Independent project cluster evaluation of the

**Drug Demand Reduction Projects in Afghanistan**

AFG/H09
Capacity Building for Drug Demand Reduction in Afghanistan

AFG/G68
Capacity Building for Drug Demand Reduction in Afghanistan

AFG/H87
Drug Demand Reduction Information, Advice and Training
communities living in Refugee Camps in Baluchistan. Service for
Afghan and North West Frontier Province Pakistan

July 2013
This evaluation report was prepared by Susan Wighton in cooperation with the Independent Evaluation Unit (IEU) of the United Nations Office on Drugs and Crime (UNODC).

The Independent Evaluation Unit (IEU) of the United Nations Office on Drugs and Crime (UNODC) provides normative tools, guidelines and templates to be used in the evaluation process of projects. Please find the respective tools on the IEU web site: http://www.unodc.org/unodc/en/evaluation/evaluation.html

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This publication has not been formally edited.
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ABBREVIATIONS AND ACRONYMS

BEST: Best Education and Employable Skill Training, an NGO partner implementing components of UNODC Drug Demand Reduction projects

BPHS: Basic Package of Health Services for Afghanistan, mandated by the Ministry of Public Health

CAR: Commissionerate for Afghan Refugees

CHW: Community Health Worker

Colombo Plan: The Colombo Plan for Cooperative Economic and Social Development in Asia and the Pacific

CND: Counter Narcotic Directorate

DDR: Drug Demand Reduction

DOST: DOST Welfare Foundation, NGO partner implementing components of UNODC Drug Demand Reduction projects

DRAT: Drug Reduction Action Team

DRD: Drug Related Death

HCW’s: Health Care Workers

HR: Harm Reduction

IDU: Injecting Drug User

IEU: Independent Evaluation Unit

MdM: Medecins Du Monde, NGO partner implementing components of UNODC, Drug Demand Reduction and HIV/AIDS projects

MMT: Methadone Maintenance Treatment

MCN: Ministry of Counter Narcotics, Government of I.R. Afghanistan


MoWA: Ministry of Women's Affairs, Government of I.R. Afghanistan


NEJAT: NGO partner implementing components of UNODC/DDR projects

NSP: Needle and syringe exchange programme, component of WHO best practice
OST: Opioid Substitution Therapy
PDU: Poly Drug User
PHC: Primary Health Care
UNAMA: United Nations Assistance Mission in Afghanistan
UNDP: United Nations Development Programme
UNHCR: United Nations High Commission for Refugees
UNDG-ECHA: United Nations Development Group executive Committee on Humanitarian Assistance
UNHAS: United Nations Humanitarian Assistance Service
UNOCHA: United Nations Office for the Coordination of Humanitarian Affairs
VSA: Volatile Substance Abuse/Solvent Abuse
WADAN: Welfare Association for the Development of Afghanistan, NGO partner implementing components of UNODC DDR projects
WHO: World Health Organisation
WFP: World Food Programme
## PROJECTS OVERVIEW

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<tr>
<th><strong>Project Title:</strong></th>
<th>Capacity building for Drug Demand Reduction in Afghanistan Kabul, Balkh, Herat</th>
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<tr>
<td><strong>Project Number:</strong></td>
<td>AFG/HO9</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>October 2003- June 2008, duration 4 years and 8 months.</td>
</tr>
<tr>
<td><strong>Executing Agency:</strong></td>
<td>UNODC</td>
</tr>
<tr>
<td><strong>Government Focal Implementation Agencies:</strong></td>
<td>Counter Narcotics Directorate of the National Security Council of the Government of Afghanistan Ministry of Public Health</td>
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<tr>
<td><strong>Total Approved Budget:</strong></td>
<td>USD $2,925,700</td>
</tr>
<tr>
<td><strong>Donors:</strong></td>
<td>UN Trust Fund for Human Security</td>
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<td>3. Prevention, treatment and integration and alternative development.</td>
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<td></td>
<td>3.1. Community-centered prevention</td>
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<td></td>
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<tr>
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<td>Capacity building for Drug Demand Reduction, Badakshan, Nangarahr and Kandahar Provinces.</td>
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<tr>
<td>Project Number:</td>
<td>AFG/G68:</td>
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<tr>
<td>Duration:</td>
<td>January 2005, duration 3 years and 9 months.</td>
</tr>
<tr>
<td>Executing Agency:</td>
<td>UNODC</td>
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<tr>
<td>Total Approved Budget:</td>
<td>In kind contribution MoPH 3 office spaces $ 8,500. Final revised Budget USD $1,002,977.</td>
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<td>Donors:</td>
<td>UN Trust Fund for Human Security</td>
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<td>3.1.4. Enhancing national capacity to prevent drug abuse</td>
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<tr>
<td>Project Title:</td>
<td>Drug Demand Reduction Information, advice and training service for Afghan communities in refugee camps in Baluchistan and North West Frontier Province.</td>
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<tr>
<td>Project Number:</td>
<td>AFG/H87:</td>
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<tr>
<td>Duration:</td>
<td>Commenced 28th September 2004, duration 6 years and 6 months.</td>
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<tr>
<td>Executing Agency:</td>
<td>UNODC</td>
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<tr>
<td>Government Focal Implementation Agencies:</td>
<td>Commissionerate for Afghan refugees [CAR], UNHCR</td>
</tr>
<tr>
<td>Total Approved Budget:</td>
<td>USD $ 898,272</td>
</tr>
<tr>
<td>Donors:</td>
<td>Italy, Japan, Norway, Switzerland.</td>
</tr>
<tr>
<td>Thematic area</td>
<td>3. Prevention, treatment and integration and alternative development.</td>
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<td></td>
<td>3.1. Community-centered prevention</td>
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EXECUTIVE SUMMARY

Summary Project Description

The evaluation considered the combined impacts of three projects: AFG/H09 and AFG/G68 Capacity Building for Drug Demand Reduction [DDR] in Afghanistan, and AFG/H87 Drug Demand Reduction Information, Advice and Training Service for Afghan Communities Living in Refugee Camps in Baluchistan and North West Frontier Province Pakistan [Khyber Pakhtunkhwa].

The current UNODC DDR programme in Afghanistan developed to address the emergent issue of rapidly increasing drug use within the Afghan population consists of eight pillars of which the three projects were component parts. The aim of the projects was to enhance national and local capacity for DDR activities in Afghanistan. All projects were formulated within the UNODC Strategic Framework [SPF] for Afghanistan [2006] to provide technical assistance in support for the identified objectives of the government of Afghanistan, and were completed in 2010. Review of key UNODC literature and the project documents prior to arrival in Afghanistan was undertaken with the evaluation questions derived from the following key UNODC publications: Afghanistan Strategic Programme Framework 2006-2010 (UNODC, 2006), Drug Use in Afghanistan surveys [UNODC 2005, 2009], Programme in Afghanistan (UNODC, 2010), Preventing and Treating Opiate Addiction and HIV/AIDS Epidemics in Afghanistan and Neighbouring Countries (UNODC, 2008) and the Thematic Evaluation of the Technical Assistance Provided to Afghanistan by the UNODC [Volume 5, Drug Demand Reduction Programme] conducted by the Independent Evaluation Unit (UNODC IEU, 2008).

Projects AFG/G68 & AFG/H09 were designed to contribute to capacity building for DDR in Afghanistan and to contribute to The UNODC thematic area of Prevention, Treatment and Rehabilitation. Project AFG/H87, Drug Demand Reduction education information, advice and training services for Afghan communities living in refugee camps in NWFP Pakistan was implemented to contribute to the UNODC’s thematic area of Prevention, Treatment, Rehabilitation and Reintegration. The overall objective was to reduce and prevent the abuse and misuse of drugs among Afghan refugees in selected camps in NWFP and Baluchistan provinces in Pakistan. The immediate objective was to improve the capacity of health professionals, social workers, teachers, community workers and community groups working with refugees in targeted refugee camps to address the abuse of drugs, and healthcare issues related to drug abuse and misuse. The project worked in close collaboration with UNHCR and the Commissionerate of Afghan Refugees [CAR] in Peshawar and Baluchistan.

The midterm evaluation report by UNODC Independent Evaluation Unit in 20082 indicated some internal and structural issues requiring resolution. This was used to identify key thematic questions for the evaluation interviews [Annex III] and included tensions between responsible ministries within the Government of Afghanistan; uncertainty over approval for continuation of the opioid substitution therapy [OST] pilot project; a reported level of organisational ambivalence within UNODC towards Drug Demand Reduction at that time, although this was stated not to be apparent at Country Office level. By the time of the terminal evaluation these issues had in the main been addressed, with comprehensive system-wide support given by UNODC, and key operational baseline surveillance information available; establishment and support for clinical laboratory facilities and the commencement of the national opioid substitution pilot in Kabul.

Given the synergistic relationship of the projects and their often interlinked outcomes as relating to individuals, communities and governmental departments, UNODC IEU determined that a cluster evaluation was appropriate methodologically utilising both qualitative and quantitative methods to explore the key issues outlined within the Terms of Reference [Annex I] for the evaluation.

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2 IEU (2008 ) Thematic evaluation of the technical assistance provided to Afghanistan by the UNODC, Volume 5, Vienna: UNODC
Summary Major Findings

All projects evaluated were well designed, with clear and achievable objectives, delivered in a timely fashion, and should have been sustainable beyond their lifecycle after initial establishment. This is evidenced in the documentation outlined in Annex IV. The projects exceeded original objectives set for implementation and delivery of capacity building activities, training, workshop delivery and community acceptance, involvement and use of services. That the projects performed exceptionally well was due to commitment and energy given to them by UNODC and partner agencies, in engagement with Afghan organisations and communities. Project services and staff were well regarded locally and nationally as evidenced in interviews, extensive waiting lists to access these services, and reported demand at village and outreach level. They collectively contributed to, and were initially integrated into national capacity, evidenced by collaborative meetings and cross cutting projects within local and national partnerships. Combined project delivery exceeded originally intended capacity in achieving initial training and replication targets, with advocacy and establishment of suitable delivery frameworks as foundation for a national drug treatment and rehabilitation service.

Without exception respondents interviewed for this evaluation requested extension and continuation of funding for these services, as had been the case historically, and is noted in the annual UNODC project revision and funding documentation submitted for the evaluation review (Annex IV). These requests were identified in interview from across the range of implementing ministries and recipient communities. The three key implementing ministries, local community representatives, local authorities, and it is understood Parliamentarians, have requested service extension. However, at the end of initial extended funding periods, all the projects at point of evaluation were stated to be unable to obtain further funding from either UNODC or the Government of IR Afghanistan at ministerial levels. It is unclear why this is the case, given the excellent performance records that are demonstrated through the evaluation audit of project documentation (Annex IV).

The expectation of satisfactory project continuation, through handover by UNODC to the Colombo Plan and Ministry of Public Health as outlined in the original proposal documents, has not been met. Significant progress in institutional governmental level capacity building, whilst excellent in activity and achievement review, has also met with similar inexplicable difficulties in continuation. It might be suggested that despite the comprehensive effort of UNODC and implementing agencies to establish services, there are difficulties in ensuring momentum for fledgling services, and development of staff capacity are maintained. The key points of the evaluation are summarised below:

(a) The Drug Demand Reduction Teams [DRAT] were reported to be underfunded since project handover by UNODC. Operational costs were stated to be unavailable for the final evaluation, as the service had been replaced with a static provision. The dispersal of DRAT team members and discontinuation of the mobile team component in particular, was stated to be impacting on service reach and cost effectiveness. The result of this was undermining the overall national health services coverage and delivery planning.

(b) The receding visibility and exclusion of women from employment within and funding of gender specific projects was particularly worrying as health and social interventions in Afghan culture require high levels of sensitivity to gender issues. None of the female workers trained within the DRAT projects were found to be employed within either Ministry of Public Health [MPH] or Ministry of Counter Narcotic [MCN] roles.

(c) The continuing exclusion of drugs services from national World Health Organisation [WHO] assisted programmes of Basic Package of Health Services [BPHS] was identified by respondents as a missed opportunity for comprehensive service coverage. Continuing difficulties persist with overall service planning, and recognition that the levels seen of self medication with opiates and pharmaceuticals is a particularly specific and complex response to prolonged exposure to war, trauma, poverty, and associated and prolonged physical and psychological hardships. This is acknowledged in the Terms of Reference for the evaluation (Annex I) and was reported by all respondents.

\[x\]
(d) There was stated to be a lack of international and national recognition of poor mental health status within the general population of Afghanistan which is driving inappropriate substance use in many forms, although national capacity building and training programmes in Psychiatry are underway at the national facility in Kabul mediated through Harvard and Oxford universities.

(e) The current financial and technical capacity within governmental administrative systems hinders effective progression of services in development of capacity. The evidence for this was triangulated in the project revision documentation and interviews outlining a general lack of funding or financial streams for key programme components in the future.

Summary Recommendations

Reinstatement of DRAT services to the previous level with extension requires commitment and prioritisation by all partner agencies. The dispersal of DRAT teams, and discontinuation of mobile teams in particular, is impacting cost effective service provision.

A comprehensive drugs services model should be adopted for Afghanistan, fully endorsed by all relevant Ministries with agreement for responsibility for provision.

Programmatic gender sensitivity should become a key condition of national reconstruction strategies. The use of ‘gender markers’ in scoping project proposals for UN pooled funds is recommended for tracking of gender-ranked allocations

There should be increased advocacy for linkage of DDR into mainstream health services, with eventual incorporation into BPHS and CHW training. Widespread societal drug use reflecting prolonged population exposure to conflict is evidenced by high national levels of drug dependence. Introduction of National Guidelines on dual diagnosis/co-morbidity should be considered in conjunction with this recommendation.

There should be continued enhancement of capacities of all responsible government agencies to facilitate them to address societal drug use and responses, building on the work of AFG/ H09 and AFG/G68.

Lengthier programme commitment by donors could substantially improve consistency and efficiency. Vertical programming does not meet best-practice models of development. Whilst appreciating that the UNODC is donor dependent with associated funding difficulties, it may be useful to investigate creative solutions from outside the organisation. Membership or affiliation of UNODC to the Cluster working groups of UNOCHA or UNDG-ECHA may be beneficial, as the majority of UN organisations in Afghanistan are participants. Affiliation to OCHA, may also be useful, as again UNODC is noticeably absent from humanitarian fund-raising appeal cycles.

