

# REPORT

## MID-TERM EVALUATION OF UNODC SMALL GRANTS PROGRAMME IN LATVIA

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### SUMMARY

This report assesses the mid-term progress made within the small grant programme of the United Nations Office on Drugs and Crime (UNODC) in Latvia. Based on desk review and site visits, it assesses relevance, efficacy, effectiveness, good practices and lessons learnt of the support for 8 community based harm reduction services and two prison based services.

The report concludes that the UNODC grant programme was largely successful in reaching its objectives, particularly increasing coverage and developing outreach work through existing low threshold and new sites. The grant programme is less successful in the prison settings but its implementation also helped to identify the challenges and overall situation in those closed settings. A number of recommendations are developed to address services, monitoring and evaluation, as well as advocacy and technical assistance.

### ABBREVIATIONS

AGIHAS	Atbalsta grupa inficētajiem ar HIV un AIDS slimniekiem
AIDS	acquired immunodeficiency syndrome
ATS	amphetamine-type stimulants
EHRN	Eurasian Harm Reduction Network
EU	European Union
HIV	human immunodeficiency virus
IDU	injecting drug user or injecting drug use
M&E	monitoring and evaluation
NGO	non-governmental organization
OST	opioid substitution therapy
PHA	Public Health Agency in the Ministry of Health of the Republic of Latvia
PLHIV	person or people living with HIV/AIDS
TB	tuberculosis
UNODC	United Nations Office on Drugs and Crime
USD	US dollar



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## **1. INTRODUCTION**

This report assesses the progress made within the small grant programme of the United Nations Office on Drugs and Crime (UNODC) in Latvia. The grant programme is implemented within UNODC project “HIV/AIDS prevention and care among injecting drug users and in prison settings in Lithuania, Latvia and Estonia.” This report provides a description of that grant programme and the services supported through it as well as a discussion of its concept, design implementation, results. Conclusions are drawn about the program relevance, effectiveness, efficiency and sustainability and good practices. These are followed by recommendations to UNODC on how the programme and related activities in Latvia can be further improved.

The report describes local drug injecting characteristics, profile of clients, the set of services provided, staff and capacity, and monitoring and evaluation systems. The context builds understanding of overall successes and challenges of Latvian low threshold services. Therefore recommendations are provided for both the grant programme and for work with a wider group of stakeholders, which we suggest UNODC target in its advocacy and capacity building and service support strategy.

## **2. EVALUATION PURPOSE**

In April 2008, UNODC contracted the Eurasian Harm Reduction Network (EHRN) to conduct an evaluation of its small grant programme 2007/2008 in Latvia. The evaluation aims to provide advice to UNODC on the further financial and technical assistance for service providers in the country based on the lessons learnt mid-term from the grant programme 2007/2008. The overall purpose of the evaluation is to determine whether the objectives planned have been achieved and to assess extent to which the needs of the beneficiaries are being met. Additionally, the evaluation provides an overview of the services and their achievements, lessons learnt and good practices which could be used to improve services, their management, as well as national coordination of low-threshold services. EHRN was asked to address the following aspects of the UNODC support in the evaluation: relevance; effectiveness; efficacy; sustainability; lessons learnt and best practices.

## **3. EVALUATION METHODOLOGY**

The evaluation was conducted by Raminta Stuikyte, EHRN using communication with UNODC staff, and country mission desk review. It started with initial briefing by Signe Rotberga, UNODC Regional Project Coordinator. A desk review of the grant programme documentation, grantees reports and other related documents was conducted. During a five-day mission to Latvia, site visits to all grantees were carried out involving meetings with key staff, service beneficiaries, and key stakeholders. A draft Harm Reduction Capacity Building Toolkit of EHRN's Harm Reduction Knowledge Hub was used to structure the

overview and design questions asked during site visits. Preliminary outcomes of the evaluation were discussed at a round table discussion with grantees and other stakeholders and feedback was incorporated. The evaluation took place in April 2008, however due to the consultant fault the report was provided with huge delay only in December 2008. List of stakeholders met is detailed in the appendix 2.

The major limitations of the methodology are:

- Site visits: fewer service beneficiaries (IDUs) were interviewed than planned. Time for interviews was limited and it was not possible to directly observe service provision such as outreach to drug using populations. Though meetings with grantees usually included interviews and discussions with stake holders, managers, outreach workers, and clients they were brief. Only one current client and two former clients were interviewed during the visits. Meeting times did not occur during service operation hours in a number of places. Translation was used for conversation with some outreach workers (in Kuldīga and Talsi). In three programmes (both programmes in prison settings and Kekava HIV Prevention Programme) on-site visits were not conducted.
- timing of the evaluation: some information is insufficient due to the recent initiation of activities in some programmes.
- reporting: In the grantees mid-term reports and in applications, data is rather incomplete or inadequate to evaluate effectiveness of the grants. The reports often provide information about overall activities of services operating (not necessarily only those services supported by UNODC). Separating UNODC and other support for the services might be difficult to do.

## **4. FINDINGS**

### **4.1. Grant Programme Design and Implementation**

In line with the UNODC mandate, EU policy and the Latvian National Drug Policy, UNODC initiated a small grants program with the aim of “assisting improving HIV prevention and care services for injecting drug users (IDUs) and prisoners, among whom the HIV epidemic in Latvia is concentrated.” The five objectives of the grant programme are:

- scale-up;
- availability, coverage and quality of comprehensive package interventions;
- outreach and peer education for reaching hidden groups;
- prevention in prison settings and among ex-prisoners;
- service cooperation (networking).

To achieve these ends, a grant competition was announced in August 2007 to which 10 organizations submitted proposals. All these were funded for programs of 1 – 2 years with grants of between 5000 and 10000 Lats. A total of 82 221 Lats were granted in 2007 to the 10 harm reduction and other HIV services including 8 low threshold services and 2 prison based services. Most of the activities supported focused on improving comprehensiveness and coverage of harm reduction services through outreach to hidden groups.

The eight community-based were located in the cities of: Kuldīga, Talsi, Jūrmala, Rīga (2 programmes), Jelgava and Jekabpils, Kekava. Most of the programs supported were in areas with relatively high rates of HIV such as Kuldīga, Rīga and Jūrmala.

At the time of this evaluation, all grant recipients had started to implement their programs. All but one program had started serving clients. Since there are substantial differences between the support of low-threshold services and programmes in prisons they are further referenced in the text separately.



## 4.2. Low threshold programmes

### 4.2.1. SERVICES

The financial and technical support of the grant programme enabled 8 low-threshold programmes to develop or expand existing services to address a range of health and social needs of injecting drug users (IDU). The range of services offered through the programmes includes: needle and syringe exchange or distribution; condom distribution; and rapid HIV testing; hepatitis testing; counselling; referral to drug treatment; peer education; primary care; adherence support and social services. Most of the programmes used UNODC funding mainly for expansions of access to services using outreach which is widely recognized as one of the most effective means of reaching hidden populations and which is discussed in more detail in the section below on coverage.

#### *NEEDLE EXCHANGE/CONDOM DISTRIBUTION*

All supported programmes offered needle exchange and condom distribution. The numbers of needles and condoms distributed increased significantly as a

result of the UNODC grants. Collection of data on syringes distributed and collected was inconsistent so it is difficult to make statements about the totals. But nonetheless the reported numbers (while often non-comparative) and summary information from the Latvian Public Health Agency show that in each of the sites, the numbers of syringes distributed and exchanged increased as a result of the UNODC small grants programme. All programmes provide alcohol swabs. The programme of Dia+logs in Riga was the only one to offer full safer use packages containing syringes, alcohol swabs, filters etc. and hygiene packages containing condoms etc. Their packages however did not include cookers. Interruptions in provision of supplies have been noted. In Riga at Dia+logs at the time of the visit the programme was in the midst of a 3 month interruption in the supply of condoms and syringes due to problems with contract for the supply of the commodities. Most programmes receive syringes and condoms from the Public Health Agency (Latvian AIDS Prevention Centre). In Kekava initially the syringes supplied by the AIDS Centre were used but clients were not satisfied with the quality and there were some challenges reported in making the contract between the Public Health Agency and non-governmental organization. The program began to purchase its own syringes and now has a reputation for providing good quality syringes among its clients and even in Riga, among other programs representatives of which mentioned Kekava's good quality syringes during the visit.

