

# Midterm Evaluation Report

Project Number TDROMJ19FBG

## **"HIV/AIDS Prevention and care among injecting drug users (IDUs) and in prison settings in Romania"**

Thematic Area: HIV/AIDS

**Country: Romania**

12 March 2009

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Vienna

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## Abbreviations and Acronyms

ALIAT	The Alliance for Fighting against Alcoholism and Drug Addictions
ANA	National Anti-Drug Agency
ANP	National Administration of Penitentiaries
ARAS	Romanian Association Against AIDS
ART	Antiretroviral Therapy
BSS	Behavioral Surveillance Survey
CAIA	Integrated Addiction Care Center, National Anti-Drug Agency
CCM	Global Fund Country Coordination Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CNASS	National Health Insurance House
CPECA	Centers for Drug Prevention, Evaluation & Counseling, National Anti-Drug Agency
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
MARA	Most-at-Risk Adolescents
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MoI	Ministry of Interior and Administrative Reform
MoJ	Ministry of Justice
NGO	Nongovernmental Organization
NPO	National Project Office
OSI	Open Society Institute
OST	Opioid Substitution Therapy
PMTCT	Prevention of Mother-to-Child Transmission
RPOSEE	UNODC Regional Programme Office for South-Eastern Europe
RHRN	Romanian Harm Reduction Network
RMCDDA	Romanian Monitoring Center on Drugs and Drug Addiction, National Anti-Drug Agency
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

# Executive Summary

## A. Summary Matrix: Findings, supporting evidence and recommendations

Findings: Problems and Issues Identified	Supporting Evidence	Recommendations
<p>1. The design and management of the project has generally been accomplished to a very high standard, and the project has collaborated in developing or has directly produced several high quality models of HIV prevention service, technical assistance and project management.</p>	<p>The strongest, best established harm reduction outreach programs offer a sophisticated model of service delivery and have excellent relations with clients; Technical assistance/training initiatives well developed; National Project Office functions highly effectively in concert with UN and other stakeholders. Strong and consistent positive feedback about the project design and management and the roles of the National Project Office staff from national stakeholders and UNODC technical and management staff in Vienna and Sofia.</p>	<ol style="list-style-type: none"> <li>1. Use existing high quality services as a guide for getting other programs further up to speed at the local, national and regional/international levels;</li> <li>2. Continue efforts to institutionalize technical assistance/training programs;</li> <li>3. After the project ends, UNODC should document or otherwise share the work of the National Project Office and related UNODC bodies as a potential best practice model of UN HIV prevention program organization and management.</li> </ol>

Findings: Problems and Issues Identified	Supporting Evidence	Recommendations
<p>2. Some project activities and indicators were poorly defined and/or may be unrealistic at this stage.</p>	<p>Ambiguous terminology used in some project objectives and elsewhere in project documents;  Project’s quantitative indicators cannot be meaningfully measured as currently written;  Objectives related to services development outside Bucharest may not be achievable or realistic;  Possibly overambitious expectations to develop normative policy/practice guidelines (e.g. VCT, outreach, peer education, monitoring and evaluation);  No regular or systematic means of involving people who use drugs in services development or monitoring.</p>	<ol style="list-style-type: none"> <li>1. UNODC should strive to use specific, widely understood terminology in all project documents and avoid ambiguous terms that do not clearly describe what a given project supports;</li> <li>2. UNODC, other donors and service providers should seek to use a meaningful definition of ‘coverage’ for syringe exchange and other interventions, based on the 2009 WHO/UNODC/UNAIDS “Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users”;</li> <li>3. The project should reconsider with the national stakeholders whether is necessary to temporarily or permanently remove the expectation of further programming outside Bucharest.</li> <li>4. Consider whether it is feasible to address issues specified among the project document’s outputs as in need of normative practice guidelines that have not already been features of the project and which have also been taken up to varying extents by other programs (e.g. GFATM, UNICEF).</li> <li>5. UNODC should consider opportunities to elicit more regular and substantial advice from people who use drugs about the Romanian project and other drug user health services and projects and, when possible, to involve people who use drugs in the design and conduct of services, advocacy, and other initiatives.</li> </ol>

Findings: Problems and Issues Identified	Supporting Evidence	Recommendations
<p>3. Despite increases in the availability of harm reduction services through the project, some project beneficiaries are still experiencing limits in access to sterile syringes.</p>	<p>Widespread documentation of syringe sharing among IDU; High rate of HCV infection; Reports from IDU interviewed during evaluation mission of frequent syringe sharing, unreliable access to pharmacy syringe sales, and lack of knowledge about evidence-based syringe cleaning methods.</p>	<ol style="list-style-type: none"> <li>1. Government of Romania, harm reduction organizations, UNODC and other donors should consider and seek to ameliorate possible barriers to syringe access created by public policies or practices adopted in services;</li> <li>2. Consider renewing efforts to promote syringe sales through Romania's private pharmacy system;</li> <li>3. Consider ways to promote evidence-based syringe cleaning techniques among IDU in order to reduce disease transmission. Steps could include: a review of current scientific literature; a review of Romanian law governing syringe cleaning/reuse in the medical system to determine whether it is relevant in a harm reduction setting; training for harm reduction staff and other stakeholders; development and dissemination of IEC materials; incorporation of evidence-based syringe cleaning messages in contacts with IDU.</li> </ol>
<p>4. The project has made great progress in supporting new services and improving accessibility, and involving new government and civil society organizations in harm reduction. Some new services, however, continue to encounter challenges related to services design and implementation.</p>	<p>Unnecessarily high threshold policies of some service providers that limit IDU access to some OST and needle exchange programs (including unnecessarily long intake periods or inappropriate fee-based services at some OST clinics; some use of inappropriately low syringe exchange ratios); Few prisoners accessing prison-based HIV prevention services.</p>	<ol style="list-style-type: none"> <li>1. UNODC and its partners should seek to adjust and improve HIV prevention services targeting IDUs as service providers become more experienced, the goals being to make services as relevant as possible, to lower barriers to drug users' access to services (including barriers created by service design), and to maximize the reach and measurable impact of such services;</li> <li>2. The project should continue to allocate technical assistance to prison programs in order to improve their effectiveness and promote scale-up. Additional education and training about the goals and methods of services is also needed, targeting both prisoners and prison staff.</li> </ol>

Findings: Problems and Issues Identified	Supporting Evidence	Recommendations
<p>5. The threat to the project’s objectives posed by uncertainty about long term funding (and therefore programmatic) sustainability is common to all project stakeholders and cannot be overemphasized.</p>	<p>Great majority of funding is currently from GFATM and UNODC programs, both of which will end in 2009-2010; Currently very limited support from government for HIV prevention among IDU, especially from the MoH.</p>	<ol style="list-style-type: none"> <li>1. Concentrate remainder of UNODC project on advocacy to build sustainability;</li> <li>2. Project staff should consider developing more detailed advocacy strategies, perhaps in partnership with other stakeholders, based on simple campaign organizing principles, e.g. defining concrete issues and desired outcomes, mapping power structures, identifying individuals to target and tactics to be employed, setting a timeline and benchmarks, etc. Outside technical assistance in campaign planning should be used as needed.</li> <li>3. In particular, an assessment of the funding environment and written advocacy strategy aimed at sustainability would be useful, done in collaboration with organizations partnering in the project and the GFATM Round 6 Program;</li> <li>4. UNODC should consider securing additional technical assistance and/or project funding in order to enhance project’s capacity to address sustainability questions.</li> <li>5. The Government of Romania should provide funding adequate to sustain and continue scale-up of IDU health services, and increasingly provide such services directly through relevant government agencies, and take steps to guarantee continuity of health services between the community, pretrial detention, and prisons.</li> </ol>

## B. Description of the Project

The UNODC project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Romania” is a roughly 4-year, USD 3 million project funded by the Netherlands Ministry of Health, Welfare and Sport. Launched in November 2006, the project is designed to prevent HIV infection among injection drug users (IDU) and prisoners by promoting increased accessibility of sterile syringes and other injection equipment, and behavior change among IDU in order to decrease transmission of HIV and other infectious diseases. The project is one component of a larger Dutch-funded program that also targets, with similar objectives, Estonia, Latvia, Lithuania and the Russian Federation.

At the time of the project's inception, Romania was experiencing a concentrated HIV epidemic, notwithstanding a major nosocomial outbreak in the late 1980s. Several troubling features of the landscape suggested, however, that urgent action was needed in order to contain HIV. Research – primarily in Bucharest – had consistently showed hepatitis C (HCV) prevalence to be very high in IDU populations that have been tested, and syringe sharing extremely common. The studies showed also HBV prevalence of 8-10% among IDUs. Romania had the third lowest rate of HIV testing in the European Union for the population as a whole,<sup>1</sup> and targeted testing of most-at-risk groups was remarkably inadequate; only 1,461 people reported as belonging to “high risk” groups (IDU, sex workers, MSM) received HIV tests in 2006.<sup>2</sup> Although harm reduction and other IDU health services had been developed in Romania since the 1990s, some of which had achieved international reputations for excellence, they were largely confined to Bucharest, underfunded, and not conducted at a scale commensurate with the community's needs. And despite widespread acknowledgement that a large proportion of Romanian prisoners had a history of drug use, and indeed that drugs were available inside the prison system, little attention or funding had been given to drug-related HIV prevention in the prisons.

The UNODC/Romania National Project Office (NPO) administers the project, and is comprised of three staff and three expert consultants. The UNODC Regional Programme Coordinator for Southeastern Europe (Sofia) and the UNODC HIV/AIDS Unit (Vienna) provide supervision and technical guidance. The HIV/AIDS Unit also contributes technical expertise when needed, coordinates the overall Netherlands/UNODC project in the Baltic States, Romania and Russia, and acts as a liaison with the donor.

The formal goal of the project is to “increase coverage of comprehensive HIV/AIDS prevention and care services among injecting drug users and in selected prison settings in Romania.” This overall goal is linked to two performance indicators: (a) that the project should contribute (alongside other donors) to IDU HIV prevention services coverage of >35% in Bucharest and at least 35% “in other localities”; and (b) that the project should establish HIV prevention services in “selected prison settings.” The project identifies three primary objectives leading to the overall goal:

**Objective 1:** Increase access to comprehensive HIV/AIDS prevention and care services for injecting drug users and in prison settings in Romania;

**Objective 2:** Create a supportive environment and ensure sustainability of HIV/AIDS prevention and care services for injecting drug users and in prison settings; and

**Objective 3:** Generate and share strategic information to keep the programme on track and to respond appropriately to the rapidly evolving HIV/AIDS epidemics among IDUs and in prison settings

In practice, the NPO has pursued these objectives by supporting the expansion of programs which offer various elements of a basic harm reduction package, including syringe exchange, basic medical care for IDUs, condom distribution and opioid substitution therapy (OST) with methadone and buprenorphine. Health services funding under the project has primarily been used to bring new actors into the harm reduction field, including both NGOs in related fields (e.g. homeless services, Roma) and government agencies - principally the National Anti-Drug Agency (ANA) and the National Administration of Penitentiaries (ANP). Coupled with funding for health services, the project has supported extensive technical assistance to new service providers, drawing on the experience of Romania's ‘first generation’ harm reduction organizations as well as the significant expertise housed in the NPO. The NPO has also sought to educate key actors, particularly in government, and to remove policy barriers to IDU health services when they are encountered. Finally, the project has

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<sup>1</sup> EuroHIV. “HIV/AIDS Surveillance in Europe. End of Year Report 2006.” Saint-Maurice: Institute de Veille Sanitaire, 2007. Online at: <http://www.eurohiv.org>.

<sup>2</sup> UNODC. “Drug Use and HIV/AIDS in 5 Romanian Counties.” Bucharest, 2007.

invested significant energy in facilitating the development of research capacity and new program data collection tools, working closely with the ANA-housed Romanian Monitoring Center for Drugs and Drug Addiction (RMCDDA) and HIV prevention service providers.

### **C. Major Findings of the Evaluation**

The midterm evaluation found that from the beginning, the UNODC project has been highly relevant to circumstances in Romania, targeting new resources at important gaps in the country's IDU HIV prevention milieu. The project has been designed and implemented in a flexible manner that has been able to respond and adapt to new information, changes in the policy environment, and new opportunities for collaboration. Despite the numerous initiatives in which the project is engaged at any given time, project objectives have been clearly and regularly communicated to relevant stakeholders. The project matches well with UNODC's broader Health and Development priorities, and because the project has been perceived as a uniquely dispassionate, trusted intermediary between NGO and government (particularly law enforcement-oriented) stakeholders, the project may be representative of a special niche for UNODC-led HIV prevention programming elsewhere.

The NPO and the broader UN system connected to the project have been highly effective in managing and backstopping the project, and in particular the NPO staff's direct contributions to technical assistance have been an asset. In terms of planning and monitoring, the staff have followed annual workplans closely, though more detailed and/or initiative-specific operational planning may be useful as a means to gauge day to day progress and avoid programmatic drift amid competing demands. Grantmaking and other spending have been accomplished in a transparent and generally efficient manner. The project has also managed to leverage substantial third party funding contributions. The project has established several overlapping layers of monitoring and evaluation of the project, both formal and informal, which in most cases appear to adequately inform project decision making and strategy, though efforts to create more direct contact with and encourage qualitative research among IDU who benefit from the program would be worthwhile.

The UNODC project and its partners have initiated an impressive array of new and innovative services, but the project should recognize that introducing new kinds of IDU health services or involving new providers requires a substantial learning curve, and that in most instances the initial design and operation of services will need to be adjusted in order to take advantages of lessons learned within a particular environment and to maximize a program's value and efficacy among people who use drugs. During the first two years of the project, service providers in the main areas of the project have encountered challenges related to services design. Going forward, UNODC and its partners should continue to provide technical assistance and work with service providers to develop critical understandings of how HIV prevention service designs are working in practice, and to build on successes to date by being willing to adjust and improve such programs as service providers become more experienced.

