

**MID-TERM EVALUATION OF UNODC PROJECT XEEJ20**

**HIV/AIDS PREVENTION AND CARE AMONG INJECTING  
DRUG USERS AND IN PRISON SETTINGS IN ESTONIA,  
LATVIA AND LITHUANIA**

**Produced**

**by**

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## ACRONYMS

AGIHAS	Latvian organisation of PLWH (Atbalsta Grupa Inficētajiem ar HIV un AIDS Slimniekiem]
AIDS	Acquired Immunodeficiency Syndrome
ASAP	AIDS Strategy and Action Plan
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENCAP	Expanding Network for Coordinated and Comprehensive Actions on HIV/AIDS Prevention among IDUs and Bridging Populations
EU	European Union
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IDU	Injecting Drug User
MMT <sup>1</sup>	Methadone Maintenance Therapy
NGO	Non-Governmental Organisation
PLWH	Person/People Living with HIV
UN	United Nations
UNAIDS	Joint UN Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
US\$	United States Dollar
WHO	World Health Organisation

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Although the term opioid substitution therapy is widely used in the project and in the region, it has been avoided in this document because of concerns over perceptions that it refers to substitution of 'street drugs' with 'state drugs' (Gerra et al., 2008). It is recognised that the use of alternatives to methadone has resulted in some using alternative terms, such as psychosocially assisted pharmacological treatment (WHO, 2008). However, in the context of the UNODC project, the degree of psychosocial support is variable and the treatment used is methadone. Hence the term methadone maintenance treatment has been preferred.

## EXECUTIVE SUMMARY

This document presents the findings of a mid-term evaluation of the UNODC project focused on HIV prevention, treatment and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania. Established in 2006, this project is funded by the Dutch government and is worth US\$5 million over 4 years. The overall purpose of this evaluation is to learn lessons from project implementation to improve future project planning, design and management. The evaluation was structured around visits to Estonia and Latvia in December 2008 and Lithuania in January 2009.

The goal and objectives of the project are extremely relevant to the responses to HIV and AIDS in each of the three countries. HIV transmission in each of these countries is strongly related to injecting drug use, and prison settings represent both an environment in which HIV transmission can occur and a context in which people living with HIV are found disproportionately. It is recognised that the project's objectives are ambitious, particularly in relation to prison settings. There are many barriers to the introduction of effective HIV prevention measures in such contexts. Nevertheless, the project has already placed the issue of harm reduction measures in prisons on each country's agenda. It is hoped that, in the next two years, this increased conversation and dialogue will lead to concrete actions, such as the introduction of opioid substitution therapy in prison settings.

Despite the relatively short time the project has been operating, there is already some evidence of progress towards the project's objectives and expected results:

- There is growing consensus about the centrality of harm reduction measures within national responses to HIV and AIDS. Although this is less marked in custodial settings than in communities, there has been increased dialogue and conversation in these settings.
- Although assessment of coverage is difficult because of the absence of agreed measures of this within the project, small grants have been used to increase the number of sites providing MMT in Lithuania and needle and syringe exchange in both Latvia and Lithuania
- The project has contributed a great deal to the increased availability of strategic information through supporting a number of studies and reviews
- The project has sought to build capacity of individuals and organisations through the small grants programme, training activities, study tours, meetings and participation in professional networks
- The project has supported the development of new national AIDS programmes in both Latvia and Lithuania, focusing on broadening consultation, inclusion of international expertise and ensuring programmes reflect epidemiological realities in each country

The project is very appropriate for UNODC given its leading role among IDUs and in prison settings within the UNAIDS joint programme. UNODC's credibility within national criminal justice systems is considered to have been important in terms of progress made to date. UNODC's role within the project is widely-praised. In particular, the performance of the project's regional coordinator is universally applauded. However, there is need to resist the temptation to further expand

UNODC's role within project implementation and management. Rather, in the last two years of the project, every effort should be made to invest in, develop and support sustainable national systems.

Overall, the project's management systems have developed in a way that has facilitated effective project implementation once start-up delays were overcome. The human and administrative resources needed to administer an effective small grants scheme were underestimated in the project design. However, this has been addressed. The current system of financial management through UNDP is in need of review and revision, and this is already under discussion. There is need to review management structures to see if they need any modification to increase the likelihood of activities being sustained once funding through UNODC ends.

The issue of sustainability is one which needs to be given more focus as the project moves into the latter stages of implementation. The current adverse economic climate is a cause of major concern in this regard. There are also concerns about the commitment of political structures in each of the countries to ensure an effective national response to HIV and AIDS. This issue is multifaceted and is explored in some depth in this report (see Table 6, p22). On balance, the absence of political commitment is not considered a fundamental barrier to effective continuation of services once the project ends. It does vary from country to country and the project can take concrete steps to strengthen relevant aspects of political commitment to an appropriate response to HIV and AIDS in each country.

**In conclusion, this is an extremely useful and well-run project that is highly relevant to the national responses to HIV and AIDS in each of the three Baltic States. There is some evidence of progress towards the objectives and results at this mid-point of project implementation. However, this could be more rigorously asserted if the project adopted a simple performance monitoring framework, including, in particular, a small number of quantitative measures of coverage of key services. The main concern raised in this evaluation is the sustainability of activities and systems established during the course of project implementation. Time should be invested now in measures to increase the likelihood of sustainability.**

## INTRODUCTION

The Baltic States have been experiencing significant HIV epidemics, although recent figures (UNAIDS and WHO, 2007) show that the rate of new infections has stabilised in all three countries with Lithuania reporting 100-135 new infections per year, Latvia 300-320 and Estonia just over 600. Estonia continues to have the highest rate of newly-reported HIV diagnoses in Europe at 504 per million and the highest adult HIV prevalence rates of 1.3%<sup>2</sup>.

The most common reported transmission route for HIV in the three Baltic States remains injecting drug use. In addition, there are high rates of HIV infection in prison settings in the three countries:

- Estonia has an HIV prevalence among prisoners of between 8.8-23.9%
- HIV prevalence in Latvia prisons has been documented as 6.2%.
- Lithuania experienced a well-documented outbreak of HIV in prisons in 2002 as a result of injecting drug use. During that period, more than 250 new HIV infections were detected. In 2006, HIV prevalence in Lithuanian prisons was reported to be 2.1%

This is of particular importance because the Baltic States have the highest rates of imprisoned people per 100,000 population within the European Union (Stöver, 2008)<sup>3,4</sup>.

## BACKGROUND

Approved at the end of 2006, the UNODC project, entitled HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania, will last for four years. It is worth US\$5 million provided by the Dutch government. The project is managed from a UNODC project office in Vilnius through cooperation with the Estonian Ministry of Social Affairs, and the Latvian and Lithuanian Ministries of Health, which act as focal points for the project in each country.

The **goal** of the project is 'to establish a favourable environment in all project countries to better implement HIV/AIDS prevention and care activities among injecting drug users and in prisons through addressing normative policy, capacity building and programmatic aspects of national HIV/AIDS prevention activities' (UNODC, 2006). The project's **objectives** are to:

- Build national and regional consensus on effective implementation strategies to address HIV/AIDS among IDUs and in prisons
- Increase coverage of comprehensive HIV/AIDS prevention and care services among IDUs and in prison settings

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<sup>2</sup> For more detail, see NIHD, 2008c

<sup>3</sup> Estonia 388, Latvia 333, Lithuania 227 and EU average 122

<sup>4</sup> According to figures supplied by UNODC, Lithuania has 8,000 prisoners in 15 prisons; Latvia has 6780 in 12 prisons and Estonia has 3676 in 6 prisons.

- 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

The project's **implementation strategy** envisages:

- Involvement of all governmental and non-governmental stakeholders in project design, implementation and monitoring
- A study tour by policy makers, service providers to countries which provide comprehensive HIV prevention and care services for injecting drug users and in prisons
- Completion of comprehensive baseline measurements and needs assessments across all framework elements
- Reviews of the legislative, administrative and operational environments, followed by normative advocacy and assistance in redrafting
- Development and introduction of relevant tools, training curricula, accreditation and quality control protocols
- The establishment of a regional capacity-building centre and information network
- The establishment of a critical mass of trained and accredited service providers
- Introduction of comprehensive interventions for injecting drug users and in prisons
- Independent mid-term and end of project evaluations

## **EVALUATION PURPOSE AND OBJECTIVE**

The project document (UNODC, 2006) envisaged mid-term and end-of-project evaluations. The overall purpose for this mid-term evaluation is to learn lessons from project implementation to improve future project planning, design and management. This includes measuring progress towards achievement of the expected outcomes and assessing the measures that the project has put in place in order to create a positive impact in the future. The scope of the evaluation is clearly stated in the terms of reference (See Annex 1, p35).

## **EVALUATION METHODS**

More details of the methods used for this evaluation are found in the terms of reference (see Annex 1, p35) and the inception report for this evaluation (see Annex 4, p46). A review of project and related literature was conducted. Details of all documents reviewed are given in Annex 3 (p42). Primary data collection was conducted mainly through semi-structured interviews with key national-level informants using a topic guide derived from key questions listed in the terms of reference. A list of potential respondents was prepared by UNODC regional office and agreed with the evaluator prior to starting the interviews. This was later modified to accommodate additional respondents as identified and requested by the evaluator. Almost all interviews were conducted in English. In a small number of cases, the respondent preferred to answer in a national language or Russian. In these cases, translation was provided by UNODC staff or another respondent. For most interviews, the evaluator was accompanied by a UNODC staff member. This

facilitated logistics, introductions and the establishment of rapport. It also enabled useful three way discussion of emerging topics and clarification of relevant facts. In most cases, respondents were offered the opportunity to speak to the evaluator without a UNODC staff member present if they wished.

In addition to national-level informants, the terms of reference provided for interviews with representatives of UN agencies in the Baltic States. These were conducted. In addition, there was provision to discuss issues by phone with UNODC HIV/AIDS unit. This was done and this call also included a representative of UNODC's Independent Evaluation Unit. It was also agreed that the evaluator would interview the Dutch government who are funding the project, a number of selected consultants who had worked closely with the project and a number of key regional partners, such as WHO Euro and EMCDDA. A full list of people interviewed is provided as Annex 2 (p40).

Country visits were conducted between 10-17 December 2008 for Estonia and Latvia, and between 5-9 January 2009 for Lithuania. At the end of each set of country visits the evaluator produced exit minutes which were discussed with the project's regional coordinator. A preliminary report was drafted and circulated to UNODC for comments. A presentation of findings was made at a regional meeting on 29<sup>th</sup> January 2009. Comments received were incorporated into the final report.

As with all evaluations of this nature there were a number of **limitations** to this evaluation:

- Time in each country was limited. However, it was considered sufficient given the evaluator's previous knowledge of the responses to AIDS in these countries and previous evaluative activities within the project
- Selection of respondents was largely done by UNODC project staff. However, an effort was made to do this in a purposive manner to ensure all views were represented, particularly those which were considered likely to be negative or critical of particular elements of the project
- Interviews were conducted in English except where respondents expressed a preference to respond in another language. High levels of English language and translation skills in the countries visited minimised the risk of significant misunderstandings occurring. The format of semi-structured interviews allowed the evaluator to check accuracy of understanding of key points
- Most interviews were conducted with a UNODC staff member present. However, this was done at the request of the evaluator who considered the benefits of having the staff member present outweighed any possible inhibitive effects of their present.

It is the view of the evaluator that these limitations were relatively minor and that they do not materially affect the findings and conclusions of this evaluation. In particular, the time available and the number of people interviewed were considered sufficient to fulfill the purpose of the evaluation.

## MAJOR FINDINGS

### UNODC Priority and Comparative Advantage

According to the UN's Joint Programme on HIV and AIDS' (UNAIDS') agreed division of labour, UNODC has lead responsibility for HIV-related services among injecting drug users and in prison settings (UNODC, undated). This project fits extremely well within that responsibility. In addition, the project builds on UNODC's comparative advantage, both as a UN agency and, specifically, as UNODC. As a UN agency, in the Baltic States, UNODC enjoys considerable convening power and is seen as having 'weight' in policy dialogue. An advantage enjoyed by UNODC, specifically, is its credibility within the criminal justice system because of its known focus on issues of drugs and crime. For example, in Lithuania, NGOs reported that UNODC was able to 'open doors' within the prison system that had previously been closed to them.

