

PREVENTION OF TRANSMISSION OF HIV
AMONG DRUG USERS IN SAARC COUNTRIES

UNITED NATIONS OFFICE ON DRUGS AND CRIME
REGIONAL OFFICE FOR SOUTH ASIA

PROJECT AD/RAS/2003/H13

MID-TERM REVIEW
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Reviewers

Dr. Mahendra Nepal

Edna H Oppenheimer

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List of Abbreviations

AIIMS – All India Institute of Medical Sciences
ANF – Anti-Narcotic Force (Pakistan)
CBO – Community-based Organisations
DNC – Department of Narcotics Control - Bangladesh
LCC – Low Cost Care
M & E - Monitoring and Evaluation
MNC – Ministry Narcotic control (Pakistan)
N&S – Needles and Syringe
NACP – National AIDS Control Programme (Pakistan)
NESP – Needle and syringe programmes
NGO – Non-Government Organisations
NSC – National Steering Committee
NUNV National United Nations Volunteers
OSP – Oral substitution Programme
PLI – Peer-led interventions
RPC – Regional Project Consultants
ROSA – Regional Office for South Asia
PAC – Project Advisory Committee
RSRA – Rapid Situation and Response Assessment
VTAG – Virtual Technical Advisory Group
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNODC - United Nations Office on Drugs and Crime

Executive Summary: Findings and Recommendations

UNODC's project 'Prevention of transmission of HIV among drug users in SAARC countries' (Project H13) was initiated in August, 2003.. The mid-term review focused on the preparatory and first phase of the project and examined the implementation process. It was too early in the project's life to assess impact. This exercise should thus be seen clearly as a 'review' and not as an 'evaluation'.

Review methodology¹

- The review methodology was formulated at the UNODC office for South Asia in Delhi with the participation of two consultants who are responsible for re-designing the project for the next phase. All relevant project documents were provided to the review team. Two consultants shared the task of visiting all 7 SAARC countries.
- At field level, discussions were held with stakeholders using a series of agreed upon questions and probes².
- Whenever possible visits were made to demonstration sites. When this was not possible participating NGOs were invited to meet the consultant at stakeholders meetings
- The review took place between the 6th and the 31st of March 2006.

Findings

1. Project concept

- The project's overall goal of reducing the spread of HIV among drug users and specifically the need to strengthen technical capacity to achieve that goal remains important and crucial in SAARC countries.
- Project H13 has in the Preparatory and in Phase I begun to add to the repertoire of approaches to HIV/AIDS prevention among drug users. It fosters 'community based' interventions and the 'participatory approach' which are as yet uncommon in South Asia. Interest and excitement about the possibilities of these approaches were evident in the countries visited.
- Project H13 emphasised the need for gender equity and expended considerable efforts in including female staff on the project teams, and in ensuring that drug users' sexual partners are included in prevention activities. This perspective has been universally praised.
- The drug use and HIV epidemic in SAARC countries varies considerably as does the national policy and the local capacity to respond. All countries wanted H13 project to continue and all requested that phase II should be more country specific.

2. Implementation

- Project implementation varied significantly from country to country. In several of the participating countries project activities are yet to actively begin (Pakistan, Maldives).

¹ For a full account of review methodology see p. 7 below

² See Annex 2

In other countries, project implementation went to plan and even exceeded project requirements.

- However, the project's main objectives were not always understood by partners and at times required clarification.
 - Country's sense of 'ownership' varied from country to country. The reasons were numerous and ranged from lack of clarity about the project's goals and objectives, to a feeling that the project is not relevant or that the financial investment is too small.
 - Delays in implementations have occurred though the reasons for delays were complex and cannot be attributable to a single stakeholder.
 - The project has provided considerable training at regional and national level³. Country and site visits provided evidence that this training has succeeded in activating communities to explore their situation and their needs. However, it became clear that more training is needed for communities to analyse what has been found in rapid situation assessments, and to help them formulate appropriate responses.

For summaries of country findings please see Annex 1

Recommendations

Overall:

- Project H13 'Prevention of transmission of HIV among drug users in SAARC Countries' to be continued.
- It is recommended that in Bhutan, active project work is modified focussing on the work of PNGO, REWA/YDF. UNODC should continue to respond to Bhutan when necessary in different ways possible.
- In Pakistan H13 project to be implemented, managed and developed by UNODC in Pakistan.
- Project H13 need not continue working in demonstration sites where the main drugs of abuse are cannabis and alcohol. However, preventing drug users from switching from oral to injecting use should remain a legitimate objective of this project
- Phase II of project H13 must focus on HIV/AIDS prevention and not on drug use prevention per se.
- 'Scaling up' responses in phase II should focus on increasing technical capacity on a national and local level and on developing the whole network of required services in demonstration sites. Scaling up should not mean an increase in the number of demonstration sites but will require a certain re-distribution to allow for equity between countries, and a discontinuation of active work in some unsuitable sites or with unsuitable partners.
- It is recommended that in Phase II all stakeholders continue to be involved in planning project activities and responses.

³ See F.7 page 19 below.

- Project H13 should take the lead in advocating for national scale ups of Oral Substitution Treatment (OST) where it is operational but still at pilot stage, and advocating for its introduction in other SAARC countries and introducing Needle and Syringe programmes wherever it is needed.
- Support to partner NGOs who are engaged and committed to abstinence-based approaches only and who are unwilling to support a risk reduction / harm minimization approach should be phased out.
- The need for better data on drug use and the emerging HIV/AIDS epidemic in South Asia should be addressed in partnership with National Narcotics control organisations.
- Database initiative to be completed by AIIMS as soon as is practicable and mechanisms to be put in place at country level for the database to ensure that the database remains up-to-date.

Management

- UNODC ROSA to continue overseeing and managing the project at the regional level. However, where possible more autonomy be devolved to national partners.
- National management and coordination mechanism of project H13 must be clarified and strengthened. The National Advisory Committees proposed by UNODC have not worked well and ways must be found to include project H13 in other key national coordinating bodies on HIV/AIDS
- Clear channels of communications should be established between participating NGOs, mentor agency and government counterpart – ensuring that government is fully cognizant of project H13's contributions in trainings and its application in the demonstration sites, thus ensuring that in the long run government will assume the responsibility for future scale up of activities
- Wherever possible the UNAIDS Theme Groups should be used to facilitate and enhance in-country communications and confirm UNODC's role as the lead UN agency responsible for drug and HIV/AIDS issues.
- To enhance government 'ownership' of the project consideration should be given to funding mentor agencies and NGOs through the government focal points, if practicable.
- Where data on drug use is missing and the real extent of HIV related problems among them and their sexual partners is not known e.g. in Sri Lanka and Maldives, project H13 should promote and assist in the establishment of surveillance of drug use, HIV and STI.
- Intervention tool kits could be expanded to meet the needs of demonstration sites (e.g. counselling, prevention of switching to injecting drug use). Existing tool kits to be translated to local languages as required.
- In all countries, training should be expanded, consolidated and continued. Trained national and NGO personnel should be facilitated to provide training to other agencies in partnership with government counterparts.
- Training at the field level by master trainers (who have been trained regionally, or nationally) should be monitored to ensure the delivery of quality services.

H13 Project Review

A. Introduction

Project H13 is a 5-year project for the SAARC region beginning in May 2003. It targets drug users in all 7 SAARC countries and aims to prevent the transmission of HIV among Drug Users in SAARC countries. UNODC Regional Office for South Asia executes the project. The project will be implemented in two parts; the first phase consisted of a 6 months preparatory phase followed by a 24-month programme phase. A review of the first phase was scheduled to take place at the end of the programme phase to document the process and the mechanisms adopted by the project, the lessons learnt and to inform a re-design of phase II based on updated information from the region and from national stakeholders and on recommendations made by the evaluation team.

A.1. Overall Aims of Review⁴

- To assess the quality and progress in delivery of project objectives/activities under the project document.
- To inform the re-design of phase II of project H13

A.2. Methodology of the Review

The review mission took place between the 6th to the 31st of March 2006⁵ and shared by two consultants. The mission was prepared at the ROSA offices in Delhi with the assistance of H13 project staff and the re-design team. A briefing meeting with AusAID in Delhi was held.

A review of project documents was undertaken. These included the signed Project Document, agreements reached with national counterparts and donor agencies, financing agreements, reports submitted to review meetings, minutes of review meetings, baseline studies. In addition semi-annual and annual reports, mission reports, reports of trainings and workshops, software, intervention toolkits and publications produced by the project have also been provided, NGO profile questionnaire and software, terms of reference and budgetary guidelines for partner and mentor agencies and guidelines on recruitment of core staff were provided.

In line with the project document and the proposed activities and outputs outlined in it, a strategy for the review was agreed. The questions and probes to be used in interviews

⁴ For TOR for Review see Annex 3

⁵ Dr. Mahendra Nepal: Work Programme: In India - for briefing and preparation at ROSA and AusAID (6th-11th March), Nepal – (12th-16th March), India – (16th –21st March), Bhutan- (22nd – 24th March) and India - (25^t - 28th March).

Edna Oppenheimer: Work Programme: In India - for briefing and Preparation at ROSA and AusAID (6th-11th March), Bangladesh (12th - 15th March), India – (17th - 20th March), Pakistan – (21st-24th March), Maldives – (26th March), Sri Lanka – (26th and 28th March)

were developed jointly by the review and redesign team members in order to ensure that the information gathered and triangulated from the interviews with different stakeholders by the review team could be used to redesign the Phase-II⁶. Visits to all SAARC countries were undertaken accompanied by H13 ROSA staff.

Project stakeholders from national and civil society were interviewed (including national ministries of Counter Narcotics, Ministry of Health HIV/AIDS programme managers, UN agencies e.g. UNODC (Pakistan) UNDP, UNICEF, UNAIDS, National and international NGOs working in HIV/AIDS and offering services to drug users, H13 project focal points, mentor agencies and partner NGOs, National UN volunteers, AusAID focal points in Nepal, Bangladesh and India). Visits to Project demonstration sites were undertaken wherever possible – where that was not possible, partner NGOs presented accounts of their work at stakeholder meetings. Whenever possible, interviews with key informants were conducted in a one- to- one basis.

A tri-partite review meeting was attended at the end of the mission in Colombo during which a group exercise was designed for the participants by the redesign team, which helped to identify the achievements, areas for improvement and gaps in H-13 project implementation. Further, the ‘lessons learnt’ resulting from this exercise helped in consolidating the review findings as well as identifying the ‘suggestions for future’ relevant for redesign. The mission ended with a meeting between the ROSA team, the consultants and AusAID.

