Evaluation Report

AD/IND/99/E40 Community Wide Drug Demand Reduction in India

AD/IND/99/E41 Community Wide Drug Demand Reduction in North Eastern States of India

Thematic area: Prevention and reduction of drug abuse

Evaluation Team

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EXECUTIVE SUMMARY

The government of India invests a large amount of resources and has mobilized an array of agencies and individuals to respond to problems arising from drug use.

The project (projects E40 and E41 are really parts of a whole and not separate from each other) being evaluated was planned to improve the 'technical' dimension of this extensive national programme. The plan was not simply to deliver a package of technical inputs for the programme to use. It went much further and set out to create an infrastructure for continued delivery of such inputs in the foreseeable future, all the way to the smallest NGO in the remotest corner of the country.

The project has been an outstanding success in this regard. It has introduced a stable, dynamic and living structure and mechanisms for system-wide qualitative improvement of existing responses by a vast network of NGOs countrywide. This addition alone, because it is has already become an integral part of the existing programme and will continue to function indefinitely as a means for improving interventions, is more than adequate return from the entire project. The potential benefit from the strategy adopted is so great that this project can be held up as a model of innovative and potentially effective institution building. It has chosen the right kind of institution or infrastructure to build.

To ensure benefits from the additional infrastructure put in place through this project, its fulcrum – the National Centre for Drug Abuse Prevention or NCDAP – has to be strengthened or an alternative found. What are most required in an 'apical body' is adequate staff, interest and commitment to the cause, and a willingness and ability to learn and change on the basis of evidence. Achievement through lower tiers, such as the Regional Resource and Training Centres and the NGOs has progressed as well as could be expected during the short time of operations. They can be expected to fulfil their anticipated roles with more experience and further guidance.

That the infrastructure and the dynamic processes set in motion will serve to improve the 'drug abuse situation' in the country remains to be assured. Improvements in national impact of the programme require that the envisaged qualitative improvements do occur. Qualitative improvement requires quality inputs. Both the MSJE and UNODC should now concentrate on ensuring quality inputs for qualitative improvement.

During the brief lifetime of this project, and that too interrupted by an unusual and disturbing failure of anticipated funds to materialize, there is a limit to what can be expected or achieved. Developing, testing and building in effective demand reduction strategies require time and a great deal of energy and critical self-examination. The mood now is supportive of this need.

Efforts to build in greater technical competence should be pursued right now, with great vigour. If not, there is a risk that everybody in the new system gets into a routine and slowly becomes comfortable with what is presently being done. Progress will then become that much more difficult. And the potential benefits from this energetic and interesting project will be lost. Momentum lost is difficult to regain.

The best way forward is to invest equivalent attention now on better developing programme content, evaluating impact of a wide range of approaches and disseminating an array of proven or promising strategies. The latter can be selected by studying what is currently known and by critically and continuously examining the results of activities that are ongoing.

A 'project' type input will be more likely to make this process happen than leaving it to the programme to take up in its normal course. Having invested much energy, and having generated such potentially promising structures and processes, both MSJE and UNODC ROSA would be well advised to follow this project with another – addressing the finishing touches outlined here and described in detail in the report.

EXPLANATORY NOTES

List of Abbreviations/ Acronyms

AIIMS	All India Institute of Medical Science, New Delhi
ARMADA	Association of Resource Managers Against Drug Abuse
CBOs	Community Based Organisations
DAMS	Drug Abuse Monitoring System
FINGO-DAP	Federation of Indian NGOs in Drug Abuse Prevention
ICDS	Integrated Child Development Scheme
ILO	International Labour Organisation
IT	Information Technology
MOUs	Memorandum of Understandings
MSJE	Ministry of Social Justice and Empowerment
NACO	National AIDS Control Organization, Ministry of Health, INDIA
NCDAP	National Centre for Drug Abuse Prevention
NGOs	Non Government Organisations
NISD	National Institute of Social Defence
RRTCs	Regional Resource Training Centres
TOT	Training of Trainers
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNDCP	United Nations International Drug Control Programme
UNODC	United Nations Office on Drugs and Crime

INTRODUCTION

a. Project and its history

I. BACKGROUND

The project document sets out much of the background to the initiation and development of the project and relevant sections from it are set out below.

Conservative estimates place the number of drug users in India above 3 million and initial reports from the national study indicate that drug abuse is increasing. Over 5-10% of HIV seropositives are injecting drug users (IDUs). The abundant availability of illicit drugs, the magnitude of the country with a population of more than one billion, a multitude of languages and a complex drug control situation, makes it difficult to address the drug abuse problem.

Alcohol, opium and cannabis have been traditional drugs of abuse in India with moderate consumption ritualized in social gatherings. Associated major health or social problems were not obvious in the past, due to informal social control against large-scale abuse. In the early 1980s, the emergence of heroin addiction and psychotropic substances abuse was noted in urban areas in India.

The drug abuse pattern in the northeastern states is quite alarming. It is estimated that there are about 40,000 drug addicts in Manipur and an equally large number in Mizoram, 30,000 in Nagaland, 150,000 in Assam (including alcohol abuse). In Arunachal Pradesh, there are a large number of opium abusers. Cannabis abuse is rampant in the region, as it grows wild. Alcohol abuse is greater. It is reported that majority of the addicts are young people, between the age of 15 to 35 years. There is increasing incidence of drug abuse among women and children their involvement in drug peddling is growing.

The Northeastern states are also an important drug trafficking route for heroin produced in Myanmar. The border states of Mizoram, Manipur, Nagaland and the district east c of river Brahmaputra in Arunachal Pradesh are used by drug traffickers to smuggle heroin into India. It is a well established and extensively documented fact that areas along the drug trafficking routes are prone to drug abuse due to affordable prices, easy availability and attempts by small couriers to encash their in-kind wages. The spread of drug abuse and HIV/AIDS is becoming critical in some areas/ communities. It is estimated that in a population of 1.8 million in Manipur, there are about 15,000 to 20,000 injecting drug, abusers, mostly heroin users. Though heroin is the primary drug of choice, other drugs like opium, cough syrups, benzodiazepines; other prescription drugs and alcohol are also abused in these states.

Since the Seventh Five Year Plan (1982-87), the Ministry of Social Justice and Empowerment (MSJE), in line with its nodal responsibility for drug demand reduction, has been supporting NGOs for public awareness

programmes and establishing counseling, de-addiction, rehabilitation and after-care centers.. In addition, from 1989 to 1998, the Government of India implemented two projects with technical support from UNDCP now known as UNODC and ILO. The first project aimed at expanding and improving drug rehabilitation and after-care services through training of drug rehabilitation professionals and development of community drug rehabilitation initiatives was implemented by the Ministry of Social Justice and Empowerment in collaboration with four NGOs in Delhi. The second project aimed at developing drug and alcohol prevention programmes in a number of specific enterprises. That project was implemented by the Ministry of Labor, in collaboration with employers' and workers' organizations and a number of enterprises.

In view of the increasing problem of drug abuse in the country the Government of India (Ministry of Social Justice and Empowerment) decided to widen coverage of services throughout the country and to improve demand reduction services. However, it realized that there was an acute shortage of manpower trained in demand reduction and, as a consequence, the delivery of services was less than satisfactory.

To successfully influence the situation, there was a need for a systematic, cost effective and well-targeted approach, which could introduce up-to-date and innovative demand reduction techniques on a nation-wide scale. This included the need to strengthen the capabilities of the Government to expand and support demand reduction activities in a systematic fashion, to strengthen the capabilities of NGOs, communities, private enterprises, employees' and employers' organizations as well as other UN agencies to carry out such activities. A comprehensive plan needed to be evolved in consultation with the Government and NGOs, with components for drug demand reduction, law enforcement, and alternative development and HIV/ AIDS prevention.

In 1995 in response to the above situation project AD/IND/94/808, Developing Community based Rehabilitation and Workplace Prevention was supported by UNODC in partnership with the Ministry of Social Justice and Empowerment, Government of India. ILO executed this project. One of the major achievements of this project, operational from June 1995-1999, was the implementation of workplace prevention programmes in 11 enterprises and initiation of community based drug rehabilitation programmes in partnership with 18 NGOs in 9 cities across the country. This project generated a great deal of interest amongst the private sector, and an important momentum has been created. As a follow-up to project AD/IND/94/808, the workplace prevention and community based rehabilitation approaches were also was incorporated in these new Community Wide Drug Demand Reduction Project in 1999.

The two projects AD/IND/99/E40 "Community Wide Demand Reduction in India" and AD/IND/99/E41 "Community Wide Demand Reduction in the North Eastern States of India", were jointly designed by the Ministry of Social Justice and Empowerment and UNODC ROSA in response to the above situation.

The two projects E40 “Community Wide Demand Reduction in India” and E41 “Community Wide Demand Reduction in the North Eastern States of India” supplement the Ministry of Social Justice and Empowerment’s (MSJE) programme of supporting non-government organizations to carry out demand reduction activities. They aim at establishing an infrastructure consisting of a Government based National Centre for Drug Abuse Prevention (NCDAP) and 8 NGO based Regional Resource and Training centres (RRTCs). The aim of the Projects was to reduce drug abuse among the general population, high-risk groups, workplace, and drug addicts and prevent the same on a nation-wide scale by NGOs, community based organizations (CBOs), government, and other United Nations agencies. The projects commenced in September 1999. The long term objective of the two projects are to reduce drug abuse and its adverse consequences on social and economic development through the introduction of effective drug rehabilitation and social integration programmes as well as workplace initiatives in a coherent national strategy to combat drug and related problems in India. Its immediate objectives were to establish the capability at the national level to mobilize community participation in developing drug rehabilitation services and workplace prevention and assistance programmes throughout India and community based services in northeastern India.

The project E40 aimed at establishing an infrastructure consisting of a Government based National Centre for Drug Abuse Prevention (NCDAP) and 5 NGO based Regional Resource Training Centres (RRTCs). The intention was to mobilize community based organizations and enterprises to reduce and prevent drug abuse on a nation-wide scale and on a sustainable basis in a huge country with almost one billion people, highly exposed to drug abuse. The key element was increase of skilled personnel and reliance on a multiplier effect in terms of training of trainers. The project covers the entire country except for the northeastern states, which is being addressed by project IND/E41. The two projects are interlinked. The project directly targets groups vulnerable to drug abuse.

Substantive training is also being carried on prevention of drug related HIV in the country through the NGOs being supported by the Ministry of Social Justice and Empowerment under their scheme of assistance for drug and alcohol prevention. Convergence of services in health and social justice, addressing gender dimensions of the problem and a decentralized approach are critical to the response.

The project E41 aimed at establishing an infrastructure comprising an NGO based regional resource and training centre, 25 NGO based de-addiction cum rehabilitation centres and 40 Community Extension Centres (CECs), consisting of suitable community based organisations (CBOs). The intention was to mobilize NGOs, CBOs, and enterprises to reduce and prevent drug abuse on a large scale in the northeastern states of India that are highly vulnerable to drug abuse and related HIV.

II. PURPOSE AND METHODOLOGY

The purpose of the evaluation exercise was at the first level to examine the concept, design and implementation framework of both the components of the project i.e. E40 and E41 vis-à-vis the programme objective of bringing about community wide drug demand reduction in India. At the second level evaluation was undertaken to assess the impact of the project interventions on demand reduction, capacity building of service providers, qualitative improvements in the delivery of services to end users and inter sectoral convergence. Some of the other aspects to be probed included structural influences of planned interventions on non-targeted groups, scope for plurality of approach and receptivity to change to meet the requirements of the community and identification of gaps in the programme.

Methodology

- Study of project documents, reports, and performance updates. This is primarily to decide on the premises and assumptions on which project was based.

- Based on this the broad focus of the evaluation to be determined, in relation to the TOR provided.

- Initial discussion with key persons of UNODC and the Ministry of Social Justice and Empowerment as to what expectations they had of this evaluation. A structured discussion on who would read the evaluation report, what for and what would happen based on different possible findings.

- Finalize plan of evaluation focus and data gathering by matching initial plan of evaluators with the requirements of major players.

The plan which evolved included the following decisions and elements.

1. Basically the same data set will be sought from both projects E40 and E41 with variation where necessary to accommodate the differences in their scope, 'penetration' and coverage.

2. Focus of the evaluation will go beyond listing and assessing the several outputs that were envisaged from this project. What outcomes, impacts or drug control objectives were achieved will be examined too.

3. Cadres involved in delivery of the different kinds of services will be questioned in detail as to what was in reality being transmitted to the service recipient or 'target groups'.

4. An attempt will be made to reach staff or workers who were not 'pre-selected' and presented by the different agencies, within the possibilities

available in the schedules arranged for the evaluation team. A purely 'random' selection of informants was not felt to be feasible within the constraints of time and territory but an attempt would be made to locate and engage persons other than just those presented to the evaluation team.

5. All levels of staff involved in the project will be questioned on the indicators they used for assessing immediate and later outcomes. What indicators were used, or planned to be used, to determine immediate or early outcomes will be assessed. Sensitivity, among all levels of personnel, to interventions being ineffective or even potentially counterproductive will be looked at.

6. The report will cover projects E40 and E41 together because the overlap and commonalities are large. Where there are issues or findings specific to either project E 40 or E 41, these will be specially mentioned.

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Chapter 1

PROJECT CONCEPTION AND DESIGN

Throughout this report the words 'Project' or 'Projects' are used to refer to both projects E40 and E41. Where an observation is relevant to only one of these, the project concerned will be mentioned specifically.

A. Overall assessment

To plan for all of India in one sweep is bold indeed. Such a step is however necessary for the national programme to make progress.

The two projects in question set out explicitly to address drug problems in all of India. This level of analysis and thinking is essential for any country and it is good that the projects in question set out to do this, undaunted by the size of the population to be addressed. The intent of the projects is to 'mobilize community-based organizations and enterprises to reduce and prevent drug abuse on a nation-wide scale and on a sustainable basis'.

Accepted formats for preparation of proposals of this nature require that immediate objectives be spelt out in specifics – usually in numerical terms. The document does this. This format, required of project documents such as this, does not allow much room for considering qualitative improvement in services delivered. And this is particularly unfortunate for this project because its thrust is to set up a means to improve an extensive network of services, precisely to improve the quality – and thereby the impact – of activities currently being carried out.

Thus the real 'logical analysis' of how the overall Drug Control Objective is to be achieved is difficult to address in such project documents. What are referred to as 'immediate objectives' in this document too then necessarily have to become biased towards listing outputs or activities relevant to the different phases.

Focus on outputs versus outcomes or results

Because project designs are obliged to provide specific outputs that can be readily monitored, the emphasis on outputs or impacts is reduced. As a result of this, the opportunity of learning from the exercise of taking on an ambitious drug control objective here could be lost – as the goal itself does not then figure significantly in the planning. The project has to proceed on the assumption that the delivery of the outputs listed will 'reduce and prevent drug abuse on a nation wide scale and on a sustainable basis'.

In fairness to the planners though it must be highlighted that a project document such as that of E40 or E41 cannot spell out detail of programme content without becoming unwieldy. But greater focus on the overall objective

would have led to more attention throughout to content, which is a crucial determinant of impact.

A second layer was probably needed, beyond this document, for 'quality control' of the content. This would have allowed more focus on outcomes or results. More analysis would there have been possible of how the overall objective was to be achieved. This analysis usually emerges in the breakdown of the overall objectives into logically antecedent immediate objectives. This layer is perhaps a worthwhile component to introduce into project proposal formats.

Appropriateness of drug control objective

In the move from overall objective to outputs, the need to specify expected or desired impacts on the drug situation becomes less crucial. As a result of this the feasibility of achieving the stated overall drug control objective does not get addressed.

Models and options

Project documents do not provide much room to spell out the specifics of how a particular objective is to be achieved. Some attention to this aspect is useful in planning.

In this project too, there is no room in which to elucidate the different models, or the range of approaches, that can potentially be used to achieve a reduction in demand. There is little room in project documents to spell out how expected results are to be achieved. What models are to be used and how they are to be assessed therefore remain unclear.

Monolithic structure

The practical arrangement proposed for bringing about nation-wide change is a training that originates at the centre spreading through a network of hierarchically arranged agencies and ultimately reaching the 'grassroots'. An unstated assumption underlying this plan is that the basic core so transmitted will result in a positive impact.

The expectation is that a cascading spread of ideas and practices originating from a single specialized agency, will lead to the expected results. The risk that such a model could potentially restrict the range of approaches and models in all agencies throughout the country should perhaps have been considered too.

'Substance specificity'

Nowhere in the activities listed is there an undue fixation on one specific substance or another. This is a very positive feature of this project. In many initiatives the entire activity is designed to fit the profile of drug problems that are currently evident in the target population. There is here a healthier 'generality' of focus.

This is an essential ingredient in a project such as this as because 'drug problems' are not a static or fixed universe. Interventions need to have a strong 'generic' component whilst addressing issues related to the specific drugs currently being used. One, common, constraint to flexibility is the focus on a specific drug or two that are seen as 'the problem'. This project is not constrained by such a 'substance specific' outlook.

B. Problem analysis, objectives and achievement indicators

An adequate analysis of the current state of affairs and justification for embarking on this project is provided. In fact, the situation with regard to drug use and resultant problems is grave enough to justify even larger initiatives in this field.

It would probably be fair to say that the project really sees the degree to which outputs are achieved as an indicator of achievement of objectives. The 'drug control objective' is not so much the focus. Thus we find little attention to indicators of this particular aspect.

The spelling out of detailed outputs is an aid to implementation. But there are numerous outputs listed under different headings and multiplied over phases – to the extent that a manager may find it difficult to come to grips with the totality. The revision of the project has resulted in the numbers becoming rather easier to deal with.

C. Outputs, activities and inputs

a. Appropriateness of outputs

Planned outputs relate mainly to setting up of structures and systems as well as generating 'technical competence' within a given pool of persons to be used for addressing drug problems. How far these address drug control objectives will depend on what these structures and technical inputs deliver to the public. A mechanism to examine the content of outputs has not been included in the proposed activities.

Utilizing an existing network of NGOs makes the approach seem cost-effective. An added burden of setting up delivery networks does not then arise. This adds to the feasibility as well as to the sustainability of the project.

Cost effective alternatives too could have been better explored. Had all of the agencies targeted for improvement in this project been activated optimally

they could still provide only a fraction of the impact that is needed to achieve the overall objective. Wider networks than that of the existing NGOs include the health or education infrastructure. Even the social welfare services may provide a more uniform coverage in some areas than the NGO network alone. Perhaps means could have been explored of supplementing the current NGO based strategy with concurrent approaches through these other formal networks.

b. Appropriateness of activities

The activities planned in relation to the outputs constitute a fair attempt to deliver the outputs concerned. Whether the necessary and known time lags in getting a project of this nature off the ground have been taken into account is another matter.

An entirely new notion is to be tried out in the project and it calls for a different way of NGOs relating to each other. These arrangements need time to be understood, accepted and implemented. The delays inherent in such a process getting off the ground appear not to be recognized.

c. Appropriateness of inputs

With the hindsight available at the time of writing this evaluation report the issue with regard to inputs takes a different flavour altogether. The planned funding input failing to materialize fully is the biggest issue with regard to inputs in this project.

Apart from this occurrence, the inputs planned are appropriate to the expected activities and outputs.

D. Executing modality and managerial arrangements

The Ministry of Social Justice and Empowerment, UNODC and ILO are all key players in the project. While project execution was the responsibility of UNODC, the implementation of the project rested with the Ministry of Social Justice and Empowerment. The latter provided technical inputs through the NCDAP. At the managerial level a National Project Manager was over all in charge, supported by counterparts for the workplace prevention component in the ILO and a manager for the E41 project located in the North Eastern state of Meghalaya. A less than cohesive chain of command, compounded by midstream changes of incumbents, resulted in lack of clarity of, and inconsistency in, the managerial and executing arrangements.

CHAPTER II.

PROJECT IMPLEMENTATION

A. Overall assessment

(i) FACILITATORS

Notwithstanding the inadequacies of the project design, which were output rather than impact centric, the project document did lay out a clear implementation path. The project was divided into distinct phases and for each phase outputs as well as activities were listed. This facilitated project implementation as the management as well as all other key participants had a clear understanding of the task at hand.

The project implementation was also facilitated by the fact that existing and well-established delivery channels were being utilized. The countrywide network of NGOs assisted by the Ministry of Social Justice and Empowerment provided the project with a familiar terrain both in terms of individuals as well as in institutions involved in unrolling the programme. This was an important factor considering the span and sweep of the project and it contributed in no uncertain terms to early take off, numerous other constraints typically associated with such ambitious projects notwithstanding. There were, however, some exceptions as well but fortunately their impact was localized. For instance the RRTCs recruited fresh staff for the project which in part offset the experience and expertise of the institutions in the field. This constraint could also manifest in the organizational set up of State Governments too.

In terms of programme content a similar facilitation was at work as most of the interventions under the project were in fact continuations of the “Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse” of the Ministry of Social Justice and Empowerment. This was both a strength as well as weakness (refer Chapter I) of the programme.

A very healthy synergy between the key participants involved in implementation of the project was visible. Despite organizational as well as cultural disparities a remarkable commitment to the project, based upon shared objectives was clearly evident amongst MSJE, UNODC, and some State Governments, participating NGOs, supporting institutions as well as contributing individuals including academics. Once again the impact of variations of commitment was localized. Participation of the state governments ranged from the very interested and proactive in Nagaland to hardly any in some others.

(ii) IMPEDIMENTS

The implementation of the project was time and again impaired by the uncertainties surrounding funding. This manifested itself in a major revision of the programme, withholding of commitments and delays in implementation of

different components. Funding constraints also appear to have caused avoidable stress to the project team potentially undermining its morale and distracting its energies.

A related impediment was the midstream 'change of guard' amongst the key management personnel. The National Project Manager working for E41 and the Project Coordinator for the ILO component left the project at the end of June 2001. Project E41 also witnessed a change of the Coordinator.

Although by utilizing the existing network of NGOs funded by the MSJE the project was treading on familiar ground, it was not able to steer clear of inconsistent delivery channels. The competence of some of the participating NGOs was probably overestimated. For instance there was a delay in identification of the RRTCs for the North East under project E41 as locating an organization with basic competence to undertake the job was arduous.

Finally the project implementation was constrained due to, "the critical assumptions" not holding good. The MSJE was not able to invigorate the NCDAP to the expected extent and provide it the staff strength needed for it to carry its assigned responsibilities. The UNDCP/UNODC was not able to bring in the anticipated funding. There were insufficient NGOs with capability to become RRTCs in E41. The assumed interest amongst NGOs and enterprises to be involved in networking and self-help activities was also found to be wanting in some regions.

B. Delivery of Inputs

The project was dependent upon the quality, quantity and timeliness of inputs emanating from the MSJE and the UNODC. In addition it was also impacted by the contributions of different State Governments, NGOs, academic and research institutions as well as involved individuals.