Respondents also identified a number of features of UNODC's overall approach to this project which they considered to have been extremely important in terms of progress achieved. These include:

- A **collaborative approach** with other agencies, including other UN agencies, such as WHO. In addition, UNODC was seen as having built dialogue and consensus among a number of stakeholders who previously may have been competing with each other
- Promoting **neutrality, professionalism and reliance on evidence-based approaches**
- A **long-term, diplomatic, incremental and persuasive approach** to solving problems and reaching consensus
- A **flexible and country-driven approach to financing**

### Objectives: Relevance and Attainability

Almost all respondents saw the project's objectives as highly relevant to each of the three countries. Not only do the objectives fit well with UNODC's areas of responsibility, but the project also is extremely appropriate for the needs of each of the countries' responses to HIV and AIDS. The project recognises that in each of these countries, injecting drug users are disproportionately affected by HIV, and that prison settings are important, both as a context in which there is a risk of HIV transmission and as an environment in which there are a disproportionate number of PLWH.

Several respondents expressed concern that the objectives were over-ambitious given the difficulties of implementing effective HIV programmes in prison settings. Many recognised that progress in prison settings was likely to be slow and gradual in comparison to community settings. Similar views are found in relevant literature (Jürgens et al., 2009; UNODC et al., 2008). However, respondents commented that

the environment for such a project was more positive in the three Baltic States than in some other countries, e.g. Russia.

A small number of respondents expressed concern about the project's objectives. One would have liked to have seen more focus on advocacy and supporting NGOs in this role. Another was concerned that the objectives were unduly driven by a 'Dutch agenda' of promoting harm reduction rather than a genuine focus on HIV prevention. However, this latter point was a minority view. Almost all respondents regarded the project objectives as highly appropriate for the context of the responses to HIV and AIDS in the three countries.

## **Progress Towards Objectives and Results**

In addition to the project's objectives, the terms of reference for this evaluation (see Annex 1, p35) also refer to intended results, namely:

- Capacity building of governmental and non-governmental organisations to better address HIV and AIDS among IDUs and in prison settings. This includes assessment of the project's contribution to human and institutional capacity building
- Increase in coverage of comprehensive HIV prevention services for IDUs
- Amendment of national HIV/AIDS strategies and action plans.

Given the similarity of these to objectives<sup>5</sup>, this section explores the project's progress towards both objectives and results. Brief comments are included here with more country-specific detail presented in tables 1, 3, 4 and 5.

Overall, across the countries, there appears to be growing **consensus** about the centrality of harm reduction measures within responses to HIV and AIDS. The project is appreciated for having supported the first large-scale conference on harm reduction centres to involve these countries and key agencies, such as EMCDDA, UNODC and WHO. Harm reduction is firmly on the political agenda in each country and there has been more debate and discussion of the issues among stakeholders. Some stakeholders have re-evaluated their opinions on the topic in light of these debates. The need for opioid substitution therapy as part of a national response to an HIV epidemic driven by injecting drug use is now widely-recognised. There is also recognition of the need to change old policies to allow new practices in each country. However, progress in the prison sector has been considerably slower than in the community. A number of respondents from within the criminal justice system expressed reluctance and/or opposition to the introduction of harm reduction elements, particularly needle and syringe programmes in custodial settings. Given the principle of equivalence between available health services in community and prison settings, this is a continued cause for concern. For more country detail see table 1 (p11).

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<sup>5</sup> For example, one of the objectives is to 'increase coverage of comprehensive HIV/AIDS prevention and care services among IDUs and in prison settings' and the intended result is an 'increase in coverage of comprehensive HIV prevention services for IDUs'

**Table 1: Progress Towards Building Consensus in Baltic States**

Estonia	Latvia	Lithuania
<p>There was perhaps more consensus on these issues in Estonia, than in other countries, prior to the start of the project related to previous funding received from the Global Fund to Fight AIDS, TB and Malaria.</p>	<p>There are concerns that the growing consensus on MMT has not yet been translated into expanded services.</p>	<p>Attitudes towards harm reduction measures have changed. There is less public criticism and less questioning of the need for services, e.g. from municipalities. There is growing consensus around the value of MMT in the community.</p>
<p>An area of growing consensus has been the need for common concepts, standards and approaches in the provision of MMT, building on existing work of the Psychiatrists' Association. Further work on this is planned.</p>	<p>In the contexts of prisons:</p> <ul style="list-style-type: none"> <li>• The establishment of a project technical working group increased dialogue between the Ministry of Justice, prisons, the probation service and NGOs</li> <li>• Although there has been more dialogue between the Ministries of Justice and Health, the latter appears reluctant to take a greater role on health in prisons without considerable additional financing</li> <li>• The existence of separate structures, e.g. Ministry of Justice and Prison Administration increases the complexity of achieving consensus</li> <li>• Attitudes of key individuals are crucial in determining progress towards consensus</li> <li>• The value of NGOs working in prisons is increasingly recognised. There appears to be some competition among NGOs. There are concerns that not all NGOs have professional skills required to work in prisons. Relationships between prison administration, individual prisons and individual NGOs are reported to vary in strength.</li> <li>• Some NGOs report feeling that government does not see them as equal partners.</li> </ul>	<p>The project has brought together people from different sectors through the project steering committee. This appears to have been more successful in this regard than other national structures, e.g. the Coordinating Committee for National AIDS Programme.</p>
<p>The project has been slowly building consensus around approaches to HIV prevention in prisons, including:</p> <ul style="list-style-type: none"> <li>• The valuable role played by NGOs in prison settings, e.g. in terms of setting up supported groups</li> <li>• Creating dialogue between key players including NGOs, the National Institute for Health Development and the Ministries of Justice and Interior</li> <li>• Promoting dialogue about the need for harm reduction services, particularly MMT, in prisons and arrest houses</li> <li>• Establishing advocates for harm reduction services within the criminal justice system, e.g. through a study tour to Germany but this circle is narrow and turnover of staff is considerable</li> <li>• Training prison staff on principles of harm reduction</li> </ul>		<p>Within the prison system, NGOs report appreciating being treated as partners by the prison administration. Dialogue has started with the Ministry of Justice and the Prisons Department about the need for harm reduction services. Officials are willing to attend meetings to discuss these services. However, there are concerns that there has not yet been progress beyond these conversations. There is currently no consensus over the need for MMT and needle and syringe programmes in prison settings. Concerns of the Ministry of Justice and Prisons Department are both conceptual and practical.</p>

It is difficult to assess progress made by the project in increasing **coverage** of key services because of the absence of adequate quantitative measures of this in the project document (UNODC, 2006). Some measures have been suggested<sup>6</sup> but these are not yet systematically monitored and reported by the project. Table 2 (p12) shows estimated coverage levels of key services at the start of the project and a comment on current levels of coverage. At the start of the project, coverage of needle and syringe programmes was considered higher in Estonia than in other countries because of the legacy of Global Fund financing<sup>7</sup>. Expanded sites in Latvia and Lithuania, as a result of the UNODC small grants programme (Sarang, 2008; Stuiyte, 2008) do not seem to have resulted in significant increases in coverage numbers, although there are some positive signs, e.g. modest increase in number of syringes distributed in Latvia<sup>8</sup>. Coverage of MMT remains low in all three countries. Discontinuity of services between the community and prison settings is a major constraint on increasing effective coverage of programmes. More country-specific details are provided in Table 3 (p15).

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<sup>6</sup> A small number of indicators from an early draft of the UNODC, WHO, UNAIDS target setting document (WHO et al., 2008) were used to establish baseline data for each country at the start of the project (UNODC, 2008g)

<sup>7</sup> The situation in Lithuania depends on figures for the estimated number of IDUs in Lithuania which is seen as something between 3200 and 11000 (Sarang, 2008; Hay, 2008)

<sup>8</sup> It would appear that clients in Latvia are taking more syringes than they used to. These might be for their own use or for secondary distribution. However, it should be noted that the number of needles and syringes distributed per IDU in Latvia remains very low (see table 2 and footnotes 18 and 19).

**Table 2: Estimated Coverage of Key HIV-Related Services for IDUs**

Indicator	Estonia		Latvia		Lithuania	
	Baseline	Current	Baseline	Current	Baseline	Current
Percentage of IDUs regularly reached by needle and syringe programmes <sup>9</sup>	Medium <sup>10</sup>	No new data	Low <sup>11</sup>	Static (see Fig 1, p14) <sup>12</sup>	Medium to Good <sup>13</sup>	Unchanged <sup>14</sup>
Syringes distributed per IDU per year <sup>15</sup>	Medium <sup>16</sup>	Increase <sup>17</sup>	Low <sup>18</sup>	Slight increase <sup>19</sup>	Low <sup>20</sup>	Decreased <sup>21</sup>
Percentage of opioid treatment slots against number of opioid injectors <sup>22</sup>	Low <sup>24</sup>	Modest increase <sup>25</sup>	Low <sup>26</sup>	Modest increase <sup>27</sup>	Low <sup>28</sup>	Approximately the same <sup>29</sup>

<sup>9</sup> High = >60%, medium = 20-60%, low = <20%

<sup>10</sup> 7169/13800 = 52%

<sup>11</sup> 6-800/10000 = 5-8% (UNODC, 2009b)

<sup>12</sup> 690/10000 = 7% (UNODC, 2009b)

<sup>13</sup> 3354. For note on denominator see footnote 28. Figure provided by UNODC, 2009b is 3400 for 2006

<sup>14</sup> 3397 in 2007

<sup>15</sup> High = >200, medium = 100-200, low = <100

<sup>16</sup> 1606889/13800 = 116

<sup>17</sup> 2033243/13800 = 147 (UNODC, 2009b)

<sup>18</sup> 117237/12000

<sup>19</sup> UNODC, 2009b gives figure for 2008 of 182019 = 18 per person per annum

<sup>20</sup> 258650. Depending on denominator figure (see footnote 28) figure is 24-81

<sup>21</sup> 187227 in 2008

<sup>22</sup> All three countries use estimated total number of IDUs as baseline

<sup>23</sup> High = >40%, medium = 20-40%, low = <20%

<sup>24</sup> 555/13800 = 4.0%

<sup>25</sup> 670/13800 = 4.8% (UNODC, 2009b)