Observations: Due to time constraints not all key areas received equal attention. It was not always possible to arrange one to one meetings with stakeholders. The review did however provide an overview of H13 strengths and achievements and an understanding of major constraints.

A.3. Project H13: A background note

Project H13 is a complex and wide-ranging project, ambitious in its scope. Baseline information informing the initial project design indicates significant variation in drug use patterns and prevalence and HIV infection attesting to the heterogeneity of the region.

⁶ See Annex 2 for lists of questions and probes

Project goal:

‘Reduce the spread of HIV among drug using populations in the SAARC region’

Overall Objective

‘ To foster regional cooperation for mainstreaming the HIV/AIDS concerns in drug demand reduction programmes of the SAARC countries

The specific objectives of the FAST TRACK

To strengthen technical capacities of governments and civil society organizations for improving the quality of services provided and accelerating the process of response to prevent the spread of HIV among drug users in SAARC countries

Outputs of FAST TRACK (PREPARATORY PHASE – 6 months)

Output 1- Implementation and coordination arrangements for implementing the project at the regional and national level are in place

Output 2 – A regional project management, monitoring and evaluation system is in place

Output 3 – Necessary mechanisms and instruments for developing regional and national strategic direction and for mounting responses planned under the project are in place.

Outputs of PROGRAMME PHASE (24 months)

Output 1 – Critical elements in preventing the transmission of HIV among IDUs are identified and accepted for mounting an effective response by stakeholders in the region

Output 2 – feasibility studies utilizing standardized protocols on Peer based Community outreach, Low –cost care, community based Care and support, NSEP and Oral substitutions are completed and the experience gained is available for adoption and scale up by countries in the region.

Output 3 – service providers are in the position to offer quality services for injecting drug users and ‘other drug’ users in the region.

B. Review Findings

B.1 Accomplishing the ‘outputs’ and ‘activities’ set out in the project document.

Tables 2 and 3 provide a summary of H13 progress. The information presented below is derived from interviews with project staff at ROSA set against the Project Document. In addition the UNODC Annual Project Progress Report July 2004 - to August 2005 was consulted.

B.1.1 Preparatory Phase

Table 1: Achievements of Preparatory phase

Activity	Output 1
1.1. Establish project office at UNODC /ROSA	Done
1.2. Identify national focal point	Done
1.3. Regional meeting to finalise operational work plan	Done
1.4. Identify potential VTAG members	Done
1.5. National stakeholders meeting in 7 countries to ensure involvement in H13	Done in 6/7 SAARC countries

Activity	Output 2
2.1. Establish PAC	Done

2.2. Organize bi-annual meetings of PAC	Not done
2.3. Annual costed work-plans	Partially done
2.4. Establish VTAG	Ongoing process
2.5. 2 meetings of VTAG	N/A
2.6. Establishment of regional level support for national activities	Done

Activity	Output 3
3.1. Documentation of Best Practice	Done
3.2. Documentation of legal and policy concerns	Done but delayed
3.3. Dissemination of UN position paper on drug demand reduction and UNGASS declaration on HIV	Done
3.4. Regional study on cross-border networks	Not Done
3.5. Study on regional capacity for HIV risk reduction	Done with 3.1
3.6. Facilitate regional data base of resource persons, capacitated organisations, donors and identify gaps	Not done
3.7. Selection criteria for pilot sites	Done
3.8. Develop process for identifying public/private institutions for piloting protocols	Done with 3.7
3.9. Identify geographical areas for pilots	Done with 3.7
3.10 Establish regional mechanisms for development of comprehensive strategy on HIV prevention among IDUs	Partially done
3.11. Strategic training plans	Done
3.12. Regional 5 day workshop to revisit the Logical Framework and undertake 'project risk analysis' and Monitoring and Evaluation framework	Done
3.13. Develop and disseminate gender strategy	Developed but not disseminated

B.1.2 Programme Phase

Table 2: Achievements of programme phase

Activity	Output 1
1.1. Draft working paper on prevention of HIV transmission	Not done
1.2. 4-day regional consultation re-consensus building on minimum interventions	Not done
1.3 Incorporate suggestions from 1.1	N/A
1.4 3 day consultation consensus on critical intervention factors	Not done
1.5 Incorporate suggestions for 1.4	N/A
1.6 3 day regional gender sensitization	Not done
1.7 Field missions to launch innovative approaches	Partially done

Activity	Output 2
2.1. Strengthen institutional capacity for a variety of service providers	Done
2.2. Sub-contract participating agencies	Done

2.3 Consultation meetings to link demonstration sites with VTAG	Not done
2.4 Costing framework for programmes developed	Done

Activity	Output 3
3.1. Intervention tool kits developed	Done
3.2. Identify pool of researchers and resource persons and establish regional network	Partially done
3.3. Organise 2 TOT programmes at the regional level	Done
3.4. Organise 10 in country training programmes	Done some
3.5. Study tours	Partially done
3.6. Enable production of regional journal	Not done

As can be seen from the tables above, the preparatory phase, which lasted 6 months, was in general successfully completed although some activities were delayed (e.g. 2 of the baseline studies) and in some cases planned project activities were replaced by others, which were considered more appropriate once project implementation began.

During the programme phase now reaching its end, many planned activities did not take place. Nevertheless, it is important to note that in some instances alternative, often similar, re-designed activities did take place (for example, instead of commissioning a draft paper on critical elements that prevent HIV transmission among IDUs, a risk reduction intervention toolkit on critical elements was developed; similarly national and sub-national proposal development workshops were used to advocate for convergence and the ‘comprehensive package approach’ that would allow for a quicker and wider scaled-up response in member countries was an alternative activity to the proposed 4-day regional consultation with representatives from NGOs and Government agencies). During the programme phase the number of demonstration sites has gone up from 40 to 53.

B.2. Examination of project’s logical Framework

Some major project activities and outputs in Phase I were tracked through the logical framework to provide a full picture of the project’s first 2 ½ years. The information presented below emerged from the review- especially from discussions with key informants, examination of project documents and from feedback by participants at the tripartite meeting in Colombo 30th-31st March 2006.

Table 3: Preparatory Phase and Phase I - progress

Country	HIV included in Drug Demand Reduction policy and programmes	Drug issues included in national HIV Policy and programme	Advocacy by H13 for prevention of HIV in IDUs	Operational Plans for H13 (at National +Stake-holders level)	Co-ordination mechanisms for execution of H13 (National)	Advice sought from Virtual Technical Advisory Group

Bangladesh	Yes, pre H13	Yes, pre H13	Yes (NSC+ DNC)	Yes, but need to disseminate	Yes	No
Bhutan	Yes, Pre H13	Yes, pre H13	Awareness 2005	Yes (limited user)	Yes	No
India	Yes, Independent	Yes Independent	Yes (Peer Led Interventions)	Yes	Yes (NSC + NGO+CBO)	No
Maldives	Yes, draft	Yes (Reproductive Health)	No	Yes	No	No
Nepal	Yes Post H13	In process	Yes (PLI, RSRA)	Yes (limited user)	Yes (NSC)	No
Pakistan	Yes Pre H13	Yes Pre H13	NSC + MNC+ ANF + NACP+ UNODC/ UNAIDS+ Civil Society	Yes (delayed)	Yes (NSC)	No
Sri-Lanka	Yes, pre H13	Yes Pre H13	Community+ service provider	Yes (limited Users)	Yes (NSC)	No

Table 4: Preparatory Phase and Phase I - progress (cont.)

Country	Risk Analysis report done	M & E adopted	Best Practice document seen	Mapping response gap at national level	Gender strategy Baseline study	Advocacy Strategy developed	Regional Journal	Critical elements for HIV intervention paper
Bangladesh	No	No	Yes	Yes, but not by H13	Aware but not yet seen	No	No	No
Bhutan	No	No	Yes, but not	No	Not seen	No	No	No

			useable					
India	Done for NACO	Yes	Yes	Yes, as part of H13	Yes, not as result of baseline study	No	No	Yes, not as part of H13
Maldives	No	No	No	No	No	No	No	No
Nepal	No	Partial	Yes	No	Yes, partially accepted ideas	No	No	No
Pakistan	No	No	No	Yes (by NGO partners)	No	No	No	No
Sri-Lanka	No	No	No	No	Yes, accepted ideas	No	No	No

As can be seen from the summary table above, some of the objectives of H13 were already in place prior to the inception of the project. For example, with the sole exception of the Maldives HIV issues were already included in National Drug Demand Reduction policy and programmes. The same holds for the inclusion of drug issues in HIV policy programmes. On the whole H13 has succeeded in raising awareness in SAARC countries on the need to focus prevention of HIV among IDUs. All countries reported that they had operational plans for H13 in place though these plans (Developed by the National Focal Points or the Mentor agencies) were not always disseminated to other stakeholders such as partner NGOs. With the sole exception of the Maldives co-ordination mechanisms for executing H13 were in place (though as will become clearer later in this report – these mechanisms were not always effective). None of the countries had sought advice from the Virtual Technical Advisory Group (VTAG) and most were unaware of its existence.

Not all the hoped for outputs have been achieved in the programme phase of the H13 project leaving out some critical project components. For example none of the countries completed a Risk Analysis (with the exception of India which had prepared such an analysis for the National AIDS Committee). The Monitoring and evaluation framework for the project was developed and agreed at a meeting of national stakeholders in Colombo in August 2005. However, with the exception of India these have not yet been

used by the project. Mapping of the response gaps have been successfully completed in India and in Pakistan under the auspices of H13 and was carried out in Bangladesh but not as part of the H13 project. The baseline studies that were commissioned by the project and designed to inform the development of the project have been delayed. The Best practice document, which was completed was not distributed or used. All countries were aware of H13's emphasis on gender equity. However the baseline strategy on gender has not been disseminated as yet. With the exception of India none of the SAARC countries had an advocacy strategy in place. India has developed advocacy mechanisms through the 8 Regional Resource Centres, which are carrying out regular advocacy programmes on drug abuse, and HIV/AIDS – but these activities are independent of the H13 project. A regional Journal has not been established.

B.3 Overall findings

B.3.1 Project concept

Overall, the goal of reducing the spread of HIV/AIDS among drug using populations in SAARC countries remains valid and important. While implementing the project, H13 has added an important component, which is to prevent the transmission of HIV from drug users to their sexual partners. This aspect of the work has received considerable prominence and has been fully accepted and praised by all stakeholders.