Health literacy should be inbuilt to all future programming so that community capacity building is increased in parallel with overall literacy. This would include BPHS health training and that delivered specifically to family target groups, as was the case in the Ministry of Public Health (MoPH) and Ministry of Woman Affairs (MoWA) projects. The resultant enhanced skills would increase community awareness, and ability to act on Drug Demand Reduction (DDR) and inappropriate drugs usage as a whole.

Afghanistan reconstruction agencies should consider the development of a medicinal pharmaceutical agency for the regulation of opium production. An example of a regional model for self reliance and production is Iran. Consideration of this could enable in the long term national self-reliance, for medicinal production of opiates, derivatives and export. It could also provide employment in a regulated agricultural /production industry and reduce future costs of opioid substitution therapy provision within the national drugs programme. An increased national pharmacopoeia with a range of prescribed substitution therapies should be considered, with domestic production of opium derivatives considered in long-term sustainable development planning.

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3 Drug Use in Afghanistan:2 009 Survey, UNODC, Vienna
Summary Conclusion

As mentioned in the midterm evaluation recommendations [UNODC 2008], UNODC might reconsider commissioning processes currently used. From a single evaluation mission, it is unclear what level of influence UNODC Country Office for Afghanistan has on financial donors, but a more prescriptive/directive position may be useful in future. This also applies to the governmental beneficiaries of the technical/advisory processes. It may be the case that from an organisational perspective, there has been a degree of powerlessness in project direction previously; however, due to the significant planning for transition in 2014; this may not be the case now. This appears not to be due to lack of expertise or awareness, but the recent history of necessity of action in crisis management; e.g. UNODC urgently assisting with the mass relocation of homeless drug users from the former Russian Cultural Centre; and urgent negotiation activity to secure provision in the recent Methadone shortage for the MdM pilot project; in addition to the reconstruction of national entities within Afghanistan civil society. A carefully negotiated and mutually agreed long-term view, which includes future projections and scenarios [e.g. UN/ OCHA humanitarian logical frameworks and scenario planning] on initial design and funding, may prove beneficial to UNODC and its partners.

UNODC Country Office Afghanistan has provided comprehensive support and foresight to the national government. This has generated both the foundations of national policy and inception of service provision, encompassing the many aspects of DDR including Harm Reduction and the related HIV/AIDS outbreak among the Afghan drug users and related populations. The key question arising from this evaluation is about political will and long-term ability of the national structure to absorb preparatory programmes such as those detailed above.
## SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

<table>
<thead>
<tr>
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<th>Evidence (sources that substantiate findings)</th>
<th>Recommendations6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insufficient funding of Drug Reduction Action Teams [DRAT] since project handover. Mobile team operational costs unavailable. Static service provision is only service model currently operational</td>
<td>The dispersal of DRAT teams and discontinuation of mobile teams in particular impacting both cost and effective service provision. This is undermining national Drug Demand Reduction coverage plans</td>
<td>Prioritise reinstatement of full DRAT operability and extend services provision across suitable areas in Afghanistan.</td>
</tr>
<tr>
<td>2. The receding visibility and exclusion of women from funding, projects and further employment is particularly worrying. Gender specific services health and social are currently required in Afghanistan.</td>
<td>None of the female workers trained within the DRATs are currently employed within MPH of MCN roles.</td>
<td>UNDP gender markers conditionality attached to all future project design and contractual arrangements in Afghanistan.</td>
</tr>
<tr>
<td>3. DDR and drugs services excluded from national health planning and WHO assisted programmes e.g. Basic Package of Health Services. Need for health services planning on complex mental health and addiction responses to political violence.</td>
<td>Acknowledged in TOR Universally reported by respondents. There is lack of international and national recognition of poor mental health status within the general population of Afghanistan which is driving inappropriate substance use in many forms.</td>
<td>Evaluation of national mental health status and levels of severity of associated post traumatic stress syndrome and self-medication for a range of depressive disorders. Development of national mental health indicators for service provision. Incorporation of drug programmes within umbrella services of psychiatry and general medical and Primary Health Care programmes.</td>
</tr>
<tr>
<td>4. Current financial and technical capacity within governmental administrative systems hindering effective progression of services</td>
<td>Triangulated in revision documentation and interviews outlining lack of funding for key programme components</td>
<td>Enhanced in-country training programmes to up-skill and support low cost drug programmatic activities.</td>
</tr>
<tr>
<td>5. Historic vertical programming inhibiting effective inter governmental/agency collaboration.</td>
<td>Evidenced in project revision documents and interviews on strategic collaboration e.g. National Aids Control Programme.</td>
<td>Adoption of 4 tier model of service delivery that is multi-faceted enabling appropriate services growth and funding.</td>
</tr>
<tr>
<td>6. Legacy of poor general</td>
<td>TOR referenced national</td>
<td>Build in health literacy</td>
</tr>
</tbody>
</table>

5 A finding uses evidence from data collection to allow for a factual statement.
6 Recommendations are proposals aimed at enhancing the effectiveness, quality, or efficiency of a project/programme; at redesigning the objectives; and/or at the reallocation of resources. For accuracy and credibility, recommendations should be the logical implications of the findings and conclusions.
| educational access | literacy rates. Need to increase literacy as subset of all programmes | component within all programming and supportive skill building. |
I. INTRODUCTION

Background and context

The Introduction to the Global Initiative on Primary Prevention of Substance Misuse states that the key approach to responding to substance use in individuals and communities is to prevent it in the first place. It also advocates helping to discourage substance use, and stop it in those who are experimenting or already using (UNODC WHO, 2005). Illicit drug consumption has a significant human dimension in the form of drug use and misuse and includes pharmaceutical preparations. The high number of drug users in Afghanistan has become a major health hazard and a serious social concern. The National Drug Use Surveys (2005, 2010) indicate that polydrug use continued to rise in Afghanistan, rather than plateau or decline. In Afghanistan, this is driven by several factors including climactic conditions of drought affecting the opium harvest of 2000-2003 and plant disease in 2010, increased availability [opium poppies replacing other crops], increased access to opium [as drug trafficking routes having increased across Afghanistan within the Golden Crescent nations, with larger population exposure en route], changes in drug use [preferences and patterns. UNHCR Afghanistan Country Operations profile 2013 states that 5.7 million refugees have returned from Iran and Pakistan in the past decade and a further 2.7 million remain in exile. The movement of internally displaced people [IDP] is also bringing drug use patterns to previously unexposed communities.

There are also linked factors behind the individual and intergenerational drug use seen in extended families and villages of Afghanistan drug debt; long standing traditional patterns of opium use for work related pain in female carpet weavers; the routine practice of pacifying of children with opium raisins or smoke; and treatment of many conditions by local traditional medical practitioners with opium owing to lack of access to basic health services.

The longstanding political violence and conflict within Afghanistan has impacted on all programme delivery to a greater or lesser extent. It has also increased the cost of all programming whilst the conflict continues. It is well recognised that emergence from any conflict with continuing instability means that programme progression is difficult. Structural elements such as capacity building are unable to progress as desired for long periods. Additionally there will be high rates of staff attrition as political and population dynamics shift.

As a result of over thirty years of conflict in Afghanistan, basic education has been disrupted leaving large sections of the population illiterate. On average, 40% of males are illiterate, however for women and girls’ illiteracy rates are 85%, as access to education was forbidden during the Taliban government. College and university education was also disrupted for long periods, meaning that there is a basic and specialist skills shortage within the country that will take time to re-emerge within reconstruction. Much of the country remains poorly covered by basic health services, and many of these are currently provided by agencies other than the government. This will continue to be the case until skills and institutional capacities are redeveloped and the political situation is stabilised. This has left an estimated 40% of Afghanistan without a functioning governmental health service provision. Alongside this, only a few NGOs are able to operate safely in areas where conflict persists.

Purpose and scope of the evaluation

The three projects - AFG/H09 and AFG/G68 Capacity Building for Drug Demand Reduction in Afghanistan; and AFG/H87 Drug demand Reduction Information Advice and Training communities living in Afghan Refugee Camps in Baluchistan and NWFP Pakistan - were developed by the UNODC over a period of time to address the emergent issue of rapidly increasing drug use within the Afghan population, both in-country and externally in refugee communities. Given the dates of the project commencement, these innovative projects developed at a time when the central tenets of harm reduction and DDR were not widely accepted. The projects were successors to AFG/F55 and developed on the basis of the drug abuse assessment, with prevention resource material, and treatment
interventions developed for Afghan communities, resulting from the implementation of the earlier project AFG/C29. These projects were formulated in line with the 2006 UNODC Strategic Framework [SPF] for Afghanistan to provide technical assistance in support for of the identified objectives of the Government of Afghanistan.

The Thematic evaluation of the Technical Assistance provided to Afghanistan was undertaken by the UNODC Independent Evaluation Unit in 2008. The evaluation report indicated some structural issues requiring resolution. These included tensions between responsible ministries with the Government of Afghanistan; uncertainty over approval of an opioid substitution therapy [OST] pilot and a reported level of organisational ambivalence within UNODC on Drug Demand Reduction [DDR] generally, although not apparent at country office level. The evaluation found these issues in the main had been addressed; with comprehensive system wide support provided by UNODC, the key operational objectives of establishment of baseline surveillance information systems, clinical laboratory development support, and the commencement of the national opioid substitution pilot in Kabul were met.

The evaluation covered the three projects’ life span from inception until termination within Afghanistan and Pakistan. It sought to identify that:

(a) Project objectives reflected the specific nature of the problem, were relevant, appropriately delivered, cost effective and sustainable.

(b) Objectives of the project aligned with the current policy priorities and action plans of Government of Afghanistan, the Afghanistan Compact, Afghanistan National Development Strategy, and UNODC mandates.

(c) The design of the projects were technically sound with clear, realistic and coherent objectives.

(d) The projects collectively contributed to the achievements of the Strategic Programme Framework and Afghanistan Development Strategy, and other strategic instruments.

(e) Activities and implementation strategy were appropriate for meeting stated objectives, with a focus on assessing project elements directly related to capacity building, coordination and sub-contract performance.

The evaluation addressed the relevance, efficiency, effectiveness, impact and sustainability of the project. The evaluation covers the project concept/design, implementation, activities, results and outputs. For further details, the Terms of Reference (TOR) can be found in the annex.

Evaluation Methodology

Given the synergistic relationship of the projects and their often interlinked outcomes relating to individuals, communities and governmental departments, the projects were evaluated jointly to identify commonalities across the projects. The evaluation sought to assess the appropriateness of the project design; the effectiveness and cost-efficiency of methods used for implementation; that intended recipients benefited from the projects as planned; and the collective contribution of the projects to the required institutional, governmental, partnership, community and individual capacity building identified within the proposal objectives. The evaluation utilised mixed methods for data collection which included the following: desk review of the relevant documents (project documents, quarterly, semi-annual and annual project reports, reports on project activities, relevant national policy

8 IEU (2008) Thematic evaluation of the technical assistance provided to Afghanistan by the UNODC, Volume 5, Vienna: UNODC.
The recommendations of the midterm thematic review [IEU 2008] were reviewed and their implementation assessed.

Individual and/or group interviews with members of key governmental stakeholders were undertaken, including representatives of the counterparts and implementing partners. A representative sample of the project beneficiaries were interviewed using questions derived from the review material and the mid-term thematic IEU evaluation [2008] [see appendices]. Field visits were undertaken to 16 services developed and/or supported under the project, where possible due to security and visa constrains. This was limited to the secure areas of Kabul and Jalalabad. Telephone calls with representatives from the UNODC Independent Evaluation Unit in Vienna and retrospective thematic discussions on the project lifetimes were undertaken. These were derived from oral and documented project histories and included methods utilised, resource allocation, issues arising from implementation, project handover and future planning. In the latter part of the evaluation recurrent themes were investigated that had arisen in initial interviews; and triangulation of all the information collected from the various and sources e.g. documentation and interviews.

**Evaluation Timetable**

All relevant project documentation was prepared by the DDR team in advance and the desk review was conducted by the evaluator prior to mission. The mission timetable consisted of on average three to four meetings or field visits per day over a ten day period in-country. The project team met for in the first morning of the mission and four presentations were given outlining key issues within Afghanistan in relation to drug use in general and the projects in question. Where this was not possible, teleconferences were held with participants in Pakistan and Vienna. A full list of interviewees, organisations and facilities visited is contained in the Appendices to the report.

**Limitations to the evaluation**

Meetings with representatives of donors and co-sponsors were not possible within the limited time frame. Interview opportunities with civil society organisations although planned were omitted because of security constraints at time of country visit.

Deteriorating security meant frequent alterations to evaluation programme schedule. The use of retrospective terminal cluster evaluation was requested by IEU one week into the field visit; however the project evaluation plan was not truly participatory but developed according to the schedule predetermined by security clearances at the time. Therefore, participants did not contribute to evaluation methodology in either question design or prearranged participatory meetings.

Although not originally defined a cluster evaluation an overview of the interactive effects of the projects evidenced synergistic impacts as the three projects addressed a common set of problems. However, owing to the concurrent conflict/post conflict situation in Afghanistan and time required to obtain UN security clearances to travel and visa applications for Pakistan, the original agenda was adapted with the visit to Herat cancelled. The Pakistan mission to visit the BEST and DOST project with Afghan refugees in NWFP was also not feasible owing to visa difficulties. These missing components of the evaluation were covered by three telephone conversations with implementing partners, and a meeting with a former project director who has recently relocated to Kabul for another agency. A visit to Jalalabad in Nangrahar Province was arranged and the team were able to visit three projects in the city. To address these limitations the evaluation triangulated and cross-referenced the data collected where possible to maximise validity and reliability of the findings.

**Projects Overview**

Projects AFG/H09 and AFG/G68: The goal was to assist the development of capacity in government counterparts, relevant UN agencies, NGOs and community groups in Afghanistan. To address the
abuse and misuse of drugs, and healthcare access, socio-economic issues and problems relating to drug abuse/misuse in Afghan society. The implementing non-governmental partner agencies for these were WADAN and NEJAT.

Project AFG/H87: The overall objective was to reduce and prevent the abuse and misuse of drugs, amongst Afghan refugees in 20 selected camps in NWFP and Baluchistan provinces in Pakistan. The immediate objective was to improve the capacity of health professionals, social workers, teachers, community workers and community groups working with refugees in targeted refugee camps, to address the abuse of drugs and healthcare issues related to drug abuse and misuse.

