THEMATIC EVALUATION OF THE TECHNICAL ASSISTANCE PROVIDED TO AFGHANISTAN BY THE UNITED NATIONS OFFICE ON DRUGS AND CRIME

Volume 5
Drug Demand Reduction Programme

Independent Evaluation Unit
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<tr>
<td>DRAT</td>
<td>Drug Demand Reduction Action Teams</td>
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<td>GTZ</td>
<td>German Agency for Technical Cooperation</td>
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<td>START</td>
<td>Support Training Advice Resources Targeting</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNAMA</td>
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<td>UNDCP</td>
<td>United Nations International Drug Control Programme</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNHCR</td>
<td>Office of the United Nations High Commissioner for Refugees</td>
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Summary

This report is part of the Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the United Nations Office on Drugs and Crime, which also includes four other evaluations, on: the Alternative Livelihoods Programme, the Rule of Law Programme, the Law Enforcement Programme and the Illicit Crop Monitoring Programme. The evaluation team reviewed the programme portfolio and activities carried out between 2001 and June 2007.

In the context of the overall country-level evaluation of programmes carried out by the United Nations Office on Drugs and Crime (UNODC) in Afghanistan, the brief was to examine the relevance, effectiveness, efficiency, impact and sustainability of the Drug Demand Reduction Programme and to provide usable recommendations to UNODC staff, including management, in order to enhance the impact of drug demand reduction efforts in the country.

Afghanistan is among the least developed countries in the world. Major economic, social and health indicators reveal an abysmal picture and the country is far from reaching any of the Millennium Development Goals (A/56/326, annex). The country is at the early stage of State-building. Over a quarter of a century of war and unrest has virtually destroyed all national institutions. Currently, over 75 per cent of the State’s public expenditure, as well as a number of essential Government services, are funded entirely by external donors.

Afghanistan has a long history of drug production and, in recent years, the country has consolidated its position as the world’s largest source of illicit opium. Although opium has been consumed traditionally for centuries, drugs are increasingly being used as painkillers and as remedies for physical or psychological problems, anxiety, insomnia, post-traumatic stress disorder and depression. They have also become a common response to social sufferings caused by decades of war. Most worryingly, the use of heroin (including by injection), first observed in Afghan refugee camps in Pakistan, has recently emerged as a phenomenon in Afghanistan, together with an increase of the consumption of cannabis, amphetamines and prescription drugs.

The national drug use problem in Afghanistan is not as well known or as well surveyed as the drug supply side and related law enforcement activities. At the crossroads of so many social, economic, health and other determinants, responses to the problem are also multiple and still highly controversial. However, the need for a coordinated and determined response is obvious since, despite the lack of good surveillance systems in Afghanistan, there are many indications that injecting drug use is increasing, as is the risk of a concentrated HIV epidemic.

Since 1989, UNODC drug demand reduction activities in Afghanistan have slowly but surely laid the foundation for a more comprehensive drug demand reduction strategy in that country and contributed to building national responses to the harmful use of drugs, a problem that has been recognized, assessed and started to be tackled. Thanks to UNODC efforts, drug demand reduction has been placed on the national agenda and surveys have started to measure the extent of the drug use problem. The number of treatment, rehabilitation and prevention facilities available in the country increased from 2 in 2002 to 39 in 2007.

Since 2001, the Government of Afghanistan has, with the help of UNODC, developed drug demand reduction and harm reduction strategies and structures to address the country’s drug problems. The National Drug Control Strategy of the Government of
Afghanistan includes drug demand reduction and shows a clear commitment to harm reduction. The Ministry of Counter-Narcotics was established and charged with coordinating and monitoring policies and strategies, while the Ministry for Public Health was made responsible for the implementation of the National Drug Control Strategy.

Although drug demand reduction is not a national priority, it has been recognized officially as part of this strategic framework. Nonetheless, the roles and responsibilities of the two ministries have not yet been clearly defined in practice.

In spite of these achievements, which have been obtained with few resources, sustainability is threatened in different ways. For more than 20 years, UNODC drug policy has advocated a balanced approach aimed at reducing drug demand while, in parallel, controlling drug supply. However, drug demand reduction is the de facto orphan child of drug policies and drug demand reduction projects only receive a fraction of all the funds allocated through the Strategic Programme Framework for Afghanistan (2006-2010). There is therefore a clear lack of interest from donors, which is linked to a poor awareness of what drug demand reduction is.

This is reinforced (but also possibly induced) by the fact that UNODC had (until early 2008) lacked a firm basis from which to implement drug demand reduction activities, while having a clear mandate with regard to implementing measures to minimize the deleterious effects of illicit drug consumption that do not preclude abstinence as part of its drug demand reduction activities. This has been counterproductive on drug demand reduction efforts in Afghanistan.

There is an urgent need to provide additional support to Afghanistan in this area: governmental capacities need scaling up. The mushrooming of drug demand reduction offers has led to a lack of coordination. Additionally, while considerable amounts of new funding for specific HIV projects whose objectives match the UNODC portfolio have been made available, the UNODC Country Office in Afghanistan has not yet undertaken sufficient measures to join these initiatives.

To counteract this state of affairs, this evaluation puts forward the following eight recommendations, according to which UNODC should:

(a) follow-up on the steps already taken by UNODC management to resolve ideological differences with regard to harm reduction and HIV issues by integrating the latter in a comprehensive drug demand reduction package;
(b) Contribute to an effective advocacy and lobbying strategy for potential donors in order to ensure sustainable funding for future project development;
(c) Support the Government of Afghanistan in developing a national research and training centre;
(d) Develop a new approach to programme and project conception through better global planning and more differentiated projects;
(e) Focus on normative work and support the Government of Afghanistan in developing innovative programmes;
(f) Find, with the international community, a way to bridge the gap between the Ministry of Counter-Narcotics and the Ministry of Public Health;
(g) Take necessary measures to address the emerging HIV/AIDS problem;
(h) Strengthen partnerships with other United Nations entities and civil society organizations to reach a larger section of the Afghan population, especially in rural areas.
Postscript

The fieldwork for this evaluation was completed on the 27th of November 2007, and hence activities that have been undertaken after that date are not reflected in this report.

The evaluation team however acknowledges that, following the evaluation, from early 2008 on, a number of initiatives took place, such as steps taken towards defining a clear policy on harm reduction.
I. Introduction

A. Afghanistan: general context and background

1. Afghanistan is divided into 34 provinces and has 32 million inhabitants.\(^1\) It is the fifth least developed country in the world, according to the Human Development Index,\(^2\) and it is far from reaching any of the Millennium Development Goals (A/56/326, annex). Afghanistan suffers greatly from extreme poverty and hunger: 6.6 million Afghans do not meet the minimum food requirement; 50 per cent of Afghan children under 5 years of age are underweight and the absence of shelter and unemployment is widespread. Between 2004 and 2007, life expectancy dropped from 44.5 years to 43.1 years. Maternal mortality is one of the highest in the world (157 per 1,000 births) and a quarter of all children do not reach the age of 5. The overall adult literacy fell from 28.7 per cent in 2003 to 23.5 per cent in 2005, and only an estimated 12.6 per cent of women are literate. In addition, despite marked progress in primary education, half of all school-age children remain out of school and only half as many girls are enrolled in school as boys, especially in rural areas.

2. The history of the country is marked by over a quarter of a century of war and unrest. It is very rare to find an Afghan who has not been directly or indirectly exposed to some sort of violence, whether as a victim or perpetrator. Between 5 million and 7 million landmines and large quantities of unexploded ordinance remain on the ground, killing or wounding up to 100 people monthly. Depression, post-traumatic stress disorder and other chronic mental health problems are widespread.

3. The human consequences of political, economic and institutional disruptions, known as “social suffering”,\(^3\) have created a massive mental health problem that is both a determinant and a consequence of drug use. Clearly, there are neither the human nor the financial resources to respond to the psychological distress faced by so many people in Afghanistan.\(^4\)

B. A country at the early stages of State-building

4. At the United Nations talks on Afghanistan held in Bonn, Germany, in December 2001, an Interim Authority was established and given a six-month mandate. Power was then to be held by a Transitional Authority for two years, after which elections were to be held (S/2001/1154). To support the State-building process, certain States were identified to lead efforts for each important sector of the reconstruction of Afghanistan.

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\(^1\) Afghanistan society is multi-ethnic: a majority of Afghans are either Pashtun (42 per cent) or Tajik (27 per cent). Other ethnicities are Hazara (9 per cent), Uzbek (9 per cent) Aimak (4 per cent), Turkmen (3 per cent) and Baloch (2 per cent). Approximately 80 per cent of the population is Sunni and 19 per cent is Shia. The two official languages are Dari, which is spoken by approximately 50 per cent of the population, and Pashto, which is spoken by approximately 35 per cent of the population.


\(^3\) Kleinman, Das & Lock, 1997.

\(^4\) WHO. MPH: Mental Health System in Afghanistan, 2006.
The United Kingdom of Great Britain and Northern Ireland, for example, was designated as the lead State for counter-narcotic efforts.5

5. At the International Conference on Reconstruction Assistance to Afghanistan, held in Tokyo in 2002, international donors pledged 5.2 billion United States dollars in non-military aid over five years to help rebuild Afghanistan. The United States of America, Japan and the European Union made the most substantial pledges.

6. At the London Conference on Afghanistan held from 29 January to 1 February 2006, the idea of sector-specific responsibilities was abandoned and the overall responsibility for reconstruction was handed back to the Government of Afghanistan. It was also decided that at least 50 per cent of the financial support allocated to Afghanistan should be channelled through the Government, thereby empowering national authorities.

7. Currently, over 75 per cent of the State’s public expenditure, as well as a number of essential Government services, are funded entirely by external parties. Most aid from the international community since 2002 has been allocated to military rather than to development and poverty relief projects.

8. The dissolution of the health-care system and the high degree of dependence on foreign donors highlight some of the challenges faced in establishing sustainable, legitimate and effective governance in Afghanistan. Thus, it is not only with regard to drug demand reduction that the Government of Afghanistan needs to be strengthened in order that it can deliver public services.

C. History of drug use in Afghanistan

9. Afghanistan has a long history of drug production and use. Opium was introduced into Afghanistan nearly 2,000 years ago and has been traditionally consumed for centuries by minorities such as the Tajik and the Turkmen. It was mainly used for medical purposes to relieve pain in the absence of primary health-care facilities in remote rural areas. Mothers have also been observed to give their children opium in order to gain some time for work. The highly addictive properties of opium were generally unknown. Opium was traditionally smoked in special pipes or ingested as food or in tea. The practice of injecting opium is fairly new and has been increasing in recent years. Often, users started injecting opium in refugee camps in the Islamic Republic of Iran and Pakistan. In addition, while it used to be expensive, the fact that Afghanistan is the world’s largest opium producer has made the drug easily accessible throughout the country.

10. The use of heroin is recent among the Afghan population and was first observed some 25 years ago in Afghan refugee camps in Pakistan. Poderi (heroin users) typically smoke ("chasing the dragon", i.e. burning heroin on a piece of tin foil and inhale the fumes through a small pipe) or inject the drug. It took a while to identify the situation as a new and serious problem and, for too long, there was a general denial of heroin use in the refugee camps and very little awareness about its dangers.

11. The use of “hashish” (cannabis resin) was mentioned in Afghan poetry 3,000 years ago. However, although its use has been common, both in urban and rural areas, charsis (hashish users, mainly men) were not respected by the community and tended to hide their practices.

5 Germany was charged with police reform, Italy with justice reform and the United States of America with military reform.
12. The main known substance abuse in Afghanistan is alcohol, which used to be easily available. Its use was never prevented other than for religious reasons. When alcohol was prohibited, heroin was used as a substitute.

13. Along with these intoxicants, high consumption of psycho-pharmaceuticals, which can easily be obtained from pharmacies without medical prescription, can be observed. Glues and solvents are mainly used by youth through inhalation or smoking. There is also a lot of poly-drug use.

14. For centuries, opium use has been part of a traditional ensemble of cultural and medical practices. Increasingly, however, drugs have been used as painkillers and remedies for physical or psychological problems, anxiety, insomnia, post-traumatic stress disorder and depression. They have now become a common response to social suffering. Settings like refugee camps are particularly risky places, as a majority of Afghan drug users report having started using drugs in refugee camps either in the Islamic Republic of Iran (60-70 per cent) or in Pakistan (15-20 per cent) before returning to Afghanistan.

15. The use of any kind of intoxicant, including alcohol, is considered haram (anti-Islamic) and forbidden in Afghanistan. Many cases of harassment of and physical violence against drug users have been reported. In practice, drug users picked up by the police are sent to a treatment centre; recidivists are taken to court and often put in jail. Thus, drug use continues to oscillate between being considered as a judicial and a medical issue.

16. With regard to drug production, Afghanistan had a record harvest of opium poppy that resulted in 8,200 tons of opium in 2007, a 34 per cent increase compared with 2006. Afghanistan is the world’s largest opium producer and opium is now easily accessible for use throughout the country. The total opium export is valued at $4 billion in Afghanistan, an increase of 29 per cent over 2006. The value of the opium economy is now equivalent to more than half (53 per cent) of the country’s licit gross domestic product and directly influences the patterns of drug use in countries in the region. In fact, there are 3 million drug users in India, 2.3 million in the Russian Federation and Eastern Europe, 1.7 million in China, 1.2 million in the Islamic Republic of Iran and 0.7 million in Pakistan.

D. Evolution of the Drug Demand Reduction Programme of the United Nations Office on Drugs and Crime in Afghanistan

17. Afghanistan received the attention of UNODC (then the United Nations International Drug Control Programme) when it became a major grower of opium poppy. Four projects were initially developed, covering the following areas: (a) awareness-raising, information, education and communication; (b) capacity-building, mainly for Government counterparts; (c) training, for different professionals working on drug use issues; and (d) establishment of community-based treatment and rehabilitation services.

18. The first drug control activities concerning Afghanistan were run from the regional office in Islamabad. After the Soviet Union withdrew its troops from Afghanistan in 1989, a cross-border initiative, the Afghanistan Drug Control and Rural Rehabilitation Project (AFG/89/580), with a budget of $9.2 million, was launched for a period of seven years. Its main objective was to reduce the area under illicit crop cultivation (supply reduction). In
parallel, it was also aimed at raising awareness about the harmful consequences of drug abuse (demand reduction) in the Afghan provinces of Badakhshan, Kunar, Nangarhar, Helmand and Kandahar, as well as in Afghan refugee camps in Pakistan. Afghan and international non-governmental organizations were mandated to implement different projects. Along with awareness-raising mass media campaigns and events, seminars and workshops were held involving community workers, health-care professionals, religious leaders, teachers, field-based staff members of non-governmental organizations, district administrators and journalists. However, the Government of Afghanistan was not involved. Those efforts were interrupted by a funding gap that lasted from March 1996 to November 1998, jeopardizing the results of the project, which could not be sustained.

19. Another initiative, the Drug Demand Reduction Support Project (AFG/C29), was implemented between 1998 and 2001. During that period, training activities took place in Baluchistan and the North West Frontier Province of Pakistan, and drug prevention material was designed. Drug abuse treatment services (in the new Akora Khattak refugee camp in Pakistan) and tertiary prevention services for Afghan street heroin addicts were established in Peshawar, Pakistan. By the end of 2000, the Drug Dependency Treatment Centre at Kabul’s Mental Health Hospital was upgraded. During that period, a series of assessments on drug use among Afghan women refugees and Afghan street heroin addicts were made. Community treatment and intervention teams were also created to provide services to drug users.

20. In 2002, UNODC established its Country Office in Afghanistan, in Kabul. A strategic programme was elaborated to help define national measures to prevent and reduce drug abuse. The development of baseline data on the drug abuse situation was one of the Office’s priorities, along with the establishment of prevention, treatment and rehabilitation services for drug users. Overall, drug demand reduction interventions were to be institutionalized.

21. The first drug demand reduction project implemented by the UNODC Country Office in Afghanistan was entitled Drug Demand Reduction Information, Advice and Training Service for Afghanistan (AFG/G26). It was intended to last one year (from June 2002 to May 2003) and was allocated a budget of $266,700. It was aimed at building the capacity of relevant United Nations entities, non-governmental organizations and Government counterparts in Afghanistan to address the problems relating to drug abuse and misuse. So-called “social multipliers” such as health-care professionals, teachers, social workers and community development workers were trained; an outreach referral system and a home-based detoxification and treatment service for drug addicts, particularly women, were established. The project also initiated the Support, Training, Advice, Resources, Targeting (START) programme, a capacity-building programme.


10 Support for planning and developing drug demand reduction strategies and policies for implementation by Government counterparts, United Nations entities, non-governmental organizations and community groups; Training of staff involved in health care provision, education, community development and social services related to drug demand reduction issues (including treatment, rehabilitation, aftercare and social reintegration); Advice on drug demand reduction strategies and activities by Government counterparts; Resources for creating culturally appropriate audio-visual material; Targeting at-risk groups such as women, youth, former combatants and persons with mental health problems.
targeting, in particular, Government counterparts. The catchy acronym was chosen to attract donors.\textsuperscript{11}

22. Additionally, drug demand reduction action teams (DRATs), each consisting of one leader and three field-based staff (responsible for information, education and communication; treatment; and social reintegration) were established. The idea for the DRATs came from the Drug Action Teams of the United Kingdom, which are formed by local representatives working in the areas of education, social services, housing and police and other volunteers, who plan and coordinate drug-related activities in the community and serve as a referral system. Similarly, the DRATs were planned to be in charge of START activities, but not to be in direct contact with drug users.

23. In parallel, a project on Drug Demand Reduction Information, Advice and Training Service for Afghan Women in Refugee Camps in Baluchistan and North West Frontier Province, Pakistan (AFG/F55), which was expected to last two and a half years, was launched in July 2001. In continuity with project AFG/C29 (see para. 19 above), a team of two female specialists developed drug abuse prevention information, advice and training services for selected workers, community groups and female drug users in targeted refugee camps.

E. Key actors for drug demand reduction in Afghanistan

24. Two ministries are mainly in charge of the drug use problem: the Ministry of Counter-Narcotics, which is responsible for policymaking and for coordinating, monitoring and evaluating all counter-narcotics activities at both the national and provincial levels; and the Ministry of Public Health, which is in charge of implementing drug demand reduction programmes and therapy (it has a drug demand reduction department and also hosts the National AIDS Control Programme).

25. Other ministries represented in the drug demand reduction working group are: the Ministry of Women’s Affairs, the Ministry of Education, the Ministry of Information, the Ministry of Culture and Youth and the Ministry of Hajj and Islamic Affairs. Other ministries dealing with drug demand reduction are: the Ministry of Labour and Social Affairs, the Ministry of Culture and Youth Affairs, the Ministry of Justice and the Ministry of Interior Affairs.

26. From the United Nations, only representatives of the United Nations Development Programme (UNDP), the Office of the United Nations High Commissioner for Refugees (UNHCR) and the World Health Organization (WHO) sit in the drug demand reduction working group. The United Nations Children’s Fund (UNICEF) and the United Nations Development Fund for Women (UNIFEM), which also have interests in drug demand reduction, have been more actively involved in HIV/AIDS issues.