During the period under review the project has made significant progress towards achieving the objectives. On the whole, the three objectives have contributed to the overall project goal by making real gains in the diversity and coverage of services and in building technical expertise among a large number of stakeholders. The main challenges remaining are the need to institutionalize public policies or healthcare practices recommended by the project, and to ensure the long-term funding sustainability of services. Work toward objective 1 has had success in bringing new NGO and government service providers into play and through a documented increase in the number of people reached by needle exchange and OST in Bucharest. Although some changes to how coverage estimates are calculated may be needed (see section 2.2 below), based on the denominator population used at the time the project began (n=24,000 IDUs), estimated coverage of needle and syringe exchange services increased from c.10% (2006) to c. 30% (2008). The availability of OST is best measured by the real number of treatment slots created by the project (with direct support or leveraged funding), which as of December 2008 numbered 609, a >100% increase. Though still limited in coverage, syringe exchange and OST programs were initiated in two prisons and

regulations on syringe possession in prisons were amended to allow implementation of such services, with intensive technical and financial support from the project. Continued work is needed to better establish prison-based services, and to continue ongoing work in technical assistance and by bodies such as the National Monitoring and Evaluation Technical Working Group on HIV/AIDS. Progress toward objective 2 has been partial, and still has considerable work ahead: the Ministry of Health remains largely uninvolved in IDU HIV prevention, the draft national AIDS strategy has not been adopted, and although the project has leveraged funds equal to at least 31% of UNODC's project spending, these funds are not sufficient to sustain existing services. Objective 3 can be defined as an ongoing process, rather than as discrete actions that can be achieved, but to date the project has fulfilled objective 3 goals by effectively communicating information related to the project and its mission to other stakeholders, and by encouraging new, more rigorous program data collection and research initiatives.

Mirroring progress toward project objectives, outputs related to HIV prevention services scale-up and capacity building have been most successfully met. Outputs related to improving the public policy environment, meanwhile, have had more mixed success, with some goals nearing completion (e.g. the new National HIV/AIDS Strategy) while others are delayed (e.g. changes in law enforcement practices, some clinical practice guidelines). Outputs related to funding sustainability are the area of greatest concern, having seen some progress in that the project has made the environment more conducive to new funding (e.g. a new funding mechanism established by ANA which may in the future fund both community and prison programs), but without winning sustainable new funds to date.

#### **D. Lessons Learned and Best Practices**

Several issues stand out as potential lessons:

**The value of flexible, accessible technical assistance as a component of programming.** Among the UNODC project's strongest features is its ability to deliver essentially on-demand technical assistance to its grantees and other partners via the expertise housed in the National Project Office and through a broader network of expert trainers and advisors. Although this arrangement necessitates additional costs to the project, the benefits far surpass any such concerns by strengthening relationships and opportunities for collaboration with partners, creating possibilities to rapidly respond to training needs and other technical issues arising during the implementation of services, and by building the capacity of implementing partners to comply with UN administrative and financial requirements.

**UNODC's ability to act as a convener and a bridge between government and civil society organizations.** The project has played an especially constructive role in bringing together a diverse group of organizations involved in HIV and drugs programs through various bodies established through the project (e.g. Steering Committee, Monitoring, Evaluation Working Group on HIV/AIDS, etc.). Perhaps UNODC's most unique potential role is as an 'honest broker' that can bridge government and civil society organizations that have not always seen eye-to-eye on the issues. As UNODC further expands its work in HIV prevention and care, it should take advantage of opportunities to facilitate better understanding and working partnerships between the harm reduction community and government, taking advantage of UNODC's history of engagement with law enforcement and drug control agencies.

**The value of using plain and concrete wording in the project documents.** Some language employed by the project document to describe harm reduction programs or related services, reflected also in some project reports, grant contracts, and a variety of other documents, has been unnecessarily vague, sometimes leading to confusion and making various aspects of the project difficult for outsiders to assess without accessing additional documentation. In general, in all communications UNODC HIV projects should strive to use specific terminology that is widely understood in the public health community, and to include detailed description of what interventions are or are not being supported through a project.

**The importance of considering long-term implications of how new services are designed.** In environments where new models or previously unavailable services are introduced, projects should consider that the particulars of HIV prevention service design are very likely to become formally and informally rooted in practice for years to come. Small-scale pilot services should be supported as an initial means to build local knowledge and experience, and as a matter of principle flexibility and appropriate adaptation to local environments should be among the goals of any new IDU health program. HIV prevention projects for IDU elsewhere should plan to continuously support the refinement of new interventions, linking service providers to ongoing evaluation efforts and technical assistance as needed in order to ensure the best possible services quality and outcomes and that counterproductive practices are resolved as services move beyond the pilot stage.

The midterm evaluation also identifies the following areas in which the project has demonstrated best practice or otherwise exceptionally high standards of practice:

**Technical Assistance Expertise.** There is great potential in using existing Romanian expertise as a base of national and/or Southeastern European regional technical assistance. The strongest services are clearly effective, and reach a large number of people who use drugs, sex workers, and others with a model of service and an attitude that reflects the very best that harm reduction has to offer. Both the national network of harm reduction organizations and the National Project serve as the hubs for this expertise, and may now have reached a point at which Romanian training and technical assistance programs could be considered potential best practice models worthy of documentation and replication elsewhere. Furthermore, ANA's efforts to establish a regional training hub for drug programs should be taken as a sign of its commitment to technical assistance and supported where possible.

**Project Organization and Management.** The UNODC National Project Office has performed exceptionally well, carrying the project far toward increasing the access of IDU and inmates to HIV prevention services, and creating innovations in services and program management that have exceeded the basic on-paper goals of the project. Perhaps most important as a model is the technical capacity the project has invested in the NPO and its commitment to providing technical assistance to its grantees, which has built the NPO's reputation as a remarkably reliable and useful partner offering far more than mere funding. The way the project has functioned within UNODC and been supported by other UN personnel in Bucharest, Sofia and Vienna is a plausible model for organization and collaboration in a UN HIV prevention project. This feature is mirrored by the NPO's unique successes in building a robust network of drug service providers and policy makers and interweaving non-governmental and governmental organizations.

## **E. Overall Conclusions**

Broadly speaking, the first two years of the project should be seen as a success. The project design is highly appropriate to circumstances in Romania, fitting squarely with the UNODC's mandate in the area of HIV/AIDS and with its strategies by reflecting the global policy of the Member States. Project planning and budgeting have been accomplished in an effective and efficient manner, and spending levels seem commensurate with the volume of activities carried out during respective years. Project objectives have, to date, been met or are well on track, though performance indicators are stated somewhat generically in the project documents and in some cases may be difficult to measure.

Assuming the project effectively follows through on its work in 2009-2010, it should be expected to produce long-term benefits in the form of a broader, more skilled network of organizations involved in IDU health services; improvements in the ability of organizations and individuals to provide high quality technical assistance; significant advances in the capacity for and quality of epidemiological and other research initiatives on IDU; and the deepening involvement of at least three key government organizations. The documented increase in the number of beneficiaries reached by needle exchange and OST and the new NGOs and government service providers brought into play demonstrate that significant progress has been achieved in the coverage of harm reduction services in the community. Though promising, prison-based programs are as yet small in scale and not well established.

By far the largest threat to the project is the uncertainty of long-term funding sustainability, a question that is all the more urgent as IDU services face the end of UNODC and GFATM funding over the remaining period. The project has made some progress in improving the environment as it relates to sustainability questions, and succeeded in raising a fairly large amount of in-kind and direct financial support for project activities, amounting to at least 31% of UNODC spending to date on the project in Romania. Nonetheless, fund development to date is nowhere near sufficient to sustain existing HIV prevention programs, and the project should focus on this issue as its first priority. Amid the current global economic crisis it may not be possible to secure sufficient state funding for harm reduction services when international funding dries up over the course of 2009-2010. Accordingly, UNODC should consider providing or securing additional funding to the project in Romania in order to consolidate its achievements and specifically target sustainability-building initiatives. The Government of Romania should recognize that harms associated with injection drug use are a major issue in Romania's public health, and should respond by providing funding adequate to sustain and continue to scale up IDU health services, adopting national standards for services based on local Romanian experience, and increasingly providing IDU health services directly through relevant agencies, including the MoH, MoI and MoJ. The Government of Romania should also take such steps as are necessary to guarantee the continuity of health services between the community, pretrial detention and prison facilities.

Other problems encountered during the midterm evaluation are generally more technical in nature, and though they may sometimes seem outside the immediate scope of the project and less overwhelming than a looming funding crisis, they are important to the long run success of harm reduction. Consequently, the project should maintain its commitment to partnership with and technical assistance to harm reduction service providers, seeking ways to further advance the quality, appropriateness and effectiveness of both new and better-established services.

Finally, the way the project has functioned in relation to the UNODC HIV/AIDS Unit, RPOSEE, and other UN agencies in Romania is a potential best practice model of organization and collaboration in a UN HIV prevention program. The National Project Office's efforts to establish in-house technical expertise and technical assistance mechanisms has led to considerable innovation, allowed the project to venture into important areas of work that are distinct from other programs in the country, and facilitated coordination among key partner organizations. After the project ends, lessons drawn from the process by which the project was organized and how it adapted over time would likely be valuable as a teaching and organizational development aid to similar programs in other countries.

# I. INTRODUCTION

## 1.1. Background and Context

The project “HIV/AIDS prevention and care among injecting drug users and in prison settings” was developed through a consultative process involving civil society organizations, key governmental stakeholders and UN agencies in Romania and aims to increase coverage of comprehensive HIV/AIDS prevention and care services among injecting drug users and in selected prison settings in Romania by rapidly increasing access to services for injecting drug users and inmates, ensuring sustainability of HIV/AIDS prevention and care services for these communities and by generating and sharing strategic information to keep the program on track and to respond appropriately to the evolving HIV epidemics among injecting drug users and in prison settings in Romania. In particular, the UNODC project was designed to coordinate and work in concert with the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) Round 6 Program, and to contribute toward the goals of the 2004-2007 National HIV/AIDS Strategy.<sup>3</sup>

By the time the project was being conceptualized in 2006, Romania has already had a nearly 20 year history with HIV. Unique in the Southeastern European region, in 1987-1989 Romania experienced a unique, large nosocomial HIV epidemic, mainly among more than 10,000 institutionalized children. As of September 2006, 16,752 cumulative cases of HIV/AIDS had been registered and 11,828 people were living with HIV<sup>4</sup> (3,812 adults and 8,016 children). At that date, Romania had 6,578 patients in antiretroviral therapy, representing the largest number of people living with HIV under treatment in all Central and Eastern Europe. Since 1994–1995, there has been a steady increase in the HIV incidence rate among adults, mainly related to transmission of the virus via unsafe sex and injecting drug use. Treatment, care and support services have been entirely covered by national resources through national and local budgets while HIV prevention among vulnerable groups (including SWs, IDUs, inmates, street children, Roma, MSM) have been primarily covered by GFATM grants (2003 – 2010) and UN support.

According to national data and reports<sup>5</sup>, injection drug use has been largely confined to Bucharest city and the surrounding suburbs of Ilfov County. In 2003-2004, the number of IDU in the capital city was estimated by using capture-recapture method at 24,000. A 2008 estimate generated under the UNODC project by the Romanian Monitoring Center for Drugs and Drug Addiction (RMCDDA) put the Bucharest IDU population at approximately 16,800 using a multiplier method based on IDU contacts with syringe exchange and drug treatment services. Heroin has been the primary injected drug, sometimes mixed with over-the-counter antihistamines such as diphenhydramine, or other drugs that can amplify heroin’s depressant and euphoric effects. During participation in harm reduction outreach, the evaluator witnessed a large number of youth and others using inhalants (e.g. aerosols like spray paint, volatile solvents like paint thinner), and alcohol is also known to be frequently used by homeless and other most-at-risk IDUs. The National Anti-Drug Agency has also reported low but increasing rates of use of other illegal drugs in recent years, notably ecstasy, amphetamine-type stimulants and, to a lesser extent, cocaine. Bucharest also appears to have quite large overlapping populations of sex workers and homeless people. Healthcare access for poor and/or undocumented people is exceptionally weak in general, as is the state of the homeless shelter system, mental health care, child protective services, and other critical services for those at greatest risk of HIV infection.

At the time the project was designed in mid-2006, HIV prevention among IDU was exclusively addressed by civil society organizations and in the capital city only. The financial support for such services provided through the GFATM Round 2 program was ending and there was no clear strategy or commitment from the Romanian Government to take over the existing HIV prevention services

<sup>3</sup> Ministry of Public Health –Matei Bals Institute, M&E Compartment [http://www.cnlas.ro/download/strategie\\_rom.pdf](http://www.cnlas.ro/download/strategie_rom.pdf)

<sup>4</sup> Ministry of Public Health –Matei Bals Institute, M&E Compartment, <http://www.cnlas.ro/hiv/arhiva.html>

<sup>5</sup> National Anti-drug Agency, National Report on the drug situation, 2005, 2007, 2008  
[http://www.ana.gov.ro/rom/10.02.2006/Raport\\_national\\_2005.pdf](http://www.ana.gov.ro/rom/10.02.2006/Raport_national_2005.pdf), [http://www.ana.gov.ro/rom/upl/RN\\_rom\\_07.pdf](http://www.ana.gov.ro/rom/upl/RN_rom_07.pdf)

among IDU, despite a policy and regulatory framework that was in principle supportive of harm reduction. Thus, for lack of funding, the country faced the imminent threat that IDU HIV prevention services would be shut down, wasting a decade of investment by various donors (chiefly the Open Society Institute, GFATM and UN) and the expertise and capacity of civil society organizations.

