PREVENTION OF TRANSMISSION OF HIV AMONG DRUG USERS IN SAARC COUNTRIES

Phase II 2007-12

UNODC/UNAIDS/WHO

TD/RAS/03/H13

Mid-Term Review

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Funded by AusAID

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Acronyms

Pakistan Acronyms

AIIMS	All India Institute of Medical Sciences
ANF	Anti Narcotics Force
INCAS	Iranian National Centre for Addiction Sciences
JPMC	Jinnah Post Graduate Medical College
MNC	Ministry of Narcotics Control
NACP	National AIDS Control Programme
PMC	Project Management Committee
RSRA	Rapid Situation and Response Assessment

Sri Lanka Acronyms

NDDCB	National Dangerous Drug Control Board
LCCS	Low Cost Community Based Services
NAITA	National Apprentice and Industrial Training Authority
NSACP	National STD/AIDS Control Program
SLFONGOADA	Sri Lanka Federation of NGOs Against Drug Abuse
UNJTA	UN Joint Team on AIDS

Nepal Acronyms

ARV	Anti-retrovirals
BCC	Behaviour Change Communication
CSU	Country Support Unit
DACC	District AIDS Coordination Committee
DIC	Drop-in Centre

DCP	Drug Control Program
FHI	Family Health International
IDU	Injecting Drug Use
IEC	Information, Education, Communication
INCB	International Narcotics Control Board
LALS	Lifesavings and Lifegiving Society
M&E	Monitoring and Evaluation
MMT	Methadone Maintenance Therapy
NA/AA	Narcotics Anonymous / Alcoholics Anonymous
NAP	National Action Plan
NCAC	National Centre for AIDS and STD Control
NGO	Non-governmental organisation
NSP	Needle and syringe programme
OI	Opportunistic infection
OST	Opioid substitution therapy
PHC	Primary Health Care
PLI	Peer-led interventions
PLC	Regional Learning Centre
STI	Sexually transmitted infection
TOT	Training of Trainers
TUTH	Tribhuvan University Teaching Hospital
VCT	Voluntary Testing and Counselling

Bangladesh and Bhutan Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal Care

APON	Ashokti Punorbashon Nibash
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
BNCA	Bhutan Narcotic Control Agency
CREA	Community Health Rehabilitation Education Awareness
DAM	Dhaka Ahsania Mission
DIC	Drop in Centre
DoPH	Department of Public Health
DU	Drug Users
FDU	Female Drug User
HISC	Health Information Service Centre
HIV	Human Immuno deficiency Virus
ICDDR,B	International Centre for Diarrhea Disease Research, Bangladesh
IEC	Information Education Communication
JDW	Jigme Dorji Wangchuk
M&E	Monitoring and Evaluation
MOHA	Ministry of Home Affairs
MSM	Men Having Sex with Men
MSTF	Multi - Sectoral Task Force
MTR	Mid Term Review
NACP	National STI and HIV and AIDS Prevention and Control Program
NASP	National AIDS and STD Program
NBA	National Baseline Assessment
NGO	Non-Governmental Organization
NSP	Needle Syringe Programs
OI	Opportunistic Infection
OST	Opioid Substitution Treatment

PNGO	Partner Non-Government Organization
PVLP	Peer Volunteers Lesson Plan
RGB	Royal Government of Bhutan
RSP	Regular Sex Partner
RSRA	Rapid Situations and Response Assessment
SAARC	South Asian Association for Regional Cooperation
SP	Sex Partner
STI	Sexually Transmitted Infection
TOR	Term of Reference
TRCDAD	Treatment and Rehabilitation centre for Drug and Alcohol Dependents
UNODC	United Nations Office on Drug and Crime
VCT	Voluntary Counselling and Testing
YDF	Youth Development Fund

Maldives Acronyms

DDRPS	Department of Drug Prevention and Rehabilitation Services
MSJE	Ministry of Social Justice & Empowerment
NCB	Narcotics Control Board
NISD	National Institute of Social Defence
NNCB	National Narcotics Control Bureau
SHE	Society for Health Education
SWAD	Society for Women Against Drugs

Executive Summary

In March 2010, Phase II of UNODC's H13 Project, *Prevention of transmission of HIV among drug users in SAARC countries 2007-12,* underwent a mid-term Review. The purpose of the Review was to identify whether mid-course corrections in the design and implementation of the project need to be made in light of new data and experience in the initial years of implementation. Two consultants were contracted by UNODC ROSA to conduct the Review, which took place between March 15 and April 5, 2010.

Phase II of H13 consists of four key components:

1. Advocacy to support change in policy and practice;
2. Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDUs and their sexual partners;
3. Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDUs and their regular sexual partners;
4. Project management.

MTR methodology included a desk review of relevant project documents from all six countries, and one-on-one interviews, focus group discussions, and project site visits in Nepal, Bangladesh, Bhutan and Maldives. Interviews were guided by a questionnaire developed by the consultants with inputs from the UNODC H13 Project Team and the WHO South East Asia Regional Office (SEARO), New Delhi. In the cases of Pakistan and Sri Lanka, where no mission was conducted, the Review is based on desk review materials, and in the case of Pakistan—feedback on the draft MTR Report from the H13 Project Officer in Pakistan.

In accordance with directions from the UNODC ROSA H13 Project staff, the Review Report is organised by country and conclusions and recommendations are provided separately for each country, in each country's section. A final Analytical Section, draws the findings together according to the requirements of the consultants' TOR, namely:

1. Review of the progress of project implementation against the project's design and timelines
2. Comment on the extent to which the objectives of the project continue to be consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies
3. Review of the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programmes in each country
4. Identification of strengths and weakness in project implementation and assessment of the extent to which the objectives of the activity are likely to be achieved
5. Recommendations to support mid-term correction of project activities

Achievements

The Review found that the project has made significant progress towards achieving its objectives (four components of the project) and its goal to reduce the spread of HIV among drug-using populations in SAARC countries by assisting governments and communities to scale up comprehensive HIV prevention and care programs for drug users, especially IDUs and their regular sexual partners. The Review found that the project objectives continue to be consistent with beneficiaries' requirements and country needs, as well as with global priorities in the area of HIV/AIDS and with donors policies. The project has been closely associated with key developments in national programming that support harm reduction approaches to HIV prevention among drug users and evidence-based drug treatment in each country. In terms of introducing comprehensive harm reduction programmes in each country, the project has made impressive contributions in each country—both by providing training and by establishing demonstration sites with implementing partners.

The project has focused the bulk of its activities on establishing effective management structures that focus on country-leadership, advocacy, and the establishment of demonstration sites. Country Support Units have been established in Pakistan, Sri Lanka and Nepal, and an alternative support structure has been developed in Bangladesh. In the area of advocacy, Advocacy Strategies have been successfully developed in all countries, along with costed roll-out plans. Access to improved data on drug use and HIV has been developed through RSRAs in Pakistan, Sri Lanka, Bangladesh and Bhutan. Demonstration sites are operational in all countries and the project has provided extensive training opportunities to implementing partners and key stakeholders. Stakeholders are closely involved in planning project activities in all countries.

Key Achievements of the H13 Project Phase II, by country, are as follows:

In **Pakistan**, the Project supports five implementing partners, offering medical treatment, psycho-social counselling, abscess management, referrals, referral to anti-retroviral treatment, and family counselling. The Review found that the project has made sustained efforts at introducing and scaling up harm reduction services for IDU, and noted in particular, the vigour of the Project's advocacy efforts in the area of OST, a Photo Document that was used to raise awareness about project activities among key stakeholders, the completion of a baseline RSRA, and the provision of training to partner NGOs. In 2010, the Government approved the initiation of a pilot study in Pakistan, that will include both methadone and buprenorphine treatment.

In **Sri Lanka**, the Review notes a number of important project achievements including the completion of a midline RSRA; the establishment of nine drop-in centres, and eighteen camps on Low Cost Community Based Services; the translation of three toolkits and pre-testing of the Sinhala translations, as well as translation of the Positive Living flipchart into local language; the catalytic impact of project activities in bringing together the Drug Control Board and the STD/AIDS Control Program; and the establishment of a National Training Centre.

In **Nepal**, the project supports 13 NGOs offering NSP, PLIs and drop-in centres, as well as MMT at two hospital facilities. The Review found that the project has contributed towards high level government support for harm reduction and OST: With project input, the Nepal Drug Control Strategy has been revised to include support for harm reduction and MMT. The MMT program has expanded to reach 262 clients at three sites—two in Kathmandu and one in Pokhara —and government approval has been received to open 7 new sites. A Regional Learning Centre has been established at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu and has trained five medical practitioners in drug treatment and MMT.

In **Bangladesh**, the project supports four implementing partners for projects that provide gender-sensitive services to female IDUs and the female regular sex partners of male IDUs. Partner NGOs offer services at DICs and via outreach and have developed stable referral linkages through a network of related institutes and organizations. The Review found that the project has accomplished important successes, most recently, contributing towards the approval of a pilot MMT program. Two toolkits—those on Methadone substitution and on Buprenorphine substitution—have been translated into Bengali. The project has encountered a number of challenges.

In **Bhutan**, the project is supporting 3 DICs offering services to drug users, and one Rehab Centre; training and capacity building opportunities have been provided to implementing partners. The Review noted important achievements such as the completion and dissemination of the RSRA and its effective use in advocacy; and the inclusion of key elements of the project in national policies, such as the Narcotics Drugs, Psychotropic Substances and Substance Abuse Act, and the National Operational Plan for HIV and AIDS 2010-2011 and its Action Plan.

In the **Maldives**, the project supports three implementing partners and one methadone clinic. The Review noted significant project achievements that include the initiation of a methadone maintenance programme in Male, the drafting of a new Drug Bill—that would distinguish between drug users and drug dealers, project contribution to the National Strategic Plan on HIV/AIDS (2007-2012) which identifies IDUs as a priority, and the effective project strategy of pooling NGO resources by bringing the three partner NGOs together in collaborative endeavours. The project has provided valuable training and capacity building to partner NGOs, has raised partner awareness about drug use, harm reduction and OST, and has worked skilfully within the local context to reach out to vulnerable drug-using populations—using the mechanism of Health Camps.

Findings of Gap Analysis

The review identified the following project challenge areas / gaps, presented below by project component:

Component 1: Advocacy to support change in policy and practice

In some countries—notably Bangladesh and Bhutan, the Advocacy Strategy has yet to be translated into tangible policy outcomes, and in most countries, government endorsement of the Advocacy Strategy into clear targets for IDU service coverage, and on

incorporating key elements of the comprehensive package such as MMT or NSP, or on drug user inclusion, has yet to take place. NGO capacity for community-level advocacy is low in all countries. Work with law enforcement has been extremely limited, and training modules for police and correctional facility staff have not been developed. Adequate institutional support mechanisms for MMT are not in place: The MMT Technical Working Group in Nepal is not functioning and the Methadone Steering Committee in the Maldives has been disbanded. There have been no activities related to the database

Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners

- None of the toolkits have been translated in Nepal, Bhutan or the Maldives; some of the toolkits have been translated in Pakistan, Sri Lanka, and Bangladesh. There is also limited evidence to suggest that toolkits have been disseminated beyond the H13 partners.
- Partner NGO understanding and support for MMT is particularly low. Most believe that the goal of methadone treatment is to draw down the methadone dose rapidly and become "clean."
- No new guidelines or toolkits on key areas identified in Project Phase II activities and recommended in the Phase I Review have been developed (ARV, managing overdose, drug interactions etc).
- Staff turnover at implementing partners (NGOs as well as government) remains a challenge in all the countries, and was primarily attributed to low salaries.
- Some of the most experienced and effective implementing partners have scaled down their services under Phase II.
- A number of partner NGOs in Nepal, as well as the implementing partner NGOs in Bhutan and Maldives are essentially abstinence-oriented.
- Referrals between DICs/harm reduction services and HIV-related services, such as VCT and ART, remain challenging and limited in all countries.
- NSP is not widely offered under H13 Phase II.
- Gender-sensitive services for women drug users and spouses of male drug users are limited in some countries.
- There are prohibitive restrictions on access to MMT at some sites, and MMT coverage remains very low in all countries. There were only 16 clients on methadone at the clinic in Male, Maldives. The target for clients on methadone in the Kathmandu Valley was set at 250, although there are an estimated 4,000 IDU in that region.
- There is no uniform understanding among implementing partners about what constitutes a "regular" client. This makes it impossible to accurately ascertain NGO access to clients and measure service coverage.
- Little progress has been made to support sustainability of Project activities by facilitating linkages of the NGOs with the national resources

Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners

Implementation of the costed roll-out plans has not been completed, scale up is proceeding slowly and targets for clients accessing OST, remain too low to have significant impact.

Component 4: Project management

Involvement of the Ministries of Health / AIDS Control programmes is eclipsed by that of the Ministry of Home Affairs / Drug Control programmes. In some countries, such as the Maldives, frequent changes in institutional arrangements within drug and HIV departments, accompanied by equally frequent changes in personnel and focal points have posed challenges for project management.

Summary of Recommendations

Recommendations for Component I: Advocacy to support change in policy and practice

- Support countries to translate Advocacy Strategies into National policies and plans
- Support NGOs to conduct grass-roots level advocacy for harm reduction approaches to preventing HIV among drug using populations
- Develop guidelines (or use/adapt existing guidelines) and/or training modules for police sensitization
- Support the development of institutional mechanisms and policies that support evidence-based drug treatment
- The utility and feasibility of the regional database should be re-assessed

Recommendations for Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners

- Continue and expand trainings and disseminate training materials to non-H13 partners
- Staff salaries should be increased to competitive levels
- Support coverage and sustainability at high-performing implementing partners
- Implementing partners that are abstinence-oriented do not support the project's stated goals and should be phased out of the project
- Build implementing partners' capacity to offer HIV related services—notably VCT and ART—on-site or via referral
- NSP through H13 should be scaled up in countries where it is offered (Nepal and Pakistan), and introduced where it is not (Bangladesh)

- Strengthen gender-sensitive service provision for female I/DU and the female spouses of male IDU
- The Project should support MMT, *not* predominantly methadone detoxification
- The M&E system should be examined to ensure that reporting from partner NGOs is streamlined in order to accurately measure coverage
- The project should support NGOs to develop sustainability strategies

Recommendations for Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners

The project should continue to support governments to roll-out implementation of harm reduction and drug treatment plans. The project should continue to provide TA support for increased procurement of methadone to support scale-up.

Recommendations for Component 4: Project management

Both the Ministries of Health and Drug Agencies (Ministries of Home Affairs) should be *equally* involved in Project management. Management and coordination arrangements require strengthening in the Maldives to address institutional and personnel changes.

Introduction

In March 2010, Phase II of UNODC's H13 Project, *Prevention of transmission of HIV among drug users in SAARC countries 2007-12,* underwent a mid-term Review. The purpose of the Review was to identify whether mid-course corrections in the design and implementation of the project need to be made in light of new data and experience in the initial years of implementation. Two consultants were contracted to conduct the Review, which took place between March 15 and April 5, 2010.

Phase II of UNODC's H13 Project, *Prevention of transmission of HIV among drug users in SAARC countries 2007-12*, is funded by AusAID, and aims to reduce the spread of HIV among drug-using populations in SAARC countries by assisting governments and communities to scale up comprehensive HIV prevention and care programs for drug users, especially IDUs and their regular sexual partners. Based on the UNAIDS Prevention Strategy, the project contains the following elements:[1]

1. A supportive policy and an enabling program environment;
2. Involvement of drug user communities in program development, design, implementation, monitoring and evaluation so as to address their felt needs;
3. Outreach, including peer education, access to condoms and primary health care (including treatment for sexually transmitted infections);
4. Access to sterile needle and syringe programmes;
5. Drug substitution treatment and
6. Strengthening prevention to care continuum, including Voluntary Counselling and Testing and access to antiretroviral therapy.

Phase II was formally launched on August 21st 2007 during the 8th International Congress on AIDS in Asia and Pacific in Sri Lanka. It works in five countries: Bangladesh, Bhutan, Nepal, Maldives, Pakistan and Sri Lanka. (An India component of the project is funded separately by DFID).

H13 Phase I

Phase II of H13 builds on the activities and components of Phase I and Extended Phase I of the project (2003-2007) in which regional and national coordination mechanisms were established, national focal points and Mentor Agencies were identified, six standardised training modules were developed, and a series of trainings was run for outreach teams working with IDU and their sexual partners. Phase I set up demonstration sites and

[1] The current UNAIDS/UNODC comprehensive package consists of the following nine interventions: (1) NSP, (2) OST, (3) VCT, (4) ART, (5) STI, (6) condom promotion, (7) IEC, (8) diagnosis, vaccination and treatment of Hep B&C, (9) TB prevention, diagnosis and treatment.

training centres in participating countries designed to build capacity and demonstrate the components necessary for a comprehensive HIV prevention program among drug users. Under Phase I, Rapid Situation and Response Assessments (RSRAs) were also carried out in Bangladesh, Bhutan, India, Nepal and Sri Lanka focusing on IDU and their sexual partners.

Review of H13 Phase I

A Review of Phase I was carried out in March and April 2006. The H13 Project Document Phase II indicates two key learnings from the review process: the need for joint involvement from drug and HIV sectors of government, and the importance of having country-led processes and national work plans in order to develop comprehensive interventions that can effectively reach drug users and their sexual partners.

At a regional meeting following the review, it was decided to build on these lessons by focusing on advocacy and the provision of regional mechanisms aimed at supporting scaled-up responses led by the governments and communities of member countries.

An examination of the Phase I Review document indicates that the Review also provided a number of other pertinent recommendations and important insights. These are as follows. (The below are direct quotations from the Phase I Review):

1. Phase II of project H13 must focus on HIV/AIDS prevention and not on drug use prevention per se. (p 5)

2. 'Scaling up' responses in phase II should focus on increasing technical capacity on a national and local level and on developing the whole network of required services in demonstration sites. Scaling up should *not* mean an increase in the number of demonstration sites but will require a certain re-distribution to allow for equity between countries, and a discontinuation of active work in some unsuitable sites or with unsuitable partners. (p 5)

3. Support to partner NGOs who are engaged and committed to abstinence-based approaches only and who are unwilling to support a risk reduction / harm minimization approach should be phased out. (p 6)

4. Intervention tool kits could be expanded to meet the needs of demonstration sites (e.g. counselling, prevention of switching to injecting drug use). Existing tool kits to be translated to local languages as required. (p 6) And: The need for further tool kits to be used in Phase II was identified – (e.g. on techniques and methodologies to prevent switching from oral drug use to injection drug use, counselling, medical management of consequences of unsafe practices, negotiation for safe practices). (p 20)

5. There was real concern at the field level regarding the low pay for outreach workers and other project personnel. In some sites this has caused a large turnover of staff. In one demonstration site, all field staff had resigned prior to the consultant's visit and were only

persuaded to stay when promises about a review of salaries was made. (p 17)

6. Needle and syringe programmes which had been initially envisaged by H13 were dropped due to directives from UNODC headquarters. (p 20)

These insights and recommendations were considered in the course of the Phase II mid-term Review.

Phase II components

Phase II of H13 consists of four key components:

1. Advocacy to support change in policy and practice;
2. Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners;
3. Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners;
4. Project management.

In recognition of the heterogeneity of the HIV epidemic, drug using populations and national responses in the region, the project works in each country based on country-specific considerations. To that end, the project works in four countries—Bangladesh, Nepal, Pakistan and India (India not reviewed here as it is not AusAID funded) by offering a comprehensive package of assistance, and in three—Bhutan, Maldives and Sri Lanka, to support strengthening their response.

Phase II Key Outputs by Component

Component	**Outputs**
Component 1: Advocacy to support change in policy and practice	1.1 Regional and national advocacy strategies for promoting evidence-based HIV prevention among drug using populations developed or strengthened 1.2 Improved access to quality information on the status and impacts of the HIV epidemic
Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially	2.1 Intervention toolkits developed by Project H13 in Phase I are widely disseminated and countries in the region adopt them in the local languages, and

IDU and their sexual partners	additional resources developed as required 2.2 NGOs from Phase I and new NGOs supported to provide and demonstrate quality services to-drug using populations 2.3 Demonstration sites demonstrate the "comprehensive community based approach" leading to adoption of safer practices by clients 2.4 National/Regional Learning Centres established 2.5 Strength technical capacity of the respective Governments and Non-Governmental Organisations for rigorous Monitoring and Evaluation 2.6 Transition Plan and Exit Strategy for Partner NGOs
Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners	3.1 Costed "roll-out" plans on essential IDU interventions, phased operational targets, clear geographic and group priorities, human resource and management, procurement, M&E and QA/QC 3.2 Secure commodity supply for scaled-up risk reduction programs
Component 4: Project management	4.1 Project activities are planned with stakeholders 4.2 Management and coordination arrangements for implementing the project at the regional and national level are in place 4.3 Project reports developed and submitted in a timely manner 4.4 Monitoring and Evaluation

Methodology

Review methodology included a desk review of relevant project documents from all six countries, and one-on-one interviews, focus group discussions, and project site visits to Nepal, Bangladesh, Bhutan and Maldives. Interviews were guided by a questionnaire developed by the consultants with inputs from the UNODC Project Team and WHO SEARO in New Delhi. The Review began with two-day meeting on March 15 and 16, 2010, at the UNODC ROSA Offices in Delhi, in which the Project Team briefed the consultants on the project. The consultants worked together to develop the research instrument and received comments and feedback in the course of that meeting. The questionnaire was used to guide the interview process. The mission to Nepal was undertaken from March 17-23 and included interviews in both Kathmandu and Pokhara. Both consultants worked together to conduct the interviews in Nepal, supported by the Nepal Project staff as well as staff from the UNODC ROSA Office. Review Team member Dr. RP Shreshta undertook a mission to Bangladesh on March 24 and 25, and a mission to Bhutan on March 31 and April 1. Review Team Leader Dr. Katya Burns undertook a mission to the Maldives from March 24-27. All missions were supported by Project staff in each country. Additionally, UNODC ROSA Project Staff accompanied Dr. Shreshta to Bangladesh, and UNODC ROSA Project Staff accompanied Dr. Burns on her mission to the Maldives. The consultants met in Delhi on April 5 to de-brief from the missions with UNODC ROSA Project staff and WHO.

Constraints on the Review

Field visits were conducted in four out of the six countries. Two countries were not visited: Pakistan and Sri Lanka. For this reason, analysis and recommendations for Pakistan and Sri Lanka are based on desk review only.

Due to scheduling challenges, it was not possible to conduct some interviews. In Nepal, it was not possible to arrange meetings at the Ministry of Health's HIV/AIDS Programme.

Review conclusions and recommendations are based on desk review and interviews with key informants; in countries with larger programs, it was not feasible to conduct one-on-one interviews with all the partners. In Nepal, the consultants thus conducted a focus group discussion with 12 of the 13 NGO partners, and held one-on-one interviews with three of them. The Review Team was able to visit two of the three methadone sites in Nepal.

Structure of the Report

The Report is structured according to country. For each country, findings are presented according to project component. The first section covers the desk review of materials on Pakistan and Sri Lanka. The second section is on Nepal, third on Bangladesh, fourth on Bhutan, and fifth on Maldives. Country-specific recommendations are incorporated into each country's section. A sixth section provides comments on inter-agency and intra-agency coordination related to the project. A final seventh section analyses the MTR country findings in the overall context of project progress; specifically, it:

1. Reviews the progress of project implementation against the project's design and timelines.

2. Comments on the extent to which the objectives of the project continue to be consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors policies.
3. Reviews the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programme in each country
4. Identifies strengths and weakness in project implementation and assesses the extent to which the objectives of the activity are likely to be achieved.
5. Provides recommendations to support mid-term correction of project activities.

1.1 Pakistan desk review[2]

1.1.0 Background

There are an estimated 628,000 opioid users in Pakistan of whom 125,000 are Injecting drug users. Injecting drug use is the most significant HIV transmission route in the country: 1,958 out of 5,237 reported HIV cases, or approximately 37.4 percent, are among IDU. Overall seroprevalence among IDU stands at 21 percent.

Pakistan has well-established harm reduction services in a number of cities, with an estimated service coverage for IDU of 20 percent for the country, and is scaling up harm reduction under Global Fund Round 9. Opioid Substitution Therapy, however, remains unavailable in the country.

Under H13 Phase II, Pakistan is working with four implementing partners: Aagosh in Quetta, Marie Adelaide House of Hope in Karachi, Ghazi Social Welfare Association in Larkana. And Mian Afzal Memorial Hospital in Gujranwala. The implementing agencies were selected in 2008. A new implementing partner was added in May 2010: Islamabad Christians Against Narcotics (ICAN), is establishing a DIC in District Sahiwal, Punjab. The Mentor Agency for the Project is the Anti Narcotics Force (ANF).

1.1.1 Achievements

1.1.1.1 Advocacy

Advocacy is a central component of the Project in Pakistan. The **Advocacy Strategy for Pakistan has been developed** and focuses on the following areas:

1. Increase outreach to and services for the spouses and families of IDUs;
2. Improve coverage and quality of services for IDU;
3. Facilitate an enabling environment by addressing discrimination and stigma surrounding HIV and drug use;
4. Sensitize law enforcement agencies by supporting cooperation between law enforcement and implementing partners;
5. Advocate for OST.

