Independent In-depth evaluation of the

Prevention of transmission of HIV among drug users in the SAARC countries - Phase II

RASH13
Bangladesh, Bhutan, India, Maldives, Nepal, & Sri Lanka

November 2016
This evaluation report was prepared by an evaluation team consisting of Dr. Punit Arora (team leader), Dr. Yatan Pal Singh Balhara (expert), and Emanuel Lohninger (IEU). The Independent Evaluation Unit (IEU) of the United Nations Office on Drugs and Crime (UNODC) provides normative tools, guidelines and templates to be used in the evaluation process of projects. Please find the respective tools on the IEU web site: http://www.unodc.org/unodc/en/evaluation/evaluation.html

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### GLOSSARY OF TERMS USED

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>AIIMS</td>
<td>All India Institute of Medical Sciences</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-Retroviral Treatment</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop in Centre</td>
</tr>
<tr>
<td>CLP</td>
<td>Core Learning Partnership</td>
</tr>
<tr>
<td>CND</td>
<td>The Commission on Narcotic Drugs</td>
</tr>
<tr>
<td>ECOSOC</td>
<td>Economic and Social Council</td>
</tr>
<tr>
<td>FAQs</td>
<td>Frequently asked questions</td>
</tr>
<tr>
<td>GLOG32</td>
<td>UNODC’s Global Programme on HIV/AIDS</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HRG</td>
<td>Human Rights and Gender</td>
</tr>
<tr>
<td>IBBS</td>
<td>Integrated Biological and Behavioural Surveillance</td>
</tr>
<tr>
<td>IDUs</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>MTR</td>
<td>Mid-Term Review</td>
</tr>
<tr>
<td>MMT</td>
<td>Methadone Maintenance Treatment</td>
</tr>
<tr>
<td>NA</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>NACD</td>
<td>National Authority for Combating Drugs</td>
</tr>
<tr>
<td>NASP</td>
<td>National AIDS/STD Program</td>
</tr>
<tr>
<td>NDDTC</td>
<td>National Drug Dependence Treatment Centre</td>
</tr>
<tr>
<td>NSEP</td>
<td>Needle Syringe Exchange Programme</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>OECD-DAC</td>
<td>Organisation for Economic Cooperation and Development- Development Assistance Committee</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PMU</td>
<td>Programme Management Unit</td>
</tr>
<tr>
<td>PUD</td>
<td>People Who Use Drugs</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>RP</td>
<td>Regional Programme</td>
</tr>
<tr>
<td>RSRA</td>
<td>Rapid Situation and Response Assessments</td>
</tr>
<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats Analysis</td>
</tr>
<tr>
<td>TI</td>
<td>Targeted Intervention</td>
</tr>
<tr>
<td>ToR</td>
<td>Term of References</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>UNAIDS RST</td>
<td>Joint United Nations Programme on HIV and AIDS Regional Support Team</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNEG</td>
<td>United Nations Evaluation Group</td>
</tr>
<tr>
<td>UNODC (HQ)</td>
<td>United Nations Office on Drugs and Crime (Headquarter)</td>
</tr>
<tr>
<td>UNODC ROSA</td>
<td>United Nations Office on Drugs and Crime Regional Office for South Asia</td>
</tr>
<tr>
<td>UNOIOS</td>
<td>United Nations Office of Internal Oversight Services</td>
</tr>
<tr>
<td>WHO SEARO</td>
<td>World Health Organization, South East Asia Regional Office</td>
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EXECUTIVE SUMMARY

The UNODC Regional Office for South Asia has supported a regional project titled “Prevention of transmission of HIV among Drug Users in SAARC Countries” (RASH13). The project is being implemented in partnership with the governments and civil society partners of the member countries of the SAARC region and has a total approved budget of USD 13,522,742. The project covers Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka. Its primary target group was planned to be policy makers, law enforcement officers, and NGOs working in the field of drugs and HIV/AIDS. The project also targets young drug users, who are at risk of HIV infection. The overall objective of the project is to “reduce the spread of HIV among drug using populations in SAARC countries”. This evaluation is a final in-depth evaluation and covers the entire duration of Phase II (2007-16).

This evaluation employed a mixed-method approach involving document review, surveys, interviews, archival data, training feedback, field missions, and focus groups to arrive at the following findings, conclusions, recommendations and lesson learned.

Evaluation Findings

Relevance: Addressing the problem of drug use and the implications thereof is one of the major mandates of UNODC. It is clear from desk review, survey and stakeholder consultations that the work of RASH13 is highly relevant to intended project beneficiaries as well as governments in the region. It is also clear that this work is aligned with numerous mandates, declarations, resolutions and decisions adopted by United Nations General Assembly, Economic and Social Council, Commission on Narcotic Drugs, Commission on Crime Prevention and Criminal Justice, and the UNAIDS Programme Coordinating Board. It also finds a prominent mention in the new Sustainable Development Goals. The overall objective of the project was to reduce the spread of HIV among the drug using populations in the SAARC region, which feeds directly into UNODC’s strategic objectives and outcomes as outlined in its Strategic Framework for 2016-2017, as well as with the UNAIDS Fast-Track Strategy for 2016-2021 (which acts as the umbrella for UNODC’s HIV/AIDS work).

Effectiveness: According to project documents and stakeholder consultations, policy environment and capacity of local governmental and nongovernmental organizations in the region to address the challenge of HIV/AIDS has significantly improved, RASH13 project has made an effective contribution in this improvement. Many of the interventions recommended by the project have been incorporated into national laws, which helped build the momentum towards rapid scaling of interventions. For example, Opioid Substitution Therapy has been established in 5 out of the 6 partner countries. Needle Syringe Exchange Programme and Opioid Substitution Therapy are enlisted as key services for prevention of HIV among Injecting Drugs Users in all the partner countries, and are currently being provided in India, Bangladesh, and Nepal. In India, the Methadone Maintenance Treatment, recommended by the project, has now been taken over by Ministry of Health as part of the national drug treatment programme. Further, Training provided by the RASH13 project form the backbone of national capacity-building efforts. A vast majority of the stakeholders consulted found the training to be very useful to their work. Overall, the evaluation finds that while the project has made significant strides in achieving the intended outcomes and objectives, the need to guard against premature complacency is evident.
**Efficiency:** The efficiency questions pertain to cost-effectiveness in converting inputs into outputs. All of the project’s activities were carried out on time. The project had a total pledged contribution of $13.5 million over a ten-year period from 2007 to 2016. A vast majority of the expenditure (over 90%) had been incurred by 2011 (and 97% by the end of 2012). This highlights the fact that the project has to manage its activities with very little resources over last 4-5 years. It has also had to rely on partner organizations including local governments, NGOs and other UN agencies. A majority of stakeholders commended the project for its “low cost” model, which suggests that the project managed its resources efficiently. The project also produced a large number of manuals, standard operating procedures, training guides, and other resources, which again suggests that the project managed to convert inputs into outputs rather efficiently. Lastly, it used Training-of-Trainers (ToT) approach with local trainers to a significant degree, which also helped the project keep its costs low. Thus, overall, the evaluation finds that the RASH13 project appears to have used its resources efficiently.

**Impacts:** Impacts i.e. change in beneficiary population’s situation occurs over a long time, typically 10-15 years. The RASH13 project appears to be delivering its intended outcomes. The changes are evident in the policy, legislation, and programs aimed at addressing HIV among drug users across the countries. The complex nature of the intervention, along with multiplicity of players in the field, makes it hard to quantify the impact attributable to the project, however the pivotal role played by the project in bringing out these changes is quiet evident. A review of archival data already shows a significant progress in reduction of people who inject drugs in India and Bangladesh. According to a mid-term evaluation of the National AIDS Control program, the adult HIV prevalence in India has declined from 0.38% in 2001-03 to 0.26% in 2015. There was also a 66% decline in new infections in India between 2000 and 2015. Other documents also note that the HIV epidemic in the South Asia region has witnessed a paradigm shift in terms of its nature, extent, scope and trends over the years. While the countries in the region probably deserve most of the credit for their improved environment, stakeholder consultations and documents revealed a deep appreciation for the advocacy and capacity-building work undertaken by the project.

**Sustainability:** The initiatives taken up as part of the project were introduced as pilot projects and the time-limited nature of the RASH13 warranted the need to transfer the ownership of these interventions over time. However, these have subsequently been adopted and scaled up by the governments in the region. A variety of approaches including ownership by the federal government, funding through alternative international donors, and linkage with other ongoing projects have been used to ensure the continuity of these interventions. While acknowledging the progress made in the region towards improving policy environment and addressing the challenge of HIV/AIDS, the evaluation notes the need for further support to ensure long-term sustainability of results obtained so far.

**Partnerships:** The project has been able to establish lasting meaningful partnerships with multiple stakeholders, including federal governments, non-governmental organizations, and community support groups. Through this project, agencies engaged in supply reduction as well as demand reduction activities have been brought together on a common platform. The partnerships between various stakeholders have been established at multiple levels including development of resource material, conducting the training, execution of specific interventions and advocacy activities. This has helped develop a sense of ownership among various stakeholders and this is likely to benefit the interventions in the longer run as well.

**Human & gender rights:** The project primarily targets marginalized and at-risk populations. The interventions undertaken as part of the project included provisions for male, female and transgender drug users. These interventions were mostly gender
sensitive and inclusive. Some stakeholders mentioned these interventions to be ‘the first of their kind’ for the female drug users, which helped them overcome stigma and barriers specific to them. However, given the low capacity utilization, especially by female drug users, the challenge of gender equity persists. Overall, the evaluation find the project has helped obtain satisfactory progress in advancing human and gender rights.

**Conclusions:**

The RASH13 project has made a significant contribution to tackling the challenge of HIV/AIDS among injecting drug users by deploying right strategies and building strategic partnerships with governmental and nongovernmental organizations. These approaches have helped shift the focus from law enforcement to harm reduction in the region, especially in India and Bhutan. While a significant progress has been achieved, it is too premature to get complacent. There is a clear need to persist with capacity building among a wide variety of organizations. Given the federal structure of most of the targeted countries in SAARC, there is also a need to pay attention to laws and regulations at the subnational (i.e., states/provinces) level. While most stakeholders commended the project for its “low cost” model, the project needs to continue exploring avenues for increased efficiency.

**Recommendations:**

Given its accomplishments to date, UNODC management needs to continue to focus on the critical work undertaken by the RASH13 project. While the project in its current shape is coming to an end, senior management needs to initiate its replacement at the earliest possible. The project itself, in the next phase, should focus its advocacy efforts at the subnational level. Given the resource constraints, the project may also focus greater attention to countries and states with higher HIV/AIDS prevalence, while countries and states with lower prevalence are best served by other UNODC drugs-related programmes. Further, interventions for HIV prevention among drug users should be integrated with other related and relevant infections. The project management team must also develop formal mechanisms for coordination at more regular intervals, and monitoring and evaluation systems used for reporting should more systematically collect data on outcomes.

**Lessons learned:**

The RASH13 project made a very effective use of pilot projects to demonstrate the potential for recommended interventions to succeed. While pilot projects are inherently risky and sometimes suffer from selection bias, the project team used the right strategies that should be looked at by other similar programmes and projects at the UNODC. The project was successful in building coalitions with wide variety of stakeholders, which helped it obtain a higher local buy-in and build a greater momentum for rapid scaling up, especially in India. This is once again worth a consideration for other projects that need to break through difficult deep-rooted socio-cultural barriers to change.

The summary matrix on the next page provides more specific information on findings, supporting evidence and recommendations made by the evaluation.
# SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

<table>
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<th>Findings</th>
<th>Evidence (sources that substantiate findings)</th>
<th>Recommendations</th>
</tr>
</thead>
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<tr>
<td><strong>Key recommendations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. The RASH13 project has made a significant contribution to tackling the challenge of HIV/AIDS among injecting drug users by deploying right advocacy strategies and building strategic partnerships with governmental and nongovernmental organizations. These approaches have helped shift the focus from law enforcement to harm reduction in all countries in the regions but especially in India and Bhutan.</td>
<td>Project documents, archival data, stakeholder consultations and survey responses</td>
<td>Given the resource constraints, the project may need to focus greater attention to countries and states with high HIV/AIDS prevalence, while countries and states with (very) low prevalence are best served by other UNODC drugs-related programmes.</td>
</tr>
<tr>
<td>2. While a significant progress has been achieved, it is too premature to get complacent. There is a clear need to persist with capacity building among a wide variety of organizations. There is also a strong need to be alert to changing political ideologies and coalitions.</td>
<td>Project documents, archival data, stakeholder consultations and survey responses</td>
<td>UNODC management needs to guard against premature complacency. While the project in its current ‘avatar’ is coming to an end, senior management needs to initiate its replacement at the earliest possible.</td>
</tr>
<tr>
<td>3. With some notable exceptions, the RASH13 project has so far largely focused its advocacy efforts at the level of national governments. Given the federal structure of most of the targeted countries, there is also a need to pay attention to laws and regulations at the subnational level.</td>
<td>Project documents, archival data, stakeholder consultations and survey responses</td>
<td>The project should consider focusing its advocacy efforts at the subnational level in the next phase. In addition, the project needs to conduct a detailed needs assessment to focus on those states that have a higher prevalence rates or those that have most antiquated laws and policies.</td>
</tr>
<tr>
<td>4. The project has started integrating its interventions with other major infections (e.g., hepatitis) that are highly prevalent among drug users. This is worth exploring further in future programmes.</td>
<td>Project documents and stakeholder consultations</td>
<td>The project management, in designing future interventions for HIV prevention among drug users, should also look to integrate other related and relevant infections such as Hepatitis C, Tuberculosis, and co-morbid mental disorders.</td>
</tr>
<tr>
<td>5. In some countries, the need for greater stakeholder consultations and need assessment was evident for design and execution of future</td>
<td>Stakeholder consultations and survey responses</td>
<td>The project should undertake rapid situation assessment and need evaluation exercises across various countries, which should help better</td>
</tr>
<tr>
<td></td>
<td>Projects.</td>
<td>Identify unmet needs.</td>
</tr>
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<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
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<tr>
<td>6.</td>
<td>While the project has developed an enormous amount of resource materials, there is a wide variation in its use. This may highlight the need for wider dissemination as well as follow-ups to ensure greater use.</td>
<td>The project team should develop tools (e.g., social media) for wider dissemination and feedback collection. It should also use web counters to keep track of resources that are being used (accessed, downloaded, etc.) to understand beneficiaries' needs better.</td>
</tr>
<tr>
<td>7.</td>
<td>There is a need to improve project planning and coordination mechanisms. The project has not held a steering committee meeting in over three years, which may have had a bearing on donor satisfaction as well as fund-raising performance for the project. Similarly, the extent of coordination and integration among various HIV/AIDS related projects within the UNODC is not very clear, which may once again suggest the need for better coordination.</td>
<td>The project management team should develop formal mechanisms for coordination, and then conduct meetings (in person, over phone or virtually) at regular intervals.</td>
</tr>
<tr>
<td>8.</td>
<td>While the project does a very good job of reporting its activities and outputs, there is a need to improve results-orientation in all aspects of monitoring, evaluation and reporting. Moreover, the quality of data needs to be more detailed for increasing effectiveness of decision-making.</td>
<td>The project should design and execute better monitoring and evaluation systems with a focus on outcomes data.</td>
</tr>
<tr>
<td>9.</td>
<td>The training manuals, standard operating procedures and other resource materials developed by the project needs to be subjected to higher quality control.</td>
<td>The project should build partnerships with academic and civil society organizations for peer review of resource materials.</td>
</tr>
</tbody>
</table>

**Important recommendations**

<table>
<thead>
<tr>
<th></th>
<th>Project documents, stakeholder consultations and survey responses</th>
<th>Project documents, archival data, stakeholder consultations and survey responses</th>
</tr>
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<tbody>
<tr>
<td>10.</td>
<td>Given the constraint of resources, the project needs to continue exploring avenues for increased efficiency.</td>
<td>The project team should continue to explore opportunities (e.g., eLearning) for greater efficiency in resource use.</td>
</tr>
<tr>
<td>11.</td>
<td>Given the high levels of socio-cultural diversity across the countries in the region, the IEC material may need to be developed in more languages.</td>
<td>The project should continue expanding the translation of resource materials in more national and regional languages, which should continue to be updated with the latest developments in the HIV/AIDS domain.</td>
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I. INTRODUCTION

Background and context

The UNODC Regional Office for South Asia has supported a regional project titled “Prevention of transmission of HIV among Drug Users in SAARC Countries” (RASH13) since 2003. The project is divided into 3 phases – Phase I, (December 2003 – August 2006), the extended Phase I (July 2006– June 2007) and Phase II (July 2007 - till date). The evaluation of the Phase 1 formed the basis for the design of the Phase II project design. While Phase I demonstrated the necessary components for a comprehensive HIV prevention program among drug users, Phase II aimed to provide catalytic assistance to the participating countries on the basis of gaps identified by the respective country strategic plans. Recognizing the diversity of the HIV epidemic, drug using populations and national responses in the SAARC region, the project works in each country on country-specific considerations.

Chart 1: RASH13 Programme at a glance

Source: UNODC Project documents.
The project is being implemented in partnership with the governments and civil society partners of the member countries of the SAARC region. The current phase of the project, known as the Phase II, was launched jointly with UNAIDS RST, WHO SEARO and UNODC ROSA, in July 2007. The project covers Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka. Its primary target group was planned to be policy makers, law enforcement officers, and NGOs working in the field of drugs and HIV/AIDS. The project also targets young drug users, who are at risk of HIV infection, and those already infected and affected. This evaluation is a final evaluation and covers the entire duration of Phase II (2007-16).

**RASH13 Project Objectives and outcomes**

The overall objective of the project is to "reduce the spread of HIV among drug using populations in SAARC countries". To achieve this objective, the project includes 4 main components as reproduced below:

| Overall Objective: To reduce the spread of HIV among drug using populations in SAARC countries |
| Component 1: Advocacy to support change in policy and practice |
| Component 2: Effective Risk Reduction Approaches to reduce HIV transmission among drug users especially IDU and their regular sex partners. |
| Component 3: Scaled-Up Risk Reduction Interventions to reduce HIV transmission among drug users especially IDU and their regular sex partners. |
| Component 4: Project Management. |

| Specific Objective: Ensure commitment of national authorities and development partners to scale up comprehensive HIV prevention and care programs for IDUs. |
| Specific Objective: Demonstrate the effectiveness of risk reduction approaches. |
| Specific Objective: Governments plan and implement risk reduction interventions essential to a comprehensive response to HIV prevention among drug users especially IDU and their regular sex partners. |
| Specific Objective: Effectively and efficiently manage the project and to provide monitoring, evaluation and reporting on project activities and outputs. |

After reviewing all the documents supplied by the project management, the evaluation team modified this results framework to be clearer on outcomes and results, and hence more suitable for evaluation purposes. It must be noted that this modified results framework also better complies with the UNODC and OECD-DAC terminology.

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1 Although limited activities (e.g., two study tours to India) were organized for stakeholders in Sri Lanka. As the evaluation team could not reach any stakeholder in Sri Lanka, it is generally excluded from the scope of evaluation, unless it is explicitly mentioned in the project documents.
Funding and disbursement history

Chart 2 shows the budget for the project for the period of 2007-16. As per documents reviewed by the evaluation team, the original budget and donor pledges for the programme was a little over thirteen million dollars. Australia as the principle donor was the largest contributor to the project. Sixty four per cent of pledged funding was contributed by Australia, followed by UNAIDS (14%), India (7%), Global Fund India (4%), Germany (4%), United Kingdom (4%) and Sweden (2%).

Chart 2: RASH13 budget / contributions (US $, %)

As per the latest audited statements summarized in Chart 3 below, RASH13 had a total expenditure of about 13.1 million US dollars as of December 31, 2014. Table 1 below provides a breakdown of total expenditure. As is to be expected of a programme of this nature, a majority of the expenditure was on subcontracts (52%), which was followed by personnel (14%), trainings (11%), project support costs to UNODC (11%), equipment (4%), miscellaneous (4%), and travel (4%).

<table>
<thead>
<tr>
<th>Description</th>
<th>Total expenditure by category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007-13</td>
</tr>
<tr>
<td>Travel</td>
<td>459,597</td>
</tr>
<tr>
<td>Personnel</td>
<td>1,665,445</td>
</tr>
<tr>
<td>Subcontracts</td>
<td>6,790,928</td>
</tr>
<tr>
<td>Training</td>
<td>1,477,823</td>
</tr>
<tr>
<td>Equipment</td>
<td>573,761</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>485,430</td>
</tr>
<tr>
<td>Support Costs</td>
<td>1,424,205</td>
</tr>
<tr>
<td><strong>Project Total</strong></td>
<td><strong>12,877,189</strong></td>
</tr>
</tbody>
</table>

Source: RASH13 project documents
Evaluation backdrop, purpose, and specific objectives

This mandatory final in-depth evaluation was undertaken as agreed with the donors and as planned and budgeted in the approved project document. The evaluation used a participatory approach, and aimed to examine the programmatic progress (and challenges) primarily at the outcome level, with supporting substantiation at the output level. Further, the results from this evaluation are to be used for the creation of a more conducive environment for addressing needs of people who use drugs and those affected by HIV.

As per terms of reference in Annex I (ToR), the evaluation had the following specific objectives:

- Analyse the relevance of the programmatic strategy and approaches;
- Identify strengths, weaknesses, opportunities and threats for the project; especially with regard to the extent it has supported the national governments in creating an enabling environment and removing barriers to improved scale-up of HIV prevention, treatment and care programs for people who use drugs and their partners;
- Assess the potential for sustainability of the results and the feasibility of on-going, member-state efforts in achieving optimum coverage of comprehensive HIV prevention, treatment and care services for people who use drugs and their partners;
- Document lessons learned, good practices, success stories and challenges to inform future work of various stakeholders in addressing rights based and gender sensitive
The evaluation covered the project results in six targeted member-states over the nine-year period from July 2007 to September 2016.

**Evaluation Methodology**

A team of three experts conducted this evaluation. Dr. Punit Arora was the team leader, while Dr. Yatan Pal Sigh Balhara was the subject-matter expert. Mr. Emanuel Lohninger from the Independent Evaluation Unit supported the team in field missions and quality assurance.

To meet the evaluation objectives outlined above (see also Annex I and Annex II), the evaluation team reviewed and revised the logical framework (Annex III) and evaluation questions specified in the terms of reference (Annex IV) to be more in line with the OECD-DAC guidelines on results-based management. The team devised a multi-pronged data collection methodology consisting of five data collection processes, some of which ran concurrently. Annex IV also provides data collection strategy for each question mentioned in the terms of reference.

The first process in this methodology consisted of an analysis of existing documents, including project reports, progress reports, review and evaluation reports and various technical notes and operating procedures developed by the RASH13 team. All relevant documents supplied by the project team were reviewed (See Annex V for details).

The second process involved visits to two countries that have received substantial assistance from the RASH13: Bhutan (August 18-22) and Maldives (Aug 23-25), which was in addition to field visit to India for the lead evaluator (August 16-18 and August 26-27).

The third process involved interviewing RASH13 core learning partners (Annex VI) and other stakeholders, including beneficiaries from across the region (Annex VII) over telephone and web. The interviews were generally based on the semi-structured protocols shown in Annex VIII. The evaluation team also followed up with specific questions to elicit relevant information during interviews. These interviews helped provide context and/or further elucidate on the work performed and results obtained in the region.

The fourth process involved interviews, either in person, telephonically or over the Internet, with cooperating international organizations including the project donors, UNAIDS, the World Health Organization (WHO), and such other stakeholders identified in consultation with project management team. Interview protocols used for this purpose are provided in Annex VIII. However, interviewers also used more specific follow-up questions based on the type of involvement of the interviewees with RASH13 and the interviewee's particular background. Overall, 59 stakeholders were interviewed in person and/or over phone.
The fifth process involved collection and analysis of additional data available from partner organizations. This included data from qualitative and quantitative information collected by these partners from beneficiary jurisdictions and officials.