At least 4 programs reported challenges in **collecting used syringes**. The service in Jurmala reported that police interference makes it unsafe for outreach workers to carry used syringes which inhibited exchange in certain parts of the city. The organization is therefore starting to place containers for collection of syringes in areas where IDU live or use. Such containers (made from regular large water containers) were already used in Kekava. The service provider in Talsi reported that collection was particularly difficult from clients who lived outside the town as they had only rare contact with services and did not tend to accumulate used syringes. Also clients are not always willing to return used injecting equipment (outreach is irregular or not as frequent, it is complicated to carry syringes back home due to fears to disclose drug use to parents or partners or to be stopped by police).

There are no safer injecting sites. Staff of one programme mentioned of clients stealing spoons from their office, using them as cookers and injecting next door to the service; the person suggested that opening a safer injecting site would address clients' needs and safety.

**Pharmacies** can be an important source of sterile syringes for IDU and harm reduction services can work to improve such access. Accessibility of syringes for IDU in pharmacies in the cities where the programmes are located is varied. In Jurmala there is one 24/7 pharmacy in the area where drug use is concentrated but, though the city is small, it is long (17km) so distance is a barrier. The program manager of that service did not know whether the pharmacy sold syringes to IDU. In some cities it was reported that there were no pharmacies open 24/7. In some cities pharmacies are reluctant to sell syringes to IDU. The visiting expert attempted to purchase syringes in one pharmacy (which was

located in healthcare center, so according to interviewed person using drugs should sell syringes) during the trip and was refused. In Talsi, pharmacies sold insulin syringes filled with insulin which increases price making them less accessible to IDU. In Riga, 24/7 pharmacies add a 30% surcharge to all goods (including syringes) sold at late hours. In contrast, in Kuldīga one pharmacy even provided information about the needle exchange point to IDU who purchased syringes there.

#### *HIV AND HEPATITIS TESTING*

All of the organizations except the ones in Jurmala and Kekava offered HIV testing during the visit. All sites use rapid tests. In Jurmala, the service is not conducting the testing services (in their van) as they were not able to attain required sanitary certification. Hepatitis C testing was available in all sites except Jurmala and Kekava. In all sites with exception of Kuldīga, Hepatitis C testing was funded by UNODC. In the services where testing was available it was thought by programme managers to attract clients. Offering testing through such low threshold programs makes it available to people who may not otherwise reach a clinic. In Riga, testing is offered at the mobile unit which has developed a relationship with the infectious diseases hospital. Counselling was reported to be available at all sites.

#### *OVERDOSE PREVENTION*

The organizations visited had limited knowledge of overdose even though overdose is likely to be a major cause of death among IDU. It is ranked 2<sup>nd</sup> most often cause of death among PLHIV in Latvia, while data on the subject are generally limited in the country.<sup>1</sup> Harm reduction services have unique opportunities to reach this population with proven effective methods of prevention of overdose death such as training in overdose prevention and response and naloxone distribution. Most services did not see overdose prevention as within the scope of their work. Naloxone was not available for IDU in any of the sites.

#### *REFERRALS TO SOCIAL AND MEDICAL SERVICES*

Many of the programs serve clients who live with HIV and, to varying degrees, provide **support related to HIV treatment and care**. All sites provide HIV-related counselling. At least one site (Dia+logs, Riga) has staff members living with HIV who speak with clients about antiretroviral therapy through sessions or counselling, as well as train. Kekava programme is also working on motivation for HIV treatment. Kuldīga reported that most if not all of their clients have limited possibilities to access HIV and HCV treatments. On one hand antiretroviral therapy is fully covered by state but not travel costs to do examination and get treatment. Also one service mentioned a requirement of 6-month abstinence for initiating therapy and that people were expelled for bad adherence to therapy; it is not clear whether after treatment interruption people are allowed to returned back to treatment program. In case of HCV a

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<sup>1</sup> Overdose: A major cause of preventable death in Eurasia, EHRN, 2008

requirement to co-pay for expensive treatment (25% of costs) is a major access challenge. None of the other programs has adherence counselling or HIV case management services though some refer clients to self-help groups. In Dia+logs and in the program in Kuldiga, support for PLHIV is more elaborate than in other sites. In Riga, Dia+logs has a good relationship with the Infectology Centre (treatment institution) though they do some times face challenges. In Kuldiga where many clients are living with HIV, there is a good link with a local self-support group for PLHIV. Of 40 PLHIV registered in Kuldiga, 20 are clients of the harm reduction service. Relations with Riga-based treatment clinic in Kuldiga are strained and cooperation is limited. None of the low threshold services provide service of taking samples for HIV monitoring tests, so that clients would avoid travel to the capital city.

**Primary care including vein care** was offered directly only at Dia+logs in Riga. Other sites provided referral to primary care facilities or limited services in stationary points (e.g. wound care in Kuldiga). All sites provided **referral to drug dependency treatment** facilities, mainly drug withdrawal symptom treatment (detoxification) and rehabilitation. Very few services mentioned substitution therapy as an option suggested. Most services have relatively negative attitudes towards the currently implemented programme of opioid substitution therapy. On contrary, the service in Jurmala and the TB clinic expressed high interested in opening such therapy or closer collaboration with existing treatment provider. Most reported that **access to social services** were limited and as mentioned above none of them offered full fledged case management services for their clients. The program offered at a TB clinic in Riga offered a relatively comprehensive set of services and even expressed interest in offering substitution treatment for its clients but ceased to pursue it due to complicated regulations. The staff at the clinic was professional, friendly, well trained and well paid. The services they offered to clients were “user friendly.” Even signage in the clinic premises used language specifically targeting drug users adding to ‘welcoming’ atmosphere for them. The slang words for syringe “mashinki” and “bayani” were used to indicate the place where syringes can be taken from and this signage reportedly have not contributed to uneasiness of other clients, as it is not understood by other clients. In Kuldiga and Talsi the places were more similar to drop-in centres, especially in Kuldiga where also some social services were provided and the organization was interested in ex

#### *INFORMATION MATERIALS*

All sites distribute information materials to clients but the quality and range of subject matter covered by the materials varied. In Kekava the program had gotten materials from the Public Health Agency but they reported that clients didn't appreciate them. The sizes of the materials were inconvenient sizes, colours dull and language inclusive of complicated terminology. Also the materials were very focused on HIV not including information on safer injection practices such as using alcohol swabs or how to properly dispose of used syringes or on vein care. Similar comments were expressed also from Jurmala. Other sites reported appreciation of the materials provided by the Public Health Agency and appreciation that they are in both Latvian and Russian. Some

materials from Narcology Center are also used by local services. Dia+logs produces its own materials and they are appreciated by clients, also some other services mentioned that they were using Di+alogs materials. One service suggested a need for additional materials, particularly on vein care.

#### 4.2.2. CLIENTS AND COVERAGE

Interviews conducted for this evaluation confirmed the diversity of IDU communities in terms of age/generations, substances used, nationality, gender and other features which vary from site to site. There is variation in the drugs used. In Jekabpils for example most clients are users of amphetamine type stimulants (ATS) while in Jurmala most are heroin users. Some sites reported poly-drug users though this seemed to be relatively rare. There is a tendency for the younger IDU and experimenting (occasional) IDUs to be more likely to use amphetamine-type stimulants, while older IDU tend to use opioid type drugs. Both programme staff and clients noted this tendency. There are however exceptions to this tendency. One programme for example noted that they had very young IDU clients using heroin. Generally, there is a gap and even tension between ATS and heroin users. At least some ATS users consider themselves 'to be not such problematic addicts as heroin users.' This difference is dealt with by the programme in Jurmala by engaging outreach workers of diverse ages, genders and from communities using different drugs. The programme though still reports challenges in reaching the younger generation, especially the occasional and experimenting injectors.

The health needs of IDUs range from assistance in dealing with drug dependency (including drug dependency treatment) to access to primary care. While the health needs of clients have not been researched specifically, given epidemiological data available, the health needs are likely related to HIV (especially in such sites like Kuldīga, where 20 clients are HIV+), HCV (most of IDUs served have HCV) and other communicable diseases (TB, HVB, other STIs), as well as sexual reproductive health, problems with access to primary care. Clients also experience need for skills and means of preventing fatal overdose, particularly where heroin or other opioid are being used. Overdose cases were known by staff of three programmes. Further analysis is needed to clarify health needs such as dental care among ATS users for example.

Analysis of **coverage** usually involves expressing percent of IDU in a given geographic area who access to harm reduction services. Analysis of coverage of the programs is challenged by the fact that there is not good data on the quantity of IDU in the various cities and towns. Comparative analysis between the programs is also challenged by the fact that they gather and report different information about their clients. Some report only new clients, some report the total number of clients to date and others reported the number of clients visiting during a specified period.