The Advocacy Strategy was shared at two regional meetings held in Nepal and New Delhi. A consultative meeting with key stakeholders was also held to reach consensus on the Advocacy Strategy and the draft Strategy was shared in order to reach agreement on advocacy issues, approaches and partnerships. In 2010, the advocacy strategy was presented to the UN Joint Team on HIV/AIDS. The resultant recommendation was to present it to the relevant Government stakeholders for ownership.

In 2008, the Project also completed a **baseline RSRA**, with the goal of providing stakeholders improved access to quality information on the status and impacts of the HIV

[2] Desk review is based on H13 Phase Project Document, Annual H13 Project Reports, the National Advocacy Strategy, and Power Point Presentation made by the Project.

epidemic, its relationship to injecting drug use, the effect on IDUs' regular sexual partners and the level of awareness about HIV/AIDS. The 4 partner NGOs undertook the data collection and entry, after receiving training on RSRA from the project.

The Project has also undertaken active advocacy via study tours: Several **study tours were organized in 2008 to familiarize and brief Pakistani delegations on OST**. The first tour was to OST Centres in Tashkent in May 2008. Following this, an advocacy and sensitization tour was organized to India between 22-24 July 2008 for a high level delegation including the Secretary, Ministry of Narcotics Control (MNC), representatives from Anti Narcotics Force, National AIDS Control Programme (NACP), Civil Society Partners, WHO and UNAIDS. The study tour involved extensive discussion on the procurement and implementation of OST with the project and AIIMS during a one-day workshop, and also included field visits to OST with Buprenorphine sites in the community and institutional settings. In November 2008, key stakeholders also visited the Iranian National Centre for Substance Abuse in Tehran.

The **study tours concluded with a plan of action for initiating OST in Pakistan** developed by the delegates. Following the tours, UNODC Pakistan submitted a proposal to initiate a 'Pilot Study on OST in Pakistan' to the Ministry of Narcotics Control, who further shared the proposal with relevant stakeholders for their comments. Also, in November 2008, a presentation was given to the ANF to brief them on plan for a pilot OST in Pakistan. In 2009, a **National Consultation on OST** was held in Pakistan to bring together government officials from the Ministry of Narcotics Control, Anti Narcotics Force, Federal and Provincial Ministry of Health, Ministry of Commerce, National and Provincial HIV/AIDS Control Programme, Professors of Psychiatry from various medical colleges, and NGOs involved in providing services to injecting and non-injecting drug users. Iranian delegates from the Iranian National Centre for Addiction Sciences (INCAS) were invited to share their experiences implementing OST in their country. The Consultation was designed to reach a consensus on initiating a pilot OST in Pakistan. A one-page brief on the pilot OST programme has been submitted to the Prime Minister. In 2010, the Government approved the initiation of a pilot study in Pakistan, that will include both methadone and buprenorphine treatment. A technical committee on OST has been formed and the first meeting was held in 11th January 2010. The SOPs and practical guidelines have been drafted and are to be shared at the 2nd meeting , tentatively scheduled for June 2010.

The Project also initiated an innovative 'Photo Document' project in November 2008, to be used for advocacy purposes. The Photo Document highlighted Project-supported service delivery at the drop-in-centres and family involvement in the rehabilitation process. In 2009, the photo documentation highlighting the project goals, activities and achievements was disseminated to all relevant stakeholders in Pakistan.

In 2010, a qualitative study entitled *The social and economic impact of drug use on families: a qualitative insight on the spouses of DUs/IDUs in Quetta, Karachi, Larkana and Gujranwala*, was completed. The report will be printed in hard copy and officially launched in June 2010.

Other advocacy efforts included walks, seminars and essay writing competitions carried out at Project sites on International Drugs Day, and radio shows hosted on a local FM station to raise awareness and sensitize the public on the occasion of World AIDS Day 2009.

1.1.1.2 Effective Harm Reduction

Training

Training is an important component of the Project in Pakistan. In 2008, trainings were held for the four implementing partners on conducting a Rapid Situation and Response Assessment, and on Positive Living. In 2009, NGO staff were trained on communication and motivation as well as on the importance of sexual and reproductive health rights. A three day training was organized in 2009 for UNODC project staff in Pakistan on the 'Basics of epidemiology' to support HIV professional staff to develop a practical approach for identification of challenges in field research issues. NGO staff also received training on 'Gender responsive harm reduction services' in October 2009. In 2010, the Positive Living visual aid and pamphlet were translated into Urdu, and a dissemination ceremony was organized on 5th May 2010. A refresher training on positive living was organized for NGO staff from 3-5 May, 2010. It was organized under the One UN initiative (UNAIDS, UNFPA, UNICEF).

The Project also supported learning and capacity building via attendance at international conferences. In 2008, the Project facilitated a female outreach worker from the partner agency in Quetta, to attend 'Response Beyond Borders' held in Nepal. A female outreach worker from Karachi was sponsored by the project to attend the IHRA's 20th International Conference on 'Harm Reduction and Human Rights', held in Bangkok in 2009.

Harm Reduction Services

Drop-in-Centres were established under the project, with services targeting drug users, specifically injecting drug users as well as their regular sex partners. The DICs also place a strong emphasis on family involvement during rehabilitation. Services provided include medical treatment, psycho-social counselling (safer practices, behaviour change), abscess management, referrals, referral to anti-retroviral treatment, and family counselling. Most of the NGOs funded do not provide NSP; only Marie Adelaide in Karachi is distributing clean needles/syringes. In 2010, the Project reported reaching 7,631 IDU clients and 495 regular sexual partners of male IDU with harm reduction services.

National Learning Centre

Jinnah Post Graduate Medical College (JPMC) in Karachi was designated the National Learning Centre in 2008.

1.1.1.3 Scale-up of Harm Reduction

Project efforts to scale up harm reduction in Pakistan have predominantly focused on advocacy. The project has also addressed the important issue of procurement necessary for introducing and scaling up OST. In 2008, the Project held meetings with the Ministry of Health to brief health officials on OST and its procurement processes. The decision about whether future scale-up would include methadone or buprenorphine is pending, dependent on the outcome of the pilot.

1.1.1.4 Project Management

In Pakistan, the H13 Project receives overall guidance from a Project Management Committee (PMC) and a Country Support Unit (CSU) was established in Islamabad. The Project Officer for the Country Support Unit was recruited in 2007 and joined the Project in January 2008. In 2008, the Country Support Unit became fully operational. The CSU in Pakistan includes a National Project Officer and Project Assistant and is managing project activities in Pakistan.

In 2008, a National Project Steering Committee meeting was held to review the status of the project and to discuss future implementation activities.

Quarterly progress reports are submitted regularly. In 2010, an interactive, web-based reporting system was initiated.

1.1.2 Challenges

The Project has made impressive and sustained efforts to support evidence-based harm reduction service delivery and in particular to generate stakeholder support for OST in a challenging environment. Other challenges include restrictions on movement due to security issues, that impact outreach and monitoring activities.

1.1.3 Conclusions and Recommendations

The H1 Project in Pakistan has made impressive efforts at introducing and scaling up harm reduction services for IDU. In particular, the MTR notes the vigour of the Project's advocacy efforts in the area of OST, the innovative Photo Document approach, the completion of the RSRA, and the provision of training to partner NGOs as Project successes.

Based on the desk review of Project documents from Pakistan, the MTR Team recommends continued and sustained advocacy on OST to support implementation of the pilot and scale-up.

Project documents from Pakistan indicate a number of areas in which the project intends to grow. These include:

1. Research: Assessments, surveys and in-depth research should be undertaken for more effective targeting.

2. Expansion: Project documents note the possibility of adding new implementing partners, establishing more Drop in Centres and/or expanding existing facilities to include services for the spouses of Drug Users/Injecting Drug Users

3. Capacity Building: More trainings should be planned for the outreach staff.

1.2 Sri Lanka desk review

1.2.0 Background

There are an estimated 45,000 heroin users in Sri Lanka, and injecting drug use is considered to represent about 1 percent of drug users. Sri Lanka has a low-prevalence of HIV infection, with only 0.1 percent of the population infected, or approximately 5,000 PLWHA. Risk factors in Sri Lanka include a growing sex industry, a highly mobile population, multiple sex partners, low condom use and growing number of STIs.

In 2006, the National HIV/AIDS Strategic Plan identified insufficient attention to drug use as a major gap in the country's HIV/AIDS interventions, and noted that while injection is not a common method of drug consumption in Sri Lanka, other countries in the region are experiencing growing numbers of IDU, and efforts in Sri Lanka should focus on addressing the transition from smoking or chasing, to injecting.

The National Advocacy Strategy for Sri Lanka focuses on this issue and the key elements of the endorsed costed work plan include support to eight partner agencies for Peer-Led Interventions (PLI). The project has also established a partnership with 'Lanka Plus' to address positive living issues. The National Dangerous Drug Control Board (NDDCB) has been identified as the National Training Centre. The H13 Mentor Agency in Sri Lanka was identified in 2008 and is the Sri Lanka Federation of NGOs Against Drug Abuse (SLFONGOADA).

1.2.1 Achievements

1.2.1.1 Advocacy

The *National Advocacy Strategy of Sri Lanka* focuses on preventing the transition to injecting and emphasizes the need for OST to prevent drug users from switching to injection. The Advocacy Strategy has two main goals:

1. Treatment and rehabilitation centres that are providing guaranteed services to clients. The Strategy notes that treatment and rehabilitation centres run by individuals, religious and other drug prevention organisations follow methods that are not evidence-based, do not follow minimum standards and lack essential services such as VCT and aftercare.
2. Drug users should be treated in a way that supports them to "get out of the habit" and prevents them from shifting to more harmful methods of taking drugs. The Strategy notes that drug users are "treated as if they are ordinary criminals" by law enforcement officers and specific interventions to treat drug users are not available; it aims to work with law enforcement to create an enabling environment.

In 2009, the *National Advocacy Strategy* was presented to the UN Joint Team on AIDS (UNJTA) and plans were made to include it in the UNJTA 2010 workplan.

The H13 Phase II Project has supported advocacy via a **midline RSRA designed to provide accurate information to stakeholders**. The key findings of that report were shared with project stakeholders in 2008 during an M&E workshop in Colombo. The data collection and entry was done by all the eight partner agencies and the analysis and report writing, by a local expert. The RSRA team was trained by the Project. The Regional Report on RSRA was presented to the Hon. Prime Minister and to the Ministry of Health Care and Nutrition on the International Day against Drug Abuse and Illicit Trafficking 2008.

The Project has also pursued advocacy via study tours. A sensitization tour for the Chairman and Director of National Dangerous Drug Control Board to Delhi was organised on 3-4 August 2008. It involved field-site visits and discussions on how to initiate more effective rehabilitation and treatment services in Sri Lanka. An important outcome of the study tour was the **establishment of nine DICs in Sri Lanka**. In addition, with support from the National Focal Point, **18 camps on Low Cost Community Based Services** (LCCS) were held across different project sites. The exercise also strengthened the Project's relationship with the NDDCB, which took ownership for the Project and agreed to act as the Mentor Agency; in this capacity, NDDCB began regularly reviewing the progress and supporting the training needs of H13 partners. The Project also subsequently organised a study tour to Chennai and included both the focal point from NDDCB and the Director of National STD/AIDS Control Program (NSACP). In this way, the **Project played a catalytic role in bringing the two ministries together**. A 'Video documentation,' capturing the initiation and scale-up of project activities in Sri Lanka, was developed and shared among stakeholders.

1.2.1.2 Effective Harm Reduction

Training

In 2008, translation began of all modules in the H13 intervention toolkit except Module 4 and 5 (Buprenorphine and Methadone substitution) into Sinhala and Tamil; NDDCB took responsibility for **formal release of the translated modules. Pre-testing of the Sinhala translation of 3 intervention tool kits**—Peer-Led Community Outreach, RSRA and low cost community based services (Health Camps) took place in 2009 under the leadership of the National Drugs Control Board, which is the National Training Centre for the project in Sri Lanka. In 2010, the Positive Living Flip Chart was translated and printed in the local language.

A number of trainings took place in 2008, including a training on RSRA and Outreach, on Positive Living with a focus on women, and on LCCS. In total 4 national trainings with 50 people trained and 30 NGO level trainings with 80 people trained took place.

In addition to these trainings, in 2009, government officers working for drug use prevention, under the President's Secretariat in Sri Lanka, requested UNODC to train their officers on counselling skills.

Harm Reduction Services

Project partner agencies in Sri Lanka organised a series of two LCCS programmes across eight distinct locations between August and September 2008 and October and November 2008. These were successful at mobilizing the community and reached a total of 597 drug users. The camps attracted participation from key stakeholders including police, corporates, NGOs/CBOs, government agencies (Health, Youth, Education & Employment) and local community leaders. In 2009, LCCS camps were organized across eight distinct locations and reached a total of 1,195 drug users.

In 2008-2009, the Project reached 3,223 drug users (36 IDUs identified) via outreach and 1559 regular sexual partners.

In addition to providing LCCS, the Project explored new areas of support for drug users: A meeting was organized with the Director of the National Apprentice and Industrial Training Authority (NAITA) in 2009 to explore avenues for vocational training and job placement for drug users. Project partners Lanka Plus and SLFONGOADA also expanded on the gender dimension of the Project by facilitating more than fifty female regular sex partners of male drug users from all the project demonstration-sites to come together to commemorate International Women's Day in 2009. The women requested more female-friendly programmes at demonstration sites.

National Training Centre

National Drugs Control Board is the National Training Centre and in 2009 it pre-tested the Sinhala translation of 3 intervention tool kits—Peer-Led Community Outreach, RSRA and low cost community based services.

1.2.1.3 Scale-up of Harm Reduction

A costed one-year workplan based on the Advocacy Strategy has been developed.

1.2.1.4 Project Management

Project documents indicate active and effective Project management geared to overseeing and providing support to implementing partners in Sri Lanka. At the beginning of H13 Phase II, the Mentor Agency organised an orientation meeting, and set up monthly meetings to discuss progress as well as capacity-building workshops to support NGOs to share their experiences. In 2008, the Mentor Agency and the National UNV also began carrying out monthly site visits. In addition, the National Focal Point began organising monthly review meetings of all partner NGOs; around four such meetings took place in 2008. The National Steering Committee organised a meeting to review partners' progress, and designated counsellors to assist the LCCS camps. The National STD/AIDS Control Program also supported the Project by providing HIV screening through provincial health authorities, as well as IEC materials, condoms and dildos for partners' outreach activities. Drug users who obtain services from the NSACP are referred to DICs and NSACP planned a mobile clinic for drug users. Lanka Plus also contributed to the Project by providing community sensitization programmes at implementation sites.

In 2008 the Project convened of an M&E workshop (20-21 November 2008), which included a reflection exercise designed to captured the progress of the project in-country. The reflection exercise facilitated stakeholder cooperation and effective Project management by enabling discussion among project partners and stakeholders from the government, UN and mentor agencies, civil society partners, technical experts and collaborating networks; this served to support national ownership and greater collaboration and networking among agencies.

1.2.2 Challenges

Project documentation indicates few Project challenges. Challenges reflected in the Project documents include difficulty retaining staff, poor knowledge among law enforcement officers, and difficulties mobilizing the regular sexual partners of male IDU.

1.2.3 Conclusions and Recommendations

The H13 Project Phase II has produced notable achievements in Sri Lanka. These include the completion of a midline RSRA, the establishment of nine drop-in centres, and eighteen camps on Low Cost Community Based Services. The Project has worked effectively with both the Drug Control Board and the STD/AIDS Control Program and has brought these two agencies together in productive and cooperative ways. Both provide leadership and oversight to the Project.

Three toolkits have been translated into a local language and pre-testing of the Sinhala translations is complete. The Project has undertaken a number of trainings and capacity building exercises in close cooperation with Project partners.

A National Training Centre has been identified and has been working to support Project activities.

Based on the challenges indicated in project documents, namely difficulty retaining staff, poor knowledge among law enforcement officers, and difficulties mobilizing the regular sexual partners of male IDU, the Review Team recommends the following:

1. Identify reasons for high staff turnover and develop a staff retention strategy;
2. Include representatives from law enforcement in project activities such as the LCCSs, and provide seminars to raise awareness among police officers. (The experience the Siddhi Memorial Foundations DIC in Nepal working with law enforcement may be helpful in this regard).
3. Offer services at Project DICs specifically geared to regular sexual partners of drug users, and organise a support group for sexual partners.

2. Nepal

2.0 Background[3]

There are an estimated 46,309 drug users in Nepal of whom 61.4 percent, or 28,439, are injecting drug users (data for 2007). In 2008, HIV prevalence among IDU was estimated at around 23 percent, a significant drop from 2003 when prevalence among IDU stood at 51 percent. According to the Nepal Advocacy Strategy document, in 2007, IDU accounted for 20 percent of reported HIV cases in Nepal,[4] however, nearly 40 percent of cases are classified as "labour migrants" and over 20 percent as "rural female" and it is not clear whether or not these categories overlap with IDU or spouses of IDU. For this reason, it is possible that IDU may be linked to more than 20 percent of HIV infections in Nepal.

Nepal was one of the first developing countries to initiate harm reduction programmes, establishing its first programme in 1991. HIV service coverage for IDU remains challenging, however, with about 25.4 percent of IDU ever reached by national prevention programmes, and reviews of harm reduction projects indicate that less than 50 percent of IDUs are in regular contact with a drop-in centre or outreach workers.

Nepal's National HIV/AIDS Strategy 2006-2011 articulates the need for harm reduction services targeting IDU, and Nepal has recently revised its National Drug Control Strategy to support harm reduction, along side demand reduction and supply reduction.

In 2007, Nepal formally endorsed Phase II of H13. The Drug Control Program (DCP) at the Ministry of Home Affairs is the Mentor Agency and the project has formal partnerships with 13 NGOs—six of which are peer-led interventions (PLI), as well as with two hospitals, where MMT is offered.

The project supports a range of activities and interventions including needle and syringe programmes, condom provision and promotion, opioid substitution therapy, development of referral networks for IDU, referral for VCT and ARV, STI diagnosis and treatment, awareness raising activities, abscess management, and psycho-social support services for drug users and their regular sexual partners such as counselling, support group services such as NA/AA and linkages for vocational rehabilitation.

2.1 Achievements

2.11 Advocacy

Advocacy to support change in policy and practice in Nepal has been a strong and enduring component of H13 Phase II, and has effectively focused on national ownership.

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[3] This section is based on information provided in the *H13 Phase II Project Document*, the *Nepal National Advocacy Strategy to Prevent HIV Transmission among IDU/DUs 2009-2012,* and *Project Annual Reports 2007, 2008 and 2009.*

[4] According to WHO, in 2007, an estimated 6,557 people who inject drugs in Nepal were living with HIV or AIDS, and IDU accounted for 10 percent of the total AIDS cases.

From the beginning, country-level project workplans were developed in line with national strategic plans, a practice that increased the likelihood of absorption under national programmes. This approach has yielded tangible results. Most notable among these are:

1. The **endorsement by the government** of the *Nepal National Advocacy Strategy to Prevent HIV Transmission among IDU/DUs 2009-2012*. The Strategy identifies six key issue areas for advocacy: ambiguous laws related to narcotic drugs, discriminatory practices of service providers and society, strengthen high level leadership and political commitment, women IDUs and human rights, no long term funding and sustainability, and social integration of drug users.

2. The **expansion of methadone sites** from a single initial site in Panipokhari (175 current clients), to two more sites in Lalitpur (25 current clients) and in Pokhara (62 current clients, 100 slots for clients), and the expansion of clients accessing methadone to a **current high of 262 clients**. Approval from the government for establishment of **seven more methadone** sites in Nepal was received in March 2010.

3. **Revision of the Nepal Drug Control Strategy** to include support for harm reduction along side demand reduction (MMT) and supply reduction, and support for collaborate relationships with NGOs. (Source: National Focal Point Shankar Prasad Koirala, Ministry of Home Affairs. The new Strategy is not yet available in English and the document itself was not reviewed by the MTR team).

In the course of the Review Team's mission, it was clear that the project has effectively cultivated high level government support for harm reduction and OST in Nepal. In the Review Team's meeting with the project focal point at the Drug Control Program of the Ministry of Home Affairs, the team noted that the focal point is very well informed about the project and about harm reduction and OST, that he is highly supportive of policy change that supports scaled up harm reduction and OST services for drug users, and that he was instrumental in bringing about critical policy changes in Nepal's Drug Control Strategy that support harm reduction and rights-based approaches.

These achievements are the result of an impressive advocacy effort on the part of the project and its partners. In the first two and a half years of Phase II, the project focused on incorporating harm reduction interventions, especially OST and NSP and gender-friendly services, into national strategies, and maintained an active dialogue to move the **National Advocacy Strategy** ahead to the national government’s executive committee in progress in Nepal.

Support for and scaling-up of OST has been an important focus of the project. The project led the effort for scaling up harm reduction activities, especially needle and syringe programmes and OST, in the National Action Plan 2008-2012 (NAP), and provided representation and technical assistance in drafting the NAP, especially in the areas of IDU and prison. In addition, the project provided technical assistance in the formation and operationalization of the extended Technical Working Group on OST that guides OST programming in Nepal. In 2009, the project provided catalytic support on the inclusion of harm reduction, including OST, in the National Action Plan on HIV/AIDS

2008-2011. The **extension and plans for further extension of OST** in Nepal are directly related to these project activities.

The project played an equally vital role in supporting critical changes to Nepal's Drug Control Strategy. In 2008, the project provided technical assistance in drafting the National Strategy on Harm and Demand Reduction. In 2009, the project provided both financial and technical support to the Drug Control Program at the Ministry of Home Affairs in developing the Drug Control Strategy for the country, and provided technical support to the National Technical Working group on Harm Reduction established under the Ministry of Home Affairs, that provides a forum to discuss the issues and challenges in this sector. The project worked actively to support incorporation of the elements of harm reduction in the Drug Control Strategy. The Strategy was presented to the cabinet for endorsement in 2009, and in March 2010, the **new Drug Control Strategy was endorsed**.

In addition to these efforts, the project also provided technical support on six indicators on IDUs which were included in the Development of Health Sector Report 2008.

2.12 Effective Harm Reduction

Training and Toolkits

The program has provided a number of trainings in Nepal under Phase II. In 2008 trainings were provided on PLI, Outreach, NSP (28-30 April, 2008) and Positive Living with a focus on women, 'Treatment of Positive IDUs;' in total 3 national trainings provided training to 84 people and 46 NGO level trainings provided training to 100 people. In 2008, an international Training of Trainers on the 'Care and Treatment of HIV Positive IDUs,' a collaborative effort among WHO, UNODC and FHI was held (Sep 15-18, 2008) and the project supported 24 participants to attend. In 2009, a three day training was provided on the technical, medical and social guidelines for starting MMT to facilitate a fully operational MMT Clinic at the Western Regional Hospital, Pokhara.

Partner NGOs visited by the Review Team had receiving trainings from the program and reported that the trainings were useful and relevant to their work. Staff from the Lifesaving and Lifegiving Society, for example, reported having attending project trainings in NSP and Positive Living, as well as a TOT, and that the director of Tribhuvan University Teaching Hospital (TUTH)—a project partner and the National Learning Centre under H13, had provided them with a workshop on MMT. Staff from the Siddhi Memorial Foundation reported taking part in a training on M&E organised by the project.

Harm Reduction Services

The project supports 13 NGOs offering a comprehensive package of harm reduction services including needle and syringe programmes, peer led interventions and drop-in centres, as well as Methadone Maintenance Treatment at two hospital facilities. In 2009, needle and syringe programmes were effectively incorporated as part of the

comprehensive package approach established in priority settings and scaled up to all project sites in Nepal.

