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Independent project evaluation of the  
**“Implementation of drug demand  
reduction components of national action  
plans in West Africa”**

RAF G66  
West Africa

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# LIST OF ABBREVIATIONS AND ACRONYMS

AADP	African Anti-Drug Programme
CBOs	Community-based Organisations
CCCD	Commission for Drug Control Coordination (Cap Vert)
CILAD	Comite Interministeriel de Lutte contre la Drogue (Côte d'Ivoire)
CILAS	Comite Interministeriel de Lutte contre l'Abus de Stupefiants (Benin)
CNAD	Comite National Anti Drogue (Togo)
CSO	Civil Society Organization
DDR	Drug Demand Reduction
DU	Drug Use
EC	European Commission
ECOWAS	Economic Community of West African States
EDCU	ECOWAS Drug Control Unit
GAP	Global Assessment Programme on Drug Abuse
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOs	Government Organizations
GTZ	Gesellschaft für Technische Zusammenarbeit,
GIZ	now Gesellschaft für Internationale Zusammenarbeit
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
ICRC	International Committee of the Red Cross
IDCCs	Interministerial Drug Control Committees
IDIS	Integrated Drug Information System
IDU	Injecting drug use
IDUs	Injecting drug users
IEC	Information, Education, Communication
INRA	Information, Needs and Resources Analysis
KH	Knowledge Hub
M&E	Monitoring & Evaluation
MoH	Ministry of Health
NACOB	Narcotics Control Board (Ghana)

MSM	Men who have sex with men
NAP	National Action Plan
NGO	Non Governmental Organization
NPC	National Project Coordinator
OAU	Organisation de l'Unite Africaine
OST	Opiate Substitution Therapy
PAAD	Programme Africain Anti-Drogue (EU regional project)
PPER	Project Performance Evaluation Report
PPMR	Project Progress Monitoring Report
PS	Permanent Secretary
ToRs	Terms of Reference
TPR	Tri-Partite Review
UNAIDS	United Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNDCP	United Nations Drug Control Programme
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
UNODC ROSEN	UNODC Regional Office
UNDP	United Nations Development Programme
UNV	United Nations Volunteers
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

# EXECUTIVE SUMMARY

## Introduction and Background

While there is a lack of evidence on the number of drug users and pattern of consumption in West Africa, the increase over the past years of drug trafficking in this transiting area, constitutes a set of serious risk factors for drug consumption. Thus drug demand reduction interventions are highly relevant and needed in this region as access to substances has become easier. They were partly framed by regional plans adopted by the Economic Community of West African States in 1997 and renewed in 2008. In parallel, a number of countries in the region had elaborated national action plans with the help of the European Commission, comprising DDR components such as prevention and treatment. These were quite ambitious programs budgeted more than three million dollars each which could not be funded.

The main goal of project G66 was to select priority interventions among these NAPs to be implemented in a set of West African countries.

During a first phase which started in 2003 and ended in 2005, beneficiary countries were the Côte d'Ivoire and Ghana. Also the creation of a regional DDR resource and information center was planned in Dakar.

During a second phase (2006-2009), three new countries were included: Benin, Cape Verde and Togo. Next to the implementation of DDR national projects, HIV interventions within prison settings were to take place in these three countries.

The whole project amounted to less than 2 million dollars donated by European countries (Sweden, Italy, France, Spain and Netherlands).

## Objectives of the project

Three main objectives were defined as follows in the official project description.

Objective I was to create a West-African knowledge base, information and reference point on drug abuse methodologies and approaches to drug abuse prevention, treatment and rehabilitation and standards/lessons learned in DDR.

It was to be fully operational by February 2005 (end of phase 1) with a production and dissemination of information material and the development of regional exchange mechanisms. It was expected that the center improved through increased access to information.

Objective II was to apply preventive demand reduction measures in social or health programmes and to implement treatment and rehabilitation programmes according to NAPs of Côte d'Ivoire and Ghana (by February 2005) and Benin, Cape Verde and Togo (by February 2007). It was expected that targeted non governmental organizations successfully implement selected components of the NAPs on prevention, treatment and rehabilitation.

Objective III was to significantly reduce the transmission of HIV/AIDS and provide effective care to HIV infected prisoners in the beneficiary countries between 2006 and 2007. The implementation was extended to 2009. By the end of the project technical assistance would have been provided to the selected project countries to carry out impact-oriented and sustainable HIV/AIDS prevention and care through Information, Education and Communication as well as voluntary counselling and testing in selected prisons in the beneficiary countries. HIV/AIDS prevention, treatment and care among prisoners, injecting drug users and people vulnerable to human trafficking were to be mainstreamed into NAPs on HIV.

## Major Findings

### Resource and Information Centre

A much needed Resource and Information Centre (RIC) was established in Dakar by 2004. But this component of G66 did not fully achieve its aims. While it housed an important set of documents it did not benefit enough clients. Its visibility remained modest and it ceased to be properly directed since 2006. Material was lost or displaced. Planned products such as a newsletter, a directory of service providers and a website never got realized. Thus the RIC did not serve the purpose of becoming a helpful instrument for exchange and networking in DDR. From start, the missions of such a structure were not clear enough. What would its perimeter be? Would it serve as a mere storage for documents (what kind of documents?). What were the target groups? Professional expertise to run the RIC was needed and was never defined. The position of the person in charge did not match basic requirements. The conditions to make the RIC efficient were not brought together.

It was also a missed opportunity which could have served as an important tool in support of project G66 itself. Being a regional project, the RIC could have helped the different beneficiary countries and others to share experiences, lessons learned, good practices, challenges encountered. It could also have been a monitoring tool for the Program Manager to follow the implementation of the national projects as well as being an instrument for technical assistance. Finally, it could have given access to stakeholders to relevant electronic material such as training modules, standards and guidelines, much needed resources in the beneficiary countries involved in G66. The collective benefit of the whole project would have been enhanced through the circulation and dissemination of national reports of the implementation of projects.

In sum, objective I was met as a RIC was established but without its aims at production, dissemination, and exchange of relevant information at regional level fulfilled.

### Implementation of DDR components of National Action Plans

Chosen DDR components of NAPs were implemented in the beneficiary countries. There were however far less comprehensive than what was proposed in the original NAPs due to a relatively short duration and a lack of overall financial resources.

But there was a good anchoring in national contexts based on fair acceptability and consensus. The most important national counterparts of the project were the Interministerial Drug Control Committees (IDCCs) which were multi-sectorial bodies. Thus key players were mainly at governmental level while the role of NGOs appeared to be less prominent in the implementation of DDR projects.

The projects all contained a preventive and a therapeutic facet.

Within school settings prevention efforts are more a sensitization allowing for a culture of discussion of the drug use thematic involving a range of actors including parents. It could have

been enhanced by broadening sensitization to health promotion. These projects lacked sustainability which should have been better built in during planning.

Treatment programs and facilities appeared more fruitful in therapeutic communities like in Cape Verde than in units embedded in psychiatric hospitals in Benin and Togo which tended to over-medicalize undifferentiated DU, confining users to a mere role of patient and using a repressive approach.

Rehabilitation played a small role in these projects. It was not enough integrated in a chain of care. Also a proper database was mostly missing to assess the trajectories of DUs in terms of relapses, change of drug use and behavioral modifications.

### **Prevention and care of HIV in prisons**

With some exceptions, prevention programs could be established within prisons involving inmates and staff. IEC initiatives were carried out while VCT were scarce.

Although this component was added towards the end of phase two of project G66 and seemed narrow and restricted, its impact has been overall remarkable. Particularly successful were contexts where the commitment of the Ministries of Justice was strong while entertaining good collaborations with Ministries of Health and, most important, strong ties with organizations (governmental or NGOs) active in the fight against HIV/Aids. This was the case in Cape Verde where this project has played a decisive role for keeping the DU issue on the agenda, legitimized by the public health threat of HIV.

However, overall, there were not enough connections established between the HIV and DDR sectors at the institutional level. They remained far too compartmentalized and prevented the mainstreaming of the issues of prevention, treatment and care for prisoners into national action plans on HIV as it was aimed at.

### **Main Conclusions**

G66 partly reached its three main objectives. A regional RIC was established even though it did not function according to expectations. DDR projects derived from NAPs were implemented giving them legitimacy at national level. The HIV thematic was introduced in prison settings thus playing an important sensitization and advocacy role.

G66 as a whole lacked coherence; it composed a sort of patchwork of three components which failed to be properly connected. The time scale of G66 was not clearly delimited from start. National projects were of short duration and should have been better funded. But the project allowed for an ongoing mobilization of national actors ready to carry on relevant DDR interventions along the lines of G66.

### **Main Recommendations**

Concerning the whole project G66, three main recommendations can be made. First future planning mechanism should be able to rely on secured financial and human resources. It should define explicit milestones and foresee corrective mechanisms (e.g. mid-term evaluations). Second, UNODC should be a broker in strengthening the role of Ministries of Health as far as DDR is concerned. Law and Order authorities should be encouraged to guarantee human rights. Third, UNODC should support civil society and encourage community approaches in the DDR domain.

It is crucial to have a functional DDR Resource and Information Centre in the region. It should clearly state its mission and objectives which can be different: (a)being a continuous collection of documents, (b)serving knowledge production by initiating research and surveys, (c)taking on a didactic function as a training centre and (d)becoming a research platform and a knowledge hub for a network in the region. These are not exclusive and can be combined.

As for the implementation of DDR components derived from the NAPs, one should ensure strong relays at national level: IDDCs appear to be the best structure; technical assistance is much needed to help NGOs to collect and manage data about their clients which will serve potential improvements and arguments for future funding; prevention and treatment paradigms should be clarified by eliminating any temptation of mere repression and differentiated therapeutic approaches should be introduced according to international standards; the latter should be better known, disseminated with an ease of access and evaluated for their utility; low threshold structures and outreach work should be strongly supported along with rehabilitation offers integrated in a chain of care.

HIV prevention, treatment and care initiatives should be up scaled in prisons. This requires good collaboration between different Ministries (Justice-Health-Interior/Security) as well as solid synergies between key players of the DDR and HIV domains. Finally, special efforts should be put into the integration of prison health into national health programs.

# SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

## Project G66 overall

<b>Findings<sup>1</sup>: problems and issues identified</b>	<b>Evidence (sources that substantiate findings)</b>	<b>Recommendations<sup>2</sup></b>
Predominance of law and order ministries over health.	Little or no involvement of public health actors as prominent stakeholders in the project	Include and support Ministries of Health; ensure human rights guaranteed by law and order Ministries
Lack of planning according to secured human and financial resources.  Frequent changes in staff. Negative impact on project implementation.	Short duration of sub-projects with little money; no mid-term evaluation and postponed final external evaluation. At the time of signature of the project, only phase I was guaranteed. Project documentation and interviews with remaining staff.	Ensure sustainability; include corrective mechanisms and strong coordination.
Small involvement of CSOs	Field visits showed that NGOs were remote from the project	Strengthen civil society and support community approaches.
Lack of sustainability and high turnover of the stakeholders	Significant stakeholders in the project could not be reached	Plan for channels of transmission of IEC and prevention interventions

## Demand Reduction Resource and Information Centre

<b>Findings: problems and issues identified</b>	<b>Evidence (sources that substantiate findings)</b>	<b>Recommendations</b>
Lack of clear objectives	Review of project documentation Lack of crucial material which could have served the evaluation, e.g. NAPs	Clarify objectives: -collection of documents -knowledge production and diffusion (research/survey) -training center -network platform

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<sup>1</sup> A finding uses evidence from data collection to allow for a factual statement.

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

## Implementation of DDR Component derived from National Action Plans

<b>Findings: problems and issues identified</b>	<b>Evidence (sources that substantiate findings)</b>	<b>Recommendations</b>
Weak IDDCs with little visibility at governmental level	Lack of resources, facilities, small budgets	Advocate and support national multisectorial counterparts
Stigmatization of DUs and other MARPSs	Strong cultural taboos; criminalization of DU; no explicit mention of MSM and SWs	Address exclusion mechanisms of DUs; do more effective gender mainstreaming
Data collection and management missing	Stakeholder interviews showed unavailability of crucial data (e.g. rates of relapse)	Install a M & E culture with adequate instruments, data processing and diffusion
Lack of visual modern updated prevention materials	Observation of different settings (schools, prisons)	Associate target groups and stakeholders in the elaboration of information and prevention materials
Clarify prevention and treatment paradigms	Observation of repression and scaring tactics	Increase technical assistance, e.g. diffusion of international standards including HR to sustain capacity building
Lack of differentiation in therapeutic approaches to DU pattern	Same approach to alcohol, cannabis, cocaine and heroin use	Increase technical assistance, e.g. diffusion of international standards including HR to sustain capacity building
Poor medical management of withdrawal symptoms	Mere detoxification as therapeutic objective	Increase technical assistance, e.g. diffusion of international standards including HR to sustain capacity building
Small or inexistent offer of low threshold structures	Review of project documentation, field visits and interviews: the only rehabilitation offer in G66 was a failure	Develop outreach work targeting vulnerable populations; presence where the problems arise
Small or inexistent offer of rehabilitation structures	Review of project documentation, field visits and interviews	Encourage rehabilitation efforts associating public and private organisations

## HIV/AIDS Prevention, Treatment and Care in prisons

<b>Findings: problems and issues identified</b>	<b>Evidence (sources that substantiate findings)</b>	<b>Recommendations</b>
DDR and HIV sectors not in contact	Planned interviews with HIV actors could not take place	Organise better collaborations between GOs and NGOs active in each sector
Prevention and care of HIV/DU in prison not mainstreamed into national HIV plans	Analysis of documents (when available) and interviews	Advocate for the integration of prison health into national health programs
Lack of sustainability, high	Interviews with inmates with	Plan for a better transmission

turnover	short sentences and prison authorities appointed after G66	of IEC between prison actors but clarify roles (security-health)
Prison health services segregated from health services extra muros	Interviews with health workers	Further closer collaboration between Ministries of Justice and Health
Lack of quality VCT	Stakeholder interviews	Ensure that each prison has quality screening offers



# I. INTRODUCTION

## Background and context

West Africa's geographic location –mid-way between South America and Europe- shows its potential importance as a transit point for illicit drug trafficking. This has not always been the case. Considering cocaine, demand and trafficking have drastically changed over a decade. In 1998, the US market was more than four times higher than the European which now approaches parity. Thus the direct route from the Andean region to Europe is doubled by one which passes through West Africa.

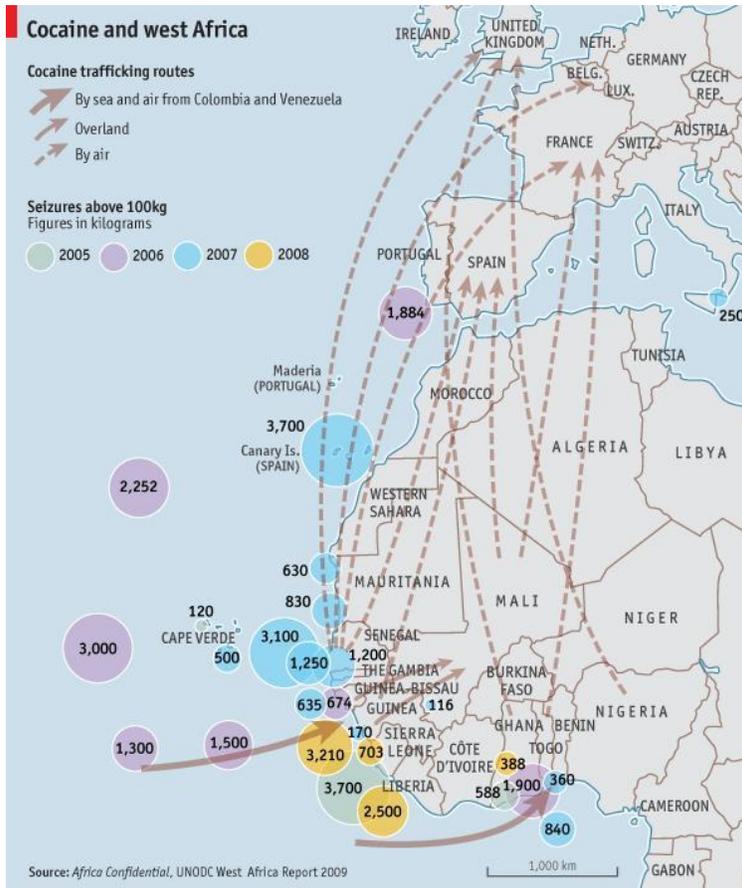
Figure I. Major changes in world Cocaine flows (1998 and 2008)



Source: UNODC, 2010 World Drug Report, June 2010.