(i) Ministry of Social Justice and Empowerment

The MSJE met the quantum of funding expected of it at the time of commencement of the project. This was critical in sustaining the momentum of the project. The MSJE also showed enterprise in incorporating financial support to new components under its scheme for Prevention of Alcoholism and Substance (Drugs) Abuse. The ownership of the project by the Ministry lent a national perspective to the project. It also imparted credibility to the programme in the eyes of the State Governments, NGOs, International Agencies as well as Client Groups. The resultant credibility also spurred higher levels of commitment towards the project from all concerned. In fact the basic fulcrum on which the project rested was provided by the MSJE – the countrywide network of NGOs as well as the schematic format of the programme interventions. However, the inability of the MSJE to strengthen the NCDAP also became one of the major constraints of the project. In particular it was unable to position the required staff so essential to power the technical hub of the project. '

(ii) United Nations Office on Drugs and Crime

The UNODC was in the first instance instrumental in evolution of the project as the very genesis of the programme lay in its commitment to bring in funds. The UNODC component of the funds enabled the MSJE to expand the ambit of its existing scheme and to experiment and innovate beyond defined parameters and existing boundaries. It is another matter that the project implementation suffered due to the anticipated quantum of funds from the UNODC not materializing. The UNODC was expected to be able to bring in national and international expertise to the project. The resultant technical inputs still appeared to be of a "one size fits all" type. This notwithstanding the participation of the UNODC certainly imparted an international perspective to the project. Besides strengthening inter-sectoral participation, the UNODC gave the project a "brand image" which proved catalytic in invoking high levels of commitments from State Governments and NGOs. The UNODC also brought continuity to the project by bringing in past experience from partnership with the MSJE.

Together the MSJE and the UNODC brought cohesion to the project, working as a binding force - so essential for the success of any project in a country of India's size and complexity.

(iii) Non Governmental Organisations

The participating NGOs provided the service network and the community out reach to the project. Together as well as individually they also brought in experience and expertise without which the project would have been a non-starter. Considering the limited incursions of the Governmental sector in the field, the reliance of the project on NGOs brought within its fold not only a reservoir of trained manpower but also a substantial client base. The NGOs provided leadership to the project at various levels. They readily shared their material as well as intellectual resources and helped to mobilize support for the programme from different quarters, including perhaps the political.

(iv) State Governments

The participation of the State Governments facilitated project implementation across the country. An inter-sectoral point of convergence was provided by them at the local level between the service providers belonging to both Governmental as well as non-governmental sectors. Some of the State Governments, like those of Nagaland and Mizoram, have identified with the project. It, however, remains a moot point as to whether or not greater participation of State Governments could have been built in the implementation strategy of the project itself. In particular examination of the participation of State Governments in the National AIDS Control Programme as well as in the Integrated Child Development Scheme might prove insightful.

(v) Academic and Research Institutions

The project implementation process received important additional inputs by way of experience, expertise and perspective from the participation of institutions (AIIMS, NIMHANS etc.) and public-spirited individuals.

C. Management and Implementation of activities

The UNODC was entrusted with the task of executing the project, with provision for a tripartite chain of command, which included the MSJE and ILO. An Advisory Committee with inter-sectoral participation was also established to provide guidance on substantive and technical matters relating to the execution and overall management of the project, such as approval of the work plan, establishing criteria for participation of NGOs, communities and enterprises in the project, training curricula and training programmes. The responsibility for the day-to-day management of the project rested with the National Project Manager including the responsibility for coordination with the ILO National Manager. The National Project Manager was also required to serve as Director of the NCDAP for the duration of the project. A National Programme Officer was stationed in the North Eastern States to supervise the day-to-day implementation of activities under project E41.

(i) Management Structure

The lack of clarity as to the managerial and executing arrangements has already been referred to in Chapter I.

Although the National Project Manager was required to serve as the Director of the NCDAP this arrangement seemingly did not get operational. The resultant void was never filled. The NCDAP through the project duration remained rudderless and never became its envisaged nucleus. And its staff strength was not ever brought in line with the responsibilities that it had to deliver. This proved to be a critical gap which showed up time and again.

The concept of constituting an Advisory Committee was laudable but its potential in good measure remained unrealized. It was perhaps unrealistic to expect such a high level inter-spectral committee to meet every two months. Asking this committee to provide guidance on matters of detail such as training curricula and selection of implementing agencies was unrealistic.

The implementation of the project was facilitated by adopting a decentralized approach to training. But the decentralization has not as yet led to much detectable variation in the content of training. The delegation of responsibility for training NGO functionaries to the RRTC's is a case in point. Similarly, the strategy of capacity building of existing service providers was prudent in as much as it optimized the utilization of the existing network. The close coordination maintained by MSJE, UNODC, the project management and participating NGOs ensured minimum levels of delivery on time.

D. Monitoring and backstopping

(i) Monitoring

Programme monitoring was facilitated by a clear and lucid programme design, sometimes spelling out outputs, activities and numbers reached with untenable precision. The mechanism of periodic reviews and performance evaluation was effectively able to assess implementation of the project. Despite important assumptions not materializing the project was able to cover its core activities with the help of pragmatic programme revisions. Clear delineation of responsibilities between important project functionaries ensured attainment of the immediate objectives set forth by the Project.

The establishment of the Drug Abuse Monitoring System (DAMS) in the NCDAP to monitor and document the extent, pattern and trends of drug abuse in the country during the third phase of the project was an important development. It would be desirable for this component to be continuously developed and strengthened as a monitoring tool. How the data generated is to feed into programme activity needs greater spelling out.

However, as brought out in Chapter I, impact assessment has not been attempted. In the process the efficacy of the programme interventions in realizing the basic objective of demand reduction remained untested, other than at rather a perfunctory level.

(ii) Backstopping

The built in mechanisms in the project for backstopping included the RRTCs at the regional level and the NCDAP at the national level. While the NCDAP was positioned to provide support to the RRTCs, the latter in turn were to provide technical inputs and backstopping to NGOs, CBOs and enterprises. A multiplier effect was anticipated through training of trainers. In addition the project planned consultations, workshops and seminars as reinforcements.

Through the better part of the project the NCDAP was unable to provide technical support and backstopping expected of it. This was primarily for want of adequate staffing and as a result the planned facilities for research and documentation, human resource development, information, education and communication. The absence of a nodal repository of technical expertise was felt by participating organizations and individuals down the line. The RRTCs in particular had no institutionalized mechanism for backstopping which limited their development at one level and impeded the coming into existence of a well-knit and cohesive research and training infrastructure so essential to the project. This situation was partly remedied in the revised phase III of the project with the placement of 3 consultants with NCDAP.

The role of the RRTCs was more satisfactory. The project was able to enhance their training, research and documentation capabilities at the outset

itself. The RRTCs were successfully brought on a common platform and provided with support packages including training manuals which enabled them to provide requisite support for capacity building of the NGOs within their jurisdiction. The role of the RRTCs was finalized through MOUs and the resultant institution building has undoubtedly been the major achievement of the project. In particular there has been wide spread appreciation of the TOT programmes which have begun to unleash the benefits of the multiplier effect strategy.

This process has been reinforced throughout the life of the project with the help of consultations, seminars and workshops. The training programmes carried out by the NCDAP as well as the RRTCs have also provided effective feedback, monitoring and backstopping opportunities. The extent to which these opportunities have been utilized, particularly collection, collation and analysis of the data generated remains suspect for want of adequate infrastructure with the NCDAP.

An informal but useful tool available with the project for backstopping has been access to a nation wide pool of subject experts. However, while the project management has had the opportunity as well as the means to tap these resource persons, the RRTCs, the NGOs and the clients have at best had limited or no access to them. It might be worthwhile for the project to institutionalize the participation of such resource persons.

An aspect of backstopping not envisaged by the project but considered desirable is the need to build upon the expertise of Programme Managers themselves as it can hardly be assumed that their competencies require no upgrading.

E. Circumstances affecting the project (prerequisites)

There has been a significant impact of the critical assumptions on the project. The interests in mainstreaming drug concerns in their respective programmes of the Government and UN agencies has been up to expectations. Besides the Ministry of Social Justice and Empowerment, the Ministry of Health and Family Welfare, Ministry of Labour and the Department of Women and Child Development have shown a positive inclination to integrate drug concerns into their respective programmes. The UNODC, the ILO and UNAIDS amongst others have demonstrated strong interest and keen participation in the programme. The response of the various State Governments has been varied but on the whole forthcoming and positive. In particular the Governments of the North Eastern states have embraced the programme actively.

The response of the participating NGOs has been a sheer delight to discover, with a number of them showing exceptional commitment and diligence to the cause. The ARMADA initiative too has met with some success although enterprises on the whole have shown a limited interest bordering on the tepid.

Once again fund constraints and inadequate provisioning of the NCDAP proved a drag on the project.

Chapter 3

PROJECT RESULTS

A. Outputs

Outputs delivered have to be looked at in the light of the unexpected budgetary constraint that occurred during the course of the project. A necessary, perhaps imposed, revision of the project undertaken in 2001 makes the original set of expected outputs already outdated.

We do not intend to list within this report, item by item, the level of achievement of each output. These detailed lists are already well prepared in reviews of project performance and can be read in conjunction with this evaluation report. The terminal project report (TPR) was not yet ready in its final form but the materials going into that were too available for perusal. An 'output-wise' summation extracted from project reports to the extent consistent with our assessment is provided as an annexure (annexe 4) at the end .

The level of documentation and itemized assessment of the outputs of both projects (E40 and E41) is good. Documentation should be specially commended. There is a thoroughness of record keeping and of presentation of findings. The Training Masterplan, (which was rapidly updated into a new revision following the meeting of the RRTCs which took place even as this evaluation was proceeding) is an example of well researched planning. (But it does require several amendments)

Taken in totality, the outputs delivered can be regarded as praiseworthy. It is probably a reflection of great commitment of several parties which has resulted in so much being delivered despite the resources available failing to come anywhere near what was expected and planned for.

It would have been reasonable to anticipate little of the 'revised' outputs being realized by the end of 2002. But the outputs achieved have been remarkable, given the realities. An unexpected interruption of the flow of funds disrupting an ongoing activity could normally be expected to create numerous problems at all levels – making the whole enterprise difficult to resurrect even if all of the funding was later restored. In this case the original level of funding was not restored, by far, but the project has delivered creditably and surprisingly well its outputs.

Much credit is due to the several individuals who were drafted into the project, along with the overall management provided by UNODC ROSA office and MSJE, for keeping the spirit of both projects alive. The partnership with NGOs probably helped these individuals in keeping their commitment high and unwavering.

Among specific outputs to be mentioned, inclusion of HIV/AIDS concerns within what the NGOs deliver has happened satisfactorily. Simply the quantum of HIV related work that the project delivers is impressive.

Workplace prevention, on the other hand, has not reached the same level. The number of workplaces reached for the creation of "workplace prevention" work is few. The level of functioning of ARMADA work too is not yet encouraging.

This is not to say that the workplace approach should be discounted. The materials generated by ILO sets out ways of approaching workplaces, using what the workplace milieu offers. These elements need more strongly to be taken on board. Results encountered during the project show clearly that the approach has potential in application too.

B. Immediate objectives (Outcomes)

Lack of opportunity to detail immediate objectives in relation to the drug control objective has already been referred to. The real position then is that the evaluators have to assess objectives in keeping with their own perceptions of what drug demand reduction activities should set out to achieve, generally. The wording in which immediate objectives are couched, not going beyond the outputs of each phase, does not quite allow and assessment of outcomes in relation to the anticipated impact.

There is difficulty in judging outcomes against the overall, or 'Drug control', objective. Much, if not all, of the documentation stops at the level of activities conducted, numbers reached and materials produced. The crucial step of determining whether these serve in practice to reduce drug problems, increase them, or have no impact either way on them has in some instances to be left to guesswork.

'Results of training'

A logical contributor to achievement of the overall Drug Control Objective is the outcome or impact achieved at the various training activities. This is an example of an immediate objective that the project could have conceived of at the inception. Although the results from given training activities is not stated as an immediate objective, it could usefully have been. The results of the training activities undertaken can be examined to verify how much they contribute to the Drug Control Objective.

The NCDAP undertook trainings of three months' and one month's duration for staff from several agencies. The impact of this training is difficult to discern. Most of the information gathered from participants refer to 'generic' elements of training – how good were the audio-visuals, were the presentations clear etc. An effort has been made to elucidate the subject

specific components carried back by the participants only through a later questionnaire.

Feedback from persons in the field obtained during this evaluation exercise shows that most of them were able to identify an improvement in capability as trainers through NCDAP and NISD trainings. With regard to drug use per se, those who had participated in NCDAP trainings reported that their counselling skills had improved. The skills they were referring to were, once again, 'generic'. Thus they were able to see an improvement in themselves in not being directive with clients, for example. Little was spontaneously identified as things gained from trainings specifically relevant to drug issues. When pressed, some former participants in such trainings said that they had learnt about the harm caused by drug use.

Trainings received from the RRTCs were similarly rated. Former participants felt that 'Training of Trainers' and 'Counseling' training were useful. Apart from these, some of the trainings came in for strong criticism too. 'A waste of time' was among the comments. This was mainly because the content at different trainings were felt to be overlapping much. Uniformly high ratings were given for trainings conducted by the RRTC in Chennai.

Data gathering

This is another example of a potential 'contributor' to achieving the overall Drug Control Objective. On data gathering the project scores highly.

Data collection is not a pleasant or favoured activity of those interested in serving a public need that they perceive. NGOs are action oriented more than research oriented. Clearly evident at all levels of the project was a recognition of the importance of finding out accurately the size and nature of the problem that they were dealing with. There was also clear commitment in the RRTCs, especially evident in those at Chennai and Imphal to examining results of their interventions.

The Drug Abuse Monitoring System is likely to generate reliable and comprehensive data as the programme flows. The contribution of this project through DAMS to the data collection aspect has been large. And it has now become part of the ongoing programme. How different parties propose to use this data was however not clear. They expressed satisfaction that they would be able to better monitor 'the situation' now because of DAMS, but were not able to explain how.

In assessing impact of treatment, all agencies concentrated exclusively on outcome data pertaining to client status after a given period of time. Thus they would be able to say how many clients were no longer using the 'primary substance', using other substances, and how they were functioning in life. Nowhere was data gathered on earlier stages of the process, which would have allowed them clearer understanding of where things needed to be changed if percentages improving were to be increased.

No data pertaining to purely preventive efforts were compiled at any of the centres.

C. Drug Control Objective

Results of treatment

Some results, immediate as well as sustained, are evident. These all related to what is broadly called 'treatment and rehabilitation'. Several centres report carefully their results in terms of numbers and percentages of clients who achieve specified levels of improvement. These include follow-up information up to three months, six months, an year and more. The RRTC of the South, TTK, was exceptional in this regard.

The results reported from all of the centres visited show that percentages of clients who remain 'drug free' at the end of, say, six months varies from 'almost nil' (reported by one organization of project E41, with regard to heroin users) to even higher than 60% (reported by several centres of both E40 and E41 projects, relating to alcohol users or heroin users). Some centres report high percentages of 'success' with alcohol users compared to heroin users, whilst others report the converse.

In all of these instances the results were those gathered by the centre itself and not independently verified. The manner in which the results were discussed and the openness that was visible suggest that these are honest reports. The spirit was mostly of wanting to improve rather than of 'showing off'. The data on treatment appears largely reliable.

Treating drug users occupies centre stage, or nearly all of the stage, in the range of activities that were seen. Both E40 and E41, even though this is nowhere acknowledged or perhaps even recognized, rely on getting drug users off their habit as the way to achieve demand reduction. All agencies that were asked reported that the drug problem in the areas served by them was increasing. The response they believed necessary to turn this around was to provide even more services for the newly emerging larger clientele.

Centres covered by the project E41 were able to provide a 'guesstimate', accurately or otherwise, of the proportion of drug dependent persons reached of those in their 'catchment' area. Centres of project E40 could not, as a rule, estimate or guess the proportion, of people in need out in 'their area', whom they were reaching. Most of them felt that they were reaching only a minute fraction and could not make a dent in the numbers of users. This has important service implications.

One could imagine a day when the network of NGOs of the North East could reach, say, half or more of all drug dependent persons in their area – with perhaps some realistic or imaginable expansion of services. In the rest of the country, or the areas of concern for project E40, there was no conceivable

way of the present delivery model reaching even a tenth (or a hundredth?) of those in need. Such a coverage could not be conceived of even with a realistic expansion of services. This has important implications.

To achieve the stated drug control objective by concentrating exclusively on the current methods appears impossible, most certainly in the areas of project E40 and probably in the areas of E41 too. The stated objective of the original document is, 'That drug abuse among the general population, high-risk groups and drug addicts is reduced and being prevented on a nation-wide scale…'. Treatment services, even if they were 100% successful in weaning all clients off drugs cannot conceivably impact on the size or number of users, at current capacity. A comparison of numbers that can maximally be reached through these services and the size of the universe in need will demonstrate that the exercise will be one of constantly grappling with an ever-increasing load. And success in treatment is rarely close to 100%.

In the majority of agencies visited treatment was primarily through residential stay at the centre itself. In some, the use of 'treatment camps' was reported as a significant component of their activities. Nearly all of the agencies that conducted treatment camps had good things to say about them. They felt that larger numbers were reached. Those less prone or willing to accept long-term residential care were engaged. Community participation was high. And results were no worse than in the intensive residential programmes.

Rarely was there understanding, even at the level of the RRTCs, of how specific feedback could be given to an NGO which reported low rates of improvement and wanted to do better.

Great faith was placed in prolonged residential supervised care as the means of helping persons overcome their drug habit or dependence. In nearly all centres there was a sequence that staff believed had to be faithfully followed. This included a phase of four weeks or so for 'detoxification', a somewhat longer period for 'de-addiction' and up to six months or more of 'rehabilitation'. In this time 'patients' had to have 'counselling' as well as help to develop skills to earn a steady income and relate healthily to others.

All clients needed to learn that they had a disease and that they were powerless, alone, to combat it. The twelve steps of AA or NA were nearly universally seen as an essential and integral part of treatment. Clients were taught that even the slightest 'slip' would result in a relapse. The way to handle 'slips' or 'relapses' was to get back in touch with the organization or counsellor who had helped the person during the initial treatment.

Prevention work

'Prevention' is always spoken of in terms of primary, secondary and so on, by nearly all those involved in implementing the project. This allows them to avoid recognizing the near total absence of primary preventive components in their work. Since dealing exclusively with drug users could also be classified

under some level of this conception of prevention (as tertiary prevention for instance) 'treatment' interventions could readily be claimed to cover 'prevention'.

When prevention activities were explored, nearly all agencies presented some activity that they called prevention. Some referred only to early detection of problems but others described activities more traditionally conducted in the name of 'primary prevention'. These included teaching children about the harm from drugs, 'creating awareness' of the drug problem, and building 'life skills'. The relevant life skill highlighted was 'refusal skills' but even on this there was no generally convincing experiences described.

The knowledge and expertise in the field of true preventive work is alarmingly low. Nowhere was to be found anything near a satisfactory understanding of how preventive work could be evaluated. This inadequacy is evident at all levels of this project.

This lacuna cannot be overemphasized. There was evident in some instances almost a dismissive attitude to purely preventive activities –as if it were a distraction from the real work that needed to be done.

Workplaces

Striking impact was visible in one large 'workplace' – the Karnataka State Road Transport Corporation. Dependent persons, mostly on alcohol, were coming forward in significant numbers to get themselves off alcohol. The management proudly and happily reported that there was a reduction in accidents, an improvement in the image of the service, increased profitability and a reduction in alcohol-related disciplinary problems within the workplace.

ARMADA as an entity was beginning to take off in some local chapters. There was as yet no visible impacts that could be attributed to ARMADA.

In the workplace interventions too little regard and recognition seemed to be paid to 'community' or milieu changes that would influence the wider range of drug users. The opportunities, which the ILO model offers, of reaching every level of alcohol consumer has not been made use of. The project appears to be using the workplace entry to locate 'clients', to treat them individually. They are treated just as a client from any other setting would be treated. Preventive elements of the workplace package do not appear to be adequately applied.

Results of 'treatment' for alcohol dependent persons identified and reached through the KSRTC intervention indicate that almost two-thirds remain 'clean' at longer term follow-up. Although no deliberate attempts were made to change the workplace milieu with regard to how the alcohol consumption was perceived, there does appear to be a milieu influence contributing to the relatively high success rate of treatment. This may possibly be the change in how management views alcohol consumption and dependence. It was clearly

coming down more strongly on workplace alcohol problems and this appeared to be producing good results.

The potential to expand the ILO materials and methodology to more informal work settings remains to be explored.

HIV/AIDS concerns

This is not quite a 'Drug Control Objective' but is most appropriately placed here given the modification in perspective that occurred in the project revision. On this parameter the project has done well. In the Northeast especially (E41) there was clearly evident good understanding of the measures that needed to be undertaken for prevention and care. In fact, there was clearly better understanding of the technicalities related to HIV prevention compared with preventing drug problems.

It would be true to say that in the North East (areas covered by project E 41) there is a move away from injecting drugs and a move away from sharing unclean injecting equipment.

This has relevance to state-wide figures of IDU transmission of HIV. The figures provided indicate that there is a decline in the numbers of persons getting infected through this route. And this is not simply a result, it appears, of 'natural history' – with injecting users switching to other methods because all their accessible veins are blocked, for example. It has been identified as being the result of good and extensive inputs on the subject in the North East region. These include the work generated NACO and SACS through several channels.

Both officials of NACO and at UNAIDS acknowledge that the inputs from project E41 is one of the likely contributors to the improvement in the situation in this region.

The integration of ideas, attitudes and practices that serve to reduce HIV transmission are delivered extremely well through project activities in the North East (E41). These ideas are included well in the project E40 areas too, even though it is not as spectacularly evident as in the North East.

D. Other Results

Building partnerships - successes

Getting all parties concerned with drug problems together is a valuable and important 'other result'. Despite all of the potential difficulties and tensions inherent in getting several NGOs working under the virtual stewardship of one among them, the plan has so far worked. Relationships, dialogue and open experience sharing is clearly becoming the order of the day. The linkages and transfer of experience and expertise is not only among NGOs but also

with other partners. The inclusion of recognized technical experts in the field is also evident.

Potential collaborators working in the field of HIV and AIDS are also linked up rather well with the increasing network of connections. Perhaps the slowest progress is with the health sector. Even here, the dialogue and exchanges as well as trust appears to be improving.

The gathering together of persons and agencies working to reduce the demand for drugs gives them greater clout. Raising the status given to drug issues in the public agenda and improving the allocations for reducing drug problems are potential results of this 'coming together'. Benefits may also occur at community level when a national groundswell is felt at grassroots.

Building partnerships – pitfalls to avoid

Potential harm from this collective partying needs to be recognized and forestalled. In many instances the joint platforms and federations formed of NGOs saw little collective action that they could undertake. The repetitive theme was that they could jointly celebrate events connected to 26th June – or 'Anti Drug Day'. If this is a start to more 'impact oriented' and sustained efforts, it will lead to major benefit.

Perhaps a greater threat is that all approaches may begin to converge – in rather an unhealthy way. Those with greater clout, reputation or earned respect could stifle innovation and branching out. A nightmare possibility of all training and learning on the subject throughout India gradually narrowing down to a limited set of interventions or approaches – or just to one - exists. This far-fetched scenario should always remain far-fetched. Acknowledged leaders within the system need to be sensitive to this risk, and ensure that their genuine superiority does not lead to everybody wanting to imitate them.