The Review Team held a meeting with partner NGOs at which NGOs reported on their projects. The salient elements of those reports are summarised in the table below:

Nepal Partner NGO Reports

Partner NGO	**Coverage**	**Services reported**	**Self-reported Achievements**
Association for Helping the Helpless	Data not available	Data not available	Data not available
Kirat Yakthung Chumlung Punarjiwan Kendra (KYC)	1,347 total	Goal: To reduce HIV and AIDS among Injecting Drug Users VCT, STI, NX, BCC, condoms, NSP, PHC, IEC, referrals.	Acceptance of NSP by local political authorities, community involvement, client involvement in project activities, contributed to reduction in HIV infection rate in IDU, DDC and municipality allocated budget for IDUs in annual plan.
Knight Chess Club	800 IDUs reached and followed up (1,165 ever reached)	NSP, PHC, IEC, BCC, condoms, counselling.	Professional M&E, decrease in HIV prevalence, "more than 150 are recovering," "more than 100 recovering clients are employed," "more than 40 clients are in treatment (rehabilitation)," "overdose minimized," "criminal cases related to drugs decreased."
Lifesaving and Lifegiving Society (LALS)*	1,850 IDU 97% male 3% female	Goal: To reduce the spread of HIV among drug using populations. BCC, counselling, NSP, condoms, IEC,	Best practices: Service Cards distribution to clients Motivated the clients to

		PHC, referral, peer educator mobilisation	DIC for service delivery Use of new syringe when they inject each time Clients with abscess, cut, wound and burn cases regularly visit DIC for follow up Home based PHC services
Najarjun Development Community	150 IDU all male 5 sexual partners of male IDU	Not reported	Not reported
NAMURA Integrated Development Council	926 total Clients at DIC Nov 09~Feb 10: Male: 450 Female: 19	Goal: To reduce the Spread of HIV among drug using populations Advocacy, harm reduction supplies via DIC and outreach, IEC, BCC, PHC, referrals	31 active sites
Naulo Ghumti*	984 (# of clients contacted) 446 (# of clients accessing DIC)	Goal: Reduce the level of harm experienced by IDUs mainly the transmission of HIV, STI and Hepatitis through promotion of safer behaviour practices among injecting drug users, in the proposed districts.	Services are provided mobilizing each outreach worker in out reach areas in Pokhara to increase coverage Family and spouses are aware on the drug and HIV issues due to our regular activities
Naya Goreto	Data not available	Data not available	Data not available
PRERANA	502 IDU 46 sex partners (data for	PLHA-led organisation NSP, counselling, PHC, BCC (IDU and sex partners),	Mobilization of IDUs and their partners as PVs helped to reach IDUs and sex partners Engaging the community

	2010)	referrals—VCT, CD4, ART, health camps, community sensitisation,	people helped to implement programs in the community Outreach, DIC services & BCC helped to reduce harmful activities among IDUs Capacity building of IDUs & their sex partners helped to raise community support Formation & mobilization of SHG helped to increase the reach for target groups
Richmond Fellowship Nepal	200 IDUs identified	Objective: To deliver Risk Reduction services, enhance an enabling environment, to provide BCC sessions to IDUs and their regular female sex partners	Data not available
Siddhi Memorial Foundation*	492 (not specified whether DU or IDU)	BCC, STI, abscess management, condoms, NSP	Data not available
Student Awareness Forum (BIJAM)	600 IDUs	IEC provision, primary health care at DIC, VCT and STI, counselling,	NGO reports decreased HIV infection rates among IDU, improvement in "health and hygiene" of IDU, increased numbers of IDU clients employed as peer educators, IDUs' spouse and parents more supportive and participate in meetings, good cooperation between the NGO and local authorities on drug-related matters.
Youth Vision	91 (though	Goal: Scaling up comprehensive risk	Data not available

	DIC) figure for IDU accessed via outreach not provided	reduction services for injecting drug users Objectives: delivery of HR services; BCC to reduce risk taking behaviours among IDUs; community sensitisation; facilitation of OST using buprenorphine for IDUs to decrease injecting drug use NSP, BCC, counselling, PHC, buprenorphine at DIC, referrals	

* MTR Team visited this NGO

The Review Team's meeting with partner NGOs found that NGOs supported by H13 are offering a wide variety of harm reduction services including NSP, counselling, IEC/BCC, condoms, and referral services. A number also reported decreases in HIV incidence among IDU, which they attributed in part to attendance at their services and resultant behaviour changes among IDU.

The Review Team also visited three NGOs and conducted site visits and interviews. These were conducted at Lifesavings and Lifegiving Society (LALS) in Kathmandu, Siddhi Memorial Foundation and DIC in Bhaktapur, and Naulo Ghumti in Pokhara. In these visits, the Team found that NGOs are offering a wide range of harm reduction related services. LALS is the longest running harm reduction oriented NGO in Nepal, has the highest coverage of any H13 partner NGO, and provides the full range of harm reduction and referral services. The Team was very impressed with the knowledge and dedication of the LALS staff.

The Siddhi Memorial Foundation DIC provides NSP, condoms, BCC, prevention of STIs, OIs, referral to rehabilitation, home visits by peer educators, and social reintegration services, and also reported that between 40 and 50 percent of their clients have attended VCT. (Data on the number of clients who attended VCT and received their results were not available. It takes 4-5 days for clients' test results to be made available). The project has been operating since 2002, works at 13 outreach sites, and has 492 regular clients (defined as clients who have been reached by services at least three times in their life) with daily access to 85 clients. Virtually all the clients are male; the DIC reports that they have ever enrolled approximately 18 women IDU, but that they all discontinued accessing services. A notable success of this project has been coordination and sensitization of the local police force. DIC staff report that when police arrest drug

users, they call the DIC to determine if the person arrested is a programme client; people identified by the DIC as clients are then released from police custody. The DIC reports **significant decreases in police harassment** as a result of their efforts.

In Pokhara, the team met with representatives from Naulo Ghumti, an NGO providing harm reduction services via DIC and outreach. Naulo Ghumti reported having 550 regular clients (of which 19 are women), and daily contact with 118 clients. NGO staff report receiving training via the H13 project on pre and post-test counselling and on syndromic STI management. In addition to offering harm reduction supplies, Naulo Ghumti is easily able to refer clients for VCT because it is housed in the same building as a VCT service supported by FHI; Naulo Ghumti reports that approximately one-third of their clients have attended VCT (most clients are accessed via outreach). This is an excellent example of **progress towards a one-stop shop** as well as of **coordination among development partners and NGOs on the ground**. Naulo Ghumti also reported establishing a productive relationship with the District AIDS Coordination Committee (DACC), and actively **collaborating with the DACC to develop the district's HIV/AIDS strategy**.

OST/MMT

In 2008, H13 extended its contract with Tribhuvan University Teaching Hospital (TUTH) for 2008-09 to provide MMT for 150 IDUs, and expanded the programme to include provision of MMT at an outpost in Lalitpur; the project also collaborated with GTZ to further support scale-up of MMT in Nepal. Starting with this extension period, H13 absorbed the costs associated with provision of OST in Nepal.

The Review Team visited the MMT services in Panipokhari and found them highly professional and well-attended. The Team spoke with clients, staff dispensing methadone, and staff for the social unit—newly acquired in January 2010 by H13 from UNDP. Panipokhari currently has slots for 175 clients, with another 25 clients receiving methadone at Lalitpur. Staff report that since the MMT programme's inception in 2007, a total of 300 clients have been enrolled, and approximately 100 of those have dropped out of the programme. Only two of the Panipokhari site's 175 clients are women. Client retention was significantly improved by the introduction of a Social Unit in 2009, initially funded by UNDP, but under H13 as of January 2010. Housed directly on the premises of the MMT Clinic, the Social Unit is staffed with four peer volunteer counsellors, and provides psycho-social support services, meetings with families of clients, and community sensitization.

The MMT clinic staff reported that demand for MMT is high and that there are 230 people on the waiting list to join the programme. Staff accept clients for methadone via an intake interview and prioritise injecting drug users (over non-injectors), people who have been on the methadone programme previously and dropped out, and people with a longer history of drug use—evidenced by repeated enrolment in detox followed by relapse. People with shorter periods of drug use and/or people who are not injecting are referred to the buprenorphine programme which offers a 45 day detox, or to rehab. The

MMT programme in Kathmandu is set to scale up to a total of 250 clients (from a current 200) next year, with 20 of the 50 new slots allocated for women.

MMT has also been expanded to Pokhara and the Review Team visited that site. The site has been operating since 2008. On September 21, 2008 a joint meeting took place at the Western Regional Hospital Pokhara to discuss and finalize the workplan for initiating MMT at this hospital for 100 clients; participants included UNODC, UNDP, MoHA, TUTH, Recovering Nepal and the Pokhara hospital team. In 2008, the Pokhara MMT programme provided MMT to 21 clients. At the time of the Review Team's mission, the Pokhara clinic had ever enrolled a total of 88 clients, and had 62 active clients, one of whom was female. MMT staff reported accepting clients into MMT according to a number of criteria: Priority is given to people who have been using drugs for at least 3-4 years, to women, and to people who are on ART. Only injectors are accepted into the programme. HIV-testing is routinely provided to clients entering the MMT programme. Although MMT is not provided in prison settings, **the Pokhara programme has on several occasions successfully negotiated to provide methadone to regular clients when they have been imprisoned**.

The model in Pokhara was the same as that in Kathmandu, where TUTH and UNDP collaborated to provide a social support component to the programme. In 2010, the UNODC H13 project took over support for the MMT Social Support Units in both Kathmandu and Pokhara.

Regional Learning Centre (RLC)

The Review Team visited the Regional Learning Centre at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu, and was impressed by the level of knowledge of the medical personnel both about MMT and about the H13 project, and their dedication to the programme. The RLC has integrated training on drug uses and MMT into university courses including modules on client evaluation, dosing, and overdose management. TUTH has trained 3 doctors in MMT at the post-graduate level, including the medical professional leading the MMT programme in Pokhara, and is currently training one medical doctor from the Maldives. In sum, the **Regional Learning Centre is functional and prepared to train medical professionals—from both Nepal and other SAARC countries, on drug use issues and MMT**.

2.13 Scale up of Harm Reduction

The government has developing a costed roll-out plan on interventions for IDU based on the National Advocacy Strategy. To support this process the H13 project supported participants from Nepal to attend the 2nd Informal Inter-Country Consultation on HIV Prevention and Care among Injecting Drug Users and in Prison Settings in Vienna from 19-21 February 2008. The purpose was to identify and develop concrete steps on how countries could integrate national drug control programmes, prisons programmes and AIDS programmes in their respective countries.

2.14 Project Management

Project management has proceeded according to plan. The Country Support Unit (CSU) in Nepal (co-located at UNDP/UNAIDS) was established in 2007 and interviews were conducted for the post of the National Project Officer for the CSU. The post was filled in June 2008 and The CSU became fully operational.

In 2008, the CSU held around 8 review meetings, organised by the CSU and the Drug Control Programme. In addition, the CSU staff met bi-monthly with the National Focal Point and the mentor agency. The project also held a series of meetings in 2008 designed to solicit inputs on geographical areas for demonstration sites, staffing, type of activities, and training needs, and these inputs were then included in revised TORs. This was useful in building ownership of the project as well as avoiding duplication of activities in the field. Project monitoring visits to partner NGOs and PLI partners to support inclusion of the NSP component into their existing programmes also took place in 2008.
During the Review Team's mission, some NGOs reported attending planning meetings at the DCP as well as visits to their project site from the DCP (Siddhi Memorial Foundation). Similarly, Naulo Ghumti in Pokhara stated that they report regularly to UNODC, to the DACC, to the District Development Committee, and to the Social Welfare Council (where all NGOs must register) in Kathmandu.

Quarterly narrative and financial reports have been submitted regularly since 2008.

2.2 Challenges

2.21 Advocacy

While the Project has made impressive strides in its advocacy efforts—most notably changes to Drug Policy and support for expansion of MMT—much remains to be done. The current coverage of MMT remains very low. There are an estimated 4,000 IDU in the Kathmandu valley, but even with the anticipated increase in 2011, plans for MMT scale-up will reach only 250 clients. In addition, those institutions currently in charge of dispensing methadone have either expressed reservations about increasing the number of clients, as in the case of TUTH, or else have not been able to effectively attract clients despite available slots, as in the case of the Pokhara facility. The Kathmandu methadone clinic reports that they wish to work on making the programme "sustainable" for clients—increasing retention in the programme, rather than increasing the number of clients accessing methadone.

Changes in Nepal's Drug Control Strategy are very encouraging and a sign that project advocacy has effectively worked to incorporate harm reduction into drug policy. Advocacy and support for sustained government support and government financing for implementation of the new Strategy will be the next step.

2.22 Effective Harm Reduction

Training

The team found that while a number of NGOs reported having received training, and also reported that the training was useful, significant training needs remain. This is in part due to **new NGOs** having joined the project recently and requiring new training, as well as **staff turnover** at NGOs that were funded through Phase I of H13. In addition, while the Review Team noted that H13 training materials were available at partner NGOs, the **materials are not yet available in the local language**.

Training needs expressed over the course of the MTR included **requests for repeat or refresher trainings** as well as **requests for trainings in areas currently not addressed** in the H13 training materials. Specific training requests include:

1. A new training on vein care management (LALS reported that groin injection has increased so that now 80 percent of their clients inject in the groin, dramatically increasing the need for proper vein care);
2. Refresher trainings on counselling (LALS DIC);
3. Trainings on the basics of HIV, on drug interactions (methadone, heroine, ART, TB/Hep C medications, buprenorphine etc.), and case management (Social Unit at Panipokhari)
4. Trainings on VCT counselling, outreach and rehabilitation (Siddhi Memorial Foundation). Staff at the Siddhi Memorial Foundation DIC report not yet receiving any training through the H13 project.
5. Training on program management and M&E (Naulo Ghumti)

Harm Reduction Services

The Review Team noted a number of challenges to partner NGOs offering harm reduction services:

Some NGOs reported that changes to their budget under H13 Phase II had adversely impacted their ability to offer services. In Kathmandu, LALS reported that after the budget decrease, they had to close two of their four DICs, that the staff to client ratio had dropped, and that some staff had been transferred to other projects. In Pokhara, Naulo Ghumti similarly reported that following budget decreases they closed one of their two DICs as well as one of their two outreach services; Naulo Ghumti staff noted that their coverage of clients has therefore dropped from over 800 regular clients to a current number of 550 clients.

Naulo Ghumti also noted continued community resistance to NSP reported in Pokhara. NSP is not widely offered under H13 Phase II. It began in Nepal only in 2009.

The Review Team noted that knowledge about MMT appears weak at several NGOs. While staff and medical professionals at MMT clinics were generally well-versed in methadone maintenance therapy, NGO staff and outreach workers in particular expressed reservations about the merits of MMT, as well as misperceptions about methadone, and support for lower methadone doses and drawing down the methadone dose to abstinence ("getting clean").

The Review Team noted a significant variation in NGOs capacity to articulate the goals of the H13 project accurately. Some of the NGOs appeared unsure about the goals of the H13 project, and stated that the goal of their program was to reduce drug use *per se* (distinct from reducing HIV in drug using populations).The Siddhi Memorial Foundation DIC, for example, reported that the goal of their program is to reduce drug use, and strongly emphasized the need for rehabilitation services with sufficient room to take in their entire client base. As evidenced in the summary of NGO reports above, a number of NGOs focus the bulk of their efforts on drug demand reduction (abstinence and rehab), and reported project successes as reduced drug use and more clients in rehab, rather than discussing clean needle and syringe use and other aspects of the harm reduction approach.

The Review Team also noted variation in NGO capacity to monitor and evaluate their projects and in reporting—with some NGOs, such as LALS, reporting well, and others struggling to collect data and report on progress. There is also variation in the ways in which NGOs define "regular client," with some NGOs defining a regular client as someone who has accessed services two or three times, other NGOs as clients who access services daily, and yet other NGOs simply counting the number of clients ever accessed by their programme. This makes it difficult to accurately ascertain NGO access to clients and measure service coverage. The use of client identifier codes appears spotty and is not coordinated with other projects, making it impossible to accurately determine coverage. The Siddhi Memorial Foundation DIC, for example, uses a client code identification system to maintain client confidentiality; however the code is not universal and is not used by another NGO offering harm reduction services in proximate areas (Prerana).

OST/MMT

The MMT clinic in Kathmandu had to move in December 2009 from its original location at TUTH, to Panipokhari, due to objections from the TUTH administration. Access to MMT remains low, and partner NGOs report low proportions of their clients accessing MMT services. LALS, with the largest service coverage among all the partner NGOs (1,850 clients) reported that only 10 of their clients had accessed MMT.

MMT programs retain a number of restrictions on access to their programmes, some of which may account for low attendance at the Pokhara programme. In Kathmandu, clients who wish to qualify for MMT must prove they have attempted abstinence and have relapsed; proof is obtained from "de-addiction doctors" and by speaking with family members. In Pokhara, clients enrolling in MMT are requested to bring family members with them at intake; clients already on MMT who miss attending for one day must make an appointment to see the doctor, obtain formal permission to re-enter the programme,

and write a letter explaining why they missed a day. International experience suggests that these practices tend to discourage participation in MMT, particularly among the most vulnerable segments of the drug-using population who may lack the requisite family support to meet enrolment conditions.

Both MMT programmes noted a need to revise methadone guidelines, as they were designed in 2001, and cannot sufficiently support current programmes, or scale-up. Both noted in particular a need for revised guidelines on take-away doses to visit family. Currently take-away doses are only allowed for attending international conferences (maximum 3 days) or to go to a funeral.

MMT staff reported poor levels of knowledge among MMT clients about sexual transmission routes and condoms as a method of HIV prevention, and reported myths among that there is no need to use a condom for people who are on MMT.

Referrals between DICs/harm reduction services and HIV-related services remain challenging. The Panipokhari MMT clinic reported sending just 5 people for VCT over the course of the previous 7 months. The Siddhi Memorial Foundation's DIC reported that referring clients to a mobile VCT service in the area was challenging because clients feared to be seen attending VCT. Some NGOs also reported that newly imposed fees for HIV-related services—VCT (350 rupees) and CD4 (100 rupees) were adversely affecting clients' access to these services. There was little access to ART for IDU clients, and little to no knowledge about ART among service providers.

MMT services noted the need for testing for Hepatitis C: Panipokhari reported that 115 clients tested and 70 percent were Hep C+.

2.23 Scale up of Harm Reduction

The project has clearly made impressive strides towards scale up of harm reduction services in Nepal but sustainability of services to IDUs delivered by NGOs appears to be challenging.

With approval for 7 new MMT sites, and the inclusion of harm reduction into several major policies, the situation looks promising for scale up of methadone.

Higher INCB quotas for methadone have not yet been obtained.

2.24 Project Management

Very few project management challenges were reported in the course of the Review Team's mission. Some NGOs indicated that they filed reports regularly with the DCP at the Ministry of Home Affairs and had also received support from the DCP. They also noted, however, that reports to the National Centre for AIDS and STD Control (NCAC) at the Ministry of Health received no feedback and that they had therefore discontinued reporting to the NCAC (LALS).

Some stakeholders reported that the MMT Technical Working Group does not meet regularly, and urged cooperation between the Ministry of Home Affairs and the Ministry

of Health to revise the MMT Guidelines. WHO reports that a meeting between the two ministries has been planned to discuss the division of labour regards to MMT.

2.3 Conclusions and Recommendations

Despite a decline in the HIV prevalence among IDUs in Nepal in recent years the HIV epidemic among IDUs remains a considerable concern. The H13 Project Phase II directly addresses the needs of this population and remains very relevant to country needs and to beneficiaries' requirements. In interviews conducted during the MTR, it was clear that the project has effectively cultivated high level government support for harm reduction and OST in Nepal. The project has made important contributions in the areas of advocacy—directly linked to national policy—and to service delivery. The *Nepal National Advocacy Strategy to Prevent HIV Transmission among IDU/DUs 2009-2012* is complete together with costed workplan, and has been endorsed by the government, although government financial support for Project Activities has not been forthcoming. With project input, the Nepal Drug Control Strategy has been revised to include support for harm reduction and MMT. The MMT program has expanded to reach 262 clients and government approval has been received to open 7 new sites. In the area of service delivery, the project has contributed to expansion of the number of services providers and built the capacity of those providers. The project has trained service providers on PLI, Outreach, NSP and Positive Living with a focus on women, 'Treatment of Positive IDUs,' and partner NGOs provide a comprehensive package of services to IDUs. Some NGOs have effectively worked with police officers to raise awareness and minimize police harassment of clients. Others have become directly involved in local policy-making to support the development of policies that support harm reduction. A Regional Learning Centre has been established at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu and has trained medical practitioners in drug treatment and MMT.

The project has encountered a number of challenges in the areas of advocacy, service provision, and project management. These are presented below in tabular format, together with recommendations on ways to address them:

#	Challenge	Recommendation for the Project
1	MMT Coverage remains low	Expansion of MMT is a major goal of the project, the project is providing technical assistance and financial support to existing MMT programmes, and the government has now approved 7 new sites. The project should support that decision by expanding current levels of TA to support scale up—such as supporting TUTH to train more medical professions on MMT, and providing trainings to new MMT sites including attached social units, as needed.
2	The Pokhara MMT site has not succeeded in filling its	Despite an expressed need for MMT and large numbers of IDU in the area, the MMT site has not

	allotted slots	reached its allotted number of 100 clients. The project should support more capacity building on MMT in Pokhara, directed both at MMT staff and importantly at partner NGOs in the area who are in contact with IDU—to increase their capacity to effectively transmit information about the programme to clients and to recruit clients. The project should also work to remove prohibitive barriers to MMT access in Pokhara such as stringent intake interviews and the requirement that clients who miss one day of the programme obtain formal permission to re-start.
3	National Guidelines on MMT are dated and cannot adequately guide a scaled-up MMT programme	The program should support the revitalization of the MMT Technical Working Group, including both the DCP and the NCAC, to revise the Guidelines.
4	Methadone for scale up has not been procured	Support for procurement of methadone is a project goal under the scale-up of harm reduction services component. The project should provide TA support for increased procurement of methadone to support scale-up.
5	Training materials are not yet available in the local language	The project should support finalisation of translation of training materials into local languages and dissemination.
6	NGOs new to the project require capacity building as do old NGOs who have experienced staff turnover	Both new and old (funded under Phase I) NGOs require additional training, including repeat trainings that address counselling, outreach, case management and M&E, and trainings that address emerging issues such as vein care management and drug interactions.
7	Some NGOs have misunderstanding about MMT and are abstinence-oriented	The project should support more training on MMT and include NGOs in the trainings.
8	Referral linkages between partner NGOs and HIV services such as VCT and ART are weak	The project should provide training on building a referral network, with particular emphasis on referral from harm reduction programmes to HIV services such as VCT and ART, as well as regular technical assistance on referrals.
9	Several more experienced NGOs have scaled down their services	Scale down of established harm reduction services is detrimental to project goals. Established NGOs should be supported to sustain their levels of services and

		coverage.
10	There is significant variation in NGO capacity to deliver services, to understand the harm reduction goals of the project, and to conduct M&E	The training recommended above (#6 & #7) will improve NGO capacity. In addition, using more experienced NGOs in a mentor capacity—such as organising small NGO-led workshops or visits to experienced NGO project sites—will support less experienced NGOs to deliver services more effectively. The project should support this process.
11	The current M&E system lack important specifics required to properly evaluate service quality and coverage.	The M&E system should be examined to ensure that reporting from partner NGOs is streamlined. Notably, NGOs should use the same definition of "regular client" when reporting. Current UNODC coverage indicators specify that a regular client is someone who has been attending services at once a week for a period not less than 3 months. Use of a common identifier code among all partners is desirable.
12	NCAC involvement in supporting partner NGOs appears low	The MTR Team was not able to conduct interviews at the NCAC. Nonetheless, from interviews with NGOs, NCAC's involvement in the project appears to be less than desirable. NCAC should be actively engaged in the project. This would support project activities related to HIV-specific services. Including an NCAC representative as a focal point for the project, or having joint focal points—one from NCAC and one from the DCP—would support this process.
13	Strategies for sustainability of NGO programmes are not in place	The project should support NGOs to develop sustainability strategies that will allow continuation of their programmes beyond the project.

3. Bangladesh

3.0 Background

Since1989, when the first case of HIV was reported in Bangladesh, IDUs have been considered one of the MARPs in the country. Size estimations conducted in 2005 found that IDUs numbered 20,000-40,000. Risk behaviours among IDUs have been identified, with sharing of needles among IDUs in Dhaka found to be 55.2 percent, and 77.3 percent in the northern district town of Chapainawabgung. IDU vulnerability to HIV infection is further compounded by interactions between male IDU and FSWs, with by 66.4 percent of male IDU reporting sex with FSWs and only 44.1 percent reporting condom use. Harm reduction services for male IDUs have been in place since 1998 and have expanded over the years.

Women are increasingly affected by the epidemic, and are considered a hidden population, especially in the case of women IDU, and the sex partners/wives of men IDU. These groups of women are vulnerable and at risk of HIV and STIs. Women using illicit drugs are more stigmatized than their male counterparts and therefore do not come forward to access services. Their vulnerability is further compounded as female drug users may be selling sex to support their drug habit. Hence they are exposed to a dual risk of HIV infection. Reaching women affected by the drug epidemic has been a challenge as there are few gender-specific services that target female IDU. The H13 project in Bangladesh is designed and implemented to address that service gap.

In April 2007, the NASP, Bangladesh endorsed Phase II of the H13 project, and in June 2007, MOHA endorsed the project and the Department of Narcotic Control (DNC) became the Project Focal Agency. The line Ministries for the Project are the DNC, the MoHA, the MoHFW and the National AIDS/STD Program (NASP). The International Centre for Diarrhea Disease Research, Bangladesh (ICDDR, B) has been appointed as the Mentor and National Learning Centre for the project. The implementing partners are four NGOs and they are, Light House, Dhaka Ahsania Mission (DAM), Ashokti Punorbashon Nibash (APON), Society for Community Health Rehabilitation Education Awareness (CREA).

3.1 Achievements

3.11 Advocacy to support change in policy and practice

The Review found that the Focal Point, DNC and mentor agency, ICDDR,B are well sensitized to the project, and very committed to working on the issue of drug use and HIV. They have internalized the essential components of Project H13 and related programs.

The *Advocacy Strategy for Prevention of transmission of HIV among drug users in Bangladesh* has been endorsed by the government, but has yet to be translated into tangible policy outcomes.

The project supported a Rapid Situation and Response Assessment in Bangladesh which was conducted from December 2007 to March 2008 with the active participation

of all four partner NGOs. The findings of the assessment provided a strong and evidence-based tool for advocacy by addressing information gaps on IDU issues.

Sensitization of the members of the community, local leaders including religious leaders, and local Government officials has been part of the advocacy strategy in Bangladesh. This was accomplished through community sensitization meetings, advocacy with local government and NGOs, and awareness-building meetings with families of clients. Thanks to the success of community sensitization efforts, communities are becoming supportive of project activities. Communities and family members themselves are becoming instrumental in motivating clients to access outreach and DIC services.

Commemoration 26th June as International Day against Drug Abuse and Illicit Trafficking and also 1st December as World Aids Day are year marked and observed as regular advocacy activities.

