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Global

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CONTENTS

Annexes (please see separate document)

LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CCM	Country Coordinating Mechanism
CSO	Community service organizations
DIC	Drop-in-centre
GARPR	Global AIDS Response Progress Reporting
GFATM	The Global Fund to fight AIDS Tuberculosis and Malaria
HAS	HIV/AIDS Section
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
HBV	Hepatitis B
HCV	Hepatitis C
IEU	Independent Evaluation Unit
MoH	Ministry/ies of Health
MSM	Men having sex with men
NSP	Needle and syringe programmes
PLHIV	People living with HIV
PR	Principal Recipient
PWID	People who inject drugs
PWUD	People who use drugs
OST	Opioid substitution therapy
RDT	Rapid diagnostic test
VCT	Voluntary counselling and testing
WHO	World Health Organization
UBRAF	Unified Budget, Results and Accountability Framework
UBW	Unified Budget and Work plan
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime

EXECUTIVE SUMMARY

Background and Context

The global acquired immunodeficiency syndrome (AIDS) response remains one of the most important and challenging public health priorities with an estimated 34 million people living with human immunodeficiency virus (HIV) worldwide in 2012[1]. Key populations, such as people who inject drugs, are more vulnerable to HIV infection and as a result the prevalence of HIV among people who inject drugs, (PWID) where reported, is higher than among the general population. In 49 countries with available data, the prevalence of HIV infection is estimated to be at least 22 times higher among people who inject drugs than for the population as a whole, with an estimated prevalence at least 50-fold higher in 11 countries[2]. The Reference Group to the United Nations (UN) on HIV and Injecting Drug Use estimated in 2008 that 15.9 million people inject drugs, of which an estimated 3 million are living with HIV[3]. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has estimated that US$24 billion is required annually to fully fund the AIDS response in low and middle income countries[4] and was agreed by Member States in the 2011 Political Declaration on HIV/AIDS[5].

The United Nations Office on Drugs and Crime (UNODC) began making significant investments in HIV prevention, treatment, care and support from 2002 and is one of the 11 co-sponsors[6] of UNAIDS with a specific mandate to work with people who inject drugs and people living and working in prisons and other closed settings as outlined in the UNAIDS Division of Labour Framework[7]. In addition to the Division of Labour Framework that outlines the roles and responsibilities of each co-sponsor, joint bi-annual strategic objectives and work plans were developed by all co-sponsors between 2008-2012, these Unified Budgets and Work Plans were replaced in 2012 by more strategic, targeted and longer Unified Budget Results and Accountability Framework (UBRAF), that will end in 2015.

Programme Description

The UNODC Global Programme on HIV/AIDS (Global Programme) has grown significantly from a single project, GLOG32, in 2002 to a portfolio of 34 on going or operationally complete projects by the end of 2012. All the projects in the portfolio cover the two main target groups that UNODC has a lead role in working with; projects that work with PWID cover 85 per cent of the Global Programme portfolio, whilst the remainder, 15 per cent, are focused on working with

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[1] Global Report: UNAIDS report on the global AIDS epidemic 2012

2 Global report: UNAIDS report on the global AIDS epidemic 2012.

3 Mathers BM, Degenhardt L, Phillips B, et al, for the 2007 Reference Group to the UN on HIV and Injecting Drug Use. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. Lancet 2008; 372: 1733–45.

[4] Investing for results: UNAIDS, Geneva 2012

[5] United Nations General Assembly. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. Sixty-fifth session, Agenda item 10. 2011

[6] UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO, World Bank, UN Women

[7] Refer to annex 3, Desk Review for further details on the UNAIDS Division of Labour.

people living or working in prisons and other closed settings. Within this broad target group are many sub-populations and the Global Programme has designed many projects that target a sub-group such as women who inject drugs, or street children vulnerable to both drug use and HIV infection.

The longest running project, GLOG32, is the core fund for the Global Programme and the UBRAF is the principal source of funding for the project. Since 2002, the project has expended US$36,334,539 (as of February 2012) and continues to mobilise resources until 2015. Eighty per cent of the total budget has been used to fund the seven Vienna based headquarters (HQ) staff, 64 in-country advisers and technical experts across 26 countries.

The remainder of the Global Programme's portfolio of projects consists of 33 projects implemented in 54 countries across five regions including 13 projects in Asia (three are regional, 10 are single country implemented), six projects in Sub-Saharan Africa (four regional, two single country), an additional six projects implemented across Eurasia (three regional and three single country) and four projects in Latin America, including three in the Federative Republic of Brazil and one in the Oriental Republic of Uruguay, and finally, four single country projects in the Middle East/North Africa region[8].

The Global Programme's total approved budget for all projects, including GLOG32, from 2002 – 2012 was US$235,604,010 and expenditure, up to February 2012 was US$202,077,823 across all projects in the portfolio. Funds were mobilised from a broad range of donors, the majority, 56 per cent from governments, followed by UNAIDS and other co-sponsors, 23 per cent, and a further 21 per cent from foundations[9].

The UNODC Executive Committee (ExCom) took a decision in 2011 to request the Independent Evaluation Unit (IEU) to undertake an independent, in-depth evaluation of the Global Programme.

Scope and Evaluation Methodology

Terms of Reference were developed around a core group of criteria that addressed relevance, efficiency, partnerships, effectiveness, impact, sustainability, gender, equity and human rights, and programme management arrangements. A team of two independent consultants were contracted and joined by a member of UNODC's IEU and began working on the evaluation from 16 September 2013. The evaluation was conducted in an independent, transparent and participatory fashion. The first task was to undertake a desk review of the core documents provided by the UNODC HIV/AIDS Section (HAS), in Vienna. At this inception phase the evaluation tools were developed that would enable the evaluation team to collect the necessary data and information from a range of sources and key informants. The evaluation tools included detailed questionnaires, designed to elicit responses from a range of key informants including UNODC staff at HQ and HIV advisors and senior leadership at country offices; interview guides for key informants from member states and civil society and specific interview guides for consulting a broad range of stakeholders during the country case study visits. In addition each project in the portfolio was reviewed and scored using a simple, visual traffic light system for the quality and relevance of the design and the effectiveness and efficiency of implementation. Additional documentation that enabled the evaluation team to triangulate their findings included evaluation reports of the 10 evaluated projects, annual progress reports submitted to the HAS and

[8] Refer to annex 6 for complete list of projects, location, duration and budget.
[9] Refer to annex 5 for details on all donors to the Global Programme from 2008-2012

information from the Financial Information Management System (ProFi) database used by UNODC to manage all data, narrative and financial.

In coordination with the IEU and the HAS, six countries were selected for country case studies and a visit by the evaluation team. Countries were selected on the basis of a broad-based geographic distribution, and a balance of on-going programming activities in both community and prison settings. The country visits began in October 2013 and were completed by December 2013. In chronological order, the visits were; the Republic of India, the Federal Democratic Republic of Nepal, the Kyrgyz Republic, the Republic of Kenya, the Republic of Zambia and finally the Federative Republic of Brazil. The evaluation team also had the opportunity to visit UNODC in Vienna, Republic of Austria and UNAIDS Secretariat and WHO Headquarters, Geneva, Swiss Confederation.

Over 250 key informants were interviewed for the evaluation and in addition the evaluation team designed an online survey that gave individuals with a stake in UNODC's policies and programmes, an opportunity to share their views, confidentially.

The findings of the evaluation are based upon a triangulation of a wide range of sources and different data collection methods and the findings have been grouped around the eight evaluation criteria.

Main Findings

The overall findings indicate that the Global Programme is relevant and contributing to the overall priorities within the UN system of progressing country needs and reaching beneficiaries needs with the types of projects and programmes that UNODC is best placed to implement. The Global Programme has not been as relevant with civil society participation at the global level and a more open, meaningful and participatory approach is required to re-establish strong linkages with civil society at the global and regional level. The portfolio efficiency and effectiveness is satisfactory and the projects are managed and documented well. However, there are concerns about how country-level projects are designed, such as unsuitable output, outcome and impact indicators to measure implementation, effect and impact effectively and without the required baseline data that can help to ensure a project's success. There are also concerns about the sustainability of the Global Programme and individual project sustainability which has evidenced that many projects are either pilots or terminate once the funding period ends. This has not allowed for integration into national programmes that can sustain and scale-up successful models implemented by the Global Programme. The majority of project evaluation reports analysed by the evaluation team substantiated this area of weakness. The findings reveal that projects that have had the most success are projects with a strong component focused on advocacy. These are projects in which UNODC has capitalized on its convening influence to bring together a strategic mix of stakeholders to influence and improve policy and laws that can have negative impacts on the health and human rights of PWID and people living in prisons and other closed settings. In addition, the evaluation findings reveal strong evidence of projects that are gender sensitive and equitable. Many projects in the portfolio are targeted toward hard-to-reach populations such as women who inject drugs, young people and refugees. There are concerns that UNODC is not using its influence and convening power in protecting human rights, and specifically in countries that continue to incarcerate PWID into forced detention centres, and in settings where primary components of the comprehensive harm reduction package are illegal (e.g. where Opioid Substitution Therapy and/or Needle and Syringe Programme are not permitted). Greater support and leadership from senior management could also generate more impact

for the Global Programme's advocacy initiatives by engaging with senior officials and parliamentarians who are responsible for bringing about changes in law and policy.

Conclusions

Based on the evaluation findings, the overall conclusion of the evaluation can be summed up as "doing well but could do better". The Global Programme clearly has had many successes, including a cadre of extremely competent and dedicated staff working across the globe. The work on advocacy, capacity building and working with, and providing services for, extremely vulnerable groups such as young people, street children and refugees/internally-displaced people is commendable. The Global Programme would benefit from public support for its work from senior leadership within UNODC and specifically for supporting the principles and methods of harm reduction and the protection from human rights abuses suffered by PWID and people living in prisons and other closed settings. At the operational level, although projects are managed well, data management and usage could be improved. More time should be spent at the design phase of projects to ensure that any project has clear outcomes, is measurable and is relevant to the country needs. Exit plans should be put in place and the management of risk at all levels within the Global Programme should be a priority and risks reviewed on a regular basis. A standardised set of core indicators that will determine both the effect and impact of programmes could be used for all projects would enable managers and advisers to more accurately measure the impact of interventions. The continuing alignment of planning and reporting within the UBRAF at the country level is important and will support UNODC in ensuring that the projects it is implementing continue to be relevant within UBRAF priorities.

Recommendations

The recommendations of the evaluation team are grouped around strategic recommendations (7), operational recommendations (6), and recommendations for the UNODC country office in the six case study reports (The Republic of India 4, The Federal Democratic Republic of Nepal 3, Kyrgyz Republic 6, Republic of Kenya 3, Republic of Zambia 3, Federative Republic of Brazil 3). The evaluation team recommends that senior leadership within UNODC should use international events where UNODC is present to reiterate the organisational support to the HAS and its support for harm reduction as an evidence informed intervention that is critical to meet the international commitments to Global AIDS Response Progress Reporting (GARPR) and UNAIDS. The Global programme needs to become more strategic. The current portfolio is too diverse and an operational strategy for the HAS that responds to the UNODC Thematic Programme and is aligned with the UBRAF is required. The HAS has begun this refocusing and has selected 24 priority countries[10]. The evaluation team recommends that the GLOG32 funds earmarked for PWID projects be allocated across these 24 countries in order to scale-up the programmes implemented in these countries. It is also recommended that the HAS recruits more

[10] Asia: Republic of Indonesia, People's Republic of China, Islamic Republic of Pakistan, Republic of India, Socialist Republic of Viet Nam, Kingdom of Thailand, Republic of the Philippines. Eurasia: Republic of Tajikistan, Republic of Belarus, Ukraine, Kyrgyz Republic, Republic of Moldova, Republic of Uzbekistan, Republic of Kazakhstan. Latin America: Federative Republic of Brazil, Republic of Argentina. MENA: Arab Republic of Egypt, Islamic Republic of Iran. Africa: Republic of Kenya, Republic of South Africa, Federal Republic of Nigeria, United Republic of Tanzania

technical advisers with skills and experiences in areas such as human rights, law enforcement and prison settings or policy and legislation to compliment the existing public health and HIV expertise that dominates the staffing structure.

A communications strategy is also recommended that will inform all stakeholders and organisations about the goals, objectives and strategies of the Global Programme. As the evaluation has found and concluded, there is a significant amount of data, achievements, challenges overcome etc., which are not disseminated sufficiently. The findings note the excellent publications that come from UNODC, either individually, or, more importantly, co-branded with UNAIDS and World Health Organization (WHO), but more regular updates of progress, challenges, successes or individual stories of human interest value would raise the profile of the Global Programme significantly. In today's communications dominated world this is more important than ever for UNODC to remain not only relevant but also visible.

Lessons Learned

The programme has produced valuable lessons learnt through more than 10 years of implementation. However, the first and most important one is related to the lack of a systematic way to recognize and identify lessons learned and best practices, as well as the means to transfer the experiences, models and best practices through a knowledge management system. In spite of this, the programme is learning from projects as they are implemented at a high cost and slow implementation rate and where many projects are closing down without prospects of continuity or exit strategies in place, not allowing for sustainability. In addition, a key lesson learned is to invest more resources in the design and identification phase of projects to include a good analysis of risks and future prospects about the interventions to be implemented. Other interesting lessons come from the model of interventions that some projects are using to reach out to most marginalized targeted people such the ones implemented in Federative Republic of Brazil with transgender population or women who inject drugs in The Federal Democratic Republic of Nepal.

SUMMARY MATRIX OF FINDINGS, EVIDENCE AND RECOMMENDATIONS

Findings[11]	Evidence (sources that substantiate findings)	Recommendations[12]
Key recommendations		
The programme is considered very relevant by the majority of the stakeholders interviewed. UNODC is fully contributing to the objectives of the UBWs/UBRAF and operationalizing it at the country level. Planning and reporting are fully in line with UBRAF mechanisms	Key Informants at country level and from other UN agencies interviews and survey.	HAS should continue with the same approach and fine tune their interventions by investing more time and resources at the design stage of projects development within the context of their priority countries.
The evaluation found that the programme fostered and achieved examples of excellent collaboration among national government counterparts that otherwise would not have happened and that were key to create the enabling environment where HIV/AIDS interventions could have a positive effect. In particular, this has occurred between institutions in the law enforcement and health sectors.	Direct observation, review of archival records and interviews.	UNODC's convening role is an essential part of the solution as well as a comparative to problems in the health sector with linkages to other key sector in the country such as law enforcement. UNODC should strengthen this convening role and expand it, including it as part of the packages of services that offers across countries and regions
During the evaluation period 2008-2012 there has been limited public endorsement of harm reduction norms and standards from senior management in UNODC, notably during annual World AIDS Day statements or CND sessions	Review of archival documents, direct observation, interviews with stakeholders.	UNODC leadership should support the objectives of the Global Programme by supporting harm reduction as a practical, evidence based solution in the CND and other important international fora.

[11] A finding uses evidence from data collection to allow for a factual statement.

[12] 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.

The evaluation has found the programme has some gaps on regards of having an explicit and detailed strategy to guide operations at the global level other than the concentration and prioritization of activities in a list of countries and the deployment of advisers in the field.	Archival records of the programme, financial documents and GLOG32 project document and revisions.	HIV/AIDS section should develop and implement a targeted, measurable and costed strategy for the Global Programme for 2015-2020. This should reflect the new strategic directions that the Global Programme has initiated and focus on GLOG32 PWID resources on the 24 priority countries, supporting civil society and providing high level leadership and technical assistance to deliver a more focused impact with less disperse coverage.
Overall the programme is performing well and individual projects have clearly had impact, particularly in the areas of policy support, training of a wide range of stakeholders in different aspects of HIV prevention, treatment and care for PWUD, advocacy, particularly with policy makers and some innovative programmes reaching hidden populations such as street children and female drug users.	Review of archival documents, direct observation, interviews with stakeholders and on-line survey.	The programme should rearrange the way to do business to release its full potential for impact. More specifically the HAS should only engage in direct delivery of services as part of demonstrative pilots. Otherwise, they should rather focus on the provision of advisory services and public policy advice filling the gap between law enforcement and health policies at country and global level. This would include high level advocacy to create an enabling environment for the provision of HIV/AIDS evidence based services to targeted populations.
There has been significant progress in ensuring more robust monitoring and reporting systems both internally and also with regard to UBRAF reporting. But substantial work is required to ensure that country offices have the necessary capacity to more effectively measure the programme's outcomes and impact and not simply focus on measuring activities and outputs.	Review of archival documents, direct observation, interviews with stakeholders	Given that there is a serious deficit in programmatic, and surveillance data on PWID to inform the HIV/AIDS global response, the HIV/AIDS Section should seek to enhance its monitoring framework to inform the area of PWID under the UN Global AIDS Response Progress Reporting and associated UNAIDS M&E and epidemiologic data triangulation as a matter of priority. The set of universal outcome level indicators that have been designed by the

		HAS and aligned with UBRAF outcomes should be finalised and introduced into country programmes before the end of 2014 to more effectively plan and monitor programmatic performance and to improve reporting upward to the HAS in Vienna and the UBRAF systems in UNAIDS. Impact indicators should be developed to be able to examine the impact of UNODC's HIV programme.
UNODC's relationship with Civil Society at the global coordination level has significantly improved since November 2012, that can, to a large degree, be credited to the HAS team in Vienna who have demonstrated a more open and collaborative approach to working with Civil Society and have prioritised this in their work plan. This was acknowledged by all the global CSOs that participated as key informants.	Interviews with stakeholders and archival reviews.	It is recommended that country strategies for the 24 priority countries should be identified in partnership with CSOs and be reviewed through an equity lens. This will ensure that, where appropriate, the needs of various age groups, genders, socioeconomic status, educational status and geographic status are addressed.
Human rights are not systematically integrated in the project portfolio. References to human rights, or to how legal and policy frameworks would be addressing human rights and legal and policy reform are issues that were not uniformly addressed.	Project reviews and assessments and interviews.	Human rights considerations and principles should be embedded in any future strategy and or intervention. UNODC should consider developing a strategy document on how to improve human rights mainstreaming within its projects and the overall global strategy of the Programme. All future projects should be reviewed for human rights, legal and policy issues, regardless of the political environment.
Important recommendations		
The HIV section has many competent and experienced HIV advisors and public health experts; however,	Archival review, interviews with stakeholders, direct observation.	Review current staff skills and capacity and produce a gap analysis for future recruitment purposes.

based on the review there may be a requirement to recruit additional skills such as legal expertise, law enforcement or policy formulation. It is important to have internal capacity in areas beside HIV and public health experience at the global and country level		
Project level evaluations found weak M&E systems in projects implemented at country level, with output and outcome indicators focusing at the activity level, rather than on the ability to assess impact and without the required baselines, targets/milestones to measure progress.	Independent project evaluations, archival review, interviews with stakeholders.	It is recommended that UNODC invest in more monitoring and evaluation capacity and systems, as evidenced throughout the evaluation report, either through specialist staff or by contracting short-term technical assistance.
The visibility and openness about the work and results that the HIV/AIDS section achieves is not sufficiently reaching and informing donors, policy-makers and civil society	Stakeholders Interviews, direct observations.	HIV/AIDS unit should develop a more targeted communications strategy using a variety of media platforms to be able to communicate different results including the excellent publications that frequently publishes.
UNODC has a comparative advantage, due to its mandates, to work in prisons and with law enforcement and drug related agencies.	Archival documents, project review and assessment, interviews.	The expansion of the Global Programme's prison work, through more investment from GLOG32 and other funding sources available should be prioritized. Equally important is the overall priority on prison work within the UBRAF and the convening role that is the responsibility of UNODC.

I. INTRODUCTION

Background and context

People who inject drugs are among the most severely affected by human immunodeficiency virus (HIV). In virtually all countries reporting data in 2012 to the Global AIDS Response Progress Reporting (GARPR), the prevalence of HIV infection is higher among people who inject drugs than among the general population. In 49 countries with available data, HIV prevalence is estimated to be at least 22 times higher among people who inject drugs than for the population as a whole, with an estimated prevalence at least 50-fold higher in 11 countries[13]. The Reference Group to the United Nations (UN) on HIV and Injecting Drug Use estimated in 2008 that 15.9 million people inject drugs, of which an estimated 3 million are living with HIV[14].

According to the United Nations Office on Drugs and Crime (UNODC), each year at least 30 million men, women and children go through prison systems globally and most of them return to the community. In some settings, UNODC estimates that the HIV prevalence rates are high (up to 65 per cent) and up to 50 times higher than in the community[15]. In closed settings without access to sterile injecting equipment, condoms and quality healthcare, HIV as well as tuberculosis (TB), hepatitis B and C (HBV, HCV) and other infectious diseases can be easily transmitted[16].

The UNODC Global Programme on HIV/AIDS (the Global Programme) is coordinated and managed by the HIV/AIDS Section (HAS) and is situated within the Drug Prevention and Health Branch that is overseen by the Division for Operations (DO) at UNODC headquarters (HQ) in Vienna and implemented globally through UNODC regional and country offices in partnership with a broad range of governmental, multilateral and non-governmental stakeholders.

The Global Programme is based on declarations, resolutions and decisions adopted by United Nations Governing Bodies[17]. The focus of UNODC's Global Programme is to support countries' progressing towards universal access to HIV prevention, treatment, care and support for people who inject drugs (PWID) and for people living and working in prisons and other closed settings. In addition the Global Programme aims to support national programmes in setting targets,

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[13] Global report: UNAIDS report on the global AIDS epidemic 2012, Page 36. Country specific data not shown. Accessible at: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/jc2434_worldaidsday_results_en.pdf

[14] Mathers BM, Degenhardt L, Phillips B, et al, for the 2007 Reference Group to the UN on HIV and Injecting Drug Use. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. Lancet 2008; 372: 1733–45.

[15] Extracted from UNODC GLOG32 project document and revisions 2012

[16] UNODC, WHO, UNAIDS, ILO, UNDP, UNAIDS (2013). HIV prevention, treatment and care in prisons and other closed settings. Accessible at: http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

[17] Refer to Annex 1 Terms of Reference for list of all relevant declarations

strengthening monitoring and evaluation, reviewing, formulating and adapting policies and legislation and building capacity to implement evidence-based interventions[18] based upon the 2009 Technical Guide[19] that was developed and co-published with The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and revised in 2012[20]. This guidance outlines the comprehensive package of HIV-related services designed specifically for people who inject drugs and explains the continuum of services framework that is implemented through outreach, primary prevention and drug dependence facilities. The nine interventions include:

(a) needle and syringe programmes; (b) opioid substitution therapy and other drug dependence treatment; (c) HIV testing and counselling; (d) antiretroviral therapy; (e) prevention and treatment of sexually transmitted infections; (f) condom programmes for injecting drug users and their sexual partners; (g) targeted information, education and communication for injecting drug users and their sexual partners; (h) vaccination, diagnosis and treatment of viral hepatitis; (i) prevention, diagnosis and treatment of tuberculosis.

The interventions have undergone rigorous peer review, and applying them correctly, consistently and at scale can significantly reduce HIV transmission[21]. In addition, the continuum of care outlines other health, social and legal services that would be beneficial to include in any programme targeting PWUD, such as people who inject drugs in reintegration services and access to employment and training opportunities.

Programmes that UNODC implements in prisons and closed settings are also guided by a joint publication/guidance that was developed and published by UNODC, WHO and UNAIDS (2006)[22], which provide tools and instructions for the development of HIV services in prisons and other closed settings. During 2011/2012 an additional policy brief was co-published with WHO, UNAIDS, United Nations Development Programme (UNDP) and International Labour Organization (ILO) that outlined the 15 key interventions that should be implemented in prisons and other closed settings[23]

The Global Programme links to the broader UNODC objectives specifically on the "Thematic programme on addressing health and human development vulnerabilities in the context of drugs and crime" and specifically contributes to the UNODC Strategic Framework 2012-2015[24] under sub programme 5 'Prevention, treatment and reintegration and alternative development" that has the following objectives and expected results:

Objective: Reduction of drug abuse and HIV/AIDS (as related to injecting drug abuse, prison settings and trafficking in human beings).

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[18] Extracted from UNODC GLOG32 Project document and revisions 2012

[19] The 2009 Technical Guide can be accessed at: http://www.who.int/hiv/pub/idu/targetsetting/en/index.html

[20] The 2012 revision can be accessed at: http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html

[21] A Ball & M Beg (2005). Editorial: Evidence for action: A critical tool for guiding policies and programmes for HIV prevention, treatment and care among injecting drug users. International Journal of Drug Policy 16S (2005) S1–S6

22 UNODC, WHO, UNAIDS HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response (United Nations, New York, 2006)

[23] UNODC, ILO, UNDP, WHO, UNAIDS: HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions (Vienna 2011)

[24] Refer to annex 5, Desk Review for details of UNODC Strategy 2012-2015

Result area 5.3: HIV/AIDS and care (as related to drug users, in particular injecting drug users and based on scientific evidence, in prison settings and trafficking in human beings).

5.3.1 Expand Member States' capacity to reduce the spread of HIV/AIDS among drug users, in particular injecting drug users and based on scientific evidence, in conformity with relevant international conventions and the established mandates of UNODC.