The whole region is concerned marked by persisting political instability. This state of affairs has mobilized European donors which have an interest in drug control in West Africa to protect their population in addition to their commitment to development in Africa.

Figure II. Seizure and trafficking of cocaine from West Africa towards Europe (2005-2008)

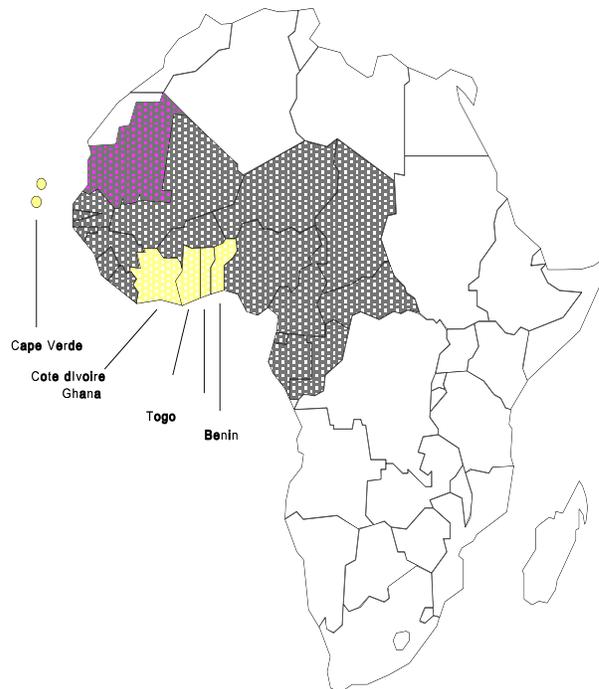


Source: Africa Confidential, UNODC West Africa Report 2009.

The need to find regional coordinated responses to drug supply and demand issues was recognized during the nineties. The Economic Community of West African States (ECOWAS, 15 member states) adopted two regional plans (1997 and 2008) to combat illicit drug trafficking and drug abuse. In parallel, a number of African countries developed National Action Plans (NAPs) with the support of the European Union. These have, in part, some drug demand components.

The aim of this project was to support regional DDR objectives and national efforts to define priorities in this domain. The project covers five countries, which is one third of the ECOWAS member states: Côte d'Ivoire, Ghana, Benin, Togo and Cape Verde.

Figure III. Countries covered by project G66



These beneficiary countries reveal a disparity on a number of indicators (Table 1): In terms of population, the span is between half a million (Cape Verde) and 22 million (Côte d'Ivoire). The percentage of the population below poverty line lies between 30%-40% and the GDP per capita between 1000 and 4000\$ per year. Life expectancy is close to 60 yrs (except Cape Verde). The percentage of the GDP allocated to health expenditures ranges between 3.9% and 5.9% with the exception of Ghana which is almost double of these figures. Literacy rates show a great variation according to countries, ranging from 35%-75%.

The epidemic level of HIV is around 3% for the general population of Côte d'Ivoire and Togo while the other countries have much lower prevalence (range 0.8%-1.8%).

Although there are few solid epidemiological studies concerning drug use, cannabis is the drug of choice in the sub-region (local production). Mainly young people are involved (21-30 yrs) covering middle class and students as well as a more deprived part of the population. Cocaine, crack and heroin consumption seem to be rising. Amphetamines and counterfeited medicines are also frequent. Multiple drug use is common, especially in combination with alcohol.

Injecting drug use in West Africa is not well documented but a recent publication talks about “a neglected epidemic”. (Raguin et al. 2011). The accessibility of trafficked opioids and cocaine in the context of high unemployment and poverty constitutes a risk factor which needs better surveillance.

The project focuses on three domains that were not well integrated:

- (a) I. The creation of a regional drug demand reduction resource centre for West Africa, established in Dakar (Resource and Information Centre)
- (b) II. The implementation of drug demand reduction components of National Action Plans in West Africa (title of the project itself)
- (c) III. The implementation of HIV prevention and care interventions in prison settings

While the three objectives clearly respond to the needs of the region to counter illicit drug consumption in terms of DDR, the project G66 lacked coherence. For instance, one would have expected to see the HIV component first targeting the whole population and not limiting itself to prisons although it concerns particularly vulnerable persons.

The project involved two phases:

Phase I (2003-2005), covering two countries: Ghana and Côte d'Ivoire (DDR projects)

Phase II (2005-2009) covering Benin, Togo and Cape Verde and (DDR projects and HIV/prison issues).

Initially planned for four years, due to start in March 2002, the project was of exceptional length (March 2003-December 2009) (operational duration: 81 months). It was officially launched in Accra in May 2003.

The overall budget was of USD 1'984'012. The main donor countries were European: Sweden, Italy and France with smaller contributions from Spain and the Netherlands.

An external mid-term evaluation should have taken place in order to improve phase two on the basis of its recommendations. This was not realized. The implementation of the project was marked by delays due to recruitment problems and managing discontinuities. The final evaluation which would have formally closed the project was due in 2009 and recurrently postponed to 2010, 2011 and finally 2012. Lack of funds and shortage of human resources (no one replaced the departure of the regional project coordinator in 2007) explain these delays.

Financial and human resources were not up to such an ambitious multifold project. The lack of such an important corrective mechanism as a mid-term evaluation in 2005 was a missed opportunity for the project. Thus the 2 phase model proved not to be useful.

The project stakeholders are situated at different levels (see Table 1): ECOWAS policy makers, regional decision makers, national governmental and non governmental representatives, project managers and partners (social workers, educational and medical staff, health workers) and ultimate beneficiaries (drug users, inmates, guards, students).

The contracting governmental counterparts were the Interministerial drug control committees of the five countries. They bear different names: Narcotics Control Board (Ghana), Comité Interministériel de Lutte contre la Drogue (Côte d'Ivoire), Commission for Drug Control Coordination (Cape Verde), Comité Interministeriel de Lutte contre l'Abus de Stupéfinats (Benin), Comité National Anti drogue (Togo).

A short overview of related projects in the UNODC portfolio shows a continuity of actions against drug abuse in the region.

Rapid assessments and baseline surveys were carried out between 1997 and 2006 in Côte d'Ivoire, Ghana, Nigeria, Senegal, Burkina Fasso, Gambia and Togo (projects C86 and G14). Experts were selected and trained for these surveys with the financial support of UNODC (project B66). Trends and patterns of DU & HIV were analyzed in Sierra Leone and Cape Verde (projects I14 and I27). On a larger scale, project GLOE 69 assessed DU in Burkina Fasso, Senegal and Togo. A project "Partnership for action & comprehensive treatment" dealt with treatment in Cape Verde, Côte d'Ivoire, Liberia, Nigeria and Sierra Leone (project GLO J71). Project GLOG32 investigated DU and HIV in Benin and Togo. Finally, project XAW-U50 consists in an ongoing assistance to the ECOWAS Commission for Development and Implementation of a Drug Control and Related Organized crime Strategy for West Africa which started in 2008.

It would have been worthwhile for this evaluation to analyze these data and identify the main actors involved but it was not in the TORs. This could not be done because relevant documents were not available and the time frame to constrained.

### Purpose of the Evaluation

The evaluation will assess the results of project G66 as a whole and then focus on each of its components, i.e. the DDR resource and information centre, the implementation of DDR projects in the beneficiary countries and the HIV prevention and care interventions for inmates.

It will be established if the strategy was relevant, if the objectives, outputs and outcomes were achieved and if interventions and resources were adequately allocated.

Good practices and recommendations will be made on the basis of positive results as well as deficiencies observed.

As suggested in the TORs (cf ANNEX) the following questions will be posed:

**Design & relevance:** were G66 objectives and activities aligned with clearly identified needs of stakeholders and end beneficiaries?

**Effectiveness:** to what extent have planned outputs and activities been completed? What was the quality of G66 deliverables and activities? To what extent have outputs and activities helped the project achieve its objectives –e.g. improved awareness, increased political commitment, enhanced coordination, improved capacity?

**Efficiency:** have project activities and outputs been achieved on time and within budget? Could activities have been done more cost-effectively delivering the same or better results? Has the project been monitored effectively in order to deliver the best results?

**Impact and sustainability:** Has G66 reached its overall objectives? What are the intended and unintended long-term effects of G66? What are the long-term micro or macro level effects of G66 on individuals, communities and institutions? To what extent have effects been after the activity was completed? Has G66 mobilized resources in order to ensure sustainability of activities and impact? Have the project stakeholders and beneficiaries taken ownership of the objectives to be achieved by the project?

**Partnerships and cooperation:** What partners were involved and what was their contribution to the project? What lessons can be drawn from the engagement with civil society and private sector stakeholders?

## Evaluation Methodology

The evaluation used different methods to answer the questions posed in the ToRs.

During the preparation phase of the evaluation, a list of the main stakeholders in the beneficiary countries was established which completed the core learning partners identified by ROSEN.

The evaluator also undertook a literature review to assess political contexts and the main development indicators comparing the beneficiary countries (see Table 2).

In Dakar, at ROSEN, the evaluator continued a desk review of all relevant material concerning G66 as a whole (project documents, annual work plans, project progress reports, project revision/extension reports, steering committee meetings reports) as well as specific documents concerning each country (NAPs, mission reports, activity and financial reports, letters of agreement, national studies) cf. ANNEX III and IV.

Extensive briefings with UNODC staff at ROSEN took place.

Three field visits to beneficiary countries were organized. Cf. ANNEX II

In Cape Verde interviews with the UNODC representative the executive secretary of CCCD and part of its members, stakeholders from different Ministries (Justice, Youth, and Education), and stakeholders in the penitentiary system (prison director, guards, inmates). A focus group with 21 residents of a therapeutic community was conducted. Site visits to a prison, a school and a playground allowed for useful observations.

In Benin, interviews with the executive secretary and the steering committee of CILAS could be made. A meeting with the Minister of the Interior was organized. Other informants reached were MDs, health workers and school teachers. Site visits were to a rehabilitation project, two NGOs and to USUT, the main treatment center for drug addicts.

In Togo, the executive secretary of CNUD as well as all members of the steering committee was interviewed along with school and prison stakeholders. There were meetings with the Minister of Security and the Minister of Justice. Separate meetings and focus groups with inmates, guards and health staff took place. Site visits included the central prison of Lomé as well as four schools. A visit to the therapeutic center CHU-Campus was organized.

An electronic open-ended questionnaire was sent to the RPC of G66 who was in charge in phase I and partly II until January 2007.

## Limitations to the Evaluation

The evaluation was limited to three of the five beneficiary countries. Desk reviews and project documentation cannot replace field visits. Interviews of key stakeholders in Ghana and Côte

d'Ivoire as well as site visits in these countries could have validated the findings of phase 2 or shown other good practices or deficiencies.

A briefing at HQ Vienna was foreseen in the ToRs which could not be organized due to a lack of funding.

While a list of relevant informants to be met during the field visits was established by ROSEN, the ultimate agenda was in the hands of the respective IDCCs. In the three countries visited, possibilities of bilateral interviews were limited or not planned. Time constraints did not allow seeing relevant actors connected to the planning and implementation of the project (other UN agencies, international agencies, project leaders, NGOs...). There was a high institutional turnover which is inevitable for a project of this length. Many important actors were no longer in a position close to G66.

Among unavailable informants in the countries visited were representatives of the respective Ministry of Health as well as national and international actors (UNAIDS) in the field of HIV (with the exception of Cape Verde).

Concerning the implementation of the project, there were no baseline surveys done in the beneficiary countries on drug use and HIV prevalence.

There was no access to the original NAPs from the five countries which could not be found at the Resource and Information at ROSEN.

It is difficult to give a clear count of the number of projects funded under G66. In numerous reports they were actually confounded with a mere list of activities.

There were specific limitations in each beneficiary country:

### **Cape Verde**

The visit took place the week before Easter, and some key players were not available, in particular from the Ministry of Health and the schools (teachers and pupils were on vacation). A mapping of NGOs was planned. This requested document was not made available. The evaluator depended on translation while understanding general messages.

### **Benin**

A ministerial shuffle took place during the field visit which mobilized governmental staff and had an impact on CILAS.

### **Togo**

Important work on revising legal documents occupied informants of the Ministry of Justice and made them less accessible.

These limitations were mitigated by the following means:

The evaluator completed the lists of informants with suggestions of persons to meet based on the desk review and local developments. The way the agenda was organized was in itself a source of

data as it revealed which actors were put forward or not, which responded or not to demands of interviews.

Baseline surveys, established within the framework of other UNODC projects, could be identified.

The NAPs were analyzed through an external evaluation of the Anti-Drug African Program (11, p. 59).

## II. EVALUATION FINDINGS

### Project G66 as a whole

#### **Design & Relevance**

Having been built on NAPs, project G66 was anchored into the beneficiary countries' realities and benefitted from a good context analysis. There was however a gap between the projects developed in the NAPs and the ones actually selected for G66.

The RIC component was also, in some ways, derived from the NAPs (at least in Benin and Togo). Under the heading of coordination of the fight against drugs, a training center as well as an observatory on drugs and addiction (including a database, documentation, and newsletter) was foreseen.

The last component, HIV prevention in prisons which was fitting the mandate of UNODC was later added bringing the HIV dimension and the prison setting into the picture.

A number of elements can be questioned in the overall design of G66. Within the region, five beneficiary countries were designated. The criteria of choice were never made clear. The number of countries is probably to be explained by a limited budget. Four countries are geographically adjacent (Côte d'Ivoire, Ghana, Togo, Benin) which could have induced horizontal inter-country coordination. But such useful synergies could not be documented. A common language was neither a criterion (English-French-Portuguese).

Cape Verde has a history of close collaboration with UNODC which led to the creation of a country office in 2007. Why was Senegal, as the host country of ROSEN not included in G66? Senegal is also at the origin of the so-called Dakar initiative which was a follow-up of the Praia Ministerial Conference supporting the ECOWAS Political Declaration and Implementation of the Regional Action Plan. Why was Nigeria not considered as a beneficiary country as it has developed good practices in the field of DU and gained quite some experience over the last decades?

The two-phase model of this project, actually imposed by limited funds available, was well thought in the sense that a thorough mid-term formative evaluation of phase 1 was planned and could have served as a useful corrective mechanism for phase 2.

The relevance of G66 was unquestionable as an attempt to find responses to the problems of DU in the region. But a large part of its *raison d'être* was the fact that, once they were elaborated, the NAPs could not be funded. The project should have emphasized the ownership of the beneficiary countries in developing their national projects within the frame of G66. It was stated: "All projects will choose their own countries priority interventions". In fact, the priority projects were proposed by the IDCCs but often downscaled by ROSEN. This was probably a missed opportunity for developing empowerment and local capacities as a bottom-up process.

## Effectiveness

By no means, one can relate a number of DU (like an expected decrease) in the region to the effect of G66. For one there is a lack of reliable data on drug use in the beneficiary countries, a gap which so far has not been filled with some exceptions.<sup>3</sup> Secondly, no simple causality can be expected to be established between the components of the project and a decrease in DU considering that most of the national projects did not exceed 6 months.

Effectiveness should be assessed in terms of advocacy, visibility and impact. At a global level, G 66 has played the role of boosting DDRs visibility and responses in this domain. The region is certainly better off by having benefitted from G66. It clearly made a difference despite the fact that objectives-outcomes were only partially attained.