<sup>26</sup> 124/10000 = 1%

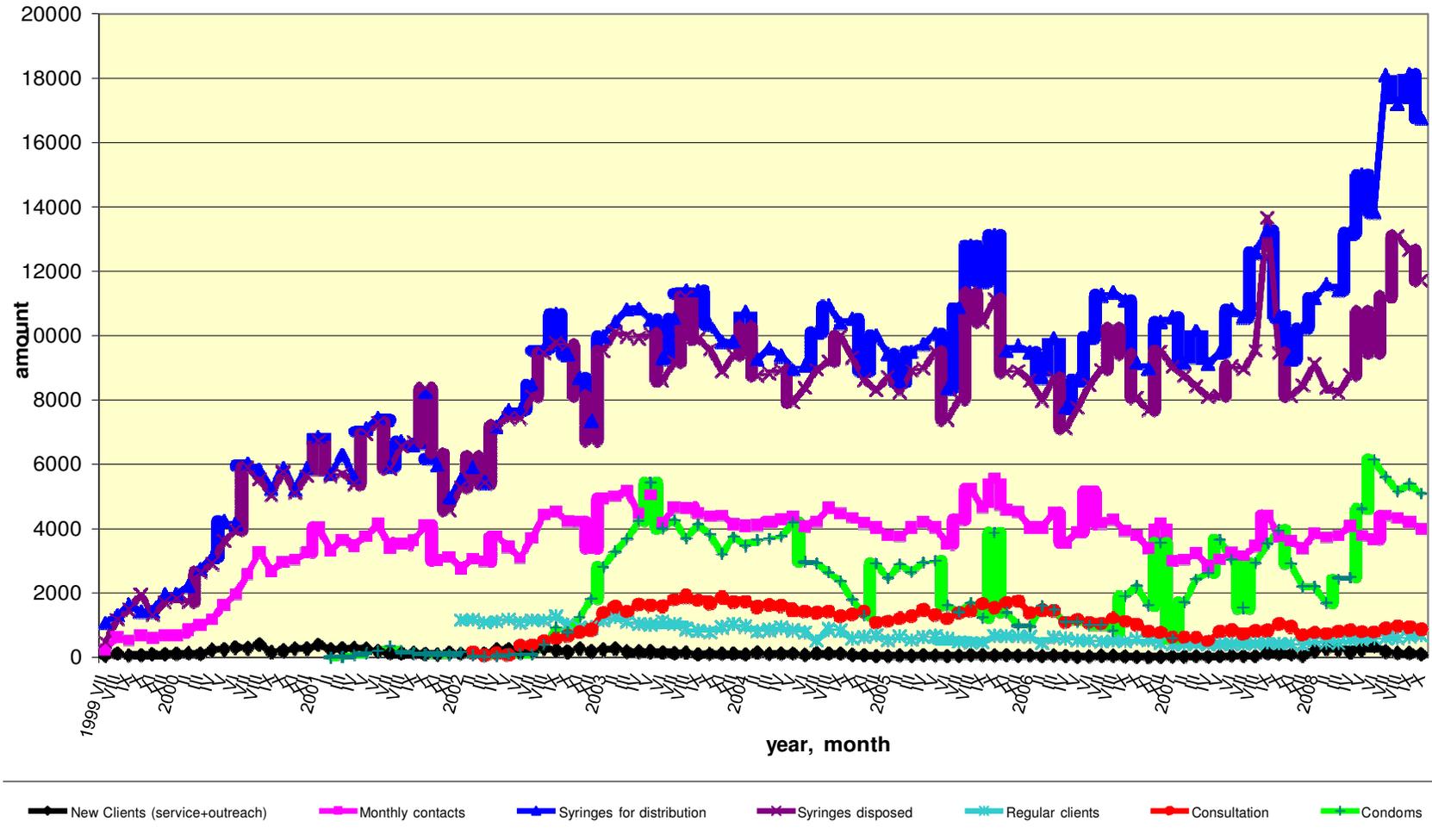
<sup>27</sup> 164/10000 = 1.6% (UNODC, 2009b)

<sup>28</sup> Various figures exist for both numerator and denominator. UNODC, 2008g gives a numerator of 402. In 2000, the Drug Control Department reported 340 people receiving MMT. Sarang, 2008 uses three different figures for number of IDUs in Lithuania – 3200, 6831 and 11000. UNODC, 2009b uses numerator of 402 and denominator of 10000.

<sup>29</sup> From 2000 to 2004, the number of people receiving MMT according to the Drug Control Department rose from 340 to 436 but it fell again to 395 in 2007. According to UNODC, 2009b, the number of people receiving MMT was 512 out of a total number of IDUs of 3200.

**Figure 1: Data of Low Threshold Centres: Latvia 1999-2008**

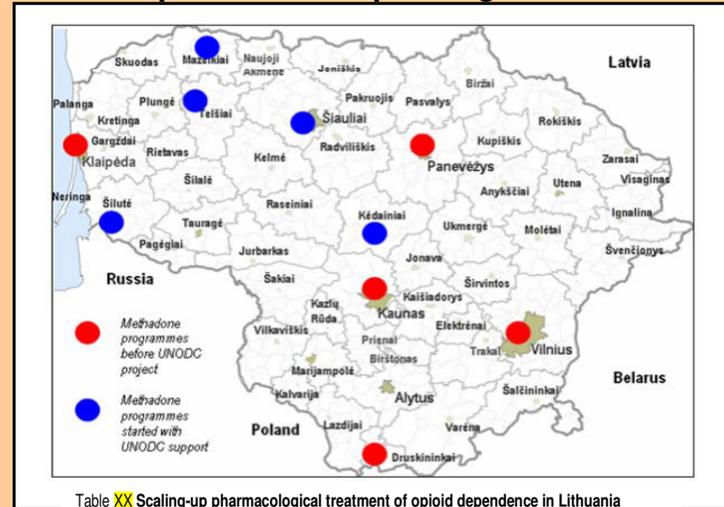
Data of Low - threshold program activities in Latvia 1999. VII - 2008.X  
(AIDS Prevention Center)



**Table 3: Notes on Coverage of Key Services**

	<b>Estonia</b>	<b>Latvia</b>	<b>Lithuania</b>
Overall	As coverage increased considerably with Global Fund support, focus has been on ensuring services, e.g. MMT are of necessary quality.	Perceived increases in coverage through small grants programme (Stuikyte, 2008).	Perceived increases in coverage through small grants programme (Sarang, 2008).
MMT	Concerns about quality of services (Subata, 2007 and UNODC, 2008b) and non-availability of services in prisons and arrest houses.	MMT remains restricted to one centre although there are plans to expand. No provision in prison settings.	Sites for MMT expanding (see Box 1, overleaf)
Needle and syringe programmes	Project has supported new approaches to increasing coverage, e.g. secondary exchange.	Project has supported expansion of low threshold centres and the introduction of mobile services.	Expansion of low threshold centres.
Antiretroviral therapy	Concerns about daily access to treatment in prisons.	Significant problems experienced with supply of antiretroviral therapy. Review planned in 2009. Prisons report recently being asked to pay for diagnostic tests whereas previously these were financed by the Ministry of Health.	Problems of antiretroviral therapy in prisons because drugs have to be purchased from the Prison Department's healthcare budget. Treatment and prevention of opportunistic infections not covered by health insurance fund.
Condoms in prisons	Increasingly restricted because of concerns among prison staff that condoms promote violence in prisons.	NGOs report that they are no longer allowed to distribute condoms in prisons. They are available for purchase in shops.	Reported to be available for long-term visits and for purchase in shops.
Others			Concern over access to HIV tests for IDUs. Free tests for IDUs only available from addiction centres.

### Box 1: Experience of expanding MMT in Lithuania



The programme in Telšiai was started as an initiative of two current clients that were going through detoxification and methadone maintenance in Klaipėda. The clients wanted to have similar services in Telšiai and discussed that with the Director of JSC Samogitian Mental Health Centre which provides treatment services for drug users. With the advice and support from the Vilnius Center for Addictive Disorders, the Director decided to write an application for a UNODC grant. This program was approved and the programme started. The grant allowed renovation of the centre's premises and purchase of additional equipment to allow the programme to start. Renovations including improving window security, purchase of a safe, methadone dosage equipment, methadone and drug tests. The grant also allowed training of the programme staff in provision of MMT. Savings from buying medications were used to buy a treadmill for clients. The programme currently provides substitution treatment to ten clients, who also organised a self support group and are discussing registering an organisation which would allow them to run separate activities and promote their health and social rights and interests. (Sarang, 2008)

The project has contributed a great deal to the increased availability of **strategic information** through supporting a number of studies and reviews (see Table 4). Respondents in Estonia commented that conducting these studies through national agencies is helping to develop a culture of evaluation and national expertise/experience of conducting evaluations. There are some concerns that strategic information is not always being used to shape the national response, e.g. in Lithuania (ASAP, 2008).

**Table 4: Studies Supported by UNODC Project**

Estonia	Latvia	Lithuania
<p>Ongoing work to describe all the conducted by Convictus in prisons since 2003</p> <p>Evaluation of fighting HIV/AIDS in Estonia in collaboration with WHO</p> <p>Evaluation of national responses to HIV and AIDS in prison settings</p> <p>Evaluation of HIV/AIDS interventions for injecting drug users</p> <p>Review of MMT (about to be published).</p> <p>Planning an evaluation of drug-free rehab</p> <p>Need for new work on levels of hepatitis, syphilis and HIV in prisons given change of prison types.</p>	<p>Evaluation of MMT provision.</p> <p>Rapid assessment of drug use in prisons</p> <p>Legal assessment</p> <p>Unable to complete study on estimation of IDU population size because of difficulties in getting information from agencies because of issues related to data protection.</p> <p>Report of twinning project (Stöver et al., undated) looking at HIV in prisons</p> <p>Evaluation of small grants programme</p>	<p>Rapid assessment of drug use in prisons (UNODC and Prison Department, 2008) which confirmed significant rates of drug use in prison</p> <p>Estimation of IDU population size (Hay, 2008). This report is seen as useful in building consensus on numbers of IDUs in Lithuania.</p> <p>Assessment of legal barriers in prison (Juodkaitė et al., 2008)</p> <p>Also some examples of agencies doing own surveys, e.g. Alytaus Correction House who did a survey of 232 inmates</p> <p>Assessment of availability of syringes through pharmacies</p> <p>Access to VCT in Lithuania</p> <p>Access to ARV in Lithuania</p> <p>Evaluation of small grants programme</p>

The project has supported a number of **capacity building** activities. For example, in 2007, the project supported:

- Training for 375 people
- Study tours for 51 people
- Meetings of 458 people
- Participation of 24 people in professional networks (UNODC, 2008a)

Observations on country-based capacity-building are provided in Table 5. In addition, respondents reported that the project had promoted cooperation and exchange of expertise between countries, e.g. role of Emilis Subata on MMT.

**Table 5: Observations on Capacity-Building Activities in Baltic States**

Estonia	Latvia	Lithuania
<p>In <b>prison settings</b>, the project has provided training for staff. In addition, seminars and training have been held with the Ministry of Justice focused on understanding their role in supporting NGOs after the end of Global Fund financing. Convictus also report that the project has built their reputation, and that this has been recognised more by individual prisons than the Ministry of Justice centrally.</p> <p>The project has also built the <b>professional capacity</b> of the National Institute for Health Development and enhanced the reputation of the Estonian Drug Monitoring Centre.</p> <p>The main role of <b>small grants</b> in Estonia has been to initiate new activities.</p> <p>It was reported that <b>international input to training</b> is valued but that it could be better coordinated with national services.</p> <p>Overall, professionals have <b>increased knowledge</b> and their use of knowledge.</p>	<p>In <b>prison settings</b>, training has been provided for prisoners and prison staff. The project has also provided opportunity for projects to start activities.</p> <p>The project has supported 26 <b>small grants</b> in two batches. These are operated by NGOs, municipalities, prisons and hospitals (UNODC, 2008k/l). NGOs have particularly valued this support because of limitations in other sources of income.</p> <p>Support for <b>international experts</b> to come to Latvia has been reported to be helpful, e.g. outreach training provided by EHRN (EHRN, 2008).</p> <p><b>Training</b> was provided on addiction severity index</p> <p><b>Exchange visits</b> have been valued, e.g. to Finland. This led to introduction of a mobile unit</p> <p>A <b>manual</b> was produced entitled risk reduction amongst IDUs in prisons (Papardes Zieds, 2008)</p> <p>However, <b>capacity of NGOs</b> remains low. For example, they report problems in dealing with funders' bureaucracy.</p> <p>There have been <b>other capacity-building efforts</b>, e.g. from a European Commission project focused on raising the capacity of low threshold centres.</p> <p><b>Training on MMT</b> for drug dependence treatment practitioners.</p>	<p>The project has supported <b>training of prison staff and the police</b> (UNODC, 2008m). As a result, knowledge has increased among prison staff.</p> <p>The Ministry of Justice values the <b>small grant scheme</b> because it has supported educational and methodological work; trainings; seminars; study visits and continuation of projects.</p> <p><b>Exchange visits, conferences and expert visits</b> have been useful to see good practice in other countries</p> <p>The project has contributed to <b>building NGO capacity</b>. This is considered important because of the limited NGO traditions in Lithuania and the limited nature of support from the state sector to NGOs. For example, the Ministry of Justice reported a lack of available NGOs to work in prisons. A recent review of small grants concluded that the programme should continue work to build NGO capacities (Sarang 2008). Particular areas of need appear to be the building of advocacy and management capacity.</p> <p><b>Training on needle and syringe programmes</b> and advocacy provided by Eurasian Harm Reduction Network.</p>

Of course, the question may be raised as to what outcomes have been produced as a result of these outputs, that is, the behaviour change as a result of project's capacity building activities. It is difficult to answer this question with any degree of rigour. This is not only the case for this project but also for others aimed at building capacity. This is because of limited availability of agreed metrics of increased capacity. For example, pre- and post-test questionnaires only measure short-term knowledge, are subject to very significant biases and say nothing about skills or

practice. It is possible to say that the project has resulted in the introduction of new community services and that respondents believe that the project's training has been very valuable in this regard. However, it is more difficult to say whether the increased capacity has resulted in increased coverage of services because of the absence of agreed quantitative measure of coverage. Similarly, it is not clear if quality of services has improved as this has not been formally assessed, e.g. through user surveys. In terms of harm reduction services in prisons, the capacity building activities appear to have contributed to increased dialogue and the introduction of some education activities. However, there has not yet been progress on critical elements, such as the introduction of methadone maintenance therapy or needle and syringe programmes to ensure equivalence with community services. Overall, it does appear that the capacity building activities are highly appropriate for a project of this nature.