5.3.2 Expand Member States' capacity to reduce the spread of HIV/AIDS in prison settings.

5.3.3 Expanding, in consultation with the Member States concerned, the capacity of relevant entities of civil society to respond to HIV/AIDS among drug users, in particular injecting drug users and based on scientific evidence, and in prison settings, in accordance with relevant international conventions and the established mandates of UNODC.

UNODC is one of the 10 (11 as of 2012) co-sponsoring agencies of UNAIDS. UNODC is the convening agency for ensuring a comprehensive and inclusive approach to preventing HIV among PWID and for people in prison and other closed settings. The UNAIDS division of labour framework[25][26] outlines the functions and responsibilities for each convening agency. UNODC is responsible for area 5 "Protect drug users from becoming infected with HIV and ensure access to comprehensive services for people in prisons and other closed settings" and works closely with six additional UN agencies[27] to ultimately enhance the efficiency and effectiveness of the global HIV response by the UN system towards responding to the needs of PWUD, and PWID specifically, and for people living and working in prisons and other closed settings. The aim of the division of labour is to "leverage respective organisational mandates and resources to work collectively to deliver results, including strengthening joint work and maximizing partnerships"[28]

The UNAIDS programme has been guided by a series of strategies and work programmes[29] that identify the key priorities, objectives, outcomes, responsibilities, deliverables and resources required by the UN system, including the UNAIDS Secretariat, to respond to the global epidemic. The current strategy runs from 2011 to 2015 and aims to revolutionise HIV prevention including all new HIV infections prevented among people who use drugs by 2015.

UNODC is also committed to supporting the 2011 General Assembly High Level Meeting on AIDS target of 50% reduction of HIV infection among PWID. UNODC's activities and projects are additionally aligned within the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF)[30].

The HIV/AIDS global programme consists of 34 individual projects that are widely varied in terms of duration, budget, geography, target group and other variables. There is no specific operational strategy for the Global Programme or specific priorities in terms of geographic

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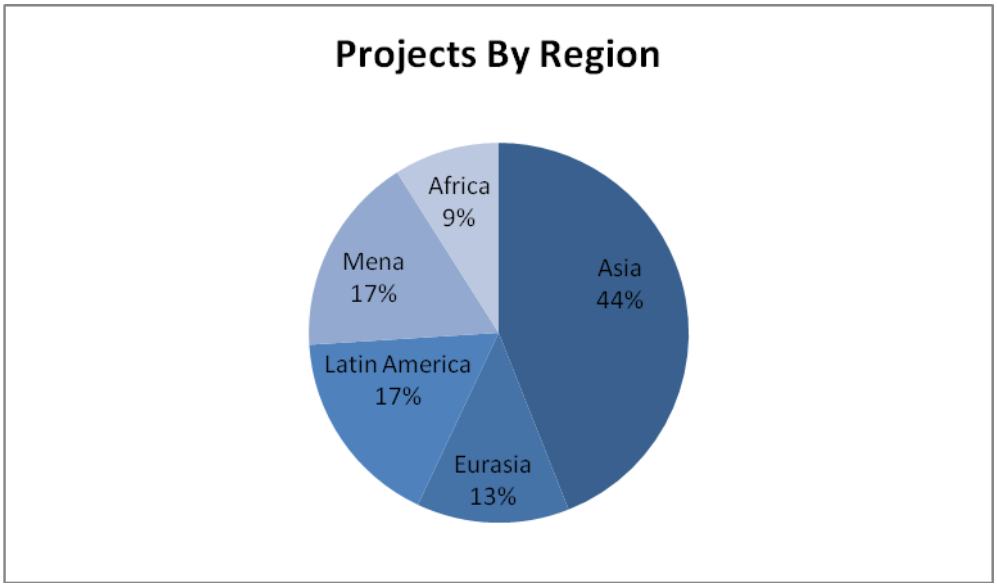
[25] UNAIDS Division of Labour 2010: Consolidated Guidance Note (Geneva, Joint United Nations Programme on HIV/AIDS, 2011).
[26] Refer to annex 5 Desk review for the complete UNAIDS Division of Labour Framework
[27] WHO, UNICEF, UNDP, UNFPA, UNESCO and the World Bank
[28] UNAIDS Division of Labour 2010: Consolidated Guidance Note (Geneva, Joint United Nations Programme on HIV/AIDS, 2011).
[29] Refer to annex 5 desk review for more details on UNAIDS strategies and UBW, UBRAF
[30] Refer to annex 5 desk review for more details on UNAIDS strategies and UBW, UBRAF

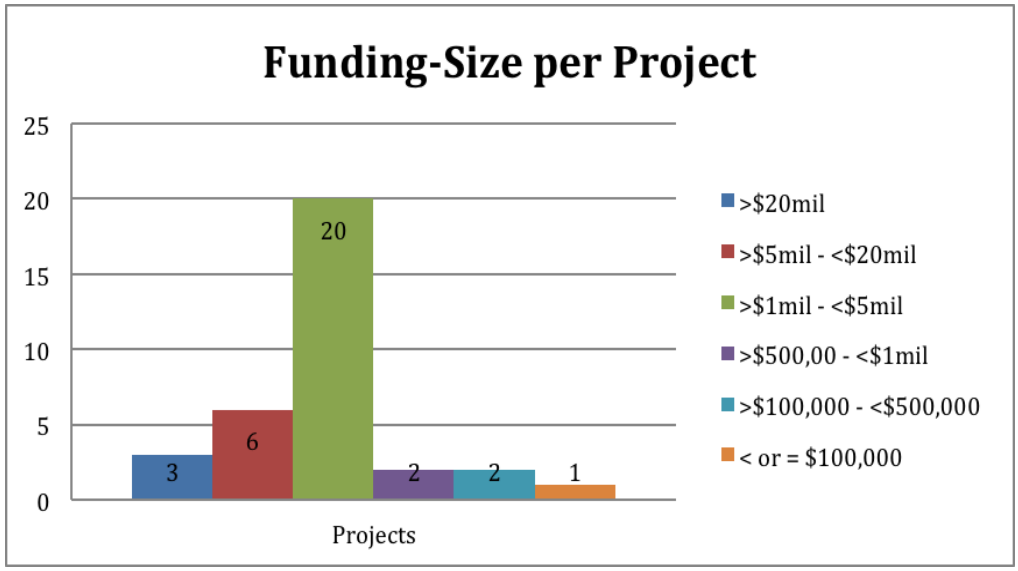
region, target groups or specific areas of intervention. Of the 34 projects[31], one is global, GLOG32, 10 are regional projects and 23 single country projects. The global project, GLOG32, is a multi-donor, long-term (13 years) project that provides the majority of human resources to both HQ and regional and country offices[32].

UNODC has been implementing projects in 41 individual countries during the evaluation period 2008-2012. In terms of geographic distribution, 44% of projects are implemented in the Asia region (3 regional projects and 10 single country projects in the Islamic Republic of Afghanistan, the People's Republic of China, the Republic of the Union of Myanmar, the Federal Democratic Republic of Nepal, the Islamic Republic of Pakistan, the Republic of India, Lao People's Democratic Republic and the Socialist Republic of Viet Nam). Sub-Saharan Africa has 9% of the portfolio including four regional projects and country projects in the Republic of South Africa and the Republic of Kenya. Similarly, 13% of projects are in Eurasia with projects implemented in the Russian Federation and Romania and three regionally based projects. Latin America consists of four projects, the majority (three) implemented in the Federative Republic of Brazil and a small project in the Oriental Republic of Uruguay. The MENA region also implements four country projects in Libya, the Arab Republic of Egypt, the Islamic Republic of Iran and Palestine. Both the Latin America and Mena regions are implementing 17% of the portfolio.

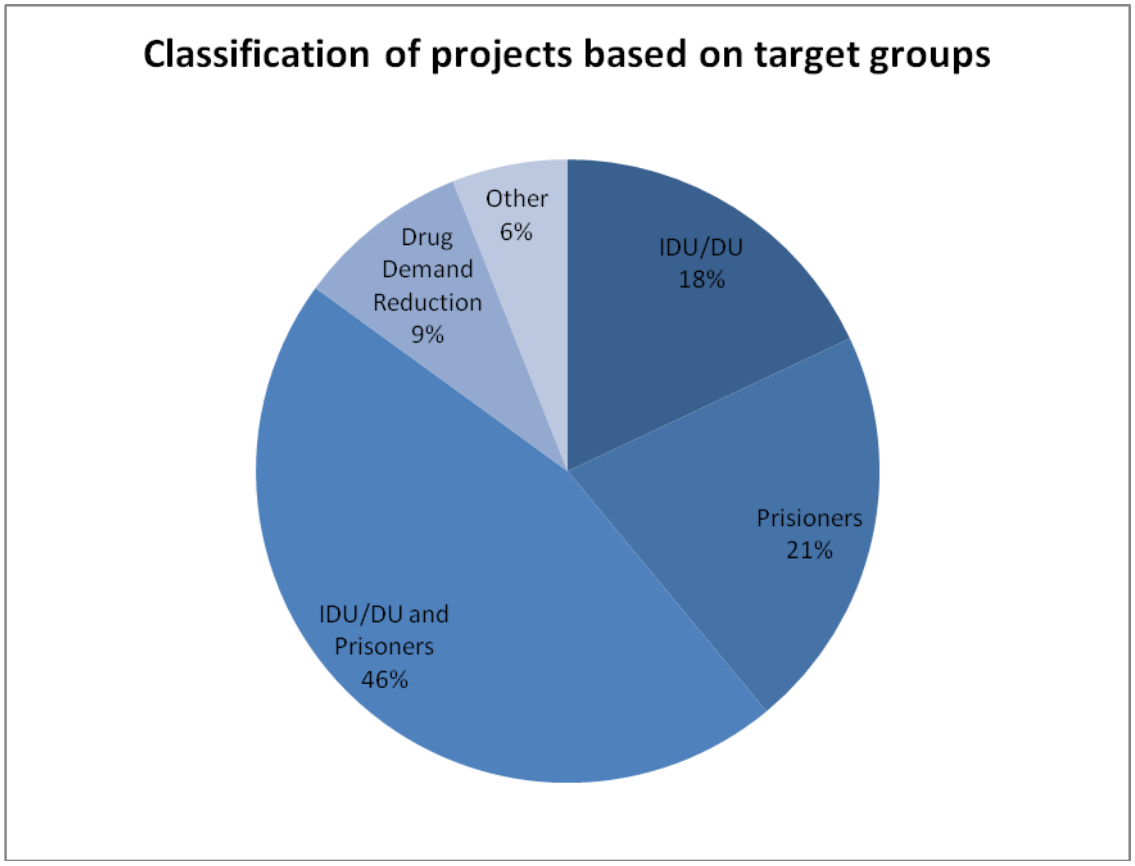


Of the 34 projects, the majority (20) have budgets ranging from $1-5 million, six projects are in the $5-20 million and three have budgets in excess of $20 million, including GLOG32 and two of the three projects implemented in the Federative Republic of Brazil. A small number (5) range from $100,00 – 1 million, although these are still fairly considerable funding levels, even at the lower scale.

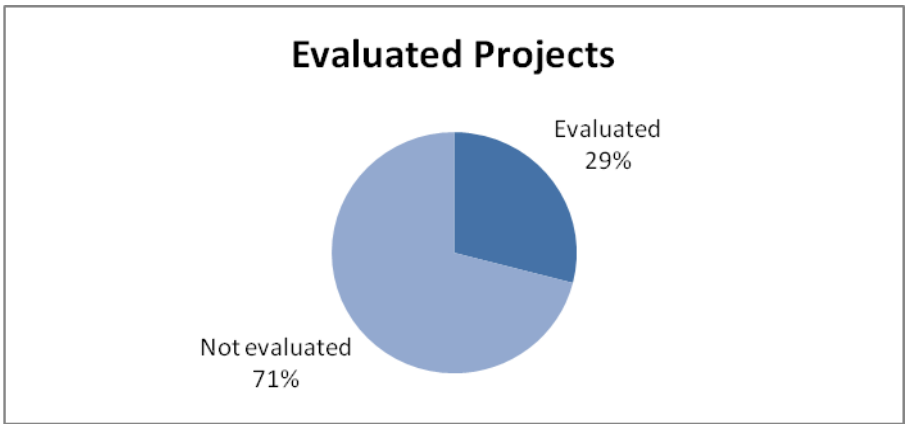
[31] Refer to annex 6 for a full list of project codes, titles, location and duration
[32] GLOG32 Project Revision Document, HAS, January 2013



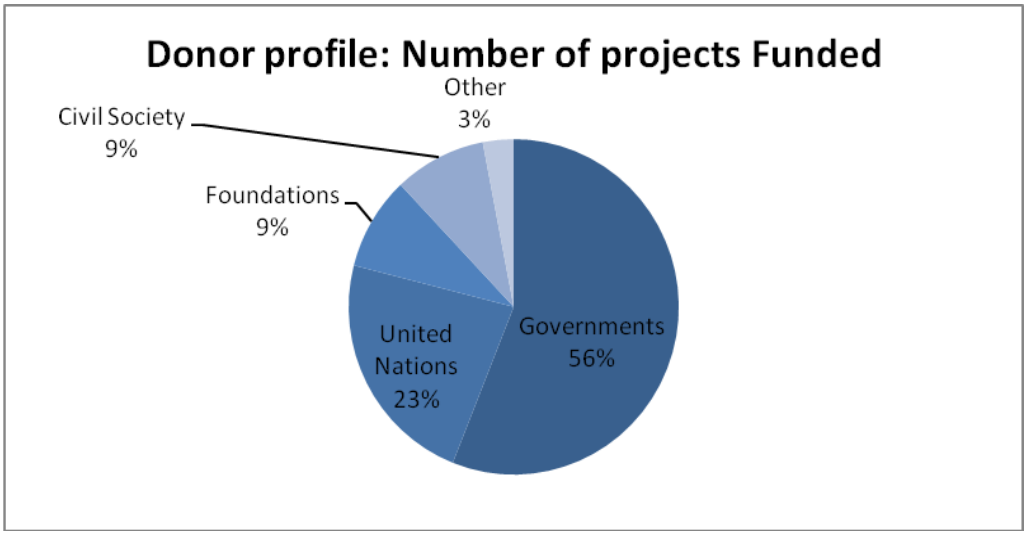
Projects with PWID as the main target group represent 18% of the project portfolio with prison/incarcerated people representing 21%. However, 46% of the project portfolio identifies both PWID in the community and in prisons as the main target groups, amounting to 85% of the entire portfolio. Somewhat surprisingly 9% of the projects, including a regional project in West Africa were primarily focused on drug demand reduction activities.



By the end of 2012, 59% of the Global Programme project portfolio (20 projects) was operationally complete. Of those 20 completed projects, six have been evaluated[33]. An additional four on-going projects have been evaluated[34], resulting in the bulk of projects in the portfolio, 70% not having received any independent evaluation including 70% of projects that are operationally complete.



The Global Programme demonstrates a large and diverse funding base. Aside from core funds received as part of the UBRAF from UNAIDS that contribute to approximately $5 million annually to the project GLOG32, UNODC benefits from a range of donor agencies, with the majority (56%) of funds received from donor member states, which would be expected for a UN agency. The Kingdom of the Netherlands and the Kingdom of Sweden have funded the most projects. The donor profile also includes foundations, funds from other UNAIDS Co-Sponsors, most notably WHO and UNDP, and also funds received from the Global Fund to Fight AIDS, TB and Malaria[35].



[33] Completed projects that have received an independent evaluation include project codes: XASJ72, RAFG66, XEEJ20, MMRJ63, ROMJ19, RUSJ12, RUSJ17

[34] On-going projects that have received an independent evaluation include project codes: RASH13, RASH71, KENI08, MMRJ69, RAFG60

[35] UNODC is not a PR or SR for any Global Fund Grants but participates on 8 CCM's and TWGs.

The evaluation of the Global Programme was requested by the UNODC Executive Committee (ExCom), which, at its meeting of 13 July 2011, decided to include an In-Depth Evaluation of UNODC's HIV programme in the work programme of the Independent Evaluation Unit (IEU) for 2012.

Terms of Reference (TOR)[36] were developed and in September 2013 a three-person team consisting of a Lead Evaluator (independent consultant), a Public Health expert (independent consultant) and a member of UNODC's IEU were formed. The purpose of the evaluation was designed to analyse the performance of the Global Programme and the portfolio of 34 projects and to develop a series of recommendations, best practices, lessons learnt. These could be used to guide the development of the next phase of the Global Programme when both the UNODC internal strategy and UBRAF end in 2015. The evaluation also aims to identify areas of weakness within the portfolio and suggest areas of improvement and in particular regarding the efficiency and effectiveness of the global programme.

There are five specific objectives for the evaluation[37]:

1. To measure the extent the Global Programme has contributed to solve the needs and problems identified in the design phase as well as the organizational distribution of roles and responsibilities among partners aimed at achieving the objectives, outcomes and outputs as stated in UNAIDS Unified Budget and Workplan (UBW) 2008-2009 and 2010-2011, UNAIDS 2012-2015 UBRAF, and UNODC Strategic Programme Framework 2008-2012.

2. To measure the Global Programme's degree of implementation, efficiency and quality delivered on outputs and outcomes as stated in UNAIDS UBW 2008-2009 and 2010-2011, UNAIDS 2012-2015 UBRAF, and UNODC Strategic Programme Framework 2008-2012, against what was originally planned or subsequently officially revised.

3. To measure to what extent the Global Programme has attained results to the targeted populations, participants whether individuals, communities, institutions, etc. as stated in UNAIDS UBW 2008-2009 and 2010-2011, UNAIDS 2012-2015 UBRAF and UNODC Strategic Programme Framework 2008-2012.

4. To identify and document substantive lessons learned and good practices as to provide recommendations on key aspects that suggest strategic directions for UNODC in the context of the organization's HIV mandate and relevant declarations, resolutions and decisions adopted by United Nations Governing Bodies.

5. To assess to which extent the findings and recommendations contained in previous evaluations of HIV related investments are or are not further substantiated by this evaluation.

As previously mentioned, the scope of the evaluation covered GLOG32 "HIV/AIDS prevention, treatment, care and support for people who use drugs and people in prison settings" along with the 33 above mentioned additional projects that were operational during the period 1 January 2008 – 31 December 2012.

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[36] Refer to annex 1 Terms of Reference
[37] Extracted from Terms of Reference

Evaluation Methodology

The Global HIV/AIDS Programme is an ongoing UNODC intervention that will continue being implemented unless there are major systematic changes within the global HIV architecture. As such the evaluation of the Global Programme is formative in nature and its main purpose has been to derive recommendations based on evidence-based findings to identify areas of improvement, tackle problems, and assess and record challenges and achievements. The unit of analysis of the evaluation is the programmatic response of UNODC to HIV/AIDS during the years 2008-2012 that comprises 34 projects.

In addition to reviewing relevance, partnerships, efficiency and effectiveness, the evaluation ToR requested evidence of impact and sustainability. Given the formative nature of the evaluation, and the type of data available, it is not possible to determine the impact of the Programme. This would involve a different type of design (i.e., an impact evaluation). To address this, the evaluation team adopted a mixed methods approach in which a variety of data sources were triangulated to increase validity of the findings in all areas. These sources included key informant interviews, focus groups, observation, an online survey, criteria-based scored project reviews and archival review.

To address internal validity of the findings, as it is not possible to determine causality, every effort was sought to strengthen the evidence of potential associations. It is not possible to assess external validity, which would require generalizability of the data and was not the purpose of this evaluation.

The sampling strategy for the key respondent interviews was both purposive and convenience sampling. This allowed for an increase in the sensitivity of viewpoints on the Global Programme and to reduce selection bias. However, not all organisations or potential stakeholders of the Global Programme were likely represented as this was beyond the scope of this evaluation.

The evaluation team devised a strategy to collect and analyse data from the 34 sub-units of analysis with the aim at minimizing the threats to validity of the study.

Design and Data collection instruments[38]

The evaluation team designed three different types of data collection instruments; an archival review and desk assessment protocol, an individualized interview guide for semi-structured interviews, an online survey administered to project stakeholders and direct observation in the field. These multiple methods of collecting data along with the various data sources consulted set the path for an improved triangulation of the data collected and reduce a major source of internal validity threats.

The archival review[39] covered written records and documents available including; original project document/proposal, log frame, project revisions and justifications and project evaluations, progress and annual reports, data tables, financial reports; project products, etc.

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[38] Refer to annex 2 for the set of evaluation tools employed by the evaluation.

[39] Refer to annex 3 for a complete list of documents reviewed.

More than 250 interviews[40] have been conducted from a wide variety of stakeholders in eight countries[41]. These include donor governments, recipient governments and other member states, global, national and local CSO representatives, UNAIDS representatives, WHO representatives, HIV/AIDS Vienna unit, in-country HIV advisors, UNODC senior managers at headquarters and in the field, direct beneficiaries and academics.

Five different types of interview guides[42] were applied to adapt the semi-structured interviews to a different range of stakeholders. All of them included questions based on the evaluation criteria established in the TOR: relevance, efficiency, effectiveness, impact, sustainability and additionally partnerships and management arrangements. For these categories, there were sub-questions, including questions on gender, equity and human rights. At least two members of the evaluation team conducted the majority of the interviews to ensure for two different viewpoints. Following the interviews, the evaluators reviewed notes and sought to derive convergent and divergent themes from the interview.

An online survey[43] of the project stakeholders was conducted as one of the core components of the Global HIV/AIDS Programme's evaluation. This survey was an integral piece of the larger evaluation, providing an opportunity to individuals with a stake in UNODC's policies and programmes to share their views, confidentially. This survey tool was developed from a standard evaluation paradigm eliciting responses in a likert-type format or in open-ended responses based on the categories (used in the larger evaluation): 1) relevance, 2) efficiency, 3) effectiveness, 4) impact, and 5) sustainability. For these categories, there were sub questions, including questions on gender, equity and human rights.

A convenience sample (as described above) of participants from 1) UNODC global, regional and country staff, 2) all individuals surveyed on the six country visits and within their civil society, stakeholder and beneficiary networks, 3) International, regional and country harm reduction organization staff, and 4) UNAIDS, WHO and other multilateral staff were sent the survey and asked to participate. The letter of invitation also invited participants to purposively send the survey to relevant stakeholders and counterparts within their organizations and within civil society. Due to this design, which aimed to maximize inclusiveness, a denominator of all potentially eligible participants is not possible to determine and therefore no response rate is provided.

Data Analysis

The combination of three different backgrounds, perspectives and expertise in the members of the evaluation team has decisively contributed to correct deviations in the interpretations of the data and consolidating the evidence into strong and credible findings. The three main data and information analysis have been always vetted by each of the three evaluators based on different analytic perspectives.

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[40] Refer to annex 4 for a detailed list of institutions, people and countries covered.

[41] Republic of Austria, the Swiss Confederation, the Federal Democratic Republic of Nepal, the Republic of India, the Kyrgyz Republic, the Republic of Kenya, the Republic of Zambia and the Federative Republic of Brazil

[42] Refer to annex 2 to consult the different templates of interview guides.

[43] Refer to annex 7 for the Project review findings and annex 8 for the analysis of results of the on-line survey.

The evaluation team carried out a criteria based review and assessment of the archival record of project documents and reports for each project of the global portfolio, translating the result into 34 project review sheets. The criteria used to assess the data were the one included in the evaluation terms of reference, Relevance, Efficiency, Effectiveness, Impact, Sustainability, and Partnerships.

The review and assessment of the portfolio is based on annual reports from the UNODC's "ProfiFinancial Information Management System (ProFi) and 12 independent evaluations completed and available for projects as of December 2012. The results have been consolidated in a chart compiling the key information coming from the review sheets for each project. A traffic light system was used for each project assessed[44].

In addition to the primary criteria for the evaluation included in the TOR a review of all projects was completed to go beyond these criteria and ensure that an examination of projects key aspect in areas of public health, human rights, gender, equity, and strategic information.[45] The traffic light system was also applied for each project assessed.

Both types of reviews and assessments of the project portfolio were conducted by two different members of the evaluation team. The two members of the team reviewed all documents and proposed a scoring for each project to the rest of the evaluation team. The rationale for the proposed scores were discussed during three working sessions in which each team member commented and provided their views. The final scoring for each project was adopted by consensus among the three-team members. A partial review of the scores was conducted during the first weeks of January following the same process mentioned above. In this occasion the working sessions were substituted by an exchange of e-mails followed by the adoption of the final scores by all members of the team.

The on-line survey was shared through a link in the emailed invitation letter. The survey was open, on-line for two weeks in December 2013. Responses were sent to the online survey platform (Adobe Forms Central, Inc.), and as such no identifying information such as email addresses were obtained.

Once on the web survey page, survey participants were invited in their capacity as a key informant/stakeholder to participate in this web-based survey on the Global Programme. Participants were informed that UNODC Independent Evaluation Unit (IEU) was conducting an independent evaluation of activities of the Global Programme HIV/AIDS for the implementation period 2008 and 2012. Participants were reminded that their input could not be traced back to them and were asked for their honest and thoughtful responses. They were also informed that their responses would be an important contribution towards understanding the implementation of the project activities and how these have impacted on their organization's progress in the area of HIV and injecting drug use. Participation in the survey was voluntary, confidential. No compensation was offered for participating in the survey.