27. Relevant international entities are: the German Agency for Technical Cooperation (GTZ) (which is mainly involved through the Integrated Drug Prevention, Treatment and Rehabilitation Project in Afghanistan), the European Commission, the Aga Khan Development Network, Caritas Internationalis (International Confederation of Catholic Charities), the Colombo Plan Drug Advisory Programme and Médecins du Monde.

\textsuperscript{11} Interview with David McDonald.
28. The main national non-governmental organizations are the following:

(a) The Nejat Centre, which was established in 1991 in Peshawar, Pakistan, and opened a drug treatment facility in Kabul in 2002. It offers a wide range of services, including access to clean syringes and HIV/AIDS awareness-raising and prevention material;

(b) The Welfare Association for the Development of Afghanistan, which has provided drug demand reduction services since 2002. It has also developed drug awareness and outreach projects, established drop-in centres and provided treatment, rehabilitation, prevention and reintegration services throughout Afghanistan (in the cities of Kabul, Ghazni, Gardez and Kandahar, and in the provinces of Helmand and Logar);

(c) The Integrated Drug Prevention, Treatment and Rehabilitation Project in Afghanistan, which is mainly funded by GTZ, was initiated in 2003 in Kabul. Through the project, training, awareness-raising, prevention, treatment and rehabilitation services are provided in Kabul, Faizabad, Gardez, Ghazni, Kandahar, Maidan, Herat, Logar and Helmand.

29. Other Afghan non-governmental organizations that deliver drug demand reduction services include the Khatiz Organization for Rehabilitation, the Shahamat Health and Rehabilitation Organization, the Afghan Red Crescent Society, the Afghan Mobile Reconstruction Association, the Organization of Technical Cooperation for Community Development and the Coordination of Humanitarian Assistance. These non-governmental organizations are mostly implementing drug demand reduction projects funded by the above-mentioned organizations.

30. Staff working on drug demand reduction at the UNODC Country Office in Afghanistan have established some form of contact and collaboration with almost all of these key governmental and non-governmental actors and provided most of them with technical and financial support.

F. Purpose and objectives of the evaluation

31. The present evaluation of the Drug Demand Reduction Programme of UNODC in Afghanistan was conducted in the framework of the 2007 workplan of the Independent Evaluation Unit. As part of the Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the United Nations Office on Drugs and Crime, five thematic evaluations (on drug demand reduction, the rule of law, law enforcement, alternative livelihoods and the illicit crop monitoring programme) were conducted simultaneously. The five individual thematic reports will be used in the consolidated Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the United Nations Office on Drugs and Crime.

32. The purpose of the present evaluation is to assess how UNODC technical assistance builds the capacity of the Government of Afghanistan at the national and sub-national levels to define a drug demand reduction policy and to support its implementation. The objective of the present evaluation is to assess the relevance, effectiveness, efficiency, impact and sustainability of the Drug Demand Reduction Programme of UNODC in Afghanistan. In order to do so, the evaluation team reviewed the programme portfolio and activities carried out between 2001 and June 2007.
G. Evaluation methodology

33. The Independent Evaluation Unit provided the evaluation team with guiding principles for carrying out the evaluation, standards and norms of evaluation in the United Nations system and detailed terms of reference (see annex II). The evaluators prepared an evaluation design matrix with specific questions and a list of persons to be interviewed, and detailed the process of data collection, analysis, organization and presentation.

34. The evaluators studied the historical and contextual background of the programme and undertook a comprehensive desk review of external and internal policies, official documents, surveys and assessment reports, scientific literature, conference proceedings, project reports and budgets, websites and other relevant sources of information.

35. Discussions and face-to-face interviews were held with UNODC management and programme staff both at headquarters in Vienna and at field offices in Afghanistan and Pakistan. Interviews were also held with officials from ministries and departments of the Government of Afghanistan, main donors, United Nations representatives, researchers and Afghan policymakers. Nine service facilities were also visited (four in Kabul, three in Jalalabad, Afghanistan, and two in Peshawar, Pakistan), where the evaluators interacted with service recipients and providers. For security reasons, a field visit to the Afghan refugee camp at Khurasan, Pakistan, had to be cancelled, but a delegation from the camp was met in Peshawar.

36. Efforts were made to evaluate the programme in a participatory manner and in an informal atmosphere, giving weight to the self-assessments of different stakeholders and triangulating the information collected to draw conclusions on findings. In this spirit, the preliminary results of the evaluation were shared with management at the Country Office in Afghanistan and drug demand reduction staff in Kabul at the end of the field mission on 26 November 2007 to validate the observations, findings and recommendations.

37. Since the problems of drug demand reduction and HIV/AIDS are interlinked, given that injecting drug use is a major vector for the spread of HIV, and that HIV/AIDS is addressed comprehensively by the Government and major development players, evaluators focused on drug demand reduction but also looked at HIV/AIDS issues and interventions in connection with injecting drug users.

II. Analysis and findings

A. Mandate and policy of the United Nations Office on Drugs and Crime

1. Drug demand reduction mandate and policies

38. Since 1961, the response of the United Nations to the drug issue has been framed by the three international drug control conventions, which focus on global drug supply: the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. The drug use aspect was left to each State to tackle according to its specific domestic situation, cultural context and political will and
was not directly addressed by those legal instruments. That led to the coexistence of many different national policies regarding the use of illegal drugs.

39. The term “drug demand reduction” was first coined during the International Conference on Drug Abuse and Illicit Trafficking, held in Vienna in June 1987. At the conference, the Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control\textsuperscript{15} was adopted by the representatives of 138 States, who decided that no single aspect of the drug problem should be considered in isolation. At its core was a comprehensive policy that balanced the traditional concern of the international community for the control of the supply of narcotic drugs and psychotropic substances and the fight against illicit traffic with an equal concern for the prevention of the demand for those drugs and substances and the reduction of drug abuse.\textsuperscript{16}

40. In the Declaration on the Guiding Principles of Drug Demand Reduction, Member States agreed that there should be a balanced approach between demand reduction and supply reduction (General Assembly resolution S-20/3, annex, para. 8 (a)). Through prevention, treatment and rehabilitation, the needs of drug users were acknowledged, complementing law enforcement strategies with public health concerns. However, the goals agreed by Member States in the Political Declaration adopted by the General Assembly at its twentieth special session (Assembly resolution S-20/2, annex), to work to eliminate or significantly reduce the illicit cultivation of the coca bush, the cannabis plant and the opium poppy and to achieve significant results in the field of demand reduction by 2008, seem to remain distant.\textsuperscript{17}

41. The organizational structure of UNODC also leaves little place to drug demand reduction. Relevant projects and programmes are undertaken by the Prevention, Treatment and Rehabilitation Unit, Global Challenges Section, whose managers qualify drug demand reduction as the “Cinderella of drug policy”. This view, which appears to be shared throughout UNODC headquarters, is an acknowledgment of the lack of visibility and legitimacy of drug demand reduction.

42. In contrast, public statements by UNODC representatives continue to affirm the importance of drug demand reduction. Thus, in the \textit{World Drug Report 2007},\textsuperscript{18} UNODC Executive Director Antonio Maria Costa stated that the world seemed to be taking seriously the commitment made at the twentieth special session of the General Assembly, in 1998, to take enhanced action to reduce both the illicit supply of and the demand for drugs by 2008. In that same publication, Mr. Costa also stated that, in order to move beyond containment and to reduce the risk of drug use to public health and public security, more attention must be paid to drug prevention and treatment and that, while much of the \textit{World Drug Report 2007} looked at world drug trends in terms of cultivation, production, seizures and prices, those were just the symptoms; if the drug problem was to be reduced in the longer term, there must be more intervention at the level of use, to treat the problem at its source: the drug users. At the 2007 International Drug Policy Reform Conference, held in New Orleans, United States, from 5 to 8 December 2007, the UNODC Executive Director stated again that there had been talk of a balanced approach for a quarter of a century and that it was time to turn that into reality.\textsuperscript{19} One of the aims of the present

\textsuperscript{15} United Nations publication, Sales No. 87.I.13, chap. I, sect. A.

\textsuperscript{16} T. M. Oppenheimer: Projections for the future development of international drug control policies, Bulletin on Narcotics, 1, 3-14, 1990.

\textsuperscript{17} See also: http://www.unodc.org/pdf/document_2003-04-08_2.pdf.

\textsuperscript{18} United Nations publication, Sales No. E.07.XI.5.

\textsuperscript{19} http://www.unodc.org/unodc/en/frontpage/free-drugs-or-drugs-free.html.
evaluation is to see whether there is any factors preventing UNODC and the international community from turning the ideal of a balanced approach into reality.

2. **Harm reduction mandate and policies**

43. While drug demand reduction policies and programmes aims at reducing the desire and preparedness to obtain and use illegal drugs, harm reduction focuses on reducing the health, social and economic harms resulting from drug use\(^\text{20}\). The concept arose outside of any formal institutional strategic framework in the mid-1980s as a response to the danger of HIV transmission through the use of contaminated drug injection equipment and related increases in risky sexual behaviour.\(^\text{21}\)

44. Harm reduction does not consist in limited measures but refers to a comprehensive package of interventions.\(^\text{22}\) The main objectives of the approach are to make users stop sharing injection equipment, switch from injection to oral drug use, decrease drug use and, ultimately, abstain from any use. Harm reduction is clearly embedded in a public health framework that is respectful of human rights and addresses drug users’ social needs while avoiding stigmatization, discrimination and marginalization. Despite policy differences among some countries, harm reduction was adopted explicitly as one of the key HIV/AIDS prevention policies, notably by the European Union.\(^\text{23}\)

45. The position of the United Nations with regard to harm reduction efforts related to drug use is guided by the Declaration of Commitment on HIV/AIDS,\(^\text{24}\) adopted by the General Assembly in June 2001. In that document, Member States declared their commitment to taking action, including by ensuring expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections. That commitment was reaffirmed in the Political Declaration on HIV/AIDS,\(^\text{25}\) adopted by the Assembly in June 2006.

\(^{20}\) United Nations publication, Sales No. E.00.XI.9

\(^{21}\) Injecting drug use is estimated to account for nearly one third of new infections outside sub-Saharan Africa, but less than 20 per cent of people who inject drugs receive HIV prevention services. In fact, prevention efforts reach less than 10 per cent of injecting drug users in Eastern Europe and Central Asia, where drug use is a major driver of the rapidly expanding epidemic. See http://www.unaids.org/en/PolicyAndPractice/KeyPopulations/InjectDrugUsers/.

\(^{22}\) Harm reduction includes providing sterile injection material; raising awareness to prevent the spread of sexually transmitted diseases (including HIV) through risky sexual and drug injection practices by, for example, distributing condoms among injecting drug users; providing access to outreach programmes and community-based interventions; providing information, advice and education about HIV and other diseases; providing access to primary health care (abscess and vein care, hepatitis B vaccination); providing referral services and offering a variety of drug treatment options, including drug substitution therapy; providing access to voluntary counselling and testing services; and offering treatment for AIDS and sexually transmitted diseases.

\(^{23}\) In its recommendation 2003/488/EC of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence, the Council of the European Union recommended that member States should set as a public health objective the prevention of drug dependence and the reduction of related risks and that they should make available, as an integral part of their overall drug prevention and treatment policies, the full range of services and facilities, particularly aiming at harm reduction.

\(^{24}\) General Assembly resolution S-26/2, annex.

\(^{25}\) General Assembly resolution 60/262, annex.
46. In its resolution 45/1 on HIV/AIDS in the context of drug abuse, the Commission on Narcotic Drugs explicitly recognized that effective prevention, care and treatment strategies require increased availability of and non-discriminatory access to, inter alia, condoms and sterile injecting equipment. By contributing to a series of publications with WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS), UNODC in 2004, has also endorsed harm reduction measures such as the provision of sterile injecting equipment, substitution maintenance therapy and outreach. UNODC has supported this approach in an advocacy guide.

47. UNODC has thus at its disposal a clear mandate and strategic framework that includes harm reduction measures for preventing HIV/AIDS transmission among injecting drug users. In spite of this, an evaluation of the activities on HIV/AIDS of the former United Nations International Drug Control Programme in 2002 revealed uncertainty among staff members and partners about how the Programme addressed HIV/AIDS and doubts about senior management’s support for prevention strategies among injecting drug users such as needle and syringe programmes and drug substitution therapy. During the present evaluation field mission, staff members in various international organizations and donor agencies were also found to have doubts as to whether the Programme was ready to implement harm reduction interventions.

48. Not all donors funding UNODC agree with harm reduction approaches. The Government of the United States, in particular, has vigorously opposed them. It considers that programmes offering clean syringes would in fact encourage drug use, in spite of compelling scientific evidence to the contrary. The pressure on UNODC not to endorse harm reduction policies and to avoid mentioning needle exchange peaked in the years 2004-2005 under the threat of having all funding to the Office cut. UNODC responded favourably to those demands.

26 UNODC has been a co-sponsor of UNAIDS since 1999.
28 At the European Cities Against Drugs 14th Mayors’ Conference held in Istanbul, Turkey, on 10 and 11 May 2007, John P. Walters, Director of the Office of National Drug Control Policy of the United States, stated: “I must be very clear – drug enabling ‘harm reduction’ policies, such as needle exchange, injection rooms, heroin distribution and decriminalization of personal use of drugs pose a dire threat to our work. […] There is no such thing as safe heroin use. Those afflicted with the disease of addiction should receive treatment, not needles. Some have argued that needle exchange reduces HIV/AIDS and other diseases. Many in the international community, and even in the United States, find this a compelling supposition. But the evidence suggests that drug-induced risky behaviour is the root cause of disease transmission, not addicts’ inability to gain access to clean needles.” Full transcript available at: http://www.ecad.net/activ/M14Walters.html.
30 On 11 November 2004, UNODC Executive Director Antonio Maria Costa wrote a letter to Robert B. Charles, Assistant Secretary of State for International Narcotics and Law Enforcement Affairs of the United States, in which he stated: “Under the guise of “harm reduction”, there are people working disingenuously to alter the world’s opposition to drugs. […] we are reviewing all our statements, both printed and electronic, and will be even more vigilant in the future.”
49. The position held by UNODC then changed, and the harm reduction approach was endorsed again, at the XV International AIDS Conference, held in Bangkok from 11 to 16 July 2004, at which the UNODC Executive Director declared: “During the past decade, we have also learned that the HIV/AIDS epidemic among injecting drug users can be stopped – and even reversed – if drug users are provided, at an early stage and on a large scale, with comprehensive services such as outreach, provision of clean injecting equipment and a variety of treatment modalities, including substitution treatment.” The evaluation team also acknowledges that, following this evaluation, from early 2008 on, several steps have been taken towards a clear harm reduction policy31.

3. Findings

50. UNODC is committed to a balanced approach to drug use, one aimed at reducing drug demand and, in parallel, at reducing drug supply. In reality, drug demand reduction still remains the orphan child of drug policies, unable to get the same kind of attention given to supply reduction efforts.

51. UNODC has at its disposal a clear mandate and strategic framework on harm reduction, yet at the time of the evaluation, there was no policy in place to integrate it into its Drug Demand Reduction Programme. Ideological debates over HIV/AIDS and drug demand reduction issues, mainly over harm reduction measures, had induced polarized positions; in turn, this has had counterproductive effects, in particular on some donors. Harm reduction responses to the drug problem had been wrongly presented by those opposed to them as being limited to needle and syringe programmes and drug substitution therapy, leaving out prevention, care and rehabilitation and, in particular, the provision of primary health-care and social services. Those responses had also fuelled conflicts between two units at UNODC headquarters (the HIV/AIDS Unit and the Prevention, Treatment and Rehabilitation Unit) and partly affected country-level programming in Afghanistan, in an already difficult and precarious environment. Previous evaluation findings32 about the uncertainty among staff members and partners as to whether senior management supports prevention strategies among injecting drug users (such as needle and syringe programmes and drug substitution therapy), were still very much valid.

52. In line with discussions and revisions of harm reduction policies that have taken place in most countries facing serious drug use problems and the continuing risk of drug-related HIV transmission, the fact that ideological differences within UNODC persisted at the time of the evaluation demands attention. As a consequence, the Office only produced mixed messages, lessening the credibility of UNODC in the eyes of many international players. UNODC should not allow itself to be bogged down by such polarized debates. However, as of March 2008, following the evaluation field mission, there is evidence that UNODC has embarked on a process of clarifying its policy position on harm reduction; this is beginning to have positive impacts on this important area.

53. At the time of the evaluation, the internal differences and the uncertainty felt by staff members in terms of the practice adopted by UNODC with regard to drug demand reduction and harm reduction, and the links with HIV/AIDS had also created a lack of

31 (i) UNODC Discussion paper - 23/01/08 - Reducing the adverse health and social consequences of drug abuse: A comprehensive approach; (ii) Paper to the Commission on Narcotic Drugs - March 2008 - Making Drug Control Fit for Purpose. Building on the UNGASS Decade; (iii) several policy statements by UNODC Executive Director (December 2007, Free drugs or drug free? Executive Director Costa at a Drug Policy Alliance meeting, New Orleans; opening of the Commission on Narcotic Drugs in March 2008 …)

visibility and legitimacy of the UNODC Country Office in Afghanistan, which has hindered the potential growth of the Drug Demand Reduction Programme in the country.

B. Assessment of drug use and HIV/AIDS prevalence in Afghanistan

1. Drug use in Afghanistan

54. Epidemiological data regarding drug use lag considerably behind surveys on drug supply, which is closely monitored in Afghanistan. After an initial assessment was done in 1999, the first widely disseminated assessment of drug use was made in 2003 but was limited to Kabul. The lowest estimated number for the whole of Kabul amounted to some 62,000 people reporting drug use (38 per cent of whom reported using “hashish” (cannabis resin), 23 per cent pharmaceutical drugs, 17 per cent opium, 11 per cent heroin and 10 per cent alcohol). A significant number of people were found to be injecting heroin and pharmaceuticals, with most of the users sharing their injecting equipment. Few women were found to consume heroin or hashish, but rather opium and mainly tranquilizers or analgesics. Nearly half of all heroin users and a quarter of pharmaceutical users interviewed had started using drugs in the Islamic Republic of Iran or Pakistan.

55. A similar survey was carried out in 2005, this time with a national coverage; key informants and drug users were interviewed in provincial capitals, district centres and villages. It was estimated that approximately 920,000 people (3.8 per cent of the total population) were using drugs. Of those, 520,000 reported using hashish, 150,000 opium and 50,000 heroin. Women were found to be using drugs mainly in private places, making such practice much less visible to the rest of the community and probably leading to an underestimation of the phenomenon.

56. A World Bank survey estimated that in 2005 Afghanistan had almost 1 million drug users, 200,000 of whom used opium and 19,000 of whom injected either prescription drugs (12,000) or heroin (7,000). A 2006 survey in Kabul estimated that several categories of drug use had increased by more than 200 per cent in 12 months.