In spite of the limited data it is clear that the programs did increase coverage by using various of reaching into IDU communities. All programs, except the one based at the TB clinic and in Jelgava used some form of **outreach**. Some outreach workers enrolled were former IDUs and in exceptional cases current

IDUs. In two programs (in Jekabpils and Kekava) outreach was carried out by workers with bicycles. Outreach was reported to be the main source of new clients and the majority of new clients were reached by new outreach workers whose positions were funded through UNODC grants. According to the service provider in Jurmala, each outreach worker brought in around 20-30 new clients from his or her own social networks. Expanding coverage beyond the social networks of the outreach workers is likely to be a challenge if the services do not get additional technical support in methodologies to reach out beyond these social networks. The programs in Talsi and Kuldiga reported to make outreach also over weekends, either through actual outreach to party scene or through clients making special arrangement with outreach worker through a call (but totals of syringes distributed over weekend was reported low, in Talsi only about 20). The techniques of outreach are largely depending on the staff and the only training mentioned on outreach was the one organized by UNODC that covered outreach not fully. The outreach is challenges that largely the drug scenes are reportedly closed with only one or two towns having more regular semi-open drug injecting sites. Peer education is well used in such services with highest number of outreach workers like NGOs Dia+logs and Jurmala service, and in such small service like Kekava.

All programs except the one in Jurmala and currently Kekava had **stationary points** and two (in Jurmala and at Dialogs in Riga) had **mobile unites**. The program in Jurmala is planning a stationary unit as their mobile unit was not able to meet the sanitary requirements necessary to offer HIV or hepatitis testing. The program in Jekabpils relies mostly on outreach to reach its clients even though it has a stationary point. Clients are unwilling to access the stationary point as to reach it they must walk through the municipality's social department's premises and their entrance to the site can be seen. The work on building a separate entrance to the service is in the progress.

The number of clients (including the newly reached clients) might be underestimated, as a number of clients take syringes for themselves and for their colleagues, as such performing **secondary exchange**. One service reported to have about a regular client providing exchanging dirty syringes to clean ones from a major drug cooking and injecting site. The program's M&E systems are not designed to adequately capture information about secondary exchange clients. An EU supported respond-driven sampling research conducted during the program period also contributed to the increase in coverage, especially in smaller sites. For the research IDUs were rewarded for bringing other IDUs to a research site (harm reduction site) where they could get free-of-charge testing for HIV, HCV and syphilis. At only two of the services (Jelgava and Jekabpils) staff was able to provide information about availability of syringes for IDU in local **pharmacies**.

Some programmes are trying to reach young people through activities with in-school youth. At least two programmes though which are also working in schools on drug prevention and other school-based activities did not report this contributing reaching new young clients. Reaching 'less hardcore drug injectors' through the low threshold programmes was challenged by their image

of being a site for 'addicts' according to the opinions of 4 programme managers. In some cases it is the younger generation that is better served. In one programme an outreach worker and peer educators are young and heroin users are not asking them for information and assistance. The outreach worker noted, "they probably know about everything from each other." In some programs the balance between male and female clients is relatively good with approximately 20 – 30% of clients being female. It is likely though that women may be underserved (especially where ATS are mainly used) as most programs have not had focused technical assistance to adapt services to the needs of women who are often difficult to reach through typical approaches. Most did not have special programming to support working with sex workers. The program in Jurmala had no knowledge of the sex worker community though Jurmala is a resort town and is likely to have sex workers in need of harm reduction services. Dia+logs, Kekava and Jelgava services had knowledge about sex workers (including those who were injecting drugs) and reported to be providing condoms and syringes to them.

#### 4.2.3. MANAGEMENT

In relation to management of the programs there are various strengths and weaknesses at the various sites. In Jelgava there was no clear **locus of responsibility** for management of the grant which is likely to cause problems related to implementation of commitments related to a new service (opening a new site and substantially increasing number of clients) is no one tasked with overall responsibility for the project. In Kekava the manager of the programme who had recently replaced a departing manager was not very familiar with the supported project. This new manager who does not read English had trouble accessing key project documentation which had not been translated and relied on volunteers to translate documentation. Most of the programmes did not conduct a needs assessment before planning services and writing grant proposals. Few of the programme managers involved other staff or clients in the process of planning the proposals.

#### *HUMAN RESOURCES*

In terms of **human resources** the grant programme enabled services to increase human resources devoted to service provision. At many sites the grants enabled them to better engage IDUs in the delivering of services, though this involvement is usually limited to former IDUs. There are concerns in some programmes regarding the engaging of current IDUs as staff members and peer educators. In some programs concerns were expressed that this may lead to high turnover of outreach workers. So far, only one program changed their outreach worker during the grant implementation and the new outreach worker was taken from peer educators. In Riga and Jurmala where active IDU were recruited as outreach workers and volunteers it was noted that they were well able to reach out to new groups of clients.

The adequacy of **payment and social packages** and safety provision for program staff varied. In many programs the pay of outreach workers was quite low. In Jekabpils for example the salary for the outreach worker was quite low

(less than 50% of the rate of other staff) and no social benefits and medical insurance were made available to them. This was not the case in all programmes though. In Dia+logs in Riga for example, though salaries were still relatively low and based on self-employment contracts, health insurance was made available for employees and very low levels of staff rotation was seen. In the program based in the TB clinic in Riga staff was well paid and professionalism and friendliness of staff was apparent. In Jurmala pay of outreach workers is linked to achievement of certain key indicators. The representative of the Riga municipality informed about challenges to increase payment for their supported Dia+logs staff due to established salary grading based on graduated education (and most ex-users do not necessarily have university or college degree and therefore their salaries are lower than those of social workers with college or university degree). In the TB clinic, the salary rates are higher than in average healthcare facilities, as all staff gets benefits for work under 'difficult conditions.' Some programmes struggle with finding good outreach workers and in the future will further experience challenges (e.g. in two sites the only or major outreach workers were looking for opportunities to study and probably not in the same town).

In terms of employee safety some serious problems were noted in the programs. Some problems were noted with **workplace safety** standards. Hepatitis B vaccination was not available to outreach workers in the programs though recommended by international protocols for such employees. In the Program in Talsi syringes are collected in plastic bags which is more dangerous than using bottles or other disposal containers. One outreach worker experienced a needle prick and post exposure prophylaxis was not provided. The program in Talsi did not give its outreach worker any kind of identification card (employees ID) to protect him from being arrested for carrying used syringes and was not trained to inform police that he was working for the municipality. Psychological "supervision" for outreach workers and counsellors was relatively underdeveloped. Though managers had been attended a seminar on the subject, they rarely had the skills to systematically provide support. The programs and Public Health Agency indicated to be developing supervision and support for low-threshold programs. It seemed that most of the programs have not yet developed appropriate safety policies and procedures.

#### *PARTNERSHIPS*

Most projects reported cooperation with the **Public Health Agency's Latvian AIDS Prevention Centre** (PHA's AIDS Centre). All low-threshold programs, with exception of Kekava one, had agreements with LAC regarding collaboration in M&E and supply with syringes, HIV tests where needed, condoms and information materials. Such contract was signed also by the TB clinic, which will enable them to continue the project without additional costs. Dia+logs in Riga mentioned satisfaction in collaboration with PHA's AIDS Centre but that reported about supply interruptions and challenges in issuing the contract (as mentioned above). The project in Kekava is purchasing supplies from their grant. All low-threshold programs reported having participated in seminars organized by PHA.

Most programs had supportive relations with their local **municipalities**. In most cases, municipality agencies or departments are running the services. In Kekava, the municipality's Care Centre is planning to provide the program with new premises and funding. In Jekabpils the municipality provides premises, a computer and funding for one staff member. They mentioned though that the resources provided were limited and that the administration of the municipality did not have a good understanding of the activities of the program. In Riga the municipal health department is providing financial support to Dia+logs but is currently reconsidering this due challenges related to drug legislation in particular the fact that possession of used syringes containing trace amounts of drugs in large enough quantities could be prosecuted as drug possession. The Centre in Kuldiga was sent clients by **probation, the children's rights institution, the Social Department** and by other **NGOs** and partners with the local **rehabilitation centre**, the municipality and representatives of the **media**. The TB clinic expressed interest in closer cooperation with **narcologists** but is not sure how to approach the issue. They would like to offer methadone to their clients but have not been able to due to complicated regulations. Most projects had not developed relationships with **pharmacies** though there is a pharmacy in Kuldiga that refers IDU to the harm reduction project.

