Final

Dates: 21.04-4.05.05

MID TERM EVALUATION REPORT

PROJECT NUMBER: **AD/RER/03/F75**

PROJECT TITLE: **Diversification of HIV prevention and drug treatment services for injecting and other drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan**

THEMATIC AREA: Prevention and reduction of drug abuse

COUNTRIES: **Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan**

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UNITED NATIONS OFFICE ON DRUGS AND CRIME

Vienna

Aknowledgements

I would like to express my sincere gratitude to Mr. Mirzakhid Sultanov, Regional Advisor on HIV/AIDS and Project Coordinator, UNODC, ROCA, for the excellent arrangement of the mission, and to Dr. Alexander Katkov, Project Consultant, Deputy-Director, National Clinical –Research Centre on Medical-Social Problems of Drug Dependence, Pavlodar, Kazakhstan, for his invaluable professional inputs during our discussions. Special thanks go to the project focal points and local coordinators who have been on the front line of the project implementation. I wish to extend my appreciation to all people with whom I met during the evaluation mission. All of them contributed to the findings of the report and to my professional enrichment.

Disclaimer

The report reflects the evaluator's personal opinions and does not represent any organization's official policies and views

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LIST OF ACRONYMS

AIDS - Acquired Immunodeficiency Syndrome

DDRP – Drug Demand Reduction Programme

HIV – Human Immunodeficiency Virus

IDU – Injecting drug users

JICA – Japanese International Cooperation Agency

ROCA – Regional Office for Central Asia of UNODC

SMART – Specific, measurable, achievable, relevant, time-bound (indicators)

STI - Sexually transmitted disease

ToT – Training of trainers

TP – Trust Points (open access low threshold services for drug users)

UNDP – United Nations Development Programme

UNICEF – United Nations Children's Fund

UNFPA - United Nations Population Fund

UNHCR - Office of the United Nations High Commissioner for Refugees

UNODC - United Nations Office on Drugs and Crime

UNTG – United Nations Theme Group (on HIV/AIDS)

WB – World Bank

WHO – World Health Organization

EXECUTIVE SUMMARY

Summary table of findings, supporting evidence and recommendations

Findings: identified problems/issues	*Supporting evidence/examples*	*Recommendations*
1.Frigile sustainability of the project	• Only partial involvement of participating treatment organizations, which themselves are fragments of the bigger health care system, in the project; absence of the mechanisms for building new professional cadres, and thus maintaining "the flow" of the appropriately trained professionals into the prototype of the new treatment system created by the project; • Absence of the strategy that would provide for national ownership of the newly created services, when UNODC support will be completed, in the situation whereby substantial part of the expenditures of participating institutions is borne by the project funds (Tables 6.1-6.7, Annex 4); • Development/adoption of the national programmes of reformation of narcological services in four participating countries has set up a condition favourable for sustaining and further expanding of upgraded treatment services but only if the donor/development aid support will be channeled to the national programmes.	To make the results of the project sustainable, there is a need to continue the project in a re-designed format. Priority should be given to the longer-term support to the newly developed/adopted national programmes on reformation of narcological services in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. At the same time, funding and technical assistance to local project sites should be continued at least for three years so that the already developed services would become models of the new specialist treatment systems within the frame of the national programmes. Serious considerations should be given to the development of exit strategies that would ensure sustainability and expansion of the results achieved through the project implementation.
2.Insufficient monitoring mechanism to measure progress of project implementation	• Lack of specificity in formulations of activities, outputs, target, baseline and progress indicators in the project description; • Unavailability of specific and relevant baseline, progress and target indicators in most of local project sites at the moment of evaluation	Results-based planning techniques should be employed while re-designing the project, with monitoring and evaluation in-built in the operational plan. Indictors that are to be used for measuring the project progress and evaluation of its results should be specific, measurable, achievable, relevant and time-bound. Partners' responsibilities, accountability and reporting schemes should also be clearly delineated in the revised project design.
3. Limited participation of Turkmenistan in project implementation	In 2003-2004 only one 2-week training course for 35 national professionals was provided in the country within the frame of the project	In view of more conducive political environment in the country after adoption, in April 2005, of the National Programme on HIV/AIDS/STI's Prevention (2005-2010), negotiations with the government of Turkmenistan on the prospect of joining the project should be resumed. A specially designed sub-project for Turkmenistan may have focus on intensive professional capacity building and introducing the evidence-based approaches for organizing the abstinence-

Findings: identified problems/issues	Supporting evidence/examples	Recommendations
		oriented treatment of drug dependence. Introduction of interventions aimed at harm minimization can be done through joint programming with locally based UN and other international organizations with relevant experience.
4. Limited involvement of other UN agencies, international and bilateral organizations dealing with HIV prevention and drug demand reduction in project implementation	• Lack of awareness of the project of representatives of UN agencies and other international/bilateral organizations present in Central Asia; • No joint programming; • Limited participation of international/bilateral organizations in project implementation at local sites.	There is a need for wider involvement in the project implementation of other UN agencies, international and bilateral organizations through joint programming and planning to make more effective use of the financial and human resources. WHO, UNICEF, UNFPA, UNDP and UNHCR can be the first choice partners in joint programming.

a) *Summary description of the project evaluated*

Originally planned for 2 years (2003-2004) the evaluated project aimed to improve and further develop HIV prevention and drug treatment services for drug users, injecting drug users (IDU's) being the primary target group, in Central Asia The project employs the concept of gradualism in HIV prevention among drug users, a combination of harm reduction interventions, as the emergency response, and drug demand reduction (treatment and rehabilitation programmes), as a long-term objective.

Piloting of the diversified services was planned in seven selected localities in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. The selection criteria included availability of reliable data on HIV/drug use situation, the comparably high prevalence of HIV/AIDS and drug use/IDU's, and status of the response to HIV epidemic.

Apart from the initial situation assessment and the concluding dissemination of the new experience, the project addressed three tiers of service development: 1) development of a concept underlying prevention and treatment interventions; 2) institutional and professional capacity building; 3) establishment of the coordination mechanism within and outside of specialist treatment services including referral modalities.

b) the major finding of the evaluation

The concept of the reformed narcological service for Central Asian countries was developed by the National Clinical–Research Centre on Medical-Social Problems of Drug Dependence, Pavlodar, Kazakhstan. The proposed model of future treatment system includes: the low threshold services (provision of health information, advice, education with focus on HIV, means of protection from HIV, VCT, and motivational counseling to enter drug dependence

treatment); out-patient and in-patient services offering counseling, detoxification, psychotherapy, health education and other relapse prevention interventions; residential care facilities offering long-term rehabilitation; and aftercare.

The actual time of service delivery within the project framework in the pilot sites ranged from 6 to 14 months. About 200 trained specialists and volunteers participated in subprojects implementation. The number of available treatment facilities (all modalities) has increased from 39 to 54. These services have become more accessible for drug users, most of all because the outreach work was intensified, no fees for services have been charged, and no records of the service user's personal details have been required. Another important factor attracting problem drug users to the services operating in the new fashion has been the widened range of treatment modalities, interventions and techniques offered. Though the coverage of drug users by low threshold services (on average 24% of the estimated number of drug users in the project catchment areas; in some localities almost 80%) has not reached the planned target of 38%, a significant proportion of clients of those services have entered out- or in-patient or residential treatment programmes of drug dependence (on average 25%, in some localities more than 90%). In total, about 10,000 drug users have used low threshold services and about 2,500 of them entered drug dependence treatment services.

In the long-run, the most important result of the project implementation is the initiation of the process of reforming of the specialist treatment service in Kazakhstan and Tajikistan, and, to some extent, in Kyrgyzstan and Uzbekistan. The national programmes on "the improvement of narcological service" in these four countries are founded on the documents (instructions, guidelines, staffing standards, etc.) developed within the frame of the project. Though the objective of the project was not explicitly formulated in terms of the initiating of national reforms, its catalyzing role in changing the whole segment of health care services so that addressing HIV/AIDS is becoming a normal element of treatment of chemical dependencies allows for suggesting the project's overall relevance and effectiveness. Evidently, the process of the service reforming would have never happened without the endorsement of the project by the governments of these countries; the fact of the endorsement signifies the appropriateness of the chosen approaches.

c) lessons learned and best practices

Specificity and relevance of indicators measured during the situation assessment are of crucial importance for the reliability of the results of project monitoring and evaluation. If the expected key results matrix (with SMART baseline, progress and target indicators), had been part of the action plan of the project, that might have allowed for more efficient remedial interventions in the course of project reviews and would have made the project evaluation more precise.

Professional capacity development is a proven strategy contributing to the aid project or programme sustainability. Training of trainers (ToT), especially with involvement of faculty of medical schools and other relevant higher education institutions, and consequent cascade trainings, could have been more efficient mode of organization of professional trainings; they would have allowed for bigger coverage of personnel for less costs.

In pilot sites, the project funds have mostly been spent for fees of participating professionals (48% in average), and procurement of office furniture and equipment. Given the lack of resources provided by state in most of the project facilities, termination of the financing by the project has greatly threatened sustainability of the achieved results. Had the project exit strategy been developed and clearly presented in the project description, it would have been easier either to phase-out or continue project implementation on more efficient terms.

The catalyzing role the project played in the development of national programmes on reforming of the narcological service in participating countries proves that investment in policy development and institutional capacity building pays off by paving ways for nationwide and sustainable change in the desired direction.

Though none of the visited sites would suit the criteria of best practices, there is an example of an innovative approach to project implementation in Osh, Kyrgyzstan. Three elements of the subproject are of interest: 1) establishment of a strong network of health services of different modalities and clear reference mechanism; 2) involvement in the subproject the faculty of local higher education institutions (psychologists) that provided for transmission of new knowledge into the academic culture and changes in teaching curricula; 3) diffusion of the new treatment experiences into local primary health care. The creativity in making the project fit the local conditions and making best use of existing resources is worth to pay attention to.

d) the recommendation, conclusions including implications to UNODC of the evaluation.

1) There is a need for continuation of the project though its design should be revised. Priority should be given to the longer-term (up to 5 years) support to the newly adopted national programmes on reformation of narcological services in Kazakhstan, Tajikistan and (pending) Kyrgyzstan and Uzbekistan with focus on technical assistance for the development of regulatory documents, standards, etc. and the establishment of national multi-disciplinary professional cadres. Funding of and technical assistance to all local project sites should be continued at least for three years; the shift should be made from piloting to modelling within the frame of the national programmes. The already developed services should become prototypes of the new specialist treatment systems covering clearly defined catchment areas.

2) During the project revision serious considerations should be given to the development of exit strategies that would ensure sustainability and expansion of the results achieved through the

project implementation. Financial schemes that would provide for gradual phasing out of donors currently supporting heath services should be developed, modelled and tested.

Results-based planning techniques should be employed while re-designing the project, with monitoring and evaluation in-built in the operational plan. Indicators that are to be used for measuring the project progress and evaluation of its results should be specific, measurable, achievable, relevant and time-bound. Partners' responsibilities, accountability and reporting schemes should also be clearly delineated in the revised project design.

4) Special considerations should be given for the possibility of project implementation in Turkmenistan. Given the adoption of the national programmme on HIV prevention in Turkmenistan (April 2005) and recent positive moves towards closer cooperation with UN and other international agencies, negotiations with the government of Turkmenistan on the prospect of joining the project should be resumed. A specially designed subproject for Turkmenistan may have focus on intensive professional capacity building and introducing the evidence-based approaches for organizing the abstinence-oriented treatment of drug dependence. Introduction of interventions aimed at harm minimization can be done through joint programming with locally based UN and other international organizations with relevant experience.

5) There is a need for wider involvement in the project implementation of other UN agencies, international and bilateral organizations through joint programming and planning to make more effective use of financial and human resources. WHO, UNICEF, UNFPA, UNDP and UNHCR can be the first choice partners in joint programming.

6) For the time being the evaluated UNODC project is the only project in Central Asia among those supported by UN or other international development organizations, whose objective is to support the governments in the establishment of the specialist treatment system that integrates harm reduction approaches with abstinence-oriented treatment and provides for continuity of care thus addressing a wide scope of health and social needs of dug users and their families. In two-year time, pilot diversified health services were developed in seven localities in four Central Asian countries, and the national programmes on the narcological service reformation were initiated. To expand and institutionalize the achieved results the long-term and large scale concerted international technical assistance to implementation of the reform is needed.

1. INTRODUCTION

1.1 Background and Context

1. Injecting drug use (IDU) has become the primary mode of HIV transmission in Central Asia; it contributed to an exponential growth of HIV in the region: up to 70-80 % of HIV positive people in the sub-region acquired this infection via illicit drugs injections [5]. Estimates of the prevalence of HIV infection among IDU's in countries of Central Asia is fluctuating from 0.3% to 15% [5, 8]. Prevalence of drug use itself in the sub-region is high and growing with highest estimates for Kazakhstan, i.e. 2% of the population in Pavlodar [8; field data, 2005].

2. As a response to the epidemics, in the late 1990es beginning of the 2000es, a number of outreach programmes and low threshold services run by NGO's have been established with financial and technical support of international aid community in all countries of Central Asia but Turkmenistan. By 2002, the coverage of IDU's by these services was still low (i.e. in Kyrgyzstan, only 2% of drug users were provided with services through the Trust Points) [8]. Substitution maintenance has only been piloted in Kyrgyzstan. On the other hand, up to 70% of IDUs who visited trust points requested counselling on how to stop their drug use. Yet, throughout the region, the system of quality abstinence-oriented treatment for drug dependency is hardly available. When it does exist, the cost of treatment puts it beyond the means of many IDUs [8].
3. The focus of international aid community on harm reduction is understandable as its primary goal is to curb HIV spread in Central Asia. On the other hand, harm minimization interventions as delivered in their present form in the sub-region are "business unfinished" as they do not reduce population vulnerability to HIV/AIDS. Taken within the wider social–economic context, improved access to a broad spectrum of social services, drug dependence treatment services among those, is believed to contribute to reduction of the population vulnerability to HIV thus making more profound impact on HIV epidemics.
4. The evaluated UNODC project, originally planned for 2 years (2003-2004), has aimed to improve and further develop HIV prevention and drug treatment services for drug users in Central Asia, injecting drug users (IDU's) being the primary target group. The project employs the concept of gradualism, a combination of harm reduction interventions, as the emergency response, and drug demand reduction (treatment and rehabilitation programmes), as a long-term objective. The range of envisaged services was to comprise outreach and low-threshold services (HIV/AIDS prevention education,

access to condoms and clean injecting equipment and counselling), outpatient and inpatient treatment/rehabilitation, and residential care and aftercare services.