The most critical conceptual difficulty facing H13 is to determine the focus of interventions. Beginning in the project document, reference is sometimes made to 'Prevention of transmission of HIV among drug users' (Title of H13) and elsewhere to the more specific need 'to scale up interventions among IDUs and other opiate users (Contract page).

The project's overall framework is drug demand reduction ⁷ that includes:

- Prevention of those who are not taking drugs from drug seeking behaviours,
- Preventing those who are taking drugs from initiation into injecting drug use, encouraging drug users to seek treatment
- Encouraging those who are IDUs into safer practices
- For those who are not able to achieve total abstinence offer harm reduction/ risk reduction as an interim goal to prevent the risk related to HIV/AIDS.

The result is that the distinction between drug prevention and HIV prevention in the project are unclear. The project is over inclusive so that in demonstration sites all drug related interventions are regarded as HIV prevention. Thus, in some H13 demonstration sites the focus is on prevention of (any) drug use, other sites focus on the prevention of switching to injecting drug use and in preventing sexual risk taking behaviours. In all demonstration sites all drug users, whether injectors or non-injectors are encouraged to seek treatment (which at present is, with few exceptions, abstinence oriented treatment).

⁷See P.5 of project document

Thus the demonstration sites have so far offered limited risk /harm reduction training or services. So far only five small scale (45 patients) and time-limited Oral Substitution Treatment pilot clinics have been established as part of H13 – all of them in India and no consideration has been given as yet to needle and syringe programmes. Thus, so far H13 look too much like a traditional demand reduction project.

The training on Rapid Situation and Response Assessment (RSRA) and Peer Led Interventions (PLI) has resulted in local situation assessments being completed in all sites and in the establishment of peer led outreach activities in many sites reaching out to drug users and their sex partners. No specific strategies have as yet been developed to deter drug users from switching to injecting drug use except through treatment in abstinence-based facilities. Very little sensitization of local police has taken place and the cooperation of the police has not been systematically sought. In some quarters there is a failure to understand that success in law enforcement does unfortunately sometimes lead to a scarcity of opiates in the streets and thus a switch to the more 'economic' injecting drug use. At the end of phase I of the project training on 'Safer Practices' has not as yet taken place

B.3.2 Project design

As indicated above project H13 is extensive in its scope and ambition. All 7 SAARC countries were included despite the differences between them in drug use and HIV/AIDS policies, in capacities to respond and in ongoing established responses. Briefly summarised, it was envisaged that in phase I all countries will have established coordination mechanisms, conducted numerous training activities and organised a study tour, selected mentor agencies, participating NGOs and demonstration sites and provided training in RSRA, PLI and Safer Practices, monitoring and evaluation and to have conducted RSRA in demonstration sites. (See tables 1-4 above)

With the benefit of hindsight it has become evident that the project was over ambitious and that in phase one insufficient attention may have been paid to country differences. These are significant to the way in which H13 project must plan trainings and future interventions. It has become clear that what can be achieved in demonstration sites will vary across the region. Thus for example, two of the countries (Bhutan, Sri Lanka) do not report injecting drug users whose risk behaviours have a direct link to HIV transmission though sexual transmission of HIV from and to drug users are recognized problems. It is likely therefore that in Sri Lanka efforts in demonstration sites will be focused on the prevention of switching from oral to injection use and promoting safe sex. In Bhutan, H-13 should focus on assisting the PNGO, REWA/YDF in its activities of prevention of HIV infection among IDUs and DUs in general rather than stretching it in other less related areas e.g. school prevention education program, support to the RGB in general.. Nevertheless, on request from the RGB UNODC should and would try to organize assistance from other sources even when it is not possible from the H-13 because of its scope of activity

Meanwhile other donors will continue to support the National AIDS response

In Maldives, data on injecting and on HIV among drug users is not available and it may be necessary to focus here on the establishment of better data gathering systems before interventions can be designed.

In a fourth country –Pakistan, political tensions with India where the South Asia regional office is based has impeded the project's efforts to implement key project activities.(i.e. visas for project staff were frequently delayed – at any event Pakistan has a UNODC country office from which H13 could be implemented) In addition, lack of clarity on roles and responsibilities among major stakeholders have impeded the smooth progress of project activities.

In addition, the project should attempt to employ a working definition of 'drug use' so that not all those who use psychotropic substances are targets for this project

B.3.3. Project management structure

At the regional level, project H13 is managed through a Regional Project Advisory Committee whose tasks include providing guidance on substantive policy and technical matters relating to the execution and overall management of the project by meeting twice a year. This committee was set up but not activated. A Virtual Technical Advisory Group (VTAG) was designed to be the technical arm of the Project Advisory committee at the regional level but was not set up. The UNODC Regional office for South Asia has appointed project staff consisting of a project coordinator, a project officer, an administrative/ financial assistant, and a project assistant. These staff members oversee the general running of the project and interact with national counterparts.

At the National level the project is managed through a National Steering committee (NSC) and National Focal Points who have a critical role in the implementation of the multi-sector, government and civil society and private sector response within the country and the region as a whole. In all countries except India just one NSC was established. However in India some states established their own State level steering committees. The mentor agencies are charged with the responsibilities to monitor and ensure implementation of agreed upon activities which include recruitment of core staff at demonstration sites, implementation of training, capacity building and rapid situation and response assessments and the creation of referral networks of services which partner NGOs can access. In all countries except India one national mentor was selected. India has eight regional mentors, which have been selected from the already existing Regional Resource and Training Centres (RRTCs) run by NGOs with the support from Ministry of Social Justice and Empowerment (MSJE), Government of India.

In each of the SAARC countries NSCs were established, and government focal points and Mentor agencies have been identified. However, the NSCs failed to provide the desired coordinating and overseeing mechanisms. As can also be seen from the Country Reports (see Annex 1). Inter-alia personnel changes, a lack of understanding of the project's goals and objectives have all led to local difficulties.

Summarising - difficulties at national level included:

- Little interest in H13 because of its relatively low budget in comparison with other donor activities
- Coordination difficulties at the national level. UNODC's partners in line ministries or departments of Narcotic /Drug control do not generally work together with Ministries of Public Health / AIDS Control departments

To overcome local coordination difficulties UNODC encouraged countries (and provided the funding) to appoint National United Nations Volunteers (NUNV) to help National Focal Points and mentor agencies to monitor the national components of the project, support the database initiative and represent UNODC in national and UN system events. The appointment of National UNVs was not included in the original project document. UN volunteers were appointed and are actively working on H13 in Bangladesh (2), Sri Lanka (1), India (3). Pakistan has advertised the National UNV post and interviews for the post have been scheduled. Nepal had two National UNV posts, which are unfilled at present. Bhutan and Maldives do not have National UNVs

Although there have been efforts by project H13 to involve UNAIDS, nevertheless its role has not been prominent in relation to H13 and needs to be strengthened. In Nepal UNAIDS participated in the selection of UNVs, In Pakistan, Bangladesh and Sri Lanka UNAIDS were only marginally involved. At least some of the management coordination difficulties could be improved by UNAIDS using their mandate to be coordinators and facilitators of HIV/AIDS activities, through existing UN mechanisms such as the UN Theme Groups and other technical committees dealing with HIV/AIDS.

Delays in implementation have occurred, but cannot be attributed to any one stakeholder (although at times the Regional Office was blamed for such delays). In the second phase of H13, attention should be given to ensuring flexibility and promoting greater country ownership and decision-making.

B.3.4 Financial management

Project H13 was perceived everywhere in the region as a financially modest project which therefore elicited relatively little official interest. In some countries disquiet was expressed about financial support going directly to NGOs and mentor agencies – not because of any suspected irregularities but because it was felt by some government counterpart that this method of funding impeded government 'ownership' of the project.

Project funding was generally 'front loaded' to partner NGOs and regular utilisation documentations provided to ROSA. Regular accounts on utilisation were provided to UNODC headquarters and to AusAID.

There was real concern at the field level regarding the low pay for outreach workers and other project personnel. In some sites this has caused a large turnover of staff. In one demonstration site, all field staff had resigned prior to the consultant's visit and were only persuaded to stay when promises about a review of salaries was made.

B.4. A critical look at the eight major elements of Project H13

The items under consideration below have been identified as the major elements upon which project H13 should be reviewed.

B.4.1. Ownership by Stakeholders

Issues of ‘ownership’ are complicated by the distinction between ‘ownership’ of the problem of HIV/AIDS among drug users (i.e. whether counterparts see HIV/AIDS among drug users as a problem or a potential problem in their country), and the question of ‘ownership’ of the H13 project (i.e. the extent to which national counterpart are aware, interested in the project and ready to consider its activities, findings and methods for scaling up of the national response). The project is not mandated to deal with the former, but ‘ownership’ of the project is essential if the project’s capacity building objectives are to be achieved.

To date, the overall sense of government ownership of project H13 is weak. The reasons for this are not always easy to determine. There were a number of misconceptions about the objectives of the project which need to be cleared up. Frequent changes in personnel are responsible to some extent. (All too often national partners met during the review were new to the job. Other possible reasons for a lack of ‘ownership’ expressed by H13 partners were the modest scale of the interventions and funding, and the fact that NGOs were funded directly by UNODC / ROSA leading to a disconnect between national government and the project.

B.4.2. Regional and national monitoring and evaluation

A regional and national framework for monitoring and evaluation was developed in Colombo in August 2005. It established a tracking process covering recruitments, meetings, stakeholder identification, trainings, RSRA etc. Mentors and partner NGOs regularly reported on these.

B.4.3. Database initiative

Database development is not an activity/output of H13 but an initiative that was began by UNODC / ROSA in a previous project and was continued with funding from H13. Work on database development is undertaken by All India Institute of Medical Sciences (AIIMS) in Delhi.

The objectives are two:

- To provide a complete picture of the situation on drugs and HIV in South Asia through the systematic collection of scientific research and ‘grey’ (i.e. unpublished reports) information from SAARC countries.

- Secondly AIIMS developed the software with which results of RSRA from the regional demonstration sites and any other qualitative and quantitative material collected during the lifetime of the project and beyond can be shared through web-based software.

Both objectives have, to a large extent been met although none of the information gathered has as yet been made available. The development of software for the database is now complete but results are not yet available on the web.

Overall the collection and dissemination of scientific research and 'grey' information about drugs and HIV issues in South Asia has been a useful exercise, provided it can be kept updated and comprehensive beyond the life of the project.