Cooperation and interaction with **police** was a challenge for most projects and inhibits the effectiveness of their outreach efforts. It seemed to be the most problematic in Riga where police were particularly strict with drug users. Sometimes officers were positioned where the mobile unit of Dia+logs was to be located causing clients to avoid the service for fear of arrest. As mentioned above the municipality which supports harm reduction activities also feels challenged by the policing. There is even a law on the books that prohibits possession of large quantities of syringes. Project in Talsi also reported that people were afraid of carrying used syringes but outreach worker did not know about concrete recent cases that someone would be arrested due to possession of syringe with traces of narcotics. In Jelgava and Kuldiga the services reported that their coverage of clients has been affected by policing, when their best 'volunteers' that helped to contact drug using communities was incarcerated. In Kuldiga, a service indicated that the policing of drug related crimes was rather selective and targeting injectors of hanka (home-based opiates produced from poppies) while ATS were more frequently used in Kuldiga. In Jurmala, on the contrary no problems with the police are observed by the service.

#### *MONITORING AND EVALUATION*

Most programs did not conduct a thorough needs assessment such as the Rapid Assessments recommended by WHO prior to designing services. Also, estimates of the number of IDU in each of the cities have not been made making evaluation of coverage challenging.

The projects though are gathering data on clients served and services provided. All the programs except the one in Kekava are tracking their progress using

monitoring and evaluation system introduced by the PHA's AIDS Centre. The Public Health Agency, which provides methodological support and collects data on monthly basis and summarizes nationally. Information is gathered on key indicators including new clients and their profile: age, nationality, sex. Dia+logs collects additional information on marital/family status, children and sex work; the Public Health Agency made relevant changes in the form of the database used by Dia+logs to reflect those changes. The monitoring system does not track data on overdose and behavioural indicators. It has a very detailed classification of consultations provided. The services themselves use indicators about their work in relatively limited basis, while a good example is Jurmala, where outputs of outreach work are connected with indicators but also Jurmala asked for advice how to demonstrate effectiveness of their work for policy makers and assess such indicators like number of IDUs in order to understand coverage. With the outreach and secondary exchange expanding at least some services feel challenges in reporting clients reached through outreach. At least two programmes do not track number of clients reached through outreach and only supplies distributed and consultations provided and outreach worker is reported as a client using all these supplies.

The monitoring system records data by client codes to protect confidentiality. Some clients fear that the system of client codes is not confidential enough, especially in small towns though it is important to note no cases of confidentiality being breached or of data being sought by or given to police have been reported. The program in Kuldīga reported that its Roma clients had a tendency to report different names each time they visit the service and thus introducing error M&E system. The service in Talsi also mentioned that its clients would report various names and also that minors tended to lie about their age. Some programmes issue client cards with the code. Kekava does not use client coding.

Monitoring of service quality and client satisfaction is not conducted systematically so managers were not able to use such information to make adjustments to programs to improve quality.

### 4.3. Prison services

Two of the projects supported within the UNODC small grant program were programmes carried out by NGOs targeting prison populations, Biedriba Apvienība HIV.LV, and Atbalsta grupa inficētajiem ar HIV un AIDS slimniekiem (AGIHAS). The services provided by both projects focus on providing information through lectures and seminars and distribution of information materials. Neither project distributes syringes or condoms. The HIV.LV program additionally engages in advocacy work and plans to incorporate more counselling into the program. Both projects are run by organisations of people living with HIV (PLHIV).

#### 4.3.1. BIEDRIBA APVIENĪVA HIV.LV

Biedriba Apvienība HIV.LV is a young organisation and received small grant of 4968 Lats (10,000 USD). Since they were such a young organisation they were not qualified to apply for larger amounts from UNODC as they lack a track record of handling larger amounts. They conduct informational work within prisons as well as advocacy activities though the latter are not funded by the grant and are conducted by volunteers.

A needs assessment was carried out prior to the start of informational work. Trainings are conducted in prisons and information materials are distributed. They had intended to train 20 "multipliers," prisoners who would further provide counselling and training to other prisoners but changed their plans as high prisoner turnover limited the effectiveness of this approach. Delays in receipt of permission for peer counsellors from outside of prison to enter the prisons to conduct trainings also impacted the project. In one prison of individual cell system there is no direct contact with prisoners but instead lectures are broadcast through the prison TV system. Through the project it is anticipated that at least 600 prisoners will be exposed to trainings.

The topics covered in the project include general information about HIV transmission, progression and treatment. Presentations on this topic provide scientific information in 'friendly' language. Information on HBV, HCV and HIV related illnesses is also provided. Information on drug use, and safer injection and safer sex is not included. One seminar covered some issues related to drug overdose. The program does not distribute syringes, bleach or condoms nor does it provide opioid substitution therapy (OST). The organization engages in advocacy activities related to countering rights violations of prisoners. The advocacy activities are carried out by volunteers. They were not able to include advocacy activities in the UNODC budget which creates a challenge as considerable advocacy is needed in order to have permission to provide more comprehensive services and engage prison administration in dialogue regarding starting the prison based harm reduction services.

The program is eager to learn more about the objectives of UNODC related to prisons in Latvia. It has benefited from the capacity building provided so far and was particularly appreciative of the work of Heino Stover though it mentioned that visits to prisons abroad and many visits from foreign specialists were of limited value as the situation in Latvia is so different. Advocacy and website development included as co-funding (advocacy is done on volunteer basis and funding for the website is being received from other sources). The organization is interested in expanding the scope of its work and would like to learn more about OST, needle exchange, the role of NGOs and approaches to advocacy. The organization hopes to get small financial support from some municipalities to conduct work outside prisons and has begun an approach through which conducts seminars for fees though so far this has brought in only small amounts of money. They do not have access to the EU "integration fund" due to stipulation that they must have a 5 year contract for their office rent. The program is almost entirely reliant on UNODC money for continuation.

#### 4.3.2. ATBALSTA GRUPA INFCETAJIEM AR HIV UN AIDS SLIMNIEKIEM (AGIHAS)

The NGO, Atbalsta grupa inficētajiem ar HIV un AIDS slimniekiem (AGIHAS), received a 7820 Lats grant for a 12 month period through which they plan to train 400 prisoners (up from only 100 trained prior to the grant). Similar to the HIV.LV program, it focuses on information distribution (seminars and information materials) on a limited range of subject matter mostly basic information about HIV and other infections, their progression and treatment. Here as in the other program the information and resources provided do not relate to safer injection or safer sex practices.

The project collaborates with prison department which has permitted the placing of posters in the prison but in general cooperation with the prison administration is challenging. There is no interaction with the probation system for after-release follow up. Attendees of seminars are selected by prison administration which limits the NGO's ability to strategically target certain prisoners. For monitoring and evaluation information is gathered on the number of people attending the seminars and writing letters. Care is taken to protect confidentiality. The data gathered though does not provide information on progress toward achievement of project objectives. The manager of the project did not have ideas on how the project could be improved.

It seems that this program is somewhat less efficient financially than the one implemented by HIV.LV as it dedicates much more funds to institutional support and does not incorporate the work of volunteers. The work of AGIHAS was also more limited in scope as no advocacy work was done. Also, unlike HIV.LV the AGIHAS project did less needs assessment and did less to tailor seminars to the expressed interests of prisoners. The AGIHAS project, like the HIV.LV project is almost entirely dependent on UNODC money for support.

#### 4.3.3. RESULTS OF PRISON PROJECTS

The results accomplished by the prison projects are not well targeting to the programme objectives. Though project indicators (which focus on number of people attending trainings and numbers of letters received) are largely met, impact on skills and behaviour is probably low. This is due to the content of the information delivered by the program. While information covers important but rather general aspects of HIV transmission, progression and treatment and similar information for other infections it neglects to build knowledge, skills and access to resources related to prevention of transmission such as safer injection and safer sex. On the other hand, the projects helped to gather information about accessibility of ART, HIV monitoring, hepatitis C treatment. Also according to the project implementation, basic information is in demand among prisoners and knowledge about HIV is low. The projects though have made some important steps in establishing relationships between NGOs and the prison authorities though considerable work to improve these relations is still necessary. Additionally, the support is important for building organizing of people living with HIV, which lacks funding from other sources.