The UNODC National Project Office in Romania implements the project with backstopping from the HIV/AIDS Unit at UNODC HQ (Vienna) and the UNODC Regional Programme Office for South-Eastern Europe (Sofia). The Netherlands Ministry of Health, Welfare and Sport funds the project as part of a larger grant to UNODC supporting HIV prevention programs in the Baltic States, Romania and the Russian Federation, with the cost of the Romanian project estimated at US\$ 3,000,000 (including UNODC project support costs). Implementation was planned to take place over four years and four months, starting 1 September 2006 and ending 31 December 2010. Since UNODC did not have an office in Romania at the time, the project established the basic necessary infrastructure for management and implementation of the project, including recruitment of local personnel and equipment purchase. The project was fully operational as of 1 November 2006. The original project documents and the project strategy have not been formally revised.

Working closely with an array of other stakeholders before the project was launched, three primary objectives were set:

**Objective 1:** “Increase access to comprehensive HIV/AIDS prevention and care services for injecting drug users and in prison settings in Romania” by increasing the absolute number of IDU served by harm reduction programs, involving new organizations in the field (particularly those working in health for other marginalized populations), building capacity among service providers, and creating model best practices for replication;

**Objective 2:** “Create a supportive environment and ensure sustainability of HIV/AIDS prevention and care services for injecting drug users and in prison settings” by facilitating the adoption of a national HIV strategy, supporting the development of IDU-related research programs, and mobilizing new, sustained financing for harm reduction;

**Objective 3:** “Generate and share strategic information to keep the programme on track and to respond appropriately to the rapidly evolving HIV/AIDS epidemics among IDUs and in prison settings” by documenting and disseminating lessons learned through the project.

The project was designed to support interventions for injecting drug users in line with the provisions of the 2005 UNAIDS Policy Position Paper,<sup>6</sup> namely: “drug substitution treatment, and the implementation of harm reduction measures (through, among others, peer outreach to injection drug users, sterile needle and syringe programs), voluntary and confidential HIV counseling and testing, prevention of sexual transmission of HIV among drug users (including condoms and prevention and treatment of sexually transmitted infections), access to primary healthcare, and access to antiretroviral therapy.”

Due to the urgency of the funding situation at the time the project launched, the early priority of the project was to immediately provide financial support to existing IDU HIV prevention services in Bucharest. Second, building on the achievements and accumulated expertise of several Romanian NGOs, the project aimed to newly involve NGOs and government agencies as harm reduction service providers in Bucharest and other localities in order to increase IDU access to HIV prevention in the community, in arrest settings, and in prisons. Another priority within the project strategy was to perform assessments of the situation of injecting drug use in other localities and in prisons as well as to provide technical assistance and support to the national stakeholders for generating reliable epidemiological data on the HIV, HBV, HCV prevalence among IDUs and inmates. In order to

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<sup>6</sup> UNAIDS. “Intensifying HIV/AIDS Prevention. UNAIDS Policy Position Paper.” Geneva, 2005. Online at: [http://data.unaids.org/publications/irc-pub06/jc1165-intensif\\_hiv-newstyle\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf)

sustain in the future the achievements in the area of HIV prevention among IDUs and in prisons, the project aimed to organize awareness raising and advocacy events/meetings with high level decision makers and various stakeholders.

## **1.2. Purpose and Objective of the Evaluation**

The midterm evaluation was embedded in the project since it was designed. The overall purpose of this evaluation according to the Terms of Reference (see Annex A) is “to reach conclusions regarding [the] project’s relevance at the country level and progress towards achieving its stated objectives. The evaluation should provide information on the achievements, lessons learnt and recommendations with regard to: appropriateness, impact and sustainability of the project. This includes any gaps or unintended outcomes, the effectiveness of the mode of implementation, and the appropriateness and use of national and international best practices.” The midterm evaluation was expected to provide insights that will help UNODC to adjust the project design and strategies for increasing the project’s effectiveness, maximizing impact and leading to a sustainable funding and policy environment.

## **1.3. Executing Modality / Management Arrangements**

The project is implemented by the UNODC National Project Office in Romania, based in Bucharest, the capital city, within the UN House. At the project level, UNODC established an arrangement with UNDP to provide administrative support for human resources management, project finances, and grant-making.

Coordination of the project at local level is the responsibility of the National Project Officer with administrative staff support from the Project Assistant and the Driver. The National Project Officer works under the direct supervision of the UNODC Regional Programme Coordinator for South Eastern Europe, with technical guidance from the UNODC HIV/AIDS Unit. The National Project Officer has basic responsibility for: the daily management of the project; maintaining partnerships and communication with national stakeholders including other UN agencies; managing the work of three expert staff; project planning; and reporting. The National Project Officer reports on a monthly basis directly to the Head of the UNODC HIV/AIDS Unit and on a quarterly, semi-annual and annual basis prepares reports that are entered into the UNODC ProFi system, which is accessible to all UNODC staff as well as to the donor. Reports to the donor cover the entire Baltics-Romania-Russia program and are prepared based on reporting from the country level and submitted by the UNODC HIV/AIDS Unit.

Within the UNODC National Project Office there are currently three expert staff who provide daily technical assistance to government and NGO implementing partners and assist the National Project Officer with various substantive aspects of the project. All experts report on a monthly basis directly to the National Project Officer.

## **1.4. Scope of the Evaluation**

The mid-term evaluation of the project covers activities from 1 November 2006 to 31 December 2008 (extended, in agreement with UNODC/Romania, from the original date of 31 August 2008). The evaluation examines:

- a. the project’s relevance in terms of national policies on HIV/AIDS and illicit drugs and the effectiveness of the project design, strategy, approach and activities taking into account the country policies on HIV/AIDS and illicit drugs;
- b. the efficiency of project planning and implementation, the progress made towards the achievement of the planned results, expected outcomes and sustainability; problems and challenges/constraints encountered during implementation; areas of best practices for replication in other countries/regions;
- c. the process of planning, coordination and implementation of activities with other donors in the area of HIV/AIDS services for IDUs and inmates: UN agencies (UNAIDS, UNICEF, WHO), Principal Recipients of the GFATM Programmes operating in the country (Round 2

- and Round 6) and the added value of the project in relation to these efforts;
- d. the relevance of the project to UNODC's mandate and UNODC's added value in contributing to the HIV prevention among IDUs and in prison settings in Romania.

The progress of project implementation was measured against project documents, costed annual workplans, financial and activity reports as well as other working documents used by UNODC in relation to project implementing partners and stakeholders.

## 1.5. Evaluation Methodology

This evaluation employed the following methodology:

- 1. Short survey** intended for staff of grantee organizations and government partners as a means of providing **early feedback to the evaluation process** (the survey questions and responses are attached in Annex B).
- 2. Desk review of project documents** (project agreement signed with the National Anti-drug Agency, Logical Framework, Project budget) and other relevant documents (quarterly, semi-annual and annual reports, annual workplans agreed with the donor, donor's remarks regarding the project implementation, working/research protocols, grant agreements and contracts with the government agencies, financial data, minutes of the Project Steering Committee and Monitoring and Evaluation Working Group, Reports on the assessments/situation analysis performed under the project, GFATM proposals and evaluation reports, National reports on the drug situation, national strategies and related action plans on HIV/AIDS, TB, drugs and STIs, UNGASS reports, UNODC Menu of services, working arrangement between UNDP and UNODC, Joint UN Strategy in support of the national response to HIV/AIDS, UNODC's mandate in dealing with HIV/AIDS among IDUs and in prisons, HIV/AIDS epidemiological data and indicators, UNAIDS Policy Position Paper 2005, UNODC Strategy 2008-2011).
- 3. Qualitative research in the form of in-depth interviews** with: a) the project team (National Project Officer, Project Assistant and three experts); b) relevant staff at UNODC HQ (Vienna) and the Regional Programme Office for South Eastern Europe (Sofia) involved in project planning, monitoring and implementation oversight; c) main national stakeholders, including representatives from civil society and governmental organizations; d) members of the Project Steering Committee including the donor representative; e) international partners including representatives from the UN agencies; and f) the Principal Recipient for the GFATM Round 6, who had worked closely to the project. A set of research questions was prepared and used in agreement with UNODC, and a total of 47 individuals were interviewed for this report. Please see attached in Annex C for a list of individuals interviewed, and Annex D for the matrix of questions used in the evaluation.
- 4. Direct observation of services** (i.e. outreach and fixed-site syringe exchange and OST programs in the community and in prisons) and **interviews with project beneficiaries** supported by the project at several sites.

The project's relevance and the effectiveness were measured against the 2005 UNAIDS Policy Position Paper, UNODC's mandate and HIV strategy, Romanian policy and research documents and in the area of HIV and drug use, and needs identified by people who use drugs in Bucharest through approximately 20 interviews with the evaluator during visits to harm reduction outreach sites.

Progress made toward achieving the planned results was measured against the project documents and the costed annual workplans agreed with the donor, as well as through feedback received from the main project partners and stakeholders.

The project's efforts to coordinate planning and implementation with other donors and technical assistance providers was considered through the views of representatives of partnering UN agencies (UNAIDS, UNICEF and WHO) and the Principal Recipient of the GFATM Round 6 Program.

Resource utilization was analyzed using basic quantitative and qualitative measures. Budget and spending management was measured principally through the delivery rate: the annual budget allocation (based on the annual costed workplans agreed with the donor) versus the total amount spent by the end of the year. The qualitative management of funds was assessed in terms of the timeliness, appropriateness and efficiency of project spending with regard to the following main areas: provision of direct services to beneficiaries, project operational costs (staff, facilities and equipment); capacity building for implementing partners and other stakeholders relevant at the country level; situation analysis/assessment/research; the mid-term evaluation and other administrative charges. Financial data was provided by the National Project Office and extracted from the ProFi system. Co-financing received from implementing partners was not recorded into the UNODC system but was compiled by the project team based on data received from the main implementing partners.

### **1.6. Limitations**

Because this is a midterm evaluation, there are limits on the extent to which the evaluation is able to analyze the medium- and long-term impacts of the project. As such, judgments about the overall success of the project should be taken as preliminary, and problems identified as eminently fixable. Quantitative analysis with regard to services development was constrained by weak coordination in data collection between the Ministry of Health and the National Anti-drug Agency, and by the sometimes limited monitoring and evaluation capacity of NGOs newly involved in providing syringe exchange services. These concerns have already been broached by the project staff and therefore should be less of an issue during the project's final evaluation.

## **II. ANALYSIS AND MAJOR FINDINGS**

This section presents an analysis of information collected during the mid-term evaluation, focusing on the project's organization and achievements during the period under review. The section discusses issues related to management, finance, planning and the project's success in achieving objectives in terms of their relevance, effectiveness, efficiency and processes of planning and coordination in the local country context.

### **2.1. Overall Performance Assessment**

#### **2.1.A. Relevance**

**The project is in line and fits squarely with the UNODC's mandate in the area of HIV/AIDS and with its strategies, reflecting the global policy of the Member States.** At the time the project was conceived, more than ten studies of injection drug use had been conducted in Romania, and a significant prevalence of both injection drug use and HIV risk factors among IDU had been concluded. Such studies have been carried out by the Ministry of Health and the National Anti-drug Agency and civil society organizations<sup>7</sup> in partnership with UNAIDS, UNICEF, EMCDDA and the GFATM Round 2 Program, and have consistently confirmed a picture of a large injection drug user population in the capital city, low HIV prevalence but frequent syringe sharing and very high prevalence of HCV. Only small-scale, somewhat inconclusive studies have been conducted outside Bucharest.

The project was designed to contribute to the efforts of Romanian stakeholders for the implementation of the national strategies on HIV/AIDS and drugs as relates to HIV/AIDS among IDU and in prisons. As part of the national policies, in recent years Romania has developed a supportive regulatory framework that allows for implementation of syringe exchange and OST in the community, among arrestees and in prisons. In spite of the basically supportive policy environment, the country lacks officially endorsed mechanisms for financing HIV prevention services for IDU and inmates, resulting in limited HIV prevention services coverage and a small number of service providers. However, the political commitment of the Government of Romania to fight HIV/AIDS has increased over the years

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<sup>7</sup> Including by ARAS (the Romanian Association Against AIDS) and the Romanian Harm Reduction Network.

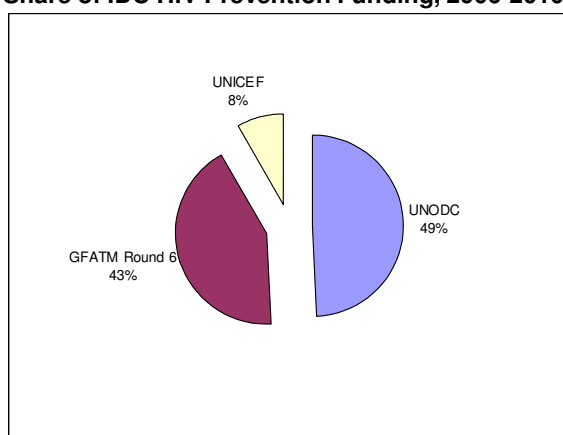
and is reflected in its commitment to universal access to treatment and care for PLWH, which includes free-of-charge ART and other medical care to HIV/AIDS patients. At the time the project began, PMTCT and VCT programs for the general population and vulnerable groups were being implemented by civil society organizations, mainly with funding from the GFATM Round 2 program (the primary funder of IDU HIV prevention programs), UNICEF, and USAID, and had been integrated to some extent with the national public health system. As there were very limited state resources allocated for HIV prevention among IDU and inmates and the GFATM Round 2 Program was due to end such activities in mid 2006, Romania submitted a GFATM Round 6 proposal. At the same time, UN HIV/AIDS programming continued and began to expand through UNODC and UNICEF projects focused on HIV prevention among IDU including most-at-risk adolescents (MARA). In contrast, bilateral donors withdrew from the country as a consequence of Romania's accession to the European Union. The UN currently estimates total funding for HIV prevention among IDU and inmates in the country for the period 2006 - 2010 to be US\$6,100,000 and was allocated through UNODC, UNICEF and GFATM Round 6 programs. The Romanian Ministry of Health, meanwhile, funds HIV treatment and care programs, VCT, PMTCT and operates two methadone clinics. The activities covered by each program are listed in the following table.