57. Comparing the different surveys shows a clear increase in the estimated numbers of drug users. Staff members working in the field tend to confirm this trend. Nonetheless, it is crucial that surveillance instruments capable of monitoring the drug use situation, detecting new trends and identifying local disparities on the basis of hard data be available in the future, as existing surveys are currently unable to give an accurate comprehensive picture.

2. HIV/AIDS in Afghanistan

58. There is a direct relationship between the increase in drug use in Afghanistan and the early stage of an HIV epidemic, as an increasing number of drug users inject drugs.

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33 UNODC: Community Drug profile #5: an assessment of problem drug use in Kabul City, July 2003. The assessment was based mainly on interviews of key informants and drug users. Biased by a general reluctance to reveal illicit drug use, fear of harassment and stigmatization, this assessment provides some baseline (minimum number of users) for the whole of Kabul.


sharing contaminated injecting equipment without knowing that using unclean syringes carries a high risk of HIV transmission.\textsuperscript{37}

59. There is no surveillance system on HIV/AIDS in Afghanistan. UNAIDS estimates that, in 2005, 2,000 people were living with HIV in Afghanistan.\textsuperscript{38} Government institutions report lower figures: the Ministry of Public Health reported that there were 69 cases of HIV infection in January 2007, but then reported 245 cases in August. However, the fact that the prevalence of HIV/AIDS is unknown does not make the problem any smaller, especially as there is the risk that the hidden phenomenon is ignored.

60. The following known risk factors indicate that Afghanistan could quickly develop a concentrated epidemic (defined as one in which HIV prevalence is greater than 5 per cent of the at-risk population):

(a) Injecting drug use is expanding;

(b) Internally displaced people, refugees returning from the Islamic Republic of Iran and Pakistan and other seasonal migrants, estimated at 2.2 million,\textsuperscript{39} are particularly vulnerable to HIV transmission;

(c) Groups engaging in risky behaviour, such as sex workers, truck drivers, prisoners and men who have sex with men, are hidden populations;

(d) The low level of education is coupled with very limited awareness about HIV/AIDS, including the modes of transmission and means of prevention.

61. The deteriorated social and public health infrastructure also makes the Afghan population more vulnerable to HIV/AIDS transmission. Health-care services are scarce and limited attention is given to the issue.\textsuperscript{40} Only four voluntary counselling and testing centres are available in the country (in Kabul, Herat, Jalalabad and Mazar-i-Sharif) and antiretroviral therapy is almost non-existent.

62. A survey conducted in four districts in Kabul revealed that almost all the 126 sex workers interviewed had no knowledge about HIV/AIDS and did not use condoms.\textsuperscript{41} Some behavioural surveys also indicated a 3 per cent prevalence of HIV among injecting drug users in Kabul. A rapid assessment carried out by Médecins du Monde in 2006 even showed that 10 per cent of the clients of their drop-in centre were HIV-positive.\textsuperscript{42}

63. A more detailed study of adult injecting drug users in Kabul for the period from June 2005 to 2006 also indicated an alarmingly high prevalence of HIV (3 per cent), hepatitis B (36.6 per cent) and hepatitis C (6.5 per cent). Among male injecting drug users, risky behaviour, including sharing syringes (50.4 per cent), paying women for sex (76.2 per cent) and having sex with men or boys (28.3 per cent), was common. The study

\textsuperscript{38} UNAIDS: Afghanistan, 2006.
\textsuperscript{41} Ora International: Survey of groups at high risk of contracting sexually transmitted infections and HIV/AIDS in Kabul, April 2005.
concluded that the high prevalence of risky behaviour indicates that Kabul is at risk of an HIV epidemic. A scaling up of harm reduction interventions is urgently needed.\(^{43}\)

64. Since as early as 2002, several United Nations agencies such as WHO, UNAIDS, UNICEF and the United Nations Population Fund (but, notably, not UNODC) have issued warnings about the potential development of an HIV epidemic in the “fertile” Afghan environment and taken concrete steps by conducting studies on the prevalence of HIV/AIDS in Afghanistan, providing test kits, implementing HIV education programmes (including prevention programmes for sex workers) and training laboratory technicians. The need for a multisectored approach was recognized and a specific HIV/AIDS department established in 2003 within the Ministry of Public Health. Very recently, the urgency of the Afghan situation has again been brought to the attention of the international community by civil servants, researchers and World Bank staff members.\(^{44}\)

3. Findings

65. The UNODC studies carried out in 2003 and 2005 are the only sources of information on drug use in Afghanistan and have been used widely by other organizations, at the national and international levels, and by the Government.

66. UNODC has the comparative advantage and expertise in Kabul to conduct either separate studies or to explore the possibility of integrating the drug use problem in its existing studies.

67. It is evident from the available information and known risk factors that Afghanistan is approaching a concentrated HIV/AIDS epidemic. Despite having a clear mandate in this area, UNODC has missed several opportunities to participate in national and international initiatives (see below) and to take timely action. Very recently, however, the HIV/AIDS Unit based at UNODC headquarters has provided (on a temporary basis) an expert to support the Country Office in Afghanistan, a step that will definitely enhance the Office’s capacity to address HIV/AIDS issues.

C. Strategic and institutional frameworks for drug demand reduction and HIV/AIDS in Afghanistan

1. Strategic framework for drug demand reduction

68. There has never been a coherent policy formulated to address the drug issue in Afghanistan in a comprehensive manner. In 2003, the then Counter-Narcotics Directorate of the Government of Afghanistan published, with the help of UNODC, a five-year National Drug Control Strategy.\(^{45}\) In this Strategy, the intention to adopt a balanced approach addressing both drug supply and drug demand was stated. The overall goal was to eliminate the trafficking in and the production and use of illicit drugs in Afghanistan. With regard to drug demand reduction, one of the five specific objectives was to reduce

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the problematic use of legal and illegal substances through prevention, treatment, rehabilitation and social integration.

69. The following drug demand reduction activities were mentioned as measures to implement that objective:

(a) Development of drug demand reduction advocacy capacity;

(b) Assessment of the scale and nature of drug use;

(c) Establishment of drug use prevention and treatment programmes covering the rehabilitation, aftercare and social reintegration of drug-dependent people, including the provision of harm reduction services to intravenous drug users as a public health measure to prevent the transmission of HIV/AIDS and other blood-borne viruses;

(d) Increase in the awareness of the general population and at-risk groups about drugs.

70. It was also stressed that drug dependent people should not be penalized by being imprisoned or punished, but that they should be provided with appropriate treatment and rehabilitation services. The Strategy therefore clearly shows a commitment to a harm reduction approach for injecting drug users. It also mentions the need to develop drug demand reduction programmes with the assistance of neighbouring States, especially the Islamic Republic of Iran and Pakistan, and to benefit from their experiences with drug abuse problems.

71. Overall, the World Bank assessed the Strategy as being cautious and gradualist on the one hand, while setting very ambitious goals on the other. In line with the Strategy, the former Minister of Counter Narcotics issued statements that, considering the situation, were indeed very optimistic. For example, he declared, in September 2006, that the drug problem would be under control within five years.

72. As one of the implementing milestones, the Government of Afghanistan, the Government of the United Kingdom and UNODC co-hosted the International Counter-Narcotics Conference on Afghanistan, held in Kabul on 8 and 9 February 2004. Representatives of relevant ministries and key international donors participated in the conference. Drug demand reduction was discussed and agreement was reached on the following:

(a) **There was a general lack of awareness** of relevant ministries and other national and international decision makers about drug use, in particular about how it related to opium poppy cultivation, the nature of drug addiction and how stakeholders can influence progress in terms of drug demand reduction;

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48 The Counter-Narcotics Directorate, the Ministry of Public Health (lead ministry for drug demand reduction), the Ministry of Education and Higher Education, the Ministry of Information and Culture, the Ministry of Labour and Social Affairs, the Ministry of Hajj and Islamic Affairs, the Ministry of Women’s Affairs, the Ministry of Refugees and Repatriation, the Ministry of Justice and Afghan non-governmental organizations. Also present were representatives of UNODC, GTZ, Italy, Ireland, Japan, the Netherlands, the United Kingdom and the United States.
(b) There was a need to identify and agree on a comprehensive treatment and rehabilitation system based on best practices in drug treatment and rehabilitation, to develop a national protocol for a comprehensive treatment and rehabilitation system and to plan for overall service delivery coordinated by the Counter-Narcotics Directorate;

(c) There was a need for coordination and monitoring, both among the various drug services and with national and international bodies (non-governmental organizations, Government institutions, United Nations entities, representatives of the media etc.). In particular, a national strategy should ensure equity in service provision between Kabul and the provinces since efforts until then had largely centred on Kabul;

(d) Training and capacity-building at all levels were critical to achieving progress in drug demand reduction facilities and services. Some staff had already been trained, but much more needed to be done in several key areas. The establishment of a national training and research centre to work on all aspects of drug abuse prevention was proposed;

(e) Drug demand reduction was perceived to be allocated fewer resources and were given less attention than law enforcement or alternative livelihoods despite being the “third pillar” of the National Drug Control Strategy and, therefore, being of equal importance.

73. By including many of the suggestions made at the conference, the Strategy was updated in 2006 around four national priorities for tackling the illicit drug problem, one of which was the reduction of the demand of illicit drugs and the treatment of problem drug users. To achieve that objective, the limited services for drug users existing in the country would have to be scaled up and mainstreamed in the health-care, education and law enforcement sectors. The revised strategy also restated that “for injecting drug users, harm reduction measures must be introduced as a public health measure to prevent the transmission of blood-borne diseases like HIV and hepatitis C.” Yearly indicators for the achievement of the priority objective on drug demand reduction are a reduction in the number of problem drug users in Afghanistan and a reduction in drug-related harm, as measured by using the 2005 UNODC figures as a baseline, under the condition that a new drug survey with the same methodology is conducted.

74. The plan for implementing the drug demand reduction part of the Strategy, recently proposed by the Ministry of Counter-Narcotics of Afghanistan, identified the following three axes, according to a classical model:

(a) Primary prevention: prevent people (particularly youth) from starting to use drugs;

(b) Secondary prevention: stop people already using drugs from continuing their use;

(c) Tertiary prevention: reduce the harm and risks caused by drug use until people are able to stop using drugs.

75. The bulk of the plan details harm reduction services (tertiary prevention), which are thus fully endorsed by the Government of Afghanistan, including through the Harm


Reduction Strategy for Injecting Drug Use and HIV/AIDS Prevention in Afghanistan. A series of measures recommended in this harm reduction strategy show that the Government of Afghanistan has fully endorsed a comprehensive harm reduction approach based on: information, education and communication; reduction of the stigma associated with drug use and HIV; needle and syringe exchange; condom promotion and distribution; and drug substitution therapy.

76. On the basis of the four national priorities of the National Drug Control Strategy, eight pillars of activities were defined for an estimated total cost of about $2.5 billion. The biggest portion was allocated to alternative livelihoods (52.4 per cent), followed by law enforcement (25.3 per cent) and drug crop eradication (12.1 per cent). Drug demand reduction projects ranked fourth (5.6 per cent), before criminal justice (2.6 per cent), public awareness (1.4 per cent) and institutional building (0.3 per cent). No money was allocated to international and regional cooperation (eighth pillar). The fact that drug demand reduction is highlighted as a specific pillar does not mean that the Government of Afghanistan and the international community have identified it as a priority issue for the country, since its budget amounts to 5.6 per cent of that allocated to countering narcotics.

77. In supporting the National Drug Control Strategy, the Government of the United Kingdom spent over 74 million pounds on those eight pillars between 2005 and 2006, allocating only 1.5 per cent (£1.1 million) to treatment, rehabilitation and harm reduction programmes (sixth pillar).

78. Opioid substitution therapy is at the early stage of development in Afghanistan. Nonetheless, it is an important issue that is linked to the range of treatments available and to the phenomenon of relapse. Drug substitution therapy permits the detoxification process and the stabilization of drug use and its subsequent reduction. Methadone, which is one of the best-researched substitution drugs, has been shown to diminish significantly morbidity, mortality, criminal behaviour and psychosocial problems. At present, however, there is no substitution therapy available in Afghanistan, despite the fact that the Government is committed to adopting comprehensive harm reduction measures (including opioid substitution therapy) and that drug substitution therapy is mentioned in the National AIDS Control Programme and is being considered for piloting.

79. A conference was held in Kabul in 2007 to define a national policy on opioid substitution therapy as an essential harm reduction measure. On the one hand, the Government expressed its concern about the lack of an adequate legal framework, the absence of control and regulation, the risk that the substitution drugs would be diverted from the legal market given the prevailing insecurity, as well as about the lack of local experience, training and good practices regarding the introduction of a “new drug”. On the other hand, some non-governmental organizations, donors and United Nations entities pointed to the urgent need to tackle the HIV problem, given the increased drug injection in Afghanistan, and insisted that time should not be lost. While the Government tended to see opioid substitution therapy as a means for new drugs to be imported from abroad, others insisted that such therapy would contribute to treatment. Government officials insisted that the issue should be managed by Afghans and that, if adopted, it should be tackled in culturally appropriate ways that responded to the needs of the country.

51 Available at: http://www.ahrn.net/library_upload/uploadfile/file2495.pdf.
53 National Conference on OST: an essential service in harm reduction, 5-6 November 2007, Kabul.
2. Strategic framework for HIV/AIDS

80. The strategic framework for HIV/AIDS is embedded in the sixth Millennium Development Goal, which aims, inter alia, to halt and begin to reverse the spread of HIV/AIDS. For Afghanistan, the goal was to do so by 2020 and to increase the proportion of injecting drug users in treatment by 2015. The first national strategic plan for Afghanistan on HIV/AIDS and sexually transmitted infections, for the period 2003-2007, was published in September 2003 by the Ministry of Public Health in response to the potential risk of the infection spreading in Afghanistan. In 2005, the Ministry of Public Health and the Ministry of Counter-Narcotics jointly published a harm reduction strategy for injecting drug use. The latest programmatic development is the Afghanistan National HIV/AIDS Strategic Framework for 2006-2010, whose goal is to maintain a low prevalence of HIV-positive cases in the population (less than 0.5 per cent) and to reduce mortality and morbidity associated with HIV/AIDS.

81. In the Afghanistan National HIV/AIDS Strategic Framework for 2006-2010, six objectives were identified. The Framework was then translated into a programme operational plan to support the implementation of the strategy. The possibility of piloting drug substitution therapy is also considered in the National AIDS Control Programme, as a means to limit the risk of HIV/AIDS transmission linked with increased drug injection.

Overall findings

82. The National Drug Control Strategy of Afghanistan was developed based on a human rights approach. Through that Strategy, the Government of Afghanistan has clearly demonstrated its commitment to a harm reduction approach for injecting drug users and recognized the need to develop drug demand reduction programmes in cooperation with neighbouring countries, especially the Islamic Republic of Iran and Pakistan, and to benefit from their experiences in dealing with domestic drug abuse problems. There is no evidence that such cooperation has been actively pursued. However, it is evident that UNODC has played a key role in preparing the National Drug Control Strategy and that the relevant stakeholders have appreciated that contribution.

83. The National Drug Control Strategy and the national harm reduction strategy also include a series of comprehensive harm reduction measures linked to drug use, including opioid substitution therapy, needle and syringe exchange programmes and condom distribution. All relevant national and international stakeholders should engage in active

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discussions to clarify ways of implementing drug substitution therapy in the Afghan context. The process of further policy definition for opioid substitution therapy will take a strong collaboration between the Ministry of Counter-Narcotics and the Ministry of Public Health. Other ministries, such as the Ministry of Justice, the Ministry of Interior Affairs, the Ministry of Foreign Affairs and the Ministry of Finance, will also have to be involved. A needs analysis and feasibility study of opioid substitution therapy for Afghanistan should be undertaken, a necessary regulatory legal and monitoring framework for such therapy (e.g. with regard to the risk of diversion and trafficking) also needs to be developed and technical assistance provided to the Government in these different areas.

84. The level of donors’ interest in and commitment to the Drug Demand Reduction Programme has been relatively low and not sustained over time. This is possibly a result of the absence of a viable programme to inform and secure donor interest, as well as a consequence of the lack of institutional capacity for coordinating and fund-raising within the Ministry of Counter-Narcotics and the Ministry of Public Health.

3. Relevant institutional framework for drug demand reduction

85. In Afghanistan, the Counter-Narcotics Directorate was created in October 2002 within the National Security Council, based in the Office of the President. It was established under the guidance and with the funding of the Government of the United Kingdom, the nominated lead State for international drug control assistance. A drug demand working group was first established informally with the technical assistance and participation of UNODC. The working group was chaired by the Counter-Narcotics Directorate.

86. Two years later, in December 2004, the Directorate was upgraded and converted into the Ministry of Counter-Narcotics as a sign of a national commitment to take action against the drug problem. The Ministry was mandated to lead the coordination, policymaking, strategic planning, monitoring and evaluation of all counter-narcotic activities and efforts in the country. It is also in charge of collecting and disseminating all available data on drug demand reduction in Afghanistan.

87. As already mentioned, the health-care system in Afghanistan is not functional, posing additional challenges for drug demand reduction activities in particular. While the Taliban were in power, the already limited health-care system worsened to the extent that women had virtually no access to health care. Non-governmental organizations provided 80 per cent of the health-care services, which were mainly curative and left little place for preventive activities. After September 2001, a health reform introduced the Basic Package of Health Services for Afghanistan funded by the World Bank, UNAIDS and the European Commission. Its implementation fell under the responsibility of the newly created Ministry of Public Health, which had, and still has, limited human and financial resources. Indeed, in recent decades, many professionals have left the country or joined non-governmental and international organizations in exchange for enormous increases in salaries instead of continuing to work in the poorly paid public sector.

Overall findings

88. Both the Ministry of Counter-Narcotics and the Ministry of Public Health, the main ministries responsible for drug use issues, are perceived by stakeholders as weak, under-

resourced bureaucratic entities with unclear roles and responsibilities. Additionally, after the Counter-Narcotics Directorate became a ministry, financial and human resources provided by the United Kingdom were withdrawn.

89. UNODC did a lot of training and advisory work, and staff members working on drug demand reduction at the UNODC Country Office in Afghanistan were instrumental in developing the National Drug Control Strategy. However, there were many changes in staff and much instability in governance in both ministries and, with the mushrooming of treatment centres, the coordination abilities of the Ministry of Counter-Narcotics declined.

90. Non-governmental organizations reproach the Ministry of Counter-Narcotics for not facilitating their work and not doing enough lobbying and fund-raising for drug demand reduction activities. Moreover, the Ministry of Counter-Narcotics apparently does not integrate data produced by non-governmental organizations in its policies. In practice, since the United Kingdom withdrew funding, the Ministry of Counter-Narcotics has relied heavily on the Colombo Funds; such reliance has forced the Ministry to reorient its work away from a harm reduction approach, in contradiction with the country’s official strategy. Since June 2007, there has been a void in governance within the Ministry of Counter-Narcotics owing to the departure of the minister; no new minister has been appointed by the President to date.

91. In parallel, the Ministry of Public Health has also been seen as having few capacities. This situation has recently improved, as the Ministry is the main beneficiary of new funds from the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria in support of harm reduction programmes.