## 5. CONCLUSIONS

### **5.1. Relevance - has UNODC assistance to service providers been relevant to the needs of the country?**

*ARE OBJECTIVES OF THE SUPPORTED PROJECTS IN LINE WITH THE POLICY PRIORITIES OF THE GOVERNMENT AND UNODC MANDATE?*

Given that Latvia's HIV epidemic is concentrated among IDUs and prisoners UNODC's support for harm reduction initiatives is very relevant. The aim of the small grants programme is to assist improving HIV prevention and care services for injecting drug users (IDUs) and prisoners, among whom the HIV epidemic in Latvia is concentrated. The five objectives of the grant programme are

- scale-up;
- availability, coverage and quality of comprehensive package interventions;
- outreach and peer education for reaching hidden groups;
- prevention in prison settings and among ex-prisoners;
- service cooperation (networking).

The UNODC grant programme's objectives are in line with the draft National HIV/AIDS Programme<sup>2</sup> which has similar objectives and goals and the HIV coordinating body was involved in planning the programme and selecting the grantees. The newly proposed national programme on HIV outlines a number of important areas of work based on a 2007 assessment of responses to HIV 2007 including the improvement of:

- low threshold services for IDUs (scale, introducing gender sensitive and youth-sensitive elements, good practices for amphetamine-type stimulant users, strengthening outreach work and peer approaches, and targeting needs of Russian speakers and the Roma community);
- prevention and management of overdose (also as part of post-prison-release work);
- work in prisons (improving HIV testing and counselling, treatment and care; improving HIV-related knowledge, competence and skills with training manual, support NGOs to work on care and support);
- HIV treatment and care and its integration with other services.

The Latvian state programme on drugs<sup>3</sup> does not mention HIV-related responses while, in country reports to the European Commission, drug-related harm reduction is identified as part of the national drug strategy. The aims of the grant programme are also linked European Union policies. The development drug related harm reduction services (to preventing HIV)) is also among the objectives agreed in the European Union's drugs strategy and action plan and

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<sup>2</sup> Draft National Programme for limiting spread of HIV and AIDS in Latvia 2008–2012. December 24, 2007. Prepared by Jean Paul Grund for UNODC and ASAP.

<sup>3</sup> Narkotisko un psihotropo vielu atkarības un izplatības ierobežošanas un kontroles valsts programma 2005. – 2008.gadam. adopted by Act No 559 of the Cabinet of Ministers on 17 August 2005. Retrieved from

[http://www.emcdda.europa.eu/attachements.cfm/att\\_35485\\_LV\\_Latvia%20Program](http://www.emcdda.europa.eu/attachements.cfm/att_35485_LV_Latvia%20Program)

as is recommended by the Council of the European Union. The UNODC mandate within the UNAIDS family is to take a lead in HIV/AIDS prevention and care among IDUs and in the prison settings and UNODC is the only remaining UN agency in Latvia which specifically works in the HIV field.

*ARE ACTIVITIES APPROPRIATE FOR MEETING THE STATED OBJECTIVES?*

### **Objective 1. scale-up:**

The provision of small grants to services throughout the country to entities expressing interest in providing low-threshold services is an appropriate activity to contribute to the scale up of such services. To promote further scale-up of access to services in Latvia, focused monitoring and evaluation of effectiveness of programs and linked advocacy of expansion and local and national funding for such programs is advisable.

Program activities did contribute to the scale up of access to harm reduction services in Latvia first and foremost by expanding access in 8 different municipalities. Most of the programs supported were in areas with relatively high rates of HIV such as Kuldiga, Riga and Jurmala though some high prevalence regions such as Ventspils were not covered by the program.

### **Objective 2. availability, coverage and quality of comprehensive package interventions:**

#### *Availability/coverage*

The expansion of reach into hidden communities through outreach is an appropriate activity for expanding the coverage of harm reduction services and nearly all of the programs engaged in some form of outreach. It should be noted though that the approaches to outreach were not those which enable maximum coverage per outreach worker such as peer driven initiatives. Therefore coverage, while increased through the projects is lower than it could be. Also evidence shows that enhanced cooperation with pharmacies can increase coverage and this approach was not used. Secondary exchange has also contributed to expanded coverage though it is not supported strategically in all of the programs.

#### *Quality*

Some activities aimed at the development of quality services have been provided but it seems that more technical assistance to support service management may be necessary. Managers may need more extensive mentoring to improve service quality. Also assistance to managers in implementing monitoring and evaluation activities which would provide them with information enabling them to assess service quality and to draw conclusions about what is necessary for improvement of service quality have not been done and this limits the managers' ability to improve quality. Enhanced monitoring and evaluation, which would include monitoring of such crucial impact indicators like behaviour changes on at least every second year and indicators linking new objectives identified in the new national AIDS programme, like on sex workers and overdose,

would enable planning of programming and technical assistance to support improved management and service quality.

### *Comprehensiveness*

Lack of needs assessment challenges the assessment of the comprehensiveness of services. It seems though that in many sites, comprehensiveness could be improved. While most sites offered improved access to sterile syringes, HIV related counselling, HIV and hepatitis testing, referral to drug dependency treatment and referral to primary care, other services which are often considered to be part of a comprehensive package of harm reduction services are not available. These include: access to safer injecting kits (which include, in addition to syringes and condoms, items such as sterile filters, cookers, alcohol swabs citric acid etc.) [NOTE: comprehensive safer injection kits were accessible through one of the sites]; drop-in centre facilities; safer injection sites; case management; Overdose prevention [given that OD is likely the primary cause of death among IDU and subsequently among PLHIV – this is a vital gap]; legal clinic; support in securing documents (ie passport etc.).

Though developing fully comprehensive services may be constrained by a variety of factors (national drug policy and public relations may challenge the initiation of safer injection rooms & operational costs of setting up case management services may inhibit their initiation – other activities such as incorporating overdose prevention messages and materials into services and providing materials and information related to hepatitis prevention and treatment literacy might be more feasible.

### **Objective 3. outreach and peer education for reaching hidden groups:**

Program activities were successful in promoting the successful application of outreach and peer education approaches to harm reduction in the various sites though in some sites this was more successful than in others. All projects with the exception of the one situated in the TB clinic, engaged some form of outreach. At most sites outreach workers were former UDUs and in exceptional cases current IDU were employed. The engagement of outreach workers was successful in enabling the programs to reach new clients. Secondary exchange has increased the involvement of peers as volunteers in some of the programs.

### **Objective 4. prevention in prison settings and among ex-prisoners:**

Activities carried out in prison settings were unlikely to have significant impact on the spread of HIV or hepatitis. This is first and foremost due to the fact that the materials needed to prevent transmission (condoms and sterile syringes) were not distributed. Information distribution and counselling, while maybe able to have impact on levels of knowledge were unlikely to impact behaviour. Impact on ex-prisoners seems challenged by a lack of cooperation with the institution responsible for probation.

### **Objective 5. service cooperation (networking):**

Activities were sufficient to promote networking between certain vital services such as the harm reduction services and PHA's AIDS Centre services and drug dependency treatment services at most sites. Cooperation with police in some

sites was inadequate and in some cases led to hindrance of attainment of project objectives. It seems that enhanced technical support to managers in developing a strategic approach to developing cooperation and networking at the local level could have positive impact. Projects rarely attempted to establish relationships with pharmacies. Also linking of some services with HIV and hepatitis medical providers to address treatment support is rather underdeveloped, which some good practice, for example, in Riga exists.

In prisons a certain degree of cooperation with prison authorities was achieved though limitations in this respect did pose challenges to the programs. The program HIV.LV through its advocacy efforts has been able to make progress in cooperating with prison officials while the AGIHAS program has made fewer advocacy efforts and subsequently has less cooperative relations with prison authorities.

#### *HOW WELL DO THEY REFLECT THE SPECIFIC PROBLEMS AND NEEDS OF IDUs AND PRISONERS?*

As a comprehensive needs assessment was not conducted therefore a thorough analysis of this issue is not possible. Clearly though the projects have been successful in reaching clients with sterile equipment, counselling, testing and other services through their low-threshold approaches including outreach. Uptake of these services, with some exceptions has been consistent which shows that the services provided are demanded by clients. Coverage of the programs as mentioned above is relatively limited so many IDU still do not have access to services. In some cases this is due to the fact that needs of specific sub-populations (such as women, stimulant users, Roma etc.) have not been adequately addressed. Language and addressing the needs of Russian speaking IDUs, which seem to make a large portion of IDUs, is addressed through available leaflets and many outreach workers and other staff are fluent in Russian. However, some smaller populations of Roma, which are often have difficulties with understanding and reading, need to be additionally addressed. The service providers could be provided with a sample check-list to assess the needs of their clients (including women, stimulant users, IDUs engaged in sex work, elder and younger IDUs, IDUs with co-morbidities like HIV, hepatitis and mental disorders) to assist further development of comprehensive services and identify the key gaps to be addressed on priority basis.