**Major HIV Prevention, Care & Treatment Activities, by Funding Agency (2006-2008)**

	<b>UNODC</b>	<b>GFATM Round 6</b>	<b>UNICEF (MARA)</b>	<b>Ministry of Health</b>
<b>IDU</b>	Syringe Exchange	Syringe Exchange		HIV Care and Treatment
	IEC	IEC	IEC	OST
	Access to Medical and Social Services	Access to Medical and Social Services	Access to Medical and Social Services	PMTCT
	Policy Advocacy	Policy Advocacy	Policy Advocacy	
	Capacity Building	Human Rights Monitoring	Capacity Building	
	Epidemiological Surveillance	Epidemiological Surveillance	Epidemiological Surveillance	
	OST/MMT	VCT	OST/MMT	VCT
	Practice Guidelines		Practice Guidelines	Guidelines for Treatment and Care of PLWH
	Condom Distribution	Condom Distribution		
	Public Education about Harm Reduction			
<b>Inmates</b>	Syringe Exchange	Peer Education		HIV Care and Treatment
	MMT	IEC		
	VCT protocol	VCT		
	Capacity building	Condom Distribution		
	Policy Advocacy	Epidemiological Surveillance		
	Human Rights Monitoring			
	Condom Distribution			

	Epidemiological Surveillance			
<b>Arrestees</b>	Human Rights Monitoring	IEC		
	Access to OST	Condom Distribution		

### Share of IDU HIV Prevention Funding, 2006-2010



The UNODC project was designed to add funding for HIV prevention services among IDU and in prisons, and to advance key issues that were either absent (opioid substitution therapy and prison-based harm reduction services, guidelines and revision of the regulatory framework, linkage of services between the community and detention facilities) or relatively small (capacity building, harm reduction campaigns, research/assessments) in other programs.

In its first months of implementation the UNODC project commissioned two reports in order to fill in gaps in knowledge directly connected to interventions it was trying to promote. The first focused on risks of blood-borne virus transmission in the prison system<sup>8</sup> and identified needs for action to improve prisoners' access to VCT for HIV and condoms, to introduce OST and needle and syringe exchange and to improve safety standards for tattooing. A subsequent report assessing the situation of IDUs and related services in Cluj, Constanta, Craiova, Iasi and Timisoara<sup>9</sup> found that there was not sufficient data in any of the localities to estimate the size of drug using population, and very little information on injecting drug use, though a significant number of drug-related arrests and drug seizures (not, primarily, injectable drugs) were noted. Although none of the five cities had harm reduction programs in place, the report noted that ANA's network of drug prevention, evaluation and counseling centers (collectively abbreviated as CPECA) formed a natural base from which to increase local policy coordination and expand harm reduction services and research.

**In summary, the project seems to have done sufficient up-front appraisal of the situation in Romania, with the result that project resources have been directed in ways likely to have a positive effect and to be minimally duplicative.**

The implementation of activities under the project has been guided by the original project document as well as by costed annual workplans that include more specific activities and identify implementing partners. Both kinds of planning documents appear to retain enough flexibility to allow the project to adjust its strategy according to changing circumstances and opportunities at the local level. The annual workplans are developed in consultation with the major stakeholder organizations and Project Steering Committee members, and reflect current challenges and needs identified through UNODC's

<sup>8</sup> UNODC. "Assessment of the current HIV prevention and drug related services in 5 Romanian prisons." 16 May 2007.

<sup>9</sup> UNODC. "Drug use and HIV/AIDS in 5 Romanian counties." June-October 2007.

membership in parallel coordination mechanisms such as the CCM, the Monitoring and Evaluation Working Group on HIV/AIDS, the UN Country Team and Joint UN Team on HIV/AIDS.

The project has targets to reach 35% of injecting drug users with HIV prevention and care services, to make these services available and accessible in prison settings; to develop the national HIV/AIDS strategy and action plans on HIV/AIDS and drugs; to review and (if necessary) seek to revise relevant national policy frameworks; promote capacity development of implementing agencies; mobilize additional resources from foreign and domestic sources; and produce updated information on drug use and HIV in Romania. Generally speaking, the objectives and outputs defined in the project documents including in the Logical Framework have proved to be realistic and implementable. Though they are often stated in generic or vague terms, the project's performance indicators offer sufficient direction toward concrete objectives that are within the project's capacity to achieve. However, the midterm evaluation found that some planned targets are stated in ways that are difficult to measure and/or may not be relevant as the project continues. In addition, the evaluation identified the following issues related to IDU HIV prevention that are directly or indirectly related to the goals of the project:

¾ The term “comprehensive package of HIV/AIDS prevention and care services” carries different definitions within various UN agencies. For example, the UNODC project's usage of the UNAIDS definition of “comprehensive package of HIV/AIDS prevention and care services” does not correlate especially well with the elements of the published WHO definition of the “comprehensive harm reduction package.”<sup>10</sup> Use of the term “comprehensive package of HIV/AIDS prevention and care services” throughout the project documents tends to obscure the actual initiatives and appears to be used by UNODC in order to avoid the use of words “harm reduction” for some political consideration. Particularly in early grant agreements and reports from the project, there have been instances in which term “comprehensive package” and “prevention commodities,” etc. has been used in ways that have sometimes made it difficult for people outside the project to assess budgets or proposed activities, to set program indicators, or to meaningfully evaluate activities supported by the project without examining additional documents. In later grant agreements, the problem was corrected by spelling out clearly needle and syringe exchange, injecting equipment, etc. **In the future, the UNODC project should strive to use language in basic project documents, grant contracts and reports that is specific, plain and concrete in order to avoid misunderstandings. By doing so, the project will improve communication about its efforts, be easier to evaluate.**

¾ Despite considerable progress in increasing the availability of harm reduction services through the UNODC and GFATM projects, people who use drugs who were interviewed during the evaluation frequently reported not having satisfactory access to sterile syringes.<sup>11</sup> Reasons cited for this included that needle exchange providers were not present at a particular location as often as needed, that people were unable or unwilling to obtain syringes from pharmacies, etc. The notion of continuing sterile syringe scarcity in Bucharest is supported by evidence showing high rates of syringe sharing and extremely high HCV prevalence. Few harm reduction staff – and no drug users – who were interviewed had accurate information about effective syringe cleaning methods. Several stakeholders expressed serious concerns about the teaching of syringe cleaning techniques given the role of syringe reuse in Romania's nosocomial HIV outbreak and legal prohibitions on syringe reuse by government medical agencies. Nonetheless, for various reasons, some people at high risk of HIV or hepatitis infection are reusing syringes, and harm reduction organizations have a responsibility to provide evidence-based information to IDU on the subject. **Moving forward, harm reduction service providers and donor agencies should consider and seek to ameliorate possible practice and public policy barriers to sufficient syringe access. Some renewed effort to promote more reliable sale of syringes through Romania's private**

<sup>10</sup> Online at: [http://www.who.int/hiv/topics/idu/harm\\_reduction/en/index.html](http://www.who.int/hiv/topics/idu/harm_reduction/en/index.html)

<sup>11</sup> It should be noted that interviews were with a small (c. 20 people) convenience sample of people accessing outreach-based syringe exchange, and though responses were fairly consistent, this is not “scientific” data and further study is warranted.

**pharmacy system may be warranted. With the continuing syringe sharing problem, service providers should also consider ways to best promote evidence-based syringe cleaning techniques among IDU in order to reduce infectious disease transmission.** With regard to syringe cleaning, a literature review may be an appropriate starting point, to be followed by training for harm reduction staff and other stakeholders, development and dissemination of IEC materials, and incorporation of appropriate and regular syringe cleaning messages in contacts with IDU. A legal review of national regulations on syringe cleaning and/or reuse may also be useful in order to clarify what government harm reduction providers may or may not do in a harm reduction context (as opposed to regular medical practice).

<sup>3/4</sup> The original project document foresaw the introduction of new harm reduction services in cities other than Bucharest. Although the project did succeed in supporting a short-lived project in Iasi, little contact was made with IDU, an experience shared by GFATM Round 6 efforts to develop services outside the capital. Research supported by the project and others, though not definitive on the subject, has suggested that there may in fact be little injection drug use in other cities – and therefore low demand for IDU health services. While the project document makes passing reference to decisions about programming outside Bucharest being based on the results of a rapid assessment, project indicators repeatedly reference increasing coverage in other localities. Consequently, as it deals with a number of other priorities, **the project should reconsider and decide with the national stakeholders whether is necessary to temporarily or permanently remove the expectation of further programming outside Bucharest.**

<sup>3/4</sup> The project has sometimes attempted to involve people who use drugs in the design and conduct of various initiatives, which is increasingly seen as a basic ethical principle in harm reduction and in fulfilling UN, GFATM and other agencies' commitments to the principles elaborated in Greater Involvement of People Living with HIV/AIDS (GIPA).<sup>12</sup> In particular in the prison needle exchange programs, the project sought out advice from people with an experience of drug use and employed peer workers in delivering services, and the project has involved organizations that are closely connected to the drug user community. Nonetheless, the project has generally not created formal mechanisms for people who use drugs to provide input into the project nor sought to build capacity for such participation in the drug user community. This situation is complicated by the fact that, more broadly, people who use drugs in Romania currently have no clear 'voice' or outlet for engagement in the form of community organizing efforts or other mechanisms that exist in many other countries, and have not been substantially involved in Romanian PLWH groups. Nonetheless, **as the project moves ahead it should continue previous efforts to engage with people who use drugs, and consider opportunities to elicit more regular and substantial advice from people who use drugs about the project and, when possible, to involve people who use drugs in services development and advocacy programs.**<sup>13</sup>

### **2.1.B. Effectiveness**

During the period under review the project has made significant progress in bringing new NGOs and governmental service providers into play, leading to a documented increase in the number of people reached by syringe exchange and OST in community and prisons and an increase in technical expertise among a large number of stakeholders. Though some outputs have been realized more completely than others, taken as a whole the project has nearly or completely fulfilled most outputs related to services expansion, and made progress toward policy-related outputs commensurate with staffing and financial outlays, despite constraints imposed by Romania's fractious political

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<sup>12</sup> For more on GIPA, see the UNAIDS 2007 "Policy Brief: The Greater Involvement of People Living with HIV/AIDS." Online at: [http://data.unaids.org/pub/Report/2007/JC1299-PolicyBrief-GIPA\\_en.pdf](http://data.unaids.org/pub/Report/2007/JC1299-PolicyBrief-GIPA_en.pdf).

<sup>13</sup> For a discussion of how GIPA should be applied to people who use drugs, see "Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Drugs," a joint publication of the Canadian HIV/AIDS Legal Network, the International HIV/AIDS Alliance and the Open Society Institute, with additional funding from UNAIDS. Online at: <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=845>.

environment. The output related to the sustainability of services is the area of greatest concern, having seen some progress in that the project has made the environment more conducive to new funding (particularly with regard to Romanian government agencies involved in the project), but without securing state commitments sufficient to replace international funding for IDU HIV prevention programs. The Ministry of Health's lack of involvement in HIV prevention for vulnerable groups, aside from its continued small-scale support for methadone programs, is perhaps the largest outstanding issue for the project.

**UNODC's flexibility relative to similar donor programs in Romania has allowed to the project to venture into important areas of work that are distinct from other programs, notably through its support for OST services in the community and prison based harm reduction services (OST and syringe exchange services). Among the key factors in the project's achievements have been frequent, positive coordination and collaboration with other donors and technical assistance providers (including UNAIDS, UNICEF, WHO and the GFATM Principal Recipient), the ability to serve as a bridge to improve working relationships between NGO and governmental HIV prevention service providers, and the project's ability to deliver essential on-demand technical assistance to its grantees and governmental partners.**

From the beginning of the project, a Project Steering Committee was established involving eight key stakeholders in the area of HIV/AIDS and injection drug use, including representatives of ANA, MoH, ANP, UN agencies, GFATM and the donor. The mandate of the Steering Committee has been to act as an advisory and coordination body, providing strategic guidance, ensuring that the project's direction is consistent with national priorities, and often act as a sounding board and source of advice for National Project Office staff and implementing organizations. The Steering Committee does not make or approve funding decisions. It appears to be functioning well, and the evaluation does not recommend changes in its organization or relationship to the project. Steering Committee members uniformly reported a high level of confidence in the project, that its organization and schedule of meetings were adequate, and that it had created "a lot of innovation" and consolidated a network of harm reduction service providers and supportive policy makers ways that have significantly improved Romania's systems for informing and coordinating IDU HIV prevention programs.