Software to capture and analyse results of the RSRA was developed through a CD (developed in house) and through a web-based software developed by a member of the VTAG. Training on the use of software for data entry from the RSRA was provided in selected sites. Data entry from demonstration sites following the completion of rapid assessments is ongoing in some sites. The exercise, if used well, can assist demonstration sites to systematically review the local situation and develop appropriate responses although it is clear that RSRA teams need further training to help them interpret and analyse their data and plan appropriate responses. Overall, it is recommended, however, that in Phase II the project provides additional training to demonstration sites to enable them to analyse and understand the data collected and put less emphasis on the mechanics of data entry into a software package.

B.4.4. Baseline studies

Four studies were completed. However, none were used to inform the project. The Best Practice study was intended to inform selection of NGOs to work in demonstration sites but because of its shortcomings was not used. The Gender study, and the Legal and Policy studies have been completed but have not as yet been disseminated. The Cross-border concept paper was completed but not used by the project as yet because cross-border activities though needed were considered impractical by some National Focal Points in the current political environment of SAARC countries.

B.4.5. Protocols

Regional experts have prepared six protocols. (HIV Intervention tool-kit and Basics of conducting Situation and Response Analysis, Peer-led Community Outreach interventions, Safer Practices, Low-cost Community-based Care for drug users, Methadone Substitution and Buprenorphine Substitution) and 4 have been extensively used for training in the region.

The reviewers did not systematically review the tool-kits, however, feedback from national counterparts indicated an overall satisfaction with the protocols. Some respondents indicated that translation into local languages would be useful. (India – National Mentor).

The need for further tool kits to be used in Phase II was identified – (e.g. on techniques and methodologies to prevent switching from oral drug use to injection drug use, counselling, medical management of consequences of unsafe practices, negotiation for safe practices).

B.4.6. Demonstration sites

Demonstration sites were selected by national governments following agreed guidelines. Pakistan has 4 sites, Sri Lanka 4 sites, India - a total of 31 sites (24 Demonstration sites, 2 Regional Learning Centres (RLC), 4 NGOs are conducting pilot Buprenorphine Substitution programmes), Maldives – has 2 sites, Bangladesh - 5 sites, Nepal - 6 sites and Bhutan has two sites.

Feedback from national counterparts revealed a concern that the number of sites does not necessarily respond to the level of problems in country. (For example respondents from Pakistan felt that more demonstration sites are needed there).

For phase II of project H13 the choice of demonstration sites needs to be re-visited. Some demonstration sites do not reflect the objectives of the project. For example, some are solely cannabis and alcohol using sites, some of the RTCs chosen in India focus on drug abuse prevention and not on HIV/AIDS prevention. Furthermore, due to financial constraints the oral substitution pilot projects are not part of a comprehensive approach necessary for demonstration sites to indicate good practice – in addition in Pakistan and Bangladesh Oral substitution was not sanctioned by the government. Needle and syringe programmes which had been initially envisaged by H13 were dropped due to directives from UNODC headquarters. .

B.4.7. Training and capacity building

The objectives of the training programme were:

- To equip participants with the knowledge to undertake a Rapid Situation and Response Assessment (RSRA), to understand issues related to substance use and HIV vulnerability.
- To present an overview of the techniques involved such as observation, interviews, focus group discussion etc to undertake RSRA.
- To facilitate recognition of the need to triangulate secondary and primary data.
- To introduce participants to the important aspects of Peer Led Intervention (PLI).
- To present basic information on services that can be delivered through peer led intervention

In addition to providing training for the nominated participants, the programme provided opportunity for other in-country representatives to co-train alongside the Regional Project Consultants (RPC) who have developed the current facilitator's guide. This approach helped build an in-country resource as the co-trainers participated as trainers cum participants. This training methodology allowed one to make the maximum use of time allotted by the project by not only training NGO partners but also enhance the training capacity of the in-country resource persons.

The participants of the training programme were peer outreach co-coordinators and peer outreach workers working in the project as well as mentors from the partner agencies, team leaders from the respective NGO partners and the UNVs. The training programme has been developed based on the premise that the participants have some field experience and basic knowledge on drugs and HIV. The participatory approach has been designed to draw upon their expertise. Mentors, team leaders and UNVs functioned as trainer-participants and received technical input.

Training methodology: The sessions were tailored to stimulate the participants to think, draw on their past experiences, assimilate new information and learn new approaches to conduct assessment and deliver effective services. The process of training helped to:

- Build on the existing level of knowledge through didactic lectures with power point presentations
- Fine tune skills through appropriate exercises to deal with issues on the field and
- Assist trainees to examine their attitudes and recognize the influence these can have on their work.

The methodology also allowed for field visits and application of some of the techniques discussed in the training. In addition, capacity building of the in-country trainers identified by the H-13 project, provided the opportunity for the co-trainers to handle some sessions independently.

The duration of the training was 5 days with 6.5 hours of training per day (excluding break time). The trainer cum participants attended an additional day of training right at the beginning when they reviewed their presentations and the activities assigned to them. All the trainings were evaluated. Daily verbal feedback as well as written evaluations on a structured format was collected on Day 5 of the programme.

The training team comprising RPCs and other in-country trainer cum participants participated in a 30 minute de-briefing exercise at the end of each day to review how much capacity building was taking place as trainers and to identify issues for improvement in this regard.

Field visits and discussions with national counterparts indicated satisfaction with the training methods and of the knowledge imparted. A suggestion was made that more national trainers be involved in the future (as some countries already have a certain number of trained drug treatment and prevention specialists).

B.4.8 Gender strategy

All project stakeholders were aware that H13 actively promotes gender equity and promotes the active recruitment of women to project staff and that accessing women drug users and sexual partners of male drug users is an overarching priority. The project was repeatedly praised for adding this perspective to an understanding of the issues and to formulating its responses. Gender sensitization was provided by the project in the initial Project Formulation Workshops and in the Terms of Reference for staff recruitment, which were provided to partner NGOs.

However, the study on gender has not yet been disseminated and did not inform project activities.

C. Conclusions

Project H13 was developed by ROSA and is being implemented with the participation of national counterparts in 7 SAARC countries. It is nearing the end of Phase I and a re-design of phase II will be undertaken when the project review has been completed. The mid term review found that the implementation of project H13 differed markedly from country to country and in some (notably Pakistan and Maldives) serious implementation is yet to begin. The smooth running of the project in some countries was impeded by delays and other logistic difficulties, though these can not be attributable to any one stakeholder. A mixture of factors, many of them unforeseen led to these delays.

The project's original goals and objectives remain valid and important in South Asia. The project's aim to increase capacity at regional and national level to prevent the spread of HIV among and from drug users needs continuing attention, expansion and re-enforcing with the implementation 'to scale' of evidence based, tried and accepted interventions. Project H13's demonstration sites which will foster good practice and promote a comprehensive approach should by the end of Phase II become models for future scaling up of interventions by national governments.

However in order to achieve this, project H13 needs to pay more attention to advocating for strategies such as Harm Reduction that are necessary for the prevention of HIV/AIDS among drug users but which are not as yet universally accepted in the region. For successful implementation of the regional H13 project it is necessary to clarify who are the major targets for the proposed interventions in the demonstration sites. To-date the project has been over inclusive in its targeting of all potential and active drug users. It may be that the project should develop a 'working definition' of what they mean by prevention of HIV among drug users', so that the work in phase II is focused on the prevention of HIV/AIDS and not on the prevention of drug use per se – an important task which is beyond the scope of this project.

Annex 1: Mid-Term Review - Country Reports

1. Bangladesh: Summary of H13 information

Total H13 financial contribution to-date	\$141,945
National focal Point: Home Ministry - Dept. of Narcotic Control	
National Mentor: International centre for Diarrhoeal diseases research Bangladesh – Centre for Health and population research (ICDDR)	
5 Partner NGOs – Light house, ALO, APON, DAM, CREA	
2 United Nations Volunteers	
NSC met three times – (Once during the review).	
Training provided by H13 - Proposal formulation and indicators development workshop, RSRA and PLI training, regional and national database training	

Major issues in Bangladesh that impact upon the work of H13

- Numerous interventions to prevent HIV among drug users already ongoing in Bangladesh. (DFID and World Bank funding)
- Largest drug related harm reduction projects by Care and FHI
- Lack of communications and good working relations between Ministry of Public Health and Home Ministry (Dept. of Narcotic Control)
- Lack of clarity existed about relationship to Regional UNODC in Delhi (highlighted by Mentor agency).
- Country sense of ownership of H13 is unclear. Project is not part of the National response.
- NSC has not met since Dec. 2004. (However, one held during review)
- Limited capacity within the Home Ministry, Dept. of Narcotic control (the focal point) for timely and total implementation of H-13.

Despite lack of country ownership country stakeholders provided the following insights:

- H13 said to provide added value to the country response by emphasising and focusing on community based, low cost interventions. Overall H13 regarded positively
- H13 praised for promoting working with networks as well as individuals and for incorporating gender dimension into interventions
- H13 through RSRA will add to knowledge pool on drug use in country

Recommendations for H13 project in Bangladesh

- Clarify coordination mechanisms (note that this may be facilitated as UNAIDS has recently taken a lead role and UNODC has been acknowledged as lead agency which will rationalize country response (to date UNICEF - Bangladesh was the lead agency on drugs and HIV)
- The National Steering Committee (NSC) to become part of a larger steering group on HIV/AIDS- no need for a separate H13 NSC
- Salaries of Peer Outreach workers and Coordinators to be reviewed and increased.
- Sites to be assisted to develop comprehensive services for drug users in Phase II

2. Bhutan

Total contribution from H-13 : USD 34,600

National Focal Point : Joint Director, QASD, Ministry of Health, Royal Government of Bhutan (RGB).

Mentor Agency: Youth Development Fund (YDF); the only NGO of Bhutan in collaboration with National Focal Point.

Main Implementers:

1. Department of Youth, Culture and Sports ; Ministry of Education.
2. REWA, of the Youth Development Fund (YDF).

National UNV: None.