[44] Refer to annex 7 for the Project review findings and annex 8 for the analysis of results of the on-line survey.
[45] Refer to annex 7 for the Project review findings and annex 8 for the analysis of results of the on-line survey.

Limitations to the evaluation

Overall, the evaluation process had some limitations that had a partial impact on the process and the quality of the outputs delivered. The evaluation team has made every effort to overcome or partially reduce them by several means including:

a) One major limitation to the evaluation was the withdrawal of one of the evaluators at an early stage in the evaluation. The HAS and IEU mitigated the loss of the evaluator by identifying and hiring a new member of the team with long standing experience and expertise in public health issues with specific knowledge on gender and human rights. The new member of the team missed an important mission to HQ Vienna where 42 stakeholders where interviewed. However, notes from interviews and the missions that followed allowed for some of the time to update her on the evaluation process and details.

b) The time and calendar of the missions has put constraints to the ability to process the data collected. The first mission started on the 13 October 2013 followed by six consecutive missions that finalized on the 15 December 2013. The first draft of the report was scheduled to be delivered on 20 December just five days after data collection process was completed. The initial prospect of having a draft of the report ready by this date was unrealistic. Thus, the days devoted to the analysis of data needed to be increased in order to produce a suitable draft report.

c) Data paucity on the quantitative side and specifically on the effects that the interventions had on final beneficiaries has been a problem. The absence of baseline data and targets and indicators of success has been a challenge to measure effectiveness and impact. This has been an issue that the team tried to mitigate by collecting data though the on-line survey.

d) Despite the portfolio size of 34 projects implemented in 41 countries, only a small number of projects, six, were visited. Delays on the mission schedule, personal reasons of team members and scarcity of IEU staff prevented all the members of the evaluation team from visiting all the countries selected and this might have introduced some bias when reporting on evidence. The selection of countries was the product of a careful purposive portfolio analysis and the discussions with the HIV team in Vienna. The evaluation team believes that these countries and projects have provided a good sample of the range of projects undertaken by the HAS across the key target groups of injecting drug users in community settings, including specific programmes targeting women, and people who are incarcerated in different prison settings.

II. EVALUATION FINDINGS

Relevance

The major findings of the evaluation related to the relevance of the UNODC Global Programme are clustered around four key questions[46]. The evaluation team has addressed all four questions and used considerable archival documentation concerning the UNODC participation and reporting of progress under the UNAIDS Unified Budget and Workplan (UBW) and UBRAF. In addition the available evaluation reports were analysed to further substantiate the findings. The main findings from the document review were triangulated during key informant interviews, particularly donors and UNAIDS in Geneva and in country offices during the case study field visits. In addition the online survey explored issues of relevance for respondents to answer.

Evaluation Question 1: To what extent have the objectives of the UNODC Global Programme (as stated in UNAIDS UBW 2008-2009 and 2010-2011, UNAIDS 2012-2015 UBRAF, and UNODC Strategic Programme Framework 2008-2012) been consistent and relevant with regard to beneficiaries' requirements, country needs, global priorities and partners and donors' policies?

The desk review [47] that formed part of the inception report in October 2013, analysed the outcomes, outputs and deliverables within the UNAIDS UBW 2008-2009 and 2010-2011 and the UBRAF 2012-2015 that UNODC was either the lead agency in terms of delivering the outcome or was responsible for specific deliverables. A summary of the commitments is shown in the table below:

UNODC Responsibility Area	UBW 2008-2009	UBW 2010-2011	UBRAF 2012-2015
Outcomes	5	5	9
Outputs	10	9	17
Deliverables	10	9	23

The increasing commitment from UNODC to contribute to the objectives of the UBWs/UBRAF indicates and mirrors the growth of the Global Programme as a whole. Key Informants from UNODC and other UN agencies were very satisfied that the Global Programme is becoming more and more aligned with the UBRAF priorities and at the country level, observed by the evaluation team, planning and reporting are fully in line with UBRAF planning and reporting mechanisms.

During the evaluation period there were numerous examples that demonstrate the relevance of the Global Programme. However, a review of the annual reports submitted by

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[46] See annex 1 Terms of reference for relevance questions/criteria

[47] See annex 5 Desk Review

the HAS focus the reporting on activities and whilst it was possible to triangulate the reports with UBW reporting it is not possible to quantify the extent to which these activities are meeting outcomes, or more specifically, how much contribution is a direct result of UNODC's programme.

During the UBW 2008-2009 the Global Programme primarily focused on increasing coverage of services for PWID, notably in the Asia region. The commencement of new projects during this UBW period included seven new projects in the Asia region and included a focus at the policy level of ensuring the harm reduction approach is embedded in national legislation, supporting country strategies and plans to scale up services in the Republic of the Union of Myanmar and the Lao People's Democratic Republic and to implement large-scale training and capacity building programmes for service providers and within the justice/law enforcement/prison sectors throughout the Asia region.

By the end of the UBW 2010-2011 the Global Programme had provided technical support to over 50 countries to conduct legal and policy reviews in relation to PWID and in prisons. Key informants from donor, government and civil society sectors rated this type of policy review and analysis as highly relevant. In line with supporting country needs, during the same period the Global Programme provided technical assistance to develop national strategic plans for prisons in 27 countries globally and continuing to provide training and capacity building to build awareness of key population vulnerabilities within governmental agencies, and particularly with law enforcement agencies and prison authorities in around 70 countries. Of significance was the assessment conducted by UNODC of prisons and HIV in Central America that led to a reform of the penitentiary system throughout the region.

The only year that corresponds to the UBRAF with this evaluation is 2012. The Global Programme has become more aligned with the UBRAF and the 2012 HAS annual report mirrors far more closely the deliverables set out in the UBRAF 2012-2015 than in previous years. This alignment is some of the strongest evidence to demonstrate a high degree of relevance of the Global Programme in terms of meeting the broader and global commitments as one of the UNAIDS co-sponsors and acknowledged by the UNAIDS Secretariat. In 2012, the Global Programme also began a refocusing exercise and specifically to work closer with Civil Society at a Global level. This refocusing has included an identification of 24 high priority countries[48] for the Global Programme to focus from 2013 -2015 that was developed and endorsed by the Civil Society Organisations (CSOs) involved. A work plan to develop joint activities with CSOs has also been approved and budget from GLOG32 allocated for joint work with CSOs.

Whilst this very open and collaborative approach toward working and partnering with civil society is both highly relevant and has the potential to increase the impact of the Global Programme it was also found that relationships between CSOs and the HAS were very fragmented and several instances of major disagreement about the approach of UNODC

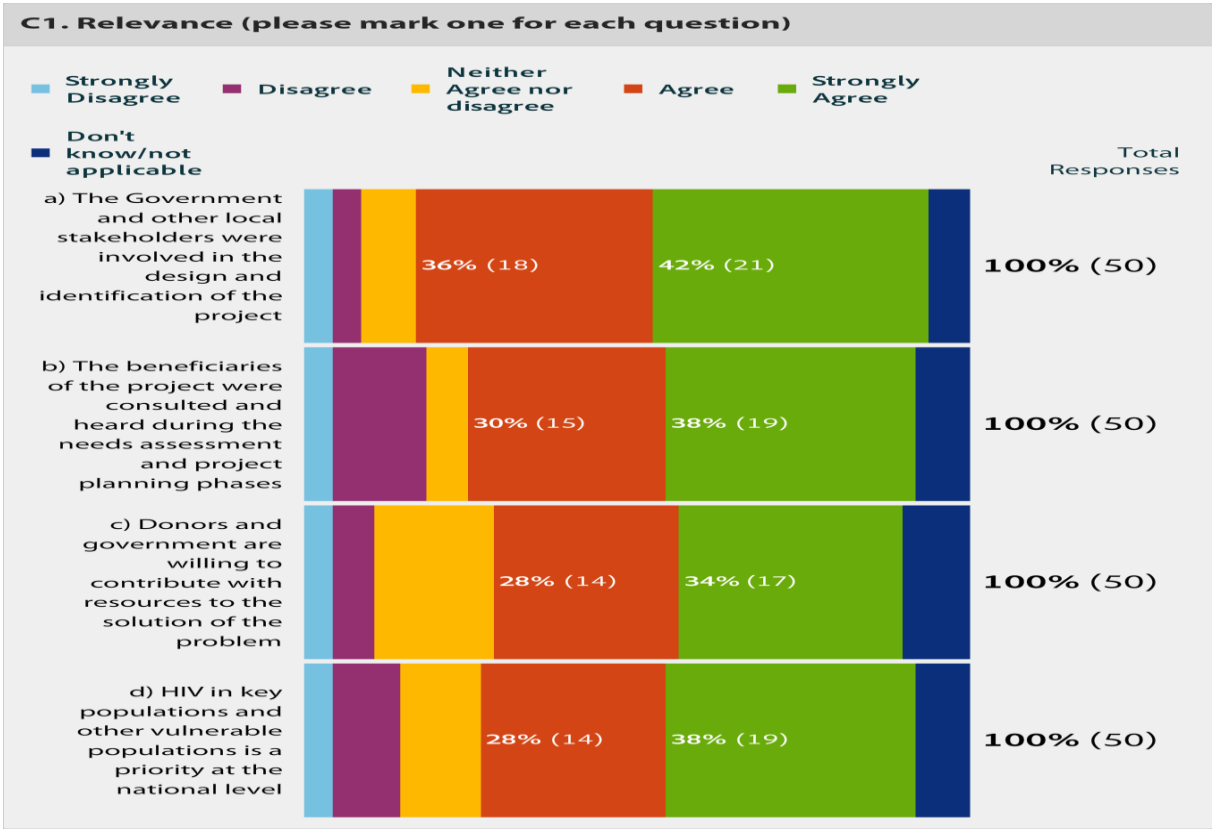
[48] Asia: Republic of Indonesia, People's Republic of China, Islamic Republic of Pakistan, Republic of India, Socialist Republic of Viet Nam, Kingdom of Thailand, Republic of the Philippines. Eurasia: Republic of Tajikistan, Republic of Belarus, Ukraine, Kyrgyz Republic, Republic of Moldova, Republic of Uzbekistan, Republic of Kazakhstan. Latin America: Federative Republic of Brazil, Republic of Argentina. MENA: Arab Republic of Egypt, Islamic Republic of Iran. Africa: Republic of Kenya, Republic of South Africa, Federal Republic of Nigeria, United Republic of Tanzania

were evidenced during the evaluation period and there was a high level of dissatisfaction among the Civil Society key informants at the global level about progress made during the previous four years.

A final example of highly relevant work during 2012 was the publication of the updated Technical Guide for target setting[49]. The guide was highly visible in all the field visits for the country case studies and UNODC and UNAIDS staff in the country offices all confirmed that it is a key reference document and one shared with government counterparts.

Key informants from donor agencies were generally of the view that the programmes that they are funding are relevant to both their own policies, such as the expansion of harm reduction services in the Republic of the Union of Myanmar, and regional prison programmes in Eastern Europe and Southern Africa. The most compelling evidence that the Global Programme is relevant to specific donor policies is the continuation of projects such as RASH13 that is operating under a second phase of funding and also the increase in donors who are funding GLOG32.

The online survey featured a section on relevance and, in response to the four questions asked, all questions had a majority of respondents answer in the green or Strongly Agree category, followed by the red or Agree category. Each category had respondents who did not find the projects relevant, although this was a small percentage



[49] The 2012 revision can be accessed at: http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html

In regard to the evaluation question on whether UNODC is developing and conducting projects through a gender-sensitive, and human rights focused lens, 74 per cent (25/35) survey respondents indicated that targeted advocacy towards a gender sensitive approach to criminal justice and treatment of prisoners was either Very Relevant or Relevant. 63 per cent (24/38) noted that targeted advocacy towards an equity approach (includes work appropriately targeted towards different age groups, people in both rural and urban areas, different backgrounds) was either Very Relevant or Relevant, and 90 per cent (34/40) noted that targeted advocacy towards a human rights based approach (specifically, reduction of stigma and discrimination, de-criminalization, improving legal and policy frameworks for people who use drugs) was either Very Relevant or Relevant. 81 per cent (30/37) responded that they were involved in support for reviewing, adapting, developing and/or implementing effective legislation and policies including on alternatives to imprisonment and that these activities were Very Relevant or Relevant. In regard to equitable programming, 79 per cent (29/37) rated assistance in ensuring equitable access to evidence based HIV services for women in prisons and their accompanying children as Very relevant or Relevant.

In regard to the evaluation question on how UNODC implements its programmes in regard to evidence-based public health strategies, 88 per cent (36/41) noted that UNODC's public health approach was either Very Relevant or Relevant and 88 per cent (35/40) reported that their work on support in developing and/or implementing comprehensive, evidence-informed strategies (the comprehensive harm reduction package) was very relevant or relevant. Lastly, in regard to the relevance of working on guidance documents, norms and standards and/or tools to countries with the implementation of the comprehensive response to HIV in prisons, 84 per cent (32/38) reported this to be Highly Relevant or Relevant.

Evaluation Question 2: To what extent has the Global Programme been aligned with the mandate, overarching strategies and policies of UNODC?

Through the desk review of project documents and project reports it was possible to determine that the Global Programme is significantly aligned within both the Thematic Programme "Addressing Health and Human Development Vulnerabilities in the Context of Drugs and Crime and also with the Strategic Framework for the period 2008-2012. UNODC annual reporting includes a section that confirms linkages to the thematic programme. In all instances the reporting states alignment within sub programme 5 "Prevention, treatment and reintegration and alternative development and specifically result area 5.3. The specific results achieved are then articulated in more detail including, where possible numbers of people trained, publications and compliance with key General Assembly and CND resolutions.

The Global Programme has been operational for over a decade and its integration into the overall strategy and policies of UNODC is to a large extent now embedded, including the role of the Global HIV/AIDS Coordinator at a senior level within the management of UNODC.

Evaluation Question 3: To what extent has the UN system's commitment to human rights based approach and gender issues been incorporated in the design of the Global Programme?

The evaluation review of human rights and gender was expanded, as previously described, to include equity. All three areas reviewed relevance as well by whether these areas had a sound public health and epidemiologic approach for each country setting.

Gender: The review of the 34 projects identified very clearly how gender is being addressed from an equity perspective in order to ensure that females who inject drugs, partners of male PWID and their children are a relevant and critical component of projects for these populations. This was evident in the project reviews and country case studies on The Federal Democratic Republic of Nepal (NPLJ80) and in Mizoram, The Republic of India (INDI81) in particular and in the project reviews of the Islamic Republic of Afghanistan (AFG76), the Islamic Republic of Pakistan (PAKJ85) and the Islamic Republic of Iran (IRNK13). It was however obvious, that while these programmes were clearly meeting an unmet need, a strategy was not always evident as to how the gender based programmes fit into a broader strategy for the respective countries. Rather, the projects appeared to be more donor-driven, with UNODC as the implementer. This strategy may have put undo pressure on small country teams and affected the programmes' sustainability[50]. Another data source, the online survey, asked what activities participants were involved in and how relevant they were (note: the questions in this category were to be answered only by those directly involved in UNODC project implementation). 74 per cent (25/35) noted that targeted advocacy towards a gender sensitive approach to criminal justice and treatment of prisoners was either Very Relevant or Relevant.

Equity: Relevance in regard to equity was reviewed among all data sources with a primary focus on a gender equitable approach, relevance for different age groups, and geographic location (equitable access for beneficiaries in rural and urban areas). There was strong evidence that all adult age groups had equitable access to UNODC's projects. Additionally, the projects had evidence-based strategies such as use of community peer workers who could assist older PWID who may have less access to drop in centres. Use of mobile vans, and outreach (including for women) to rural areas was a clear theme in key informant interviews in the country case studies among all stakeholders. In the online survey, 63 per cent (24/38) noted that targeted advocacy towards an equity approach (includes work appropriately targeted towards different age groups, people in both rural and urban areas, different backgrounds) was either Very Relevant or Relevant. 79 per cent (29/37) rated assistance in ensuring equitable access to evidence based HIV services for women in prisons and their accompanying children as Very relevant or Relevant. Note that although the projects were reviewed for equity, as it was not part of the TOR, no specific project numbers or scoring are provided.

Human rights: In regard to the relevance of the human rights based approaches, the results were mixed in this evaluation. This assertion was triangulated by multiple data sources including key informant interviews and the country case studies and some responses in the online survey. A uniform strategy to addressing human rights was not evident consistently and in particular was not evident of human rights, legal and policy reform in the global project GLOG32, the People's Republic of China (CHNJ42), Libya (LIBI36), the Russian Federation (RUSJ12), and the Socialist Republic of Viet Nam (VNMK1). In contrast, the online survey identified that 90 per cent (34/40) noted that targeted advocacy towards a human rights based approach (specifically, reduction of stigma and discrimination, de-criminalization, improving legal and policy

[50] For further details refer to annex 7 for project reviews, and the findings section for case studies and sustainability findings

frameworks for people who use drugs) was either Very Relevant or Relevant. 81 per cent (30/37) noted that they were involved in support for reviewing, adapting, developing and/or implementing effective legislation and policies including on alternatives to imprisonment and that these activities were Very Relevant or Relevant and 88 per cent (35/40) reported that their work on support in developing and/or implementing comprehensive, evidence-informed strategies (the comprehensive harm reduction package) was very relevant or relevant. Some open-ended responses in the survey noted a weak response to human rights issues in regard to compulsory detention in Asia.

In summary, gender, equity and human rights is being addressed in the Global Programme, however it is not being done consistently and with a strategy for each.

Evaluation Question 4: Have the objectives and expected results of the Global Programme (outputs, outcomes and impact), considering relevant indicators, been clear, realistic and coherent in terms of contributing to the achievements of UNAIDS UBW 2008-2009 and 2010-2011, UNAIDS 2012-2015 UBRAF, and UNODC Strategic Programme Framework 2008-2012?

The project review of the 34 projects in the Global Programme portfolio and evaluations identified a number of projects that had unrealistic logframes including objectives that were too ambitious, for example RUSJ17 and MMRJ63 and that, in most cases, no baseline data was provided so that an accurate measurement of impact is not possible. A second finding from the documentation reviews was that many projects had too many indicators, particularly at the activity level to effectively monitor progress and attribute activities to outcomes and outputs. Weak monitoring and evaluation frameworks were highlighted in several of the evaluation reports including XASJ72,

However, 17 (50 per cent) of the projects reviewed, scored highly (Green or Green amber[51]) in terms of a clear and coherent design and implementation of the project and, specifically XWWK05 and ROMJ19 that also received excellent evaluation reports.

The Global Programme has responded to some of these weaknesses and as previously mentioned, is becoming more aligned with the UBRAF in terms of planning and reporting at the country and global levels. In addition a set of standard outcome indicators has been developed by the HAS that will be used as the basis for future project design and development. The indicators respond to the five outcome areas in the thematic framework and are limited to 14 indicators that are aligned with the UBRAF.

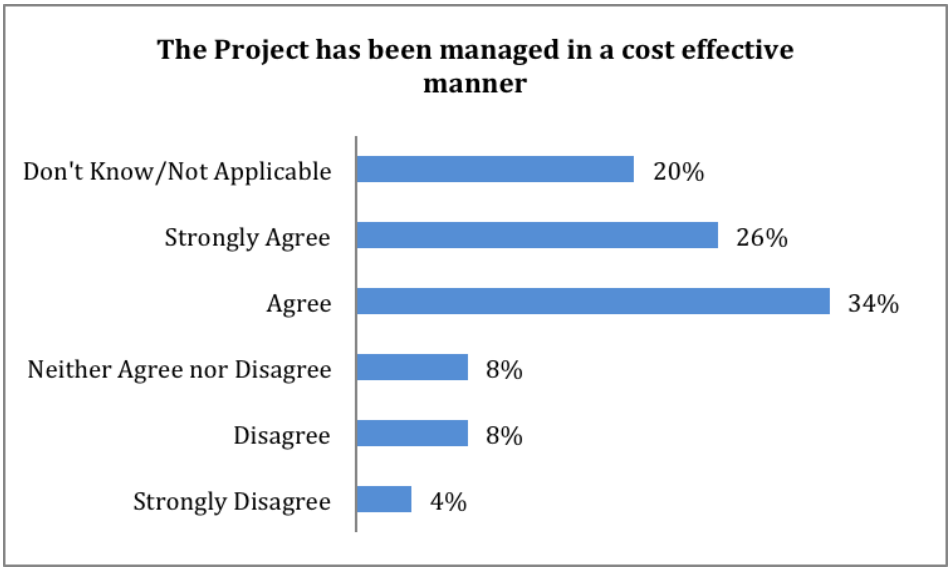
Although 47 per cent of projects have had project durations of five years or longer, 15 per cent were from one to two years and, aside from specific technical assistance projects, the time period is unlikely to produce any impact or sustainable results but will have impacted on the overall portfolio management as small, short timescale projects still require considerable monitoring, reporting and resources (time, human and technical).

[51] Refer to Methodology Section for details on scoring mechanism for use in project reviews and annex 7 for the project review scores

Efficiency

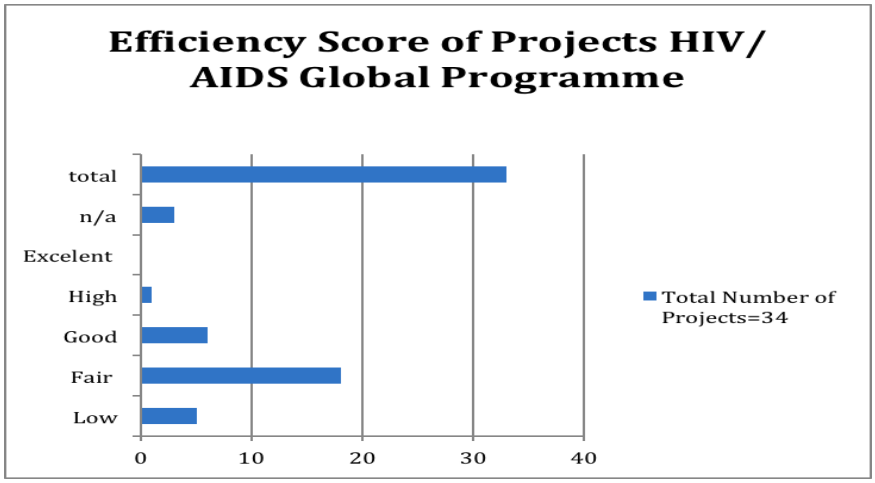
The evaluation team has addressed the five efficiency evaluation questions[52] and utilised criteria such as whether the objectives were achieved on time, coordination issues, and managerial decisions with which to base the findings on. The findings come from the analysis and triangulation of data from archival records, an assessment of key informant interviews of a diverse group of relevant stakeholders and respondents to the online survey tool referenced in the evaluation methodology.

A total of 60 per cent of respondents to the online survey[53] strongly agree (26 per cent) or agree (34 per cent) with the statement "the project has been managed in a cost effective manner".



Nevertheless, there are some aspects of efficiency that must improve if the programme is to increase its efficiency in a context of continued financial constraints/limited opportunities for available funds in the HIV/AIDS sector. The project review[54] shows that the most common score obtained by the 34 projects comprising the global HIV programme is fair (19 projects) followed by six projects that obtained good as a score, five scored low and one scored high. There were three projects not suitable for this assessment.

[52] See annex 1 terms of reference for efficiency questions/criteria.
[53] See annex 8 for complete set of results from the online survey.
[54] See annex 7 for details of project review.



Evaluation Question 1: To what extent have the resources/inputs (funds, expertise, staff time, etc.) been converted to outputs in a timely and cost-effective manner?

Funds: At national level the interviews conducted and the survey administered showed that the majority of the stakeholders were satisfied with the way programmes were managed. The evaluation team has observed several cases where scarce resources are well allocated to yield increased outputs. In the Federal Democratic Republic of Nepal, strong partnerships with CSOs, along with small investments, provided access to HIV testing and other comprehensive package services such as OST (Buprenorphine) to thousands of injecting drug users, and more specifically for females who inject drugs as reported by the CSO Youth Vision.

At global level, the majority of resources allocated through GLOG32 (currently the budget is approximately $5 million annually) supports staff and expert costs to provide support in UNODC priority countries based on its epidemiological situation fulfilling UNODC commitments to the UNAIDS UBRAF. A total of 43 staff were funded under GLOG32 during 2012, which is a reduction from 60 positions that were funded in 2010. Taken over the four-year evaluation period GLOG32 has contributed to between 50-85 per cent of HIV/AIDS human resource costs both at HQ and in the field. Further analysis has shown that GLOG32 is increasingly being utilised to fund staff positions. Between 2002-2009, 60 per cent of GLOG32 was allocated to human resourcing, followed by annual increase up to 67 per cent in 2010 and 2011 and rising to 80 per cent during 2012. The increased reliance on GLOG32 for UNODC to maintain it's global human resource commitments could be regarded as a missed opportunity to focus the global programme in priority regions/countries where there are higher risks for people who use drugs and for people living and working in prisons and other closed settings instead of maintaining a small presence in a large number of countries (over 60 during 2012). A realignment and shift of emphasis to a more focused set of deliverables in relation to the programme's new context of operation would ensure more efficient use of the flow of income from UNAIDS.

Time: The 12 independent evaluation reports and many of the annual project monitoring reports identified significant delays in the implementation process. This seems in fact, one of the causes for a limited efficiency of the portfolio of projects.