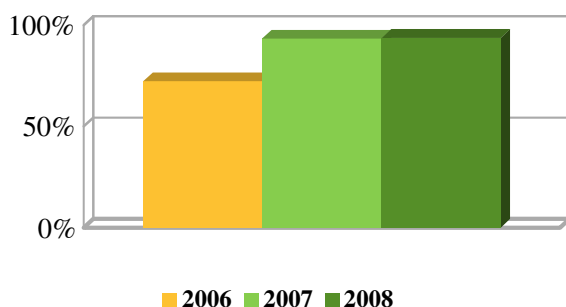
### **2.1.C. Efficiency**

The midterm evaluation examined the efficiency of the project by looking at whether the project is coordinated with other donors so as to minimize duplication of effort and increase impact; whether costs are reasonable and commensurate with progress toward the objectives; whether the annual workplans and budgets are a clear guide to programming and whether they are actually implemented; and whether managerial and administrative arrangements effectively support the project. Because there is considerable overlap with other sections of the standard UNODC evaluation report format, this section will deal primarily with the project's efficiency in terms of budgeting, financing and grantmaking.

The project has been well coordinated with other programs, particularly the GFATM Round 6 Program managed by the Romanian Angel Appeal Foundation and with UNICEF, for example in that the project filled a major funding gap for community based harm reduction services before GFATM Round 6 program began in June 2007, and through joint provision of funding and technical assistance for behavioral and serological surveillance surveys among IDU and inmates. UNODC, represented by the National Project Officer, also retains a seat in the CCM, allowing direct participation in GFATM Program decision-making and communication of UNODC project activities with other stakeholders.

Spending against the annual budget has been at a very high level and has increased over time. As the project launched later than initially planned, some activities originally budgeted for 2006 were postponed for 2007, which resulted in an initially lower delivery rate (72.3%), compared to subsequent rates of 93.3% (2007) and 93.6% (2008). The annual delivery rates are shown in the chart below.

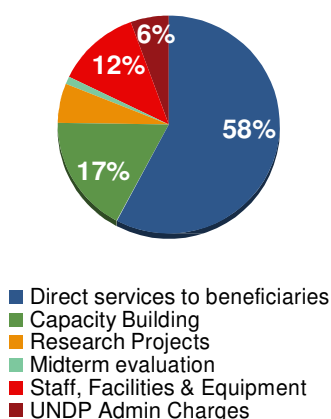
### Rate of Budget Expenditure by Year



Efficiency in terms of how funds have been used was assessed in relation to the following main areas of programming: provision of direct services to beneficiaries; project operational costs (staff, facilities and equipment); capacity building for implementing partners and other stakeholders; situation analysis, assessment and research initiatives; and the mid-term evaluation and other administrative charges. The 13% project support cost charged by UNODC HQ (in accordance with the Final Arrangement signed on 10 August 2006 between the Netherlands Ministry of Health, Welfare and Sport and UNODC) was not considered in this assessment.

A review of project spending (including obligations) totaling US \$1,817,615 over the period 2006-2008 revealed that 12% of direct project funding was spent on project operational costs, including staffing (much of which has been used in providing technical support to project partners), facilities and equipment, and an additional 6% on UNPD administrative support fees. By far the largest portion of spending, approximately 58% to date, has been dedicated to direct support for HIV prevention services, including needle exchange and OST. Capacity building programs have received 17% of spending, which includes technical assistance (primarily for services, but partially for research programs), training, advocacy, technical workshops and participation in conferences or other high level meetings. Finally, 6% has gone to research and situation assessments in support of services.

### Project Net Spending by Area, 2006-2008



Considering only the direct services supported by the project, a large majority of funds - approximately 78% - has been spent through grant agreements with NGOs, while 22% was spent for initiating services with the governmental partners ANA and ANP. Civil society organizations were selected through a publicly advertised, competitive and transparent process conforming to standard UNDP guidelines and procedures. Grant proposals were reviewed by expert committees usually consisting of relevant UN/Romania staff (UNODC, UNAIDS, UNDP, UNICEF and/or WHO). Based

on documents provided during the evaluation and interviews with project staff, the review process has functioned well by ensuring consistency between grantee line item costs and in the selection of proposals appropriate to project objectives.

Initially, two key governmental stakeholders - ANA and ANP - were identified in the original project document as implementing partners. Besides instituting HIV prevention service projects, the governmental partners were to engage in policy reform efforts in several areas: to codify basic national standards for drug treatment practice; to build continuity of care for OST patients between the community, pre-trial detention and in prisons; to resolve prosecutorial and judicial inconsistencies in handling drug-related crimes; and to review the implementation of the National Anti-drug Strategy at the local and national levels and develop a future action plan. Formal commitments of the governmental stakeholders involved as implementing partners has been expressed through signed "Letters of Agreement," which are consistent with NGO grant agreements in terms of their basic organization, how deliverables are specified and for most budgeted costs.

The project has also succeeded in raising a fairly large amount of in-kind and direct financial contributions for the project from ANA, ANP, MoH, GFATM, UNAIDS, UNICEF, WHO and CDC Atlanta. Although the value of some in-kind contributions has not been calculated, direct financial contributions and valued government in-kind contributions (e.g. space and staffing provided by ANA and ANP for services) is equal to at least 31% of UNODC spending to date on the project in Romania. Most of these funds were contributed through co-financed OST and needle and syringe exchange services, research initiatives among IDU and inmates, and by providing expert staff in the service of particular technical assistance needs.

**The evaluations' findings allow one to conclude that project funds have been spent efficiently and according to standard UN financial and grantmaking controls, and that the attraction of significant additional resources has amplified the reach and effectiveness of the project.**

## **2.2. Attainment of the Project Objectives**

**During the period under review the project has made significant progress towards achieving the objectives. On the whole, the three objectives have contributed to the overall project goal by making real gains in the diversity and coverage of services and in building technical expertise among a large number of stakeholders. The main challenges remaining are the need to institutionalize public policies or healthcare practices recommended by the project, and to ensure the long-term funding sustainability of programs.**

The following section reviews progress toward attaining the three project objectives. Project outputs that contribute to the objectives are described in the subsequent section, 2.3 Achievement of Project Results.

**Objective 1:** *Increase access to comprehensive HIV/AIDS prevention & care services for injecting drug users and in prisons in Romania.* The project has sought to fulfill this objective by directly funding the expansion of HIV prevention and care services for IDU through preexisting providers, and by creating planning, coordinating, research and technical assistance structures that support coverage scale-up.

Information collected during the midterm evaluation indicated that the project has indeed served to increase IDU access to syringe exchange, OST and other harm reduction services. By the time of the evaluation, two NGOs (Integration and Samu Social) had launched entirely new services programs, a third (Sastipen) was on the verge of starting, and two more (ARAS and ALIAT) expanded existing programs. Although various issues in how services data are used make it difficult to calculate how much coverage has increased (see below), it can be said that new services are reaching hundreds of new clients and expanding geographic coverage in the city and the regularity of services in some high IDU prevalence neighborhoods, such as Ferentari. The availability of OST can be more easily

measured by the real number of treatment slots created by the project (with direct support or leveraged funding), which as of December 2008 numbered 609, a roughly 100% increase. Though still limited in coverage, syringe exchange and OST programs were initiated in two prisons and regulations on syringe possession in prisons were amended to allow implementation of such services, with intensive technical and financial support from the project.

A challenge in measuring the progress towards Objective 1 is related to the calculation of needle exchange coverage. The 2006 baseline of 10% coverage was calculated using a denominator Bucharest IDU population of 24,000 IDU, based on a 2004 ANA estimate. Using a different methodology, ANA produced a new population estimate of 16,800 in 2008. The project has used both denominator populations at different times, somewhat confusing increases in coverage when reported as a percentage of the estimated IDU population. In absolute terms of the number of people reached by syringe exchange, there was a threefold increase between 2006 (2,400 individuals) and 2008 (7,267) – a major achievement for service providers and donors. Based on the denominator population in use at the time the project began, estimated coverage increased from c. 10% (2006) to c. 30% (2008). An additional issue is that the nominator population in coverage estimates produced by the GFATM and UN system in Romania is based a minimum of only one contact by an individual with an HIV prevention intervention per year, and thus does not allow for a meaningful understanding of coverage. **Considering the still-evolving nature of IDU public health research in Romania in the future the project could usefully reflect coverage estimates by using absolute numbers of individuals reached by services in addition to coverage rate estimates in order to ensure that quantitative data are comparable over time. UNODC, other donors, and service providers should also seek to use standard, meaningful definitions of coverage for all funded interventions, including through the use of data on how often IDU access a given intervention. This effort should be based on the 2009 WHO/UNODC/UNAIDS “Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users”,<sup>14</sup> focusing on the Technical Guide’s idea of “effective coverage.”** Some adapted version of the coverage indicators suggested by WHO/UNODC/UNAIDS will probably not be unduly burdensome for Romanian services, and may likely be implemented using data already collected through GFATM, UNODC and other projects.

The evaluation found that the project has achieved significant progress in reaching Objective 1 by bringing new NGOs and government service providers into play and through a documented increase in needle exchange and OST services in Bucharest. Continued work is needed to scale-up prison-based services, and to provide ongoing technical assistance to newer service providers.

**Objective 2:** *Create a supportive environment and ensure sustainability of HIV/AIDS prevention and care services for injecting drug users and in prison settings.* The project has sought to fulfill this objective through a combination of efforts to educate policy makers about the project’s issues and to convene and coordinate bodies to propose national policy guidelines supportive of IDU HIV prevention programs. The project has realized some progress in reaching out to new entities, both directly (e.g. work with ANP, MoI, the National Agency for Roma, and Roma community and health leaders) and through collaborative bodies including the Steering Committee and CCM. Progress on institutionalizing changes to Romania’s public policy environment is more tentative. The project has put considerable effort, for example, into draft recommendations for law enforcement professionals about prosecution of low-level drug offenses; supporting ANA to develop a new 2009-2012 Action Plan of the National Anti-Drug Strategy that incorporates HIV prevention priorities; and producing revised national guidelines on OST service delivery. In all three cases, draft documents have been produced but progress has somewhat stalled as they await decisions and/or comment at the ministerial level and in relation to Romania’s pending /or the new Penal Code reform level. As such this area cannot be meaningfully evaluated at this stage of the project, though on a practical level the project is

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<sup>14</sup> Online at: <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>.

having a positive impact through its influence on ANA strategy and funding, and on the practice of OST, a majority of which now receives funding and/or guidance from the project.

The project has consistently coordinated with other UN agencies on a common policy reform agenda. UNODC, represented at country level by the National Project Officer, acted as a focal point with UNAIDS and other agencies on issues related to prevention and care of HIV/AIDS among injecting drug users and in prison settings and participated in inter-agency meetings, the Joint UN Country Team on HIV/AIDS, UNDAF and other relevant forums. UNODC – through the National Project Officer and the Regional Programme Coordinator - regularly communicated with the UN Resident Coordinator in Romania with regard to the project's progress current needs and challenges. Such issues were also placed on the agenda of the UNODC Executive Director during his mission to Romania in April 2008.

**Although the project has made partial progress for this objective, it has still considerable work ahead. The MoH remains largely uninvolved in HIV prevention targeting IDU, and key national AIDS and drugs policy documents have been drafted but not yet been adopted. In a strict sense, the project has fulfilled its objective of mobilizing additional resources for HIV prevention services, but has been unable to ensure that funding is sufficient to meet long-term needs.**

**Objective 3:** *Generate and share strategic information to keep the programme on track and to respond to the rapidly evolving HIV/AIDS epidemics among injecting drug users and in prison settings.* Efforts toward meeting this objective have included the expected array of basic reporting and communication about the project, as well as funding to allow the project team and key project stakeholders to participate in national and international conferences and technical meetings. The former has included a September 2008 UNODC-organized workshop with personnel involved in all three components of the overall Netherlands/UNODC project (Baltic States, Romania and Russia), which in interviews was cited by UNODC Romania and Vienna staff as a good opportunity for experience sharing and worthy of replication. Participation by stakeholders in international events has served to improve their technical knowledge (e.g. ANP staff participation in the conference of the WHO Project on Prison and Health in Kyiv) and as a way of broadening stakeholders' exposure to current practices in the field directly relevant to the project (e.g. participation of professionals from NGOs, ANA and UNODC in the 2008 International Harm Reduction Conference, which included site visits to Catalanian prison needle exchange and OST programs). **This objective can be defined as an ongoing process, rather than discrete actions that can be achieved, but to date the project has fulfilled it by effectively communicating information related to the project and its mission to other stakeholders, and by encouraging new, more rigorous program data collection and research initiatives.**

### **2.3. Achievement of Project Outputs and Results**

The UNODC project has pursued six outputs as the building blocks for the achievement of the project's objectives. The project has completed most outputs related to the expansion of HIV prevention services, and achieved progress toward policy-related outputs consistent with expectations for the halfway mark of the project, with some goals nearing completion (e.g. the new National HIV/AIDS Strategy) and others delayed (e.g. some clinical practice guidelines, work with people under arrest). Outputs related to funding sustainability are the area of greatest concern, having seen some progress in that achieved outputs have made the environment more conducive to new funding, but without winning substantial long-term funding commitments to date.

The following section reviews progress toward realizing each output.