The project has supported development of new **national strategies/programmes** in Latvia and Lithuania. In **Latvia**, the previous programme ended in 2007. A review of this was conducted in 2006, with support from WHO, and a new draft developed. However, this made little reference to IDUs or prison settings. Peer review was proposed through ASAP and an international team assembled. This led to major change in the document, which was more inclusive of IDUs and prison settings. The proposed programme is seen as very progressive and focused. However, there have been difficulties and delays in compiling the budget. As a result, the document has not yet been approved although it is expected that this will be done early in 2009 (Alban and Mieztis, 2007; ASAP, undated, a; ASAP, 2008; Cabinet of Ministers, 2007; Gotsadze, 2007; Grund, 2007).

In **Lithuania**, the project also supported technical review of the proposed new national programme on HIV, AIDS and sexually transmitted infections. This also concluded that there needed to be a stronger focus on IDUs rather than the general population, given the epidemiology of the epidemic in Lithuania. The project has also sought to support those responsible for the development of the new programme to adhere to agreed deadlines and to adopt a consultative process to programme development. Nevertheless, progress has been slow. It was reported that the Ministry of Health had left the process almost completely to the National AIDS Centre and it was feared that this perceived lack of leadership had contributed to delays. Concern was expressed that respondents did not know the status of this programme or when it might be expected to be adopted.

### **Usefulness of Results**

The usefulness of the results and outcomes of this project is tied very closely to the relevance of the project's objectives (p9). The results of the project so far mean that there is greater consensus about the importance of IDUs and prison settings in the HIV epidemic in all three countries and the central importance of harm reduction activities in national responses to HIV and AIDS. This has resulted in a more focused and progressive national programme in Latvia with hopes of a similar result in Lithuania. In addition, increased capacity of key players, such as government agencies and NGOs means that programmes are likely to be more effective and to reach more people.

## **Likely Impact**

If these results are realised, it is likely that they will result in reduced HIV transmission among injecting drug users and in prison settings in Baltic countries. However, it may be difficult to attribute any change in HIV transmission directly to project activities. However, it would be reasonable to conclude that those activities may have contributed something to any observed change. Because of different starting points, in terms of the scale of national epidemics and responses, and differing rates of implementation, countries may experience differing impacts from the same project.

## **Sustainability**

Although respondents are hopeful that the benefits of the project will continue after the end of the project, it appears that this issue has been given less attention than the more pressing issue of enduring that the project delivers immediate results.

In general, most respondents expressed the view that national governments should take on responsibility for activities started by the project when it ends. In Estonia, this seems likely to happen because the scale of project activities is relatively modest and the Estonian government already fulfilled the commitment to continue those activities started with financing from the Global Fund.

The situation in both Latvia and Lithuania is less clear, particularly in the context of this current global economic crisis. Although one respondent saw the current financial crisis as an opportunity to make critical decisions about most effective priorities to pursue in terms of responding to HIV and AIDS, all other respondents were extremely concerned that current economic realities made it extremely unlikely that governments would be unable to sustain project activities once funding through UNODC ends.

One question which arises is whether there is sufficient 'political commitment in the three countries to ensure that these activities continue and that there is an effective national response to HIV and AIDS. However, political commitment is multi-faceted. Table 6 (p22) seeks to analyse elements of this in order to decide where support might be most appropriately focused.

Two areas of project activity should perhaps be scrutinised in terms of implications for sustainability. First, the establishment of project steering committees in both Latvia and Lithuania is widely seen as having had beneficial effects in terms of project planning and implementation, and also in terms of improving coordination between different actors. However, the latter function should ideally be part of a national coordination process which is not bound to a time-limited process. Indeed, even project-specific processes could be handled by a sub-committee of an effective national coordinating authority if one was in place. It is of concern that considerable time and effort is being expended in developing a steering committee which will cease to function when the project ends with significant risk of loss of learning and capacity. In addition, although some respondents reported that they thought that UNODC was playing a useful coordination role itself, concerns need to be raised about the appropriateness of UNODC taking on such a role.

Second, the grant programmes in both Latvia and Lithuania are being administered directly by UNODC. Considerable time and effort is being expended in developing UNODC's systems for managing such a small grants programme and in building capacity of grant recipients to meet UNODC requirements. Unless such systems are transferable to a more sustainable funding source, e.g. government, it is likely that these systems and associated learning will be lost when the project ends. However, almost all respondents were reluctant to change the mechanism for administering the grants programme or the way funding flows. Government agencies were either unwilling or unable to take on such a responsibility. NGOs and UNODC expressed strong preference for the current system. However, it is the view of the evaluator that failing to address this issue at this stage risks creating more challenges when the project ends and reduces the likelihood of sustainability.

**Table 6: Analysis of Elements of Political Commitment in Three Baltic Countries**

	Estonia		Latvia		Lithuania	
Recognition as political priority	++	HIV recognised as significant priority	-	HIV not seen as high priority	-	HIV not seen as high priority. Prison health care department sees HIV as small part of overall work
Political continuity		No data collected	-	Politicians reported to have short-term perspective	-	Weak – three ministers of health since 2006
Financing	++	Government committed to maintain activities at level supported by Global Fund	-	No clear funding commitment to continue activities started by external donors	-	No clear funding commitment to continue activities started by external donors
Roles and responsibilities clearly defined and communications handled effectively	+	De facto the National Institute for Health Development is playing a leading role but Ministry of Social Affairs could be more proactive	-	Split of responsibilities unclear, e.g. between Ministry of Health, Public Health Agency and other players	++	Strong and proactive leadership from senior officials within the Ministry of Health
National coordination mechanism	+	Reportedly weak. Only met once to adopt national plan	+	National Commission operates and was recently involved in dealing with issues relating to antiretroviral therapy	-	Commission for National AIDS Programme currently not operational as awaiting adoption of new national programme
National coordination capacity	++	National Institute for Health Development has strong capacity as a result of being Principal Recipient of the Global Fund grant	-	Many actors with unclear role. No clear figure of senior leadership	+	Positive step was establishment of drug control department in 2004. Also strong leadership from Ministry of Health
Focus based on epidemiological evidence	++	Strong commitment to focus response on those most vulnerable to infection	+	Reports that new programme is strongly-focused but has not yet been adopted	-	Concerns that new National AIDS Programme lacks focus on most vulnerable
Political environment for providing harm reduction services - community	++	Good – no major political barriers to either needle and syringe programmes or MMT	+	Seems good for needle and syringe programmes but more difficult for MMT	+	More political discussion of harm reduction now. Previously lack of support from politicians at state and municipal level.
Political environment for providing harm reduction services - prisons	-	Some progress on policy, e.g. National HIV Programme, but many within prisons seem to prefer to address issues through security measures	-	Poor –although principal of equivalence of health services in community and prisons is accepted	-	Little progress – some dialogue amongst officials. Position of new Minister of Justice unknown. Introduction of services in prisons requires a political decision

In order to promote increased likelihood of sustainability, it is proposed that new grants have a sustainability assessment and preference is given to projects with higher likelihood of sustainability:

- Level 4 In addition to levels 1-3, funding flows through identified sustainable mechanism
- Level 3 In addition to levels 1-2, sustainable funder is involved in project management and supervision
- Level 2 In addition to level 1, sustainable funder gives in-principle commitment to continue funding activities
- Level 1 Sustainable source of future funding clearly identified and agreed
- Level 0 No identified future funding source

It seems that risks of non-sustainability may be higher for some activities rather than others. Table 7 seeks to analyse these for different activities in Latvia and Lithuania.

**Table 7: Potential Risks of Non-Sustainability of Different Activities in Latvia and Lithuania**

MMT		Low – once services are established they are likely to be continued through Health Insurance Fund
Low Threshold Centres		Moderate – in Latvia and Lithuania there is reliance on municipalities and commitment varies
Prisons		High – very difficult to get harm reduction services started. Politically sensitive and vulnerable to low budgets. Less contentious services, such as education and training are more likely to be sustained.
NGO services		High – particularly in prisons and for advocacy activities

In addition to establishing mechanisms for funding to be channelled after the project ends, it is crucial that in-country advocates call on government to provide funds to sustain services started by external partners. NGOs have a clear role to play in this regard. For example, Estonian NGOs played a pivotal role in advocacy with government for continuation of services started with finances from the Global Fund. NGOs in other countries seem more passive and resigned on this topic, concerned about how small they are and that no-one listens to them. As a result, most NGOs in Latvia and Lithuania live from hand to mouth.

Little work has been done to develop the ability of NGOs in Latvia and Lithuania to raise funds on a sustainable basis. Estonian NGOs have had some success in raising funds from government but they would also benefit from further work in this area. Currently, NGOs are excessively dependent on international donors and it is likely that this source of funding will further reduce. Most NGOs do not have fundraising strategies. These need to be developed considering the following possible sources of funds:

- International foundations – currently there are very few of these

- EU structural funds – these are difficult to apply and administer particularly for NGOs with limited administrative capacity
- Businesses – it is likely that funding from business will reduce during the current economic climate. It is reported that they favour certain types of NGOs
- Individual – currently, this is not well-developed in the region. It is, however, one of the main sources of NGO income in other European Union countries
- Government – currently very little government funding flows through NGOs, except in Estonia. This is a major source of NGO funding in other EU countries

## Problems and Constraints

This section briefly considers problems and constraints which affected the project as a whole. A number of country-specific problems are explored in Table 8 (p24). The project took longer to initiate than originally envisaged. This issue is explored more fully in the section on planning, implementation and management (p26).

Many respondents referred to the **adverse economic environment** globally. Not only does this undermine the likelihood of sustainability of project activities (see p20) but there is a significant risk of project funds being used to cover deficits in state budgets. Many examples were given of this happening, particularly the use of funds from the small grants programme to renovate work environments because funds were not available from the state or municipal budget. In Latvia, in particular, there were concerns that the difficult economic situation was one factor delaying the adoption of the new national AIDS programme. One possibility under discussion was that the programme be agreed without a budget and that this would then be approved annually.

At least one respondent reported that many of the challenges of seeking to work in **prison settings** also relate to money. The key principle of equivalence between health services in prison and community settings is difficult to ensure particularly when prison and community health systems are distinct and administered by different ministries. In Latvia, discussions on seeking to bring the prison health system under the responsibility of the Ministry of Health appear to have foundered because of concerns from the Ministry of Health that they would be given additional responsibility without additional financial resources. However, there are undoubtedly other issues which make the introduction of effective HIV prevention programmes, such as harm reduction, difficult in the context of prisons. Hierarchies within justice ministries and prison administrations are often steep and their primary focus is not on prisoners' health but on security. The absence of a common approach to harm reduction in prisons across the European Union was also given as a reason why the prison system in the Baltic countries has been reluctant to introduce harm reduction measures.