The reasons for these delays were and are linked to deeper causes other than weak planning. Evaluations reported examples such as overambitious project designs, problems at the managerial level, lack of leadership, high turnover of staff, etc. Furthermore, there are additional causes

reported that are out of the control of the managers such as armed conflict (Libya), social unrest (Arab Republic of Egypt).

The evidence coming from the project review documents as well as the observations made in the field, suggest a weak culture of risk management that has affected the projects through different means in the form of delays, quality of the delivery, etc. An investment from headquarters on risk management services and guidance could improve the efficiency and effectiveness of the interventions including risk mitigation activities and actions.

Expertise: The team of evaluators has been able to confirm that the HAS in headquarters is a small highly committed team with different and complementary expertise that played a crucial role in the management of the daily operations in the portfolio of projects.

In the field, interviews and observations have revealed that the majority of staff managing projects are health related experts. This has been adequate to the scale and priorities of the programme until now. However, the questions that remains to be addressed now is if having this type of labour force with the same profile and functions holds in the midst of a new context where the programme is operating under financial constraints, the changing nature and status of the epidemic and the leadership role that UNODC is called to play both as an essential cosponsor of UNAIDS at creating an enabling environment at country level.

New strategic thinking about the direction of the programme should come along with an innovative profiling of its human resources including an innovative use of the existing resources and the incorporation of new experts with knowledge and experience in human rights, law enforcement and policy analysis and formulation. New experts would not necessarily require increasing the number of staff or human resource costs. Reprofiling positions to meet the technical needs required for UNODC's Global HIV Programme in the post-2015 agenda might mean reviewing whether certain staff positions should be phased out to post new positions in other technical areas.

Evaluation Question 2: To what extent has UNODC's HQ based management (HIV/AIDS Section, Drug Prevention and Health Branch and Division for Operations) support, coordination and monitoring have been efficient and appropriate for Field Offices for project implementation, advocacy, and communication with Donors and other stakeholders?

The UNODC's HQ based management (HIV/AIDS Section, Drug Prevention and Health Branch and Division for Operations) has played a key role in the implementation of the programme. It is clear that without their guidance, support and coordination the global programme could not have been implemented as such.

This team has provided useful and essential services to the staff managing projects in the field including administrative, legal, substantive technical guidance, quality assurance, and monitoring and evaluation services. They have also been fulfilling the role to liaise with UNAIDS secretariat and other cosponsors such as WHO and are the global focal points for planning and reporting against the UBRAF.

The available evidence shows a clear positive effect on topics such design, projects have benefited from the quality assurance during the design phase and to a certain degree regarding the monitoring function. However, in spite of major efforts 75 per cent of the evaluations reported weak M&E systems, with indicators focused at the activity level, and without the required

baselines and targets/milestones to measure progress and impact. The project review has also noted considerable weaknesses with the design and implementation of monitoring systems.

On the other hand advice and assistance on financial issues and procurement topics had also played an important part in the efficient implementation of the programme and the smooth running of its daily operations.

The services provided are considered appropriate with some room for improvement. In general there is an ad hoc approach to provide these services that could benefit from a more systematic and coherent approach. The HAS might contemplate strengthening existing areas of services such as monitoring but also the expansion of services to new demanded areas. These should be done by identifying the new demands from the field as well as considering the strategic needs and direction that the programme will take in the near future. As an example, a knowledge management plan could be considered as part of this scheme.

Evaluation Question 3: To what extent and in what ways has the organizational structure of UNODC, UNODC's HQ based management, including UNODC's financial and human resources management, and other global, regional and country level UN coordination and support mechanisms, including those related to Joint United Nations Programme on HIV/AIDS (UNAIDS), been supporting UNODC's HIV/AIDS programme to deliver its outputs?

The interviews conducted during the evaluators' visit to the Vienna HQ confirmed that the cooperation of UNODC sections (including financial and human resources departments) with the HIV/AIDS unit has been adequate although a "silo system" of operating within UNODC was noted by the majority of the sections/units with some exceptions such as the ongoing collaborations with the Justice section on HIV in prisons in line with prison reform and the Research and Trend Analysis Brach on data gathering and reporting. This cooperation is based on an ad hoc case by case basis and could be strengthened to increase organisational efficiencies at headquarters level as well as in the field offices by coordinating activities such as capacity building and/or other technical cooperation events.

A significant number of interviewees reported there were major communication and coordination problems between the HAS and the Prevention, Treatment and Rehabilitation Section (PTRS) . Several of these operational disputes have been resolved but it will require continued willingness from both sections to continue to align and harmonise their activities. Drug dependence treatment is an area of overlap between the two sections and could be a useful technical area for joint work.

The observations during the field visits indicated that the degree of cooperation with UNAIDS, WHO and other UN agencies varies from country to country but the evaluation team has observed in general an open spirit for cooperation. This desire for cooperation might not crystalize in something specific more than an exchange of information like in The Federal Democratic Republic of Nepal but in other cases materializes in specific actions. Such as the United Nations joint response to AIDS in Brazil where UNHCR, ILO, UN Women, PAHO, UNDP, UNAIDS, UNESCO, UNFPA, UNICEF and UNODC[55] jointly designed and implement an integrated plan that coordinate the agencies' interventions based on identified needs operating through the UN team on HIV/AIDS. Key Informants from all sectors in both the Republic of Zambia and Kyrgyz

[55] See List of Acronyms page ix

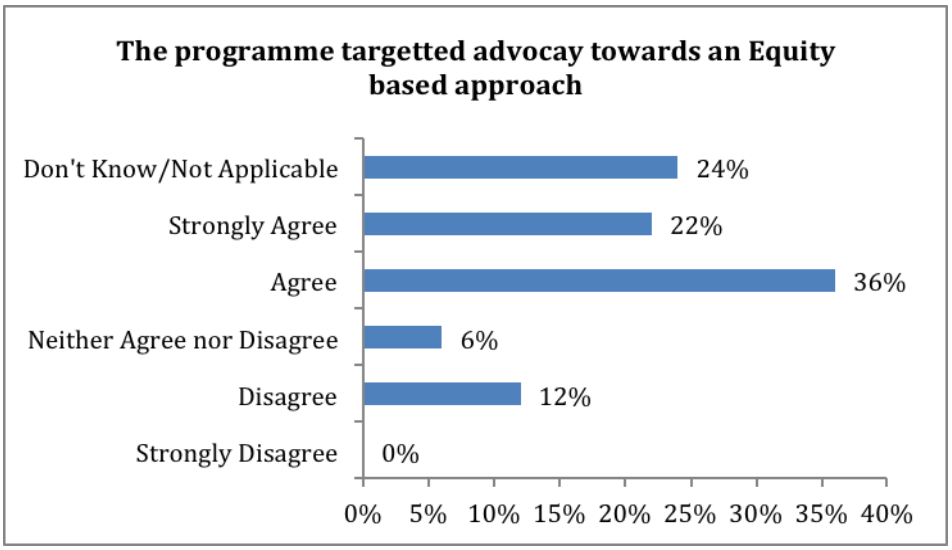
Republic rated UNODC's active participate, cooperation and responsiveness to joint work as extremely high.

In any case, the coordination and mutual cooperation with other global, regional and country level UN coordination and support mechanisms, including UNAIDS is an issue that needs to be closely examined in a more financially constrained environment and based on the current epidemiologic needs in each country where the programme operates. This is seen as a future field to seek opportunities for the Global Programme to expand its added value as a "bridge between public health and law enforcement".

Evaluation Question 4: To what extent does the allocation of UNODC HIV/AIDS resources to targeted groups take into account the need to prioritize those most marginalized?

The project review data and observations in the field indicate that UNODC has concentrated the majority of its project portfolio in the key target groups of people who use drugs, injecting drug users and people living and working in prisons, in particular projects have been designed and implemented focusing on hard to reach subgroups such as women who use and inject drugs, sex workers, street children, migrants and refugees[56].

Data collected through the survey administered to programme stakeholders shows that a total of 58 per cent of the respondents strongly agree or agree with the statement that the programme targeted advocacy towards an equity based approach, including programmes targeting various age groups.



The country visits and projects provided good examples of UNODC's interest for rural PWID, through active engagement of rural communities in countries like the Federative Republic of Brazil or the Republic of the Union of Myanmar. Moreover, in countries like The Republic of India (state of Mizoram) the interventions targeted youth and female drug users in prisons in a very rural and inaccessible part of The Republic of India.

[56] Refer to annex 7 for specific target groups by project as part of the project review sheets

Partnerships and cooperation

The evaluation team has addressed the two evaluation questions relating to partnerships and cooperation within the Global Programme and analysed the extent to which partnerships have been articulated, established and fulfilled. The findings discussed in this section come from the analysis and triangulation of data from archival records, an assessment of the project portfolio, reviews of the available existing project evaluation reports and key informant interviews and most significantly through direct observation during the country case study visits.

Evaluation Question 1: To what extent have UN inter-agency coordination mechanisms been successfully established?

The establishment of coordination mechanisms with other UN agencies is an essential requirement for UNODC to successful contribute to the UBRAF, and previously within the UBW framework. The evaluation found examples of effective partnership building and coordination mechanisms in place at both the global level, primarily with the UNAIDS Secretariat and WHO and equally at the country level and the coordination mechanisms that exist within the Joint Teams on HIV/AIDS. The partnership arrangements articulated in the UBW and UBRAF have been adequately reported in UNODC annual reports for the four years covered by the evaluation from 2008-2012.

Direct observation and interviews with key informants during the country case study visits verified that robust UN inter-agency coordination mechanisms exist in all six countries. For example, in Kyrgyz Republic, key informants noted that strong coordination mechanisms between UNODC and UNDP was central in creating an improved policy environment for providing a more comprehensive package of services in prisons including needle and syringe programmes and the provision of OST. In Brazil there is a United Nations joint response to AIDS involving UNHCR, ILO, UN Women, PAHO, UNDP, UNAIDS, UNESCO, UNFPA, UNICEF and UNODC jointly designed and implemented an integrated plan that coordinates the agencies' interventions based on identified needs operating through the UN team on HIV/AIDS

However, it was also noted that coordination mechanisms should be further aligned between agencies including relatively simple actions such as sharing work plans between UN agencies. A significant barrier to more enhanced coordination is where UNODC country offices are staffed by national staff, such as the Federal Democratic Republic of Nepal and the Republic of Zambia. There is a lower status conferred on the office within the UN hierarchy and it was noted by key informants from other UN agencies and within UNODC that this has hampered the establishment of coordination mechanisms where each agency is given equal status. This is potentially an area where the placement of new staff, resources permitting, that have legal, law enforcement or policy skills could be recruited to provide both technical expertise and to ensure that the UNODC country office has a mix of national and international staff inline with other UN agencies.

Inter-agency rivalries, personality clashes and other inter-agency conflicts have all contributed to a more opaque partnership arrangement in practice that does not, in all cases, reflect the documentation outlining clear coordination mechanisms that were analysed by the evaluation team. Partnership arrangements that do not function well under one type of leadership can sometimes improve once leadership changes. An example of this is the situation in The Republic of India where the arrival of a new UNAIDS country coordinator has brought about significant changes in the way the Joint Team on AIDS is working.

Evaluation Question 2: To what extent have roles and responsibilities in terms of partnerships and cooperation been clearly defined, realistically set up and fulfilled in UNODC's HIV/AIDS programme?

Findings from the project review, from both the design and delivery perspective indicate that partnership and coordination arrangements are clearly defined in all the project documents including the original funding document, logframes, monitoring and annual reports. Partnerships from key sectors include government, civil society and service providers, in addition to partnerships with UN agencies.

In many instances it has been UNODC that has initiated and maintained partnerships over many years. A good example of this type of proactive approach is in the Republic of Kenya and the long-term investment the country office has made in partnering with NGOs to deliver components of the essential package of services. A significant number of NGOs that provide harm reduction services and sustainable livelihood programmes for PWID in the coastal regional of the Republic of Kenya have benefited from their partnership with UNODC and has allowed the NGOs to both grow their own capacity to deliver, manage and monitor the services they provide and also to benefit from access to additional funding opportunities due to their partnering with UNODC. Very similar findings were evident during the case study visit to The Federal Democratic Republic of Nepal and the support UNODC has provided to selected NGOs.

There have been some major challenges for the Global Programme and the HAS in Vienna in defining and sustaining it's partnerships with global CSOs. Key informant feedback, substantiated by documentation, outline concerns of civil society toward the direction of the Global Programme during the evaluation period and specifically the "indifference" of leadership within both the HAS and senior management of the agency to harm reduction, the lack of partnership with civil society and a lack of any information about the Global Programmes activities and results. The current leadership of the HAS has changed and significant work has been established since the end of 2012 to clarify the partnership arrangements and meaningful participation in all areas of the Global Programme with civil society at the global, regional and country levels.

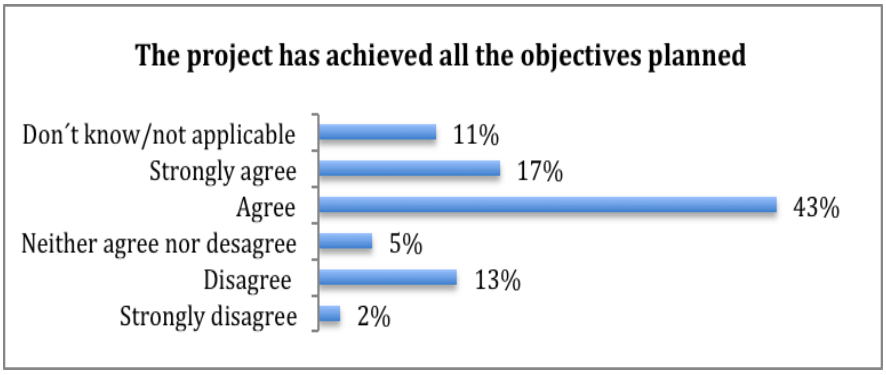
The partnership and cooperation arrangements that are contained in the key documents for each of the projects implemented during the evaluation period such as memorandum of understanding (with partner government ministries and agencies) or grant agreements with NGOs or other implementing partners clearly define the roles and responsibilities. Key informants verified that they were very aware of the roles and responsibilities entailed when partnering with UNODC and were clear that this was most important if there was a financial element to the partnership that required agreements to be clear and precise regarding roles and responsibilities.

Effectiveness

The evaluation team has addressed the four 57evaluation questions relating to the effectiveness of the Global Programme and analysed whether and how the objectives and outcomes have been achieved and their contribution to the attainment of the results contained in the UNODC strategy and the relevant UNODC thematic, regional and country strategic frameworks. The findings

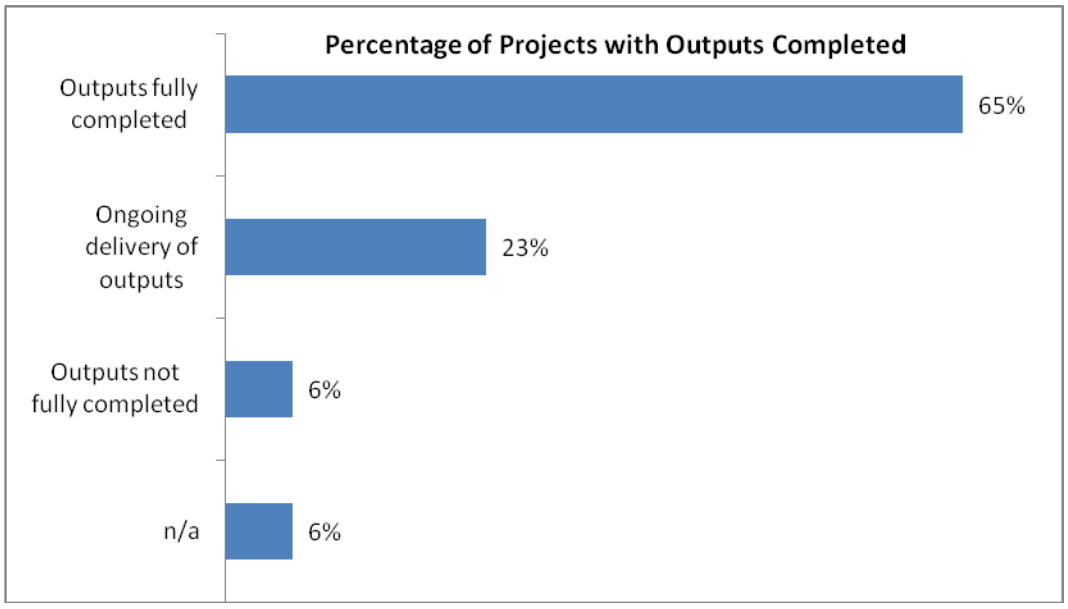
[57] The fourth question included in the TOR is addressed in the recommendations section of this report.

discussed in this section come from the analysis and triangulation of data from archival records, an assessment of the project portfolio, the interviews conducted to diverse and wider group of relevant stakeholders and respondents of a survey tool administered to programme stakeholders.



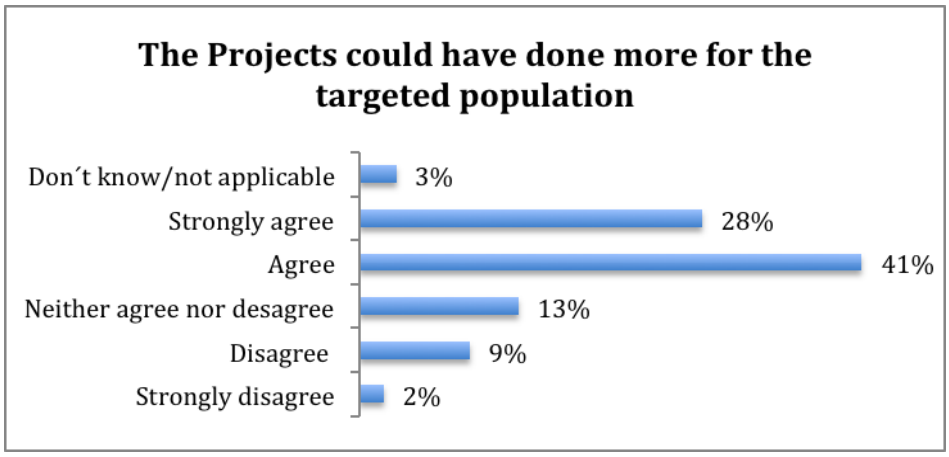
The on-line survey described under the methodology section, included several questions on effectiveness. As shown above, the majority of respondents agreed (43%) or strongly agreed (17%) "the project has achieved all the objectives planned"[58].

The review and assessment of the project portfolio[59] shows that 65% of projects have fully completed their outputs and objectives planned in their respective project documents, while 23% of the projects are working on delivering them. Only in very few cases, (6%) some outputs of projects have not been fully delivered as a consequence of armed conflict or general social unrest.



[58] See methodology section for survey details and annex 8 for complete survey results
[59] See methodology section and annex 7 for details on the scoring of the design and delivery of the HIV/AIDS portfolio.

A frequently heard statement from key informants in the field was: "the programme is doing good but could do better". The majority of respondents from the survey administered, 69%, strongly agree (28%) or agree (41%) with this statement that projects could have done more for the targeted population.



This is also evidenced in the overall scoring of the project portfolio with the majority of projects categorised in the "Green Amber" section (52% design, 53% delivery) that signifies performing relatively well but that improvements should be made to improve efficiency/effectiveness/impact.

Evaluation Question 1: To what extent has progress been made towards achieving the objectives and outcomes of the programme (as stated in UNAIDS Unified Budget and Workplan 2008-2009 and 2010-2011, UNODC Strategic Programme Framework 2008-2011, drug demand reduction and HIV components of the UNODC Regional Programme Framework, and the Thematic Programme addressing health and human development vulnerabilities in the context of drugs and crime)?

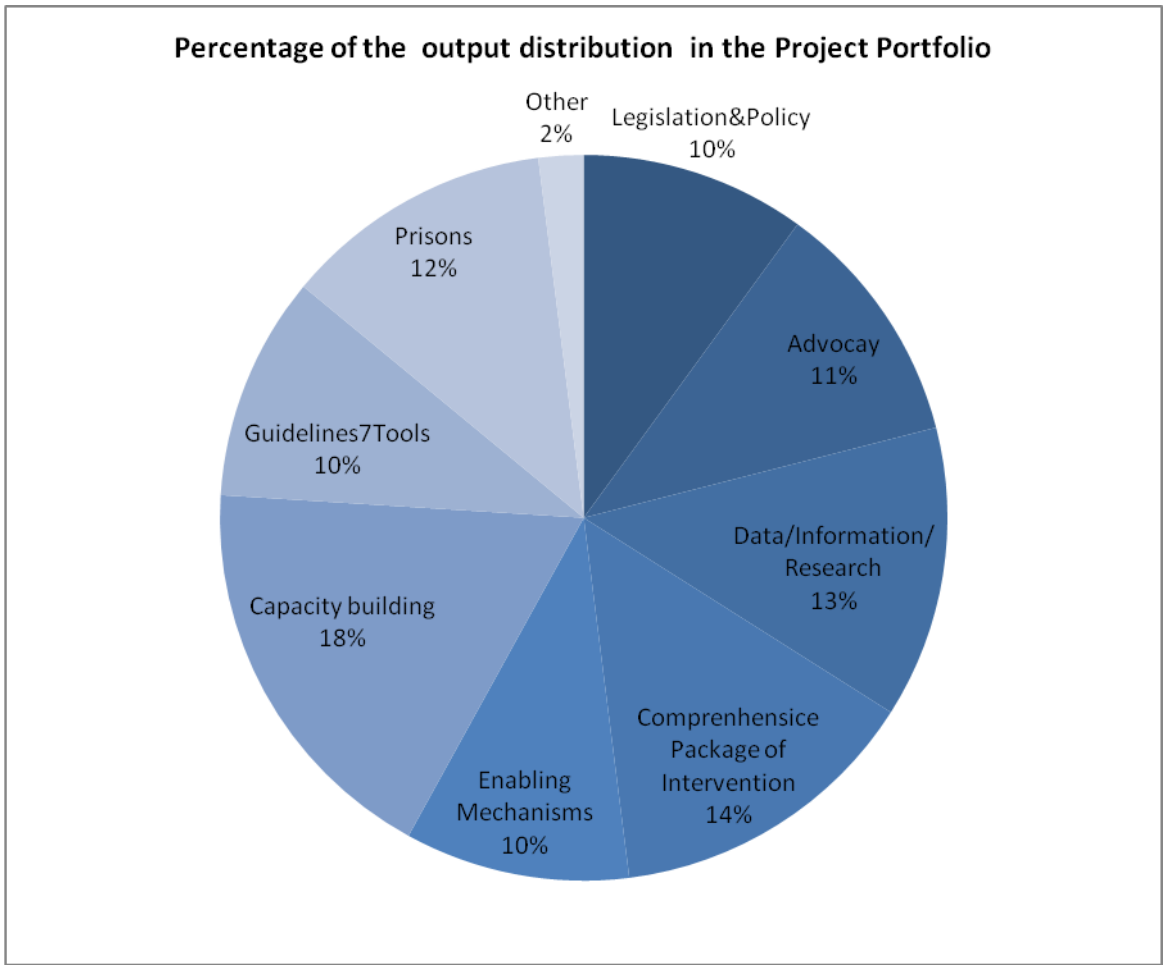
The Global Programme has achieved some significant results, particularly in the areas of policy support, training of a wide range of stakeholders in different aspects of HIV prevention, treatment and care for PWUD, advocacy, particularly with policy makers and some innovative programmes reaching hidden populations such as street children and female drug users.

UNODC has contributed to the objectives and commitments under the UBW and UBRAF programming structures. It is not possible to exactly quantify or allocate a percentage achievement because the country and regional projects do not align themselves 100% within the UBRAF. However, in all countries visited during the evaluation it was clear that the internal UN reporting and planning reflects the overall UBRAF.

The extent of the contribution varies depending on time but also on contextual elements such as political, social, cultural and economic factors as well as the life of the HIV/AIDS programme during its implementation in each of the countries where it has been active.

The below chart illustrates the percentage of projects of the Global Programme that include outputs directly related to both the UBW/UBRAF commitments, the UNODC Strategic Programme Framework 2008-2011, drug demand reduction and HIV components of the UNODC

Regional Programme Framework, and the Thematic Programme addressing health and human development vulnerabilities in the context of drugs and crime



The seven categories of products and/or services displayed in the above graph clearly contributed to the major UBW/UBRAF outputs for which UNODC is directly responsible. There is a good balance/mix of services and products suggesting that technically, the Global Programme is effectively contributing to the global response.

During the 2008-2009 UBW the majority of the 34 projects focused on establishing the basics to start the implementation processes of projects, including recruiting and placing staff, identifying and opening a dialogue with the counterparts and partners, etc. Project reports, archives and interviews with stakeholders showed a total of 19 projects that included advocacy related outputs in their strategy of intervention.

Moreover, outcome 2 and key output 4 of the UBRAF committed UNODC to provide countries with technical assistance to the relevant agencies as well as facilitated the participation of beneficiaries. This was done to ensure the inclusion of the needs of key populations and vulnerable groups. Evidence obtained through the country case study visits confirmed that

UNODC is a well respected and trusted convenor with all key stakeholders including CSOs working with most at risk groups.