Background:

- Situated on the laps of the eastern Himalayas, the mountainous, Buddhist Kingdom of Bhutan is flanked by India on south & Tibet region of China on north.
- Population: 2.1 million.(2004)
- GDP per capita (PPP) : \$ 1,969 (2005), with significant improvement in living standards of population.
- Total adult literacy rate: 47% (with high female enrolment in schools of the SAARC region)
- Despite of rise in living standards & socioeconomic development efforts, the country remains largely closed from the outside world to protect its values & traditions.
- Growth in tourism is slow & controlled. (It's important here to note the relationship between tourism & drug problem as existence in other countries of the region.)
- No figures available on drug abuse but the RGB recognize seriousness of the potential problem. (Type 2 or Modern type of drug abuse).
- Anecdotal evidence (also from rapid assessment) indicate rising drug abuse problem in Thimphu, and southern parts bordering India.
- Commonly abused substances are: Amphetamines, Benzodiazepines, Cannabis, Opiates, Alcohol etc.
- Estimate suggests: around 5 to 6 IDU deaths in a year attributable to opiates.
- Alcohol consumption poses a health problem. (WHO, SEARO 2002)
- Gross under-reporting exists on often stigmatized addictive behaviour.
- Traditional pattern of abuse (Type 1) of Alcohol, Cannabis should be prevalent as in neighbouring countries.
- Because of geographical proximity to high-IDU prevalence areas of Nepal & North-eastern states of India, Bhutan is vulnerable to IDU.

FINDINGS:

Due to several reasons, Bhutan endorsed H-13 much later than other countries, therefore implementation of the H-13 was delayed.

1. RSRA Training (20-25 January, 2006)

- Highly appreciated by the participants, trainers & observers.
- New useful data generated during that e.g. commonly used substances, mode of abuse etc.
- Possible networking discussed.
- Agencies/stakeholders identified.

Actual RRA is yet to be conducted, request has been made to so soon.

2. School-based Drug Prevention Programme:

- Initiated to incorporate chapters on prevention education in classes 7 & 8 of the schools.
- Prevention education of students during winter holidays.

3. Support/guidance to REWA of YDF in Drop in centre and Rehabilitation services.

NFP/NM: About H-13:

- Useful & needed.
- Programs should be tailored to fulfill the needs of Bhutan.
- Requests for support in establishing new nodal agency, Narcotic Control Agency and in development & implementation of the Masterplan of drug abuse control for Bhutan.
- Requests for more resources, both technical & financial.
- Requests in assistance in establishing Drug abuse treatment & rehabilitation services (as this is non-existent within government) in the context of free healthcare service provided by the government.
- Make planning/implementation more participatory; considering local issues and problems
- Country specific implementation measures should be used.
- More proportionate distribution of resources.

4. Others

- UNDP : Resident Coordinator
- Officer In charge of HIV/AIDS control of MoH.
- High officials of Ministry of Education.
- Officials of YDF/REWA

Suggestions:

- Need to work in close coordination with different stakeholders.
- Close alliance with HIV/AIDS sector in govt. or in UN system.

OBSERVATIONS :

-Issues of Drug abuse and HIV/AIDS have not been perceived as public health problems at present but considered to be potential threats.

-Although traditional pattern of substance abuse exists (type 1), involving alcohol, cannabis etc., the newer pattern of drug abuse (type 2) has not been recognized as yet . Anecdotal evidence suggests existence of drug abuse akin to other SAARC countries though exact extent and nature of which need to be studied.

-IDU is also prevalent in Bhutan especially among youths, males, in capital and southern border town of Bhutan.

RECOMMENDATIONS:

1. YDF/REWA should be strengthened and assisted in providing services of Drop in centre and Rehabilitation services for drug users & recovering addicts and in other risk reduction services.
2. RSRA needs to be conducted soon and replicated in different areas to get an overview of the drug and HIV scenario of the country.
3. More focussed mapping exercises should be planned on high –risk groups e.g. IDUs, CSWs, and their partners in Thimphu and other towns.
4. RGB should be assisted to enhance its capacity to tackle the drug abuse problem in terms of assistance in establishing the new Narcotic control agency and formulation and implementation of Masterplan of the Drug Abuse control for Bhutan.
5. Planning and implementation of the next plan of H-13 should be tailored to the needs and realities of Bhutan - its government and society.

3. INDIA

Total contribution: USD_361,976. (as per document provided)

National Focal Point: Joint secretary, Ministry of Social Justice & Empowerment, New Delhi.

National Mentor Agency: National Centre of Drug Abuse Prevention (NCDAP), National Institute of Social Defence (NISD), MSJE, New Delhi

National UNVs: 3

Regional Mentor Agency:

* 8 Regional Resource & Training Centres (RRTC) (RRTC-North; RRTC-East 1 & 2; RRTC-North-East-1,2 & 3; RRTC-South & RRTC-West), and

* 3 Regional Learning Centres (RLC): (RLC; TTK Foundation, Chennai for Low-cost Community-based Care & Support); Galaxy Club Imphal for Peer-led Intervention; and All India Institute of Medical Science (AIIMS) for Oral Substitution -Buprenorphine (OSB).

* Network/collaboration with:

1. Positive Women's Network (PWN+)
2. FINGODAP, an umbrella organization of Drug Demand Reduction NGOs of India.

Background:

- Largest democracy, second most populous country of the world (more than 1 billion population)
- Big land mass with heterogeneity in everything in everywhere.
- Rapid economic growth but poverty is pervasive (260-290 million poor).
- Recent surveys show:
 - * 2.7 million people use opiate currently (0.7%); 0.5 million of them are dependent users.
 - * Cannabis: current users: 3% of population (8.7 million) ; and dependent users : 2.3 million
 - * Recent shift towards injecting drug use (IDU) exact number: N./A; But surveys suggest 0.1% to 43% of Drug Users are IDUs). Rapid Assessment Survey (RAS) shows in Imphal (80%), Chennai (43%) and Kolkata (38%) IDU.
 - * Drug-driven HIV/AIDS: Rise in HIV prevalence in IDU from 7.4% to 14.4% in New Delhi recent years. In North East, although stabilized, prevalence is very high (up to 80% in one town). In main urban areas, HIV prevalence among IDUs is more than 5% causing major public health concern. Danger of 'generalization' of HIV prevalence from 'concentrated epidemic' present both through high risk

drug and sexual behaviours. Increasingly “Feminization” of epidemic is happening; epidemic is moving more towards general population from the high-risk groups.

FINDINGS/OBSERVATIONS

NFP/NM: About H-13 Project:

- consider “very useful and needed” project :
- keen to continue in the next phase but requests for more resources for RRTC & PNGOs,
- request assistance in enhancing the training capability of the National Mentor, NCDAP-NISD;
- suggest documents to be produced in local languages;
- wishes to have more effective coordination and communication within H-13 implementers and other stakeholders,
- wants to start cross-border programs;
- After H-13 initiated similar activities on line of H-13 (H-13 acted as catalyst).

RRTC/PNGO

- consider it as “ useful and needed program”
- H-13 has added value to their works among IDUs and in HIV sector (except one out of eight, who disagreed , and said that “ this type of work is needed but H-13 project functions in ‘top down’ way and so this is not participatory”
- Highlights of H-13
 - (i) Participatory approach in planning, implementing & M&E.
 - (ii) Focus on females and families (female DUs.& IDU; female sex workers & regular sex partners & spouse and family of DU/IDUs)
 - (iii) Empowers staff.
 - (iv) Training method is practical and “hands on”; and readily usable.
 - (v) Components are effective. RSRA; PLI, SP, & OSB are in great demand after introduction by the PNGOs.
 - (vi) Low cost and community based approach.
- Allowed females to come out openly; family accepting them too.
- Issues/concerns: accepting the HIV positive female members by the family & society.
- Delay in start of ground- level activity;
- Even more mentoring/technical guidance needed.

- Danger of being overwhelmed and non-effective while dealing with all the problems of deprived community.
- Relatively poor remuneration (salary, travel allowance and allowance to entertain clients/members with tea etc.) but lots of expectations from the field workers. More number & types of intervention-activities, in comparison with other similar projects.
- Poor communication/coordination observed at places. No clear guideline on Peer-Led Intervention reported at places–on what to do next or how to proceed further etc. also in communication between field staff and community people on future course of the project etc.
- Lack of mechanism to assess the effectivity of the trained field staff.

Recommendations:

1. H-13 should continue in the next phase with availability of more resources.
2. Not to stray away from the main focus of “HIV prevention amongst DU/IDUs”.
3. Drop demonstration sites which are not fitting in this frame or not performing well despite of lots of support. Focus and concentrate more on the ones performing well & working with IDUs, opiate users etc.
4. More collaboration/ coordination with National AIDS Control Organization (NACO), and state level AIDS/HIV counterpart agencies; and other related organizations.
5. Place surveillance mechanism to assess HIV prevalence rates & dynamics among any IDUs/DUs on regular basis.
6. Initiate “Comprehensive Package of All Interventions “(with all components of designed intervention tool-kits) in a few sites in order to have clearly visible outcomes of intervention.
7. Expand coverage area with more demonstration sites and partner NGOs (PNGO) as per availability of resources and on the basis of prevalence of HIV among IDU/DUs.
8. Activate National Steering Committee (NSC), its state-level Steering Committees. and also other stakeholders.
9. Involve leading academic, scientific institution and their components in various roles e.g. AIIMS, Postgraduate Institute of Medical Sciences & Research, Chandigarh (PGI), regional medical institution of Imphal, etc. for provision of evidence-based technical support, potential of replication of activities, sustainability of the activities etc.
10. Special initiatives (with PWN+ and FINGODAP) : its utility needs to be clearly defined; if they do not fit in the overall goal then it may be more useful to

- discontinue linkages with them in this particular work; not excluding the possibility of collaboration with those in any other ways.
11. Regular and frequent updating on progress of implementation of H-13 discussed amongst its internal implementers (RRTC, PNGO, field staff etc.) and any alteration/modification planned on the basis of the progress done. Progress reports to be produced and widely disseminated in easily understandable languages.
 12. Modification in any activity/work plan implemented on the basis of those updates and progress reports.
 13. Effectiveness of training of ground level field staff - ultimate deliverers (PV, POW, POC, Team leader) needs to be continuously monitored , and if found to be unsatisfactory, then provision of remedial measures of further training, more intensive & individualized should be there in work plan./place.
 14. Specially for the peripheral level, keep the M & E even simpler and more easily implementable, with a provision of assessment of one's one performance or one's own organization's..