Finally, one respondent identified specific challenges of seeking to develop effective national response to HIV and AIDS in **small countries**. There is often a small pool of people and organisations. So, an influential person or organisation can be a significant bottleneck to project implementation, particularly where they have entrenched positions on issues of specific relevance to the project.

**Table 8: Problems and Constraints Affecting Project Implementation in Individual Countries**

Estonia	Latvia	Lithuania
<p>There are many challenges to work in <b>prison settings</b>. One NGO reported that although the Ministry of Justice had committed to support activities at levels supported by the Global Fund, they had made some significant changes, e.g. reduced use of NGOs to train prison staff and the use of local rather than international consultants<sup>30</sup> on antiretroviral therapy.</p> <p>Overall, the biggest barrier to the introduction of harm reduction measures in prison settings was seen to be the attitude of senior staff. These staff see issues mainly in terms of control of access to drugs. Other problems include high turnover of prison staff and the lack of continuity of services between community and prison and vice versa. Services for those released from prison need to be further developed.</p> <p>Other challenges include the <b>changing nature of drug use</b> in Estonia, including the growing use of Fentanyl and amphetamines (Ojanperä, I. et al., 2008; Estonian Drug Monitoring Centre, 2008).</p> <p>Services are limited for some groups of people, including <b>pregnant women and children</b>.</p>	<p><b>Health</b> is reported to be a relatively <b>low priority</b> for the Latvian government. Public expenditure on health is low and expected to decline<sup>31</sup>. As a result, the need for co-payments is likely to increase. Within health, public health, in general, and HIV, in particular, are given relatively low priority.</p> <p>There is <b>limited leadership</b> on AIDS from government, in general, and the Ministry of Health, in particular (see Table 6, p22). There is no single body responsible for coordinating the response to HIV and AIDS. The National Commission on HIV and AIDS has no decision-making power and no budget. Within the Ministry of Health, mechanisms of coordination between different departments are highly formal and of limited effectiveness. Although the formation of a single Public Health Agency is likely to be helpful in this regard, elements within the agency continue to operate largely as separate bodies with the result that efforts risk being fragmented. The recent review of the project's small grants identified the lack of a systematic and harmonised approach to monitoring and evaluation as a significant concern (Stuikyte, 2008).</p> <p>The <b>capacity of NGOs</b> working on HIV and AIDS is weak. They are unduly dependent on short-term project funding.</p>	<p>There are many challenges to work in <b>prison settings</b>. Because of separate budgets and administrative structures, it is difficult to continue services between community and prison settings. This is important because of the high turnover of prisoners. This applies to a range of services including antiretroviral therapy, treatment for tuberculosis and harm reduction services. There is poor referral of drug users on release from prisons to addiction services and there are limited resocialisation services for released prisoners. It is reported that salaries for medical staff are lower in prison settings.</p> <p>Standards of medical ethics appear to be relatively under-developed in the prison context. Medical staff are reported to participate in security searches. All new prisoners are tested for HIV.</p> <p>Although NGOs are increasingly involved in prisons, it is unclear whether access is gained through the prison administration or directly through individual prisons.</p> <p>Several challenges affect <b>NGOs</b> including recent changes in tax laws and limitations of funding from municipalities, who award grants annually. Their procedures mean that there may be a funding gap</p>

<sup>30</sup> A specific concern raised about this was the ability to speak Russian

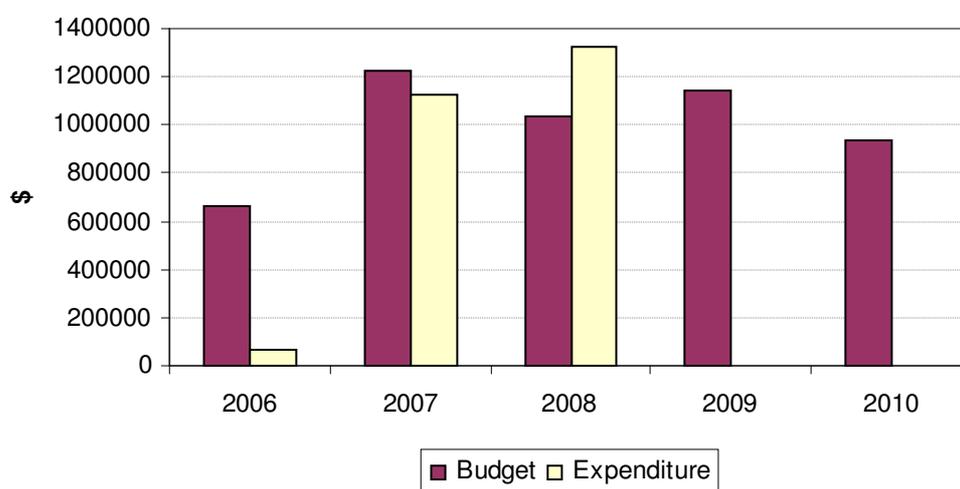
<sup>31</sup> According to the latest available data in the WHO database 'European Health for All' the total health expenditure as a percentage of GDP in Latvia was 6.8 in 2004 and 6.4 in 2005. In Estonia, it was 5.2 in 2004 and 5 in 2005, and in Lithuania 5.7 in 2004 and 5.9 in 2005. In Latvia public sector health expenditure as a percentage of total health expenditure is around 52%, whereas in Lithuania it is around 70% and in Estonia around 77%. Public sector expenditure on health as percentage of GDP in Latvia was 4% in 2004 and 3.8% in 2005. In Lithuania, it was 3.9% in 2004 and 4% in 2005. In Estonia, it was 3.9% in 2004 and 3.8% in 2005. Among European Union member states, the public sector expenditure on health as a percentage of GDP is lower only in Romania.

Estonia	Latvia	Lithuania
	Health issues in <b>prisons</b> are the responsibility of the Ministry of Justice. As a result, the health system in prisons is separated from that in communities and depends on the financial abilities of the Ministry of Justice.	between December and March.  There are some <b>restrictive policies</b> , e.g. a law that prohibits people with a sexually transmitted infection, including HIV, going into social institutions.

## Planning, Implementation and Management

Initially, **project implementation was slower than planned** because of time taken to sign the project document by national governments and to establish project implementation structures. As a result, the initial rate of use of project funds was much lower than planned (see Figure 1).

**Figure 1: Comparison of Project Expenditure<sup>32</sup> and Original Budget**



The project has similar **management structures** in both Latvia and Lithuania, consisting of a project steering committee and main partners with responsibility for particular areas of project work.

In Latvia, the main partners are:

- Riga centre for psychiatry and addiction for MMT
- Public health agency for low threshold centres
- The Ministry of Justice and the prison administration for prisons (UNODC, 2008h)

In Lithuania, the main partners:

- Vilnius centre for addiction disorders for MMT

<sup>32</sup> Figures for 2008 are for eleven months only

- Drug control department for low threshold centres
- The Ministry of Justice and the prison department for prisons
- The Ministry of Health and Lithuanian AIDS Centre for monitoring and evaluation

The project has a 'light touch' management structure in Estonia. There is no project steering committee. UNODC works directly with the National Institute for Health Development and the Ministry of Justice. Table 9 explores issues of project management and coordination in each country in more detail.

**Table 9: Project Management and Coordination in Individual Countries**

Estonia	<p>In Estonia, the project envisaged more involvement of the National HIV and Drugs Coordination Commissions. Although there has been some joint planning, this could be stronger, for example by involving more sectors in a preliminary planning meeting in March each year and finalising those plans in November.</p> <p>Initially, project management in Estonia was 'hectic'. It took time to establish how things would be done. Initially, management was handled by the Development Department of the National Institute for Health Development. However, progress was slow, so responsibility was transferred to the Institute's Research Department. Responsibility has now been transferred back to the Institute's Development Department.</p> <p>Currently, the Ministries of Social Affairs, Justice and Interior all work separately on the project and report independently to UNODC. The National Commission is seen as weak. It meets rarely, e.g. to adopt the national plan and does not coordinate activities on a regular basis. Leadership from Ministry of Social Affairs on issues relating to HIV and AIDS is limited. Turnover of staff responsible for HIV and AIDS in the Ministry of Social Affairs has been high. Although not recognised by all stakeholders, the National Institute for Health Development has considerable management capacity, in part due to its experience of acting as Principal Recipient for the Global Fund grant. However, one area identified that it could strengthen is flow of information to community partners.</p>
Latvia	<p>In Latvia, the original plan was to use the National Coordination Committee on HIV and STI for coordination and oversight of project matters. However, this did not work well because the committee lacked initiative and was considered too big. Consequently, the Ministry of Health and UNODC established a small steering group with representatives from three agencies. The committee seeks to ensure a common approach to the project and to solve any problems that may arise, e.g. delays in decentralising methadone provision. There are some concerns that the steering committee has no NGO representatives. There are also concerns about whether the lead partners are the most appropriate for each topic, e.g. MMT. The efforts and approach of the regional UNODC coordinator are appreciated, as is the fact that she speaks Latvian. There is reported to be good coordination between UNODC and ENCAP<sup>33</sup></p>
Lithuania	<p>In Lithuania, the steering committee has established a clearer, more transparent planning process. The committee meets two to three times per year. In addition to planning, it provides advice to the project and reviews progress. It also allows discussion of sensitive issues. There were some problems with the first grants competition with concerns that there had not been enough information available and that the budgeting process had not been fully transparent. It was reported that UNODC had 'underestimated how structured, careful and clear things need to be'. However, UNODC responded and addressed these issues. Generally</p>

<sup>33</sup> A European Commission-funded project that ends in June 2009. It is worth €1m over 3 years. It is also working in Estonia, Lithuania, Bulgaria and Finland

	<p>things function well now although there is sometimes delay in getting materials.</p> <p>There are reported to be problems with national coordination structures. Neither of the commissions for the national drugs or HIV/AIDS programmes works well. In particular, there are concerns that these commissions are not fully inclusive of all actors, and that power resides in the hands of a few individuals. The project steering committee is considered to have more diverse representation than the commissions. In addition, the commissions have no decision-making authority, so real power lies with ministries.</p>
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A valued feature of UNODC’s approach to project management is its flexibility in responding to country needs. For example, UNODC responded to the issue of drug-related deaths in Estonia by supporting materials development. In addition, NGOs, e.g. in Lithuania, appreciate the supportive way they are treated by UNODC project staff. They also report that UNODC’s approach has resulted in improved relations between themselves and the prison administration. The strength of project management was documented in a recent review of the small grants programme in Lithuania. ‘The programme is well-managed and organised in a way that programme grantees receive constant administrative and methodological support (Sarang, 2008). Government partners, e.g. in Lithuania, report that the project is well-managed.

The project has contributed to the increased availability of strategic information (see p17), e.g. through special studies, and has actively integrated this information into ongoing processes, e.g. reporting of national focal points to EMCDDA. However, a significant shortcoming of the project is that it has **no clear monitoring and evaluation framework**. The project document (UNODC, 2006) does have a logical framework as annex 2, but this is weak and is not being used in practice to monitor project performance. This is of particular importance in relation to the project’s objective of increasing coverage of comprehensive HIV/AIDS prevention and care services among IDUs and in prison settings. In order for this to be tracked, the project needs to agree key quantitative indicators to be used for this purpose and to systematically collect and report data for these. As pointed out in the recent review of small grants in Lithuania (Sarang, 2008), this should be done in a coordinated way as part of an overall national system of monitoring and evaluation. In addition, there may be need for additional special studies, e.g. on mapping the extent and quality of services provided through low threshold centres. One concern raised about use of quantitative indicators is that it might not be possible to attribute all of a measured change, e.g. increased coverage of a particular service, to project activities<sup>34</sup>. This should not be of major concern to UNODC because documentation of project activities and the activities of others will allow UNODC to describe the contribution its efforts have made to a particular result.

In the absence of such indicators, it is difficult to assess the adequacy of project reports. To date, these have consisted largely of descriptive narrative combining activities and achievements. These would be strengthened by:

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<sup>34</sup> This is particularly the case for activities which are not direct service provision, e.g. training and standards development. Requiring attribution of results to a particular project significantly increases transaction costs and risks undermining principles of harmonization, alignment and national ownership.