3.12 Effective harm reduction approaches

Training

The project's intervention toolkits are endorsed by the Government, particularly the toolkits on Methadone substitution and Buprenorphine substitution as these are imminent intervention. (MMT was approved in Bangladesh during the course of the MTR though implementation is likely to take some time). These **two toolkits have already been translated into Bengali** and are being prepared for dissemination in Bangladesh. The Positive Living materials are in the process of translation; the other project toolkits are also in the process of being translated. The NGOs have also developed local level IEC/BCC materials in Bangla.

The project has supported a number of trainings in Bangladesh. These include a National Peer Volunteers Lesson Plan (PVLP) training, 24-28 February 2007, for partner NGOs with 35 participants; a Training on Positive Living and Services for Female IDUs and Female Regular Sexual Partners of Male Drug Users (26-28 February 2008); and Training on Outreach Activities and Needle Syringe Program (1-3 March 2008) in Dhaka. Other trainings include a training on M&E, on Counselling, and on STI organized by ICDDR,B, and also a training from UNODC, ROSA on project implementation. Partner NGOs reported that their knowledge and skill sets improved as a result of participation in project trainings. The Mentor Agency has also facilitated linkages with other projects of the ICDDRB for training purposes, expanding partner NGOs access to a wide variety of training opportunities. The Review Team found that partner NGO staff were equipped with the knowledge they needed to implement their programs and highly motivated and dedicated to the project.

Pre- RSRA training and conducting the RSRA were also recognized as very effective capacity building activities, as was participation in developing the M&E tools—which are now used effectively by project staff. The Project Mentor and NGOs also use these tools for reporting.

Cross visits among the partner NGOs is another important activity that has fostered the capacity of NGOs by allowing them to share experiences and learn about good practices. This activity is conducted on a quarterly basis. Regular contact between NGOs and the Mentor Agency, to seek guidance and for monitoring purposes, has been a common practice. Regular participation in meetings with different stakeholders was also found to be an important capacity building activity.

Harm Reduction Services

The activities and services provided by partner NGOs are of two fold: a) DIC base services and b) outreach activities.

The DIC base services provided are clinical sessions for general health check ups, and syndromic STI management and treatment by qualified medical personnel. In case of need, clients are referred to dedicated and pre-linked institutions for services like VCT, drug treatment, partner management for STI diagnostic services, severe abscess or injury care, perinatal care, PPTCT, ART and associated services, immunizations from the children of clients, and OI management. Referral linkages are implemented through a network of related institutes and organizations (government and non-governmental) and referral services are provided through accompanied outreach workers.

One-on-one, group and family counselling services are also provided to the clients at DICs. Self-help group meetings for FDUs, support Group Meetings, Peer Volunteer training, DIC advisory committee meetings and community sensitization and awareness meetings are regularly conducted. Rest and educational recreational activities have been one of the main attractions of the DICs for clients.

The outreach based activities conducted include identifying and meeting with beneficiaries, particularly identifying and registering female I/DU and female sex partners of male I/DUs. Health education including HIV and STI related information for individuals and groups is provided. Follow-up and default tracing of cases is also done. BCC and IEC materials are provided, as well as condom demonstration and distribution. Sensitization meetings and family counselling/meeting are done regularly.

Overall clients reached by partner NGOs are as follow:

	FDUs	FRSPs
APON	44	60
CREA	61	116
DAM	37	165
Light House	69	112
Total	211	453

Annual data for 2009, reported in *Annual Progress Report*

Records and documents pertaining to all activities conducted are kept updated through a daily track sheet, photo documentation, and updated clients list. The increased level of

staff knowledge and skill through the training on M&E that was organized by the project office and then taken further by ICDDR,B, proved to be a strong tool for development of M&E tools and the M&E system was subsequently adopted and implemented by project staff. A system of quarterly submission of quantitative and narrative reports to the Mentor is in place. A financial report is done regularly on a quarterly basis. External and internal audits are also conducted regularly.

3.13 Scaled up harm reduction approaches

OST is recognized as an important activity and the Government of Bangladesh has approved the license to import methadone, and has given the mentor agency— ICDDR,B, permission for a pilot study on MMT at 3 centres for 300 drug users. At the time of the MTR mission to Bangladesh in March 2010, signing of the procurement contract with UNDP was still a pending. **In April 2010, MMT was officially approved in Bangladesh.** The contract has been signed and the process of procurement of methadone is ongoing.

3.14 Project management

The MTR mission found that effective implementation of the program is place, monitoring- evaluation and reporting of activities and outputs are done regularly. At the national and local levels there is a coordinated and harmonized approach among the stakeholders in program management processes. National operational plans have been developed and endorsed by the government, civil society, drug user communities and also UN partners.

The regional project office is the core project facilitator. The HIV/AIDS Advisor in the UNODC country office, together with the mentor agency oversee the project. The Mentor is also the learning centre of the project and also monitors the program regularly through meetings, visits to the project sites and analyzing the reports produced by implementing partners. Narrative and financial Project Reports are obtained from the partner NGOs and submitted to the program office in a timely manner. For effective monitoring of program activities the tools of the national M&E plan are used.

3.2 Challenges

3.21 Advocacy

The *Advocacy Strategy for Prevention of transmission of HIV among drug users in Bangladesh* has yet to be translated into tangible policy outcomes.

Although high-level advocacy strategies are in place, awareness and sensitivity at the community level and among law enforcement remains comparatively weak. Incidents of eviction of FDUs and also the Regular Sex Partner (RSP) of male DUs from hotspots are still common.

3.22 Effective harm reduction

Frequent staff turnover and dropout of staff at partner NGOs means the introduction of new less experienced staff who require training.

There lack of gender-focused IEC/BCC materials for the clients and community use.

The H13 Project does not have provision for vocational training for FDUs and RSP of DUs. During the MTR mission, clients expressed interest in vocational training opportunities.

The DICs do not offer NSP.

There is ongoing demand for basic primary health care services and also for STI management for male partners and for the family members of beneficiaries.

There is insufficient capacity to meet maternal health demands including ANC/PNC services and nutritional support to pregnant mothers and infants.

3.23 Scale up of Harm Reduction

With the approval of the MMT pilot in Bangladesh, come new needs and opportunities for project TA, notably in the areas of procurement and the development of a support policy environment.

3.24 Project Management

The Review Team noted regular staff inputs regarding the lack of competitiveness in salaries; hence staff drop-out rates are high. This creates difficulties in smoothly running the project.

The partner NGOs have noted that more visits / supervisions from UNODC would be helpful. At the same time exposure visits for outreach workers and peer educators and counsellors to other SAARC countries to observe similar projects would be a learning opportunity for better project management.

3.3 Conclusions and Recommendations

The MTR found that the project in Bangladesh has accomplished important successes. Most recently, the project's advocacy for MMT has contributed towards the approval of an MMT pilot program in Bangladesh in April 2010. The *Advocacy Strategy for Prevention of transmission of HIV among drug users in Bangladesh* has been endorsed by the government, and the project has supported a Rapid Situation and Response Assessment that has been used effectively for advocacy purposes. Two toolkits—those on Methadone substitution and on Buprenorphine substitution—have been translated into

Bengali and are being prepared for dissemination. The project supports four implementing partners in Bangladesh for projects that provide gender-sensitive services to female IDUs and the female regular sex partners of male IDUs. Partner NGOs offer services at DICs and via outreach and have developed stable referral linkages through a network of related institutes and organizations. The project has conducted a broad range of trainings in Bangladesh and also facilitated cross visits among the partner NGOs—an activity that has proven effective at fostering the capacity of NGOs to provide services.

The project has also encountered a number of challenges and these are presented below in tabular format, together with recommendations on ways to address them:

#	**Challenge**	**Recommendation for the Project**
1	The *Advocacy Strategy for Prevention of transmission of HIV among drug users in Bangladesh* has yet to be translated into tangible policy outcomes.	The project should advocate for the inclusion of key components of the Advocacy Strategy in national policies and plans.
2	The MMT pilot has been approved but implementation processes may take some time.	The project should support implementation of the MMT pilot with procurement support and training. (This process is already under way).
3	Frequent staff turnover and dropout of staff at partner NGOs	The project should examine the reasons for staff drop-out and develop a staff retention strategy; the project should offer regular refresher trainings to keep senior staff skills up-to-date, and to train new staff members.
4	There lack of gender-focused IEC/BCC materials	The project should seek appropriate information resources and develop gender-focused IEC/BCC materials
5	There is insufficient capacity to meet maternal health demands	The project should build implementers' capacity to meet maternal health needs through trainings on gender-responsible harm reduction

4. Bhutan

4.0 Background

The first case of HIV in Bhutan was reported in 1993 and by 2009, the total reported HIV cases were 185, out of which 2 were among drug users. The HIV prevalence in the adult population is still low, at 0.1 percent. Drug use is a relatively recent phenomenon in Bhutan, however, the number of registered drug users is rising. In 2001, there were 59 registered cases and in 2008, the figure stood at 428.

A National Baseline Assessment (NBA) conducted in 2009 by the Bhutan Narcotic Control Agency (BNCA), in collaboration with UNODC ROSA, interviewed 991 drug user respondents, (male:female ratio being 917:74, and majority of them being youth). Among respondents, 98 men and one woman reported ever injecting. The study also revealed other risk factors among respondents such as low rates of condom use, presence of STIs, MSM, and also high rates of alcohol use (80 percent of respondents). The report of the NBA was a revelation for the country, and provided the first concrete data on drug use and HIV in Bhutan.

Against this backdrop, all stakeholders interviewed by the Review Team expressed the opinion that the H13 project is a timely and necessary intervention, and important for preventing the emergence of a drug-use driven HIV epidemic in the country.

4.1 Achievements

4.11 Advocacy to support change in policy and practice

The **first ever conducted 'National baseline assessment of drugs and controlled substance use in Bhutan 2009,'** using the RSRA methodology supported by the project, was found to be a very strong tool for advocacy on HIV prevention among drug users. The principles of H13 project activities have been well internalized at all policy levels, and **key elements of the project have been incorporated into the National Narcotics Drugs, Psychotropic Substances and Substance Abuse Act**. Although in monitory terms, the project may appear small, it has produced quality results and generated high-level support. The project is well recognized as an important contributor towards initiating the program for preventing HIV infection among drug users.

The Focal Point, Mentor Agency, DoPH, NACP and implementing partners are very committed, supportive and dedicated to the issue of drug use and HIV. The mentor agency is actively playing a key role in facilitating the relationship between advocacy and implementing partners through strategy meetings and organizing forums.

Advocacy efforts have also been undertaken via study tours: in Phase II, the project supported a study visit to TTK Hospital in Chennai, India.

Although the National Strategic Plan for Prevention and Control of STIs and HIV/AIDS, 2008 does not adequately reflect the issue of drug use and HIV, the Royal Government of

Bhutan (RGB) did subsequently develop a **National Operational Plan 2010-2011, and an Action Plan that clearly identify the various issues and components related to drug use and prevention of HIV infection.**

Meetings on drug use and related problems with teachers and parents in schools are conducted on a regular basis. Meetings and workshops on law enforcement with lawyers and heads of the Royal Bhutan Police are also conducted in regular basis. Meetings and workshops with district education officers and principals of schools on drug use and related problems are also reported as regular activities and supportive of the H13 project. Commemoration 26th June as International Day against Drug Abuse and Illicit Trafficking and also 1st December as World Aids Day are year marked and observed as regular advocacy activities.

4.12 Effective harm reduction approaches

Trainings

Training on Rapid Situations Response Assessment (RSRA) of drug use and HIV in Feb 2008

Training workshop on the Basics of Drug /HIV for outreach and community involvement were found to be very important and useful. Similarly, the Pre-DIC training and Pre-rehab training were useful for supporting the DICs and Rehab centre.

One Training of Trainers Programme on the Basics of Drugs/HIV was undertaken in Phuentsholling on 15 to 17 January, 2008.

Training on counselling for drug dependence-issues and processes (April 2009), for outreach workers and peer counsellors have been offered.

Training of the health workers (physicians, nurses and health assistants) on "Drug use and related HIV" has also been conducted by Department of Mental Health, JDWNRH in collaboration with NACP.

Harm Reduction Services

The project supports services at 3 drop–in centres, at Thimphu, Phuntshoelling and Gelephu, and one Treatment and Rehabilitation Centre for Drug and Alcohol Dependence at Sebithang, Thimpu. They are closely linked with the Detox Centre at the JDW National Referral Hospital, Thimpu. The DIC in Phuntshoelling, where the concentration of drug usage is highest, was established in July 2008. In total there are 9 peer outreach workers/counsellors supported by UNODC, two (1 male and 1 female) each at Phuentsholling and Gelephu and three (2 male and 1 female) at Thimphu; two (both male) of the rehab counsellors are also supported by UNODC project H-13. Thus out of the 9 -6 are male and 3 are female.

The DICs in Bhutan are geared to addressing drug and alcohol dependence and provide the following services: Information and education through IEC and BCC materials on

drugs and HIV, treatment for drug dependency, demonstration sessions on condom use, and condom distribution through networking. DICs also provides group / family / individual counselling services, and play an important role in motivating active drug users to seek treatment, including rehabilitation for their drug dependence (in the pre-detox\pre-rehab phase), and motivating recovering clients who are facing relapse to seek treatment and rehabilitation as early as possible. In total 7 self help groups are running attached to the DICs. Among them, 5 (including one exclusively for female drug users) are in Thimphu and one each in Phuentsholling and Gelephu. The stated goal of these groups is: " Through mutual aid, members help one another to seek services, maintain abstinence and also to bring about desired social and personal change."

The outreach program is run by peer outreach workers, peer educators, and counsellors. One DIC which was visited by the Review Team at Thimpu, operates in close proximity to the HISC run by the NACP. VCT services are managed by the HISC. The close proximity of HISC facilitates quick access to VCT services.

The H13 Project has provided the impetus for establishing the Treatment and Rehabilitation Centre for Drug and Alcohol Dependence (TRCDAD) at Serbithang, near Thimpu. The centre focuses on the principle of 3Rs: Relapse prevention, Rehabilitation and Reintegration. It has the capacity for only 12 clients. To date the total number of beneficiaries is 40 and the present group of clients is the third one. The success rate of the rehab program is reported at 75 percent, although it is not clear how this is measured.

The centre is run by YDF, an NGO, and supervised by BNCA. Personnel involved are 1 Rehab Manager (supported by RGB), 4 Peer counsellors (2 supported by UNODC & 2 by UNICEF), service of a spiritual / Meditation GURU (volunteer).

Implementing partners have developed **effective referral linkages** for providing relevant services to clients through a network of inter-related institutes and organizations. The referral services are provided by an accompanied outreach worker. Services available via referral are: VCT service, Drug Treatment, Management for STI, TB diagnosis and treatment, overdose management, other diagnostic services. DICs and the rehab centre have also built a referral mechanism with the psychiatric unit of the national referral hospital for treatment and continuum of care after discharge from hospital.

The updated record as of March, 2010, of clients reached is shown in the table below; targets are set at covering 80 percent of all drug users are accessed.

	Thimphu	**Phuentsholling**	**Gelephug**	**Total**
Number of beneficiaries reached through PLI/LCCS/Outreach activities	304	98	45	447
% of drug users outreached	87 %	74%	63%	91%
No. of IDUs outreached	4	7	0	11

No. of DUs attending DICs	108	56	34	198
% of outreached attending DICs	36%	57%	76%	44%

4.13Scaled up harm reduction approaches

The Bhutan Advocacy Strategy costed work plan for 1 year has been developed and submitted to the UNODC for possible funding support.

District based **Multi-Sectoral Task Forces (MSTF) have been established** have proven to be an important step forward in scaling up the program at the district level. In principle expansion of DICs in all the vulnerable districts (14), has been accepted as an essential step forward in implementing service provision for drug users.

In the one year since the treatment and rehab centre has been operational, it has been recognized as useful intervention.

4.14 Project management

The Bhutan Narcotic Control Agency (BNCA) with the Executive Director, Mr. Kinley Dorji is the Focal Point and Mentor Agency of the Project H13. The Executive Director was very supportive to the project. He is supported by Chief Program officer, Mr. Chhador Wangdi, and the Drug and HIV consultant from the H13 project, Mr. Debashis Mukherjee.

Country-level and local M&E has been developed with the participation of all stakeholders, and was finalized in national workshops and subsequently endorsed by the government.

Recording, reporting and monitoring activities were found to be in place according to the stipulated timeframe in the workplan. Project activities were discussed and planned with the stakeholders at regular basis. Documentation and reporting of all implementing partner activities including financial reporting were also found to be accomplished as stipulated in the TOR and workplan.

4.2 Challenges

4.21 Advocacy

The BNCA is not well aware of the current status of *Bhutan advocacy strategy paper on prevention of HIV among DU and their SP*. According to Dr. Chencho, the consultant for Strategy, the draft document has been submitted to the UNODC the government is waiting for feedback from UNODC for its implementation at the country level.

4.22 Effective harm reduction

Training

The intervention toolkits developed by Project H13 in phase I are not yet available in local languages, however, IEC materials related to drug and HIV have been developed and are widely available in the local language.

Ongoing refreshers trainings are required for program managers, peer counsellors, and outreach workers in order to keep staff up-to-date as well as to train new comers.

There are expressed demands for refresher trainings on pre-DIC and pre-rehab counselling and also demands for vocational trainings for drug users. There are also demands for certification of trainees: During the MTR mission, recipients of trainings (peer educators/counsellors, outreach workers) asked that the training programs have provision for issuing certificates.

Harm Reduction Services

The H13 project has focused considerable effort on high level advocacy, and while government officials are broadly supportive of the project, the Review Team found a lack of awareness about the project and about drug use and HIV linkages in general, at the community-level.

DICs, Treatment and Rehab Centre and Detox Centre are overstretched hence there is a waiting listed of clients for each service. And also there is a need for a rehab centre for women clients.

Services such as DICs have inadequate room to provide private counselling sessions. Due to the lack of privacy for counselling clients are unwilling to attend counselling services. Also, additional staff are required in the DIC for effective program implementation. One peer counsellor noted that the current remuneration is insufficient, and should be reconsidered to support staff retention and continuity in the program.

4.23 Scale up of Harm Reduction

Embarking on at comprehensive harm reduction program, including the NSP, will require sustained efforts at community sensitization.

Services provided by the DIC are gaining in popularity, and there is realization of the need to increase the number of DIC sites. There is also a need for treatment and rehab options for women.

4.24 Program Management

The project supported program is quite new Bhutan. The position of the consultant on Drug and HIV under the project has proved to be an asset for program management.

4.3 Conclusions and Recommendations

Although HIV prevalence is still low in Bhutan, and drug use has not yet been fully recognized as a risk factor, awareness is growing about the link between drug use and HIV. Implementation of the H13 project in Bhutan is timely, and the project is working to prevent the outbreak of an epidemic in the IDU community.

The H13 project in Bhutan has achieved important successes in the areas of advocacy and service delivery. The RSRA 'National baseline assessment of drugs and controlled substance use in Bhutan 2009,' was completed and has been widely disseminated and used effectively for advocacy purposes. Key elements of the project have been incorporated into national policies, such as the National Narcotics Drugs, Psychotropic Substances and Substance Abuse Act, and the National Operational Plan 2010-2011—both of which clearly identify the various issues and components related to drug use and prevention of HIV infection. The project has provided capacity building and training on RSRA methodology, the basics of drug /HIV for outreach and community involvement, counselling for drug dependence-issues, and pre-DIC and pre-rehab training. H13 is supporting 3 drop-in centres and one Treatment and Rehabilitation Centre for Drug and Alcohol Dependence in Bhutan. DICs offer a range of drug-related services and have established an efficient referral network linked to STI and HIV services.

The project has encountered a number of challenges. These are presented below in tabular format, together with recommendations on ways to address them:

#	**Challenge**	**Recommendation for the Project**
1	The BNCA is not well aware of the current status of *Bhutan advocacy strategy paper on prevention of HIV among DU and their SP*	The project should work with BNCA and YDF to support endorsement and implementation of the *Bhutan advocacy strategy paper on prevention of HIV among DU and their SP*.
2	The National Strategic Plan does not clearly address the linkage between drug use and HIV	The project should advocate for inclusion of drug use and HIV in The National Strategic Plan.
3	The H13 training materials are not available in the local language.	The project should support translation of the H13 materials into the local language, as needed.
4	Staff turnover has meant loss of trained capacity at implementing partners.	The project should collaborate with BNCA/YDF/ UNICEF / WHO / MoH to undertake a training needs assessment, provide further training for the program mangers/peer educators / counsellors / outreach workers
5	The DICs and drug treatment options are abstinence-oriented	The project should provide training and awareness raising opportunities focused on OST and harm reduction, for example through study tours.

6	The Review Team found a lack of awareness about the project and about drug use and HIV linkages in general, at the community-level.	Focused IEC materials are required for public awareness and education on drug and prevention of HIV. The Project should collaborate with government and other UN organisations—BNCA/UNICEF/Ministry of youth /social welfare/ financial and corporate institutions—to develop a community sensitization strategy.
7	DICs, Treatment and Rehab Centre and Detox Centre are overstretched hence there is a waiting listed of clients for each service.	The project should advocate for scaling-up of drug treatment services, and for introduction of evidence-based treatment such as OST, to increase service coverage.
8	There are no drug treatment options for women.	The project should support capacity building for offering gender-sensitive and female-friendly drug treatment services for women.

5. Maldives

Background

HIV prevalence in the Maldives is less than 0.1 percent and the estimated number of PLWHA is fewer than 100. Major risk factors in the Maldives include a highly mobile population, drug use, multiple sexual partners and low condom use. The National Narcotics Control Bureau (NNCB) estimated in 2002 that there are around 3000 drug users in the Maldives, but unofficial estimates put the number at around 8000. A 2006 Situation Assessment of HIV/AIDS suggests that the proportion of injectors has grown to 20%–25% of drug users. In 2009 the number of IDUs ranges from 300 – 2000.

The H13 project supports three partner NGOs in the Maldives: Society for Health Education (SHE), Society for Women Against Drugs (SWAD) and Journey—a network of recovering drug users, and one pilot programme on Methadone Maintenances Therapy.

The initial mentor agency for the project was the National Narcotics Control Bureau (NNCB); in 2009, however, in connection with institutional changes in the Maldives, the Drug Rehabilitation Services became the mentor agency—currently called the Department of Drug Prevention and Rehabilitation Services (DDPRS), under the Ministry of Health.

5.1 Achievements

5.11 Advocacy

Advocacy is a critical component of the H13 Project in the Maldives and has met with considerable success, notably the **initiation of a methadone maintenance programme in Male**.

In 2008, the Project organised a study tour to Delhi and Chennai for a delegation from Maldives which included representation from the National Narcotics Control Bureau, Ministry of Home Affairs, Department of Prisons, and the partner NGOs. The study tour was designed to sensitize key stakeholders to effective approaches to drug and HIV prevention, treatment and care including OST. The delegation visited the Ministry of Social Justice & Empowerment (MSJE), National Institute of Social Defence (NISD), NACO, and Narcotics Control Board (NCB) of India. In addition, field visits to NGO demonstration sites and OST with Buprenorphine sites in prisons were undertaken. In Chennai, visits were made to TTK Hospital.

These advocacy activities resulted in the initiation of the methadone programme in the Maldives.

Another critical focus of the Project's advocacy efforts has been drug policies laws that criminalise possession of all narcotic substances (including marijuana) regardless of the

amount, and do not distinguish varying prison terms for drug users, peddlers and dealers—this legal provision is known as Section 77. At the time of the MTR mission, **a new Drug Bill that would make these distinctions had been drafted and was pending in Parliament.**

The Maldives Advocacy Strategy for IDUs together with a costed workplan were developed in 2009. The Strategy includes the following components:

1. Amend the drug law (to distinguish among drug dealers, peddlers and users)
2. Conduct nationally representative, comprehensive reliable and up-to-date research on the issue of substance use and HIV
3. Empower every island to serve the needs of drug users by strengthening available resources through mobile training teams
4. Support proper coordination among stakeholders at the national level
5. Increased awareness leading to better policy decisions in the context of drugs and HIV prevention, improved planning and strategy development

In addition to supporting the development of the Advocacy Strategy, H13 also contributed to the mid-term review of the **National Strategic Plan on HIV/AIDS (2007-2012) in Maldives. IDUs were identified as an immediate priority target and OST as an intervention where UNODC would take the lead.**

In addition, the Project worked closely with the Government of the Maldives and the European Commission to develop a comprehensive drug prevention and treatment project to support the drug prevention and treatment components (including HIV prevention) of the Drug Control Master Plan of the Maldives. That project has now been funded.

In 2008, the Project held a national level M&E workshop in Male, Maldives (17-18 November 2008) which included a reflection exercise that captured the progress of the project in-country. The reflection exercise enabled discussion among project partners and stakeholders from the government, UN and mentor agencies, civil society partners, technical experts and collaborating networks in Maldives, and thereby served to facilitate ownership and greater collaboration and networking among agencies.

In interviews during the MTR mission, it was evident that **the Project has garnered high level government support** and that government officials with institutional memory recognise the Project's positive contributions to policy change as well as to capacity building for NGOs via trainings.

5.12 Effective Harm Reduction

Training

Trainings form an important part of H13 project activities in the Maldives. In 2008, H13 provided 4 national trainings with 40 people trained and 7 NGO level trainings with 50 people trained. Trainings focused on the basics of drugs/HIV, outreach and community involvement, issues of drug use prevention, drug-related HIV vulnerabilities, and initiating peer led interventions and MMT.