**Output 1.1:** *Action plans developed for scaling up comprehensive HIV/AIDS prevention and care services for injecting drug users and in selected prison settings.* Activities associated with this output seek to create a framework of information, inter-agency coordination and public policy in order to support scale-up of HIV prevention services for IDUs. The basic goal has been to develop the new National HIV/AIDS Strategy (2008-2013) and the Action Plan (2009-2012) of the National Anti-drug

Strategy in order to give due priority to IDU-related issues in both documents and to promote the adoption of health interventions by the Romanian government in such a way as to direct relevant ministries and government agencies to fulfill IDU HIV prevention funding and policy needs. The precursors to this were the assessment of the situation of IDU and HIV prevention services in the community and in prisons, IDU population size estimation, and the founding of a government-civil society national technical working group to coordinate IDU HIV prevention policy. The assessments have fulfilled their purposes, and are widely cited as the most thorough and up-to-date information available on the subject. Strategic planning exercises have been organized and facilitated by the project for ANA's local CPECA centers. **Overall, except for the adoption of the National HIV/AIDS Strategy, which is pending and expected, Output 1.1 has been completed, though the real value of the work will be in translating the strategy and the action plan into real practice and funding. Results in this area directly underpin the overall goal of the project and are closely linked to work toward outputs 1.3, 2.1 and 2.2.**

**Output 1.2:** *Enhanced knowledge, skills and competencies of the service providers in delivering effective HIV/AIDS prevention and care services to injecting drug users and in prisons.* This is the main area of the project around which technical assistance and good practice guidance has been organized. Technical assistance and professional training initiatives have been linked to every other area of the project, and work to support all of the project's outputs and objectives. In budget terms, contributions to this output have been modest, and were by and large front-loaded in the life of the project in order to more intensively support new organizations or staff taking on HIV prevention services. Ongoing work has included efforts to institutionalize technical assistance through the successful accreditation of RHRN training programs by the MoH's College of Pharmacists and Physicians and in the form of proposed harm reduction courses through the University of Bucharest School of Social Work. Output 1.2 has been amplified by output 3.1, which supported other kinds of education and capacity building. This output also envisions work to develop practice guidelines in several areas. To date, progress has been made by UNODC, ANA and RHRN to formulate a national guideline for OST services, which has involved WHO technical support and the convening of a series of meetings attended by relevant stakeholders including the MoH. Further work is needed to finalize and reach consensus on the guideline. Working protocols and internal regulations have been prepared and reviewed under the project and formally endorsed by ANP so as to allow initiation and implementation of needle exchange and OST in prisons. In order to fulfill drug control requirements, with the project support ANP succeeded to get certification from MoH for its units to store and distribute methadone. **Mechanisms established by UNODC under the project have allowed successful identification and immediate response to the technical assistance needs of service providers. However, because of numerous competing priorities for the project and in order to avoid duplication with other programs (e.g. UNICEF), UNODC should consider whether it is feasible to address issues specified in the project document as in need of normative practice guidelines – VCT, outreach, peer education, and monitoring and evaluation – but which have not to date been features of the project.**

**Output 1.3:** *A comprehensive package of HIV/AIDS prevention and care services is available and accessible.* This output centers on improving the accessibility and coverage of HIV prevention services for IDU and inmates and additional technical assistance and research activities designed to inform and support services. The project has contributed to real improvements in the availability of services, especially OST, and to the quality and reach of technical assistance and research programs. As discussed elsewhere in this report, some changes are likely needed in how the project analyses coverage of supported interventions in order to make coverage estimates more consistent and meaningful. That said, the contribution of the project to doubling the availability of OST and (alongside GFATM round 2 and round 6 programs) the documented increase in the number of people reached by community syringe exchange threefold should not be minimized. Moreover, the project has supported the harmonization of individual NGO and governmental databases and proposed common core indicators to be measured and reported on every six months. A challenge remains in the MoH OST data collection and reporting system, which does not provide a reliable count of the number of OST patients in the MoH centers.

This was by far the largest output in budget terms, with approximately 58% of total project spending dedicated to direct services for people who inject drugs. Between the launch of the project in 2006 and the end of 2008, the number of programs offering syringe exchange and related services increased from 2 to 8 in 2008, and the number of OST programs from 2 to 7. Developments in this area have had the added benefit of raising the profile of HIV prevention services for IDU and inmates by involving some state agencies for the first time. New programs have also succeeded for the first time to involve organizations from outside the immediate fields of drugs and HIV, notably homeless services and Roma health groups. The project has also sought to build new research programs with the RMCDDA, implementing the country's of the first HIV/HBV/HCV behavioral and serological survey (BSS) among IDU. The U.S. Centers for Disease Control and Prevention and UNAIDS provided assistance to develop the survey protocol and train the BSS team, and the protocol and questionnaire were endorsed by the national Monitoring and Evaluation Working Group on HIV/AIDS.

**In all, the project has largely met Output 1.3, making clear and significant progress in rolling out new harm reduction services despite the aforementioned issues related to coverage estimation. Continued technical assistance is needed for all new services. Particularly with regard to the project's collaboration with ANP, the project should assist prison programs to learn lessons from the initial phase of implementation, to support additional education for prison staff and inmates about the goals and methods of the programs, and to scale-up pilot prison programs. Finally, although progress is on track toward the establishment of an HIV/HBV/HCV sero-surveillance system through the BSS project, its contribution towards this output cannot be evaluated at this time.**

**Output 2.1:** *Agreed national strategy for addressing HIV/AIDS among injecting drug users and in prison settings in place.* Work performed for the achievement of this output focused on a collaborative effort of UNODC with multiple stakeholders and other UN agencies (UNAIDS, UNICEF, WHO) for the official adoption of the National HIV/AIDS Strategy (2008-2013) and the Action Plan (2009-2012) of the National Anti-Drug Strategy. Work under this output has also sought to promote guidelines for police and prosecutors dealing with minor drug offenses. The project has strategically broken these goals into several component parts in an effort to ensure that all necessary stakeholders are involved in creating a national framework for IDU HIV prevention and that when such a framework comes to be, much of the groundwork allowing it to actually be carried out will have been laid. In practice, this has meant that much of the work associated with this output is education and/or coordination, and is often intermingled with work toward other outputs, especially 1.1, 1.2 and 3.1. Efforts to create new prosecutorial guidelines or changes in criminal law in order to differentiate between possession of small amounts of drugs and more clearly specify the intention to sell (which, highly problematically, are not currently defined in Romania's drug laws) resulted in ANA submitting amendments to the Penal Code, which are now under consideration by the Romanian parliament as part of a much larger (and much delayed) attempt at criminal law reform. The Action Plan for 2009-2012 seems likely to be adopted in the near future, and will be an important step toward aligning drug and HIV policies in Romania. Although adoption of the National HIV/AIDS Strategy (2008-2013) is expected, there have been major delays due to weak commitment on the part of the MoH. **Progress on Output 2.1 has been primarily process-oriented (as opposed to formal adoption of strategic documents), but with the exception of the National HIV/AIDS Strategy is basically in line with predefined expectations for the project.**

**Output 2.2:** *Additional resources are mobilized from internal and external sources to rapidly scale up and sustain the HIV/AIDS prevention and care response for injecting drug users and in prison settings.* As discussed above in section 2.1 Efficiency, the project had leveraged third party funding equal to at least 31% of project spending in Romania. ANA's contribution has come in their decision to fund two additional CAIA centers modeled on the UNODC-funded OST center (Pantelimon). In addition, ANA provided the premises for a drop-in center run by an NGO under the project, and opened a day center and a vocational center, which provides support to OST patients in the form of groups, psychotherapy, treatment adherence and other supports, and job training. In all, the ANA's

contribution was calculated at US\$384,500. ANA's financial commitment is expected to rise further with plans in 2009 to offer methadone and other drug services through CAIAs in the cities of Iasi and Bihor, where plans and budgets are already in place, and in another 12 centers (for a total of 15) pending decisions about ANA's 2009 budget in the wake of the current global economic crisis. The ANP has provided in-kind support by funding all ANP staff involved in the needle and syringe exchange and OST programs at Jilava and Rahova prisons. Though the amount of the contribution has not yet been estimated and is probably relatively small, it still represents an important commitment by the ANP. The project also succeeded to build strategic alliances with other UN agencies (UNAIDS, UNICEF, WHO) and the GFTAM Round 6 Program by coordinating and accessing technical assistance opportunities (WHO, U.S. CDC, etc.), jointly assessing project proposals submitted by NGOs for funding under the UNODC project and the GFATM Round 6 Program, planning and co-funding activities (i.e. direct services to beneficiaries, sero-surveillance, advocacy, data collection and reporting etc.). Additional co-funding came from UNICEF near the end of 2008 for six grants supporting needle and syringe exchange and OST services and training. The UNICEF contribution of US\$181,370 represented one-third of the total grant budget (US\$546,400) during the grant cycle in question. Representatives from UN agencies and the Principal Recipient for the GFATM Round 6 also sit on the Project Steering Committee, creating further opportunities for fund coordination and informing other donors about UNODC project priorities.

**In summary, the project has also succeeded in raising a fairly large amount of in-kind and direct financial support for the project from ANA, ANP, MoH, GFATM, UNAIDS, UNICEF, WHO and the U.S. CDC. Though not all these sources will form the basis for long-term funding (e.g. UNICEF's contribution in 2008), they have each been helpful in advancing project objectives at various times. On the other hand, funding and staffing commitments from ANA and ANP have set important precedents for the involvement of governmental institutions in service delivery, and potentially (in the case of ANA) in funding for civil society activities. The project should be considered highly successful in leveraging third party resources, though progress to date on Output 2.2 represents the beginning rather than completion of this output, and further progress is needed in order to make achievements meaningful and lasting.**

**Output 3.1:** *Government of Romania, civil society partners, the UN and other relevant agencies working at the country level are provided with updated strategic information and analysis concerning HIV/AIDS prevention and care among injecting drug users and in prison settings in Romania.* This output has been geared toward improving technical capacity and exposure of project stakeholders, including the project team, to current best practices and new ideas in the fields of harm reduction, general HIV prevention and care, and drug policy. As noted above in section 2.2 Objective 3, this output can be said to have been realized primarily because associated activities are a regular, ongoing feature of the project. **Although work toward this output is fairly small in budget terms, it can be considered an extension of technical assistance programming for service providers, officials and policy makers. The project has not generally evaluated outcomes or individuals' experience of particular conferences or technical meetings but this output likely has a positive effect on Objectives 1 and 2 by introducing or reinforcing concepts central to the project mission.**

## **2.4. Implementation**

The project operates based on the Project Document signed on 22 August 2006 between UNODC and the National Anti-drug Agency (Ministry of Interior) and in accordance with the annual costed workplans which serve as the project's basic operational plans, and which are reviewed and approved by the UNODC HIV/AIDS Unit and the donor, following consultation with national stakeholders. The workplans are organized in spreadsheets with planned activities matched to the project's objectives and outputs and assigned budgets, needed inputs and a timeline for the activity. Descriptions of activities are virtuously succinct, but also sometimes too vague and so would benefit from elaboration in some form. Though project staff have been effective in putting the annual workplans into practice, detailed strategy documents are not produced by the project. To some extent this allows the project a valuable degree of flexibility; certainly the goal is not to burden project staff with extra work or rigid plans. However, as the project becomes more focused on public policy advocacy (including public

financing), it may need to adopt different strategies and tactics than were useful in promoting services expansion and would likely benefit from more tangibly defining and prioritizing policy objectives. **Project staff should consider developing more detailed advocacy strategies, perhaps in partnership with other stakeholders, based on simple campaign organizing principles, e.g. defining concrete issues and desired outcomes, mapping power structures, identifying individuals to target and tactics to be employed, setting a timeline and benchmarks, etc. Outside technical assistance in campaign planning should be used as needed.**

The majority of the stakeholders interviewed during the midterm evaluation were satisfied with UNODC's management of the project. One problem was identified in that one of the NGO implementing partners experienced a period without funding, which led to serious disruptions in syringe exchange outreach services. Although UNODC planned to continue funding the NGO after the previous grant agreement expired, the NGO had faced certain challenges in disbursing funds and complying with reporting requirements. Although UNODC issued a renewal grant contract within roughly 15 days from the time the grantee's final reports were delivered, the resulting interruption in services is still notable and could perhaps been avoided with greater attention from UNODC. **In spite of UNODC's efforts to ensure timely grant renewals and avoid gaps in funding for direct services, some current or future grantee organizations will likely have weaknesses in various aspects of grants management and compliance with reporting requirements. UNODC should invest further technical assistance to increase capacity in this area, especially to prepare organizations for other funders' expectations after the UNODC project ends.**

Project staff monitor the project's overall progress by several means. Grant agreements and contracts with the government institutions specify objectives, activities, targets and indicators as well as schedules for narrative and financial reporting, which is the project's basic first line of documentation. The project in turn produces monthly, quarterly, semiannual and annual progress reports (each with a somewhat different format and scope of information). Since most of the project staff provide technical assistance to grantees and/or are involved in advocacy or negotiations with government and other partners, project staff are afforded regular opportunities to see how particular components of the project are functioning and to identify problems and potential remedies. Regular monitoring visits are paid both to governmental and non-governmental partners, more intensively to prison settings and services run by more newly involved NGOs. As discussed in section 2.1 Effectiveness, the Steering Committee has also served as a largely impartial platform for feedback to the project in which strategy (especially with regard to national policy and sustainability/funding issues) is discussed in a way not limited to the views of project team and implementing partners. Likewise the project's frequent interaction with the GFATM principal recipients and project staff's participation in the CCM have ensured that the project operates with effectively all available relevant information.

## **2.5. Institutional and Management Arrangements**

As previously described above in section 1.1 Introduction, currently the NPO consists of six people based at the UNODC/Romania office, whose work is coordinated, supported and monitored by management and administrative bodies in Sofia, Vienna, and Bucharest, respectively the UNODC Regional Programme Office for Southeastern Europe, the UNODC HIV/AIDS Unit, and UNDP Romania. The project team frequently interact with UNAIDS, UNICEF and WHO staff in Romania, with whom the project is formally coordinated (via joint UN/Romania strategies for HIV/AIDS programs) and who informally but consistently advise and otherwise support the project. Experts have been hired from time to time to provide expertise or outside perspective.