5. Piloting of the diversified services was planned in seven selected localities in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. The selection criteria included availability of reliable data on HIV/drug use situation, the comparably high prevalence of HIV/AIDS and drug use/IDU's, status of the response to HIV epidemic, and the commitment of local governments for cooperation
6. The human-rights perspective was taken into account in the project development that provided for participation of all stakeholders including clients/patients and service providers in planning, implementation and monitoring of its activities. Availability of the diversified services for drug users, their accessibility, quality, effectiveness and continuity of care would ensure the fulfillment of drug users' rights for the best attainable health care, HIV prevention included.
7. Apart from the initial situation assessment and the concluding dissemination of the new experience, the project has addressed three tiers of service development: 1) development of a concept underlying prevention and treatment interventions; 2) institutional and professional capacity building; 3) establishment of the coordination mechanism within and outside of specialist treatment service including referral modalities.
8. The following results were to be achieved [8]:

- functional coordination mechanisms/groups on drug abuse and HIV/AIDS in each target locality serving as a strategic advisory body;
- functional needs-based diversified services in 1 or 2 selected localities in each Central Asian country and referral mechanisms to other health and social services;
- trained service providers providing quality diversified services for target groups;
- experiences acquired systematized and lessons learned disseminated through UNODC publications, web site and networking.

9. The following steps were proposed to achieve the above indicated results:

- needs assessment and mapping of existing services in selected localities;
- development of the action plan and its endorsement by local governments and other stakeholders;
- professional training of involved service providers;

- monitoring of project implementation through quarterly and mid-year reviews and field missions by UNODC to make necessary adjustments to project implementation.

10. The project was designed in accordance with UNODC guidelines. The description of HIV and drug related situation in Central Asia is rich and, together with the part on the problems to be addressed, convincingly justifies the necessity of the proposed interventions, though it is too large (17 of 27 pages or 56% of the main text). On the contrary, the project strategy is concise (about two pages) and the section on objectives, outputs and activities is too brief (one and a half page). While strategy description gives clear steps of the project implementation and execution modality, no exit strategies at the completion of pilot subprojects are proposed. The terms "input", "output" and "outcome" are used inconsistently throughout the project. Perhaps the lack of relevant data at the time of the project preparation (the situation assessment and service mapping were parts of the project activities) has prevented the project designer from having more elaborated and consistent description of outputs and outcomes.
11. It should be noted that the project would have been much easier to monitor and evaluate if it had had the Key Results Matrix (baselines, expected outcomes, progress indicators, quantified if possible) as part of the time-bound Action Plan showing specific activities, implementing agencies/responsible persons, expected outputs and estimated/ allocated funds.
12. The original design of the project has been elaborated after monitoring field missions, quarterly reviews and the project revision, especially with regard to specification of expected outputs and progress indicators. While some of the flaws of the original version of the project were addressed in the revised document (i.e. more clearly defined support to policy development and identification of core monitoring indicators), the issue of sustainability of the achievements was not taken into consideration. Such questions as how to exit from pilot sites, what would be the scheme of future financing of the supported sites, where and how the national cadre of professionals will be trained on the systemic basis, were not responded to. Also coordination with other UN and international/bilateral organizations working in HIV/AIDS domain and possibilities of joint programming were not explicitly considered in the revised project document.
13. Originally total budget of the project was $500,000 funded by UNAIDS. After revision in 2004, the timeframe of the project was extended up to 2006, and the budget was raised to $1,260.000 with UNAIDS, Germany, Ireland and Sweden as donors [9].
14. The scope of the revised project was expanded and its goals became even more

ambitious. The revised project will aim to scale up interventions in the selected target regions, to expand activities to the additional regions in each country of Central Asia, and to widen successful pilot services to the national level, providing technical assistance in policy formulation and planning activities. The plausibility of achieving its targets in the planned time span and with available financial and human resources is doubtful. And again, the formulated new outputs and outcomes not always are SMART - **s**pecific, **m**easurable, **a**chievable, relevant and **t**ime-bound, meaning that they do not answer the questions of how much of what and when should happen or will be delivered.

1.2 Purpose and Objective of the Evaluation

15. The purpose of the evaluation was to assess the process of the project implementation in relation to the objectives and the outputs set out in the project document. The objectives of the evaluation were to examine the design, strategies, objectives, relevance, effectiveness, appropriateness, impact and sustainability of the project. It is hoped that the evaluation findings would contribute to results-based management of the project through improving the project monitoring and evaluation system. Based on findings and lessons learned recommendations were developed for further actions so that to adjust the project strategy to maximize the impact from the project inputs.

1.3 Executing Modality/Management Arrangements

16. The project has been managed by UNODC (ROCA) Regional Project Coordinator through the newly established network of National Focal Points (senior management officials of the Ministry of Health or State Commissions/Agencies on Drug Control) and local counterparts (mostly heads of drug use treatment services, government and non-government, and AIDS centres).The local Coordination Groups on HIV/AIDS and Drug Abuse with multi-sectoral representation were to be established to provide for comprehensiveness and coherency of the planned activities. This managerial structure proved to be effective since it allowed for easy vertical and horizontal communications between and among the ROCA, national level and local counterparts (see more in Section 2.5) providing for timely solving of emerging problems and applying remedial measures.

1.4 Scope of the Evaluation

17. The mid-term evaluation covered the activities of the project implemented from February 2003 (start of the project) up to the end of 2004, in Kazakhstan, Kyrgyzstan,

Tajikistan, Turkmenistan and Uzbekistan. Evaluation of the project process and outcomes covered the following [11]:

- The effectiveness of the project design, strategy and approach in response to the need;
- The progress of the project implementation: are the activities planned under the objectives moving on track (schedule and substance wise)?
- The outcome of project interventions, in particular,
  - nature and extent of diversification of services in the sub project areas;
  - accessibility and utilization of these services by the target group (DU/IDU);
  - delivery of training programmes and their appropriateness in response to the training needs of the target groups (service providers);
  - development of competencies/skills among the various service providers in response to their needs;
  - utilization and use of competencies/skills by the service providers in improved service delivery at the target sites;
  - development of guidelines, methodologies, instructional manuals, and other instruments developed / adopted for various training programmes and service delivery;
  - factors contributing to or impeding achievement of the results/outcomes
- The process of coordination and cooperation between different stakeholders at the local, national and regional levels for project and sub projects' implementation
- The level of effectiveness of programme management including
  - process of local assessments, identification of sub project sites, grant applications and their awards;
  - process of reporting monitoring and evaluation in terms of their relevance, quality and timeliness, by all parties concerned;
  - technical backstopping and inputs to the sub projects and service providers as one of project's target group
- The extent to which the project has contributed to the overall improvement of institutional and technical capacities to address HIV/AIDS and drug abuse problems in specific sites in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan
- The sustainability of project results after the project's completion and its anticipated impact in prevention and treatment of drug abuse and HIV/AIDS among IDU.
- Based on the above, recommend future directions, changes or modifications in substantive

areas of project implementation, identify areas of best practices for replication in other UNODC projects at other locations and within the region.

1.5 Evaluation Methodology

18. Evaluation methodology included the following:

- Desk review of relevant documents (project document, project revision document, semi-annual and annual project progress reports; sub-project grant documents and reports; mission reports, materials developed under the project)
- Initial briefing by responsible UNODC staff in the Regional Office for Central Asia
- Meetings with national focal points, officials from the Ministries of Health, Drug Control Coordinating bodies, local governments, departments of health, heads of AIDS centres at central and local levels, experts and other knowledgeable parties in the region
- Meetings and discussions with local implementing partners and service users (drug users in treatment) during field visits to 7 project sites
- Meetings with the members of the UN Theme Group on HIV/AIDS and other representatives of international aid community.

2. ANALYSIS AND MAJOR FINDINGS

2.1 Overall Performance Assessment

19. Countries of Central Asia encounter numerous challenges in their struggle with HIV/AIDS, the lack of financial and human resources to tackle the growing epidemic being the major concern. In a situation where injecting drug use is the preponderant way of HIV transmission, and specialist drug treatment services are not able to respond to various health and social needs of drug users, the multi-country project's goal to support the governments in establishing diversified treatment systems that provide for continuum of quality care for drug users - from outreach services to detoxification, to relapse prevention and aftercare - should be praised not only as appropriate but also very courageous.
20. The project's strategy that was developed based on local needs assessment provides for implementation of culturally sensitive and socially acceptable interventions aimed at expanding and upgrading existing services by introducing a new treatment paradigm, the paradigm which reconciles the apparent controversy between harm reduction and abstinence-oriented treatment of drug dependence.

21. The budget disbursed in 2003-2004 for implementation of sub-projects at local level

comprised $315,923 or 36% of total $876,980 (Tables 1 and 2, Annex 4). By end of 2004 all available funds were utilized. Substantial financial inputs were made to professional capacity building ($155,632 or 18% of total budget) and the development of standards of the new services (types of facilities, their staffing, competencies of staff, etc.) – $125,000 or 14% of total budget. The standards were immediately applied by trained professionals in project implementation sites, to the extent possible and with differing successes.

22. Surely, the choice of the National Clinical–Research Centre of Medical-Social Problems of Drug Dependence, Pavlodar, Kazakhstan (thereafter referred as Kazakhstan Narcological Research Centre) as the think tank and education base for the project was crucial, as the centre had already developed a considerable amount of methodological materials and educational modules that fit the project's philosophy and were ready for use.

23. In parallel to the local project implementation, national senior heath mangers (focal points of the project trained through the project) submitted treatment reform proposals to the relevant ministries; the proposals being the foundation of the new policy framework which materialized later on as the national programmes of upgrading of narcological services. Initiation of the process of reforming of the specialist treatment service in Kazakhstan and Tajikistan, and, to some extent, in Kyrgyzstan and Uzbekistan, is the most important result of the project implementation.

24. The national programmes on "the improvement of narcological service" in these countries are founded on the concept and documents (instructions, guidelines, staffing standards, etc.) developed within the frame of the project. The catalyzing role of the project in changing the whole segment of health care services so that addressing HIV/AIDS is becoming a normal element of treatment of chemical dependencies is the strongest argument for the appropriateness of the chosen approaches. Evidently, the process of the service reforming would have never happened without the endorsement of the project by the governments of these countries. This fact allows for suggesting the project's overall relevance and effectiveness, though the objective of the project was not explicitly formulated in terms of initiating national reforms.

25. The efficiency of the project is difficult to assess as no comparable projects have been implemented in the sub-region. Moreover, in some cases the partner organizations have also received support from other international organizations (Tables 6.1-6.7, Annex 4). In these instances it means that the project has contributed to the results

achieved by concerted efforts of several agencies. Nevertheless, the fact that it is only two years of the project implementation with cost of $500,100 during which the ground for initiation of the above mentioned reforms in four countries with total populations of about 51 mln and estimated number of drug users of around 300,000 [5] had been prepared, may suggest the project's quite high efficiency.

26. Turkmenistan was the only country where the project could not be fully implemented. The project's emphasis on HIV prevention among drug users through, in the first place, providing access to low threshold services is apparently politically and culturally unacceptable in a country where officially only one of HIV-positive case is registered and most of the drug users (up to 70-80%) are smokers, not injectors. Nevertheless, the country accepted the 2-week training course for health managers, physicians and psychologists working in narcological service. This reflects the willingness of health authorities to upgrade the abstinence-oriented treatment of dug dependence and signifies the recognition of the necessity of longer-term rehabilitation interventions. Perhaps, supporting of rehabilitation interventions in Turkmenistan will be more welcomed and may become the entry point for gradual reformation of the whole specialist service.

27. With regard to the project description (see for example pg 21-23 of the Project Document, 2002) the above remarks on the vague formulations and inconsistency in using terms of activity, deliverables, inputs, outputs and outcomes are also applicable to the usage of terms effectiveness and efficiency. Definitions of what is meant under activity, deliverable, output, outcome and impact, effectiveness and efficiency if given in project description, would add clarity to the goal of the project and would provide for consistency in the usage of these terms. Also, there is some blurring between the activities related to management of the project and activities directly related to project implementation (i.e. Output 1). These terminological ambiguity and lack of baseline, progress and target indicators (or their irrelevance) has made the formal evaluation of the project results attainment difficult and almost prevented the quantified assessment (most of numerical data referred to in the below sections and presented in Tables 3-6, Annex 4) were received on the evaluator's request at the time of the report preparation).

2.2. Attainment of the Objectives

28. The overall objective of the project is described in terms of the UNODC support to Central Asian countries in "achieving significant and measurable result in reducing demand for illicit drugs". The immediate objective of the project "is to minimise the adverse health

and social consequences of drug injecting, including the prevention of transmission of HIV and other blood-borne infections among injecting drug users of selected project target areas through diversification of HIV prevention and drug treatment services"[8]. In accordance with the objective the expected results of implemented interventions should be decreased levels of such adverse health consequences as drug overdoses, incidence of hepatitis and HIV infection among drug users (and numerous of other measurable outcomes that fall under the category of minimization of adverse consequences of drug injecting) in target sites.

29. Given the complexity of causality of the phenomenon of drug use itself and its medical-social consequences, taking into account social-economic context of the implementing countries and available project funds, the planned attainment of the objective in 2-year time seems unrealistic. In reality, implementation of the project at local level started in November 2003, lasting from 6 to maximum 14 months in different localities. Surely, this time span was not enough for the development of full-fledged services on spots, and any significant changes in the clients' behaviour could hardly be expected.

30. An attempt to make at least rough assessment of the project impact was hampered by unavailability of baseline data, progress and target indicators in most of project sites. In the sites where some of indicators (the incidence of HIV, hepatitis, STI's among drug users covered by services) were available (i.e. surveillance data in Pavlodar, Kazakhstan), their interpretation was complicated because of concerns about the whole reliability of data and lack of clarity of what was the exact contribution of the project into the claimed change.

31. If the wording of the objective had been put to emphasize the improved access of drug users to the diversified health care services, it would have been easier to measure its attainability. And indeed, the project is about increased availability of treatment facilities, the broadened range of treatment modalities, lowered barriers to the services, and improved quality of services. Taken from this angle, the project objective was achieved since the overall number of facilities providing health care services for drug users has increased and, what is more important, the spectrum of services has been significantly widened in terms of types of treatment (low-threshold, out-patient, in-patient and residential care) and medical and psychological-social interventions used to improve the clients/patients health and social wellbeing (Table 3, Annex 4).

2.3 Achievement of Programme/Project Results

32. As it was proposed above, for the sake of measuring the results of the project, the working definition of the project objective is the improved accessibility of health care services that provide for HIV prevention and address medical and social needs of drug users, including social and health problems associated with HIV positive status of drug user, in project target sites. The following outputs contributed to attainment of the objective.