92. The Basic Package of Health Services for Afghanistan has made donors subcontract national and international non-governmental organizations directly, thus bypassing the Ministry of Public Health as a health-care implementer. As a consequence, the national public health system and local capacities have not been built up.\(^60\) Therefore, while the proportion of the population with access to health services increased from 9 per cent in 2002 to 82 per cent in 2006, the quality of those services remained poor, with long waiting times, shortage of medicines, absence of laboratories and even disrespect for patients.

93. The fact that the responsibility for national health care is in the hands of (mainly international) non-governmental organizations weakens the Ministry of Public Health. Contractual arrangements with non-governmental organizations are generally short-term and do not allow for the development of a long-term vision for the country. If the volatile security situation deteriorates, some of the international non-governmental organizations could leave, thus depriving a large part of the population of health-care services. There is also a trend towards privatizing health-care services, which further increases inequities with regard to access. Additionally, the fact that there are so many non-governmental organizations leads to coordination difficulties, the duplication of services and inefficiencies. Finally, there are no quality standards.

94. In order to counter those difficulties, it is necessary to strengthen the Ministry of Public Health. More and better resources are also needed to develop a national strategy able to organize, plan, supervise, monitor and evaluate an Afghan-owned health-care system. With such an improvement, the drug issue could benefit from being included in the Basic Package of Health Services for Afghanistan on both the preventive and curative sides.

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D. Major funding for drug demand reduction and HIV/AIDS prevention in Afghanistan

1. Counter-Narcotics Trust Fund

95. The Counter-Narcotics Trust Fund was established in October 2005 to mobilize resources for the Government of Afghanistan to meet the objectives contained in the National Drug Control Strategy. The Ministry of Counter-Narcotics is the first beneficiary of the Fund. While the initial needs requirement was $900 million, donors have to date committed a total of $82 million to date, \(^{61}\) of which only $42.6 million has actually been received.

96. Additionally, there is massive under-spending. Two years after the Fund was established, only $2.5 million had been disbursed. This poor disbursement rate is usually attributed to poor project formulation and appraisal processes and to weaknesses in the relevant ministries, which are not able to develop sound projects.

97. The majority of funds have been allocated to alternative livelihoods (15 projects). Six drug demand reduction projects have been partially funded, \(^{62}\) in addition to one awareness-raising, one law enforcement and two capacity-building projects. Thus, drug demand reduction is not the most neglected component. Yet an analysis of project components shows that no coherent and coordinated approach seems to be followed in making funding decisions. UNODC should therefore consider playing a more proactive role and support the Ministry of Counter-Narcotics and the provincial governments in the design and implementation of projects and in facilitating access to Fund resources.

2. Global Fund to Fight AIDS, Tuberculosis and Malaria

98. The Global Fund to Fight AIDS, Tuberculosis and Malaria has enabled the identification of three gaps in the fight against HIV/AIDS in Afghanistan: the absence of a surveillance system, limited awareness and knowledge of the epidemic and the absence of preventive measures.

99. On the basis of those gaps, the Global Fund project for Afghanistan aims to achieve five objectives, which include: strengthening the national health system in connection with HIV; creating a supportive environment for an effective national response to HIV; preventing the transmission of HIV among the most at-risk and vulnerable segments of the population; and providing care, treatment and support to people living with HIV.

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\(^{62}\) The drug demand reduction projects presently funded by the Counter-Narcotics Trust Fund are the following: Two drug demand reduction residential treatment centres, one of which was opened in Balkh in February 2007 and the other in Nangarhar in December 2006 (US$ 358,848 during the first year (timeframe three years), 75 per cent expenditure); A provincial community outreach project on drug treatment covering eight provinces (US$ 935,364 during the first year, 70 per cent expenditure); A drug awareness-raising campaign (US$ 31,928 (timeframe six months), 98 per cent expenditure); A drug-free educational environment project (US$ 5,015,200 (timeframe two years), 15 per cent expenditure); A mosque-based drug abuse prevention project offering also aftercare services (US$ 681,766 (timeframe one year), not started yet so no expenditure to date); A harm reduction project in the framework of the National HIV/AIDS Control Programme (US$ 132,182 (timeframe one year), no expenditure to date). See the Counter-Narcotics Trust Fund Progress Report, August 2007, Ministry of Counter Narcotics.
100. The principal recipients of the $10 million fund are the Ministry of Public Health, in charge of coordination at the national level, and GTZ, in charge of implementation at the provincial level. The grant agreement is to be signed in 2008.

3. World Bank

101. In 2007, the World Bank approved a total of $10 million for increasing awareness of HIV and reducing stigma and discrimination through communication and advocacy; strengthening HIV surveillance through biological and behavioural surveys and studies on knowledge, attitudes and practices related to HIV; implementing targeted interventions to prevent the further spread of HIV among vulnerable groups most at-risk (like injecting drug users and their partners); and strengthening programme management and capacity-building, as well as monitoring and evaluation.

Overall findings

102. The Counter-Narcotics Trust Fund has sufficient resources to fund drug demand reduction projects in Afghanistan; however, a bureaucratic approval process and the weak capacity of recipient Government agencies limit the utilization of Fund resources.

103. Global Fund and World Bank projects overlap with the main objectives of the Drug Demand Reduction Programme of UNODC (discussed below) while failing to touch upon existing drug demand reduction service facilities:

(a) Injecting drug users are targeted as a high at-risk group for HIV/AIDS; and HIV/AIDS prevention is clearly nested in drug demand reduction under harm reduction measures. The networks and stakeholders are the same. Any effective HIV/AIDS referral system must integrate drug use in general and injecting drug users in particular;

(b) Awareness-raising efforts, information, education and communication efforts, and community mobilization efforts for both HIV/AIDS and drug demand reduction are trying to reach out to those who practice unsafe behaviours;

(c) The Global Fund proposal mentions provincial health offices as focal points for harm reduction services, but does not refer to the fact that those offices already serve as bases for UNODC DRATs and that synergies could be reinforced;

(d) The objective of integrating both HIV/AIDS and drug demand reduction issues into the Basic Package of Health Services for Afghanistan is to mainstream those issues in the health-care system of the country.

104. Both the proposals of the World Bank and the Global Fund include a pilot project to establish the feasibility of an effective and appropriate opioid substitute therapy system for Afghanistan.\(^63\)

105. Donor fatigue has set in and funding for drug demand reduction projects is declining, despite the fact that donors had initially shown some commitment. The Counter-Narcotics Trust Fund bureaucratic process, the weak linkages between the Ministry of Counter-Narcotics and the Ministry of Public Health, and the absence of innovative, evidence-based and viable projects are possible determinants of such donor fatigue, reinforced by the absence of a common approach of the donors’ community on harm reduction.

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\(^{63}\) See page 54 – http://theglobalfund.org/search/docs/7AFGH_1463_0_full.pdf.
E. Drug Demand Reduction Programme of the United Nations Office on Drugs and Crime in Afghanistan

106. This evaluation considered four drug demand reduction projects (including one that has been completed)\(^{64}\) in the context of international assistance to Afghanistan and provided key achievements as documented in project reports and a general assessment of each project.

107. The drug demand reduction projects of the UNODC Country Office in Afghanistan form a programme covering different regions in Afghanistan, as well as refugee camps in Baluchistan and the North West Frontier Province in Pakistan. The projects are separated mainly for funding reasons but they all have the same overall objectives, albeit with a different geographical focus. The current programming continues the work started through projects that took place between 1988 and 2003, but in a different political environment.

108. Projects have a very broad approach that includes general awareness-raising about the harmful effects of drug use, drug demand information, advice and training services to a wide range of stakeholders (Government counterparts, non-governmental organizations, United Nations agencies and social multipliers), as well as an assessment of drug use trends at the national level. They function within the framework of the capacity-building programme START and build upon the existing DRATs.

109. In the latest UNODC programme overview for Afghanistan,\(^ {65}\) the importance of prioritizing institutional capacity-building was reaffirmed, mainly in the areas of law enforcement and alternative livelihoods. Demand reduction activities for the prevention of drug use and the treatment of drug addicts were also mentioned as key elements in developing a balanced counter-narcotics and crime prevention policy.\(^ {66}\) In practice, however, the part allocated to drug demand reduction amounted to only about 4.5 per cent\(^ {67}\) of the amount allocated to the entire UNODC programme in Afghanistan, which does not reflect a balanced policy. This is partly because the Drug Demand Reduction Programme consists of soft components (such as training and other services) that are less expensive than building infrastructure (such as prisons) and, possibly, also because the then-existing debate on and inconsistency in the implementation of drug demand reduction and harm reduction approaches within UNODC contributed to the lack of donor interest in committing funds.

1. Project AFG/G26: Drug demand reduction information, advice and training service for Afghanistan (2002-2006)

110. The project was completed in 2006, with a budget of $504,249. Its short-term objectives were: to make a rapid assessment of drug use in Kabul, establish an outreach referral system and provide home-based detoxification and treatment services for drug addicts, targeting women in particular.

111. The following two components were added, with additional funding from the United States, who could not transfer money directly to implementation partners:

\(^{64}\) Project AFG/G26.


\(^{66}\) Ibid., p. 3.

\(^{67}\) Three drug demand reduction projects (AFG/H09, AFG/G68 and AFG/H87) budget compared to the total portfolio of the UNODC Country Office in Afghanistan, UNODC Programme in Afghanistan, September 2007.
(a) A community-based outreach drug treatment, rehabilitation and prevention programme for men, women and children in Jalalabad, implemented by the Nejat Drug Treatment Centre;

(b) An information, education and communication project involving radio broadcasts on drugs and HIV/AIDS through the BBC in Dari and Pashto.

Key achievements of project AFG/G26

112. Under this project, technical advice, support, training and resources were provided to the following institutions: the Counter-Narcotics Directorate, the Ministry of Public Health, the Ministry of Education, the Ministry of Labour and Social Affairs, the Ministry of Information and Culture, the Ministry of Hajj and Islamic Affairs, the Ministry of Women’s Affairs, the United Nations Assistance Mission in Afghanistan, UNHCR, UNIFEM, WHO, the State Department of the United States, the Government of Japan, the Government of the United Kingdom, the Colombo Plan Drug Advisory Programme, GTZ, the Aga Khan Foundation and community-based non-governmental organizations involved in drug abuse treatment.

113. UNODC took the lead for organizing and facilitating the working group on demand reduction and helped to write the National Drug Control Strategy of the Government of Afghanistan.

114. An outreach referral system for treatment was developed in collaboration with Nejat and the Drug Dependency Treatment Centre of the Government of Afghanistan. Through Nejat, 856 addicts received motivational counselling and in Nangarhar 35 recovering addicts had been employed.

115. An assessment in Kabul involving 200 drug users and 100 key informants was published in 2003 by UNODC.

116. Anti-drug use events were funded and held in Kabul, Jalalabad, Kandahar, Helmand and Mazar-i-Sharif. Awareness-raising initiatives on the negative consequences of drug addiction and needle-sharing and the associated risks regarding HIV, hepatitis B and hepatitis C reached 10,626 men, women and children. In addition, 46 episodes aimed at educating listeners about drugs were broadcast in the two national languages of Afghanistan by BBC radio.

Findings

117. A number of anecdotal and local qualitative assessments that had been carried out in Afghanistan and refugee camps in Pakistan before the beginning of the project had shown an increase in the use of opium, heroin and pharmaceuticals. They also showed a lack of knowledge of the harmful effects of these substances, often taken for self-medication. Thus, the project’s objectives responded to the obvious need for training professionals who could address those problems and establish treatment facilities for drug users. The situation also needed to be better assessed for raising the awareness of decision makers and for advocacy and planning.

118. Many stakeholders were mobilized and reached within the framework of this project, contributing to the establishment of an important network. The working group on drug demand reduction, established in 2003, allowed national and international stakeholders to meet and share ideas and visions and is still currently the arena for the main key players on drug issues.
119. There was no governmental strategic framework to deal with drug demand reduction in Afghanistan at the start of the project. Since then, national policies have been developed with the assistance of UNODC. In this respect, the survey undertaken in Kabul was instrumental in placing the issue of drug demand reduction on the public policy agenda.

120. The results of training remain difficult to evaluate but, considering the low baseline, the training obviously laid the foundation for drug demand reduction work and ensured that the non-governmental organizations involved with drug users gained sufficient knowledge to provide them at least with basic services. There are no indicators to assess the extent to which United Nations entities have benefited from advice and training, but it appears that such services did not lead those entities to become significantly involved in their respective fields of competence.

121. The community-based outreach centre in Jalalabad implemented by Nejat had to be closed because of a shortage of funding. This project component had been included mainly to channel funding from the United States as money could not transferred directly to implementing partners. This raises the question of how strategic UNODC is in its programming, in particular with regard to the sustainability of its interventions.


122. Initially, project AFG/H09 was to be implemented between 2003 and 2005. It was then prolonged until December 2006, then June 2007 and, finally, December 2007. Originally, the project was supposed to cover six provinces but it was eventually decided to cover three provinces by project AFG/H09 and the other three by project AFG/G68, fully funded by Japan. The objectives and activities of both projects remained similar, despite the different geographical focus. The budgets were constantly revised following the different extensions, with a final total approved budget of $2,045,320 for project AFG/H0968 and $999,600 for project AFG/G68.

123. Six DRATs implemented the project in six locations: Faisabad (Badakhshan), Herat, Jalalabad (Nangarhar), Kabul, Mazar-i-Sharif (Balkh) and Kandahar, where the six provincial drug units of the Counter-Narcotics Directorate were also located. Their task consisted in carrying out drug demand reduction activities, mainly community-based drug treatment and drug abuse prevention. An additional aim throughout the implementation process was to involve and empower more non-governmental organizations in drug demand reduction activities. One of the short-term objectives was also to carry out a rapid assessment of the extent, pattern and nature of drug use at the national level.

Key achievements of project AFG/H09

124. Staff for three DRATs were selected from health and education departments in Kabul, Balkh and Herat. They were then transferred close to the provincial health directorates and given training and necessary equipment (computers, printers, photocopiers, audio-visual material, generators, projectors, cameras and vehicles).

125. At the time of the evaluation, the project had reached 39,955 persons through awareness-raising activities, trained 1,573 social multipliers and organized 71 training workshops, 150 one-day community meetings and 61 social events against drug use.

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68 As of November 2007, when the present evaluation took place. The budget was increased in January 2008 to US$ 2,339,000.
Among drug addicts, 1,974 men and women received treatment services and 2,249 received pre-treatment motivational counselling, while 311 were referred to residential treatment centres and 332 recovering addicts received vocational training. Special support was given to the Ministry of Women’s Affairs to launch community-based drug awareness programmes for women. Two non-governmental organizations working on women’s issues were subcontracted to train social multipliers on awareness-raising and prevention methods targeting this group, considered to be at risk for drug abuse. However, the effect of those activities could not be determined by the present evaluation.

126. In May 2005, a nationwide rapid assessment of the nature, extent and pattern of drug use and abuse started, using a combination of quantitative and qualitative data. Surveyors were selected among the staff involved in the regular UNODC opium surveys, the DRATs and non-governmental organizations, and trained in interviewing skills. Specific interview questionnaires were developed. As a result, 1,480 key informants and 1,393 drug users were reached in 32 provincial centres, 30 districts and 161 villages.

127. Within the START framework, training workshops for staff at the Ministry of Counter-Narcotics, United Nations entities and non-governmental organizations were conducted by UNODC. Study tours were arranged for staff of the Drug Dependency Treatment Centre of the Mental Health Hospital depending from the Ministry of Public Health.

128. New partnerships with non-governmental organizations, including GTZ and the Aga Khan Foundation, were established and their capacities in delivering prevention, treatment and rehabilitation services were enhanced through training. These organizations were then subcontracted to support the activities of the DRATs and to extend their services (pre-treatment motivational counselling, aftercare, rehabilitation for recovering drug addicts) and are now fully active in delivering their services to drug users, despite shortfalls in funding for many of them.

129. A system for referring drug addicts to residential treatment centres was established through a network and has since become operational in these three regions.

130. In partnership with Islamic Relief UK, a community-based health clinic was established to address opium use among Turkmen in the district of Shortepa (Balkh Province), while also functioning as a general health-care facility. The local community offered houses free of charge for the clinic. The evaluation team could not visit the clinic due to time constraints. However, as indicated in the project progress report, between January and June 2007, 112 male and 32 female opium addicts received treatment in the clinic. In addition, 3,095 women and 831 men were treated as outpatients and 334 pregnant women were examined; 24 opium-dependent women gave birth with assistance from the clinic. In view of the positive results, drug users from neighbouring provinces reached the health facility in Shortepa to benefit from the treatment services.

131. Sport events (a cricket tournament and a bicycle race) were organized to communicate the message “sport as an alternative to drug abuse”.

132. Training on drug abuse issues was given to 75 journalists from the news agency Nai Supporting Open Media in Afghanistan. A round-table discussion was also held on national television to introduce the drug problem to a wide segment of the population. Better equipped to reach a wider section of the community and make them aware of the danger of drug abuse/misuse, the journalists are now expected to disseminate the messages to the public. However, the impact of those activities could not be determined by the present evaluation.
133. Relevant resource material (booklets, posters, pamphlets and brochures) was distributed to the main stakeholders involved in drug demand reduction. However, the effect of those activities could not be determined by the present evaluation. The high illiteracy rate in Afghanistan was taken into account and posters were devised accordingly.

134. A focal point for drug demand reduction was established within the Ministry of Public Health. UNODC also provided financial and technical support to install a new drug demand reduction directorate to address drug abuse problems and to coordinate and monitor all drug demand reduction activities carried out by the Government and non-governmental organizations across the country.

Key achievements of project AFG/G68

135. Staff for three DRATs were selected, trained and equipped, and started working by 2006. They worked in close collaboration with the provincial offices of the Counter-Narcotics Directorate in Faisabad (Badakhshan Province), Jalalabad (Nangarhar Province) and Kandahar (Kandahar Province), the main opium poppy cultivation provinces in Afghanistan. They delivered community-based treatment, motivational counselling, aftercare and follow-up services, referred drug addicts to residential centres (when needed) and introduced recovered addicts to vocational training.

136. At the time of the evaluation, the DRATs had delivered community-based treatment to 1,813 drug addicts, provided motivational counselling to 2,058 substance-dependent persons, referred 110 drug addicts to residential treatment centres and introduced 351 recovering addicts to vocational training. Members of the DRATs had also trained 1,939 social multipliers through 73 training workshops and made 52,502 vulnerable persons aware of the negative consequences of drug abuse through 77 one-day community meetings and 73 social mobilization events.

137. In order to provide a healthy recreational environment for youth as an alternative to drug abuse, the project helped to rebuild the cricket academy in Kabul in order to enable cricket players, along with the members of the national cricket team and various cricket clubs in Kabul, to practise the sport and become role models for youth, urging them to turn to sport and avoid drug use.

138. In the framework of the project, the Ministry of Women’s Affairs was contracted to raise the awareness of vulnerable women in the district of Paghman (Kabul Province) about drug abuse. The Ministry conducted 14 community drug abuse awareness-raising meetings for 260 women.