4. Maldives: Summary of H13 information

Total H13 financial contribution to-date	\$70,050
National focal Point: National Narcotics Control Bureau	
National Mentor: National Narcotics Control Bureau	
2 Partner NGOs – SHE, FASHAN	
No United Nations Volunteers	
NSC met four times	
Training provided by H13 - Proposal formulation and indicators development workshop, RSRA and PLI training, regional and national database training	

Background note: Drug use and HIV in Maldives

- Injecting drug use is estimated to be between 20-22% of total users (recent sampling NNCB). There is little information about drug use practices.
- Considerable testing for HIV- But no specific information on HIV among drug users (Drug users not represented in groups selected for testing)
- The links between drug and HIV are indirect. However, there is evidence that drug users engage in risky sexual behaviours and of multiple sexual partners in Maldives
- UNODC has assisted the Maldives to develop a Drug Control Master-Plan

H13 Project activities

- Beginning of community-based work in 2 Demonstration sites: Veildhoo (FASHAN), Naifaru, Hinnavaru and Kurendhoo(SHE)
- Two RSRA were completed
- Local coordination mechanisms identified
- Needs assessment of primary community conducted and mapped

H13 Review findings:

- Government 'ownership' of H13 and multi-sectoral collaboration are weak
- NNCB unsure of how H13 benefits the Maldives
- Incomplete understanding of project goals and objectives both at central level and at partner NGO level
- Incomplete understanding of the RSRA process. RSRA done too rapidly - communities not engaged or prepared.

However, Government highlights benefits of regional collaboration and sharing of skills and information and wishes to continue H13 project

NNCB requests UNODC support in developing strategy for capacity building (SAARC learning strategy H13) and in meeting human resources gaps.

Recommendations for project in Maldives:

- Maldives to take steps to complete Phase I of H13 and commitment to the project to become evident before the beginning of Phase II
- Understanding of project goals and objectives to be improved
- Coordinating mechanisms in the country to be improved so as to increase stakeholders' understanding and ownership.
- Provide additional training for RSRA to ensure community participation and ownership

- Develop strategies to collaborate with police to allow risk reduction work to continue and expand.

5. NEPAL

Total contribution from H-13 : USD 110,000

National Focal Point: Joint Secretary, Ministry of Home Affairs, His Majesty's Government of Nepal.

National Mentor Agency: The Drug Control Program (DCP), Ministry of Home Affairs, HMG.

Main Implementer: DCP and partner NGOs.

Partner NGOs: Total six.

In Kathmandu valley: 4.

1. CAADA, Nepal 2. Nepal Youth 3. Prerana, Kathmandu. 4. Drug Abuse Prevention Association of Nepal (DAPAN), Kathmandu.

In Rupandehi district: 2

1. Namuna Integrated Development Council, Rupandehi.
2. Nagarjun Development Community, Rupandehi.

- Also works in collaboration with National Centre for AIDS and STD Control, Ministry of Health.

Background:

- Nepal lies on the southern side of the middle and main part of the Himalayas; it is flanked by India on three sides namely, east, south and west and by Tibet region of China on north side. The country has three distinct topographic regions; the mountainous part on the north full of tall Himalayan peaks; the hilly middle part full with hills & valleys and the flat land of south called Terai bordering Indian states.
- Because of its position in between, two big and diverse countries of Asia, Nepal has lots of mixed features in terms ethnicity religion, culture & traditions, language, where different traditions & people have been intermingling together since centuries which has produced unique blend of diversities in society.
- This diversity amongst its people coupled with topographical varieties of land mass having all types of climatic zones, tropical to tundra because of altitude from near sea level to the highest point on earth within a country has produced heterogeneity in everything.
- Population: 24.6 million
- Life expectancy: 60; males' higher than females.
- Total adult literacy rate: 42%

- Total urbanized population: 13%
- GDP per capita (PPP): 1,420 USD.
- Nepal is one of the poorest countries of the world which shares porous borders with India which causes relatively free flow of people & goods in between these countries and accompanying trafficking of drugs and human beings.
 - Along with this the armed Maoist insurgency since 1996 has led to worsening of development & economic scene.
 - The political turmoil of recent times has added to that producing much hardship to people.

Since ancient times, Nepal has been a drug consuming society in the form of cannabis, alcohol, opium etc. (Type 1 abuse). But this pattern of abuse has been socially accepted & not considered to be a social or health problem. The modern type of abuse which started in the sixties has been changing as per global trends and is similar to abuse pattern of the neighbouring countries. (Type 2 abuse).

- Exact number of drug abusing (excluding alcohol) is not known but estimated in between 100,000 to 200,000. Commonly abused drugs are cannabis, codeine-containing cough syrups, nitrazepam, buprenorphine, heroine etc. A clear switch from ingestion or inhalation to injecting has been seen recently due to unavailability of drug etc. which has been worrisome. The injection drug use significantly overlaps with the commercial sex work both of which have been considered to be the main drivers of the HIV epidemic in Nepal, spreading it towards general population.
- HIV sero-prevalence rate of IDUs is also significantly high, although decreased in 2005;
 - In 2003: 68%
 - In 2005: 51.7%
- Considering the extent of the drug abuse-driven nature of HIV epidemic in Nepal, there is a paucity of responses to drug demand reduction.
- Total number of people with HIV is 6128 (February 2006) out of which 981 have AIDS. IDUs and clients of sex workers are the major groups amongst which HIV prevalence has been consistently increasing in recent years.
- Nepal has entered in the “concentrated epidemic” phase with IDUs, sex workers & their clients, migrant workers, girls victims of trafficking are the main high-risk groups.

FINDINGS/OBSERVATIONS

NFP/NM

About H-13 project

- consider – ‘useful and needed’ project

- keen to continue in the next phase albeit with changes in management, work focus and support
- request for assistance in capacity building of NFP and DCP as well as for NGOs
 - request for assistance in national drug abuse survey; in programs/activities to be generated from new policy
 - would like to start risk reduction program like oral substitution therapies (Methadone and Buprenorphine) and also needle syringe exchange program (NSEP)
- requests for school prevention education program too
 - with a view to unavailability of free or relatively inexpensive treatment and rehabilitation facility in public sector in Nepal drug user, request to assist in such services also made. One possible method could be establishing drug abuse treatment facility in the zonal hospitals of the MOH; and provide such services in collaboration with NGOs
- NGOs need a lot of guidance/mentoring both from DCP and UNODC.
- H-13 implementation has been smooth except staff transfer
 - need for better coordination with NCACS, MOH, UNAIDS and other similar agencies highlight

PARTNER NGOs

- All are enthusiastic to work with H-13. Within a relatively short duration of start, a lot has been achieved.
- All need more resources, remuneration and technical support. Delay in receipt of fund also highlighted.
- Expressed the need for:
 - a) 'free'/cheaper treatment option of IDU/DU
 - b) assistance in networking and alliance formation

HIGHLIGHTS OF H-13

- Participatory approach- in planning, proposed development, training etc.
 - Focus on female DU/IDU; female sex partner of DU; spouses and family members- is one of the most important features
- Emphasis on HIV/AIDS, other blood- borne infection and medical conditions- like abscess also important fact.
- RSRA: very useful

ISSUES:

- Need for more communication with H-13 implementers especially field - trip as details of future plan etc.
- Need for coordination with HIV/AIDS sector.
- Minimize delays as much as possible e.g. in distribution of fund.
- Give ample time period to get the results/outcomes.
- Concern also raised by one or two on:
 - a) lack of clear guidance about future of H-13 and its sustainability
 - b) training done in English not understood by a few trainee
 - c) complicated and length record keeping.
 - d) largely unaware of baseline studies and details of protocols etc
 - e) more training to be effective at ground level and guidance needs.
- More focussed/targeted approach needed. Comprehensive means not use as yet; needs to be
 - Great need exists to work together DCP, NCASC and UN agencies to work together and DCP can provide leadership in the area.

RECOMMENDATIONS

H-13:

- should have more country specific programmes and activities as per need of the countries
- similarly the operational management of H-13 also should have differential approach for each country especially for Nepal
- cross- border programs also need to be initiated which seems possible between Nepal and India
- conflict affected areas of Nepal should be involved in H-13 in next phase because of the vulnerability of –escalation of epidemics of IDU use and HIV there.

6. Pakistan: Summary of H13 information

Total H13 financial contribution to-date	\$ 140,000
National focal Point:	Ministry of Narcotic Control
National Mentor:	Anti-Narcotic Force
Partner NGOs	4 Partner NGOs – Caritas, Aagosh, New Horizon, Community Development Network Forum
United Nations Volunteers	– one to be appointed next month
Training provided by H13	- Proposal formulation and indicators development workshop

H13 Project - Delays in implementation were due to a number of interlinked factors

- Difficulties for ROSA to access project in Pakistan and make the necessary plans or project activities (just two visits in phase I)
- Lack of clarity on H13 ‘ownership’ between Ministry of Narcotic Control (MNC) and Anti-Narcotic Force (ANF)
- Key staff changes in MNC and ANF.
- Lack of decision making mechanisms leading to delays in convening national steering committee and consequent delays in project trainings (RSRA and database training not provided)

Findings of Review in Pakistan

- Counterparts would like project H13 should be continued
- Government views H13 as a small project (\$140,000) but concept worth pursuing
- Government counterparts highlight the importance of regional sharing of expertise and resources
- More demonstration sites needed
- Project H13 has yet to start functioning in Pakistan.
- Partner NGOs have made considerable progress despite the lack of training from H13 apart from the project formulation workshop has taken place. (e.g. notable success in Quetta in reaching women)

Recommendations for project in Pakistan

- Clarify role of UNODC Pakistan. H13 to be executed and managed in Pakistan.
- Strengthen and enable H13 National and Regional implementation.
- H13 to start functioning prior to the beginning of Phase II funding
- Effective coordination between stakeholders at the national level.
- Position H13 steering committee meeting within existing National Steering Committee on HIV.
- Develop links with provincial authorities - much drug use and HIV risk behaviour is in provincial centres RSRA and PLI training implemented before the end of Phase
- Implement drug substitution projects
- Strengthen Secondary data collection and sharing of existing information (e.g. through database initiative (e.g. UNODC study on women in Lahore not generally known - even in Lahore).

7. Sri Lanka: Summary of H13 information

Total H13 financial contribution to-date	\$ 70,425
National focal Point:	National Dangerous Drugs Control Board.
National Mentor:	SLFONOADA
4 Partner NGOs –	ADIC, Mithuru Mithuro, Ape Kedella, Slana
1 United Nations Volunteer	
NSC	met once
Training provided by H13 -	Proposal formulation and indicators development workshop, RSRA and PLI training at regional and national level, national data base training

Background note: Drugs and HIV in Sri Lanka

- About 1-2% of opiate drug users inject drugs (NDDCB - 2005)
- Only one case of HIV among drug users reported (returnee from abroad)
- Drug users not systematically included in HIV/AIDS surveillance.
- Links between drug use and HIV in Sri Lanka are at present mediated through unsafe sex.
- Government drug control policy is tends to focus on supply reduction and abstinence-based treatment approaches.