Output 1: Analysis of situation and mapping of existing services

33. The assessment and mapping along with recruitment of the project staff comprised the so called "inception phase "of the project that was expected to be completed in 3 months. Two major deliverables of this output were: a) "… conceptual model of the future network of services to be available, identifying the type of services to be developed and linkages between them"; b)"…plan of action reflecting what services, where, by whom and how [they will operate] will be developed" [8].
34. Assessment and analysis of drug and HIV-related situation was done in all five countries of Central Asia in the frame of other UNODC projects [7]. Based on these data and in consultation with national authorities, two localities in each country were identified as project sites for the establishment of the pilot treatment system, selection criteria being high prevalence of drug use and HIV, and willingness of the local authorities to endorse the project.
35. In 2003, more focused situation assessment was carried out in the seven selected localities of the four countries (Turkmenistan was not included since it had not endorsed the project). The extent and severity of drug-related medical-social problems, HIV prevalence among drug users in the first place, was described and quantified, and needs of drug users for treatment services were identified. Completed in September 2003, mapping of existing services for drug users in these localities elicited gaps in service provision. Based on the mapping results the needs for institutional and professional capacity building were identified, a concept of the model treatment system providing for continuum of care was developed. It should be noted that the assessment and mapping were done by UNIDC consultants in the manner which ensured active participation of national stakeholders, local authorities, medical service providers, clients/patients among them. For details see relevant reports [1, 6].
36. International organizations working in HIV prevention/harm reduction in Central Asia were involved in the above process to much lesser extent. This became clear during meetings with representatives of UN and other international agencies and organizations at the time of the present evaluation (21 April-4 May 2005): for many of them these

meetings were the first opportunity to learn about the project. Moreover, only UNICEF Kyrgyzstan (Ms. Gulsara Osorova, Project Officer) indicated its intent for joint programming in developing youth-friendly services for vulnerable young people, drug users among them. Other agencies and organizations did not project their interventions beyond the support of low threshold services and were quite indifferent to the prospect of establishment of good quality rehabilitation services for drug users. So it was the commitment of national side that allowed to not only implement the project as it was planned, but also to utilize the underlying concept and developed technical guidelines for initiating a reform of the whole specialist treatment service. On the other hand, as the Tables 6.1-6.7, Annex 4, indicate, some local managers of the project have successfully pooled financial resources offered by a variety of international aid organizations to boost the project implementation.

37. As it was mentioned earlier, the concept of the reformed narcological service for Central Asian countries was developed by the Kazakhstan Narcological Research Centre. In this model the harm reduction interventions were regarded in terms of the tertiary prevention of drug-related disorders, while other medical-social interventions with the ultimate goal of abstinence from the psychoactive substance in question were considered the secondary prevention. The use of the widely known concept of primary, secondary and tertiary prevention of a disorder or disease has helped to find the right place for harm reduction in the continuum of care and, in a way, to institutionalize functioning of low threshold facilities within the bigger frame of health care services.
38. The proposed model was supplemented with a pack of technical guidelines and drafts of regulation documents (see the list in Annex 4). The current evaluation is not meant to assess the quality of methodological materials developed for the reformation of the narcological services. However, it would be desirable, at the early stages of the reform, to review the package by international experts (in the first place by WHO and UNODC experts) so that to ensure that the proposed strategies and standards are results-oriented, effective, efficient, and human-rights based.
39. Based on the proposed model and taking into consideration results of the situation analysis and mapping, the overall action plan for the development of upgraded health care system for drug users was developed. Grant proposals by local organizations and budgeted action plans for each subproject were submitted to UNODC in September 2003. The delay was mostly caused by the lack of experience of local health managers in the development of project proposals so that draft proposals were returned (sometimes not once) for their revision and corrections.

40. Thus, with the cost of $14,000 (1.6% of total budget), the implementation of this output, though with delay, laid a foundation for the initiation of the upgrading and development of the diversified services for drug users.

Output 2: Functional local coordination groups on drug abuse and HIV/AIDS

41. The establishment of multi-sectoral coordination groups at local level was meant for harmonization of work around HIV and drug use in project sites. Though no Terms of Reference for the coordination groups were available, the groups were indeed established in each visited site. Typically, their membership included the local project focal point, heads of organizations (state-run and non-governmental) participating in the sub-project, a representative of health authorities, director of AIDS centre, director of STI clinic (in Khoudjand also Director of Oblast Drug Control Agency).
42. Such groups were also created at the national level and their members were represented by senior management of ministries of health, directors of national AIDS centres, STI's clinics and drug control agencies. The ministry of interior (the police and penitentiary system) did not have representation in the groups, neither at national nor at local level.
43. According to the accounts of the project focal points, quarterly meetings of the coordination groups were held as planned. The possibility to see other colleagues, to raise and discuss issues of concern, if not to solve them, was the main value of these meetings.
44. It should be noted that there has been some confusion among the project focal points and members of these coordination groups about the scope of groups' functions, and especially about their relation to the same kind of coordination groups on HIV/AIDS and, at the central level, to the Common Country Mechanism (where exists) and UN Theme Groups on HIV/AIDS.
45. Anyhow, with all above reservations, the establishment of the local coordination groups contributed to greater coherency of work within the project frame. In some places it has been a well functioning decision- making and partner accountability mechanism whose decisions were to be implemented and results to be reported to the group (in comparison with others the decision making power of the coordination group in Khoudjand was the strongest).

Output 3: A critical mass of expertise anchored in practice in each of the targeted service delivery centres

46. This project component was started in July 2003 with the training needs assessment of service providers in the project sites. As it follows from the project mid-year review

report issued in August 2004 [10], a mini-survey of 52 specialists directly participating in project implementation showed that majority of them had recognised their lacking of up-to-date professional knowledge and skills. Skills in psychotherapeutic and psychological techniques that could be applied in rehabilitation of drug users were identified as the most and urgently needed (up to 80% of respondents). Most of the respondents had preferred short-term intensive training courses provided by experienced faculty.

47. Based on the data of this survey, special training programmes were developed at the Kazakhstan Narcological Research Centre covering issues of organization and management of outreach work and rehabilitation of drug users; psychotherapy in narcology; and psycho-social counselling. In three months (from October 2003 to December 2003), 249 professionals most of them psychiatrists-narcologists, psychotherapists, psychologists, social workers, outreach workers, and public health managers gained knowledge and skills in relevant professional fields through education cycles provided at this centre and on spot (i.e. in Turkmenistan) by the faculty of the Centre and international specialists. Only 6 academics from higher education institutions have been involved in the training courses. It should be noted that by May 2005, only 151 people of the trained staff have remained in the project (without trained staff from Turkmenistan, see Table 4, Annex 4).

48. A specially developed impressive information package (24 titles, see the full list in Annex 4) containing drafts of prototype documents for reforming of specialist narcological service with a set of standards for the service organization, as well as guidelines on evidence-based preventive, diagnostic, treatment and rehabilitation methods, was handed in to each student on the completion of the cycle. This core group of trained specialists, health managers among them, equipped with a tool-kit for reforming the service became a pivotal force for the treatment paradigm change and initiation of the reformation process.

49. The total cost of this output was $108,000 (about 13% of total budget) mostly spent for trainings (Table 1, Annex 4).

Output 4: Diversified HIV prevention and drug treatment services in project target areas

50. Based on the results of the selection of subproject proposals a range of organizations was identified as partner institutions in seven geographical sites (Table 2, Annex 4). In consultation with local authorities decisions were taken what granting scheme to apply and how to monitor project implementation. Subprojects' action plans were

agreed upon.

51. As it follows from the Table 2, Annex 4, the amount of grants ranged between about $35,000 to $20,000 with the planned average period of project implementation of about 13 months. It should be noted that the quality of subprojects action plans differs from place to place. Some of them are quite specific, time-bound and have quantified indicators as targets. However, the relevance of targets to the objectives of subprojects and their achievability are questionable (see subprojects grants proposal, sections Expected Project Results, and Monitoring and Evaluation).
52. The below analysis of the degree of scaling up, upgrading and diversification of health services for drug users is based on data presented in the available documents [1,2,6,10], information collected during the evaluation mission (21.04.05-04.05.05) and at the time of preparation of this report. Details of the results of subprojects implementation are shown in Tables 3-5, Annex 4.
53. The actual time span of service delivery within the project framework ranged from 6 months (Bishkek) to 14 months (Dushanbe). On average, about 200 specialists and volunteers directly participated in subprojects implementation. In summary, the number of available facilities (all modalities) increased from 39 to 54, with the number of low-threshold facilities increased from 21 to 29. By May 2005, the services operated within the project framework were represented by 6 hotline telephones, 31 Trust Points, 1 Drop-in Centre, 9 outpatient treatment units, 85 beds of day care, 437 beds of inpatient units, and 33 beds of the residential care (therapeutic community type).
54. What is more important, the above services have become more accessible for drug users, most of all because the outreach work was intensified, no fees for services have been charged, and no registration of the user's personal details has been required. Another important factor attracting problem drug users to the services operating in the new fashion has been the widened range of treatment modalities, interventions and techniques offered by existing facilities.
55. As it comes from the Mid-year Project Report-2004 [10], in the first 6 months of sub-projects implementation (by August 2004), 89 involved specialists delivered 368 types of intervention starting from information giving and advice, to provision of condoms and syringe exchange, to various counsellings, detoxification, to out- and in-patient individual and group psychotherapeutic sessions, to providing residential accommodation, and to social support as aftercare; in total 6267 clients/patients received at least one type of the listed treatment. While the number of people covered

by services looks impressive, the monthly workload roughly calculated for the four-month operation time (though 76% of staff had been in the project for more than 4 months) is quite modest: about 18 clients/patients per specialist (with about 24% of interventions being only condoms provision and syringe exchange).

56. The question of the efficiency of the used operation modes was raised in each visited project site. Unfortunately, it was difficult to assess the efficiency by making comparisons between the subproject sites as the partner institutions had used differing monitoring and reporting systems. In cases when relevant data were available the efficiency was quite moderate: i.e. in Tashkent, in 2004, the workload of the unit for anonymous counselling was 4 patients per day, providing for 8 psychotherapeutic sessions per month, with 30 clients enrolled in 12- step programme annually, and 113 laboratory tests on STIs and HIV taken over the year [3]. This notion is not meant to diminish the achievements of the newly established services most of which had started their work from scratch. Despite the project support and other humanitarian or developmental assistance most of the facilities have been in a very poor condition with their managers struggling each day to overcome shortages of all kinds from insufficient supply of pharmaceuticals to the problems with procurement of food for their patients to the urgent need for renovation of shabby and unsuitable buildings labouredly adjusted to serve the needs of drug users.
57. The issue of financial efficiency and cost-effectiveness of the proposed interventions and operation modes of the new services needs close attention of UNODC Project Coordinator, if the project is to be continued; and the question about the services efficiency is of crucial importance for future reforming of narcological service as a whole.
58. Other issues related to accessibility, continuity and quality of the offered services, including referral mechanisms, were discussed with the personnel of the project and service users. One of the repeatedly raised issues by drug users in open access services was about being jeopardized by the police, i.e. the police watch drug users exiting pharmacies where the latter come in for purchasing syringes, especially in cases where Trust Points geographically are not easily accessible (interviews with drug users on treatment in the Republican Narcological Centre in Tashkent, clients of Trust Points in Chimkent). It suggests the necessity of more intensive collaboration with law enforcement agencies so that to develop the common human-rights-based and law-abiding platform suitable for all sides, drug users seeking harm minimization, the service providers, and the police itself.

59. More clarity is needed with regard to who should provide HIV pre- and post-testing counselling, and where it should be done. So far, in most visited places it has been the domain of specialists of AIDS centres even if the patient was on in-patient treatment from drug dependence (especially post-testing counseling in case of HIV positive status). There is a common feeling among the project staff that counselling skills should be an unalienable competency of any physician and clinical psychologist, and that HIV counselling should be provided in the place and fashion most acceptable and convenient for the patient/client.
60. Another related issue was the obstacles to the accessibility of the diagnostic and auxiliary services. As it was stated by clients of Trust Points in Pavlodar (Kazakhstan) and in Bishkek (Kyrgyzstan), in many instances the required laboratory testing and other diagnostic procedures necessary for entering drug treatment programme (i.e. test on syphilis, X-ray examination, blood tests, etc.) should be paid for by the potential patient and, moreover, there was no guarantee of confidentiality. Also, the links of drug treatment services with STI's clinics should be cleared up. In some places this problem was solved, i.e. at the Tajik National Narcological Centre, where consultants on STI, TB and other somatic disorders prescribe the treatment, and physicians-narcologists manage the case.
61. Some observations regarding the assessment of drug dependence at the entry to treatment and the content of treatment interventions may be useful to mention. The general opinion of the usefulness of the modified Addiction Severity Index (BelASI) as the diagnostic tool was rather positive. However, practically all specialists made a notice of the instrument as time consuming and not always well accepted/understood by patients. The indiscriminate application of all known techniques to all treated patients noticed in most of the visited treatment facilities made the impression that specialists had used the questionnaire because it is required by protocol rather than truly needed for treatment planning.
62. The list of the used treatment techniques is wide and rich with the mixture of underlying theoretical concepts ranging from the disease model (i.e. 12-steps programmes) to psychoanalysis (i.e. transaction analysis), to social learning theory and to trans-theoretical models. The psychotherapeutic and life skills education sessions, and other non-pharmacological treatment interventions are very intensive and take almost all day-time of the specialists and patients. The specialists are very enthusiastic in the applying these techniques, and the clients/patients are equally enthusiastic in receiving them, and both sides are optimistic about the effectiveness of

the interventions. Given the short period of actual service delivery and very limited set of available progress and outcome indicators it was impossible even roughly to assess the effectiveness of any of the used techniques. Whether it is a novelty of the techniques for the professional and drug users' cultures that creates such a special, elated, treatment environment, or the proposed combination and sequence of interventions are really highly effective, is the important question for the future evaluations to respond to.

63. The issue of adherence to treatment protocols and standards needs very close attention of the project managers and project consultant as it was noticed that treatment approaches used in some treatment facilities participating in the project go much beyond the proposed set of interventions (i.e. using atropine coma in "Musa'ada" residential facility in Osh, Kyrgyzstan; the facility has only very limited basic medical equipment).
64. The question of cultural adjustability of the offered diagnostic, psychotherapeutic and education techniques, most of which were developed in the countries of Anglo-Saxon cultures, was raised by psychotherapists and psychologists of the Osh Narcological Dispensary. In their opinion the adjustments (not only translation into local languages) especially are needed for the techniques based on the use of language constructs (proverbs, metaphors, etc), and it is especially needed when they are applied for treatment of patients/clients from rural areas.
65. Out of all visited sites the methadone substitution was available only in Kyrgyzstan. In Osh Narcological Dispensary, substitution treatment has been piloted since April 2002, methadone being used as the maintenance pharmaceutical. In November 2005, the shortage of the stocks of the medicine, as a consequence of stopping of the methadone supply because of some regulatory issues at the national level, forced the management of the dispensary to consider the option of the gradual tapering of the methadone dosages to ultimately to withdraw the patients from it. The acquired clinical experience of the methadone detoxification was very valuable but the question whether methadone will be available for the future is still there.
66. On a whole, the project specialists have preferred in-patient mode of interventions to the outpatient one, though in some places actual utilization of outpatient services was higher than planned (Table 5, Annex 4). Some of the specialists expressed their diffidence with regard to applying the newly acquired therapeutic skills for the clients/patients undergoing treatment in ambulatory settings. Others had the opinion about ineffectiveness of the interventions provided on the out-patient basis. There is a

need, at the professional trainings, to pay more attention to the development of skills for the assessment of patients at the treatment entry and psychotherapeutic techniques that were proven to work in out-patient regime. The demand for more systematic and continued professional education of those involved in the project implementation, and, generally, in all types of service delivery was made constantly by project staff in all visited sites.