A number of constraints weighed on the planning and implementation of the whole project. Such a complex and ambitious venture was narrowed by limited funding. The two phases approach did not prove to be the best. No clear milestones have been defined. The projects' duration was very short, a mean of 6 months- which inherently limited its impact and sustainability. A lack of human resources weighed on the management of the project. Planning was dependent on financial means which should have been secured for the whole projected duration of G66. Criteria of selection of beneficiary countries should have been clearly set up and known to key actors in the region.

## Efficiency

The following table gives an overview of the allocated and spent sums to each beneficiary country during G66.

Table 1. G 66: Allocated and spent sums to each beneficiary country

<b>Country (IDCC) Date of agreement</b>	<b>Amount allocated (\$)</b>	<b>Amount spent</b>	<b>DDR components</b>
Ghana, NACOB May 2004	70'910		
Côte d'Ivoire, CILAD Sept 2004	80'450		
Benin, CILAS May 2005 Nov 2007	75'000	76'559	Prevention: 37'273 Therapy 39'286

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<sup>3</sup> Between 2007 and 2013, several surveys have been conducted on DU in Cape Verde. In Ghana, 2 studies on DU in schools settings and ongoing data collection on treatment requests in psychiatric services have been realized. But these data were not available for the evaluation.

Togo, CNAD	75'000	80'856	Prevention 47'960
June 2005			Therapy 32'896
April 2007			
Cape Verde, CDCC	75'000	183'580	Prevention 81'863
Oct 2005			Therapy 101'717
April 2007			

Time was very short, according to informants, between the call for national projects and its proper submission. There have been also delays in fund allocation. The overall budget for G66 was 1'563'300\$ which is less than three times each budgeted NAP. These budget constraints in G66 consequently limited the duration of the projects (planned for 2 years in the NAPs and funded only for 6 months in G66).

With the addition of a third component, i.e. HIV & DU, the budget came up to 1'894'012\$ which is quite a modest sum for an ambitious project.

At origin, project G66 was due to operate during four years, from May 2002-April 2006 with two phases, each lasting two years. At the time of signature of the project document by the five governments of the beneficiary countries, the ECOWAS Drug Control Unit and UNDCP, only phase 1 funds were secured, i.e. 756'000\$.

The formal start of the project took place one year later than planned, in March 2003 with the appointment of a Regional Project Coordinator based at ROSEN. He stayed 4 years and left in January 2007. The epidemiologist and HIV expert from UNODC who replaced the RPC was at the time involved in some other important projects and faced a tremendous workload. Thus she asked a NPO from Cape Verde to assist her with the third component of G66, i. e. the prison part, which was done very efficiently during the year 2008. Unfortunately, this position was not upheld in 2009.

The fact that no new RPC was appointed who could have dealt entirely with project G66 as well as the frequent changes in human resources had a negative impact on the project implementation.

A Project Steering Committee was established in May 2003 with representatives from each national IDCC of the five beneficiary countries as well as a member of the ECOWAS Drug Control Unit and the RPC. It was meant to meet biannually in the first two years and then once a year when projects were on the way. Actually, there have been four annual meetings between 2003 and 2006 in Dakar, Accra and Cotonou. These were fruitful meetings during two days and a useful instrument to pilot the project and emphasized the participatory aspect of the stakeholders concerned. There were an important opportunity for exchange of good practice and problems encountered during implementation.

There were also a number of field visits to the beneficiary countries by the RPC, sometimes twice a year to the same country.

Table 2. Field visits to beneficiary countries

Cape Verde	Benin	Togo	Ghana	Côte d'Ivoire
Sept 2005	March 2007	April 2007	May 2003	July 2003
Feb 2007	Oct 2007	Oct 2007	May 2004	
Jan 2008	Apr/May 2008	June 2008		
April 2008	June 2008			

Thus there was an adequate monitoring from the Regional Office as far as the implementation of the DDR components derived from the NAPs was concerned.

But there was no significant backstopping from UNODC HQs for the project.

### **Impact & Sustainability**

The main impact which was not the one put forward in the project was probably its function as advocacy for DDR in the region and particularly in the beneficiary countries. G66 helped to put key DU issues on the agenda. Surprisingly, it was for a large part the third component, DU/ HIV-Aids prevention and care in prisons which proved to be an eye-opener to decision-makers which came to support it. It paradoxically mobilized more the judiciary authorities than those in charge of public health.

G66 was a major input to draft the Regional Action Plan 2008-2011 drafted by ECOWAS with the support of UNODC to fight drug abuse and organized crime and adopted in 2008 in Praia. The Regional Program for West Africa 2010-2014, especially its sub-program "Improving Prevention & Health" in continuity was built on G66.

It also paved the way to important programs in 2009. One is Treatnet II under its facet "Partnership for comprehensive treatment" (PACT) as well as "Treating drug dependence and its health consequences" a OFID-UNODC joint program which was implemented in Côte d'Ivoire, Nigeria, Sierra Leone and Cape Verde (GLO/J71).

Another project dealing with drug abuse and HIV/Aids prevention was introduced to two beneficiary countries in August 2009: Togo and Benin and built on previous experiences made in this field by project G66 (GLO/G32).

The regional consultation of December 2009 held in Grand Bassam was an important step to elaborate a strategy to combat HIV among IDUs, including prisoners. It involved 11 West and Central African countries. Each one designed a roadmap to include DUs in their National Aids strategy plans. It would be worthwhile to investigate to what extent these road maps were implemented as an indicator of the impact of G66.

The extension of the African HIV in Prison Partnership Network (AHPPN) is also to be mentioned in the continuity of the work accomplished by project G66.

Finally, a comparison between NAPs and NIPs would provide interesting results of the impact and sustainability of G66 in terms of continuity and innovation.

Overall, a timely evaluation in 2009 would have directly informed the Regional Program for West Africa.

### **Partnerships and cooperation**

G66 being a regional project, transnational cooperation was important. Contacts with the EU have been numerous in preparation of the project. The EU had helped countries to develop their NAPs between 1994 and 2000 within the framework of PAAD (African Program against Drugs). The interest of European donors had grown as trafficking flows were more and more targeting their markets. G 66 was entirely financed by European donors. It was the first step towards implementing at least a fraction of the NAPs.

The EU support continues in the development of the National Integrated Programs within the Regional Program for West Africa 2010-2014.

There is also an ongoing partnership between UNODC and ECOWAS established since the 90s which translated into the Regional Action Plans for fighting the abuse and illicit trafficking of drugs. The main problem in these efforts is the unbalanced attention given to DDR in favor of supply reduction. This is particularly obvious in the important Political Declaration (Abuja Declaration) agreed on during the 35<sup>th</sup> ordinary session of ECOWAS in December 2008.

At national levels, it was important to choose as main counterparts the IDCCs which were already in place since the 90s. They all were meant to be considerably strengthened in the NAPs with the help of significant financial resources. Due to lack of funds this could not be accomplished.

In the beneficiary countries, trans-ministerial cooperation was more or less successful according to national contexts. In the foreground were Law & Order authorities with Ministries of Health not visible enough considering the important public health challenges at stake.

While the objective to involve NGOs and CSOs in project G66 was explicit, this could not be implemented. Much remains to be done in the strengthening and mobilization of civil society. This is crucial for the sensitization, prevention and care of vulnerable populations where a community approach has been evidenced to be the best. The access to marginalized and discriminated DUs has much more chances when proximity interventions are possible. Few NGOs in West Africa are secular. Prevention, treatment and care are in majority in the hands of faith-based organizations. Sectarian drifts with priorities other than a public health agenda are not rare in the landscape of NGOs. Also a lack of transparency in the funding management has led to difficult situations in the field. NGOs most often are very competitive with each other. Cooperation between them is usually very difficult to achieve. Finally, there is a clear need for capacity building in CSOs.

Regarding the domain of HIV/Aids prevention in prison, a close partnership was established with ESTHER and UNAIDS. The former supported a regional consultation on these issues held in Grand Bassam in December 2009.

By the same token, the private sector was quasi absent as a partner in DDR issues, particularly in the role it could play in the field of rehabilitation. By offering work opportunities to often marginalized people, such cooperation with local economic actors is crucial.

## Components of Project G66

### **I. The Regional Resource Information Center**

Objective 1 was to establish the DDR Resource Centre for West Africa within the premises of UNDCP Regional Office in Dakar. It was meant to produce and disseminate relevant information material to governments and actors from the civil society involved in drug issues. It should also serve as a regional exchange mechanism. Apart from a proper library, it should have created an updated directory of DDR service providers in the region, a quarterly newsletter and a website "according to the needs of potential users". In sum, the RIC should have been a full knowledge-base, information and reference point on drug abuse methodologies and approaches to drug abuse prevention, treatment and rehabilitation meant to facilitate information collection, exchange and networking

Moreover, the NAPs developed in 1999 have all projected a documentation Centre within their coordination component at national level. Unfortunately none of these could be realized due to lack of funding.

The predecessor of the projected RIC is to be found within the Drug Control Unit set up by the ECOWAS Secretariat as early as 1996. It was to serve as a centre of information and reference on drug control in West Africa with a coordination function at regional level. Described as being poorly staffed and under-resourced its achievements are described in terms of advocacy for drug control at the "highest possible level".

During these years, the West African countries which were to become beneficiaries of G66 had established national IDCCs which were supposed to cooperate as a network with the assistance of such a center.

#### ***Design & Relevance***

The relevance of such a Centre was high. But from start its function was not clearly enough defined. The need in the region of a centralized and accessible information source is high. Its visibility could have contributed to be a useful advocacy tool for DDR. It could have allowed creating a whole network of service providers, trainers, decision-makers for governments and civil society.

Created within the frame of G66, it could have served the project itself by for instance disseminating minutes of meetings, work plans, review reports, highlight important events and overall offer a space of dialogue for stakeholders and beneficiaries at all levels.

#### ***Effectiveness***

There is a lack of data on the effective overall use of the RIC as a library and document collection. No statistics of use and access have been established. No proper catalogue giving an overview on quantity and quality of the information material could be consulted. There was from the beginning a lack of suitable space to store material. ROSEN changed premises three times during project G66. During the moves there was a loss of documents. Essential documents like the original NAPs were unavailable and could not be localized.

Informants from the visited countries did not find any use in the RIC for their work at country level. This was in contrast with expressed needs for relevant documentation like DU prevention material to be used in schools. The RIC could not provide these.

There has been no production of information material at the RIC. DDR manuals were developed by the countries themselves according to and fitting local context and specific demands.

Neither newsletters nor website were developed.

There is no evidence that the RIC ever served the purpose of neither sustaining nor creating networks and perform as an exchange tool for standards or lessons learned in DDR at any level.

The RIC was never used as an information platform for the activities and results of G66.

This component of G66 lacked careful planning and milestones. Adequate human resources should have been appointed. Instead, from start, it was foreseen to hire a UNV staff without any explicit expertise as an archivist, documentarist, or librarianship. Indeed it would have needed specific skills in information science, knowledge management, cataloguing and indexing techniques.

As the creation of a website was planned, a webmaster should have been recruited for this purpose, and eventually having helped to develop an electronic library.

Also there was a lack of analysis of users' needs and demands from a RIC.

### ***Impact & Sustainability***

The person from UNV in charge of the RIC left already in July 2006. There was no replacement. Thus besides a lack of competence regarding for managing a RIC, the conditions to at least maintain the sum of documents were not met. The RIC was meant to be a lasting structure after the end of project G66 enhancing it's capacities during the years. This has not been the case.

### ***Partnerships and cooperation***

This component of project G66 was mainly the responsibility of ROSEN. No technical assistance was requested from headquarters to help to establish the RIC. ECOWAS was supposed to be a main supplier in documentation, reports, action plans and other written and audio-visual material on DDR. There is no information to what extent such cooperation has been functional. No organization dealing with HIV issues has been involved.

## **II. The implementation of DDR components derived from countries' NAPs**

The objective of this component was to apply preventive demand reduction measures in social or health programmes and to implement treatment and rehabilitation programmes according to National Action Plans (NAPs) of Côte d'Ivoire and Ghana (Phase I) and Benin, Cape Verde and Togo (Phase II)

### ***Cape Verde***

#### ***Design & Relevance***

There is a high relevance of this component as a close match to national priorities and an alignment with local needs. The projects to be implemented were issues directly derived from the national plans established in a consensual way. Thus national ownership and governmental leadership were clearly established.

The NAP of Cape Verde has been assessed as the best of all beneficiary countries. DDR aspects were well represented in comparison with projects tied to repression.

Three projects were selected for G66. DU prevention in schools, sports in streets and the improvement of quality within a therapeutic community.

Targeting youth (15-38) is adequate as it concerns the most touched population by DU and is correlated with social problems such as unemployment, violence and delinquency and a lack of meaningful leisure. There is also a high rate of mono-parental families in which children grow up without fathers. Women are family heads very often and happen to be involved in drug trafficking to sustain the household.

### *Effectiveness*

The effectiveness of the three DDR projects was contrasted.

Prevention efforts in the school setting (sensitization) were organized in a fruitful manner. DU in schools does not seem to be massive. Each school tries to define appropriate responses to the sporadic cases occurring in their institution. Parents were involved and prevention activities were proposed in a participatory way at each school. A brochure for DU prevention in schools was developed and appreciated. Primary and secondary teachers were trained on DU issues during the G66 period and continued in 2011. Some teachers deal with the topic of DU and take on a preventive role along with orientation and general counseling. There were no data available concerning the actual use of the manual.

Although "Sports against drugs" was a very relevant project in the context of Cape Verde, targeting drop-outs and jobless youth, there was a lack of follow-up in this sub project. Relatively small urban spaces were chosen in difficult areas to cater for game activities. On week-ends, there was an animator to organize activities. There was usually benevolent staff affiliated to youth organizations. The project covered only the island of Santiago and involved four municipalities which did not all respond favorably to this initiative. It was difficult to establish the reasons for the limited achievements of this sub-project. No staff directly involved in the field could be met during the evaluation.

There was a religious NGO involved in this sub-project which priority seemed to evangelize DUs while being remote from modern prevention approaches.

The objective of strengthening care and treatment services was followed in a therapeutic center called Granja San Felipe. It was established in 2005 and mainly supported from funds from Luxemburg. Its services are offered to around 20 people due to stay for 9 months. Data on the number of residents were scarce and statistics on premature discharges or interruptions unavailable. Precise abstinence rates were missing.

The therapeutic community was built on a Portuguese model which in turn was derived from the "Minnesota Model", based on an abstinence approach from the 50s originally devised for alcoholics and inspired by a 12 steps approach. The idea is to create strong bounds between residents and residents and staff. This approach seems culturally sound for Cape Verde. Its content was accessible in Portuguese; material and technical assistance was available.

Staff comprised 6 persons, mainly psycho-social workers. The present director had been recently appointed, in November 2011. The criteria for admission is age (18-45), legal status, i.e. not being involved in a judiciary process and mental health (no psychotic diagnosis). Members of a same

family are not simultaneously admitted. There seems to be a performing network with strong synergies with the health and police system (referral, information, and training).

A focus group held with 21 residents (17 males, 4 females, mean age 30, almost all jobless) by the evaluator bore interesting results. There was an overall expression of satisfaction to be in this program. The supportive role of the group was acknowledged. Skills of each one are valued and recognized and should be better put to use in terms of learning from each other. Some residents were very open about their past criminal activities linked to DU (7 have a history of detention). Most of them started very young (11-13 yrs) with cannabis and then used crack, cocaine and heroin. There were very few cases of IDU. A widely shared concern was reinsertion with a priority: finding a job. For some, unemployment is a determinant of DU. In their view, there were not enough training and vocational opportunities during their stay at the therapeutic centre. Some propose that practical employment placements as a good initiative to prepare their way back into society which they wish for. Apart from real rehabilitation perspectives, this would help to build their skills for self-presentation and enhance their self-esteem. A shortcoming mentioned by several residents is the lack of recreational possibilities. Sport facilities clearly need refurbishment (for which funds were allocated). There is also staff missing to give them sport classes.