139. The curriculum development committee of the Ministry of Education was trained in approaches to educating people about drug-related topics, enabling the Ministry to integrate such topics and messages in the new curriculum of the schools.

140. With the involvement of the non-governmental organization Afghan Amputee Bicyclists for Rehabilitation and Recreation, 200 disabled persons were trained so that they could raise awareness of drug-related issues in Nangarhar Province.

141. A clinical laboratory was established in the Drug Dependency Treatment Centre of the Mental Health Hospital in Kabul to test drug levels in the blood and diagnose infectious diseases such as hepatitis and HIV/AIDS. The laboratory conducted 940 tests.

142. Close collaboration with the Ministry of Education led to the introduction of drug education material in schoolbooks. New posters on the link between the sharing of unsafe injecting equipment and HIV/AIDS and on drug use among children were produced and distributed. A manual on drug abuse treatment produced by UNODC was translated into
Pashto and Dari and disseminated to relevant stakeholders. However, the effect of those activities could not be determined by the present evaluation. One thousand blackboards carrying messages against drug use were produced and provided to the Ministry for distribution to various schools in target provinces.

143. Training workshops on drug abuse prevention were organized for 25 staff members of United Nations agencies and 22 medical doctors from 13 provinces. However, the impact of those activities could not be determined by the present evaluation.

Findings for both projects

144. The Ministry of Public Health, which was empowered through the establishment of new specific drug demand reduction structures, assigned coordination and monitoring tasks. This, however, could lead to duplication and conflicts with the mandate of the Ministry of Counter-Narcotics.

145. The drug use assessment carried out in 2005 is the first and only national baseline to which decision makers, professionals and researchers refer.

146. Reaching women, the hidden drug users in Afghanistan, is an important step that can be reinforced by developing home-based detoxification approaches while also fighting the stigma attached to drug abuse.

147. Combining general health care with drug treatment is an interesting model that could constitute good practice.

148. The sustainability of the DRATs is still in question; the action teams could benefit from being linked with national public health initiatives.

149. A specific analysis of the prevention material and of its impact should be undertaken, in particular considering the high illiteracy rate in Afghanistan and the different segments of the population to be targeted through specific messages.

3. Project AFG/H87: Drug demand reduction information, advice and training service for Afghan communities living in refugee camps in Baluchistan and the North West Frontier Province of Pakistan

150. This project is the successor to project AFG/F55, which dealt with reducing and preventing drug use by women in refugee camps. Project AFG/H87 widens the scope of the earlier project to include both men and women. The aim is to improve the capacity of health-care professionals, social workers, teachers, community workers and community members in targeted refugee camps in Baluchistan and the North West Frontier Province of Pakistan to counter the abuse and misuse of drugs and related health-care issues. The project has a total approved budget of $572,000. Apart from UNODC, the main stakeholders (including facilitation and implementing partners) are UNHCR, the Commissionerate for Afghan Refugees (mainly its Community Development Unit), the Afghan community, health-care service providers, the implementers of the Basic Education for Awareness Reforms and Empowerment/Basic Education for Afghan Refugees (BEFARE) project, the DOST Welfare Foundation and the non-governmental organization Basic Education and Employable Skill Training (BEST).

Key achievements of project AFG/H87

151. The DOST Welfare Foundation conducted a drug use survey between 2005 and 2006 in 11 districts of the North West Frontier Province, targeting 18 refugee camps, to assess the prevalence of drug use. The number of drug users was estimated at 2.6 per cent of the
refugee population in the targeted camps. In total, 1,301 drug abusers were identified in four refugee camps, 738 of whom were men and 563 of whom were women. Of those users, 778 (60 per cent) used opium (335 men and 443 women), 349 (27 per cent) used hashish (all were men), 143 (11 per cent) abused pharmaceuticals (23 men and 120 women) and 31 (2 per cent) used heroin (all were men).

152. Numerous community meetings were held in the camps to sensitize refugees to the drug problem and to establish drug demand reduction groups in each camp. Training workshops were organized in 21 camps for religious leaders, community activists, school teachers and youth groups. Workshops on drug addiction treatment and relapse prevention were conducted in four camps and training was provided to traditional birth attendants, community health-care workers and basic health-care unit staff. Meetings to build the capacities of implementing partners on drug issues were also held.

153. Information material on drug abuse prevention was developed and distributed to community members and social multipliers in the camps. A video illustrating the harm caused by drug use was shown to participants during drug awareness training sessions.

154. Home-based detoxification services were provided, together with aftercare and follow-up services. Vocational skills training and income generation activities for former drug users and people at risk of drug addiction were provided. Training on how to start a small business was organized in refugee camps. Channels were organized for getting the products of carpentry, embroidery, tailoring and electrical works to the market.

Findings

155. Vocational skills training allowed former addicts, whether alone or in groups, to start a small business and generate enough income from local markets to make a living. As of June 2007, 96 trainees (43 men and 53 women) completed their vocational skills training in various trades. Toolkits were provided to the trainees. Channels to the market were established and the income generated by former trainees, both men and women, amounted to $11,500 for the first six months of 2007. However, the evaluation could not determine the viability of those small businesses.

156. Self-help groups of recovered drug users were set up within the community with the aim of contributing to the prevention of drug use, the treatment of addicts and the provision of aftercare services related to drug use.

157. A number of drug users were able to follow home-based detoxification programmes, while more serious cases were referred to treatment facilities. However, no detailed statistics were maintained on rates of success and relapse.

158. The situation of children and young adults who have little or no education remains of special concern given that, left to themselves, they are particularly at risk of drug abuse.

159. An efficient network of stakeholders capable of providing drug demand reduction services in refugee camps is yet to be established and drug demand reduction committees are still not involved in awareness-raising efforts.

160. People from the same provinces as those of former drug addicts have come from Afghanistan to the refugee camps to get drug demand reduction services, further emphasizing the need for such services.

161. Some former drug users have thought of going home to sensitize people to the risk of using drugs, teach them vocational skills and give them income generation training courses modelled on the services provided in the refugee camps.
Overall findings on the Drug Demand Reduction Programme of the United Nations Office on Drugs and Crime in Afghanistan

162. UNODC chose to hand over responsibility for the DRATs to the Ministry of Public Health in 2006, to ensure the sustainability of the model. However, the length of the contracts of staff members on the DRATs (between 6 and 12 months) is too short, leading many staff members to spend this time of employment to look for their next job. Staff also get little financial reward for what is, in most cases, difficult work that requires a great deal of dedication.

163. Much more training is also needed to enhance the performance of the DRATs. For instance, DRAT staff members often understand motivational interviewing as unilateral finger-pointing at addicts, delivering a message about the harm caused by drug use and “telling them everything about their lives”. Assessments of users’ needs, readiness for behaviour change and willingness to undergo treatment are almost always lacking because staff members do not have the necessary listening skills or knowledge regarding theories of change.

164. Outreach work is difficult to assess, as the presence of observers modifies behaviour. Visual material posted near the DRATs show a stiff and bureaucratic approach to drug users met on an outreach basis. For example, social workers interacting with users in the streets carry writing pads, while this type of recording should be reserved for the office in order to focus on building trust.

165. The DRATs are generally perceived as a positive model. The fact that they are embedded in the community in which they work is seen as an asset, as staff members have access to drug users (who are usually stigmatized) and good knowledge of the drug scenes. Home-based detoxification programmes also allow them to come into contact with women who would not go to a service provider outside the home.

166. Some stakeholders, however, do not find them very responsive. Non-governmental organizations, in particular, think the DRATs have become less efficient and more bureaucratic under Government supervision. Important regional differences in the way in which the action team model is implemented have also been pointed out.

167. Most would like to see the model expanded to other regions and improved working and financial conditions for the DRATs. The need to provide action team staff members with better training has also been widely acknowledged.

168. In Afghanistan, the treatment that drug users receive is limited to a generic detoxification process that usually lasts 2-3 weeks. However, detoxification should be considered only as a precursor to treatment.69

169. It is not known what drug users expect from treatment, which is part of the reason why the idea of providing a wide range of services that can be adapted to the needs of each individual has not been promoted. Services should be tailored to the needs of the patient and his or her personal history and drug experiences, as no single treatment is appropriate for all individuals. Such a differentiated approach is not yet common in Afghanistan.

170. The effects of the prevention material is not known. A specific analysis of the prevention material and of its effect should be undertaken, in particular considering the

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high illiteracy rate in Afghanistan and the different segments of the population to be targeted through specific messages.

171. Field visits have left contrasting impressions. The fact that only a limited number of sites were visited means that it is not possible to make generalizations. What was observed, however, evidenced that there are insufficient human resources for personalized care. Treatment sites are more or less friendly, hospitable and clean. In some places, however, patients are like prisoners, wearing a kind of uniform. Some have their heads shaved, a practice that stigmatizes them further, even if it is done for hygienic or medical reasons. Treatment facilities affiliated to mental health-care services are the least agreeable, in a country where psychiatry is in its infancy. Physical withdrawal pains are responded to with insufficient means, considering the existing scientific evidence and experience on the matter. The degree of empathetic care given varies greatly from place to place.

172. Home-based detoxification is especially able to meet the needs of women, minimizing the sense of shame and stigmatization, and should be encouraged. However, openly seeking treatment can also facilitate rehabilitation, and community work is essential in that regard.

173. Clean syringes are available in many treatment facilities managed by medical personnel. Besides limiting the harmful effect of injecting, smaller syringes also contribute to reducing drug use. Condom distribution and HIV counselling services are available in some facilities. The availability of such services is closely related to the policies of specific donors on harm reduction.

F. Project management and implementation

174. External factors impacting the effectiveness of drug demand reduction activities by the Country Office in Afghanistan are the structural constraints of the country’s situation: the lack of basic infrastructure, governance and resources. Ongoing political instability and security problems also relegate the drug abuse issue to the background.

175. In addition to these, a low level of commitment to drug demand reduction at UNODC headquarters and mixed messages about the UNODC position on harm reduction (until early 2008) had undermined efforts to anchor drug demand reduction to the National Drug Control Strategy and to support the expansion and scaling up of drug demand reduction activities of the Country Office in Afghanistan. They have also not helped in attracting stable and predictable funding (whose volatility is aggravated by the absence of a structured fund-raising strategy and donor fatigue).

176. At the time of the evaluation, practice and management with regard to harm reduction at the Country Office in Afghanistan clearly affected the effectiveness of the programme: harm reduction approaches were avoided in official statements and project proposals; some relevant stakeholders were not received; and staff from the Country Office were absent from the important discussions about opioid substitution therapy.

177. Relations with the HIV/AIDS Unit at UNODC headquarters, which has taken the lead with regard to the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria, are non-existent because of the wait-and-see policy adopted by the Country Office on the HIV/AIDS issue. As a result, the Country Office has been bypassed by the HIV/AIDS Unit, which contributed to the writing of two large grant proposals for Afghanistan in 2007. At the same time, the Country Office has developed project proposals for integrating a comprehensive drug treatment system into the national health-
care system through the Basic Package of Health Services for Afghanistan. Those proposals duplicate what is already stated in the Afghan National Strategic Framework for HIV/AIDS for 2006-2010\(^{70}\) to be implemented through World Bank and Global Fund projects. This illustrates the absence of coordination with realistic and viable developments initiated by the HIV/AIDS Unit at UNODC headquarters, which is involved in drug demand reduction issues and current activities, and should therefore involve the Country Office more.

178. With regard to the overall Drug Demand Reduction Programme of the Country Office in Afghanistan, no new donors have been contacted and the possible closing down of drug demand reduction activities has been mentioned. New project proposals such as the one written by the UNODC office in Peshawar (attached to the Country Office) on the provision of drug use prevention and drug demand reduction services to street youth in June 2007 had received no feedback from staff at the Country Office at the time of the evaluation. It is not clear to the evaluators why the Country Office is less than enthusiastic about supporting and promoting drug demand reduction activities given the actual needs of the people of Afghanistan.

179. Government counterparts at the Ministry of Public Health deplore the lack of vision of the Country Office, in particular in terms of developing adequate responses to HIV, while non-governmental organizations tend to consider UNODC just like another non-governmental organization. From UNODC side, there is a diffusion of responsibility, as managers at the Country Office blame the Government’s state of dereliction. There is overall a clear loss of leadership among the drug demand reduction community, compared with the leading role achieved in the early years of such activities by UNODC in Afghanistan.

180. In contrast, the collaboration with non-governmental organizations (which act as implementing partners) as part of the UNODC project in refugee camps in Pakistan is particularly serene and fruitful. The reasons for this should be analysed in terms of lessons learned.

181. It should be noted that national and international non-governmental organizations compete against each other, levelling accusations of “stealing clients”. This is not unusual, especially as resources are so scarce. However, while some might see in this state of affairs an opportunity to boost the quality of services, it should be kept in mind that such competition might also jeopardize the existence of an efficient referral system.

182. All these elements constrain the work of Country Office staff working on drug demand reduction, who have, with few resources, shown their ability to manage an ambitious portfolio, thereby contributing significantly to raising the visibility of drug demand reduction issues in Afghanistan. Management at the Country Office has not shown a similar level of involvement. Certainly, other United Nations entities are also far less involved in drug demand reduction issues than in supporting HIV programmes, but UNODC should remain active in the field since it is part of its mandate.

### III. Results and impact

#### A. Overall

\(^{70}\) “To strengthen the health-care sector capacity to implement an essential package of HIV/AIDS prevention, treatment and care services within the framework of Basic Package of Health Services and Essential Package of Hospital Services.”
183. The programme of the Country Office in Afghanistan has laid the foundations for drug demand reduction in Afghanistan and contributed to building national responses to the harmful use of drugs. Drug use has been recognized, measured and efforts are being made to tackle it. The programme has established a baseline that has significantly influenced the national strategy and Government policies. Overall, the results of the Drug Demand Reduction Programme are remarkable in terms of quantity but could be improved in terms of quality. A lot more also needs to be done to enhance the position of drug demand reduction activities within the global framework of drug control policies, in order to achieve a truly balanced strategy.

184. The section dedicated to drug demand reduction issues at the Country Office in Afghanistan has gained high visibility in the national drug demand reduction landscape, which it has largely contributed to establish and develop, despite scarce resources. It has also been able to build an extensive network at the national and regional levels.

185. As already mentioned, however, in recent years the Country Office has lacked a programme and fund-raising strategy for drug demand reduction activities and the perception is growing among key stakeholders that UNODC is losing ground and leadership, in part because of its long-unclear position on many aspects of drug demand reduction and harm reduction. Current drug demand reduction activities are threatened by the absence of funding and the impact and sustainability of most of what was achieved could be lost if UNODC is not able to follow up on the initial impetus.

B. Drug demand reduction assessments

186. The two main assessments conducted under the Drug Demand Reduction Programme of UNODC were effective advocacy tools. They are still referred to by many stakeholders, even though they no longer reflect current patterns and the current extent of drug use. However, they have helped to put the drug use problem and drug demand reduction responses on the Afghan agenda and to have harm reduction included as one of the eight pillars of the National Drug Control Strategy.

C. Awareness-raising and information, education and communication

187. It has been widely recognized that drug use needs to be dealt with as a public health issue, which does not mean that it has completely ceased to be considered a judicial problem. The tension between these two aspects is inherent to the drug issue. A lot more, therefore, needs to be done to raise awareness and enhance the position of drug demand reduction vis-à-vis drug control policies in order to achieve a balanced strategy.

188. Drug use is recognized and talked about in Afghanistan, but nationwide awareness-raising and information campaigns on the issue have to be increased in order to mobilize communities and fight stigma. A prevailing problem remains the high level of illiteracy, which has to be taken into account in the design of any large-scale awareness-raising and prevention campaign.

189. Innovative prevention campaigns and solidarity messages, which have not been used so far, have to be launched. The aim should not be to scare people but to equip them with the knowledge to enable them to protect themselves and reduce the harm resulting from drug use.
190. A number of reports on drug use in Afghanistan, most of which address an international audience, can be found on the Internet. This material has not, however, been used to inform and raise awareness among potential donors.

D. Capacity-building and training

191. The main aim of the technical assistance provided by UNODC in Afghanistan is to advise the Government on the different areas for which the Office has a mandate. But as capacities were almost non-existent after the fall of the Taliban, national institutions had to be constructed from scratch. Thus, the need to empower the Government goes far beyond drug demand reduction issues.

192. With regard to drug demand reduction, capacity-building efforts have targeted primarily Afghan institutions and staff. The objective of such efforts has been to introduce effective management structures and processes, a legal framework and improved networking abilities in relevant governmental institutions, but also to endow civil servants with the necessary understanding, skills, information and training on drug issues to optimize their performance.

193. The Ministry of Counter-Narcotics was established as a powerful sign of the commitment by the Government of Afghanistan to tackling drug-related issues. This move, however, weakened both the cross-cutting aspect of drug control and its mainstreaming into governmental actions. Currently, no fewer than nine ministries are involved.

194. National capacity-building achievements are mitigated. To be empowered by external assistance always creates paradoxical situations\(^1\) and the conditions for the efficient transfer of knowledge still do not exist. The ministries in charge of the drug problem are generally perceived as weak and still need to define their respective roles and responsibilities. The line between coordination (Ministry of Counter-Narcotics) and implementation (Ministry of Public Health) is blurred. There is also little coordination, within the Ministry of Public Health, between the drug demand reduction department and the National AIDS Control Programme.

195. The establishment of a national working group on drug demand reduction has been useful for networking and for discussing and elaborating national drug control strategies. Three subgroups of the working group have also been established to deal with: treatment and rehabilitation; harm reduction; and prevention. That has enabled Afghan specialists in these areas to come together and develop and review relevant documents and discuss technical issues. Group work was perceived as useful by participants, but also as providing opportunities for power struggles between the Ministry of Counter-Narcotics and the Ministry of Public Health. The sharing of information was appreciated but the lack of implementation force was exposed. However, in the current context, too many working groups consisting mainly of the same participants might not be the most effective way to deal with such pressing issues.

196. Senior management at the Country Office in Afghanistan has been very critical of national institutions, denouncing their lack of direction and basic organizational and managerial capabilities. In its view, capacity-building efforts have totally failed, which is inaccurate, as significant improvements have been made, as the evidence gathered by the evaluators has shown.

197. Additional capacity needs to be built, as the level reached so far is not satisfactory, but it is unclear how UNODC and the international community propose to rectify the situation. Unless the capacity of Afghan institutions is developed so that Afghans can manage those issues themselves, all investment will be wasted.

198. The effect of training, workshops, meetings, events targeting non-governmental organizations and relevant staff cannot be directly assessed. The exponential development of viable drug demand reduction services in the country could be considered a proxy indicator. It is evident that a considerable number of professionals have gained general competencies in the field of drug use, though there continues to be a great need for trained social workers, psychologists and counsellors. The desire for additional guidance and training is widespread and a process of training the trainers has started, mainly within the network of non-governmental organizations.