67. Among the project partner organizations there are facilities providing their services for women and adolescents (Pavlodar, Kazakhstan, Osh, Kyrgyzstan, Khoudjant and Dushanbe, Tajikistan) but on the whole these population groups are underserved, i.e. women comprise only 3% of all patients undergoing treatment in narcological clinics while it is estimated that their proportion among drug users is about 15% (field data, Pavlodar, 2005). There was a common consent among project specialists and service users alike of the necessity to develop treatment services better adjusted for the needs of adolescents and women.
68. One more area of concern was the unclear role of social worker in the treatment, rehabilitation and aftercare. No terms of reference or description of professional competencies of social worker were available. The scope of work of those trained as social workers in Pavlodar and on spot stretched from finding jobs for the discharged patients to giving them education sessions. Special arrangements in the project with regard to the roles and education background of the involved social workers would be useful. In a long-term perspective, there is a need for upgrade of teaching programmes of relevant higher education institutions so that to ensure the establishment of national cadre of social workers.
69. Despite drawbacks in planning and programming in the development of the system of diversified services, the achievements are encouraging (Table 5, Annex 4). The presented results show that previously scattered and unlinked health services for drug users are being shaped into a system, which has a potential for continuity of quality care. These results also indicate that the establishment of national professional cadre and ensuring sufficient financing of the continuum of care will be the biggest challenges for the new national policies aimed at reforming health services for drug users.

Output 5: Experiences acquired systematized and lessons learned disseminated through UNDCP publication, its web site and expert networking

70. This project component was aimed to ensure the better effectiveness of future

interventions based on the lessons learned. However, the monitoring mechanisms which were presented during the evaluation were not elaborated enough to easily understand the process, outputs and outcomes of the project. The monitoring system which had to be established as the deliverable of this component virtually does not exist, though a simple monitoring tool which gives some quantitative data related to project implementation was introduced in March 2004.

71. As it was already mentioned, the lack of specificity in formulations of activities, outputs, target, baseline and progress indicators is the most visible flaw of the project description. Even in this section, which is about monitoring and evaluation, the description of activities is such that allows for making different guesses (i.e. is it the monitoring and evaluation system for health care system that will be developed, or is it meant to measure progress of project implementation and evaluate its results?).

72. Nevertheless, meetings of national partners and project staff planned by this project component and convened for sharing experiences gained in the process of project implementation had their own value. The exchange of information and experiences were useful and contributed to the attainment of the overall objective. Also these meetings helped to create the sense of belonging to the innovative project and to establish a peer support network among the involved professionals.

2.4 Implementation

73. The project was implemented through operational plans developed by UNODC project staff and the workplans developed by partners in each subproject site. As it was mentioned earlier, objectives and quantified targets (where they were presented) were not always specifically formulated and realistic to achieve in the given period of time (i.e. increase of remission rates among the discharged patients, in Tashkent Narcological Dispensary and Dushanbe Narcological Centre, or deceleration of HIV infection rates in the treated patients, in Dushanbe Narcological Centre).

74. Nevertheless, the main goal of the establishment and expansion of the diversified treatment system for drug users was achieved (Table 5, Annex 4) through coordinated efforts of local steering groups consisting of the project coordinators, heads of the facilities participating in the project and local health authorities.

75. As local project coordinators noted, four areas supported by the project were of the major importance: 1) professional capacity building, 2) creation of the decent milieu in the facilities (repair and renovation of the treatment premises, provision of office furniture, etc), 3) contribution to procurement of pharmaceuticals and food for patients, and 4) paying fees for all staff involved in project implementation (Tables 6.1-6.7 , Annex 4). In

average, the proportion of the project budget spent for salaries of the treatment services personnel was 48%, renovation and maintenance - 37%, administrative and public utilities expenses – 6%, providing food for patients – 3%, and procurement of medicines – 1% (Fig. 1, Tables 6.1-6.7, Annex 4).

76. Though questionable from the project sustainability point of view, such a distribution of resources is quite understandable in a situation whereby the state financing does not cover all needs of the services. For instance, in 2004, estimated state budget expenditure for treatment (pharmaceuticals and food) per patient per day ranged from $0.70 in Osh Oblast Narcological Dispensary, Kyrgyzstan, to $0.20 in the Republican Narcological Centre in Dushanbe, Tajikistan (interviews with head physicians of these centres), and, on a whole, the humanitarian aid comprised of more than 50% of expenditures of the services involved in the project (interviews with head physicians/directors of visited facilities, Tables 6.1-6.7, Annex 4). Monthly salaries of specialists working in drug treatment system do not exceed $35 in Kyrgyzstan, Uzbekistan and Tajikistan (interviews with head physicians/directors of visited facilities).
77. The issue of the state insufficient financing schemes was referred to repeatedly during the evaluation mission and was indicated as the major constraint for expanding the services. Another concern was a discrepancy between the regulations and procedures (standards and protocols, rules, instructions, etc.) currently employed in health care, and the new ones proposed by the project (as the discrepancy mentioned above on the problems with confidentiality when taking laboratory tests before entering the services supported by the project; or the requirement of patient's co-sharing costs for pharmaceuticals, in Kyrgyzstan).
78. Lack of experience in up-to-date public health administration of most of counterparts could also be listed among constraints that prevented more efficient project implementation. Also very limited participation of faculty from teaching higher education institutions in the above trainings prevented more rapid knowledge and skills transmissions among other relevant professionals in the countries.
79. One of the impeding factors was the fact that in many project sites (i.e. Dushanbe, Chimkent, Pavlodar, Bishkek, Osh) only part of the staff of the facility was involved in the project and the other, the bigger part, of the same organization was not participating in the project because of financial limitations and short duration of the project. In two project sites the major medical institutions that are responsible for the development of strategies in treatment of drug users, methodological support, monitoring and reporting in their catchment territories were not directly involved in the project i.e. Sogd Oblast

Narcological Dispensary in Khoudjand, and the Uzbek National Republican Narcological Centre (though some staff of the latter organization had participated in professional trainings provided by the project and were using the newly acquired psychotherapeutic and psychological techniques). In view of the newly adopted national programmes aimed at reforming of the narcological service in four Central Asian countries, the professional capacity building strategy of the project should be revised.

80. Practically all of the above findings that now may be interpreted as limitations can be explained by the original design of the project which was focused on the piloting of new schemes of services, and thus the intent was to immediately apply the acquired knowledge and skills into clinical practice, to see whether the techniques work at all, in the chosen facilities that were ready to implement them. In turn, this rather narrow geographic focus of the project is justified by the limited budget and a short time span for the project implementation. In general, the project's positive influence on the development of new types of treatment systems significantly overweighs the limitations.
81. The listed constraints and many other smaller issues of implementation of the operational plans were addressed to during field missions of the project staff, working meetings with implementing partners, quarterly, mid-year and annual reviews. The reports of these reviews show that monitoring results were taken into consideration by Project Coordinator and UNODC Headquarters and national partners, and remedial actions were undertaken, i.e. revisions of the operational plans of sub-projects in Dushanbe and Khoudjand, Tajikistan, and in Chimkent and Pavlodar, Kazakhstan.

2.5 Institutional and Management Arrangements

82. The project was managed from the UNODC Regional Office for Central Asia (ROCA) with the Project Coordinator as the executive official and Project Assistant as administrative support staff. An expert with solid research background, rich teaching experience and public health administration skills was hired for the whole duration of the project implementation time as the Project Consultant being resource for technical assistance. National Focal Points and Local Project Coordinators along with UNODC Project Coordinator and the Project Consultant were the executive group for the project implementation. UNODC ROCA country offices also backed-up the project implementation. As it was said, regular meetings of the above group were held in accordance with the project action plan and per monitoring schedule.
83. Good working relationships of the UNODC Project Coordinator and Consultant with national and local counterparts were demonstrable during the evaluation visit. Easy access

of the evaluator to high level national and local authorities and professionals, possibility of contacts with drug users in treatment, openness in discussing sensitive issues, the partners' willingness to expand approaches used by the project and their expressed desire for improvements of the created services – all this was the reflection of trustful relationships established between ROCA management and counterparts and the indication of genuine appreciation of the process and results of project implementation. Surely, the most impressive evidence of the successful management of the project is the fact that its philosophy and proposed standards were endorsed by the governments of all four countries participating in the project.

84. Results of collaboration with stakeholders representing international development aid organizations in Central Asia are not so impressive. In fact no joint programming or any other forms of joint work with numerous international organizations present in Central Asian countries, who are directly involved in HIV prevention among vulnerable groups, were envisaged in the project, neither consistent attempts were made to establish such a collaboration throughout the project implementation. The mechanism of UN Theme Groups on HIV/AIDS was also not fully used for better coordination and possible collaboration with other UN agencies to make them contributing to diversification of services for drug users including drug dependence treatment.

85. Besides the mentioned low awareness of representatives of international development aid organizations of the project, there were mixed attitudes related to the worthiness of the project. While sympathetic feelings towards the work done by the project were expressed by most of participants present at meetings, the impression was that for many of them HIV prevention is seen only in the frame of harm reduction in the narrow sense. Treatment of drug dependence was perceived as something separate from HIV prevention, and there was some skepticism expressed with regard to its results. On the other hand, in some of the project localities (i.e. in Khoudjand-Chkalovsk, Tajikistan; Osh, Kyrgyzstan; Pavlodar, Kazakhstan) the project counterparts have attracted funds of international aid organizations to the concerted effort to establish diversified services for drug users (Tables 6.1-6.7, Annex 4).

86. It should be noted that throughout the project implementation, starting from project design to the mid-term evaluation, the UNODC headquarters in Vienna provided technical guidance, participated in mid-year and annual review meetings and contributed to the necessary corrective actions. UNODC Treatment and Rehabilitation Advisor (Ms Juana Tomas) and UNODC Global Assessment Regional Epidemiological Advisor (Mr. Kamran Niaz) participated as resource people in the seminar on protocols and standards of services

held in Pavlodar in March 2004. Besides, UNODC treatment and rehabilitation toolkit [4] have been widely distributed among all partners.

87. Nevertheless, more advocacy efforts are needed on the side of the UNODC headquarters among UN family and donors for the acceptance of drug dependence treatment as a necessary element of the bigger HIV prevention strategy and due attention to funding the reforming of the drug dependence treatment system at country level.

3. OUTCOMES, IMPACTS AND SUSTAINABILITY

3.1. Outcomes

88. The major outcome of the project, though not explicitly planned in the project, is the adoption of the national programmes of the reformation of narcological services in Kazakhstan and Tajikistan (in Kyrgyzstan and Uzbekistan draft national programmes are under consideration of the government). The programmes contain provisions for organization and maintenance of the open access services as well as residential rehabilitation services along with medical out- and inpatient services including substitution treatment (the latter has been piloted in Kyrgyzstan; relevant governments decisions are pending in Kazakhstan, Tajikistan and Uzbekistan). The programmes provide for new structure of the treatment system, expanded professional composition of staff (not only physicians but also psychotherapists, psychologists, and social workers) and for increased financial allocations.

89. While in Kazakhstan substantial preparatory work for initiation of the reform had been done before the project implementation, the project's catalyzing role in the process of the programmes development in Kyrgyzstan, Uzbekistan and Tajikistan (also adoption) can not be denied. Adoption of the national reformation programmes opens a venue for radical change of the treatment system that is expected to more effectively respond to the health and social needs of drug users; the system that will allow to embrace and institutionalize HIV prevention among drug users.

90. Introduction of a new diagnostic tool (Addiction Severity Index) and a broad range of new treatment techniques into practice by a pool of professionally trained specialists and volunteer outreach workers (about 200 people) is another outcome of the project which will facilitate the forthcoming reforms. As it was indicated earlier (Section 2.3), there is a need for in-depth evaluation of the applied treatment methods to judge their effectiveness and efficiency.

91. Improved access of drug users to a broad range of services based on the expanded networks of treatment institutions and facilities including low threshold services (Trust

Points, Drop-in Centres), out-patient rehabilitation/relapse prevention services, substitution therapy, in-patient rehabilitation and residential care in the project sites is the third outcome of the project. As shown in Table 5, Annex 4, the coverage of drug users by low threshold services by end of 2004 on average comprised 24% of estimated number drug users in catchment areas of the partner facilities (64% in Bishkek and 77% in Khoudjand)**;** a significant proportion of clients of those services enter out- or in-patient or residential treatment programmes of drug dependence (25% on average; in Khoudjand – 94%). In total, about 9,634 drug users (out of estimated 40,829 drug users in the project catchment areas**)** have used low threshold services and 2,365 of them entered drug dependence treatment services.

3.2. Impacts

92. The short duration of the project and its piloting character did not allow for expecting any tangible and sustainable behavior changes among drug users having access to the services supported by the project. A decrease of the prevalence of HIV or other blood-borne and sexually transmitted infections in the project sites is even less expected.

93. Nevertheless, the project initiated a new paradigm shift in drug treatment field which may be regarded an impact. The "first paradigm shift" - from the abstinence-oriented treatment to substitution and harm reduction approaches - was brought to Central Asia mostly by international NGOs in the late 1990es, and it took almost a decade to legitimize these approaches. The "second paradigm shift" which is ongoing now in the countries participating in the project is about embracing harm reduction interventions into the integrated diversified services for drug users that would provide for continuity of care, and thus address much broader spectrum of health and social needs of drug users and their families. The impact on the HIV- and drug-related situations in the countries will depend on the timeliness and comprehensiveness of the materialization of the new paradigm into the state run treatment services for drug users.

2.3 Sustainability

94. The issue of sustainability of the results that have been achieved over the time of project implementation is a sensitive one. On the one hand, the project provided for professional capacity development and gave the know-how for arrangements of the new type of specialist treatment system. On the other hand, only partial involvement of participating treatment organizations which themselves are fragments of the bigger health care system makes the possibility of having sustainable positive effects doubtful.

95. Absence of the mechanisms for building new professional cadres, and thus maintaining the flow of the appropriately trained professionals into the prototype of the new treatment system created by the project, also jeopardizes the project sustainability.

96. Yet the most serious factor that threatens the project sustainability is the absence of the exit strategy of the supporting agency in the situation whereby substantial part of the expenditures of partner facilities is borne by the project funds (Tables 6.1-6.7, Annex 4) Reintroduction of fees paid by patients for entering treatment in some of the participating organizations (i.e. in Bishkek, NGO's Chance and Sotsium), when the project funding was stopped, is the evidence of fragility of its achievements.

97. At the same time, adoption of the mentioned national programmes of reformation of narcological services gives an excellent opportunity not only to sustain the project results but to scale them up and further develop the services by channeling project support to the national programmes.

4. LESSONS LEARNED AND BEST PRACTICES

4.1. Lessons

98. Specificity and relevance of indicators measured during the situation assessment are of crucial importance for the reliability of the results of project monitoring and evaluation. Absence of relevant quantified baseline and target indicators (as well as irrelevance of progress indicators) severely hampers project monitoring and evaluation and negatively influences the reliability of conclusions on the project achievements. Gaps in data of Table 5, Annex 4 reflecting results of the project implementation indicate insufficient preparations at the stage of project planning. If the expected key results matrix (with SMART baseline, progress and target indicators), had been part of the action plan of the project, that might have allowed for more efficient remedial interventions in the course of project reviews and would have made the project evaluation more precise.