There appeared to be a high potential for self-organization and empowerment within the beneficiaries of the therapeutic community. Their discourse was surprisingly articulate and realistic, far from denial. It is difficult to evaluate the part of personal existing resources and the psychological transformation due to the therapeutic community.

In sum, there is a clear value in the work of this therapeutic centre. It has a good distance from too rigid religious references and could serve as a model of good practices in Cape Verde and possible in the sub-region. There is a double challenge for this therapeutic approach: a) based on a disease model the issue of stigmatizing the residents has to be addressed and b) there is a balance to be maintained between focusing the psychosocial needs of the group and a client-centered approach targeting individual needs.

### *Impact & Sustainability*

The work in schools seems to have some sustainability. Health promotion was integrated into school curricula.

The sub-project "Sports against drugs" as such had no continuity. However, with the support from the UN "Deliver as One" Program, a number of youth centers could be financed (n=20 in Cape Verde). Another impact was, within the same framework, the creation of five mobile units to do outreach work.

It seems that the continuity of the therapeutic community is not threatened. It would be worthwhile to see how these experiences could be applied in other locations on Santiago and other islands. The positive results of this approach merit gaining in visibility in order to benefit a growing number in need of drug treatment.

### *Partnerships and cooperation*

There is a good amount of coordination between the different actors in the field of DU. Governmental bodies and UNODC are in close cooperation. The actual UNODC national coordinator was the former executive secretary of the CCDC which is under the authority of the Ministry of Justice. The different ministerial focal points have shown a clear engagement in the implementation of DDR projects.

Despite the fact that the NAP mentions over 70 NGOs active in the economical and social sectors, their role does not seem to be predominant in G66.

Exchange with other beneficiary countries was judged to have been insufficient.

Cape Verde is one of the eight countries part of the "Deliver as One" mechanism of the UN which has shown good results.

Municipalities (more than 40 throughout the whole country) were important partners for the projects. However the overall knowledge of the different projects was unsatisfactory.

There have been some communication problems with ROSEN as well as the unfortunate departure of an important resource person who has acted as a support for the RPC at ROSEN.

### *Recommendations*

DU prevention in schools should take a wider approach in form of health counseling with easy access for any student. Particular care should be given to those threatened by school failure. DU is often a precursor or a correlate of dropping-out of school. An orientation space should be maintained or even developed for such individuals. A school nurse or physician should be associated to these efforts.

In parallel to the sub-program "Sports against drugs", outreach work should be emphasized through mobile units and/or DICs or other low-threshold facilities located in places close to drug trafficking and drug using areas.

A network of potential employers should be identified willing to give (ex) DUs a chance of reinsertion in the workplace. A database could be created for potential donors offering such opportunities.

A system of micro-credit should be explored for those who can present a sound project.

Intermediary structures which could facilitate the process of rehabilitation should be developed.

The period of stay in the therapeutic community could be made more flexible to accommodate individual needs by either prolonging or shortening their time within the centre.

## ***Benin***

### *Design & Relevance*

The NAP of Benin is a balanced approach to supply and demand reduction. Concerning DDR, it is a remarkable integrated sum of sub-projects targeting youth and mono-parental families, vulnerable populations, focusing on vocational training and community mobilization through proximity and outreach work implying NGOs and CSOs. Unfortunately none of these components have been retained as a priority project for G66. The translation of DDR components into the frame of G66 was much remote from the integrated project defined in its NAP.

Instead two projects were funded: A rehabilitation and reinsertion project for young recovered addicts working on a poultry farm and the refurbishment of a treatment centre within a psychiatric hospital in the capital.

The need for a treatment centre is obvious, filling a gap in a country lacking such facilities.

### *Effectiveness*

*Poultry farm project.* This sub-project combined a number of objectives which were not very well planned. It comprised vocational training, rehabilitation which had necessarily to take place in a rural environment. It faced many difficulties. The choice of beneficiaries of this program was not well thought through. Many of them suffered of detoxification withdrawal symptoms in parallel to serious psychosocial problems. There were conflicts among DUs and a trying cohabitation with staff with episodes of violence.

Avian influenza exterminated the whole poultry. Thus the sub-project was suspended in 2008. No concrete proposal has emerged since then to develop an alternative or an entire new project based on lessons learned. No clear coordinated support from CILAS helped the sub-project.

The chain of care including rehabilitation is important. But to conceive of a rehabilitation program in a domain which requires special expertise outside of the drug field was less relevant. Indeed, major problems occurred like avian influenza which ruined all efforts put into this sub-project. A broad vocational offer not restricted to a poultry farm would have been more judicious. It excluded all type of community work and targeted DUs who had not undergone any treatment before being part of this sub-project.

No steering committee had been foreseen to monitor the project implementation. There was a lack of follow-up and no proper technical assistance was available touching upon the domain of the environment, food and rural affairs as well as veterinary competence. These shortcomings of which the main stakeholders were aware were explained by a lack of time and pressure from ROSEN to present the country's priority projects eligible under G66. They wanted to avoid delays in the actual start of the sub-projects which were adapted to available funding rather than properly designed and thought over and then submitted to financial support.

An "*emergency*" unit of treatment (USUT) was officially opened in June 2006 as the only national treatment facility. It is part of the premises of the national psychiatric centre. Around 200 patients have been received since 2006 but it appeared that precise data were scarce and socio-demographic indicators entirely missing. There was no proper follow-up on patients' trajectories and no clear figures on relapse but estimates indicated that there were high. The majority of patients were under 30, mainly an educated population (more than half were university students). The therapeutic approach was undifferentiated regarding specific drug use. Cannabis users were described as having "psychopathological personalities" in the same way as cocaine and heroin users. Socio-economic aspects were left aside or hardly considered. The overemphasis on a psychiatric approach to DU feeds existing or potential stigma attached to DU. It contrasts with the benefits of a therapeutic community such as the one outlined in Cape Verde.

The field visit to the treatment centre showed that patients were confined to prison like cells. A security discourse was prevalent. The main concerns about treated persons were risks of "evasion" of those patients with heavy withdrawal symptoms instead of offering adequate medication to deal with their status. Concerns were more on appropriate fences closing the roof of the facilities than therapeutic endeavors.

Positive aspects were a good integration of relatives, reaching out to families which in turn benefitted from psychological support. There was a performing interdisciplinary team of occupational therapist, psychologist, and psychiatrist in place. But there were neither proper reinsertion activities nor plans developed in this sense.

### *Impact & Sustainability*

The impact of the rehabilitation subproject was limited to its extreme due to a lack of proper planning touching on the objectives, the target group, the setting, the activities, and the supervision. The question of sustainability did not even come up as the sub-program had to be prematurely closed. No sound proposal has been formulated since.

The impact of the therapeutic centre is important, mainly by the fact that it is the only one supported by the government. As such it is in a good position to continue to receive funding to sustain its activities and revise its approaches.

### *Partnerships and cooperation*

In Benin, CILAS is the inter-ministerial coordination body in charge of drug issues. Its action has been hampered by a lack of visibility, a lack of funding and human resources as well as a clear support from the government. CILAS had also been subjected to a high turnover of its executive secretaries. The present one in charge, appointed in August 2011 is the fourth one active during G66. While having a good overview of the dossiers, the present secretary of CILAS could only acquire it through desk work and knowledge transmitted by a couple of players embodying the institutional memory around this project. Informants said that the motivation of most of the ministries (19) represented in CILAS was very low. CILAS is placed under the authority of the Ministry of Security and the Interior. Within CILAS there was no culture of integration and cooperation. The government is actually not recognizing its importance by allocating CILAS enough resources. Ministries concerned were no active interlocutors. Thus the whole aspect of advocacy is missing in Benin.

There were hardly any contacts between the actors dealing with DU and those active in the field of HIV. Solicitations to meet the latter did not find any response. The place of the health authorities in the project was very small. No staff affiliated with the Ministry of Health could be seen. Civil society appeared very weak as far as their involvement into drug issues was concerned.

One exception was a private NGO called "Association St. Camille", which received over 1000 patients a year and had 260 residents run a reinsertion structure for 60 recovered DUs offering vocational training. Unfortunately fruitful synergies between USUT and this NGO have not been developed which is deleterious considering the enormous needs existing.

### *Recommendations*

Local projects should not be set up under pressure and be funded considering the obvious threats these bear for their implementation. Rehabilitation should be considered carefully in the frame of a chain of care including a therapeutic component and a sound network of actors helping the reinsertion process adapted to the needs, possibilities and interests of the potential beneficiaries. Possible synergies should be identified and created between DDR actors.

The unit of treatment should undertake a reorientation of their therapeutic approach towards a more differentiated one. Treatment modules, particularly those available under UNODC's Treatnet would be of great benefit. More effort should be made on therapeutic capacity building.

Links to the community should be intensified especially for rehabilitation purposes. Tied to a psychiatric institution a drug treatment centre should be aware of the dangers of negative labeling and stigmatization.

## *Togo*

### *Design & Relevance*

The priority projects submitted and supported in Togo by project G66 are well aligned with its NAP although much leaner. The NAP included a very comprehensive DDR project comprising the creation of multi-sectorial structures to organize, coordinate and manage prevention of DU within youth. It aimed also to reinforce capacities to reach out to this younger population and their families through counseling antenna, sensitization and prevention campaigns targeting rural areas and mono-parental families. The focus on outreach and community mobilization was an asset in the NAP. The development of treatment facilities was also proposed.

Two priority projects were chosen for G66: primary prevention in schools and the refurbishment and expansion of a treatment centre.

Targeting youth, 60% of Togo's population are under 20, with a high rate of drop-outs and disrupted families in poor socio-economic conditions thus a highly vulnerable group, is relevant even if limited to educational settings. Work in DU ghettos and consumption areas would have been a welcome component in Togo.

In the context of a general weak medical coverage, it is necessary to have offers of care for DUs.

### *Effectiveness*

As for the first sub-project, primary prevention in schools, capacity-building interventions involved school directors, teachers and students which were trained as peer educators. Parents have also been involved through media covered events like debates, contests. "Anti-drug clubs" were created within some schools. The coverage however was very limited: only 22 schools were implicated out of more than thousand educational institutions existing in the country (about 2%). Despite lobbying for it and several attempts, DU prevention has not yet been integrated in school curricula.

The evaluator visited four schools with over 1000 students, located in difficult urban areas in drug trafficking surroundings. The sub-project certainly helped school actors to overcome ignorance or denial of drug issues. It created awareness, interest and concern. DU was thematized in many discussions and present in some pedagogical contents. Visual material such as billboards on the external school walls or entrance helped to facilitate the thematization of still a difficult topic. However their content was obsolete and did not use the potential of an efficient visual communication with a greater impact.

There was a lack of capacities and trained professionals to face concrete cases of DU within the school setting. Strategies were unclear hesitating between punishment and help. There were fears that DU contaminates others within school walls. Outside school settings there were traffickers seeking students as clients which increased perception of insecurity.

In some schools the evaluator noted a form of passivity regarding this sub-project as it was perceived as a top down initiative. Its objectives seemed not have been explicit enough in some settings.

The sub-project also met with difficulties in the implementation as project managers were not paid and it happened that governmental staff was assigned to this function.

The CHU-Campus Lomé hosting the treatment centre supported by UNODC interestingly does not make itself visible as such. Instead it is called "service d' assistance médico-psychologique" leaving out all mention of addiction.

Its premises (2 buildings) which have been refurbished are integrated within the perimeter of the psychiatric hospital. It had been inaugurated the same day than its counterpart, USUT in Cotonou in June 2006. During a field visit by the evaluator its director and project leader were traveling and no patients could be seen. There were no stationary patients treated while there is a capacity of 12 beds. Over the last 5 years, 345 patients underwent ambulatory treatment. There were neither precise data on socio demographic characteristics of this population nor any recovery/relapse data. The main drug of use was cannabis; alcohol addiction was also frequent as well as polytoximania.

A recently appointed psychiatrist (who had previously worked at USUT) explicitly excluded any form of substitution treatment as recommended by international standards. He also displayed a disturbing sum of misconceptions about methadone. He even mentioned measures of constraint against patients with withdrawal symptoms. Apparently agreements on abstinence had to be signed by patients. The breaking of this "contract" was responded by repressive measures instead of an offer of adequate medication and the building up of a therapeutic alliance. There was 10 other health staff, most of them in teaching practice as part of their curriculum in psychiatry.

In face of the tremendous needs of the country in terms of therapeutic offers, the very existence of the centre has to be welcomed. However its equipment was far too basic. There seems to be a need to clarify therapeutic approaches as a general policy.

Rehabilitation components were totally absent and have not been planned so far.

The sub-project included the creation of a multidisciplinary team with the support and supervision of the Ministry of Health. This had not yet taken place.

### *Impact & Sustainability*

Most of the teachers and students trained as peer educators are no longer in place and have left. There are no many signs of motivation to pursue these activities put in place by the sub-project. In some schools there are still anti-drug clubs but they seem to be an exception. Each year new students should be trained to maintain continuity in the sensitization and prevention efforts first put in place.

Sensitization in schools has induced awareness of the DU issue and mobilized directors, teachers, parents and students the time of the sub-project. The CNAD, thanks to its engagement and qualification continues this work in terms of advocacy for more concrete governmental support to respond adequately to the challenge of increasing DU, especially in youth. It should ultimately become an issue borne by governmental instances.

New funding seems available through the NIPs developed in the Regional Plan. Part of it is earmarked for treatment centers. This could allow CHU-Campus Lomé to structure and develop its functioning and development.

### *Partnerships and cooperation*

The need to strengthen coordination bodies had been underlined in the NAP. The CNAD, established in April 1996, is under the supervision of the Ministry of the Interior and Security. It is a recognized platform even though underresourced. While a clear political will to fight DU is

expressed at governmental level, its translation into financial support lags behind. The CNAD has had the advantage of having had the same executive secretary at its head for the whole duration of G66. He had attended most regional meetings on DU issues even before the start of the project. CNAD has quite adequate premises, archives, IEC material and a small team. CNAD is asked directly by schools for presentations, conferences and debates to do advocacy and prevention work. It also receives DUs for psychosocial counseling as they have a very competent young psychologist to provide such services.

Concerning the implementation of the two sub-projects, the Ministries of Education and of Health were the main stakeholders along with two NGOs.

### *Recommendations*

DU prevention in schools should appeal much more to students to propose their own initiatives rather than complying with a project coming from the outside. It should foster bottom-up processes. Students should be encouraged for instance to make use of modern electronic tools for discussions or benefit from existing school radios. They could be also invited to propose visual content for posters and billboards.

School authorities need to clarify their strategies. Repressive attitudes alone have proven to be ineffective. A proper referral system should be put in place based on trust to be helped and not punished.

DU should be integrated in more general health promotion activities and counseling offers.

The therapeutic centre should counter possible stigmatization of its activities on assuming visibility. Many of the recommendations made for USUT remain valid in this case. A special effort should be made for capacity-building as well as the adoption of modern internationally endorsed standards and guidelines.

### **III. Prevention and care of HIV/DU in Prison settings**

The objective of the third component of project G66 was to significantly reduce the transmission of HIV/AIDS and provide effective care to HIV infected prisoners in the beneficiary countries. HIV/AIDS prevention, treatment and care among prisoners, injecting drug users and people vulnerable to human trafficking were to be mainstreamed into National Action Plans on HIV.

While HIV prevention belongs mainly to the realm of interventions by WHO, prisons are part of UNODC's mandate. Project G66 was built on the objective to implement priority DDR projects issued from the NAPs of a number of chosen countries with the support of RIC centrally located at ROSEN, the prison component appeared not conceptually integrated but as a mere addition of activities as it touched upon HIV, drug abuse and this particular setting.

But there are antecedents to this domain of work which had previously mobilized a coalition of organizations such as UNODC, UNAIDS, WHO, WB, GF and ESTHER during a joint event in 2008 at ICASA in Dakar.