The National Project Office is organized in a way that generally promotes efficient work within the project. All staff have unique and sufficiently specific terms of reference in their contracts, and although there is some overlap in the work of the three experts (e.g. multiple staff assigned to various aspects of the prison programs, or to providing technical assistance to new harm reduction grantees), staff functions are largely discrete from one another, with little if any duplication of effort. The current level of staffing seems appropriate. Management decisions and the overall direction of the

program are primarily decided by the National Project Officer, who is supervised by the UNODC Regional Programme Coordinator and the Head of the UNODC HIV/AIDS Unit. The HIV/AIDS Unit offers technical guidance to the project, coordinates the overall program in Romania, Russian Federation and the Baltic States, and liaises with the donor. The administrative and financial actions are coordinated by the program assistant with supervision from the RPOSEE. UNDP also provides implementation support services to the project and ensures compliance with the UN finance and accounting procedures. During interviews with the managerial bodies of the project -- the project team, HIV/AIDS Unit UNODC-HQ, RPOSEE, and UNDP -- no problems were identified. Staff in Bucharest, Vienna and Sofia clearly have mutual respect and trust for one another, understand each other's roles, and know when it is appropriate to involve one another. RPOSEE and HIV/AIDS Unit staff expressed their feeling that the NPO is largely self-sufficient and very effectively organized. The project team felt that when assistance from the HIV/AIDS Unit or RPOSEE was required, such help was useful and provided quickly. It was noted that in particular the Regional Programme Coordinator for Southeastern Europe has periodically played a crucial role in galvanizing higher-level political support for the project, especially with regard to collaboration with the ANP.

### **III. OUTCOMES, IMPACTS and SUSTAINABILITY**

#### **3.1. Outcomes**

The project does not identify formal outcomes in the sense of the UNODC standard evaluation report guidelines. Some discussion of the project's medium term effects, however, is found below in sections 3.2 and 3.3.

#### **3.2. Impact**

Achievements in several components of the project suggest that the project has the potential to create permanent positive change. Observation of harm reduction outreach services at better-established programs revealed exceptional professionalism and an impressive level of trust between staff and clients. To varying degrees these qualities were apparent in all the major areas of the project. Gauged by progress in the first two years, three areas of the project's work do seem more likely than others to have special influence on IDU health services in the long run. First, the collaboration with ANA on OST programs seems to have been a natural fit and has produced important changes in ANA's work by enhancing and improving drug health services and, most consequentially, making the first real advances in OST services in many years. ANA has already taken initiative to build beyond what UNODC funding allows. Second, UNODC's work with the RMCDDA on research has helped ANA to clarify and better fulfill its mission as the clearinghouse for reliable information on drugs and drug use in Romania. In particular, new methods introduced through the behavioral and serological surveillance partnership and related research initiatives promise to have a major influence on the quality and conduct of HIV and drugs research in Romania. Third, though a number of other organizations have been involved in promoting Roma-oriented harm reduction programs, the UNODC project deserves much of the credit for the launch of the first syringe exchange program run by a Roma NGO and for bringing the National Agency for Roma on board, both considerable breakthroughs.

Other areas of the project show promise though are less clearly on a path toward achieving long-term impact at this stage. With direct technical and financial support from the project, ANP succeeded to initiate needle exchange and OST in 3 units of two prisons. After 6 months of pilot implementation, ANP has made the decision to expand these services to another six units. It is essential for the project to continue to provide technical assistance to ANP in order to increase the availability of syringe exchange and OST services in prisons and to further build ANP's political commitment, ownership of programs, and resource allocation. The collaborative and participatory processes promoted by UNODC created helped to develop a sense of ownership of HIV prevention services among the main stakeholders. By succeeding to involve new civil society organizations in the provision of HIV prevention services for IDUs, the project not only increased the number of service providers but also

usefully brought in agencies serving other vulnerable groups (e.g. homeless people, Roma) with overlapping risks.

### **Unintended Outcomes**

The UNODC project and its partners have initiated an impressive array of new and innovative services with a far larger network of stakeholders than had previously existed in Romania. The project should recognize that introducing new kinds of IDU health services or involving new providers requires a substantial learning curve, and that in most instances the initial design and operation of programs will need to be adjusted in order to take advantages of lessons learned within a particular environment (e.g. conditions in a prison unit, the drug scene in a neighborhood) and to maximize a program's value and efficacy among people who use drugs. During the first two years of the project, service providers in all areas of the project – community harm reduction, drug treatment and in the prison system – have encountered challenges related to services design. Going forward, UNODC should continue to provide technical assistance and work with service providers to develop critical understandings of how the design of services is working out in practice. UNODC and its partners should prioritize efforts to continuously adjust and improve HIV prevention services as service providers become more experienced, the goals being to make services as relevant as possible to the lives of people who use drugs, to lower barriers to drug users' access to services (including barriers created by service design), and to maximize the reach and measurable impact of services. Practices or policies in health services that contravene any of those basic ideas should be identified and reformed or removed whenever possible.

### **3.3. Sustainability**

The long term programmatic and financial sustainability of harm reduction programs has been a major emphasis of the project, and is the preeminent problem now on the minds of virtually all the project's stakeholders. Whether the project can truly succeed in this area is the foremost challenge of the remaining two years, particularly with regard to securing funds to replace sun-setting UNODC and GFATM Programs.

At least on paper, Romania's legislative base in support of HIV prevention for IDU is strong. HIV/AIDS services are in principle guaranteed, and national legislation requires the ministries to develop internal orders and budgets to implement HIV programs in their areas of competency, leaving few policy barriers to such action. In practice, however, with the exception of Romania's longstanding commitment to universal access to HIV treatment, HIV programs have not been cemented in ministerial budgets. The National Multisectoral HIV/AIDS Commission has been inactive since 2007, having been to some extent replaced by the GFATM CCM and other bodies, the effect of which is that some government agencies that should be taking a leading role are able to sidestep responsibility. And though a new national HIV/AIDS strategy was drafted, it has not yet been adopted due to an unstable political environment in the Ministry of Health. It is unlikely that the project will be able to resolve all (or any) of these issues; the important thing to focus on is that the basic policy instruments needed for state support may be unused, but they are at least in place, presenting opportunities for UNODC and its partners to foster incremental advances.

#### **Funding Sustainability**

In discussions with UNODC and other UN staff, the project Steering Committee, grantees and other stakeholders, a largely common vision emerged for how harm reduction services should be funded in the long term, involving a much greater role for the MoH, and contributions in particular areas from Romania's National Health Insurance House (CNASS, the public medical insurance system), municipal governments, as well as ANA and ANP. In its first two years, the UNODC project has made inroads with most of these potential funders. ANA and ANP have, of course, begun to make significant funding contributions to community OST, research and prison harm reduction programs. ANA has as well established internal rules and requested a budget from the MoI that would allow it to fund community based needle exchange, though at the time of the midterm evaluation there was some

doubt as to whether money would be forthcoming in the present economic climate. ANP programs, while equally important, are considerably more fragile and will probably require continued, intensive support from UNODC during the remainder of the project. In any event, ANP and especially ANA can be said to have taken steps as a result of the UNODC project to institutionalize funding for harm reduction services and appear likely to remain involved in the field beyond the life of the project.

Similarly the National Agency for Roma appears to be a potentially strong partner in that early concerns among Roma community leaders about harm reduction have been resolved to the extent that the Agency is supporting a new harm reduction program by a Roma health NGO. The Agency now describes itself as “very open to any proposal” for further collaboration on harm reduction with UNODC, though in funding terms the Agency has little money, instead operating as a policy coordinator and advocate for Roma issues vis-à-vis other government agencies. With what is generally perceived to be a strong organization with political power, the Agency could play a valuable role in prompting other government institutions, most importantly the MoH, to contribute funding to harm reduction services benefiting the large number of Roma drug users in the country. The Agency may also be able to direct European Union social funds to some harm reduction services through its existing collaboration with ANA to promote social integration of people who use drugs.

The MoH will continue to be a bigger, but crucial challenge. As has been mentioned elsewhere in this report, UNODC and other organizations involved in harm reduction have repeatedly approached the MoH, aiming for the ministry to take a larger role. The Netherlands Ministry of Health, Welfare and Sport has also been involved in this effort by communicating directly with the Romanian MoH. Unfortunately, progress has been negligible, with HIV prevention for IDU receiving no funding from the MoH aside from its existing, small-scale methadone programs. The problem has been exacerbated by frequent changes in MoH senior leadership in recent years, caused most recently by the 2008 parliamentary elections.

Other potential funding sources, namely municipal governments and CNASS, have received less direct and/or more sporadic attention from the project. The project team and other stakeholders have approached the Bucharest municipality, where there may be avenues for funding from existing city social services programs. Some NGOs involved in the project have also begun to form relationships with local government, and one former project grantee in Iasi received a small amount of city funding to continue their project. The UNODC project has done some initial investigation of funding possibilities through CNASS, but more focused work is needed if new funding is to materialize.

**During the next two years, the project should, above all, concentrate on advocacy promoting incremental steps toward full public financing of harm reduction and related health services in the community and in prisons, working in concert with organizations already partnering in the project and with the Principal Recipient of the GFATM Round 6 Program. It is apparent that additional, detailed, policy-oriented analysis of the long-term funding environment is needed, and the midterm evaluation recommends that the UNODC project and its partners undertake such an exercise in 2009, bringing in outside expertise as needed.**

Despite the now uncertain road to public funding, the project has made progress toward sustainability. However, a serious worry identified by project staff, the Steering Committee and others is that amid the economic crisis it simply may not be possible to secure sufficient state funding for harm reduction services when international funding dries up over the course of 2009-2010. Moreover, the limited remaining project funds for 2009-2010 will constrain its ability to, for example, leverage start-up grant programs. **The midterm evaluation therefore recommends that UNODC consider providing or securing additional funding to the project in Romania in order to consolidate its achievements and to specifically target sustainability-building initiatives.**

## IV. LESSONS LEARNED AND BEST PRACTICES

### 4.1. Lessons Learned

Virtually every component of the project offers lessons but the midterm evaluation singles out four lessons that may be especially relevant for the project and for other UNODC projects. Most of them derive from the managerial approach used in project implementation.

- **The value of flexible, accessible technical assistance as a component of programming.** Among the UNODC project's strongest features is its ability to deliver essentially on-demand technical assistance to its grantees and other partners via the expertise housed in the National Project Office and through a broader network of expert trainers and advisors. Although this arrangement necessitates additional costs to the project, the benefits far surpass any such concerns by strengthening relationships and opportunities for collaboration with partners, creating possibilities to rapidly respond to training needs and other technical issues arising during the implementation of services, and by building the capacity of implementing partners to comply with UN administrative and financial requirements.
- **UNODC's ability to act as a convener and a bridge between government and civil society organizations.** The project has played an especially constructive role in bringing together a diverse group of organizations involved in HIV and drugs programs through various bodies established through the project (e.g. Steering Committee, Monitoring, Evaluation Working Group on HIV/AIDS, etc.). Perhaps UNODC's most unique potential role is as an 'honest broker' that can bridge government and civil society organizations that have not always seen eye-to-eye on the issues. As UNODC further expands its work in HIV prevention and care, it should take advantage of opportunities to facilitate better understanding and working partnerships between the harm reduction community and government, taking advantage of UNODC's history of engagement with law enforcement and drug control agencies.
- **The value of using plain and concrete wording in the project documents.** Some language employed by the project document to describe harm reduction programs or related services, reflected also in some project reports, grant contracts, and a variety of other documents has been unnecessarily vague, sometimes leading to confusion and making various aspects of the project difficult for outsiders to assess in the absence of additional documentation. In general, in all communications UNODC HIV projects should strive to use specific terminology that is widely understood in the public health community, and to include detailed description of what interventions are or are not being supported through a project.
- **The importance of considering long-term implications of how new services are designed.** In environments where new models or previously unavailable services are introduced, projects should consider that the particulars of HIV prevention service design are very likely to become formally and informally rooted in practice for years to come. Small-scale pilot services should be supported as an initial means to build local knowledge and experience, and as a matter of principle flexibility and appropriate adaptation to local environments should be among the goals of any new IDU health program. HIV prevention projects for IDU elsewhere should plan to continuously support the refinement of new interventions, linking service providers to ongoing evaluation efforts and technical assistance as needed in order to ensure the best possible services quality and outcomes and that counterproductive practices are resolved as services move beyond the pilot stage.

### 4.2. Best Practices

Because time spent with individual organizations during the evaluation mission was brief and program reports provide only a cursory view of how services are functioning, the midterm evaluation faced some limitations in identifying best practices associated with the project. Yet some things do stand out.

**Technical Assistance Expertise.** The best harm reduction services in Romania are the equal of any program in Eastern Europe and, in many ways, the harm reduction field as a whole. There is great potential in using existing Romanian expertise as a base of national and/or Southeastern European regional technical assistance. Romanian organizations' experience in service delivery, training and other technical assistance, and in building and using networking mechanisms are in many ways best practice models worthy of documentation and replication elsewhere.

**Project Organization and Management.** The UNODC National Project Office has performed exceptionally well, carrying the project far toward increasing the access of IDU and inmates to HIV prevention services, and creating innovations in services and program management that have exceeded the basic on-paper goals of the project. Perhaps most important as a model is the technical capacity the project has invested in the NPO and its commitment to providing technical assistance to its grantees, which has built the NPO's reputation as a remarkably reliable and useful partner offering far more than mere funding. The way the project has functioned within UNODC and been supported by other UN personnel in Bucharest, Sofia and Vienna is a plausible model for organization and collaboration in a UN HIV prevention project. This feature is mirrored by the NPO's unique successes in building a robust network of drug service providers and policy makers and interweaving non-governmental and governmental organizations. Following the project's conclusion, UNODC is strongly encouraged to document the work of the NPO in order to share such lessons and best practices.