99. Professional capacity development is a proven strategy contributing to the aid project or programme sustainability. In the frame of the project under evaluation, intensive professional trainings were provided by qualified instructors to more than 200 specialists of various profession and volunteers; new knowledge and skills immediately were applied to the practice. However, claims were done by many professionals involved in the project implementation on the necessity of more comprehensive and systematic post-diploma education. Training of trainers (ToT) with following cascade trainings could have been more efficient mode of organization of professional trainings providing for bigger coverage of personnel for fewer costs. Especially effective would have been the

involvement in ToT's the appropriate faculty of medical schools and other relevant higher education institutions as this would allow for reproduction of knowledge and skills through the established education systems (under-graduate, and post-graduate), and thus for introduction and diffusion of new concepts and therapeutic techniques into professional culture.

100. As it was noted (Tables 6.1-6.7, Annex 4), the project funds mostly supported fees of participating professionals and maintenance of the premises. The financing was stopped by 1 January 2005, but in all project sites the partner organizations tried to maintain the operational mode they had introduced while implementing the project. However, with lack of sufficient funding they had to deviate from previously employed approaches that provided for easy access of drug users to the services, namely, some partner organizations re-introduced treatment entry fees; also salaries of involved professionals which were paid from the project funds could not be sustained. Besides partners' disappointment and frustration, the basic principles of treatment organization, the project had advocated for, were compromised. If the project exit strategy had been developed and clearly presented in the project description, it would have been easier either phase-out or continue project implementation on the more efficient terms.

101. A very important lesson can be drawn from the catalyzing role the project played in the development of national programmes on reforming of the narcological service in participating countries. With relatively modest funding provided by the project, the Kazakhstan Research Narcological Centre produced several sets of policy and administration documents, standards and clinical protocols, as well as professional training modules that became a ready-for-use package for the reformation of specialist service in Central Asian states. Having this know-how it was easier for national project focal points to advocate for the long needed change in the structure and management of narcological service. Thus, investment in policy development and institutional capacity building pays off by paving ways for nationwide and sustainable change in the desired direction.

4.2. Best Practices

102. Though none of the visited sites would suit the criteria of best practices, there is an example of an innovative approach to project implementation. In Osh, the subproject team has managed to create the desired continuity of care through establishment of referral links among low-threshold services run by NGO's (one of them specifically designed for service delivery for women), the state-run Oblast Narcological Dispensary that provides for out- and in-patient treatment of dug dependence (including methadone

substitution), and a private non-commercial rehabilitative residential facility. In the frame of the ongoing health sector reform, the dissemination of the experience gained during the project implementation to the local primary health care system has been started. The local project coordinator has taken advantage of the presence of several higher education institutions (training clinical and social psychologists) in Osh to involve the relevant faculty into the project implementation. It resulted in changing teaching curricula in these institutions so that undergraduate students could learn new concepts and acquire up-to-date technical knowledge. The graduating students participate in education and psychotherapeutic sessions held in the process of project interventions. It is the academics from these institutions who raised the issue of the necessity of cultural adjustments of the applied diagnostic and therapeutic tools. Surely, there are areas that need improvements in the subproject management but the creativity in making the project fit the local conditions and making best use of the existing resources is worth to praise of and pay attention to.

4.3 Constraints

103. As it was formulated by Project Consultant "the project has huge ambitions but too little funding"; time shortage could be added to the constraints that prevented attaining of the project objective.

104. Lack of awareness of the project concept and its mode of operation by the international aid community present in Central Asia, and the consequent lack of their cooperation with UNODC ROCA also could be seen as the constraint that prevented possible joint programming and planning.

105. Relatively late introduction of the technical guiding documents on the integrated diversified services for drug users produced by UNODC and WHO (i.e. the Drug Abuse Treatment and Rehabilitation, UNODC, 2003) and their insufficient use by local project managers can also be listed as a constraint for providing efficient and quality health care.

106. All other limitations indicated in previous sections (especially regarding the number of trained professionals and the still modest coverage by diversified services of drug users) are derivates of the three above constraints.

5. RECOMMENDATIONS

5.1. Issues resolved during the evaluation

107. The issues of specificity and relevance of monitoring indicators used as baselines, progress indicators and targets were discussed with partners. The common agreement was achieved on the necessity of further elaboration of the monitoring tools and revision of the objectives and outputs to make them results-oriented.

108. The use of the Addiction Severity Index as the feasible diagnostic instrument was questioned in some project sites. The decision was taken to continue its use but request more training on its application and technical support in its cultural adjustments. The same requests for cultural adjustments were made for the use of some of the psychotherapeutic techniques. It was agreed that these requests will be considered by UNODC Project Coordinator and that the Kazakhstan Research Narcological Centre will be responsible for making the adjustments.

109. More general concerns about professional education of the involved local project staff were discussed in the discourse of the continuation of the project; it was accepted by the partners that to upgrade professional education and institutionalize it the project should support the national programmes of reforming of the narcological services.

110. One of the options for avoiding multiplication of the coordination groups with overlapping responsibilities could be creation of the Working Groups on Drug Use under already existing coordination mechanisms on HIV/AIDS. Terms of Reference of this working group should clearly define its responsibility, composition, accountability and relationship with the common coordination mechanism.

111. The schemes for the tapering of financial flows to the services currently supported by donors/development aid agencies were discussed. It was decided that the models of the gradual decreasing of donors' share in the service financing and increasing the state financing should be developed within the frame of the national programmes on reformation of narcological services.

5.2. Actions/decisions recommended

112. The project should be continued though its design should be revised. Priority should be given to the longer-term (up to 5 years) support of the newly adopted national programmes on reformation of narcological services in Kazakhstan and Tajikistan, and (pending) Uzbekistan and Kyrgyzstan. During the first year, the assistance should be focused on the development of Action Plans of the national programmes. The Action Plans should be interlinked with the national plans on HIV/AIDS prevention. In the long-run technical assistance especially with regard to the development of regulatory documents, standards, etc. and the establishment of the national multi-disciplinary professional cadres should prevail.

113. The funding and technical assistance to local project sites should be continued for at least three years. While implemented, the shift should be made from piloting to modelling within the frame of the national programmes. The already developed services should serve as prototypes of the new specialist treatment systems covering clearly defined catchment areas. These services should become testing grounds for high quality service administration, management, standards and protocols, including standards for monitoring and reporting.

114. During the project revision serious considerations should be given to the development of donor/development aid agency's exit strategies that would ensure national ownership and thus sustainability and expansion of the results achieved through the project implementation. This notion equally relates to the support of the national programmes and the model sites. Support should be given to the development, modeling and testing of financial schemes that would provide for gradual phasing out of donors currently supporting heath services.

115. Results-based planning techniques should be employed while re-designing the project with monitoring and evaluation in-built in the operational plan. Indictors that are to be used for measuring the project progress and evaluation of its results should be specific, measurable, achievable, relevant and time-bound. Partners' responsibilities, accountability and reporting schemes should also be clearly delineated in the revised project design.

116. There is a need for wider involvement of other UN agencies, international and bilateral organizations through joint programming and planning in the project implementation to make more effective use of financial and human resources. WHO, UNICEF, UNFPA, UNDP and UNHCR can be the first choice partners in joint programming as all of them have programme components related to establishment of friendly services with focus on HIV prevention. The most feasible way to advocate for collaboration between UNODC and other UN and bilateral agencies for support to diversification of services for drug users would be to use the mechanism of UNTG on HIV/AIDS in each country.

117. Given the adoption of the national programmme on HIV prevention in Turkmenistan (April 2005) and recent positive moves towards closer cooperation with UN and other international agencies, negotiations with the government of Turkmenistan on the prospect of joining the project should be resumed. A specially designed sub-project for Turkmenistan may have focus on in-country intensive professional capacity building and introducing the evidence-based approaches for organizing the abstinence-oriented treatment of drug dependence, the latter is the only one recognized as legitimate by the

government. Introduction of interventions aimed at harm minimization can be done through joint programming with locally based UN and other international organizations with relevant experience.

6. OVERALL CONCLUSIONS

118. For the time being the evaluated UNODC project is the only project in Central Asia among those supported by UN or other international development organizations, whose objective is to support the governments in the establishment of the specialist treatment system that integrates harm reduction approaches with abstinence-oriented treatment and provides for continuity of care thus addressing a wide scope of health and social needs of dug users and their families. In two-year time, pilot diversified health services were developed in seven localities in four Central Asian countries and reforms of the narcological service were initiated

119. New diagnostic tools and treatment techniques were introduced in practice of newly established treatment systems by trained specialists and volunteers. Drug users, dwellers of the pilot localities, got easier access to a broad range of services embracing low threshold services as well as residential rehabilitation services along with medical out- and in-patient services including substitution treatment (the latter is available only in Kyrgyzstan). The increased number of drug users, men, women and adolescents, have received medical-social interventions aimed at reducing their vulnerability and risk of HIV infection and preventing or mitigating other drug-related health and social harms. A significant proportion of clients involved in harm minimization programmes provided by newly network of services have entered drug-free treatment.

120. Political environment in Turkmenistan was not conducive for the acceptance of the project with its emphasis on HIV prevention among injecting drug users through improved access to harm reduction services. Nevertheless, the opportunity for professional capacity building provided by the project was used for in-country training of health professionals including health care managers and faculty of the national school of medicine. It is very likely that the project support, if focused on upgrading of abstinence-oriented services in Turkmenistan, will be welcomed by the government. In future, the established partnership between national authorities and UNODC may pave ways for initiation of the services diversification.

121. The necessity of continuation of work on the further development of treatment models created in the process of the project implementation is of no doubt. It is believed that sustainability and the efficiency of the project would increase if support is extended to the

national programmes of reforming of narcological services. The local project sites that have already established new diversified services could become prototypes of the future national health services. While revising the project, close attention to the planning and programming ensuring that results-based management tools are used in its design would provide for improved effectiveness of the project.

122. Wider participation in the project of other UN agencies and international organizations would facilitate its scaling up and thus would increase the project's contribution to HIV prevention and drug demand reduction in participating countries.

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Annex 1

TERMS OF REFERENCE FOR THE PROJECT MID-TERM EVALUATION

PROJECT TITLE: Diversification of HIV prevention and drug treatment services for injecting and other drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan

PROJECT NUMBER: AD/RER/03/F75

BACKGROUND

In the last few years drug abuse problem in Central Asia has been acquiring worrying dimensions, particularly as far as the intravenous use of heroin is concerned as this directly links to the potential spread of HIV/AIDS and other blood borne infections. Opiates, particularly heroin, account for 80% of drugs consumed, and 50-75% of drug user are youth below the age of 25. UNODC studies show that approximately 1,1% of the population over 15 consumes opiates, which is three times as high as the ratio for the corresponding demographic group in Western Europe.

Although Central Asia is considered as a region with low HIV/AIDS prevalence, the rate of HIV/AIDS incidents is rapidly increasing, mainly among IDU communities. The registered cases have grown exponentially from less that 100 in 1995 to more than 7,000 in 2003. The Centre for Disease Control and Prevention (CDC) estimates the number of people living with HIV/AIDS in Central Asia at some 90,000. The HIV/AIDS epidemic in the region currently is characterized as concentrated with prevalence rate exceeding 5 percent among IDUs but remaining below 1 percent in the general population. About 60 – 80 % of all HIV new incidents are attributed to IDU. According to estimations there may be about 500,000 problem drug users in Central Asia, most of whom inject drugs and share needles, placing them at high risk of contracting HIV/AIDS.

Facing the threat of further spread of HIV/AIDS, the governmental and non-governmental organizations in all Central Asian countries have responded to the early HIV epidemic with various interventions. With the technical support from UN and other international programmes targeted interventions have been piloted in the areas of HIV epidemic outbreak, such as Temirtau City of Kazakhstan, Yangi-Yul City of Uzbekistan, Osh City of Kyrgyzstan. Harm reduction interventions have been widely accepted by the society and governments in the region as a concept, and officially introduced into the practice of public health systems. A network of Trust Points is set up in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan to provide various HIV prevention services to vulnerable population including IDUs.

The governments have developed national strategic plans on HIV/AIDS prevention and control with multi-sectoral approaches involving the health sector, penitentiary, interior, educational, military and other sectors. Each has developed strategic plans and allocated limited resources. In Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, functional bodies that promote interaction among the government and civil society - Country Coordination Mechanisms (CCMs) - have been established. The CCMs played a crucial role in successfully seeking financial resources through the Global Fund to Fight AIDS, TB and Malaria, which has approved applications from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, which will be receiving $22, $17, $2,5 and $24 million, respectively, over the next five years for their HIV/AIDS prevention and control programmes.

One of the core mandates of UNODC tasks it with assisting Member States to prevent the abuse of drugs and to address the negative health and social consequences of drug abuse. UNODC advocates comprehensive approach in addressing HIV prevention among IDUs that covers a range of strategies, from preventing the initiation of drug use to addressing issues of risk minimization to providing treatment and rehabilitation to lead to a drug free life.

With the purpose of assisting the Governments of the Central Asian countries in developing comprehensive response models to address HIV/AIDS prevention among IDUs, UNODC launched regional project AD/RER/F75 "Diversification of HIV/AIDS prevention and drug treatment services for injecting and other drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan". It is a unique project that promotes evidence-based strategic development of the conceptual model of the future narcological services system, which operates in close coordination with the legal, social and health sectors including HIV/AIDS services, ensures provision of quality and attractive services to clients, and contributes to effective and efficient achievement of reduction in demand for illicit drugs and containing and reversing HIV/AIDS spread among and from IDUs. The project was developed on the basis of findings of the UNODC-supported two assessment projects (Drug abuse situation assessment project and Needs assessment on drug demand reduction in Central Asia, 2001-2002) and recommendations of the *"Central Asian Regional Conference on Drug Abuse: Situation Assessment and Responses"* held on 26-28 June, 2002 in Tashkent, Uzbekistan.

The project addresses the needs to improve and further develop range of HIV prevention and drug treatment services for injecting drug users in selected localities in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. This includes outreach and low-threshold services including HIV/AIDS prevention education, access to condoms and clean injecting equipment and counselling as well as outpatient and inpatient detoxification, treatment and

rehabilitation. Emphasis is to be placed on the replication of existing successful initiatives in the region, in-service training through exchanges among organisations in the region and training seminars organised at the regional and national levels.

The original project design envisaged 2-year duration with the total aggregated budget of US$ 500,000 (including 13% of project support costs). Funding for the project was secured through partly UNAIDS 2002-2003 Unified Budget and Workplan mechanism (US$ 300,000) and German Government contribution (US$ 200,000). The project implementation started in February 2003 with issuance of the first allotment of US$ 243,280. In May 2004 the project was revised in order to scale up the project interventions in the selected target regions, expand activities to the additional localities and widen successful pilot services to the national level, providing technical assistance in policy formulation and planning activities. The project was extended until February 2006 and accommodated additional funds with total amount of USD 760,000 (USD 300,000 secured from UNAIDS UBW 2004-2005, US$ 150,000 from Ireland, US$ 310,000 from Sweden) for the expanded interventions to address HIV/AIDS and drug abuse in Central Asian countries.