It is also worth highlighting other key contributions that fall under the 2008-2009 and the following UBW/UBRAF and in particular, principle outcome 4 and key output 5 in (08-09). An important effort was made to increase the capacity of countries (29 projects) to provide the comprehensive package of interventions (23 projects).

Virtually all countries (16 projects) where the programme operates have benefited from the support to adopt the producing and/or adapting technical guidelines and tools and provision and follow up technical support have delivered products or services related to this topic, many of them with a high degree of satisfaction in delivery, such as in the case of The Republic of India regional projects.

The review and assessment of project documents and the interviews conducted with stakeholders revealed that multisectoral working groups and other coordination and enabling mechanisms were established comprising various stakeholders, including relevant government ministries/departments, counter-narcotic agencies, the national AIDS programme, civil society organisations, UN and other multi- and bilateral agencies. A total of 17 projects fully delivered this type of outputs. In key countries, UNODC has facilitated the establishment of technical working groups

UNODC has established partnerships among national and local governments, bilateral partners, multilateral organizations, foundations, the private sector, international and national civil society organisations and community-based organisations, and supported the establishment of, for example, the HIV African Prison Partnership Network. These active technical and advocacy forums play an important role in advancing policy and legislation reforms and in scaling-up the agenda in each country. A total of 17 projects have delivered outputs related to legislative and policy work but there is still room to intensify this work in the future.

During the years 2010-2012 the project portfolio increased their efforts in implementing high quality interventions with a renewed focus on the theme of prisons and close settings as well as a geographical expansion to eastern European countries. Two independent project evaluations showed evidence of this success in countries such as Romania and the Republic of Lithuania.

Evaluation Question 2: What are the reasons for the achievement and non-achievement of the programme objectives and outcomes?

Project documents and stakeholder interviews showed that most projects under the global programme have been diligently managed producing the expected outputs and outcomes. However, in some cases, the evaluation team has been able to identify a few causes for projects not to achieve objectives and/or outcomes. Namely, some had too ambitious designs; others had problems related to human resources, procurement, leadership, etc. It is also important to mention negative external factors that some projects had faced during its implementation, such as social unrest or war. This has been the case of projects in the Republic of Libya where the open armed conflict delayed and at even some point prevented the project from being implemented. In other cases such as in the Arab Republic of Egypt, the project needed to be readjusted to face the problems derived from the general social unrest occurring at the time of project implementation.

From the public health perspective a technical review of the project portfolio showed that the Global Programme was applying a greater emphasis on a public health perspective. However,

observations in the field and archival data, illustrated that some of the projects do have a prominent focus on providing services to PWID but may not have sufficient impact on reducing new HIV infections (such as an out-dated model of voluntary counselling and testing (e.g. free-standing, lengthy, intrusive pre-test counselling, or only referral to government facilities, barriers not being addressed regarding access of the public health system and bridging the stigma and discrimination gap). For these projects the remaining question is how to ensure the designs reflect the current state of the evidence and can make an impact on the ultimate goal of the Global Programme, to reduce the transmission of HIV/AIDS among the male and female injecting drug users.

Evaluation Question 3: To what extent has a monitoring system been set up for relevant and reliable monitoring of results throughout the programme?

The programme has a monitoring system organised in a bottom-up fashion. The data is collected at country level where the projects are being implemented. Once the collection process is completed, data is transmitted with different frequencies, depending upon donor requirements but monthly reports are sent to HAS in Vienna and monthly telephone conferences take place where the HAS in Vienna discuses results with the country teams. The most important moment comes at the end of the year where the HAS uses this data to compile and assembles its annual report.

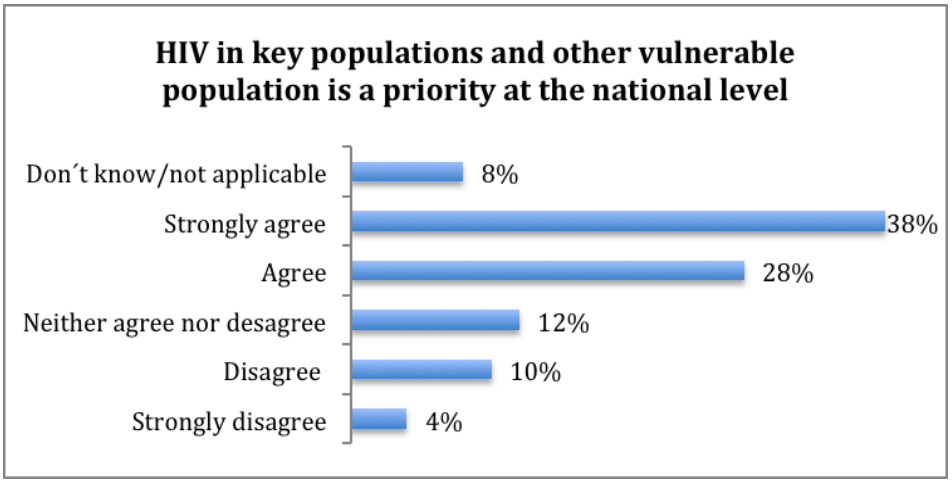
At a programmatic level, the evidence collected through interviews to relevant stakeholders showed a satisfactory assessment regarding the fulfilment of monitoring and data commitments to UNODC units and UNAIDS.

On the other hand, the analysis of data reported by the portfolio of 34 projects comprised the HIV/AIDS global programme, analysis of the 11 project evaluations, interviews with country managers and the direct observations conducted by the evaluation team in the field demonstrated that while all the projects have a monitoring system in place, these mechanisms are not homogenously applied throughout all project components making it difficult to have a clear picture where the projects stand at a certain point in time.

Moreover, many of the projects either lack baselines or relevant indicators to measure results. Some projects use either activity or process based monitoring systems while a few have a results focus on measuring outcomes. The observed trend when providing indicators is to use mostly quantitative information related to outputs. While this is important, it should be complemented with qualitative indicators that measure the worth of the products and services provided.

Evaluation Question 4: To what degree were the results of UNODC HIV/AIDS Programme achieved equitably among the stakeholders group?

The evidence coming from the online survey, the archival documents and key informant interviews indicated that UNODC projects have an effect on the way the stakeholders at country level address HIV in key populations and other vulnerable population. The majority of survey respondents (66%) strongly agree (38%) or agree (28%) that key and vulnerable populations are a priority after the UNODC interventions were implemented.



Moreover, the evaluation team confirmed during the field visits to The Federal Democratic Republic of Nepal, The Republic of India and the Federative Republic of Brazil how the projects addressed equity issues and achieved these towards different age groups like in the Republic of Indian state of Mizoram where the interventions delivered services to people of different ages, including very young people, rural populations in the state of Amazonia in the Federative Republic of Brazil or female drug users in urban areas of The Federal Democratic Republic of Nepal.

Impact

The evaluation team has addressed the single evaluation question relating to impact within the Global Programme and attempted to analyse the major achievements of the Global Programme. The findings have been developed from analysis and triangulation of data from archival records, an assessment of the project portfolio, reviews of the available existing project evaluation reports, the case study findings[60], key informant interviews and the online survey.

Evaluation Question: To what extent has the HIV/AIDS programme contributed, or is likely to contribute, to long-term impact and/or intermediate results (directly or indirectly, intended or unintended) for its beneficiaries, target groups, communities involved, and institutions related to the programme?

It is not possible to provide an accurate measurement of impact that has validity and because conducting an impact evaluation was not part of the ToR. The programme management structure of the Global Programme does not systematically measure impact and annual reporting is focused more at the activity and outcome levels and does not provide information on measurement of impact at the objective level. A review of GLOG32 annual reports found that whilst extensive information and data is provided for numbers of people trained, countries receiving technical assistance, numbers enrolled in OST programmes, among others, there is no higher level analysis of how these activities have impacted national programme progress. The structure of the UNODC annual reports does not provide an opportunity for more detailed analysis of results.

[60] Refer to case study section for additional findings around impact

The review of evaluation reports also highlighted several examples where impact was not possible to be assessed, including RUSJ17, RASH71 and XASJ72. Additionally the evaluations suggest that a focus on small-scale projects and activities such as RASHH71 and RAFG66 that have short durations were never likely to produce anything other than minimal impact that was unlikely to be scaled-up or sustained.

Several key informants from UN agencies and donors felt that the Global Programme is too focused on small-scale pilots that may or may not produce results or evidence that can lead to scaling-up. In some settings, pilot programmes were the only way to introduce new public health interventions (e.g., India) where local priorities necessitated this approach. It is not disputed that such pilots may fail to produce any impact, but it is important to recognise that innovation often is inherently more risky but can produce new and more appropriate models for reaching key populations. In this regard the Global Programme has had a major impact and can demonstrate new models for working with key populations that have been very hard to reach or not adequately addressed. Examples include working with street children (RASH17) who have multiple and complex vulnerabilities, female drug users (RASH13) and refugees (XWWK05).

Individual projects have clearly had impact (although this is based on qualitative findings), notably around advocacy (RASH17, RASI09, XEEJ20 and KENI08) and, to a lesser degree, service delivery (MMRJ63, MMRJ69, RASH13). The case study visits also identified significant impact of prisons programmes in the Kyrgyz Republic and the Republic of Zambia.

Measuring the impact of capacity building has not been undertaken by the Global Programme. However, key informants from all sectors indicated a high degree of satisfaction with the amount of capacity building and training initiatives undertaken during the evaluation period. Thousands of individuals from key sectors including government, CSOs, service providers and beneficiaries have been recipients of training. The most striking example has been the focus on training law enforcement officials, particularly in Asia and Eurasia. All key informants indicated that this is a significant achievement and that sensitisation of law enforcement is essential to remove barriers and protect the human rights of PWID.

The online survey also sought to elicit responses from participants on impact and any significant achievements of the Global Programme. The participants were asked an open-ended question, asking what they considered the Global Programme's main achievements have been. To answer this question in the evaluation, an analysis of convergent themes was conducted. Several convergent themes emerged in this analysis (listed in order of prominence): i) helping to reduce stigma and discrimination at country-level; ii) bringing the issue of women who use drugs and are living with HIV to multiple national governments and helping to institute harm reduction or prison related programmes for women and HIV; iii) addressing the issues of harm reduction, closed settings and HIV at the global and national levels; iv) developing of policies, guidance and standard operating procedures where none previously existed; v) training staff in addressing HIV and drug use/harm reduction; and vi) several responses noted that UNODC has tried to effect change but has not been able to at a sufficient scale due to political impediments at the country level and a lack of commitment from UNODC leadership.

Sustainability

The evaluation team has addressed the four evaluation questions relating to sustainability within the Global Programme and analysed how sustainable the individual projects and the Global Programme as a whole has been sustained. The findings discussed in this section are from the analysis and triangulation of data from archival records, an assessment of the project portfolio, reviews of the available existing project evaluation reports, the case study findings, key informant interviews and the online survey

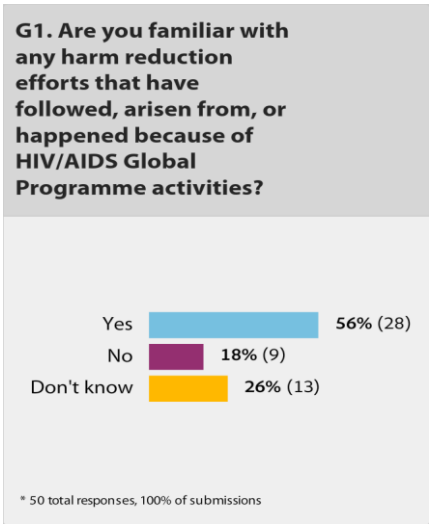
Evaluation Question 1: To what extent are the results (outcomes and impact) generated through the programme likely to be sustained in the countries after the end of UNODC's HIV/AIDS programme activities?

An analysis of the 20 projects that were operationally completed during the evaluation period 2008-2012, which included analysis of seven projects that were evaluated[61] found that unless a follow-on phase of funding was introduced the majority, 75%, of projects closed and activities were terminated. The relatively short duration of projects, with the average duration being three years, does not allow for sustainability planning unless donors can be identified to continue the work.

It should be noted that many of the activities undertaken were time-bound and as such would not have been planned around sustainability. These include assessments and reviews of policy, specific advocacy campaigns, training and capacity building. Whilst the activities are considered "stand-alone" and not sustainable the impact can be judged to be sustainable. In several of the country case studies an improved policy environment that UNODC contributed significantly toward, sustainability is now embedded in these changes. Examples include the introduction of needle and syringe and OST services in prisons in the Kyrgyz Republic. However, this potential impact is somewhat tempered by the proposed Central Asia Customs Union that may threaten the availability of medications such as methadone and could threaten the sustainability of a very enlighten prison policy toward essential HIV prevention services for PWID.

The online survey included a question on sustainability, relating directly to Evaluation Question 1 (noted above). Respondents were asked if they were familiar with any harm reduction efforts that have followed, arisen from, or happened because of UNODC HIV programme activities. The majority of respondents 56% (28/50) responded with "Yes" to this question, 26% (13/50) indicated that they didn't know if any harm reduction efforts had occurred, while 18% (9/50) said "No".

[61] Completed projects with evaluation reports include XASJ72, RAFG66, MMRJ63, XEEJ20, ROMJ19, RUSJ12, RUSJ17



There was little evidence of an exit strategy for completed projects both from the project reviews and the case study visits[62], although assets purchased through the projects were distributed to either implementing partners or partner governments that do provide a degree of sustainability for these organisations in terms of using resources beyond the project period.

Evaluation Question 2 Taking into consideration the relative contributions of other stakeholders to results, to what extent has UNODC contributed to increased coverage and sustainability of programmes for HIV prevention, treatment, care and support in countries where project activities have been implemented?

It is not possible to determine the extent of contribution by any single agency with regard to increasing coverage of services. Data at the national level does not disaggregate service delivery coverage by donor/implementing agency and UNODC does not track any attribution data that would enable an accurate analysis of coverage contribution. However, in projects that have service delivery components, for example, in the Republic of Kenya, UNODC has made a significant contribution through it's work with NGO's to increasing harm reduction services, including sustainable livelihood programmes and has been a key partner for ensuring sustainability by working with the Kenyan government to ensure that the policy environment allows for and supports such services. The Republic of Kenya also provides a good example of how UNODC is working with major funders of harm reduction service delivery such as the Global Fund to ensure that the activities funded are sustained through the Global Fund grant mechanisms. This was also very evident in the Kyrgyz Republic and UNODC's support and active participation in the Global Fund Country Coordinating Mechanism that provides oversight to the grants that are supporting increased coverage of harm reduction services in communities and in prison settings.

Evaluation Question 3: Have the programme stakeholders and beneficiaries taken ownership of the objectives to be achieved by the programme? Are they committed to continue working towards these objectives after the end of the UNODC HIV/AIDS programme activities? Is

[62] Please refer to case study findings for further details on sustainability findings for the six country case studies.

programme stakeholders' and beneficiaries' engagement likely to continue, be scaled up, replicated or institutionalized after external funding ceases?

Key Informants that are directly working with UNODC on projects in all six of the country case study locations very clearly demonstrated ownership of the collaborations with UNODC. There was an almost unanimous support for the work undertaken and several implementing partners have continued providing services through other funding mechanisms that were initiated with UNODC projects. However, as with evaluation question 1, virtually all services provided by NGOs require external funding, either through governments or external donors. The implementing agencies are all very active in resource mobilisation and have developed projects for continued funding based on the experiences and evidence from the work on UNODC projects. A good example of government ownership of activities is in the Republic of India where the National AIDS Control Organisation, NACO, has sustained several initiatives and advocacy findings from UNODC projects. This is particularly evident with OST services and similar findings can be found in other South Asian countries such as the Republic of Maldives.

Evaluation Question 4: Can the initiatives developed by the UNODC HIV/AIDS programme become domestically funded and/or integrated in national programmes (on prisons, drug use, health, HIV/AIDS)?

The evaluation team found strong evidence from key informants, and specifically government that many of the elements of UNODC activities could be domestically funded, if funds were available. Although programmes designed for PWID and people living and working in prisons are high priorities for national governments issues of internal budget allocation were out of the scope of this evaluation. There was a clear commitment to including the comprehensive package of services for PWID, or specific components, as part of future Global Fund submissions.

The policy and advocacy work was particularly emphasised by government key informants as vital to sustaining national programmes and was emphasised in the Kyrgyz Republic and the Republic of Zambia as the area of work that the government would wish to see sustained and expanded and for UNODC to continue to mobilise resources to ensure continued advocacy and policy work that is required to provide the evidence needed to enable changes to laws and policies.

Gender, Equity and Human Rights

The evaluation team has addressed the evaluation questions relating to gender and human rights of the Global Programme and analysed whether and how the objectives and outcomes have been achieved, as well as whether these contributed to the results in the UNODC strategy and thematic, regional and country strategic frameworks. The findings discussed in this section come from the analysis and triangulation of data from archival records, an assessment of the project portfolio, key informant interviews among a diverse and a convenience sample of stakeholders and respondents from an online survey. A review of the projects from an equity perspective was also conducted, however equity was not addressed in the Terms of Reference. Additional findings

associated with gender, equity and human rights are also addressed in the project design reviews[63].

The United Nations is encouraging its organizations to demonstrate their accountability to gender mainstreaming, and to address equity and human rights within all programmes of their respective organizations. For example, the UNSWAP[64] is the UN System Wide Action Plan for gender equality. The Secretary General has recently called for a UNSWAP to address youth equality[65] (Youth-SWAP).

Under the UNAIDS Division of Labour, UNODC states that it supports countries in addressing the special needs of women who use drugs and of female prisoners by conducting situation and needs assessments, designing and implementing tailor-made comprehensive HIV services and developing appropriate monitoring and evaluation tools. Under UNAIDS Strategic Direction 3, Advancing human rights and gender equality for the HIV response, all organizations should ensure that their strategic agenda's address human rights and gender.

As well as gender and human rights, this section also addresses the concept of equity. Although not included as part of the ToRs for this evaluation, it is useful and important to also view projects by whether they address the following equity areas: age (e.g., are youth being addressed), socioeconomic status (is access available to those in the greatest socioeconomic need), education status and geographic location status (rural, urban). Gender can also be included under the category of equity as it pertains to equitable access for males and females.

For gender, equity and human rights, (GER), it is important that it is determined through assessments and the local, regional and global epidemiology that addressing or disaggregating data by GER is appropriate and relevant to the situation, in addition to its appropriateness to the socio-political context. Through triangulation of various data sources described in the methodology section, the UNODC projects, country case study trips, interviews and the online survey were viewed through a GER lens.

Evaluation Question 1: To what extent has the UN system's commitment to human rights based approach and gender issues been incorporated in the design of the Global Programme?

Gender

Addressing the needs of women PWID and women in some prison settings are clearly an important focus for the UNODC Global HIV/AIDS Programme. The portfolio of projects clearly addresses gender equality and country visits substantiated the project portfolio evidence of gender mainstreaming. Furthermore, there have been some important effects related to UNODC's work in the area of gender. Some country programmes (e.g., The Federal Democratic Republic of

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63 Refer to appendix 7 for project design review and scoring

64 Promoting UN Accountability. http://www.unwomen.org/en/how-we-work/un-system coordination/promoting-un-accountability

65 Briefing for Member States and Permanent Observers on the Secretary- General's Five-year Action Agenda related to youth, pursuant to resolution 51/1 entitled "Policies and programmes involving youth" adopted at the fifty-first session of the Commission for Social Development. Accessible at: http://www.youthpolicy.org/library/wp-content/uploads/library/2013_Y-SWAP_Member_State_Briefing_Eng.pdf

Nepal and in Mizoram, Republic of India) primarily address women PWID's needs, policy, advocacy and promotion exist in some settings where it did not exist previously and projects witnessed and reviewed were excellent examples of addressing the intersecting issues of drug use and sex work.

However, sustainability of donor driven programmes was extremely risky given that programmes, at the time of the country visits, cannot continue after funding ends (this is the case in the Federal Democratic Republic of Nepal and in Mizoram, Republic of India).

Furthermore, it is not always clear why only women are being addressed when the epidemiologic context may not call for this extent of focus. A comprehensive country strategy, not based on donor input only, should be developed.

Equity

The portfolio of projects does a sound job overall of equity principles. In some settings, equity is extremely well addressed, where UNODC is doing a laudable job addressing the needs of adolescents, street children, older age groups, single parents and orphans, migrants and refugees. The country visits and projects provided strong examples of UNODC's awareness of the needs of rural PWID, through active engagement of rural communities, mobile service delivery and networks of peer counsellors. However, it is recommended that the portfolio of existing projects be assessed to determine the extent to which equity is being taken into account, strategically.

Human rights

It is not possible to have a technically sound programme that addresses the HIV related needs of PWID and people in prisons and other closed settings without addressing human rights and the legal and policy setting in each country, region and globally. To do so undermines the efficiency, effect, impact and sustainability of projects and would not be in line with UN Human Rights international law[66]. The evaluation focused on the following areas of investigation, namely: i) Has the UNODC Global HIV/AIDS Programme sought to address best human rights practices and if not, has the Programme attempted to improve human rights in the settings in which they work and at a global level; ii) If the Programme does address the above, does UNODC leadership assist the Programme to address human rights and if not, does this undermine the efforts of the HIV Programme? iii) Do the project reviews, country case studies and the online survey provide evidence towards the level of the UNODC Global HIV/AIDS Programme's response to address human rights?

In regard to the project reviews, the results presented a mixed picture in this evaluation. For example, not every project description referred to human rights, or to how legal and policy frameworks would be addressed. In regard to the global project (GLOG32), the project document does not describe much detail on human rights or legal and policy frameworks[67].

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[66] International human rights law. Office of the High Commissioner for Human Rights. Accessible at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/InternationalLaw.aspx

[67] Comments on whether the projects in the project portfolio met criteria for human rights can be found in Annex 7 Technical Design Reviews

Another example of how human rights were not described in sufficient detail was gleaned from responses provided in the key informant interviews, online survey responses and from the project reviews. Evidence of a clear human rights strategy, or a human rights strategy as part of a comprehensive HIV global strategy was not evident.

In regard to 1a and 1c (case studies), the results are varied. In some settings, UNODC HIV staff have worked tirelessly to address human rights, improve the lives of PWID and people in prisons and other closed settings and to work to address legal and policy challenges. Some examples of this include how in the Federal Democratic Republic of Nepal, the country staff worked regularly with key agencies from law enforcement and drug control to remove barriers for PWID to access NSP and OST and in the Republic of India similarly, the country staff successfully worked to build up civil society (esp. in Mizoram) so that responses can also come from the grassroots level. In the Kyrgyz Republic, the UNODC office is working diligently to seek a law that will ensure NSP, OST and other harm reduction components remain intact prior to the Russia Customs Union implementation, while in the Republic of Zambia, UNODC is at the forefront of guidelines development that will set minimum standards for HIV in prison settings. Although PWID are not part of the HIV project in Zambia (as one example) and therefore cannot be evaluated as part of this evaluation, it is important to note that a comprehensive HIV in prisons programme should include or seek to include through addressing legal and policy barriers the full range of HIV prevention care and treatment services for all prisoners. While this is a limitation as a result of Zambian law (in which harm reduction, condoms etc. are not legal in prison), the WHO/UNODC package of harm reduction interventions for prisoners who use/have used drugs, should also be encouraged at a legal/policy level and should be advocated as part of UNODC's global prison programme objectives. The evaluation team acknowledges that the UNODC programme in prisons focuses on the broader issue of HIV in prisons, however the needs of drug users (the agency's mandate) is a component of work in this setting. In the Republic of Kenya, UNODC has worked with strong effect to advocate for NSP and OST implementation as well as prison reform.

In other settings, human rights and legal and policy reform are not uniformly addressed in the project portfolio. If legal and policy reviews are conducted, the Evaluation Team did not see evidence of this and therefore cannot comment on these reviews. This is especially apparent in project descriptions in settings where harm reduction and compulsory detention and detoxification are a matter of governmental policy. Such work may exist even in the absence of this information in the project descriptions, but there is no evidence to suggest it based on the documents reviewed or the key informant interview data.

In regard to whether the UNODC Global HIV/AIDS Programme evidences its support of the comprehensive package and a harm reduction perspective, it does so in its co-logoed publications with WHO and UNAIDS, peer review publications and monographs. Furthermore, the UNODC country HIV advisors interviewed in country were strongly committed to expanding the interventions in the package and to supporting harm reduction. There was not sufficient evidence that UNODC leadership fully supports UNAIDS in its mission to improve the situation for PWID and HIV in the Russian Federation and in other settings where harm reduction is not legal or encouraged.

There was evidence seen in country visits in sub-Saharan Africa and in project descriptions in the portfolio that indicate the disputed idea of substance use as a mental disorder is being promoted and therefore should be treated within the confines of a psychiatric setting by mental health professionals. Substance use programmes are often embedded within mental health programmes

or alongside, however, referral to substance use as a mental disorder is absent from WHO, UNODC and UNAIDS co logoed publications[68]. While mental health can be affected by substance use, and comorbid conditions such as depression can co-occur in the presence of substance addiction, the Evaluation Team saw evidence that the approach being used was stigmatizing and as such, PWID were not accessing the services. Further evidence of stigmatizing language or approaches included in some project documents and based on interviews with UN counterparts and UNODC other documents, evidence of stigmatizing language to refer to the beneficiary population (e.g., people who inject drugs are referred to within a frame work of drug addiction as being a mental disorder, or as drug users as being "addicts" or "substance abusers". While this may not be intentional, it is important to not add to the stigmatization of this population as the primary agency that seeks to support their improved health status. Doing so, can be damaging to the trust that UNODC would like to build with civil society.