In prisons where transmission is a risk, materials necessary to prevent transmission (sterile syringes and condoms) were not provided and as such some key needs of prisoners are not addressed. Participation in informational and counselling sessions which indicates that some informational and psycho/social support needs have been addressed. In the prison where direct contact with prisoners was not allowed and material was transmitted through the internal television system, needs for social support were not addressed.

In the cases where participants in seminars were selected by prison authorities the ability of the program to select those most in need was hindered but this was not

the case in all prisons. In the program by HIV.LV a needs assessment was conducted and program content and language was revised based on the assessment. It is important to note that, while basic information about HIV and other infectious diseases was provided, information on safer sex and on safer injecting was not provided. Overdose education was not included in the curriculum and, given that high rates of overdose are noted among recently released prisoners, a key need is not being addressed.

## **5.2. Effectiveness - is the UNODC's approach and assistance effective?**

*TO WHAT EXTENT HAVE THE PROJECTS ACHIEVED THE STATED OBJECTIVES? WHAT ARE THE REASONS FOR ACHIEVEMENT AND NON-ACHIEVEMENT OF OBJECTIVES?*

### **Objective 1. scale-up:**

The small grants program directly contributed to the scale-up of harm reduction services in Latvia by expanding access in 8 different municipalities. Most of the programmes supported were in areas with relatively high rates of HIV such as Kuldīga, Rīga and Jūrmala though some high prevalence regions such as Ventspils were not covered by the program. Enhanced contribution of scale up could be achieved by strategic evaluation and advocacy on the local and national levels.

### **Objective 2. availability, coverage and quality of comprehensive package interventions:**

#### *Coverage*

While most sites have effectively reached into drug user communities, coverage overall seems relatively low. Prior to program implementation coverage was estimated to be only around 5%<sup>4</sup> of the IDU population (in 2007) while at the time of this evaluation coverage was estimated to be nearly 13%<sup>5</sup> according to the Latvian Public Health Agency so it seems that the program made a contribution to increasing coverage. Since comprehensive needs assessment studies have not been conducted (ie studies of the number of IDU and the needs of IDU) it remains difficult though to assess the true degree of coverage. Coverage recommended to slow HIV incidence rates is 60%. The methods of outreach used resulted in each outreach worker contacting regularly around 30-40 clients from their own social network, which helped to change largely the previously rather slow dynamics of enrolling new clients.

To expand coverage, other outreach methods such as (peer driven initiatives) should be considered. Also while in some of the programs engaged outreach workers with varied backgrounds to reach varied communities (ie female to reach female clients; stimulant users to work with stimulant users etc.) other

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<sup>4</sup> Jean Paul Grund (2007) Focusing the Response: Strategies for Addressing the Twin Epidemics of Drug Injecting and HIV in Latvia. Situation analysis & Summary of proposed interventions. Annex to Latvia (final) draft Strategy HIV/AIDS Program, 2008–2012. Prepared for UNODC and ASAP

<sup>5</sup> Inga Upmace. HIV PROFILAKSES PROGRAMMAS DARBĪBAS RĀDĪTĀJI. Presentation on April 18, 2008.

programs did not seem to reach the varied and often separate communities of drug injectors in their municipalities, leaving these populations not covered by the services. Greater coverage could have also been achieved by incorporating closer cooperation with pharmacies. Secondary exchange contributed to increased coverage at some sites though the M&E systems were not designed to show the extent to which this occurred.

#### *Quality*

It is difficult to assess the quality of services without a considerably more in-depth research including service user surveys/focus groups etc. Some weaknesses were noted in service management which are likely to lead to problems in the quality of services. Though the program contributed to the creation of a firm foundation on which improved quality can be built, additional technical assistance to promote improvement in project/service management is necessary. Enhanced monitoring and evaluation would enable planning of programming and technical assistance to support improved management and service quality. Managers need support to learn how to use monitoring and evaluation internally for quality improvement.

#### *Comprehensiveness*

Since an in-depth needs assessment and a quality assessment has not been conducted it is difficult to comment in depth about the effectiveness of the degree of comprehensiveness of the programs. The services though by providing sterile syringes, access to counselling, testing and referral have likely been effective in improving the health of their clients. As mentioned above though, more comprehensive services would likely do so more effectively.

#### **Objective 3. outreach and peer education for reaching hidden groups:**

As noted above, all of the community-based programmes (except the one based in the TB clinic) successfully applied some form of outreach and/or peer approaches which enabled them to reach new clients. As such the programs effectively used this means of reaching their populations. Outreach within the programs could be more effectively applied if it were managed as in "peer-driven initiatives" (which enable constant expansion of coverage beyond the immediate social network of the individual outreach workers), if outreach workers were recruited from broader ranges of sub-populations of IDU (ie women, stimulant users, varied age groups, varied ethnic groups). Also the working conditions for outreach workers (safety precautions and social benefits) were lower than desirable. Improvement here would also probably improve the effectiveness of outreach work.

#### **Objective 4. prevention in prison settings and among ex-prisoners:**

Some significant improvements are necessary to enhance the effectiveness of the prevention programmes in prisons. The current activities are unlikely to have impacted the transmission of HIV or hepatitis in prison settings due to the fact that the materials needed to prevent transmission (condoms and sterile syringes) were not distributed. Information distribution and counselling, while maybe able to have impact on levels of knowledge were unlikely to impact behaviour. Information provided though, while covering the HIV basics and knowledge

about disease progression did not contain information or skills building on safer sex or injecting. As such the programs were unlikely to have impacted behaviour.

**Objective 5. service cooperation (networking):**

As mentioned above, most of the low-threshold services effectively cooperated with AIDS Center services and drug dependency treatment services at most sites. Cooperation with police in some sites was inadequate and in some cases limited the effectiveness of the projects.

In prisons a certain degree of cooperation with prison authorities was achieved though limitations in this respect did pose challenges to the programs. The program HIVLA through its advocacy efforts has been able to make progress in cooperating with prison officials while the AGIHAS program has made fewer advocacy efforts and subsequently has less cooperative relations with prison authorities.

*HAVE UNODC ASSISTED SERVICES BEEN EFFECTIVE IN MEETING NEEDS OF THE TARGET POPULATION?*

(See section on meeting client needs p. 18 above)

*WHAT ARE THE POSITIVE AND NEGATIVE, INTENDED OR UNINTENDED, EFFECTS OF THE SMALL GRANTS PROGRAMME ON PEOPLE, INSTITUTIONS AND THE PHYSICAL ENVIRONMENT?*

<p><b>Intended/positive</b></p> <ul style="list-style-type: none"> <li>• Increased access to sterile equipment</li> <li>• Increased contact of IDU with health and social services and substantial increase of coverage of harm reduction services</li> <li>• Increased awareness of harm reduction approaches</li> <li>• Enhanced cooperation between civil society organizations and governmental institutions</li> <li>• Enhanced awareness at municipal and national level of the significance of low-threshold services</li> <li>• Increased satisfaction of managers with possibilities to expand accessibility and coverage of new clients</li> <li>• No reports about complains of neighbours were reported</li> <li>• Increased demand for drug treatment</li> </ul>	<p><b>Unintended/positive</b></p> <ul style="list-style-type: none"> <li>• Community empowerment as communities exposed to project become aware for the first time that someone is working to improve their well being</li> <li>• Rotation and future rotation of outreach workers and peer educators</li> <li>• Major first grant for the national PLHIV association, which build their organizational and exposed their advocacy capacities</li> <li>• One programme managers report improved English, project management skills</li> <li>• Collection of dirty syringes arises as a problem and a solution was found, however it needs further to be promoted</li> <li>• A growing understanding of a need for service providers, particularly NGOs, to network</li> </ul>
<p><b>Intended/negative</b></p>	<p><b>Unintended/negative</b></p> <ul style="list-style-type: none"> <li>• Salaries and benefits for outreach workers and volunteers are reported to be low, which affects negatively their satisfaction and motivation</li> </ul>

	<ul style="list-style-type: none"> <li>• Outreach workers not vaccinated for Hepatitis B may be at increased risk for infection through risky practices at work</li> <li>• Without adequate 'supervision' and psychological support some outreach workers may be at increased risk for relapse.</li> <li>• The conflict of HIV program and drug legislation got more focus and is not resolved.</li> <li>• Due to language requirements, one potentially new programme did not apply to UNODC and a number of managers experience problems with English-language documentation.</li> </ul>
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*HOW ARE EXTERNAL FACTORS (SUCH AS ACCESS TO SERVICE SITES, RESOURCE CONSTRAINTS ETC.) AFFECTING EFFECTIVENESS?*

In some cases external factors have negatively impacted program effectiveness. Of particular concern are certain policies and policing practices which have constrained program effectiveness. Policies which make possession of any amount of illicit drugs liable for criminal persecution inhibit needle exchange work as program clients and outreach workers are reluctant to transport used syringes as they contain trace amounts of illicit drugs and could lead to arrest.