'Shutting out' options

This is an extension of the point made in the preceding paragraph. Nowhere in this project is there an intention to shut out some approaches and embrace others. The consultant who serves as National Training Advisor said that one principle behind all training was to expose participants to the idea that there were a range of approaches to treatment in this field and that no one size fits all. Prof Rajath Ray who contributes especially to the training of medical staff at NCDAP described the range of treatment options to which participants are exposed.

The principle of opening out the range of treatment options and experimenting with different options is certainly not evident in the field. The 'time lag' which for inputs at the top to penetrate to the field is one possible reason behind this. But there was inadequate appreciation of this issue even at the level of the RRTCs.

There may be other factors inhibiting attempts ‘at the top’ of injecting variety or widening the repertoire of options being picked up. The relative rigidity of government structures acting as an inhibitor may be one. Eventually all NGOs do have to satisfy the funder, which is the Government. The NGOs may fear that any innovation may not be seen for what it is.

Inertia or fervent commitment to one’s own approach could also contribute. If all NGOs are fervently committed to the same approach, the technical agencies and agents will have a hard time overcoming the resultant inertia and possibly overt resistance. This is a serious worry. All agencies may comfortably be working together and cooperating now purely because there is no philosophical or other differences whatsoever between them. Room will, if so, need to be made for at least a few more flowers to bloom.

Other potential harm

Sensitivity to the risk that interventions carried out with good and pure intentions – minute or grand – can have results opposite to those intended is not adequately existent. This cannot really be expected at the ‘lower’ or unsophisticated tiers of the enterprise. But it must strongly be present at the highest technical levels. The degree to which the potential for well-intentioned efforts to be counterproductive is recognized, and evidently taken into account, is inadequate. This failure does not amount to complacency but is nonetheless worrying.

The small but real possibility that the array of interventions now being carried out could potentially be causing more harm, overall, than good is increased by two factors. One of these is the lack of indicators to assess sensitively the outcomes or early impacts of activities. The other is the relative neglect of wider ‘structural’ or ‘systemic’ influences of interventions, because of the more or less exclusive concern for benefits to the individual client.

Lack of adequate indicators

The dearth of indicators to assess immediate or early outcomes from the interventions carried out increases the risk of unwitting harm. The manner in which a treatment programme was evaluated was to the study of long term follow up to verify the numbers of clients attaining specified levels of improvement. So also with prevention. Effectiveness of intervention was to be assessed by looking at the numbers of persons who took up, or did not take up, drug use later in life.

This reliance on the formal controlled study masks the lack of understanding of more sensitive indicators by which immediate outcomes of interventions should be assessed. The shortcoming applies to both prevention work as well as to ‘treatment’.

Inadequate sensitivity to 'structural' influences

It is easy to create a hypothetical scenario where a campaign, say, to engage injecting drug users could have negative repercussions on others not deliberately targeted. How such a campaign can unintentionally increase the probability of a non-injecting group being nudged ever so slightly towards experimenting with injecting is not difficult to imagine. There was no evidence of this potential risk being seriously considered. In the absence of an understanding of population effects of interventions targeted to specific groups these will not be recognized. (Nor will they be in the absence of interest in measuring shifts in attitudes and opinions.)

Two examples stand out. In one of the centres visited there was a speech by a 'recovering alcoholic' in which alcohol use was portrayed in ways that went beyond the average user's experience of it. 'At the age of 17 I had my first drink and it was so enjoyable that I went search of it again and again'. The image of alcohol's effects given to the non-user is of some magical or wonderful experience. This may not match with most people's real experience of the substance but serves to create an unrealistically attractive aura based on seemingly first-hand experience.

The second example is of a poster intended to prevent sharing of needles. A poster of a large needle was shown, with the caption 'Use Me' and beneath it 'But don't share me'. The intent was to help users avoid sharing unclean equipment. But the poster was for public display. The possibility of this message having other impacts on the wider public was not recognized by the agency concerned.

E. Sustainability

A major strength of this project is that it is virtually embedded in the programme of the MSJE. Thus the structures that are set up and technical inputs that are delivered through the project simply continue as part of programme, by and large.

New structures that are created, on the other hand, are more likely to fold up or atrophy with time. The Project Advisory Committee is an example of such a new structure which probably didn't quite serve its function even during the lifetime of the project. Committees of Concern, where they do begin, will again likely require continued expenditure of energy to keep them ticking after the initial enthusiasm wanes.

More crucial to sustaining the spirit of improving technical capacity in the system is the continued development and improvement of the RRTCs as RRTCs. Their current level of functioning cannot be considered adequate across the spectrum of inputs that they are intended to deliver. And this applies even to the RRTC in Chennai.

CHAPTER IV. CONCLUSIONS

- Energy, enthusiasm and a willingness to work hard was evident at all levels of implementation. This is not to say that there was no pre-existing enthusiasm among all of the parties concerned. But the project has certainly succeeded in providing greater opportunity for many parties to give greater expression to their interest and potential. It has achieved the intended benefit of energizing the ongoing programmes both of the Government as well as of the NGOs in the sector.

  There are several 'tiers' at which project activities occur. Even at the level of MSJE and UNODC the manner in which the project was spoken of, the familiarity with the substance and detail of the project, and the work that had been put in was impressive. This was a refreshing finding – as things tend usually to be a little 'impersonal' at the highest level of any operation.

- A striking capacity, and willingness for people with different agendas and from different agencies to work together for a common objective was evident. This is particularly noteworthy within the NGO sector. As a result the Drug Demand Reduction Programmes have acquired higher priority both in the scheme of affairs of the Government as well as the NGOs.

  The project has also established a nucleus for the future growth of the sector by imparting cohesiveness to the efforts being made by different participants – Government, NGOs, international agencies as well as academic and research institutions.

- Engagement or a remarkably wide range of players into the enterprise was evident. This was described as a bonus that resulted from having to cope with the sudden drying up of expected funds.

  The manner in which the parties concerned – especially UNODC ROSA and also the MSJE – responded to the funding shortfall is an expression again of commitment to the enterprise. Remarkable efforts appear to have been put in, to rescue somehow the activities that had got underway.

  Programme staff of the UNDCP ROSA office deserves to be commended for the effort and perseverance shown in rescuing this project from collapse in the face of severe budget cuts midstream. It appears that the Ministry Of Social Justice and Empowerment and UNODC headquarters (even to the extent of providing inputs from general purpose funds) shared in, and responded in very supportive ways, to the spirited efforts of UNODC ROSA office.

- Both projects (E40 and E41) are need based. They have contributed to filling some of the gaps in the Drug Demand Reduction Programme of the country. Some of the significant achievements being institution building, development of training programmes, documentation of processes and best practices, identification of resource persons and upgrading of their technical competence, improved servicing of client groups, base line assessment of the problem and inter-sectoral convergence. It, however, needs to be qualified that in most cases only beginnings have been made and more ground needs to be covered.

- The project should be viewed in the context of the programme of the MSJE through a network of NGOs for providing services to people with drug problems. The project has introduced into this programme several useful elements.

  One of these is the setting up of a system for improving technical capacity of the agencies and for monitoring this aspect too. There is now scope for technical inputs more readily to be given to the NGOs funded by the MSJE as well as for assessing their effectiveness and efficiency.

  The inclusion of minimum standards of care is another aspect of qualitative improvement. This process is already in place and running rather well. There is evidence that 'unethical' or unprofessional methods of dealing with drug users that were clearly present in the past have mostly been stopped.

  Effective approaches have come to light. The use of peers as educators or 'outreach' to engage current users, the development of self-help groups, and the discovery of the concept of 'drug-free (primarily opium-free)' villages are examples. The potential to extend reach and coverage through the 'camp' approach has received increased attention because of this project. These can be now disseminated to add to the efficiency and effectiveness of the programme.

  The project has facilitated the incorporation of some fresh interventions in the Ministry's programme. These include self-help groups, drop in centers and use of peer educators. The use of a cross section of resource persons, the strategy of capacity building of potentially strong organizations, development of training material and invigorating of ARMADA and FINGODAP are other examples of such initiatives.

- The project has at best been able to elicit only a mixed response from the State Governments. Primarily this has been the case because strong institutional mechanisms have not been built in the project to

involve State Governments. As undisputed stake holders it would be imperative to ensure more active participation. Amongst others the project management may like to draw upon the experience of the National AIDS Control Programme and the ICDS in this regard.

- The question of cost effectiveness of the programme interventions requires to be probed in depth. For a country of India's size it is questionable whether an institution based treatment and rehabilitation programme can ever be scaled to obtain the desired level of coverage. This is particularly true of the area covered through project E40.

  (The assessment contained in the Training Master Plan prepared by the NCDAP reveals that the training cost per person has been higher than Rs.60,000, in the case of the 3 months certificate programme.)

Content

- Several structures have been mobilized or created and extensive processes set in motion to deliver a desired set of inputs, eventually to recipients among the general public. The attention paid to the content of what's being delivered has been inadequate. The argument was often put forward that this would be addressed as the next step in the process. This argument is unsatisfactory. The content to be delivered cannot be parcelled out for later inclusion.

- The project has not made adequate effort to involve and address community-based and community-wide activity, despite its title. The value of adding a community-wide focus to interventions is not appreciated or used adequately. The entire project appears dominated by a focus on how to help drug users. 'Community' is brought in as a means for wider help in the treatment or rehabilitation of the user, rather than as an entity to be addressed or changed for its own sake. This is true even of how most 'treatment camps' have been organized.

  The settings in which the community could have been brought in included the workplaces. This has not been used adequately as a training ground for true community approaches. The only setting where community mobilization was significantly to be seen was in the 'opium free' villages of Assam. Although the approach itself was not primarily generated through the work of the project (E41) it did pick it up for further strengthening and perhaps dissemination.

- There is, at all levels, inadequate attention to process. The 'Training Masterplan recognizes the importance of processes in moving things towards desired changes or outcomes. But there was hardly any

recognition within the wider system sampled or within the contents of training modules of how change in individuals and communities could be set in motion, monitored for their evolution and guided in desired directions.

- An almost exclusive focus on services to drug dependents was evident. Primary prevention is either ignored or paid lip service. Understanding of what measures should or should not be tried in the name of prevention was weak.

- Amongst treatment and rehabilitation activities undertaken there is almost a uniform approach adopted throughout the country. At the higher levels of training, the resource persons concerned said that they were pushing hard to widen the range of services and options offered to drug users. But these efforts appear somehow to have become, or been made, ineffective.

- A strong emphasis on research and data gathering is visible. Despite having a system of information and data gathering that is probably not matched by many countries, there was a constant lament that there was not enough assessment and research. Not enough focus was placed on what could be done with the large amount of data available and further being generated, through DAMS for instance.

  Data gathered on implementation was not often the most useful for improvement of quality or efficiency. There is evident lack of awareness of the more sensitive indicators that would be useful for qualitative improvement of ongoing programmes.

Results

- The project has served more to channel a centrally driven set of ideas, training and materials to the entire system. Movement in the opposite direction, of things that could be learnt from the wide range of experiences available throughout the country, is less.

  There is still a risk that the centralized training system that is in place may serve to stifle innovation. The means are theoretically available for experiences of any agency to be fed back into the wider system. But success of such effort will depend on the ability of the relevant agency to market its approach. There is little evidence of such innovation at the grassroots having been picked up by the system for dissemination. The avenues available for picking up and disseminating such promising strategies are not evident within the system at present.

- The project, to its credit, has probably achieved much in making services for drug users 'client centred'. In many instances there were reports of drug users becoming less stigmatised and marginalized. Punitive approaches have been replaced by more humanitarian ones.

- An almost 'universally' recognized benefit from the project was the improved capability of a wide range of staff in training others. There was not only a recognition of the more efficient methodologies of training but also evidence that these were already being applied by those trained, with noticeable benefit.

Other partnerships

- Attention to issues of HIV prevention and care are well integrated into programme activities and this is specially evident in the North Eastern project (E41). There is better appreciation of technical matters and appropriate intervention and 'messages' about HIV than, perhaps, about drug use issues.

  The integration of HIV issues and concerns is thorough. Drug issues are not seen in isolation from these concerns. This applies to the risks from sharing injecting equipment as well as to the need for promoting safe sexual practices among drug users met as clients.

- The so-called 'ILO component' of looking at workplace prevention provides examples of promising outcome. In these too the focus is mostly on the 'problem' or dependent users and how they may be provided services. The scope for the workplace to be used as a community and a focus for system wide changes leading also to the prevention of problems is not satisfactorily developed.

Continuity

- The inputs from the project are likely to lead to sustained benefits. The ongoing scheme of the MSJE has already adapted itself to support the RRTCs in addition to funding the NGOs operating the mainstream programmes. Within the NGOs themselves there is definite appreciation of the core components of the project, which would ensure continued participation.

  Ideally this input should have commenced now, so that the momentum already built and visible is not disrupted.

CHAPTER V. RECOMMENDATIONS

1. Recommendation : Logical next step

The value additions to the programme of the ministry through this project have been of sufficient weight to justify its continuation. The scope for further useful contribution is still high. The complete potential of this project has not yet been realized and that is not primarily due to a weakness of implementation but to a shortfall of funds. Efforts to further continue the contributions that this project made to the country programme are amply justified.

This has not been 'just any other project' completed and to be closed. The infrastructure and dissemination channels to transmit new learning, and to guide NGOs through feedback on their work and its outcome, are 'ready and waiting' to be used. The MSJE and UNODC ROSA should do their utmost to maximize the benefits of the system put in place by building in a further phase.

2. Recommendation : NCDAP

The primary benefit that this project offers to the Ministry's programme for drug demand reduction is the setting up and activation of an infrastructure to improve technical capacity within its NGO network. NCDAP is central in the efficient utilization of this system now made available.

This agency needs to be strengthened, or alternative arrangements need to be worked out, for the technical inputs to flow. As presently constituted the NCDAP has neither the capability nor the staffing strength to meet its responsibility adequately.

The Training Masterplan prepared by the National Training Advisor sets out a framework for an increased staffing strength. Even though this is an increase in numbers from the present woefully inadequate cadre it still is likely to be inadequate. The function of the apex agency is not merely to train but to monitor and give feedback to the entire system. Such a process requires adequate staff, perhaps five to six persons at lecturer level.

The Ministry pays salaries for around 3000 persons (including 450 accountants!) within the NGO network, to achieve a given impact on the nation. The investment for adequately strengthening the NCDAP to achieve better monitoring and technical feedback is miniscule in comparison. And improving the quality of work of the NGOs could realistically be expected to lead to a significant jump in impact.

An appropriate vision needs to be drafted for the NCDAP in consultation with key partners, drawn from the Government, NGOs and academic institutions, based upon which a path can be chartered for it. Besides being a repository

of technical expertise in the area of drug demand reduction, the NCDAP needs to be equipped with adequate research and documentation capabilities its abilities need to be spruced up, to become the premier training institute of the country, regarding drug use and problems. This would entail augmentation of its administrative and infrastructural capacity. A suggestion worth consideration would be to put in place an inter-sectoral Board of Directors, which could usefully include representatives from RRTCs/NGOs.

Other options, probably less satisfactory, exist. Creating a technical cell within the Ministry is one. Bringing in expertise and commitment by drawing in the RRTCs and other NGOs into a broader forum or taskforce for training, monitoring, ongoing evaluation and feedback is another.

3. Recommendation :RRTCs

The concept of RRTCs constitutes one of the success stories of the project. Their capacities need strengthening to different degrees. All need to be stimulated to study and implement effective preventive initiatives. All centres need to be stimulated to widen the range of treatment options and approaches that they transmit to the NGOs in their region. These have to be taken on as a matter of academic discipline even if the approaches are not entirely in keeping with that practiced in the NGO in which the RRTC resides.

Institutionalised coordination mechanisms between RRTCs need to be built.

The distinction between the RRTC functions and the other functions of the NGO in which the RRTC is based has to be made clearer.

Staffing of RRTCs should be re-examined as to whether the right balance between 'practitioners' (coordinators and field staff) and 'support staff' is achieved. Is there adequate RRTC-related work for an accountant and a documentation officer?

A 'minimum standards' agenda for RRTCs may not be inappropriate. This can be subject to peer verification by the others and by the NCDAP – if its capacity grows adequately.

The potential of increasing their number, strengthening their library and documentation facilities and promoting their usage amongst NGOs as resource centres beyond organisers of training programmes, should be explored.

4. Recommendation : NGO partnerships

NGOs should have a greater voice in determining what they are given as training and guidance. The training needs mapping has to be complemented by a means for NGOs to be able to influence who should be selected for training, for how long, on what subjects or capabilities, when, and so on.

A forum expressly designed to allow individual NGOs to express their ideas and give their inputs to the RRTCs, NCDAP and others may be useful. A system of asking each NGO to contribute at least a short input during training sessions, in rotation, will probably be useful. In this way the combined wisdom residing in the NGOs may better be harnessed.

Efforts at marketing the products of NGOs/self-help groups etc. would go a long way in facilitating rehabilitation and micro credit programmes.

Micro credit arrangements would be better worked out with a financial institution centrally on behalf of NGOs and self-help groups.

5. Recommendation : Committees of Concern

The Committee of Concern of Nagaland represents an outstanding example of inter-sectoral and Governmental – Non-Governmental cooperation which needs to be replicated in all the states possibly as a model initiative.

6. Recommendation :Training

An annual training calendar should be brought out and circulated to all concerned well on time. Training programmes need to be well spaced out during the year as they tend to congest the last quarter thereby straining the infrastructure of the RRTCs and NGOs. Participating NGOs often receive information on training programmes at the eleventh hour making their participation difficult.

- The duration of the training programmes needs to be moderated as the NGOs find it difficult to sponsor participants for programmes of extended duration.
- It would be desirable to involve RRTCs as well as participating NGOs in formulating the training calendar and designing course content.
- A need has been projected to allow RRTCs flexibility in deciding upon training inputs, particularly to incorporate learnings from the field and develop local variations.
- Training programmes need to be developed for doctors, nurses and ward boys. In addition State Government functionaries as well as heads of NGOs need to be trained.
- Graded levels of training programmes need to be introduced so that they can be delivered to homogeneous groups.
- Certification training programmes are likely to enhance quality of participation.
- Computer literacy needs to be promoted through incorporation of inputs in subject training programmes.
- A compilation of Frequently Asked Questions (FAQ) needs to be provided to out reach workers and to Counselling and De-addiction Centres.

7. Recommendation : Training masterplan

The Training Masterplan attempts to provide a basis for determining the training agenda for the coming few years. It forms a good base for planning, but the funding arrangements will probably need to be made clearly evident before starting out. The Masterplan, with suitable modifications and additions, can serve as a base for planning NCDAP training activities for the next few years.

How the content of various subjects are to be spelt out should be made clear. Building the necessary diversity is essential. Appropriate attention must also be given to preventive work.

Greater attention will need to be given to the development of sensitive indicators of process as well as outcome. NGO staff being trained in future should have more inputs on how the outcomes of any one step in a treatment or prevention programme can be evaluated, without having to wait for results that emerge months or years later.

An important part of training that is now inadequately covered is that of guiding processes. Skill in determining change, or absence of expected change, in individuals or communities reached has to be fostered. Staff will then need to be trained in giving appropriate inputs guide and facilitate further progress in desired directions.

8. Recommendation : Indicators

The development of indicators can usefully be made an integral component of interventions. People delivering the service should be guided on the principles for developing indicators to assess progress. This should help to broaden the focus of 'monitoring' – to include evaluatory elements. Agencies will then learn to broaden the scope of what they look for now. Not only will they count, say, the 'Number of counselling sessions conducted' but also think about how many of these were optimally useful.

9. Recommendation : Widening the repertoire

Within the scheme of things in place for what is called treatment and rehabilitation there is an unfortunate restriction to one particular model. All NGOs are being trained in 'counselling', for example. What is imparted, other than generic counselling skills, is not examined carefully and may be teaching all of India's NGOs a particular way of looking at drug dependence.

Different models of understanding the behaviour in question and of interventions have to be given room. The single monolithic training structure could usefully be decentralized as well as widened in the range of approaches that it takes on board.

10. Recommendation :Primary prevention

Greater attention should be paid to primary prevention. Cosmetic activities that pass for prevention should be recognized for what they are. Competence in basing preventive activity on the accumulated knowledge available to date has to be fostered. This should be supplemented with improved capacity for assessing the impact of preventive work.

The recognized risks of counterproductive measures being taken up and disseminated because they are popular must be emphasized.

11. Recommendation : Generating community responses

The skills needed for this go beyond just giving information to large numbers of people in one go. There were several agencies and individuals met during the course of this evaluation who appeared to have the requisite skills. These can be harnessed for training.

General ability to work with communities has to be supplemented by skills in assessing change in communities. Here too the development and use of appropriate indicators should form part of the training.

12. Recommendation : Focus on process

Relative inattention to process in both prevention and care for drug users is visible. Sensitivity to the fact that most change is the result of incremental process was evident among some individuals met during the evaluation. They should be a good resource for training others on the issues involved.

13. Recommendation : Building in feedback

Recognizing the importance of process implies guiding the activities that are happening in directions that are desired. This is a training activity. But it cannot simply be a curriculum that is imparted. Giving useful feedback on a continuing basis requires different skills. NCDAP (or alternative structure at the helm) and the RRTCs have to learn how to match the outcomes that NGOs are achieving with the broad understanding of where they should be taking individuals, families, groups and other communities. Appropriate feedback based on this comparison is an important of ongoing training.

14. Recommendation : Work Place Prevention Programmes

Notwithstanding their modest beginning, workplace prevention programmes need to be further developed and strengthened. The general perception has been that after integration of the project 808 with E40 while the programme direction has been maintained, the momentum has been lost. This trend

needs to be checked. It would be desirable to introduce preventive and early intervention strategies. The programme should endeavour to reach out to the unorganised sector as well. Success stories and best practices need to be widely disseminated.

15. Recommendation : Given that the workplace initiative offers promise, as yet to be properly realized, an attempt to rejuvenate ARMADA will be worthwhile.

16. Recommendation : Learning lessons

Whatever structure or agency is eventually given the responsibility of providing technical inputs to the wider system should have a mechanism built in to look for promising elements in all of the work carried out by the numerous NGOs working in the field. The component of learning lessons and the testing and dissemination of promising approaches cannot be left to chance attention or to formal evaluations.

Part of the prescribed work of the central agency (most probably the NCDAP) and of the RRTCs should be that of picking up ideas that are new. They also need formally to be assigned the task of picking up interventions, new or old, that are showing good results.

17. Recommendation : IT based communication

It was found that the project was making limited use of modern communication and information technology. Even though participating organizations showed only a limited inclination to use IT, it is a foregone conclusion that within the next few years itself IT will make incursions into the programme. It would be advisable to, therefore, evolve a strategy for induction of IT on a planned basis. The sensitivities involved in a programme such as Drug Demand Reduction make communication and IT a double edged sword which is capable of inflicting more harm than good if not used carefully and thoughtfully. The ability of IT based interventions reaching a large but thinly spread client group cost effectively cannot be ignored, the pitfalls notwithstanding.

Although the social sector is not known to widely recognize it, there are indisputable learnings from the corporate sector on harnessing core competencies. The project would be well advised to make forays into the world of Communications and IT using professional agencies.

In the first place there is a need for the programme to develop a Communication strategy. This can be best done with the help of a professional communications partner. The Communications strategy would need to address issues relating to client servicing, information dissemination, advocacy, opinion making and interagency communication. While subject

experts would need to provide technical inputs and put in place safeguards against unintended ramifications of communication, the strategy to be adopted keeping in mind the target groups should be left to the advice of a professional communication partner.