**Chart 4. Survey Participant Information**

<table>
<thead>
<tr>
<th>4A. Sample size and response rate:</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons originally invited to participate</td>
<td>100</td>
</tr>
<tr>
<td>Invitees not reached (wrong email addresses/ vacation responses/ opt-outs)</td>
<td>11</td>
</tr>
<tr>
<td>Total eligible respondents (=100-11)</td>
<td>89</td>
</tr>
<tr>
<td>Invitations opened (i.e., links clicked)</td>
<td>57</td>
</tr>
<tr>
<td>Respondents emailing non-recall</td>
<td>5</td>
</tr>
<tr>
<td>Completed responses</td>
<td>44</td>
</tr>
<tr>
<td>Response rate (=49/89)</td>
<td>55%</td>
</tr>
</tbody>
</table>

**4B. Survey respondents (by type of assistance received):**

![Survey respondents pie chart]

**4C. Survey respondents: Demographic information**

<table>
<thead>
<tr>
<th>Gender</th>
<th>9%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>77%</td>
</tr>
<tr>
<td>Unspecified</td>
<td>14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country of residence</th>
<th>Age groups (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>Under 30 10%</td>
</tr>
<tr>
<td>Bhutan</td>
<td>31-40 48%</td>
</tr>
<tr>
<td>Others/ unspecified</td>
<td>41-50 36%</td>
</tr>
<tr>
<td></td>
<td>51-60 2%</td>
</tr>
<tr>
<td></td>
<td>Over 60 5%</td>
</tr>
</tbody>
</table>

Last but not the least, a central output of the project is the training workshops conducted by the programme. In order to measure its effectiveness, the training feedback forms collected by the project were randomly selected for review and analysis. While these feedback forms
provided information on the change in awareness, 100 trainees were randomly selected for the survey for measuring use of the training and other technical assistance received. The survey was in English and conducted via the surveying website www.surveymonkey.com. The survey questionnaires were developed on the basis of the desk review, and are included in Annex VIII. More information on sample and respondents is provided in Chart 4.

Over all, the evaluation team followed a mixed-methods approach with adequate triangulation and counterfactuals to arrive at credible, reliable and unbiased findings to the extent possible.

**Limitations**

The evaluation team must specifically note the following possible limitations:

1. While the evaluation team selected only those trainees who had participated in a training programme over last three years, even then it is possible that their responses suffered from recall issues. It was not possible to limit the sample to even shorter period given the smallness of training pool over last few years.

2. Adequate data on some of the outcomes and impacts has not been collected and the evaluation team struggled to triangulate information on some indicators. The evaluation team tried to overcome this limitation by collecting as much indicative evidence as possible (including in some cases by systematically collecting anecdotal evidence). The team also highlights limitations and suggests the need for improvement, where applicable.

3. The evaluation team had undertaken primary data collection on a very tight timeframe, and hence confronted the trade-off between wide participation and timely completion. While concerted attempts were made to interview all core-learning partners, in some cases their unavailability during data collection period necessitated for the evaluation team to take a call on their participation. In some cases, the evaluation team determined that the information was available from alternative sources and their participation was not necessary.

4. The evaluation team had to face other data constraints such as missing baseline and monitoring data. This created the need for the evaluators to retrospectively reconstruct the baseline data, which generally suffers from retrospective bias. The evaluation team tried to use triangulation and counterfactuals, as much as possible, to overcome this limitation.

5. This project has witnessed major reductions in its activities over last 3-4 years, which lead to attrition in availability, recall and interest of stakeholders. This posed challenges for the evaluation team in getting high quality, in-depth information from stakeholder consultations.
II. EVALUATION FINDINGS

In this section, the primary findings from this final evaluation of the Prevention of transmission of HIV among drug users in the SAARC countries - Phase II (RASH13) are detailed. The findings are discussed and grouped by the following OECD DAC criteria: design and relevance, efficiency, effectiveness, impact and sustainability of the project’s activities and outcomes. Additionally, partnerships, human rights mainstreaming and institutional arrangements as called for by the terms of reference for this evaluation were assessed. For each of these criteria, findings are then organized by the research questions driving the evaluation. While the findings cover all the questions asked or topics raised in terms of reference, the focus is on those issues or topics that are identified as salient from the triangulated data. This section includes a table summarizing all study findings by outcomes from the programme logframe (See Chart 8) and concludes with a SWOT analysis that provides a bird’s eye view of programme’s strengths, weaknesses, opportunities and challenges.

Design and relevance

1. How relevant is the project to beneficiaries, including governments in the region? To what extent is the project aligned with the policies and strategies of the Governments of the region in addressing HIV prevention and treatment? How has the project responded to the changing drug, HIV and related legal and policy environment to remain relevant to the needs of the beneficiaries?

➢ The agenda of the RASH13 is fully in line with UNODC mandates as well as its regional and global priorities. It is also fully aligned with the priorities and strategies of regional governments and civil society organizations. The project has been very flexible in responding to the changing needs of Member States.

Addressing the problem of drug use and the implications thereof is one of the major mandates of UNODC. HIV/ AIDS is one of the major adverse consequences associated with drug use. While HIV/ AIDS is primarily a medical condition, its ramifications extend way beyond the medical domain, as it is associated with adverse psychological, financial, occupational and social consequences. High-risk behaviors such as injecting drug use and sexual behaviors put people who use drugs (PUDs) at a greater risk of acquiring HIV/ AIDS. In fact, injecting drug users have been identified as one of the high-risk groups in the population with highest sero-positivity of HIV. The most recent estimates from the National AIDS Control Organization (NACO) of India, for example, puts the HIV prevalence among IDUs at 9.9% (second highest among high-risk groups). The high prevalence of HIV among the drug users (especially injecting drug users) also contributes to the prevalence of the HIV among general population as it gets transmitted from those with high-risk behavior to those without such behaviors.

It is clear from desk review, survey and stakeholder interviews that the work of RASH13 is highly relevant to intended project beneficiaries as well as governments in the region. It is
also clear that this work is aligned with numerous mandates, declarations, resolutions and decisions adopted by United Nations General Assembly, Economic and Social Council, Commission on Narcotic Drugs (CND), Commission on Crime Prevention and Criminal Justice (CCPCJ), and the UNAIDS Programme Coordinating Board. These mandates are reflected in the UNODC Strategic Framework 2016-2017 as well as the UNAIDS Fast-Track Strategy 2016-2021. It is also encouraging to note that the new Sustainable Development Goals and new commitments and mandates to support Member States including the April 2016 UN General Assembly Special Session on the World Drug Problem Outcome Document also reflect outcomes related to this project (Chart 5). The chart also provides an overview of some of the key recent mandates and resolutions on the subject. These mandates and resolutions show that the member-states continue to be concerned about the spread of HIV/AIDS, especially among high-risk populations such as the injecting drug users.

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ECOSOC Resolution 2004/35: Combating the spread of HIV/AIDS in criminal justice pre-trial and correctional facilities</td>
</tr>
<tr>
<td>CND Resolution 56/6 (2013): Intensifying the efforts to achieve the targets of the 2011 Political Declaration on HIV and AIDS among people who use drugs, in particular the target to reduce HIV transmission among people who inject drugs by 50 per cent by 2015</td>
</tr>
<tr>
<td>CND Resolution 54/13 (2011): Achieving zero new infections of HIV among injecting and other drug users</td>
</tr>
<tr>
<td>CND Resolution 53/9 (2010): Achieving universal access to prevention, treatment, care and support for drug users and people living with or affected by HIV</td>
</tr>
<tr>
<td>CND Resolution 51/14 (2008): Promoting coordination and alignment of decisions between the Commission on Narcotic Drugs and the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS</td>
</tr>
</tbody>
</table>

Given the high prevalence and likelihood of further spread of HIV/AIDS in the SAARC region (Chart 6), the overall objective of the project was to reduce the spread of HIV among the drug using populations in the SAARC region. This objective feeds directly into UNODC’s Strategic Framework for 2016-2017, as well as with the UNAIDS Fast-Track Strategy for 2016-2021 (which acts as the umbrella for UNODC’s HIV/AIDS work). Note also, however, that given the wide difference in prevalence rates of HIV among various countries in the region, their needs, and hence degrees of relevance of RASH13, are quite divergent. See the effectiveness and impact sections for more details.

All the stakeholders interviewed recognized the project to be relevant to their respective countries. They identified drug use and HIV/AIDS as important public health issue in their countries with an increasingly adverse impact over the past decade. While the initiatives to address the issue of HIV in general population and certain high-risk groups were in place in most of these countries, the focus on drug users (including injecting drug users) was a recent phenomenon. Moreover, the countries were yet to roll out inclusive and/or specialized services for female drug users and sexual partners of male drug users. These interviewees, as well as survey respondents, acknowledged the important role played by
the RASH13 project in bringing these issues to the attention of policymakers and civil society.

<table>
<thead>
<tr>
<th>Country</th>
<th>Prevalence rate</th>
<th>Year</th>
<th>Method</th>
<th>Source</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>5.3%</td>
<td>2011</td>
<td>Seroprevalence study</td>
<td>National HIV Serological Surveillance, 2011 Bangladesh. 9th Round Technical Report. National AIDS/STD Program (NASP), Directorate General of Health Services. Ministry of Health and Family Welfare</td>
<td>HIV prevalence in Dhaka reported, as this is where most PWID reside. PWID defined as those who were primarily injectors and had injected in the previous year</td>
</tr>
<tr>
<td>Bhutan</td>
<td>No data available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>0%</td>
<td>2009</td>
<td>Seroprevalence study</td>
<td>UNAIDS Country Progress Report</td>
<td>Zero HIV infections among 276 PWID tested</td>
</tr>
<tr>
<td>Nepal</td>
<td>4.6 to 8.1%</td>
<td>2011/12</td>
<td>Seroprevalence study</td>
<td>Factsheet N 7: HIV Surveillance in Nepal, 2013. Government of Nepal, Ministry of Health and Population, National Centre for AIDS and HIV Control.</td>
<td>Range is a reflection of the results of 4 IBBS studies conducted in 2011 (Katmandu, 6.3% and Pokhara, 4.6%) and 2012 (Eastern Terai, 8.1% and Western Terai, 5%)</td>
</tr>
</tbody>
</table>

Source: UNODC Database available at [https://data.unodc.org/#state:3](https://data.unodc.org/#state:3)

Further, the interviewees identified that certain components of the project (such as Needle Syringe Exchange, Peer Led Interventions) were well synchronized with the ongoing efforts in the country and helped strengthen the same further. More importantly, the project was instrumental in introducing certain initiatives (such as Opioid Substitution Therapy (OST), interventions for female drug users) aimed at addressing HIV among drug users for the first time in these countries. While the interventions offered through the project have been explored for their effectiveness in other countries and regions of the world, there was limited evidence for their feasibility and effectiveness in the SAARC countries. The project
not only helped initiate these services and interventions in the SAARC countries, but also helped explore their feasibility and effectiveness.

The advocacy efforts undertaken as part of the project were identified as ‘much needed’ by a vast majority of interviewees as these countries were yet to formulate a comprehensive policy and programme to address drug use at the inception of the project. The unease among policymakers about the relevance and feasibility of these initiatives did not help the cause as the respondents reported that this often meant limited resource allocation for such efforts and barriers to its delivery. Exposure to the already established and operational services aimed at prevention of HIV among drug users during the study tours to other countries were reported as ‘much needed’ to help overcome these deep-rooted suspicions, which helped change the mindset from crime prevention to harm reduction.

These initiatives were reported to be relevant even in countries that already had some systems in place for addressing drug use and HIV. The interviewees reported that ‘in spite of many players in this area there was little coordination’ that often led to fragmented service delivery, lack of continuity of care and even duplication of services. The limited capacity of the countries in the SAARC region on rolling out various components of services for drug users required initiatives at developing trained human resources, development of training resource material, dissemination of these resources and opportunities to acquire the necessary skills. The project included components that catered to these needs.

Apart from the technical expertise on addressing the issue of HIV among drug users, most of the countries in the SAARC region had limited financial resources identified and allocated for this area. Provisions were made in the project for financial resources for establishment of infrastructure, setting up of interventions and services, etc. that helped in the execution.

Most of the countries in the SAARC region were in a transition phase with regards to the policy on drug use during the period 2007-2016. Certain components of the project helped execute the domains identified in the existing policy on drug use in these countries. Moreover, initiatives undertaken as part of the project shaped the policy on drugs across many of these countries. These initiatives and their outcomes are further detailed and discussed in the effectiveness section.

Lastly, training and capacity building of law enforcement, health, policymakers, advocacy and other civil society organizations has been an important component of this project. Most of stakeholders interviewed and surveyed recognized the relevance and importance of these trainings in building capacity of their personnel. Both national focal points and trainees themselves acknowledged the important role RASH13 had played in helping their institutions learn about the important developments in their respective domains. A review of survey responses on the concepts learned by trainees is presented in Chart 6 below. These responses are presented with the help of two figures. The top panel shows a “word cloud” i.e. text analysis of key words using an automated software (www.wordcloud.com). The larger the size of the text in the word cloud, the higher is its prominence (i.e. frequency) in responses. The bottom panel presents coding and classifying responses in appropriate categories chosen after reviewing the responses as well as word clouds. From Chart 7, it is readily apparent that a vast majority of the respondents reported learning new concepts and skills, generally pertaining to harm reduction and drug dependence strategies such as
those relating to OST and peer-lead interventions. Interestingly, many respondents also learned about other prominent diseases (e.g., hepatitis) that are associated with drug use.

Chart 7. Self-cited learning from the training

This was also a recurring theme in stakeholder interviews, where almost everyone suggested need for even more training and other technical assistance. Thus, both in terms of intended design and actual practice, the evaluation finds RASH13 to be highly relevant to
fulfilling the mandates of UNODC, as well as for success of member-states in overcoming the challenge of HIV/AIDS in the region. Stakeholders, who were interviewed in person or focus groups meetings, also confirmed that the project has been very responsive to their changing needs. This was also confirmed from the project documents that showed, for example, that when the project learned about the need to include other diseases such as hepatitis that were gaining in prominence, the project made attempts to incorporate these in the training programs and materials.

Hence, the evaluation notes that the project objectives continue to be consistent with beneficiaries’ requirements and country needs, as well as with UNODC’s mandates and global priorities in the area of HIV/AIDS. It has been closely associated with key developments in national programming that support harm reduction approaches to HIV prevention among drug users and evidence-based drug treatment in each country. Further, the project also has been reasonably flexible, within the limits of its own mandates, in responding to the changing environment.

2. To what extent is the project aligned with the policies and strategies of the Global Programme on HIV/AIDS (GLOG32)?

- While the project design for RASH13 is completely aligned with the UNODC’s Global Programme on HIV/AIDS (GLOG32), there may be a need for better coordination between the two programmes in practice.

UNAIDS and UNODC estimate that around 12 million people in 151 countries inject drugs. Of these, an estimated 1.7 million are infected with HIV. Around 10% (30%, if sub-Saharan Africa is excluded) of global HIV infections are due to unsafe injecting drug use. Further, the prevalence of HIV, sexually transmitted infections, hepatitis B and C viruses and tuberculosis among prison populations is 2 to 10 times higher than in the general populations.

As a co-sponsor of the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNODC is the convening agency and its global HIV programme (GLOG32) is one of main tools for UNODC’s work on HIV prevention, treatment, care and support among people who use drugs and ensures access to comprehensive HIV services for people in prisons. The global programme is expected to support both governments and civil society organisations in implementing large-scale and wide-ranging evidence-informed and human rights-based interventions.

Through global, regional and country-specific programmes, UNODC seeks to “end the AIDS epidemic as a public health threat among people who use drugs and people in prisons by 2030”\(^2\). GLO/G32, in particular, targets support to countries in sub-Saharan Africa (West and Central Africa, eastern Africa, southern Africa), Middle East and North Africa, Eastern Europe and Central Asia, South Asia and South East Asia. RASH13 project, thus, fits in perfectly in this larger picture. GLO/G32 targets its technical assistance on advocating for a comprehensive intervention package, supporting up-to-date legislation, policies and practices, mainstreaming gender responsive services, meaningfully involving civil society and other key stakeholders, and supporting countries in continuing the services during

humanitarian emergencies. All of these intervention components are also prominently incorporated in the RASH13 project design. Thus, in terms of research design, RASH13 is in alignment with the GLO/G32. In addition to document review, field mission, surveys, interviews and focus group discussions all confirmed this finding.

That said, stakeholder interviews also revealed that the communication and interaction between the two interventions was rather infrequent. While this provided RASH13 with greater flexibility to adapt to regional needs, the potential downside was lack of coordination and exchange of knowledge and resources among the programmes. Periodic reports appears to have been the main mechanisms for monitoring progress, but the two interventions could have potentially reaped greater synergistic benefits by setting up explicit mechanisms for greater coordination and more frequent interactions.

Overall, the evaluation notes that while the achievement of objectives and outcomes by the RASH13 project feeds directly into the success of GLOG32, opportunities for better coordination could and should be explored.

3. To what extent are the outputs, outcomes and objectives of this project relevant to implementing the Sustainable Development Goals?

- Yes. Multiple sources reveal a strong relevance of the outputs, outcomes and objectives of this project to implementing the Sustainable Development Goals.

Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly in September 2015 provide a plan of action for people, planet and prosperity to be implemented over the next 15 years. UNODC’s HIV work is in direct alignment with the SDG target 3.3, which calls for ending the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases by 2030. To achieve this target, the Fast-Track Strategy 2016-2021 adopted by the UNAIDS seeks for a 75 per cent reduction of new HIV infections including among people who inject drugs by 2020.

While the SDGs were adopted towards the end of the RASH13 project, the project fits well with the objectives and outcomes outlined as a part of the SDGs. In addition to advocacy and technical assistance for modernizing legislation by incorporating evidence-based interventions, the project also focuses on creating awareness among various stakeholders, strengthening the prevention and treatment of substance abuse (including narcotic drug abuse), reduction of premature mortality from non-communicable disease by one-third, and increased health financing and the recruitment, development, training and retention of the health workforce in developing countries. Similarly, the project also develops and disseminates resource materials such as manuals and standard operating procedures for use by various government and civil society organizations, including law enforcement and health professionals. These resources have been made available to relevant stakeholders in multiple local languages. Stakeholder interviews, survey responses, focus group discussions and project documents all confirmed that the work being undertaken by the RASH13

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4: Some other SDGs, particularly 5, 10, 16 and 17, are also very closely linked to the AIDS response.
FINDINGS

project was highly relevant to the needs of the stakeholders supported. Hence, the evaluation finds the RASH13 project to be in alignment with the SDGs.

**Effectiveness**

4. To what extent were the planned objectives and outcomes in the project document achieved? What was not achieved in full and why? What are the project’s unintended positive and negative results beyond those envisaged in the project logframe? During implementation of the project, to what extent were potential gaps in the respective national drug and HIV countries programme identified and addressed? To what extent did the project/programme implement recommendations of relevant previous evaluation(s) and reviews?

- The RASH13 project has largely been successful in achieving its stated outcomes. While it is hard to quantify the extent to which project has contributed to the achievement of objectives (i.e., impacts), given the (small) size of the project and multiplicity of players in the field, it is fair to say that the project made a substantial contribution.

For a programme like RASH13 to be effective in achieving its results, it needs to accomplish a series of outcomes, which are a bit like building blocks of progress in a cyclical loop. As Chart 8 below shows, the project needs to work towards a comprehensive intervention ranging from researching effective interventions and advocating norms and standards to providing support to policy-making and building capacity of various governmental agencies and nongovernmental beneficiaries. The first step for the RASH13 is to advocate for evidence-based policy, which is then used widely by the project’s intended beneficiaries and potential partners.

The second step is to leverage those partnerships to remove stigma and overcome barriers to interventions, both in terms of changes to legislations and policies as well as in the capacity of those institutions to respond to their unique local challenges. Once interventions have been piloted and tested, they need to be adopted and used extensively. The experience from these interventions, then, feeds into the next round of policy research.

As mentioned in the methodology section, the evaluation team revised the project’s results framework (Annex III) to be more evaluable in terms of outcomes. Chart 9 provides a summary of expected and actual outcomes. It also mentions the outputs that contributed to achievement of these outcomes. Below the evaluation notes some of the major outcomes accomplished through the RASH13 project.

**Chart 8: RASH13 Programme Intervention Design**
The RASH13 project played an important role in this change in policy environment. Advocacy work undertaken by the project, in combination with capacity and coalition building, created conditions conducive to widespread acceptance of interventions outlined below. According to project documents, stakeholder interviews and archival information available from national counterparts, Opioid Substitution Therapy has been established in 6 out of the 7 partner countries (Bangladesh, Bhutan, India, Nepal, Maldives and Pakistan). In 2015, the Royal Government of Bhutan launched its first ever OST programme for opioid dependence using Buprenorphine. Needle syringe programme, Voluntary HIV testing, anti retro viral therapy for those infected with HIV, STI diagnosis and treatment and condom promotion have been approved as essential services for prevention, treatment and care of HIV. Needle Syringe Exchange Programme (NSEP) and Opioid Substitution Therapy (OST) are enlisted as key services for prevention of HIV among IDUs in all the partner countries and is currently being provided in India, Bangladesh, and Nepal. OST (Methadone) is available in Maldives as a drug treatment option not only for IDUs, but also for all opioid users. In India, the Methadone Maintenance Treatment (MMT) initiated in partnership with the National Drug Dependence Treatment Centre (NDDTC) at All India Institute of Medical Sciences (AIIMS) has now been taken over by Ministry of Health, Government of India as part of the national drug treatment programme.

Similarly, people who use drugs, especially those through the injecting route and their sex partners have been recognized as key affected populations and included in the national HIV prevention treatment and care strategy documents in all the seven partner countries. The project is now also bringing attention to the need for incorporating Hepatitis C prevention and treatment and care services. It has developed a 'Z card' to help generate awareness on

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5 Technical assistance to Pakistan, one of the targeted countries early on, is now managed separately under a different project.
Regional as well as country-specific advocacy strategies have been put in place in Bangladesh, Bhutan, India, Maldives, Nepal, and Pakistan. While the regional advocacy strategy has been endorsed by the project steering committee, the advocacy strategies for individual countries have been endorsed by relevant government agencies. The project was successful in facilitating evidence-based programming by undertaking a baseline and an end line Rapid Situation and Response Assessments (RSRA) each in India, Bangladesh, Pakistan, Bhutan and Sri Lanka. These RSRA’s were the first ever to assess the needs of female drugs users and female sex partners of male drug users in the region.

Bangladesh, India, Nepal and Pakistan have Needle Syringe, Methadone (Buprenorphine in India) and condoms in their National HIV procurement plans. Maldives has been procuring Methadone through the national plan. Bhutan has currently made the necessary modifications to procure buprenorphine through its national plan.

Further, the project focused a significant proportion of its activities on establishing effective management structures for developing local leadership, advocacy, and the establishment of demonstration sites. Country Support Units were established in Pakistan, Sri Lanka and Nepal, and an alternative support structure was developed in Bangladesh. In the area of advocacy, Advocacy Strategies have been successfully developed in all countries, along with detailed rollout plans. Access to improved data on drug use and HIV has been developed through RSRA’s in Pakistan, Sri Lanka, Bangladesh and Bhutan. Demonstration sites are operational in all countries and the project has provided extensive training opportunities to implementing partners and key stakeholders. Stakeholders are closely involved in planning project activities in all countries.