Evaluation of Project Objectives

AFG/H09 and AFG/G68 - These two projects worked towards the development of capacity building for DDR in Afghan institutions and society. UNODC undertook technical support through advocacy and Ministerial negotiation. Multidisciplinary Drug Reduction Action Teams [DRATs] were selected, trained and commenced work in three provinces Kabul, Balkh and Herat through project AFG/H09 in 2003. This was extended to a further three provinces in project AFG/G68, to Badakshan, Nangarhar and Kandahar in 2005. Mainstreaming of drug demand reduction was achieved within the activities of relevant Government counterparts, UN agencies, NGOs and community groups.

AFG/H87 – This project worked on the development of the capacity of social multipliers and healthcare professionals, social workers, teachers, community workers and community groups, working with Afghan communities in 20 target refugee camps in North West Frontier Province (NWFP) and Baluchistan, to address drug use and related health care issues. Two specialist teams (with four females and two males in each team) were created to deliver drug demand reduction information, advice and training services. Project partners were trained to establish community-based drug treatment, rehabilitation, aftercare and re-integration services for refugee male, female and child drug users; and to develop prevention programmes and activities for refugee communities at risk of drug abuse. Significant vocational training, small business development and skill acquisition was part of the process. The project was implemented by UNHCR and the Commissionerate for Afghan Refugees (CAR) with NGOs, Dost Welfare Foundation and BEST.

Project Activities

In conjunction with the Counter Narcotics Ministry, and the Ministries of Education and Public Health, UNODC identified, selected and trained 12 project staff to be operational at provincial level. Formed into 3 Demand Reduction Action Teams (DRATs) with 4 members, the teams were allocated to the provincial offices of the Counter Narcotic Directorate (CND) in Badakshan, Nangarhar and Qandahar. This was complemented by the selection and training of 36 local Afghan staff, in interviewing skills and ethnographic techniques for data collection in the field.

Mainstream drug demand reduction was delivered through the START programme [Support: Training: Advice: Resources: Targeting] for partner agencies and organisations. This included the provision of healthcare, education and social/community services for Afghan communities in targeted provinces.

Project Indicators and Outputs

Establishment of effective operational national drug treatment, rehabilitation and prevention services.

Effective monitoring and evaluation via mission, training and NGO reports/ treatment centre reports with treatment outcome data.
Outcome evaluation workshops held on a four monthly basis, with the staff of the DRATs to monitor the outcomes of previous training programmes, to identify any training gaps and to resolve any work related issues/problems.

A nationwide assessment of drug use was conducted in 2005 and repeated in 2009, with results disseminated to relevant government organizations, UN agencies, NGOs, embassies and interested institutions. The most significant impact of the drug use survey was said to be that the government and communities realised the direct link between illicit crop cultivation, and the growing drug addiction problems within the national population.

Establishment of a clinical laboratory in Kabul which improved government capacity in diagnosing infectious diseases among drug users and detecting the blood borne viruses associated with drug injecting –hepatitis B and C and HIV/AIDS. The laboratory assists in provision of effective drug treatment services. It also offers local testing help to injecting drug users referred by NGOs providing treatment services for drug dependence, and thus contribute to preventing spread of HIV/AIDS and viral hepatitis.

The Ministry of Health, Ministry of Education, Ministry of Counter Narcotics and other governmental and civil society organisations now undertake a range of drug demand reduction activities in Afghanistan.

Provision of targeting strategies to Government counterparts, NGOs, UN agencies, community groups and social multipliers identify those groups most at risk of drug abuse/misuse e.g. The Ministry of Education was supported to include anti-drug messages in the school curriculum and primary schools were supplied with drug education material.

Collective ownership of drug problems was established at all levels provincially, and within refugee communities for appropriate community-based demand reduction activities.
II. EVALUATION FINDINGS

The effective design and use of mobile facilities and numbers treated are shown in the table below.

Table 2: Cost comparison of treatment delivery modes

<table>
<thead>
<tr>
<th>Facility type</th>
<th>Numbers reached per treatment cycle</th>
<th>Duration treatment [not including awareness raising or needs assessment]</th>
<th>Annual per person treatment coverage</th>
<th>Cost USD per facility /team per annum.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO residential facility with private building rental</td>
<td>20</td>
<td>90 days</td>
<td>80</td>
<td>$80,000</td>
</tr>
<tr>
<td>MoPH residential with donated RCSA facility</td>
<td>20</td>
<td>60 days</td>
<td>120</td>
<td>$50,000</td>
</tr>
<tr>
<td>Mobile village based DRAT with donated office and village base</td>
<td>100 people and families</td>
<td>30 days</td>
<td>1200</td>
<td>$4,200</td>
</tr>
</tbody>
</table>

Design and Relevance of projects

Refugees, returnees, deportees and Internally Displaced Persons [IDPs] have a greater risk of exposure to drug use and its associated harms. Returning refugees and deportees from Iran and Pakistan are attributed to the importation of high levels of heroin use and risky injecting behaviours, which are estimated as 40% of all returnees now thought to be opiate dependant. Many IDPs have flocked to the relative safety of secured cities over the past 10 years, bringing or developing high risk patterns of drug use. Homeless and disengaged drug users are thought to have been under-represented in both surveys as not included in the national drug surveys which were undertaken in urban and rural settlements. Family networks generally try to support family members who are drug users in Afghan society, reported to the evaluation team in some cases as obtaining drugs for family members, to ease physical and psychological symptoms of withdrawal. Family savings also contribute to the purchase of both private health care and drug rehabilitation services.

Injecting drug use

In Afghanistan heroin use is increasing as the local/national market is saturated with cheap heroin being distributed locally for quick profit rather than exported. There are thought to be 20,000 injecting drug users in Afghanistan the majority in Kabul city [current total population approximating four million]. Other cities Herat and Mazar I Sharif also report high levels of heroin use. Unsterile needle and syringe sharing is reported by 89% of injectors, at least once in their drug use history, and 60% report routinely sharing with 2-5 others. Of these 90% are estimated to require both support and treatment.
Efficiency

**Development of national laboratory capacity**

Hepatitis C [HCV] infection is described by the World Health Organisation as a global public health emergency. HCV spreads more rapidly and efficiently than HIV, favouring blood residues connected with drug injecting. The national prevalence rates for HIV and hepatitis C are uncertain, but 45% of IDU are thought to be at risk of infection because of injection sharing frequencies. One estimate was given of several hundred people possibly infected in the 20-40 year age group who had been chronically injecting for 10 -15 years. The hepatitis B [HBV] rate in Afghanistan is 70% and HCV at 30% which would appear to be an underestimate. However there is no funding allocated at present for HCV treatment.

Currently it is unclear which genotypes of hepatitis C are prevalent in Afghanistan, although it may be surmised that imported injecting- related infections from Iran and Pakistan will predominate. Identification of national genotype prevalence should be undertaken as soon as possible. International guidance recommends that hepatitis C testing and treatment should be considered within all drug and HIV/AIDS programming, as long-term morbidity and mortality would further diminish Afghanistan’s post conflict economic recovery. Also the potential for spousal and familial transmission is far greater with HCV than that of HIV. This support was essential in the overall package of health reforms in particular laboratory assistance and training and health promotion and education for health and drug workers.

**HIV/AIDS/BBVs**

Afghanistan now has a concentrated HIV/AIDS epidemic with a general prevalence rate of 7% within the injecting drug user population [WHO definition > 5%]. This was predicted in the 2005 national drug surveys and the mid-term thematic evaluation of these projects [2008] and verified in the 2009 national drug survey. A recent Johns Hopkins University [JHU] study (unpublished) into HIV infection in injectors found some areas; particularly the national re-entry points for returnees and deportees have higher rates of infection. Herat [on the border with Iran] is estimated to have an 18% HIV prevalence rate in IDU’s. In Kabul the HIV rate is thought to be 3% in IDU’s. National targets include reduction of HIV national prevalence rate to less that 0.5% and reduction of heterosexual transmission. The most at risk populations are identified as residing in the eight provinces currently defined as ‘insecure’. Both drugs workers and medical staff are unable to operate without threat in these areas that are either directly Taliban controlled, or subject to ISAF/NATO counter-insurgency operations.

Partnerships and Cooperation

**Health and Drug Services coordination and coverage**

The rollout of the Basic Package of Health Services [BPHS] is now thought to reach 80% of the Afghan population. However climate, mountainous geography, and lack of infrastructure mean that access is very limited. Drug services are not included within this PHC model. Drug services coverage is estimated to be 1% of current need, with 90% unreached at present. The total number of facilities available to drug users across the country is 47 centres in 23 provinces including two police centres. Drug prevention programmes run in fourteen provinces [out of 34].

There remain gaps in national surveillance systems which remain rudimentary identifying only numbers of clients and numbers treated currently. Several respondents reported that drug users are frequently turned away from hospital facilities when unwell, unable to gain admission. One service
provider reported that a collapsed drug user had subsequently died after being refused urgent hospital admission in Kabul.

**Coordinated national activity on drugs and associated risks**

The Ministry of Education, Ministry of Hajj and Religious Affairs and the Ministry of Counter Narcotics have responded to drug issues with formation of the National Drug Prevention Working Group which meets on a monthly basis. Until recently differences of opinion on programme fundamentals within the Afghan Government and the Ministry of Health has influenced the drug debate at government level. However, these issues appear to be resolving as the impact of the national drug crisis is grasped at the national level. The expertise of the DDR and HIV teams at UNODC has played a significant part in furthering understanding across all political levels. Two sub-groups advise on technical issues [a] Prevention and Treatment [b] Harm Reduction. The HIV/AIDS Coordination Committee for Afghanistan [HACCA] meets on a two monthly basis. UNODC UNAIDS and WHO are collaborating on technical assistance with the delivery of the ‘Treatnet’ programme. There is a lack of usable data for planning and surveillance purposes available attributed in part to the hidden nature of drug use as in any society. There is also a lack of local and centralised data, which can be used for recording and analysis purposes. National targets are being set within those advised within global guidance, e.g. harm reduction activity to reach 60% of at risk populations and drug service access to expand from 1%- 40 % over the five year period 2010-2015.

**Policy formulation**

National policy priority has been given to the combined issues of drug use and HIV/AIDS.

Drug Demand Reduction [DDR] is one of the 8 pillars of the national strategy which includes treatment and rehabilitation components. The Afghan National Drug Strategy 2006-2011 [ANDS] has been developed with oversight by the Ministry of Counter Narcotics [MCN] and implementation of the drug treatment aspects by the Ministry of Public Health [MPH].

The National HIV Strategy for Afghanistan 2011-2016 is being implemented. The National Drug Regulation Committee [DRC] which approves and licences national pharmaceopia is located within the Ministry of Counter Narcotics and NODC has initiated and supported two national surveys ; The National Drug Survey [2005, 2009], and the annual Opium Survey. A needle and syringe programme policy has been established in alignment with UNAIDS, UNODC and WHO guidance. Introduction of Opioid Substitution Therapy (OST) has been an on-going issue of contention; however a national pilot project is underway in Kabul run by an international NGO [Medicines du Monde] for 71 service users. The government is thought to need to ‘step up’ its commitment and activities surrounding DDR as noted by respondents.

**Criminal justice systems**

Judiciary and police have been targeted with diversionary sentencing programmes through close liaison with the Ministry of Interior. Although drug use remains a criminal offence, drug users are less routinely arrested and imprisoned, but are now referred to treatment facilities. Societal trends in drug use are mirrored within the Afghan police force. This has been addressed by the creation of two specialist treatment facilities exclusively for police rehabilitation by UNODC/UNDP with the Government of Japan as part of police training and rehabilitation function [Herat and Kabul].

**Prisons**

In the Afghanistan penal system, incarceration of individuals occurs for differing reasons according to gender. 30% of male prisoners are thought to be incarcerated for drug related crime. Women are more likely to have committed offences against societal codes of conduct. However female drug patterns of
hashish and opium use are replicated in women’s prisons. Moreover, children are frequently incarcerated with their mothers and are exposed to drug use in prison. UNODC has ensured that prison drug use is now being addressed in both male and female prisons [Herat]. Previously only male prisoners at Pol I Charki [Kabul] and Jalalabad were included. Health care and harm reduction interventions are offered according to the capacity of the prison system to do so. Female prisoners are supported and returned to the family unit.

Effectiveness

**Governmental development**

The mandate of the MCN includes policy formulation and Drug Demand Reduction. It administers the 8 pillars of the National Drug Control Strategy [2006] with focus on prevention and treatment of drug dependency. Policy documents generated since 2005 include:

(a) The National Drug Treatment Guidelines [the updated version is subject to controversy at the moment]

(b) The National Drug Education Guidelines

(c) The National Harm Reduction Strategy

Some of the above guidelines have yet to be distributed to all centres owing to publication delays into the two national languages of Dari and Pashto. There remain differences regarding implementation of international requirements for drug control versus harm minimisation. However, these should be resolvable through expanding national drug treatment programmes they hamper progress towards nationally agreed systems of service delivery and public health targets. The MCN chairs monthly donor meetings that are partially attended but do not have a regular donor coordination meeting. The MCN also chairs monthly meetings on Drug Policy, Drug Education, Treatment and Prevention and Harm Reduction and the related subsidiary technical meetings. However, the national objective of scaling up drugs services coverage across Afghanistan from the current figure of 1% population coverage to 40% coverage within the next five years will require significant commitment and coordination between the donors and national counterparts.

Relative to its increasing national role with a total complement of nine staff, the MCN is notably under-resourced. There is acute awareness of the issues of lack of systematic national data and information on the treatment process and the systematic problems of ideological differences and capacity. The MCN preference is for a comprehensive drug treatment and prevention service that includes a range of interventions. This includes responsibility for national policy coordination and surveillance and analysis of drug use and treatment, and control and classification of drugs under international law. It is responsible for all aspects of data collection and collation and the development of national policy. The MCN also is the regulatory and signatory body for the National Drug Regulation Committee. The notable resources limitations of the Ministry, mentioned above, coupled with the lack of a research and training centre [recommended in the mid-term evaluation] is additional strain on staff at MCN that are trying to address national policy formulation, implementation and generation of national statistical databases.

The monitoring of all narcotics related Afghan policy and programme implementation.

Training and capacity enhancing needs identified at MCN include:

(a) Further follow-up to initial training received in Dari and Pashto

(b) Regional collaboration and shadowing in differing roles

(c) Comprehensive planning
(d) Needs assessment increasing capacity at the MoCN

(e) Consolidation of national/annual reporting mechanisms and no country wide information available other than the periodic national drug surveys.