The Team also saw evidence of an abstinence-based approach being utilized in sub- Saharan Africa. As with the issue of mental health described previously, the evidence was not clear that knowledge sharing was occurring sufficiently between HQ and country and regional teams with regard to disseminating the latest findings on the spectrum of treatment options available.

In regard to prisons and other closed settings, the Programme has made some significant in roads to addressing HIV in some countries in sub-Saharan Africa (e.g., the Republic of Zambia and other parts of Southern Africa) and in other select settings (e.g., New Delhi) despite significant obstacles to adding components of the comprehensive package in such settings. Women prisoners as well as addressing reintegration into communities and programmes seeking to reduce stigma are part of the project portfolio. Progress in this area is slow given significant country opposition in many settings. Evidence of how legal and policy reform could transform HIV in prison settings was not clear. For example, there was no evidence that UNODC is sufficiently partnering with organizations or academia, etc. that could model how altering the legal landscape could contribute to reduction of HIV transmission, other communicable diseases and costs associated with incarceration.

Programme Management Arrangements

The evaluation team has addressed the four evaluation questions69 aimed at assessing the Global Programme management arrangements. Based on the analysis of the questions included in the evaluation terms of reference the evaluation team understands that programme management arrangements are the group of decisions made and actions taken to implement the programme during the years 2008-2012.

Evaluation Question 1:To what extent have HIV/AIDS programme's management arrangements been conducive to an effective programme implementation, including to mitigating risks and to assuring quality?

Overall, the programme management arrangements have contributed to the effective delivery of the programme's outputs. The review of archival records and the assessment of the project

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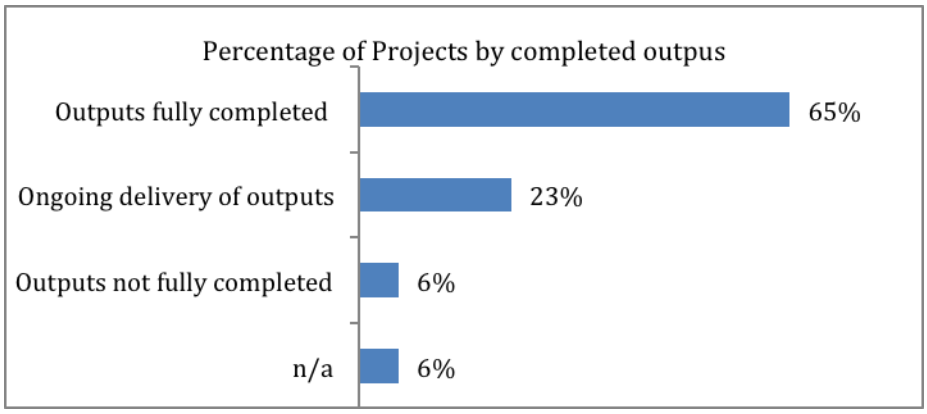
[68] Example of one of the WHO, UNODC and UNAIDS position papers dating form 2004. http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf

[69] See annex 1 terms of reference for programme management arrangements questions/criteria

portfolio demonstrate that the majority of the projects, 88%, have completed, or are on course for meeting all their outputs and objectives[70]. The remainder [71]have not been able to achieve or complete the project due to external factors such as armed conflict or social unrest. Two [72]projects could not complete the planned outputs due to a change in government priorities and there are two [73]projects where this measurement is not applicable.



The measurement of the programme contributions to effectiveness can be further analysed under three main categories:

(a) Strategic Decisions in the Global Programme

The Global Programme was established during a phase in the global response to HIV and was more than adequately resourced. For example, many co-sponsors of UNAIDS received significant funding that had to be absorbed in a relatively short period of time. Moreover, UNODC engagement in the HIV/AIDS field was very limited until the development of GLOG32 in 2002.

As a theme, the HIV/AIDS sector was not one that the broader UNODC constituency was familiar with and the high level of funding for HIV programming contributed to not only a rapid expansion of programming but also a degree of independence that other UNODC sections and Branches did not possess. This independence had a positive impact and reflects on simplifying decision-making and transmitting decisions to the field, speeding up some processes that otherwise would have taken considerable time project approval, processing of funding requests, etc. On the other hand, this independence has, in some cases, led to a degree of isolation of the HAS both within the Division of Operations and more broadly among other Divisions, Sections and Branches. Of the UNODC staff that participated as Key Informants, over 90% expressed this view and the "siloed" perception of the HAS. A frequent comment from UNODC in Vienna was that "The HAS is more of an NGO than a section within UNODC. The comments were not

[70] It should be noted that this is based upon internal UNODC assessments. A lack of baseline data and targets for the majority of the projects means a quantifiable measurement is not possible.

71 Projects LIBI36 and EGYK08
72 Projects CHNJ42 andRUS17
73 Projects BRAK02 and BRAK57

exclusively to reinforce a negative perception but it has created an "otherness" of the HAS in the eyes of many in Vienna and in country and regional offices.

An important programme arrangement was the decision to deploy HIV/AIDS advisers at country level with initial resources to design and implement small and medium projects that would help to mobilise consensus and resources around harm reduction services in countries where the starting point was near zero. This decision shaped the model of intervention of the programme's past and present. This model was deemed adequate given the circumstances of a global context with high demand for harm reduction services, a relatively good amount of resources that had to be transformed into tangible deliverables in a short period of time.

Moreover, keeping a small team in headquarters to coordinate, support and manage the programme has played a crucial role in the management of the daily operations of the portfolio of projects. This team has provided high quality and useful services to the staff managing projects in the field including administrative, technical guidance, quality assurance, and monitoring and evaluation services.

(b) Risk Management

The review and assessment of the archival data on the projects and the observations in the field indicated that there is a significant lack of a risk management culture. Most of the log frames reviewed did not correctly address the real risks that the project faced and consequently did not provide useful responses to foreseen and unforeseen consequences. This gap in risk management culture has affected the timely delivery of outputs in at least 23 of the projects. With investment in developing a risk management culture toward programming it is possible project design and delivery will improve.

(c) Quality assurance

Projects have benefited from a quality assurance process at the design phase of the projects. The review of archival data showed the revisions and efforts by the HAS and the Strategic Planning Unit (SPU) to improve the designs of these projects has been successful. Furthermore, the monitoring function has provided excellent guidance and support to projects in order to comply with UNAIDS requirements and align as much as possible the portfolio with the UBRAF. However, the indicators and data collected are mainly measuring activities and processes and less focused on outcomes. This hinders the programme to demonstrate the actual impact that the projects are having in the targeted population.

Evaluation Question 2: To what extent did the interests and priorities of the different stakeholders converge and to what extent were they reconciled by the UNODC's HQ based management (HIV/AIDS Section, Drug Prevention and Health Branch, and Division for Operations)?

The landscape in the field reveals that UNODC has done increasingly well convincing different types of stakeholders governmental and non-governmental to proactively engage in harm reduction work. The role of UNODC as a mediator has also made important contributions to bridge the gap between law enforcement and health. This coordination of efforts should be part of the strategic approach that UNODC applies in countries.

The evaluators have been able to confirm during their visit to Brazil that UNODC started to engage in high level advocacy efforts with government counterparts and CSO in the late 90's.

This approach contributed to bringing about change in the pieces of legislation passed during that period of time that contributed to close the gap between the regulations of the health sector and law enforcement sector. In the last decade UNODC has been closely working with CSO and the Brazilian Health administration to provide harm reduction services that reach out to the most marginalized population. There was a clear change in the Brazilian situation before and after UNODC engaged in the harm reduction field but this impact of course should not be understood in terms of attribution but only in contribution to a wider alliance and effort with key stakeholders in the country.

At international level, the evidence describes a different picture where there was a lack of consensus about the role of harm reduction in the fight against the HIV/AIDS epidemic. In this setting, the programme engaged in heavy advocacy work that concluded with the endorsement by CND of the comprehensive package of services in 2009. This unfavourable context also had a reflection within the Branch under which the Global Programme was operating affecting to some extent the normal life of programme implementation.

A majority of respondents described that the voice of the CSO was not sufficiently taken into consideration during the past years. The evaluators had however observed and confirmed that this point has been well taken by the HIV unit and this communication is established anew. Now an open and transparent dialogue is on-going between the CSO and UNODC HIV/AIDS programme.

Evaluation Question 3: To what extent has UNODC's HQ and Field-based Senior Management been supporting UNODC's HIV/AIDS programme? What lessons can be drawn from the governance structure of UNODC?

The observations and interviews conducted in the field revealed that the support of senior management at the field level was in general adequate. However, in some country contexts where harm reduction is still not accepted or widely endorsed at the policy level it would be beneficial to strengthen senior manager support in the form of advocacy at the highest political level. For example, it could be beneficial to repackage the topic of HIV and place it in the context of a continuum of care; more precisely, to provide the services included in the comprehensive package of HIV prevention, treatment and care among people who inject drugs.

The field visits gave the team an opportunity to confirm that some of the Global Programme staff deployed in the field were performing functions that are not directly related to their specific employment ToR. They are accountable to the HAS and are performing non-HIV-related activities and functions. Although they are furthering the overall mandate of UNODC, this may be diverting their expertise away from their primary HIV focus. This indicates that time allocation and priorities were not fulfilled in accordance to the needs of the programme.

On the other hand, interviewees report that the lines of communication and the relationship between the HAS and their staff deployed in the field were not always accessible to senior and more general management in the field. This has created misunderstandings and coordination problems that need to be properly addressed in order for senior managers to perform their role properly.

At the global level, the senior management in the HAS have done commendable efforts to support the implementation of the comprehensive package. However, UNODC is at a crossroads and much more is expected at this moment in time on regards the leading role of the organisation in enabling an environment that allows for the comprehensive package of services to be delivered at the right scale to ensure public health impacts in the key targeted population.

Evaluation Question 4: What lessons can be drawn from the programme management arrangements regarding implementation of UNODC's thematic, regional and country programmes as these relate to the HIV/AIDS programme of UNODC?

Recent UNODC country and regional evaluations showed that the Global Programme has operated to a certain extent in isolation from other UNODC operations both at HQ and in the field. The main lesson to be learned is that this isolation perhaps was necessary in the past. However, the clear demand from the majority of stakeholders requires UNODC to upgrade the profile of the programme in the field offices as well as in HQ and to fulfil UNODC's leadership role.

The main lessons learned after analysing the reality of the HIV/AIDS management arrangements is that that a well thought-out strategy of intervention should be in place before deploying a large labour force in the field. The new strategy of intervention should address each country individually and comprise a thorough analysis of the profile of human resources needed to fulfil the job. This would include the capacity to innovate and adapt to the leadership role that UNODC demands.

Country Case Studies

Given the portfolio size of 34 projects, six countries were visited. In light of this, the countries selected, the Republic of India, the Federal Democratic Republic of Nepal, the Republic of Kenya, the Republic of Zambia, Kyrgyz Republic and the Federative Republic of Brazil were selected following discussions with the HIV team in Vienna and provide a sample of the range of projects undertaken by the HAS across the key target groups of people who inject drugs in community settings, including specific programmes targeting women, and people who live and work in prisons and other closed settings. Case studies looked for evidence on the main criteria of investigation (relevance, efficiency, effectiveness sustainability) for all HIV activities in each country, including GLOG32 plus regional or country specific projects currently implemented or any closed projects. The evaluators interviewed the following key informants:

I. UNODC HIV staff.
   I. Other UNODC staff.
   II. Government counterparts – health, law enforcement, prisons.
   III. Any CSOs that were contractors or are in any other kind of partnership with UNODC.
   IV. If the project had service delivery components interviews with direct beneficiaries either in prison setting or in community.
   V. Local CSOs working on HIV/harm reduction.
   VI. UNAIDS and other UN Agency staff.

In each case study, several sources were used to triangulate data from the country visits. Data sources were as follows:

Country Case Studies	Interview	Survey	FGD	Document Review
In-country HIV advisers/project managers	X	X		X
Government counterparts Health Law Enforcement Prison authorities National Aids Programmes	X			
Local contractors	X		X	
CSOs	X		X	
Beneficiaries of project Service Delivery Capacity Building	X		X	

Other data sources included: UNAIDS country reporting mechanisms and progress reports for each country. UNODC web portals, and other relevant websites, including the World Drug Report. Data from the UN Reference Group on Injecting Drug Use. Harm Reduction International: State of Harm Reduction. UNAIDS epidemiologic fact sheets and country profiles. AIDSinfo (UNAIDS online database). HIV and AIDS Datahub for Asia and the Pacific. Other regional, donor and country reports as indicated country reports.

Case Study 1: The Republic of India

This case study pertains to the following UNODC projects:

- RASH13: Prevention of transmission of HIV among drug users in the SAARC countries - Phase II
- RASH71: Prevention of spread of HIV among vulnerable groups in South Asia;
- INDI81: HIV/AIDS project design in four North Eastern States of The Republic of India

Map I. South Asia with the Republic of India[74]

HIV in the Republic of India is characterized by a concentrated epidemic affecting primarily key populations at higher risk for HIV. The most recent estimates reported to UNAIDS indicate that HIV prevalence is slowly decreasing and ART coverage is increasing. HIV prevalence among

[74] Department of Field Support, Cartographic Section, http://www.un.org/Depts/Cartographic/map/profile/Souteast-Asia.pdf

PWID is estimated to be 7.2%, among female sex workers, 2.8% and among MSM 4.6%, with variability among geographic regions. South Asia's most severe epidemics occur in parts of The Republic of India, particularly in a cluster of southern and western states. Epidemics also occur in some of the Northeastern states where injecting drug use is the primary mode of transmission[75].

Government reporting to UNAIDS in 2013 noted that among PWID, 46.7% have received an HIV test in the past 12 months. Although government-run Integrated Care and Treatment Centres (ICTCs) have scaled up dramatically in recent years, according to data from NACO (presented at a UNAIDS meeting), only 14.8% of people tested at integrated care and treatment centres (ICTC) are key populations. Regarding self-reported safe injection practices, 87% of PWID surveyed in Manipur reported using sterile injecting equipment at last injection. Population size estimates are available for PWID and a new IBBS round with a PWID survey is planned for 2014.

A legal and policy climate that supports human rights, dignity and gender equality can help to prevent people from becoming infected with HIV and dying from AIDS-related causes.

UNODC's current technical cooperation programme in the Republic of India consists of select interventions on HIV prevention, treatment and care supported by UNODC in South Asia including: 1) empowering communities for prevention of drugs and HIV in the Republic of India, 2) Joint UN Prevention of HIV and AIDS project in four North Eastern states of The Republic of India. Other projects involve:

- Providing seed funding for civil society in Mizoram State to advocate for harm reduction services.

- Conducting multiple pilot projects and operations research on NSP, OST (methadone maintenance), integrated harm reduction services in prison, services for female PWID, and others with the goal of handing over projects to the government[76].

The evaluation team visited the UNODC Office for South Asia (the Republic of India programme is also located in this office) in New Delhi in October 2013. Following briefings, key informant interviews and focus group discussions were arranged with the key Ministries, the UN Joint Team, and civil society and other key stakeholders in the HIV response among people who inject drugs and in prisons and other closed settings in New Delhi. For example, a site visit was conducted to a methadone maintenance programme that provides peer support, peer supported referrals, readiness for HIV testing and counselling and educational programmes. The evaluation team then travelled to Mizoram in Northeastern India and conducted a series of key informant interviews and site visits to beneficiaries of UNODCs programme.

Relevance

UNODC projects in the Republic of India were and are relevant to the problems they are trying to tackle. Unmet demand from final beneficiaries is high and the size of the HIV problem among PWID, and women PWID, both within the community and prisons remains challenging.

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75 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org

76 UNODC South Asia Regional Office. Accessible at: http://www.unodc.org/southasia/

A primary challenge is how to scale up projects, such as those documented in pilots through cost effective interventions that are undertaken by the government of the Republic of India, both at national and regional levels.

NACO appears strongly interested in greater consultation and an open dialogue with UNODC. This is important because the Government is in the driver's seat and appears to have a strong interest in pilots and projects that can evidence their ability to work in the Republic of India, and within different regions of the Republic of India. This is a challenge, because international norms and standards, while taken very seriously still must be reviewed and adapted at country level.

Efficiency and Partnerships

While there appears to be opportunities for improved working relations among all the UNAIDS partners, UNAIDS regularly holds coordinating meetings, with room to enhance cooperation between UNODC and UNAIDS. New avenues could and should be pursued but it might require both a top-down effort and a simultaneous action at technical level.

Strong and collaborative relationships between UNODC country, regional offices and civil society were well noted. The coordination and support from the UNODC global office could be improved and strategic and operational level decisions should be made with greater openness.

Partnerships with UNODC and the government could be improved. As noted above, strategies are not always aligned, thus reducing the likelihood of project success. An improved UNODC and UNAIDS alignment may help these efforts.

Effectiveness

The projects seem to be producing expected results but these are limited to small-scale projects. While pilots are important in the Republic of India, as noted previously, if they are not taken on or sustained, their effectiveness and impact may be null and void.

Impact

Although it is early to see impact with respect to projects that are currently in a pilot phase or just completing a pilot (e.g., methadone maintenance therapy among PWID in New Delhi), the evaluators observed early impact related to projects providing support to females partners of drug users (peer to peer support), OST and the work completed in prisons with diagnosis and treatment of HIV/AIDS.

Successful advocacy efforts and a quality programme (as evidence by responses from beneficiaries) made a case for OST (this includes buprenorphine which was instituted prior to the methadone pilot), care for prisoners and female PWID to be included in the political agenda of the country, making the problem visible to all stakeholders. Trainings and materials were developed and conducted. Based on key informant interviews with UN counterparts in the Republic of India, it appeared that there has been a fruitful collaboration and partnership with many of the relevant actors at country level (CSOs and Government). These collaborations facilitated relations among stakeholders involved and bridging the gap between health and law enforcement.

Sustainability

The projects are very dependent on donor funding and therefore the sustainability is linked to the availability of funds and donor behaviour. An exit strategy must be in place before it is too late. Projects in the Northeast may not continue and it is unclear how certain populations will continue to receive support.

Case Study 2: The Federal Democratic Republic of Nepal

This case study pertains to the following UNODC projects:

- NPLJ80: HIV prevention care and treatment for IDUs, female prisoners and women living with HIV and AIDS in the Federal Democratic Republic of Nepal.

- NPLJ96: Technical assistance to a co-ordinated response for the prevention of HIV among drug users in the Federal Democratic Republic of Nepal: advocacy, capacity building and monitoring and evaluation.

Map II. Federal Democratic Republic of Nepal [77]

The Federal Democratic Republic of Nepal is currently publishing the results of the most recent IBBS round, which included a survey among PWID[78]. In the most recent Global AIDS Response Progress Reporting, 2012, HIV is a concentrated epidemic in the Federal Democratic Republic of Nepal with HIV prevalence of 0.30 per cent among adult aged 15–49 years in 2011. HIV national estimated prevalence among female sex workers is estimated to be 1.7%, for MSM it is 3.8% and

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77 UN Cartographic Section, http://www.un.org/Depts/Cartographic/english/htmain.htm

78 The evaluation team attended a presentation on this round of the IBBS, Kathmandu, October 2013.

for PWID, 6.3%. There has been an increase in the availability of HIV testing and counselling centres throughout the country between 2009 and 2011, and the coverage of key populations at higher risk for HIV testing and counselling services expanded during this period. However, among PWID, only 21% are estimated to have tested for HIV in the past 12 months, signalling an urgent need for improvement[79].

People who inject drugs (PWIDs), men who have sex with men (MSM) and female sex workers are the key populations who are at a higher risk of HIV. Migrant communities and female sexual partners of male PWID are also at higher risk. The Ministry of Health and Population, National Centre for AIDS and STD Control noted in their 2012 report that it is critical to improve the coverage of proven prevention interventions and HIV testing and to sustain these interventions for achieving the national target of halving new drug-injecting related HIV infections by 2015[80].

However, political instability in recent years has slowed progress on HIV. Interviews revealed that posts in the Ministry of Health and the Ministry of Home Affairs can remain vacant or frequently experience changes in Ministers. One of the most challenging aspects of changing staff members has been that those staff that have been sensitized to the importance of harm reduction in the HIV response, may be shifted elsewhere, necessitating the process of education and advocacy again and again.

In the Federal Democratic Republic of Nepal, UNODC's current technical cooperation programme consists of[81] select interventions on HIV prevention, care and support for people who use drugs for both males and females and in prisons. It also supports the government in the implementation of elements of The Comprehensive Package for HIV treatment and care among people who inject drugs as well as capacity building in drug law enforcement through a regional programme (1).

The evaluation team visited the UNODC the Federal Democratic Republic of Nepal office in October 2013. Following in depth briefing of the evaluation team, key informant interviews and focus group discussions were arranged with the key Ministries, the UN Joint Team, and civil society and other key stakeholders in the HIV response among people who inject drugs and in prisons and other closed settings. Three site visits were also conducted with 1) a government hospital to meet with the staff of a UNODC-sponsored OST site and those providing health and mental health services to people who inject drugs, 2) several civil society organizations and members and 3) a visit to a UNODC sponsored female PWID programme. Only sites in Kathmandu were visited.

Relevance

In the area of programmes, UNODC is working primarily in the area of female PWID, a previous gap area, serving women and their children with a residential facility that also serves as a drop in

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79 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org

80The Federal Democratic Republic of Nepal Country Progress Report, 2012.
http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NP_Narrative_Report.pdf.

81 UNODC. The Federal Democratic Republic of Nepal information platform. Accessible at: http://www.un.org.np/unodc

centre, has some health services, provides care and support, referral by peers to HIV testing and ART initiation, and for some, a drug rehabilitation longer-stay programme.

However, while staff commitment is high, there are insufficient resources to take a comprehensive residential home.

Efficiency and partnerships

The UNODC office is currently working at multiple levels to engage with government, bilaterals, multilaterals and civil society to promote harm reduction policies and to serve the needs of people who inject drugs. Based on interviews with civil society and beneficiaries, the work of UNODC in the Federal Democratic Republic of Nepal appears to be highly regarded. One challenge, however, is that UNODC national staff do not share the same rights and privileges as international staff within the UN hierarchy, which can hamper relations. Lastly, given the constraint in funding, and as a best practice, all efforts should be made for UNODC in the Federal Democratic Republic of Nepal (and with the assistance of the regional office) to strengthen UN partnerships under the UNAIDS country coordinating mechanism.

Effectiveness

It is clear that UNODC has been effective in putting the needs of women who inject drugs and their children on the agenda and this call has been taken up by civil society and acknowledged by the government. Further strengthening of government participation in female PWID programmes is however urgently needed.

Furthermore, UNODC appears to have been an effective and strategic partner in the development of norms and standards and dissemination of international best practices in the country.

Impact

UNODC has had impact, as noted above in bringing the issues of women who use drugs on the national stage, however it may not be possible to attribute impact to UNODC in the long run as continued funding for the programme is not currently possible.

In regard to impact on specific strategies that reduce HIV transmission among PWID in the Federal Democratic Republic of Nepal, this is less clear because the projects that were conducted were based on specific funding from other donors and not as a result of a comprehensive strategy to tackle HIV broadly among PWID and in prisons and closed settings. While the efforts of the UNODC team are highly commendable, the regional and global level UNODC counterparts should have ideally provided a coherent strategy for a small and under resourced country office in the Federal Democratic Republic of Nepal to work.

There is evidence of impact in the UNODC office's engagement and co development of norms and standards that are currently in practice.

Sustainability

Unfortunately, the sustainability of the female PWID programmes looks bleak, as at the time of this evaluation, there were no other funds for this work. An exit strategy should be detailed at the start of the programme. It is concerning that women who have been enrolled in these programmes may have few options to turn to. While some programmes in the Global Programme may be funded until November 15, 2015, not all programmes are continuing to be funded.

Case Study 3: Kyrgyz Republic

This case study pertains to the following UNODC project:

- RACI129: Effective HIV/AIDS prevention and care among vulnerable populations in Central Asia.

Map III. Republic of Kyrgyzstan[82]

Injecting drug use is the primary mode of HIV transmission in the Kyrgyz Republic and in many countries in the Region. According to the State of Harm Reduction (2013) harm reduction services have increased in recent years, but coverage remains limited. NSP is provided in all countries in the Region and the majority also provide OST. Most of the OST programmes are reported to be in the pilot stage and still require scale-up. OST is prescribed to prisoners in some countries, however access to sterile injecting equipment among prison populations remains low[83].

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82 UN Cartographic Section, http://www.un.org/Depts/Cartographic/map/profile/kyrgysta.pdf

83 Harm Reduction International (2013). Global State of Harm Reduction. Eurasia regional overview. Accessible at: http://www.ihra.net/eurasia

HIV in the Kyrgyz Republic is characterized by a concentrated epidemic affecting primarily key populations at higher risk for HIV. The most recent estimates reported to UNAIDS indicate that HIV prevalence among PWID is estimated to be 14.6%, among female sex workers, 3.5% (in 2011) and among MSM estimated to be 2.7% (in 2007)[84]. There is geographic variability as well, notably in border areas, although further investigation of hot spots and new BSS rounds is needed.