**Chart 9. Expected and actual outcomes**

<table>
<thead>
<tr>
<th>Expected outcomes</th>
<th>Actual results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Increase in consensus on recommended elements and targeted for the intended beneficiaries</td>
<td>All six countries in the region have made considerable progress in moving from law enforcement to harm reduction approach. OST has been established in 6 out of the 7 partner countries. Needle Syringe exchange programme and OST are enlisted as key services for prevention of HIV among IDUs in all the partner countries, and is currently being provided in India, Bhutan, Bangladesh, and Nepal. It is also available in Maldives as a drug treatment option (although there are some worrying signs on policy reversals in this case). In India, the MMT has now been taken over by Ministry of Health, Government of India as part of the national drug treatment programme. All of these indicators show increased consensus on the evidence-based HIV agenda.</td>
</tr>
<tr>
<td>1.2 Increased number of national authorities and development partners that adopt and scale up comprehensive HIV prevention and care programs for IDUs.</td>
<td>4 countries (India, Sri Lanka, Bhutan and Maldives) have modified the legislations and 2 countries (Nepal and Bangladesh) have changed policies without changing the legal framework to incorporate harm reduction as a normal response. All 6 countries have by and large adopted RASH13 recommendations. As noted in the partnerships section, the project is also working with several partners to</td>
</tr>
<tr>
<td>Expected outcomes</td>
<td>Actual results</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>gain greater acceptance for the harm reduction agenda. All 6 countries have adopted drug substitution therapy and needle exchange programs as part of the national response. Further, India and Bhutan have significantly scaled up programmes, although progress in Maldives seems to have slowed down a bit of late.</td>
<td></td>
</tr>
<tr>
<td>1.3 Increase in awareness and/or knowledge on issues of concern to the project and its beneficiaries</td>
<td>Stakeholder consultations, including surveys, showed a significant improvement in awareness, although project activities seem to have tapered off a bit over last 2-3 years.</td>
</tr>
<tr>
<td>1.4 Increase in advocacy by supported stakeholders</td>
<td>Stakeholder consultations and desk review revealed a broad consensus on harm reduction agenda, especially in India and Bhutan. Because of frequent regime changes in Nepal and Maldives, the trends are not very clear. No clear information was available on Bangladesh and Sri Lanka (due to limited stakeholder consultations).</td>
</tr>
<tr>
<td>1.5 Use of training by targeted law enforcement officials</td>
<td>Stakeholder consultations, and especially surveys, showed that trained officials were putting their knowledge to good use. However, the magnitude of officials that still needed to be trained remains significant across all countries. The efforts to have a direct and meaningful dialogue between the demand reduction and supply reduction agencies have been achieved by integration of these two components under same authority (BNCA) in Bhutan. The project was instrumental in BNCA’s initiatives for drug users in the country following the initial years of its inception. Over the last few years the government of Bhutan has entrusted BNCA with the responsibility of both demand reduction and supply reduction. This shall help the issue of drug use comprehensively in the country. Establishing a synchronized system for drug demand reduction and supply reduction remains a challenge in many countries as the two are addressed by two separate agencies with well-defined (and mutually isolated) mandate.</td>
</tr>
<tr>
<td>2.1 Increase in use of translated and localized training modules, standards and guidelines by targeted countries and stakeholders</td>
<td>All targeted countries and most of the partners and other stakeholders reported using training modules, standards and guidelines. Some of the resource material has been adopted as part of the national program in Bhutan and India after certain modifications. However, in other countries only a limited number of these resources were being used, and it appeared that awareness of other resources could be enhanced.</td>
</tr>
<tr>
<td>2.2 Increase in number of targeted beneficiaries assisted by trained NGO staff and volunteers</td>
<td>There has been a substantial increase in number of beneficiaries assisted by trained NGO staff and volunteers, especially in India and Bhutan. The learning from the project has also helped these organizations successfully secure funding from other donors to execute other projects for drug users. In Maldives, for some reasons, these numbers seem to be in decline and may need further monitoring.</td>
</tr>
<tr>
<td>2.3 Increase in use of the “comprehensive community based approach” advocated by RASH13</td>
<td>There has been some progress in all 6 countries in using comprehensive community based approach. In India, the interventions established as part of the project (OST) have been taken up by the federal government and have been scaled up across the country. These demonstration sites</td>
</tr>
</tbody>
</table>
## Expected outcomes vs Actual results

<table>
<thead>
<tr>
<th>Findings</th>
<th>Actual outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Expected outcomes</td>
<td>have served as sites for study tours for stakeholders from other parts of India as well as other countries like Bhutan and Sri Lanka. The demonstration sites have served as learning centers during scale up of OST services across India. Linkages have been established between the demonstration sites, regional learning centers, governmental agencies (Ministry of Health, ministry of Social Justice and Empowerment) and other international donor agencies. In Bhutan, the BNCA has been mandated with the responsibility to be the central agency for demand reduction and supply reduction. It continues to administer and execute various interventions for drug users across the country as part of the “comprehensive community based approach”.</td>
</tr>
<tr>
<td>2.5 Establishment of National and Regional Learning Centres with the support of RASH13</td>
<td>The extent to which National and Regional Learning Centres have been established is not clear, although several institutions such as AIIMS in India and icddrb in Bangladesh have been conducting research on the effectiveness of various interventions.</td>
</tr>
<tr>
<td>2.6 Increase in number of governmental and Non Governmental Organisations that use rigorous Monitoring and Evaluation</td>
<td>A noticeable progress in use of M&amp;E by governmental and Non-Governmental Organisations has been observed. Most recently, India carried out a mid-term evaluation of its National AIDS Control Programme, and this evaluation included indicators on HIV and drug use.</td>
</tr>
<tr>
<td>2.7 Identified NGOs that use recommended transition plans and exit strategies</td>
<td>The project has supported several NGOs such as HIV/AIDS Alliance in India, Journey in Maldives, and Youth Development Forum in Bhutan. Detailed information on development and use of transition plans and exit strategies is not available. The civil society organizations engaged in advocacy and delivery of project interventions for PUD and PLHA. These have been able to secure funding from other donor agencies as well as federal government. In the Maldives the civil society organization ‘Journey’ was key player in rolling out the interventions under the project. It continues to be the leading non-government organization in the country that works with drug users. Another civil society organization “SHE”, however, has gradually phased out as it has identified other priority areas.</td>
</tr>
<tr>
<td>3.1 Increase in number of governments that plan and implement risk reduction interventions essential to a comprehensive response to HIV prevention among drug users especially IDU and their regular sex partners</td>
<td>All 6 countries have initiated harm reduction interventions. India, Bhutan and Bangladesh seemed to have made the most progress in scaling up these interventions. In India it has been scaled up at the national level as part of the national program on prevention of HIV/ AIDS. In Bhutan the project introduced the interventions for prevention of HIV among drug users and their sexual partners and the federal government continues to deliver these services with plan to scale it up further. In Bangladesh and Maldives the interventions initiated at part of the project are being continued with support from the government. In Nepal the interventions initiated under project are being supported by other donor agencies with...</td>
</tr>
</tbody>
</table>
### Expected outcomes vs. Actual results

<table>
<thead>
<tr>
<th>Expected outcomes</th>
<th>Actual results</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2 Increase in number of governmental and Non Governmental Organisations that use secure commodities supplied or identified by the project</td>
<td>The project has introduced/ strengthened OST, NSEP and peer led interventions across the SAARC countries. The OST, NSEP and peer led interventions continue to be used in a scaled up manner in India. OST and peer led interventions are being used in a scaled up manner in Bhutan and Nepal. The OST and peer led interventions are being used in Bangladesh and Maldives. The IEC material aimed at prevention of HIV among drug users is being used across all the countries (either adopted or adapted). Additionally, resource material such as treatment guidelines, manuals, SOPs is also being used across the countries (either adopted or adapted). The project has helped establish mechanism and system to procure medicines for the OST and MMT programme in Bhutan and Maldives that is being followed currently.</td>
</tr>
<tr>
<td>4.1 Detailed regional and national project operational plans are endorsed by governments, civil society, drug user communities, UN partners and other key stakeholders</td>
<td>The project has been gradually tapering off over last few years, and no steering committee meetings have been held over last 3 years. Hence, it is not clear how many, if any, governmental and non-governmental stakeholders have endorsed operational plans for the RASH13 project. The intervention introduced as part of project in India (OST) has been endorsed and adopted by the federal government and has been scaled up as part of the national programme for HIV/ AIDS prevention. The drug using community across the country is utilizing these services. On of the models of delivery of OST in India (the GO- NGO model) links up government and the civil society organization in delivery of these interventions. In Bhutan, BNCA is coordinating various activities aimed at drug use prevention. This includes the interventions initiated as part of the project. The civil society organizations (YDF) are important stakeholders in these initiatives and the drug using community is utilizing the services. The federal government and civil society organization continue to roll out interventions for drug users in Maldives. In Bangladesh, the federal government has endorsed the MMT programme, the services of which are being utilized by the drug using community.</td>
</tr>
<tr>
<td>4.2 Increase in stakeholder satisfaction with the management and coordination arrangements at the regional and national level</td>
<td></td>
</tr>
<tr>
<td>4.3 Increase in stakeholder satisfaction with the monitoring and reporting arrangements deployed by the project</td>
<td>Adequate information to determine stakeholder satisfaction with the monitoring and reporting arrangements is not available. Further, the evaluation finds that the M&amp;E systems used by the RASH13 project could have been more systematic, detailed and results-oriented. Most of the annual progress reports did a good job of reporting activities and outputs, but not so much on outcomes.</td>
</tr>
</tbody>
</table>

### Capacity-building

Training and associated resources form the backbone of the work carried out by the RASH13 project. Given its criticality to achievement of project’s objectives and outcomes, the evaluation conducted an online survey of trainees. The results from this survey were triangulated against data collected from other sources, which included analysis of feedback.
forms submitted at the training sessions, stakeholder interviews over phone and in person, and focus group discussions.

A vast majority of the stakeholders consulted found the training to be very helpful to their work. The evaluation team reviewed the feedback forms and tests administered at five (5) recent trainings organized by the project, and this review indicated that trainees were very content with the training provided to them. This was also confirmed during stakeholder interviews and discussions. Most trainees and their managers expressed complete satisfaction with the content of training, and in most cases expressed their desire for addition of even more training courses. Further, a review of tests administered at these trainings indicated a significant improvement (19% on an average) in their knowledge as a result of the training (Chart 10).

<table>
<thead>
<tr>
<th>Training event</th>
<th>N</th>
<th>Pre-training</th>
<th>Post-training</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project managers Training-of-Trainers (ToT)</td>
<td>32</td>
<td>9.60</td>
<td>11.55</td>
<td>20.31%</td>
</tr>
<tr>
<td>Comorbidity ToT</td>
<td>25</td>
<td>9.11</td>
<td>11.50</td>
<td>26.23%</td>
</tr>
<tr>
<td>PE ToT</td>
<td>30</td>
<td>13.30</td>
<td>14.70</td>
<td>10.53%</td>
</tr>
<tr>
<td>ORW ToT</td>
<td>32</td>
<td>63.33</td>
<td>82.88</td>
<td>30.87%</td>
</tr>
<tr>
<td>Clinical staff</td>
<td>26</td>
<td>9.01</td>
<td>9.73</td>
<td>7.99%</td>
</tr>
<tr>
<td><strong>Total # of trainees</strong></td>
<td></td>
<td><strong>145</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weighted average improvement</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>19.43%</strong></td>
</tr>
</tbody>
</table>

Source: Project documents/ Tests administered at the training

Chart 11 below captures the perception of trainees on the strengths of the trainings. It is clear from their responses that they considered training methodologies (32%), trainers (32%) and content of the training (20%) to be the major strengths of the training. Some respondents listed multiple strengths in a single response. A typical response was along the lines of “very informative training”, “trainers facilitated each training session using appropriate training methodology and involving every participant for imparting adequate knowledge and training skills”, or “very effective use of training material especially animations and use of multimedia.” These responses indicated a high degree of satisfaction with the trainings provided.

| Chart 11. Strengths of trainings as perceived by the trainees |
While expertise of the trainers was identified as the most common uniqueness of the training workshops, the focus of the training workshops was cited as the second unique feature of the same (Chart 12). The resource material used for these training workshops was also identified as one of the unique features of the training workshops. Typical responses to this question were along the lines of "all participants had the opportunity to
freely discuss issues because of the environment created by the trainer”, “UNODC is the best … It used renowned resource persons”, and “enthusiastic trainer who encouraged trainees”. These responses once again highlighted the deep satisfaction with trainers hired by the project.

Chart 12. Perceived uniqueness of training

Stakeholder interviews also highlighted the close working relationship between UNODC and law enforcement agencies as one of the major strengths and uniqueness of the training provided. This close relationship helped RASH13 in convincing these critical stakeholders to switch focus from law enforcement to harm reduction.

Chart 13. A snapshot of training and its use by the RASH13 beneficiaries
In terms of suggested improvements (Chart 14) to the training, there were no clear observable trends. The most common suggestion (22%) pertained to the training duration, but some respondents suggested longer training while others suggested shorter duration.
Other more observable suggestions pertain to training location and facilities or localization of resource material. Most of these improvements were in the nature of requests for more trainings, material or resources. These findings were also corroborated by the interviews and post-training feedback forms examined by the evaluation team.

For a training to make a difference and contribute to larger impacts, it must be used on a regular basis. Therefore, the survey asked the trainees if and how they had used their newly acquired knowledge (Chart 15). Their responses indicated that a vast majority of them (all but 2%) had been using their training for various purposes, which was widely divergent given the variety of organizations and professions these had been arranged for. Almost a third of the respondents reported that they were using the learning from their trainings to
train others. Use of the learning for patient care and advocacy purposes were other common responses in the survey. Typical responses included sentences such as “I used the training for capacity building among IDU staff”, “I have given training to my staff at TI level”, or “it helped me think of better options for opioid dependent clients”.

The survey respondents were also asked to opine regarding other resource materials such as training manuals, standard operating procedures (SOPs), guidelines, notes and other published resources developed by the RASH13 project. A vast majority of the respondents rated these published resources highly (5 or higher on a 7-point scale) with regards to their usefulness, depth of research, relevance, ease of understanding, localization and timeliness (Chart 16). These resources were identified to be up-to-date with current information and relevant to local needs. These findings were similarly corroborated in the stakeholder consultations, although there was some variation in knowledge and use of resource materials. A majority of stakeholders in the interviews exhibited knowledge of a few popular SOPs and manuals, and were not really aware of others. While it is somewhat to be
expected given the vastness of resource materials produced by the project, it also indicated (as was also highlighted during the mid-term review of the project) the need for wider dissemination among relevant stakeholders.

**Chart 16. Survey respondents’ opinion on other RASH13 outputs (e.g., manuals)**

The survey respondents were also asked about what their respective countries needed the most. This question on need assessment aimed at understanding whether the RASH13 project was focusing on the right outcomes. As Chart 17 shows, respondents felt that there was a need for far greater capacity-building efforts. This finding was also confirmed in other stakeholder consultations. For example, interviewees in Bhutan mentioned that only a limited number of health care professionals (3 psychiatrists and 1-2 support staff) in Thimphu had yet received the training, and there was a need to train many others around the country. This was more apparent from the interviews in India, where despite the availability of local capacity, the sheer size of the country (and problem of “contained epidemic” as some interviewees put it) makes the need for further training that much more imperative.

Surprisingly, need for advocacy did not feature that prominently either in surveys or interviews. This could be either due to the fact that people who were interviewed were already well-versed in the HIV issue or the fact that a decade of advocacy by a variety of organizations has already raised to a significant extent.

**Chart 17. Country need assessment by the survey Respondents**
Echoing these findings, stakeholders’ recommendations (Chart 18) for future programming mostly included requests for more training; including for refreshers, follow-ups and supplementary materials in more geographically-dispersed locations. Some of them also recommended for local adaptation of trainings as well as resource material developed by the project. All of these suggestions, further confirmed in stakeholder consultations, were in the nature of further development of training and resource materials. Taking all of the above information into account, the evaluation finds that the RASH13 project has made an effective contribution to capacity building in targeted countries.

5. During implementation of the project, to what extent were potential gaps in the respective national drug and HIV countries programme identified and addressed? To
what extent did the project/programme implement recommendations of relevant previous evaluation(s)?

- The project has made considerable progress in addressing the gaps raised by the 2010 review. The evaluation notes some other issues to consider for the next programming cycle.

The 2010 Mid-Term Review (MTR) had identified following “gaps” (i.e., concerns):

a. Increased health, rather than law enforcement, focus in some countries;
b. Translating advocacy strategy into tangible policy outcomes, especially on incorporating key elements of the comprehensive package such as MMT or NSP, especially in Bangladesh and Bhutan;
c. More ambitious targets for clients accessing OST;
d. Wider dissemination of toolkits beyond the direct project partners, including if necessary, by greater translation into local languages;
e. Lesser prohibitive restrictions on access to MMT at some sites, more uniform understanding among implementing partners, and more progress on sustainability of project activities;
f. Advocating more stable institutional arrangements in countries such as Maldives.

The stakeholder consultations revealed a substantial progress in overcoming many of these concerns. As mentioned at the beginning of this section (Refer back also to the Chart 8 that compares expected and actual outcomes realized through the RASH13 project), Bhutan has already incorporated all the elements of an effective health-focused oriented policy that the MTR recommended (Charts 19 & 20). In addition to expanded drug dependence treatment and rehabilitation services and risk reduction provided at the Drop in Centers (DIC), it has also incorporated OST at one center. However, the utilization of these services remains low and is something to look into.

<table>
<thead>
<tr>
<th>Country</th>
<th>NSP (No. of sites)</th>
<th>OST (No. of sites)</th>
<th>ART for PLHIV</th>
<th>Condom use among PWIDs (with regular sex partner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>88</td>
<td>3 sites</td>
<td>48%</td>
<td>31%</td>
</tr>
<tr>
<td>Bhutan</td>
<td>NA</td>
<td>1 site (Buprenorphine)</td>
<td>16.7%</td>
<td>53.7%</td>
</tr>
<tr>
<td>India</td>
<td>266 sites: 12 million syringes and 17 million needles distributed</td>
<td>208 sites (Buprenorphine and Methadone)</td>
<td>79.6%</td>
<td>41%</td>
</tr>
<tr>
<td>Maldives</td>
<td>NA</td>
<td>1 site (Methadone)</td>
<td>81.7%</td>
<td>NA</td>
</tr>
<tr>
<td>Nepal</td>
<td>40 sites</td>
<td>16 sites</td>
<td>21.8%</td>
<td>46.5%</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

ART: Anti-Retroviral Therapy; PLHIV: Persons Living with the HIV; NSP: National Strategic Plan; NA: Not Applicable.

Similarly, stakeholder interviews suggested that Bangladesh was one of the first countries in South Asia to adopt the harm reduction approach (although its legislation had not formally been modified to accommodate this new approach), and three centres in the country were providing OST treatment.

The RASH13 project has probably witnessed the greatest success in India. Some interviewees suggested that government’s adoption of RASH13 recommendations as a “normal activity” seems to have been its most important success. Most of the project’s recommendations have been incorporated into legislation, policy and practice. Hence, unsurprisingly, the number of OST centres in India went up from 193 in March 2015 to 212

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as of March 2016, where an estimated 23,077 Injecting Drug Users (IDUs) — 64% of targeted 35,000 — were accessing these services.

Chart 19 highlights some of the achievements in adopting harm reduction approaches in the region. While it is difficult to quantify the extent of the role played by the RASH13 project given the multiplicity of players involved, it is fair to say that it at least made a significant contribution to improving the HIV/AIDS response in the region. It probably played even bigger role in advocating for injecting drug users, a high-risk group, in this context.

MTR had raised the issue of expanding access to OST services; however, it still continues to be an issue, especially in Maldives, but also in other countries. Stakeholder consultations suggested that it could be due to limited requirement, limited felt need, inadequate awareness, or persistence of stigma. Given the lack of clarity on reasons, the project may need to conduct a follow-up situation analysis with concerned stakeholders. The project had conducted need assessment for prevention of HIV among drug users in India during the initial phase, which had helped to identify the gaps and the areas that required strengthening. As countries in the SAARC region are quite diverse, it would be helpful to undertake similar exercises in other countries in the region. This would be along the lines of a baseline evaluation of the legislative framework that was carried out across these countries. There may now be a need for assessing the extent of problem of HIV among drug users, gaps in service delivery etc.

This evaluation also identified certain other gaps in coverage of services, which are mentioned below. Please note that while many of these were evident from triangulated sources, others are based on unique sources (e.g., interviewees). The latter are mentioned for the project team to look into, but may need further validation for greater reliability and acceptance.

- Interventions with “comprehensive community based approach” have been established across the countries to variable extent. There has been a complete integration of drug demand reduction and supply reduction initiatives in Bhutan through BNCA, which has also been scaled up across the country. In other countries like India, only certain components (OST) of the project have been continued after scaling up. While OST has been integrated in the national response to prevention of HIV/AIDS other components such as peer led interventions have not achieved similar resounding success.

- Some of the stakeholders identified certain areas as ‘not the strong aspects of the project’. In Nepal the project primarily focused on strengthening MMT. Apart from the MMT other interventions aimed at HIV prevention among IDUs were not introduced. It was felt that these areas could have been addressed more intensely and extensively. Also, certain aspects of the project were identified as ‘too limited’ in their scope. These were identified as restricted to a few and the same could not benefit many potential beneficiaries. The respondents felt that the project could have supported the interventions at more number of sites in Bangladesh and Maldives. However, these limitations could be understood well in the context of the mandate and funds availability for the project.

- Various stakeholders suggested the MMT programme in Maldives to have been very effective. However, it has not been extended beyond one site and the country would
benefit from establishing the services at multiple sites, given the geography of the country and demographic distribution. Adequate information to draw inference with respect to other countries, especially Sri Lanka, Nepal and Bangladesh was not available.

- A systematic monitoring and evaluation system continues to be an issue of concern. The project would, for example, benefit from collecting data on the effectiveness and efficiency of various components and interventions.

Overall, the evaluation finds that while the project has made significant strides in achieving the intended outcomes and shows a significant promise of achieving its intended objectives. However, the project does need to improve its monitoring system by establishing an ongoing system of data collection on outcomes and impacts, which should be done in partnership with national counterparts to better demonstrate its results to various stakeholders.

**Efficiency**

6. Were the resources and inputs converted to outputs in a timely and cost-effective manner? What can be done to make this resource conversion more efficient?

- From the limited information available, it appears that the project has utilized its resources efficiently.

Efficiency, the most basic economic measure of success, concerns ratio of outputs to inputs. It involves conducting comparative cost-benefit analysis of various strategic options for delivering programme outputs and outcomes. The evaluation considered criteria relating to timely delivery of outputs and achievement of objectives, as well as alternative (i.e., counterfactual) scenarios, to determine the efficiency with which resources and inputs were converted into outputs. Further, analysis of project documents was triangulated against opinions of stakeholder consulted.

All of the project's activities appear to have been carried out on time. None of the stakeholders reported any delays in implementation. The project had a total budget of US$14,329,500 and total pledged contributions of $13,590,236 (94.8% of total budget) over a ten-year period from 2007 to 2016. By 2014, the period for which audited statements were available, the project had already spent $13,164,690, which left around 3% of total pledged contributions for the last two years. In fact, as Chart 21 below, which tabulates annual and cumulative expenditure by various categories, shows that a vast majority of the expenditure (over 90%) had been incurred by 2011 (and 97% by the end of 2012). This both highlights the fact that the project has to manage its activities with very little resources over last 4-5 years, but also poses its own unique challenges in evaluating efficiency.

While the average annual expenditure for a ten-year period is around $1.36 million; but if this period is divided into two halves, the average annual expenditure for the first five years (2007-11) is $2.37 million and for the latter five years (2012-2016) is $345 thousand. The reduction becomes even more stark if divide into three periods. The average annual expenditures were $3.11 million, $4.29 million, and $212 thousand for 2007-09, 2010-12, and 2013-16 respectively. Thus, it is evident that the project has had to manage with limited resources over last 4-5 years. This reduction was attributed to shift in donor priorities for the region.
It is also evident that this has implied reduction in overall activities undertaken by the project, however as there were no complaints by various stakeholders, it does not appear that this affected the project very much. A major reason for this seems to have been adoption of project’s activities by the governments in the region. The project also appears to have leveraged partnerships with other international organizations to underwrite some of
the expenses. For instance, as highlighted in the partnerships section, the project recently conducted a training program for Bhutan that was supported by funding from the Global Fund.

Charts 21 and 22 further show that a majority of the expenditure was on subcontracts (including pilot projects, 52%), followed by personnel (13%), training (11%), travel (4%), equipment (4%), miscellaneous (4%) and Support Costs (11.0%). This breakdown of expenditure is in consonance with the capacity building thrust of the project.

Further, to the extent that a majority of stakeholders commended the project for its "low cost" model, it is indicative of the fact that the project managed these resources efficiently. A further confirmation of this emerged from review of resource materials produced and translated by the project, which numbered in hundreds of manuals, standard operating procedures, training guides, and so on. While it is not clear how many of these are regularly used by the beneficiaries (as mentioned in the effectiveness section), it is evident that the project has been busy in producing numerous outputs within the constraint of declining resources.

Furthermore, it is evident from desk review, stakeholder consultations and survey that the project utilized Training-of-Trainees (ToT) approach to a significant degree, and a majority of these trainers appear to be using their training to train others (See also Chart 13 on the use of training in the effectiveness section). Use of this approach, in combination with partnerships with local governmental and nongovernmental actors that incorporated project activities into their own normal way of doing business, appears to have helped the project make a significant contribution with its limited resources. Availability of local capacity (e.g., skilled trainers) in the region, especially in India and Bangladesh, but also in other countries to a significant extent, also helped the project keep its costs low.

Lastly, in terms of counterfactuals, the project could have perhaps explored the option to use Computer-Based Training (now, eLearning), however it is not clear if that would be equally effective, especially given RASH13’s focus on training-of-trainers. It could still be examined, going forward, for refreshers and basic training. Perhaps, this platform can also be used for better digitization, dissemination and use of manuals, SOPs, and other resource material produced by the RASH13 project. Thus, overall, the evaluation finds that the RASH13 project appears to have used its resources efficiently.

**Impacts**

7. To what extent has the project contributed to long-term intended or unintended impact for its targeted beneficiaries? What can be done to enhance the impact of the project?

- Although due to complexity of interventions and multiplicity of players involved, quantifying the impact is beyond the scope of this evaluation, the project appears to have made a significant contribution to the improved HIV/AIDS situation in the region.