The core elements of a communication strategy would include the following:

(i) An interactive website designed to provide information to clients as well as service partners. It might be worth limiting access to the website to enrolled members beyond obtaining general information. The website could also be used to communicate by the service partners with each other as well as with the Project Management. The construction, management and updation of the website could be outsourced.

(ii) Adopting a CRM approach, a telephone based communication facility (Call Centre) may be developed once again with the help of a professional agency. Such a facility could be used by citizens to obtain information and by clients for counselling. The CRM agency may also be required to collect, collate and mine data arising out of usage of the service. Once again the facility could be outsourced to a competent agency under the supervision of subject experts. Making use of IT a centralized facility may be created which can be accessed countrywide toll free.

(iii) Following a similar outsourcing model a mail order facility may be considered which brings out periodicals for subscriptions by clients and service partners on different aspects of the subject. In addition there may be a related facility for interested subscribers to obtain detailed information/advice on demand.

(iv) A distance learning programme for service providers may be initiated to complement institutional training efforts. This is likely to be functional as well as cost effective.

(v) A well planned effort needs to be made to develop libraries in RRTCs and reading rooms in the premises of selected service partners. The NCDAP might be well positioned to coordinate such an effort.

18. Recommendation : Ministry scheme

The scheme of the implementing agency of this project, the MSJE, could re examine its ‘Scheme for prevention of alcoholism and substance abuse’. It should be useful to build in more flexibility and room to accommodate a multiplicity of approaches.

19. Recommendation : Vigilance about unintended harm

A special heading for this subject is included simply to highlight the risks involved of unintended adverse consequences of some interventions. This is specially a risk when individually focussed interventions have a ‘spill-over’ onto the wider community. Perhaps a component can be built in, requiring agencies to consider the potential harm from whatever activity they plan.

CHAPTER VI. LESSONS LEARNED

- A proportion of total funding required should be secured up front before embarking on projects. This project had a major hiccup when originally anticipated donor funds did not materialize. Activities had by then begun on the basis of projected resource availability, leading to potentially damaging loss of morale and cooperation, when the funds dried up. Future projects should attempt to ensure that at least a given proportion of funds (50% or more) is assured at commencement and the 'guaranteed' versus 'hoped for' quantum communicated to all parties at the beginning itself. (Ref. 'Inputs' – Ch 2)

- The project provides a good example of efforts and resources being directed to optimise functioning of existing agencies rather than creating new ones. Adding a continually operative 'quality assurance' loop to existing programmes allows benefits from the project to outlive the life of the project. If it can be secured, as here, by creating a 'permanent' infrastructure and processes for the quality improvement inputs to flow indefinitely, the benefit will be tremendously enhanced. (Ref. Conception and Design, and Conclusions #2)

- Critical vigilance as to how far immediate objectives reflect antecedent or logical contributors to the overall drug control objective should be exercised. The standard and accepted design for projects such as this one appears to be skewed towards emphasising outputs at the expense of real outcomes or impacts. Whether these outputs lead to reduction, increase or no change in drug use and related problems seem not to be adequately addressed in the current formats for project design. (Ref first comments under 'Conception and Design' – Ch 1)

- In projects such as this, which make lasting contributions to ongoing programmes, any further input (as a 'follow up' project), if necessary, should be put in place without delay. The momentum will thereby be maintained. Projects that are designed to make programmatic inputs should perhaps be subject to a rapid evaluation six months before termination simply to verify whether the programmatic objective requires a further input to consolidate it. (Ref: Conclusions – final item).

Annexe 1: Terms Of Reference

Project strategy, approaches and design, fund flow mechanisms, and in particular:

a) The adequacy of the analysis and identification of the problem to be addressed;

b) The strategy in terms of appropriateness and obtainability of objectives (both immediate and long-term) and attainability of planned outputs / activities within the time frame provided both in the original and revised project documents.

c) The executing and implementing modalities and managerial arrangements and its impact on program delivery issues.

d) The mechanisms for fund flow to ensure adequate and smooth project delivery.

e) The clarity, logic, coherence of the project document including the revised documents.

f) The outputs, implementation methodologies and therefore the appropriateness of agreed prerequisites for project implementation

g) The adequacy of the phases in the work plan and the planned duration of the project as well as the ability of the project to meet with the emerging needs / changing trends of the problem.

h) Indicators utilized to verify achievements of objectives in the revised project proposal.

Project implementation and in particular

a) Project strategy implemented as planned in the project or has it been revised (and for what reasons) during the course of project implementation.

b) The quality and timeliness of inputs;

c) The management framework in terms of the tripartite chain of command.

d) The efficiency and effectiveness of activities carried out;

e) The adequacy of administrative monitoring and backstopping of the project by ILO, UNODC Headquarters, UNODC ROSA and the Government;

f) The fulfillment of agreed prerequisites by the project parties and its impact on the project deliverables.

Project results, impact and sustainability

a) The quality and quantity of outputs produced and of outputs likely to be produced.

This was to be seen in two components: The E 40 and E41 component.

In the E40 component, in line with the revised project proposal, the following was required to be looked at in particular:

1) The ability of the project to develop infrastructure and networks for drug demand reduction programming.
2) The ability of the project to establish a nationwide training infrastructure on drug abuse prevention and reduction and establish a system of analysis for trainings conducted and change training services accordingly.
3) The ability of the project to standardize training inputs through the development of training manuals, resource directory, ngo directory, training master plan, database of trainers working in the field of drug abuse and HIV and other tools.
4) The ability of the project to develop an effective Drug Abuse Monitoring system and complete an initial run.
5) The ability of the project to impact on issues of quality assurance among service providers.
6) The ability of the project to energise national and state level federations on drug abuse prevention and reduction including workplace prevention.
7) The ability of the project to energise and network managers from industries for workplace prevention and adapt modern methods for workplace prevention.

In the E41 component, in line with the revised project proposal, the following were required to be looked at in particular:

1. The ability of the project to sensitize key community groups, NGOs and other stakeholders in drug demand reduction activities and initiate community awareness programmes and lead the receptive communities towards a community based demand reduction program.
2. The ability of the project to involve centre based NGOs to take up community based demand reduction programmes and plan, develop, and enthuse communities and NGOs to utilize community based detox camps as an approach in a resource poor, inaccessible areas.

3. The ability of the project to develop peer based programs and Drop in Centres to complement and supplement detox camps and other community/NGO/CBO based initiatives in far-flung areas.
4. The ability of the project to initiate self-help groups that would provide support to recovering users and women affected and afflicted by drug abuse and drug linked HIV.
5. The ability of the project to bring in convergence among the Social Welfare and Health Ministries at the state level in the vulnerable states of the northeast through Committees of Concern and Meetings of Secretaries/Chief Secretaries.
6. The ability of the project to experiment with innovative approaches to drug abuse prevention using music and sports.
7. The ability of the project to explore alternative models for drug deaddiction and rehabilitation like the Mizo therapeutic Community model.
8. The ability of the project to make available appropriate skill building training for staff of service providers.

a) The likely achievement of the revised immediate objectives;
b) The likely contribution of the project to achievement of the revised long-term objective and the likely impact in terms of drug control;
c) The likely sustainability of project results.

D. Context and external linkages of the project

The evaluation aimed at assessing:

1. The positioning of the revised project objectives within the framework of impacting policy on drug abuse and HIV prevention and control,
2. The adequacy of the revised project outputs complementing the activities of the national/state government schemes and other UN and international agency initiatives
3. The development of linkages with other networks and sustainability mechanisms.
4. The ability of the project to take on board and adapt internationally recognised good practice in drug abuse prevention

Annexe 2: Organizations and places visited and persons met

April 21, 2003

UNODC ROSA

1.	Ms. Renate Ehmer ROSA	Regional Representative, UNODC
2.	Ms. Ashita Mittal UNODC	Sr. National Programme Officer,
3.	Dr. Anand Chaudhuri	Programme Officer, UNODC
4.	Mr. V. Sasi Kumar	National Consultant E40 and E41
5.	Dr. Manjul Khanna	Project Coordinator, E41

ILO OFFICE

1.	Mr. Maurizio Bussi	Director, ILO
2.	Mr. Ravi Chandran	Programme Officer, ILO
3.	Mr. Mukhtiar Singh, IAS 808	Former National Project Coordinator –

MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT

1.	Ms. Jayati Chandra, IAS	Joint Secretary (SD)
2.	Mr. Satyendra Prakash	Deputy Secretary
3.	Mr. S. K. Dev Verman, IAS	Director NISD
4.	Mr. Aditya Joshi	Hon. Project Coordinator E40
5.	Mr. Arun Goswami	Desk Officer, DP-II (MSJE)

PROJECT E40 TEAM

1.	Mr. Anand Bordia	Former National Project Coordinator
2.	Mr. Mukhtiar Singh, IAS	Former Project Coordinator 808
3.	Mr. Aditya Joshi	Hon. Project Coordinator
4.	Dr. Harinder Sethi	National Training Advisor
5.	Dr. Rajat Ray	National Research Advisor
6.	Dr. Suruchi Pant	Project Associate
7.	Mr. V. Sasi Kumar	National Consultant E40 and E41
8.	Ms. Namita Bhutani	Research Associate
9.	Mr. Kamal Gupta	Admin. Assistant

April 22, 2003

UNODC ROSA

1.	Mr. Anand Bordia	Member Finance, National Highway Authority of India & Former National Project Coordinator

NISD

1.	Mr. S. K. Dev Verman,	IAS Director NISD
2.	Mr. Sunil Kumar	Lecturer, NCDAP
3.	Dr. P. Madhava Soma Sundram	Head of Division Training, NISD

4.	Mr. Pravesh Kumar	Consultant, NISD – UNICEF
5.	Dr. Suruchi Pant	Project Associate

TRAINING

1.	Dr. Harinder Sethi	National Training Advisor, E40
2.	Dr. Suruchi Pant	Project Associate
3.	Mr. Pravesh Kumar	Former Consultant, Training Coordinator, E40

RESEARCH

1.	Dr. Rajat Ray	National Research Advisor
2.	Ms. Namita Bhutani	Research Associate

SPYM/RRTC North FINGODAP

1.	Dr. Rajesh Kumar	Executive Director, SPYM (RRTC North)

ARMADA (at ILO)

1.	Dr. Zeenat Naqueti	Secretary, ARMADA
2.	Mr. Ravi Chandran	Programme Officer, ILO

April 23, 2003

T. T. Ranganathan, Chennai

1. Ms. Shanti Ranganathan
2. Ms. Thirumagal
3. Ms. Anita Rao
4. Ms. Maya

April 24, 2003

NIMHANS, Bangalore

1.	Dr. Pratima Murthy	Associate Professor
2.	Mr. Vivek Benegul	

KSRTC, Bangalore

1.	Mr. Hegde	Labour Welfare Officer
2.	Mr. Pratima Murthy	Assistant Professor

April 26, 2003

Calcutta State Transport Corporation, Kolkata

1.	Mr. Santanu Roy Choudhury	Labour (Welfare) Officer
2.	Bhupesh Chakraborty	Union Representative

Vivekanand Education Society (VES), Kolkata, RRTC East Zone – I

1.	Mr. C. G. Chandra	Secretary
2.	Ms. Tapushi Bandopadhyay	Assistant Secretary
3.	Ms. Susmita Banerjee	Co-ordinator
4.	Monideepa Sarkar	Documentation Assistant
5.	Sunita Choudhury	Field Worker
6.	Siddhartha Chatterjee	Field Staff

April 28, 2003

Galaxy Club, RRTC, Manipur

1.	Dr. Jayanta Kumar	Director
2.	Nutan	Field Worker
3.	Jibanmala	Field Worker
4.	A. Basanta	Co-ordinator
5.	Ahonjao	Accountant
6.	Rahaman`	Caretaker

Sneha Bhawan

1.	Mrs. Hatnu	Counselor
2.	Mr. T. Seikhasana	Counselor
3.	Sister Teresa	Director

SASO

1.	Mr. Arjun	Project Manager (OXFAM)
2.	S. Ranjan	Community Worker (RIAC)
3.	L. Laingam	Counselor (OXFAM)
4.	Ch. Boris Singh	Core Worker (RIAC)
5.	S. Sobita Devi	Core Worker (RIAC)
6.	K. Saroj	Assistant Probation Officer (SW)
7.	W. Molenson	Peer Educator (UNDCP)
8.	Kh. Hringkung	Peer Educator (UNDCP)
9.	N. Ibunumgshi devi	President, Ngauulima Council 'Welfare Association
10.	Langoljam Purnima Devi	Counselor (OXFAM)
11.	Th. Sunita Devi	Care Group (President)
12.	W. Banbam_Devi	Care Group (J.S.)
13.	Th. Asha Devi	Secretary Care Group
14.	R. K. (O) Elena Devi	Sr. Social Worker (OXFAM)
15.	L. Birendrajit Singh	Secretary, SASO

April 28, 2003

<u>Meeting with NGO</u>

1.	Dr. A. Rajan Singh	Medical Officer H. C. Centre Thoubal. CommunityDe-addiction Centre Community Development

		Programme Centre M. I. Road Thoubal.
2.	Dr. N. Santakumar Singh	Project Director Rural Development Society Wangjing – 755148
3.	Ch. Phishakmacha	Secretary, Centre for Mental Hygeine (CMH)
4.	Dr. N. Surjeet Singh	Project Director, CMH
5.	Dr. H. Indramani Singh	General Secretary, RHO
6.	S. Mokhendro Singh	Secretary, YDO
7.	Ch. Tikendra Singh	Chief Functionary, MRIS
8.	A. Devidas Sharma	Secretary, Gram Seva Sangh
9.	A.K. Swaranjit Singh	Counselor, Social Reformation and Development Organization, Thoubal
10.	J. C. Sharma	President, YDO Tera
11.	Hopingson Ronglo	Counselor, Healing Point Drug De- Addiction & Rehab Centre, Kakching
12.	Ksh. Dineshwar (Inao) Singh	HIV/AIDS Counselor, Healing Point Drug De-Addiction & Rehab Centre
13.	B. Kh. Schankheep	Secretary, Lamka Rehab Center, Churachandpur district, Dorcas hall.
14.	K. Maharabi Singh	Secretary General, United Voluntary Youth Council, Imphal
15.	Kh. Dinesh Singh	A.P.D, Mangaal Deaddiction Centre, Churachandpur
16.	L. Birendrajit Singh	Secretary, SASO
17.	Naobi Phurailatpam	State Support Person (SSP), Shine Deaddiction Centre, C/o IWCDC
18.	Sandhya M.	IWCDC
19.	Annie Mangsatabam	Secretary, IWCDC
20.	M. B. Sanghnuna	Director, Social Care Ministry, Churachandpur
21.	Dr. M. Rajkumar Singh	KHA – Manipur Yoga & Nature Cure Association
22.	Ms. Moi Ngaihte	Sneha Bhawan, Imphal
23.	S. Teresa Karot	Sneha Bhawan, Imphal
24.	Nancy VungSuanching	LRRC, P.O. Box – 6
25.	Manlalnem	LRRC
26.	L. Miranjan	Centre For Social Development, Imphal
27.	Th. Somorjit	Centre For Social Development, Imphal
27.	Ch. Anand	Kripa Foundation, Imphal

<u>You n I (S.H.G.)</u>

1.	Premananda
2.	Ng. Shatyajit Singh

3. Leishangthem Bobv Singh
4. Kangabam Sananjaima Singh
5. Chanambam Inaobi Singh
6. Ayekpam Jaminichandra
7. Moirangthem Jayanta Kr. Singh

Self Help Groups/Women Groups

1. Sarita Thongbam
2. Sangita
3. Premabati
4. Gaitri
5. Ragina
6. Pratima
7. Pramo
8. Rani
9. Inao
10. Ashalita
11. Ranitombi
12. Udita
13. Ibe

Ministry of State – Social Welfare, Manipur

1.	D Karungthang	Minister of Social Welfare
2.	Mr. A.R. Khan	Commissioner Social Welfare
3.	Lokendra,	Probation Officer, Social Welfare

April 29, 2003

Nagaland

Committee of Concern

1.	Mr. R S Pandey	Chief Secretary, Government of Nagaland
2.	Mr. Sakhrie	Special Secretary to the Chief Minister, Secretary Education
3.	Dr. Kumuini	Project Director, Nagaland State AIDS Control Society
4.	Dr. Yangley	Joint Director Nagaland State AIDS Control Society
5.	Dr. Joyce Angami	Director RRTC and Kripa Foundation Secretary Social Welfare Secretary Health

April 29, 2003

DIC Kripa Foundation

1.	Peshia Lam	President	Network of Naga People Living with HIV/AIDS
2.	Lano Aier	Field Worker	Network of Naga People Living with HIV/AIDS
3.	Gwabinlo	Peer Educator	Kripa Foundation
4.	Seyyie	Peer Educator	Kripa Foundation

		Member of ELPIS	
5.	Rokozo	Member of ELPIS Foundation	
6.	Tribhuvan Lama	Peer Educator	Kripa Foundation
7.	Abou Mere	Kripa foundation	

Youth Mission

1.	Rev. Thupu O Nyekha		
2.	Dr. Rose'		

DRC KRIPA

1.	N. Allem Zargchor		Member of ELPIS Foundation
2.	Sanjay		Kripa Foundation
3.	Abhoa	Coordinator	

SHALOM

1.	Sr. Philo Mylady	Nursing Care
2.	Mrs. Mary Joseph	RNRM, Field Worker
3.	Dr. L. Odymo	Consultant Doctor
4.	Sr. Mariett	RNRM PAN
5.	Wapang	
5.	Gaihai Zeme	
6.	Tanjen	
7.	Menem	
8.	Alfred	
9.	Yangen	
10.	Asuo Solo	
11.	Daniel John	
12.	K. MhasiLekho	
13.	Joseph	

April 30, 2003

BETHESDA

(S.H.G.)

1.	Amenla		
2.	Ahila Aier		
3.	Bubu Mpom		
4.	Chubasenk		
5.	Asenla		
6.	Kezurimo		(Kripa Kohima)
7.	Pangjunglemla	Peer Educator	
8.	Zukumi	Peer Educator	
9.	Anenla Shihi	Peer Educator	
10.	Y. Mchumbemo	Peer Educator	UNDCP/MSJE
11.	Susan Konyak	Peer Educator	Prodigals Home
12.	C. Meren Chang		IECS Tuensang
13.	Abemo Tsopoe		Bethesda, Sannis
14.	N. Renbomo Yanthan Chumikedima		Bethesda DIC ,

15.	Mhabeni Ngvllie	Peer Educator	Shalom
16.	Martin Humtsoe	Peer Educator	Shalom
17.	Rose		SHG
18.	Amongla Wallina		SHG
19.	Sentila		
20.	Amenla		
21.	Amenla Longchar	SSP-MSJE/UNDCP	
22.	David Humtsoe		Bethesda
23.	W. C. Humtsoe	Director	Bethesda

State Bank of India

1.	Mr. Surjya Nath Phukan	Dy. General Manager, SBI Regional Office, Dimapur

May 1, 2003

Tinsukia

1.	Mr B.N. Das	DC, Tinsukia
2.	Mr. Gogoi	SP Police Tinsukia
3.	Mr. Rana K Changmai	Secretary, Probohon Social Service Wing
4.	Dr. Rabbi Kipa	Secretary, Health Consciousness Society of Arunachal Pradesh
5.	Mr. Dipen Moran	Secretary, All Assam Moran Students Union
6.	Mr. Pradyut Bardoloi	Minister of Environment and Forest, Government of Assam SP Excise

May 2, 2003

Tinsukia

1. Ms. Renate Ehmer

May 5, 2003

UNODC ROSA

1. Meeting With E40 and E41 Team

Ministry of Social Justice and Empowerment

1.	Ms. Jayati Chandra, IAS	Joint Secretary (SD)

May 7, 2003

NACO

1.	Dr. Sadhana Rout	Joint Director, IEC
2.	Mr. Pratik Kumar	Deputy Director, IEC

UNAIDS

1.	Mr. Olavi Elo	Interim Country Director
2.	Ms. Nandini Kapoor	National Programme Officer

May 9, 2003

Debriefing Meeting at Meeting Room – II, India International Centre

MINISTRY OF SOCIAL JUSTICE AND EMPOWERMENT

1.	Mr. C. Gopala Reddy	Secretary
2.	Ms. Sarita Prasad	Additional Secretary
3.	Ms. Jayati Chandra, IAS	Joint Secretary (SD)
4.	Mr. Satyendra Prakash	Deputy Secretary
5.	Mr. S. K. Dev Verman, IAS	Director NISD
6.	Mr. Aditya Joshi	Hon. Project Coordinator E40
7.	Mr. Arun Goswami	Desk Officer, DP-II (MSJE)
8.	Mr. P. Madhav Soma Sundaram	Head of Training, NISD
9.	Mr. Sunil Kumar	Lecturer, NCDAP

UNODC ROSA

1.	Ms. Renate Ehmer	Regional Representative, UNODC ROSA
2.	Ms. Ashita Mittal	Sr. National Programme Officer, UNODC
3.	Mr. V. Sasi Kumar	National Consultant E40 and E41
4.	Dr. Manjul Khanna	Project Coordinator, E41
5.	Dr. Rajat Ray	National Research Adviser
6.	Dr. Harinder S. Sethi	National Training Adviser
7.	Dr. Suruchi Pant	Research Associate
8.	Mr. Kamal Gupta	Admin. Assistant
9.	Mr. Jayant Chopra	Secretary

ILO OFFICE

1.	Mr. Maurizio Bussi	Director, ILO
2.	Mr. Ravi Chandran	Programme Officer, ILO

Annexe 4: Summary of outputs

This is an 'output-wise' summation extracted from project reports to the extent consistent with the assessment of the evaluators. Primary data was not sought on all of the outputs.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40)	PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES	
Objectives & Outputs	Activities	Remarks
UNODC PHASE I Output 1 A National Centre for Drug Abuse Prevention (NCDAP), to carry out research, provide documentation, act as a clearing house and conduct training in demand reduction, is set up in terms of premises, staff and equipment. The Centre will contain a Department for Research and Documentation and a Department for Human Resource Development.	Activities 1. The Government to provide building for housing the NCDAP and depute the Deputy Director, two Lecturers, one Research Officer, one Research Assistant, a Documentation Officer, a Technical Officer, Technicians and supporting administrative staff. 2. Provide infrastructure facilities including furniture for the Centre. 3. Provide equipment for the training, research and documentation activities.	The NCDAP came into being in this phase with infrastructure and facilities which even though minimal were sufficient to support commencement of the project.

Output 2 Five Non-Governmental Organizations (NGOs) are selected and contracted to act as Regional Resource and Training Centres (RRTCs) in demand reduction.	Activities 1. Define the functions of RRTCs and criteria for the selection of NGOs to act as RRTCs. 2. Carry out fact-finding and consultation missions to potential RRTCs. 3. Have agreements concluded and signed with selected RRTCs. 4. Develop packages of direct assistance to the organizations, in order to meet the conditions to act as RRTCs, including technical advice, equipment, training and resource material. 5. Define functions, responsibilities and relationships between NCDAP and the RRTCs. 6. Develop a system for the NCDAP to monitor the activities of the RRTCs.	A criteria for selection of NGOs to act as RRTCs as well as a document on functions of RRTCs was finalised. A team led by the Project Manager made visits to different cities for selection of RRTCs. Subsequently, in consultation with the Project Advisory Committee NGOs were selected to function as RRTCs for the southern and western zones. The selection of NGOs for the eastern and northern zone RRTCs could not be completed which affected the take off of the project in the two zones.