The main objective of the project is to minimise the adverse health and social consequences of drug injecting, including the prevention of transmission of HIV and other blood-borne infections among injecting drug users of selected project target areas through diversification of HIV prevention and drug treatment services. Through implementing various strategies and inter-related activities the project targets to create a precedent of achieving an effective control of HIV and drug abuse at local level and disseminate the successful experience and effective model to other localities across the Central Asia.

The immediate operational objectives of the project include:

- Conduct situation assessment and mapping of existing services for drug users in the selected target localities;
- Conduct needs assessment for diversification of services including training needs analysis among professionals involved in service delivery;
- Capacity building with the identified service providers through trainings and developing knowledge, skills, know how and technical expertise among key professionals and staff involved in diversified service delivery process;
- Provide technical, methodological, advisory and financial assistance to the selected state-run and NGO-based service providers in the development and implementation of integrated sub-projects aimed at diversification of services for drug users at selected localities level;
- Strengthen coordination of local responses to HIV/AIDS and drug abuse issues at local levels, including consolidation of existing resources around the general strategy of the project;
- Systematize acquired experience and disseminate lessons learned, update legal and normative framework for modernisation of comprehensive narcological services system in Central Asian countries.

The main components of the project implementation strategy include:

- Development and implementation of range of attractive HIV prevention and drug treatment services;
- Increase as much as possible the coverage of drug users population with these services;
- Regular monitoring of the project activities and services covered by the project;
- Modification of the narcological services system in Central Asian countries in accordance with the gained and systematized experience of the project pilots.

To date, the following project achievements have been made:

- Analysis of problem drug use and related HIV/AIDS situation, mapping and assessment of availability and accessibility of the existing services and gaps, assessment of training needs, priority needs-based service development plans have been accomplished in each of the 7 selected cities;
- 7 sub-projects addressing diversification of services at localities have been developed and launched jointly with the selected local implementing partners in Pavlodar and Shymkent (Kazakhstan), Bishkek and Osh (Kyrgyzstan), Dushanbe and Sogd (Tajikistan) and Tashkent (Uzbekistan) under grant funding scheme;
- Series of needs-based training seminars for personnel involved in HIV prevention and drug treatment services have been developed and delivered;
- Series of technical guidelines, methodological manuals and other recommending information materials on service organisation and implementation policy and practices have been developed and disseminated among policy makers and experts;
- Assessment of problems and needs, mapping of existing services have been conducted in additionally identified 14 localities through holding project planning and development workshops in Kazakhstan,

Kyrgyzstan, Tajikistan and Uzbekistan. Additional sub-project proposals have been developed for screening and possible grant funding under the project.

PURPOSE OF EVALUATION

In compliance with the project revision document the external mid-term evaluation is initiated by UNODC to assess the process of the project implementation in relation to the objectives and the outputs set out in the project document. The evaluation findings should also contribute to strengthening the monitoring and evaluation system to support results-based management of the project. The evaluation should provide information on findings, lessons learned and recommendations with regard to efficiency, effectiveness, appropriateness, relevance, impact and sustainability of the project. Findings of the evaluation will be used to adjust the project strategy to maximize the impact from the project inputs.

The main stakeholders with whom the evaluation report will be shared include relevant units of UNODC, government counterparts (National Focal Points), donors (UNAIDS, Germany, Ireland, Sweden).

EVALUATION SCOPE

The mid-term evaluation covers the activities of the project implemented from February 2003 (start of the project) up to the end of 2004 in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. In particular the specific areas of evaluation (process and outcome) should cover the following:

1. The effectiveness of the project design, strategy and approach in response to the need;
2. The progress of the project implementation: are the activities planned under the objectives moving on track (schedule and substance wise)?
3. The outcome of project interventions, in particular,
    a. Nature and extent of diversification of services in the sub project areas
    b. Accessibility and utilization of these services by the target group (DU/IDU)
    c. Delivery of training programmes and their appropriateness in response to the training needs of the target groups (service providers)
    d. Development of competencies/skills among the various service providers in response to their needs
    e. Utilization and use of competencies/skills by the service providers in improved service delivery at the target sites
    f. Development of guidelines, methodologies, instructional manuals, and other instruments developed / adopted for various training programmes and service delivery.
4. Factors contributing to or impeding achievement of the results/outcomes;
5. The process of coordination and cooperation between different stakeholders at the local, national and regional levels for project and sub projects' implementation.
6. The level of effectiveness of programme management including
    a. Process of local assessments, identification of sub project sites, grant applications and their awards
    b. Process of reporting monitoring and evaluation in terms of their relevance, quality and timeliness, by all parties concerned.
    c. Technical backstopping and inputs to the sub projects and service providers as one of project's target group
7. The extent to which the project has contributed to the overall improvement of institutional and technical capacities to address HIV/AIDS and drug abuse problems in specific sites in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan;
8. The sustainability of project results after the project's completion and its anticipated impact in prevention and treatment of drug abuse and HIV/AIDS among IDU;
9. Based on the above,
    a. recommend future directions, changes or modifications in substantive areas of project implementation
    b. identify areas of best practices for replication in other UNODC projects at other locations and within the region.

EVALUATION METHODS

Suggested evaluation methodology includes the following:

1. The study of relevant documents (project document, project revision document, semi-annual and annual

project progress reports; sub-project grant documents and reports; mission reports, materials developed under the project);
2. Initial briefing by responsible UNODC staff in the Regional Office for Central Asia (ROCA) and in the UNODC Sub-Offices in Kazakhstan, Kyrgyzstan, Turkmenistan and Tajikistan;
3. Interviews with national focal points, officials from the Ministries of Health, Drug Control Coordinating bodies, local governments, departments of health, social welfare, interior at local levels, experts and other knowledgeable parties in the region;
4. Field visits to some of the target localities of the project to meet with local implementing partners and get familiarised with the field activities and outputs;
5. Meetings with the members of the UN Theme Group on HIV/AIDS;

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

COMPOSITION OF THE EVALUATION MISSION

The mid-term evaluation of the project will be carried out by an independent expert appointed by the UNODC. Each assisted country government and interested donors to the project may provide experts to participate in the evaluation as observers. Costs associated with the UNODC and national experts will be borne by the project. All costs for experts appointed by donors will be borne by the donor government directly. The experts shall act independently in their individual capacities, and not as representatives of the government or organization which appointed them. The report will be prepared by the independent expert appointed by the UNODC. This expert should have the following qualifications:

- International drug demand reduction experience at a senior level;
- Experience in conducting independent evaluations;
- Familiarity with the drug abuse and HIV/AIDS situation in the Central Asian region;
- Knowledge of bilateral/multilateral technical cooperation, particularly in demand reduction;
- Fluency in English with working knowledge of Russian language.

PLANNING AND IMPLEMENTATION ARRANGEMENTS

The evaluation expert may be briefed and debriefed on the project by UNODC HQs and the field office in Tashkent (ROCA). ROCA shall elaborate and make available to the evaluation team an up-to-date status of the project. The UNODC Representative for Central Asia and his staff will also provide necessary substantive and administrative support.

Although the evaluation expert should be free to discuss all matters relevant to its assignment with the authorities concerned, it is not authorized to make any commitment on behalf of UNODC or the Government.

The evaluation expert will submit its report to UNODC Headquarters and to ROCA. The report will contain the findings, conclusions and recommendations of the evaluation team as well as a recording of the lessons learned during project implementation.

The draft evaluation report should be discussed with the Governments of Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, Turkmenistan, the donors of the project and, to the extent possible, with other parties to the project. The evaluation expert, while considering the comments provided on the draft, would use its independent judgment in preparing the final report.

The final report should be submitted to UNODC no later than one week upon completion of the mission. The report should be not longer than 25 pages, excluding annexes and the executive summary. The report will be distributed by UNODC as required to the governmental authorities and respective donors, and will be discussed at a Tripartite Meeting by the parties to the project.

The timetable of evaluation mission as follows:

- 12 working days in the field (excluding travels inside the region);
- 1 week working time for the preparation to the filed mission and 1 week for writing final evaluation report.
- Suggested dates for the evaluation field mission: April, 2005

The filed mission will include visits to the following localities:

- Tashkent, Uzbekistan – 2 days
- Pavlodar, Kazakhstan – 2 days
- Shymkent, Kazakhstan – 1 day
- Bishkek, Kyrgyzstan – 2 days
- Osh, Kyrgyzstan – 1 day
- Dushanbe, Tajikistan – 2 day
- Khadjent, Tajikistan – 1 day
- Ashgabat, Turkmenistan – 1 day

PERFORMANCE INDICATORS

- Timely and accurate submission of the documents.
- Substantive and linguistic quality of the documents prepared.
- Conformity of the project evaluation report with the standard format and guidelines for the preparation of project evaluation reports and technical guidance received.
- Report should contain recommendations for future course of action.

Annex 2

Organization and places visited and persons met

UZBEKISTAN
Tashkent-city

No	Name	Title/professional position
Tashkent-city Drug Dependence Treatment Centre (*Narcological dispensary*)		
	Mr. Oleg Mustafin	MD, Chief Physician
	Ms. Elena Popova	MD, Deputy Chief Physician, Treatment and Rehabilitation
	Mr. Ulugbek Alymov	MD, Chief *Narcologist*, Ministry of Health, Republic of Uzbekistan, Consultant of the project, Coordination
	Ms. Ludmila Tursunkhodjaeva	MD, PhD, Head, Department of *Narcology*, Tashkent–city Institute for Advanced Professional Education of Physicians
	Mr. Igor Bokun	NGO "Qalb Sadosi", Consultant of the project, Monitoring and Evaluation
	N/A	Group of volunteers and psychotherapists
Republican AIDS Centre		
	Ms. Gosel Ghiyasova	MD., PhD, Director
	Ms Farida Latipova	MD.,Head, Department for Management and Methodology
	Mr. Sabir Usmanov	MD.,Chief Physician, Tashkent-city AIDS Centre
	Ms. Oysara Ansrukulova	MD., GFTAM Expert
Republican *Narcological* Centre (centre for drug dependence treatment)		
	Mr. Guliam Burykhodjayev	MD., Chief Physician
	Mr. Rowshen Alikhodjayev	MD., Deputy-Chief Physician, Treatment and Rehabilitation
National Centre on Drug Control under Cabinet of Ministers		
	Mr. Kamol Dusmetov	Director
	Mr. Alexander Arteomov	MD., Head, Department of Coordination
Ministry of Health		
	Mr. Abdukhakim Khadjibayev	MD., PhD., 1-st Deputy-Minister
	Mr. Shukrat Khashimov	MD., Head, Department of Preventive and Curative Services
UNODC ROCA (Round Table Meeting)		
	Mr. Kamran Nyaz	Regional Advisor on Assessment
	Mr. Mirzakhid Sultanov	Regional Advisor on HIV/AIDS
	Mr. Aziz Khudoberdiev, MD.	Programme Officer, UNAIDS
	Mr. Iskandar Ismailov, MD.,	Technical Officer, Coordinator HIV/AIDS/STI, WHO, Regional Office for Europe
	Mr. Atabek Sharipov	Programme Manager/Country Representative, DFID,
	Ms. Dilnara Isametdinova	National Programme Officer, World Bank
	Mr. Askar Akhmedov	Specialist, Drug Dependence, Drug Demand Reduction, USAID
	Mr. Zafar Oripov	Programme Coordinator, CAPACITY project

KAZAKHSTAN
Chimkent-city

No	Name	Title/professional position
Narcological dispensary of Shimkent oblast (province)		
	Mr. Sayidjemal Pakeyev	MD, Chief Physician
	Mr. Marat Shayikenov	MD, Deputy Chief Physician, Treatment and Rehabilitation
	Mr. J. Korganbayev	MD, Physician Narcologist
	Mr. B. Monakhayev	MD, Physician Narcologist
	Ms. S. Yergesheva	MD., Psychotherapist

	Ms.T.Uoteghenova	MD., Psychotherapist
	Mr. B.Tourgounbayev	MD., Epidemiologist, AIDS Centre of Chimkent-city
	Ms G. Tourlybekova	Psychologist
	Ms. I. Khilimova	Psychologist
	Ms. S. Dosayeva	Social worker
	Mr. I. Soultin	Social worker
	Ms. V. Skryabina	Social worker
	Ms. L. Moushuga	Consultant, Rehabiliation
	Mr. R. Toulegenov	Volunteer
	Mr. D.Touranin	Volunteer
	Mr. V. Khalimov	Volunteer
	N/A	Two male and two female clients of the trust point
Pavlodar-city		
National Clinical-Research Centre on Medical-Social Problems of Drug Dependence (Research Department, In-patient Rehabilitation Department, Residential Rehabilitation Unit "Asar" (50 beds)		
	Mr. Sagat Altynbekov, MD., PhD.	Director
	Mr. Alexander Katkov, MD., PhD.	MD., PhD., Deputy-Director, Reserach
	Ms. Gulnara Altynbekova	Head of Rehabilitation Unit "Asar"
	Mr. Yuri Rossinsky, MD., PhD.	Chief Psychotherapist of pavlidar Oblast
	Mr. Alexander Gruzman MD. MSc	Head, Dpt. of Science and Education
	N/A	Group of researchers (16)
	N/A	Group of residents (20)
NGO "Turan"		
	Dr. Feodor Fesenko	Director
Narcological Dispensary for Pavlodar province (In-patient Rehabilitation Unit, Unit for Re-adaptation of Adolescents, Out-patient Unit)		
	Dr. Vladimir Danevich	Chief Physician
	Dr. Valeria	Psychotherapist
	N/A	Group of young adult patients (two males and one female)
	N/A	Group of adolescent patients (one female and three males)
Almaty-city		
	UN House (Round–table meeting with UN and other international agencies	
	Mr. Alexander Kossukhin	NPO UNAIDS
	Ms Rakhima Nazarova	Uzbekistan Country Director, CAPACITY project, USAID
	Ms. Asel Djanaeva	Soros Foundation
	Ms Yuri Kalujny	NGO's Association on HIV and Harm Reduction
	Ms. Marina Chernova	PSI
	Mr. Martin Bell	PSI

KYRGYZSTAN

Bishkek-city		
Republican Narcological Dispensary, NGO's "Chance" and "Sotsium"		
	Ms. Fatima Estebesova	Coordinator, NGO " Chance"
	Ms. Aida Parpieva	Head of Unit for Medical-Psychological Rehabilitation
	Ms. T.V. Borisova, MD	Deputy-Director, RNC
	Ms. G.A Lebedinskaya, MD	Psychotherapist, Outpatient Department , RNC
	Mr. I.T. Muradov, MD	Psychotherapist, Outpatient Department , RNC
	Ms. Mayrambek-kyzy,MD	Psychotherapist, Outpatient Department , RNC
	Ms I.V. Godunova, MD	Psychotherapist, Outpatient Department , RNC
	Ms. L.V. Novichenok	Psychologist, Unit for Medical-Psychological Rehabilitation, RNC
	Mr. A. Stamkulov –	Social Worker, Unit for Medical-Psychological Rehabilitation, RNC
	Ms. K. Makashova	Senior Nurse, Unit for Medical-Psychological Rehabilitation, RNC
	Ms. M. Chernova	Nurse, Unit for Medical-Psychological Rehabilitation, RNC
	Ms. G. Khristolubova	Nurse, Unit for Medical-Psychological Rehabilitation, RNC
	Ms I. Mamatova	Nurse, Unit for Medical-Psychological Rehabilitation, RNC