(f) National database for collecting reported data.

(g) Reported data is often out of date as it is a mix of electronic [where internet provision exists] and hard copy – [delivery of which can necessitate a two-day track from a rural health post to an urban centre e.g. from Bamiyan to Kabul]. Moreover mountainous terrain and climate renders many of these routes impassable in the winter, leaving data gaps in the surveillance systems.

Impact

Methadone Maintenance Therapy

The national pilot project in Kabul operated by the French NGO Medecins du Monde, has not been without controversy. It remains unclear at what level the problem resides; however, the result has been governmental uncertainty over the validity of OST and limited permission restricted to three monthly import licences only. This is problematic as sourcing methadone and negotiating import is a lengthy process, and the necessary signatory process can mean that supplies expire before the next batch can be imported to Kabul. This has in the past resulted in fatalities through return to street drugs and loss of tolerance. It may be useful for UNODC and WHO to convene a national Consensus Conference based on expertise and regional experiences in order to develop a unified and harmonious approach with all parties involved in drafting policy guidance.

Other projects as part of the prevention programmes in Afghanistan included religious [mosque based] outreach in 24 provinces in conjunction with Colombo Plan, including referral to treatment centres, training, job placement [limited as are employment opportunities]. Additional support includes 12 step programme peer support groups, drugs messages at Friday Prayers [average 3000], mosque attendance for religious and social instruction [500] and food based after care programmes.

Sustainability

Visit to MPH Public Hospital psychiatric unit. Male Treatment Centre, Jalalabad.

The local public health hospital in Jalalabad had a DRAT programme with training, material production and office space. Staff, training and equipment were supported by UNODC which operated for two years with funding from the Colombo plan. For more than a year, a donor has not been found to continue supporting the programme since hand over the government which has not continued to adequately fund programmes or staff, and many have ceased employment. A few staff now remain, operating a static service as running cost have not been provided for community based components, drug awareness or village based treatment. There were also two female members of staff working with women and families in home based treatment. The female programme has ceased completely due to lack of funding; the female drugs workers were released from employment and the specialist family room closed down. Previously the team undertook two key activities:

Education and awareness-raising: in which the project held three day workshops in secure areas where they met with community heads and elders, and obtained agreements to deliver drug education and awareness sessions in schools and organised sporting events.

Home-based drug treatment activities including [7-10 days] preparation for commencement of treatment. Serious cases were referred to residential treatment at the public hospital. Vocational
training based on existing or new skills was given to recovered addicts to help prevent relapse. All activities were initially supported by UNODC funding but there are now significant gaps.

**Visit to WADAN Women’s Residential Treatment Facility Jalalabad**

WADAN operates the only drug treatment centre for women in the region which consist of four provinces. Access for women in eastern Afghanistan to drug treatment centres was stated to be extremely difficult. One reason given was denial on the part of village or household elders and husbands, although it was stated there was also local prejudice and stigma to overcome before seeking treatment. Female drug consumption patterns were stated to consist mainly of opium followed by pharmaceuticals and heroin, although there is increasing heroin production in the area. The proximity of Jalalabad to increasing opium poppy production is cited as a main cause of local addictions, with heroin use more commonly recognised in refugees returning from Iran and Pakistan.

A new 20 bed facility with an additional 15 cots for children was established 14 months previously. There is also a supported 20 bed home based programme. Employees were predominantly female including three qualified female medical and clinical psychologists. The facilities offered sleeping areas, communal treatment rooms, a small health facility and classroom holding around 40 primary age children under 10 years were seen. Several toddlers were also evident, and two babies aged less than 6 months with their mothers.

The unmet need is for adolescents aged between 10-17 years. This group is partially omitted in the national drug surveys as the questions currently address drug use in ages from 15-25 years and all over 15 years [defined as adults].

Polydrug use in this age range included; alcohol, cigarettes, hashish, opium and heroin and volatile substance abuse [VSA]. Russian vodka is smuggled in via Pakistan and Tajikistan or locally produced alcohol is used. Male children presenting for treatment are turned away as the centre had no remit for their care. The Colombo Plan Adolescent Centre treats 100 children per year.

Drug related stigma and expulsion of families relating to HIV/AIDS persists and is addressed by referring the family to the drug treatment centre as a female medical facility. The most benefit is said to be derived from community health workers delivering drugs education and treatment in the home. This enables general health and drug medication to be delivered. The centre’s facilities are now being publicised by clients returning home on completion of treatment and are experiencing a rise in service demand.

**Visit National Methadone Maintenance Treatment pilot, Male Treatment Centre. Medecins du Monde [NGO], Kabul**

The national Methadone Maintenance Therapy (MMT) pilot has been running at the centre since February 2010. The facility had a small clinical area and patients requiring stabilisation were kept in for observation. Staff were trained in all therapeutic aspects of dispensing. There continues to be a problem with restrictive short import licensing of three months duration for only 200 patients which is preventing scaling up of the service. The World Bank project contract stipulated treatment of 200 individuals by June 2011 and at the time of visit 71 people were in receipt of MMT. In April 2011 the World Health Organisation undertook a third party evaluation of the MMT trial in 16-25 year olds, the findings of which were very positive. However serious difficulties are frequently encountered methadone shortages occur due to delays in signatory processes at governmental level. This has led to emergency improvised opioid substitution with opioid derivatives [Codeine and Tramadol] for between 25-30 clients ‘squatting’ at the centre in various stages of withdrawal. Four drug related deaths [DRD] occurred at this time through loss of tolerance on returning to use of street heroin. This affected overall performance results, although it remained comparable with other studies. The programme retention rate was estimated as 74% after 12 months.
All of the 71 MMT pilot project clients were heroin users, a third of whom had previously been injecting 3 - 4 times daily, the majority for between 7-9 years duration.

Service user 1 - A chronic heroin user commenced heroin use at 18 years of age. He had undergone treatment in the past with over 6 cycles of relapse following discharge. These had included periods of treatment at the government facility in the Jangalack Drug Treatment Centre, and his family had also paid for private drug rehabilitation. This had caused resulting in family debt, as private treatment costs between 15,000-20000 Afghans [local currency equivalent to USD 400, more than an average family's monthly income]. However, he had usually relapsed within one month of treatment. Prior to admission to the MMT pilot programme he attended both the needle and syringe exchange and Harm Reduction projects at the centre. Now a peer-worker and reunited with his family, he is happy to be on the MMT pilot as he feels it has stabilised him. He has successfully reduced from 26 mgs to 5 mgs methadone dosage and with a job and social reintegration feels he is doing well. He stated that others, who are less stable, require adjusted methadone dosage to maintain adherence to the treatment programme.

Service user 2 - Addicted to heroin for 15 years since thirty years of age, he injected on average 3-6 times into the femoral vein and testicles. He said he had lost count of the number of overdose episodes he had experienced. Since starting MMT 15 months ago, he sees this as a ‘golden chance’, and were it not available he thinks he would have died from drug use. He explained that femoral and testicular injecting are popular locally, as it avoids visible needle tracks on the arms and hands. Neck injecting is also now becoming more frequent. Many injectors are living on different sites in the city mainly in destroyed buildings, and the numbers are continuing to increase. As heroin smoking is visible to the authorities [and an offence], most people learn to inject or use professional injectors who use unsterile injecting equipment.

Prior to the harm reduction, education, and needle and syringe exchange programme, he stated there was a lot of equipment sharing around Kabul. Now people use safer injecting and antiseptics. He explained that prior to these programmes, he also did not know of the risks associated with unsafe injecting.

Visit to Charikar Afghan Red Crescent Society [ARCS] premises, Male Treatment Centre [closed].

The former drug rehabilitation facility funded through Project HO9 was visited which had been located in a building donated by the Afghan Red Crescent Society. The local ARCS director was contacted as the premises were now empty and locked as the facility closed in December 2010. When functioning, the centre had catered for an estimated 5000 drug users in the area. It had offered medical and social services in addition to drug treatment. The former medical director also met the team and a tour of the building was conducted. The 10 room building was in good repair, brightly decorated and all funded resources including office furniture, beds, medical equipment remained in the unused building. Patient records were also still stored in an unlocked cupboard.

The reason for closure was given as failure to provide running costs. The facilities’ total operational cost was $50,000 per year operating a 45 day residential service, community outreach, and social and family welfare programme. The salaries whilst running had always been paid 5 months late. When funding ended the Director had borrowed money at the local market to pay staff salaries. After this ran out staff worked at the end of the project for 2 months without pay in the hope that a donor would be found to continue the centre’s operations. Peer support groups were founded on a voluntary basis without pay. Of the 13 staff previously employed only 6 are now in work. This is unfortunate as in this area drug use and service demand is increasing. The project location had been considered ideal as it was located in the ground of a free Red Crescent Society clinic, which conferred good security for all

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10This is of concern as considered at the most extreme end of risky injection practices, associated with public injecting and physical harms.
staff and clients, with the added benefit of de-stigmatising the facility and encouraging families to come for general health issues with signposting to addiction services; it was visible from the Salang–Kabul highway and convenient for drug users travelling from as far as Kabul, Kandahar and Maydan. Clients who were Farsi/ Dari speakers also attended as unable to go to Pashto speaking services.

In the Afghanistan routine drug use in the 15-64 age group was thought to approximate one million people with problematic drug use, in a population variously estimated at between 29 million [World Bank] and 32 million [Government IR Afghanistan]. There is added concern over the increase in heroin use in the past decade, from 59,000 regular users to 120,000 [National Drug Survey 2009]. This is an alarming 140% increase on the baseline national drug survey findings in 2005.

Opium use is also rising from an estimate of 1.4% prevalence [National Drug Survey 2005] to 2.6% in 2009. These figures are thought to indicate that 2.64% of the total Afghan adult population are addicted to psychoactive drugs. This national prevalence rate equals the combined drug use totals of neighbouring Iran and Russia at present. The opium survey outlines crop production, movement and drug production annually. Use of mobile laboratories and a porous border with Pakistan are attributed to the increasing problems with drug production, availability and use.

Institutional and management arrangements and constraints

Funding and program development

The following themes and examples were recurrent during interviews. UNODC is not independently core funded as is the case with other UN agencies. All funding has to be independently sought. Budget and programme instability are a result. Donor funding preference and interference drives programme/project development. Drugs as an issue are not popular, whereas HIV/AIDS resonates globally with funders. However, linking the arguments to those of health rights, rather than criminality may be more useful. It may be useful to include WHO in programme discussions, as it has responsibility for assisting the Afghan government in the implementation of Primary Health Care [PHC] at national level. Each donor has separate application and reporting procedures, which as UNODC is the conduit to funding distribution, prove complex for UNODC to coordinate amongst recipient and implementing NGOs.

The major UNODC donors for Drug Demand Reduction programmes are currently: INL [USA State Department]; the European Union [EU]; the governments of Germany, Japan; Canada; Italy and previously the UK [Foreign and Commonwealth counter-narcotics branch Afghanistan]. The UN Trust Fund for Afghanistan and the World Bank Reconstruction Fund for Afghanistan contribute to general healthcare systems costs. UNESCO contributes towards drugs educational and training project costs. HIV/AIDS programme donors include the World Bank, the Global Fund to combat AIDS TB and Malaria, USAID and the UN. However, secure funding for the next two years is available only from the Global Fund and World Bank for HIV/AIDS programmes. In alignment with domestic policy as donors, both the USA and Japan would not [until recently in the case of the USA] fund either needle and syringe programmes or opioid substitution therapy.

All respondents indicated that current resource allocation for components of DDR are insufficient to maintain services at current operational level, let alone scale up services to meet targets set within related national strategies over the next five years. Whilst UNICEF, UNHCR and WHO collaborate on specific project activities, individual donors have their own funding cycles which are not synchronised to overall programmatic support on the ground. Owing to past difficulties with governmental financial distribution arrangements, national donors prefer to continue funding oversight through UNODC. This creates additional work for UNODC in the role of overall programme/project manager. There is no apparent end to this issue in sight although other UN agencies are now actively addressing fiscal competency and other components through various training programmes. This has led to UNODC assisting in many aspects of programme maintenance for the majority of drug related services within Afghanistan for the foreseeable future.
Data and national capacity shortfall

Lack of accurate and specific surveillance data in relation to drug supply and use remains an obstacle to accurate impact assessments. National surveillance needs, equipment, training, programme support needs, resource requirements were repeatedly raised in interviews. This is evidenced by the lack of national data sources mentioned earlier. This impacts efficient evaluation of the entire drug treatment programme regarding effectiveness assessments, identification of treatment delivery, completion, individual and programmatic success, e.g. relapse rates and drug related deaths.

Continuing uncertainty over long-term donor commitment was reported by recipients with the need for standardised reporting systems on sector progress. There is an overwhelming need for expanded DDR facilities nationally. This was raised in interviews and evidenced by national services quotas at all levels: local [clinic or counselling space for outreach workers, night shelters], district [treatment and substitution therapies] and national [clinically complex residential detox and support facilities].

National drug sensitisation training is required to integrate drug services into all layers of the health care system in Afghanistan, [presumed to be a tertiary referral system with majority using PHC facilities]. ‘Refusal to admit or treat issues’ were reported by agencies when taking drug users to general hospitals.

It was stated repeatedly that donors often wish to fund specific programme modes e.g. in Jalalabad donors only wished to fund residential facilities; or employ international staff, which has drawbacks. The other problem is the short term nature of funding that assumes the government will take responsibility on cessation of funds. Lack of ministerial coordination is now seen as the key issue for long term programme sustainability. The Ministry of Finance is thought to be particularly influential in this process. An example of disjointed planning was given as the development of the Afghan National Drug Strategy by the Ministry of Counter Narcotics which excluded entirely the Ministry of Public Health.

An example of discontinuation of programmes owing to failure to uplift running costs was given, where UNODC-donated vehicles were the subject of a dispute between Parliament and the Ministry of Finance. This led to cessation of mobile DRAT activity noted by the evaluation. This was explained by interviewees as responses to addressing the national drug problem being very complicated, with lack of sustainable funding leading to gaps in provision. However problematic heroin use if increasing, with high levels of unemployment thought to be a contributory factor.