199. Training social multipliers is important. In this respect, special attention should be paid to involve religious leaders and to turn places of worship into credible settings of prevention.72

200. The Drug Demand Reduction Programme of the Country Office in Afghanistan has had limited impact in terms of getting United Nations entities to mainstream drug demand reduction into their respective mandates, which include health, food, shelter, work, displacement and the rights of women and children. Donors have not been targeted either, which is unfortunate, as they need to better understand drug demand reduction issues in order to provide the needed funding.

201. UNHCR has been an important partner with regard to the work carried out in refugee camps. It has also established a drop-in centre in Ghazni for returning refugees that had to be handed over to UNODC and managed by an Afghan non-governmental organization owing to a shortage in funding.

E. Outreach and treatment

202. The number of drug abuse treatment, rehabilitation and prevention facilities available in Afghanistan increased from 2 in 2002 to 39 in September 2007.73 About half of those facilities are residential treatment centres. However, 10 are located in Kabul, while there are still 12 provinces without any drug treatment facility, mainly in the central south-eastern area of the country.74 Although only 10 of those facilities were directly funded by UNODC, the establishment of overall drug demand reduction services in the country was facilitated by UNODC through active and timely networking and the provision of advice and training.

203. The demand for treatment and rehabilitation facilities is increasing and implementing organizations report long waiting lists. A lot of lobbying by parliamentarians to obtain treatment centres in their province has also been reported. A progress report on the implementation of the National Drug Control Strategy prepared by the Ministry of Counter-Narcotics in January 2007 underlines that the few drug rehabilitation facilities and community-based treatment initiatives that exist are unable to face the growing demand of assistance from Afghan drug addicts.

72 A Colombo Plan mosque-based drug awareness and aftercare programme has worked in that sense since 2002, but its impact has not been evaluated.
73 Demand Reduction Directorate, Ministry of Counter Narcotics.
74 See in annex IV the maps of drug abuse treatment, rehabilitation and prevention facilities.
204. There is, therefore, a need to further extend drug demand reduction services and to cover all provinces, paying special attention to remote areas that do not have general health-care services. New locations should be identified on the basis of drug use prevalence and of the results of a gap and needs assessment.

205. Table 1 gives an idea of how many drug users underwent treatment between 2006 and 2007, according to the results of the five most important non-governmental organizations in the country.\textsuperscript{75}

\textsuperscript{75} Data collected by UNODC; the last column shows the percentage of returning refugees and their provenance: Iran and Pakistan.
Table 1
Opiate users treated in treatment facilities in Afghanistan, 2006-2007

<table>
<thead>
<tr>
<th>Centre</th>
<th>Treated</th>
<th>Opium</th>
<th>Heroin</th>
<th>From Pakistan</th>
<th>From the Islamic Republic of Iran</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Dependency Treatment Centre</td>
<td>1 236</td>
<td>369</td>
<td>867</td>
<td>16</td>
<td>64</td>
</tr>
<tr>
<td>Nejat Drug Treatment Centre</td>
<td>943</td>
<td>521</td>
<td>422</td>
<td>24</td>
<td>60</td>
</tr>
<tr>
<td>Welfare Association for the Development of Afghanistan</td>
<td>1 348</td>
<td>533</td>
<td>815</td>
<td>11</td>
<td>47</td>
</tr>
<tr>
<td>Shahmat</td>
<td>536</td>
<td>300</td>
<td>236</td>
<td>2</td>
<td>26</td>
</tr>
<tr>
<td>GTZ</td>
<td>1 119</td>
<td>853</td>
<td>266</td>
<td>11</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>5 082</td>
<td>2 576</td>
<td>2 606</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

206. If one refers the number of opiate addicts treated to the 2005 baseline, that figure represents 1.7 per cent of the estimated total number of opium addicts and 5.2 per cent of the estimated number of heroin addicts. In absolute terms, these figures are low, especially bearing in mind that the baseline reference is outdated and that drug use has most probably increased since 2005. Considering the limited amount of beds available in residential treatment centres, however, they are very high.

207. Residential and community outreach treatment data collected by the five centres funded by the Integrated Drug Prevention, Treatment and Rehabilitation Project are more complete (see table 2). They show, for example, that residential treatment was catering almost entirely to men, while women were entering treatment on a community outreach basis.

Table 2
Number of drug users in five treatment centres, April 2006-March 2007

<table>
<thead>
<tr>
<th>Programme</th>
<th>Men</th>
<th>Women</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness</td>
<td>37 927</td>
<td>27 176</td>
<td>14 226</td>
<td>79 329</td>
</tr>
<tr>
<td>Motivation</td>
<td>5 220</td>
<td>2 445</td>
<td>554</td>
<td>8 219</td>
</tr>
<tr>
<td>Treatment (residential)</td>
<td>589</td>
<td>7</td>
<td>17</td>
<td>613</td>
</tr>
<tr>
<td>Treatment (community outreach)</td>
<td>326</td>
<td>810</td>
<td>82</td>
<td>1 218</td>
</tr>
<tr>
<td>Follow-up</td>
<td>3 924</td>
<td>4 564</td>
<td>375</td>
<td>8 863</td>
</tr>
<tr>
<td>Referral</td>
<td>107</td>
<td>71</td>
<td>25</td>
<td>203</td>
</tr>
<tr>
<td>Relapse</td>
<td>79</td>
<td>75</td>
<td>3</td>
<td>157</td>
</tr>
<tr>
<td>Information, education and communication material distributed</td>
<td>1 019</td>
<td>661</td>
<td>60</td>
<td>1 740</td>
</tr>
<tr>
<td>Vocational training</td>
<td>77</td>
<td>23</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

208. These examples show how much would be gained by having a unique data collection framework with precise indicators and criteria. Such a framework would make it possible to gain precious information about patients (gender, age and other sociodemographic data) and type of services provided.

209. For a number of reasons, this evaluation could not determine quantitative changes among the population such as in relapse prevention, addiction prevention and access to medical services by drug users. There is an absence of follow-up studies tracking the overall progress made over the years, compounded by problems associated with the maintenance of systematic record keeping of drug users at the national level and, in particular, of progress made by individuals in terms of rehabilitation.

210. Most treatment and rehabilitation facilities are not connected with general health-care services and with social welfare organizations capable of addressing all of a patient’s needs, including his or her need for food, shelter, first aid and basic hygiene facilities. Two exceptions to this were found: in the community drug demand reduction work in refugee camps in Pakistan and in the few existing drop-in centres, only one of which offers harm reduction services. The possibility to connect treatment and rehabilitation facilities with general health care services, when existing, should be considered in developing future projects.

211. The question of whether drug care facilities should develop generic drug demand reduction services (prevention, treatment and rehabilitation) or whether they should become specialized entities for the treatment or rehabilitation of drug users remains unanswered. In the second option, referral systems should be very efficient and coordination and collaboration between facilities strong, which is far from being the case. At any rate, practitioners working in drug-related fields need more and better training.

212. More funding to ensure sustainability is also needed. Currently, all drug treatment centres for drug users run by non-governmental organizations have limited funding and the funding they do have is not expected to last long in the future. Except for the facilities implemented by the Ministry of Public Health, many will have to close down if sufficient funds cannot be found. UNODC is the first concerned, as its drug demand reduction projects ended by 2007.

213. It can be concluded that a lot has been done with modest financial and human resources in terms of the following: assessing drug use in Afghanistan; information, education and communication; awareness-raising; training; capacity-building; and the establishment of drug demand reduction services integrating treatment and rehabilitation.

IV. Sustainability

214. The Drug Demand Reduction Programme of the Country Office in Afghanistan has found its place within national strategies, a place it will probably keep if some of the problematic issues highlighted in this evaluation are tackled.

215. Nevertheless, the future of the drug demand reduction section at the Country Office is uncertain since the UNODC Drug Demand Reduction Programme in Afghanistan has never been able to rely on regular resources. Funding arrangements disrupted the very structure of the portfolio, allowing projects with identical objectives to appear separately. Sustainability has never been built into the programme.

216. Badly needed financial resources are unavailable to drug demand reduction efforts. Almost all drug treatment and rehabilitation facilities in Afghanistan function on limited
funds, both in terms of the amount and the timeframe, and there are very few alternatives, even for organizations whose achievements have been recognized.

217. This issue should be discussed with donors. Unless funding can be guaranteed for a minimum period (e.g. three years), no new project should be started, particularly if it is community-based. In fact, interruptions are deleterious for all kinds of programmes but especially for those in the drug field. Drug awareness activities need to be continued and assessments need to be updated regularly.

218. More crucially, treatment for drug users is a long-term process and rehabilitation is an even longer process. Stakeholders, partners and programme beneficiaries (drug users, former drug addicts, communities at risk etc.) develop expectations. Collaborations and national and regional networks founded on communication, mutual trust, accountability and transparency cannot be built up quickly and need prospects in order to be maintained. Once disrupted, significant financial resources and staff time are needed to rebuild those capacities. In addition, trained and experienced staff from implementing non-governmental organizations or institutions can be forced to work in very different areas where their skills do not apply. It is in fact difficult to retain competent personnel, especially in the public sector, without offering financial recognition comparable with that currently being offered by United Nations entities and even non-governmental organizations.

219. Additionally, when there are funding opportunities, proposals often have to be submitted within very tight deadlines, leaving no time for a proper strategic planning of the project activities and potential partnerships.

V. Lessons learned and good practices

220. A good practice in the realm of drug demand reduction in Afghanistan is undoubtedly the comprehensive community-led approach to prevention, treatment, care and rehabilitation. An example of such an effective community mobilization effort can be found in the UNODC project carried out in refugee camps in Pakistan, which even attracts people from Afghanistan who come to get drug demand reduction services in the camps. In particular, vocational training and capacity-building in small business management with realistic ties to markets is exemplary. In fact, offering recovered addicts practical options for supporting themselves and their families is the ideal way out of the drug experience. The organization of communities into drug demand reduction committees is also a remarkable achievement, as such committees constitute self-help groups on a large scale. The support they give to potential and current drug abusers is invaluable.

221. Lessons can also be learned from countries of the region that have seen sharp rises in the number of injecting drug users and related cases of HIV infection. For example:

(a) In Uzbekistan, where drug injection has increased almost 10-fold in the last 10 years while a 200-fold increase in HIV infections has been observed during the last five years;

(b) In Tajikistan, where the number of recorded cases of HIV infection rose from 4 in 1999 to over 500 in 2004, in 97 per cent of which HIV was contracted through drug injection;

(c) In the Islamic Republic of Iran, where, in 2001, 0.1 per cent of the population was living with HIV, a situation that corresponds to the current situation in Afghanistan.
By 2006, the figure had increased and 66,000 people were living with HIV. The Islamic Republic of Iran also has the highest rate of heroin addiction in the world. As many as 23 per cent of injecting drug users in Tehran are HIV-positive, which amounts to a 15 per cent increase from the previous year.

222. In neighbouring countries, and in those of Central Asia in particular, UNODC has made efforts to ensure appropriate coordination of drug demand reduction and HIV/AIDS prevention activities, and specific projects have aimed at implementing HIV/AIDS prevention and care among vulnerable populations to avoid a generalized epidemic. In Tajikistan, Turkmenistan and Uzbekistan, in particular, a four-year project was developed to provide injecting and other kinds of drug users with treatment services, including outreach, low-threshold services and inpatient education about HIV/AIDS prevention, access to condoms and clean injecting equipment, counselling, detoxification, treatment and rehabilitation. Capacity-building on policy development, implementation, coordination, monitoring and evaluation for the Governments of Central Asian countries were also reinforced. Drug abuse and HIV/AIDS prevention campaigns have been launched through mass media outlets, non-governmental organizations and civil society groups.

223. Coordinated drug demand reduction efforts, including HIV/AIDS prevention programmes, that are based on the Central Asian model are needed in Afghanistan. There have been some attempts but no guidelines or minimum standards (including best practices) on drug demand reduction have been developed to date. Both should be developed and include best practices.

VI. Recommendations

224. The following recommendations are closely interrelated. They aim at ensuring the sustainable development of drug demand reduction activities in Afghanistan, at enhancing capacities and the quality of those activities and at reviewing the way in which programmes are conceived, after a decade of building the necessary foundation for drug demand reduction.

Recommendation 1: UNODC management should urgently follow-up on the first steps taken in early 2008 to resolve ideological differences about harm reduction and HIV issues by integrating the latter into a comprehensive drug demand reduction package. Further, management should ensure that the clarified policy position is adhered to by all UNODC employees working in this area.

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77 UNODC project RAC/I29.
78 UNODC project RER/F75.
79 UNODC project RER/H36.
80 UNODC project RER/H37.
81 National Treatment Guidelines were developed in 2004/5 and signed off by both MCN and MPH. While they were not accredited as such nor disseminated, they present the minimum standards of care expected of any drug treatment service in Afghanistan.
225. The evaluation team suggests that the following shift in programming, from a classical model to an integrated approach, should be considered. Such a shift could be seen as a step towards the normalization of harm reduction.

226. The model developed in the current implementation plan for drug demand reduction of the National Drug Control Strategy is based on a classical model:

(a) Primary prevention: awareness, education programmes;

(b) Secondary prevention: treatment and rehabilitation;

(c) Tertiary prevention harm reduction.

227. Harm reduction is conceived as a set of measures limiting the damages linked to drug use until treatment is possible.

228. The alternative proposal is to fully integrate harm reduction into a broad treatment and care service:

(a) Primary prevention: sensitization, information and education;

(b) Secondary prevention: extensive treatment and care catering to the needs of clients (both injecting and non injecting drug users); change in the mode of use, reduction and detoxification, and change in the available harm reduction package (HIV prevention included);

(c) Tertiary prevention: rehabilitation and reintegration (social-community support, vocational training).

229. In the alternative proposal, the aim of the first step is identical to that in the classical model: the need to sensitize, inform and educate the general public and decision makers about the drug use problem in Afghanistan remains a key feature of drug demand reduction.

230. Rehabilitation is considered separately even if the different treatment steps lead to it. The rehabilitation and reintegration component of drug demand reduction services should be in the hand of different actors whose common goal is to help recovered drug users to build a new life. Efficient referral systems have to be developed in that regard.

231. Given the high rates of relapse experienced by drug users during detoxification, the integration of harm reduction measures into the treatment phase allows for a gradual approach towards the stabilization of drug use, a progressive reduction of doses, a change in the means of use (from injecting to oral use) and, if possible, abstinence from drug use. This is how change would ideally take place, although a certain back and forth between different stages should also be possible, as proposed by Prochaska and others in their theory of change.

232. In cases where risk-taking behaviour is taking place, harm reduction interventions are necessary and urgent to keep drug users alive and to avoid the development of dangerous abscesses, overdoses and the transmission of blood-borne infections. In the alternative model outlined above, the issue of HIV is seen as part of the larger drug use issue and can be perceived as such by decision makers and donors. It helps to clarify previous mixed messages and diffuse tensions that have placed drug demand reduction in opposition to harm reduction. To have a harm reduction approach embedded in treatment allows for its normalization, in other words for harm reduction to stop being the stake of

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ideological battles. It simply becomes one of multiple options for providing treatment according to patients' needs.

233. In order to implement this recommendation, the necessary steps have to be taken to integrate the HIV/AIDS issue into UNODC drug demand reduction plans and activities. The new programme funded by the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria will have to take over facilities set by the Drug Demand Reduction Programme of UNODC in Afghanistan. UNODC will also have to facilitate and lead discussions on a new treatment concept. That would include helping the Government of Afghanistan to keep the question of opioid substitution therapy on the agenda and finding a viable solution for Afghanistan on the matter.

Recommendation 2: UNODC should put a great deal of effort into effective advocacy and lobbying in order to strengthen government and international community commitment to addressing the drug use problem and to ensure sustainable funding for future programmes.

234. Since future drug demand reduction activities in Afghanistan are threatened because of a severe lack of funding, it is vital to put a great deal of effort into effective advocacy and lobbying to ensure sustainable funding. Drug demand reduction is poorly understood, which is not surprising considering its position within drug control policies. International donors often pay more attention to their own national drug use problem and ignore or neglect that of Afghanistan. Ideological battles about harm reduction add to the general reluctance to act, either because the stakes are not understood or because certain States, such as Japan and the United States, refuse to provide funding for projects that include needle and syringe programmes.

235. The first step is to map donors’ funding agenda (past involvements, thematic priorities, unexplored domains) to identify potential gaps and key players for drug demand reduction lobbying (who is who). Staff members in charge of fund-raising at headquarters (in the Co-financing and Partnership Section) could mandate this research. Regular workshops could be set up targeting donors, given that, due to the ongoing rotation of personnel, new staff members are not always updated on the funding situation in their own organization. Regular feedback on the implementation, results and impact of funded projects should also be communicated. Field visits to funded projects should be considered. A closer involvement in project design and participation in working groups should be proposed.

Recommendation 3: UNODC should seriously consider supporting the Government of Afghanistan in developing a national research and training centre in order to enable coordinated human capacity development and harmonized research. UNODC should also facilitate fund-raising and donor support for such an initiative.

236. The Government of Afghanistan and all major non-governmental organizations perceive the need for a research and training centre and actually plan to set up their own. These efforts need to be recognized and coordinated. Since 2001, a lot of competencies were built up in terms of experience with drug use. UNODC and non-governmental organizations trained many stakeholders. Putting all this expertise to use in a unique resource and training centre would be more fruitful than dispersing it among various, and necessarily smaller, centres.

237. Research should be carried out covering all drug-related issues, including HIV/AIDS. Most non-governmental organizations supervising treatment centres collect useful data. Such data collection should be harmonized and not be a mere bureaucratic
exercise. The data collected could be useful for assessing and monitoring the drug use situation in the country. Relapse studies, in-depth cohort studies on knowledge of and attitudes to drug use and on drug use patterns could contribute to a solid second generation surveillance system. Researchers from other countries could also elect Afghanistan as a site for the production of useful studies on drug-related issues.

238. All available relevant documentation could be made available and updated through modern electronic tools. For instance, conference proceedings could be collected and distributed electronically in order to save on travel costs. Available minimum standards, guidelines and identified good practices could be used and adapted to the local context.

239. The establishment of a research and training centre could be the subject of a proposal to donors. The Government of Afghanistan should play a leading role and all participants in the drug demand reduction working groups should be involved in this project on a “bring and take” basis.

240. The main function of such a centre should be to introduce long-term accredited programmes so that eventually Afghans will no longer have to rely on foreign trainers or have to send practitioners out of the country for training.

Recommendation 4: UNODC should develop a new approach to programme and project conception through better global planning and more differentiated projects.

241. Laying the foundation of drug demand reduction services in Afghanistan (by raising awareness about the existence of a drug use problem and then by empowering professionals to provide treatment, aftercare and rehabilitation services) has taken almost 20 years of intense effort in an extremely difficult political, economical, social and security context without predictable funding.

242. Over the years, objectives and strategies have remained almost unchanged. The time has come, however, to build on those foundations and to think of new approaches, possibly on the basis of the motto: “Better global planning and more differentiated projects”.