	Mr. A. Sultangaziev	Director, NGO "Chance"
	Ms. A. Danilchenko, MD	Psychotherapist, NGO "Chance"
	Mr. E. Iriskulbekov	Layer, Juridical Clinic "Adilet"
	Ms. Khalida	Resident of RNC
	Mr. Ulan	Resident of RNC
	Mr. Ruslan	Resident of RNC
	Mr. Lev	Resident of RNC
	Mr. Ruslan	Resident of the "Chance" Social-Rehabilitation Unit
	Mr. Vyacheslav	Resident of the "Chance" Social-Rehabilitation Unit
	N/A	Group of residents of the Unit for Psychosocial Rehabilitation, NGO "Chance" (12 males)
National Drug Control Agency		
	Mr. Jalil Ilipaev, Col.	Deputy-Diector
National AIDS Centre		
	Mr. Boris Shapiro, MD	Director
	Ms. Damira Imanaliva	Deputy-Director
Business-lunch with representatives of UN and other international agencies		
	Mr. Gerald Moebius	Project Coordinator, UNODC
	Ms. Ainura Bekkoenova	Associate Project Officer, UNODC
	Ms. Gulnara Kadyrkulova	Project Coordinator, UNFPA
	Mr.	Representative, UNHCR
	Ms. Gulsara Osorova	Programme Officer, UNICEF
	Ms. Meerim Sarybaeva	Programme Manager,a.i.
	Ms. Georgia Varisco	UNV
	Mr. Kubanych Takyrbashev	Programme Officer, UNAIDS
	Mr. Oskon Moldokulov	Liaison Officer, WHO
	Mr. Aibek Mukanbetov	Project Manager, PSI
	Ms. Natalia Shumskaya	Project Manager, AFEW
	Ms. Elvira Muratalieva	Medical Programmes Coordinator, Soros-Kyrgyzstan Foundation
	Ms. Damira Bibosunova	USAID, Health Specialist
	Ms. Aida Tashirova	Programme Manager, DFID
	Ms. Asel Sargaldakova	HD Operations Officer, World Bank
	Mr. Talgat Subanbaev	Programme Manager, GFTAM
	Mr. Marat Bozgunchiev	Director, WHO Information Centre on Health for Central Asian Republics
	Mr. Mirlan Mamyrov	Expert, Unit for Coordination and Monitoring of HIV/AIDS Projects under Prime-Minister of the Republic of Kyrgyzstan
Osh-city		
Narcological Dispensary for Osh province (Out-patient Rehabilitation Unit)		
	Mr. Mamasobir Burkhanov	MD., Chief Physician
	Ms. Gulasyl Sutueva	Psychotherapist
	Ms. Chinara Akimkhanova	Social Worker
	Ms. Olga Tuliakova	Social Worker
	Mr. Allaberdy Mukhmiev	MD., Physician-Narcologist
	Ms. Togtaajym Umurbekova	Psychologist
	Ms. Gulipa Borblieva	Psychologist
	Mr. Mamat Sarykov	MD., Physician- Narcologist
	Mr. Kylych Akaev	MD., Physician-Narcologist
	Ms. Galia Yanina	Office Manager
	N/A	Group of patients (4 males and one female)
	N/A	Group of students-psychologists of the Osh university (two females and one male)
Public Foundation "Musaada" Residential Treatment Unit (18 beds)		
	Mr. Isa Nurmamatov, MD.	President
Osh province AIDS Centre		

	Mr. Tugelbay Mamaev, MD, MSc.	Chief Physician

TAJIKISTAN

Dushanbe-city		
Ministry of Health		
	Mr. Naim Khaitbaev	Deputy-Minister
	Mr. Amonullo Gaibov	Focal Point of the UNODC project F75, Chief Specialist, Public Health Department, Office of the President of Tajikistan
	Ms. Fayzinisso Sultanova	Head, Department of Legal Drug Trade, Drug Control Agency
	Mr. Andrei Onitshenko, MD	Chief Physician, Republican Narcological Centre
	Mr. Azam Mirzoev	Director, Republican AIDS Centre
Republican Narcological Centre		
	Mr. Andrei Onitshenko, MD	Chief Physician
	Ms. Elena Khasanova, MD	Head of In-patient Rehabilitation Department
	Mr. Bakhtyar Muminov	Psychologist
	Ms. Nigora Yusupova	Psychologist
	Ms. Zebo Abdurakhmanova	Psychologist
	Ms. Svetlana Valyavskaya, MD	Psychotherapist
	Ms. Lilya Pyatirisova	Social Worker
	Ms. Sadat Shevchenko	Social Worker
	Mr. Batyr Zalimov	Senior Consultant
	Mr. Alisher Ismailov	Consultant
	Mr. Asomuddin Burkhonov	Consultant
	Mr. Pulod Djamolov	Consultant
	Mr. Vladimir Khalilov	Consultant
	Ms. Ibozat Mirzoeva	NGO "Youth Against Drugs"
	N/A	Group of patients (16 males)
Round-table meeting with UN and other international organizations		
	Mr. Manuchehr Loikov	OSIAF-Tajikistan
	Mr. Vladimir Magkoev, MD	OSI- DDRP
	Mr. Rasoul Rakhimov	UNODC
	Mr. Muratboki Beknazarov	UNDP, GFTAM
	Mr. Shuhrat Rejabov	DFID
	Mr. Nicolas Cantau	Regional Director, CAR, AIDS Foundation East-West
	Mr. Mikhail Chitalkin	Country Representative, AIDS Foundation East-West
	Mr. Saleban Omar Saleban	UNAIDS Advisor, Tajikistan
	Ms. Husniya Dorgabekova	NPO HIV/AIDS, WHO
Khoudjand-city		
Drug Control Agency of Sogd province		
	Mr. Sherawliye Mirzoavliev, Gen.	Head
Department of Health of Sogd province		
	Mr. Abdudjalil Toshmatov, MD	Deputy-Head
	Mr. Turabek Kuralbaev, MD	Director, Narcological Centre of Sogd province
	Mr. Khabibullo Aripov, MD	Director, AIDS Centre, of Sogd province
	Mr. Mumin Sahripov, MD	Director, STI's Dispensary of Sogd province
	Ms. Dilbar Burakova, MD	Head, Department of Health, town of Chkalovsk
Counselling Centre of NGO"DINA"		
	Mr. Dilshod Pulotov	Head, NGO "DINA"
	Ms. Elena	Outreach Worker
	Mr. Igor	Outreach Worker
Rehabilitation Centre of NGO"DINA"		
	Mr. Furkat Pulatov	Director
	Ms. Shafoat Nuriddinova	Social Worker
	Mr. Sayidjon Sayidov	Psychotherapist
	Ms. Mansura Bobodjanova, MD	Internist
	Ms. Rakhbar Sadykova	Consultant on Dependence
	Group of residents (9 people)	

Drop-in Centre of NGO"DINA"		
	Mr. Mobin	Consultant on Dependence
Town of Chkalovsk		
Centre for Treatment of Chemical Dependence		
	Mr. Yefrem Kitjuk, MD	Psychotherapist
	Mr. Alexander Bakhtin, MD	Psychotherapist
	Ms. B. Beknazarova	Psychologist
	Ms. Mansura Salakhuddinova, MD	Physician of AIDS Laboratory
	Ms. Bikhol Aripova, MD	AIDS/STI's Centre
	Mr. Alim Djuraev, MD	Physician-narcologist
	Mr. Alexander Babenko, MD	Deputy-Head

TURKMENISTAN

No	Name	Title/professional position
Ministry of Health and Medical Industry of Turkmenistan		
	Mr. Rowshan Melekhanov, MD	Chief Specialist, Division of Curative and Preventive Medicine

Annex 3

EVALUATION ASSESSMENT QUESTIONNAIRE

Project Title: **Diversification of HIV prevention and drug treatment services for injecting and other drug users in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan**

Project Number: **AD/RER/03/F75**

Introduction:

This assessment form must be completed by the evaluator or evaluation team and submitted to the Independent Evaluation Unit. The purpose of the assessment is to provide information for UNODC evaluation database. This information will be used to provide an overview of UNODC's overall performance of programmes and projects.

Ratings:

The evaluators are required to give a rating to each of the items shown below. The ratings are on a scale of 1 – 5 (1 being the lowest and 5 being the highest). Ratings are based on the following criteria:

Excellent	=	90% +	(5)
Very good	=	75 – 89 %	(4)
Good	=	61 – 74 %	(3)
Fair	=	50 – 60 %	(2)
Unsatisfactory	=	- 49 %	(1)

The ratings must reflect the level of achievement, completion, attainment or impact depending on what is being measured. These ratings are base on the findings of the evaluation and hence are a translation of the evaluation results.

A.	**Quality Performance Items**	Ratings				
		1	2	3	4	5
1.	Project Design (clarity, logic, coherence)			3		
2.	Appropriateness of overall strategy				4	
3.	Achievement of objectives			3		
4.	Prerequisites fulfillment by Government			3		
5.	Adherence to Project Duration			3		
6.	Adherence to Budget				5	

B.	**Implementation**	Ratings				
		1	2	3	4	5
7.	Quality and timeliness of UNODC inputs			3		
8.	Quality and timeliness of Government inputs			3		
9.	Quality and timelineness of Third Party inputs			N/A		
10.	UNODC HQ Support (administration,				4	

	management, backstopping)					
11.	UNODC FO Support (administration, management, backstopping)				4	
12.	Executing Agency Support			N/A		

C.	**Results**	Ratings				
		1	2	3	4	5
13.	Achievement of results			3		
14.	Timeliness and quality of results			3		
15.	Attainment, timeliness and quality of outputs			3		
16.	Programme/project impact			3		
17.	Sustainability of results/benefits		2			

D.	**Recommendations**	Ratings				
		1	2	3	4	5
18.	Continue/extend no modifications					
19.	**Continue with modifications (extensive)**					
20.	Complete Project Revision					
21.	Terminate					

E.	**Comments** (provide relevant explanations as well as issues of clarification, explicability, best practices etc.) The term *narcological service* refers to the specialist treatment system that provides treatment for people with dependences on different types of psychoactive substances (alcohol, illegal drugs, legal pharmaceuticals, solvents, etc). Though the report was concerned with the accessibility and quality of care for drug users (IDU's being in its focus), it is believed that, if established and institutionalized, the new treatment system will cover wider groups of patients/clients and thus its potential for HIV prevention will be manifold increased. This adds the value to the evaluated project especially in the situation with increasing rates of sexual transmission of HIV in Central Asia.

Annex 4

Supporting materials

Table 1

BUDGET INFORMATION (Project Revision Document, August 2004)

RERF75 Budget Breakdown

FO/UZB

BL	Description	2003 expenditure	2004	2005	2006	Total Budget
15-00	Travel	10,738	18,500	17,000	2,000	48,238
15-99	**Total Travel**	**10,738**	**18,500**	**17,000**	**2,000**	**48,238**
11-50	Short term Intern. Consultants	11,723	31,800	20,000	0	
13-00	Admin. Support Personnel	4,709	12,300	8,000	2,000	27,009
14-00	UN Volunteers	2,426	1,400	0	0	
16-00	Other Personnel Costs	0	0	10,000	10,000	
17-00	National project staff and consultants	10,917	41,600	12,500	3,000	68,017
19-99	**Total Personnel**	**29,775**	**87,100**	**50,500**	**15,000**	**182,375**
21-00	Sub-contracts	0	125,000	30,000	0	155,000
22-00	Grants	103,823	212,100	120,000	0	435,923
29-99	**Total Sub-contracts**	**103,823**	**337,100**	**150,000**	**0**	**590,923**
31-00	Training	0	70,000	20,000	0	90,000
32-00	Study Tours	8,116				
34-00	Group Training	29,616				
35-00	Meetings	17,891	30,000	54,000	5,000	106,891
39-99	**Total training**	**55,623**	**100,000**	**74,000**	**5,000**	**234,623**
41-00	Expendable equipment	0	0	0	0	0
42-00	Non-expendable equipment	3,510	3,000	0	0	6,510
49-99	**Total Equipment**	**3,510**	**3,000**	**0**	**0**	**6,510**
51-00	Operation and maintenance of equipment	15,696	20,000	20,000	3,000	58,696
52-00	Reporting costs	0	5,000	5,000	3,000	13,000

53-00	Sundries	6	200	0	600	806
59-99	**Total miscellaneous**	**15,702**	**25,200**	**25,000**	**6,600**	**72,502**
90-99	**Project subtotal**	**219,171**	**570,900**	**316,500**	**28,600**	**1,135,171**
56-02	PSC to UNODC (11%)	24,109	62,800	34,800	3,100	**124,809**
99-99	**Project total**	**243,280**	**633,700**	**351,300**	**31,700**	**1,259,980**

Table 2

Grant per Subproject Site
January –December 2004 (AD/RER/02/F75 Annual Project Progress Report)

Institution	Location	Amount of grant	Duration
NGO Turan in cooperation with the Oblast Narcological Centre	Pavlodar, Kazakhstan	US$ 25,000	November 2003-December 2004
South Kazakhstan Oblast Narcological Centre and NGO "Nadejnaya Opora"	Shymkent, Kazakhstan	US$ 23,000	January – December 2004
Republican Centre of Narcology in cooperation with the NGO "Socium"	Bishkek, Kyrgyzstan	US$ 28,000	November – December 2004
Oblast Narcological Centre in cooperation with NGO "Musaada"	Osh, Kyrgyzstan	US$ 20,000	November 2003– December 2004
Republican Clinical Narcological Centre	Dushanbe, Tajikistan	US$ 22,000	November 2003– December 2004
NGO Dina in cooperation with the Chkalovsk City Hospital	Sogd, Tajikistan	US$ 21,430	November 2003– December 2004
Tashkent City Narcological Centre	Tashkent, Uzbekistan	US$ 34,993	November 2003– December 2004

List materials developed in the frame of F75 project

1. Draft Decree of the Ministry of Health on "Further improvement of narcological services to the population";
2. Draft Concept Paper on development of narcological services to the population;
3. Draft Programme for the development of narcological services to the population;
4. Draft Guidelines for the monitoring of the narcological situation in the country;
5. Draft standards for narcological services, including primary, secondary and tertiary prevention;
6. Draft organisational standards (structure and staffing) in the narcological services system;
7. Draft standards of staffing regulation at narcological institutions, including job profiles and descriptions for all staff units;
8. Draft medical and economical standards (protocols) of narcological services by modality types;
9. Draft qualification standards of specialists and other staff involved in drug prevention, diagnostics, treatment and rehabilitation services at narcological institutions;
10. Technical guide on medial and social rehabilitation of drug users in Kazakhstan;
11. Statute on clinical (medical) psychologists involved in medical and social rehabilitation of drug users;
12. Technical guide on organisation of social work within the drug treatment institutions;
13. Manual on psychological counselling of drug users;
14. Manual on application of body-oriented psychotherapy in drug treatment and rehabilitation;
15. Manual on pre- and post-test counselling;

16. Manual on creativity training in the programmes medical and social rehabilitation of drug users;
17. Manual on communication skills training in the programme of medical and social rehabilitation;
18. Manual on situational and role playing training in the programme of medical and social rehabilitation of drug users;
19. Manual on assertiveness training in the programme of medical and social rehabilitation of drug users;
20. Manual on sensitivity training in the programme of medical and social rehabilitation of drug users;
21. Three-volume book with the collection of articles on best practices in drug use diagnostics, prevention, treatment and rehabilitation (2003);
22. Four-volume book with the collection of articles on best practices in drug use diagnostics, prevention, treatment and rehabilitation (2004);
23. Monograph on integrative developmental psychotherapy of drug users (Dr. Katkov);
24. Monograph on out-patient rehabilitation of drug users (Dr. Valentik).