At the time of evaluation the Ministry of Public Health had yet to approve the National Drug Demand Reduction Strategy. This was perceived as hampering donor contacts, and development of a comprehensive strategic framework for implementation. Distribution of resources from central government was also an issue as individual Ministries are financially protective, and unwilling to allocate from their own budgets. Tripartite meetings are held between the Afghan government, UNODC and representatives of donor nations. Regarding UNODC donor coordination of programme funding, national Afghan staff remain excluded from meetings which are held in Vienna owing to travel difficulties for Afghan nationals and the donor reporting process is conducted through the UNODC.

Continuing national lack of coordination was seen as detrimental by all parties, with the Ministries and Deputy Ministers’ meeting only occasionally. External interference in mid-programme delivery by NGOs is another issue, with unexpected alteration to budgets and staffing levels the norm. The other issue of loss of staff to projects is attributed to the great differences in salary scales for public and NGO employees. At the MPH support processes were described as evidence based, but ultimately dependant on Ministerial judgement for final decisions on continuation.

The DDR strategy was perceived as problematic owing lack of clarity and agreement at the NCAP and the MCN with the late addition of MMT to that strategy, stated to have undermined other methods of OST under consideration at the time. There was feeling that it would be difficult for the three drug
related vertical programmes, currently operational within the different ministries, to merge into parallel programming. However, a comprehensive national drug programme was thought to be desirable in the long term. It was hoped that establishment of the Treatnet programme with UNODC and WHO assistance, would assist in overcoming institutional barriers leading ultimately to closer intergovernmental working.

Quality and delivery issues were felt to be related to frequent staff turnover at all participating Ministries. A number of reasons were given for this which included political change, contractual length and safety. The lack of sufficient remuneration for government employees working in insecure areas was mentioned, as were the low skill levels of many healthcare staff, attributed to continuous disruption of education.

Outcomes, impacts and sustainability.

Outcomes

Visit to Jangalack Drug Treatment Centre, Kabul, NEJAT [NGO].

The International Organisation for Migration funded the opening of the Jangalack Centre after an emergency appeal from the UNODC, to shelter injecting drug users being evicted at short notice from the former Russian Cultural Centre. One thousand people were displaced and emergency facilities were provided for food and shelter. A humanitarian crisis was averted and despite initial community resistance to development of a drug treatment centre, the facility was developed in a war damaged building. This was repaired, although it has no running water or electricity supplies. At the point of the evaluation the staff had not been paid salaries for past two months, which was said to be due to disagreement with UNODC finance office over audit requirements. Project staff were being paid using funds from another project accounts until UNODC reimbursed the NGO.

It was stated that the Centre was still relatively unknown by many at government level. This was also stated to be the case regarding the presence of Kabul Mental Health Hospital patients residing in part of the Centre. There was felt to be a general lack of understanding of the components of drug treatment programmes on the part of officials, from initial client work on awareness raising and motivational interviewing, to residential rehabilitation. However, the system is operating under increasing demand as clients attend the city night shelters and the centre’s work becomes known through word of mouth. More frequently, relatives request assistance for people who use drugs and other agencies also request treatment places. The Centre has also adapted to the new national drug treatment guidelines of 60 days in-patient treatment regime. In addition to the growing waiting list, a further 40 people from the night shelter were waiting for assessment and admission to treatment. This number was continuing to increase with the presence of the estimated 80,000 refugees thought to be currently living in Kabul. NEJAT also operates another 20 bed male facility supported by Caritas [Germany].

The programme is based on best practice guidance offering; awareness raising, treatment, attention to personal health and hygiene, rehabilitation with literacy, IT skills, tailoring, carpet weaving, baking skills and production of drugs education material e.g. hand sewn footballs with anti-drugs messages on the football panels. Peer-mentoring is an important part of the process with service users groups established. Two former patients were introduced to the evaluation team as staff members, having successfully completed therapy. The programme produces its own bread in the kitchen and residents undertake cooking and cleaning duties to reduce costs, however it is otherwise unsustainable without continued funding.

Interviewees stated that a comprehensive needs assessment of treatment needs, both locally and nationally, was required and also that the government has a responsibility to implement long term programmes, as it has partially supported some former UNODC programmes in the past. However this
was haphazard and the example was given of a shelter programme having to close, after operating for one year.

A representative Parliamentary committee of 20 members has been identified to take responsibility from UNODC for these issues. However, profound social stigma around injecting drug use still prevails, meaning that even educated former injectors cannot find employment on leaving rehabilitation. This reflects the high rates of unemployment and under employment in Afghanistan undermining economic growth.

**Visit to WADAN Research Centre and National Opium Survey offices, Jalalabad.**

Operating out of Jalalabad a village based drug treatment programme, was using the original project model developed by the MPH. This consists of introductory team visits to establish the programme, home-based detoxification and then rotational follow-up visits at 6 monthly intervals. Entire villages have been found to be addicted to opium, which is being replaced by newly accessible substances such as heroin. The office also ran the drug use and HIV surveys and the local component of the national opium survey; however, currently the DDR team is not involved in this activity.

The Government continues efforts to eradicate opium poppy cultivation after pressure inked to security issues, from the international community. Government controlled areas are now growing less poppies, however where there continues to be insecurity, poppy production increases. The predicted crop for the 2011 harvest was expected to be larger, as there were signs of increased growing activity in the regions.

**Impacts**

**WADAN NGO Male Treatment Centre, Kabul.**

WADAN were originally located in the Jangalack centre with NEJAT later moving to new premises. The NGO operates a 40 bed centre in Kabul offering a complete package of care [minus OST].

Initially set up by UNODC and now funded through the Colombo Plan /INL, WADAN operates 14 treatment centres, one of which is for women in Jalalabad. It also runs two centres in Kandahar Prison [male]; a female home-based programme; and a community based drop-in centre in Ghazni. Despite good capacity the WADAN treatment centre also has a waiting list averaging 140-150 people at any one time, which is similar to the NEJAT facility is increasing as people hear about the centre.

WADAN operates family reunification and has successfully reunited an estimated 100 homeless former injectors and their families. On the day of the evaluation visit, three former patients were working at the centre, one as a volunteer and two employed as staff [one as a health worker in Gardez, one as a social worker].

The centre also caters for home-based treatment, varying in length between 45-90 days duration depending on drug of dependency. In a recent case review of 122 clients, 90 were identified as heroin users, indicating the growing severity of the problem. It was stated that those in relatively early stages of their drug career were easier to treat, than those who had progressed to chronic use and dependence. This was also found to be the case in those who did not have complications related to mental health, with issues such as depression, war related illnesses or co-morbid conditions incurred through drug use.

**Sustainability**

The size of all facility waiting lists was reported as a significant problem. As mentioned above the lack of government support and salary scales were thought contributory factors, and it was frequently stated by respondents that residential and community drug services should be linked.
The lack of comprehensive care packages in Afghanistan, coupled with short in-patient periods and lack of OST and vocational training was thought contributory to the 30% relapse rates in heroin users in particular. Lack of data owing to terrain and systems were also cited as problematic.

Owing to the incomplete nature of data access, it was difficult to estimate the relapse rate in rural areas as there was no follow up programmes in place as the mobile DRATs have ceased to function. This also applies to the health care and hospital programme previously running in Jalalabad prison, [total 1360 prisoners of whom approximately 50 were problematic drug users] which has been curtailed owing to lack of funding for basic medication.

All projects visited during the evaluation were sustainable if incorporated into national structures. At present, this is not the case. The UNODC Country Office has extensive expertise of national service set up, and it should continue to mediate between the MoCN, MPH, and Ministry of Finance. Using this expertise, UNODC should encourage the establishment of total resource availability for all areas of healthcare, including mental healthcare, and within that, drug treatment services. The drug problem in Afghanistan and the surrounding region is a relatively new phenomenon. As with the emergence of global substance use from the 1980’s onwards, it is omitted from the original WHO declarations on Primary Health Care. However, the declarations on general health services, mental health and spiritual wellbeing are relevant, and drugs services are entitled to be apportioned sufficient budget under those remits.

It has to be acknowledged that Afghanistan is currently resource- poor until national reconstruction is firmly established. The national budgets cannot afford to continue vertical programming, and pooled resources will permit establishment of longer lasting and more efficient national structures. However this will require collaboration on joint policy formulation, strategic agreement, and funding. Unfortunately with many institutions not functioning at optimal capacity, the continuation of aid dependency, and low national revenue, the growth of all aspects of institutional capacity will take time.

The observations and interviews indicated an obvious outcome of autonomous project planning over the years by NGOs; and other agencies, which is the emergence of vertical programming. Whilst in the initial relief and reconstruction phase of the complex conflict in Afghanistan this was acceptable, in order to get aid delivered without the existence of formal governmental mechanisms, the next evolutionary stage is programmatic development and delivery. For this reason, the following recommendations are based on sectoral support for the initial capacity building projects.

Discussions should be urgently resolved over whether Tier One and Tier Two drugs services could be offered within Primary Health Care [PHC] facilities. This would encourage enhanced single point of service use instead of duplication. This would also comprehensively address the national aspiration of eventual total primary health care coverage, as the most cost effective route in meeting physical, mental and spiritual health needs. It would also integrate responsiveness to socio-economic determinants of health, within the emergent Afghan Health Care system.

The example of donor pump-priming a sustainable OST programme for a two year period at the national mental health hospital was suggested by interviewees, with the dual aim of developing long-term programme management expertise and national capacity.

Further Health Systems Management training was requested by interviewees. This specifically included service design and coordination, health information systems, monitoring and evaluation. Development of overall national capacity was stated to require an accurate assessment of both clinical and social care skills, needed to operate national drug treatment services. It was suggested that a national services mapping exercise should be undertaken, to identify ready availability of individuals and facilities and further training requirements.
There is a demonstrable need for further research and understanding of the drugs issues in Afghanistan. The WHO cluster oversees the Health Resources Availability Mapping System [HRAMS], Health Management Information System [HMIS] and Disease Early Warning System [DEWS] which could be useful in providing data expertise and sharing for UNODC, MCN and internally at MPH.

As a matter of some urgency and as suggested, Afghanistan should be advised to consider adopting a multi-tier, or other suitable referral structure for significantly increasing user access and uptake, and drug services provision. As the national drug crisis continues to grow it would be sensible to incorporate first point of access into basic package of health services provision. As illicit drug use is recognised as a form of self-medicating, either thorough lack of access to services or post trauma, this would address several issues simultaneously.

It would also up-skill Primary Health Care workers who cannot be oblivious to localised problems of opium, inappropriate use of prescription medication or heroin use. It would enable establishment of contact with drug users and their families, assist in reduction of stigma, and would facilitate health education, prevention of drug related harms and facilitate appropriate referral to specialist services where needed. Currently the BPHS addresses mental health, malaria, HIV/AIDS and TB but not drug dependency. As DDR falls within the remit of mental health services, agreement on national mental health services provision incorporating drug dependency and dual diagnosis should be negotiated as soon as possible.

Design - Best Practice

A range of good practice was identified within the evaluation projects, and all were using highly effective social marketing, communication and inclusion strategies.

Innovation – All three projects used a wide range of excellent innovatory social marketing and inclusion practices. Street theatre, media training for journalists, nationwide activities to mark the 26th UN Day against drug use and trafficking, tee shirts printed, speeches made by ministers and TV and radio coverage. Additionally all NGO implementers offer either certified vocational training or Certified Drug Counsellor programmes.

Material Produced - The Drug Counsellors Handbook translated into Dari and Pashto; colour illustrated posters with harm reduction messages; tee shirts for drug awareness days; traditional tablecloths with colour illustrations of the harms of opium use in the family; 1000 blackboards with anti drugs awareness messages for schools; videos on drug harms; billboards with the Afghan National Cricket Team promoting sport as an alternative to drug use.

Example: The Basic Education and Skill Training [BEST] refugee projects

Run by NGO DOST under Project AFG/H87, these projects evidenced the most-cost efficient use of resources in developing sustainable and self sufficient projects. This was in part due to the organized nature of refugee camp life with strong community involvement. This enabled the start up of 10 small businesses developing both local Afghan, and international markets in Dubai. The skills taught were both practical and sustainable, and enabled income generation [carpentry, masonry, welding, electrical wiring, plumbing, auto-mechanics, shoe making, tailoring, gardening, food preservation, tailoring, weaving, and hand and machine embroidery]. The demand for handicrafts, tailoring and waistcoats had assisted in return of refugees to Afghanistan, as product demand was high. Those with essential skills were also employed within the refugee camps, or ran small outlets in them. This project is also now looking for continuation funding.

Example: Ministry of Public Health-DRAT

In interview the example was given of a village in Charikar, which had 350 drug users. Local elders wrote to the MP and Provincial Governor requesting assistance with the problem. The MPH
negotiated village contribution to the programme with Elders, religious leaders and police on security for DRAT members. The team comprised of 8 people, including a manager, 2 social workers for families and female drugs workers to see women in the home on a one month treatment programme. This enabled ownership and commitment to the use of a 6 room house within the village as a programme base, staff office and accommodation. The DRAT members conducted a needs assessment, and after initial 30 days planning and setup period, commenced a one month village based home based detoxification, treatment and rehabilitation programme. Villages were revisited on rolling 6 monthly follow-up cycles. The provincial government also agreed to give 2-3 rooms as office base for the teams.

One hundred villagers were seen at the base-house, and community involvement included bringing food to the base three times daily for clients and staff. Reintegration for former users was arranged with the community with agreed mechanisms for monitoring of successful rehabilitation, evaluation and follow up. This led to the establishment of a sequential rolling programme through villages, using the same negotiated supports and assurances of operational security. The involvement of respected elders and religious leaders ensured continuity for both the community and the DRATs, with surveillance and involvement in beneficial group outcomes.

The provincial teams then adopted this model using one month’s home-based detoxification in 10 extended houses per village, on three monthly rotations to different villages, revisiting the original village in the programme cycle for a week at six monthly intervals for follow up. The programme would then be restarted in new areas at 6 monthly intervals. Neighbouring village leaders would then request the programme to become established in their villages. This demonstrated good social marketing of the programme through local community and provincial networks, as word of mouth and provincial networks learnt of the delivery, content and success.

In one village community commitment was demonstrated in closing down a shop in the area known to be selling drugs. In another, a family was said to have destroyed its opium poppy garden after an education session on the hazards of home use. Therefore, this model was identified as both suitable and effective, in terms of culture, terrain and climate where harsh winters prevent movement, and motorised vehicles are replaced with donkeys and horses on journeys ranging from 6-13 hours. The MPH viewed this model as having greater efficiency than 20 bed inpatient facilities, and recently presented an overview to a Paris Pact meeting as a model that was sustainable, effective and the most cost efficient. Its success was stated to be linked to the fact that residential facilities are problematic to attend owing to cost of travel, being located in urban centres, necessitating travel from family [particularly for women], stigma for the family and the individual.