In 2008, translation of 3 H13 intervention toolkits into Dhivehi was started under the supervision of the National Narcotics Control Bureau: Module 2 Peer-Led Community Outreach Intervention, Module 5 Methadone Substitution and Module 6 Low Cost Community-Based Care for Drug Users.

The Project also organised a national training on M&E in Male in November 2008.

NGOs interviewed for the MTR reported that the H13 trainings were informative and useful to their work. SHE reported receiving training on counselling, outreach, drug use, drug treatment, HIV prevention, treatment and care, as well as training in art therapy (it was not clear if this latter was supported by the Project).

Harm Reduction Services

The Project supports three partner NGOs in the Maldives: Society for Health Education (SHE), Society for Women Against Drugs (SWAD) and Journey—a network of recovering drug users. Service delivery is geographically focused on Male and the adjacent island of Hulhumale'.

One of the most successful aspects of H13's work with these partners is the way in which **the project has brought these three NGOs together** to allow their respective skills to complement one another. All three NGOs noted the benefits this interaction had brought to their work and the catalytic impact of the project on their cooperation.

Due to the sensitivity of harm reduction in the Maldivian context, the state of drug laws and policies, and the illegality of distributing condoms or conducting NSP, H13 and its partners in the Maldives have developed creative approaches to accessing the drug-using population. Among the most successful of these efforts have been the **Community-Based Health Camps**, organized by partner NGOs to mobilize drugs users, civil society and government agencies. The three project partners worked together to hold four such Health Camps in 2008; the camps effectively attracted both drug users and the general population.

SHE is an established NGO with an expertise in family planning and counselling—two skills which it has put to good use under H13. SHE has organised community and stakeholder meetings on Hulhumale', trained staff on HIV and drug use issues, built support for the project and organised support groups on Hulhumale', and **worked through its family planning services to increase awareness of condoms as a method of HIV prevention.**

Journey is a network NGO of former drug users, and is conveniently located on the same premises as the MMT clinic. The NGO has played an important role in bringing clients to the MMT program and in providing psycho-social support to MMT clients. Journey also

provides instruction on safe injection, overdose management, relapse prevention, condom promotion, hosts NA meetings and has recently begun a VCT service—there is a separate room inside the Journey offices for VCT—where they provide pre and post-test counselling and send blood samples to the lab for testing. Journey staff use a questionnaire to determine which clients are selected to MMT, giving priority to injectors and attempting to screen out those with pending legal charges that could result in imprisonment (since methadone is not allowed to be administered in prison settings). Journey also offers mobile outreach services in a van staffed by 6 people; they visit dealing hot-spots and provide information about drug services such as rehab, detox, and MMT. NSP and condom promotion are not allowed in the Maldives.

SWAD is an organisation founded by mothers and wives of male drug users and is predominantly focused on advocacy for supply reduction and for increasing police enforcement of drug laws. It has approximately 500 members and works with former drug users to facilitate reintegration into communities. Under H13, SWAD has organised a number of support groups and trainings for their staff, participated with SHE and Journey in Health Camps, and organised a self-help group specifically geared to the families of MMT clients. They also cooperated with SHE and Journey to lobby for the new Drug Bill and worked with a lawyer to participate in drafting it.

OST/MMT

The MMT pilot program for 30 clients opened in the Maldives on October 16, 2008. Two experts from India were contracted by the H13 Project to facilitate roll-out of OST in Maldives, and received training from a Project consultant. The Project also provided technical support to the NNCB as it set up the MMT site in consultation with the Health Ministry. For procurement of methadone, the Ministry of Health wrote to INCB to obtain a quota, and the Project followed up on that request. The purchase of methadone was undertaken by the State Trading Organisation on behalf of NNCB. The project also established an OST with Methadone steering committee which met regularly in 2008 and had representation from all key stakeholders in the Maldives.

The MMT clinic was originally located outside the city of Male', but in 2009 it moved to the Community Health Centre in the centre of Male, where it was ideally located next to Journey and the laboratory for blood screening. By 2009, the MMT site had 40 clients, the pilot has shown effective results, and the government attitude was positive to scale-up. The pilot program was analyzed and documented. The International Narcotics Control Bureau allocated a fresh stock of methadone at the request of the Ministry of Health and Family, and the project facilitated and supported the Drug Rehabilitation Services in the procurement of the fresh stock of methadone. By March/April of 2009, the MMT programme had reached a total of 47 clients and had 36 clients attending regularly. The programme subsequently encountered difficulties (see Challenges section below), and at the time of the MTR, had only 16 regular clients. In interviews with the MMT experts dispensing methadone at the clinic, the Review Team found the quality of expertise to be very high.

According to reports from Journey, the MMT programme has ever enrolled a total of 3 women, one of whom was subsequently imprisoned, one who quit drugs and methadone, and one who is currently enrolled.

5.13 Scale-up of Harm Reduction

The Project has worked effectively to support scale-up of harm reduction programmes, most notably the MMT programme for which it supported training, supplied trained medical experts, and facilitated procurement of methadone through close cooperation with government. These strategies have served to support government ownership of programmes—an essential step towards scale-up.

5.14 Project Management

The Project has worked to put management structures in place in the Maldives, and has met with a number of challenges which were beyond the control of the Project (see Challenges section below).

In 2008, UNODC ROSA placed a Drug Demand Reduction Officer in Male for a period of three months, beginning in March 2008. The DDR Officer was responsible for coordinating the various Project activities in the Maldives, and the Project supported 80 percent of the cost for the DDR Officer. During this period, the Mentor Agency and Focal Point were identified, as were partner NGOs; inputs were solicited on the appropriate geographical location of demonstration sites, staffing, type of activities, and training needs, and these inputs were then included in the revised TORs. This exercise was useful in building ownership of the Project as well as avoiding duplication of activities in the field. In 2008, bi-monthly meetings were convened by the mentor agency to review Project progress. With the inception of the Methadone programme in October 2008, an OST with Methadone Steering Committee was formed, which met regularly to problem solve and provide direction to the clinic.

5.2 Challenges

5.21 Advocacy

The Project has encountered numerous challenges in the area of advocacy, many linked to circumstances beyond the Project's control, such as frequent institutional rearrangements within the government and consequent changing of the Focal Point. In addition, prohibitions on condom promotion and distribution and on NSP pose challenges for both advocacy and implementation of harm reduction programmes. (Condoms are available for purchase at pharmacies).

5.22 Effective Harm Reduction

Institutional instability in the Maldives has been an on-going challenge to the Project, and has impacted Project ability to support delivery of effective harm reduction services in a

number of ways: The planned translation of the toolkits had not been completed at the time of the MTR mission to Maldives. The Methadone Steering Committee was disbanded in 2009 following a change in government and has not been reconstituted.

In the area of training, the Review Team noted continued training needs expressed by H13 partners, including training on program management (SHE); on M&E (SHE, Journey and SWAD); on how to lead a ToT, on outreach (SWAD), and on HIV and drug education (SWAD).

The provision of counselling and social support services at the Male MMT clinic has proven challenging. When the clinic opened, SHE offered regular group counselling sessions at the clinic with the intent of improving adherence to the programme. During the MTR, SHE reported that although between 10 and 12 clients initially attended counselling sessions, the numbers dropped to only 1 or 2 clients per session, and SHE therefore decided to **discontinue counselling at the clinic**. SWAD had a similar experience in organising a self-help group for family members of MMT clients, noting that it was difficult to attract and retain family members to the group.

NSP are not currently operated in the Maldives and do not form part of the official package of interventions provided to IDUs. Anecdotal evidence suggests that while sterile injecting equipment can be procured relatively easily and cheaply from pharmacies, access for those who may be injecting drug users is limited.

Scale-up of the MMT program is challenging due to uncertainty about government support, insecure staffing, unforeseen disruptions to the clinic's schedule, and differences in understanding of MMT between the MMT doctors and the NGOs with most proximate access to drug users.

The MMT clinic does currently have staff including a psychiatrist, however, according to the Mentor Agency, staff are not permanently assigned to the clinic but are instead borrowed from other departments. This makes it difficult to ensure staff continuity.

Disruptions of the MMT clinic's dispensing schedule occurred in August and September 2009, when the administration of the Community Health Centre where the clinic is housed ruled that methadone should not be taken during daylight hours in observance of Ramadan. The clinic was ordered to shift dispensing hours from their regular morning time slot, to the evening, and dispensing time was limited to one hour. During this period, 17 clients relapsed (nearly half of the clients), and one committed suicide.

The MMT clinic medical experts also noted a disparity between their approach to MMT—based on the training they received from the Project consultant, and that of the partner NGOs. NGO capacity related to methadone was markedly weaker than that of the trained doctors at the MMT clinic. All the NGOs interviewed over the course of the MTR felt that the goal of the methadone program was for drug users to draw down their methadone dose and move towards abstinence. Some explained that the goal of the MMT programme was to "quit drugs totally, including methadone, over a 9 month period, with psycho-social support." NGO staff expressed a preference for detox to abstinence, were concerned about side-effects from methadone, and were not well versed in methadone

dosing (not fully aware that higher doses of methadone are appropriate to curtail or stop injection). Several also believed that MMT clients who are caught using heroine should be expelled from the methadone programme. Misgivings about the benefits of MMT were also evident during the MTR Team's meetings with the Mentor Agency, in which some Mentor Agency representatives argued that the programme's effectiveness was in doubt because clients continued to take other drugs, such as cannabis, and also cited clients smoking cigarettes inside the compound where the MMT clinic is located as an indication of poor MMT programme performance.

5.23 Scale up of Harm Reduction

Geography inherently renders the delivery of harm reduction services challenging in the Maldives. Drug users are spread over a large geographic area consisting of numerous islands and travel between islands is costly and time-consuming. The population of each island is small, and this means that the drug-using population is thinly spread over multiple disparate sites. NGOs working at the Project site on Hulhumale' reported, for instance, that there are 9 drug users living on the island and that 2-3 of them are injecting. This poses special challenges to achieving wide service coverage in the Maldives.

5.24 Project Management

The Project has encountered numerous challenges to its management component, most notably frequent changes in institutional arrangements within drug and HIV departments, accompanied by equally frequent changes in personnel and focal points. The focal point for the Project has been changed four times since 2008, and at the moment, the Project lacks a government appointed focal point—to be identified by the DDPRS.

In interviews during the MTR, most representatives from the Mentor Agency indicated that they were new to the Project and therefore have little institutional memory and are unsure about their roles and responsibilities vis-à-vis the Project. Most were not familiar with the H13 Project documents and said they had misplaced the file. Some pointed out that due to institutional changes, the DDPRS is now a small section under the Department of Medical Services in the Ministry of Health (while previously it was its own separate institution); as a result, they argued, their position in the political structure of the country has diminished, and one Mentor Agency representative said "we have no authority to do anything."

Some NGOs reported that budget cuts under the project rendered project management more challenging. One NGO reported that cutting the line for a project focal point at the NGO made it difficult to manage the project effectively. The NGO also reported that Project funding to support counsellors was insufficient and amounted to less than half of a counsellor's regular salary.

5.3 Conclusions and Recommendations

The H13 Project has made impressive strides towards improving harm reduction services for drug users in the Maldives. Notable achievements include the initiation of the

methadone maintenance programme in Male, the drafting of a new Drug Bill and its submission Parliament, its contribution to the National Strategic Plan on HIV/AIDS (2007-2012) which identifies IDUs as a priority, and its effective strategy of pooling NGO resources by bringing the three partner NGOs together in collaborative endeavours. The project has provided valuable training and capacity building to partner NGOs, has raised partner awareness about drug use, harm reduction and OST, and has worked skilfully within the local context to reach out to vulnerable drug-using populations: In this regard, the initiation of Health Camps—which simultaneously reached out to drug users and their communities and did so in an effective and culturally acceptable manner—is one of the most innovative aspects of the Project. In a similar manner, the Project partners have found ways to support condom promotion in a culturally appropriate manner by working through family planning services. In the area of Project management, the Project has adapted well to rapidly changing circumstances and institutional structures and has succeeded in maintaining relations with the Mentor Agency and contact with at least some Mentor Agency staff with institutional memory. It was clear to the Review Team that the Project has succeeded in garnering high level government support and supported the development of an enabling environment.

The Project has encountered numerous challenges in its work in the Maldives. These are enumerated below in tabular format, together with recommendations on ways to address them:

#	**Challenge**	**Recommendation**
1	Condom distribution and NSP are not allowed in the Maldives	NGO partners should continue to support the new Drug Bill and the Project should build government capacity to recognise NSP and condoms as methods of HIV prevention for IDU. Awareness raising of how other predominantly Muslim nations address issues of condom and needle distribution is warranted.
2	Toolkits are not available in the local language	Complete toolkit translation
3	The Methadone Steering Committee has been disbanded	Support reconstitution of the Methadone Steering Committee and advocate for methadone scale-up
4	Training needs remain	Offer trainings to NGOs in requested areas, notably on reporting and M&E, outreach, programme management, and refresher trainings on HIV and drug use as needed
5	High quality counselling services at the MMT clinic are not available	Build NGO capacity to provide quality harm reduction oriented counselling to MMT clients and support NGOs to resume counselling sessions at the clinic and

		with the families of drug users.
6	Access to methadone is restricted for people with pending or possible convictions leading to imprisonment	Work with project partners to advocate for access to methadone in prison settings. Advocacy in support of the new Drug Bill which will reduce prison sentences for drug users and peddlers (see #1 above)
7	The number of clients attending the MMT programme has diminished	Work with government to improve capacity to undertake MMT scale-up. Address issues around offering MMT during the month of Ramadan.
8	NGO capacity on MMT requires building	Build NGO capacity on MMT, if possible providing training for NGO staff on MMT in collaboration with the Project consultant and the medical staff at the MMT clinic.
9	Mentor Agency representatives are new to the Project and lack institutional memory	Brief Mentor Agency on the Project, if possible through a short workshop, provide them with the latest Project documents, and support them to interact with partner NGOs.

Comment on Inter- and Intra- UN Agency Coordination

H13 Phase II is predicated on inter- UN Agency cooperation. In April 2007, the joint UN workplan for the project was developed and submitted to UNAIDS. It defined the broad areas that would be covered by each of the three UN agencies collaborating on this project. It was agreed that UNAIDS and WHO would support activities related to advocacy, developing costing and procurement systems and providing technical inputs. A UN Coordination Meeting for the UN agencies partnering on the project was held in August 2007 in which the administrative and financial details between the partnering agencies were discussed.

The project has implemented inter-Agency cooperation through a series of meetings as well as through on-the-ground cooperation—most notably in Nepal.

Inter-Agency Meetings

A series of inter-Agency meetings have facilitated cooperation among the UN Agencies responsible for the project: At its inception, the project organized its Project Steering Committee meeting in Colombo on 15 November 2007; participants included national focal points and government counterparts from line ministries from seven SAARC countries, experts, representatives from AusAID, M E advisors, representatives from the Technical Advisory Group, UNAIDS, WHO and UNODC ROSA and Pakistan.

A subsequent meeting was held with UNAIDS, UNODC Pakistan, and ROSA in June 2008 to discuss ways forward for developing the advocacy strategy. UNAIDS took the lead to support the development of country and regional advocacy strategies.

A Project Management Meeting of UNODC, WHO and UNAIDS via telecom was held on 16 June 2008. It involved discussion of country M&E plans with UNAIDS and WHO, a calendar of activities for the remaining two quarters of 2008 and the advocacy strategy for the project. This was followed up with a face-to-face meeting between UNODC ROSA, UNODC Pakistan and UNAIDS on 20 June 2008. The meeting focused on issues around the approval of a pilot study on OST in Bangladesh, advocacy strategy, the role of the Technical Advisory Group in developing a training strategy, and reviewing the country assessments indicators and the list of uniform indicators for demonstration sites.

Additionally, a meeting of UNAIDS RST, UNODC ROSA and Pakistan, and the CSU-Nepal on 20 June 2008 was held to discuss the regional and national advocacy strategies.

Further regional level management meetings were held in Bangkok on 3 November 2008 and in Kathmandu on 11 February 2009. These meetings were held to coincide with other regional or H-13 events. The meetings provided an opportunity to update all partners on key planned activities, to agree on key regional activities and dates and to confirm management arrangements.

Country-Level Inter-Agency Coordination

Country-level inter-agency coordination related to H13 is much in evidence in **Nepal**. In 2007, meetings were held with the UNDP Project Management Unit to discuss issues related to duplication of interventions in Nepal and future collaboration in rolling out the IDU component of DFID's HIV support to UNDP. It was agreed that a common Terms of Reference for comprehensive services would be developed for partner agencies supporting IDU interventions in Nepal.

Coordination with UNDP has been a major collaborative achievement in Nepal. In 2008, it was agreed that UNDP would provide the needle, syringe and associated supplies to five Peer Led Intervention partners of the H13 project. This is similar to the arrangement for OST with Methadone in Nepal, where the medical unit was supported by UNODC and social support unit was supported by UNDP. (This arrangement operated until January 2010, when H13 took over responsibility for the MMT social units in both Kathmandu and Pokhara).

The Project in Nepal has also worked closely with the GFATM process in Rounds 7 and 9: The Country Support Unit was involved with UNDP, Technical Working Group, GFATM Round 7 in activities related to incorporating IDU issues in the national HIV/AIDS and drug plans. The project also contributed to reviewing DFID supported proposals on IDUs, GFATM Round 7 Expressions of Interests and Proposals, and coordinated with national counterparts on IDUs, including the Principal Recipient for GFATM Round 7—Save the Children, to avoid duplication and ensure proper utilization of resources. The project also coordinated with the Nepal CCM team in preparation for GFATM Round 9 Proposal.

In the course of the MTR, the Review Team found evidence of on-the-ground cooperation between project implementers and programmes funded by other donors. In Pokhara, for instance, the NGO Naulo Ghumti' offices were located in the same building as a VCT Centre supported by FHI, and Naulo Ghumti regularly refers clients there for VCT.

In the **Maldives**, the project has coordinated with GFATM initiatives. The project supported the development of and was closely involved with GFATM rounds in order to advocate for national ownership of its programs and interventions. In addition, the Project staff cooperated to develop a proposal to the European Commission to fund a drug demand reduction programme that compliments the H13 work, and that EC project has now been funded.

In **Bangladesh**, the project successfully collaborated with PPTCT—a UNICEF funded project, to refer clients from partner NGOs to the VCT unit of ICDDRB 'Jagori' where they can receive 'free of cost' VCT services. Jagori has also been conducting satellite VCT sessions in the DICs of the Dhaka-based partner NGOs.

In **Bhutan**, the Review Team found that collaboration and inter-agency linkages between the government sector, NGOs, H13 project, and other developmental partners were well established, especially in running the DIC and rehab and treatment centres.

In **Sri Lanka**, the project presented the *National Advocacy Strategy* to the UN Joint Team on AIDS and agreement was reached to include in the UNJTA 2010 workplan.

Intra-Agency Coordination

The MTR Team noted the close and productive coordination between H13 and UNODC's projects on Female IDU in both Nepal (Project J80) and Pakistan (Project J85). In Nepal, some of the H13 partner NGOs, such as Naulo Ghumti, also participate in J80, and this has yielded benefits for both projects' work to build gender capacity and to reach women IDU and female partners of male IDU with appropriate services. In Pakistan, participants from both H13 and J85 projects participated in a training workshop on developing gender-responsive harm reduction services, and this afforded them an opportunity to build gender capacity in both projects as well as to interact and learn from one another.

Analytical Section

This section provides analysis according to the following five points:

6. Review of the progress of project implementation against the project's design and timelines
7. Comment on the extent to which the objectives of the project continue to be consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies
8. Review of the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programmes in each country
9. Identification of strengths and weakness in project implementation and assessment of the extent to which the objectives of the activity are likely to be achieved
10. Recommendations to support mid-term correction of project activities

1. Review of the progress of project implementation against the project's design and timelines

This section reviews project progress against the project logframe and activities. Findings and gap analysis are based on MTR interviews in four countries, country workplans, and project reports. Each country office or Country Support Team developed national workplans on an annual basis indicating which activities they planned to carry out over specific time periods of one-year or less. The Review Team did not review any document that stipulated precise timeframes or goals for completing project activities that covered the lifespan of the project. The Analytical Table below, provides information from six countries—including the four countries that the team visited and the two countries where desk reviews were carried out—Pakistan and Sri Lanka. The Activities Table focuses on the four countries that the Team visited. The two countries where desk review only was carried out are not reviewed in the Activities Table because the team felt that country visits were necessary in order to accurately and completely report on project activities. However, the salient aspects of project activities in Pakistan and Sri Lanka are indicated in the Analytical Table, below.

The Analytical Table is followed by a brief comment on overall project progress. A more detailed discussion of the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programmes in each country (achievements under Components 1, 2 and 3) is provided under Point 3, below. Discussion of the strengths and weakness in project implementation and assessment of the extent to which the objectives of the activity are likely to be achieved (Components 1, 2 and 3 and Gaps indicated in the Analytical Table, and Activities analysis in the Activities Table) is provided under Point 4, below. Point 5 provides Recommendations based on the Gap Analysis outlined in the Analytical Table and discussed under Point 3. For facility in understanding the link between the gap analysis and the recommendations, a recommendation column has been included in the Analytical Table.

Analytical Table

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
Component 1: Advocacy to support change in policy and practice			
Output 1.1 Regional and national advocacy strategies for promoting evidence-based HIV prevention among drug using populations developed or strengthened	In Sri Lanka, in 2009, the *National Advocacy Strategy* was presented to the UN Joint Team on AIDS (UNJTA) and plans were made to include it in the UNJTA 2010 workplan. In Nepal the Advocacy Strategy has been developed and endorsed, the harm reduction has been incorporated into the National HIV/AIDS Strategy 2006-2011 (pre-Phase II) and the National Drug Control Strategy (during Phase II). In Bangladesh, the *Advocacy Strategy for Prevention of transmission of HIV among drug users in Bangladesh* has been endorsed by the government. In Bhutan, key elements of the project have been incorporated into the National Narcotics Drugs, Psychotropic Substances and Substance Abuse Act. The National Operational Plan 2010-2011 for the National Strategic Plan for Prevention and Control of	Work with law enforcement (Activity 1.1.9) has been extremely limited. NGO capacity for advocacy is low in all countries. In Nepal, the MMT Technical Working Group is not functioning. In Bangladesh, the Advocacy Strategy has yet to be translated into tangible policy outcomes. In Bhutan, the National Strategic Plan for Prevention and Control of STIs and HIV/AIDS, 2008 does not adequately	The Project should support NGOs to conduct grass-roots level advocacy for harm reduction. The Project should develop guidelines (or use/adapt existing guidelines) and/or training modules for police sensitization, and provide training. In Nepal, the program should support the revitalization of the MMT Technical Working Group, including both the DCP and the NCAC, to revise the Guidelines.

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
	STIs and HIV/AIDS, and an Action Plan, clearly identify the various issues and components related to drug use and prevention of HIV infection. In the Maldives, the project successfully advocated for the initiation of methadone treatment, and implementing partners have been actively engaged in drafting a new Drug Bill that would distinguish drug users from drug dealers; the Bill has been drafted and was pending in Parliament at the time of the Review. The project also contributed to the National Strategic Plan on HIV/AIDS (2007-2012) in Maldives. IDUs were identified as an immediate priority target and OST as an intervention where UNODC would take the lead.	reflect the issue of drug use and HIV. In the Maldives, the Methadone Steering Committee has been disbanded and the number of clients had dropped to 16 (from 36).	In Bangladesh, the project should advocate for the inclusion of key components of the Advocacy Strategy in national policies and plans. In Bhutan, support endorsement and implementation of the *Bhutan advocacy strategy paper on prevention of HIV among DU and their SP* and advocate for inclusion of drug use and HIV in The National Strategic Plan. In the Maldives, the project should continue to support the new Drug Bill and the Project should build government capacity to recognise NSP and condoms as methods of HIV

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
			prevention for IDU. The project should support reconstitution of the Methadone Steering Committee and advocate for methadone scale-up.
Output 1.2 Improved access to quality information on the status and impacts of the HIV epidemic	In Pakistan, the Project supported a baseline RSRA. In Sri Lanka, The H13 Phase II Project has supported advocacy via a midline RSRA designed to provide accurate information to stakeholders. In Bangladesh, a RSRA was conducted from December 2007 to March 2008. In Bhutan, a National baseline assessment of drugs and controlled substance use was carried out in 2009.	There have been no activities related to the database and the database initiative appears to have been dropped.	The project has provided strong data on drug use and HIV in all countries. This project goal has been achieved. The utility and feasibility of the regional database should be re-assessed.
Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners			
Output 2.1 Intervention toolkits developed by Project H13 in Phase I are widely disseminated and countries in	A training on Positive Living which includes a focus on spouses/partners of IDU has been developed at the regional level.	None of the toolkits have been translated in Nepal, Bhutan or the Maldives. Some of the toolkits have	The project should support finalisation of translation of training materials into local

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
the region adopt them in the local languages, and additional resources developed as required	In Pakistan, in 2010, the Positive Living visual aid and pamphlet were translated into Urdu, and a dissemination ceremony was organized on 5th May 2010. In Sri Lanka, translation began of all training modules toolkit except Module 4 and 5 (Buprenorphine and Methadone substitution) into Sinhala and Tamil in 2008; Pre-testing of the Sinhala translation of 3 intervention tool kits—Peer-Led Community Outreach, RSRA and low cost community based services (Health Camps) took place in 2009 under the leadership of the National Drugs Control Board. In 2010, the Positive Living Flip Chart was translated and printed in the local language. Some H13 partners in Nepal have some of the toolkits. In Bangladesh toolkits of Methadone substitution and Buprenorphine substitution have been translated into Bengali, and the Positive Living materials are in the process of being translated.	been translated in Pakistan, Sri Lanka, and Bangladesh. There is limited evidence to suggest that toolkits have been disseminated beyond the H13 partners. There appears to be significant overlap between the H13 toolkits and the WHO/UNODC/FHI training on Care and Treatment of HIV Positive IDUs No new guidelines on key areas identified in Project Phase II activities and recommended in the Phase I Review have been developed (ARV, managing overdose, drug interactions etc)	languages and dissemination. The project should develop new toolkits or guidelines in areas identified by beneficiaries and implementing partners, or else supply appropriate toolkits in these areas from other sources such as WHO and UNAIDS.