Chart 23 below depicts the results chain used by the OECD/ DAC evaluation guide. It is easier to visualize that the RASH13 project has delivered its intended outputs.

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7 An impact evaluation is needed for that purpose.
It is also evident that that these outputs are influencing intended outcomes such as on improved policy environment, use of training to build capacity of others and improved provision of services for targeted at-risk populations. However, it is worth noting that, given the complex dynamics related to HIV, it is hard to measure the impact without specific impact evaluation. These complexities originate from the inherent nature of drug use and users.

Design of interventions and limited scale of implementation (many initiatives were executed as pilots in certain geographical regions only) make it even more difficult to quantify the change attributable to the current project. However, the initiatives taken as part of the project have been implemented in other regions of the world to achieve prevention of HIV among drug users, and stakeholder consultation can provide some indicative evidence.

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8 Drug use is a complex bio-psycho-social phenomenon. Not only various biological, psychological and social factors are relevant to its causation, the implications of drug use and efforts aimed at addressing these ramifications are complex. Assigning the cause and attributing the impact to a single or even a few factors is not feasible for interventions aimed at drug users. Similarly, it is complex to measure the impact of the interventions targeted at addressing HIV among drug users. For example, while the number of the service users for a particular intervention can be counted, without a systematic evaluation of various issues relevant to the context (logistic, social, policy, availability of resources, etc.) it will be erroneous to attribute a drop in this number over time as a reflection on the effectiveness of the intervention. It is essential to carry out a systematic evaluation of these interventions using specific methodology and research tools designed for such purposes.

9 In Sri Lanka, with the support of RASH13 and Global Fund, OST has been approved and funds allocated for implementation (http://www.aidscontrol.gov.lk/web/), it has not yet been actually initiated.
The project progress reports provide some indication to early impacts. All partner countries have modified policies and laws to make the ‘comprehensive package of services’ accessible by drug users and their sex partners. The National HIV Programmes in all partner countries adopted the comprehensive package of services as key elements in prevention, treatment and care and included them in the National HIV strategies. Further, in terms of introducing comprehensive harm reduction programmes in each country, the mid-term review of the project noted that the project has made impressive contributions in each country—both by providing training and by establishing demonstration sites with implementing partners. Other project documents also note that the HIV epidemic in the South Asia region has witnessed a paradigm shift in terms of its nature, extent, scope and trends over the years. Chart 24 below also highlights the changes in the policy environment, including its key elements, over the life of the RASH13 project. As can be seen, while a substantial progress has already been made, there are areas (e.g., prevention and treatment services for the prisoners) that still need to be addressed.

A review of archival data (Chart 25) also showed a significant progress in reduction of PWIDs (People Who Inject Drugs) in India and Bangladesh, although there was an increase in Nepal and information on other countries was not available.

<table>
<thead>
<tr>
<th>Chart 25. HIV/AIDS changing scenarios in the SAARC region</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>PWIDs</td>
</tr>
<tr>
<td>HIV prevalence among PWIDs (%)</td>
</tr>
<tr>
<td>Hep-C among PWIDs (%)</td>
</tr>
</tbody>
</table>

PWID: People Who Inject Drugs; NK: Not Known; NA: Not Available

Furthermore, according to a mid-term appraisal of India’s National AIDS Control programme (NACP), the adult HIV prevalence (15-49 years) at national level has declined from 0.38% in 2001-03 to 0.26% in 2015. Adult HIV prevalence also reportedly declined in all the erstwhile seven high prevalence States (Andhra Pradesh, Telangana, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu). There was also a 66% decline in new infections between 2000 and 2015 at the national level.

While the countries in the region probably deserve most of the credit for their improved environment, stakeholder consultations revealed a deep appreciation for the advocacy and capacity-building work undertaken by the RASH13 project. Anecdotal evidence collected by

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the evaluation also corroborated this. See Annex IX for a sample of anecdotal evidence reviewed by the evaluation team, which suggested that both the governmental and civil society organizations appreciated the support provided by the project. A letter from Bhutan Narcotics Control Agency acknowledged project’s crucial support in drafting new legislation as well as for providing support to policy-making and capacity-building. Two letters from schools highlight the demand for sensitization training expressed by various schools in India, and the remaining two letters from Maldives and Indian governmental agencies showcase the project’s role in piloting and demonstrating the usefulness of OST/MMT as policy options. This is significant because the success of these pilot studies convinced governments on the potential of harm reduction agenda, which then got incorporated in their routine affairs. Further, stakeholder consultations and surveys also suggested that the capacity built as a result of the RASH13 project helped bring together a variety of institutions, which in turn helped build momentum towards making a bigger impact.

This is in contrast of one of the findings in the evaluation of Global HIV/AIDS programme (GLOG32), where the evaluators had noted that ”several key informants from UN agencies and donors felt that the Global Programme is too focused on small-scale pilots that may or may not produce results or evidence that can lead to scaling-up.” The current evaluation finds these concerns to be unnecessary. While pilots are inherently risky, the evaluation found them to have served a very useful purpose in convincing governments in the region.

Overall, the evaluation finds that the RASH13 has made substantial contribution to improving the HIV/AIDS situation in the SAARC regions, although better M&E systems need to be put in place for future programme cycles, if any, to ensure the monitoring of medium- and long-term changes.

**Partnerships and cooperation**

8. To what extent have partnerships been sought and established (including with other units within UNODC and other UN agencies, professional associations, and civil society engagement) and synergies been created in the delivery of assistance? Were efficient internal cooperation and coordination mechanisms identified and established in building and managing these partnerships?

- Partnership arrangements currently in place have helped the RASH13 project achieve its results. More partnership opportunities exist and should be explored.

The RASH13 project has been reasonably successful in building partnerships beyond the UNODC. As noted in previous sections, its partnerships with nongovernmental organizations such as HIV/AIDS Alliance in India, Journey in Maldives, and Youth Development Forum in Bhutan helped the project build momentum towards greater acceptance of the harm reduction approach.

**Chart 26. Training data enumerators with support from with the Global Fund**
Drug-use study to begin next week

The findings will help in the creation of a prevention and treatment programme

Survey: To determine drug use patterns in Bhutan, the Bhutan Narcotics Control Authority (BNCA), in collaboration with the United Nations Office on Drugs and Crime (UNODC) will conduct a National Drug Use Survey starting this month.

Besides estimating the prevalence of drug use other than tobacco and alcohol in Bhutan, the study is also expected to assess the extent, pattern and profile of people who use drugs.

It is also expected to determine the risk factors associated with drug use and service uptake by the drug using community.

It will also assess the social and health consequences of drug use.

BNCA director general, Phuntsho Wangdi, said that rapid development in the country including easier and faster connectivity, increased migration to the urban centres and immigration to other counties, among others, may have contributed to the changing drug scenario with new drugs and patterns of use.

There is a need to find out what new drugs are being used in the country and services availed by the abusers. “The study is a high priority. The survey will help the authority to develop appropriate strategies for a drug prevention and treatment programme,” Phuntsho Wangdi said.

Some 80 university graduates and 40 peer counselors and recovering drug users were provided a two-day training on data enumeration on October 2.

Source: http://www.kuenselonline.com/drug-use-study-to-begin-next-week/

The project also built partnerships with relevant governmental agencies and parliamentarians (political leaders) to expand the scope and impact of its work in the region. The project organized a series of sensitization and training workshops to build awareness, increase knowledge and develop skills of public officials in a wide variety of
organizations from health to law enforcement. The partnerships with Bhutan Narcotics Control Authority, National AIDS Control Organization in India and All India Institute of Medical Sciences in particular stand out. These partnerships enabled the project to use local experts for capacity building, technical support, accreditation and roll out of services. These partnerships have helped the project find and develop local champions. Field missions, in particular, showcased the depth of these relationships in India, Maldives and Bhutan.

The project also partners with other UN agencies under the umbrella of the Unified Budget, Results and Accountability Framework of the UNAIDS. A recent training for the 120 enumerators (80 graduates and 40 PUD/PWID community members) for conducting a National Drug Use Survey in Bhutan provides an example of partnerships cultivated by the project. This training was conducted by two experts hired by the project with funding from the Global fund, and was conducted after extensive consultations with government, civil society (including the PUD community) and other development partners. Organized in October this year, the training provided enumerators with basic skills on identification of different types of drugs, their effects, signs and symptoms and on developing skills necessary to understand and conduct the survey along with mock sessions to hone the required interview skills. These skills will be put to use almost immediately.

Similarly, Chart 27 provides a very good example of nebulous partnerships with private sector corporations and foundations to raise awareness on the drugs and HIV/AIDS.

Chart 27. RASH13 and Corporate partnerships: An Illustration

The desk review, confirmed by stakeholder consultations, also provided some evidence on conduct of joint activities with various partners. For example, different resource materials have been published in collaboration with various agencies including Lawyers Collective, HIV/ AIDS Unit, AusAID, DFID, WHO, UNAIDS, icddrb, BNCA, NACO, NISD and TISS. These include advocacy, intervention toolkits, operational research and diagnostic studies, SOPs, guidelines and training manuals.
However, the extent of cooperation between various HIV/AIDS programmes within the UNODC cooperate with each other is not very clear. This is in keeping with the concerns raised by the evaluation of the Global Programme on cooperation and coordination between global, regional and country programmes within the UNODC. Therefore, the evaluation notes the need for further examining working arrangements and integration of various projects' activities in the HIV/AIDS domain.

Overall, the evaluation finds that while the extent of internal coordination is not clear, the project has made an effective use of external partnerships towards achieving its objectives and outcomes.

**Sustainability**

9. To what extent will the benefits generated through the project be sustained after the project ends?

- The extent of sustainability of the project’s results varies by the country.

Many of the initiatives taken up as part of the project were initiated as pilots as these interventions were introduced for the first time in these countries. The pilot studies helped provide information on feasibility and applicability of these interventions. In certain countries like India and Bangladesh, these were subsequently completely owned by the national governments, and many of these continue to be supported by the federal funding. Some of the interventions were scaled up and even incorporated into the national response and programme on management of HIV/AIDS in the country. In some countries like Bhutan certain components have been incorporated into the national programme, but these continue to be supported financially directly through the project. It is likely that the federal funding shall support these in near future. In countries like Nepal the components initiated through the project have been taken up by other donor agencies and are being continued with certain modifications. This should help make many of the project contributions self-sustainable (with some governmental interest and adequate nongovernmental participation).

Similarly, the resource material developed as part of the project such as training manual, SOPs, IEC material etc., are being used by various national governmental and civil society organizations in its original form. Many of these have been adapted into local languages and adopted by various governmental and civil society organizations, and these continue to be used to varying degrees.

To the extent that governments in the region have taken ownership of the project interventions, at least a partial sustainability is virtually guaranteed even after RASH13 winds down. However, when we compare the magnitude of problem to the scale of interventions made so far, it is premature to make such claims given the enormity of unsatisfied need (and demand) for capacity-building. Further, as illustrated by the case of Maldives, where frequent regime changes with differing ideologies have moved the needle back and forth, sustainability of progress made should not yet be taken for granted. In other words, a premature onset of complacency, which some stakeholder consultations hinted at, may be a cause for worry rather than celebration. Hence, while acknowledging the progress made in the region towards improving policy environment and addressing the challenge of
HIV/AIDS, the evaluation notes the need for further support to ensure further progress and long-term sustainability of results obtained so far.

**Human Rights and Gender**

10. To what extent were human rights considerations including on marginalized groups, incorporated into project development and implementation, and with what effects? To what extent were gender-sensitive outcome incorporated into project development and implementation, and with what effects?

- Despite working in a challenging environment, the RASH13 project pays adequate attention to human and gender rights considerations in its design as well as implementation.

The project primarily targets marginalized and at-risk populations. The interventions undertaken as part of the project included provisions for male, female and transgender drug users. These interventions were mostly gender sensitive and inclusive. The stakeholders reported that individuals of all genders utilised the services and benefited from the same. In Bangladesh, for example, certain interventions were designed and executed specifically for the female drug users. This was carried out keeping in mind the specific challenges faced by female drug users in these settings, as females experienced gender specific barriers to service utilisation. Some stakeholders mentioned these interventions to be 'the first of their kind' for the female drug users, which helped them overcome stigma and barriers specific to them. Local governments, later on, adopted and scaled up these interventions. Lastly, it must be restated that getting countries in the region to shift their focus from law enforcement to harm reduction (i.e., health orientation) by itself is a move towards greater human rights advancement.

The various interventions undertaken as part of the project were aimed at the marginalized sections of the society. The drug using community is subject to stigma across the SAARC countries. When viewed in the context of HIV/AIDS the issue becomes even more complex and the stigma increases significantly. Finally, addressing the issues of drug use and HIV/AIDS among female drug users and sexual partners of drug users is even more challenging as females are still struggling for the basic rights in many sections of the societies across these countries. Since the project was targeted at the drug users, it contributed towards mainstreaming of these individuals in the society. Also, inclusion of the end users (i.e. drug users) in planning and execution also contributed immensely towards their participation. In fact, some of the interventions such as peer-led interventions were rolled out solely through the drug using community.

The IEC material prepared as part of the project also addressed the issues related to the rights of the drug users. It aimed at addressing the stigma associated with drug use and HIV/AIDS. It focused on various aspects related to the lives of the drug users such as the right for seeking help and treatment; right for inclusion in decision-making process for the programme targeted at them; right to live a dignified life, etc. It also advocated mainstreaming of the drug using community.
The legislative changes brought across different countries also helped contribute to the cause of human rights and these amendments helped address the existing impingements on their human rights. Provision for harm reduction services in the national treatment framework across the countries also contributed to their inclusion in the mainstream national treatment programme.

Various project interventions collected information on the female users of the services. The IEC resources included materials targeted specifically to address human and gender rights. The monitoring data collected under the project also included details on integration and synchronization of the interventions delivered through the programme with other services meant for the general population, e.g., the OST intervention while aimed at offering opioid therapy also included referrals for HIV testing and treatment for AIDS through the treatment centers meant for the general population. The project has also conducted special studies aimed at understanding the HIV/AIDS situation of women who use drugs, both in India11 and Bangladesh12.

Over all, desk review and consultations with the programme management and other stakeholders revealed that the training content complies with due diligence on human and gender rights. However, given the low capacity utilization, especially by female drug users, the challenge of gender equity persists. Overall, the evaluation find the project has helped obtain satisfactory progress in advancing human and gender rights.

III. CONCLUSIONS

The evaluation concludes that:

1) The RASH13 project has made a significant contribution to tackling the challenge of HIV/AIDS among injecting drug users by deploying right advocacy strategies and building strategic partnerships with governmental and nongovernmental organizations. These approaches have helped shift the focus from law enforcement to harm reduction in all countries in the regions but especially in India and Bhutan.

2) While a significant progress has been achieved, it is too premature to get complacent. Several of these countries have gone through conflict and post-conflict transitions, whether it is transition from Monarchy to democracy as in Nepal or LTTE conflict in Sri Lanka. Resultantly, the risk of reversion continues to be very high. Further, major changes in drug production and use patterns, including emergence of India as one of the important producers of drugs is also creating opportunities as well as challenges for the HIV/AIDS interventions. Thus, there is a clear need to be alert to changing political ideologies and coalitions — as in some cases, changes in political regimes have been associated with progressions and regressions. There is also a strong need to persist with capacity building among a wide variety of organizations.

3) With some notable exceptions such as the state of Sikkim in India the RASH13 project has so far largely focused its advocacy efforts at the national level (i.e., federal). Given the federal/ decentralized structure of most of the targeted countries in SAARC, there is also a need to pay attention to laws and regulations at the subnational (i.e., states/provinces) governments.

4) The project has started integrating its interventions with other major infections (e.g., hepatitis) that are highly prevalent among drug users. This is worth exploring further in future programmes.

5) In some countries, the stakeholders felt that the project should have delivered more interventions beyond what was executed, which may indicate the need for greater stakeholder consultations and need assessment in project design and execution. This is also needed, for example, to understand the reasons for limited success in Sri Lanka or non-expansion of MMT beyond one site (with declining enrolment) in Maldives. Similarly, interventions with “comprehensive community based approach” have been established across the countries to variable extent. Unlike Bhutan, India, for example, has adopted only certain components of the project. Similarly, Capacity utilization at


\[\text{14} \text{https://www.unodc.org/documents/southasia/reports/Legal} \text{_} \text{and} \text{_} \text{Policy} \text{_} \text{Concerns} \text{_} \text{related} \text{_} \text{to} \text{_} \text{IDU} \text{_} \text{Harm} \text{_} \text{Reduction} \text{_} \text{in} \text{_} \text{SAARC} \text{_} \text{countries} \text{_} - \text{A} \text{_} \text{Review.pdf} \text{. See also: } \text{http://www.aidsdatahub.org/sites/default/files/documents/2009} \text{_} \text{A} \text{_} \text{Preview} \text{_} \text{of} \text{_} \text{Law} \text{_} \text{and} \text{_} \text{Policy} \text{_} \text{in} \text{_} \text{South} \text{and} \text{_} \text{South} \text{_} \text{East} \text{_} \text{Asia} \text{_} \text{Drugs} \text{_} \text{Treatment} \text{_} \text{and} \text{_} \text{Harm} \text{_} \text{Reduction.pdf}\]

many of the intervention centres has been rather low. It may indicate inadequate awareness or prohibitive stigma among potential users.

6) While the project has developed an enormous amount of resource materials, there is a wide variation in its use. This may highlight the need for wider dissemination as well as follow-ups to ensure greater use.

7) There is a need to improve project planning and coordination mechanisms. The project has not held a steering committee meeting in over three years, which may have had a bearing on donor satisfaction as well as fund-raising performance for the project. Similarly, the extent of coordination and integration among various HIV/AIDS related projects within the UNODC is not very clear, which may once again suggest the need for better (more formal and regular) coordination mechanisms.

8) While the project does a very good job of reporting its activities and outputs, there is a need to improve results-orientation in all aspects of monitoring, evaluation and reporting. Moreover, the quality of data needs to be more detailed/ granular to not just generate reports that clearly lay out expenditures on various major activities (e.g., cost effectiveness of various components and interventions), but also link these to planned and obtained outcomes specified in the results-matrix. This information is needed for more effective decision-making.

9) While most stakeholders commended the project for its “low cost” model, given the constraint of resources, the project needs to continue exploring avenues for increased efficiency (without compromising effectiveness), which could include use of eLearning for basic and refresher training courses.

10) The training manuals developed as part of the project were used to train the trainers as well as other professionals who executed the respective interventions across the countries. An expert in the specific area developed each of these manuals, however these manuals have not been subjected to adequate quality control (e.g., peer review).

11) Given the high levels of socio-cultural diversity across the countries in the region, especially in India, the IEC material may need to be developed in more languages.

Overall, the findings and conclusions of this evaluation can be summarized with the help of the SWOT analysis in Chart 29:

<table>
<thead>
<tr>
<th>Chart 29. SWOT Analysis for the RASH13 programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths</strong></td>
</tr>
<tr>
<td>“Low cost” delivery model</td>
</tr>
<tr>
<td>UNODC network and credibility</td>
</tr>
<tr>
<td>Efficient delivery on outputs</td>
</tr>
<tr>
<td>Pool of local experts</td>
</tr>
<tr>
<td>Support from the government and civil society organizations</td>
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<tr>
<td><strong>Opportunities</strong></td>
</tr>
<tr>
<td>State-level (i.e. subnational) interventions and</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Reforms</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huge unmet demand for training</td>
<td>Inadequate donor interest</td>
</tr>
<tr>
<td>eLearning for basic and refresher training</td>
<td>Unfavourable changes in the political environment</td>
</tr>
<tr>
<td>Better integration with other HIV/AIDS programmes and projects at global, regional and national levels</td>
<td>Limited technical and financial resources in certain countries</td>
</tr>
</tbody>
</table>
IV. RECOMMENDATIONS

Key recommendations:

1) Given the resource constraints, the project may need to focus greater attention to countries and states with high HIV/AIDS prevalence, while countries and states with (very) low prevalence are best served by other UNODC drugs-related programmes.

2) UNODC management needs to guard against premature complacency. While the project in its current ‘avatar’ is coming to an end, senior management needs to initiate its replacement at the earliest possible.

3) The project should consider focusing its advocacy efforts at the subnational level in the next phase. In addition, the project needs to conduct a detailed needs assessment to focus on those states that have a higher prevalence rates or those that have most antiquated laws and policies.

4) The project management, in designing future interventions for HIV prevention among drug users, should also look to integrate other related and relevant infections such as Hepatitis C, Tuberculosis, and co-morbid mental disorders.

5) The project team should undertake rapid situation assessment and need evaluation exercises across various countries, which should help better identify unmet needs.

6) The project team should develop tools (e.g., social media) for wider dissemination and feedback collection. It should also use web counters to keep track of resources that are being used (accessed, downloaded, etc.) to understand beneficiaries’ needs better.

7) The project management team must develop formal mechanisms for coordination, and then conduct meetings (in person, over phone or virtually) at regular intervals.

8) The project management team should develop better M&E systems with a focus on outcomes data. For example, in case of training, the project should send out two follow up surveys: Once 6-9 months after completion of training to collect data on its use and the second after 2-3 years after to collect data on impacts, if any. This is in addition to tests administered at the time of training to measure change in knowledge (i.e., pre and post-tests).

9) The project team should build partnerships with academic and civil society organizations for peer review of resource materials.

Important recommendations:
10) The project team should continue to explore opportunities (e.g., eLearning) for greater efficiency in resource use.

11) The project team should continue expanding the translation of resource materials in more national and regional languages, which should continue to be updated with the latest developments in the HIV/AIDS domain.
V. INNOVATIONS AND LESSONS LEARNED

1. The RASH13 project made a very effective use of pilot projects to demonstrate the potential for recommended interventions to succeed. While pilot projects are inherently risky and sometimes suffer from selection bias (i.e., pilots generally work, but not when they are scaled to a larger scale), the project team used the right strategies that should be looked at by other similar programmes and projects at the UNODC.

2. The project was very successful in building coalitions with wide variety of stakeholders ranging from law enforcement and health professionals to politicians and civil society organizations. This helped the project obtain a higher local buy-in and build a greater momentum for rapid scaling up, especially in India. This is once again worth a consideration for other projects that need to break through difficult deep-rooted socio-cultural barriers to change.

3. The project relied on local experts for its capacity-building efforts that helped it develop and use a low cost model. This is also useful in ensuring that local expertise is further strengthened and engaged with UNODC.

4. It is also evident that much of the progress can be quickly eroded and rolled back with a change in policy environment in any given country, which indicates the need for meticulous risk assessment, planning and management.
# ANNEX I. TERMS OF REFERENCE OF THE EVALUATION

## I. BACKGROUND AND CONTEXT

<table>
<thead>
<tr>
<th>Project number:</th>
<th>TDRASH13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project title:</td>
<td>Prevention of transmission of HIV among Drug Users in the SAARC countries</td>
</tr>
<tr>
<td>Duration:</td>
<td>01 July 2007 – 30 June 2016</td>
</tr>
<tr>
<td>Location:</td>
<td>Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka</td>
</tr>
<tr>
<td>Linkages to Country Programme:</td>
<td>Strategic Theme 3- Prevention, treatment and reintegration and alternative development: Result Area 3.3- HIV/AIDS Prevention and care</td>
</tr>
<tr>
<td>Linkages to Regional Programme:</td>
<td>Drug Demand Reduction Subprogramme 5: Drug use prevention and treatment and HIV and AIDS</td>
</tr>
<tr>
<td>Linkages to Thematic Programme:</td>
<td>Subprogramme 5: Drug use prevention and treatment and HIV and AIDS</td>
</tr>
<tr>
<td>Executing Agency:</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>Partner Organizations:</td>
<td>National Counterparts in Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka dealing with the problem of Drug and HIV/AIDS</td>
</tr>
<tr>
<td>Total Approved Budget:</td>
<td>USD 13,522,742</td>
</tr>
<tr>
<td>Donors:</td>
<td>Australia (AusAID), Germany (GIZ), India (National AIDS Control organisation (NACO)), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Tata Institute of Social Sciences (TISS), UNAIDS and UNDP.</td>
</tr>
<tr>
<td>Project Manager/Coordinator:</td>
<td>Kunal Kishore</td>
</tr>
<tr>
<td>Type of evaluation</td>
<td>Final evaluation of the project.</td>
</tr>
<tr>
<td>Time period covered</td>
<td>July 2007 till Date (with special focus on 2010 to September 2016)</td>
</tr>
<tr>
<td>Geographical coverage</td>
<td>Bangladesh, Bhutan, India, Maldives, Nepal, &amp; Sri Lanka</td>
</tr>
<tr>
<td>Planned budget for this evaluation:</td>
<td>USD 40,000</td>
</tr>
<tr>
<td>Core Learning Partners (entities):</td>
<td>Government counterparts and civil society partners from Bhutan, Bangladesh, India, Maldives, Nepal, and Sri Lanka, Donors and HIV/AIDS section in HQ.</td>
</tr>
</tbody>
</table>
The Core Learning Partnership (CLP) are the key stakeholders of the subject evaluated (project, programme, policy etc.) who have an interest in the evaluation. The CLP works closely with the Evaluation Manager to guide the evaluation process.