Resource constraints of course impact the program. For increased coverage increased program staffing for service provision and advocacy work would be necessary.

### **5.3. Efficiency - how efficient has been the implementation of the small grants programme?**

*IS THERE EFFECTIVE COORDINATION BETWEEN UNODC AND OTHER IMPLEMENTING PARTNERS?*

While the grant programme has clearly been effective in establishing low-threshold services and it interacted with existing support for those services, particularly provided by the PHA's AIDS Centre, some improvements could be made in the efficiency of interaction between UNODC and the programmes. Since monitoring activities and indicators were not harmonized UNODC's ability to evaluate progress may be inhibited and thus decisions about needs for further technical assistance may be challenged. Overall, the collaboration with the partners led also to sometimes lower visibility of the UNODC support (e.g. many services saw the major UNODC training as part of the PHA's support and did not associate with UNODC), which should be taken in consideration in further UNODC work.

Additionally, the local municipalities and service providers (including managers) have some challenges in understanding English, the official grant programme language.

#### *HAS ADEQUATE SUPPORT AND BACKSTOPPING BEEN PROVIDED BY UNODC?*

Support has been adequate to establish the low threshold services and the trainings and support that was provided was greatly appreciated by the projects. Continued technical support focused on improvement of quality and coverage, as well as introducing tailored approaches to women, addressing overdose, linking services, as well as project management is necessary. Incorporating mentoring into the system of support for project managers would be helpful. In some cases projects have intention to expand services in very positive ways (such as the TB clinic wanting to provide opioid substitution therapy, or the low threshold service wanting to offer HIV and hepatitis testing directly) but have been unable to do so due to complicated regulations. UNODC consultants and advocacy assistance could help them overcome these limitations.

#### *WHAT ARE THE POTENTIAL CHALLENGES THAT MAY PREVENT PROJECTS FROM PRODUCING THE INTENDED RESULTS?*

There are several challenges faced by the programme that, while in most cases will not prevent them from producing intended results, may inhibit maximum achievement of these results.

1. The lack of a systematic and harmonized approach to monitoring and evaluation will inhibit national level and local level advocacy.
2. National policy and policing practices limit project effectiveness related to criminalization of possession of trace amounts of illicit substances.
3. In prisons, the lack of provision of materials and information to enable safer sexual and injection practices is likely to prevent projects from producing the intended results
4. The TB clinic has expressed interest in offering opiate substitution therapy directly (which is considered to be a good practice) but has been unable to do so due to complicated regulations.
5. Overall concentration of services for drug users in the capital city (including HIV, hepatitis care, opioid substitution therapy) is a challenge to link clients to other services.

#### **5.4. Sustainability - are UNODC supported interventions sustainable?**

#### *DO THE INTERVENTIONS HAVE A POTENTIAL FOR SCALING UP OR REPLICATION?*

The programs have great potential for scale up and replication but for this to become a reality, as mentioned above a carefully planned monitoring and

evaluation approach must be implemented which is capable of identifying good practices, providing information on effectiveness, impact, and cost-effectiveness of programs. The M&E system should be linked to advocacy activities including both national level and local level. Local implementers will need technical assistance for both M&E and for development and implementation of advocacy activities.

#### *HOW HAS UNODC ENSURED THAT BENEFITS FROM ITS ASSISTANCE CONTINUE AFTER UNODC ASSISTANCE STOPS?*

Most of the supported grantees are municipality agencies, which due to the provided support realized the value of involvement of outreach workers in improving services. In a number of cases, managers mentioned their plans or current work with municipality to ensure more staffing for their services. The assessment of how this is successful could be done in a longer term, probably at the beginning of 2009. In one case, the support is provided for developing a municipality strategy, which could be basis for long-term sustainable policy (and funding) for low threshold programmes.

Again improved M&E and advocacy would give added value to the grant programme by encouraging national investment in low-threshold services which will be vital to the programmes as UNODC support comes to an end. The skills that UNODC has given to the people involved in the programmes as well as the cooperation established between the low threshold services is likely to have long term existence outliving the UNODC assistance.

## **5.5. Lessons learnt and best practices**

#### *LESSONS LEARNED AND BEST PRACTICE – ARE THERE ANY LESSONS LEARNED FROM UNODC PROVIDED ASSISTANCE?*

- Identify key lessons that can provide a useful basis for strengthening UNODC support to Latvia and other Baltic States.
  - Highlight features to be considered as good practices at country or regional level for learning and replication.
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- Use of bicycle in Kekava and Jekabpils is an innovative and cost-effective approach to outreach worker mobility which is probably worth replicating in future programmes
  - Kuldīga pharmacy provides information about needle exchange. This should be studied further and highlighted so that more programs could undertake this type of interaction.
  - Services offered in the TB clinic were noted to be rather drug user friendly. Staff was well paid and professional. Posters in the clinic helped clients to feel welcome there. This innovative approach (including provision of sterile injecting equipment) at the TB clinic where clients come in for treatment should be well-documented and expansion of such an approach in other TB clinics in the country should be supported. While their coverage is limited but

including needle exchange will be cost effective in the future, as according to the clinic manager, no additional funding needed to do needle exchange they get them and condoms and publication from PHA.

- The low threshold sites in Kuldiga and at Dia+logs in Riga offered direct access to primary care including vein care. This good practice should also be documented and expansion should be encouraged.
- In Riga, Dia+logs has a good relationship with HIV care providers. In Kuldiga where many clients are living with HIV, there is a good link with a local self-support group for PLHIV. In both Dia+logs and the programme in Kuldiga support is more elaborate than in other sites and reflects elements of case management. Such approaches should be documented and promoted.
- In Jurmala, the outreach team has been relatively successful in reaching out to different IDU sub-populations through the diversity of the outreach team itself. This programme also is among the most comprehensive offering both mobile and stationary services as well as outreach. They have intentions to introduce substitution treatment. Their progress and intention to achieve continued improvement in comprehensiveness should be supported and others should be exposed to it as a mode. It is also an interesting example of a civil society group receiving support from rather small municipality. This is the kind of interaction with municipalities which will lead to sustainability in the long term.
- Secondary exchange has expanded coverage in some of the programmes and should be more strategically developed.

## **6. RECOMMENDATIONS**

### **6.1. Monitoring and evaluation**

- A harmonized set of indicators would be helpful to UNODC and project managers in assessing program impact including behavioural indicators.
- Information on behavioural indicators should gathered on a regular basis in the country and should be used to evaluate impact and also to design programmes that specifically target relevant changes
- Systematic monitoring and documentation of good practices will contribute to advocacy efforts to further scale up low threshold programming. This is especially important as the use of outreach and peer education approaches are relatively new in the country.
- Systematic monitoring and documentation of good practices will also contribute to exposing programmes to ways to improve their own services.
- Provision of information on cost-effectiveness and public health impact of programs will be helpful for local and national level advocacy, particularly in the light of economic crisis and limited budgets in municipalities.
- Managers should be given additional support to gather information useful for the improvement of the quality and coverage of services and use/interpret the information that is already being collected.
- Monitoring practices should be adjusted to capture information about secondary exchange which has played an important role in increasing coverage, and to balance the needs for monitoring and making it not too heavy for small service providers (for example, reducing number of

monitored counselling, reviewing also other indicators collected and frequency of their collection).