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
Output 2.2 NGOs from Phase I and new NGOs supported to provide and demonstrate quality services to drug-using populations	In Pakistan, trainings have been conducted on Rapid Situation and Response Assessment, on Positive Living, and on 'Gender responsive harm reduction services.' In Sri Lanka, A number of trainings took place in 2008, including a training on RSRA and Outreach, on Positive Living with a focus on women, and on LCCS. In Nepal, trainings were provided on PLI, Outreach, NSP and Positive Living. In Bangladesh, trainings were conducted on the National Peer Volunteers Lesson Plan (PVLP), Positive Living and Services for Female IDUs and Female Regular Sexual Partners of Male Drug Users; and on M&E, on Counselling, and on STI organized by ICDDR,B; and also a training from UNODC, ROSA on project implementation. In Bangladesh, clients from the demonstration sites clients are referred to dedicated and pre-linked institutions for services like VCT, drug treatment, partner management for STI diagnostic services, severe abscess or injury care, perinatal care,	Need for refresher trainings and repeat trainings for new staff. Staff require new trainings in areas such as vein care management, drug interactions, case management, and program management. In Nepal, LALS reported Project budget decreases forced them to close two of their four DICs. In Pokhara, Naulo Ghumti similarly reported that following budget decreases they closed one of their two DICs as well as one of their two outreach services—coverage dropped from over 800 regular clients to a current number of 550 clients. Referrals between DICs/harm reduction	Both new and old (funded under Phase I) NGOs require additional training, including repeat trainings that address counselling, outreach, case management and M&E, and trainings that address emerging issues such as vein care management and drug interactions. The project should support more training on MMT and include NGOs in the trainings. The project should provide training on building a referral network, with particular emphasis on referral from harm reduction programmes to HIV services such as VCT and ART, as well as regular technical

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
	PPTCT, ART and associated services, immunizations from the children of clients, and OI management. In Bhutan, trainings were conducted on RSRA, Basics of Drug /HIV for outreach and community involvement, Pre-DIC training and Pre-rehab training, counselling for drug dependence-issues and processes, and "Drug use and related HIV" for health care workers. The DICs in Bhutan are closely linked with the Detox Centre, and also provide referral for VCT, Management for STI, TB diagnosis and treatment, overdose management. In the Maldives, trainings were provided on the basics of drugs/HIV, outreach and community involvement, issues of drug use prevention, drug-related HIV vulnerabilities, M&E, and initiating peer led interventions and MMT.	services and HIV-related services, such as VCT and ART, remain challenging and limited in all countries. NGO understanding and support for MMT is particularly low.	assistance on referrals. Using more experienced NGOs in a mentor capacity—such as organising small NGO-led workshops or visits to experienced NGO project sites—will support less experienced NGOs to deliver services more effectively. The project should support this process. Scale down of established harm reduction services is detrimental to project goals. Established NGOs should be supported to sustain their levels of services and coverage.
Output 2.3 Demonstration sites demonstrate the "comprehensive community based approach" leading to	In Pakistan, the Project supports five implementing partners, offering medical treatment, psycho-social counselling (safer practices, behaviour change), abscess	**Staff turnover** at implementing partners (NGOs as well as government) remains a	Staff salaries need to be increased. The primary reason given for staff turnover—both in the

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
adoption of safer practices by clients	management, referrals, referral to anti-retroviral treatment, and family counselling. Only Marie Adelaide in Karachi is distributing clean needles/syringes. In Sri Lanka, nine DICs have been established and LCCS programmes were offered across eight distinct locations in 2008 and 2009. Vocational training has been offered at some locations. In Nepal, the project supports 13 NGOs offering NSP, PLIs and drop-in centres, as well as MMT at two hospital facilities. In Bangladesh, cross visits among the partner NGOs are conducted on a quarterly basis. The four implementing partners provide health education including HIV and STI related information, BCC and IEC materials, condom demonstration and distribution. MMT was approved in Bangladesh in April 2010. In Bhutan, the project supports services at 3 drop–in centres, and one Treatment and Rehabilitation Centre for Drug and Alcohol Dependence. The DICs provide information	challenge in all the countries. **NSP** is not widely offered under H13 Phase II. It began in Nepal only in 2009, and only one partner in Pakistan provides NSP. There is no H13-suported NSP in Bangladesh. **Methadone Treatment** is geared to drawing down the dose and is this primarily **methadone detoxification**, not methadone maintenance as defined by WHO. MMT programs retain a number of restrictions on access to their programmes, such as repeated attempts at abstinence. Coverage of methadone	Phase II and the Phase I Reviews, was non-competitive salaries. NSP through H13 should be scaled up in countries where it is offered (Nepal and Pakistan), and introduced where it is not (Bangladesh). In Bhutan, Sri Lanka and Maldives services are primarily offered to drug smokers, so advocacy efforts should focus on future introduction of NSP. The Project should clarify to Project Staff and implementing partners what MMT means, according to WHO Guidelines, and clarify the difference between MMT and methadone detoxification. The

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
	and education through IEC and BCC materials on drugs and HIV, referral to treatment for drug dependency, demonstration sessions on condom use, and condom distribution through networking. The also support Support Groups geared to maintaining abstinence. In the Maldives, the project supports three partner NGOs: Society for Health Education (SHE), Society for Women Against Drugs (SWAD) and Journey—a network of recovering drug users, and one pilot programme on Methadone Maintenance Therapy.	treatment is extremely limited. The current target for the Kathmandu Valley is 250 people on methadone in 2011, and the estimated IDU population in the Kathmandu Valley is 4,000 IDU. This means a maximum coverage target of 6.25% only. In Pokhara, the methadone program has been in operation since September 2008, but has still not succeeded in reaching its target of 100 clients. With the notable exception of LALS in Nepal, most NGOs have little understanding of methadone maintenance and are primarily abstinence-oriented.	Project should support MMT, not methadone detoxification. The Project should continue to support scale of methadone treatment, and set coverage targets that will have an impact. Remove prohibitive barriers to methadone treatment such as requirements of repeated attempts at abstinence. In Bangladesh, the project should seek appropriate information resources and develop gender-focused IEC/BCC materials. In particular, it should build implementers' capacity to meet maternal health needs through trainings on gender-responsible

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
		In Bangladesh, where the implementing partners focus on services for women, there is insufficient capacity to meet maternal health demands including ANC/PNC services and nutritional support to pregnant mothers and infants. In Bhutan, the implementing partners provide abstinence-oriented services. Also, there are no drug treatment options for women. In the Maldives, prohibitions on condom promotion and distribution and on NSP pose challenges for both advocacy and implementation of harm reduction programmes.	harm reduction. In Bhutan, the project should provide training and awareness raising opportunities focused on OST and harm reduction, for example through study tours. The project should support capacity building for offering gender-sensitive and female-friendly drug treatment services for women. In the Maldives, NGO partners should continue to support the new Drug Bill and the Project should build government capacity to recognise NSP and condoms as methods of HIV prevention for IDU. Work with project partners to advocate for access to methadone in

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
		Access to methadone is restricted for people with pending or possible convictions leading to imprisonment.	prison settings. Provide training for NGO staff on MMT in collaboration with the Project consultant and the medical staff at the MMT clinic.
Output 2.4 National/Regional Learning Centres established	In Pakistan, the Jinnah Post Graduate Medical College (JPMC) in Karachi was designated the National Learning Centre in 2008. In Sri Lanka, the National Dangerous Drug Control Board (NDDCB) has been identified as the National Training Centre. In Nepal, the Regional Learning Centre was established at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu	The National Learning Centre in Pakistan is not functioning due to ongoing unrest in the country. The Regional Learning Centre in Nepal is functioning, however training of regional stakeholders has been limited.	Expand the training activities of the Nepal Regional Training Centre and support it to train regional stakeholders.
Output 2.5 Strength technical capacity of the respective Governments and Non-Governmental Organisations for rigorous Monitoring and Evaluation	M&E support has been provided.	There is variation in the ways in which NGOs define "regular client." This makes it difficult to accurately ascertain NGO access to clients and measure service	The M&E system should be examined to ensure that reporting from partner NGOs is streamlined. Notably, NGOs should use the same definition of

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
		coverage.	"regular client" when reporting.
Output 2.6 Transition Plan and Exit Strategy for Partner NGOs	Not developed.	To date, little progress has been made to support sustainability of Project activities by facilitating linkages of the NGOs with the national resources (Activity 2.6.3)	The project should support NGOs to develop sustainability strategies that will allow continuation of their programmes beyond the project.
Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners			
Output 3.1 Costed "roll-out" plans on essential IDU interventions, phased operational targets, clear geographic and group priorities, human resource and management, procurement, M&E and QA/QC	A costed roll-out plans on interventions for IDU has been developed in all countries.	Implementation of the costed roll-out plans has not been completed.	The project should continue to support governments to roll-out implementation of harm reduction and drug treatment plans.
Output 3.2 Secure commodity supply for scaled-up risk reduction	In Pakistan, the Project held meetings with the Ministry of Health to brief health officials on OST and its procurement	Scale up is proceeding slowly and targets for clients accessing OST remain too low to have	The project should continue to provide TA support for increased procurement of

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
programs	processes. Meetings on procurement and scale-up have been held in Nepal and Bangladesh.	significant impact.	methadone to support scale-up.
Component 4: Project management			
Output 4.1 Project activities are planned with stakeholders	Stakeholders have been closely involved in planning project activities in all countries.	In Nepal, there has been little cooperation between the Ministry of Home Affairs and the Ministry of Health on Project Activities, and particularly on revising the MMT Guidelines.	As recommended in the Phase I Review, both the Ministries of Health AND Drug Agencies (Ministries of Home Affairs) should be equally involved in Project management. In most countries, the role of the Drug Agency now eclipses that of the Ministry of Health.
Output 4.2 Management and coordination arrangements for implementing the project at the regional and national level are in place	In Pakistan, a Country Support Unit (CSU) was established and reports directly to the UNODC Islamabad office, as recommended in the Review of Phase I. In Sri Lanka, the Project organised a study tour to Chennai and included both the focal point from NDDCB and the Director of	In the Maldives, frequent changes in institutional arrangements within drug and HIV departments, accompanied by equally frequent changes in personnel and focal points have posed	Management and coordination arrangements are in place in all countries. They require strengthening in the Maldives to address institutional and

Component Outputs	Summary of findings	Gaps	Summary Recommendations based on gaps
	National STD/AIDS Control Program (NSACP). In this way, the Project played a catalytic role in bringing the two ministries together. In Nepal, the CSU was established in 2007. In Bangladesh, there is no CSU. Instead, the HIV/AIDS Advisor in the UNODC country office together with the mentor agency oversee the project.	challenges for project management.	personnel changes.
Output 4.3 Project reports developed and submitted in a timely manner	Submitted regularly in all countries.	No gaps	Effectively established reporting system.
Output 4.4 Monitoring and Evaluation	M&E for project activities is well established.	NGOs in some countries find M&E challenging (e.g. some NGOs in Nepal).	M&E system is well established. Some NGOs require further training.

As evidenced in the Analytical Table above, as well as the Activities Analysis (page 93), it is clear that the project has made significant progress towards achieving its objectives (four components of the project) and its goal to reduce the spread of HIV among drug-using populations in SAARC countries by assisting governments and communities to scale up comprehensive HIV prevention and care programs for drug users, especially IDUs and their regular sexual partners.

To date, the project has focused the bulk of its activities on establishing effective management structures that focus on country-leadership, advocacy, and the establishment of demonstration sites. Country Support Units have been established in Pakistan, Sri Lanka and Nepal, and an alternative support structure has been developed in Bangladesh. In the area of advocacy, Advocacy Strategies have been successfully developed in all countries, along with costed roll-out plans. Access to improved data on drug use and HIV has been developed through RSRAs in Pakistan, Sri Lanka, Bangladesh and Bhutan. Demonstration sites are operational in all countries and the project has provided extensive training opportunities to implementing partners and key stakeholders. Stakeholders are closely involved in planning project activities in all countries.

2. Comment on the extent to which the objectives of the project continue to be consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies

The goal of the project is to reduce the spread of HIV among drug-using populations in SAARC countries by assisting governments and communities to scale up comprehensive HIV prevention and care programs for drug users, especially IDUs and their regular sexual partners. Data from the region shows that drug use and drug use-associated HIV infection continue to be serious problems and the project objectives are therefore consistent with beneficiaries' requirements and country needs, as well as with global priorities in the area of HIV/AIDS and with donors policies.

3. Review of the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programmes in each country

The project has been closely associated with key developments in national programming that support harm reduction approaches to HIV prevention among drug users and evidence-based drug treatment in each country. A key mechanism by which the project has linked to national programming has been the development of National Advocacy Strategies in each country and subsequent advocacy with key stakeholders on the basis of the Strategies. In Pakistan, the project has actively advocated for the introduction of opioid substitution therapy, and in 2010, the government approved the initiation of a pilot study that will include both methadone and buprenorphine treatment. In Nepal, harm reduction has been incorporated into the National HIV/AIDS Strategy 2006-2011 (pre-Phase II) and the National Drug Control Strategy (during Phase II). In Bhutan, he

National Operational Plan 2010-2011 for the National Strategic Plan for Prevention and Control of STIs and HIV/AIDS, and an Action Plan, clearly identify the various issues and components related to drug use and prevention of HIV infection. In the Maldives, the project successfully advocated for the initiation of methadone treatment, and implementing partners have been actively engaged in drafting a new Drug Bill that would distinguish drug users from drug dealers.

In terms of introducing comprehensive harm reduction programmes in each country, the project has made impressive contributions in each country—both by providing training and by establishing demonstration sites with implementing partners. In Pakistan, the Project supports five implementing partners, offering medical treatment, psycho-social counselling, abscess management, referrals, referral to anti-retroviral treatment, and family counselling. In Sri Lanka, nine DICs have been established and LCCS programmes were offered across eight distinct locations in 2008 and 2009. In Nepal, the project supports 13 NGOs offering NSP, PLIs and drop-in centres, as well as MMT at two hospital facilities. In Bangladesh, four implementing partners provide health education including HIV and STI related information, BCC and IEC materials, condom demonstration and distribution. MMT was approved in Bangladesh in April 2010. In Bhutan, the project supports services at 3 drop–in centres, and one Treatment and Rehabilitation Centre for Drug and Alcohol Dependence. And in the Maldives, the project supports three partner NGOs: Society for Health Education (SHE), Society for Women Against Drugs (SWAD) and Journey—a network of recovering drug users, and one pilot programme on Methadone Maintenance Therapy.

4. Identification of strengths and weakness in project implementation and assessment of the extent to which the objectives of the activity are likely to be achieved

Strengths

Key strengths of the project, as enumerated above under Point 2, are advocacy for promoting evidence-based HIV prevention among drug using populations, improved access to quality information on the status and impacts of the HIV epidemic, provision of extensive training opportunities in each country, and the establishment and strengthening of service provision sites in each country that demonstrate quality services to drug-using populations. Stakeholders have been closely involved in all project planning activities. In support of future scale-up, costed roll-out plan on interventions for IDU has been developed in all countries and meetings on procurement and meetings on scale-up have been held in Pakistan, Nepal and Bangladesh.

Gaps

Component 1: Advocacy to support change in policy and practice

While advocacy efforts have been a key achievement of the project, some gaps remain:

1. In Bangladesh, the Advocacy Strategy has yet to be translated into tangible policy outcomes. In Bhutan, the National Strategic Plan for Prevention and Control of STIs and HIV/AIDS, 2008 does not adequately reflect the issue of drug use and HIV. In addition, although the Advocacy Strategy has been endorsed in most countries, translation of that endorsement into clear targets for IDU service coverage, and on incorporating key elements of the comprehensive package such as MMT or NSP, or on drug user inclusion, has yet to take place. (Activity 1.1.2)

2. NGO capacity for advocacy is low in all countries, and community sensitization to and acceptance of harm reduction remains under-developed.

3. Work with law enforcement (Activity 1.1.9) has been extremely limited, and training modules for police and correctional facility staff have not been developed.

4. Introduction of evidence-based drug treatment in Nepal, Maldives and Bangladesh (and approval in Pakistan) is an important project success, however much remains to be done in terms of institutional support mechanisms, as well as implementation (see Component 2 discussion below) and scale-up (see Component 3 discussion below). In Nepal, the MMT Technical Working Group is not functioning. In the Maldives, the Methadone Steering Committee has been disbanded and the number of clients had dropped to 16 (from 36).

5. There have been no activities related to the database and the database initiative appears to have been dropped.

Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners

Although the project has made important progress in setting up demonstration sites with implementing partners, important gaps remain:

1. In the area of **training**, none of the toolkits have been translated in Nepal, Bhutan or the Maldives; some of the toolkits have been translated in Pakistan, Sri Lanka, and Bangladesh. There is also limited evidence to suggest that toolkits have been disseminated beyond the H13 partners, and important component to demonstrate effectiveness, build national capacity, and scale-up. In addition, there appears to be significant overlap between the H13 toolkits and the WHO/UNODC/FHI training on Care and Treatment of HIV Positive IDUs. In general, partner NGO understanding and support for MMT is particularly low. No new guidelines or toolkits on key areas identified in Project Phase II activities and recommended in the Phase I Review have been developed (ARV, managing overdose, drug interactions etc). Staff require new trainings in areas such as vein care management, drug interactions, case management, and program management. The Review of H13 Phase I also noted the need for new toolkits: "The need for further tool kits to be used in Phase II was identified – (e.g. on techniques and methodologies to prevent switching from oral drug use to injection drug use,

counselling, medical management of consequences of unsafe practices, negotiation for safe practices). (Review Phase I p. 20). The Regional Learning Centre in Nepal is functioning, however training of regional stakeholders has been limited.

2. **Staff turnover** at implementing partners (NGOs as well as government) remains a challenge in all the countries, and was primarily attributed to low salaries. (There is therefore a need for refresher trainings and repeat trainings for new staff). The Review of H13 Phase I also noted this issue: "There was real concern at the field level regarding the low pay for outreach workers and other project personnel. In some sites this has caused a large turnover of staff. In one demonstration site, all field staff had resigned prior to the consultant's visit and were only persuaded to stay when promises about a review of salaries was made." (Review H13 Phase I p.17)

3. In terms of **coverage**, some of the most experienced and effective implementing partners have **scaled down their services** under Phase II. In Kathmandu, LALS reported that project budget decreases forced them to close two of their four DICs. In Pokhara, Naulo Ghumti similarly reported that following budget decreases they closed one of their two DICs as well as one of their two outreach services—coverage dropped from over 800 regular clients to a current number of 550 clients. The Review of Phase I included recommendations for scaling-up coverage, notably: "Scaling up should *not* mean an increase in the number of demonstration sites but will require a certain re-distribution to allow for equity between countries, and a discontinuation of active work in some unsuitable sites or with unsuitable partners." (Review H13 Phase I). In Phase II, it appears that some of the most experienced NGOs have been obliged to scale down their harm reduction services, while new, and inexperienced, NGOs—a number of which are abstinence-oriented—have been added to the project.

4. **A number of partner NGOs in Nepal, as well as the implementing partner NGOs in Bhutan and Maldives are essentially abstinence-oriented**, and thus do not fully support harm reduction philosophy, as defined by the International Harm Reduction Association, namely: "Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs." (http://www.ihra.net/Whatisharmreduction). The Review of Phase I similarly noted the need to focus on delivering harm reduction services rather than abstinence-oriented approaches: " Phase II of project H13 must focus on HIV/AIDS prevention and not on drug use prevention per se." (Review H13 Phase I)

5. In terms of the **comprehensive package**, few implementing partners offer the complete package of services, including via referral. Referrals between

DICs/harm reduction services and **HIV-related services, such as VCT and ART, remain challenging and limited** in all countries. The Review of Phase I also noted the need to develop the full range of services at demonstration sites: "'Scaling up' responses in phase II should focus on increasing technical capacity on a national and local level and on developing the whole network of required services in demonstration sites." (Review H13 Phase I).

6. **NSP is not widely offered under H13 Phase II**. It began in Nepal only in 2009, and only one partner in Pakistan provides NSP. There is no H13-supported NSP in Bangladesh. In the Maldives, prohibitions on NSP (as well as on condom promotion and distribution) pose challenges for both advocacy and implementation of harm reduction programmes. It was not clear to the Review Team why NSP started late in Nepal, is offered at only one site in Pakistan, and is not offered in Bangladesh, given the project goal, articulated in the Project Document Phase II, of achieving 100% service coverage by 2010. The Review of Phase I stated that: "Needle and syringe programmes which had been initially envisaged by H13 were dropped due to directives from UNODC headquarters." (Review Phase I p. 20). The Review Team was not able to verify this explanation.

7. **Gender-sensitive services for women drug users and spouses of male drug users are limited in some countries.** The training on Positive Living which focuses on women and female spouses of male drug users has been provided throughout the region and spouses are a stated focus of the project. However, few H13 implementing partners have specific strategies or practices in place to access women drug users or female spouses of male drug users. It should be noted, however, that in Nepal and Pakistan, work on female drug users and spouses of male drug users has effectively been taken over by the UNODC project on women drug users, and in Bangladesh, the H13 project focuses exclusively on women drug users. Also, some of the partners in the Maldives do provide services to female family members of male drug users, however, access to and services for women drug users are limited. Partners in Bhutan and Sri Lanka have limited to no services for women, and in Bhutan, there are no drug treatment options for women. In Bangladesh, where the implementing partners focus specifically on services for women, there is insufficient capacity to meet maternal health demands including ANC/PNC services and nutritional support to pregnant mothers and infants.

8. **Correct understanding of methadone maintenance therapy is limited—especially among partner NGOs, there are prohibitive restrictions on access to MMT at some sites, and MMT coverage remains very low in all countries.** At all sites visited by the Review Team where methadone treatment is offered, most partner NGOs and some MMT staff clearly indicated that methadone treatment is geared to drawing down the methadone dose with the goal of abstinence (generally articulated as "getting clean" or becoming "drug-free"). This approach is **methadone detoxification**, not methadone maintenance, as defined by WHO. It is important to note that in both Nepal and Maldives where MMT

sites were visited, most medical professionals working at MMT programmes have a correct understanding of methadone maintenance and have been trained by the project consultant, Dr. S. Kumar.

[According to the WHO 2009 *Guidelines for Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*: "Opioid agonist maintenance treatment is defined as the administration of thoroughly evaluated opioid agonists, by accredited professionals, in the framework of recognized medical practice, to people with opioid dependence, for achieving defined treatment aims. Both methadone and buprenorphine are sufficiently long acting to be taken once daily under supervision, if necessary. When taken on a daily basis they do not produce the cycles of intoxication and withdrawal seen with shorter acting opioids, such as heroin. (p. x)….To maximize the safety and effectiveness of agonist maintenance treatment programmes, policies and regulations should encourage flexible dosing structures, with low starting doses and high maintenance doses, and without placing restrictions on dose levels and the duration of treatment. (p. xv)….A different approach is that of assisting people dependent on opioids to withdraw from opioids completely, a process also referred to as opioid detoxification. (p. x)….Opioid withdrawal (rather than maintenance treatment) results in poor outcomes in the long term (p. xii)].

MMT programs supported by H13 retain a number of restrictions on access to their programmes, such as repeated attempts at abstinence. In the Maldives, access to methadone is restricted for people with pending or possible convictions leading to imprisonment.

Coverage of methadone treatment is extremely limited. The current target for the Kathmandu Valley is 250 people on methadone in 2011, and the estimated IDU population in the Kathmandu Valley is 4,000 IDU. This means a maximum coverage target of 6.25% only. In Pokhara, the methadone program has been in operation since September 2008, but has still not succeeded in reaching its target of 100 clients. With the notable exception of LALS in Nepal, most NGOs have little understanding of methadone maintenance.

9. The project M&E system is on place, however, challenges remain for measuring project coverage, such as, **there is no uniform understanding among implementing partners about what constitutes a "regular" client.** Thus, some partners count clients as people who have been reached by services at least once, others as people who have been reached by services twice or more. This makes it impossible to accurately ascertain NGO access to clients and measure service coverage.

10. To date, **little progress has been made to support sustainability** of Project activities by facilitating linkages of the NGOs with the national resources (Activity 2.6.3).

Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners

1. Although costed roll-out plans on interventions for IDU has been developed in all countries, **implementation of the costed roll-out plans has not been completed**.