In 2012 reporting to UNAIDS, an estimated 54% of PWID self-reported that they have tested for HIV and learned their results in the previous 12 months, with an estimated 71.5% of PWID self reporting that they engage in safe injecting practices[85].

UNODC reports that since the first detected cases of HIV in the region in the early 1990s, the organization has been working to reduce HIV transmission in Central Asia. According to UNODC, current and past activities have focused on developing an understanding of the range of comprehensive services for prevention of HIV and other blood-borne infections among PWID and other people who use drugs and in prison settings. They note that this has been on-going through: support of focused interventions, improving standards for professional qualifications for healthcare workers and prison staff, developing comprehensive educational programmes, and assisting in legislative review and reforms to facilitate universal access to services.

In the Kyrgyz Republic, UNODC's current technical cooperation programme consists of[86] projects aimed at both the national and local levels, among government officials and civil society. UNODC works as part of the Joint Team on AIDS.

The evaluation team visited the UNODC Office in Bishkek in November 2013. Following briefings by UNODC, key informant interviews and focus group discussions were arranged with a number of organizations[87].

No site visits were conducted because the evaluators were informed that UNODC is not a direct service provider in the Kyrgyz Republic. The Global Fund is the primary funder of harm reduction programmes. UNODC does not provide much funding for programmes, rather it contributes through leveraging with government in policy, advocacy and legal issues. Extensive training is also conducted in drug-related issues. UNODC is working with law enforcement in 3 areas: harm reduction, demand reduction and supply reduction.

The Kyrgyz Republic has an advanced harm reduction agenda that includes an HIV in prisons programme with access to NSP, OST, education, HTC and ART provision and monitoring. TB is a serious threat to public health in the prisons and a source of high mortality, thus providing the rationale for a strong integrated HIV/TB programme.

Relevance

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84 AIDSinfo Online Database. Accessible at: http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx

85 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org

86 UNODC Central Asia Regional Office. Accessible at: http://www.unodc.org/centralasia/en/hiv-and-aids.html

87 The UN Joint Team on AIDS (UNDP, UNAIDS, Global Fund), a joint meeting with law enforcement representatives (State service on Drug Control; Penitentiary System; Police Academy), Ministry of Health, National AIDS Centre; Narcology Centre; Public Health Department, bilateral and other major donors, seven civil society organizations, and the Global Fund CCM Secretariat.

The relevance of UNODCs presence and activities on PWID and in prisons and other closed settings appeared essential and appreciated by the various government, civil society, donors and other multi and bilaterals.

Interviews and other fact gathering evidenced the added value that UNODC brings in working with narcology, legal and prison sectors of the Kyrgyz government.

Efficiency and partnerships

There is broad agreement that UNODC is a "strong team player" with the highest levels of government, the UN Joint Team and with civil society. Furthermore, key informants noted that UNODC plays a highly active and useful role on the CCM and in the UN Joint Team. UNODCs partnering with UNDP on laws related to drugs were also stressed by key informants was helpful in creating an improved policy environment.

Given that there is only national staff member working on HIV activities at UNODC, work in several sectors integral to advancing the PWID, prisons and HIV agenda exist. However, it is concerning that the programme is based in large part on the work of one individual in-country[88].

Effectiveness

The Kyrgyz Republic enjoys a less restrictive environment related to drug policy and implementation of harm reduction. While this was a convergent theme conveyed in interviews, it was also conveyed and evidenced that UNODCs staff, presence at all levels and technical expertise was integral to expanding harm reduction efforts.

UNODC is providing leadership related to OST and working to ensure it remains a part of the comprehensive package of services in the country.

Impact

It is difficult to attribute impact directly to UNODC because the country has an existing legal, policy and public health environment that is relatively conducive to the policies and plans of the HIV programme of UNODC.

However, at indirect levels, there was evidence that UNODC plays a critical role in advocating for the needs of PWID, harm reduction and access to care and treatment and prevention in prisons and other closed settings.

Strong provision of technical assistance by UNODC and sharing of global best practices has likely indirectly led to impact of global UNODC policies, norms and standards.

[88] The programme also receives support from a regional coordinator and HQ staff.

Sustainability

Russian policies on drug use, harm reduction, treatment and HIV remain a serious concern as the region moves towards a Customs Union in the coming year.

As such there is a need to ensure that laws that respect human rights among people who inject drugs as well as ensuring the comprehensive package of services are codified into law. One specific area that the Customs Union could also have an impact in the Kyrgyz Republic is on the import of medications (e.g., methadone). This may threaten existing OST advances in the country.

Not addressing the looming concerns related to the Customs Union is a serious risk to the gains that UNODC has achieved in country, a risk to the Region and must be addressed urgently.

Case Study 4: Republic of Kenya

This case study pertains to the following UNODC projects:

- KENI08: Prevention of drug abuse and HIV and AIDS in high-risk setting with vulnerable populations in Kenya.
- RAFG60: Programme development and advocacy for drug demand reduction and HIV/AIDS in Africa.

Map IV. Republic of Kenya[89]

Recent behavioural surveillance from the Republic of Kenya, the United Republic of Tanzania, the Republic of Mauritius and the Republic of South Africa indicates that injecting drug use is more of a problem than had previously been documented in sub Saharan Africa[90]; consequently, HIV must be part of the HIV response in these settings. In settings where there are no data,

89 http://www.un.org/Depts/Cartographic/map/profile/kenya.pdf

90 UNAIDS, 2013. http://www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx

surveys should be undertaken to determine the epidemiologic profile of HIV and injecting drug use so that programmes and the legal and policy framework in these settings can be improved.

According to the State of Harm Reduction (2013) the Republic of Mauritius remains the only country in the region with established needle and syringe programmes[91]. Opioid substitution therapy is also available in the Republic of Mauritius and to a lesser extent in the Republic of South Africa, and the Republic of Senegal. The Republic of Kenya and the United Republic of Tanzania are beginning to develop plans for implementation of OST. NSP is provided in all countries in the Region according to the Report. The Report notes ,however, that access to OST, sterile injecting equipment and in some settings, condom distribution (e.g., the Republic of Kenya) are illegal or at very low levels to have an impact on HIV transmission.

HIV in the Republic of Kenya is characterized by a generalized epidemic, affecting all sectors of the population, with an estimated HIV prevalence in the general adult population of 6.1% (2012). Key populations, including PWID are also severely affected. The most recent estimates reported to UNAIDS indicate that HIV prevalence among PWID is estimated to be 18.3%, and among MSM 12.2%. Significant pockets of injecting drug use occur along the coast (Mombasa to Malindi, Lamu District) and in Nairobi[92].

Among PWID, 60.4% (in 2011) have received an HIV test in the past 12 months. Although HTC is integrated in the health sector and VCT is available throughout the country, PWID continue to report difficulty accessing testing and, if HIV positive, care and ART. Regarding self-reported safe injection practices, 51.6% (2011) of PWID surveyed in Kenya reported using sterile injecting equipment at last injection (UNAIDS, 2013).

UNODC in Eastern Africa has been working on addressing issues related to HIV, injecting drug use, including in prisons [93]. According to UNODC project documents and briefings, current and past activities have focused on advocating at the government and local levels, including with civil society, to address the role of injecting drug use in the Republic of Kenya's HIV epidemic. The office has worked on both demand reduction as a means of preventing HIV and on advocating for increased access to HIV care, prevention and treatment services tailored to the needs of PWID. More recently, methadone has been advocated for as the OST of choice. Planning for its initiation and implementation are currently on going with a roll out expected beginning in 2014.

UNODC is very involved in advocating with Ministers and ministry officials, as well as the prison leadership to improve laws and policies that may hinder the scale up of harm reduction services. UNODC has also been engaged in pilot projects, along with other donors (e.g., Global Fund, International HIV/AIDS Alliance, CDC), which have led to sustained civil society influence and implementation of community based harm reduction services. These services provide NSP through DiCs. VCT is available, education and peer support and peer referral networks to ART initiation and community reintegration. Sustainable livelihood programmes have been initiated through funding by UNODC to assist primarily female PWID with a means of income during the course of drug use treatment.

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91 Harm Reduction International (2013). Global State of Harm Reduction. Sub Saharan Africa regional overview. Accessible at: http://www.ihra.net/sub-saharan-africa

92 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org

93 UNODC website for Eastern Africa. Accessible at: http://www.unodc.org/easternafrica/

The evaluation team visited the UNODC Office in Nairobi in November 2013. Sites and organizations in Nairobi, Mombasa and Malindi were visited. Following briefings by UNODC, key informant interviews and focus group discussions were arranged with a number of organizations and beneficiaries[94].

Relevance

UNODCs role in the Republic of Kenya has been extremely relevant. Advocating for key populations in the Republic of Kenya, in the context of a generalized epidemic was not of interest to donors until recently. UNODC has been advocating for the needs of PWID in the community and in prisons and closed settings when few else were interested.

As a partial consequence of UNODCs involvement, the Republic of Kenya has seen significant improvements in addressing HIV and injecting drug use in recent years with its first IBBS, population size estimation, NSP increasing in coverage and with a firm base in rights based approaches (e.g., Mombasa and Malindi sites) and now with the soon to be initiation of OST.

Efficiency and partnerships

UNODC has shared a fruitful and continuing partnership with PEPFAR and has helped to encourage PEPFARs expansion into addressing the needs of key populations in the context of generalized epidemics.

Key informant interviews and briefings appear to indicate strong collaborations between UNDOC and some of the partners in the UN family as well as among the bilateral partners, e.g., USAID and the PEPFAR office.

However, further partnership strengthening could help facilitate additional shared work agendas and support shared actions (e.g., CDC Kenya) as well as other partners under the Joint Programme.

There have been several key moments where UNODC played a critical role in convening partners, most importantly, members of society to tackle the needs of PWID (most notably on the coast, among multi faith denominational leaders and women's groups).

Effectiveness

UNODC has been effective in placing the needs of PWID and persons in prisons and closed settings on the agendas of the highest levels of Kenya's government.

Through the establishment of a Parliamentarian network as well as a multi-party network comprising civil society, government, bilateral and multilateral partners, UNODC has clearly

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[94] Meetings were held with: UNAIDS, USAID, CDC, PEPFAR, National Authority for the Campaign Against Drug Abuse (NACADA), Kenya Prisons Service, National AIDS and STIs Control Programme (NASCOP), Ministry of Health, National AIDS Control Council, Department of Mental Health, Mathari Hospital, civil society organizations and consortia and beneficiaries.

been an important player in building a momentum to address HIV among people who inject drugs in Kenya.

UNODC has been effective in convening key stakeholders for study tours that appeared to alter the mind-set of key governmental players on issues of PWID.

UNODC has appeared to work effectively to develop guidelines, norms and standards and SOPs and to distribute international best practices on issues related to NSP, OST, etc.

Impact

In regard to impact, it is always difficult to attribute impact directly to one organization or action, however UNODC appears to have made a lasting impact on bringing the issues of PWID on the HIV agenda in the Republic of Kenya. Furthermore, UNODC has brought the attention of major donors (e.g., PEPFAR) to assist in the needs of PWIDS and prisons in the Republic of Kenya. It was also evident that civil society has received substantial recognition and empowerment as a result of UNODC (and other major donors) in Kenya.

Sustainability

UNODC has seen funding drop off and has not and will no longer be able to provide direct project support to the extent it has previously. Therefore, an exit strategy for UNODCs involvement in projects has not been clear and has caused undue concern for those organizations that had previously benefited.

Case Study 5: Republic of Zambia

This case study pertains to the following UNODC projects:

- XASJ72: HIV prevention, care, treatment and support in prison settings in Southern Africa.

- XSSV02. HIV and AIDS prevention, treatment, care and support in prison settings in sub-Saharan Africa.

Map V. Republic of Zambia[95]

According to the State of Harm Reduction (2013) the Republic of Mauritius remains the only country in sub Saharan Africa with established needle and syringe programmes. Opioid substitution therapy is also available in the Republic of Mauritius and to a lesser extent in the republic of South Africa. The Republic of Senegal, the Republic of Kenya and most recently, the United Republic of Tanzania are seeking to and beginning to address how to implement OST. The Report notes that NSP is provided in all countries in the Region, but whether this is at scale depends on geographic location. OST is prescribed to prisoners in some countries, however access to sterile injecting equipment and in some settings, condom distribution are illegal (e.g., the Republic of Zambia) or at very low levels to have any impact on HIV transmission. No data are reported from the Republic of Zambia relative to OST or NSP as these services are not legal

[95] UN Cartographic Section, http://www.un.org/Depts/Cartographic/map/profile/zambia.pdf

in the country (including in prisons)[96]. While the UNODC HIV Global Programme aims to address HIV in prisons (and not only prisoners who have used or are using drugs), harm reduction programmes in prisons are also integral to having an impact on the HIV epidemic in settings where evidence of PWID in prisons exist. In settings where the surrounding community do not have access to harm reduction services, UNODC should seek and document its plans for advocating for policy change. It is also recognized that where the presence of UNODC could be jeopardized by such advocacy, the risks and benefits of improving services for all prisoners must be taken into account. In examining HIV and prisons in general, there is insufficient evidence that UNODC programmes are having an effect or impact on the epidemic. Opt in VCT services are insufficient to identify persons in need of treatment and care and other prevention in prisons and other closed settings. Since 2007, WHO and UNAIDS have recommended provider initiated HIV testing and counselling in health care settings. WHO and UNODC guidelines for HIV testing in prisons (2009) have however indicated that special consideration must be made to prisoners, a vulnerable population in settings where those identified as HIV+ could be discriminated against or in danger, which remains a critically important issue. The risks and benefits must always be weighed. Given the 2013 WHO ART treatment guidelines and the current evidence that ART significantly reduces HIV transmission, it is imperative that all settings seek to reduce barriers to testing (e.g., by recommending an HIV test, TB screening and STI screening) to all persons in health care settings, including on admission to prison settings. If not, prisoners have to risk seeking out HIV testing as an exceptional reason, risk standing out to prison staff, and presenting for testing when they are advanced in their HIV disease. Although current prison policy sought to protect the most vulnerable, it is time to reconsider this strategy which given today's evidence may be viewed as paternalistic. Where ART is available, UNODC works with partners in the prisons to provide access to treatment for persons already identified (or those newly identified through opt in VCT). However, this is not an efficient strategy to address HIV comprehensively in prisons and other closed settings.

HIV in the Republic of Zambia is characterized by a generalized epidemic, affecting all sectors of the population, with an estimated HIV prevalence of 12.7% (2012), however there is significant geographic variability with an estimated 21-22% of people in Lusaka living with HIV. New HIV infections are estimated to be decreasing (National HIV/AIDS/STI/TB Council), while the proportion of eligible adults receiving ART is increasing. The proportion of HIV positive TB cases receiving treatment for both HIV and TB was 41% at the end of 2012 among the general population[97].

Sex work, MSM and PWID are illegal activities in the Republic of Zambia[98]. Only data are available from 2007 on HIV prevalence among sex workers (65.4%). A convenience sample conducted cross-sectionally (over a 4 year period) estimated HIV prevalence to be significantly higher than that of the general population. People who use drugs can account for the majority of persons in custody (remand and post-trial detention) in Zambian prisons. Of these, a small proportion are believed to be people who inject drugs, with the majority being individuals held on small quantity marijuana charges. However, the impact of prison on the HIV epidemic in the Republic of Zambia is not known. These populations migrate in and out of prison, sometimes

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96 Harm Reduction International (2013). Global State of Harm Reduction. Sub Saharan Africa regional overview. Accessible at: http://www.ihra.net/sub-saharan-africa

97 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org and www.aidsinfoonline.org

98 UNAIDS, 2013. Accessible at_ www.unaids.org

multiple times and have little to no access to health care, including HIV prevention or other diagnostic services[99].

The Republic of Zambia plans to use the Investment Framework[100], developed by UNAIDS in its next Global Fund proposal and to focus its strategic response. Hard to reach, vulnerable and key populations will be included in their investment case. Although the Evaluation Team has not seen a copy of the modelling study conducted to inform the investment case, the fact that key populations will be included in the new response may indicate that the epidemic cannot sufficiently decrease without attention to these populations.

A legal and policy climate that supports human rights, dignity and gender equality can help to prevent people from becoming infected with HIV and dying from AIDS-related causes.

UNODC in Southern Africa has been working on addressing issues related to HIV, injecting drug use and prisons, with this year's publication (2013) of the Southern African Development Community (SADC) Region guidelines. For example, UNODC has been involved in improving health related conditions in prisons and closed settings. In the Republic of Zambia, as in the SADC Region, prisoner occupancy levels are significantly over capacity with primarily sexually active males between 10 and 35 years old, age groups with the highest HIV prevalence in the Republic of Zambia. UNODC, in partnership with SADC, recently developed the SADC Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region[101].

The evaluation team visited the UNODC Office in Lusaka in November 2013. Sites and organizations in Lusaka and Kabwe were visited. Following briefings by UNODC, key informant interviews and focus group discussions were arranged with a number of organizations[102].

Relevance

UNODCs programme in the Republic of Zambia, while focusing on prison settings is extremely relevant and adds value to the UN family by liaising successfully with the prison systems and narcotics branches of government and law enforcement.

99Human Rights Watch. 2010. Unjust and Unhealthy, HIV, TB and abuse in Zambian prisons Accessible at: http://www.hrw.org/reports/2010/04/27/unjust-and-unhealthy-0

100 Investing for results. Results for people. A people centred investment tool towards ending AIDS. Accessible at: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2359_investing-for-results_en.pdf

101 SADC website. Accessible at: http://www.sadc.int/themes/politics-defence-security/public-securit/correctional-servicesprisons/ and SADC. Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region (2011).

102 Members of Parliament (Coalition of African Parliamentarians Against HIV and AIDS (CAPAH), Ministry of Home Affairs, National AIDS Council, Ministry of Community Development, Mother and Child Health, Ministry of Health, Prison AIDS Advisory Committee (PAAC), Zambia Prisons Service, site visit to a VCT centre under construction at Kabwe Prison, Swedish Norwegian Team on HIV/AIDS in Africa, UNAIDS, UNFPA, USAID, CDC, PEPFAR, civil society organizations and consortia.

Efficiency and partnerships

UNODC has some challenges to being efficient in the Republic of Zambia, namely, it is short staffed and lacking in resources. Considering this, the office and the staff have demonstrated an exemplary level of commitment to their work and have been acknowledged by multiple stakeholders for their efforts and achievements.

Effectiveness

There are significant challenges to conducting HIV related prevention, care, treatment and harm reduction (comprehensive package of services in the Republic of Zambia due to laws that prohibit:

- Acknowledgement of MSM activity (in and out of prison)
- Distribution of condoms, assessing whether there is a need for safe injecting equipment or OST both in the community and in prisons, stronger recommendation for HIV testing and counselling and access to ART, considering this,

Although it has been very successful in advocating for the rights of prisoners, the UNODC office, through the PAAC and CAPAH, requires additional support from UNODC leadership at the global level to affect the highest level of policy and legal change that is required for the Republic of Zambia to halt and reverse HIV.

Impact

It is difficult to attribute impact to one programme, however, the evaluators saw evidence of impact in regard to the significant development of interest in addressing HIV in prison settings among key government stakeholders.

The SADC guidelines, the African HIV in Prisons Partnership Network (AHPPN) as well as the African prisons online for and networks have been extremely important for furthering improvements in prison settings in sub Saharan Africa.

Case Study 6: Federative Republic of Brazil

This case study pertains to the following UNODC projects:

- BRAK02: HIV prevention and care: strengthening the health services coverage at the prison system

- BRAK57: Improving management, surveillance, prevention and control of STD, AIDS and viral hepatitis among drug users, sex workers, prison population and people living with HIV/AIDS

Map VI. Federative Republic of Brazil[103]

The national HIV infection prevalence rate has been stable at approximately 0.6% since 2004, being 0.4% in females and 0.8% in males in 2012.104 The AIDS epidemic is stable and

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[103] Brazil: Department of Field Support, Cartographic Section, http://www.un.org/Depts/Cartographic/map/profile/eclac.pdf

concentrated in certain vulnerable population subgroups that have clearly a disadvantaged position in society among them; injecting drug users, people who use drugs in communities as well as in prisons and closed settings.

Different sources of federal, state and municipal governments have reported since 2002-2003 a decrease in transmission among PWID through the use of infected syringes and needles. Only a small percentage of drug users still use this modality of drug use concentrated in some urban areas such as the North district of Sao Paolo or areas in the state of Rio Grande do Sul.

The Federative Republic of Brazil has legal and policy climate that supports human rights, dignity and gender equality can help to prevent people from becoming infected with HIV and dying from AIDS-related causes.

UNODC technical cooperation in the Federative Republic of Brazil has characterized by a strong sense of partnership with the governments at federal, state and municipal level as well as with CSOs. UNODC partnership has evolved through time starting as an advisory collaboration with the federal government in the 90´s, to become an advocate based allied of evidence based policies that has transformed into an implementing partner of a structured technical assistance programme financed by a World Bank loan.

UNODC in the Federative Republic of Brazil has worked in virtually all areas including basic and applied research, the provision of capacity building, advocacy and policy advise, direct support to CSOs to provide harm reduction services, etc. The width and depth of the interventions executed mainly by the government but in close partnership with UNODC seems to have worked and is really appreciated.

The evaluation team visited the Federative Republic of Brazil in December 2013 and visited firstly Sao Paolo and secondly Brasilia.

In Sao Paolo the evaluator had the opportunity to meet with the local government of the Municipality of Sao Paolo- HIV AIDS Programme coordinator and team (research and social welfare) Health Secretariat and members of civil society namely REDUCI (the national harm reduction network) and a national CSO, LEI..

The scale of Sao Paolo as an urban region is enormous, 11 million inhabitants with a high degree of inequalities in areas like the North, Northeast, Centre and South where health indicators and HIV indicators are at similar levels to parts of sub-Saharan Africa.

The Secretariat operates through a network of nine health centres that provide a wide array of services including the ones on the UNODC harm reduction package. These centres are staffed with doctors, nurses as well as social assistants. Health agents that bring the services, guidance and advice to users at their homes supplement the network of centres. Furthermore the Secretariat commissions several high quality research products to support their planning and decision-making throughout the year.

104 UNAIDS. AIDSinfo database. Accessible at: www.unaids.org

REDUC is a network of drug users for harm reduction. This organization brings together expertise and experience within the Federative Republic of Brazil to fight for the rights of people who use drugs. REDUC collaborates directly with UNODC in the implementation of harm reduction projects targeted to population at risk including transgender and sex workers.

LEI, is an active organization, to provide harm reduction services to key populations including PWID and other drug users in the Sao Paolo region. They have collaborated with UNODC in various activities including the provision of capacity building to harm reduction professionals, collaboration in research activities and products, advocacy to protect the rights of drug users and the distribution of safe "sniffing kits".

The mission completed with a segment in Brasilia where the evaluator had the opportunity to interview stakeholders from the federal government UNODC managers, UNAIDS and project staff.

Relevance

UNODC interventions in the federative Republic of Brazil have addressed the most salient problems with people who use drugs and HIV from a multidisciplinary perspective that affects policy at the federal and state level, decentralization of health services research and innovation. The pioneering vision of working with key populations in urban areas like Sao Paolo and in remote and rural areas in the Goanias or Amazonia contrast with the unmet need to promote strong interventions in prisons where there are only small examples of work and a pressing need to start interventions at a bigger scale.

Efficiency and Partnerships

UNODC has shown an impressive record of meaningful partnerships through the years with a well-respected reputation in the country both from the technical point of view and as high and relevant partner to combat HIV/AIDS that is connected to a global network of knowledge and influence. Overall all the stakeholders that the consultant interacted with have shown a good degree of satisfaction while engaged in partnerships with UNODC.

The impressions from the perspective of efficiency come from the observations during the mission and the analysis of some archival records from the programme. Government counterparts executed the bulk of the projects in the Federative Republic of Brazil and UNODC has a comparatively small tranche of resources to manage in most of the cases. However it is worth to highlight the amount of work that such a small team in UNODC can deliver the high amount of outputs in the last four years.

Effectiveness

The evaluator has been able to contrast the information coming from the interviews and direct observations conducted during the visit to be able to confirm that UNODC interventions in the Federative Republic of Brazil have overall, achieved their objectives and are producing effects in key populations. Although, the scope and reach of the interventions occur in many occasions at a higher hierarchal level rather than with direct beneficiaries, the research products and the quality of the capacity provided seem to contribute to produce effects at the beneficiary level. There are

many examples including key publications such as dissemination of the experiences of 21 successful projects, the organization of high level policy seminars, symposiums and the dissemination of the HIV/AIDS data at the regional level.

Impact

The main impact that UNODC has contributed to the country is to position harm reduction as a key strategy to combat HIV. Furthermore, UNODC has been key to channel and link the international community's diversity and knowledge into this important support.

Sustainability

The sustainability prospects are high due to a strong commitment by the federal government, state government and CSOs. The Federative Republic of Brazil has been a case study of good practices and lessons learned at international level. Despite the leading efforts and the excellent results the fight against HIV/AIDS will continue high in the national agenda and this will likely increase the demand of interventions that address the epidemic in the forthcoming years.