- Including numbers relating to key coverage indicators
- Sharper and more visual analysis of progress to date, e.g. through use of colour coding

At least one respondent identified the need for more ‘hands on’ monitoring, e.g. through project visits.

**Staffing levels** are now considerably greater than the Regional Coordinator and Assistant originally planned. The project has appointed a National Project Officer for each of Latvia and Lithuania. It is reported that it is planned to appoint a technical adviser in both countries. Although it is recognised that more human resources were needed to administer the small grants scheme than originally envisaged, it is of concern that these additional human resources are being deployed as a separate UNODC project management team rather than within national, sustainable structures. This would appear to be at odds with principles of harmonisation and alignment as outlined in the Paris Declaration on Aid Effectiveness.

Respondents singled out UNODC’s Regional Coordinator for her dynamism. Logistics are done and information is communicated efficiently and on time. Communications are seen as good. One concern raised is that the coordinator’s focus on project implementation may result in her not always being able to take in the bigger picture. However, the project’s funder commented that the project leader is very capable and is trusted by them.

One respondent commented that the **flow of information** could improve, e.g. through the project website. No website had been available in the first year. Information is now on the UNODC website but it was reported that this was hard to find. The respondent thought it would be better for the project to have its own site.

The project’s **finances** have been managed through the UNDP office in Lithuania. This has been problematic, particularly recently, especially in relation to the administration of small grants. UNODC staff report that the processes have become slow and bureaucratic, and that requirements have been unclear and have changed. The underlying problem is that if UNDP is responsible for authorising payments, staff have to ensure that UNDP procedures have been followed. In the case of small grants, this requires UNDP staff to actively participate in grant selection and approval processes. This is not currently happening and would not be appropriate for a UNODC-managed project. These issues have become more pressing recently as the grants programme has expanded and as UNDP prepares for an audit in early 2009. The current proposal is that UNODC would establish and approve procedures and UNDP would simply be responsible for making payment. It is not completely clear if UNODC headquarters have agreed to this but it is envisaged that someone from that office will visit Lithuania early in 2009 to attempt to resolve this matter. UNODC project staff report that this issue has caused some delays in establishing and administering contracts for small grants. Latvian NGOs expressed some concerns about the timeliness of decision-making and communications. For example, at the time of visiting in December 2008, they reported that they were not aware of decisions on projects for 2009.

Given the nature of Lithuania and the other Baltic countries, the **UN's presence** is fairly limited. As a result, the formal coordination structures found in other countries are not all in place, e.g. UN country team, a theme group on AIDS, joint UN team on AIDS. However, there have been some instances where coordination of efforts has not been as strong as it could have been. For example, UNODC staff were given relatively little time to comment on the application for PAF funds and were unaware of the use of the Resident Coordinator's budget to support the Lithuanian AIDS Centre's commemoration of World AIDS Day. Although amounts are small, it is important that these are coordinated with the work of UNODC and any other relevant UN agencies because they are working with the same national partners on the same issues. Also, UNODC's collaboration with WHO is good in all three countries. Examples of this collaboration include conducting a joint evaluation of the national response in Estonia, support for revision of national HIV programmes in Latvia and Lithuania and a planned joint assessment of availability of antiretroviral therapy in Latvia.

### **Role of UNODC**

Overall, respondents were extremely positive about UNODC's role within the project, both in general and in terms of the role of the Regional Coordinator, in particular (see p29). The Regional Coordinator is seen as having a sense of 'gravitas', as do international consultants employed by the project. Both carry considerable weight with national stakeholders, e.g. the Ministry of Justice in Estonia. In addition, the Regional Coordinator has a diplomatic and persistent way of communicating, even on sensitive issues, which has been pivotal in carrying people and issues forward.

Generally, the relationship between the project office and UNODC headquarters in Vienna is seen as constructive and of mutual benefit. There were some concerns initially that UNODC's HIV/AIDS unit was perhaps too involved in day-to-day management of the project. However, this was perhaps understandable given the size, importance and political sensitivity of the project. However, this involvement has reduced to a more manageable and constructive level now that the Project Coordinator has begun to establish a track record.

Two concerns need perhaps to be raised about UNODC's role. First, the agency is seen as lacking technical expertise in certain areas of HIV/AIDS work, e.g. antiretroviral therapy. However, rather than developing this expertise, it may be more appropriate to draw on agencies with such technical expertise, e.g. WHO. Second, the expansion of UNODC's role, e.g. as an advocate for harm reduction services, has been useful in terms of moving issues forward and ensuring efficient project implementation. However, it has attendant risks regarding sustainability (see p20). It may be preferable, in the second half of the project period, for UNODC to start exiting from the 'front seat' identifying agencies that can be supported from the 'back seat' to take on this role.

### **LESSONS LEARNED**

Four key lessons that could be learned from the project's experience are briefly presented here. First, **prison settings** are of central importance as environments in

which HIV transmission can occur in the Baltic States and they are also a context in which people living with HIV are particularly found. Introducing effective HIV prevention programmes in prisons, e.g. harm reduction measures, is therefore a crucial part of an effective national response to HIV and AIDS. However, it is very difficult because there are many obstacles to the introduction of such measures in prisons. Projects working in this area need to take a long-term view, being persistent in their approach and celebrating what may appear to be small steps forward.

Second, **NGOs** are of crucial importance in effective national responses to HIV and AIDS. They have a particularly valuable role to play in prison settings. They can provide services that may be difficult for a state to provide directly, e.g. to those who are illegally injecting drugs, and, as a result, they may be more trusted by IDUs than state services. They often demonstrate a more constructive and supportive way of working with IDUs than state agencies. NGOs are particularly able to provide peer-led services, such as self-help groups. NGOs are also able to advocate with and influence state providers of services. Yet, there is a limited tradition and little experience of developing and running such NGOs in the Baltic States. In particular, the advocacy function of NGOs is under-developed. As a result, NGOs are often relatively new and of limited capacity. Efforts to support such NGOs, e.g. through programmes of small grants are important, particularly when combined with other measures to support the capacity development of NGOs and to support their involvement in key decision-making processes. NGOs need, in particular, to develop strategies to be able to function sustainably in an environment in which the availability of project funding from external donors is declining.

Third, **considerable human and financial resources are needed to manage effectively a small grants programme**. A great deal of time and effort are needed to develop and implement these. If such a programme is to be established by an external donor and then transferred to national structures, e.g. government, considerable time and effort will be saved if structures and mechanisms established are largely transferable. A good example of this is the Global Fund support to Estonia which was channelled through the country's National Institute for Health Development. That same structure is now being used to channel state funds to the same activities.

Fourth, in order to effectively monitor progress towards results, a project needs a practical **monitoring and evaluation framework**, which it uses on a routine and regular basis. This is easier to develop for certain activities, e.g. direct delivery of services, than for others, e.g. building of consensus and capacity. However, a system which combines routine monitoring and evaluative activities should be able to effectively track a project's progress towards its objectives and delivering its expected results.

## **RECOMMENDATIONS AND CONCLUSIONS**

This report concludes with a series of conclusions and recommendations which are structured into a number of different sections. First, there are some general conclusions and recommendations. These are then followed by country-specific conclusions and recommendations.

## General

1. The UNODC project and the countries' national responses to HIV and AIDS should **maintain and further strengthen their focus on activities among IDUs and in prison settings.**
2. All countries participating in the project should seek to **ensure the equivalence of the provision of health services in communities, arrest houses and in prison settings.** The project could assist this by supporting reviews of and plans to improve the continuity of key medical services between community and prison settings, such as antiretroviral therapy, tuberculosis treatment, condom distribution, opioid substitution therapy and needle and syringe programmes.
3. Based on the principle of a continuum of services, **efforts should be made to build bridges and to promote coordination between services,** such as MMT and drug-free rehabilitation, including the establishment of referral procedures.
4. UNODC should **rapidly adopt a monitoring and evaluation framework** to track more rigorously project progress. This could include:
  - a. Quantitative indicators to track key measures of coverage
  - b. Policy mapping of prison settings
  - c. Clear definition of expected results to be assessed through a final evaluation
5. Over the remaining two years of the project, **UNODC should consider introducing activities focused on the organisational development of NGOs.** This would be expected to have a strong emphasis on financial matters, such as developing strategies for fundraising, risk management and building up financial reserves.
6. **UNODC should look for ways in which coordination mechanisms established within the project can be made more sustainable.** This is likely to involve trying to embed steering groups within National Commissions and activities to support and strengthen National Commissions, including, where necessary, dialogue over expanding representation on such coordination bodies beyond government.
7. **UNODC should introduce 'sustainability assessments' into their procedures for assessing applications for small grants.** Higher priority could be given to those applications considered to have more chance of sustainability, according to the four point scale proposed on p21.
8. **UNODC should retain its flexible and responsive approach to financing** in order to allow it to respond to needs identified by countries, such as the need to work with sex workers in Latvia and to respond to increasing numbers of overdose-related deaths in Estonia. However, such flexibility should not be allowed to divert the project from its core focus on IDUs and prison settings.

9. **UNODC should carefully review its role within the management of the project** given the need for project activities to be sustained without UNODC support in two years time. In particular, UNODC should strongly resist the temptation to further expand its staffing or its role in management. Indeed, it should explore ways in which its staff and management hands over functions to national agencies in an organised and well-managed way over the next two years. This might mean that UNODC could avoid the pain and chaos of a disorganised and rapid transfer of activities when the project ends.
10. **UNODC might consider including providing training on relevant elements of medical ethics to health professionals**, particularly those working in prison settings and those managing databases. Relevant topics are likely to include confidentiality and appropriate cooperation with security services.
11. **UNODC might consider supporting a mapping survey of services provided by low threshold centres** including an assessment of quality of services provided
12. **UNODC should explore ways of further improving the flow of information about the project to project stakeholders**. One specific step could be the introduction of a project-specific entry page for the website.
13. **UNODC and UNDP need to resolve issues related to financial management of the project** as a matter of urgency.
14. **UN agencies in the Baltic states should consider the feasibility of establishing 'light' versions of joint UN teams on AIDS** to ensure improved coordination of activities in similar areas and with the same national partners

## **Estonia**

15. **Develop national operational guidelines for the provision of MMT** which includes the aim of MMT, the relationship between provider and client, the role and level of psychosocial support, take-home medication, roles of different professionals, case management, collaboration with other services and payment mechanisms. Once developed, quality assurance mechanisms will be needed to assess the extent to which the guidelines are being followed by programmes. In addition, the possibility of establishing a professional association for MMT workers open to doctors, nurses and social workers should be explored. There is also a need for an approved and systematic approach to training for MMT staff and ways should be explored of involving clients more in MMT programmes, e.g. by forming an association/alliance of methadone users. Consideration should be given to ways of influencing Russian-language media on issues related to MMT.
16. **Consideration should be given to conducting a study in Tartu prison into barriers for the introduction of MMT**. In particular, this should explore attitudes of staff and prisoners, the source of information that influences those attitudes and the appropriateness or otherwise of planned approaches to service provision, e.g. limiting MMT to those already on it when entering the prison system.

## Latvia

17. **Establish a task force, inclusive of all key players, to urgently promote the expansion of community MMT services beyond Riga.**
18. **Commit to piloting the provision of MMT in at least one prison in Latvia before the end of the UNODC project** and ensure that this is then implemented.
19. **Conduct the planned review of the provision of antiretroviral therapy in Latvia** including issues of clinical guidelines and management, procurement/cost and decentralisation of services.
20. **Rapidly adopt the new national AIDS programme.**

## Lithuania

21. **Review and revise the new National AIDS Programme in the light of ASAP comments** ensuring, in particular, that the programme is appropriate for the epidemiology of HIV in Lithuania, i.e. that the programme is strongly focused on IDUs and prison settings.
22. **Commit to piloting the provision of MMT in at least one prison in Lithuania.** This could be seen as an extension of the current pilot in arrest houses and/or might take the form of introducing Methadone a month or so prior to release from prison. This step is going to be of critical importance given the expansion of community-level MMT services and the likelihood of more people coming into the prison system already on MMT.
23. **Explore ways in which antiretroviral therapy can be financed in prison settings.** UNODC might consider financing a study of available options if this were considered appropriate by Lithuanian national authorities.