In November 2009 the African HIV in Prisons Partnership Network (AHPPN) was launched in Johannesburg. It is a platform involving multiple decision-makers and stakeholders such as prison authorities, national aids councils, health research and academic institutions, actors from civil society and UN agencies.

Even though G66 was considered operationally terminated, an international four day meeting took place in Grand Bassam in December 2009 as a direct impact of the project. It counted 80 participants from 10 countries. Its objective was to elaborate a plan to combat HIV in prison settings among inmates, considered as major bridge populations for HIV and other infectious diseases. Each country was to develop a road map to integrate HIV & DU in their national aids strategy programs.

### ***Cape Verde***

The third component of G66, prevention of HIV in prison has been successfully implemented in Cape Verde. It was recognized by informants as the most important component in the whole G66 project. The bulk of the activities funded in Cape Verde were training of peer educators (guards and inmates). Prevention brochures were produced. Psycho-social staff could not be involved due to a lack of funding. The sub-project could involve 2 prisons out of the 4 existing in the country.

Cape Verde has entered a phase of concentrated epidemic in 2011. Inmates were identified as a special vulnerable group for HIV.

The main prison concerned by the sub-project was the one on Praia which had a population of 775 inmates. The director was relatively new to the place, appointed in January 2010. A field visit showed that inmates had access to good medical services. But health issues in general and HIV in particular are not a priority for inmates. Vocational training and finding a job is a higher preoccupation. Even though the role of peer educators was not systematically implemented, inmates and guards expressed their interest and appreciation in this approach. It gave inmates the opportunity to be recognized for something else than their legal status. It helped guards to de-stigmatize the disease. However, the issue of MSM remains a big taboo and is not openly addressed.

The sums engaged in this sub-project were small, a sum between 15'000-18'000\$.

There was a clear political will and engagement at governmental level to support this sub-project. The fact that the CCDC depends on the Ministry of Justice has certainly played an important role in this positive outcome. There was also a very good coordination and collaboration with the Commission of fight against AIDS which is directly attached to the Prime Minister of Cape Verde.

The main impact of this component was beyond its implementation in the field. It found a great echo in decision-makers to acknowledge the public health issues linking HIV to IDU. It kept key players mobilized on DU and helped to consolidate a broad national coalition on these issues.

### ***Recommendations***

HIV and DU should be made more visible. For instance Prevention posters should be displaced within the prison setting. Leaflets for the visitors (family and relatives) could be realized. Work on the stigma around MSM should be undertaken.

### ***Benin***

Prisons in Benin (9 throughout the country) are known to lack hygiene, proper medical care and poor capacities of its health staff which is said not to be very motivated. Unfortunately, no prison visit could be organized for the evaluator.

An informant who was to implement this component mentioned that CILAS had not been very open to this project: there seems to be an overall lack of response and inertia from the actors who should have been concerned.

Under G66, visits to a number of prisons and approaches of the penitentiary authorities were undertaken but did not lead to any form of implementation.

In June 2008 a small project was initiated to improve the care of HIV/TB co-infection in prisons. The objective was to train peer educators (inmates, guards, health staff, and social workers) to sensitize inmates and others working in prison to TB and HIV. One goal was to have a maximum of prisoners tested. A multi-sectorial steering committee was set up in 2009 under the direction of a public health expert from the National Committee of fight against aids (CNLS). Two members of CILAS were formally invited to participate but did not assist the meetings.

This project was implemented between November 2009 and March 2010. Its effect was limited to the extent that 67% of the 169 detainees trained as peer educators were no longer incarcerated and the 33% who were still in prison did not take on this role. There was little follow-up and no data on testing. Also, activities in prison were not monitored. Overall people were poorly informed about this project. No meeting with one of the project leaders from CNLS could be organized. In fact during the preparation of the agenda for the evaluation, CNLS did not respond at all to any demand from CILAS.

### *Recommendations*

A proper prison project should be launched in Benin. This supposes the active collaboration between actors in the HIV and DU fields with a good coordination of health and judiciary authorities.

### *Togo*

This third component of G66 met with a very good support from the Ministry of Justice who presided over a multisectoral steering committee. Funds engaged were small amounts, around 10'500\$.

Only one prison could be involved out of the 12 penitentiary institutions of the country. Guards (n=40) health staff (n=38) and inmates (n=40) were trained in January 2009 on the ties between HIV and DU. Meetings with these three categories took place during the field visit.

Guards mainly retained aspects of HIV detection and how to interact with sick inmates. They would have liked to have more information on the different drugs. From their observation the main drug use is cannabis and to their knowledge there is no IDU.

Prison health staff generally felt remote from the ordinary medical world extra muros. Thus the training was perceived as useful. They felt that the topic HIV-DU should be addressed throughout the year by conferences, debates and presentations.

For inmates the training helped to correct misconceptions on HIV transmission. They also said to have benefitted through training a concern for their own health problems. They reported changes in their own sexual risk taking.

Overall, it appeared that the impact was strongest for the latter population.

There were a number of limitations to this project. The general prison of Lomé was then occupied by over 2000 inmates which is more than 3 times its capacity.

A foreseen trainer's manual could not be produced due to a lack of funds. There was no condom distribution program. VCT took place occasionally but there was no continuity in the communication of the results and the necessary counseling.

### *Recommendations*

This project is worth upscaling essentially because it could find very influential and useful resonance with the Minister of Justice and high-level civil servants for these types of activities in prison. It should be in first line for funding and well advocated to potential donors.

Proper training material should be produced and disseminated. Clear testing strategies should be defined. DUs should be involved as trainers and/ role models. Inmates could be solicited to make proposals for prevention posters and other visual material to be displayed within the prison setting. Possible financial recognition should be given to inmates for their peer work. Events like conferences, debates and films on HIV & DU should take place several times a year for a wider sensitization intra-muros. The entry point of this topic could enlarge towards efforts in more general domains like sexual health and, ultimately, health promotion.

A continuity of health services between prisons and the community should be maintained. An ongoing exchange of experiences, training and information should be established between the two worlds.

### III. CONCLUSIONS

This evaluation was an anachronism as it could only be undertaken well after the ending of project G66. In the meantime, a series of new programs and projects have been developed. Covering an exceptional long period (almost 7 years) it did not allow for contacting important stakeholders who were no longer available. Field visits proved to be essential to gather significant data. Documents alone were insufficient to evaluate the efficiency, effectiveness, partnerships, impact and sustainability in the countries of phase 1 (Ghana and Côte d'Ivoire).

It was important to be present in the region on the DDR front during the period following the NAPs and contributing to the actual UNODC Regional Program for West Africa 2010-2014, especially the DDR component entitled Drug prevention and health.

G66 as a whole lacked coherence; it was patchwork of three components which failed to be properly interconnected. The time scale of G66 was not clearly delimited from start. National projects were short and should have been better funded. But the project allowed for an ongoing mobilization of national actors ready to carry on relevant DDR interventions along the lines of G66.

Despite many imperfections, G66 did approach the fulfilment of its three main objectives. A regional RIC was established even though it did not function according to expectations. DDR projects derived from NAPs were implemented giving them legitimacy at national level. The HIV thematic was introduced in prison settings thus playing an important sensitization and advocacy role.

Prevention of drug abuse should have been integrated into wider health education efforts. The role of civil society needs to be strengthened by community approaches. Advocacy for these issues has to be scaled up with national authorities to sustain significant support especially to IDCCs. It is crucial that better links are established between HIV and DDR in general. And in particular prevention in prison should be equivalent to interventions accessible extra muros on the principle that prison health is public health.

Treatment and care have to be more differentiated according to patterns of drug use. Existent evidence based protocols and standards, including harm reduction, should be used and disseminated to improve quality. Rehabilitation offers remain very scarce and need to be expanded. Finally, coordination is essential. Thus the project of a RIC corresponds to the needs of many stakeholders and is worth being reconceptualised and developed.

## IV. RECOMMENDATIONS

### General

The appropriate response to drug abuse in West Africa is to operate at a regional level. The key is to maintain continuity between NAPs-sub projects funded by G66 and NIPs developed under the Regional Program for West Africa 2010-2014.

The comprehensive approaches developed in the NAPs covering coordination and integrated community health approaches should remain reference points for future DDR initiatives in the region. Members of civil society could then be better mobilized with strengthened capacities to become full-fledged partners in national actions against DU.

Successful sub-projects could be identified and given a status of model projects as examples of good practices to be replicated by other beneficiary countries.

Special attention should be given to efforts of support and empower national IDDCs. Ministries of Health should take on the lead as stakeholders in DDR initiatives. The involvement of public health actors should be markedly increased at all levels.

Donors have to be better and regularly informed about the DU situation in the region. National budgets are very limited in the region but have to be solicited to testify the countries' commitment to DDR. Foreign aid from the international community will have to constitute the main source of funding. In first place should be agencies fighting HIV. This domain is better supported than DDR. The positive results from the HIV prevention and care interventions in prison settings are an asset.

### Resource and Information Center

A RIC is an essential tool for DDR objectives in West Africa. But it should have clearly defined functions. Four possible functions can be outlined:

- (a) -a collection of documents, i.e. a library of written and audio-visual material
- (b) -a knowledge production center: research and survey
- (c) -a knowledge diffusion center: training modules, didactic material
- (d) -a network center

The scale of a RIC will obviously depend in funding. If it is to operate as a collection of material it should be run by experts in library science and knowledge management. If it includes data and knowledge production, it should comprise much needed epidemiological studies endorsing a sentinel function. As such it would be best affiliated with an academic structure possibly dealing with public health. By extension it can serve as a training facility.

Finally, the RIC could become the host institution to a sustainable regional network. Most of NAPs had planned the creation of documentation centers in their countries as information,

capacity building and advocacy resources. These could be developed according to existing detailed proposals and become knowledge hubs. A RIC as a network center located in Dakar could become a platform of coordination of these knowledge hubs.

ROSEN would be an important technical assistance provider in any of these cases.

## Implementation of DDR components from NAPs

### **Sensitization-Prevention activities**

These have mainly taken the form of school-based interventions in the beneficiary countries funded by G66.

It is recommended to encourage bottom-up initiatives at school level in a participatory way: inspectors, teachers, parents, students should be involved. Students' initiatives should be especially supported (e.g. events, debates etc.). Health promotion issues should be in foreground, integrating DU and sexual health domains. It would be useful to create or develop existing orientation spaces to offer counseling on student's problems including those which might be a cause or consequence of DU. Persons in charge could be a school nurse or even a school physician. It would be useful to establish a good referral system if therapy is needed. Parents should be included to find non repressive solutions.

The coverage of sensitization interventions should be significantly increased. The underlying approaches to sensitization and prevention should be made more explicit. A subtle balance between vigilance and attention and care and integration is to be promoted. Any demonization, stigmatization and exclusion are to be avoided.

Visual prevention material, like billboards should be renewed. Posters could be created by students. The pictorial language and messages should be revisited. References to self reliance and self esteem should be developed.

A strong prevention project should be developed reaching out to marginalized youth. It should be built on their perspective and experience. A good start would be to go back to integrated DU prevention projects developed in the NAPs, rescale it with a particular attention to furthering links with the community.

It is crucial to connect with the HIV national network but also to look for new partnerships and donors at national and international level.

Civil society should be strengthened. Special support for ex DU organizations should be made available. Their participation in the elaboration and implementation of DDR projects would be much needed.

Another prevention approach has been used in Cape Verde, targeting youth helping them to structure meaningful leisure time. Such initiatives should improve their local implementation, in particular work with local authorities. Ideally youth centers should be developed with good visual material, brochures, discussion space. These can also function as low threshold drop-in centers. The presence of volunteers should be increased. Capacity building in supervision and counseling is important. Outreach work should be expanded to trafficking spots and deprived areas where marginal groups live.

Proximity interventions should be highly encouraged. Drop-in facilities, street work, mobile prevention units should be created for drop-outs and other vulnerable populations.

### **Treatment- rehabilitation**

Treatment centers should have a recognizable identity as such. Multidisciplinary team should be created and properly trained.

Treatment paradigms should be reviewed in the light of a more differentiated approach to DU pattern. Guidelines on therapy with a special attention given to the management of withdrawal symptoms should be used. Coercive treatment should be banished. The needs and expectations of clients should be targeted. A careful balance between medication and psychosocial interventions should be sought. Work with families should be improved in terms of information, support, and counseling. Therapeutic groups could be created within treatment centers.

A solid referral system has to be built up. Patient's rights have to be fully respected. OST has to be considered as a treatment option.

Transnational synergies have to be developed between treatment centers in the region.

A rehabilitation network has to be put into place.

One should not develop separate rehabilitation projects but strengthen a well conceived chain of care.

Another form of treatment facility can be developed through a community approach.

One priority for such institutions is to create good M&E tools to enable to test effectiveness. A systematic database should be a must, recording precise relapse and rehabilitation figures (quantitative and qualitative). This not only can improve the internal functioning but also attract more funding and new donors.

The rehabilitation process needs to be improved. Learning from each other should be encouraged and recognized. Vocational training offers should be developed. Networks of potential employers should be identified ready to hire ex-DUs. Possibilities of a micro-credit system (small loans) should be examined and tested. This furthers responsibility, motivation and can be a good basis for further training and education. Training opportunities for staff should be envisaged and a multidisciplinary team would be of great benefit to such a project.

### **Prevention of DU and HIV in prisons**

It is imperative to create and sustain ties with national and international HIV actors and stakeholders. Links between HIV prevention and DU extra-muros have to be established. The AHPPN should be actively used. A prison health platform of dialogue between judiciary and health authorities should be created. A close collaboration between Ministries of Health and Justice should be aimed at and scaled up.

There should be much more visual material at disposal within penitentiary institutions in form of information/prevention posters and brochures. The latter should be systematically made available to families and visitors. Prevention kits should be made available intra-muros. VCT programs and Tb screenings should be in place. International medical standards of prison health which are easily available via internet should be used for training and practice.

Prison settings constitute special challenges to the judiciary and medical systems. Both should know of each other's mandate and specific role intra muros. Targeting inmates and socio-medical staff to become the main carriers of prevention messages was adequate. To take guards as actors of prevention in the domain of HIV and DU seems to be less adequate. The sensitization of all actors about risk taking and means for self protection is necessary. But to add preventive functions to the strict surveillance and security mission is not to be encouraged.

## V. LESSONS LEARNED

Project G66 demonstrated the well-known unbalanced position of DDR next to drug supply reduction in drug policies. The gap was however less evident in the NAPs. But DDR interventions are always supervised by law enforcement institutions (Ministries of Justice or Interior) rather than public health authorities. Thus ongoing advocacy is needed to keep DDR on national and regional political agendas. This is crucial to guarantee sufficient resources to fund an integrated chain of care (from IEC, sensitization, prevention, treatment and rehabilitation). Psychosocial aspects of drug use are best integrated into a general health promotion and community health approach. Issues related to sexual health should be part of it. Judicial authorities would be most relevant for any questions touching upon human rights. This has been well illustrated by interventions which took place in prison. They would have been impossible without the collaborative efforts of the judicial body.

The HIV threat is an important advocacy tool to gain access to difficult settings like prisons. It also permits giving MARPs like MSM and SWs a visibility which they did not have before. But a lot of work needs to be done to counter the stigmata which still often marks these marginalized populations. Gender issues were given a place in the planning of G66 but were seldom given enough attention in the implementation of DDR projects.

The strength of G66 was to anchor the project into local contexts on the basis of NAPs conceived by a participatory approach which needed a consensus between stakeholders. NGOs were sometimes left in the background. Strengthening civil society should remain an objective to improve future projects.

A sense of national ownership is an important condition of successful DDR actions. It can, to a large extent, ensure sustainability by maintaining gained benefits, continue, replicate and scale up good practices by unified efforts.

Opportunities to learn from each other, e.g. steering project meetings and study visits at regional level have been both important for the whole project G66 as well as national sub-projects, although critical feed-back was not always used for corrective measures in the respective countries.

As for future regional large-scale program design, important elements are planning according to secured human and financial resources, ensuring sustainability of actions after the end of the project and build in good coordination mechanisms with strong local relays.