Output 3 A training module for medical/paramedical and other staff in the medical sector is developed in collaboration with the Ministry of Health and Family Welfare and the following training modules on demand reduction and management of demand reduction programmes are developed for introduction into the training programmes of NCDAP and RRTCs: - Long term, broad based, multidisciplinary training modules (3-6 months) for service providers in drug education and prevention, treatment and rehabilitation at the senior level in NGOs and Government. These courses will be conducted at NCDAP and will include a one-month on-the-job training component with the RRTCs or other suitable NGO. - Medium term (2-3 week) training modules in community based prevention for NGO/CBO staff. - Short term (3-7) days training modules of a thematic nature in specific areas of drug education and prevention, treatment and rehabilitation for service providers at the middle and junior level in NGOs and Government.	Activities 1. Carry out needs assessment to identify the contents and scope of the modules. 2. Examine existing training modules in India. 3. Review relevant international experiences. 4. Develop training curricula and material.	Within an year of coming into existence the RRTCs succeeded in making their presence felt organising as many as 21 long term and short term training courses in which over 500 NGO functionaries were trained. In collaboration with the Ministry of Health & Family Welfare and the World Health Organisation training courses for medical personnel engaged in the field were organised in leading national institutions. In all as many as 200 doctors working in Government Hospitals and NGO run de-addiction centres were trained. Through a series of consultations short and medium term specific demand reduction topics were identified and training modules prepared which improved the quality of training courses and helped in upgradation of the skill of service providers.

Output 4 Working groups set up in collaboration with UN sister organizations and concerned Government agencies, such as the Ministry of Social Justice and Empowerment, Ministry of Finance, Ministry of Health and Family Welfare and Ministry of Labour, and the Departments of Education, Youth and Sports Affairs and Women's Development, to mainstream drug concerns in their ongoing programmes.	Activities 1. To obtain agreement by UN sister organizations and concerned Government agencies on terms of reference for the working groups and invite them to appoint participants. 2. Convene working group meetings.	Collaborative energies were realised by the project through constitution of the Project Advisory Committee consisting of representatives from related Governments Departments and international agencies. A series of meetings were also organised with Ministry of Health & Family Welfare, Ministry of Youth Affairs and Sports, Department of Women & Child Development, National Commission for Women, Ministry of Tribal Affairs, UNICEF and UNESCO.
Output 5 Initial capability of the NCDAP, Department of Research and Documentation to carry out research and produce documentation.	Activities 1. Provide technical advice to NCDAP staff to conduct research, monitor trends and organise a data base on drug abuse and demand reduction. 2. Identify, review and compile documentation. 3. Link NCDAP to relevant databases around the world through Internet. 4. Develop technical specifications for a computer based drug abuse monitoring system (in collaboration with project IND/D83).	Available information indicates that little or no effort could be made to strengthen the research and documentation capabilities of the NCDAP in the first phase beyond provision of equipment. However, by strengthening related capabilities of the RRTCs some beginning was made.
Output 6 Initial capability of the NCDAP, Department of Human Resource Development, to carry out training activities, established.	Activities 1. Provide technical advice to NCDAP staff. 2. Establish a roster of trainers. 3. Provide orientation and technical advice to identified trainers.	There seems to have been no reported progress on any of the listed activities.
PHASE II		

Output 1 The capability of the NCDAP, Department of Research and Documentation to monitor and document the extent, pattern and trends of drug abuse in India is established.	Activities 1. Establish a computer based drug abuse monitoring system. 2. RRTCs to provide information for the system through standardized electronic reporting to the NCDAP. 3. NCDAP, Department of Research and Documentation to analyse information.	In collaboration with Project D83 – National Survey on Extent, Patterns and Trends of Drug Abuse in India, the process of building a Drug Abuse Monitoring System (DAMS) within the NCDAP was initiated. As many as 14 training courses for DAMS participating NGOs were undertaken.
Output 2 Documentation is produced by the NCDAP, Department of Research and Documentation, consisting of: - A compendium on demand reduction consisting of a series of components addressing different aspects of demand reduction. - A newsletter and a drug demand reduction journal. - A study of groups most vulnerable to drug abuse. - A web-site accessible through the Internet, containing a wide range of information on demand reduction.	Activity 1. NCDAP, Department of Research and Documentation to carry out the research activities required and produce the documentation.	Training modules on specific demand reduction topics were prepared through a series of consultations. A consultant was engaged to edit the manuals. This material contributed to enhancement of technical capacities of service providers in the country. The rest of the capability enhancement programme of the NCDAP did not keep pace with the schedule. Its research and documentation capabilities lagged behind. The NCDAP was also not able to bring out a newsletter and a drug demand reduction journal. Its ability to use web based services also remained restricted. The project made useful progress in forging convergence with NACO and UNAIDS. 100 NGOs engaged in drug demand reduction activities were selected to undertake HIV/AIDS prevention work in collaboration with NACO. The UNAIDS extended funding for training process and RRTC strengthening for IEC and database, advocacy, training and placement facilitation for service providers. During this phase the project also gained ground to work with female drug users. A couple of consultations were held on the subject and a handbook for use by women groups, NGOs and service providers was drafted.

Output 3 Capability of RRTCs to provide information, training and technical support in demand reduction established.	Activities 1. Establish the capabilities of RRTCs in accordance with the package developed for direct assistance to RRTCs. 2. Establish the support and reporting linkages of RRTCs with the NCDAP, including computer linkages. 3. RRTCs to prepare information-, education-, and communication-, (IEC) and resource material in regional languages. 4. Develop and establish Databases and Web sites at the RRTCs.	Three RRTCs for the eastern and northern zones were finalised and support packages prepared for release to them. A meeting was scheduled to bring all the RRTCs on a common platform. There was some progress in establishing the Drug Abuse Monitoring System both at the NCDAP as well as in the RRTCs. On most of the counts the project lagged behind schedule including preparation of databases and operationalisation of a website.
Output 4 50 service providers in drug education and prevention, treatment and rehabilitation at the senior level, in NGOs and Government, trained through long term, broad based, multidisciplinary training courses at the NCDAP.	Activities 1. Establish and announce the criteria for participation in the courses with full information on the courses. 2. Review applications, select and inform participants. 3. Hold the courses.	The NCDAP was able to make insignificant progress in most of the required areas clearly exposing itself as the weak link of the project.
Output 5 150 service providers in drug education and prevention, treatment and rehabilitation at the middle and junior level in NGOs and Government are trained through short term training courses on specific demand reduction issues at RRTCs.	Activities 1. Establish and announce the criteria for participation in the courses with full information on the courses. 2. Review applications, select and inform participants. 3. Hold the courses.	While the training programmes continued to be held, criteria for participation in the courses could not be finalised. This adversely effected the quality of participation in the programmes.

Output 6 50 representatives of NGOs/CBOs, including National Service Scheme – (NSS) and the Nehru Yuvak Kendras – (NYK) Youth Coordinators are trained in community based prevention through medium term training courses and the NCDAP (with participation of RRTCs) and action plans for drug abuse prevention are subsequently developed and launched by the NGOs/CBOs.	Activities 1. Establish and announce the criteria for participation in the courses with full information on the courses. 2. Review applications, select and inform participants. 3. Hold the courses. 4. NGOs/CBOs, with technical support from the NCDAP and/or RRTCs, to develop and launch action plans; and the RRTCs (in collaboration with the NGOs/CBOs) to establish systems for the RRTCs to monitor the implementation of the plans.	A poster on sports against drugs was published and distributed, efforts were also made to establish links with youth groups, media, NGOs working in the field. However, the progress on listed activities was unsatisfactory.
Output 7 150 medical/para medical and other service providers in the medical sector are trained at 10 short term training courses.	Activities 1. Establish and announce the criteria for participation in the courses with full information on the courses. 2. Review applications, select and inform participants. 3. Ministry of Health and Family Welfare to carry out the courses.	The collaboration with the Ministry of Health & Family Welfare resulted in more than 50 doctors being trained. Participation of doctors from the Government institutions and NGOs resulted in developing a framework of cooperation in their respective areas. The criteria for participation in courses and process of review of applications etc. seem to have remained unattended.
Output 8 The relevance, efficiency (cost effectiveness) and effectiveness of training courses are strengthened through evaluation of the courses.	Activities 1. Carry out evaluations through questionnaires for participants and follow-up interviews some time after completion of the courses. 2. Adjust training courses and training material in the light of the evaluation results. 3. Undertake monitoring missions to ascertain the level of utilization of trainees by the nominating agencies.	A structured evaluation of training courses does not seem to have been carried out during this phase.

Output 9 Awareness of drug problems and the possibilities to address them is raised among decision makers at the state level.	Activity Conduct a one-day workshop for parliamentarians and State Government personnel in the Health and Welfare sectors in each State.	Activity not reported upon during Phase II.
Output 10 Curricula for training of trainers and core information packages are developed for inclusion in the programmes of Government and UN sister agencies.	Activity Working groups to develop training curricula and information packages with support from NCDAP.	Activity not reported upon during Phase II.
Output 11 With emphasis on reaching out to groups most vulnerable to drug abuse, 1,70,000 persons are targeted with preventive measures.	Activity RRTC to provide information and technical support and backstopping to NGOs and CBOs, in particular including monitoring of and technical support and backstopping to the implementation of the action plans of 15 NGOs/CBOs in community based prevention.	Activity not reported upon during Phase II.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
OUTPUT 1 The capacities of the NCDAP as a national centre for human resource development is strengthened and a Training Master Plan for drug demand reduction and HIV/AIDS prevention in drug using populations for the next 5 years is in place.	a. Evaluate the training programmes (long and short term) conducted so far through the NCDAP and RRTCs and based on feedback from resource persons and trainees on coverage, content, duration, periodicity, cost structure, eligibility criteria and professional needs, explore the possibilities and mechanisms of incorporating HIV concerns in ongoing programmes and resultant training needs. b. Develop a computerised database of service providers to assess their experience / expertise and accordingly assess their training needs	The NCDAP is seen as the fulcrum on which much of the institutional capacity building envisaged under the project is premised. The organisation still lacks in requisite technical manpower to be able to perform it's role on a sustainable basis. It needs be guided by a vision not yet in place. There is also a need to enrich it with wider and more active linkages with the academic as well as the practising world through formal and informal mechanisms. However given the active time frame of the project the planned interventions have begun to have an impact on it's profile and delivery, though much more ground needs to be covered. The capacities of the NCDAP as a national centre for human resource development has been strengthened by: Placing the following consultants ƒ National Training Advisor ƒ Consultant-Training Coordinator ƒ Consultant- Training & ƒ Research Associate The short-term consultants, a training coordinator and a training & research associate, were placed with the NCDAP for expeditiously rolling out the training activities planned under the Project. The two consultants assisted the National Training advisor in compiling feed back from trainees on coverage, content, duration, periodicity, cost structures and eligibility criteria of the training programmes being conducted by the NCDAP and the RRTCs. These form an integral part of the Training Master Plan, which was developed by the National Training Advisor. A computerized database of the service providers working in the field of drug demand reduction has been compiled to assess their experience, expertise and accordingly assess the training needs for fine-tuning the demand reduction and HIV/AIDS training programmes. The training master plan is based on assessed training needs.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		

	c. Compile a computerised roster (database) of trainers and experts in the filed of drug demand reduction and HIV/AIDS prevention based on the areas of specialisation d. Carry out revision of the curriculum incorporating HIV concerns, and review structure, eligibility, duration and costing of the long term/short term courses	The training programmes (long and short term) conducted so far through the NCDAP and RRTCs (based on feedback from trainees on coverage, content, duration, periodicity, cost structure, eligibility criteria and professional needs) have been evaluated. In this context, the training needs assessment was carried out at various levels: • A bilingual questionnaire was sent to all MSJE funded NGOs to record the NGO profile and training needs of all clinical staff. Responses were received from 286 NGOs. The responses are indicative of the various training needs of the organization and the functionaries. This, in turn has been developed into a computerized database whereby the data may be updated on a continuous basis. The software would not only make the data entry easy but also the maintenance of these databases will be easier in the future also. However, the project team is aware that it is not possible for the project to maintain the database after its completion. There is a need to therefore develop a mechanism to sustain and maintain the database. (• The opinion of RRTCs was taken as to their perception of training needs • Training needs of participants of training-of-trainers programmes was enquired into. • Through analysis and assessment of feedback questionnaires filled by participants of the 3 month and 1 month training programmes Through interaction with trainees during the training courses conducted by NCDAP

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		

	e. Develop an Annual Calendar of Training Events with details on eligibility criteria, dates etc and circulate to all the NGOs f. Develop a Training Master Plan for 5 years based on the assessed training needs	The main task of the National Training Advisor was to provide technical backstopping to the training activities of NCDAP and the Regional Resource and Training Centres (RRTCs). The advisor has also developed a training master plan and systems and mechanisms for strengthening the technical capacities of the RRTCs and NCDAP. A training master plan for the next five years has been developed. Additionally, the Training Advisor has developed modules, manuals, curricula, concept notes for various programmes. An attempt was made to revise the curriculum by incorporating HIV/AIDS concerns in the ongoing programmes of trainings on drug demand reduction issues. In this context, a Facilitators' manual on `Prevention, Care and Support of Drug related HIV/AIDS' has been developed. This manual (along with the Participants manual) enables `user-friendly' techniques and participatory methodologies to conduct a 5-day training programme on the issue. This is likely to bring uniformity in the delivery of HIV/AIDS concerns into training programmes conducted by NCDAP and RRTCs. A TOT facilitator's manual and a manual on Counselling Skills has been developed. The following Databases have been compiled: • NGOs and service providers working in the field of drug demand reduction and HIV/AIDS prevention (both Ministry supported and non MSJE supported NGOs) • ource persons/ Master trainers and experts working in the field of drug demand reduction and HIV/AIDS prevention • Training programmes/ activities conducted by NCDAP, NISD (of Ministry supported and non MSJE NGOs) An annual calendar of training events has been finalised

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
OUTPUT 2 Drug Abuse Monitoring System is established in the NCDAP/MSJE to monitor and document the extent, pattern and trends of drug abuse in India and make annual recommendations for appropriate interventions	• Establish a computer based drug abuse monitoring system (in collaboration with project IND/D83) incorporating HIV concerns • Analyse the Report on the Drug Abuse Monitoring System (developed in Project D-83) and carry out modifications, if any, in the reporting instruments • Develop systems for reporting, compilation and analysis of information • Provide orientation to the core staff in the NCDAP/MSJE/RRTC on compilation and analysis of information • RRTCs to provide information to the NCDAP from all the participating agencies represented by them through standardised electronic reporting • Provide technical backstopping to the organisations in reporting on the instruments to ensure that all the agencies funded by the MSJE are capacitated to provide correct information • Bring out an annual report on the extent, patterns and trends of drug abuse.	Project E-40 collaborated with Project D83 (National Survey on Extent, Pattern and Trends of Drug Abuse in India). One of the components of the project consisted of establishing a Drug Abuse Monitoring System (DAMS) within the National Centre for Drug Abuse Prevention. During the final phase of the project, one of the activities was to build the capacity of NCDAP to carry out the DAMS activity as an ongoing programme at the NCDAP. In order to roll out this activity, a consultant was hired to develop a proposal for incorporating DAMS activities into the ongoing activities of NC-DAP. The consultant has submitted the report. From the recommendations of Project D 83 (National Survey on Extent, Pattern and Trends of Drug Abuse in India), ongoing DAMS project in NC-DAP is in the process of being implemented) 3 Monographs have been culled out from the D-83 ((National Survey on Extent, Pattern and Trends of Drug Abuse in India) Project and have been printed: a) Drug Abuse Monitoring System, b) Drug Abuse Among Prison Population, c) Drug Abuse Among Women (annexure: printed monographs) ‰ The Research Assistant at NC-DAP has been provided training in SPSS to handle the compilation and analysis of data and preparing reports The National Report of the Project on Extent, Patterns and Trends of Drug Abuse (D-83) has been submitted to the Government of India and UNODC, ROSA. The government has accepted this report. The DAMS is not yet a regular ongoing process and would need attention to get incorporated as a sustainable mainstream activity of the centre.
OUTPUT 3 The NCDAP and 8 RRTCs are equipped with essential documents/manuals on various aspects of drug demand reduction & HIV/AIDS prevention	• Collate and compile on CD Rom as well as in print, an information and behaviour change communication package on drug abuse and HIV prevention for NCDAP and 8 RRTCs and for distribution to 450 MSJE NGOs across the country.	The NCDAP and 8 RRTCs have been equipped with the available documents/manuals on the subject. Handbooks, field guides that were developed during phase I and II of the project were edited and printed. Besides, the following materials have also been provided: Resource materials including training modules, thematic pamphlets etc. An information package containing T-

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	• Make available copies of the training manuals developed in Phase-I and II of the Project after the required editing, redrafting and printing	shirts, posters, stickers, cassettes, and a set of 5 CDs on thematic issues of drug abuse prevention, treatment and rehabilitation was sent to 100 MSJE supported NGOs on 26th June 2002. Copies of the training manuals developed in Phase-I and II of the Project after the required editing, redrafting and printing were made available to all the RRTCs. The following three manuals have been developed, printed and disseminated: Drug Addiction- Identification and Initial Motivation Documentation for Addiction Management- Assessment, Client Profiling, Recording and Evaluation Counselling for Drug Addiction- Individual, Family and Group A Facilitator's Manual on `Counselling Skills' has been developed and pre-tested.  For prevention of HIV among drug using population, the following have been developed: A handbook on `Prevention and Management of Drug Abuse and HIV/AIDS' A Facilitators' and Participants' manual on `Prevention, Care and Support of Drug related HIV/AIDS'. A Training manual for empowering women drug users vulnerable to HIV and women burdened by drug use and HIV titled "Drug Abuse and HIV/AIDS concerns of Family Members". With support from the RRTC-West (Muktangan Mitra), a website (www.rrtcindia.org) on RRTCs was launched. This website contains information about each RRTC. In addition to this, it contains a brief write-up on the main stakeholders of the project. Along with this, the website contains articles, a news bulletin, publications and other relevant information on drug related issues. However, it was proposed that the current website would be renamed as the NCDAP website. The functioning would, in turn be carried forth by the NCDAP by outsourcing it to an external agency/ person.
	Make available Guidelines / Handbooks/ Manuals for skill building of service providers on drug and HIV issues for the following high-risk groups: • Prevention of HIV among drug using populations • Handbook for empowering women drug users vulnerable to HIV and women burdened by drug use and HIV. • Developing effective responses to drug and HIV epidemic amongst high-risk populations. • Life skills education for youth in formal and non-formal educational settings. • Increasing coverage of populations vulnerable to drug abuse/HIV/STD through camp based approaches.	
	Facilitate the development of a web site of the NCDAP (through contracting an agency) containing wide range of information on drug demand reduction and HIV/AIDS prevention and responses with appropriate hyperlinks and containing updated information of all important activities of the NCDAP	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
CAPACITY BUILDING OF THE ORGANIZATIONS ENGAGED IN DEMAND REDUCTION		
OUTPUT 4 A cadre of Master Trainers is developed as resource persons for imparting training at the national and regional level on drug and drug related HIV issues and concerns.	60 master trainers (15 each from North, South, West and South Zones) are provided with specialised training skills through 4 Training of Trainers (TOT) programmes on the important thematic areas in drug abuse and HIV through a panel of national and international experts	At the outset, it was decided that international consultants would be invited to impart training to create a cadre of master trainers for the country. Due to unavailability of an appropriate consultant and paucity of time, national consultants would were identified to carry forth this activity. In the process of developing a cadre of Master trainers, a National Consultation of experts was held to finalize the "Guidelines in making training modules and conducting training programmes". The purpose of this consultation was three-fold: To allow resource persons from India to guide the TOT team, and As the first meeting of experts who will constitute the TOT team. To develop guidelines for making training modules and conducting training programmes. The effort was to standardize the array of modules produced so far which range from textbooks, to field manuals to facilitators' manuals Subsequently, a Facilitators' Manual and TOT Guidelines have been developed and pre-tested. To carry forth the objective, 5 training of trainers (TOT) programmes were organized in different regions of the country: 1st TOT Programme at Shillong from 16th to 20th September 2002 2nd TOT Programme at Chennai from 26th to 30th September 2002 3rd TOT Programme at Delhi from 7th to 11th October 2002 4th TOT Programme at Pune from 21st to 25th October 2002 5th TOT Programme at Kolkata from 28th October to 1st November 2002 Through the 5 Training of Trainers programme, 110 trainers have been trained in five regions of the country. These Master Trainers have effectively participated as co-trainers in various training programmes organized by the project. The training of trainers programme has come in for appreciation from field functionaries as possibly the most useful training activity of the project.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
OUTPUT 5 The capacity of the NGOs engaged in demand reduction is strengthened by ensuring that NGOs funded by the MSJE for demand reduction is sensitised through training of key service providers supplemented by the need-based specialised skill development programmes in drug abuse and HIV/AIDS prevention.	Train 100 NGOs and CBOs to provide care and support to HIV infected drug users in ambulatory and inpatient settings- through developing skills via hands on training and placement, in primary health care and management of opportunistic infections, skill building in prevention, early identification, referral and home based care through 10, 5- day training programmes for 200 service providers	This activity was rolled out very judiciously and logically. At first a vulnerability and resource map was drawn to highlight the HIV sensitive areas. A Facilitators manual on `Prevention, Care and Support of drug related HIV/AIDS' was developed. This Facilitators' manual was used for imparting training to the organizations. Approximately 200 service providers have been trained under this activity. An attempt was made towards convergence activities by using training as a tool. For instance, one of the training programmes was organized by the Kerala State AIDS society (KSACS. The participants invited for this programme were not just from the MSJE funded NGOs but also from government organizations, MOH centres, VCTCs and NACO funded targeted interventions. 10 training programmes on `Prevention, Care and Support of Drug Abuse related HIV/AIDS' were conducted by various organizations across the country. The following NGOs were contracted to carry out the training programmes: ƒ Kripa Foundation, Mumbai- 02 training programmes ƒ Sharan India, New Delhi- 01 ƒ TT Ranganathan Clinical Research Foundation, Chennai- 01 ƒ Nirvan, Lucknow (UP)- 01 ƒ Gujarat Kelavani Trust, Ahmedabad- 01 ƒ Link Deaddiction, Mangalore- 01 ƒ Kerala State Aids Control Society (KSACS)- 01 ƒ Gurugobind Singh Study Circle, Ludhiana- 01 ƒ The Calcutta Samaritans, Kolkata – 01 The training programme was structured in such a way that it provided for 4 days of in-house training and 1 day of field placement of the participants in a HIV/AIDS care and support organization. This was done so that the participants could get a feel of HIV/AIDS through observation in a care and support organization. However, TT Ranganathan Clinical Research Foundation conducted a four-day training programme on special request. Also, participants of the Training of Trainers (TOT) programmes were invited to be co-trainers in this training.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA [AD/IND/99/E40} PHASE I, II AND III (Revised} IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outeuts and Activities	Activities	REMARKS
Phase III (Revised}		
STRENGTHENING THE REGIONAL RESOURCE TRAINING CENTRES AS REGIONAL CLEARING HOUSES ON IMPLEMENTATION OF THE PROGRAMMES FOR DEMAND REDUCTION		