Project overview and historical context in which the project is implemented

UNODC, Regional Office for South Asia is supporting a regional project titled “Prevention of transmission of HIV among Drug Users in SAARC Countries” (RAS/H13) that is being implemented in partnership with the governments and civil society partners of the member countries of the SAARC region. The project is divided into 3 phases – Phase I, (December 2003 – August 2006), the extended Phase I (July 2006 – June 2007) and Phase II (July 2007- till date). The learnings and recommendations of the evaluation of the Phase I of the project formed the basis for the design of the Phase II document. Phase II of the project is a joint UN project, with UNAIDS RST, WHO SEARO and UNODC ROSA.

This End of the project evaluation will focus on the UNODC portion of the Phase II of the project (herein referred to as “The Project”) i.e., from July 2007 till date and will cover Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka. Pakistan was a part of the original project document, the Country Office Pakistan was given a separate allocation to implement the project. The Pakistan Component of the project ended in 2012. Hence Pakistan component is not being included in this evaluation.

Project Related Information:

“The Project” draws upon the experience of Phase I (which demonstrated the necessary components for a comprehensive HIV prevention program among drug users) and provides catalytic assistance to the participating countries by providing services based on the gaps identified by the respective country strategic plans. Recognising the diversity of the HIV epidemic, drug using populations and national responses in the SAARC region, “The Project” works in each country with varying degrees of intensity based on country-specific considerations. Four countries i.e., India, Nepal, Bangladesh, and Pakistan have been identified as Intensive countries and Bhutan, Sri Lanka and Maldives have been identified as Emerging countries. The project retains the flexibility to change the level of response in each country, if required.

**Project Goal:** Reduce the spread of HIV among drug using populations in SAARC countries

**Project purpose:** Assist governments and communities to scale-up comprehensive prevention and care programs for drug users, especially Injecting Drug Users, and their regular sex partners

**Target groups and area:** The project concentrated in the seven SAARC countries i.e., Bangladesh, Bhutan, India, Nepal, Maldives, Pakistan and Sri Lanka. The target group was planned to be policy makers, planners, academicians and NGOs working in the field of drugs and HIV/AIDS. Indirect target group were to be young drug abusers who were at risk of HIV infection and those infected and affected.
Component 1: Advocacy to support change in policy and practice

**Specific Objective:** Ensure commitment of national authorities and development partners to scale up comprehensive HIV prevention and care programs for IDUs.

Component 2: Effective Risk Reduction Approaches to reduce HIV transmission among drug users especially IDU and their regular sex partners.

**Specific Objective:** Demonstrate the effectiveness of risk reduction approaches

Component 3: Scaled-Up Risk Reduction Interventions to reduce HIV transmission among drug users especially IDU and their regular sex partners.

**Specific Objective:** Governments plan and implement risk reduction interventions essential to a comprehensive response to HIV prevention among drug users especially IDU and their regular sex partners

Component 4: Project Management.

**Specific Objective:** Effectively and efficiently manage the project and to provide monitoring, evaluation and reporting on project activities and outputs

**Expected end of project situation:** The intended impact is a contribution to a reduction in the transmission of HIV among drug users through the development and implementation of government-led comprehensive national plans of sufficient scope and scale. This is consistent with the stated goal and purpose of the project.

By the end of the Project, it is expected that comprehensive community-based interventions, which meet the aspiration of a majority of injecting and oral opioid drug users and their sex partners will be in place. Oral Substitution/Maintenance treatment with opioid agonists will have been piloted and expanded in countries that need substitution treatment.

**Project Management:**

The project is being implemented by the United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC, ROSA) in close collaboration with the governments and civil society partners of the member countries of the SAARC region. The project is being executed by the UNODC ROSA Project team under the overall strategic oversight and guidance of the Regional Representative, UNODC ROSA. The Project Coordinator is responsible for day to day project management, liaising with governmental and project implementing partners, all execution aspects of the project, including coordination and management of partners, the direct execution of several project components, and overall monitoring and reporting.

Short-term consultants are recruited as needed to provide support in specific technical areas.
Key Implementing Partners:


Project Steering Committee:

A Regional Project Steering Committee comprising of representatives from the Government, civil society representatives, UNODC ROSA, UNODC Pakistan, UNAIDS RST and WHO SEARO has been set-up to provide policy and program oversight to the project. The main role of the Steering Committee is to provide guidance on substantive policy and technical matters relating to the execution and overall management of the project. The Steering Committee meets once a year to ensure achievement of the overall project objectives.

Project monitoring and evaluation:

The project document made provisions for a mid-term review and a final independent project evaluation. The mid-term review took place in March-April 2010 and aimed at reviewing project progress and achieved outputs and outcomes for the implementation period and present and highlight features to be considered as good practices and lessons learned for further utilization in project implementation. The mid-term review included field visits to four project countries and desk reviews of two countries by independent reviewers and in-depth interviews with project management team, government counterparts, implementing partner organizations and beneficiaries. No previous independent evaluation of the project was undertaken.

Project Beneficiaries:

The project has two sets of beneficiaries. First are the people who use drugs (injecting as well as oral opioid users) and their sex partners. Second are the policy makers, planners, law enforcement officers, government health staff and NGO service providers working in the field of drugs and HIV/AIDS who have benefited from the support provided through the project.

The two sets of beneficiaries have enabled the project to catalyze national responses by demonstrating effect based on adopting globally standardized methodologies to address drug HIV vulnerability in demonstration sites and not directly carrying out large scale interventions which would have duplicated national efforts.

Context analysis of the project:

Drug use and vulnerability
The project countries were wedged between the world’s two largest areas of illicit opiate production, commonly referred to as the Golden Crescent and the Golden Triangle.

In India, Nepal, Bangladesh and Pakistan the traditional abuse of opium and cannabis had shifted to heroin and injecting drug use with a range of pharmaceutical products also being abused. Heroin, buprenorphine (tidigesic/ tangesic), diazepam (calmpos), promethazine (phenargan), chlorpheneramine maleate (avil), other synthetic opiates (pethidine, pentazocine and morphine) and dextropropoxyphene (spasmo-proxyvan) were the commonly injected drugs in the region. Sharing of injection equipment and unsafe sexual behaviours was common in the IDUs.

Injecting was relatively less common in Sri Lanka, Maldives and Bhutan where majority of heroin users inhaled or snorted the drug.

**HIV prevalence among drug users**

HIV prevalence among drug users in the region indicated a differential epidemic characterized by unacceptably high levels in certain areas and escalating levels in certain regions among the injecting drug users. There were also countries like Sri Lanka, where HIV was yet to be demonstrated among drug using population. This illustrated a worrying trend for countries in the region, where injecting behaviour was virtually unknown.

The existing knowledge indicated that it was possible to contain the epidemic with HIV prevention programmes. However, in many parts of South Asia, implementing large-scale prevention programmes was far from optimal. The general picture was of vast disparity between the current coverage and the drug users in need for treatment. The challenge was not only to increase the number of programmes to a scale commensurate with the magnitude of the problem but also to ensure quality of services. Many agencies did not have the required technical ability to design or develop appropriate interventions, and properly implement and evaluate them.

**HIV prevention activities at a glance (start of the project situation in 2007)**

<table>
<thead>
<tr>
<th><strong>HIV prevention interventions</strong></th>
<th><strong>Bangladesh</strong></th>
<th><strong>Bhutan</strong></th>
<th><strong>India</strong></th>
<th><strong>Maldives</strong></th>
<th><strong>Nepal</strong></th>
<th><strong>Sri Lanka</strong></th>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Outreach</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Coverage inadequate in all countries</td>
</tr>
<tr>
<td>Peer interventions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Excellent model in Bangladesh</td>
</tr>
<tr>
<td>Needle Exchange</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Community</td>
</tr>
<tr>
<td>Programmes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>opposition inadequate coverage</td>
</tr>
<tr>
<td>Substitution programmes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Inadequate coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lack of quality control</td>
</tr>
<tr>
<td>Prison Based programmes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>HIV prevention Activities missing</td>
</tr>
</tbody>
</table>
Country Specific

information: Bangladesh:

Drugs and HIV scenario: The national estimate, at the start of “The Project”, of people living with HIV was 7677² and the national adult HIV prevalence was estimated to be well below 1 per cent. The national serological surveillance recorded the highest HIV infection rates among IDUs among whom HIV prevalence was rising steadily. The country had an estimated 20,000 to 40,000³ IDUs. Drug of choice for the IDUs was changing from Heroin to Buprenorphine, which was frequently mixed with a cocktail of other drugs.

Bangladesh had a robust needle/syringe program (NSP) and operated primarily through outreach workers and drop-in centers (DICs) within the community which provided services for sexually transmitted infections (STI), abscess management, rest and recreational facilities, HIV/AIDS education, needle/syringe exchange and male condoms. However, the national prevention programmes for most at risk populations reached only about 7% of IDUs.

Legal and Policy Environment: Bangladesh was already a signatory to the three UN Conventions (1971, 1972, 1988 and 1990) on Narcotic Drugs and Psychotropic Substances. The country had begun to consider drug use as a treatable condition rather than a criminal offense. The Narcotics Act law allowed the Director General of the Department of Narcotics Control to send drug users for treatment. Government policies provided for needle and syringe exchange, but the country didn’t have any drug substitution treatment program. Methadone was not approved by the national drug and cosmetics laws and the national drug control authorities as required by the Narcotic Control Board.

Institutional context: The Department of Narcotics Control (DNC), Ministry of Home Affairs, was responsible for implementing activities for drug abuse treatment and rehabilitation as well as law enforcement under the guidance of a ministerial-level National Narcotics Control Board (NNCB). The National AIDS Prevention and Control Programme was within the Ministry of Health and Family Welfare.

Service Provisions: existing responses by civil society organizations and government:

The Ministry of Home Affairs provided drug dependence treatment through its 40 bedded Central Drug Addiction Treatment Centre (CTC) and three other regional treatment centres with five beds each. Six NGOs provided residential detoxification and care facilities with a few offering drug rehabilitation services on a long term residential basis. CARE Bangladesh, an NGO group, delivered peer driven intervention that included needle exchange and covered over 3000 IDUs in Dhaka. Access to medication, treatment and care for HIV/AIDS was reportedly not available in Bangladesh. There was very little awareness or training in medical fraternity on the clinical management of HIV/AIDS cases including treatment of opportunistic infections and dispensation of anti-retroviral therapy. NGOs were primarily focused on prevention and little attention was being paid to people infected with HIV/AIDS.

Bhutan:
**Drugs and HIV scenario:** The first case of HIV was detected in 1993 and the country had 72 total reported cases at the end of 2004. Heterosexual behaviour was found to be the primary mode of transmission\(^5\). Although Bhutan was a low prevalence country, it displayed all the risk factors for the rapid spread of HIV, including high STI, internal and external migration, increasing commercial sex work, low condom use and an emerging problem of substance use. There were less than 500 PLWHAs with a national HIV prevalence of less than 0.1% among adults and less than 100 deaths due to AIDS were reported at the time of development of the project document. Bhutan did not have a drug policy or a formal policy on HIV at the beginning of the project.

**Legal and Policy Environment:** The country was signatory to only one UN Convention related to narcotic drugs, namely, the United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances, 1988.

**Institutional context:** There were two statutory bodies i.e., the Narcotic Control Board (NCB) and Bhutan Narcotics Control Agency (BNCA) dealing with drug issues. NCB was responsible for preventing and combating the abuse and illicit trafficking, regulate the use of narcotic drugs, psychotropic substances and other controlled substances, and to regulate treatment, rehabilitation and social reintegration of drug users. BNCA, as the Secretariat to the NCB, implemented its decisions. BNCA was also responsible for proposing, revising and implementing Bhutan’s national drug control strategy or prevention, reduction and eradication of drug abuse, illicit drug supply and drug related crime.

**Service Provisions: existing responses by civil society organizations and government:** Though the law had extensive provisions for prevention and treatment of drug use, there were no dedicated drug treatment and rehabilitation centres in Bhutan except for a few government hospitals which provided some services as part of the mental health program. Drug users had to access these services in the neighbouring countries.

**India:**

**Drugs and HIV scenario:** With an estimated 5.2 million people infected with HIV, and a prevalence rate of approximately 0.9 per cent, India had the largest absolute number of people living with HIV, accounting for approximately 10 per cent of the world’s affected population. The number of IDUs were estimated to be in the range of 90,000-190,000\(^6\). HIV transmission through injecting drug use accounted for 2.79% of the total HIV infection\(^7\). National prevention programmes for most at risk populations were reaching 47.8% of IDUs\(^8\).

**Legal and Policy Environment:** India was signatory to all 3 (the 1961, 1971 and 1988) UN conventions and the SAARC convention on Narcotic Drugs and Psychotropic substances. The National AIDS Control Organization (NACO) strategy of preventing HIV among high-risk groups endorsed needle exchange programmes and substitution treatment as valid interventions. Although the Narcotic Drugs and Psychotropic Substances (NDPS) act presented certain obstacles for HIV prevention work, its interpretation and enforcement had not caused any significant obstacle to prevention/treatment work with drug users.
**Institutional context:** Narcotics Control Bureau (NCB) was the national coordinating agency, but it was more active in law enforcement. The Ministry of Social Justice and Empowerment and the Ministry of Health handled drug demand reduction issues. The National AIDS Control Organization (NACO) as part of the Ministry of Health looked after HIV related programmes.

**Service Provisions: existing responses by civil society organizations and government:** Over 300 centres were being supported by the Ministry of Social Justice and Empowerment and about 100 Centres by the Ministry of Health and Family Welfare. While most service providers offered detoxification, counselling and after-care focusing on abstinence, a few agencies provided treatment options that included community outreach, peer support, needle exchange and substitution programmes.

**Maldives:**

**Drugs and HIV scenario:** The HIV prevalence among the adult population was less than 1.1% and the estimated number of PLWHA was less than 100. The major risk factors for Maldives included high internal and external mobility, booming tourism industry, presence of STI, drug use, multiple sex partners and low condom use.

**Legal and Policy Environment:** Maldives had ratified all 3 UN conventions related to narcotic drugs. The Law on Narcotics Drugs (Law No. 17/77), enacted in 1977, and amended in 1995 was the principal Legislative Act of Maldives dealing with narcotics. This Law had two tables; one containing a list of illegal drugs and the other containing a list of controlled substances. Both of these tables had been drawn up according to the UN conventions. The Law provided the drug users with an opportunity to seek treatment and become useful members of the society.

**Institutional context:** The National Narcotics Control Board (originally known as Narcotics Control Board) was created in December 1997 to coordinate and implement all activities related to the overall drug control policy and strategy of the country and demand reduction activities. The main policy making body for the AIDS control programme was the National AIDS Council, a multi-sectoral body of government institutions and NGOs.

**Service Provisions: existing responses by civil society organizations and government:** NNCB was the only body legally permitted to provide treatment to drug users through its detoxification centre called the Drug rehabilitation Centre housing more than 300 people. There were no needle syringe exchange, drug substitution or condom distribution programs. NGOs were providing counselling services and were working towards raising awareness.

**Nepal:**

**Drugs and HIV scenario:** The estimated number of PLWHA at the start of “The Project” was 75,000 with an estimated prevalence of 0.5 per cent. The first HIV infection was identified in 1988. HIV prevalence rates among IDUs rose dramatically from zero per cent in 1994 to 50 percent in 1999 and then to 68 percent in 2001.
Injecting drug use was the principal means for heroin use. Use of buprenorphine and sharing of syringes were common practice.

**Legal and Policy Environment:** Nepal was a signatory to the 1961 and 1988 UN convention. The national AIDS Prevention and Control Programme (NAPCP) had been established in 1987. Policies in Nepal provided for needle and syringe exchange and Drug substitution.

**Institutional context:** The Ministry of Home, in collaboration with the Ministries of Health and Education, had the overall responsibility for drug control issues. The HIV/AIDS programme in the country was part of the Ministry of Health. The national coordinating body for HIV/AIDS prevention and control was the National AIDS Coordination Committee (NACC), which was chaired by the Health Minister.

**Service Provisions: existing responses by civil society organizations and government:** NGO supported interventions for IDUs had low coverage and issues around quality control. Methadone was prescribed through the Government’s teaching college for drug substitution treatment, however there were no large-scale, government-run, drug substitution treatment programs. NGOs were using buprenorphine in small quantities for drug substitution treatment.

**Sri Lanka:**

**Drugs and HIV scenario:** At the beginning of “The Project”, there were 5000 estimated PLWHA and the estimated prevalence was less than 1%. The first case of HIV was reported in 1987. In 2003 there were 3500 reported cases of HIV in Sri Lanka. Drug consumption mainly through inhalation was considered to be high. Most commonly used drugs were alcohol, cannabis and heroin. There were an estimated 300,000 drug dependents of whom 40,000 were heroin dependents. Injecting drug use was considered to represent about 1 per cent of drug users.

The country was considered vulnerable due to a range of risk factors, including a growing commercial sex industry, low use of condoms, high and growing number of STDs, external migration, internal mobility and displacement of populations due to conflict, tourism etc.

**Legal and Policy Environment:** The country was a signatory to all 3 UN conventions. The country had two laws that governed the use of drugs. These were The Cosmetic, Devices and Drugs Act (CDA) which dealt with the pharmaceutical drugs and was enacted to regulate the medicinal drugs. Another act was the Poisons, Opium and Dangerous Drugs Act (PODD) which dealt specifically with narcotics and psychotropic substances. PODD allowed medical practitioners to administer, prescribe or supply any dangerous drug to a patient for treatment, implying drug substitution was possible. It however, specifically prohibited methadone by placing it in Group B of its scheduled drugs. The law also prohibited possession of injection paraphernalia except on the orders from the medical practitioner.
**Institutional context:** National Dangerous Drugs Control Board (NDDCB), under the Ministry of Defence, was responsible for overseeing and coordinating all drug control activities of law enforcement as well as prevention, treatment and rehabilitation, through a number of agencies. The National STD/AIDS Control program (NSACP) under the Ministry of Health was the main body for the implementation of HIV programs. There were no NSEP programs and no formal drug maintenance programs in Sri Lanka at the start of the project.

**Service Provisions: existing responses by civil society organizations and government:** NDDCB provided treatment and rehabilitation services through four centres in three major cities with a total capacity of 143 beds and through 7 counselling and rehabilitation centres.

**Justification of the project and main experiences / challenges during implementation**

Building on the achievements of Phase I, Phase II of the project has been planned to be larger in scope and funding. It supports the planning of national responses on the scale required to prevent HIV among drug users.

Rationale for the project:

a. responses to HIV prevention among drug users need to be comprehensive in nature;
b. such responses need to be at sufficient scale to contribute to HIV prevention and reduction in HIV prevalence among drug users; and

c. a skilled workforce drawn from both government and civil society is required.

**Main challenges:**

The fast changing nature of the HIV epidemic, its dynamic interface with the problem of drug use and the fast changing political environment in the South Asia region can adversely affect the project design, implementation plan/s and objective. To counter this aspect the project has been engaging with local, national and regional counterparts also through advocacy initiatives and has seen significant success. However, much remains to be done/seen, to ensure that issues impeding the HIV response for drug users is of the scale required to achieve 100%.

- **Drug use remains a public health crisis** - In many countries, sub-populations of injecting/incarcerated drug users and similar other high risk populations have much higher HIV prevalence than the general population. Measures to improve legal environments for services to drug users can assist HIV programmes to reach these populations who are most-at-risk of HIV, and stem the spread of the epidemic.

- **Punitive legal responses undermine efforts to halt and reverse HIV and AIDS** – In some countries in the region, there is a trend towards use of punitive laws to address HIV, especially amongst drug users. Punitive legal environments make it more difficult for HIV programmes to reach people who inject drugs. Leadership is required to reverse this situation. Laws and law enforcement practices should support people living with HIV and most-at-risk populations to access HIV services – not drive them away. Protecting public health and promoting human rights are mutually reinforcing strategies. This is being addressed by the project but requires long
term engagement which may go beyond the project period.

- Legal support to harm reduction will prevent HIV spread due to injecting drugs.
- Injecting drug use should be considered primarily as a health issue, not a criminal justice issue. Harm reduction approaches that have proved to be effective in preventing HIV include needle and syringe programmes, substitution therapy (e.g. methadone programmes), peer education and decriminalization of possession of injecting equipment. It is essential that people working in harm reduction services, including outreach workers, are allowed to work without fear of arrest. This may require licensing of harm reduction services and legislation to protect needle and syringe programme workers from prosecution for carrying out their work.

**Project documents and revisions of the original project document**

Based on the initial project document for Phase I, recommendations from the review of Phase I and newer needs arising from the changing situations in the partner countries, an updated project document was developed for the Phase II (RASH13 Prevention of transmission of HIV among drug users in SAARC countries Phase II-2007-2012).

The project was revised twice during the course of time:

- **Revision I** was effected in 2012, the objectives for the revision were as below:
  (i) to absorb additional funding of USD 822,417 received from The Global Fund to fight AIDS, Tuberculosis and Malaria (GF ATM) for developing standard operating procedures, development of training modules, training of trainers and helping the National AIDS Control Organisation (NACO) to scale up activities by providing evidence and suggestion regarding the gaps in the current national program aimed at IDUs.
  (ii) to conduct the feasibility assessment of Methadone Maintenance treatment (MMT) in India; and
  (iii) to implement programmed activities aiming at HIV Prevention among injecting drug users in line with the approved work-plan for the project.

- **Revision II** was effected in 2013, with the following objectives:
  (i) to extend the duration of the project till 31 October 2015.
  (ii) to absorb additional funding of USD 465,000 to be received from The Global Fund to fight AIDS, Tuberculosis and Malaria (GF ATM) for developing standard operating procedures, training modules, conduct training of trainers and helping the National AIDS Control Organisation (NACO) to scale up activities for injecting drug users and their partners by providing evidence and suggestion regarding the gaps in the current national program aimed at IDUs; and
  (iii) to bring to logical conclusions programmed activities aimed at HIV Prevention among injecting drug users in line with the originally approved work-plan for the project.
The overall objectives, outcomes and execution modality of the project remained realistic and unchanged during all the revisions.

**UNODC strategy context, including the project’s main objectives and outcomes and project’s contribution to UNODC country, regional or thematic programme**

As indicated in the Strategic project framework (SPF) for South Asia, one of the strategic objectives of UNODC ROSA is to provide the means for key stakeholders to prevent the spread of drug abuse and related drug-abuse-driven HIV in South Asia, especially among vulnerable populations.

The project refers to the following:

**Strategic Framework Sub programme** -Sub programme 5: Health and livelihood (Combating Drugs and HIV)

**Regional Programme** –Sub programme 5: Drug use prevention and treatment and HIV/AIDS treatment and care

This project has been strategized to respond to the twin epidemics of drug use and HIV in SAARC countries by supporting governments and communities to scale up comprehensive prevention and care programs for drug users especially for Injecting Drug Users and their regular sex partners.

### II. DISBURSEMENT HISTORY

<table>
<thead>
<tr>
<th>Over all Budget</th>
<th>Total Approved Budget (time period)</th>
<th>Expenditure (time period)</th>
<th>Expenditure in % (time period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>USD 10,338,203</td>
<td>USD 9,584,984</td>
<td>USD 9,211,642</td>
<td>96%</td>
</tr>
</tbody>
</table>

### III. PURPOSE OF THE EVALUATION

**Reasons behind the evaluation taking place**

The final, end-of-project independent evaluation will be conducted by an independent, external team. The evaluation is mandatory, undertaken as agreed with the donors and as planned and budgeted in the approved project document. It will assess programmatic progress (and challenges) at the outcome level, with measurement of the output level achievements and gaps and how/to what extent these have affected outcome-level progress. The evaluation will consist of desk review, country visits, in-depth interviews with UNODC staff and in-depth interviews with key stakeholders and beneficiaries as well as an online survey. It will contribute to results-based management through a participatory approach that documents results achieved, challenges to progress, and
contributions to the creation of a more conducive environment for addressing needs of People Who Use Drugs and those affected by HIV.