Explicit criteria for the selection of beneficiary countries of a project need to be formulated in order to build up a coherent regional program able to reduce drug demand in West Africa.

# ANNEX I. TERMS OF REFERENCE OF THE EVALUATION

## Terms of Reference

### Final Independent Evaluation of Project AD/RAF/G66 (Phases I and II)

#### **“Implementation of Drug Demand Reduction Components of National Action Plans in West Africa”.**

#### **1. BACKGROUND INFORMATION**

Since the nineties, West African countries are confronted with growing illicit drug trafficking and rising local abuse of cannabis, psychotropic substances, heroin and cocaine. More recently, the West African Region has become a major transit route for cocaine trafficking from Latin America en route to Europe. This trafficking has an impact on local abuse with health, social and economic consequences in countries affected by this phenomenon. Governments in the region strived to fully implement the provisions of the three international drug conventions, apply the Declaration on the Guiding Principles on Drug Demand Reduction, and to achieve significant and measurable results in eliminating or significantly reducing the demand of drugs by the year 2008 as stated in the 1998 Political Declaration<sup>4</sup> adopted by the 20<sup>th</sup> special session of the United Nations General Assembly to countering world drug problem. At the same time, essential data and knowledge on drug abuse in the countries/region, and on possible countermeasures, are lacking. In the end of the nineties, under the PAAD<sup>5</sup> (EU) project and with the assistance of the former UNDCP, several countries in West Africa had formulated National Action Plans (NAPs), which also contained demand reduction components. The current project aimed at assisting priority countries to select and implement key demand reduction components of their NAPs in the areas of information collection and analysis, preventive education and other drug abuse prevention measures, including drug dependence treatment, and to create a regional drug demand reduction resource centre in Dakar, Senegal. In line with the project revision undertaken in 2006, the current project also aimed at enabling the implementation of targeted effective HIV/AIDS prevention and care interventions in selected prisons within the framework of the reform of the criminal justice system of the selected countries.

Project phase I covered the creation of this regional resource centre to facilitate information collection, exchange and networking on drug abuse related matters, and country level assistance to the Governments of Cote d’Ivoire and Ghana in the context of their NAPs. Project phase II has been extended to Benin, Cape Verde and Togo for implementing key DDR components of their NAPs and starting HIV AIDS activities in prison settings. At the end of this project, a regional demand reduction resource centre was expected to be fully operational and serve West Africa as an information and reference base. Direct expert, training, logistic and financial support was also expected to be provided to Regional Economic Commission<sup>6</sup> and to Government bodies as well as NGOs in the project countries. Much needed national demand reduction projects were also expected

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<sup>4</sup> Resolution S-20/2

<sup>5</sup> PAAD means African Program against Drug (*Programme Africain Anti- Drogue*)

<sup>6</sup> i.e. ECOWAS, namely the Economic Commission of West African States

to be implemented and new prevention activities initiated in the area of HIV in prison settings in line with the UN Standards Minimum Rules for the Treatment of Prisoners.

It is worth noting that this project supported the development and contributed to respond to the main thematic priority of the ECOWAS Regional Action Plan to combat illicit drug trafficking, organized crime and drug abuse (2008-2011) adopted by the ECOWAS Heads of States and Governments in 2008, in particular the Key Area 4 regarding Drug Demand Reduction and HIV AIDS interventions among drug users and prisoners. Furthermore, the project is in line with UNODC Regional Programme for West Africa (2010-2014) in its sub-programme drug prevention and health.

Although the project was elaborated in 2002, it effectively started in March 2003 following the recruitment of a Project Coordinator. It has been implemented in 5 countries under 2 phases:

- Phase I (2003-2005): Côte d'Ivoire, Ghana and Dakar
- Phase II (2006-2009): Benin, Cape Verde and Togo.

The last activity was executed in December 2009 with a Regional Consultation in Grand-BASSAM, Côte d'Ivoire and the project was considered as operationally terminated.

Several Governments contributed to the funding of the project which amounted to a total budget of USD 1,894, 012. Within this budget, the different donations came from Sweden (USD 737, 000), Italy (USD 550, 000 USD), France (USD 547, 709), Spain (USD 30, 003) and Netherlands (USD 29, 000).

A Regional Project Coordinator and a Program Assistant were hired respectively in March and May 2003 to implement the project. An Associate Expert (ASSEX) supported by Netherlands joined the team in 2005. As from March 2007, after the Project Coordinator and ASSEX departure, and until September 2009, the project supported personnel costs of different staff whose time was partially devoted to the project: an Expert on Drug Abuse Epidemiology, a Program Assistant – both based in Dakar - and a National Program Officer –based in Praia. In 2010, the personnel budget was devoted to a Program Assistant for one quarter only in order to help in the evaluation process but due to the lack of personnel, the final evaluation was not conducted. However, in 2004, a self-evaluation has been conducted to assess the achievements of the project Phase I.

The project was revised in November 2006 and extended until December 2007. The project objectives remained the same, though a third output specifically dealing with HIV AIDS in prison settings and including new implementing activities was added under the Objective 2. The anticipated departure of the Project Coordinator and of the ASSEX in March 2007 did not allow completing the project on time and required a revision and an extension until 2009. The implementation of the third output under the Objective 2 was completely executed in December 2009. The evaluation process started in 2010 but was interrupted due to the lack of personnel and was therefore postponed to the last quarter 2011 with the view to formally close the project.

The objectives of the project read as follows:

**Objective 1: To create a West African knowledge-base, information and reference point on drug abuse methodologies and approaches to drug abuse prevention, treatment and rehabilitation, and standards/lessons learned in demand reduction.**

**Output I:** A Demand Reduction Resource Centre for West Africa fully operational in Dakar by February 2005 (end of Phase 1). Production and dissemination of information material and the Development of regional exchange mechanisms.

**Objective 2: Apply preventive demand reduction measures in social or health programmes and to implement treatment and rehabilitation programmes according to National Action Plans (NAPs) of Côte d'Ivoire and Ghana (Phase I) and Benin, Cape Verde and Togo (Phase II) and to significantly reduce the transmission of HIV/AIDS and provide effective care to HIV infected prisoners in the beneficiary countries.**

**Output II:** Based on NAPs, preventive demand reduction measures carried out through social or health programmes, and treatment and rehabilitation projects implemented in  
Côte d'Ivoire and Ghana by February 2005 (Phase I)  
Benin, Cape Verde and Togo by February 2007 (Phase II)

**Output III HIV/AIDS prevention and care in prisons:** By the end of the project, technical assistance will have been provided to the selected project countries to carry out impact-oriented and sustainable HIV/AIDS prevention and care through Information, Education and Communication (IEC) and Voluntary Counseling and Testing (VCT) in selected prisons of the beneficiary countries.

The following project Outcomes and Outputs should be evaluated:

**Outcome 1:** The knowledge-base in West Africa on substance use prevention, treatment and rehabilitation methodologies and approaches, and related standards/lessons, is improved through increased access to information.

*Output 1.1:* A Demand Reduction Resource and Information Centre for West Africa is set up in Dakar.

**Outcome 2:** Targeted NGOs successfully implement selected components of the beneficiary countries' National Action Plans (NAPs) on prevention, treatment and rehabilitation.

*Output 2.1:* Sub-Projects are identified from NAPs and financially supported.

**Outcome 3:** HIV/AIDS prevention, treatment and care among prisoners, injecting drug users and people vulnerable to human trafficking are mainstreamed into National Action Plans on HIV.

*Output 3.1.:* A Regional Consultation is held to include HIV/AIDS among vulnerable groups into NAPs.

*Output 3.2.:* HIV/AIDS prevention, treatment and care activities are supported in selected prisons in the beneficiary countries.

## 2. PURPOSE OF THE EVALUATION

In compliance with the project document, the final project evaluation is undertaken by initiative of UNODC, with the Regional Office for West and Central Africa HIV AIDS Advisor being the evaluation manager, to measure its achieved results against planned outcomes and outputs.

More specifically, the external evaluation will contribute to (1) assess the impact of implementing activities, (2) make recommendations regarding best practices, (3) draw lessons from the project implementation and (4) highlight any deficiencies that could be the basis for instituting improvements to new projects planning, design and management.

Broader, it is expected that the evaluation will provide insight that will help UNODC increase the effectiveness and impact of its technical assistance in the interrelated fields of drug demand reduction and HIV AIDS.

The main stakeholders of the evaluation are the domestic authorities and civil society that benefited from project activities in each of the beneficiary countries, management of UNODC HQ and ROSEN, as well as project staff. All stakeholders will participate in the evaluation according to their roles in project implementation by submitting project related information to the evaluator (i.e. ROSEN and project staff), take part in interviews and other exercises undertaken during the evaluation. The draft evaluation report will be shared with relevant units of UNODC, Government counterparts and the donor country for feedback and comments. All stakeholders will be provided with a copy of the final report.

### **3. SCOPE OF THE EVALUATION**

The evaluation will measure results of project implementation in Dakar and all five countries participating in the project (Benin, Cape Verde, Ghana, Côte d'Ivoire and Togo) over the period from May 2003 to December 2009 against the various outputs of the project (cf. above). The evaluation will assess the impact of:

- Phase I (2003-2005)
  - o the establishment of a Resource Information Center in Dakar, Senegal;
  - o the activities carried out in the peer clubs in school settings in Ghana and Côte d'Ivoire;
  - o the rehabilitation projects for persons affected by drug use and dependence supported in Benin and Ghana;
  
- Phase II (2005-2009)
  - o the activities carried out in the peer clubs in school settings in Cape Verde and Togo;
  - o the refurbishment of specialized drug dependence treatment centers in Benin, Cape Verde and Togo;
  - o the refurbishment of sport areas for preventing drug use in vulnerable places in Cape Verde;
  - o the training sessions on drug dependence treatment in Benin and Togo;
  - o the training sessions on drug abuse and HIV AIDS prevention in prison settings in Cape Verde and Togo and the sensitization activities supported by the Civil Society Organization in Togo;
  - o the Regional Consultation on HIV prevention and treatment among injecting drug users and prisoners in West Africa held in Grand- Bassam, Cote d'Ivoire;

- the UNODC support to ECOWAS Annual Meetings of Drug Control Committees Coordinators.

The evaluation will make recommendations regarding best practices and highlight any deficiencies. The evaluation will also assess whether or not the recommendations from the previous self-evaluation have been considered and implemented into programming and if not, why this was the case.

The thematic coverage of the evaluation will focus on drug demand reduction and HIV AIDS in prison settings.

The evaluation will specifically address the following quality criteria: project relevance and utility, impact, effectiveness, efficiency and sustainability, as well as lessons learned and best practices.

The following areas should be presented and evaluated in the evaluation report:

- Priority area and comparative advantage of UNODC;
- Relevance and attainability of the project objectives;
- Results achieved;
- Relevance and utility of the results;
- Sustainability of results and benefits;
- Partnership and governance (efficiency of cooperation with national, regional and international stakeholders);
- Problems and constraints encountered during implementation.

In particular the specific areas of evaluation should cover the following:

### **Project Relevance and Utility**

- To what extent is the project aligned with the policy, strategies and needs of West African countries/ of the partner country in particular, in respect of:
  - eliminating or significantly reduce the demand of drug?
  - halting and reversing the HIV AIDS epidemics in prison settings?
- To what extent is the project aligned with the policy and strategies of UNODC, UNAIDS, other United Nations Organizations and bilateral donors?
- Does the project provide appropriate solutions to the problems it is intended to address?
- Are the objectives of the project still relevant? Are drug abuse, drug dependence and HIV AIDS in prison settings still a major problem in the beneficiary countries?
- What is the value added of the project in relation to other priority needs and efforts made to solve it (in particular efforts under other UNODC projects)?
- Is the project in line with the priority areas for technical cooperation identified by UNODC and does it make use of the Office's comparative advantage, in particular its field knowledge and expertise?

## **Impact**

- Has the project pursued the possibility of assessing impact? Which provisions were made, or could have been made, at the planning and implementation stage to assess change?
- What difference has the project made to beneficiaries?
- How this impact is being reflect in terms of:
  - o accessibility of HIV services in prison settings?
  - o successful treatment of drug dependent persons?
  - o reintegration of drug dependent persons?
  - o reduction of crime in deprived neighborhoods?
  - o reduction of drug demand in schools?
- What are the intended or unintended positive and negative long-term effects on individuals and institutions?

## **Effectiveness**

- Has the project achieved its objectives and results (outputs, outcomes, impact)? If not, has some progress been made towards their achievement?
- How has the project enabled domestic authorities to strengthen their capacity to counter money laundering and financial crimes resulting from drug trafficking and organized crime?
- What are the reasons for the achievement or non-achievement of the project objectives/outputs?
- To what extent is the progress made so far the result of the project rather than of external factors?
- What are the major challenges, opportunities and obstacles encountered by the project as a whole?
- Have the NGOs and CBOs fully been involved in the implementation of NAP priority projects in individual countries, in the development, testing and utilization of the demand reduction manuals, and in a direct cooperation with the Regional Demand Reduction Resource Centre?
- What could have been done to make the project more effective?

## **Efficiency**

- Has the budget been allocated and spent as planned? If not, for what reasons?
- Has the project delivered its outputs on time? If not, for what reasons?
- Has the staff been selected and recruited in a timely manner? If not, for what reasons?

- Compared with alternative approaches to accomplishing the same objectives, has progress been made at an acceptable cost?
- Could more have been achieved with the same input?
- Could the same have been achieved with less input? Would alternative approaches accomplish the same results at a lower cost?
- What measures have been taken during planning and implantation to ensure that resources were efficiently used?
- To what extent are the organizational structures of UNODC, the managerial support provided to the project, and the coordination mechanisms used by UNODC, both at Field and HQ level, supporting the project?

### **Sustainability**

- To what extent will the benefits generated through the project be sustained after the end of the project? After the end of donor funding?
- Have the beneficiaries taken ownership of the project objectives? Are they committed to continue working towards these objectives once the project has ended?
- Is their engagement to reduce drug demand reduction and reverse HIV epidemics in particular likely to continue, to be scaled up, replicated or further institutionalized after the project ends?

### **Partnership**

- Have coordination mechanisms between UNODC, ECOWAS Drug Control Unit and governments and other relevant stakeholders been successfully established?
- What lessons can be drawn from the working arrangements between UNODC, ECOWAS Drug Control Unit and Governments?
- What were the comparative advantages of ECOWAS Drug Control Unit, Governments and UNODC and was the project implemented with these in mind?
- What lessons can be drawn from the working arrangements between UNODC and other agencies UN (UNAIDS, WHO) and non UN (ESTHER)?
- And with NGOs, CSOs?

### **Lessons learned and Best Practices**

- What lessons can be learned from the project implementation in order to improve performance, results and effectiveness of UNODC project activities in the future?
- What best practices emerged from the project implementation?
- Can they realistically be replicated in the West Africa context?
- What lessons can be drawn from unintended results, if any?

#### 4. EVALUATION METHODOLOGY

The proposed final evaluation is planned to be undertaken in form of an independent external project evaluation. At this end, an external evaluator will be recruited. S/he will review available key documents and conduct a thorough desk review. All key documents of this Desk Review have been listed into the grid in Annex I and have been archived in the Regional UNODC Office in view of the external evaluation.

The evaluation will be conducted using the following methods:

- desk review of the project document, concept note, logical framework, action plan, annual work plans, terms of reference for consultancies, official correspondence, reports of training sessions, project progress reports, activity and financial reports, management expenditures reports, project revisions and extensions;
- interviews with key stakeholders and counterparts from the beneficiary countries, including domestic agencies, UNODC regional office in Dakar, relevant staff at UNODC Headquarters in Vienna; and
- observation during field visits.