2. Scale up is proceeding slowly and targets for clients accessing OST, remain too low to have significant impact.

Component 4: Project management

1. In most countries, **involvement of the Ministries of Health / AIDS Control programmes is eclipsed by that of the Ministry of Home Affairs / Drug Control programmes.**

2. In some countries, such as the Maldives, **frequent changes in institutional arrangements within drug and HIV departments, accompanied by equally frequent changes in personnel and focal points** have posed challenges for project management.

5. Recommendations to support mid-term correction of project activities

Recommendations are directly linked to the gap analysis elaborated under Point 4 above, and are also outlined in the Analytical Table, above.

Recommendations for Component I: Advocacy to support change in policy and practice

1. **Support countries to translate Advocacy Strategies into National policies and plans.** In particular: In Bangladesh, the project should advocate for the inclusion of key components of the Advocacy Strategy in national policies and plans. In Bhutan, the project should support endorsement and implementation of the *Bhutan advocacy strategy paper on prevention of HIV among DU and their SP* and advocate for inclusion of drug use and HIV in The National Strategic Plan. In the Maldives, the project should continue to support the new Drug Bill and the should build government capacity to recognise NSP and condoms as methods of HIV prevention for IDU. [Responsible partners: Project staff, CSUs, focal points, other government counterparts].

2. **Support NGOs to conduct grass-roots level advocacy for harm reduction approaches to preventing HIV among drug using populations.** [Responsible partners: Project staff, implementing partner NGOs].

3. **Develop guidelines (or use/adapt existing guidelines) and/or training modules for police sensitization,** train partner NGOs on working with police and correctional facilities, and hold workshops for police and correctional facility staff including sensitization to harm reduction and evidence-based drug treatment. [Responsible partners: Project staff, implementing partners].

4. **Support the development of institutional mechanisms and policies that support evidence-based drug treatment.** In particular: In Nepal, the program should support the revitalization of the MMT Technical Working Group, including both the DCP and the NCAC, and revise the MMT Guidelines. In the Maldives, the project should support reconstitution of the Methadone Steering Committee and advocate for methadone scale-up (or at least continuation of the programme). [Responsible partners: Project staff, national government counterparts].

5. The utility and feasibility of **the regional database should be re-assessed**. [Responsible partners: Project staff].

Recommendations for Component 2: Demonstrate the effectiveness of comprehensive risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their sexual partners

The project should support finalisation of translation of training materials into local languages and dissemination.

1. **Continue and expand trainings and disseminate training materials to non-H13 partners**: Both new and old (funded under Phase I) NGOs require additional training, including repeat trainings that address counselling, outreach, case management and M&E, and trainings that address emerging issues such as vein care management and drug interactions. The project should develop new toolkits or guidelines in areas identified by beneficiaries and implementing partners, or else supply appropriate toolkits in these areas from other sources such as WHO and UNAIDS. The project should especially support more training on MMT and include NGOs in the trainings. The project should also provide training on building referral networks, with particular emphasis on referral from harm reduction programmes to HIV services such as VCT and ART, as well as regular technical assistance on referrals in these areas. Using more experienced NGOs in a mentor capacity—such as organising small NGO-led workshops or visits to experienced NGO project sites—will support less experienced NGOs to deliver services more effectively. The project should support this process. The training activities of the Nepal Regional Training Centre in Kathmandu should be expanded and it should be supported to train regional stakeholders. In all countries, training should be expanded, consolidated and continued. This recommendation echoes that from the Review of Phase I which stated: "Trained national and NGO personnel should be facilitated to provide training to other agencies in partnership with government counterparts." (Review Phase I). [Responsible partners: Project staff, experienced implementing partner NGOs, Regional Training Centre Kathmandu].

2. **Staff salaries should be increased to competitive levels.** The primary reason given for inordinately high staff turnover—both in the Phase II and the Phase I Reviews, was non-competitive salaries. [Responsible partner: Project].

3. **Support coverage and sustainability at high-performing implementing partners.** Scale down of established harm reduction services is detrimental to project goals. Established NGOs should be supported to sustain their levels of services and coverage. [Responsible partner: Project].

4. **Implementing partners that are abstinence-oriented do not support the project's stated goals and should be phased out of the project.** [Responsible partner: Project].

5. **Build implementing partners' capacity to offer HIV related services**—notably VCT and ART—on-site or via referral. [Responsible partner: Project]. This will help to bring H13 activities in line with WHO and UNODC's current recommended nine harm reduction interventions, namely: (1) NSP, (2) OST, (3) VCT, (4) ART, (5) STI, (6) condom promotion, (7) IEC, (8) diagnosis, vaccination and treatment of Hep B&C, (9) TB prevention, diagnosis and treatment.

6. **NSP through H13 should be scaled up in countries where it is offered (Nepal and Pakistan), and introduced where it is not (Bangladesh).** In Bhutan, Sri Lanka and Maldives, services are primarily offered to drug smokers / sniffers / chasers, so advocacy efforts should focus on sensitization for future introduction of NSP, as needed. In the Maldives, NGO partners should continue to support the new Drug Bill and the Project should build government capacity to recognise NSP (and condoms) as methods of HIV prevention for IDU. [Responsible partner: Project].

7. **Strengthen gender-sensitive service provision for female I/DU and the female spouses of male IDU.** The project should support capacity building for offering gender-sensitive and female-friendly harm reduction and drug treatment services for women. In Bangladesh, the project should seek appropriate information resources and develop gender-focused IEC/BCC materials for women. In particular, it should build implementers' capacity to meet maternal health needs through trainings on gender-responsible harm reduction. [Responsible partner: Project, implementing partner NGOs].

8. **The Project should support MMT, *not* predominantly methadone detoxification.** The Project should clarify to project staff and implementing partners what MMT means, according to WHO Guidelines, and clarify the difference between MMT and methadone detoxification. (A few project staff unequivocally stated that drawing down the methadone dose ***is*** methadone maintenance therapy). Prohibitive barriers to methadone treatment, such as requirements of repeated attempts at abstinence, should be removed. The Project should continue to support scale-up of methadone treatment (maintenance), and set coverage targets that will have an impact. In the Maldives and Nepal, the Project should work with partners to advocate for access to methadone in prison settings, and provide training for NGO staff on MMT, in collaboration with the Project consultant and the medical staff at the MMT clinics and Regional Training

Centre. [Responsible partner: Project staff, Regional Training Centre, Kathmandu].

9. **The M&E system should be examined to ensure that reporting from partner NGOs is streamlined in order to accurately measure coverage.** Notably, NGOs should use the same definition of "regular client" when reporting. [Responsible partner: Project].

10. **The project should support NGOs to develop sustainability strategies** that will allow continuation of their programmes beyond the project. [Responsible partner: Project, implementing NGOs, government counterparts].

Recommendations for Component 3: Scaled up risk reduction approaches to reduce HIV transmission among drug users, especially IDU and their regular sexual partners

1. **The project should continue to support governments to roll-out implementation of harm reduction and drug treatment plans**. [Responsible partners: Project, government counterparts].

2. **The project should continue to provide TA support for increased procurement of methadone to support scale-up**. [Responsible partners: Project, government counterparts].

Recommendations for Component 4: Project management

1. As recommended in the Phase I Review: **Both the Ministries of Health *and* Drug Agencies (Ministries of Home Affairs) should be *equally* involved in Project management**. In most countries, the role of the Drug Agency currently eclipses that of the Ministry of Health. This likely accounts for the comparatively poor capacity of implementing partners to adequately provide key HIV-related services such as VCT and ART.

2. Management and coordination arrangements are in place in all countries. **Management and coordination arrangements require strengthening in the Maldives** to address institutional and personnel changes.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
Component 1: Advocacy to support change in policy and practice				
Objective: To ensure commitment of national authorities and development partners to scale up comprehensive HIV prevention and care programs for IDUs.				
Output 1.1: Regional and national advocacy strategies for promoting evidence-based HIV prevention among drug using populations developed or strengthened.				
1.1.1 Brief the respective UN Regional Offices and UN Theme Groups on advocacy initiative and request high-level engagement	UN Regional Offices and UN Theme Groups briefed.	UN Regional Offices and UN Theme Groups briefed.	UN Regional Offices and UN Theme Groups briefed.	UN Regional Offices and UN Theme Groups briefed.
1.1.2 Organise national meetings of key stakeholders to achieve consensus from member countries on: • Including as part of the goals of Universal Access, ensuring human rights and gendered approaches, clear targets for IDU service coverage, identify gaps in achieving them and develop solutions to overcome them • a basic package of essential intervention elements into	Meetings with key stakeholders have been held. Consensus has yet to be reached on establishing clear targets for IDU service coverage, on key elements of the comprehensive package such as MMT and NSP, or on drug user inclusion.	Meetings with key stakeholders have been held. Consensus has yet to be reached on establishing clear targets for IDU service coverage, on key elements of the comprehensive package such as MMT scale-up, or on drug user inclusion.	Meetings with key stakeholders have been held. Consensus has yet to be reached on establishing clear targets for IDU service coverage, on key elements of the comprehensive package such as MMT or NSP, or on drug user inclusion.	Meetings with key stakeholders have been held. Consensus has yet to be reached on establishing clear targets for IDU service coverage, on key elements of the comprehensive package such as MMT, NSP or condom distribution (the latter two are illegal), or on drug user inclusion.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
interventions targeting injecting drug users irrespective of laws regulations and policies • including drug users at all levels in program design, implementation and M&E				
1.1.3 Identify key decision makers and key obstacles on IDU related legal and policy issues	Achieved.	Achieved.	Achieved.	Achieved.
1.1.4 Formulate and prepare country advocacy strategies, with specific targeting of policy makers, programmers, law enforcement agencies, religious leaders and other key groups to promote HIV prevention, care and support for drug users especially IDUs and their regular sex partners.	Country Advocacy Strategies developed and endorsed. Nepal's National HIV/AIDS Strategy 2006-2011 articulates the need for harm reduction services targeting IDU, and Nepal has recently revised its National Drug Control Strategy to support harm reduction, along side demand reduction and supply reduction.	Country Advocacy Strategies developed.	In Bhutan, key elements of the project have been incorporated into the National Narcotics Drugs, Psychotropic Substances and Substance Abuse Act. The National Operational Plan 2010-2011 for the National Strategic Plan for Prevention and Control of STIs and HIV/AIDS, and an Action Plan, clearly identify the various issues and components related to drug use and prevention	In the Maldives, the project successfully advocated for the initiation of methadone treatment, and implementing partners have been actively engaged in drafting a new Drug Bill that would distinguish rug users from drug dealers; the Bill has been drafted and was pending in Parliament at the time of the Review. The project also contributed to the

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
	Revision of the Nepal Drug Control Strategy to include support for harm reduction.		of HIV infection.	National Strategic Plan on HIV/AIDS (2007-2012) in Maldives. IDUs were identified as an immediate priority target and OST as an intervention where UNODC would take the lead.
1.1.5 Explore the potential benefits of a regional advocacy strategy, and if considered appropriate, develop strategy with key stakeholders	The project has focused on country-level advocacy strategies.	The project has focused on country-level advocacy strategies.	The project has focused on country-level advocacy strategies.	The project has focused on country-level advocacy strategies.
1.1.6 Prepare evidence based advocacy material at the national and regional level for identified target groups as appropriate	Materials developed by some implementing partners, such as LALS.	Materials developed by some implementing partners.	Materials developed by some implementing partners.	Materials developed by implementing partners.
1.1.7 Ongoing advocacy by UN and development partners on changes in IDU related policy and regulations based on compiled advocacy material (UNODC, UNAIDS RST, WHO,	Advocacy on-going.	Advocacy on-going.	Advocacy on-going.	Advocacy on-going.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
UN Resident Coordinator)				
1.1.8 Support other stakeholders, in particular drug user communities and civil society organisations, to undertake advocacy	CSO and other stakeholders have low level of access to policy-makers and limited advocacy capacity.	Limited CSO and drug user community advocacy.	There is a need for community-level advocacy—which is not yet in evidence.	Implementing partners are active in advocacy efforts.
1.1.9 Identify opportunities for mainstreaming IDU/HIV concerns into existing training for law enforcement officers including judiciary, police and correctional facility staff and develop/adapt and implement training modules as required	The Siddhi Memorial Foundation DIC in Bhaktipur has worked on the coordination and sensitization of the local police force. Training modules for police and correctional facility staff not developed.	Limited engagement of law enforcement. Training modules for police and correctional facility staff not developed.	Limited engagement of law enforcement. Training modules for police and correctional facility staff not developed.	Limited engagement of law enforcement. Training modules for police and correctional facility staff not developed.
1.1.10 Arrange periodic meetings with the community opinion leaders and law enforcement officers to enhance support for HIV prevention, care and treatment for IDUs and their sex partners.	Some localized meetings have taken place.	Limited progress.	Limited progress.	Limited progress.
1.1.11 Monitor impact	Project is aware of	Project is aware of	Project is aware of	Project is aware of

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
of advocacy strategy and review as required	impact.	impact.	impact.	impact.
Output 1.2: Improved access to quality information on the status and impacts of the HIV epidemic				
1.2.1 Facilitate countries to archive and/or access secondary data on drug and HIV through the database established in Phase I.	Database initiative not active.	Database initiative not active.	Database initiative not active.	Database initiative not active.
1.2.2 Train the implementing agencies in analysis and reporting of the data generated through initial and repeat rapid situation and response assessments in order to document the status of the epidemic and to develop and redesign interventions appropriately. *(This Activity will be carried out in conjunction with Activity 2.3.3 and Activity 2.5.2)*	Done in Phase I.	In Bangladesh, a Rapid Situation and Response Assessment was conducted from December 2007 to March 2008.	In Bhutan, a National baseline assessment of drugs and controlled substance use was carried out in 2009.	Not done.
1.2.3 Help the countries with the database initiative by strengthening the local	Database initiative not active.	Database initiative not active.	Database initiative not active.	Database initiative not active.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
capacity for data management.				
Component 2: Effective risk reduction approaches to reduce HIV transmission among drug users especially IDU and their regular sex partners.				
Objective: To demonstrate the effectiveness of risk reduction approaches				
Output 2.1: Intervention toolkits developed by Project H 13 in Phase I are widely disseminated and countries in the region adopt them in the local languages and additional resources developed as required.				
2.1.1 Disseminate widely, modules of the intervention toolkits developed during phase-I of the project, based on country specific needs	LALS has the toolkits. It was not clear how many of the other NGOs have the toolkits, or whether the toolkits have been disseminated beyond the H13 partners.	Implementing partners have the toolkits. It is not clear whether the toolkits have been disseminated beyond the H13 partners.	Implementing partners have the toolkits. It is not clear whether the toolkits have been disseminated beyond the H13 partners.	Implementing partners have the toolkits. It is not clear whether the toolkits have been disseminated beyond the H13 partners.
2.1.2 Encourage country adoption of the modules through translation and local adoption, consensus building through national dissemination workshops etc.	No toolkits have been translated.	Toolkits of Methadone substitution and Buprenorphine substitution have been translated into Bengali, and the Positive Living materials are in the process of being translated.	It was decided not to translate the toolkits, because it was felt they would be more accessible in English.	No toolkits have been translated.
2.1.3 Develop additional standards and guidelines, if required, to provide IDU care and support including ARV, managing overdose,	A training on Positive Living which includes a focus on spouses/partners of IDU has been developed at the regional level.	A training on Positive Living which includes a focus on spouses/partners of IDU has been developed at the regional level.	A training on Positive Living which includes a focus on spouses/partners of IDU has been developed at the regional level.	A training on Positive Living which includes a focus on spouses/partners of IDU has been developed at the regional level.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
drug interactions, size estimation, engendering outreach interventions etc	Specific standards/guidelines on ARV, overdose, drug interactions, have not been developed. These are available elsewhere.	Specific standards/guidelines on ARV, overdose, drug interactions, have not been developed. These are available elsewhere.	Specific standards/guidelines on ARV, overdose, drug interactions, have not been developed. These are available elsewhere.	Specific standards/guidelines on ARV, overdose, drug interactions, have not been developed. These are available elsewhere.
Output 2.2: NGOs from Phase I and new NGOs supported to provide and demonstrate quality services to drug-using populations				
2.2.1 Enhance learning opportunities in the region through developing appropriate linkages with training programs/placements: • Maintain a roster of regional and national experts • Establish a training database • Establish a training and placement calendar at the national and regional level • Suggest mechanisms and opportunities to provide IT enabled distance learning	Training calendar developed. Roster, database, and IT enabled distance learning opportunity not developed.	Training calendar developed. Roster, database, and IT enabled distance learning opportunity not developed.	Training calendar developed. Roster, database, and IT enabled distance learning opportunity not developed.	Training calendar developed. Roster, database, and IT enabled distance learning opportunity not developed.
2.2.2 Train appropriate individuals and	In 2008 trainings were provided on PLI,	Trainings were conducted on the	Trainings were conducted on RSRA,	Trainings were provided on the basics of

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
organizations in the following: rapid situation and response assessment, size estimation, peer-led interventions, safer practices, low-cost community based care & support including ARV and opioid substitution treatment	Outreach, NSP and Positive Living with a focus on women, 'Treatment of Positive IDUs;' an international Training of Trainers on the 'Care and Treatment of HIV Positive IDUs,' a collaborative effort among WHO, UNODC and FHI was held. In 2009, a three day training was provided on MMT.	National Peer Volunteers Lesson Plan (PVLP), Positive Living and Services for Female IDUs and Female Regular Sexual Partners of Male Drug Users; and on M&E, on Counselling, and on STI organized by ICDDR,B; and also a training from UNODC, ROSA on project implementation.	Basics of Drug /HIV for outreach and community involvement, Pre-DIC training and Pre-rehab training, counselling for drug dependence-issues and processes, and "Drug use and related HIV" for health care workers.	drugs/HIV, outreach and community involvement, issues of drug use prevention, drug-related HIV vulnerabilities, M&E, and initiating peer led interventions and MMT.
2.2.3 Assist the demonstration sites to develop comprehensive package of essential services for IDUs, opioid users and their sex partners through the establishment of referral network services	Some referrals are in place, including to VCT and ART.	Clients are referred to dedicated and pre-linked institutions for services like VCT, drug treatment, partner management for STI diagnostic services, severe abscess or injury care, perinatal care, PPTCT, ART and associated services, immunizations from the children of clients, and OI management	The DICs are closely linked with the Detox Centre, and also provide referral for VCT, Management for STI, TB diagnosis and treatment, overdose management.	Some referrals are in place, including MMT.
Output 2.3: Demonstration sites demonstrate the "comprehensive community based approach" leading to adoption of safer practices by clients.				

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
2.3.1 Strengthen capacity of the implementing agencies to deliver a comprehensive package of services through funding and technical assistance.	The project supports 13 NGOs offering a comprehensive package of harm reduction services including needle and syringe programmes, peer led interventions and drop-in centres, as well as Methadone Maintenance Treatment at two hospital facilities (current number of clients is 262. In 2009, needle and syringe programmes were effectively incorporated as part of the comprehensive package	The project supports 4 implementing partners who provide health education including HIV and STI related information, BCC and IEC materials, condom demonstration and distribution. MMT was approved in Bangladesh in April 2010.	The project supports services at 3 drop–in centres, and one Treatment and Rehabilitation Centre for Drug and Alcohol Dependence. The DICs provide information and education through IEC and BCC materials on drugs and HIV, referral to treatment for drug dependency, demonstration sessions on condom use, and condom distribution through networking. The also support Support Groups geared to maintaining abstinence.	The H13 project supports three partner NGOs in the Maldives: Society for Health Education (SHE), Society for Women Against Drugs (SWAD) and Journey—a network of recovering drug users, and one pilot programme on Methadone Maintenances Therapy. The NGOs have organised Community-Based Health Camps, to mobilize drugs users, civil society and government agencies. SHE has worked through its family planning services to increase awareness of condoms as a method of HIV prevention. Journey refers clients to the MMT program and provides psycho-social support to MMT clients. Journey also provides instruction on safe

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
				injection, overdose management, relapse prevention, condom promotion, hosts NA meetings and has recently begun a VCT service.
2.3.2 Identify appropriate demonstration site indicators for mid course correction.	Indicators not developed. To be developed on the basis of MTR.	Indicators not developed. To be developed on the basis of MTR.	Indicators not developed. To be developed on the basis of MTR.	Indicators not developed. To be developed on the basis of MTR.
2.3.3 Train the implementing agencies in analysis and reporting of the data generated through initial and repeat rapid situation and response assessments in order to document the status of the epidemic and to develop and redesign interventions appropriately *(This Activity will be carried out in conjunction with Activity 1.2.2 and Activity 2.5.2)*	Done in Phase I.	Done	Done	Not done.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
2.3.4 Support linkages between demonstration sites and government.	Not a specific activity, however, some NGOs report visits from government partners.	Not a specific activity.	Not a specific activity.	NGOs actively working with government on new Drug Law.
2.3.5 Support linkages between demonstration sites and the National and Regional Learning Centres, including placement learning opportunities for service providers trained at the National and Regional Learning Centres.	Not a specific activity.	Not a specific activity.	Not a specific activity.	Not a specific activity.
2.3.6 Document the lessons learned in the demonstration sites for wider dissemination in the country and the region.	Not done.	Not done.	Not done.	Not done.
2.3.7 Organize cross field visits to the demonstration sites from government and community agencies and by neighbouring countries.	Not done.	Cross visits among the national partner NGOs are conducted on a quarterly basis. International cross visits not done.	Not done.	Not done.
2.3.8 Facilitate adoption of funding of demonstration sites from	Not done.	Not done.	Not done.	Not done.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
national resources within the life of the project.				
2.3.9 Strengthen capacities of demonstration sites to advocate for a comprehensive package of services as part of the national strategy *(Linked to Activity 1.1.8)*	Not done.	Not done.	Not done.	Comprehensive package is illegal in the Maldives—notably NSP and condom distribution.
2.3.10 Support communities to form self-help groups around income generation.	Not done.	Not done.	Not done.	Not done.
Output 2.4: National/Regional Learning Centres established				
2.4.1 Establish criteria for new Regional Learning Centres.	Regional Learning Centre established at Tribhuvan University Teaching Hospital (TUTH) in Kathmandu	National Learning Centre established at the International Centre for Diarrhea Disease Research, Bangladesh (ICDDR, B)	No National learning Centre.	No National learning Centre.
2.4.2 Provide technical assistance and institutional support to specific agencies to develop them as sustainable National Learning Centres.	Technical support provided by project consultant, Dr. S. Kumar.	Unclear from Review.	Not applicable.	Not applicable.
2.4.3 Support National	Linkages in place.	Unclear from Review.	Not applicable.	Not applicable.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
Learning Centres to provide ongoing linkages to Demonstration Sites.				
2.4.4 Document the lessons learned for wider dissemination in the region.	Not done.	Not done.	Not done.	Not done.
Output 2.5: Strengthen technical capacity of the respective Governments and Non Governmental Organisations for rigorous Monitoring and Evaluation				
2.5.1 Strengthen National Focal Points through supporting their offices with technical assistance from CSUs to manage and mentor the project, based on the Monitoring and Evaluation tools developed for the project.	Support provided.	No CSU in Bangladesh.	Not clear from Review.	Not provided due to frequent changes in focal point. There is currently no focal point.
2.5.2 Train the implementing agencies in analysis and reporting of the data generated through initial and repeat rapid situation and response assessments in order to document the status of	Done.	Done.	Done.	Done.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
the epidemic and to develop and redesign interventions appropriately. *(This Activity will be carried out in conjunction with Activity 1.2.2 and Activity 2.3.3)*				
2.5.3 Support Governments to integrate risk reduction indicators in national M&E plans	Support provided.	Support provided.	Support provided.	Support provided.
2.5.4 Support the inclusion of (injecting) drug use indicators in national surveillance systems	Support provided.	Support provided.	Support provided.	Support provided.
Output 2.6: Transition Plan and Exit Strategy for Partner NGOs				
2.6.1 Review the Partner NGOs with National Focal Points and CSUs to remove non-performing NGOs, NGOs not addressing risk-reduction among IDUs and oral opioid users and NGOs which were not in geographic cohesion to serve as	Done at initiation of Phase II. A number of implementing partners continue to be abstinence oriented.	Done at initiation of Phase II. A number of implementing partners continue to be abstinence oriented.	Implementing partners continue to be abstinence oriented.	Implementing partners are abstinence oriented, with the exception of the methadone programme.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
cost-effective placement learning sites.				
2.6.2 Disbursement of obligated amounts to Partner NGOs	Done.	Done.	Done.	Done.
2.6.3 Facilitate linkages of the NGOs with the national resources	Not done.	Not done.	Not done.	Not done.
Component 3: Scaled-Up Risk Reduction Interventions to reduce HIV transmission among drug users especially IDU and their regular sex partners				
Objective: Governments plan and implement risk reduction interventions essential to a comprehensive response to HIV prevention among drug users especially IDU and their regular sex partners				
Output 3.1: Costed 'roll-out' plans on essential IDU interventions, phased operational targets, clear geographic and group priorities, human resource and management, procurement, M&E and QA/QC				
3.1.1 Support governments to develop nationally endorsed drug substitution policies	Support provided, methadone program is growing, coverage remains very low.	MMT was approved by the government in Bangladesh in April 2010. The project contributed to supporting this development.	Methadone not approved and government is not supportive.	Support provided. However, methadone programme is rapidly losing clients.
3.1.2 Support governments to include risk reduction interventions in national AIDS Strategic Plans and Universal Access Plan	Nepal's National HIV/AIDS Strategy 2006-2011 articulates the need for harm reduction services targeting IDU (Pre-H13 Phase II)	National Advocacy plan has not translated into policy outcomes.	Risk reduction not included in government HIV plans.	Drug Law under review during MTR. Harm reduction not included.
3.1.3 Support	Support provided.	Support provided.	Support provided.	Project focus is on

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
governments to develop comprehensive national risk reduction plans, including target, identified obstacles and solutions	National risk reduction plan not developed.	National risk reduction plan not developed.	National risk reduction plan not developed.	Health Camps. Harm reduction interventions not acceptable (illegal) in the Maldives.
3.1.4 Support governments to identify financing gaps and resource mobilization strategies	A costed roll-out plan on interventions for IDU has been developed.	A costed roll-out plan on interventions for IDU has been developed.	Bhutan Advocacy Strategy costed work plan for 1 year has been developed and submitted to the UNODC for possible funding support.	A costed workplan has been developed.
Output 3.2: Secure commodity supply for scaled-up risk reduction programs				
3.2.1 Develop a regional database with frequently updated information on specific goods, quality, prices of HIV risk reduction materials and supplies and thematic experts.	Not done.	Not done.	Not done.	Not done.
3.2.2 Review the benefits and acceptability of a regional vs. national procurement systems	Focus on national procurement.	Focus on national procurement.	Focus on national procurement.	Focus on national procurement.
3.2.3 Based on above, assist with the development of	Support provided.	Support provided.	Support provided.	Support provided.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
regional/national procurement guidelines systems				
3.2.4 Organize training with appropriate technical support, on all aspects of procurement to key stakeholders from the concerned nodal agencies of governments	Not done.	Not done.	Not done.	Not done.
Component 4: Project Management				
Objective: To effectively and efficiently manage the project and to provide monitoring, evaluation and reporting on project activities and outputs				
Output 4.1: Project Activities are planned with stakeholders				
4.1.1 Detailed regional and national project operational plans are developed with, and endorsed by, government, civil society, drug user communities and UN partners	Workplans developed.	Workplans developed.	Workplans developed.	Workplans developed.
Output 4.2: Management and coordination arrangements for implementing the project at the regional and national level are in place				
4.2.1 Regional project office plays the core facilitation and management role with	Regional project office plays the core role.	Regional project office plays the core role.	Regional project office plays the core role.	Regional project office plays the core role.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
member countries in the region, including liaison with UNODC Pakistan, UNAIDS RST, WHO SEARO52, UN co-sponsors as well as the international donor community				
4.2.2 Establish Country Support Units (CSU) at the country level in Bangladesh, Nepal, Pakistan and Sri Lanka to coordinate the implementation of various activities at the country level and to work closely with the Regional project office.	Country Support Unit established in 2007.	In Bangladesh, there is no CSU. Instead, the HIV/AIDS Advisor in the UNODC country office together with the mentor agency oversee the project.	Unclear from Review.	CSU is not functional due to frequent institutional changes in the Maldives.
Output 4.3: Project Reports developed and submitted in a timely manner				
4.3.1 Submit narrative and financial reports	Done.	Done.	Done.	Done.
Output 4.4: Monitoring and Evaluation				
4.4.1 Develop and implement a project M&E framework and processes using existing mechanisms where possible.	Done.	Done.	Done.	Done.