### **4.3. Constraints**

The project faced several political, financial and technical constraints. In the last two years Romania has faced a political crisis born from the disagreement between the main political parties governing the country. This crisis was also reflected in an unstable climate within ministries and other central administrative institutions. Decision makers' attention was more often focused on political matters than public health issues. Due to other priorities in the public health sector, there have been only limited state financial resources. The MoH has been only weakly involved in dialogue with other stakeholders (i.e. civil society organizations, IDU community, ANA, ANP). And because of its relatively weak capacity to develop and manage programs that respond to the needs of vulnerable groups, the MoH remained largely uninvolved in actually providing HIV prevention services for IDU, notwithstanding a modest, ongoing budget allocation for a small number of methadone treatment slots. With regard to the ANP, the agency's senior management team was repeatedly changed during the first two years of the project, leading to delays in the implementation of HIV prevention in prisons and to low coverage of pilot services.

## **V. RECOMMENDATIONS**

### **5.1 Issues Resolved During the Evaluation**

Throughout the midterm evaluation process, a number of issues arose which suggest particular directions for the future or require some corrective action by the project. Among the topics regularly discussed in the evaluation interviews were long-term sustainability and the related need to more systematically organize advocacy efforts (i.e. to win government endorsement of the draft national AIDS strategy, OST guidelines, and recommended drug policy reforms; and to increase public funding for harm reduction programs). Generally speaking, issues discussed during interviews were not of a kind that could be resolved immediately, though there was some agreement with project staff on the need for change in various areas of the project. The following section therefore offers recommendations to further strengthen the effectiveness of the project in the service of its stated objectives.

## 5.2 Actions/decisions recommended

Overall, the project is on sound footing and should follow the path it has set out for itself. This section offers recommendations to strengthen the effectiveness of the project in the service of its stated objectives, based on the findings of the midterm evaluation. Note that unless otherwise specified, 'UNODC' refers collectively to the National Project Office, the HIV/AIDS Unit and the Regional Programme Office for Southeastern Europe.

### 5.2.A. Recommendations regarding program design, management, and reporting

- ¾ In recent years, services coverage estimates produced by UNODC and other organizations do not appear to utilize a clear, consistent, meaningful definition of what constitutes "coverage," and different denominator population estimates have been used in ways that may confuse attempts to gauge trends over time. In the future the project could usefully reflect coverage estimates by using absolute numbers of individuals reached by services in addition to coverage rate estimates in order to ensure that quantitative data are comparable over time. UNODC, other donors, and service providers should also seek to use meaningful definitions of coverage for all funded interventions, including through the use of data on how often IDU access a given intervention. This effort should be based on the 2009 WHO/UNODC/UNAIDS "Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users",<sup>15</sup> focusing on the Technical Guide's idea of "effective coverage."
- ¾ It is important that the language used by UNODC in project documents (including in the form of project objectives and indicators, and in grant contracts, annual workplans, and all reports) be as explicit as possible in order to avoid misunderstandings and improve the ability of stakeholders to assess the project. In all communications, UNODC should strive to use specific terminology that is widely understood in the public health community, to avoid terms such as "comprehensive HIV prevention package" that may be misunderstood or do not accurately describe project activities, and to include detailed description of what interventions are or are not being supported through a project.
- ¾ At the current stage of the project, objectives aimed at launching IDU services in localities other than Bucharest may be unrealistic and/or in low demand. The project should reconsider and decide with national stakeholders whether it is necessary to temporarily or permanently remove the expectation of further programming outside Bucharest.
- ¾ The project has undertaken work on several national guidance documents (e.g. with regard to OST program standards, law enforcement practices and petty drug crimes, etc) that may become valuable tools for policy making in the long run. However, because of numerous competing priorities for the project UNODC should consider whether it is feasible to address issues specified among the project document's outputs as in need of normative practice guidelines – namely VCT, outreach, peer education, and monitoring and evaluation – but which have not to date been features of the project and which have also been taken up to varying extents by other programs such as GFATM and UNICEF.
- ¾ In order to better fulfill the principle of Greater Involvement of People Living with HIV to which the UN system subscribes, UNODC should consider opportunities to elicit more regular and substantial advice from people who use drugs about the Romanian project and other drug user health programs and, whenever possible, to involve people who use drugs in the design and conduct of services, advocacy and other initiatives.
- ¾ Following the project's conclusion, the UNODC HIV/AIDS Unit is strongly encouraged to document or otherwise present the work of the National Project Office and related UNODC

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<sup>15</sup> Online at: <http://www.who.int/hiv/pub/idu/targetsetting/en/index.html>.

management bodies as a potential best practice model of UN HIV prevention program organization and management. The work of some of the project's health services and technical assistance partners may also be worthy of documentation as best practice examples.

### **5.2.B. Recommendations regarding development of HIV prevention services and technical assistance**

- <sup>3/4</sup> Despite considerable progress in increasing the availability of harm reduction services through the UNODC and GFATM projects, people who use drugs who were interviewed during the evaluation frequently reported not having satisfactory access to sterile syringes.<sup>16</sup> Reasons cited for this included that needle exchange providers were not present at a particular location as often as needed, that people were unable or unwilling to obtain syringes from pharmacies, etc. The notion of continuing sterile syringe scarcity in Bucharest is supported by evidence showing high rates of syringe sharing and extremely high HCV prevalence. Few harm reduction staff – and no drug users – who were interviewed had accurate information about effective syringe cleaning methods. Several stakeholders expressed serious concerns about the teaching of syringe cleaning techniques given the role of syringe reuse in Romania's nosocomial HIV outbreak and legal prohibitions on syringe reuse by government medical agencies. Nonetheless, for various reasons, some people at high risk of HIV or hepatitis infection are reusing syringes, and harm reduction organizations have a responsibility to provide evidence-based information to IDU on the subject. Moving forward, harm reduction service providers and donor agencies should consider and seek to ameliorate possible practice and public policy barriers to sufficient syringe access. Some renewed effort to promote more reliable sale of syringes through Romania's private pharmacy system may be warranted. With the continuing syringe sharing problem, service providers should also consider ways to best promote evidence-based syringe cleaning techniques among IDU in order to reduce infectious disease transmission. A literature review may be an appropriate starting point, to be followed by training for harm reduction staff and other stakeholders, development and dissemination of IEC materials, and incorporation of appropriate and regular syringe cleaning messages in contacts with IDU. A legal review of national regulations on syringe cleaning and/or reuse may also be useful in order to clarify what government harm reduction providers may or may not do in a harm reduction context (as opposed to regular medical practice).
- <sup>3/4</sup> During the first two years of the project, service providers in all major areas of the project – community harm reduction, drug treatment and in the prison system – have encountered challenges related to services design. Going forward, UNODC should continue to provide technical assistance and work with service providers to develop critical understandings of how service designs are working out in practice. UNODC and its partners should prioritize efforts to continuously adjust and improve HIV prevention services as service providers become more experienced, the goals being to make services as relevant as possible to the lives of people who use drugs, to lower barriers to drug users' access to services (including barriers created by service design), and to maximize the reach and measurable impact of such services. Practices or policies in health services that contravene any of those basic ideas should be identified and reformed or removed whenever feasible.
- <sup>3/4</sup> With regard to prison-based programs, UNODC and ANP should review progress and lessons learned to date from the pilot needle exchange and OST programs, and continue to make adjustments in their design and practice in order to improve their effectiveness and build toward scale-up. UNODC should continue to allocate technical assistance to ANP as needed.
- <sup>3/4</sup> Additional familiarization, technical training and education about the roles and objectives of prison-based needle exchange and OST would strengthen the programs. UNODC, ANP and their

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<sup>16</sup> It should be noted that interviews were with a small (c. 20 people) convenience sample of people accessing outreach-based syringe exchange, and though responses were fairly consistent, this is not scientific data and further study is warranted.

partners should facilitate such activities, targeting prisoners, and both prison health and security staff. It may be useful to consider opportunities to facilitate internships or professional exchange with countries where prison-based needle exchange and OST services are more established.

- ¾ In spite of UNODC's efforts to ensure timely grant renewals and avoid gaps in funding for direct services, some organizations still have weak capacity to manage grants and comply with reporting requirements, which in some cases has led to delays in funding renewal and disruption of HIV prevention services. UNODC should provide further technical assistance to increase capacity in this area, especially to prepare organizations for other donors' expectations after the UNODC project ends.

### **5.2.C. Recommendations regarding future project strategies and services sustainability**

- ¾ The project faces a variety of challenges in shifting away from HIV prevention services development and more toward public policy questions in its final two years. The project may need to adopt different strategies than were useful in promoting services expansion and would likely benefit by making more of an attempt to tangibly define and prioritize policy objectives and to produce a written advocacy strategy. Such a strategy should be organized around basic campaign organizing principles, e.g. defining concrete issues and desired outcomes, mapping power structures, identifying individuals to target and tactics to be employed, setting a timeline and benchmarks, etc. Outside technical assistance in campaign planning should be used as needed.
- ¾ During the next two years, the project should, above all, concentrate on advocacy promoting incremental steps toward full public financing of harm reduction and related health services in the community and in prisons, continuing to work in concert with organizations partnering in the project and with the Principal Recipient of the GFATM Round 6 Program. It is apparent that additional, detailed, policy-oriented analysis of the long-term funding environment is needed, and the midterm evaluation recommends that the UNODC project and its partners undertake such an exercise in 2009, bringing in outside expertise as needed.
- ¾ A serious concern identified by the project team, the Steering Committee and other project partners is that amid the economic crisis it may not be possible to secure sufficient state funding for harm reduction services when international funding dries up over the course of 2009-2010. The midterm evaluation therefore strongly recommends that UNODC consider providing or securing additional funding to the project in Romania in order to consolidate its achievements and specifically target sustainability-building initiatives. In addition, senior UNODC officials and representatives of the Netherlands government may consider more involvement in advocacy and negotiation with Romanian government institutions that have the authority to allocate adequate resources for existing services and enact policy changes supportive of sustainability.
- ¾ The Government of Romania should recognize that harms associated with injection drug use are a major issue in Romania's public health. For more than a decade, international funding has helped to develop a deep base of expertise and experience in HIV prevention and other public health programs targeting IDU. In the future, the Government of Romania should take greater ownership of the issue by providing funding adequate to sustain and continue to scale up IDU health services, adopting national standards for services based on local Romanian experience, and increasingly providing IDU health services directly through relevant agencies, including the MoH, MoI and MoJ. The Government of Romania should also take such steps as are necessary to guarantee the continuity of health services between the community, pretrial detention and prison facilities.

## VI. OVERALL CONCLUSIONS

Broadly speaking, the first two years of the project should be seen as a success. The project design is highly appropriate to circumstances in Romania, fitting squarely with the UNODC's mandate in the area of HIV/AIDS and with its strategies by reflecting the global policy of the Member States. Project planning and budgeting have been accomplished in an effective and efficient manner, and spending levels seem commensurate with the volume of activities carried out during respective years. Project objectives have, to date, been met or are well on track, though performance indicators are stated somewhat generically in the project documents and in some cases may be difficult to measure.

Assuming the project effectively follows through on its work in 2009-2010, it should be expected to produce long-term benefits in the form of a broader, more skilled network of organizations involved in IDU health programs; improvements in the ability of organizations and individuals to provide high quality technical assistance; significant advances in the capacity for and quality of epidemiological and other research initiatives on IDU; and the deepening involvement of at least three key government organizations. The documented increase in the number of beneficiaries reached by needle exchange and OST and the new NGOs and government service providers brought into play demonstrate that significant progress has been achieved in the coverage of harm reduction services in the community. Though promising, prison-based programs are as yet small in scale and not well established.

By far the largest threat to the project is the uncertainty of long-term funding sustainability, a question that is all the more urgent as IDU programs face the end of UNODC and GFATM funding over the remaining period. The project has made some progress in improving the environment as it relates to sustainability questions, and succeeded in raising a fairly large amount of in-kind and direct financial support for project activities, amounting to at least 31% of UNODC spending to date on the project in Romania. Nonetheless, fund development to date is nowhere near sufficient to sustain existing HIV prevention programs, and the project should focus on this issue as its first priority. Amid the current global economic crisis it may not be possible to secure sufficient state funding for harm reduction services when international funding dries up over the course of 2009-2010. Accordingly, UNODC should consider providing or securing additional funding to the project in Romania in order to consolidate its achievements and specifically target sustainability-building initiatives. The Government of Romania should recognize that harms associated with injection drug use are a major issue in Romania's public health, and should respond by providing funding adequate to sustain and continue to scale up IDU health services, adopting national standards for services based on local Romanian experience, and increasingly providing IDU health services directly through relevant agencies, including the MoH, MoI and MoJ. The Government of Romania should also take such steps as are necessary to guarantee the continuity of health services between the community, pretrial detention and prison facilities.

Other problems encountered during the midterm evaluation are generally more technical in nature, and though they may sometimes seem outside the immediate scope of the project and less overwhelming than a looming funding crisis, they are important to the long run success of harm reduction. Consequently, the project should maintain its commitment to partnership with and technical assistance to harm reduction service providers, seeking ways to further advance the quality, appropriateness and effectiveness of both new and better-established services.

Finally, the way the project has functioned in relation to the UNODC HIV/AIDS Unit, RPOSEE, and other UN agencies in Romania is a potential best practice model of organization and collaboration in a UN HIV prevention program. The National Project Office's efforts to establish in-house technical expertise and technical assistance mechanisms has led to considerable innovation, allowed the project to venture into important areas of work that are distinct from other programs in the country, and facilitated coordination among key partner organizations. After the project ends, lessons drawn from the process by which the project was organized and how it adapted over time would likely be valuable as a teaching and organizational development aid to similar programs in other countries.

## **List of Annexes**

Annex A: Terms of Reference for Midterm Evaluation

Annex B: Pre-evaluation mission survey and responses

Annex C: List of People Interviewed

Annex D: Evaluation Questions Matrix

Annex E: Evaluation Assessment Questionnaire