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		

OUTPUT 6 The capability of RRTC/RTCs is established as regional clearinghouse on all aspects of drug demand reduction (including workplace prevention and HIV/AIDS prevention) for their allocated regions	To develop a background paper on the envisaged role of RRTC/RTCs and FINGODAP	The role of the RRTCs was envisaged to provide support for capacity building of the NGOs within their jurisdiction/ region for quality service delivery. Two national consultations were organized to discuss major issues and develop a composite, integrated and needs based proposal to carry out the mandate of the RRTCs. A Memorandum of Understanding (MOU) was signed between each RRTC and NCDAP/ MSJE. The signing of MOU enabled the effective and focussed implementation of various programmes at regional levels. It has demarcated the jurisdictions, responsibilities and accountabilities of RRTCs for effective service delivery. A background paper on the envisaged role of RRTCs and FINGODAP has been developed. A national consultation was held in New Delhi from 21-23 February 2002 for the Regional Resource Training Centres. The NCDAP and the Project E40 jointly organized this. This consultation was attended by representatives of the 8 RRTCs- Muktangan Mitra (RRTC-West), TT Ranganathan Clinical Research Foundation (RRTC-South), Vivekananda Education Society (RRTC-East 1), The Calcutta Samaritans (RRTC-East 2), The Society for Promotion of Youth and Masses (RRTC-North), Galaxy Club (RRTC-Manipur, Assam and Arunachal Pradesh), Kripa Foundation (RRTC-Nagaland, Meghalaya), Mizoram Social Defense & Rehabilitation Board (RRTC-Mizoram, Tripura). Representatives of the Ministry of Social Justice and Empowerment, Projects E40 and E41, UNODC, ROSA and ILO also attended the consultation. The role of the RRTCs was envisaged to provide support for capacity building of the NGOs within their jurisdiction/ region for quality service delivery. This national consultation with the heads of RRTCs was therefore convened to discuss major issues and develop a composite, integrated and need based proposal to carry out the mandate of the RRTCs. Representatives from all the RRTCs made presentations and recommendations relevant to their work areas based on the agenda points circulated to them earlier which consisted of training needs, documentation, advocacy, research, monitoring and strategies for further strengthening of NGOs capacity. The participants discussed and finalized the Memorandum of Understanding (MOU) and took the responsibility of strengthening the capacity of their network organizations as

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	To hold 3 day national consultation with the representatives of RRTC/ RTCs, FINGODAP besides MSJE, MHFW and UN agencies to determine/develop the following: • Additional support, manpower, equipments etc.) required by the RRTC/RTCs in carrying out their mandated role • Terms of reference for the RRTC/RTCs/state level federations • MOU between the RRTC/RTCs and NCDAP/MSJE • Modalities for networking of CBR and WPP programmes • Modalities for self-help groups at the city level • Monitoring mechanism for the networking arrangements • Monitoring mechanism for RRTCs	
	Signing of MOU between the RRTC, NCDAP and MSJE demarcating jurisdiction, responsibilities and accountability	
	Formulation of Action Plan of all the RRTCs consistent with the Training Master Plan	
	Provide them with the package of desired technical information and equipment support based on the outcome of the consultations	
FACILITATE PILOTING OF INNOVATIVE INTERVENTIONS FOR DRUG AND HIV RISK REDUCTION		
Output 7 NGOs, conducting community based Deaddiction camps, are strengthened to reach out to over 200000 drug users and at risk young people through spread of HIV/AIDS and Substance Abuse prevention messages	Identify 4 MSJE supported NGOs organizing Deaddiction camps in areas vulnerable to drug and HIV	This activity was subcontracted to Society for Promotion of Youth & Masses (SPYM), the RRTC of the Northern region to coordinate the activity. One resource person from SPYM and one from TTK Hospital will form the resource team to train the organisations involved in organising de-addiction camps in areas vulnerable to drug and HIV/AIDS.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	Train and strengthen NGOs organizing Deaddiction camps to launch a campaign on drugs and drug related HIV/AIDS prevention as part of their ongoing activities being supported by MSJE.	Select NGOs were trained to organize deaddiction camps to launch a campaign on drugs and related HIV/AIDS prevention messages. 1 five-day training course has been conducted and 6 core trainers have been trained. Subcontracts were given to TTK, Chennai and Manaklao Trust, Jodhpur to carry out the proposed activity. One of the NGOs namely, Manaklao Trust launched an awareness campaign at the following sites: 1. Pushkar Fare – 20-10-02. 2. Thar Divas (Barmer)_ - 25-12- to 30-12-02. 3. MARU MELA – Jaisalmer – 1-2-03. 4. Mobile Camp at NOKHA (Bikaner) – 15-2-03 to 01-3-03 In the Pushkar Mela about 1500 persons were benefited through an awareness campaign on drug abuse and HIV/AIDS prevention. In the THAR DIVAS and the MARU MELA the Camel Riders, Tourist guides and the Owners of the Guest Houses were made aware of the HIV / AIDS and advised to use condoms. The youth population was approached by social workers at various places. In addition to this, a 5-day camp was organized at a national highway. A manual on “Integrating HIV/AIDS Prevention into Community based programmes” has been developed.
	Sub-contract these four NGOs to launch a campaign on drugs and drug related HIV/AIDS prevention as part of their ongoing activities being supported by MSJE.	
	Document and disseminate the experience	
Output 8 MSJE supported NGOs/CBOs working with women drug abusers and partners of male drug abusers are strengthened to reach out to such vulnerable women and empower them to reduce risks related to drug use and HIV/AIDS	Organize training programmes for 100 NGOs and CBOs to assist them in incorporating drug related HIV concerns and activities, assist drug and HIV afflicted/infected and affected women to form self help groups and empower them to identify risks and vulnerability to drug related HIV and respond appropriately- STD detection, referral information, coping skills, condom negotiation, relapse prevention, voluntary counselling and testing, home based care and support etc.	In its terminal phase, the project gave a lot of emphasis on training & capacity building of service providers on issues related to empowering women for drug abuse prevention and on reducing the burden of drug abuse on women including prevention of HIV/AIDS especially among afflicted and affected women. The idea was to train NGOs/CBOs including peer educators/female partners of addicts. These functionaries and peer educators in turn would empower affected and afflicted women. For expediting part of this output, the RRTC-

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	Identify 5 NGOS/CBOS and support them to pilot initiatives that will prevent risk and vulnerability in women afflicted by drugs or burdened by drug use in their partners through peer driven mechanisms.	South (T T Ranganathan Clinical Research Foundation, Chennai) developed a course curriculum and training manual for training women affected and afflicted with drug related HIV/AIDS Concerns. This was pre-tested in a training programme conducted by them. Based on this training manual, 10 training programmes were conducted in different regions of the country by RRTCs. Approximately 180 people were trained from various NGOs/ CBOs across the country. The methodologies used in the training were very participatory and interactive. The components of the training programmes included assisting women to form self help groups, to empower them to identify risks and vulnerability to drug related HIV. Information was given on STD detection, referral information, coping skills, condom negotiation, relapse prevention, voluntary counseling and testing, home based care and support. The other part of this output was expedited by inviting proposals from various organizations for supporting pilot initiatives that aimed at preventing risk and vulnerability in women afflicted by drugs or burdened by drug use in their partners through peer driven mechanisms. Invitations were sent out to 19 NGOs in the country out of which 12 responded by submitting their proposals. Out of the 12, 9 were identified for providing support. The names and proposals were sent to the Ministry for approval. Finally, a delay in the final selection process allowed for selecting the following 7 NGOs/CBOs for support. • The Calcutta Samaritans, Kolkata ƒ Indian Institute of Women and Child Health Trust, Dindigul, Tamil Nadu ƒ Mahila Chetna Samiti, Varanasi ƒ Women's Coordinating Council, Kolkata ƒ Mukti Sadan Foundation, Mumbai ƒ NIRVAN, Lucknow ƒ Vivekananda Education Society, Kolkata
	Make available to such identified NGOs, IEC material available in the UN systems/ bilateral agencies and NACO	
	Document and disseminate the experience	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
Output 9 Support community based pilots for risk reduction amongst IDUs	Identify and support 5 NGOs/CBOS to carry out interventions to reduce HIV risk in IDUs	In its final phase the project supported community based pilots for risk reduction amongst IDUs. This included awareness generation on injectable drug use (IDU) and HIV/AIDS. A very important component of this being reducing the risk related to injecting practices thus emphasizing safer injecting practices. In order to expedite this activity, invitations were sent to 11 NGOs inviting proposals for carrying out community based pilot interventions. Out of the 11 NGOs, only 8 responded with proposals and only 4 were identified for support by the project team. The selected list was sent to the Ministry for comments and after substantial delay only two were considered for support. The process of invitation for more proposals could not take place due to paucity of time and finally, the final selection of proposals was downsized to only one proposal. This was Sankalp Rehabilitation Trust, Mumbai
	Document and disseminate the experience	
ESTABLISHING CONVERGENCE WITH THE PROGRAMMES OF THE MINISTRY OF HEALTH AND FAMILY WELFARE FOR SUBSTANCE ABUSE PREVENTION		
OUTPUT 10 Convergence is established between the substance abuse prevention of MSJE and HIV/AIDS prevention programme of MHFW based on terms of reference and action plan accepted by the MSJE and NACO	a. The identified organisations are to be provided with financial support for recruiting the field worker and initiating the programme according to the action plan developed by NACO	In the earlier phase of the Project, in collaboration with MSJE, NACO and UNAIDS a comprehensive proposal was finalized for NGOs engaged in drug demand reduction to undertake specified HIV/AIDS-related activities. The structure, content and implementation details were finalized at an all-India meeting of experts. Select NGOs engaged in drug demand reduction undertook HIV/AIDS prevention activities through a specified field worker. This was a major achievement in operationalising extensive drug demand and HIV/AIDS prevention activities with collaboration of two government ministries (MSJE and Ministry of Health) and two UN agencies (UNDCP and UNAIDS). 10 training courses were organized for training 300 service providers.On the whole the project has made an unusually promising beginning in forging convergence between two government programmes.This partnership would be worth nurturing with care.
ACTIVITIES	b. Develop and print 500 copies each, of 2 manuals, one each for the field worker in HIV/AIDS Prevention and Substance Abuse Prevention Collate and disseminate UNAIDS publications on drugs and HIV/AIDS	
	c. Develop a mechanism for documentation and evaluation of programmes	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	d. Based on evaluation of the programme and explore the possibilities of expanding the programme to all the funded organisations	Additionally, in the revised phase of the project, convergence was established between the substance abuse prevention of MSJE and HIV/AIDS prevention programmes through various training activities in the country. This was established by using training as a tool by inviting MOH deaddiction centre health staff, NACO funded NGOs doing targeted interventions; staff of VCTCs in district hospitals and MSJE funded NGOs in various training programmes conducted by the Project. A meeting with a NACO official in the Ministry of Health (MOH) was convened in mid March 2003. As an outcome of the meeting, it was agreed that in future, an attempt would be made by the MOH to look at RRTCs towards training of their staff in the forthcoming training programmes being conducted by NCDAP or RRTCs in their respective regions. Convergence activities were also attempted by using training as a tool. For instance, in output 5 of the work plan whereby training activities were organized by the Project, an attempt was made to invite participants not just from the MSJE funded NGOs but also from government organizations/ Deaddiction centres and VCTCs and MOH centres. Additionally, another exercise in convergence, which was achieved through the NCDAP budget, was 5 sensitisation programmes for officials of concerned government departments like departments of social welfare, WCD and Health.
	Conduct a one-day workshop for legislators, policy makers and implementing authorities in the Government related to health and welfare sector of each State/UT on drugs and HIV/AIDS	
	Develop a framework for collaboration in monitoring the implementation of the community wide demand reduction programme of the Government of India and sustainability of the interventions initiated under the project	
OUTPUT 11 National Strategy on Alcohol and Drug Demand Reduction is developed in terms of the resolutions/declarations of the UN General Assembly Special Sessions (UNGASS) on Drug Abuse in 1998 and HIV in 2000	To coordinate with the MSJE on the development of a National Strategy on Drug Abuse Prevention and Drug related HIV Risk Reduction in consultation with all concerned agencies.	Communication with the Ministry of Social Justice & Empowerment was established in order to initiate a dialogue on developing a National Strategy on alcohol and drug demand reduction. The outputs emanating from the project are believed to be facilitating the preparation of the The National Strategy by the Government.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN INDIA (AD/IND/99/E40) PHASE I, II AND III (Revised) IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs and Activities	Activities	REMARKS
Phase III (Revised)		
	Establish a working group with representatives from MSJE, NACO, UNDCP, NCDAP, ILO, UNAIDS and RRTCs and ICMR for drafting the MSJE policy and strategy for mainstreaming HIV/AIDS concerns in ongoing Drug Demand Reduction programs.	
	A national consultation is held in New Delhi with the representatives of all partners in the implementation of the Strategy to deliberate and finalise the document.	
	Develop an institutional framework in consultation with the MSJE for periodic review of the implementation of the National Strategy.	
Output The end of the project evaluation is available.	Project co-ordinator to draft the terms of reference for the evaluation in consultation with the UNDCP, the Ministry of Social Justice and Empowerment , ILO .	
	Identify and recruit an international consultant and a national consultant for the external evaluation of the project and field the evaluation mission.	
	Incorporate lessons learnt from capacity building activities undertaken as part of this project into the policy and strategy of the ministry.	
	Final TPR meeting held	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
UNODC PHASE I Output 1 An NGO is selected and contracted to act as Regional Resource and Training Centre (RRTC) in demand reduction.	1. Define the functions of the RTC and criteria for the selection of an NGO to act as RRTC. 2. Carry out fact-finding and consultation missions to potential RRTCs. 3. Conclude and sign agreement with selected RRTC. 4. Develop a package of direct assistance to the organization, in order to meet the conditions to act as RRTC, including technical advice, equipment, training and resource material. 5. Define functions, responsibilities and relationships between the National Centre for Drug Abuse Prevention (NCDAP) and the RRTC. 6. Develop a system for the NCDAP to monitor the activities of the RRTC.	1. Process for selecting RRTCs for the North East was initiated. A team consisting of Project Manager-E40, National Programme Officer, UNDCP-ROSA, and National Project Coordinator, ILO, visited Guwahati and Shillong to evaluate NGOs for selection of the RRTCs. Field visits were also undertaken to evaluate the leading NGOs. Discussions were held with the directors, counsellors and other service providers. Research studies and documents prepared by these NGOs were also reviewed. A report was prepared recommending selection of RRTCs. 2. A list of consultants was compiled and some IEC material collected. Books, manuals and audio visual material were also obtained. 3. Since no RRTC was as yet selected no agreement could be signed. 4 & 5 The project office performed the dual function of its own as well as that of an RRTC. It was provided technical assistance by the NCDAP. 6. A strict monitoring system was not introduced as the project office continued to work as RRTC as well.
Output 2: Existing resources including information, education and communication (IEC) material, documentation, research and experts available in the north-east are identified.	Activities 1. Collate and compile existing documentation, research and IEC material available in the region on drug demand reduction (including drug related HIV/AIDS). 2. Prepare a roster of technical experts available within the region on all aspects of demand reduction (including drug related HIV/AIDS).	1. The process of collecting information on activities of CBOs and NGOs in the North East was initiated. The process is not reported to have been completed during phase I. 2. A roster of Directors of existing De-addiction Centres and a few other research and training experts was compiled.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 3: The extent and patterns of drug abuse in the north-eastern states, in particular including areas and groups at high risk, are identified (in collaboration with UNDCP project IND/D83 to carry out a national drug abuse survey.)	Activities 1. Conduct Rapid Assessment survey to review the trends, extent and patterns of drug abuse in the north-eastern states in collaboration with the national survey on drug abuse in India. 2. Identify high risk groups and areas. 3. Establish systems for continued monitoring of changing patterns of drug abuse and their consequences in these states, including computer based linkages for collating information from the NGOs and CBOs working on drug demand reduction related issues in the north-eastern states. 4. Integrate the monitoring system for the north-eastern states in the drug abuse monitoring system developed under the project covering the main part of India. Publish a quarterly newsletter for dissemination of information. 5. Publish a quarterly newsletter.	1. Progress on these activities not reported upon during Phase I. 2. This was completed. 3&4. This was done through DAMS and with the help of DRCs. 5. There is no progress indicated during the phase on this activity.
Output 4: 25 NGOs are selected and contracted to become de-addiction cum rehabilitation centres (DCRCs).	Activities 1. Define the functions of the de-addiction cum rehabilitation centres and criteria for the selection of NGOs to act as de-addiction cum rehabilitation centres. 2. Carry out fact-finding and consultation missions out to potential de-addiction cum rehabilitation centres. 3. Conclude and sign agreement with selected NGOs. 4. Develop packages of direct assistance to the organizations, in order to meet the conditions to act as de- addiction cum rehabilitation centres, including technical advice, equipment and resource material. 5. Define functions, responsibilities and relationships between the RRTC and the de-addiction cum rehabilitation centres. 6. NGOs to identify their communities for outreach work on community based drug abuse prevention, treatment and rehabilitation. 7. Develop a system for the RRTC to monitor the activities of the de-addiction cum rehabilitation centres.	The project team undertook three separate missions across the region and appraised the capabilities of over 60 NGOs and CBOs. At each site evaluation of the organisation was carried out by visiting its de-addiction centres, interaction with patients and community members, discussions with functionaries of the NGO concerned, and by examination of case files etc.. By the end of Phase I, 14 NGOs and 6 CBOs were selected for participation in the project. This was a strenuous exercise which enabled early take off of the project.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 5: 20 Community-based organizations (CBOs) are selected and contracted to become Community Extension Centres (CECs).	Activities 1. Define the functions of the Community Extension Centres and criteria for the selection of CBOs to act as Community Extension Centres. 2. Conduct orientation and needs assessment workshop for representatives of 20 selected CBOs 3. Conclude and sign agreements with the CBOs. 4. Define functions, responsibilities and relationships between the RRTC, and the Community Extension Centres and between the de-addiction cum rehabilitation centres and the Community Extension Centres. 5. Develop a system for the RRTC and the de-addiction cum rehabilitation centres to monitor the activities of the Community Extension Centres.	20 training courses were held for CBOs through which an understanding of the drug problem, the causes of abuse, the process of addiction, the process of de-addiction and rehabilitation etc. were disseminated. The programme covered major community organisations (Young Mizo Association, Naga Mothers Association, Meira Paibis and Synjuk Seng Samla Shnog). This provided an exceptionally good opening to the project by way of a committed cadre to undertake demand reduction activities through major community based organisations. Agreements were not formally contracted for there was a possibility of the CBOs contravening their strength as community supported institutions due to external funding.
Output 6 : Training modules on de-addiction and rehabilitation, community based prevention and management of demand reduction programmes are developed.	Activities 1. Develop training courses for introduction in the north-eastern states in collaboration with the project covering the main part of India.	A number of training activities were designed and implemented to respond to the local needs including a 3 month training course in the RRTC, a study cum on site training at RRTC Chennai, a short term course on counselling skills and 3 courses for workers, counsellors and field workers.
Output 7 : A sensitization and fund raising programme is developed and launched.	Activities 1. Organize one sensitization programme for parliamentarians. 2. Establish contact by the programme office with representatives of the industries, tea gardens and state chapters of the confederation/federation of industries to sensitize and motivate them to extend support to the drug demand reduction programme in the region.	1. The programme was deferred to phase III as consultations with the North East Council and Governors of two states suggested that sensitisation of Parliamentarians should take place after sensitisation of the community. 2. Consultations were held with the Indian Tea Association for support to the programme resulting in a one day sensitisation programme for managers of tea gardens and staff of NGOs working in the area in the field of addiction rehabilitation. However, no consistent support for the programmes was forthcoming.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
ILO PHASE I Output 8 : Training modules on workplace prevention and vocational rehabilitation of recovering drug addicts are developed.	Activities 1. Develop training courses for introduction in the north-eastern states in collaboration with the project covering the main part of India.	Relevant material was used by an NGO in the Assam tea gardens.
UNODC PHASE II Output 1: The capability of the RRTC to provide information, training and technical support in demand reduction is established.	Activities 1. Establish the capabilities of the RRTC in accordance with the package developed for direct assistance. 2. Establish support and reporting linkages of the RRTC with the National Centre for Centre Drug Abuse Prevention, including computer-based linkages. 3. Prepare IEC, resource and training material by the RRTC in regional languages. 4. Establish a Database and a Web site at the RRTC.	1. The RRTC developed a list of trainers, it was provided access to training materials and information on linkages with information networks and institutions that could be contacted for further materials. 2. Financial constraints inhibited development of computer based linkages between NCDAP and RRTCs. 3. The RRTC began exploring the possibility of preparing IEC and training material in collaboration with local universities. 4. Preliminary fact finding work begun. On a more substantial basis a consultation involving 20 NGOs and CBOs of the region was organised by the RRTC at Shillong which enhanced cooperation between the participants, helped build consensus on programme implementation and reiterated the need for community participation in the programme by involving religious leaders, family, self help groups etc.
Output 2: Personnel from the 25 De-addiction cum rehabilitation centres and the 40 community extension centres are trained in prevention of HIV infection amongst drug users.	Activities 1. RRTC in collaboration with NACO to organize 25 city level workshops on prevention of HIV infection amongst drug abusers and the significant others	The early initiatives of the project of integrating HIV concerns in the programme (using Meira Paibis a women's group) got fillip by way of a grant from UNAIDS for accelerating the HIV component. As a result efforts began to develop self-help groups, peer educators and health workers to support vulnerable communities. De-addiction and Rehabilitation Centres were provided support to provide referral/care facilities for drug users with HIV. In addition advocacy at policy making level was undertaken to facilitate collaboration in the twin sectors. 8 out of 10 workshops with the help of UNAIDS were completed and support from NACO for 20 similar workshops was secured.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 3: 25 NGOs are established as de-addiction cum rehabilitation centres.	Activities 1. Train 250 NGO representatives in de-addiction and rehabilitation, community based prevention and management of demand reduction programmes 2. Provide the packages of technical advice, equipment and resource material, based on specific needs, to each NGO. 3. The Ministry of Social Justice and Empowerment to provide funds to the de-addiction cum rehabilitation centres. 4. Establish monitoring system for ensuring minimum standards of care and practice for de-addiction cum rehabilitation centres.	1. 150 NGO representatives were trained during the period including: A training on patient profiling and documentation was held at Dimapur for NGOs of Nagaland with the help of TTK Clinical Research Foundation Chennai. The participating NGOs were given documentation software incorporating Minimum Standards as prescribed by MSJE. The NCDAP organised a 3 months certification course at Shillong for staff of Drug and Rehabilitation Centres of the North East. The project also supported establishment of six drop-in-centres with a view to strengthening out reach programmes. 2. Requisite material was provided, however, equipment needed could not be provided due to financial constraints. 3. In addition the MSJE continued to support de-addiction cum rehabilitation centres under its programme. 4. NGOs of the region were trained in basic process of maintaining minimum standards.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 4: 20 CBOs are established as Community Extension Centres.	Activities 1. Train 2 persons from each CBO and one representative of each de-addiction cum rehabilitation centre (90 persons) in community based drug abuse prevention through 4 training programmes. 2. Provide information package on prevention of drug abuse, early warning signs and early identification. 3. Organize meetings at the city level for representatives of DCRCs and CECs, where each DCRC networks with at least 1 CEC to provide technical inputs and services. 4. Establish institutional links between Community Extension Centres, the RRTC and the de-addiction cum rehabilitation centres.	1. The process of training CBO representatives was initiated. 2. A manual providing the required information package was developed. 3. State level meetings for representatives of DRCs and CECs were organised in stead. 4. Nagaland was selected to establish links between CECs, RRTCs and DRCs. In addition a number of other initiatives involving CBOs were taken including: A consultation involving all the participating NGOs and CBOs of the region was organised at Shillong. A number of Detoxification camps were conducted targeting use of opium across the region with the help of a specialist agency drawn from western India (Jodhpur), doctors from Assam Medical College and the Arunachal Medical Service. These camps marked a important beginning in empowering the communities in the region to take the initiative against drug use on a sustainable basis. The camps also established a cost effective community based intervention. Other initiatives to mobilise community participation included (a) A project to involve Meira Paibis – a women's organisation which has fought a long combative battle against alcohol (b) Training of headmen and elders of specific tribes of Nagaland to strengthen their involvement against drug use. (c) Campaign in Aizwal using positive recreation to enable youth to stay away from drugs. (d) Proposals for support to a Halfway Home and Drop in Centre in Nagaland. (e) Sensitization training in Assam to members of the Moran community against use of opium. (f) Support to a Drop in Centre in Meghalya to target youth following a sensitisation training programme.
Output 5 : A second batch of 20 CBOs are selected and contracted to become Community Extension Centres.	Activities 1. Conduct orientation and needs assessment workshop for representatives of the 20 selected CBOs Conclude and sign agreements with the CBOs.	The second batch was identified for the training. MoUs were not initiated as they were likely to undermine the strength of the CBOs.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 6 : Community based prevention, treatment and rehabilitation programmes are developed and carried out in high-risk areas, throughout the duration of the project, by 7 NGOs/CBOs or Primary Health Care Centres (PHCs).	Activities 1. Select and contract 37NGOs/CBOs/PHCs (in consultation with Ministry of Health and Family Welfare) to implement community based prevention, treatment and rehabilitation programmes in high-risk areas in collaboration with the Ministry of Health and Family Welfare. 2. Train the staff/representatives of these organisations to undertake the assigned work. 3. Develop action plans. 4. Release funds to these organisations for implementation of action plans and the Ministry of Health and Family Welfare to monitor activities.	1-3 These activities could not be initiated due to security reasons. 4 The State AIDS Control Society supported the programme.
Output 7: Action plans are developed and launched (initially piloted) by de-addiction cum rehabilitation centres.	Activities 1. With support from the RRTC, Deaddiction cum rehabilitation centres to develop Action Plans for their out-reach, de-addiction and rehabilitation work. 2. Release funds not exceeding US $ 1,250 per de-addiction cum rehabilitation centre, per year, for the implementation of action plans. 3. The action plans will include 12 city level workshops organized by the 25 de-addiction cum rehabilitation centres in partnership with the RRTC. 4. De-addiction cum rehabilitation centres explore the possibility of organizing group vocational training programmes by subcontracting activities to a government institution or an NGO. 5. Conduct periodic review of the implementation of the Action Plans by the staff of the de-addiction cum rehabilitation centres (and corrective action taken, as required) and monitoring and backstopping of the implementation of the action plans by the RRTC.	1. The draft action plans were finalised. 2. A delay was experienced in the release of the funds. 3,4&5 Non availability of funds stalled action.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 8 : Action plans for high-risk groups and areas are developed and launched (initially piloted) by Community Extension Centres.	Activities 1. With the Help of the RRTC and the Deaddiction cum rehabilitation centres, 20 Community Extension Centres to develop action plans for high-risk areas, taking into account existing resources and key influences in the community. 2. Provide a grant of US $ 4,000 per Community Extension Centre for the duration of the project to implement the action plans. 3. Provide a one-time grant, not exceeding US$ 500 to each Community Extension Centre for purchase of sports goods, musical instruments etc., for organizing events such as sports/music against drugs at the community level. 4. Community Extension Centres to establish leisure time and sports activities through networking with the Department of Youth Affairs in their areas. 5. Each Community Extension Centre to establish links with Nehru Yuva Kendras (NYKs) and Women's groups in their area and organize sensitization programmes to mobilize youth and women for drug abuse prevention. 6. Monitor the action plans continuously and take corrective action as required, in consultation with the RRTC.	1. Plans reached finalisation stage. 2. Fund constraints reduced the scale of the grants. 3. Due to fund constraints exploratory efforts were initiated to secure alternate funding mechanisms. 4. Inhibited by financial crunch of state level Ministries. 5. NYKs contacted but were found to have presence in limited areas. 6. Action plans were monitored.
Output 9: Youth co-ordinators at NYK and CBOs are trained on life skill education for reducing risk-taking behaviour related to drug abuse and HIV/AIDS	Activities 1. Organize 8 training programmes in RRTCs to cover 200 youth co-ordinators of NYKs and CBOs.	Instead of RRTCs help of NGOs was taken to begin the training programmes as this was considered a more sustainable approach.
Output 10 : To reduce the spread of HIV/AIDS, five community outreach pilot programmes to prevent drug abusers from starting injecting drug use are launched through NGOs.	Activities 1. Identify and select 5 NGOs to undertake innovative pilot projects to prevent initiation of drug abusers into injecting drug use and prevent the spread of HIV-infection amongst drug users. 2. NGOs to submit proposals and prepare workplans.	1. Substitution programmes were carried out on an experimental basis in Manipur and NACO was engaged to finalise the protocol for the same. 2. Only a few NGOs submitted the work plans.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 11: State level decision-makers are sensitized to the drug problems and the possibilities to address them.	Activities 1. Based on the material available develop an information package including a video film for Members of Legislative Assembly (MLAs) and other decision-makers on the subject. 2. Organise a one day workshop in 7 states.	1. Arunachal Pradesh, Mizoram, Nagaland, Meghalaya and Manipur were covered by advocacy programmes. Discussions were initiated to make a video film. 2. The World AIDS Day was used to reach out to all the states.
Output 12: Awareness of the drug problems and the possibilities to address them is raised among key industries and funding arrangements for the activities of the Community Extension Centres are established.	Activities 1. Prepare an information package and distribute it to the functionaries of the key industries. 2. Hold consultations with the enterprises to muster their support for the programme. 3. Regional mechanisms are devised for establishing a fund for drug abuse prevention in the North Eastern states by private enterprises	The project was unable to carryout these activities for want of requisite interest of the Government and industries. Although small support was secured from agencies like Coke and APTECH.
Output 13: A revolving fund is established to provide credits to recovering drug addicts for income generating activities.	Activities 1. Criteria for provision of credits are developed, aiming at a repayment rate of at least 90 percent over the duration of the project.	The project did not have the money to fund this.
III. ILO PHASE II Output 14 : The capability is established for the RRTC to provide information and training in workplace prevention.	Activities 1. Representatives of RRTCs responsible for workplace prevention are invited to attend the national training course in this area conducted by ILO. 2. RRTC is provided with necessary equipment and material to organize training courses. 3. The RRTC representatives are prepared to conduct enterprise and city level training.	1. Training was organised for the tea garden managers and NGOs but not for the staff of the RRTCs. 2&3 The RRTC had the requisite information and its efforts were supplemented on a need basis by the ILO.
Output 15: The capability is established of 25 de-addiction cum rehabilitation centres to carry out vocational rehabilitation and income generating programmes for recovering addicts.	Activities 1. A two-day training workshop on developing income-generating activities is held for representatives of de-addiction cum rehabilitation centres.	Financial constraints impeded this activity although a proposal envisaging support to six poor families affected by drug abuse and HIV to make a living from rearing pigs was formulated.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised). IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
	Activities	Remarks (Evaluation team)
Output 16: Representatives of 2 enterprises (including employers and employees) and 2 NGOs are trained in workplace prevention on a pilot basis with participation of National Centre For Drug Abuse Prevention and RRTC staff.	Activities 1. Under the supervision of ILO, the RRTC will approach 2 enterprises that are interested and meet the criteria. 2. Conclude ILO agreements with 2 enterprises and their partner NGOs. 3. Hold a training of trainers course on workplace prevention programming by the RRTC for representatives of the enterprises (including employers and employees) and NGO staff. 4. RRTC to organize enterprise level workshop for managers, supervisors, employees representatives and NGO staff for the participating 2 enterprises and 2 NGOs. 5. Develop Policy and Action Plan.	Although progress on listed activities is not reported, the project did active work on workplace prevention. A two day training programme for Managers, Supervisors and other facilitators of the 17 tea gardens under Assam Branch Indian Tea Association (ABITA) was held on drug abuse prevention at workplace. A sensitisation programme for members of Mothers Association and workers representatives of tea gardens was organised. A survey of six tea gardens was undertaken by the ABITA and the Association was equipped by the project to undertake training and sensitisation programmes. A five day workshop on workplace prevention for representatives of ABITA held at Kolkata. A survey on assessment of alcohol and drug abuse in selected tea plantations was completed. A MoU for a project proposal on drug demand reduction among tea community and traditional alcohol user tribes was signed by the project with North East Affected Area Development Society. A five day workshop on workplace programming for alcohol, drug and HIV/AIDS related problems was organised in collaboration with ABITA and involving the ILO office.
PHASE III (Revised)		