## **6.2. Services**

- Further development and expansion of outreach work and peer education maybe including use of peer driven interventions (through which extended social networks are engaged in behavioural change work) rather than relying on reaching the immediate social contacts of particular outreach workers.
- Secondary exchange which is practiced in some sites should be monitored (in the way that would be agreed with PHA and service providers) and expanded
- Strategic work with pharmacies would likely result in expanded coverage
- Expansion to new cities and new sites (the latter in case of the Riga city) would further contribute to scale-up
- The spectrum of services provided should be expanded to include additional services based on needs assessment such as overdose prevention, adherence support, case management, integration of services;
- Projects should be encouraged and given technical and financial support to expand the sub-groups that they are able to target for greater reach in sex-worker communities and other IDU sub-populations in need.
- The quality and range of subjects covered in information materials should be improved. A strategic approach basing subjects covered on needs assessment should be taken. Materials should be designed to meet needs of Latvian clients, using appropriate language etc. Some good materials already exist in the country and some samples of other possible versions of brochures for clients could be brought from other (Russian-speaking) countries.
- Managers should be given support to learn how to better involve drug users in the planning, implementation and monitoring and evaluation of programs. It includes but is not limited to ensuring adequate payment and health/social benefits for staff from drug using community. This will lead to improved programme quality and impact.

## **6.3. Advocacy**

- Programs should be given support to engage in local advocacy among municipal authorities (for financial and other support), with local police (to ensure safety of programmes) and with pharmacies (to increase drug users access to syringes, particularly in 24/7 pharmacies).
- In prisons, enhanced advocacy work involving key stakeholders with active participation of UNODC staff is necessary for increased access to prisoners and for expanded range of services provided
- Support national networking, which can have a sustainable impact on the formation of a mechanism for indigenous advocacy efforts.
- Assist with strategic promotion of harm reduction aiming to ensure sustainability by showing the impact of programmes and advocating for national investment in sustainable scale up of such low-threshold services.

- National level advocacy should focus on the development of a supportive policy environment for harm reduction services (drug policy, also addressing regulations for salaries).
- Particular attention should be given in raising awareness of national and local stakeholders about the need to focus drug demand reduction on the needs of problem drug users (also addressing occasional and experimenting ones) and not to focus on primary prevention in the context of HIV and overall drug strategy. Lessons from the EU on that could be used. This is essential, as a number of harm reduction programmes are run by municipality addiction centres which tend to implement primary prevention activities and have some levels of frustration regarding unavailable funding.

#### **6.4. Technical assistance**

- Programmes should take advantage of an EU project which will include opportunities for experience exchange, including possibly internships and site visits. UNODC should encourage programs to take advantage of these opportunities and plan its technical assistance programming not to overlap this programme.
- UNODC should support project managers to improve management skills and provide more mentoring services rather than only isolated trainings
- Technical assistance should be focused on giving programs the ability to address the monitoring and evaluation, advocacy and service provision improvements recommended above.
- Opportunities should be provided for outreach teams from various locations in the country to meet and exchange experience. Capacity building exercises for them should be interactive and focused on skills-building. For outreach workers who are active drug users and less able to travel to training activities innovative approaches such as on-site work with them should be considered.
- There is growing expertise in the country. Therefore there is a growing need for mapping of local expertise and putting this into a network of potential counsellors and trainers (with additional assistance in building training skills).
- Better promotion of available UNODC support, particularly as there is a new country-based UNODC staff, will allow to provide support for project management, communication about ongoing and longer-term technical assistance needs and feedback.

# **APPENDIX 1. TERMS OF REFERENCE: EVALUATION OF UNODC SMALL GRANTS PROGRAMME IN LATVIA**

## **Background**

The assignment will be performed within the framework of the United Nations Office on Drugs and Crime (UNODC) project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Lithuania, Latvia and Estonia" (XEE/J20). The main objective of the project is to establish a favourable environment in all project countries to better implement HIV/AIDS prevention and care activities among injecting drug users (IDUs) and in prison settings. Currently, the coverage rates of harm reduction services are very low: it is estimated that only 5% of IDUs are reached with needle and syringe programmes, and only 1% with opioid substitution therapy. In 2007, UNODC provided financial support through small grants for 10 governmental and non-governmental organizations with the aim to scale-up and improve HIV prevention and care services for IDUs and prisoners.

## **Purpose of consultancy**

The purpose of the consultancy is to evaluate UNODC grants programme in Latvia and to advise UNODC on improvement of the grants programme for 2008. The overall purpose is to determine whether the planned objectives have been attained and to assess extent to which the needs of the beneficiaries are being met. The evaluation will seek to draw lessons and good practices which will be used to improve project management. The evaluation report will serve as a basis for planning of further UNODC financial and technical assistance for service providers in Latvia.

## **Evaluation scope**

Evaluation shall mainly focus on the concept, design, implementation and results of the UNODC small grants scheme. Evaluation should answer the following key questions:

- Relevance – has UNODC assistance to service providers been relevant to the needs of the country?
  - Are objectives of the supported projects in line with the policy priorities of the Government and UNODC mandate?
  - Are activities appropriate for meeting the stated objectives?
  - How well do they reflect the specific problems and needs of IDUs and prisoners?
- Effectiveness – is the UNODC's approach and assistance effective?
  - To what extent have the projects achieved the stated objectives? What are the reasons for achievement and non-achievement of objectives?
  - Have UNODC assisted services been effective in meeting needs of the target population?
  - What are the positive and negative, intended or unintended, effects of the small grants programme on people, institutions and the physical environment?

- How are external factors (such as access to service sites, resource constraints etc.) affecting effectiveness?
- Efficiency – how efficient has been the implementation of the small grants programme?
  - Is there effective coordination between UNODC and other implementing partners?
  - Has adequate support and backstopping been provided by UNODC?
  - What are the potential challenges that may prevent projects from producing the intended results?
- Sustainability – are UNODC supported interventions sustainable?
  - Do the interventions have a potential for scaling up or replication?
  - How has UNODC ensured that benefits from its assistance continue after UNODC assistance stops?
- Lessons learned and best practice – are there any lessons learned from UNODC provided assistance?
  - Identify key lessons that can provide a useful basis for strengthening UNODC support to Latvia and other Baltic States.
  - Highlight features to be considered as good practices at country or regional level for learning and replication.

### **Methodology**

- Initial briefing by UNODC Regional Project Coordinator.
- Desk review of grant guidelines, project proposals, mid-term reports and other background documents (2 w/days).
- Mission to Latvia (5 w-days) to:
  - Conduct interviews with grant recipients;
  - Conduct interviews with clients of selected services;
  - Present initial findings and recommendations in a round table discussion with service providers and programme managers.
- Prepare evaluation report according to the following outline:
  - Summary
  - Introduction
  - Evaluation purpose
  - Evaluation methodology
  - Major findings
  - Conclusions and recommendations

### **Timeframe and expected outputs**

By 10 April 2008: desk review of background documents, 2 w/days;

14 – 18 April 2008: mission to Latvia, 5 w/days;

By 25 April 2008: preparation and submission of draft report to UNODC, 2 w/days.

By 1 May 2008: incorporating UNODC comments and preparing the final report, 1 w/day.

### **Implementation arrangements**

UNODC National Project Officer in Latvia will accompany Consultant to all meetings and provide interpretation, if needed; book the hotel and make all travel arrangements in Latvia.

**Competencies and skills**

- Advanced university degree or equivalent in public health, social work or related area.
- Competence and at least five years of practical experience with planning and evaluation of HIV prevention among IDUs.
- Familiarity with UNAIDS, UNODC and WHO policy documents on HIV prevention and care in prisons.
- Working experience in East European region.
- Excellent analytical and communication skills.
- Excellent command of English with proven drafting skills.

## **APPENDIX 2. STAKEHOLDERS INTERVIEWED**

Kuldīga City Social Office's Addiction Counseling Site  
Manager, outreach worker and decision maker from municipality

Talsi City Council's Addiction Counseling Site  
Manager and two outreach workers including one ex-user (and ex-client)

NGO Parents for Jūrmala  
Manager (he is also outreach worker)

Kekava Social Protection Centre's HIV Prophylaxis Programme (HPP)  
Service manager (also outreach worker in Dia+logs)

Jelgava City's Social Affairs Authority  
Service manager and social worker, as well as representative of municipality

AGIHAS  
Manager, as well as ex-client

HIV.LV  
Manager

Dia+logs  
Service manager, social worker, needle exchanger, psychologist and mobile unit team (social worker and nurse), as well as current client (secondary exchanger)

TB clinic  
Service manager

Jekabpils  
Service manager and outreach worker

Rīga Municipality  
3 representatives (decision-makers)