## **ANNEX 1: TERMS OF REFERENCE**

### **1. BACKGROUND INFORMATION**

The HIV epidemic peaked in the Baltic States in the years 2001 to 2002 and until now HIV prevalence rates remain one of the highest in the European Union. Different from other EU countries, the main HIV transmission mode is injecting drug use. As of August 2008 there were 6685 persons infected with HIV registered in Estonia, 4761 in Latvia and 1358 in Lithuania.

UNODC project XEEJ20 – “HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania” was approved by the UNODC Executive Director in November, 2006 and signed by the Governments of Estonia, Latvia and Lithuania during the period from November 2006 till January 2007. Duration of the project is 4 years (till December 2010). The total budget is USD 5,000,000. Funding for the project is secured by the Government of the Netherlands.

The Executing Agency is UNODC, and day-to-day execution is ensured through the UNODC Project Office in Vilnius, Lithuania. The Government Focal Implementation Agencies are the Estonian Ministry of Social Affairs, Latvian Ministry of Health and Lithuanian Ministry of Health. These focal implementing agencies serve as the key point of contact, liaison, information and communication with UNODC, local stakeholders and other interested parties for the purposes of this project.

The overarching goal of the project is to establish a favourable environment in all project countries to better implement HIV/AIDS prevention and care activities among injecting drug users and in prisons through addressing normative policy, capacity building and programmatic aspects of national HIV/AIDS prevention activities.

The project has the following objectives:

- Build national consensus on effective implementation strategies to address HIV/AIDS among IDUs and in prisons;
- Increase coverage of comprehensive HIV/AIDS prevention and care services among IDUs and in prison settings;
- 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.

The project addresses the policy makers in order to increase the government's commitment for the implementation of the HIV/AIDS prevention and care programmes among injecting drug users and in prisons. It also aims at strengthening the governmental and civil society organizations in delivering high quality services to high risk populations. The implementation strategy involves the development of a sustainable and ongoing enabling political environment, increasing capacity to provide quality interventions, and the introduction of comprehensive interventions targeted to injecting drug users and prisoners.

The elements of the strategy comprise:

- Involvement of all governmental and non-governmental stakeholders in project design, implementation and monitoring;
- Completion of comprehensive baseline measurements and needs assessments across all framework elements;
- Reviews of the legislative, administrative and operational environments, followed by normative advocacy and assistance in redrafting;

- A study tour by policy makers, service providers to countries which provide comprehensive HIV prevention and care services for injecting drug users and in prisons;
- Development and introduction of relevant tools, training curricula, accreditation and quality control protocols;
- The establishment of a regional capacity-building centre and information network;
- The establishment of a critical mass of trained and accredited service providers;
- Introduction of comprehensive interventions for injecting drug users and in prisons;
- Independent mid-term and end of project evaluations.

The following main performance indicators are formulated for the project:

- Countries adopt national HIV/AIDS strategies which include comprehensive HIV/AIDS prevention and care measures for injecting drug users and inmates;
- Increasing number of injecting drug users and inmates are provided with services;
- Training/workshops implemented with full participation of key service providers;
- Increasing number of sites providing comprehensive HIV/AIDS prevention and care services;
- Increasing number of prisons offering comprehensive HIV/AIDS prevention and care services for inmates;
- Annual project progress reports and other strategic information is documented and disseminated.

## **2. PURPOSE OF THE EVALUATION**

The overall purpose for the evaluation is to learn from the project implementation so that lessons can be drawn that can be the basis for instituting improvements to further project planning, design and management. The purpose of evaluation is to measure progress towards achievement of the expected outcomes and to assess the measures that the project has put in place in order to create positive impact in the future.

Mid-term evaluation is foreseen in the project document signed by the three Governments and UNODC. It is initiated by UNODC Project Office for the Baltic States, and it is agreed with UNODC Independent Evaluation Unit, HIV Unit and the Donor Government. The main stakeholders are the Ministries of Health and Ministries of Justice in Estonia, Latvia and Lithuania, service providers, civil society organisations and UNODC.

## **3. EVALUATION SCOPE**

The mid-term evaluation should cover implementation period from November, 2006 to October, 2008. The geographical scope of the evaluation is Estonia, Latvia and Lithuania. While the main emphasis should be on measuring outcomes and sustainability, the evaluation should also cover the project concept and design, implementation, results and outputs.

The evaluation should include findings, lessons learned and recommendations in the following areas:

- An analysis of how efficiently project planning and implementation are carried out. Are management arrangements of the project such that efficient execution and implementation is guaranteed?
- Relevance and attainability of the objectives. Whether the project addresses the identified needs to ensure sufficient focus on specific issues related to HIV and AIDS among IDUs and in prisons. Are the project objectives still relevant? What is the value of the project in relation to other priority needs and efforts? Is the problem addressed still a major problem?

- Whether the project contributes to a priority area or comparative advantage for UNODC,
- Assess progress made towards achievement of the planned results and expected outcomes, in particular:
  - capacity building of governmental and non-governmental organizations to better address HIV/AIDS among IDUs and in prison settings. This includes assessment of project's contribution to human and institutional capacity building;
  - increase in coverage of comprehensive HIV prevention services for IDUs;
  - amendment of national HIV/AIDS strategies and action plans.
- The usefulness of results and outcomes;
- What impact the project is most likely to have? Have the measures been put in place to create positive impact in the future?
- Sustainability of results and benefits. Are the initiated activities likely to continue after donor funding ends? Do the beneficiaries accept the project, are they willing to continue, and is the host institution developing the capacity and motivation to administer it? Can the activity become self-sustaining financially? Will the results continue after the project funding?
- Effectiveness: Is the project achieving satisfactory progress toward its stated objectives?
- Problems and constraints encountered during implementation;
- The role played by UNODC Project Office in the implementation of the project.

#### **4. EVALUATION METHODS**

The mid-term evaluation should include but not necessarily limit to the following methods:

- desk review of relevant documents (project document, quarterly, semi-annual and annual project reports, minutes of technical meetings, reports on project activities, relevant national policy documents etc.);
- individual and/or group interviews with members of the Project Steering Committee (main governmental stakeholders and civil society), representatives of the counterparts and implementing partners;
- interviews with representatives of the project beneficiaries;
- meeting with representatives of UNAIDS co-sponsors present in the Baltic States;
- field visits to services developed/supported under the project;
- conference calls with representatives from the UNODC HIV/AIDS Unit;
- questionnaires.

The evaluation consultant should present a detailed statement of proposed evaluation methods in the technical proposal. The evaluator has to take into account the Guiding Principles for Evaluations at UNODC (Annex 2).

#### **5. EVALUATION TEAM COMPOSITION**

Evaluation should be conducted by an independent expert without prior involvement in the project. The evaluator will not act as representative of any party and should remain independent and impartial throughout the evaluation.

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

##### **6.1. Planning and reporting arrangements**

The evaluation should be planned and conducted in close consultation with UNODC Project Office for the Baltic States. The evaluation tools and methodology must be agreed with the UNODC Project

Office for the Baltic States. Project Office will provide the necessary substantive support, including travel arrangements, organisation of meetings and submission of all documents for desk review.

Although the evaluator should be free to discuss all matters relevant to this assignment with the authorities concerned, he/she is not authorized to make any commitment on behalf of UNODC.

The evaluator reports directly to UNODC Project Office for the Baltic States. The report will contain the findings, conclusions and recommendations of the mid-term evaluation as well as a recording of the lessons learned during project implementation. The draft report must be discussed with the project counterpart agencies, the representative of the donor and, to the extent possible, with other parties involved in the project. While considering the comments provided on the draft, the evaluation expert would use his/her independent judgment in preparing the final report. The report should not be longer than 25 pages, excluding the annexes and the executive summary. The report should be developed with respect to the following chapters:

- executive summary (maximum 4 pages)
- introduction
- background (project description)
- evaluation purpose and objective
- evaluation methodology
- major findings
- lessons learned (from both positive and negative experiences)
- constraints that impacted project delivery
- recommendations and conclusions.

Annexes to the evaluation report should be kept to an absolute minimum. Only those annexes that serve to demonstrate or clarify an issue related to a major finding should be included. Existing documents should be referenced but not necessarily annexed. Maximum number of pages for annexes is 15.

After completing the evaluation process, consultant should fill in the Evaluation Assessment Questionnaire (Annex 3).

## 6.2. Timeframe and work plan

Expected engagement: 27 working days during 17 November 2008 - 31 January 2009, three missions to the Baltic States: 10 – 17 December 2008, 5-9 January 2009, 28-29 January 2009.

Task	Number of w/days	Timeline	Outcome
Desk review of project document, reports and other relevant documents	4	17-20 November	Draft inception report with detailed evaluation plan and methodology prepared; including draft evaluation tools (interview sheets; questionnaires)
Briefing of evaluator by the responsible official at the HIV Unit, UNODC HQ (Vienna) and Regional Coordinator for the Baltic states (by phone)	1	3 December	Inception report finalised, methodology and evaluation plan agreed

Mission to Estonia and Latvia: meetings and interviews with identified stakeholders, identified beneficiaries and collaborative partners; debriefing with the Regional Coordinator	8	10–17 December	Data from major stakeholders collected; Exit minutes prepared and discussed
Mission to Lithuania: meetings and interviews with identified stakeholders, identified beneficiaries and collaborative partners; debriefing with the Regional Coordinator	4	5-9 January	Data from major stakeholders collected; Exit minutes prepared and discussed
Data analysis and preparation of draft report	5	12-16 January	Evaluation draft report with findings, lessons learned and results submitted to UNODC for review
Receiving feedback on draft report, incorporating comments	2	22-23 January	Evaluation report refined
Stakeholder meeting (mission to Latvia)	2	28-29 January	Evaluation findings presented and recommendations refined
Finalisation of the evaluation report	1	31 January	Final evaluation report submitted to UNODC

## 7. COMPETENCIES AND SKILLS REQUIRED FOR EVALUATION EXPERT

- Advanced university degree in social sciences, medicine or public health, with specialized training in evaluation and project/program management;
- At least 5 years of international experience in designing and managing program/project evaluations including in the area of HIV/AIDS prevention and care services for most-at-risk groups (injecting drug users, inmates, sex workers);
- Proven experience in conducting independent evaluations of HIV prevention projects/programmes; experience in evaluating HIV prevention projects targeting IDUs is an asset.
- Familiarity with HIV/AIDS epidemics and substance abuse in the Central and Eastern Europe region;
- Knowledge of the UN guiding principles/recommendations on HIV/AIDS prevention and care among injecting drug users and in prison settings;
- Personal skills: good communication, analytical and drafting skills;
- Fluency in English; fluency in Russian, Estonian, Latvian or Lithuanian is an asset.