Evaluation Objectives:

The specific evaluation objectives are to:

- Analyze the relevance of the programmatic strategy and approaches;
- Validate project results in terms of achievements and/or weaknesses toward the outcomes and outputs, with a critical examination of how/to what extent the project supported the national governments in creating an enabling environment and removing barriers to improved scale-up of HIV prevention, treatment and care programs for People Who Use Drugs (especially injectors) and their sex partners;
- Assess the potential for sustainability of the results and the feasibility of ongoing, nationally led efforts in achieving optimum coverage of comprehensive HIV prevention, treatment and care services for People Who Use Drugs and their sex partners;
- Document lessons learned, good practices, success stories and challenges to inform future work of various stakeholders in addressing rights based and gender sensitive approach within the context of providing comprehensive HIV prevention, treatment and care services to People Who Use Drugs and their sex partners; and
- Document and analyze possible weaknesses in order to improve future interventions in the area of health services for People Who Use Drugs and their sex partners in the region.

The information generated by the evaluation will be used by different stakeholders to:

- Contribute to building the evidence base on effective strategies for addressing the needs of People affected and effected by HIV and also People Who Use Drugs.
- Support to contribute to strategic planning to convert the project outputs into sustainable outcomes.
- Facilitate UNODC’s strategic reflection and learning for programming in addressing the needs of People affected and effected by HIV and also People Who Use Drugs in support of the development of the outcomes of the UNODC’s next Regional Programme for South Asia.

Under the overall guidance of UNODC Independent Evaluation Unit, the evaluation process will be coordinated by the Project Coordinator in close consultation with the Independent Evaluation Unit, the Regional Representative, UNODC based at the Regional Office in New Delhi, as well as with key Government counterparts.
The other key stakeholders of the evaluation will be members of the government and civil society who have been involved in implementation of key initiatives outlined in the project documents. The government and civil society partners, in consultation with respective UNODC team propose a Core Learning Partnership (CLP) to encourage a participatory evaluation process from the beginning to the end of the evaluation. Members of the CLP shall be the national counterparts in the project countries and the Civil Society represented by NGOs, members of selected academic and research institutes, as deemed applicable. A detailed list of CLP members is provided in Appendix.

Assumed accomplishment of the evaluation

The project has gone through an evolutionary process of responding to the changing drug HIV scenario, subsequent responses and the needs of the governments. The project, under the guidance of the PSC, has modified its plans with the changing scenario to better respond to the needs of the national governments and the community networks.

The evaluation will help measure and document the concrete achievements of the project in terms of:

- Effectiveness of the project’s evolutionary planning with the changing situations and needs in the partner countries
- Project planning versus service delivery
- Project’s role and effectiveness in (regionally and in individual countries):
  - Introducing evidence based harm reduction and drug treatment services through advocacy, legal and policy changes
  - Scaling up of harm reduction and drug treatment services
  - Capacity building of service providers for delivering harm reduction and drug treatment services
  - Quality assurance
  - Evidence generation
  - Generating additional funds
  - Sustainability of on ground interventions
  - Innovations –especially in terms of resource generation, utilisation and partnerships
- Weaknesses and shortfalls-for future planning

The main evaluation users

The main users of this evaluation will be the UNODC to use the findings, lessons and recommendations for future programming in the region. The next user of the report will be the governments particularly the health (drugs and HIV) related Ministries to use the findings, lessons and recommendations to understand the situation and progress of their collaboration. The partner NGOs will also benefit from this evaluation in knowing the effectiveness and drawbacks of their involvement and approaches.

- Donors
- UNODC HQ
- UNODC Regional Office
- Governments of individual countries
IV. SCOPE OF THE EVALUATION

The scope of the evaluation is limited to project activities in the Project Countries i.e., Bangladesh, Bhutan, India, Maldives, Nepal, and Sri Lanka. The evaluation will cover the time period from July 2007 (when Phase 2 of the project started) through September 2016. The evaluation will start with the Desk review, followed by a briefing session at UNODC Regional Office for South Asia (New Delhi, India). Field missions to selected project countries will be held subsequently. The evaluation team in consultation with the project managers and the IEU will select the countries to be visited during the Inception Phase of the evaluation. The evaluation team will review documents, develop an evaluation methodology in an Inception Report, develop and disseminate a survey, meet and interview stakeholders and beneficiaries, undertake field visits and draft the evaluation report and subsequently finalise the evaluation report and hold a presentation of the evaluation findings. The level of engagement of the Evaluators with stakeholders may vary accordingly, and may include telephone interviews as well as a survey.

The Evaluators will assess project strategy, approaches and design with special reference to the following key areas: Relevance, Efficiency, Effectiveness, Impact, Sustainability, Partnerships and Cooperation, Innovation, Lessons Learned and Best Practices as well as Human Rights and Gender.

The Evaluators will focus on crucial and strategic issues during project design and implementation. The major emphasis will be on measuring outcomes, impact, and sustainability of project results. The evaluation will also analyse project concept and design, and project implementation.

The Evaluators will also assess whether the desired results have been achieved, and if not, whether there has been some progress made towards their achievement, whether the programme addresses the identified needs/problem (relevance), whether the programme/project contributes to a priority area or comparative advantage for UNODC in the country or region.

The Evaluators will ensure that lessons learnt and best practices from the project will be recorded and recommendations on possible follow-up activities will be made as appropriate. The evaluation will also assess the spin-offs, if any, as well as any achievements, beyond the project mandate. While analyzing the challenges in implementation, the efforts made to address the challenges will also be evaluated including efforts made to sustain the activities. This ToR guiding the evaluation defines the major parameters and core questions/issues which the evaluation seeks to answer in its final report. The Evaluators will develop specific questions and required instruments (questionnaire/checklist) to gather field information in order to fulfil the evaluation ToR requirements.

Project Outputs, Outcome, Impact and Sustainability:
The Evaluators will assess the achievements of project objectives, 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 project objectives. The Evaluators will, in particular, assess:

a. The anticipated positive and negative, intended and unintended, effects of interventions on beneficiaries, institutions, and the physical environment after implementation of project.

b. The perceptions of the different stakeholders, especially government counterparts, implementing partners, and other relevant agencies, about the overall impact of project interventions.

c. The sustainability of project results after the project completion in terms of continuity of the project activities either by the government or by implementing partner after the project funding.

Findings, Lessons learned, best practices and Recommendations

The Evaluators will make recommendations, as appropriate. Recommendations may also be made in respect of issues related to the planning, execution and implementation of the project. They should constitute ideas and 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 national/regional projects.

The Evaluators will record lessons learned and best practices from the project, which are valid beyond the project itself. The evaluation shall also record the difference this project has made to the beneficiaries and their willingness to sustain the activities.

Recommendations made should be:

- Understandable and clear for the users
- Useful and relevant: recommendations must be realistic and reflect potential constraints to follow up on them
- Actionable and implementable: recommendations should identify what should be done, by whom and by when. Each recommendation should clearly identify its target group and stipulate the recommended action and rationale.
- Timely

The time period to be covered by the evaluation

The evaluation will cover the period July 2007 till date.

The geographical coverage of the evaluation

Bangladesh, Bhutan, Nepal, Sri Lanka, Maldives and India

V. EVALUATION CRITERIA AND KEY EVALUATION QUESTIONS

The evaluation will be conducted based on the following DAC criteria: relevance, efficiency, effectiveness, impact, sustainability, as well as partnerships and cooperation,
gender and human rights and lesson learned, and, will respond to the following below questions, however, provided as indicative only, and required to be further refined by the Evaluation Team.

<table>
<thead>
<tr>
<th>Relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td>is the extent to which the objectives of a project are continuously consistent with recipients' needs, UNODC mandate and overarching strategies and policies.</td>
</tr>
<tr>
<td>1. How relevant is the project to beneficiaries, including Governments’, needs and priorities?</td>
</tr>
<tr>
<td>2. To what extent is the project aligned with the policies and strategies of the Governments of the region in addressing HIV prevention and treatment as well as the UNODC Regional Programme for Southeast-Asia and Pacific?</td>
</tr>
<tr>
<td>3. How did the project respond to the changing drug, HIV and related legal and policy situations to remain relevant to the needs of the beneficiaries?</td>
</tr>
<tr>
<td>4. To what extent are the outputs, outcomes and objectives of this project/programme relevant to implementing the Sustainable Development Goals?</td>
</tr>
<tr>
<td>5. How could the project increase its relevance for beneficiaries in the region?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>is a measure of how resources/inputs (funds, expertise, time, etc.) are converted into outputs</td>
</tr>
<tr>
<td>1. To what extent were the project inputs appropriate in terms of funds, staff and other resources for the objectives and delivery mode?</td>
</tr>
<tr>
<td>2. To what extent did the project inputs provide value-for-money and were delivered within stated time frames?</td>
</tr>
<tr>
<td>3. To what extent did the project identify risks (existing and new) to progress and outcomes and how have they been managed, with what impacts/consequence?</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Effectiveness</th>
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</thead>
<tbody>
<tr>
<td>is the extent to which a project or programme achieves its objectives and outcomes.</td>
</tr>
<tr>
<td>1. To what extent were the planned objectives and outcomes in the project document achieved? What was not achieved in full and why?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>is the positive and negative, primary and secondary long-term economic, environmental, social change(s) produced or likely to be produced by a project, directly or indirectly, intended or unintended after the project was implemented</td>
</tr>
<tr>
<td>1. Has the project contributed or is likely to contribute to long-term social, economic, technical changes for individuals, communities, and institutions related to the project?</td>
</tr>
<tr>
<td>2. What difference has the project made to the beneficiaries?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>is concerned with measuring whether the benefits of a project or programme are likely to continue after its termination. Projects need to be environmentally as well as financially</td>
</tr>
<tr>
<td>1. To what extent are the project results likely to continue after the project ends?</td>
</tr>
</tbody>
</table>
2. To what extent will the project activities and delivery approach lead to enduring benefits after the project funding cease?

<table>
<thead>
<tr>
<th>Partnerships and cooperation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation assesses the partnerships and cooperation established during the project/ programme as well as their functioning and value.</td>
</tr>
</tbody>
</table>

1. To what extent have partnerships been sought and established (including UN agencies as well as UNODC) and synergies been created in the delivery of assistance?

2. To what extent are the built partnerships likely to continue even after the end of the project?

3. To what extent has civil society engagement proved beneficial in service delivery?

<table>
<thead>
<tr>
<th>Human rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation needs to assess the mainstreaming of human rights aspects throughout the project/programme.</td>
</tr>
</tbody>
</table>

1. To what extent were human rights considerations mainstreamed into project development and implementation?

2. To what extent did the project foster the understanding of human rights in its activities, outputs and outcomes?

<table>
<thead>
<tr>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evaluation needs to assess the mainstreaming of gender aspects throughout the project/ programme.</td>
</tr>
</tbody>
</table>

1. To what extent does the project include gender-sensitive outcomes into its objectives and is there evidence of progress towards it?

2. Does the project advance gender equality and promote women’s empowerment through: advancing equal access to gender-responsive health and education services and increasing women’s voice in decision making?

3. Were there any changes made by partners in response to evidence of gender impacts?

<table>
<thead>
<tr>
<th>Lessons learned and Best Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lessons learned concern the learning experiences and insights that were gained throughout the project/programme.</td>
</tr>
</tbody>
</table>

1. What positive and/or negative lessons can be learnt from the implementation of the project?

2. What lessons can be learned for the implementation of future UNODC projects on preventing the transmission of HIV among drug users in the SAARC countries?

3. What best practices of this project can be identified and should be replicated in the future?

VI. EVALUATION METHODOLOGY

The methods used to collect and analyse data

This evaluation will use methodologies and techniques as determined by the specific needs for information, the questions set out in the TORs and the availability of resources. In all cases, evaluators are expected to analyse all relevant information sources, such as reports, programme documents, thematic programmes, internal review reports, programme files, evaluation reports (if available), financial reports and any other documents that may provide further evidence for triangulation on which their conclusions will be based. Evaluators are also expected to use interviews, surveys or any other relevant quantitative and/or qualitative tools as a means to collect relevant data for the evaluation. While maintaining independence, the evaluation will be carried out based on a participatory
approach, which seeks the views and assessments of all parties identified as main evaluation users, the Core Learning Partners (CLP).

The present ToR provides basic information as regards to the methodology, however this should not be regarded as exhaustive. It is rather meant to guide the evaluators in elaborating an effective, efficient, and appropriate evaluation methodology that should be proposed, explained and justified in an Inception Report.

The evaluators will present a summarized methodology (evaluation matrix) in an Inception Report which will specify the evaluation criteria, indicators, sources of information and methods of data collection. The evaluation methodology must conform to the United Nations Evaluation Group (UNEG) Norms and Standards.

While the evaluators shall fine-tune the methodology for the evaluation in an Inception Report, a mixed-methods approach of qualitative and quantitative methods is mandatory. Special attention shall be paid to an unbiased and objective approach and the triangulation of sources, methods, data, and theories. Indeed, information stemming from secondary sources will be cross-checked and triangulated through data retrieved from primary research methods. Primary data collection methods need to be gender sensitive.

The credibility and analysis of data are key to the evaluation. Rival theories and competing explanations must be tested once plausible patterns emerge from triangulating data stemming from primary and secondary research.

The limitations to the evaluation will be identified by the evaluators in the Inception Report, e.g. data constraints (such as missing baseline and monitoring data), which may create the need for the evaluators to retrospectively reconstruct the baseline data and to further develop result orientation of the programme.

The main elements of method will include:

- Preliminary desk review of all relevant project documentation, (Annex II), as provided by the Project Manager and further requested by the evaluation team;
- Preparation and submission of an Inception report (containing preliminary findings of the desk review, refined evaluation questions, data collection instruments, sampling strategy, limitations to the evaluation, and timetable) to Project Management (review for factual errors) and IEU for review and clearance before any field mission may take place;
- Initial meetings and interviews with Project Manager and other UNODC staff;
- Dissemination of the survey to all stakeholder groups of the project;
- Interviews (face-to-face or by telephone), with key project stakeholders and
beneficiaries, both individually and (as appropriate) in small groups/focus groups, as well as using surveys, questionnaires or any other relevant quantitative and/or qualitative tools as a means to collect relevant data for the evaluation; including field missions.

- Analysis of all available information;

- Preparation of the draft evaluation report (based on Guidelines for Evaluation Report and Template Report to be found on the IEU website http://www.unodc.org/unodc/en/evaluation/index.html). The evaluators submit the draft report first to Project Managers for the review of factual errors and afterwards to IEU for quality control. Once the draft report is cleared, IEU or Project Management shares the final draft report with all Core Learning Partners for comments on factual errors.

- Preparation of the final evaluation report. The evaluators incorporate the necessary and requested changes and finalizes the evaluation report; following feedback from IEU, the Project Manager and CLPs for IEU clearance. It further includes a PowerPoint presentation on final evaluation findings and recommendations;

- Presentation of the evaluation results to internal and external stakeholders;

- In conducting the evaluation, the UNODC and the UNEG Evaluation Norms and Standards are to be taken into account. All tools, norms and templates to be mandatorily used in the evaluation process can be found on the IEU website: http://www.unodc.org/unodc/en/evaluation/index.html

**The sources of data**

The evaluation will utilize a mixture of primary and secondary sources of data. The primary sources for the desk review may include, among others, interviews with key stakeholders (face-to-face or by telephone), the use of surveys and questionnaires, field missions for case studies, focus group interviews, observation and other participatory techniques. Secondary data sources will include the project documents and their revisions, progress and monitoring reports and all other relevant documents, including visual information (e.g. pictures, videos, etc.).

**Desk Review**

The evaluators will perform a desk review of existing documentation (please see the preliminary list of documents to be consulted in Annex II). This list is however not to be regarded as exhaustive, as additional documentation may be requested by the evaluators.

**Primary Research Methods**

Primary sources of data include, among others:

- Qualitative methods: structured and semi-structured interviews with key stakeholders, key representatives of different entities (face-to-face, by telephone or by webcam).
- Quantitative methods: survey questionnaires.
- Field mission
Phone interviews / face to face consultations  
The evaluators will conduct phone interviews / face-to-face consultations with identified individuals from the following groups of stakeholders:

- Member States
- relevant international and regional organizations;
- Non-governmental organizations working with UNODC;
- UNODC management and staff Etc.

Questionnaire  
A questionnaire (on-line) will be developed and used in order to help collect the views of stakeholders (e.g. trainees, counterparts, partners, etc.), if deemed appropriate.

TIMEFRAME AND DELIVERABLES

Time frame for the evaluation  
The evaluation will be carried out in **July-October 2016**

Expected deliverables and time frame:  
The evaluation team will submit the following:

- Draft and Final Inception report, including the evaluation objectives and scope, description of evaluation methodology/methodological approach, data collection tools, data analysis methods, key informants/agencies, evaluation questions, performance criteria, issues to be studied, work plan and reporting requirements (to be reviewed and cleared by IEU before the field mission)
- Draft and Final Evaluation report (including management response, if needed) highlighting key evaluation findings and conclusions, lessons learned and recommendations (to be reviewed and cleared by IEU)
- Power Point presentation and an outline on findings, lessons learned and recommendations.

Language of all the deliverables will be English

*(The actual dates will vary based on the time and date when the Consultants will be on board. This table is therefore indicative only):*  

| Duties                  | Time frame | Location | Deliverables |
|-------------------------|------------|----------|--------------|--------------|

69
<table>
<thead>
<tr>
<th>Task</th>
<th>Date Range</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review and preparation of draft Inception Report</td>
<td>15/07/2016 – 27/07/2016 (9 working days)</td>
<td>Home base</td>
<td>Draft Inception report containing: preliminary findings of the desk review, refined evaluation questions, data collection instruments (including questionnaire and interview questions), sampling strategy, evaluation matrix and limitations to the evaluation.</td>
</tr>
<tr>
<td>Review and subsequent clearance of draft Inception Report by IEU</td>
<td>28/07/2016 – 05/08/2016 (3 working days)</td>
<td>Revised draft Inception Report</td>
<td></td>
</tr>
<tr>
<td><strong>Deliverable A: Final Inception Report in line with UNODC evaluation norms, standards, guidelines and templates</strong></td>
<td>By 10/08/2016 (12 overall working days)</td>
<td>Final Inception report to be cleared by IEU</td>
<td></td>
</tr>
<tr>
<td>Interviews with staff at UNODC ROSA; Evaluation mission: briefing, interviews; presentation of preliminary findings</td>
<td>15/08/2016 – 30/08/2016 (10 working days)</td>
<td>UNODC/ROSA; Countries/Cities to be decided by eval team, PM and IEU</td>
<td>Presentation of preliminary findings to internal stakeholders and IEU</td>
</tr>
<tr>
<td>Drafting of the evaluation report; submission to Project Management for review of factual errors and to IEU for review and</td>
<td>01/09/2016 – 14/09/2016 (10 working days)</td>
<td>Home base</td>
<td>Draft evaluation report</td>
</tr>
<tr>
<td>Consideration of comments from the project manager and incorporation of comments from IEU (can entail various rounds of comments)</td>
<td>28/09/2016 – 30/09/2016 (3 working days)</td>
<td>Home base</td>
<td>Revised draft evaluation report</td>
</tr>
</tbody>
</table>
### Deliverable B: Draft Evaluation Report in line with UNODC evaluation norms, standards, guidelines and templates

**By 30/09/2016 (23 overall working days)**

**Draft evaluation report, to be cleared by IEU**

| Project Management to share draft evaluation report with Core Learning Partners for comments (copying IEU to receive responses) | 05/10/2016 – 14/10/2016 |
| --- |
| Consideration of comments from Core Learning Partners | 17/10/2016 – 19/10/2016 (3 working days) |
| Home base | Revised draft evaluation report |
| Final review by IEU; incorporation of comments and finalization of report | 20/10/2016 – 28/10/2016 (2 working days) |
| Home base | Revised draft evaluation report |

### Deliverable C: Final evaluation report incl. Management response (if needed); presentation of

**By 28/10/2016 (5 overall working days)**

**Final evaluation report; Presentation of evaluation results. All to be cleared by IEU**

| Project Management: Finalise Evaluation Follow-up Plan in ProFi | By 04/11/2016 |
| --- |
| Final Evaluation Follow-up Plan to be cleared by IEU |

| Project Management: Disseminate final evaluation report | Final evaluation report disseminated |

### VIII. EVALUATION TEAM COMPOSITION

**Number of evaluators needed**

The evaluation will be undertaken by two independent evaluators (one Evaluation Team Leader and one substantive expert) who will be contracted on the basis of experience in project evaluation, monitoring, implementation and knowledge of the subject.
The Evaluators should possess extensive knowledge of, and experience in applying, qualitative and quantitative evaluation methods; a strong record in designing and leading evaluations; technical competence in the area of drug abuse prevention and treatment/drug demand reduction (advanced University degree or practical experience) and excellent oral communication and report writing skills in English. The Evaluators could either be a National or international Consultant. Relevant work experience with the UN will be an asset.

The Project team, led by the Project Coordinator will brief the Evaluators. The Evaluators will also consult the Representative of UNODC, Regional Office for South Asia, New Delhi and the competent authorities and any others persons/agencies as s/he deems appropriate. Based on the finalized evaluation methodology the Evaluators will be provided with the mission plans and the project team will facilitate interviews and discussions in the project sites. The Evaluators will present the findings in a concise but comprehensive report.

The timetable of the missions and the allocated budget (as per the UN guidelines) shall be shared with the selected Evaluators.

The role of the Evaluator 1 – Evaluation Team Leader

- Lead and coordinate the evaluation process and the oversee the tasks of the expert;
- Undertake the desk review of all relevant project documentation, (Annex II), and on this basis oversee the finalization of the evaluation methodology, in compliance with the UNODC and UNEG evaluation norms and standards;
- Produce an Inception Report based on the UNODC Evaluation guidelines, as well as a Questionnaire;
- Implement quantitative tools and analyse data; triangulate data and test rival explanations;
- Undertake mission to UNODC ROSA and field mission to the agreed upon project countries and provide appropriate briefings;
- Provide timely coordinated inputs throughout the process to help to ensure that all aspects of the Terms of Reference are fulfilled;
- Draft the evaluation report (with inputs from the expert), to be circulated for comments and factual validation to Project Management and IEU. Once the draft evaluation has been cleared by IEU, it is further sent to Core Learning Partners for their review and comments;
- Consider comments received from IEU, as well as comments on factual errors received from Project Manager, Core Learning Partners;
- Finalize the final evaluation report on the basis of comments received, as well as a PowerPoint presentation on final evaluation findings and recommendations;
- Present the final evaluation report and its evaluation findings and recommendations.

All tools, norms and templates to be mandatorily used in the evaluation process can be found on the IEU website: to be found on the IEU website, http://www.unodc.org/unodc/en/evaluation/index.html)

More details will be provided in the job description in Annex I.

The role of the Evaluator 2 – Substantive Expert
● contribute with specific knowledge on HIV/AIDS;
● carry out the desk review;
● in collaboration with the Lead Evaluator, draft the inception report (in particular, the parts relevant to his/her expertise);
● implement data collection tools and analyze data;
● triangulate data and test rival explanations;
● in collaboration with the Lead Evaluator, draft an evaluation report (in particular, the parts relevant to his/her expertise) in line with the UNODC evaluation policy, guidelines and templates;
● review and finalize the evaluation report on the basis of comments received;
● in collaboration with the Lead Evaluator, present the findings and recommendations of the evaluation as required.
● Participate in field missions, if needed.
● Act as interpreter, if needed.
More details will be provided in the respective job descriptions in Annex I.

Absence of Conflict of Interest

According to UNODC rules, the consultant must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefited from the programme/project or theme under evaluation.

Please refer to Annex I and II for the details of the evaluation team’s ToR.

IX. MANAGEMENT OF EVALUATION PROCESS

Roles and responsibilities of the Project Manager

The Project Manager is responsible for:

● managing the evaluation,
● drafting and finalizing the ToR,
● selecting Core Learning Partners (representing a balance of men, women and other marginalised groups) and informing them of their role,
● recruiting evaluators following clearance by IEU,
● providing desk review materials (including data and information on men, women and other marginalised groups) to the evaluation team including the full TOR,
● reviewing the inception report as well as the evaluation methodology,
● liaising with the Core Learning Partners,
● reviewing the draft report for factual errors,
● developing an implementation plan for the evaluation recommendations as well as follow-up action (to be updated once per year),
● disseminate the final evaluation report and facilitate the presentation of evaluation
results;
The Project Manager will be in charge of providing logistical support to the evaluation team including arranging the field missions of the evaluation team, including but not limited to:

- All logistical arrangements for the travel of the consultants as well as IEU staff (including travel details; DSA-payments; transportation; etc.)
- All logistical arrangement for the meetings/interviews/focus groups/etc., ensuring interview partners adequately represent men, women and other marginalised groups (including translator/interpreter if needed; set-up of meetings; arrangement of ad-hoc meetings as requested by the evaluation team; transportation from/to the interview venues; scheduling sufficient time for the interviews (around 45 minutes);

ensuring that members of the evaluation team and the respective interviewees are present during the interviews; etc.)