H13 Review Findings:

- All government and civil society agencies engaged in demand reduction are dedicated to abstinence-based interventions as are ¾ partner NGOs
- Risk reduction strategies for drug users are considered irrelevant to local conditions.
- H13 project objectives are not integrated into the government's drug control framework
- Partner NGOs are not regarded by government as accountable to them and hence the government is concerned about the sustainability of the project

Achievement of H13

- All 4 NGOs completed RSRA - training seen as useful.
- Data entry completed by NGOs - (However, interpretation of the data has not yet been systematically undertaken)
- Gender sensitivity evident in work of partner NGOs

Recommendations for project in Sri Lanka

- Limit interventions in Sri Lanka to ensuring capacity on RSRA, PLI and the prevention of switching from oral to Injection drug use. H13 should not undertake overall drug prevention activities.
- Increase understanding on drug users' vulnerability to HIV and Hep C by increasing surveillance and encouraging VCT
- Strengthen government 'ownership' and involvement in the project to ensure that project goal of increasing capacity in the country are realised.
- Ensure more involvement in planning and implementation with the HIV/AIDS sector.

Master Probe H13 March 06 review

A. Regional level

Issue- Ownership

1. What is the added value of this project to HIV prevention among injection drug users
2. How beneficial (or potentially beneficial) was the project to IDUs?
3. Are you happy to continue with this project?
4. Any suggestions or modifications in continuing the project?
5. Which part of the project do you consider as redundant?
6. What could have been done better in this project?
7. In future would you like to do anything differently?
 - a) Working with which ministry or ministries you think would help develop better ownership at the country level?
 - b) What could be an effective management structure to run this project in future?
 - c) How inter-UN agency collaboration could be enhanced for this purpose?
 - d) How many times did the National Steering Committee meet? Who were the members and what was their role in this project?

Issue: Baseline Studies

8. Have these (base line studies) been useful to you in this project- if so have you incorporated it into this project?
If not, Why?

Issue - Database

9. What potential do you see in the database initiative (as it is not in the activities of the Project)?

Issue- Protocols

10. What is the rationale for selecting the topics for these protocols?
11. Have the protocols been disseminated widely in the region?
12. How do feel about the acceptability of the protocols? – User friendly? Relevance? Language?
13. In future, do you think more protocols are needed?

Issue- Demonstration sites

14. What is the rationale for selection of the demonstration sites?
15. Why so many demonstration sites in India?
16. Did you use the baseline study to help you identify the demonstration sites?
17. Did the National focal points contribute to the selection of demonstration sites?
18. Did you think the process of selection of demonstration sites was satisfactory?
19. Do you want to continue with the same demonstration sites in the future?

20. What is the rationale behind different combinations of interventions (PLI vs PLI plus) at different demonstration sites?

Issue- Training and capacity

21. What is the process of selecting trainers for RSRA and PLI and OSB?
22. Have training modules been developed / adapted for all the protocols?
23. What has been the outcome of the trainings?
24. What has been the contribution of Trained trainers (co-trainer) to the project?
25. How do you propose to use the skill of training in future?

Issue- Monitoring & Evaluation

26. Does the existing M&E system capture the progress of the project at regional level?
27. Is there a scope for improvement in the existing M&E system? if yes – in which way?
28. What was difficult in implementing the existing M&E framework?

B. Country level

Position of the Key Informant, Department, Date

Issue- Ownership

29. What is the added value of this project to the country in HIV prevention among injection drug users?
30. How beneficial (or potentially beneficial) was the project to IDUs in the country?
31. Are you happy to continue with this project in this country?
32. Any suggestions or modifications in continuing the project in this country?
33. Which component/s of the project you consider as not needed in this country?
34. What could have been done better in this country while implementing this project?
35. In future would you like to do anything differently here in this country?
 - a) Working with which ministry or ministries you think would help develop better ownership in this country?
 - b) What could be an effective management structure to run this project in future?
 - c) How inter-UN agency collaboration could be enhanced for this purpose?
 - d) How many times did the National Steering Committee meet? Who were the members and what was their role in this project?

Issue- Baseline Studies

36. Are you aware of baseline studies (capacity of NGOs, Best practices, gender, legal and political concerns)?
37. If yes to question 36 – Have these studies been useful to you in this project- if so have you incorporated it into this project? (If not , Why)?

Issue- Database

38. Are you aware of the database initiative?
39. If yes to question 38, what potential do you see in the database initiative?

Issue- Protocols

40. Have the protocols been disseminated widely in the country?
41. How do you feel about the acceptability of the protocols? – User friendly? Relevance? Language?
42. In future, do you think more protocols are needed? If yes what should be the topics and what process should be followed to develop them?

Issue- Demonstration sites

43. What is the rationale for selection of the NGO partners?
44. Did you use any baseline study conducted by the regional project (H-13) to help you identify the demonstration sites?
45. Did the National focal points contribute to the selection of demonstration sites? What was the mentor's role in it?
46. Did you think the process of selection of NGO partners was satisfactory?
47. Do you want to continue with the same sites in the future?
48. What is the rationale behind different combinations of interventions (PLI vs PLI plus) at different sites?
 - a) When did the training on RSRA and PLI take place? When was RSRA conducted?

Issue- Training and capacity

49. What was the process of selecting trainers from NGO partners for RSRA and PLI and OSB?
50. Have training modules been developed / adapted for all the protocols?
51. What has been the outcome of the trainings?
52. What has been the contribution of Trained trainers (co-trainer) to the project (H-13) in this country?
53. How do you propose to use the skill of the co-trainers in future? Have these trainers been utilized in any other project as yet in the country?

Issue- Monitoring & Evaluation

54. Does the existing M&E system capture the progress of the project at the country level?
55. Is there a scope for improvement in the existing M&E system? if yes – in which way?
56. What was difficult in implementing the existing M&E framework in this country?

C. Civil society organizations

Name of the organization, Position of the Key informant, Focus Group Discussion with the drug users / FGD with the regular sex partners

Issue- Ownership

57. What is the added value of this project to your organization?
58. How beneficial (or potentially beneficial) was the project to IDUs in your area?
59. Are you happy to continue with this project?
60. Any suggestions or modifications in continuing the project?

61. Which component/s of the project you consider as not needed?
62. What could have been done better while implementing this project?
63. In future would you like to do anything differently here?

Issue- Baseline Studies

64. Are you aware of baseline studies (capacity of NGOs, Best practices, gender, legal and political concerns)?
65. If yes to question 64 – Have these studies been useful to you in this project- if so have you incorporated it into this project? (If not , Why)?

Issue- Database

66. Are you aware of the database initiative?
67. If yes to question 66, what potential do you see in the database initiative?

Issue- Protocols

68. Have the protocols been disseminated widely within the organization?
69. How do you feel about the acceptability of the protocols? – User friendly? Relevance? Language
70. In future, do you think more protocols are needed? If yes what should be the topics and what process should be followed to develop them?

Issue- Demonstration sites

71. Did the National focal points contribute to the selection of your site?
72. Did you think the process of selection was satisfactory?
73. Do you want to continue with this project in future?
74. Why are you carrying out the following interventions (PLI vs PLI plus)?
75. What has been the staff turn over in this project (how many paid staff since the beginning are present now in the project)?

Reasons

76. Any other difficulty that you faced in implementing the project? (suggestions for improvement)

Issue- Training and capacity

77. What was the process of selecting trainers from your organization for RSRA and PLI and OSB?
78. Have training modules been developed / adapted for all the protocols?
79. What has been the outcome of the trainings?
80. What has been the contribution of Trained trainers (co-trainer) to this project (H-13)?
81. How do you propose to use the skill of the co-trainers in future? Have these trainers been utilized in any other project as yet?
82. What is the benefit of RSRA? Do you see a point in repeating it in future in the population group you are working with?

Issue- Monitoring & Evaluation

83. Does the existing M&E system capture the progress of the project?

84. Is there a scope for improvement in the existing M&E system? if yes – in which way?

85. What was difficult in implementing the existing M&E framework

Annex 3: Consultants' Terms of Reference

PURPOSE OF THE REVIEW AND REDESIGN

Aim:

Aim I: To assess the quality and progress in delivery of project objectives/activities under the project document.

Firstly the review team will measure achievements, outcomes and impacts both positive and negative of Fast Track of the project.

The project is concentrating activities in the seven SAARC countries i.e., Bangladesh, Bhutan, India, Nepal, Maldives, Pakistan and Sri Lanka. The main stakeholders are the national counterparts dealing with the problem of drugs and HIV/AIDS. The target groups are policy makers, planners, academicians and NGO service providers working in the field of drugs and HIV/AIDS. Indirect target group are drug abusers who are at risk of HIV infection and those who are infected and affected.

The project has set in place regional and national coordination mechanisms comprising key stakeholders from government and civil society. The review process will be designed to be fully participatory and access views from all concerned through appropriate methods.

Although the review team should take the views expressed by the concerned parties into account, they should use their independent judgment in preparing the review report. The review team will also develop instruments and processes to access all sectors and stakeholders involved in Fast Track of the project.

Aim II: Based on the review and lessons learned, provide a design for phase II of the project.

According to the current project document, at the end of Fast track evaluation, the team would revisit the project design for phase II and explore potential donors interest and support to national programmes in participating countries. As originally planned, Track II will last for a period of 24 months and will consolidate and scale up the achievements and disseminate experiences of the Fast Track.

The phase I of the project has attracted wide-scale interest in countries of the region in terms of incorporating the process and methodology of imparting capacity in technical aspects such as carrying out a rigorous RSRA (rapid situation and response assessment), peer led approaches, oral substitution therapy with Buprenorphine (OSB) and Low Cost Community based care and support (LCCS).

Phase II needs to go beyond what was planned in the current project document and take on a more comprehensive and expanded programme that would consider scale up in the context of meeting the aspirations of member countries in the light of their National AIDS Control Programme projections over the next 5 years.

Phase II needs to reflect different methods of working in each SAARC member country's unique environment and needs to provide scope to national governments for better buy-in through a good analysis of how resources provided will be used in each country. Focus should be on safer practices (both drug use risks and sexual risks) involving peers who are current users and stress should be laid on prevention of HIV among all drug users including injecting drug users. This is particularly true in the South Asian context as a majority of drug users currently do not inject but have the potential and consequent risks of doing so and the practice of injecting is spreading to newer areas including remote rural sites.