## **ANNEX 2: PEOPLE INTERVIEWED**

### **Regional/International**

Wil de Zwart, Ministry of Health, Welfare and Sport, the Netherlands  
Martin Donohoe, WHO Euro  
Dagmar Hedrich, EMCDDA  
Zhannat Kosmukhamedova, UNODC  
Ulrich Laukamm-Jostens, WHO Euro  
Riku Lehtovuori, UNODC  
Signe Rotberga, UNODC  
Fariba Soltani, UNODC  
Heino Stöver, UNODC Consultant  
Barbara Torggler, UNODC  
Franz Trautmann, Trimbos Institute  
Lucas Wiessing, EMCDDA

### **Estonia**

Katri Abel-Ollo, Estonian Drug Monitoring Centre  
Latsin Alijev, Convictus  
Ellu Eik, West Tallinn Central Hospital  
Kristina Joost, Convictus  
Kristel Jürgens, Ministry of Justice  
Nelli Kalikova, Elulootus  
Ene Katkosilt, Tallinn Prison  
Aljona Kurbatova, National Institute for Health Development  
Merilin Mäesalu, Ministry of Social Affairs  
Maret Miljan, Ministry of Justice  
Maris Salekešin, Ministry of Social Affairs  
Igor Sobolev, Estonian Network of PLWH  
Ave Talu, Estonian Drug Monitoring Centre

### **Latvia**

Leonora Bebere, Iļģuciema Prison  
Ainārs Čivčs, Public Health Agency  
Evija Dompalma, UNODC  
Sergejs Dubčaks, Investment Department, Ministry of Health  
Sandra Dudareva, AIDS and STI prevention unit, Public Health Agency  
Regīna Fedosejeva, Prison Administration  
Andris Ferdats, AIDS and STI prevention unit, Public Health Agency  
Roberts Girgensons, Medical Department, Prison Administration  
Gunta Grīse, Public Health Department, Ministry of Health  
Ruta Kaupe, DIA+LOGS  
Iveta Kelle, Latvia's Association for Family Planning and Sexual Health  
Kristīne Kipēna, Ministry of Justice  
Ivars Kokars, AGIHAS  
Inga Landsmane, Riga Centre for Psychiatry and Addiction  
Egija Lapiņa, ENCAP

Uldis Līkops, Public Health Agency  
Ilze Maksima, Addiction Unit, Public Health Agency  
Valentīna Maļcāne, Iļģuciema Prison  
Aleksandrs Molokovskis, HIV.LV  
Aija Pelne, Addiction Unit, Public Health Agency  
Aiga Rūrāne, WHO  
Agita Sēja, DIA+LOGS  
Sarmīte Skaida, Riga Centre for Psychiatry and Addiction  
Astrīda Stirna, Riga Centre for Psychiatry and Addiction  
Māris Taube, Public Health Agency  
Nadežda Trosjuka, Iļģuciema Prison  
Inga Upmace, AIDS and STI prevention unit, Public Health Agency

## **Lithuania**

Virginija Ambrazevičienė, Ministry of Health  
Jurgis Andriuška, Pozitivus Gyvenimas  
Audronė Astrauskienė, Drug Control Department  
Dalia Bagdžiuvienė, UNDP  
Irena Bikulčienė, Alytus City Municipality  
Rasa Burneckytė, Alytus Public Health Centre  
Saulius Čaplinskas, Lithuanian AIDS Centre  
Janė Cikanienė, Anonymous Consulting Office 'Pasitikėjimas'  
Raimonda Cikanienė, Anonymous Consulting Office 'Pasitikėjimas'  
Česlovas Daugėla, Alytus City Municipality  
Adelė Dimšienė, Alytus City Municipality  
Andrej Ivanov, NGO Pusiaukelis  
Lyra Jakulevičienė, UNDP  
Albertas Jankauskas, Alytaus Correction House  
Kęstutis Jasmontas, Alytaus Correction House  
Vladas Kasperūnas, Health Care Division, Prison Department  
Justė Kelpšaitė, UNODC  
Jonas Muzikevičius, Alytaus Correction House  
Jurgita Poškevičiūtė, NGO Coalition 'I Can Live'  
Marius Rakštelis, Ministry of Justice  
Romualdas Sabaliauskas, Ministry of Health  
Rimantas Šagždavičius, Drug Control Department  
Birutė Semėnaitė, Health Care Division, Prison Department  
Rolandas Sereika, Alytus City Municipality  
Raminta Štuikytė, Eurasian Harm Reduction Network  
Emilis Subata, Vilnius Center for Addictive Disorders  
Rūta Svarinskaitė, UNDP  
Rima Vaitkienė, Ministry of Health  
Roma Varnelienė, Anonymous Consulting Office 'Pastikėjimas'  
Artūras Vasilauskas, Alytus Polyclinics

## **ANNEX 3: DOCUMENTS REVIEWED**

### **Regional/International**

Drew, R.S. (2008) *Mid-term Evaluation of UNODC Project XEEJ20: HIV Prevention, Treatment and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania: Inception Report*

Gerra, G., Maremmani, I., Capovani, B., Somaini, L., Berterame, S., Tomas-Rossello, J., Saenz, E., Busse, A. and Kleber, N. (2008) *Long-acting Opioid-agonists in the Treatment of Heroin Addiction: Why Should we Call them 'Substitution'?*

Gibson, D.R., Flynn, N.M. and McCarthy, J.J. (1999) *Effectiveness of Methadone Treatment in Reducing HIV Risk Behavior and HIV Seroconversion among Injecting Drug Users* AIDS, 13, 1807-1818

Jürgens, R., Ball, A. and Verster, A. (2009) *Interventions to Reduce HIV Transmission Related to Injecting Drug Use in Prison* Lancet, Vol 9, pp57-66

Kastelic, O., Pont, J. and Stöver, H. (2008) *Opioid Substitution Therapy in Custodial Settings: A Practical Guide*

UNAIDS and WHO (2007) *North America, Western and Central Europe: AIDS Epidemic Update Regional Summary*

UNODC (undated) *How UNODC Deals with HIV/AIDS*

UNODC (2006) *Project Document* also includes several annexes including budget, log frame and work plan

UNODC (2007a) *Costed Annual Workplan*

UNODC (2007b) *Annual Project Progress Report 2006*

UNODC (2008a) *Report on Building Professional Capacities by UNODC Project*

UNODC (2008c) *Costed Annual Workplan*

UNODC (2008d) *Semi-Annual Project Progress Report: January to June 2008* also quarterly reports for first three quarters of 2008 [Excel]

UNODC (2008e) *Annual Project Progress Report 2007* – also quarterly reports for 2007 [Excel]

UNODC (2008f) *Various Documents Relating to Small Grants* including announcements of tenders; grant application guidelines; grant application form; grant assessment form; interim and final financial report templates; interim and final narrative report templates; and guidelines for the UNODC grants committee in Latvia

UNODC (2008g) *HIV/AIDS Prevention and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania* – three PowerPoint presentations dated June 2007, February 2008 and September 2008

UNODC (2008h) *Project Implementation Arrangements* for Latvia and Lithuania

UNODC (2008i) *Independent Evaluation Unit: Evaluation Handbook*

UNODC (2009a) Project financial reports for 2006-8

UNODC (2009b) *HIV/AIDS Prevention and Care among Injecting Drug Users and in Prison Settings in Estonia, Latvia and Lithuania* – PowerPoint presentation dated 29<sup>th</sup> January 2009

UNODC, WHO and UNAIDS (2008) *HIV and AIDS in Places of Detention: A Toolkit for Policy Makers, Programme Managers, Prison Officers and Health Care Providers in Prison Settings*

WHO (2008) *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*

WHO, UNAIDS and UNODC (2007) *Guide to Starting and Managing Needle and Syringe Programs*

WHO, UNODC and UNAIDS (2008) *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*

## **Estonia**

Convictus (undated, a) *Client Monitoring Books* (Russian/Estonian)

Convictus (undated, b) *Information Leaflet* (Russian/Estonian)

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**ANNEX 4: INCEPTION REPORT**

**MID-TERM EVALUATION OF UNODC PROJECT XEEJ20**

**HIV PREVENTION, TREATMENT AND CARE AMONG  
INJECTING DRUG USERS AND IN PRISON SETTINGS IN  
ESTONIA, LATVIA AND LITHUANIA**

**INCEPTION REPORT**

**Produced  
by  
Roger Drew**

**December 2008**

## **1 PURPOSE OF THIS REPORT**

- 1.1 This report briefly outlines the approach to be taken by the evaluator in conducting this mid-term evaluation in order to ensure a clear and shared understanding of the approach to be taken, the methods to be used and the expected deliverables.

## **2 GENERAL COMMENTS ON TERMS OF REFERENCE**

- 2.1 The terms of reference for this evaluation are considered extremely clear and an adequate guide for conducting the evaluation. They have been discussed and agreed in advance between UNODC and the evaluator. The scope of the evaluation is as stated in the terms of reference. However, the evaluator will ensure that the issue, raised by the Dutch government, of the political commitment of the three countries covered by the project, will be considered, under the existing heading of sustainability of results and benefits.

## **3 PRINCIPLES**

- 3.1 The evaluator will follow the guiding principles specified for UNODC evaluations contained in Annex 2 of the Terms of Reference. In addition, the evaluator will endeavour to adopt a flexible and iterative approach to the evaluation within the overall scope and the specified level of effort.

## **4 METHOD**

- 4.1 The main method of primary data collection will be through semi-structured interviews conducted with key informants. Key informants will consist of national stakeholders in each country identified through discussion between the evaluator and UNODC. Interviews will be conducted either with individuals or small groups. Interviews will be loosely structured around the following topic guide derived from the terms of reference:

- Efficiency of planning and implementation

- Management
- Relevance and achievability of objectives
- Progress towards achieving objectives
- Extent to which the project contributes to a priority area or comparative advantage for UNODC
- Progress towards expected results in areas of (a) capacity building; (b) coverage of services; (c) strategies and plans
- Usefulness of results
- Likely impact
- Sustainability
- Problems and constraints
- Role of UNODC Project Office

4.2 It is not envisaged that every respondent would cover every topic, nor that the topic guide would be used in a linear fashion. Rather respondents would be asked to identify key strengths and challenges of the project as an opening question, and then prompted on other relevant issues and topics as the conversation unfolded.

4.3 In addition to national level stakeholders, the terms of reference envisaged the evaluator talking to UNODC headquarters staff in Vienna. Following discussions between the evaluator and UNODC, it is proposed to expand the list of non-national stakeholders to include key consultants utilised by UNODC and selected regional partners, such as WHO Euro and EMCDDA. These interviews will be conducted by telephone.

4.4 Secondary data will be collected from documentary sources identified in the terms of reference. In particular, it should be noted that this is not the first evaluative activity conducted under the auspices of/in cooperation with this project and that information will be drawn from these sources which include:

- Rapid review of OST in Estonia and Latvia
- In-depth reviews of OST in Estonia and Latvia

- Review of small grants programme in Lithuania
- Mid-term evaluation of National AIDS Programme in Lithuania
- Evaluation of national response to HIV and AIDS in Estonia, including in-depth reviews of responses among IDUs and in prison settings
- Review of Latvian AIDS strategy, including in-depth reviews of activities among IDUs and costings
- Twinning project report in Latvia entitled *Capacity building for institutions involved in surveillance and prevention of communicable diseases in Latvian's penitentiary system*

4.5 Given the availability of a large amount of pre-existing evaluative data, it is not proposed that this evaluation will involve a significant number of direct visits to project services, except where this is considered critical by either the evaluator or UNODC. Given the qualitative nature of the data required, it is not envisaged that the evaluation will involve administration of a questionnaire.

## **5 EVALUATION PLAN AND TIME FRAME**

5.1 The plan and time frame is as specified in the terms of reference. In particular, country visits are to be conducted according to the time frame in the terms of reference. A detailed draft plan of who to meet whilst in country will be provided to the evaluator prior to arrival in each of the three countries. This plan may need to be adapted to accommodate additional interviews with stakeholders suggested by the evaluator and/or changes in availability of potential respondents.

5.2 A regional feedback meeting will be held in Latvia on 29<sup>th</sup> January as specified in the terms of reference. A draft report will be circulated to UNODC by 16<sup>th</sup> January, comments received by 22<sup>nd</sup> January and changes incorporated. The final report is to be produced by 31<sup>st</sup> January.

## 6 DELIVERABLES

6.1 The agreed deliverables for this evaluation are captured in the terms of reference as ‘outcomes’. These are re-stated here for the sake of clarity along with due dates:

Inception report	18 <sup>th</sup> December
Exit minutes Estonia and Latvia	18 <sup>th</sup> December
Exit minutes Lithuania	10 <sup>th</sup> January
Draft Evaluation Report	16 <sup>th</sup> January
Presentation of Findings	29 <sup>th</sup> January
Final Report	31 <sup>st</sup> January

6.2 The final report will follow the requirements specified in the terms of reference. It will also seek to follow the guidance provided in UNODC’s evaluation manual. Where variations in style are proposed, these will be agreed between UNODC and the evaluator.

Roger Drew  
December 2008