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41)
PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES

Outputs	Activities	Remarks
Output I: Three NGOs strengthened to serve as Resource and Training Centre (RTC) in the north-eastern states of India. .	• Define the functions of the RTC and develop terms of reference for its activities. • Identify and select three NGOs in the north-eastern states to serve as resource and training centers • Conclude and sign agreements with 3 RTCs and MOU is between the RTCs UNDCP and NCDAP. • Transfer assets to NGO based RTCs from existing RRTC at Project office as well as develop a package of direct assistance to the RTCs in order to meet the conditions to act as RTCs. • Project Office, in consultation with NCDAP, develops the training plan for the Northeast of India to be carried through the identified NGO based RTCs • NCDAP develops a system to monitor the activities of the RRTCs	During the period of implementation a strategic decision was taken by the Ministry of Social Justice & Empowerment (MSJE) to identify three Regional Resource and Training Centers (RRTCs) for northeastern states to link and be capacitated by the UNODC supported Office at Shillong. Three lead NGOs in Manipur, Nagaland and Mizoram respectively were thus identified and linked to 40 NGOs supported by MSJE. The RRTCs have also established contact with the National Centre for Drug Abuse Prevention (NCDAP), which is the nodal training arm of the MSJE. The selection of the 3 NGOs initially seem to have posed a challenge. The quality of the RRTCs visited was expectedly inconsistent .There is a perceived need to enhance the documentation and research capabilities of the RRTCs of the region.The NGOs of the region have shown a positive response to the concept of the RRTCs as integrators as well as capacity builders.
Output 2: The extent and patterns of drug abuse in the northeastern states, in particular including areas and groups at high risk, are identified (in collaboration with UNDCP project IND/D83 to carry out a national drug abuse survey.	• Support preparation of report for the same	In collaboration with UNDCP's Project D 83, a Survey on Extent and Patterns of Drug Abuse in NE states, covering high- risk behavior groups has been completed. The document would establish a benchmark to measure future activity. The research corroborated existing studies gathering evidence that HIV in at least 4 of the northeastern states was directly linked to drug use, particularly injecting drug use and that two of these state were into a generalized epidemic of drug related HIV.
Output 3: 25 NGOs are strengthened to serve as de-addiction cum rehabilitation centres (DRCs) and implement community wide drug demand reduction programmes in the 7 north-eastern states of India.	• Project Advisory Committee (PAC) selects and approves 11 more NGOs, (in addition to the 14 NGOs already selected in the phase I & II of the project) to serve as DRCs and to implement community drug demand reduction programmes amongst drug abusers. • 25 NGOs identify their communities for outreach work in community based drug abuse prevention, treatment and rehabilitation. • 25 selected NGOs develop work-plans for community based Drug Demand Reduction activities. • Issue subcontracts to 11 NGOs for carrying out the planned activities.	The project has been able to make effective use of deaddiction camps to reach out to the community .In Assam the camps succeeded in three cases to catalyze the village community to completely eradicate use of opium. The camps were complemented by 23 Drop in Centers (DIC), which reach out to both the recovering users and HIV affected and infected. Each DIC reaches about 200 people. The services offered include preventive education, condom promotion, injecting risk reduction services, VCT, aftercare and post test referral and follow-up. The project has reached a stage where the elements of community-based work have taken hold among the NGOs and CBOs. As there was a need to catalyze the process to move faster, State Support Persons were provided to four selected NGOs in Manipur and Nagaland, of which two are the identified RRTCS. This enabled accelerated decentralized responses at the state and community level.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41)
PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES

Outputs	Activities	Remarks
Output 4: 5 Community-Based Organisations (CBOs) are strengthened to undertake Drug Demand Reduction and HIV/AIDS prevention activities in partnership with the 5 NGOs already selected by the project to work within the communities selected by them.	• Project Advisory Committee select, approve and finalise the list of 5 CBOs for undertaking community based drug demand reduction and HIV/AIDS prevention activities. • Facilitate the networking between the NGOs and CBOs by developing closer linkages through coordinated programming. • Subcontract CBOs for implementation of the action plans. • NGOs provide technical support to CBOs for preparing their action plans and implementation of community based drug abuse and HIV/AIDS prevention activities.	The CBOs are grassroots organizations and are a major presence in communities of the Northeast of India. They are in touch with and provide services for all social problems of the community including that of drugs and HIV. Women and youth groups, church and religious leaders play a significant role in providing an enabling environment. The CBOs have forged linkages with the NGOs in their respective areas and are working towards community-based interventions and awareness programs in drug abuse and HIV. Four such CBOs have been strengthened and are working in partnership with MSJE supported NGOs in the area. The fifth is working on an ILO based program within the ambit of the project in Assam. Self-help groups are being formed by CBOs, giving the project a wider base at the grass root level.The project has been imparted a distinctive flavour by the participation of these organizations and theire involvement provides an important lesson for future direction of similar community based interventions.
Output 5: Committees of concerns are established in four states i.e. "Nagaland, Manipur, Mizoram and Meghalaya" for inter sectoral collaboration on drug demand reduction and HIV/AIDS prevention.	• Establish committees of concern with representatives from departments of welfare, health, Youth Affairs & sports, State AIDS cells, Law enforcement agencies, Churches and other community stakeholders, for monitoring the implementation of activities proposed under the project. • Facilitate development and advocacy for creation of an enabling environment within the states and grassroots level through the committees of concern. • Project Office and Committees liase with and explore possibilities of mobilising additional resources from International and other development agencies for addressing other socio-economic issues related to drug and HIV/AIDS. • Organise bi-monthly/quarterly meetings at the state level for reviewing the progress.	The Committee of Concern (COC) is a concept that has been mooted by the project in an effort to consolidate the learning from the project, disseminate it within the state governments and enable government staff to act on the same. The body is composed of senior government functionaries, opinion makers, NGOs, private institutions and the media. They have a mandate to act as a pressure group, initiate studies and learning to add to the existing body of knowledge, and build convergence with various government ministries to tackle the issues of drugs and HIV/AIDS. The COCs are the vehicle to ensure that the project learning are not lost after the project life but are taken on by the state governments and developed into substantive responses by the states.The project can justifiably count the COC of Nagaland as a major success worthy of emulation across the country.Already: • In Meghalaya and Nagaland, action plans have already been formed and would soon be put into practice. In Nagaland, the COC has requested for the inclusion of drugs and HIV in the school curriculum. It has also formulated a drug and HIV State Plan for Nagaland. • In Manipur, the responsibility is being taken up by the RRTC. In Mizoram, the Chief Minister of the state has taken the initiative to organize and establish a "Care Committee". • In Meghalaya, a Planning Meeting for Stake Holders was facilitated at the Project office for working out ways and means of collaboration between the state Social Welfare departments and Health departments, the State AIDS Control Societies and the RRTCs.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs	Activities	Remarks
IV. Output 6: Technical capacities and skills of 100 service providers from the 25 NGOs and collaborating CBOs identified under the project are strengthened in drug demand reduction and HIV/AIDS prevention and care.	• Organize 6 training programmes for representatives of NGOs and CBOs in community based drug abuse prevention and rehabilitation as well as care and support of HIV/AIDS affected.	The project has facilitated the MSJE supported NGOs to move from a center-based approach to a community-based approach. The project is now looking at expanding the ownership of this vision and getting the NGOs and CBOs to carry the program forward. Methodologies have been developed to enable communities to manage drug abuse rehabilitation within their geographical areas with support of the NGOs supported by the project and the MSJE. Alliances have been fostered with CBOs and other institutions in the government and non-governmental sectors for district level joint planning on an identified continuum of care for drug and HIV risk reduction and possible mechanisms of care and support referral. This has been a significant achievement. Training of Trainers (TOT): The project facilitated training needs assessment for the MSJE NGOs and the identified CBOs on provision of minimum standards of care and support. A needs assessment survey highlighted gaps in skills on thematic issues related to both drugs and HIV, outreach services, relapse prevention, counseling through the peer approach etc. It also highlighted the issue of identifying and training resource persons who could then capacitate key stakeholders in the local language. Following a meeting of all the 8 RRTCs in India, at New Delhi, the process of identifying and training of such master trainers was crystallized. The TOT process was carried out subsequently at the UNODC office in Shillong and was highly appreciated by the 3 RRTCs and the trainees. Peer Educator Training: 120 Peers both affected and afflicted were identified, trained and short listed for placement and interventions with MSJE NGOs and identified CBOs in the 4 badly affected states of Manipur, Nagaland, Mizoram and Meghalaya. 40 peer educators are now in place and are undertaking risk reduction initiatives in Nagaland and in Manipur. They have been provided skills and tools for relapse prevention and setting up Self Help Groups. District level trainings: 10 district level training Service Providers were planned and completed. National AIDS Control Organization (NACO), Government of India, is providing financial support for carrying out 20 more training programs at the district level. Skill Building: Five skill-building trainings for NGOs in counseling, relapse prevention and family counseling have been submitted to the Ministry for approval. This would provide focused and comprehensive care to the recovering users and People Living With HIV/AIDS (PLWAs).
	• Provide opportunities for skill building on specific issues of counselling, community based care and support, relapse prevention and self help groups at the NGO level by placing technical support person from other NGOs in the region.	
	• Evaluate the impact of the training programmes organized in Phase I, II and III with the help of a technical consultant.	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs	Activities	Remarks
V. Output 7: Build the capacity of UNDCP-MSJE office at Shillong to act as a Regional Resource & Training Center for the Northeast	• Establish potential linkage with NCDAP using computers and normal post.	The UNODC-MSJE project office has organized a number of trainings to mainstream HIV concerns in ongoing drug demand reduction activities and has been providing technical support to the NGOs/CBOs in the northeast. The documentation section at the project office has functioned as an archive on drugs and HIV for the region. This has enabled communities to have better access to information and services through the resource kits, available at Shillong on the thematic issues. Two technical consultants were contracted for backstopping the project and ensuring decentralized focus on drug and HIV issues, designing and monitoring interventions and building of capacities in the region.
	• Develop a Documentation Unit at RRTC to prepare IEC materials, store information, and establish a training resource database. State wise collection of data by support persons, reports on trainings, any other ongoing activities, updating information on programs in each state.	
	• Hire consultant for coordinating activities specific to HIV/AIDS at UNDCP RRTC.	
Output 8: Strengthen the SACS through TRG-IDU process to manage & monitor programs at the state level. Sate and regional resources identified to facilitate ongoing capacity building for a multi-sectoral response	• Strategic planning meeting of CMs – ½ day along with meeting of Northeastern Council. • This would have to be done through the Minister for Northeastern Affairs, Mr. Arun Shourie	The State AIDS Control Society (SACS) is the nodal agency for HIV/AIDS in each state and are active partners in all project interventions. The project has been able to develop and establish several approaches that are community based and sustainable. In order that this be debated, discussed and internalized at the highest levels of the state, a meeting of the Chief Secretaries, Secretaries and Directors of Health, SACS and Social Welfare from all the Northeastern States was held. This meeting aimed to advocate convergence, provision of comprehensive quality services and perceiving both drugs and HIV as developmental issues. Nodal Officers of the health and social sectors met before the meeting to plan out strategies that would be holistic and time bound in terms of activities and outcomes. The Secretary, Joint Secretary from Ministry of Social Justice and Empowerment Government of India, also attended the meeting. A strategic alliance was also forged and facilitated by the project between the MSJE and National AIDS Control Organization (NACO). NACO has also placed an supported through skill enhancement, an HIV Field worker in 25 of the 40 NGOs in the Northeast supported through the MSJE in order to expand the network and referral system, sensitize communities at risk and mobilize them to fight stigma and discrimination.