- All logistical arrangements for the presentation of the evaluation results;
- Ensure timely payment of all fees/DSA/etc. (payments for the evaluators need to be released within 5 working days after the respective deliverable is cleared by IEU).

For the field missions, the evaluation team liaises with the UNODC Regional/Field Offices and mentors as appropriate

Roles and responsibilities of the evaluation stakeholders

Members of the Core Learning Partnership (CLP) are identified by the project managers. The CLPs are the main stakeholders, i.e. a limited number of those deemed as particularly relevant to be involved throughout the evaluation process, i.e. in reviewing and commenting on the TOR and the evaluation questions, reviewing and commenting on the draft evaluation report, as well as facilitating the dissemination and application of the results and other follow-up action. Stakeholders include all those to be invited to participate in the interviews and surveys, including the CLPs.

Roles and responsibilities of the Independent Evaluation Unit

The Independent Evaluation Unit (IEU) provides mandatory normative tools, guidelines and templates to be used in the evaluation process. Please find the respective tools on the IEU website http://www.unodc.org/unodc/en/evaluation/evaluation.html. Furthermore, IEU provides guidance and evaluation expertise throughout the evaluation process.

IEU reviews and clears all steps and deliverables during the evaluation process:: Terms of Reference; Selection of evaluator(s); Inception Report; Draft Evaluation Report; Final Evaluation Report; Evaluation Follow-up Plan.

IEU might participate in any stage of this evaluation as part of the evaluation team (e.g. data collection).

X. PAYMENT MODALITIES

Consultants will be issued lumpsum consultancy contracts (including consultancy fee, travel, Boarding & Lodging and Miscellaneous costs). The payment will be done in accordance with UNODC rules and regulations on completion of deliverables as per the details given below:
The evaluator(s) will be issued consultancy contracts and paid in accordance with UNODC rules and regulations. The contract is a legally binding document in which the evaluator agrees to complete the deliverables by the set deadlines. Payment is correlated to deliverables and three installments are typically foreseen:

- The first payment upon clearance of the Inception Report (in line with UNODC evaluation norms, standards, guidelines and templates) by IEU;

- The second payment upon clearance of the Draft Evaluation Report (in line with UNODC norms, standards, evaluation guidelines and templates) by IEU;

- The third and final payment (i.e. the remainder of the fee) only after completion of the respective tasks, receipt of the final report (in line with UNODC evaluation norms, standards, guidelines and templates) and clearance by IEU, as well as presentation of final evaluation findings and recommendations.

- 75 percent of the daily subsistence allowance and terminals is paid in advance before travelling. The balance is paid after the travel has taken place, upon presentation of boarding passes and the completed travel claim forms.
ANNEX II. JOB TOR OF EVALUATORS

A. Terms of Reference for Team Leader

Title: Independent Evaluator (Team Leader)

Organisational Section/Unit: United Nations Office on Drugs and Crime. Regional Office for South Asia.

Name and title of Supervisor: Ms. Katharina Kayser

Duty Station or home-based: Home-based/missions to India; further missions to Bangladesh, Bhutan, Nepal, Sri Lanka, Maldives and India (to be confirmed)


Period 2: 17 October – 28 October 2016

Actual work time: 40 working days

Fee Range: C

1. Background of the assignment:

The United Nations Office on Drugs and Crime is the main UN agency in the fight against illicit drugs, crime, corruption and terrorism in virtue of the UN Conventions and Universal Instruments in this regard.

The UNODC Regional Office for South Asia is located in New Delhi (India) and covers six countries of the region: Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka. Its Regional Programme for South Asia” Promoting the rule of Law and countering drugs and crime in South Asia (2013-2015)” has five sub-programmes relating to (1) addressing transnational organized crime, (2) countering corruption, (3) terrorism prevention, (4) promoting efficient, fair and humane justice systems and (5) drug use prevention and treatment and HIV. In keeping with its sub-programme (5), UNODC Regional Office for South Asia is supporting a regional project titled “Prevention of transmission of HIV among Drug Users in SAARC countries (RAS/H13)” that is being implemented in partnership with the governments of the member countries of the SAARC region.

The project focuses on creating an enabling environment and removing barriers to improved scale-up of HIV prevention and care programs for injecting drug users (IDUs) and oral opioid users through advocacy and demonstration. Its overall aim is to foster
national responses which are conducive to the scale required to achieve 100% coverage of comprehensive HIV prevention and care services for injecting drug users.

The project is nearing its completion and as per its approved project document would like to carry out a final independent project evaluation. The purpose of this evaluation is to measure achievements of project objectives, outcomes and impact. The overall expectation of the evaluation is to draw lessons from project implementation that form the basis for instituting improvements to the existing and future project planning, design and management. It will also help UNODC and other stakeholders to take stock of the project, learn from its implementation process and results, and identify gaps. In this regard UNODC seeks to engage an evaluation team leader to conduct this final independent project evaluation. The time frame covered by the evaluation is 2007 up to September 2016 with a special focus on 2010 to September 2016.

2. **Purpose of the assignment:**

The purpose of this assignment is to undertake the final independent project evaluation of the UNODC project RAS/H13. In line with the approved project document, the final Independent Project Evaluation of RAS/H13 will be undertaken between –July and October 2016 with the following purposes:

- to review progress and get feedback and appraisal on the activities undertaken;
- to identify areas for improvement and propose solutions;
- to determine to which extent the project objective was met and whether resources were wisely utilized;
- to assess the relevance, efficiency, effectiveness, impact and sustainability of the project as well as human rights and gender;
- to identify lessons learned and provide recommendations for future UNODC drug use and HIV prevention projects.

The results of the evaluation will be used internally by UNODC staff members, Member States and other organizational units of UNODC, etc.

The overall evaluation process and field based activities in the SAARC region will be conducted in consultation with the Project Coordinator (RAS/H13), under the guidance and overall supervision of the UNODC Independent Evaluation Unit, as well as in consultation with the Representative, UNODC, Regional Office for South Asia in line with UNODC’s evaluation policy and UNEG Norms and Standards.

The Independent Evaluation Unit reviews and clears all deliverables of this independent evaluation.

3. **Specific tasks to be performed by the evaluation consultant:**

Under the guidance of the Independent Evaluation Unit, the key responsibilities of the evaluator include (i) development of the evaluation design with detailed methods, tools and techniques that are gender-inclusive and gender-sensitive, generating
information from and about men, women and other marginalised groups as well as about key gender as well as human rights issues (ii) ensuring adherence to the UNEG Norms and Standards, UNODC evaluation norms, standards, guidelines and templates and the evaluation TOR, and (iii) ensuring that all deliverables are submitted in a timely and satisfactory manner and in line with the quality criteria checklist.

According to UNODC rules, the evaluator must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefited from the programme/project or theme under evaluation.

The evaluator shall respect the UNEG Ethical Guidelines.

4. **Expected tangible and measurable output(s):**

The Evaluation Team Leader will have the overall responsibility for the quality and timely submission of all the deliverables (including those of the Substantive Expert), as specified below. All products should be well written, inclusive and have a clear analysis process

- Lead and coordinate the evaluation process and oversee the tasks of the expert;
- Undertake the desk review of all relevant project documentation and on this basis finalize the evaluation methodology and tools in coordination with the Substantive Expert, in compliance with the UNODC and UNEG evaluation norms and standards;
- Produce an Inception Report based on the UNODC Evaluation guidelines, as well as a Questionnaire in coordination with the Substantive Expert;
- Implement quantitative tools and analyse data; triangulate data and test rival explanations in coordination with the Substantive Expert;
- Undertake mission to UNODC ROSA and field mission to the agreed upon project countries and provide appropriate briefings;
- Provide timely coordinated inputs throughout the process to help to ensure that all aspects of the Terms of Reference are fulfilled;
- Draft the evaluation report (with inputs from the expert), to be circulated for comments and factual validation to Project Management and IEU. Once the draft evaluation has been cleared by IEU, it is further sent to Core Learning Partners for their review and comments;
- Consider comments received from IEU, as well as comments on factual errors received from Project Manager, Core Learning Partners;
- Finalize the final evaluation report on the basis of comments received, as well as a PowerPoint presentation on final evaluation findings and recommendations;
- Present the final evaluation report and its evaluation findings and recommendations


*Please note that those guidelines and templates must be used for this evaluation process. IEU reviews and clears all deliverables and provides quality assurance throughout the process.*
5. Dates and details as to how the work must be delivered:

The consultant will be hired full time for 43 working Days (home-based and field missions) between July and October 2016

On the basis of the Evaluation Terms of Reference, s/he will carry out the following deliverables and tasks. A time-bound calendar will be proposed when the contract will be signed.

*The detailed, tentative timeline for the evaluation is as follows:*

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Output</th>
<th>Working Days</th>
<th>To be accomplished by (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Inception Report</td>
<td>12</td>
<td>10 August 2016</td>
</tr>
<tr>
<td>C.</td>
<td>Final Evaluation Report</td>
<td>5</td>
<td>28 October 2016</td>
</tr>
</tbody>
</table>

75 percent of the daily subsistence allowance and terminals is paid in advance before travelling. The balance is paid after the travel has taken place, upon presentation of boarding passes and the completed travel claim forms.

Payments will be made upon satisfactory completion and/or submission of outputs/deliverables and cleared by IEU.

6. Indicators to evaluate the consultant’s performance:

Timely and satisfactory delivery of the above mentioned outputs as assessed by IEU (in line with UNODC evaluation policy, handbook, guidelines and templates as well as UNEG Standards and Norms).

7. Qualifications/expertise sought (required educational background, years of relevant work experience, other special skills or knowledge required):

- Advanced university degree in international development, health, law, public administration, public health, social science, or in a related field, and formal training/education on evaluation methodologies and principles;
A minimum of 7 years of professional technical experience in the field of evaluation, including a track record of conducting various types of evaluation, preferably with experience in conducting one of several contributions to the accomplishment of evaluations for the United Nations, involving high complexity and impact is desired;

Experience in the subject of evaluation preferably in a development/health-related field (HIV/AIDS prevention), law enforcement, research, criminal justice, countering illicit trafficking and organized crime, drug trafficking, anti-corruption, justice and health areas or other related areas;

Extensive knowledge of, and experience in applying, qualitative and quantitative evaluation methods and experience in gender sensitive evaluation methodologies and analysis, and understanding of human rights and ethical issues related to evaluation;

Working experience in the region specific to the project;

Expertise and knowledge of the UN System, and preferably of UNODC;

Excellent communication and evaluation report drafting skills in English;

Fluency in oral and written English is required; the ability to communicate in another UN language is a strong asset.
B. Terms of Reference for Evaluator 2: Substantive Expert

Title: Independent Evaluator (Team Leader)
Organisational Section/Unit: United Nations Office on Drugs and Crime. Regional Office for South Asia.
Name and title of Supervisor: Ms. Katharina Kayser
Duty Station or home-based: Home-based/missions to India; further missions to Bangladesh, Bhutan, Nepal, Sri Lanka, Maldives and India (to be confirmed)
Actual work time: 30 working days

The United Nations Office on Drugs and Crime is the main UN agency in the fight against illicit drugs, crime, corruption and terrorism in virtue of the UN Conventions and Universal Instruments in this regard.

The UNODC Regional Office for South Asia is located in New Delhi (India) and covers six countries of the region: Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka. Its Regional Programme for South Asia” Promoting the rule of Law and countering drugs and crime in South Asia (2013-2015)” has five sub-programmes relating to (1) addressing transnational organized crime, (2) countering corruption, (3) terrorism prevention, (4) promoting efficient, fair and humane justice systems and (5) drug use prevention and treatment and HIV. In keeping with its sub-programme (5), UNODC Regional Office for South Asia is supporting a regional project titled “Prevention of transmission of HIV among Drug Users in SAARC countries (RAS/H13)” that is being implemented in partnership with the governments of the member countries of the SAARC region.

The project focuses on creating an enabling environment and removing barriers to improved scale-up of HIV prevention and care programs for injecting drug users (IDUs) and oral opioid users through advocacy and demonstration. Its overall aim is to foster national responses which are conducive to the scale required to achieve 100% coverage of comprehensive HIV prevention and care services for injecting drug users.

The project is nearing its completion and as per its approved project document would like to carry out a final independent in-depth evaluation. The purpose of this evaluation is to measure achievements of project objectives, outcomes and impact. The overall expectation of the evaluation is to draw lessons from project implementation that form the basis for instituting improvements to the existing and future project planning, design and management. It will also help UNODC and other stakeholders to take stock of the project, learn from its implementation process and results, and identify gaps. In this regard UNODC seeks to engage an evaluation team leader to conduct this final
independent in-depth evaluation. The time frame covered by the evaluation is 2007 up to September 2016 with a special focus on 2010 to September 2016.

2. Purpose of the assignment:

The purpose of this assignment is to participate as a team member (HIV/AIDS expert) in the final independent in-depth evaluation of the UNODC project RAS/H13. In line with the approved project document, the final Independent in-depth Evaluation of RAS/H13 will be undertaken between –July and October 2016 with the following purposes:

- to review progress and get feedback and appraisal on the activities undertaken;
- to identify areas for improvement and propose solutions;
- to determine to which extent the project objective was met and whether resources were wisely utilized;
- to assess the relevance, efficiency, effectiveness, impact and sustainability of the project as well as human rights and gender;
- to identify lessons learned and provide recommendations for future UNODC drug use and HIV prevention projects.

The results of the evaluation will be used internally by UNODC staff members, Member States and other organizational units of UNODC, etc.

The overall evaluation process and field based activities in the SAARC region will be conducted in consultation with the Project Coordinator (RAS/H13), under the guidance and overall supervision of the UNODC Independent Evaluation Unit, as well as in consultation with the Representative, UNODC, Regional Office for South Asia in line with UNODC’s evaluation policy and UNEG Norms and Standards.

The Independent Evaluation Unit reviews and clears all deliverables of this independent in-depth evaluation.

3. Specific tasks to be performed by the evaluation consultant (team member):

Under the guidance of the Independent Evaluation Unit, the Substantive Expert will collaborate with the Evaluation Team Leader on the Independent Project Evaluation of the UNODC project RAS/H13. On the basis of the Evaluation Terms of Reference, key responsibilities of the Substantive Expert include (i) supporting the Evaluation Team Leader in developing the evaluation design with detailed methods, tools and techniques (ii) supporting the evaluation from the sector specialist point of view (iii) Implementing the tools developed for evaluation and data analysis (iv) Supporting the Evaluation team leader in finalizing the evaluation report (v) ensuring adherence to the UNEG Norms and Standards, UNODC Evaluation Guidelines and Templates, and the evaluation ToR, and (vi) ensuring that all deliverables are submitted timely to the Evaluation specialist in line with UNODC evaluation policy, handbook, guidelines and templates.
According to UNODC rules, the evaluator must not have been involved in the design and/or implementation, supervision and coordination of and/or have benefited from the programme/project or theme under evaluation.

The evaluator shall respect the UNEG Ethical Guidelines.

4. Expected tangible and measurable output(s):

The Substantive Expert will be responsible for the quality and timely submission of his/her deliverables to the Evaluation Team Leader. All products should be well written, inclusive and have a clear analysis process. The consultant will specifically do the following:

- carry out the desk review;
- in collaboration with the Lead Evaluator, draft the inception report (in particular, the parts relevant to his/her expertise);
- implement data collection tools and analyze data;
- triangulate data and test rival explanations;
- in collaboration with the Lead Evaluator, draft an evaluation report (in particular, the parts relevant to his/her expertise) in line with the UNODC evaluation policy, guidelines and templates;
- review and finalize the evaluation report on the basis of comments received;
- in collaboration with the Lead Evaluator, present the findings and recommendations of the evaluation as required.
- Participate in field missions, if needed.
- Act as interpreter, if needed.

5. Dates and details as to how the work must be delivered:

The consultant will be hired full time for 30 working Days (home-based and field missions) between –July and October 2016

On the basis of the Evaluation Terms of Reference, s/he will carry out the following deliverables and tasks. A time-bound calendar will be proposed when the contract will be signed.

The detailed, tentative timeline for the evaluation is as follows:

<table>
<thead>
<tr>
<th>Deliverable</th>
<th>Output</th>
<th>Working Days</th>
<th>To be accomplished by (date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Inception Report</td>
<td>8</td>
<td>10 August 2016</td>
</tr>
</tbody>
</table>
75 percent of the daily subsistence allowance and terminals is paid in advance before travelling. The balance is paid after the travel has taken place, upon presentation of boarding passes and the completed travel claim forms.

Payments will be made upon satisfactory completion and/or submission of outputs/deliverables and cleared by IEU.

6. Indicators to evaluate the consultant’s performance:

Timely and satisfactory delivery of the above mentioned outputs as assessed by IEU (in line with UNODC evaluation policy, handbook, guidelines and templates as well as UNEG Standards and Norms)\textsuperscript{12}.

7. Qualifications/expertise sought (required educational background, years of relevant work experience, other special skills or knowledge required):

- Advanced university degree (Master’s degree or equivalent) in health or other level university degree in a related scientific field (preferred, but other relevant educational background may be accepted in lieu of);
- A minimum of 10 years of professional technical expertise in a relevant health-related field
- A minimum of 5 years of progressive expertise in the subject of the evaluation HIV/AIDS prevention, etc.;
- Understanding of human rights and ethical issues related to evaluation;
- Working experience at the international level specific to the project;
- Expertise and knowledge of the UN System, and preferably of UNODC;
- Experience in the accomplishment of evaluations for the United Nations, is an asset;
- Excellent communication and drafting skills in English.
ANNEX III. REVISED RESULTS FRAMEWORK/ EVALUATION MATRIX

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Outcomes</th>
<th>Performance Indicator of Outcome</th>
<th>Baseline</th>
<th>Data Source</th>
<th>Data Collection Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Objective: To reduce the spread of HIV among drug using populations in SAARC countries.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Component 1: Advocacy to support change in policy and practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National meetings of key stakeholders organized to achieve consensus from member countries on essential elements including on human rights and gender components, clear targets for IDU service coverage, and identifying gaps in achieving them and developing solutions to overcome them</td>
<td>1.1 Increase in national meetings that reach consensus on recommended elements and targeted for the intended beneficiaries</td>
<td># of agreements achieved at these meetings</td>
<td>Project team and stakeholders</td>
<td>Minutes of the meetings and stakeholder interviews</td>
<td></td>
</tr>
<tr>
<td>Regional and national advocacy strategies for promoting evidence-based HIV prevention among drug using populations developed or strengthened. Rapid Assessments undertaken and analyzed</td>
<td>1.2 Increased number of national authorities and development partners that adopt and scale up comprehensive HIV prevention and care programs for IDUs.</td>
<td># of national authorities that adopt RASH13 recommendations</td>
<td>Baseline: 0 Target: all 6 countries and region -2016 Source: Prodoc revision 4</td>
<td>Project team and stakeholders</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
</tr>
<tr>
<td>Ongoing advocacy by UN and development partners on changes in IDU related policy and regulations based on compiled</td>
<td>1.3 Increase in awareness and/or knowledge on issues of concern to the project and its beneficiaries</td>
<td>Level of awareness/knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>advocacy material</td>
<td>1.4 Increase in advocacy by supported stakeholders</td>
<td>Level of advocacy</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support other stakeholders, in particular drug user communities and civil society organisations, to undertake advocacy</td>
<td>Change in knowledge/awareness of law enforcement officials</td>
<td>Use of training by targeted law enforcement officials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training for law enforcement officers, including judiciary, police and correctional facility staff, that incorporates IDU/HIV concerns developed, provided, and supported</td>
<td>Baseline: 0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic meetings with the community opinion leaders and law enforcement officers to enhance support for HIV prevention, care and treatment for IDUs and their sex partners</td>
<td>Level of database use by targeted countries, partners and other stakeholders</td>
<td>Database established or not</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor impact of advocacy strategy as required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved access to quality information on the status and impacts of the HIV epidemic through:</td>
<td>2.1 Increase in use</td>
<td>Number of targeted</td>
<td>Surveys,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to archival and secondary data on drug and HIV use facilitated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The implementing agencies trained in analysis and reporting of the data generated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The targeted countries are assisted with setting up the database</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Component 2: Effective Risk Reduction Approaches to reduce HIV transmission among drug users especially IDU and their regular sex partners**
developed by RASH13 in Phase I are widely disseminated and countries in the region adopt them in the local languages and additional resources developed as required

Consensus building through national dissemination workshops

Additional standards and guidelines, if required, developed to provide IDU care and support including ARV, managing overdose, drug interactions, size estimation, engendering outreach interventions

NGOs from Phase I and new NGOs supported to provide and demonstrate quality services to drug-using populations:

Learning opportunities in the region through appropriate linkages with training programs/ placements are enhanced

Appropriate individuals and organizations are trained in the following: rapid situation and response assessment, size estimation, peer-led interventions, safer practices, low-cost community-based care & support

<table>
<thead>
<tr>
<th>Annex</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 Increase in number of targeted beneficiaries assisted by trained NGO staff and volunteers</td>
<td>Level of assisted beneficiaries</td>
</tr>
<tr>
<td>of translated and localized training modules, standards and guidelines by targeted countries and stakeholders</td>
<td>countries, partners and other stakeholders that adopt and use training modules, standards and guidelines through translation and localization</td>
</tr>
</tbody>
</table>
including ARV and opioid substitution treatment

<table>
<thead>
<tr>
<th>Demonstration sites assisted in demonstrating the &quot;comprehensive community based approach&quot; to adoption of safer practices by clients</th>
<th>2.3 Increase in use of the &quot;comprehensive community based approach&quot; advocated by RASH13</th>
<th>Number of targeted communities that adopt the &quot;comprehensive community based approach&quot;</th>
<th>Surveys, interviews and archival data collected by the programme or its partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linkages between demonstration sites and government, and between demonstration sites and the National and Regional Learning Centres are supported</td>
<td>2.4 Increase in number of linkages between demonstration sites, governments, and the National and Regional Learning Centres established</td>
<td>Number of beneficiaries supported under this approach</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
</tr>
<tr>
<td>Criteria for new Regional Learning Centres developed</td>
<td>2.5 Establishment of National and Regional Learning Centres with the support of RASH13</td>
<td>Number of National and Regional Learning Centres established</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
</tr>
<tr>
<td>Technical assistance and institutional support to specific agencies for developing them as sustainable National Learning Centres provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Learning Centres provided ongoing linkages to Demonstration Sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical assistance to governmental and Non Governmental Organisations for rigorous Monitoring and Evaluation</td>
<td>2.6 Increase in number of governmental and Non Governmental Organisations that use rigorous Monitoring and Evaluation</td>
<td>Number of governmental and Non Governmental Organisations that use rigorous Monitoring and Evaluation</td>
<td>Survey and interviews</td>
</tr>
</tbody>
</table>
### Component 3: Scaled-Up Risk Reduction Interventions to reduce HIV transmission among drug users especially IDU and their regular sex partners

<table>
<thead>
<tr>
<th>Monitoring and Evaluation</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that include (injecting) drug use indicators in national surveillance systems</td>
<td></td>
</tr>
<tr>
<td>Number of non-performing NGOs, NGOs not addressing risk-reduction among IDUs and oral opioid users and NGOs not in geographic cohesion that transition out</td>
<td></td>
</tr>
</tbody>
</table>

**Partner NGOs assisted in developing transition plans and exit strategies**

- Disbursement of obligated amounts to Partner NGOs
- Linkages of the NGOs with the national resources facilitated

2.7 Identified NGOs that use recommended transition plans and exit strategies

Surveys, interviews and archival data collected by the programme or its partners

---

**Costed ‘roll-out’ plans on essential IDU interventions, phased operational targets, clear geographic and group priorities, human resource and management, procurement, M&E and QA/QC**

3.1 Increase in number of governments that plan and implement risk reduction interventions essential to a comprehensive response to HIV prevention among drug users especially IDU and their regular sex partners

Number of governments that plan and implement these risk reduction interventions

Surveys, interviews and archival data collected by the programme or its partners

---

**Regional database developed and frequently updated with information on specific goods, quality, prices of HIV risk reduction materials and supplies and thematic experts**

3.2 Increase in number of governmental and Non Governmental Organisations that use secure commodities supplied or identified by the project

Level of use of commodities supplied

Dropped in consultation with donors (Source: Prodoc Revision 4)
and provided

Appropriate technical
support, on all aspects
of procurement
provided to key
stakeholders

<table>
<thead>
<tr>
<th>Component 4: Project Management</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Detailed regional and national project operational plans are developed in consultation with governments, civil society, drug user communities, UN partners and other key stakeholders</td>
<td>4.1 Detailed regional and national project operational plans are endorsed by governments, civil society, drug user communities, UN partners and other key stakeholders</td>
<td>Number of governmental and non-governmental stakeholders that endorse operational plans</td>
<td>Surveys, interviews and archival data collected by the programme or its partners</td>
</tr>
<tr>
<td>Management and coordination arrangements for implementing the project at the regional and national level are in place</td>
<td>4.2 Increase in stakeholder satisfaction with the management and coordination arrangements at the regional and national level</td>
<td>Level of stakeholder satisfaction with the management and coordination arrangements</td>
<td>Survey and interviews</td>
</tr>
<tr>
<td>Project Reports developed and submitted in a timely manner</td>
<td>4.3 Increase in stakeholder satisfaction with the monitoring and reporting arrangements deployed by the project</td>
<td>Level of stakeholder satisfaction with the monitoring and reporting arrangements</td>
<td>Survey and interviews</td>
</tr>
<tr>
<td>M&amp;E framework and processes using existing mechanisms developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate mechanisms for M&amp;E, including the UN Regional Task Force on ‘IDU and HIV’ in Asia and the Pacific are used to provide expertise and experience from other countries of the region</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### ANNEX IV. DATA COLLECTION STRATEGY

<table>
<thead>
<tr>
<th>EQ #</th>
<th>Evaluation question (EQ) as per the ToR</th>
<th>Data source and collection method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Design &amp; relevance:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1.   | How relevant is the project to beneficiaries, including governments in the region? How could it be made more relevant for them? How has the project responded to the changing drug, HIV and related legal and policy environment to remain relevant to the needs of the beneficiaries? | Desk review  
Stakeholder interviews  
Survey of beneficiaries |
| 2.   | To what extent is the project aligned with the policies and strategies of the Governments of the region in addressing HIV prevention and treatment as well as the UNODC Regional Programme for South Asia as well as the Global Programme on HIV/AIDS (GLO/G32)? | Desk review  
Content analysis  
Stakeholder interviews  
UNODC and CLP interviews |
| 3.   | To what extent are the outputs, outcomes and objectives of this project/programme relevant to implementing the Sustainable Development Goals? | Stakeholder interviews  
UNODC and CLP interviews  
Survey of beneficiaries |
|      | **Effectiveness:**                      |                                  |
| 4.   | To what extent were the planned objectives and outcomes in the project document achieved? What was not achieved in full and why? What are the project’s unintended positive and negative results beyond those envisaged in the project logframe? | Desk review  
Content analysis  
Stakeholder interviews  
Archival data  
Survey of beneficiaries |
| 5.   | During implementation of the project, to what extent were potential gaps in the respective national drug and HIV countries programme identified and addressed? To what extent did the project/programme implement recommendations of relevant previous evaluation(s)? | Desk review  
Content analysis  
Stakeholder interviews  
Archival data |
### Efficiency:

6. Were the resources and inputs converted to outputs in a timely and cost-effective manner? What can be done to make this resource conversion more efficient?