Ministry of Women’s Affairs, Women's outreach programmes.

Effective and efficient cascade ‘training of trainers’ was organised by the Ministry of Women’s Affairs, to address drug use in the home and with children, primarily of opium and pharmaceutical preparations. Initially it was found that there was little difference in response to the training, as the age range of the women being targeted were 85% illiterate. An alternative method of video production was then developed and used with great success. This was included general training in health matters, hygiene and drugs awareness and prevention.

One mentor trainer on completion of the course visited households to inform the women of the hazards of opium and hashish cultivation. Often grown for home use owing to lack of access to health facilities and poor knowledge of drug related harms, in the gardens the opium plants were later destroyed once training had taken place. One remaining issue was stated to be self-medication owing to lack of accessible health care facilities, and few alternatives to medicinal opium use in the home. After training communities mobilised in deciding how to deal with and tackle opium cultivation in their village. One example was after the training was delivered, when the team went back to the village for monitoring and evaluation purposes they found sites of opium production destroyed, and a special lunch of thanks was given in their honour by the village.
The less didactic approach has been so successful that there are many requests for the women’s teams to go to villages, once word of mouth passes on the benefits of the initiative. This initiative was deemed to be very successful with significant acclaim. Although it was only funded for a short duration in the first instance once implemented with the target group, the MCN extended its funding to cover a further five provinces, [$40,000 USD over five provinces for four months, equating to $2000 USD per month per implementing team]. The total annual project cost over 5 provinces is stated to be $20,000 USD.

However, because of limited funding only smaller villages could be included in the project. Once completed, a further five funding proposals were submitted to the MCN and the Colombo Plan, but no further funding was available. This programme also supplemented the expanded soya production programme [development of micro finance and sustainable business] and technical, vocational and health literacy courses also implemented by the Ministry of Women’s Affairs.

Example: NEJAT NGO/DIC Female and Family Clinic, Old Kabul.

The clinic is located in the old city of Kabul above a row of shops and was started in 2008 in partnership with UNODC. It is advertised locally as a family medical centre, rather than drug treatment centre. More than 18 staff were employed, and additional training was offered on a quota selection basis, with travel to Iran for skill enhancement. The clients seen by the clinic are 80% female, and include children and partners of clients. Dr Rafi, the Medical Director is a doctor of medicine, and specialised in obstetrics and gynaecology. The centre also employs nurses, medical assistants and social workers. This is stipulated under the TOR of the project for provision of medical and health care. The clinic is open to clients without appointment in the morning, with scheduled outreach visits in the afternoons. This includes home visits, and distribution of medicines and dressings for people who inject drugs.

Testing and treatment for the following are offered: Blood-borne viruses and Sexually Transmitted Infections [STIs] including HIV, Hepatitis B and C and Syphilis. Examinations for pelvic inflammatory infections and other obstetric or gynaecological conditions are also offered. Peer workers were employed without salary, but in return were enrolled as health workers and entitled free family treatment at the centre. Families, partners and children were offered Primary Health Care treatment free of charge. This was viewed as very helpful as a client retention incentive.

The clinic currently sees 22 female injectors, and in 2010 recorded 99 people who inject drugs as clients receiving care. A total of 200 drug users, plus 70 spouses of male drug users, were also registered at the time of the evaluation [May 2011]. In many cases the pattern of drug use were stated to have started with the husband, followed by the wife becoming addicted. Opium was the most frequent drug of choice, followed by heroin and tranquillisers. Some of the clients had returned from Iran where they commenced their drug dependency. A combination of social factors including war and displacement were thought contributory to the addictions observed in the clinic population.

A relapse rate was given of approximately 30% for women in currently in treatment. However, this is considered to be higher in male clients. Previously treatment was home based; now the more difficult cases are referred to the DIC centre. Follow-up has been enhanced by the use of ‘client contracts’ in which cooperation is mutually agreed between client and clinic. Drug detoxification is viewed by the clinic staff as a useful advocacy tool. The stated problem was programme sustainability as the funding was ending in three months. During the evaluation, visit concern was expressed by all staff members, in terms of both continuity of provision and all contracts were ending on the 14th June 2011.
III. CONCLUSION

In Afghanistan prolonged periods of war, instability, localised conflict and associated drugs crisis have brought about significant social transformation over the past thirty years. These impact significantly on any programme efficiency and operationality as well documented in literature on humanitarian functioning in climates of political violence. An example was given on the extent and nature of organised crime and drug debt distorting previous societal values and customs, with the trafficking of women and girls to pay drug production debts emerging in many areas. Reliance on anecdote was applicable in many areas as the rapidity of the national drugs phenomena was said to be overwhelming, with data systems constantly responding to contemporary issues. This continues to inhibit long-term planning, which combined with uncertainty of funds, and small budgetary allocations, undermines much of the considerable effort that is put into DDR capacity building.

Lack of employment (widely prevalent at time of evaluation) with high levels of underemployment nationally cited as contributing to drug use and relapse; however there has been no systematic study on this, or on confounding factors to drug prevention, successful treatment and rehabilitation. The National Drug Survey [2005, 2009] recognised the majority of the population is less than 25 years old, with increasing ease of access to drugs of concern. Migration, for work or to avoid conflict, was also thought to contribute to the problem, particularly in more secure urban centres. Many respondents in this evaluation stated that drug demand ‘was everywhere, and getting worse everywhere’.

In conclusion, continuation of capacity building in Afghanistan as a response to the issue of drug use remains, as urgently needed, if not more so, as when these projects were initiated. The collective skills and expertise present in UNODC COAFG should be acknowledged in the creation of the national drug policies and structures in Afghanistan.
IV RECOMMENDATIONS

Priority should be given to the reinstatement of previous and extended DRAT operationality. The dispersal of the DRAT model and team members with discontinuation of mobile teams in particular, appear to be severely impacting on national service development. This will in turn continue to undermine national coverage plans. As documented in the evaluation the DRATs have failed to be sufficiently funded since handover, mobile team running costs are unavailable and only static service provision is currently operational.

That serious consideration should be given to the development of comprehensive service model. This could incorporate the following features;

Comprehensive 4 tier system for drug demand reduction and treatment

(a) Tier 1 - Screening and referral at PHC level.

This could be implemented within the BPHS facilities, with training of community health workers to identify the nature of drug use, appropriate response and referral to specialist agencies. e.g., for opium use, heroin, or prescription drug dependency.

(b) Tier 2 - Brief interventions, Harm Reduction, Immunisation, Home Based care

This would combine the responsibilities of health care workers and specialist drugs workers, and has been successfully used within projects by MPH in urban and rural centres, but is currently funded for only static services without the mobile outreach component.

(c) Tier 3 - Specialist drug services, Care planning, Opioid Substitution Therapy [with harm reduction components integral]

This level was delivered by the MPH and the total compliment of services is on-going with the first national MMT pilot being run in Kabul for 71 clients by MdM. However the continuous three month importation and licencing period is causing problems due to lengthy process.

(d) Tier 4 - Medical monitoring, residential rehabilitation, complex detoxification

Political and donor preference appears to be for residential rehabilitation facilities which are more costly and serve smaller numbers. Whilst residential use may be essential where individuals are shunned by their families or communities, overuse was identified for less acute cases, and alternative treatment models could be developed. It was the view of several respondents that should OST and outreach services become established, with home based detoxification and increased availability of a range of provision, that inappropriate use of residential services would decrease, e.g., for opium detoxification. It is the view of many respondents that opium addiction is less entrenched than that of heroin injecting, and that residential services should be reserved for use with chronically drug dependent users with a long / complex personal histories.

The lessening visibility and exclusion of women from funding, projects and further employment is particularly worrying as there is considerable health and social catch up required in Afghanistan that is gender specific. The evaluation team also encountered expressed preference to treat men by an international NGO, with the rationale that force of numbers necessitated the opening of male facilities rather than female. It is well evidenced that ‘post conflict’ women and gender issues are often
forgotten and “fall between the cracks”. Relief and development programmes for women have the effect of reaching the entire family, whereas those targeted at men tend to reach the individual.

In terms for value for money, it is more cost efficient to target funding toward women’s’ programmes in the knowledge that successful coverage will capture between 8-20 people in a household. Gender sensitivity is a key condition of all national reconstruction strategies. The UN is currently piloting the use of ‘gender markers’ in scoping project proposals for UN pooled funds, which enable tracking of gender-ranked allocations. It would be useful to consider prior to it becoming a UN system-wide requirement. In this evaluation, the majority of female outreach services and female staff employment were being undermined as projects ended. Linkage with other national solidarity projects to ensure gender issues are addressed may be beneficial. Increased advocacy of linkage with eventual incorporation into BPHS and CHW training as drug use in Afghanistan reflects both a complex emergency and conflict, and post traumatic national mental health epidemiology.

The national reconstruction agencies in Afghanistan should consider the development of a regulated medicinal pharmaceutical agency for meeting its national medicinal needs in future. A model for such production is already utilised in neighbouring Iran. This would enable several areas of national self reliance-economically regenerating agricultural production; enhancing industry production skills; and reduce the costs of imported opioid substitution therapy that will be required in future within the national drugs programme.

An expanded pharmacopeia of opiate derivatives should be further investigated as already used in neighbouring countries, for future development of sustainable affordable treatment options. At the time of the evaluation less than 0.3% [71/23,000] coverage with opioid substitution therapy existed for people dependant on heroin.

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V LESSONS LEARNED

Given the current economic situation of ongoing conflict and post conflict recovery in Afghanistan, short-term funding strategies for projects cannot rely on anticipated absorption into national services at a later date. The UNODC should consider utilising sustainable development models that are being initiated within other areas of UN delivery. This may assist UNODC in future to move from crisis driven and reactive humanitarian delivery by necessity, and enhance donor negotiation.

As stated above, although notably and commendably designed with gender sensitivity as a consideration, all three projects appear to have lost this key component. This is of concern as women in contemporary Afghanistan continue to face significant barriers to health, and education activities, in the coming period of transition and reconstruction. The community based mobile programmes offered by the DRATs were the most cost efficient and effective form of treatment and rehabilitation programme delivery, with greatest cultural acceptability and potential reach in Afghan society.

The national stated objective for drug treatment and rehabilitation services by the collaborative partnership of the Ministries of Counter Narcotics and Public Health was that service coverage was to be expanded from the current 1% of all drug users to reach 40% over the next five years, in areas that were sufficiently secure within Afghanistan. In order to facilitate scale-up of overall provision by the government ministries, a range of supplementary measures need to be considered, defined as desirable within national policy context and strategically implemented.

Efforts should be made to facilitate effective and innovative resource management and collaboration between government departments, as the Afghan economy is not to experience public sector growth for a considerable period of time. Although UNODC already provides considerable support and technical advice at national level, it has also has leverage on donor selection, preferences and programme funding distribution.

Service erosion on project handover to either Government or other implementers is undermining much of the capacity building achieved at all levels since inception by these UNODC projects.

Programmes targeting women were found to be considered of less importance, both in service provision and staff retention, with premature programme closure a feature. Women and family projects were identified as being terminated at greater rates than those offering exclusively male services. Female staff members have been made unemployed in the majority of the projects evaluated. This is despite the fact that women’s programmes were evidenced as being the most efficient in total service delivery; and achieving many of the strategic objectives of the Afghanistan reconstruction plan in delivering increased levels of female literacy; health literacy; female employment and reduction in drug demand in individuals, families and communities.

One problem identified by respondents was concern that some project funding mechanisms are bypassing governmental processes. The rationale for this activity appears to be in order to circumvent lengthy delays experienced, often of many months, within the formal approval processes. The perception is that this activity perpetuates both underfunding and sidelining of government agencies which are undermined whilst NGOs are seen to meet donor delivery targets. The implications are that donor preference and target specifications continue to drive project creation and government needs and recommendations remain unmet, or even ignored.

National coordination of DDR programmes remains fragmented with disagreement at the ministerial level hindering the very real progress that was achieved during the evaluated projects combined lifespan. Government bureaucracy and lack of efficient funding procedures, have led to the cessation of DRAT mobile outreach teams, and the unemployment of many trained drugs workers. This is particularly the case for female DRAT workers, none of whom were stated to still be in employment at the time of the evaluation. This has a major impact on effectively targeting women in the home.
Additionally, the cost of government mobile teams is significantly less than NGO teams, e.g. in terms of office space government teams obtain free or cheaper rental of smaller local properties at $200USD per month instead of $1000 USD monthly. Mobile teams were found to be static during the evaluation, offering a reduced and office-based service. This was stated to be due to running costs for vehicles and medication not being provided by the Government. Therefore, commitment to support the DRATs is required at both district and provincial level.

The lack of capacity of provincial health Directorates to address women’s needs was noted. The issue of women’s drug use continues to be overlooked, as for reasons of cultural segregation women require separate programmes from men. The treatment system was thought to prioritise male service users needs, although there were not enough centres even to meet this demand given the male population’s far easier ability to travel and attend centres. The issues of women and children left in the homes and villages were thought to be less obvious with subsequently deemed less important. In Afghanistan there are five treatment centres for women and children out of the total 41 facilities in existence. MoWA data was being reported to the provincial women’s data system but the programme needed to be sustainable which requires considerable input, and resources to maintain data viability. The model of ‘whole family treatment’ either in the home or at a centre was thought to be more sustainable and would create support networks for those recovering from addiction. For many women the key issue was lack of access to income. For this reason vocational training and micro finance initiatives were undertaken. Women also play as significant role in family income generation if in an extended household, and it is often difficult for them to leave their domestic roles or children to travel to a static treatment centre. The other issue is lack of literacy and lack of vocational skills so literacy with carpet weaving, handicrafts and agricultural skills were taught in addition to drug prevention.

There is a lack of national guidance criteria applicable to the function of DDR in Afghanistan, and this includes both practice and advocacy approaches. Further difficulties persist with strategic approval and agreement on future directions. Neither the Ministry of Counter Narcotics nor the Ministry of Public Health is thought to be adequately resourced in order to deliver the DDR agenda. The six monthly funding cycles currently operative were stated by most informants to be inefficient. Projected departmental budgets for the year [2011-2012] were also stated to be insufficient, and in the case of Ministries both approval and commitment was required for full running costs in the following year 2012-2013. An example given was the MPH had planned for integration of the DRAT model into its services in 2011, but ran out of funding for both staff salaries and programme running costs.