243. Overall, drug demand reduction should have more visibility within the National Drug Control Strategy. Synergies should also be found with the objectives on HIV/AIDS, which are closely tied to drug demand reduction. More provinces need to be served. The Basic Package of Health Services, which currently covers over 85 per cent of the population, includes HIV testing but should also provide treatment for the harmful consequences of drug use. Gradual and realistic milestones should therefore be introduced to guide the Government of Afghanistan.

244. At the same time, future drug demand reduction projects should be differentiated, based on relevant international evidence-based experiences. For instance, a vast prevention project should be implemented to target the general population (including through solidarity messages) and groups at risk. The visual communication material used should be reviewed and updated, keeping in mind lessons learned from past unsuccessful experiences. School-based preventive efforts should be expanded. Drug use and HIV/AIDS related topics should be included in the curricula of trainee social workers and health-care providers, including in medical schools. Community-based initiatives addressing local needs should be facilitated. By the same token, a nationwide vocational training project could be developed. There are lots of interesting international and regional experiences in this domain that could be shared in a process of mutual learning. Just as treatment was seen as urgent in the past and was very prominent in drug demand reduction efforts, so the psychosocial and economical aspects of rehabilitation should be developed now.
245. In laying the foundation of a drug demand reduction approach in Afghanistan, the emphasis has rightly been put on building the capacity of the Government. In the next phase of programme and project conception, strengthening civil society should also be high on the agenda in order to ensure a comprehensive and balanced representation and involvement of stakeholders.

Recommendation 5: UNODC should consider focusing increasingly on normative work (in other words, on policies, guidelines, surveillance systems, etc.) and on supporting the Government of Afghanistan in developing an innovative and viable Drug Demand Reduction Programme. In doing so, UNODC should consider strengthening its collaboration with other entities (the World Bank, WHO, UNAIDS etc.) in order to develop coherent institutional development efforts.

246. UNODC should consider whether it wants to continue performing the role of a non-governmental organization, as it is perceived by the Government of Afghanistan and other drug demand reduction stakeholders, or whether it wants to stand as an agency providing advisory and technical support to the Ministry of Counter-Narcotics and the Ministry of Public Health as part of its mandate of building the capacity of the Government of Afghanistan. Very recently, UNODC prepared a project proposal for the expansion of its normative work on drug demand reduction, but other agencies are also aiming for such actions. UNODC should undertake collaborative efforts to develop a harmonized action to support the Government of Afghanistan. The Government, staff at UNODC headquarters and donors should support such an initiative. As other relevant stakeholders are also planning or have already started to provide assistance to the Government, UNODC should consider collaborating with them in designing this new project.

247. Most of the assistance currently given by UNODC focuses on the establishment and support of service delivery centres or outreach activities. There is no doubt that such efforts are needed, but these activities can only be sustainable if they are integrated in the national public health-care system network. Presently, responsibility for providing health care at the national level is mainly in the hands of non-governmental organizations, which weakens the Ministry of Public Health. Staff working with non-governmental organizations are generally offered short-term contracts, which does not allow for a long-term vision for the country. If the volatile security situation deteriorates, some international organizations (only a small number of national non-governmental organizations are involved) could leave, thus depriving a large part of the population of health-care services. There might also be a trend towards the privatization of health-care services, further increasing inequities in terms of access. Additionally, the high number of non-governmental organizations involved leads to coordination difficulties and duplication and inefficiency of services. Finally, there are no quality standards. More and better resources are needed to develop a national strategy for organizing, planning, supervising, monitoring and evaluating an Afghan-owned health-care system. With such an improvement, the drug issue could benefit from being included in the Basic Package of Health Services for Afghanistan, both as part of the preventive and curative components. Special attention should be given to mental health problems in Afghanistan, as these constitute an important determinant in drug use. Thanks to its expertise in this domain as well as in harm reduction, WHO is a key United Nations entity to be involved in drug demand reduction initiatives.

Recommendation 6: UNODC and the international community should find a way to bridge the gap between the Ministry of Counter-Narcotics and the Ministry of Public Health in order to work together to address drug demand reduction and HIV/AIDS problems comprehensively. The roles and responsibilities of both ministries should be
delineated clearly. Effective links among all existing coordination committees and working groups should be established.

248. Both ministries dealing with the drug problem are generally perceived as weak and as having vaguely defined roles and responsibilities, as the line between coordination (Ministry of Counter-Narcotics) and implementation (Ministry of Public Health) is blurred, weakening both entities. In addition, there is little coordination within the Ministry of Public Health between the drug demand reduction department and the National Drug Control Programme. Finally, effective links among all existing coordination committees and working groups should be established; ideally, all stakeholders should be brought together on a single platform. The drug demand reduction working group set up by the Ministry of Counter-Narcotics is perceived as useful by participants but also as providing opportunities for power struggles between the Ministry of Counter-Narcotics and the Ministry of Public Health. The sharing of information is appreciated but the lack of implementation force is exposed. A working group on harm reduction and a country coordination mechanism of the Global Fund to Fight AIDS, Tuberculosis and Malaria were also set up by the Ministry of Public Health, creating confusion and overlaps. It was therefore decided, at a conference on opioid substitution therapy held in November 2007, to merge the working group on harm reduction of the Ministry of Public Health with its counterpart in the Ministry of Counter-Narcotics. Nonetheless, more efforts are needed to ensure a smooth and efficient coordination in the long run.

Recommendation 7: Based on the mandate of UNODC and considering that there are clear indicators of a possible concentrated HIV/AIDS epidemic in Afghanistan in the near future, it is strongly recommended that UNODC undertake necessary measures to join other national and international initiatives, develop programmes and projects, and play an active role in policy and coordination efforts to address the HIV/AIDS problem.

249. It is evident from the information available and known risk factors that Afghanistan is heading towards a concentrated HIV/AIDS epidemic. Despite having a clear mandate on HIV/AIDS, UNODC has missed opportunities to join forces with other national and international initiatives and to undertake timely action.

250. In that respect, UNODC should also renew and expand partnerships with development and public-health agencies in order to help to create synergies to address the HIV/AIDS problem; to support the mainstreaming of drug demand reduction, including HIV/AIDS programming, into the Afghan health-care system; and to coordinate national institutions dealing with the drug issue (the Ministry of Counter-Narcotics and the Ministry of Public Health).

251. Recently, significant funding for addressing the HIV/AIDS problem has been allocated to the Government of Afghanistan through the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. UNODC has missed opportunities to join forces with these initiatives and to participate in national efforts aimed at responding to the possible risk of a concentrated HIV/AIDS epidemic in Afghanistan. This course should be corrected by seeking collaboration with the World Bank, the Global Fund, UNAIDS, UNICEF and the Government (through the Ministry of Public Health, which has received funds to coordinate information, education and communication efforts on prevention and treatment, including harm reduction). UNODC should also participate in networks.

252. The Country Office in Afghanistan will have to enhance its capacity to address HIV/AIDS issues. Recently, an expert from the HIV/AIDS Unit at UNODC headquarters was sent to the Country Office. It would not be a good idea to replicate the UNODC
headquarters structure at the Country Office by separating HIV/AIDS issues from the drug use problem at the country level; instead, both issues should be addressed in a comprehensive manner.

**Recommendation 8:** The UNODC Country Office in Afghanistan should strengthen further its collaboration with other United Nations entities (UNICEF, WHO etc.) to mainstream drug demand reduction as a public-health issue, especially with regard to the community awareness-raising/education component, in order to reach a wider segment of the population, especially in rural communities, where basic information is most needed.

**VII. Conclusions**

253. Most of the objectives of the Drug Demand Reduction Programme in Afghanistan were implemented and a lot was accomplished with few resources. This is largely due to the dedication and competence of project supervisors, leaders and coordinators at the UNODC Country Office in Afghanistan, who had been in charge of drug demand reduction for more than a decade. They were able to build a broad and solid network throughout the country and were recognized as competent and trustful partners by all stakeholders. This was a great achievement, in the difficult and instable context of a (post-) war country, with a still weak and bureaucratic administration, a lack of infrastructures, health care facilities and health professionals.

254. However, the Drug Demand Reduction Programme was hampered by the fact that there was no clear approach or support given to it, either at UNODC headquarters or at the Country Office. Drug demand reduction activities received little money and very little attention. In addition, at the time of the evaluation, the concept of harm reduction was still a debated issue within UNODC, but not in most other United Nations entities, Governments and international organizations. Under pressure from donors, the concept of harm reduction was avoided in drug demand reduction activities carried out by the Country Office in Afghanistan, leading to many misunderstandings. Nonetheless, many of the 39 treatment facilities in the country distribute clean syringes to drug users when needed. Similarly, UNODC did not participate in the discussion on how to integrate opioid substitute therapy in future treatment approaches in Afghanistan. Mixed messages were therefore sent by UNODC to all stakeholders, including donors and non-governmental organizations that act as implementing partners. In general, the Country Office is seen as very dependent on headquarters, from which it expects clear guidelines, instead of developing its own initiatives mindful of the local context.

255. By refusing to tackle or even discuss these important issues (and by refusing, for example, to meet with important stakeholders), the UNODC Country Office has lost its influence as the lead agency on the issue of national drug use.

256. Moreover, the conflicts that have arisen between the HIV/AIDS Unit and the Prevention, Treatment and Rehabilitation Unit at UNODC headquarters have had negative consequences on the situation in Afghanistan. The Country Office has not been engaged early in dealing with the current threat of an HIV/AIDS epidemic, while the main decision makers have been involved in that discussion for a while already. Consequently, the UNODC Country Office was also unfortunately absent from the discussion on HIV in Afghanistan and did not contribute to the drafting of a strategic framework for a policy on HIV/AIDS. It was also bypassed by the HIV/AIDS Unit at headquarters, which took the lead in writing the two big grants to Afghanistan this year. These are missed opportunities,
as there are so many synergies between the objectives and measures of drug demand reduction and harm reduction programmes, as can be seen in Central Asia, where they have been integrated into the regional programme of UNODC.

257. The Government’s capacity needs to be enhanced further, starting with what has already been achieved by the Drug Demand Reduction Programme. Progress achieved to date has relied, and continues to rely, heavily on experts from other countries whose assignments are often too short and who do not always perceive their task to be the creation and enhancement of national capacities. Thus, yet more skills and knowledge need to be transferred.

258. All drug demand reduction projects are coming to an end and there are no solutions in sight. Strategic and innovative project and programme planning and fund-raising are urgently needed if UNODC is to sustain its activities and implement its mandate in a country facing increasing levels of drug abuse and, possibly, an HIV/AIDS epidemic. For now, however, the loss of credibility of UNODC on drug demand reduction issues in Afghanistan is significant and does not encourage donors to support further development.
Annex I

List of persons interviewed and field visits made

A. Persons interviewed

Afghanistan

Ministry of Counter-Narcotics
Mohammad Zafar, Deputy Minister/Head, Drug Demand Reduction

Ministry of Education
Mohammad Sidique Patman, Deputy Minister of Education

Ministry of Public Health
S. Najeebullah Jawid, Supervisor, Drug Demand Reduction Action Teams (DRATs), Drug Demand Reduction Department, Kabul Public Health Directorate
Faizullah Kakar, Deputy Minister for Technical Affairs
Farmanullah Malangyar, Supervisor, Nangarhar DRAT, Drug Demand Reduction Department, Nangarhar Public Health Directorate
Temor Shah Mosamin, Chief, Psychiatric Department, M.M.H. and Shefa Curative Hospital
Ajmal Pardis, Head, Provincial Health Department
Saif-ur Rehman, National HIV/AIDS Control Programme
Joseph Rittmann, HIV Adviser, National AIDS Control Programme
Abdullah Wardak, Head, Drug Demand Reduction Department

Other Government entities

Italy
Cristiano Congiu, Counter-Narcotics Attaché, Embassy in Kabul

Norway
Andreas Lovold, Second Secretary, Political Affairs, Embassy in Kabul

Pakistan
Waheed Khattak, Director, Community Development Unit, Commission for Afghan Refugees, Peshawar

United Kingdom of Great Britain and Northern Ireland
Ahmad Shah Habib, Drug Demand Reduction Adviser, Embassy in Kabul
United Nations system

United Nations Office on Drugs and Crime
Vienna
Gautam Babbar, Project Coordinator, Strategic Planning Unit
Monica Beg, Drug Abuse and HIV/AIDS Adviser, HIV/AIDS Unit
Stefano Berterame, Chief, Prevention, Treatment and Rehabilitation Unit, Global Challenges Section
Doris Buddenberg, Senior Manager, Global Initiative to Fight Human Trafficking (former Representative, UNODC Country Office in Afghanistan)
Sandeep Chawla, Chief, Policy Analysis and Research Branch
Bernard Frahi, Chief, Partnership in Development Branch, Division for Operations
Gilberto Gerra, Chief, Health and Human Development Section (former Chief, Global Challenges Section)
Francis Maertens, Director, Division for Policy Analysis and Public Affairs
Andrea Mancini, Project Coordinator, Europe and West/Central Asia Section
Paul Williams, Expert, HIV/AIDS Unit

Afghanistan
Elisabeth Bayer, Deputy Representative (Officer-in-Charge), former Drug Control and Crime Prevention Officer, Europe and West/Central Asia Section, Vienna
Mohammad Alam Ghaleb, Provincial Coordinator
Manzoor-ul-Haq, National Project Coordinator, Drug Demand Reduction, Peshawar, Pakistan
Jehanzeb Khan, International Programme Manager, Drug Demand Reduction
Mohammad Naim, National Project Coordinator, Drug Demand Reduction
Christina Oguz, Representative

United Nations Development Programme
Laigullah Obaidy, Provincial Coordinator, Counter-Narcotics Trust Fund Treatment Center

Office of the United Nations High Commissioner for Refugees
Isa Musulo, Health Coordinator
Mata-ul-Hussain Changaiz, Protection Unit
Intergovernmental and non-governmental organizations

Adam Smith International
David McDonald, Drug Demand Reduction Adviser

Basic Education and Employable Skill Training (BEST)
Mr. Siddiqueullah, Project Assistant (AFG/H87)

Basic Education for Awareness Reforms and Empowerment (BEFARE)
Azad Khan Khattak, Project Manager

DeutschOrdensWerke International
Ulrich Köhler, Adviser to the non-governmental organization Nejat

DOST Welfare Foundation
Mohammad Ayub, Programme Director
Nabeela Elahi, Manager, drop-in centre for children
Mohammad Jawad, Project Assistant (AFG/H87)
Parveen Azam Khan, President

German Agency for Technical Cooperation (GTZ)
Bayan Shairshah, Project Coordinator, Integrated Drug Prevention Treatment and Rehabilitation Project in Afghanistan
Harald Waesch, Drug Demand Reduction Adviser, Integrated Drug Prevention Treatment and Rehabilitation Project in Afghanistan

Médecins du monde
Olivier Maguet, Head, Harm Reduction Programme in Afghanistan

Nejat Drug Treatment Centre
Tariq Suliman, Director

Social Services to Afghan Women
Dr. Toorpanikay, Head, Sanga Amaj Treatment Centre

Welfare Association for the Development of Afghanistan
Mohammad Nasib, Managing Director
Sardar Wali, Drug Demand Reduction Coordinator
Others

Catherine Todd, Researcher, University of California, San Diego, United States of America

B. Field visits made

Kabul

• Drug dependency treatment centre, Alawodia and drug demand reduction action team in Kabul: saw the drug scene and drug area, and visited a family (a mother and her two sons, one of whom was detoxified and the other thinking of undergoing treatment)

• Nejat Drug Treatment Centre: social development, drug rehabilitation and medical services

• Sanga Amaj Treatment Centre: social services for women

• Médecins du monde: Drop-in centre

Jalalabad (Nangarhar province), Afghanistan

• Nangarhar DRAT: met a group of detoxified drug users (men and women), motivational counselling in outdoor settings, vocational training (tailoring, carpentry)

• Counter-Narcotics Trust Fund Treatment Centre

• Afghan Amputees Bicyclists for Rehabilitation and Recreation

Peshawar, Pakistan

• Met with Khurasan camp inhabitants, drug demand reduction committee members, former drug users (men and women), vocational trainers, health-care workers, implementation partners (DOST Welfare Foundation and BEST)

• DOST Welfare Foundation: Street children treatment centre, drop-in centre, Foundation headquarters
Annex II

Terms of reference

I. Background

1. Twenty-eight years of war have led the population in Afghanistan to suffer the world’s largest migration, massive internal displacement and severe mental problems. Post-trauma syndrome, the loss of loved ones and property and a drastic escalation in opium production in Afghanistan have caused an increase in drug use among Afghans living in the country or in refugee camps in neighbouring countries. Most Afghan refugees (estimated at 7 million) have lived either in Pakistan or in the Islamic Republic of Iran, both of which are facing severe drug addiction problems.

2. In order to address the problem of opium poppy cultivation and drug use, the United Nations Office on Drugs and Crime (UNODC) implemented, from 1989 to 1996, a cross-border project on Drug Control and Rural Rehabilitation (AFG/580). The project consisted of two components: (a) the implementation of a community development programme aimed at reducing illicit crop cultivation (supply reduction); and (b) awareness-raising among Afghans of the dangers of drug abuse (demand reduction). The project was implemented in selected districts of Nangarhar, Helmand, Kandahar, Kunar and Badakhshan provinces, as well as in Afghan refugee camps in Pakistan.

3. Between November 1998 and June 2001, the Drug Demand Reduction Support Project (AFG/C29) promoted drug demand reduction initiatives in Afghan communities, achieving considerable success despite a severe funding shortfall and constant security constraints. The gap left in the provision of drug demand reduction facilities and services for Afghan communities between the end of project AFG/580 in 1996 and the start of project AFG/C29 in 1998 seriously undermined the sustainability of the activities previously implemented. One of the first tasks to be carried out in the framework of project AFG/C29 was the organization and facilitation of workshops to establish links between UNODC and the non-governmental organizations in Baluchistan and the North West Frontier Province engaged in drug demand reduction activities among refugees, both in Pakistan and in Afghanistan.

4. Within the current portfolio of drug control and crime prevention activities of the UNODC Country Office in Afghanistan, the following four drug demand reduction projects have been developed to enable the Government and the people of Afghanistan to address the problem of drug use:

   (a) AFG/G68 on capacity-building for drug demand reduction in Badakhshan, Nangarhar and Kandahar provinces (2005-2007);
   (b) AFG/H09 on capacity-building for drug demand reduction in Afghanistan (Kabul, Balkh and Herat, 2003-2007);
   (c) AFG/H87 on drug demand reduction information, advice and training services for Afghan communities living in refugee camps in Baluchistan and the North West Frontier Province, Pakistan (2005-2007);
   (d) AFG/G26 on drug demand reduction information, advice and training service for Afghanistan (2002-2006).

5. To implement activities under project AFG/H09 and project AFG/G68 in Afghanistan, six Drug Demand Reduction Action Teams (DRATs), comprised of staff
from the Ministry of Public Health and the Ministry of Education of Afghanistan, were established and provided with resources and training for staff. The action teams were located within the provincial health directorates in Kabul, Kandahar, Nangarhar, Balkh, Herat and Badakhshan. The action teams carry out demand reduction activities in their respective provinces, mainly aimed at community-based drug treatment and drug abuse prevention. The capacities of Government organizations and ministries were built, as were the capacities of civil society through the involvement of non-governmental organizations active in the field of drug demand reduction.