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41)
PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES

Outputs	Activities	Remarks
	• Strategic planning meeting with Secretaries, Director level staff of Health & Social Welfare as well as NGO/CBO representatives. • Twin track meetings with • Track one having Secretary level/ DGHS and equivalent from Social Welfare, SACS PDs, NGO coordinators, Key NGOs, Hospital Doctors • Track two with CBOs, Women's Groups, Youth Groups, Priests, and Teachers etc. • 3 such Twin Track meetings in Manipur, Mizoram, Nagaland This should be the UNICEF supported workshop. Dates are at the convenience of UNICEF. Manipur workshop could be planned for October 2001. The Mizoram and Meghalaya ones every two months starting January 2002. Nagaland one is complete.	
VI. Output 9: Develop capacities of MSJE funded NGOs and CBOs working in Drug Demand Reduction to incorporate HIV concerns in their ongoing activities, undertake rapid situational analysis, raise quality of services and undertake new initiatives	• 5 day training of approx. 200 selected service providers from NGOs and CBOs through 10 city level workshops, on providing HIV care and prevention services to different target populations in a community wide demand reduction context. Includes strengthening of these CBOs/NGOs to undertake such activities. • City Level Trainings in: Khliehriat (kh), Tura (tu), Aizawl (az), Lunglei (ln), Dimapur (dm), Tuensang (tn), Wokha (wk), Imphal (im), Ukhrul (uk), Churachandpur (ch)	Innovative initiatives facilitated further involvement of community based structures and resources and enabled formation of links and networks to better respond to drug and HIV mitigation. Skills were built round demonstration projects such as community-based detoxification, income generation and vocational therapy pilot programs, setting up drop-in-center pilot initiatives etc. This provided communities and service providers to interact and accept issues that were sensitive, hidden and did not allow the social mobilization process. This was a seminal achievement of the project. The project has ensured that along with drug demand reduction activities, HIV risk reduction among drug using populations is also focused on. District level trainings have enabled a variety of service providers and NGOs to enhance their skills in dealing with HIV amongst IDUs and drug users. Proposals for 3 Family Support Centers, one each for Mizoram, Nagaland and Manipur have also been submitted to the Ministry. This would enable the NGOs to provide counseling to the family members so that they become aware of the signs of relapse and identify high-risk behavior in the recovering user. The family would also learn to overcome the discrimination and stigma attached to addiction and thus is able to help in the recovery process. Income Generation activities have been provided to NGOs in Manipur who have clients who are infected, affected or inflicted by HIV/AIDS. The Project is facilitating the formation of 10 Self Help Groups amongst PLWAs in Nagaland (Tuensang district).
	• Four peer educator trainings for selected persons from CBOs and NGOs (60 people). Three trainings Nagaland/ and Meghalaya in September 2001, Manipur in November 2001, Mizoram in February.	
	• Pay 30 peer educators for 12 months. They are linked with CBOs and reports on work done are expected from CBOs and / or the NGO linked with them. Rs. 2000/person for 12 months.	
	• Train 30 significant others on health care for PWA. They will work as health workers/peer educators. This will be focused in two places, Nagaland and Manipur	
	• Pay 30 health workers/peer educators for 12 months. They are linked to CBOs in preventing HIV spread as well as enabling provision of care at community level. Rs. 1000/person for 12 months.	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41)
PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES

Outputs	Activities	Remarks
	• Provide support to 5 CBOs and 10 NGOs for implementing action plans. USD 1250/NGO and USD 1000/CBO for 2 years. (Budgetted for 1 year only)	The Project facilitated the participation of 6 IDU-PLWHAs at the recently concluded Workshop at Pune for the Greater Involvement of People Living With HIV and AIDS (GIPA). The participants also went on a study tour to various NGOs dealing with drugs and HIV/AIDS issues in Pune and Mumbai.
	• Release funds to 10 NGO-CBO units to initiate innovative projects ensuring quality and coverage @ $3000 per unit Supporting the first camp detox managed by NGOs and CBOs in Nagaland and Manipur. Follow up camps would be requested from MSJE.	
	• Provide On site training for Camp Detox service providers	
VII. Output 10: Document best practices in the continuum of care for HIV/AIDS prevention & management as well Drug Demand Reduction	• (Part of the support provided by the state based short termers)Report on best practices	Significant activities in risk reduction to drugs and its consequences including HIV have taken place in small pockets across the northeastern states. These need to be examined for quality and scale up potential and documented for building advocacy initiatives and for providing scientific examples of best practice for scale up in other areas. A strong need exists to carry out documentation of best practices.
	• Process planning documentation, review of activities and support to NGOs	
VIII. Output 11: National level meeting of 350 MSJE supported De-addiction agencies for sensitizing them about HIV/AIDS and encouraging them to mainstream HIV concerns into existing Drug Demand Reduction activities	• FINGODAP Conference, Chennai, December 2001	The meeting of the Federation of Indian NGOs in Drug Abuse Prevention (FINGODAP) comprising of over 400 NGOs and representatives of UNODC, UNAIDS and the Ministry of Social Justice & Empowerment was held in Chennai in January 2002 and has brought about significant inter-sectoral synergy.
IX. Output 12: 30 Self-help groups established by NGOs and CBOs in the north-eastern states.	• Organize 4 training programmes for representatives from NGOs and CBOs on setting up self help groups.	Self-help groups were the crying need especially in areas where the community based detoxification was held. The affected and afflicted women in several places also showed a keen interest in processing these gaps. The project decided that it should be a major priority. The project's aim of establishing SHGs two fold. • The ex users/HIV positive clients would have a sensitive group to discuss their emotional and other problems. • To provide a forum for the drug and
	• 25 NGOs work in partnership with CBOs establish 30 self-help groups for recovering addicts and their partners and their significant others.	

COMMUNITY WIDE DRUG DEMAND REDUCTION IN NORTH EASTERN STATES OF INDIA (AD/IND/99/E41) PHASE I, II and III (Revised), IMMEDIATE OBJECTIVE, OUTPUTS AND ACTIVITIES		
Outputs	Activities	Remarks
	• Facilitate networking of self-help groups and encourage them to establish regional federation of self-help groups with support from RTCs.	HIV affected and afflicted (especially women) to meet and, through mutual support, accept the reality of what has happened in their lives and gather their strength in unity for making change happen. As against the planned 30 SHGs to be established in the project, 70 SHGs have already been formed in Nagaland, Manipur, Mizoram and Meghalaya. These groups directly supports 1400 people who are either affected or afflicted. Indirect coverage reaches out to another 14000 people. The SHGs help in enabling new recovering users get support to keep them from relapsing, enables to support appropriately a relapsed user and to help a client get prompt treatment & referral services as well as to work together for building sustainable livelihoods. 20 self help groups have generated funds for themselves through various activities and are using this as seed money for future growth. Several women based Self Help Groups have also been formed.

UNITED NATIONS OFFICE OF DRUGS AND CRIME

PROJECT EVALUATION

TERMS OF REFERENCE

Project title: Community Wide Demand Reduction in India and Community Wide Demand Reduction in the North Eastern States of India

Project number: AD/IND/99/E 40 and AD/IND/99/E 41

Project sites: All India remit for E 40 and northeastern states for E 41

I. BACKGROUND

Conservative estimates place the number of drug users in India above 3 million and initial reports from the national study indicate that drug abuse is increasing. Over 5-10% of HIV seropositives are injecting drug users (IDUs). The abundant availability of illicit drugs, the magnitude of the country with a population of more than one billion, a multitude of languages and a complex drug control situation, makes it difficult to address the drug abuse problem.

Alcohol, opium and cannabis have been traditional drugs of abuse in India with moderate consumption ritualized in social gatherings. Associated major health or social problems were not obvious in the past, due to informal social control against large-scale abuse. In the early 1980s, the emergence of heroin addiction and psychotropic substances abuse was noted in urban areas in India.

The drug abuse pattern in the northeastern states is quite alarming. It is estimated that there are about 40,000 drug addicts in Manipur and an equally large number in Mizoram, 30,000 in Nagaland, 150,000 in Assam (including alcohol abuse). In Arunachal Pradesh, there are a large number of opium abusers. Cannabis abuse is rampant in the region, as it grows wild. Alcohol abuse is greater. It is reported that majority of the addicts are young people, between the age of 15 to 35 years. There is increasing incidence of drug abuse among women and children their involvement in drug peddling is growing.

The Northeastern states are also an important drug trafficking route for heroin produced in Myanmar. The border states of Mizoram, Manipur, Nagaland and the district east c of river Brahmaputra in Arunachal Pradesh are used by drug traffickers to smuggle heroin into India. It is a well established and extensively documented fact that areas along the drug trafficking routes are prone to drug abuse due to affordable prices, easy availability and attempts by small

couriers to encash their in-kind wages. The spread of drug abuse and HIV/AIDS is becoming critical in some areas/ communities. It is estimated that in a population of 1.8 million in Manipur, there are about 15,000 to 20,000 injecting drug, abusers, mostly heroin users. Though heroin is the primary drug of choice, other drugs like opium, cough syrups, benzodiazepines; other prescription drugs and alcohol are also abused in these states.

Since the Seventh Five Year Plan (1982-87), the Ministry of Social Justice and Empowerment (MSJE), in line with its nodal responsibility for drug demand reduction, has been supporting NGOs for public awareness programmes and establishing counseling, de-addiction, rehabilitation and after-care centers.. In addition, from 1989 to 1998, the Government of India implemented two projects with technical support from UNDCP now known as UNODC and ILO. The first project aimed at expanding and improving drug rehabilitation and after-care services through training of drug rehabilitation professionals and development of community drug rehabilitation initiatives was implemented by the Ministry of Social Justice and Empowerment in collaboration with four NGOs in Delhi. The second project aimed at developing drug and alcohol prevention programmes in a number of specific enterprises. That project was implemented by the Ministry of Labor, in collaboration with employers' and workers' organizations and a number of enterprises.

In view of the increasing problem of drug abuse in the country the Government of India (Ministry of Social Justice and Empowerment) decided to widen coverage of services throughout the country and to improve demand reduction services. However, it realized that there was an acute shortage of manpower trained in demand reduction and, as a consequence, the delivery of services was less than satisfactory.

To successfully influence the situation, there was a need for a systematic, cost effective and well-targeted approach, which could introduce up-to-date and innovative demand reduction techniques on a nation-wide scale. This included the need to strengthen the capabilities of the Government to expand and support demand reduction activities in a systematic fashion, to strengthen the capabilities of NGOs, communities, private enterprises, employees' and employers' organizations as well as other UN agencies to carry out such activities. A comprehensive plan needed to be evolved in consultation with the Government and NGOs, with components for drug demand reduction, law enforcement, and alternative development and HIV/ AIDS prevention.

In 1995 in response to the above situation project AD/IND/94/808, Developing Community based Rehabilitation and Workplace Prevention was supported by UNODC in partnership with the Ministry of Social Justice and Empowerment, Government of India. ILO executed this project. One of the major achievements of this project, operational from June 1995-1999, was the implementation of workplace prevention programmes in 11 enterprises and initiation of community based drug rehabilitation programmes in partnership with 18 NGOs in 9 cities across the country. This project generated a great deal of interest amongst the private sector, and an important momentum has been

created. As a follow-up to project AD/IND/94/808, the workplace prevention and community based rehabilitation approaches were also was incorporated in these new Community Wide Drug Demand Reduction Project in 1999.

Projects AD/IND/99/E40 "Community Wide Demand Reduction in India" and
AD/IND/99/E41 "Community Wide Demand Reduction in the North Eastern States of India"

The two projects AD/IND/99/E40 "Community Wide Demand Reduction in India" and AD/IND/99/E41 "Community Wide Demand Reduction in the North Eastern States of India", were jointly designed by the Ministry of Social Justice and Empowerment and UNODC ROSA in response to the above situation.

The two projects E40 "Community Wide Demand Reduction in India" and E41 "Community Wide Demand Reduction in the North Eastern States of India" supplement the Ministry of Social Justice and Empowerment's (MSJE) programme of supporting non-government organizations to carry out demand reduction activities. They aim at establishing an infrastructure consisting of a Government based National Centre for Drug Abuse Prevention (NCDAP) and 8 NGO based Regional Resource and Training centres (RRTCs). The aim of the Projects was to reduce drug abuse among the general population, high-risk groups, workplace, and drug addicts and prevent the same on a nation-wide scale by NGOs, community based organizations (CBOs), government, and other United Nations agencies. The projects commenced in September 1999. The long term objective of the two projects are to reduce drug abuse and its adverse consequences on social and economic development through the introduction of effective drug rehabilitation and social integration programmes as well as workplace initiatives in a coherent national strategy to combat drug and related problems in India. Its immediate objectives were to establish the capability at the national level to mobilize community participation in developing drug rehabilitation services and workplace prevention and assistance programmes throughout India and community based services in northeastern India.

The project E40 aims at establishing an infrastructure consisting of a Government based National Centre for Drug Abuse Prevention (NCDAP) and 5 NGO based Regional Resource Training Centres (RRTCs). The intention is to mobilize community based organizations and enterprises to reduce and prevent drug abuse on a nation-wide scale and on a sustainable basis in a huge country with almost one billion people, highly exposed to drug abuse. The key element is increase of skilled personnel and reliance on a multiplier effect in terms of training of trainers. The project covers the entire country except for the northeastern states, which is being addressed by project IND/E41. The two projects are interlinked. The project directly targets groups vulnerable to drug abuse.

Substantive training is also being carried on prevention of drug related HIV in the country through the NGOs being supported by the Ministry of Social Justice and Empowerment under their scheme of assistance for drug and alcohol prevention. Convergence of services in health and social justice, addressing gender dimensions of the problem and a decentralized approach are critical to the response.

The project E41 aims at establishing an infrastructure comprising an NGO based regional resource and training centre, 25 NGO based de-addiction cum rehabilitation centres and 40 Community Extension Centres (CECs), consisting of suitable community based organisations (CBOs). The intention is to mobilize NGOs, CBOs, and enterprises to reduce and prevent drug abuse on a large scale in the northeastern states of India that are highly vulnerable to drug abuse and related HIV.

Highlights of the progress of the two projects

UNODC, ROSA and the Ministry of Social Justice & Empowerment, Government of India, through these two Projects, have reached out into the far-flung remote areas of India. Building of synergy and substantive issues-based networking among NGOs and civil society has been a key to the success of these initiatives. There has been a lot of synergy and networking amongst the NGOs, Government line departments and civil society. In the North Eastern states, this has been synthesized in the formation of Committees of Concern, which bring together policy makers programme implementers, NGOs and community based organizations to address the twin issues of drugs and HIV in this region. The Project E 41 has successfully piloted and launched the camp approach for detoxification with an increased partnership through Civil Society Organizations. Establishment of Drop-In Centres and placement of Peer Educators with NGOs & CBOs (Community Based Organizations) followed this. Women's Self Help groups have been formed, through a strong network of women NGOs, to address gender issues.

As part of the project E40 emphasis was laid on technical capacity building of service providers engaged in drug abuse prevention treatment, rehabilitation as well as introducing the consequences of drug abuse including HIV/AIDS. The National Centre for Drug Abuse Prevention (NCDAP) located in National Institute of Social Defence, Government of India, organized a series of training programmes for service providers on a wide range of drug demand reduction related issues. Based on a comprehensive evaluation of the programmes implemented so far through the NCDAP, the project made important contribution towards updating the contents and structure of training programmes. A computerized database of training needs have also been

developed. A decentralized approach for imparting training to NGOs and CBOs has also been facilitated through the establishment of 8 Regional Resource and Training Centres (RRTCs), which are housed in 8 leading NGOs across the country. To ensure the continuity and sustainability of the program the RRTCs would be appropriately strengthened. They are being provided with standardized training modules. A cadre of master trainers have been identified and trained with specialized inputs on thematic issues related to drug and HIV mitigation.

To consolidate the programs being implemented at the community level and make them part of the national framework, networking has been strengthened at the city and state level by building on the FINGODAP (Federation of Indian NGOs for Drug Abuse Prevention) network of 400 NGOs which is supported by the MSJE, Government of India. In order to strengthen the community based rehabilitation program, the income generating and micro-credit content is being strengthened. Linkages and networking among the self-help groups at the city level would be strengthened so as to initiate steps for the establishment of State Self Help Organizations.

Protocols for reporting on program implementation have been developed and integrated with the Drug Abuse Monitoring System to put into a place a sustainable mechanism of co-ordination between the implementation of programs at the community level and formulation of policy response at the national level.

For Workplace Prevention, thrust has been three pronged, namely (i) establishment and strengthening of Association of Resource Managers Against Drugs and Alcohol (ARMADA) India in order to strengthen propagate and initiate workplace prevention programs; (ii) strengthening the networking of NGOs working in the field of addiction rehabilitation and problem solving and (iii) strengthening of Self Help Groups of recovering addicts. The establishment of ARMADA India has helped in converging the resources of member enterprises, and NGOs to strengthen their existing programs and initiate the program in new enterprises. State ARMADAs are being established to ensure a countrywide networking.

X. PURPOSE OF THE EVALUATION

The end of project evaluation will assess:

A. Project strategy, approaches and design, fund flow mechanisms, and in particular:

i) The adequacy of the analysis and identification of the problem to be addressed;

j) The strategy in terms of appropriateness and obtainability of objectives (both immediate and long-term) and attainability of planned outputs / activities within the time

frame provided both in the original and revised project documents.

k) The executing and implementing modalities and managerial arrangements and its impact on program delivery issues.

l) The mechanisms for fund flow to ensure adequate and smooth project delivery.

m) The clarity, logic, coherence of the project document including the revised documents.

n) The outputs, implementation methodologies and therefore the appropriateness of agreed prerequisites for project implementation

o) The adequacy of the phases in the work plan and the planned duration of the project as well as the ability of the project to meet with the emerging needs / changing trends of the problem.

p) Indicators utilized to verify achievements of objectives in the revised project proposal.

B. Project implementation and in particular

g) Project strategy implemented as planned in the project or has it been revised (and for what reasons) during the course of project implementation.

h) The quality and timeliness of inputs;

i) The management framework in terms of the tripartite chain of command.

j) The efficiency and effectiveness of activities carried out;

k) The adequacy of administrative monitoring and backstopping of the project by ILO, UNODC Headquarters, UNODC ROSA and the Government;

l) The fulfillment of agreed prerequisites by the project parties and its impact on the project deliverables.

Project results, impact and sustainability

c) The quality and quantity of outputs produced and of outputs likely to be produced.

This should be seen in two components: The E 40 and E41 component.

In the E40 component, in line with the revised project proposal, the following should be looked at in particular:

1. The ability of the project to develop infrastructure and networks for drug demand reduction programming.
2. The ability of the project to establish a nationwide training infrastructure on drug abuse prevention and reduction and establish a system of analysis for trainings conducted and change training services accordingly.
3. The ability of the project to standardize training inputs through the development of training manuals, resource directory, ngo directory, training master plan, database of trainers working in the field of drug abuse and HIV and other tools..
4. The ability of the project to develop an effective Drug Abuse Monitoring system and complete an initial run.
5. The ability of the project to impact on issues of quality assurance among service providers.
6. The ability of the project to energise national and state level federations on drug abuse prevention and reduction including workplace prevention.
7. The ability of the project to energise and network managers from industries for workplace prevention and adapt modern methods for workplace prevention.

In the E41 component, in line with the revised project proposal, the following should be looked at in particular:

9. The ability of the project to sensitize key community groups, NGOs and other stakeholders in drug demand reduction activities and initiate community awareness programmes and lead the receptive communities towards a community based demand reduction program.
10. The ability of the project to involve centre based NGOs to take up community based demand reduction programmes

and plan, develop, and enthuse communities and NGOs to utilize community based detox camps as an approach in a resource poor, inaccessible areas.

11. The ability of the project to develop peer based programs and Drop in Centres to complement and supplement detox camps and other community/NGO/CBO based initiatives in far-flung areas.
12. The ability of the project to initiate self-help groups that would provide support to recovering users and women affected and afflicted by drug abuse and drug linked HIV.
13. The ability of the project to bring in convergence among the Social Welfare and Health Ministries at the state level in the vulnerable states of the northeast through Committees of Concern and Meetings of Secretaries/Chief Secretaries.
14. The ability of the project to experiment with innovative approaches to drug abuse prevention using music and sports.
15. The ability of the project to explore alternative models for drug deaddiction and rehabilitation like the Mizo therapeutic Community model.
16. The ability of the project to make available appropriate skill building training for staff of service providers.

d) The likely achievement of the revised immediate objectives;

e) The likely contribution of the project to achievement of the revised long-term objective and the likely impact in terms of drug control;

d) The likely sustainability of project results.

D. Context and external linkages of the project

The evaluation would assess:

5. The positioning of the revised project objectives within the framework of impacting policy on drug abuse and HIV prevention and control,
6. The adequacy of the revised project outputs complementing the activities of the national/state government schemes and other UN and international agency initiatives
7. The development of linkages with other networks and sustainability mechanisms.
8. The ability of the project to take on board and adapt internationally recognised good practice in drug abuse prevention

XI. RECOMMENDATIONS

Recommendations should be made by the evaluation, on :

1. proposals for concrete action, which could be taken in future to improve or build on project outcomes.
2. issues related to the implementation mechanism and management of the project with an aim of improving management of implementation of future projects.
3. Recommendations should be made on also be made in respect of issues related to the implementation or management of the project with aim of improving management of implementation of future projects.

XII. LESSONS LEARNED

Lessons learned from the projects, which are valid beyond the project itself, should be recorded by the evaluator(s).

XIII. METHODOLOGY

The evaluation will be based on the study of pertinent documents, interviews with key persons and visits to at least two project cities/towns under each project. Major documents, which will be reviewed, will include, the project document, project progress reports, work plans, documents and materials produced, strategy papers and any other relevant documents. The above documents will be sent to the evaluators prior to the commencement of the mission. In addition, any other documents, which may be requested by the evaluation team, will be made available during their briefing in Delhi by ILO, UNODC and Ministry of Social Justice and Empowerment. During the course of the mission, the team may have specific interviews or site visits added to or changed as deemed necessary.

XIV. COMPOSITION OF THE EVALUATION TEAM

The Evaluation Team will comprise two/three members:

- One international evaluator (as a team leader) to be nominated by ILO/UNDCP/MSJE
- One/two national evaluator/s to be nominated by MSJE/UNODC/ILO

The team should have extensive experience in programme management and evaluation in drug demand reduction field. He/she is familiar with different drug demand reduction approaches, including community-based rehabilitation and work place prevention. He/She should be familiar with UNODC demand reduction programmes as well as ILO's drug prevention and rehabilitation programmes. Experience in evaluating UNDP or ILO

programmes (or UN development projects) and knowledge of the region are added advantages. He/She shall be responsible for providing overall guidance to the team and for preparing and submitting the evaluation report.

The evaluators should not have been involved directly in the design, appraisal or implementation of the project. Furthermore, they will not act as representative of any party, but should use their independent judgement.

XV. BRIEFINGS AND CONSULTATION IN THE FIELD

Upon arrival in Delhi, the team will be briefed by UNODC, ILO and Ministry of Social Justice and Empowerment in Delhi. The National Project Coordinator (NPC) and other relevant staff and consultants will provide the team with full account of the progress of the project and the outputs obtained. Necessary logistics and administrative support will be provided by the office of the NPC. The evaluation will last three working weeks, starting on 24th March 2003.

The team will maintain close liaison with the UNODC/ILO/Ministry of Social Justice and Empowerment in New Delhi. The team is also expected to visit selected project sites as deemed appropriate by the team.

Although the evaluation team members should feel free to discuss all matters relevant to their assignment with the authorities concerned, they are not authorized to make any commitments on behalf of UNODC, the Government or ILO.

XVI. EVALUATION REPORT AND FOLLOW-UP

Before the submission of the evaluation report to the UNODC, the team will discuss the findings and recommendations with representatives of the Ministry of Social Justice and Empowerment, UNODC and ILO in New Delhi. Although the team members should take the views expressed by the concerned parties into account, they should use their independent judgement in preparing the final report.

The team leader will complete the evaluation report and submit it to UNODC before departure from Delhi. UNODC will forward it to ILO and the Government of India. Moreover the team leader will complete the attached summary assessment questionnaire, which will be forwarded to UNODC together with the report.

XVII. TENTATIVE TIMETABLE

The timetable of the mission is as follows:

Day 1	Arrival of international evaluator. Meeting with and discussions with the national evaluator/s.

Day 2	Briefings by UNODC, ILO and Ministry of Social Justice and Empowerment officials in Delhi, and Reviews of documentation;
Day 3-13	Visits to selected project cities, including travel time;
Day 14-18	Preparation of the draft evaluation report;
Day 19	Discussions of findings, recommendations with UNODC, ILO and MSJE;
Day 20-21	Finalize report; and
Day 22	Submission of report and departure of international evaluator.

Qualifications and experience

The evaluators should have a background in Social Sciences / Public Health / Psychiatry with previous experience in drug demand reduction work at community level preferably in South Asian countries. Knowledge and experience of related HIV/AIDS work, policy formulation planning and implementation at the National or International level would be an added advantage. Experience in programme /project development as well as earlier experience of handling similar nature of assignments in other sectors such as Health, Drug Demand Reduction, Poverty Alleviation programs and ability to work with GO-NGO-Other counterparts would be of immense value.
The person should additionally have excellent drafting skills, co-ordination and communication skills to interact with Government and NGOs and computer literacy skills.