A level of frustration was expressed by interviewees at both Ministries over the range and independence of non governmental agency activity, with lack of coordination with and responsiveness to the emergent governmental institutions. This was stated to be particularly relevant in the regions and was attributed to lack of capacity and transparency by both parties. As stated by the interviewed MCN representative, NGOs should be responsive to national directives and this was not the case. These concerns include inappropriate activity and reduced effectiveness. An example given was the differing duration of residential rehabilitation programmes currently operated by NGO partners, as duration ranged from 45 days to 90 days, whereas the national guidance advocates 60 days.

Staff capacity was urgently in need of upgrade as the rolling training schedule had been discontinued. As stated earlier one of the key problems recognised for Afghanistan is the inheritance of mass illiteracy and partial literacy from the war years. Also internal migration of people moving away from military operations in conflict affected areas, adds to difficulties in continuity. In terms of maintaining and enhancing skills for national staff, international conference attendance and sharing of experiences were stated to be beneficial. However regional conferences were identified as more suitable, because of visa restrictions for Afghan nationals wishing to travel. There was also concern over the differing social consequences over the currently unregulated of private and public providers available, with families often going into significant debt in order to pay for repeated private residential rehabilitation for family members.

UNODC should continue to meet with major donors, MPH and MCN to secure funding and commitment to continuation of DRAT running costs over a five year period 2011-2016, in order to
embed the service within the national healthcare framework. This approach would assist in meeting three national targets: MCN drugs strategy coverage [1% - 40% in same period]; basic package health services coverage MPH 60%- 80%; and HIV and AIDS services scale up [2011-2015 objectives MPH] as would encourage enhanced services utilisation and cross referral.

UNODC could enable joint negotiation with the World Bank, Global Fund and all other major donors, relevant ministries, partner agencies and donors. Collaboration would assist with designing and implementing an appropriate tiered drugs service referral system, as recommended in UNODC/WHO/UNAIDS technical guidance [2009]. This could assist in resolution of several more difficult issues as it would render them less publicly visible; contribute to reduction in the long-term of expenditure on the current unnecessary dependence on residential facilities; and would release resources to address areas of concern, such as continuation of mobile outreach and family based village services. It would also assist in addressing the growing needs of the majority of the population who are under 15 years at present and entering the recognised high risk phase for experimental drug use.

UNODC and partner agencies should continue to develop community consultation and participation into all future programming, as demonstrated by the acceptance and effectiveness of the mobile DRATs and MoWA outreach projects in creating ownership and longevity. UNODC should continue to support all responsible agencies within the government towards enhancing technical capacity to address societal drug use, building on work of projects AFG/ H09 and AFG/G68.

Low cost community interventions, evidenced as the most sustainable in the long-term in terms of knowledge transfer and community empowerment, should be strongly supported.

Health literacy should be inbuilt to all future programming with enhanced skill support offered to increase community awareness and ability to act.

Membership or affiliation of UNODC to the Cluster working groups of UNOCHA or UNDG-ECHA\(^\text{13}\) may be beneficial as the majority of UN organisations in Afghanistan are participating and UNODC would benefit from participation in cross cutting strategic development. Affiliation to OCHA may also be useful as again UNODC is noticeably absent from humanitarian fund raising appeal cycles. The current strategy of vertical programming whilst recognised as an immediate humanitarian response model does not fit with models of sustainable development. Whilst appreciating the UNODC has a perpetual funding crisis it may be useful to investigate creative solutions from outwith the organisation.

\(^\text{13}\) Cluster Working Group on UNDG-ECHA Working Group on Transition, Guidance Note on Early Recovery April 2008
ANNEX I. TERMS OF REFERENCE OF THE EVALUATION

FOR THE TERMINAL EVALUATION OF THREE DRUG DEMAND REDUCTION PROJECTS: AFG/H87, AFG/G68, AFG/H07

INTRODUCTION
Almost three decades of war and conflict in Afghanistan has resulted in the country becoming one of the least developed and impoverished countries in the world. A recent report by the Food and Agriculture Organisation of the United Nations (FAO) claims that Afghans, along with Haitians and Somalis, are more “chronically hungry” than any other people in the world. Unemployment rates are high with few off-farm job opportunities for the mainly rural population, and there has been a continuous erosion of civil society and human rights, particularly those of women.

Over the last decade, Afghanistan has become the world’s leading producer of opium. The 2008 survey revealed that there was a 20% reduction in land under poppy cultivation and the provinces declared free of poppy increased to 19 against the 15 province declared poppy free last year.

A quantity of this opium is converted into morphine base and crude heroin in clandestine laboratories in the border areas with Pakistan for onward smuggling to mainly western countries. With increased policing and security operations against traffickers on Afghanistan’s borders, however, some traffickers have taken the low-risk option of selling onto local markets at a reduced profit. It is inevitable that increased opium production over the past decade has resulted in greater quantities of both opium and heroin becoming available on the local market, where there has been a growing demand for such drugs.

With extreme human deprivation and suffering, the increased availability of opium and heroin, along with a wide range of cheap and easily available pharmaceuticals and other psychoactive substances such as charas (hashish), has resulted in an escalation of drug-related problems in Afghan communities. War and social disruption has devastated traditional coping mechanisms and has left the population, both inside and outside the country, extremely vulnerable to a range of mental health problems, particularly chronic depression, anxiety, insomnia and post-traumatic stress disorder.

Underlying many of these mental health problems is the central problem of loss. Some people will understandably turn to drugs to help cope with the pain, both physical and psychological, caused by the loss of family members, home, job, well-being, personal security and, in the case of refugees, their country. While such self-medication with illicit substances has been seen by an increasing number of Afghans as a short-term palliative for their suffering, in the longer term it has resulted in a wide range of social, economic, legal and health-related problems for the individuals, families and communities concerned. In short, it has posed a distinct barrier to human and socio-economic development.

The first ever nation-wide assessment of drug use in Afghanistan, conducted in 2005 by UNODC and the Ministry of Counter Narcotics, estimates nearly one million drug users in the country. This figure represents 3.8 percent of the total population and 7 per cent of the adult population. There are strong indications that the figures presented in this survey are underestimated, particularly the number of women and child drug users, which are likely to be underestimated for cultural reasons.

The amount and type of drugs consumed and the frequency of use indicate that many people in Afghanistan are dependent on a range of drugs. At least 200,000 people are regular users of opiates in...
the form of either opium or heroin (150,000 opium and 50,000 heroin) accounting for between five and ten per cent of Afghanistan’s opium harvest. An estimated 180,000 people use pharmaceutical drugs illicitly, including 60,000 women and 30,000 children less than 15 years of age. Majority of these drug users live in the rural areas of the country.

Although there is no accurate information, it has been estimated that over 2 million Afghans have been killed as a result of the fighting. Very few families have been untouched by the violent death of their relatives. It has also left Afghanistan with an estimated 2 million widows, plus their children, one of the most vulnerable and impoverished groups in an already impoverished population. As such the entire population considered to be at risk of drug abuse requiring development of universal prevention strategy to be targeted for DR programmes.

Reports from various organizations suggest that there are more than 50,000 children working on the street only in Kabul city. Likewise a study conducted by organization TDH, revealed that out of thousands of children working in Torkham border town, 7% are either using drugs or are involved in drug trafficking. It is to note that a considerable number of these children have also been sexually abused.

In the north, the Turkman women have traditionally been using opium to cope with their back ache caused by hard carpet weaving activities. The carpet weavers also give opium to their children to pacify them to get free for their work. The pregnant carpet weavers with their drug habit give birth to opium dependant babies.

Lack of proper health facilities in some remote areas and harsh weather have led the inhabitant (Ismaelee and other communities) to use opium for medicinal purposes which have led to drug dependency among them. There are still two important factors for continuation of opium use among these communities, firstly, less stigma attached to opium use in the area secondly, their strong belief on opium as a proper substance for the treatment of certain diseases. These groups should be targeted for proper awareness programmes based on the selective prevention strategy and programme to change their drug use behaviours and belief.

PROJECT COMPONENTS
To cope with the growing drug abuse/misuse problem, the projects AFG/G68 and AFG/H09 “Capacity building for drug demand reduction in Afghanistan” were designed in partnership with the Ministries of Public Health, Education and Counter Narcotics of the government of Afghanistan in 2004. The projects aimed at enhancing capacity of relevant government institutions in primary, secondary and tertiary prevention approaches enabling them to address the problem of drug addiction effectively and efficiently in the country. Under the projects, launched in November 2003 and January 2005 respectively six Demand Reduction Action Teams DRATs were established, trained and equipped and made operational in the targeted provinces of Kabul, Balkh Herat, Nangararhar, Kandahar and Badakshan. The (DRATs) composed of staff of the provincial health and education departments have been providing quality community-based services in all three level of drug abuse prevention. The DRATs with enhanced capacity had been providing quality services to the client groups through community-based drug treatment and rehabilitation and drug abuse prevention program. They had so far treated and rehabilitated a high number of drug dependents and a similarly high number of people being at risk of drug abuse about the hazardous consequences of drug addiction. Similarly the 10 beds residential treatment facility in Charikar, the drop-in-day care centre for returnees from Iran and the community-based drug treatment facility in Shortepa of Balkh province provided an excellent opportunity to the drug addicts to undergo treatment. Despite the good work of the DRATs, the project, due to shortage of sufficient funding, was not able to continue financial support to them.
Therefore arrangements were made with the Ministry of Public Health and Colombo Plan that the DRATs be financially supported by the Colombo Plan and UNODC to continue to provide technical and advisory support.

Besides Ministries of Education and Women Affairs were supported to incorporate drug related topics in the school’s curriculum and create awareness among women, the most marginalised and vulnerable groups for drug abuse, respectively. The first nationwide assessment of drug use in Afghanistan was conducted under the project. The survey results enabled relevant governmental and non-governmental organizations to plan and develop realistic and rational long term drug prevention intervention strategies including universal, selective and indicated prevention programmes. Youth were provided with healthy recreational facilities for leisure time activities in the hope to avoid turning to drugs. Within the context of the UNODC Demand Reduction Programme, support was provided for the establishment of the clinical laboratory established in the Drug Dependency Treatment Centre (DDTC) of the Mental Health Hospital in Kabul. Through this support, testing and examinations of drug addicts undergoing treatment in the centre could be done.

To address the existing drug problem among the most vulnerable Afghan refugee communities residing in camps in NWFP and Baluchistan of Pakistan, the project H87 “Drug demand reduction information, advice and training services for Afghan communities living in refugee camps in North West frontier province (NWP), Pakistan was developed and launched. The project in collaboration with UNHCR and Commissionerate for Afghan Refugees (CAR) and in partnership with NGOs, Dost Welfare Foundation and BEST has targeted 20 Afghan refugee camps of NWFP for the project activities. In addition to the recruitment of the project staff, Community Health Workers (CHWs) both men and women were identified from the refugee camps in consultation with the CAR and the community elders and were trained to deliver DR services to the clients in the targeted refugee camps. The Afghan communities are organized and DR committees are established comprised of elders of tribes living in the camps to support and enable DR services in the refugee camps, self-help support groups of recovering are established for sustainable recovery, vocational skills training opportunities are provided to the recovering drug addicts in the camps and for their economic growth and recovery, small business set ups are established at the community level on self help basis and are linked with the markets for ongoing revenue generation.

Project AFG/H87 pursues the main objective to improve capacity of healthcare professionals, social workers, teachers, community development workers and community groups working with men and women in targeted refugee camps to address the abuse and misuse of drugs and health care issues related to drug abuse and misuse.

This evaluation should examine progress achieved in light of this objective but also taking into account the condition under which implementation has occurred.

EVALUATION SCOPE
The evaluation shall focus mainly on the project’s concept, design, implementation, results, outputs and outcomes. The evaluation should appraise:

(a) Project concept and design:
The evaluation should analyse whether and how the project contributed or is contributing to a priority area or comparative advantage for UNODC. It should review the problems identified by the project and the corresponding strategy chosen in order to address these. The evaluation should also encompass an assessment of the relevance and attainability of the objectives and of planned outputs, activities and
inputs, as compared to other cost-effective alternatives. An analysis of the clarity, logic and coherence of the project should also be conducted. Some of the questions that this evaluation should address are:

- Are the objectives of the project aligned with the current policy priorities and action plans of Government of Afghanistan, the Afghanistan Compact, Afghanistan National Development Strategy, and UNODC mandates?

- Is the design of the project technically sound? Are the project objectives clear, realistic and coherent in terms of collectively contributing to the achievements of the Strategic Programme Framework and Afghanistan Development Strategy, and other strategic instruments?

- Are response activities and implementation strategy appropriate for meeting stated objectives, with a focus on assessing project elements directly related to capacity building, coordination and sub-contract performance?

- How well do the project objectives reflect the specific nature of the problem?

(b) Objectives, outputs, impact and sustainability:

The evaluation should seek to determine whether results have been achieved, and if not fully, whether there has been some progress made towards their achievement. Taking into account these factors, the overall impact of the project should be assessed. This should also encompass the likely sustainability of results and benefits as well as the project’s contribution to human and institutional capacity building.

The beneficiaries’ perception towards the achievements should be taken into consideration, as appropriation is an important factor in determining sustainability. Another fundamental aspect in result sustainability is beneficiary capacity building (have the beneficiaries gained the necessary tools and skills?). Furthermore, financial sustainability should also be assessed (for instance, once the project is terminated, will the benefits be self-sustainable?). Taking into account the project life is not completed, some of the questions that this evaluation should address are:

- To what extent has the project contributed to the achievement of the Afghanistan Compact and or Strategic Programme Framework and Afghanistan National Development Strategy? What are the reasons for the achievements and non-achievement of objectives? Are the work plans and impacts in line with project document?

- Have improvement of leadership skills been enhanced at institutional and individual levels in order to drive coordination and more effective actions in the health system to address the problem of drug addiction and prevention?

- Is there any improvement in programming and acting in terms of addressing the country problem related to drug abuse treatment, rehabilitation and prevention?