The evaluator should provide a detailed description of the evaluation methods to be used prior to the field mission, and to summarize the review of documentation in an **Inception Report**. The latter should determine the exact focus and scope of the exercise, including the evaluation questions. The methodology will include, but not necessarily be limited to, those listed above. This step is needed because it enables the evaluation manager, project staff and the evaluator to check whether the evaluation is proceeding as desired and to discuss any previously unidentified challenges or limitations that may have emerged. The Inception Report should also be submitted to UNODC/Independent Evaluation Unit (IEU) prior to the field visits for consultation and clearance.

Judgments presented in the evaluation report should be supported by reference to the methods used for coming to a certain conclusion. In conducting the evaluation, the evaluator needs to take account of relevant international standards, including the UNODC / IEU Evaluation Policy and Guidelines and the United Nations Evaluation Group (UNEG) Norms and Standards.

Upon completion of the fact-finding and analysis phase, a draft evaluation report will be prepared. The draft should be circulated to the parties for comments. The evaluator will take the comments into account and may choose to address them in producing the final report, for which he/she will be solely responsible.

The domestic stakeholders that should be met with during the field missions include, but are not limited to:

- Benin:
  - o Ministry of Interior, National Drug Control Agency, Executive Secretary

- Ministry of Health, Mental Health Department
  - Head of the Emergency Care Unit for Drug Users located in Psychiatric Hospital Jacquot in Cotonou
  - National AIDS Secretariat
  - CSO working with prisoners involved into the project (RaBeJ)
  - UNAIDS Country Coordinator and Co-Sponsors
- Togo:
- Ministry of Interior, National Drug Control Agency, Executive Secretary
  - Ministry of Health, Mental Health Department
  - Ministry of Justice, HIV Focal Point and Head of the Penitentiary Administration
  - Head of the Specialized Treatment Center for Drug Addicts in CHU Lome
  - CSO working with prisoners involved into the project (UCJG)
  - UNAIDS Country Coordinator
- Cape Verde:
- Ministry of Justice, National Drug Control Agency, Executive Secretary
  - Ministry of Justice, Head of National Penitentiary Administration
  - Focal point at the Ministry of Education responsible for drug abuse prevention in school settings
  - Therapeutic Community of Granja San Felipe
  - National AIDS Commission
  - Ministry of Health
  - UNODC colleagues

The domestic stakeholders that should be interviewed on phone include, but are not limited to:

- Ghana:
  - Ministry of Interior, National Drug Control Agency, Drug Demand Reduction Directorate,
  - Consortium of CSO working on drug abuse (chair: Philip Foundation)
- Côte d'Ivoire:
  - Ministry of Interior, Special Advisor to drugs and National Drug Control Agency
  - CSO working on drug abuse (CLUCOD)

## **5. EVALUATION TEAM COMPOSITION**

The evaluation of the project will be carried out by an independent expert (international evaluator) appointed by UNODC. The donors to the project may provide an expert to participate in the evaluation as an observer.

Costs associated with the UNODC expert will be borne by the project. All costs for a donor appointed observer will be borne by the donor government directly.

The expert shall act independently in his/her individual capacity, and not as a representative of the government or organisation which appointed him/her. The independent expert should adhere to the independence and impartiality of the evaluation process discussed in the UNODC guiding principle for evaluation and have no previous experience or involvement with the project. This expert should have the following qualifications:

- Five years experience in conducting independent evaluations (if possible within the UN system), i.e. experience in developing and applying both qualitative and quantitative evaluation methods, and technical competency in evaluation.
- Advanced degree in Public Administration, Econometrics, Statistics, or related degree.
- Substantive record of practical experiences.
- Familiarity with the substance matter, i.e. drug demand reduction strategies, HIV AIDS prevention services for prisoners, knowledge of context and experience in West Africa;
- Excellent analytical, drafting and communication/writing skills in French and English;
- Knowledge of Portuguese will be considered as an asset;
- Field experience in West Africa or in developing countries in other parts of the world is an asset.
- Ability to work in a multicultural environment and within tight deadlines;

## **6. PLANNING AND IMPLEMENTATION ARRANGEMENTS**

The essential project documents will be sent to the evaluator in advance to allow for preliminary familiarization with the project subject and preparation of the inception report.

The evaluator will be briefed on the project by the UNODC Integrated Programming Branch (IPB) / Regional Section for Africa and the Middle East when arriving at UNODC Headquarters in Vienna as well as by the Independent Evaluation Unit, PTRU, HAU and by the Regional HIV AIDS Advisor upon his/her arrival into the region (via Dakar, Senegal).

UNODC Regional HIV AIDS Advisor and the project staff in countries will provide necessary substantive and administrative support during the evaluator's field visits. Although the evaluator should be free to discuss all matters relevant to his/her assignment with the authorities concerned, he/she is not authorized to make any commitment on behalf of UNODC or the Government.

The evaluator will submit the evaluation report (in English) to the Regional HIV AIDS Advisor, UNODC ROSEN. The report will contain the findings, conclusions and recommendations of the evaluator as well as a recording of the lessons learned. The draft evaluation report should be shared with UNODC ROSEN, as well as with the Core Learning Partners and the Chief of the Independent Evaluation Unit and IPB/Regional Section for Africa and the Middle East UNODC HQ in Vienna for their review prior to its finalization. The evaluator, while considering the comments provided on the draft, would use his/her independent judgment in preparing the final report. IEU will serve

to provide quality assurance throughout the process by providing comments on the evaluation tools, the draft report and will provide final clearance for the final evaluation report.

The final evaluation report should be submitted to UNODC within one week after receiving stakeholders' feedback to the draft report, and no later than xxx 2012. The report should be no longer than 15 pages, excluding annexes and the executive summary. The report will be distributed by UNODC as required to the governmental authorities and to the donors.

## 7. Indicative Timeframe for the evaluation

The suggested timeframe for the evaluation mission is from 25 January 2012 to 23 March 2012

(seven weeks and a half).

<b>TIMEFRAME for TRAVELS and FIELD MISSIONS of the Consultant</b>		
<b>When (Tentative dates)</b>	<b>What tasks</b>	<b>Where (location)</b>
25 January 2012	Flight from home to Dakar, Senegal, if applicable	Dakar, Senegal
26-27 January 2012 <b>2 working days</b>	Desk review of background documents	
Week of 30 January 2012 <b>5 working days</b>	Desk review of background documents (ctd) Briefing with IEU and IPB (on phone) Briefing with UNODC project manager Development of evaluation methodology	Dakar, Senegal
05 February 2012	Flight to Lome	Lome, Togo
Week of 6 February 2012 <b>5 working days</b>	Start of field visit to Lome, Togo	Lome, Togo
11-12 February 2012	Travel to Cotonou via the road	Cotonou, Benin
Week of 13 February 2012 <b>4 working days</b>	Start of field visit to Cotonou, Benin	
16- 17 February 2012	Flight from Cotonou to Dakar	Cotonou, Benin Praia, Cape Verde
17 February <b>1 working day</b>	Debriefing with UNODC project manager	Dakar, Senegal
19 February	Flight to Praia	Praia, Cape Verde
Week of 20 February 2012 <b>4 working days</b>	Start field mission to Praia, Cape Verde	Praia, Cape Verde
24 February 2012 <b>1 working day</b>	Flight back to Home via Dakar- Debriefing with UNODC project manager	Dakar, Senegal
25 February	Flight back to home, if applicable	Home
Week of 27 February 2012 <b>10 working days</b>	Prepare draft report	home
Week of 12 March February 2012 <b>no consultancy fees for this</b>	Round of comments among relevant stakeholders	

<b>period</b>		
Week of 19 March 2012 <b>5 working days</b>	Finalization of the report and submission to UNODC	home
<b>Total 36 working days</b>		

## 8. Expected deliverables

- 1 Inception Report, containing methodology, evaluation work plan and finalized design matrix
- Summary of findings to be presented during debriefing meeting with ROSEN, Dakar
- 1 Draft Evaluation Report
- 1 Final Evaluation Report

NOTE : the UNODC standard format and guidelines for evaluation reports should also be attached to the terms of reference.

## 9. PAYMENT

Consultants will be issued consultancy contracts and paid in accordance with United Nations rules and procedures.

A lump-sum will be paid in three instalments:

- A 75% advance for travel expenses (DSA and terminals) will be paid out before the start of the field visits. The remaining expenses will be paid out after the field mission on the basis of a duly completed F10 form.
- The consultancy fee will be paid out in two steps.
  - A first payment of 50% of the fee will be made upon receipt of the draft report by UNODC (i.e. by the relevant units/sections at headquarters and field offices, as well as by the Independent Evaluation Unit).
  - The remaining 50 % of the consultancy fee will be paid out after completion of the respective tasks and receipt of the final report and its clearance by the Independent Evaluation Unit.

## 10. PERFORMANCE INDICATORS

- timely and accurate submission of the documents;
- substantive and linguistic quality of the prepared documents;
- conformity of the project evaluation report with the standard format and guidelines for the preparation of project evaluation reports and technical guidance received;
- report should contain recommendations for future course of action.

### DESK REVIEW: Preliminary list of documents to be consulted

Document Description	Number
Project doc RAFG66	1

Annual and Semi-Annual Project Progress Report (APPR)	13
Project revision/ extension document	5
Evaluation Guidelines- Final UNODC	1
NAPs	2
First Evaluation (mid-term Phase 1)	1
Minutes (meetings Steering groups)	4
Initial surveys conducted in the countries	3*
Reports of the baseline surveys conducted in the countries (INRA)	3*
Protocol of Agreements	13
Political declaration 1998 and 2009 <sup>7</sup>	2
ECOWAS Action Plan 2008-2009	1
Guidance Note on the UNODC role in the response to the HIV and AIDS epidemics as related to drug use	1
UNODC Regional Programme for West Africa, 2010-2014	1
Activity and Financial Reports	26
Tripartite Review Meeting Reports	0
Project workplans	7
Logical framework	2

\* Through another project (n°G14)

## CORE LEARNING PARTNERS (21)

<sup>7</sup> <http://www.unodc.org/unodc/en/commissions/CND/political-declaration-1998.html>

<http://www.unodc.org/unodc/en/commissions/CND/political-declaration-2009.html>

<b>UNODC (5)</b>	
<b>Head Quarters (3)</b>	<b>Field Offices (2)</b>
Ms. Giovanna Campello, O-i-C, DO, DPHB, PTRU	Ms. Margarete Molnar, Regional HIV AIDS Adviser, ROSEN, Dakar
Dr Fabienne Hariga, Senior Expert, DO, DPHB, HAU	Ms. Cristina Andrade, Senior National Coordinator, ROSEN, Praia
Ms. Aisser Al-Hafed, Desk Officer, DO, IPB, Regional Section for Africa and the Middle East	

<b>Countries</b>	<b>Key actors of Government (10)</b>	<b>Civil Society Institutions (6)</b>
Benin	<ol style="list-style-type: none"> <li>1. Commissaire Hounsou ( Executive Secretary, CILAS, Ministry of Interior)</li> <li>2 . Pr Mathieu Tognide (Focal Point of Ministry of Health in CILAS, Head of the Elergency Care Unit for Drug Users located in Psychiatric Hospital Jacquot in Cotonou)</li> <li>3. Dr Antoinette Obey ( Head of NAC)</li> </ol>	<ol style="list-style-type: none"> <li>4. Mr Gabin/ RaBeJ , CSO working with prisoners</li> </ol>
Cape Verde	<ol style="list-style-type: none"> <li>1. Dr Fernanda Marques (Head of the National Drug Commission, Ministry of Justice)</li> <li>2. Focal point at the Ministry of Education responsible for drug abuse prevention in school settings</li> <li>3. Mr. , Head of National Penitentiary Administration</li> </ol>	<ol style="list-style-type: none"> <li>4. Dr. , Head of the Therapeutic Community of Granja San Felipe</li> </ol>
Cote d'Ivoire	<ol style="list-style-type: none"> <li>1. Dr Yao Ronsard, Special Advisor on Drugs to the Ministry of Interior</li> </ol>	<ol style="list-style-type: none"> <li>2. Mr Lacina Tall, NGO CLUCOD</li> </ol>
Ghana	<ol style="list-style-type: none"> <li>1. Mr Francis Tokornoo, Head of the DDR Directorate, NACOB</li> </ol>	<ol style="list-style-type: none"> <li>2. Mr Philip Mensah, Chair of the consortium of NGOs working on drugs</li> </ol>
Togo	<ol style="list-style-type: none"> <li>1. Lieut-Col. Wanta R. Badombena (Secrétaire Permanent du CNAD/ Ministère de l'Intérieur)</li> <li>2. Mme Justine Ahadzi (MJ)</li> </ol>	<ol style="list-style-type: none"> <li>3. Dr Valentin Dassa, Psychiatre, Service d'Aide Médico- Sociale aux Usagers de Drogue du CHU de Lomé</li> <li>4. Mr Lambert A. Daischer, ONG UCJG, Pairs éducateurs prisons</li> </ol>

<b>Final TIMEFRAME for TRAVELS and FIELD MISSIONS of the Consultant</b>		
<b>When (Tentative dates)</b>	<b>What tasks</b>	<b>Where (location)</b>

22 March 2012	Flight from Geneva / Switzerland to Dakar, Senegal,	Dakar, Senegal
23 March 2012 <b>1 working day</b>	Briefing with UNODC project manager Desk review of background documents	Dakar, Senegal
Week of 26 March 2012 <b>5 working days</b>	Briefing with IEU (on phone) Desk review of background documents (ctd) Development of evaluation methodology Drafting of an Inception Report	Dakar, Senegal
01 April 2012	Flight to Praia	Praia, Cape Verde
Week of 2 April 2012 <b>4 working days</b>	Start of field visit to Praia, Cape Verde	Praia, Cape Verde
06 April 2012 <b>1 working day</b>	Interview on phone with Ghana Interview on phone with Cote d'Ivoire	Dakar, Senegal
9 April 2012	Flight to Cotonou	Cotonou, Benin
Week of 10 April 2012 <b>4 working days</b>	Start of field visit to Cotonou, Benin	Cotonou, Benin
15 April	Travel to Lome via the road	Lome, Togo
Week of 16 April March 2012 <b>4 working days</b>	Start field mission to Lome, Togo	Lome, Togo
20 April 2012 <b>1 working day</b>	Flight from Lome to Dakar Debriefing with UNODC project manager	Dakar, Senegal
21 April	Flight back to Geneva / Switzerland	Home
Week of 23 April 2012 <b>9 working days</b>	Prepare draft report	Home
Week of 07 May 2012 (10 days) <b>no consultancy fees for this period</b>	Round of comments among relevant stakeholders	-
Week of <b>21 May 2012</b> <b>5 working days</b>	Finalization of the report and Submission to UNODC	Home
<b>Total 34 working days</b>		

## ANNEX II. LIST OF PERSONS CONTACTED DURING THE EVALUATION

### ROSEN

- M. Alexander Schmitt, UNODC Country Representative, ROSEN, Dakar
- Margarete Molnar, Regional HIV and AIDS Advisor Regional Office for West and Central Africa

### CAPE VERDE

#### April 2

- Cristina Andrade, Senior National Coordinator UNODC, former CCDC Executive Secretary
- Fernanda Marques, Executive Secretary, Coordinating Committee on Drug Combat, Ministry of Justice
- Maria Celina Ferreira, Responsible for Monitoring and Evaluation, Coordination Committee to combat AIDS, Cabinet of the Prime Minister
- Vanusa Pereira, Coordinating Committee on Drug Combat, Ministry of Justice
- Antonio Roliano M. Cardoso, Director of the Social Reinsertion Service, Ministry of Justice
- Ana Paula Ortet, Psychologist, prisons, Ministry of Justice

#### April 3

- Emilio Tavares Silva, Director
- José Luis Gomes Tavares, Director Adjunto
- Francisco Ramos, Guard
- Helio Fonseca 33 yrs, incarcerated 6yrs and 4 mo, by this year should be in half detention
- Olair Semedo OS, 33 yrs, incarcerated, 7 yrs and 1 mo, president of the prisoner's association, has passed 2/3 of his sentence, can be liberated, needs a job
- Antonio Pires Cardoso, director since Nov 2 2011
- Elisa Borges, sociologist, Ministry of Justice
- Focus Group 21 residents, 4 women during 90 minutes
- Staff (service providers) n= 6  
4 women, 2 men; 5 psychologists, 1 male nurse.