Therefore, the redesign team will examine the deliverables for Phase II as per the project document, redesign the outputs based on review of phase I of the project in terms of project planning, design, management and indicative budgeting. Additionally it will, in consultation with regional policy makers and programmers expand the nature and scope of phase II.

In the light of the above, the project envisages a total funds requirement of over US \$ 5 million (against the earlier requirement of US \$ 1.3 million) for phase II, with duration of 5 years instead of three years as earlier envisaged. The project has approached other potential donors who are engaged with current project partners and/or who have shown interest in achieving the UNAIDS "three ones" in member countries with specific relation to drug driven HIV.

The redesigned document for Phase II will be reviewed at a regional stakeholders meeting and participant comments will be incorporated in the final report which will be further appraised by independent consultants.

REVIEW & REDESIGN TEAM

The team will comprise of four regional experts. Preference will be given to those experts who have wide-ranging experience of the SAARC countries in terms of existing circumstances and culture specific drug use and related sexual practices. The experts should be widely conversant with the current nature of the situation and responses and should ideally have evaluated large regional and national projects in SAARC countries for the international donor community or national governments. The consultants should have insight into government and civil society structures and processes (i.e., resources and constraints), in order to provide a focused review of the project and in order that practical recommendations can be operationalised through the existing structures and mechanisms without undue delay. Personal experience of either direct or indirect involvement with other large-scale programming in the region will be an added advantage. They should ideally have domain-specific expertise in mental health, public

health, sociology, or related disciplines with in-depth expertise in epidemiology, monitoring and evaluation, drug/HIV risk reduction methodologies.

The regional consultants will be short listed by UNODC. AusAID and UNODC will jointly select and empanel the review and redesign team with clear Terms of Reference (see below). UNODC Project H13 will contract the consultants and support their travel and other review related costs. The review and redesign team will be assisted at all times in the effective discharge of responsibilities by the core staff at UNODC Project H13 and the AusAID Focal Point(s).

REVIEW PROCESS

The review team shall follow the guiding principles for evaluations at UNODC (attached as Annexure V).

Basic Reference Documents: The original project document, agreements reached with national counterparts and donor agencies, baseline documents, financing agreements, and reports submitted to review meetings and minutes of review meetings should be the basic documents for review. The semi-annual and annual reports, mission reports, reports of trainings and workshops and drafts of reports, software, Intervention Toolkits and publications produced by the project shall also be taken into consideration. Further, documents like the NGO profile questionnaire and software, Terms of Reference and budgetary guidelines for partner and mentor agencies and guidelines on recruitment of core staff will be provided. Other monitoring tools developed by the project and PowerPoint presentations, as relevant, will be available for the review team. The above documents will be sent to the review team prior to the commencement of the mission. In addition, any other documents that may be requested by the review team will be made available during a briefing in Delhi by UNODC.

Mission Travel: The review should include participation of mentor agencies, partners NGOs and stakeholders. The review team will interview representatives from the competent authorities of as many of the project countries as feasible, visit at least four countries where training programmes were conducted, interview some of the participants of the training programmes especially those who underwent Training of Trainers (ToT) programmes (core staff of partner NGOs), and visit at least three sites in at least four countries where peer-led and other risk reduction interventions had been mounted. Efforts should be made to interview drug users and regular sexual partners who are beneficiaries of this project. Additionally, the team should visit the Regional Learning Centres. The review team may use questionnaires, observation and other participatory techniques to gather information with regard to both the review and the redesign of Track II of the project.

PLANNING AND IMPLEMENTATION ARRANGEMENTS

REVIEW TEAM:

The review team will receive, at the outset, a set of “basic reference documents” so as to be fully informed about the project. The review team will meet with UNODC and AusAID to understand the issues and concerns to be incorporated in the review process.

On this basis, the team will develop instruments and mechanisms to capture the widest possible information on project deliverables. This should comprise a mix of questionnaires, site visits, personal in-depth interviews, tele-communication, focus group discussions, key stakeholder meetings etc. AusAID will get de-briefed by the team before the final report is submitted. The review team will undertake missions to member countries using the above instruments to better understand the current status of the project in terms of effective operationalization.

The Project Coordinator will prepare the mission programme for the review team and provide necessary technical and administrative support. The project team will also support travel arrangements and logistic support for the review mission. The review mission shall take place from 5 March to 5 April 2006. (See annexure VI for flowchart of activities)

RE-DESIGN TEAM:

The redesign team will meet with UNODC and AusAID to understand the issues and concerns to be incorporated in the redesign process. The redesign team will give their inputs on the instruments developed by the review team. The review team will at all times work closely with the redesign team in terms of providing country specific feedback on the review and also in co-facilitating national consultations of key stakeholders who would give inputs into the review and redesign components.

The redesign team will develop instruments and mechanisms to capture the widest possible information on elements that will provide inputs for project redesign of Phase II. The redesign team will base the redesign of phase II on current country projections, plans and programme strategies analysing needs and gaps in addressing drug related HIV consequences, existing good practices emerging in SAARC countries, other donor funded activities already on ground so as to avoid duplication of scarce resources etc. The redesign team will undertake missions (individually or jointly) to member countries and co-facilitate (along with the review team member) national consultations that will contribute to preparing a Phase II document that will be country specific. The Project Coordinator will prepare the mission programme for the redesign team and provide necessary technical and administrative support. The project team will also support travel arrangements and logistic support for the redesign mission. The review mission shall take place from 5 March – 12 April 2006. (See annexure VI for flowchart of activities)

UNODC and AusAID will get de-briefed by the team before the final report is submitted.

METHODOLOGY AND SCOPE OF THE WORK

The review team should focus on crucial and strategic issues impacting project concept, design and implementation of the Fast Track of the project. Emphasis will also be laid on measuring outcomes, impact and sustainability. The review team will report on gains and adversities (in terms of “unfinished business and reasons thereof”) with possible insights on how better risk management strategies may have facilitated outcomes. The review team will ensure that lessons learned from the project will be recorded and recommendations on possible follow-up activities will be incorporated into the redesign of Track II. The review team will share findings of the review at the country level with the redesign team at all times.

The review team along with the redesign team will also carry forward the dissemination of findings of the review and redesign of Track II of the project, to key stakeholders at a regional stakeholders meeting. The redesign should include advice to the project in terms of regional as well as country-specific components and processes that will ensure ownership and scale up of the three strategic pillars of the project, i.e., capacity building, gender sensitivity and sustainability.

Independent consultants will further appraise the draft report on review and redesign, and these comments should be incorporated into a final document for presentation to UNODC and AusAID.

The final submission of the report will be made to the Peer Review Group at AusAID HQ.

PART I:

REVIEW OF THE FAST TRACK

I. Project concept and design

The consultants shall assess project strategy, approaches, design and fund flow mechanisms with special reference to the following:

1. Examine the project concept, design and operationalization in light of the available evidence of the nature of the drug/HIV situation in South Asia in 2003 and the most feasible manner of attempts to head off drug-abuse driven HIV.
2. In this context the review team should examine specifically:
 - a. The adequacy of the analysis and identification of the problem to be addressed;
 - b. The clarity, logic, and coherence of the original project design;
 - c. The relevance of the long-term objective to the prevention of drug abuse and HIV/AIDS amongst young people in South Asia;

- d. The manner in which the project addressed the problem and the strategy in terms of appropriateness and obtain ability of objectives (both immediate and long-term) and attainability of planned outputs and activities within the time frame/appointment of personnel and inputs provided in the project document
 - e. The executing modality and managerial arrangements, and the agreed prerequisites by the project partners and government counterparts;
 - f. The appropriateness of the immediate objectives to achieve the long-term objective of the project; (as compared with alternate approaches to accomplishing the same objectives) and
 - g. The relevance of the outputs to achieving the objectives.
3. On the basis of the examination the review team will document inputs, processes, outputs and outcomes both positive and negative.
 4. The review team will then comment on the understanding of, ownership, and prioritisation in response by key stakeholders to drug related HIV risks and consequences in the SAARC countries- at the local, national and regional levels.

II. Project Implementation:

The review team shall assess:

1. Whether the project strategy has been implemented as planned in the project document or it has been revised (and for what reason) during the course of the project implementation;
2. The executing and implementing modalities and managerial arrangements and its impact on program delivery issues;
3. The inputs, outputs, implementation methodologies and therefore the appropriateness of agreed prerequisites for project implementation;
4. The terms of reference, efficiency and effectiveness of project management in carrying out the activities to achieve each of the outputs;
5. The annual work plans and planned duration of the project;
6. The administrative monitoring and backstopping of the project by UNODC Headquarters, UNODC ROSA and the Government counterparts;
7. The effectiveness of the mentor and partner structure in member countries;
8. The ability of the project to meet with the emerging needs / changing trends of the problem;
9. The obstacles encountered and measures taken to overcome them;
10. The fulfilment of agreed prerequisites by the project parties and its impact on the project deliverables; and
11. Indicators utilized to verify achievements of objectives in the original project document and subsequent revisions.

III. Project Outputs, Outcome, Impact and Sustainability:

The review team shall assess the quality and quantity of outputs produced and of outputs likely to be produced, outcomes and impact achieved or expected to be achieved by the project. This should encompass an assessment of the achievement of the immediate

objectives and the contribution to attaining the objective of preventing transmission of HIV among drug users. If objectives other than these are stated in the project document, the review should also assess the achievement of these, but care should be taken to prevent the reviewers from diverting if the project has had significant unexpected effect, whether of beneficial or detrimental character. The review team should, in particular, assess:

1. The ability of the project to provide an assessment of the situation in relation to drug abuse and HIV/AIDS related vulnerabilities among drug users and their sexual partners as conceived of in the original project document;
2. The ability of the project to capacitate agencies to mount evidence-based responses to reduce risk-taking behaviour related to drug abuse and HIV/AIDS amongst these groups;
3. The ability of the project to develop networks for drug demand reduction and HIV prevention as required;
4. The ability of the project to address the gaps as assessed in the demonstration sites
5. The ability of the project to produce standardized interventions in HIV risk-reduction amongst drug users through the development and use of peer-led and other intervention toolkits to capacitate agencies to mount responses;
6. The ability of the project to achieve the immediate objectives towards attaining the long-term objective of the project;
7. The likely impact in terms of drug control and HIV prevention; and
8. The likely sustainability of project results.

VI. Findings, Lessons Learned and Recommendations

The review team shall make recommendations, as appropriate. Recommendations may also be made in respect of issues related to the execution and implementation of the project. They should constitute proposals for concrete action, which could be taken in future to improve and rectify undesired outcomes and could be included in the design of future regional projects.