<table>
<thead>
<tr>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review</td>
</tr>
<tr>
<td>Content analysis</td>
</tr>
<tr>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Archival data</td>
</tr>
<tr>
<td>Survey of beneficiaries</td>
</tr>
</tbody>
</table>

### Impact:

7. To what extent has the project contributed to long-term intended or unintended impact for its targeted beneficiaries? What can be done to enhance the impact of the project?

<table>
<thead>
<tr>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review</td>
</tr>
<tr>
<td>Content analysis</td>
</tr>
<tr>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Archival data</td>
</tr>
<tr>
<td>Survey of beneficiaries</td>
</tr>
</tbody>
</table>

### Sustainability:

8. To what extent will the benefits generated through the project be sustained after the project ends?

<table>
<thead>
<tr>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review</td>
</tr>
<tr>
<td>Content analysis</td>
</tr>
<tr>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Archival data</td>
</tr>
<tr>
<td>Survey of beneficiaries</td>
</tr>
</tbody>
</table>

### Partnerships and cooperation:

9. To what extent have partnerships been sought and established (including with other units within UNODC and other UN agencies, professional associations, and civil society engagement) and synergies been created in the delivery of assistance? Were efficient internal cooperation and coordination mechanisms identified and established in building and managing these partnerships?

<table>
<thead>
<tr>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desk review</td>
</tr>
<tr>
<td>Content analysis</td>
</tr>
<tr>
<td>Stakeholder interviews</td>
</tr>
<tr>
<td>Archival data</td>
</tr>
<tr>
<td>Survey of beneficiaries</td>
</tr>
</tbody>
</table>

### Human rights and gender:

10. To what extent were human rights considerations, including that of marginalized groups, incorporated into project development and implementation, and with what effects? To what extent were gender-

<table>
<thead>
<tr>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content analysis</td>
</tr>
<tr>
<td>Stakeholder</td>
</tr>
<tr>
<td>sensitive outcomes incorporated into project development and implementation, and with what effects?</td>
</tr>
<tr>
<td>Archival data</td>
</tr>
<tr>
<td>Survey of beneficiaries</td>
</tr>
</tbody>
</table>
ANNEX V. DESK REVIEW LIST

1) RASH13 Phase II Project documents including revisions 1-4
2) Annual progress reports
3) Quarterly progress reports to donors
4) M&E frameworks and health indicators
5) Numerous PSC (Project Steering Committee) presentations
6) Midterm review report
7) Midterm review of Phase I report
8) Certified financial statements
9) Gender mainstreaming in the work of UNODC: Guidance Note
10) Regional programme for South Asia: Promoting the rule of law and countering drugs and crime in South Asia, 2013-15
11) Independent In-Depth evaluation of the UNODC Global Programme on HIV/AIDS, 2014
12) Independent project evaluation of the Prevention of spread of HIV amongst vulnerable groups in South Asia, 2014

Brochures and technical assistance documents:
1. Hepatitis C information brochure
2. Journeys of Change: The Story of Methadone Maintenance Treatment in India
3. Legal And Policy Concerns Related To IDU Harm Reduction In SAARC Countries
4. MMT posters
5. Removing barriers to scale-up of HIV/AIDS prevention and care programmes for injecting drug users and oral opioid users in South Asia
6. Intervention Toolkits developed in Phase 1
7. Intervention Tool-kit
   Module 1: Introduction to 'HIV intervention tool-kit' and 'Basics of conducting rapid situation and response assessment': Modules 1 to 6
8. Association of Drug Use Pattern with Vulnerability and Service Uptake among Injecting Drug Users
9. Capacity building needs assessment In the context of IDU Interventions in India
10. Factors Influencing The Performance Of Targeted Interventions Among IDUs
11. Barriers to and Opportunities for Uptake of HIV Testing and Antiretroviral Treatment among Injecting Drug Users (IDUs) in the Context of Targeted Interventions
12. Gaps and Barriers to implement and scale up HIV prevention intervention among IDUs and their Partners in Punjab, Haryana and Chandigarh
13. Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs: Assessing Care Needs and Developing Responsive Services
14. Needle Syringe Exchange Programme among Injecting Drug Users
15. Operational research understanding the contexts and response related to overdose among Injecting Drug Users
16. Amphetamine type stimulants (ATS) use in India: An exploratory study
17. Rapid Situation and Response Assessment among Female Drug Users and the Female Regular Sex Partners of Male Drug Users
18. Rapid Situation and Response Assessment (RSRA) of HIV/AIDS related risk behaviours, adverse health consequences, knowledge and attitudes relating to HIV/AIDS amongst drug users and their regular sex partners in Bangladesh, Bhutan, India, Nepal and Sri Lanka
19. Methadone Maintenance Treatment In India: A Feasibility And Effectiveness Report
20. National Baseline Assessment of Drugs and Controlled
21. Opioid Substitution- Buprenorphine in India Substance Use in Bhutan-2009
23. Women who use drugs in northeast India
24. Pharmacological treatment For Opioid Dependence
25. Providing Drug Treatment Services Through Drop-In Centres
26. Drug Treatment Cum Rehabilitation Centres Guidelines for 27. Accreditation of Drop in Centres & Treatment cum Rehabilitation Centres in Bhutan
28. Standard Operating Procedure for Needle Syringe Exchange Program in Mizo
29. Standard Operating Procedure for Needle Syringe Exchange Program in Bangla
30. Standard Operating Procedure for Needle Syringe Exchange Program in Malyalam
31. Standard Operating Procedure for Needle Syringe Exchange Program in English
32. Standard Operating Procedure for Needle Syringe Exchange Program in Hindi
33. Standard Operating Procedure Drop-in Centre For Injecting Drug Users in English Language
34. Standard Operating Procedure Drop-in Centre For Injecting Drug Users in Hindi Language
35. Standard Operating Procedure Outreach For Injecting Drug Users in English language
36. Standard Operating Procedure Outreach For Injecting Drug Users in Hindi language
37. Standard Operating Procedure for Opioid Overdose Prevention And Management For Injecting Drug Users
38. Standard Operating Procedure for Abscess Prevention and Management Among Injecting Drug Users
39. Standard Operating Procedure Care and Support for Co-morbid Conditions Among Injecting Drug Users
40. Standard Operating Procedure for Intervention Among Female Injecting Drug Users
41. Standard Operating Procedure for Methadone Maintenance Treatment in The Republic of Maldives
42. Opioid Substitution Treatment (Buprenorphine) Intervention Toolkit
43. Methadone Maintenance
44. Treatment Intervention Toolkit
45. A Trainer’s Manual on drug use prevention, treatment and care for street children
46. Staying Safe: A Manual To Train Clinical Staff In IDU Interventions
47. Staying Healthy: A Manual To Train Clinical Staff On Co-Morbidities Associated With Injecting Drug Use
48. Counselling in targeted Intervention for Injecting Drug Users – A Resource Guide
49. Counselling in targeted intervention for Injecting Drug Users – A Facilitator’s Manual
50. Counselling In Targeted Intervention For Injecting Drug Users – A Counsellor’s Handbook
51. Staying Safe: A Manual To Train Outreach Workers In IDU Interventions
52. Documents pertaining to training, seminars, consultations, sensitization and study tour activities
### ANNEX VII. STAKEHOLDERS CONSULTED FOR THE EVALUATION

<table>
<thead>
<tr>
<th>Number of interviewees</th>
<th>Organisation</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>UNODC ROSA</td>
<td>India</td>
</tr>
<tr>
<td>1</td>
<td>UNODC field office</td>
<td>Bhutan</td>
</tr>
<tr>
<td>5</td>
<td>UNODC HQ</td>
<td>Austria</td>
</tr>
<tr>
<td>1</td>
<td>UNODC</td>
<td>Others</td>
</tr>
<tr>
<td>7</td>
<td>National counterparts including NGOs and civil society</td>
<td>India</td>
</tr>
<tr>
<td>18</td>
<td>National counterparts including NGOs and civil society</td>
<td>Bhutan</td>
</tr>
<tr>
<td>15</td>
<td>National counterparts, police and narcotics</td>
<td>Maldives</td>
</tr>
<tr>
<td>5</td>
<td>National focal persons in countries not physically visited</td>
<td>South Asia</td>
</tr>
<tr>
<td>2</td>
<td>Donors</td>
<td>Various</td>
</tr>
</tbody>
</table>

Total: 59 (49 Males, 10 Females)
ANNEX VIII. EVALUATION TOOLS: QUESTIONNAIRES AND INTERVIEW GUIDES

The following interview protocols for in-person interviews are preliminary, and they would continue to be revised on the basis of both further desk review and responses received from interviewees i.e. interview protocols would be updated to probe issue that appear more relevant and necessary. Also, time constraints imposed by interviewee availability and the length of field missions are likely to result in selected sub-sets of questions being used for each group of interviewees.

A. Questions for the UNODC staff:

1. How relevant is the RASH13 project in terms of fulfilling the mandates of UNODC?
2. To what extent does the project actually meet the needs identified in various programme documents?
3. To what extent do you consider the material and support provided by the staff at headquarters useful to your work? How could it be improved?
4. What is your vision for UNODC positioning on HIV/AIDS in this region? How could UNODC position itself better?
5. To what extent are the RASH13 activities aligned with the HIV/AIDS Global Programme? How could this be improved?
6. To what extent do you consider the support provided by UNODC field offices useful to your work? How could it be improved?
7. Do the working arrangements (contract, remuneration etc.) provide a good basis for carrying out your assignment? What should be improved?
8. To what extent do you work with staff from other organizations of the UN system?
9. Which lessons learned could be drawn from this cooperation? (What, if any, are the main difficulties in working with them?)
10. How would you characterize your cooperation with partner organizations and other providers of TA in the field of HIV/AIDS support?
11. Which lessons learned could be drawn from this cooperation? (What, if any, are the main difficulties in working with them?)
12. How would you characterize your cooperation with country counterparts? Which lessons learned could be drawn from this cooperation? (What, if any, are the main difficulties in working with them?)
13. What do you consider to be the main results you have helped make happen through RASH13? (Break it down by time and country)
14. How do you keep track of the outcomes that your work made happen?
15. Do you see any long-term impact of RASH13? Please describe.
16. What are the strengths and weaknesses of RASH13, compared to providers of TA in the same field?
17. How and to what extent do the programmes incorporate human rights and gender dimensions?
18. How do you ensure that the programmes have been implemented in an efficient and cost-effective way and that inputs are converted to outputs in a timely and cost-effective manner?
19. What are the internal and external factors that have facilitated and/or impeded achievement of programmes’ results? What steps have you undertaken to analyze, manage and mitigate risks?

20. How satisfied are you with programmes monitoring and evaluation systems? What could be done differently or significantly improved?

**B. Questions for UNODC field representatives:**

1. From your perspective, how relevant is the RASH13 project in terms of fulfilling the mandates of UNODC?
2. To what extent does the programme actually meet the needs identified in various project documents?
3. What is your role in connection with RASH13?
4. Do you see any interlinkages between RASH13, the field and other sections of UNODC? (Which ones?)
5. How do RASH13 coordinate their work with the field and other sections of UNODC?
6. What type of cooperation and interaction did you have with RASH13 (since 2007)?
7. How would you characterize your cooperation with RASH13 and what lessons learned could be drawn from this experience?
8. Do you see any impact of RASH13 at the level of intergovernmental bodies?
9. What do you consider to be the main results of RASH13? What are your contributions to these results?
10. How can these results be measured? (What is the evidence?)
11. What do you consider the main obstacles to achieving results in the field of HIV/AIDS? How could those obstacles be overcome?
12. In your view, what are RASH13’s strengths and weaknesses?
13. What should be improved?
14. Do you see any long-term impact of RASH13? Please describe.
15. What are the strengths and weaknesses of RASH13, compared to other providers of TA in the same field?
16. How and to what extent do the programme and its various training course modules incorporate human rights and gender dimensions?
17. How do you ensure that the programme has been implemented in an efficient and cost-effective way and that inputs are converted to outputs in a timely and cost-effective manner?
18. What are the internal and external factors that have facilitated and/or impeded achievement of programme results? What steps have you undertaken to analyze, manage and mitigate risks?
19. How satisfied are you with programme monitoring and reporting? What could be done differently or significantly improved?

**C. Questions for representatives of partner organizations:**

1. What type of cooperation and interaction have you experienced between your organization and RASH13 programmes of UNODC since 2007?
2. Which lessons learned could be drawn from this experience?
3. Which services or products that RASH13 providers are you aware of?
4. Do you know of other providers of the type of assistance RASH13 provides?
5. In your opinion, what makes RASH13’s assistance unique? What are RASH13’s strengths? What do you see as the main added value provided by RASH13?
6. In your view, how could RASH13 improve their products and services?
7. Are RASH13 contributing to improved harmonization among forensic service providers in the field of synthetics monitoring & forensic support? How?
8. In your opinion, have RASH13 effectively contributed to improved synthetics monitoring & forensic support in your area(s) of interest?

9. Would you say that RASH13 have effectively contributed to improving synthetics monitoring & forensic support in general in your area(s) of interest? How and to what extent?

10. Which other factors have contributed to an improved capacity of law & order regimes in your area(s) of interest?

11. What is your vision for UNODC positioning on HIV/AIDS in this region? How could UNODC position itself better?

**D. Questions for country counterparts and beneficiaries:**

1. Which services or products that RASH13 provide are you aware of? What type of assistance have RASH13 provided to your country? Which of these services and course modules have you and/or your teams used?

2. Overall, have you been satisfied with the assistance provided by RASH13?

3. Has the TA been provided according to your needs?

4. Do you see any long-term effects of the assistance provided by RASH13?

5. In your opinion, have RASH13 effectively contributed to improved local capacity?

6. Have RASH13 contributed to making your country’s capacity building more effective? Why or why not?

7. Which other factors have contributed to an improved HIV/AIDS response in your country?

8. Do you know of other providers of the type of assistance RASH13 provide?

9. In your opinion, what makes RASH13’s assistance unique? What are RASH13’s strengths? What do you see as the main added value provided by RASH13?

10. How could RASH13 improve their services and products?

11. How do you and your team ensure that capacity building efforts adhere to human and gender rights standards envisaged under the UN/UNODC position papers?

12. What steps have you undertaken to ensure long-term sustainability of the capacity built under this programme?

13. Hypothetically speaking, if RASH13 support were to be withdrawn, what effect/s would you foresee on capacity building in your jurisdiction? What could/would you do to negate these effects?

14. What is your vision for UNODC positioning on HIV/AIDS in this region? How could UNODC position itself better?

**E. Survey Questionnaires for management and trainees at beneficiary institutions.**

An online preview of the survey questions is available [here](#).
ANNEX IX. ANECDOTAL EVIDENCE ON RASH13 RESULTS

BNCA/Chairperson-NCB/2013-14/684

Date: 11th Dec, 2013

Ms. Cristina Albertin
Resident Representative
Regional Office (South Asia)
United Nations Office of Drugs and Crime (UNODC)
New Delhi

Dear Cristina,

I take this privilege to write to you for the very first time in my capacity as the new Health Minister and as the Chairperson of Bhutan Narcotic Control Agency.

First and foremost, I would like to express my sincere appreciation and thanks to you and your colleagues of UNODC for the supports that have been rendered to Bhutan Narcotic Control Agency (BNCA) till now. I would also like to acknowledge UNODC for considering extending its further cooperation with BNCA hereafter. The BNCA has ventured into many programs in pursuit of controlling the ill effects of narcotic drugs and psychotropic substances in the country with the support of UNODC and has resulted good progress.

Therefore, in order to further strengthen the existing programs and in devising viable strategies to cope with new emerging problems relating to drugs and psychotropic substances in Bhutan, the continued support of UNODC in the following areas is of paramount important.

1. Technical support in the revision of Narcotics Drugs and Psychotropic Substance Act
   I am told that the UNODC had provided technical assistance to BNCA in drafting the current NDPSSA Act 2005 which is one of our main tools for drug control program in the country. However, we are now faced with an urgent need to review and revise this Act to meet the requirements of the changing times. The BNCA has already undertaken revision of the act and first draft has been completed but in view of the sensitivity of the subject, it has become important to seek some professional input from the UNODC before the draft Act is being ratified by the Parliament. The support if possible, is required immediately as we intend to finalize the draft act for its endorsement by the forthcoming 2nd Parliament session sometime towards the end of January 2014.
2. National Baseline Assessment Survey

I understand that the UNODC had assisted the BNCA with the training and the conduct of the first National Baseline Assessment Survey on drugs in 2009. The strategic information generated from this survey has benefited a lot in developing our drug control plans, programs and policies. It is now more than 4 years since this survey was conducted and during this period there have been significant changes in the status of drug cases in the country. Furthermore, the first survey being based on ‘Rapid Assessment method’ lacked finer details of drug scenario in the country.

Therefore, it is felt very important to initiate the 2nd National Baseline Drug Survey to update with the latest information, which is vital in developing effective plans and programs to overcome the current challenges of increasing drug related cases in the country. As a result we would like to request UNODC for the technical and financial support to carry out the same, most preferably in the first quarter of the 2014.

Since UNODC has been a pioneer partner of BNCA and has contributed a lot in its endeavor, we feel that it would be appropriate to approach your organization for the necessary support. The implementation and costing schedules for the above mentioned activities can be jointly worked out with the UNODC once the possibility of the UNODC’s support is confirmed.

I look forward to working with you to further strengthen the collaboration between our two institutions and, in particular, forge stronger partnership in the field of health and well-being.

Please accept assurances of my highest consideration.

With warm regards,

Tandin Wangchuk
MINISTER
Chairperson for BNCA
July 2016

Mr. Kunal Kishore
National UNV Project Officer
UNODC
EP 16/17, Chandragupta Marg,
Chanakyapuri
New Delhi

Dear Mr. Kishore

At Tagore International School, our aim is to make our students aware of social issues around them. Over the years our students have been sensitized on issues related to the rights of the LGBTQI community and acid attack survivors, and have helped raise funds to sponsor the medical requirements of some of the survivors.

This year we are planning to address the issue of drug use amongst the youth and them to draft a prevention policy and a safety manual for school. It would be our honor and privilege if UNODC could help us in this endeavour and guide our students in executing the project. We have no objection to UNODC conducting a survey on risk assessment with our students, which will act as the base for drafting the prevention policy.

We look forward to working with UNODC on this project and are confident that our students will be benefitted from this association.
National Narcotics Control Bureau
Malé, Maldives

No. 172-B/MIS/2007/464
04th December 2007

Mr. Gary Lewis,
Regional Representative,
United Nations Office on Drugs and Crime
Regional Office for South Asia
EP 16/17, Chandragupta Marg,
Chanakyapuri, New Delhi 110 021
India

Dear Mr. Lewis,

Subject: Minutes of the Ministerial Committee held at the Ministry of Gender and Family, Male', Maldives, 30th October 2007

I am attaching here with the minutes of the ministerial committee held on 30th October 2007, in Male'.

As the government of the Maldives is keen to have the methadone maintenance programme start in Maldives in 2008, we would like to request UNDOC to initiate the process of the project rollout starting from training and capacity building.

Thanking you for your continued support and cooperation.

Yours sincerely,

Ameen Ibrahim
Deputy Executive Director

cc: Ms. Ashita Mittal
Officer-in-charge
MESSAGE

I am very happy to note that the National Drug Dependence Treatment Centre (NDDTC), AIIMS, Ghaziabad in collaboration with the United Nations Office on Drugs and Crime (UNODC) is organizing a meeting on 19th December 2014 in New Delhi on “Dissemination of the findings of Methadone Maintenance Treatment in India”, to share the findings of the recently concluded multi-centre study on Effectiveness and Feasibility of Methadone Maintenance Treatment (MMT) in India that was carried out in five government hospitals in the country (in Delhi, Mumbai, Punjab and Manipur).

2. Methadone which is known as a cornerstone of Opioid Substitution Treatment in majority of the countries has withstood the test of time and rigorous scientific scrutiny. However, it was unavailable in the country till a few years back. The present study, commissioned by UNODC-ROSA and coordinated by NDDTC, AIIMS has been able to provide a good understanding of operational and clinical issues related to Methadone Maintenance Treatment. The data and experience from centres from across the country, i.e. NDDTC, AIIMS; KEM Mumbai; RIMS Imphal; Civil hospital Kapurthala and Civil hospital Bathinda went into formulating this report. I take the opportunity to congratulate everyone involved with this project and for making it possible to have Methadone as an important option in the menu of treatment options for opioid dependent individuals.

3. I am happy to announce that the Drug De-Addiction Programme, Ministry of Health and Family Welfare is planning further strengthening of its services by initiation of Drug Treatment Clinics in its de-addiction centres and other hospitals in a phased manner. These drug treatment clinics will provide various treatment modalities to opioid dependent individuals (both injecting and non-injecting drug users) based on clinical practice guidelines and after proper training.

4. Given this background, I am especially happy to note that the Methadone Maintenance Treatment, being one of the interventions to be delivered through the Drug Treatment Clinics, will substantially strengthen the Drug dependence treatment services through the Drug Treatment Clinics. We are committed to use the findings from the study to carry forward as well as scale up this intervention through the drug treatment clinics and hope that it will be an important milestone towards our efforts to reduce the pain and suffering associated with substance and drug abuse in our country.

5. I wish each and every one involved with the study all success for this meeting and expect that they will continue to work with greater vigour and zeal in coming up with new initiatives on drug dependence treatment and rehabilitation options in the years to come. The success of this study, I am sure, will give them the much needed enthusiasm and energy for similar and greater achievements in future as well. On behalf of the Ministry of Health & Family Welfare, I assure fullest cooperation and support in the noble path of drug dependence treatment and rehabilitation in our country.

(K.C. Samria)