#### April 4

- Ms Armanda Prado, Ministry of Youth and Labor, Focal point Ministry of Youth

- Ms Dirce Melo, focal point Ministry of Education, responsible for drug prevention in schools. In place since sept. 2011
- Ms Teresa Delgado Lima, general Director of primary and secondary schools took this post in February 2011
- Ms Maria Madalena R.F. Santos, secondary school teacher
- Janice Silva
- Briefing C. Andrade, Senior National Coordinator UNODC, former CCDC Executive Secretary

#### **April 5**

- Honris Fragata, Missionary from Angola, religious therapeutic place **EL SHAADDEI**
- Debrief at CCCD: Fernanda Marques, Executive Secretary, Coordinating Committee on Drug Combat, Ministry of Justice, Ms Dirce Melo, focal point Ministry of Education, Antonio Roliano M. Cardoso, Director of the Social Reinsertion Service, Ministry of Justice, Cristina Andrade, Senior National Coordinator UNODC, former CCDC Executive Secretary
- Emilio Tavares Silva, Director Central Prison
- 2 guards

### **BENIN**

#### **April 10**

- Meeting with 6 CILAS members: Aristide Dagou, commissaire principal police officer, Germain Housou, ex executive secretary of CILAS, Professor Matthieu Tognide, present director of the treatment center USUT and director of the national center for psychiatry, Marcellain Abbé, commissaire, law enforcement officer, Madame E. Boussou, represents Ministry of Finance at the CILAS and project manager for the reinsertion aspects (chicken farm), Dr. Adjido, ex director of the treatment unit USUT and ex director of the national center for psychiatry

#### **April 11**

- Field visit Pahou, about 25 km from Cotonou
- Field visit to Avrankou, about 40 km from Cotonou
- Field visit to Association St. Camille
- Field visit to Center Padre Pio, "Oasis d'amour", private NGO
- Jules Kokoun, male nurse since 2007
- Innocent Amadi, director was a teacher since 2004
- Sister Joanna, specialized educator, came first to Benin in 1963, spent 20 years in Côte d'Ivoire
- Dr. Moise Dossa, young psychiatrist at the center since 2011

#### **April 12**

- Field visit to the CNHP, Centre National Hospitalier Psychiatrique which integrates the USUT, Unité de Soins d'Urgence Psychiatrique  
With Dr. Mathieu Tognide, director of the CNHP  
E. Bossou

G. Houssou  
Dr. Ajido  
Aristide Dagou  
Dr. Grégoire Gansou, vice-director  
Briefing

### **April 13**

- Monsieur Benoît Assouan C. DEGLA, Ministre de l'Intérieur, de la Sécurité Publique et des Cultes
- Dr. Germain Monteiro, public health MD, works since 4 years at the CNLS. The connection with G66 which he does not know is a project financed in 2008 by UNODC on TV/HIV confection in prisons.

### **TOGO**

### **April 15**

- Col. W. Ranougo Badombena, biologist, Armed Forces, executive secretary of CNUD
- Komlan Bohm, clinical psychologist

### **April 16**

Meeting with the steering committees:

- President: Justine Ahadzi-Azanledji, HIV focal point, Ministry of Justice, Colonel Wanta Ranougo Badombena, secrétaire permanent Comité national anti-drogue, Kebezi Yodo, director NGO ANVAD, K.D. Nonon, project leader, drug prevention in schools, Lambert Daisher, project coordinator, TMCA, Togo, K.C. Lodonou, K.M. Mensah, focal point drugs, MEPSA, Ministry of primary/secondary education and literacy, J.J. Kojjo, administrative director of penitentiary services, T. Tchangai, consultant, project DU-HIV in prison

Meeting with project leaders:

- Colonel Wanta Ranougo Badombena, secrétaire permanent Comité national anti-drogue, Kebezi Yodo, director NGO ANVAD, K.D. Nonon, project leader, drug prevention in schools, Lambert Daisher, project coordinator, TMCA, Togo, K.C. Lodonou, K.M. Mensah, focal point drugs, MEPSA, Ministry of primary/secondary education and literacy

### **April 17**

Field visit to Lomé central prison with

- Justine Ahadzi
- Patrice Labodja Djato, directeur prison civile de Lomé, Direction de l'Administration Pénitentiaire et de la réinsertion

Meeting with 8 guards, and a chief guard, beneficiaries of the training in January 2009.

Justine Ahadzi, Col. Badombena, G.G. Kodjo, director of the administration pénitentiaire et de réinsertion, Lambert Daisher, project coordinator YMCA, K. Yodo, ANVAD NGO Meeting with 3 health staff: the chief male nurse, his female assistant and another one from outside.

- Lambert A. Daisher, YMCA
- K. Yodo

Meeting 7 inmates

- Colonel Awizoba K. Egoulou, director Office central de la répression du trafic illicite des drogues et du blanchiment, Ministère de la sécurité et de la protection civile

### **April 18**

- Joseph Nadjombé Ogone, directeur Collège d'enseignement général de Kodjoviakope

1400 students between 10-16

Enseignant encadreur, since 2007

- M. Nonon, chef de projet, inspector
- M. Bohm
- Sister Brigitte, director since 2004. Private school, Notre Dame des Apôtres

2 encadreurs

- Frantz A. Dosseh Collège Protestant Lomé -Tokoin, Eglise Evangélique du Togo, private school, director. Has worked for 27 years in this school, was appointed director 2 years ago. Before was adjoint director.
- Kodza Ameyunya-Kodzovi, éducateur encadreur. Sport teacher

CHU-CAMPUS Lomé

- Professor Gnansa C. Djassoa, health psychologist, trained in Geneva PhD in Rennes.
- Dr. Kooky Messanh Soedje, very recently appointed, studied in France, has worked at USUTbin Cotonou.
- Dr. Todin Dovi Djagba, directeur CHU Campus since only 2011.
- 8 health staff

### **April 19**

- Kouassi-Kouma Cléophas Dzidzokou, proviseur, Lycée d'enseignement général de Gbenyedzi-Kope

- SE Dokisime Gnama Latta, Minister of Security and civil protection. Pilot. Since February 2011.
- SE Tchitchao Tchalim, Minister of Justice
- Briefing: Colonel Badombena, Lambert Daisher YMCA, Komlan Bohm, GG Kodjo, penitentiary administration, M. Nonon

## ANNEX III. EVALUATION TOOLS: QUESTIONNAIRES AND INTERVIEW GUIDES

A first desk review of project documents was undertaken according to the levels of analysis defined:

### West Africa

- Regional plans, programs and political declarations

### Regional

- 18 Annual and semi-annual Project Progress Reports (UNODC perspective)
- 1 Project Revision Extension Report, 2006, (UNODC perspective)
- 1 Project Revision, 2011, (UNODC perspective)
- 4 Reports of the meetings of the steering committee, (regional perspective)

### National

- A package of letters of agreement of each beneficiary country (national perspective)
- 5 NAPs (PAAD evaluation second-hand) (national perspective)

### Field

- More than forty activity and financial reports

This first review was completed by the research of relevant documents on internet as well as scientific journals.

A series of interviews are planned with significant stakeholders knowing of or having contributed to the project.

### Semi-structured interviews

Focus group meetings, mainly with beneficiaries

Desk research

Electronic questionnaire

Partner mapping

Three field visits of four days each are planned to the beneficiary countries of phase 2: Cape Verde, Benin and Togo. Government representatives, civil society representatives, project leaders will be interviewed. At each site, a visit to therapeutic structures is foreseen allowing direct observation of the project's outputs and assessing quality of services.

Possible focus groups with direct beneficiaries (social workers, educators, medical staff, health workers, CSOs, (ex) drug users, prisoners, pupils, trained youth) could be organized.

Finally, a list of questions put to identify key actors which cannot be met directly will be addressed electronically in order to test and/or validate evaluation findings.



## ANNEX IV. DESK REVIEW LIST

### GENERAL

- 1) UNODC Project Document: Project of the Governments of Benin, Cape Verde, Côte d'Ivoire, Ghana et Togo, Project Document AD/RAF/02/G66, 18pp
- 2) UNODC, Project Revision/Extension document AD/RAF/02/G66, 10pp
- 3) Terms of Reference, Final independent evaluation of project AD/RAF/G66 (Phases I and II), "Implementation of Drug Demand Reduction Components of National Action Plans in West Africa", 15 pp
- 4) Project Progress Reports, semi-annual and annual: 2003-2011, n=18, 79pp
- 5) Reports of the meetings of the steering committee: 2003-2006, n=4, 46pp
- 6) Package of Protocols of Agreements
- 7) UNODC, Regional Programme for West Africa, 2010-2014, New York, 2010, 145 pp
- 8) ECOWAS, Regional action plan to address the growing problem of illicit drug trafficking, organized crimes and drug abuse in West Africa, 2008-2011, 21pp
- 9) UNODC, UNAIDS, Le VIH en Prisons; possibilités d'intervention en Afrique subsaharienne, septembre 2007, 29pp.
- 10) UNODC, The transatlantic cocaine market, research paper, April, 2011, 64pp
- 11) Union Africaine, Plan d'action de l'union africaine sur la lutte contre la drogue et la prévention du crime (2007-2012) et son mécanisme de mise en œuvre, de suivi et d'évaluation, 14pp
- 12) Political declaration, guiding principles of drug demand reduction and measures to enhance international cooperation to counter the world drug problem. Special session of the General Assembly devoted to countering the world drug problem together. 8-10 June 1998, 40pp.
- 13) Van der Vaeren, C. & Labrousse, A. Evaluation a mi-parcours du programme africain anti-drogue (PAAD), Collectif d'échanges pour la technologie appropriée (Cota) rapport final, juillet 2000, 62pp
- 14) UNODC, UNAIDS & WB. HIV and Prisons in sub-Saharan Africa : Opportunities for Action, 38pp.
- 15) Human Development Report, 2011
- 16) Reid, S.R., Injection drug use, unsafe medical injections and HIV in Africa : a systematic review. Harm Reduction Journal, 2009, 6:24, 11pp.
- 17) Andrew A Adjei, Henry B Armah, Foster Gbagbo, William K Ampofo, Isaac Boamah, Clement Adu-Gyamfi, Isaac Asare, Ian FA Hesse and George Mensah, Correlates of HIV, HBV, HCV and syphilis infections among prison inmates and officers in Ghana: A national multicenter study. BMC Infectious Diseases, 2008, 8:33, 12 pp. <http://www.biomedcentral.com/1471-2334/8/33/> - ins5

- 18) Raguin, G., Lepretre, A., Ba, I., Ndoye, I., Toufik, A., Brucker, G. & Girard P.-M., Drug use and HIV in West Africa: a neglected epidemic. *Tropical Medicine and International Health*, 19:9, September 2011, 3pp.

## Cape Verde

- Strategie nationale de lutte contre la drogue et le crime connexe. Reunion thematique de mobilization de financement, Praia 15-16 Juillet 2004. Sommaire executive, 10pp.2009
- One UN Programme, annual report, Cape Verde, 28pp.
- Hjerstroem, C. (2011). Delivering as One. Country led evaluations. Synthesis Report, 66pp.
- Country-led evaluation of delivering as One, United Nations in Capo Verde, Sept. 2010 Final Evaluation Report, 89 pp.
- Ministry of Justice, Commission for Drug Control Coordination & UNODC, (2007). Study on the situation of drug abuse and drug related HIV/AIDS in Cape Verde. Preliminary Report, 121 pp.
- Mission reports, 5-7 September 2005 (Mickel Edwerd): 6-9 February 2006, (Mickel Edwerd), 4-7 November 2007 (Margarete Molnar), 1-8 February 2009 (Janice da Silva)

## Benin

- Politique nationale de Lutte contre la Drogue "PO.LU.DRO", CILAS finalized in July 1999, 230pp.
- Ministère de la Justice, de la Législation et des Droits de l'Homme. Stupéfiants et substances psychotropes. Recueil de Textes, 78pp.
- Mission report, Mickel Edwerd, 8-11 October 2006
- CILAS Evaluation mi-parcours de l'exécution du projet AD/RAF/G66, phase II
- Uehlinger, C. Evaluation des besoins, des ressources, et du renforcement des capacités du personnel soignant dans un centre de traitement des dépendances récemment créé par l'ONUDC à Cotonou au Benin. 29.11. 2006-1.12.2006, rapport final, December 2006. ,
- Protocols of the steering committee of the project TB/HIV in prison

## Togo

- Fiche synthétique Rapports/Etudes sur l'abus des drogues 2000-2005/6, 3pp
- Project AD/RAF//02/G66, Mise en oeuvre de réduction de la demande de drogues des plans nationaux d'action en Afrique de l'Ouest, rapport final, 2005-2006,10pp
- C. Uehlinger, Evaluation des ressources et du renforcement des capacités du personnel soignant dans un centre de traitement des dépendances récemment créé par l'ONUDC à Lomé au Togo, rapport final 27.12. 2006, 11pp.
- 3 Mission reports to Togo
- Antonio Mazzitelli, Mickel Ewerd 25-27 June 2006, 5pp
- Mickel Ewerd, 11-14 October 2006,3pp

- Janice Helena da Silva, 5-19 January 2009, 5pp
- T. Tchanghaï, rapport du consultant sur l'exécution du projet AD/RAF/G66 VIH Prison. Prévention du VIH et de l'abus de drogue en milieu carcéral, 35pp.
- Ministère de l'Intérieur, de la sécurité et de la décentralisation, Comité national anti-drogue. Plan national d'action anti-drogue, P.N.A.A.D., 176pp.

## ANNEX V. PROJECT STAKEHOLDERS AT DIFFERENT LEVELS

<i>Level</i>	<i>Organisations Actors</i>	<i>Documents and Interventions</i>
West Africa global strategic framework policies	ECOWAS	Declarations Plans Programs
REGIONAL	UNODC-ROSEN	G66 Research and Information Centre Project Portfolio
NATIONAL	National Coordination Governments	NAPs (5 countries) DDR components HIV components
FIELD	Project Managers	Projects: Capacity building Prevention Treatment Rehabilitation
Ultimate beneficiaries	Social workers Educators Medical staff Health workers CSOs DUs Prisoners Guards Students	

## ANNEX VI. MAIN DEVELOPMENT INDICATORS OF THE BENEFICIARY COUNTRIES

Table 2. Main development indicators of the beneficiary countries

<i>Country</i>	<i>Population</i>	<i>Percentage Pop. Below poverty line</i> <i>(World Factbook, Feb 2012)</i>	<i>GDP per capita in dollars</i> <i>(World Factbook, Feb 2012)</i>	<i>Life Expectancy</i> <i>(World Factbook, Feb 2012)</i>
Benin	9'598'787	37.4	1'500	60.2
Cape Verde	523'568	30	4'000	71
Côte d'Ivoire	21'952'093	42	1'600	57.2
Ghana	25'241'998	28.5	3'100	61.4
Togo	6'961'049	32	900	63.1
Senegal	12'969'606	54	1'900	60.1

<i>Country</i>	<i>HDI Position on 187</i> <i>(Human Development Report 2011)</i>	<i>Gender Inequality Position on 146</i> <i>(Human Development Report 2011)</i>	<i>Percentage HIV prevalence 15-49yrs</i> <i>(UNAIDS 2009)</i>	<i>HEALTH Expenditure: % of GDP</i> <i>(World Factbook Feb 2012)</i>	<i>Percentage of Literacy: Age 15 and over who can read and write</i> <i>(World Factbook Feb 2012)</i>
Benin	167	133	1.2	4.2	34.7
Cape Verde	133	---	---	3.9	76.6
Côte d'Ivoire	170	136	3.4	5.1	48.7
Ghana	135	122	1.8	10.6	57.9
Togo	162	124	3.2	5.9	60.9
Sénégal	155	114	0.9	5.7	39.3