- Has the capacity of Government counterparts, UN agencies, NGOs and community groups being enhanced to develop realistic, pragmatic, and achievable and evidence based drug demand reduction programmes and strategies, including prevention, treatment, rehabilitation, aftercare and social reintegration programmes?
- Has the assessment of the extent, pattern and nature of drug abuse/misuse and the provision of DDR services/facilities in Afghanistan being carried out in a professional way in order to provide baseline data for future planning of DDR activities?

- What is the impact of the skills-based training on drug demand reduction for those workers in healthcare, social work, education and community development who are already providing generic and specialised services for drug users in Afghanistan?

- What is the impact of the training on drug demand reduction for those social multipliers such as school teachers, mullahs, police and public information staff who are engaged in drug use prevention activities with at-risk groups such as women, youth and ex-combatants?

- What has been the impact of the development and dissemination of culturally appropriate resource material that provides information and advice on drugs and drug-related healthcare and socio-economic issues for Afghan men, women and children?

- Did the drug prevention interventions respond to the risk and protective factors relevant to the specific group the activities targeted?

- Is the DRAT model effective? If yes, what are the key factors/elements of DRAT contributed to make it a successful model? Assess DRAT model and identify effect of DRAT model.

- Has home-based detoxification intervention increased access and ensured quality of care? If so, is there any evidence in support of this, please document.

- Have training, workshops and other capacity building efforts, implemented under these projects, made any effect in terms of knowledge and behavioural change? If yes, provide evidence in support of this. Provide an assessment of quality and use of communication materials (IEC materials)

- Are supports to start small business to generate income from local market by trainees/addicts an effective approach? Are the small businesses already established viable?

- Is there an effective monitoring and information system at UNODC and are its partners in place? Assess quality of data and provide recommendation for improvement.

(c) Overall implementation process:
The evaluation should assess how effectively/efficiently project planning and implementation have been carried out. This includes assessing the extent to which organizational structure, managerial support and coordination mechanisms used by UNODC effectively support the project. Efficiency should be analyzed namely as the project’s capacity to achieve the desired effects at an acceptable cost when compared to alternative approaches reaching the same effects. The role played by the field office in the development and implementation of the project or program should also be assessed. The evaluation will analyse problems and constraints encountered during implementation as well as the quality and timeliness of inputs and the efficiency and effectiveness of activities carried out.

- Are there less costly methods which could achieve the same outcome/impact at the beneficiary level?
To what extent was a transparent operating environment and accountability of government established?

To what extent have partnership been sought with other relevant actors (including UN-agencies) and synergies been created in the delivery of assistance?

Was there effective coordination among government, UNODC and other implementing partners including donor countries?

Has adequate and appropriate backstopping support been provided by field and HQ staff (administrative / managerial support and coordination)? Have partner institutions fully and effectively discharged their responsibilities?

What are the anticipated positive and negative, intended and unintended, effects of interventions on people, institutions and the physical environment after implementation of project?

How were project internal UNODC factors affecting effectiveness, including human resources logistic support, and the predictability and regularity of resources and flexibility of the budget (UNODC constrains)?

How are project external factors like limits on access to interventions sites, human resource constraints etc. impacted on effectiveness (security situation)?

To what extent were the project interventions sustainable?

What concrete actions or measures have been taken, or are required, to ensure the sustainability of national agencies strengthened by the project (e.g. structural, managerial and behaviour change)?

(d) Lessons learned from the concept, design and implementation of the project, as well as good practice:

Recommendations may also be made in respect of issues relating to the implementation and management of the future projects as well as follow up projects dealing with the same issues. The evaluation shall assess in what ways the project design and/or delivery can be improved to enhance its effectiveness. The evaluation should identify the key elements, assumptions and risks for the development of similar initiatives in other regions. Some of the questions that this evaluation should address are:

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

Do the project interventions have a potential for scaling up or replication?

What are the outstanding needs of the prison system and concerned institutions?
What are the good practices, and blueprint for the further expansion of the DDR program in Afghanistan?

EVALUATION TEAM COMPOSITION
In addition to the International Evaluation Consultant, the evaluation team will consist of two national DDR experts, tasked with supporting the Evaluator during field assessment missions in the designated Afghan provinces under evaluation as well as supporting the administration of focus groups, meetings and interviews.

PLANNING AND IMPLEMENTATION ARRANGEMENTS
This evaluation will be a joint effort between the Evaluation Team and UNODC. As for substance, it is critical that the evaluation should be carried out independently and directly by the Evaluator, supported by two DDR experts, tasked to carry out a thorough evaluation addressing all aspects of the project objectives, achievements, implementation and management. The Evaluator should also follow-up implementation of recommendations of the thematic evaluation carried out in 2007-2008, and provide an assessment on the status. The Evaluator will have access to all relevant documents and the UNODC Country Office for Afghanistan will provide the required support for the Evaluator during the evaluation. The UNODC officials responsible for briefing of the Evaluator are:

UNODC Country Office for Afghanistan:
- Representative
- Deputy Representative
- DDR International Consultant
- DDR National Project Coordinator

UNODC Head Quarters in Vienna (Austria):
- Senior Interregional Advisor, Human Security Branch
- Chief, Health and Human Development Section
- Chief, Europe, West and Central Asia Unit
- Project Coordinator, Europe, West and Central Asia Unit
- Chief, Independent Evaluation Unit
- Deputy Director, Division for Operation
- Chief, Human Security Branch

Following an induction and documentation review he/she will undertake the field visit in Afghanistan. While in Kabul, the Evaluation Team will receive a briefing from the relevant staff of the Country Office and will carry out a desk-review of the Drug Demand Reduction program and the project’s documentation.

Meetings with stakeholders, beneficiaries and partners will be organized in Kabul, followed by the mission phase to provincial project execution sites.

At the end of the field visits, meetings, interviews and focus groups will be conducted, predominantly in Kabul the evaluator will prepare the draft report within ten working days and submit it to the UNODC Country Office for Afghanistan and UNODC HQs for comments.

UNODC Country Office will secure office space, administrative basic support, and travel arrangements for the evaluation team during their stay in Kabul.
After a short break, comments will be provided to the evaluator for integration into the report.

Note: Detailed itinerary and programme will be prepared upon arrival and in consultation with the Evaluator.

**Deliverables of the evaluation:**

1) Evaluation plan and detailed terms of reference with methodology;
2) Final evaluation draft report with findings;
3) Lessons learned and results;
4) Briefing meetings, focus groups, questionnaire, and presentations;
5) Final evaluation report.

**Project Modality, budget and payment:**

All costs relating to the terminal evaluation will be funded through AFG/H87.

The Evaluator will be issued an SSA consultancy contract and paid as per the common UN rules and procedures. The final payment will be made only after the acceptance of the final draft of the evaluation report by UNODC HQs and the Country Office for Afghanistan.

**Final Evaluation report** (see also Annex Standard format and guidelines for project evaluation report):

The evaluation report should follow the standard UNODC report outline that is listed below:

1. Evaluation summary (maximum 4 pages)
2. Introduction
3. Background (Project description)
4. Evaluation purpose and objective
5. Evaluation methodology
6. Major findings
7. Lessons learned (from both positive and negative experiences)
8. Constraints that impacted project delivery
9. Recommendations and conclusions

Annexes to the evaluation report should be kept to an absolute minimum. Only those annexes that save to demonstrate or clarify an issue related to a major finding should be included. Existing documents should be referenced but not necessarily annexed. Maximum number of pages for annexes should not exceed 15. The format of the reporting is attached. The Terms of Reference of the Evaluator, including methodology and questionnaires and the UNODC Format and Guidelines for the Evaluation should be annexed to the report. Also the Evaluator should fill in an evaluation assessment questionnaire (attached).

**2. PURPOSE OF THE EVALUATION**
The overall purpose of this terminal evaluation is to determine what impact has been made by the projects, what has been achieved and whether they have attained their objectives successfully and efficiently, taking into account the often difficult conditions on the ground in Afghanistan. In this regard, 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 should also be assessed.

3. SCOPE OF THE ASSIGNMENT

The evaluation will seek to draw lessons and good practices from the project implementation which will be used in the development of future DDR projects to improve future planning, design and management. Furthermore, the evaluation must seek to measure the project’s achievements, outcomes and impacts, both positive and negative.

The main stakeholders of this project are: (i) The Ministry of Counter Narcotics (MCN), Ministry of Public Health (MOPH), Ministry of Education (MOE), relevant UN agencies and NGOs.
ANNEX II. LIST OF PERSONS CONTACTED DURING THE EVALUATION

Dr. Mohammad Naseer Sharifi, Director DDR, Ministry of Counter Narcotics, Kabul
Dr. Sayed Jawid Badakhsh, Ministry of Counter Narcotics, Kabul
Mr. Ayoub, Director Colombo Plan Drug Advisory Program for Afghanistan, Kabul
Dr. Abdullah Wardak, Director of DDR section of Ministry of Public Health, Kabul
Dr. Marghalare Sakhi Khara, Director of Health Section, Ministry of Women Affairs, Kabul
Dr. Temoursha Samim, Director of Kabul Mental Health Hospital MPH, Kabul
Dr. Tariq Suliman, Director of NEJAT, Kabul
Dr. Atal Ahmadzai, Drug, Demand Reduction Coordinator WADAN, Kabul
Dr. Wahidullah, DRAT, team leader, Jalalabad
Dr Amini, Project Coordinator, Jalalabad
Dr. Samin Stanikzai. Medical Doctor, Counter Narcotic Trust Fund, Jalalabad
Mr. Sanop, Medical Coordinator, Medecins Du Monde, Kabul
Drop in Centre team, Service Users and Peer Educators participants in the MMT pilot study, Medecins du Monde, Kabul
Katherine Kayser UNODC Vienna
Anja Buss and Elizabeth Saenz, IEU UNODC Vienna
Dr. Nimatullah, Coordinator of HO9 and Afghan Red Crescent Society Charikar
Mohammad Aqa Stanikzai, Director of OHSS, Kabul
Dr Mohammad Fida Paikan, NACP Manager MoPH, Kabul
Mr. Hamesh Khan, Director of BEST project for H87, Pakistan
Dr. Manzoor, former project Coordinator UNODC/AFG/HO9
Jean Luc Lemahieu Country Representative Afghanistan, UNODC, Kabul.
ANNEX III. EVALUATION TOOLS: QUESTIONNAIRES AND INTERVIEW GUIDES

Derived from key recommendations within the midterm evaluation of the projects circa 2008 and summaries in UNODC Programme in Afghanistan. These were introduced into interviews, with overview summaries of performance and discussions of programme achievements and difficulties.

1. Did the ideological differences regarding Harm Reduction and HIV that were felt to be hampering programme coordination between ministries in the midterm evaluation still exist? If so how was there an impact on programme delivery?
2. Was there evidence of increased advocacy to ensure commitment by the government and international agencies to address the problem and ensure sustainable funding of programmes?
3. Was the government supported in the creation of a national research and training centre to increase human capacity and develop harmonised policy research streams?
4. Was there evidence that UNODC had adopted a new approach to programme and project conception, with improved global planning and more differentiated projects?
5. Was there evidence of an increased focus on policies, guidelines, surveillance systems and innovative drug projects?
6. Was there evidence that the UNODC and the international community had found a method of bridging the apparent gap between the Ministry of Counter Narcotics and the Ministry of Public Health. Was there increased coordination of roles and responsibilities?
7. With the predicted emergence of the concentrate HIV epidemic within injecting drug users in Afghanistan did UNODC engage with national and other initiatives in the development of projects and play an active role in policy and coordination to address this emergent threat?
8. Was there evidence that UNODC had strengthened collaboration with WHO and UNICEF to mainstream Drug Demand Reduction as a public health issue especially in rural communities?

14IEU. (undated). Thematic evaluation of the technical assistance provided to Afghanistan by the UNODC, Volume 5. Vienna: UNODC
ANNEX IV. DESK REVIEW LIST

UNODC Strategic Programme Framework for Afghanistan AD/AFG/03/H09 Capacity Building for Drug Demand Reduction in Afghanistan. Project Revision. Authors Jenazeb Khan, Mohammad Naim [2005].

UNODC COAFG. AFG/H09 Capacity Building for Drug Demand Reduction in Afghanistan. Project Revision. Authors Jenazeb Khan, Mohammad Naim [undated].


UNODC COAFG. AFG/H09 Capacity Building for Drug Demand Reduction in Afghanistan. Project Revision No. 4. Authors Jenazeb Khan, Mohammad Naim [undated].

UNODC COAFG. AFG/H09 Capacity Building for Drug Demand Reduction in Afghanistan. Project Revision No. 5. Authors Jenazeb Khan, Mohammad Naim [undated].

UNODC COAFG. AFG/H09 Capacity Building for Drug Demand Reduction in Afghanistan. Project Revision No. 7. Author Dr Mohammad Raza Stanikzai [undated].

UNODC COAFG Project AFG/H09 2008-2010 Revised Budget [undated].

UNODC COAFG Project AFG/H09 2007-2008 Revised Budget [undated].

UNODC COAFG Project AFG/H09 2006-2008 Revised Budget [undated].


UNODC COAFG. AFG/G68 Capacity Building for Drug Demand Reduction in Badakhshan, Nangarhar and Kandahar provinces. Prevention, Treatment and
Rehabilitation. Project Revision No. 3. Authors Jenazeb Khan, Mohammad Naim [undated].


UNODC COAFG Annual 2010 Progress Report for AFGH/ 87 Drug Demand Reduction information, advice and training services for Afghan communities living in refugee camps in Baluchistan and North West Frontier Province [NWFP] Pakistan. Author Dr Mohammad Raza Stanikzai [2010].


UNODC COAFG Project AFG/H87 2006/07 Revised Budget [undated].

References


UNAIDS (2011) Middle East and North Africa ready to scale up harm reduction services in its response to AIDS. New York: UNAIDS.


**Further to Recommendations UN Gender documents and web-links**

UN Implementation of Strategy on Gender Mainstreaming within the United Nations System - Depository of policies, strategies and action plans within the UN systems.

UN Agenda for accelerated country action for women, girls, gender equality and HIV. How civil society, governments and the UN system can together create an effective response. A briefing note for action by communities:
www.unaids.org/en/PolicyAndPractice/Gender/default.asp or by contacting genderandhiv@unaids.org.

UNDP Guidance Note - Tracking Gender-Related investments and expenditures in ATLAS, Bureau for Development Policy, UNDP Gender Team [undated].

WHO Integrating Gender Perspectives in the Work of WHO, WHO Gender Policy 2002, [2009].

WHO Gender, women and primary health care renewal, a discussion paper July [2001]