant |
| 15:30 – 15:45 |  | Tea Break | | |
| 15:45 - 16:45 | 60 mins | Reflection on the **general recommendations** on the project | * 4 different groups (Care Myanmar Staff, Peer Educators, Staff from partner organizations and other stakeholders) * [Group work](file:///D:/Users/pswai/Documents/Ma%20ESYW/MMR073%20H&HR/AppData/Local/Temp/7zO1F8A.tmp/GW-General%20comments.docx) on discussion of general recommendations to the project which include lessons learnt best practices, unexpected outcomes and key challenges etc. | Dr. Moe Thant |
| 16:45 – 17:00 | 15 mins | Wrap Up | * Filling up the individual questionnaires * Overview of the day * Closing Remarks | Dr. Moe Thant |

**Annex 10: IEC materials produced by CARE**