Activities Column	Nepal	Bangladesh	Bhutan	Maldives
4.4.2 Utilize appropriate existing mechanisms for M&E, including the UN Regional Task Force on 'IDU and HIV' in Asia and the Pacific to provide expertise and experience from other countries of the region in drawing up an overall project specific M&E at local, national and regional levels and the proposed AusAID Technical Advisory Group for South Asia	Done.	Done.	Done.	Done.
4.4.3 Provide M&E information as required to stakeholders	Done.	Done.	Done.	Done.

List of Meetings by Country

Nepal

Joint Partner Meeting March 17, 2010

Partner NGO	**Attendance**
Association for Helping the Helpless	Attended
Kirat Yakthung Chumlung Punarjiwan Kendra	Attended
Knight Chess Club	Attended
Lifesavings and Lifegiving Society (LALS)	Attended
Najarjun Development Community	Attended
NAMURA Integrated Development Council	Attended
Naulo Ghumti	Attended
Naya Goreto	Absent
PRERANA	Attended
Richmond Fellowship Nepal	Attended
Siddhi Memorial Foundation	Attended
Student Awareness Forum (BIJAM)	Attended
Youth Vision	Attended

Meetings

Name	**Title**	**Date**
Shankar Prasad Koirala	Joint Secretary, Planning and Special Services, Ministry of Home Affairs	March 18, 2010
Padma Shree Shreshta & Rajesh Man Singh	Programme Manager Staff Lifesaving and Lifeliving	March 18, 2010

	Society (LALS)	
Anan Pun	Recovering Nepal	March 18, 2010
Shyam S. Dhaubhadel	Siddhi Memorial Foundation, Bhaktapur	March 19, 2010
Lumeshome Acharya	Director MMT Programme, Western Regional Hospital, Pokhara	March 21, 2010
Bobin Nepali Sandash Subedi Padam Lama Mana Gyawalu	HR Program Officer Finance Coordinator Outreach Team Leader Director NGO Naulo Ghumti, Pokhara	March 22, 2010
Saroj Prasad Ojha	Associate Professor, Tribhuvan University Teaching Hospital, MMT Director, H13 Regional Learning Centre	March 23, 2010

Site Visits

Site	**Description of People met**	**Date**
Lifesaving and Lifeliving Society DIC, Kathmandu	DIC staff and outreach workers	March 18, 2010
MMT Site Panipokhari	Staff, clients, social unit staff	March 19, 2010
Siddhi Memorial Foundation DIC, Bhaktapur	DIC staff and outreach workers	March 19, 2010

Joint Partner Meeting, March 24th, 2010

Partner NGO	**Attendance**
Light House	attended

Dhaka Ahsania Mission (DAM)	attended
Ashokti Punorbashon Nibash (APON)	attended
Society for Community Health Rehabilitation Education Awareness (CREA)	attended

Bangladesh

Meetings

Name	**Title**	**Date**
Tasnim Azim Ezazul Islasm Chowdhury	Focal Point International Centre for Diarrhea Disease Research, Bangladesh (ICDDR,B)	March 24th, 2010
Salil Panakadan Avra Saha Munir Ahmed	Country Coordinator Adviser HIV/AIDS Social Mobilization and Partnership Adviser	March 24th, 2010
Abdur Rahman	Program Manager, National AIDS and STD Program (NASP)	March 25th, 2010
Monowar Islam	Additional Secretary and DG, DNC, MoHA,B	March 25th, 2010

Site Visits

Site	**Date**
Ashokti Punorbashon Nibash (APON) DIC	March 24th, 2010
DIC at Gazipur run by Dhaka Ahsania Mission (DAM)	March 25th, 2010

Bhutan

Meetings Bhutan

Name	Title	Date
Kinley Dorji	Executive Director, Bhutan Narcotic Control Agency (BNCA), the Focal Point and Mentor Agency for the Project	March 31st, 2010
Chhador Wangdi	Chief Program Officer, Demand Reduction Division, BNCA	March 31st, 2010
Yangdey Penjor Kinley Tenzin Mr. Wangchuk	Executive Director Program Officer Program Manager Youth Development Fund (YDF)	March 31st, 2010
Dr. Ugyen Dophu	DG Department of Public Health, Ministry of Health	April 1st, 2010
Kencho Wangdi	Program Officer, National STI and HIV and AIDS Prevention and Control Program (NACP)	April 1st, 2010
Dr.Chencho Dorji	Consultant Psychiatrist, National Consultant for the National Advocacy Study, and Consultant to the Treatment Centre for Substance Abuse, JDW National Referral Hospital	April 1st, 2010

Site Visits

Site	Date

Drop in Centre (DIC) for Drug and Alcohol Dependents, Thimpu	March 31st, 2010
Treatment and Rehabilitation centre for drug and alcohol dependents, Sebithang, Thimpu	April 1st, 2010

Maldives

Meetings Maldives

Name	**Title**	**Date**
Iyasha Leena Mohamed Ajmal	H13 Project Coordinator & Deputy Director of Social Services Chief Executive Officer Society for Health Education (SHE)	March 24, 2010
Aiy Adyb Four Staff Members	Director Staff Journey	March 24, 2010
Fathimath Afiya Aishath Rishtha	Chairperson Program Manager Society for Women Against Drugs (SWAD)	March 25, 2010
Chengappa Monnanda Nanjunda Antonio D'Costa	Doctors MMT Clinic	March 25, 2010
Aminath Zeeniya Aishath Ibrahim Mamddoha Ali Shareef	Director General Director International Division Deputy Director General Department of Drug Prevention and Rehabilitation Services (DDPRS)	March 25, 2010

Site Visits

Site	**Date**
MMT Clinic	March 25, 2010
Hulhumale' Health Camp Site	March 26, 2010

Sources Consulted

Sources Pakistan

Advocacy Strategy for Pakistan

Annual Project Progress Reports 2007, 2008, 2009

H13 Review Report, March-April 2006, Dr. Mahendra Nepal, Edna H Oppenheimer

In-country workshops to review country level project M&E frameworks for H-13 Project in the 6 SAARC Countries (Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, and Bhutan) Closure Report

Log frame Pakistan

Minutes of the Monitoring and Evaluation Workshop for the Project "Prevention of transmission of HIV among Drug Users in SAARC Countries" (TD/RAS/03/H13), 16th November 2007, Hotel Taj Samudra, Colombo

Pakistan Country Update, Presentation, Regional Project Steering Committee Meeting, September 2009

Pakistan National Response, National HIV/AIDS Strategic Framework 2007~2011 (NSF Two), Ministry of Health Government of Pakistan

Pakistan—Reflection Exercise Report, Period: January 2008 – December 2008. Based on *Reflections* of the key stakeholders of the H-13 project from Pakistan, September 2009

Prevention of transmission of HIV among drug users in SAARC countries TD/RAS/03/H13, Project Document Phase II

Two Year Country Work plan for H-13 Project in Pakistan (Updated in September 09)

Two Year Country Work plan - for H-13 Project in Pakistan (Updated December 2009)

Updates on the Process of Project Monitoring and Evaluation and Ways Forward (PPT), Regional Project Steering Committee Meeting, Project RAS/H13, 26 September 2009

Hotel Taj Samudra, Colombo, Sri Lanka

Sources Sri Lanka

Annual Project Progress Reports 2007, 2008, 2009

H13 Review Report, March-April 2006, Dr. Mahendra Nepal, Edna H Oppenheimer

In-country workshops to review country level project M&E frameworks for H-13 Project in the 6 SAARC Countries (Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, and Bhutan) Closure Report

Log Frame Sri Lanka

Minutes of the Monitoring and Evaluation Workshop for the Project "Prevention of transmission of HIV among Drug Users in SAARC Countries" (TD/RAS/03/H13), 16th November 2007, Hotel Taj Samudra, Colombo

National Advocacy Strategy of Sri Lanka

Partner TORs

Prevention of transmission of HIV among drug users in SAARC countries TD/RAS/03/H13, Project Document Phase II

RAS/H13: Prevention of transmission of HIV among drug users in SAARC countries (PPT), Sri Lanka, 20-21 November 2008

Sri Lanka, Reflection Exercise Report

Sri Lanka, Presentation, Regional Project Steering Committee Meeting, September 2009

Two Year Country Work plan for H-13 Project in Sri Lanka (Updated in Nov 08)

Two Year Country Work plan for H-13 Project in Sri Lanka (Updated Nov 2009-2010)

Updates on the Process of Project Monitoring and Evaluation and Ways Forward (PPT), Regional Project Steering Committee Meeting, Project RAS/H13, 26 September 2009

Hotel Taj Samudra, Colombo, Sri Lanka

Work Plan of H-13 Project in Maldives January 2008 to December 2009

Sources Nepal

Annual Project Progress Reports 2007, 2008, 2009

H-13 Log frame Nepal - Review and Feedback

H13 Review Report, March-April 2006, Dr. Mahendra Nepal, Edna H Oppenheimer

In-country workshops to review country level project M&E frameworks for H-13 Project in the 6 SAARC Countries (Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, and Bhutan) Closure Report

Minutes of the Monitoring and Evaluation Workshop for the Project "Prevention of transmission of HIV among Drug Users in SAARC Countries" (TD/RAS/03/H13), 16th November 2007, Hotel Taj Samudra, Colombo

Monitoring and Evaluation Indicators for HIV/AIDS in Nepal, Government of Nepal, Ministry of Health and Population, National Centre for AIDS and STD Control, December 2006

National Consolidated HIV/AIDS Work Plan 2006-2008, Ministry of Health and Population, Department of Health Services, National Centre for AIDS and STD Control

Nepal National Advocacy Strategy to Prevent HIV Transmission among IDU/DUs 2009-2012

Nepal National HIV and AIDS Strategy 2006 – 2011

Nepal—Reflection Exercise Report, Period: January 2008 – December 2008. Based on *Reflections* of the key stakeholders of the H-13 project from Nepal, 15 July 2009

Prevention of transmission of HIV among drug users in SAARC countries TD/RAS/03/H13, Project Document Phase II

RAS/H13: Prevention Of Transmission Of HIV among Drug Users in SAARC Countries – Nepal, Presentation by Mr. Shankar P. Koirala, Ministry of Home Affairs, Regional Project Steering Committee Meeting, September 2009

Training on Outreach Activities and Needle Syringe Program (28-30 April 2008) and Training on Positive Living and Services for Female IDUs and Female Regular Sexual Partners of Male Drug Users (2-4 May 2008) in Kathmandu, Nepal. Training Report.

Two Year Country Work plan - for H-13 Project in Nepal (Updated in July 09)

Two Year Country Work plan - for H-13 Project in Nepal (Updated in December 2009)

Updates on the Process of Project Monitoring and Evaluation and Ways Forward (PPT), Regional Project Steering Committee Meeting, Project RAS/H13, 26 September 2009

Hotel Taj Samudra, Colombo, Sri Lanka

Sources Bangladesh

1. Advocacy Strategy for prevention of Transmission of HIV among drug users in Bangladesh; Shaikh Abdus Salam, 07 July 2009
2. Report paper on Training on positive living and services for Female IDUS and female regular sex partners of male drug users (26-28 Feb. 2008) and Training on outreach activities and needle syringe program (1-3 march 2008) in Dhaka, Bangladesh; UNODC/UNAIDS/WHO
3. Report on Rapid Situation and Response Assessment (RSRA) among female drug users and the female regular sex partners of male drug users; UNODC, ICDDR,B
4. Bangladesh Country presentation at the project steering committee on phase II of the H13 project in September 2009
5. National Strategic Plan for HIV/AIDS 2004-2010, National AIDS/STD program, Directorate General of Health Services, Ministry of Health and family welfare , government of Bangladesh

6. National HIV serological Surveillance 2006 and 2007; 7th and 8th rounds technical reports; National AIDS and STD Program (NASP), Directorate General of Health services, Ministry of Health and family welfare.

Sources Bhutan

1. National Strategic plan for prevention and control of STI and HIV/AIDS 2008, Royal Government of Bhutan
2. National Operational Plan for HIV and AIDS 2010-2011, Royal Government of Bhutan
3. Guidelines on Treatment and Rehabilitation centre for drug and alcohol dependency 2009 , Bhutan Narcotic Control Agency
4. A rapid assessment on the drug use situation and responses in schools and communities in Phuentsholing, Bhutan (2008), UNODC, UNAIDS, WHO,RGB
5. Manual for the Dzongkhag multi-sectoral Task force (MSTF)for STI &HIV/AIDS prevention and Control 2005, department of Public Health, Ministry of Health, Royal Government of Bhutan
6. Narcotic drugs , psychotropic substances and substance abuse Act 2005, Kingdom of Bhutan
7. Rules and regulations for Narcotic drugs , Psychotropic Substances and Substance Abuse Act 2005, Bhutan Narcotic Control Agency
8. National Baseline Assessment on Drug and controlled substance – Bhutan 2009
9. Bhutan advocacy strategy paper on prevention of HIV among DUs and their SPs
10. Annual project report of Drop in Centre at Thimpu for the Period 2009-2010 by Bhutan youth development fund
11. Annual project report of treatment and Rehabilitation centre for Drug and Alcohol dependents, Serbithang, Thimpu for the Period 2009-2010 by Bhutan Youth Development Fund
12 Report on training workshop on Rapid Situation Response Assessment (RSRA)of drug use and HIV (11-13 Feb.2008 and Training workshop on basics of drug/ HIV; outreach and community involvement 15-17 Feb. 2008; UNODC, UNAIDS, WHO
13 Bhutan Country presentation at the project steering committee on phase II of the H13 project in September 2009

Sources Maldives

Annual Project Progress Reports 2007, 2008, 2009

H13 Review Report, March-April 2006, Dr. Mahendra Nepal, Edna H Oppenheimer

In-country workshops to review country level project M&E frameworks for H-13 Project in the 6 SAARC Countries (Pakistan, Bangladesh, Nepal, Sri Lanka, Maldives, and Bhutan) Closure Report

Maldives Advocacy Strategy for IDUs 09/09/2009

Maldives Log Frame

Maldives Revised Work Plan 2008

Minutes of the Monitoring and Evaluation Workshop for the Project "Prevention of transmission of HIV among Drug Users in SAARC Countries" (TD/RAS/03/H13), 16th November 2007, Hotel Taj Samudra, Colombo

National Strategic Plan on HIV/AIDS Republic of Maldives 2007 – 2011, Ministry of Health Male, Maldives July 2007

Partner TORs

Prevention of transmission of HIV among drug users in SAARC countries TD/RAS/03/H13, Project Document Phase II

Progress Report H13 Maldives from January 2008 to October 2008, Based on Reflections of the project team, November 18th 2008

The HIV/AIDS Situation in the Republic of Maldives in 2006, National HIV/AIDS Council (NAC), Ministry of Health of the Maldives and the UN Theme Group on HIV/AIDS, Mr Jan W de Lind van Wijngaarden, UNICEF consultant, 3 August 2006

UNODC ROSA Project, RAS/H13: "Prevention of transmission of HIV among Drug Users in SAARC Countries" Presentation by the Department of Drug Prevention & Rehabilitation Services, Ministry of Health and Family, Maldives, Regional Project Steering Committee Meeting, September 2009

Updates on the Process of Project Monitoring and Evaluation and Ways Forward (PPT), Regional Project Steering Committee Meeting, Project RAS/H13, 26 September 2009 Hotel Taj Samudra, Colombo, Sri Lanka

Instrument MTR H-13

Component 1: Advocacy

1) Are you familiar with the H-13 national advocacy strategic plan? Have you read it? Did you contribute to its development?

2) Has the H-13 national advocacy strategic plan been endorsed at the national level? Have it recommendations been implemented? If not, why not? i.e. Have the elements of the comprehensive package been incorporated into National Plans? Specifically, are OST and NSP part of the national response?

Have any changes been made to the HIV or drug policies as a result of the H-13 advocacy plan?

- OST
- NSP
- VCT
- ART
- Condom promotion
- STI

3) Do you feel the recommendations of the advocacy strategic plan are achievable? What challenges have you encountered to implementing the recommendations of the advocacy strategic plan? Please explain. Is there something you would like to add to the advocacy strategic plan?

4) Have you worked with civil society organisations to undertake advocacy, and if so, how?

5) Have Rapid Assessments been conducted, and were they used in advocacy efforts?

6) Have the H-13 indicators been integrated into the national M&E instrument?

Component 2: Effective harm-reduction approached adopted

TRAINING—human resources

1) How do you understand harm reduction within your own local or national context? What does it mean to you?

2) Have you taken the regional ToT? How useful was it for you? Have you offered trainings for your own staff or others since taking the ToT?

3) Have you taken the training? If so, did you find the training helpful? Are you using it in your work? Have you set up additional referral systems since taking the training? What

challenges have you met in applying the knowledge you gained in the training to your daily work?

4) Are the H-13 toolkits widely available? (Are you familiar with the H-13 toolkits? If so, which ones?) Have they been translated into local languages? (Have you used the toolkit in a language other than English?)

5) Have the toolkits been modified to the local context? Was the mentor agency involved in modifying the toolkit?

6) Have implementing agency partners received training? How many people have been trained? Have post-training evaluations been conducted—when, and what are the results?

7) How many demonstration sites are there and how functional are they? To what extent do they encompass the comprehensive package i.e. which elements of the comprehensive package are included?

8) Is there a training calendar? Is the calendar followed?

9) Has the capacity of implementing agencies been improved through funding and TA? How?

LINKAGES

10) What linkages exist between the demonstration sites and government, national and regional learning centres? How do these linkages function?

11) Have there been field visits from government to the demonstration site?

DOCUMENTATION

12) Have the lessons learned been documented?

13) Sustainability—Has the national government begun financially supporting the demonstration site? How much?

14) Have the demonstration sites advocated for the comprehensive package to be adopted in national policy?

LEARNING CENTRES

15) Learning Centres—Have the lessons learned been documented? Did the implementers receive support from the LC? Was it useful? Did implementers provide feedback to the LC? Do the LCs feel they have sufficient capacity to offer TA to implementers?

M&E

16) Are you familiar with the M&E indicators? Have you received training on the M&E tools? Have you used them? Please describe your reporting system including indicators, reporting format, frequency of reporting. What challenges have you encountered in

reporting: human resources, capacity? Data collection challenges? Technical capacity? Do you have a system to collate and analyse the data? Do you have a database system?

17) Have you aligned your H-13 activities with national HIV and national drug plans?

Component 3: Scaled up harm reduction approaches

1) Is there a strategy in place to scale up services for IDU? Please explain.

2) What are the challenges to scaling up IDU services? Which services in particular are challenging to scale up and why?

3) Are IDU-related commodities (methadone, buprenorphine, needles and syringes, condom, STI drugs) included in national procurement plans? Are there plans to scale up? Is there a national procurement guideline system for IDU commodities?

4) Did you participate in the training programme on procurement? If yes, was it useful? If not why not?

Component 4: Project Management

1) Have national project operational plans been developed and endorsed by government, civil society stakeholders and UN partners?

2) Have management and coordination plans been developed? Adopted?

3) How often does the steering committee meet? How is it involved in project activities? Who are the members and how frequently do they turn over?

4) When was the CSU established? How many members? How frequently do they meet? Activities completed and planned? Challenges encountered? Turn over?

5) How regular are the project reports?

6) Is the M&E system operational?

7) Is the one UN system operational? Are the UN partners cooperating on this project?

MTR TOR

Background

Phase-1 (2003-2007) of the UNODC executed South Asia regional project titled "Prevention of Transmission of HIV among Drug Users in SAARC Countries" emphasized the need for developing capacity in the region for scaling up of HIV intervention among IDUs and other opiate users in view of the heterogeneity that exists in the South Asia region in the pattern of drug use as well as HIV prevalence among drug users. The project facilitated the process of the developments of protocols on treatment and care, which were field-tested by selected national/regional learning centres, and initiated the establishment of model quality interventions with a view to enabling governments, service providers and others to facilitate the scaling up of interventions.

Phase - II of the project began in September 2007 and is being jointly executed by UNODC, WHO (SEARO) and UNAIDS (RST) in partnership with the governments and civil society partners in South Asia

The project since its inception of phase - II is supporting the planning of national responses with respect to the scale required to prevent HIV among drug users. The rationale for this proposal is three-fold: (i) responses to HIV prevention among drug users need to be comprehensive in nature; (ii) responses need to be at sufficient scale to contribute to HIV prevention and reduction in HIV prevalence among drug users; and (iii) a skilled workforce drawn from both government and civil society is required.

The overall goal of this project is to reduce the spread of HIV among drug using populations in SAARC countries and its purpose is to assist governments and communities to scale-up comprehensive prevention and care programs for drug users, especially Injecting Drug Users, and their regular sex partners. Based on the UNAIDS Prevention Strategy, the project contains the following elements:
1. A supportive policy and an enabling program environment ;
2. Involvement of drug user communities in program development, design, implementation, monitoring and evaluation so as to address their felt needs;
3. Outreach, including peer education, access to condoms and primary health care(including treatment for sexually transmitted infections;
4. Access to sterile needle and syringe programmes
5. Drug substitution treatment and,
6. Strengthened prevention to care continuum, including Voluntary Counselling and Testing and access to antiretroviral therapy

Scope of the Review

The mid-term review of the phase II of the Project will assess the overall response in terms of the four project components:

1. Advocacy to support change in policy and practice
2. Effective risk reduction approaches to reduce HIV transmission among drug users especially IDU and their regular sex partners.
3. Scaled-up risk reduction interventions to reduce HIV transmission among drug users especially IDU and their regular sex partners.
4. Project management

On the basis of its examination, the review team will document inputs, processes, outputs and outcomes. The review will identify whether mid course corrections in the design and implementation of the project need to be made in the light of the new data and experience in the initial years of implementation. To ensure the achievement of the goal and objectives of the project, the mid-term review will specifically:

1. Review the progress of project implementation against the project's design and timelines.
2. Comment on the extent to which the objectives of the project continue to be consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors policies.
3. Review the project's linkage with national programming (in terms of planning, policy and strategy) and the contributions of the project to date to scaling up a comprehensive harm reduction programme in each country
4. To identify strengths and weakness in project implementation and assess the extent to which the objectives of the activity are likely to be achieved.
5. Provide recommendations to support mid-term correction of project activities.