Annex 4

UNODC F75 project results

Table 3

Capacity of services participating in UNODC F75 project (5 May 2005)

Type of service	KAZAKHSTAN				KYRGYZSTAN				TAJIKISTAN				UZBEKISTAN		TOTAL	
	Pavlodar[1]		Chimkent[2]		Bishkek[3]		Osh[4]		Dushanbe[5]		Khoudjand+ Chkalovsk [6]		Tashkent[7]			
	Units /Beds	All staff	Units /Beds	All staff	Units /Beds	All staff	/Units Beds	All staff	Units/Beds	All staff	Units/ Beds	All staff	Units/ Beds	All staff	Units/ Beds	All staff[8]
Crisis intervention (i.e. hot lines, shelters)	1 hot line	No data	1 hot line	No data	1 hot line	No data	No data	No data	1 hot line telephone	6	1 hotline	No data	1 hot line	1	6 hotline services	Incomplete data
Low threshold/ open access (i.e. Drop-in Centres, Trust Points)	6 TP's	No data	3 TP's	No data	7 TP	No data	3 TP	50	None	None	1 DC 1TP	No data	10TP	6	31 Trust Points 1 Drop-in Centre	Incomplete data
Out-patient treatment	2 units	No data	1 unit	18 physicians	1unit	No data	2 units	18	1 unit	16,25	1 unit	No data	1unit	4	9 out-patient units	Incomplete data
Day care	40	No	20	1	None	None	None	None	None	None	None	None	25 beds	2 (not	85 day	Incomp

1 Republican Research Centre on Medical Social Problems of Drug Use + Pavlodar Oblast Narcological Dispensary + NGO Turan
2 Chimkent Oblast Narcological Centre + NGO " Nadejnaya Opora"
3 Republican Narcological Centre + NGO 'Chance"+ NGO " Sotsium"
4 Osh Oblast Narcological Dispensary + NGO " Podrughy"+NGO "Musa'ada"
5 Republican Clinical Narcological Centre + NGO "RAN"+NGO "Youth against Drugs"
6 Narcological Centre of the General Hospital of town of Chkalovsk +NGO "DINA"
7 Narcological Dispensary of Tashkent-city+ Republican Narcological Centre
8 Number of people

	beds	data	beds	physician										financed by F75)	care beds	lete data
In-patient treatment	100 beds	No data	70 beds	No data	137 beds	No data	20 beds	10	100 beds	137,75	20 beds	No data	30 beds in RNC	N/a	437 beds	Incomplete data
Residential care (i.e. therapeutic community)	None	None	None	None	None	None	18 beds	7	None	None	15 beds	None	None	None	33 beds	Incomplete data
Other services	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None

Table 4

Professional capacity of services participating in UNODC F75 project

Professional category	**Number of trained staff**									**Total**
	Kazakhstan		**Kyrgyzstan**		**Tajikistan**			**Turkmenistan**	**Uzbekistan**	
	Pavlodar	**Chimkent**	**Bishkek**	**Osh**	**Dushanbe**	**Khoudjand**	**Chkalovsk**	**All country**	**Tashkent**	
Health managers	2	1	2	1	1	3	1	10	2	**23**
Physicians	1	1	5	5	4	1	5	21	2	**43**
Psychotherapists	2	2	8	3	5	1	2	1	-	**26**
Psychologists	2	2	4	2	4	2	1	1	2	**20**
Social Workers	5	3	3	2	7	1	None	-	1	**23**
Nurses	None	None	None	None	-	None	10	-	-	**10**
Volunteers	6	9	None	None	5	1	4	-	8	**29**
Academics/faculty	None	None	2	2		None		2	-	**6**
Other categories	None	None	None	None	None	6 outreach workers	None	None	None	**6**
Total	18	18	24	15	26	15	23	35	15	**186**

Table 5

UNODC F-75 Project Outcomes

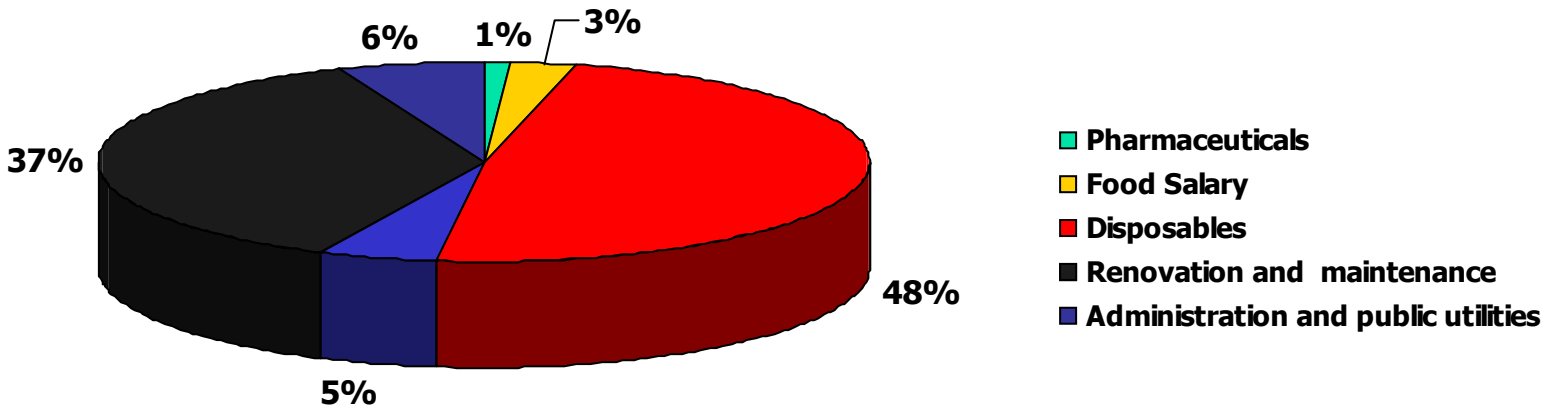
Outcomes	**Implementation sites**							**Project as a whole**
	Kazakhstan		**Kyrgyzstan**		**Tajikistan**		**Uzbekistan**	
	Pavlodar (11months)	**Chimkent (12 months)**	**Bishkek (6 months)**	**Osh (12 months)**	**Dushanbe (14 months)**	**Khoudjand+ Chkalovsk (12 months**	**Tashkent (Akmal-Ikram district) (12 months)**	
Expanded range of accessible services for drug users (number of facilities/units)								
Target	11	11	8	6	3	4	4	**47**
Baseline	9	9	8	6	3	2	2	**39**
Actual result	11	11	16	6	3	4	3	**54**
Increased number of low threshold facilities providing services for drug users								
Target	11	5	4	3	Not planned	Not planned	1	**24**
Baseline	9	3	1	3	4	1	None	**21**
Actual result	11	3	5	3	4	2	1	**29**
Coverage of IDU's by low-threshold services (actual number of IDU's who used service/estimated number of IDU's in catchment area)								
Target	2500/6000= 42%	1500/6000 =25%	1200/2889= 42%	1850/800 0=23%	8000/16000= 50%	200/240= 83%	300/1700= 18%	15550/ 40829 = **38%**
Baseline	1300/6000= 22%	No data	900/2889= 31%	1372/ 8000= 17%	1500/16000= 9%	105/240= 44%	No data	5177/ 33129 **=16%** (Chimkent and Tashkent not included)
Actual result	2200/6000= 37%	1300/6000 = 21%	1850/2889= 64%	1850/ 8000= 23%	2100/16000= 13%	185/240= 77%	149/1700= 9%	9634/ 40829= **24%**
Percent of drug users entering treatment or rehabilitation services after contacting low threshold services								

Target	250/2500=10%	1200/1500= 80%	Not planned	500/1850 =27%	Not planned	80/200=40%	No data	2030/6050 =**34%**
Baseline	66/2200 = 3%	No data	10/900= 11%	100/1372 =7%	No data	14/105=13%	No data	190/4577= **4%**
Actual results	934/2200=43%	920/1300= 71%	16/1850= 0.9%	150/1850 =8%	35/2100= 1.7%	174/185= 94%	136/149= 91%	2365/9634 = **25%**
Utilization rate of out-patient treatment/rehabilitation services (substitute treatment excluded) during implementation period (number of patients treated)								
Target	130	1200	60	700	100	Not planned	150	**2340**
Baseline	None	None	None	None	None	21	None	**21**
Actual result	467	768	84	585	124	41 Khoudjand 31 Chkalovsk	113	**2213**
Utilization rate of out-patient substitution treatment services (number of patients treated by methadone)								
Target	Not planned	Not planned	50	100	Not planned	Not planned	Not planned	**150**
Baseline	None	None	30	85	None	None	None	**115**
Actual result	None	None	64	68	None	None	None	**132**
Utilization rate of day care services (number of patients treated)								
Target	150	80	Not planned	Not planned	Not planned	Not planned	Not planned	**230**
Baseline	None	None	None	None	None	None	None	**None**
Actual results	87	30	None	None	None	None	87	**204**
Utilization rate of in-patient treatment and rehabilitation services (number of patients treated)								
Target	100	408	35	120	100	100	30 patients to be referred to Rep. Narcological Centre	**893**
Baseline	None	None	None	None	None	48 (Chkalovsk)	No in-patient units available. No data on previous referral volume	**48**

Actual result	847	244	40	24	102	178 (Chkalovsk)	23 patients referred to Rep. Narcological Centre	**1458**
Utilization rate of residential care, therapeutic communities types (number of patients passing through the service)								
Target	Not planned	Not planned	Not planned	50	Not planned	20	Not planned	**50**
Baseline	No data	None	None	12	None	No data	None	**12**
Actual result	No data	None	None	57	None	89	None	**146**

Fig 1

Breakdown of expenditures by partner organizations in 2004
(Combined data for all subprojects, total sum $174,423)



Funding of organizations participating in UNODC F75 project

Table 6.1

Funding of NGO Turan, Pavlodar, Kazakhstan *(2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharmaceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	None	None	None	None	None	None	None	None	**None**
UNODC F75 project	None	None	None	15500	2,460	5,500 (2003) 1,540 (2004)	None	None	**25,000**
Soros Foundation	None	None	None	7,896	1,022	12,100	None	500	**21,518**
GFTAM	None	None	None	5,400	None	9,323	None	None	**14,723**
Total				**28,796**	**3,482**	**28,963**	None	**500**	**61,241**

Table 6.2

Funding of Chimkent Oblast Narcological Centre, Chimkent, Kazakhstan *(2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharmaceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	117,989	12,594	55,477	38,2673	115,543	None	None	None	**684,185**

UNODC F75 project	None	None	None	14,432	420	None	None	8,148	**23,000**
Total	**117,898**	**12,594**	**55,477**	**397,105**	**115,963**	**None**	**None**	**8,148**	**707,185**

Таблица 6.3

Funding of Republican Narcological Centre, and NGO's Chance and Sotcium, Bishkek, Kyrgyzstan *(2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharmaceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	None	None	**1,387.5**		**17,450**	None	None	None	**18,837.5**
UNODC F75 project	None	None	**1,064**	**8,046**	**2,850**	None	None	None	**11,960**
Total	**None**	None	**2,451.5**	**8,046**	**20,320**	None	None	None	**30,817.5**

Table 6.4

Funding of Osh Oblast Narcological Dispensary *(2004)*

Sources of funding	**Annual budget (equivalent USD)**							
	Office furniture and facilities	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**	**Equipment and other expenditure**	**Total**
Government	None	2,454.53	9,920.5	22,189.73	4,737.5	**-**	**-**	**39,302.26**
UNODC F75 project	1,545	None	None	10,560	465	None	7,430	20,000

Soros Foundation	None	10,035	None	5,040	1,750	None	None	16,825
DDRP	None	None	None	2,976	2,600	None	None	5,576
GFTAM	976.5	None	None	3,060	350	None	405	4,791.5
UNDP	1,158.75	None	None	3,825	318.75	None	3,615	8,917.5
Total	**3,680.25**	**12,489.53**	**9,920.5**	**47,650.73**	**10,221.25**	None	**11,450**	**95,412.26**

Table 6.5

Funding of Tajik Republican Narcological Dispensary, Dushanbe *(2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharmaceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	3,260	None	4880	21,170	4,560	None	None	None	**33,870**
UNODC F75 project	None	None	None	8,972	490	None	None	None	**9,462**
Total	**3,260**	**None**	**4,880**	**30,142**	**5,050**	**None**	**None**	**None**	**43,332**

Table 6.6

Funding of participating organizations in Khoudjand+Chkalovsk, Tajikistan (*2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharmaceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	**500**	None	None	None	None	None	None	None	**500**

UNODC F75 project	**2,000**	None	**4,200**	**6,900**	**2,570**	None	None	None	**15,670**
Soros Foundation	None	**25,600**	None	None	None	None	None	None	**25,600**
DDRP	None	None	**3,722**	**13,252**	**9,816**	None	None	None	**26,790**
USAID	None	None	None	**17,202**	**25,047**	None	None	None	**42,249**
FBG	**1,500**	None	None	None	None	None	None	None	**1,500**
Total	**4,000**	**25,600**	**7,922**	**37,354**	**37,433**	**None**	**None**	**None**	**112,309**

Table 6.7

Funding of Tashkent-city Narcological Dispensary, Tashkent, Uzbekistan *(2004)*

Sources of funding	**Annual budget (equivalent USD)**								
	Pharma ceuticals	**Disposable materials (syringes, шприцы, cotton, bandages, etc.)**	**Food for clients/patients**	**Salary of personnel**	**Maintenance and administration (electricity, running water, etc)**	**Low threshold services**			**Total**
						Syringes	**Condoms**	**Other disposables**	
Government	None	None	None	3,200	No data	None	None	None	**3,200**
UNODC F75	None	None	None	19,695	770	None	None	1,250	**20,000**
LSA	None	None	None	None	None	40,000	None	None	**40,000**
Total	**None**	**None**	**None**	**22,895**	**770**	**40,000**	**None**	**1,250**	**63,665**