6. In addition, the drug demand reduction capacities of governmental and non-governmental organizations working for Afghan refugees in Pakistan were built through project AFG/H87. For this purpose, a memorandum of understanding was signed with the Office of the United Nations High Commissioner for Refugees (UNHCR) in Pakistan with the aim of carrying out joint initiatives on drug demand reduction among Afghan refugees.

7. Through project AFG/G26, advisory and training services were provided to Government counterparts, United Nations entities and non-governmental organizations. An assessment was carried out of the extent, pattern and nature of drug abuse and misuse in the Kabul area and a home-based detoxification programme and referral services were provided for drug addicts in Kabul. In conjunction with the Ministry of Public Health, a working group on drug demand reduction was organized to prepare for the Second International Drug Control Coordination Meeting, held in Kabul on 17 October 2002.

8. The present evaluation will, therefore, provide an opportunity to evaluate the whole UNODC Drug Demand Reduction Programme in Afghanistan and assess the respective projects’ impacts and achievements. This evaluation will also contribute to the assessment of the overall achievements and impacts of UNODC assistance to Afghanistan.

9. The findings of the evaluation should be clearly compared with, but not limited to, the objective and expected results listed above.

II. Purpose of the evaluation

10. The present evaluation will be carried out as part of the Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the United Nations Office on Drugs and Crime.

11. The UNODC Drug Demand Reduction Programme in Afghanistan has evolved and continued to expand since its inception in 2003. The current programme includes projects aimed at strengthening the capacity of the Government and civil society in this area.

12. The overall purpose of the evaluation is to determine how the assistance provided by UNODC has contributed to the overall goals of building governmental capacity at the national and subnational levels, increasing understanding of demand reduction and designing appropriate responses.

13. Through the evaluation, the extent to which the needs of the beneficiaries are being met, as well as what has been achieved in terms of impact and sustainability, will be determined. In addition, an analysis will be made to evaluate how thoroughly and effectively the strategy for strengthening drug demand reduction capacity in a post-conflict environment was planned and implemented.

14. The main stakeholders of the projects are: (a) the Ministry of Public Health, the Ministry of Education, the Ministry of Counter-Narcotics, the Ministry of Women’s
Affairs and the National Olympic Committee of Afghanistan; (b) international organizations (including UNHCR, the United Nations Children’s Fund (UNICEF) and the United Nations Development Fund for Women (UNIFEM)) and various non-governmental organizations; and (c) donors to the UNODC Drug Demand Reduction Programme in Afghanistan (Canada, Ireland, Japan, Italy, the Netherlands and Norway). The stakeholders are the beneficiaries of the evaluation.

15. The evaluation will seek to draw lessons learned and best practices that can be used by UNODC to improve future project planning, design and management in the field of drug demand reduction capacity-building in Afghanistan and, possibly, in other post-conflict countries. The evaluation will also be of interest to the donors of the project, as they are envisaging funding additional projects in this field.

III. Scope of the evaluation

16. The evaluation team will undertake a comprehensive review of the programme portfolio of the UNODC Country Office in Afghanistan and the activities it carried out on drug demand reduction between 2001 and March 2007.

17. The evaluation team will measure effects and impacts of the UNODC Drug Demand Reduction Programme in Afghanistan, examine the support given by UNODC to the Government of Afghanistan, assess the programme’s performance and draw lessons learned and best practices. In addition, the evaluation team will concentrate on whether and how the support given by UNODC has played a role in developing national capacity, enhancing national ownership, advocating and fostering an enabling policy environment, and fostering partnerships and coordination throughout the evaluation process.

18. The evaluation team will answer the key questions given below in its final report. The questions are generic and are consistent with standard approaches to programme evaluation. There should be an element of flexibility, as the evaluation progresses, to adjust the focus of the evaluation to changing circumstances.

19. The consultant selected will have to develop evaluation questions specific to drug demand reduction, using the following generic questions as a basis.

Key evaluation questions: relevance

1. Has the assistance given by UNODC in the field of drug demand reduction been relevant to the needs and demands of the Government of Afghanistan in its fight against the consumption of illicit drugs?

   • Are the objectives of the Drug Demand Reduction Programme and associated projects aligned with the current policy priorities and action plans of the Government of Afghanistan, UNODC mandates, the United Nations Development Assistance Framework for Afghanistan (2006-2008)\(^a\) and other policies and development frameworks?

   • Have the programme and projects been designed in a technically sound manner? How were the needs of the at-risk segment of the population and other specific groups assessed? Are the programme and project objectives clear, realistic and

coherent in terms of collectively contributing to the achievements of the UNODC Strategic Programme Framework and the Afghanistan National Development Strategy, as well as other strategic instruments?

• Are drug demand reduction activities and their implementation strategies appropriate for meeting the stated objectives (with a focus on assessing programme and project elements directly related to capacity-building, coordination and the performance of subcontractors)?

• Are drug demand reduction activities responsive to the country’s needs? How well do the programme and project objectives reflect the specific nature of the problem and the needs of the Government of Afghanistan?

• Have stakeholders actively and meaningfully participated in developing and implementing drug demand reduction strategies, programmes and projects?

Key evaluation questions: effectiveness

2. Has the approach adopted by UNODC and the assistance it has given been effective in enabling the Government of Afghanistan to fight the illicit drug use menace?

• To what extent has the Drug Demand Reduction Programme contributed to achieving the Afghanistan Compact (S/2006/90, annex), the UNODC Strategic Programme Framework and the Afghanistan National Development Strategy?

• To what extent have the objectives of the Drug Demand Reduction Programme and associated projects been achieved? What are the reasons for the achievement or non-achievement of the objectives?

• Has the UNODC response helped agencies responsible for drug demand reduction to be better equipped to deal with the steep increase in drug abuse in Afghanistan?

• Have the enhanced institutional capacity, advocacy activities and training improved the ability of the Government of Afghanistan to respond to the drug problem?

• To what extent has information generated by the project (e.g. baseline and other studies) influenced national policymaking and programming?

• Has there been any improvement in programming in terms of addressing the country’s problems and producing results?

• Has integration both within and among thematic areas taken place while implementing different project activities?

• How are factors and constraints within UNODC affecting effectiveness, including in terms of human resources, logistic support, and the predictability and regularity of resources and the flexibility of the budget?

• How are external factors (such as limited access to the sites of intervention, the security situation, human resources constraints etc.) impacting on effectiveness?

Key evaluation questions: efficiency

3. How efficient has the implementation of the UNODC programme and associated projects been?

• Have other, less costly, intervention modalities been considered in designing projects? Do such alternatives exist?
• Are there less costly methods that could achieve the same outcome or have the same impact for beneficiaries?

• To what extent have partnerships been sought with other relevant actors (including United Nations entities) and synergies been created in the delivery of assistance?

• Has there been effective coordination among the Government, UNODC and other implementing partners?

• Is the human resources structure at the UNODC Country Office in Afghanistan appropriate and efficient? The quality, timeliness, effectiveness and sustainability of management arrangements, technical inputs and assistance should be assessed.

• Has adequate and appropriate backstopping support been provided by staff members at headquarters and in the field (administrative and managerial support and coordination)? Have partner institutions fully and effectively discharged their responsibilities?

• What could have been prevented or could, in the future, prevent UNODC operations from producing intended results?

**Key evaluation questions: outcomes and impact**

4. **What are the outcomes and impact of the assistance provided by UNODC in Afghanistan?**

• What are the positive and negative, intended and unintended, effects of interventions on people, institutions and the physical environment? The medium- and long-term effects of UNODC assistance should be assessed.

• Have the beneficiaries and other stakeholders affected by the intervention perceived the effect of the interventions?

• What is the perception of the different stakeholders (in particular, the Government of Afghanistan, implementing partners, other United Nations entities and bilateral and multilateral donors) of the overall impact of UNODC drug demand reduction activities?

**Key evaluation questions: sustainability**

5. **Are UNODC efforts in Afghanistan sustainable?**

• Have the drug demand reduction policies and strategic issues supported by UNODC been mainstreamed into key national development documents?

• Is there the potential for project interventions to be scaled up or replicated?

• To what extent have the findings and recommendations from past project evaluations been followed up and implemented to address some of the challenges already identified?

• How does UNODC ensure that its assistance continues to provide benefits after such assistance has stopped?

• How has sustainability been built into the programme and associated projects?
Key evaluation questions: lessons learned and best practices

6. Are there any lessons to be learned from UNODC involvement in Afghanistan?

- Identify key lessons learned on drug demand reduction and on positioning that could be useful for strengthening UNODC support to Afghanistan and for improving programme and project performances, results and effectiveness
- Through an in-depth drug demand reduction assessment, highlight good practices at the country level for learning and replication
- Draw lessons from unintended results where possible

IV. Evaluation methodology

20. The evaluation team will take into consideration agreed international evaluation norms and standards, including the Guiding Principles for Evaluation at UNODC, the Standards for Evaluation in the UN System and the Norms for Evaluation in the UN System of the United Nations Evaluation Group.

21. The present terms of reference provide an overarching framework for the evaluation. The leader and members of the evaluation team are expected to note with appreciation the terms of reference and to develop an evaluation framework with instruments to be discussed and agreed with the Independent Evaluation Unit of UNODC. The evaluation framework should be flexible enough to accommodate any adjustment due to the volatile political and security situation in Afghanistan and produce the best possible output.

22. The following key elements should be kept in mind when carrying out the evaluation (the list is not exhaustive):

   (a) A historical and contextual review of the problem of drug use in Afghanistan;
   (b) A document review (desk study) that includes all major documents (the UNODC Strategic Programme Framework, the Afghanistan Compact, project documents, progress and monitoring reports, evaluation reports and terminal narrative reports, as well as assessments and manuals developed in the framework of the projects);
   (c) Interviews of key stakeholders including representatives of the Government (the Ministry of Public Health, the Ministry of Counter-Narcotics, the Ministry of Education, the Afghan Red Crescent Society, the National Olympic Committee of Afghanistan etc.), donors, United Nations entities (the United Nations Development Programme (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS) etc.) and UNODC at headquarters and at the Country Office in Afghanistan;
   (d) Project site visits at the national and provincial levels to meet with team members, beneficiaries and other organizations involved in the execution of the projects;
   (e) Presentation of major findings to stakeholders after the fieldwork has been done.

23. The evaluation will be a participatory process that will give due importance to self-assessment by stakeholders involved in programme design and implementation. All information will, to the greatest possible extent, be triangulated (three or more sources of information will be used to verify and substantiate an assessment) and validated. Findings, conclusions, recommendations and lessons learned should clearly be action-oriented and feed into major decision-making processes for future strategy and programme development.
V. Evaluation team

24. The evaluation team will consist of an international expert (evaluator) with relevant skills for the task. The evaluator should have an excellent understanding of drug demand reduction capacity-building in developing countries.

25. The evaluator should hold an advanced degree in social science or a related field and have proven experience in the implementation of drug demand reduction projects or programmes, preferably in West Asia. In addition, the evaluator should also have the following minimum qualifications:

   (a) Familiarity with project implementation in the United Nations and, ideally, in UNODC;
   (b) Experience in conducting independent evaluations;
   (c) A minimum of 10 years of relevant professional experience in drug demand reduction capacity-building in developing countries and organizational and supervisory experience in the field of drug demand reduction;
   (d) A graduate degree in a relevant field;
   (e) Excellent analytical, communication and writing skills in English. Knowledge of languages spoken in Afghanistan is an asset.

26. The evaluator of the Drug Demand Reduction Programme will work as part of a technical team of six international consultants and an evaluation officer for the Independent Evaluation Unit, evaluating the technical assistance provided to Afghanistan by the United Nations Office on Drugs and Crime.

27. The key responsibilities of the evaluator will be the following:

   (a) To support the leader of the evaluation team in developing evaluation methods and tools;
   (b) To evaluate policies, strategies and interventions in his or her specific thematic area;
   (c) To write the thematic evaluation report;
   (d) To perform any other tasks assigned by the Team Leader.

28. The evaluator will be selected by staff members of the Independent Evaluation Unit of UNODC in consultation with staff members of the Country Office in Afghanistan. Coordination will be sought with staff members of the Europe and West/Central Asia Section at UNODC headquarters in Vienna, using the agreed criteria and drawing on experts from the roster.
VI. Management arrangements and deliverables

29. The Independent Evaluation Unit will manage the evaluation and ensure coordination and liaison with the relevant regional desk at UNODC headquarters. The Task Manager in the Independent Evaluation Unit will, together with the Chief of the Unit, lead the process, in close consultation with the regional desk and the country management (the Representative and the Evaluation Focal Person). The Chief of the Independent Evaluation Unit and the Task Manager will also ensure substantive supervision of all members of the evaluation team and determine the team’s composition.

30. The UNODC Country Office will play a lead role in dialoguing and interacting with stakeholders on the findings and recommendations, support the evaluation team in liaising with the key partners and facilitating discussions with the team, and make available to the team all relevant material. The Country Office will provide logistical and planning support.

31. The Independent Evaluation Unit will meet all costs directly related to the conduct of the evaluation. These will include costs related to the participation of the evaluation consultants, the staff member of the Unit and to the holding of any stakeholder workshops during the evaluation mission.

Key deliverables

32. The evaluator is expected to deliver the following key outputs:

   (a) An initial report containing the evaluator’s appreciation of the terms of reference and the final evaluation methodology and instruments, including the evaluation matrix;

   (b) A draft evaluation report of the UNODC Drug Demand Reduction Programme in Afghanistan, with findings and recommendations by project;

   (c) A final evaluation report of the UNODC Drug Demand Reduction Programme in Afghanistan, with findings and recommendations by project.

33. The evaluator will hold a feedback session and present the initial findings during a workshop to the management team in Afghanistan and external stakeholders based in Kabul after the field mission in Afghanistan. The task manager and the Chief of the Independent Evaluation Unit will attend and participate in the presentation and feedback workshop.

34. The draft evaluation report will be examined by the Independent Evaluation Unit and assessed for quality and fulfilment of the terms of reference.

35. The Independent Evaluation Unit will organize a session to present the draft report to UNODC staff members at headquarters and at the Country Office in Afghanistan and to stakeholders for feedback, comments and the correction of any errors or omissions.

36. The present evaluation will be carried out as part of the Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the United Nations Office on Drugs and Crime, which covers five thematic areas: rule of law; law enforcement; alternative livelihoods; drug demand reduction; and illicit crop monitoring. These terms of reference are for the recruitment of a drug demand reduction evaluator. Separate terms of reference were drafted for the rest of the team.

37. The Team Leader of the overall evaluation will prepare a final report incorporating the five thematic areas evaluated, including the part on drug demand reduction; take into
account the comments of the Independent Evaluation Unit, UNODC programme staff and stakeholders; adjust the report accordingly, subject to agreement with the comments made; and send the final report to the Independent Evaluation Unit.

**Timetable**

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
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<tbody>
<tr>
<td>September-October 2007</td>
<td>• Circulation of the draft terms of reference to staff members concerned at UNODC headquarters and at the Country Office in Afghanistan for comments</td>
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<tr>
<td></td>
<td>• Finalization of the terms of reference</td>
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<tr>
<td>October 2007</td>
<td>• Recruitment of consultant</td>
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<tr>
<td></td>
<td>• Briefing on Afghanistan country programme at UNODC headquarters</td>
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<tr>
<td></td>
<td>• Appreciation of terms of reference and development of evaluation methodology, with instruments</td>
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<tr>
<td>October-November 2007</td>
<td>• Independent review by the evaluation team (headquarters and country mission)</td>
</tr>
<tr>
<td>November-December 2007</td>
<td>• Submission of draft report by the evaluation team</td>
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<tr>
<td></td>
<td>• Briefing on findings and recommendations contained in the draft evaluation</td>
</tr>
<tr>
<td></td>
<td>• Circulation of draft report for feedback</td>
</tr>
<tr>
<td>December 2007</td>
<td>• Submission of final report</td>
</tr>
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**Payment**

38. The consultant will be issued a contract and be paid as per United Nations rules and procedures. The consultant will be paid a lump sum, disbursed in three instalments:

   (a) The first instalment will be paid upon signature of the contract (travel expenses plus 75 per cent of the daily subsistence allowance);

   (b) The second instalment will be paid upon receipt of the draft evaluation report by the Independent Evaluation Unit (50 per cent of the consultancy fee plus 25 per cent of the daily subsistence allowance);

   (c) The third and final instalment will be paid only after completion of assigned tasks, receipt of the final evaluation report and clearance by the Independent Evaluation Unit (remaining 50 per cent of the consultancy fee).
Annex III

National drug demand reduction and harm reduction model

Secondary prevention services

**Examples of treatment and rehabilitation services:**
- Pre-treatment motivational counselling
- Drug demand reduction programme
- Detoxification
- Treatment and rehabilitation programme
- Aftercare
- Follow-up
- Relapse prevention
- Social support and reintegration (e.g. vocational training, self-help groups, family therapy, individual counselling, advocacy etc.)
- Harm reduction services for patients on a waiting list

Tertiary prevention services

**Examples of harm reduction services:**
- Narcotic substitution therapy
- Opioid substitution treatment
- Primary health care (wound care, abscess treatment etc.)
- Information, education and communication (safer injection practices, HIV prevention, safe sex etc.)
- Social services (bathing, food, clothing, shelter etc.)
- Antiretroviral therapy
- Motivational counselling (prevent smokers from injecting etc.)
- Referral for treatment

Integrated and comprehensive network of services providing a continuum of care for both injecting and non-injecting drug users responsive to the changing needs of patients

Standardization of services
- National treatment and rehabilitation/harm reduction policy and strategy
- National treatment and rehabilitation/harm reduction guidelines and protocols

The drug demand reduction directorate of the Ministry of Counter-Narcotics is responsible for coordinating and monitoring drug demand reduction policy and strategy (including both treatment and rehabilitation and harm reduction).

The Ministry of Public Health is responsible for coordinating and monitoring the technical implementation of drug demand reduction programmes (including both treatment and rehabilitation and harm reduction). This function is carried out by the drug demand reduction directorate with regard to treatment and rehabilitation and jointly by the drug demand reduction directorate and the National AIDS Control Programme with regard to harm reduction.

Liaison with key ministries and United Nations entities involved in drug demand reduction, such as the Ministry of Education, the Ministry of Interior Affairs, the Ministry of Justice, the Ministry of Women’s Affairs, the Ministry of Hajj and Islamic Affairs, the United Nations Office on Drugs and Crime, the Office of the United Nations High Commissioner for Refugees and the World Health Organization.
Annex IV

Afghanistan, 2005: Drug Demand Reduction Facilities and Estimated Number of Drug Users per Province

Note: The roadbases and names shown in the side caption used on this map do not reflect official and intended or assistance to the United Nations.
THEMATIC EVALUATION OF
THE TECHNICAL ASSISTANCE PROVIDED TO
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OFFICE ON DRUGS AND CRIME

Volume 5
Drug Demand Reduction Programme

Independent Evaluation Unit