III. CONCLUSIONS

The UNODC Global HIV/AIDS Programme has made some important contributions to the global response to the HIV epidemic and the Global Programme is becoming more aligned within the United Nations division of labour in terms of UNODC's role as a lead agency working to protect drug users from becoming infected with HIV and ensuring access to comprehensive services for people in prisons and other closed settings. In addition, the projects that UNODC is designing, raising resources for and implementing are becoming more aligned with the overall UNAIDS UBRAF, and most significantly the programme is using the same indicators and reporting mechanisms required by UNAIDS for all country programmes where UNODC implements HIV projects in both community settings and in prisons and other closed settings.

Most significantly, in terms of attribution of success, is the commitment, professionalism and passion of the UNODC HIV/AIDS Section in Vienna and the 41 countries where UNODC has implemented HIV programmes during the evaluation period. Evidence, notably from key informants consistently commented on the commitment and responsiveness of UNODC staff both in HQ and in the country offices. Key informants and direct observation during the country case study field visits confirmed that the credibility and success of UNODC is primarily due to the international or national staff managing the HIV programmes. Additionally, the low turnover of staff that the HAS has benefited from has enabled organisational knowledge to stay within the organisation.

The evaluation findings, from multiple data sources (the project review analysis, additional country documents, key informant interviews and the survey data) can draw some over-arching conclusions regarding the successes or challenges of the Global Programme. It is clear that there have been some significant achievements of the programme. The findings around relevance and impact highlight the successful advocacy that has been implemented around improving or introducing new legislation and policy that allows for a broader range of HIV prevention services in prisons such as the Kyrgyz Republic, or improved protection of PWID in the coastal areas of the Republic of Kenya. Other examples from the evaluations previously conducted also identified considerable achievements with regard to advocacy work that was targeted towards law enforcement and other criminal justice agencies including the advocacy implemented in Eastern Europe (XEEJ20) and South East Asia (RASI09).

The advocacy programme, however, would be significantly more impactful if, firstly, advocacy is targeted more towards parliamentarians and lawmakers, rather than from bureaucrats and officials who implement policy, where the majority of the Global Programmes activities have focused. A significant example of this, and one which could be replicated, is the advocacy, convening and coordination of the parliamentarian's forum in the Republic of Zambia. Secondly, and highlighted in the relevance, effectiveness and human rights findings and supported by key informant interviews and country case study visits was the stated lack of senior UNODC leadership in supporting the advocacy initiatives that would provide greater credibility for the field staff to actively engage higher level government officials and parliamentarians.

A second area of success has been the capacity building of an extremely broad range of stakeholders. This increased capacity across all 41 countries and directed at individuals across all

sectors of government, legal authorities, civil society, medical service providers and beneficiaries of services has enabled country responses to advance by improving knowledge, awareness, practices and attitudes toward PWID and people living in prisons. The investment is long term and was out of the scope of the evaluation to measure the impact but the evidence from the findings indicates that a significant component of UNODC's programming activities is relevant and will produce impact over the long term.

A frequently heard comment from key informants across all sectors, however, that neatly summarises the programme is "doing good but could do better". This is also evidenced in the overall scoring of the project portfolio with a just over majority of projects categorised in the "Green Amber" section (52% design, 53% delivery) that signifies performing relatively well but that improvements should be made to improve efficiency/effectiveness/impact. The focus on developing pilots as discussed in the relevance findings, may have value in terms of driving innovation and more choices available for beneficiaries but more analysis is required to ensure such pilots have a clear scaling-up strategy if the intervention is considered a success. Additionally, pilot projects need to be more effectively monitored at the outcome level rather than focused at measuring activities. This is equally important and applicable for all the Global Programme's projects.

There is no clear, overarching strategy to guide UNODC's HIV work globally. The approach has been to achieve coverage through the placement of advisers that will generate demand and resources for programming activities as outlined in the GLOG32 project document and revisions. This is a strategy that may have worked when funding was more available but the resourcing environment for HIV programming in the short and long term is more of a "do more with less" scenario and as such the HIV section should consider if the current strategy for deploying GLOG32 resources is the most appropriate. Alignment of GLOG32 to the high priority country list developed jointly with civil society and articulated in the partnerships section has the potential to deliver a more focused impact with less coverage rather than the current situation of having large coverage/presence but a more diffuse portfolio dependent upon non-GLOG32 resources to develop programmes.

UNODC's relationship with Civil Society at the global coordination level has significantly improved over the last 12-18 months, that can, to a large degree, be credited to the HAS team in Vienna who have demonstrated a more open and collaborative approach to working with Civil Society and have prioritised this in their work plan. This was acknowledged by all the global CSOs that participated as key informants. Significant evidence, as outlined in the partnerships findings include working jointly with the HAS to analyse and produce a list of 24 priority countries for implementing the core of UNODC's HIV programme from 2013-2015 and producing and implementing a joint work plan and regular coordination meetings funded by GLOG32 resources.

Throughout the evaluation period 2008-2012 there has not been a public endorsement of harm reduction norms and standards from senior management. Events such as World AIDS Day events (held on December 1st annually) CND and UNGASS assemblies etc. would have been an opportunity for UNODC leadership to endorse harm reduction and acknowledge the impact such an approach has made on reducing HIV among PWID. Key Informants, from Civil Society, as evidenced in the partnership findings in particular, have raised this as a limitation towards working closer with the UNODC HAS. It should be noted that UNODC leadership does support

the Comprehensive Package as outlined in the "Technical Guide" in an explicit manner e.g. through public statements advocating for the public health importance of harm reduction.

Partnerships with Civil Society in the countries selected for case studies demonstrated a strong working relationship with UNODC and key informants noted that UNODC support and responsiveness were particularly welcome. As the programme management findings outline, the selection of CSO's as recipients of grants or contracts could be made more transparent. There was little evidence of many open and transparent contracting mechanisms in place in the country case study visits. There is an over reliance on known partners who have worked and benefited from working with UNODC for a long period of time. Aside from transparency and governance issues this is not best practice and a more open, competitive and accountable system for selecting implementing partners needs to be introduced in all countries where UNODC is operating and contracting services.

A significant weakness of the Global Programme, evidenced in the effectiveness and relevance sections, the project reviews and evaluation reports is the poorly designed monitoring and evaluation mechanisms and indicators contained in the log frames of the projects. Without the right type of tools and benchmarks to effectively measure progress, rather than simply reporting on progress, the HAS will find it increasingly difficult to justify the level of investment in the Global Programme and with the other 10 Co-Sponsors of UNAIDS. There has been significant progress in ensuring more robust monitoring and reporting systems both internally and also with regard to UBRAF reporting. The linkages and harmonisation of reporting within the UBRAF and the phased introduction of the core set of outcome indicators discussed in the findings section will strengthen reporting at the global/UNAIDS level but significant work is required to ensure that country offices have the necessary capacity to more effectively measure the programme's outputs and impact and not simply focus on measuring activities.

With the exception of TB programming, where little evidence was revealed of any major focus on this area, UNODC is contributing to the objectives and commitments under the UBW and UBRAF programming structures. It is not possible to quantify or allocate a percentage achievement because the country and regional projects do not align themselves 100% within the UBRAF. However, in all countries visited during the evaluation it was clear that the internal UN reporting and planning reflects the overall UBRAF. There is little evidence that UNODC is prioritising TB programming aside from it's work as a member of Global Fund CCMs or technical working groups and, in some cases, as part of a comprehensive/basic package of services for people living in prison.

UNODC has a comparative advantage, due to it's mandates, to work in prisons and with law enforcement and drug related agencies who are key stakeholders in ensuring that UNODC meets the commitments outlined in the UNAIDS division of labour and elaborated in the background section of the evaluation report. Key informants consider the prison programming and sensitisation of law enforcement agencies to be some of the major achievements of the Global Programme, evidenced during the country visits in the Kyrgyz Republic and the Republic of Zambia. The expansion of the Global Programme's prison work, through more investment from GLOG32 and other funding sources available should be prioritised. Equally important is the overall priority on prison work within the UBRAF and the convening role that is the responsibility of UNODC.

The Global Programme has done a sound job of addressing the needs of women affected by HIV. Based on a review of multiple data sources (e.g., the project portfolios, country case studies and key informant interviews), this is evident. The needs of women living with HIV and women in prisons has in some countries, been the majority of the work (e.g., the Federal Democratic Republic of Nepal, the Islamic Republic of Afghanistan, the Republic of India). As noted in these project design reviews and the case studies, country programmes focused primarily on services to women appear to be donor driven and not always part of an overall country strategy. In regard to equity, UNODC has a strong track record in some settings of addressing youth, street children and in particular, mobile services (in multiple countries) to populations in underserved rural areas. Further attention can be paid in the future to ensuring that the populations served and revised norms and standards address the epidemiologic needs of women, youth, and hard to reach populations at global, regional and country level.

In regard to human rights, as noted from key informant interviews with UN partner organizations, UNODC has been working to improve relations with civil society in recent months and the response is reportedly favourable. Some survey respondents noted that they have been disappointed with the Programme's response to HIV and compulsory detention centres in Asia. A common theme from the survey was that there was reported variability in the technical expertise of UNODC staff assigned to the HIV programme on a country by country basis, potentially accounting for some of the different levels of engagement on human rights issues and other harm reduction related issues. Another common theme referred to a disconnect between the UNODC HIV Programme's promotion of the comprehensive package and harm reduction as a principle itself and the larger UNODC organization which is at odds with this purpose.

There were many similar themes identified through the 12 evaluations analysed by the evaluation team that have also been identified in this global evaluation of the HIV programme. In 9 (75%) of the 12 evaluations that have been reviewed by the evaluation team, weak M&E systems at the country- and regional-level implemented projects, poorly selected indicators and a focus at the activity level, rather than impact were identified and substantiated by this evaluation. A majority of the projects that have been evaluated and reviewed by the evaluation team found that the M&E systems used by UNODC at the country and regional level are inadequate and data collection is consistently weak or inappropriate. For example, the majority of projects, which the evaluation team had evaluated and reviewed in the portfolio do not have specific indicators to measure progress or process, effect or impact. A large amount of data are collected, but most are activity or process based and are not able to capture the effect of the interventions that UNODC is implementing. Impact would be important to assess as well, but the projects do not appear to be designed to assess impact. It may be possible for UNODC to partner with academic and other institutions, including UNAIDS that can seek to assess impact (e.g., prospective longitudinal cohorts of PWID where HIV transmission can be examined), but this has not to our knowledge been explored. In addition, a perceived lack of information coming out of the HAS on progress of its programme and by which key stakeholders, including donors, could be further engaged, was frequently expressed. A more targeted communications strategy using a variety of media platforms could be established that would be able to communicate different results and one that would compliment the excellent publications that UNODC frequently publishes.

Lastly, with regard to other strategic information (SI), findings suggest that the relationship at country and global level between UNODC SI and UNAIDS Secretariat SI (both surveillance and M&E) need to be strengthened. It is very positive that in the absence of an independent Reference Group Secretariat, that UNODC will be working in tandem with UNAIDS Secretariat,

WHO and the World Bank on the next round of global estimates and reporting. Not only will this strengthen UNODCs capacity in this area, but will also increase transparency and allow for a critically needed iterative process on the estimates. Note that this new process does not preclude the UN Reference Group on IDU and HIV from continuing to monitor externally or from its members providing guidance on future injecting drug use and HIV related directions. It also does not preclude the importance of commissioning external systematic reviews on IDU and HIV.

IV. RECOMMENDATIONS

Key Recommendations

1. UNODC leadership should support the objectives of the Global Programme by supporting harm reduction as a practical, evidence based solution in the CND and other important international fora. A statement of support for the Global Fund's most recent policy on detention centres105would be a step in aligning UNODC's support with other global institutions and would also be in line with UNAIDS priorities concerning human rights as outlined in the conclusions and findings of the evaluation.

In line with the above recommendation, UNODC leadership could support the UNAIDS Executive Director in UNAIDS' work with the Russian Federation to advocate for the removal of punitive laws and policies which harm both human rights and the HIV response and are affecting the entire Region, as highlighted by the concerns expressed by key informants in the Kyrgyz Republic and from UN and other international donors.

2. Commit to the development of a strategically targeted, measurable and costed strategy for the HIV section for 2015-2020. Without a more detailed strategy than the objectives of the Thematic Programme described in the background section of the evaluation report, the Global Programme will continue to function more like an NGO implementing a broad range of projects without maximising its potential for impact (that clearly exists based on project reviews and country case studies). For much of the evaluation period, it appears that resources were relatively easy to mobilise. However, these resources have been increasingly attached to a more restricted budget for HIV/AIDS programmes from the majority of UNODC's donors. Therefore, it important for the HAS to be more aware, and able to communicate, the potential impact and "added value" that the Global Programme brings. The strategy should also clearly outline the risks inherent within the plan and develop a risk management and mitigation plan that should be reviewed at least annually.

3. The strategy should identify key "niche areas" or gaps where the Global Programme can add value. Examples identified during the evaluation and outlined in the relevance and country case study sections of the findings were in accordance with other evaluation reports and included work with female drug users, refugees and street children and sustainable livelihoods. These all were identified as examples of best practice in the findings and conclusions, and could be developed, scaled up and systematically disseminated through the development of a proper knowledge management system. However, these niches should be part of an overall country strategy and not the only focus of a country programme.

4. A less donor-driven approach to resource mobilisation and a more detailed analysis at the design stage of any future project could strengthen sustainability and impact of the Global Programme and could streamline the Global Programme's very diverse portfolio of projects. The

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[105] http://www.aidspan.org/gfo_article/identifying-monitor-viet-nam's-drug-treatment-centres-becomes-condition-global-fund-supp

development of the global strategy indicated in recommendation 2 may also drive the resource mobilisation efforts, allowing donors to invest in all or parts of the strategy.

5. As the evaluation findings and conclusions allude to, a more enhanced monitoring framework needs to be introduced and integrated with UN Global AIDS Response Progress Reporting as a matter of priority. The set of universal indicators that have been designed by the HAS and aligned with UBRAF outcomes should be finalised and introduced into country programmes before the end of 2014 to more effectively plan and monitor programmatic performance and to improve reporting upward to the HAS in Vienna and the UBRAF systems in UNAIDS.

6. It is also essential that human rights considerations and principles are embedded in any future strategy and that a strategy for UNODCs approach to human rights should be developed. All future projects should be reviewed for human rights, legal and policy issues, regardless of the political environment.

Important Recommendations

1. Realign GLOG32 to reflect the new strategic directions that the Global Programme has initiated and focus on GLOG32 PWID resources on the 24 priority countries, supporting civil society and providing high level leadership and technical assistance.

2. Review current staff skills and capacity and produce a gap analysis for future recruitment purposes. The HIV section has many competent and experienced HIV advisors and public health experts; however, based on the review there may be a requirement to recruit additional skills such as legal expertise, law enforcement or policy formulation. It is important to have internal capacity in areas beside HIV and public health experience at the global and country level.

3. It is recommended that UNODC invests in more monitoring and evaluation capacity and systems, as evidenced throughout the evaluation report, either through specialist staff or by contracting short-term technical assistance. The evaluation has identified project-level monitoring as a weakness of the programme. Increasingly the UN and other stakeholders are being forced to justify expenditure and as such it is vital that country and regional offices have skilled and competent staff that are able to not only monitor project activities but also to more effectively monitor and analyse impact and value for money.

4. A more targeted communications strategy using a variety of media platforms could be established that would be able to communicate different results and one that would compliment the excellent publications that UNODC frequently publishes. An enhanced visibility and openness about the work and results that the HAS achieves would inform donors, policy-makers and civil society and was a recommendation from many key informants who would like to know more about the Global Programme.

Case Study Recommendations

The Republic of India

1. UNODC may be able to continue in its role of addressing sub populations, e.g., children of and in the street, youth, new geographic hot spots, through its resources and expertise. It is and should partner with UNAIDS in improving the state of strategic information and in data sharing.

2. In Mizoram, UNODC is working primarily in the area of female PWID, however, providing services to primarily female PWID, while important, should also be one part of a comprehensive harm reduction strategy in the Republic of India. Therefore, given the lack of resources, UNODC may wish to consider developing a strategy that promotes at a higher level of engagement that is required to scale up the comprehensive harm reduction package in the Republic of India. In the Republic of India, where the government is providing greater proportions of funding to the HIV response, integration with the government objectives need to go hand in hand.

3. While OST and NSP are available, HIV diagnostic services are not available within CSOs. There are currently policy barriers for HIV testing to be conducted in community based settings (i.e., rapid diagnostic tests are available but are conducted in laboratory settings) and ART services are similarly in government run institutions, PWID have barriers to learning their HIV status and initiating care, treatment and other prevention and treatment for common comorbid conditions (e.g., hepatitis C, TB, STI). UNODC should work with WHO and CSOs to encourage delivery of services at the point of care for PWID.

4. Lastly, given shrinking resources, UNODC should review the technical capacity to deliver high level advocacy for legal and policy reforms that are hindering the enabling environment among PWID and in prisons and other closed settings. Furthermore, UNODC should work with the government to develop solutions for PWID who are not accessing services and who are falling out of the care and treatment cascade. It is not enough to have freestanding services for these most vulnerable populations.

The Federal Democratic Republic of Nepal

1. Given the lack of resources, UNODC may need to develop a strategy that promotes at a higher level of engagement what is required to scale up the comprehensive harm reduction package in the Federal Democratic Republic of Nepal. While low threshold services among PWID were excellent examples of evidence based programming, UNODC is not in a position to sustain or take such services to scale. Efforts should be made to encourage government ownership and to seek funding from other sources that can take such programmes to scale.

2. While OST and NSP are available, they need to be further scaled up. In addition, where OST and NSP are available (in some settings) HIV diagnostic services are not available. There are currently policy barriers for HIV testing to be conducted in community based settings (i.e., rapid diagnostic tests are available but are conducted in laboratory settings) and ART services are similarly in government run institutions, PWID have barriers to learning their HIV status and initiating care, treatment and other prevention and treatment for common comorbid conditions (e.g., hepatitis C, TB, STI).

3. Given strong CSOs and the government's stronger role in their HIV response, this is an excellent time for other donors to provide resources so that the gains that have been made will not be lost. UNODC can continue, hopefully, with fewer resources by addressing legal and policy barriers, norms and standards, advocacy and strengthening of partnerships.

Kyrgyz Republic

1. The Kyrgyz Republic is a strong example of the ways in which other countries can move forward in Central Region to expand their evidence based work among PWID and in prisons and

closed settings. With OST and NSP availability in some prison settings at an estimated 90% (personal communication, UNODC), it is important to share the lessons learnt from the scale up of harm reduction in the country.

2. The Kyrgyz Republic is one of the 24 priority countries for 2013-2015 in collaboration with Global CSOs and therefore further resources could be focused here (there is only one staff member focusing on HIV currently in the country) considering the serious threat to public health and human rights in Central Asia and Eastern Europe.

3. While the country programme is well supported by the regional office of UNODC, given the highly political nature of the drug debate in the Region, and with respect to the Russian Federation, it is critical that UNODC senior leadership support sound technical work of the UNODC country office and promote evidence-based harm reduction in the Region at every opportunity.

4. Although there has been tremendous progress on harm reduction implementation in the country, there are still common reports of police harassment among PWID and sex workers. UNODC law enforcement training and sensitization projects require review and further scaling up in tandem with law enforcement senior management.

5. It is estimated that half of the prison population at any given time may be using drugs with half of those injecting. Drug laws require on-going review and high-level advocacy from UNODC leadership both at the country, regional and global level to reduce the proportion of persons in closed settings for drug-related offences.

6. While there is encouragement for PWID to learn their HIV status and for those who test positive to engage in care and treatment, these efforts are no longer sufficient given the recent scientific evidence and revised international guidelines on HIV diagnosis, care and treatment. UNODC office is encouraged to align its advocacy among PWID and prisons towards earlier more proactive diagnosis and rapid diagnostic testing, and explore new models for earlier access to treatment.

Republic of Kenya

1. There is concern that services for people who inject drugs is placed within a medical-psychiatric model in which drug use is viewed as a “mental illness”. As such, OST services are going to be implemented initially at a psychiatric hospital in Nairobi that is reportedly not used by PWID due to its stigmatizing views towards drug use. This is a concern because the methadone demonstration project (critical to beginning OST in the country) must be in a site that is trusted by the community. It is recommended that this strategy be re-evaluated to ensure the success of the OST initiation in the Republic of Kenya.

2. While the Republic of Kenya has excellent integrated HTC for individuals who access health services, PWID do not necessarily feel comfortable or they have barriers to accessing HTC in the health sector. Access to rapid diagnostic tests is widely available in the Republic of Kenya. HIV testing is the way to access HIV treatment and prevention (as well as TB, STI services-significant problems among PWID), however, an out-dated VCT model was observed (i.e., long pre-test counselling sessions, invasive questions, in some cases the need to return for results). HTC for PWID needs to be reviewed and revised, in the Republic of Kenya to meet the latest international

standards. ART initiation is not available in most CSO settings. Too many barriers remain for PWID to learn their status and initiate treatment. This should be re-evaluated to ensure earlier and easier access to treatment among PWID.

3. Lastly, given declining resources and the need to focus on where UNODC can have the greatest impact, it is recommended that UNODC continue to advocate for improved legal and policy reforms, most especially in regard to prison and legal reforms in the Republic of Kenya among PWID.

Republic of Zambia

1. There has been a gap in strategic information on PWID (key populations in general, globally) and among prison populations and other closed settings. Where evidence based harm reduction interventions are illegal, it is not possible to develop programmes for PWID and thus it is difficult to make an impact on the HIV epidemic in this population. Where evidence based comprehensive HIV programs are illegal in prisons, .UNODC should continue to advocate for improved strategic information (in the form of qualitative rapid assessments and behavioural sero surveillance) in order to examine in a data driven manner whether services and what services are needed among the entire prison population (which may include PWID based on the findings) in Zambia. The Evaluation Team acknowledges that the grant was focused on HIV in prisons and not specifically on PWID, however a comprehensive prison programme in the future should account for the possibility of PWID interventions being needed.

2. In recent years, there has been more interest from bilateral partners and the National HIV/AIDS/STI/TB Council on key populations and it is expected that PEPFAR funds will be provided to both inform and develop activities to this sector of the HIV response. In regard to prisons, of importance is to ensure new and rigorous estimates of blood borne pathogens and other infectious diseases common in prisons and other closed settings is conducted soon. If possible, use these estimates for parameters in a modelling exercise of the effect of prison variables on the HIV epidemic in the Republic of Zambia (and to replicate this in the region). Such an exercise could potentially be used to advocate for a more conducive legal and policy structure, thus enabling government to revise the penal code that is impeding advancement of health and human rights.

3. Sustainable livelihood initiatives are a good niche area potentially for UNODC that is seeking to make an impact on post prison populations. It is expected that these activities can lead to marked improvements in both income generation, reintegration with family and on health indicators and UNODC in the Republic of Zambia should explore opportunities to develop such programmes.

Federative Republic of Brazil

1. Stakeholders view UNODC as a global leader of knowledge on HIV/AIDS and key populations. They have requested technical support in the past and it is recommended that technical support is provided around country case studies and experiences, best practices, health systems strengthening including drug dependence treatment and coverage and reach of HIV/AIDS diagnosis, treatment, care and support.

2. There is a gap in working in prisons despite an urgent demand for advocacy, training and services to be introduced. UNODC is in a good position to develop a prison programme and should begin a situational assessment and analysis.

3. The changing institutional context might demand from UNODC facilitation services based on the privileged impartial role that the UN has in any country along with a powerful advocacy efforts to established evidence based interventions exercised in the past. UNODC should prepare to perform both functions in the near future.

V. LESSONS LEARNED

The evaluation team has addressed the six evaluation questions relating to lessons learned included in the evaluation TOR. Lessons learned are defined in the TOR as: "Generalizations based on evaluation experiences with projects, programs, or policies that abstract from the specific circumstances to broader situations. Frequently, lessons highlight strengths or weaknesses in preparation, design, and implementation that affect performance, outcome, and impact".

Evaluation Question 1. What lessons can be learned from the UNODC HIV/AIDS programme implementation in order to improve performance, results and effectiveness in the future?

Design

Investment in design yields high gains in effectiveness and impact. Although the designs of projects had overall good quality, a lesson learned is that the teams should have spent more time and resources at the design stage in order to identify and address the most relevant HIV-related public health challenges at country level. Country strategies should be developed that recommend implementation of evidence-based interventions (i.e., the comprehensive package of services for PWID), and should be refined based on the local epidemiology. This will ensure a more focused added value interventions that will increase impact among the key populations that UNODC serves.

Implementation

A system to coordinate partner efforts at the national level will increase the likelihood of improving results. The evidence found in the evaluation points out that there is a need for a strong and systematic harmonization-effort among partners and actors at country and international level. This effort should be lead from headquarters Vienna in close connection with UNAIDS co-sponsors and mainstreamed at regional, country and local level.

Sustainability is key for achieving long-term impacts. Scale up and Sustainability have clearly emerged as a weak point to be tackled from the very inception phase of the projects. A clear sustainability plan that considers different scenarios including an exit strategy for the interventions needs to be in place for every single project implement at country level. A sustainability plan also needs to consider the broader public health goals of the country context to ensure that UNODCs pilots and programmes have a strong chance of country adoption.

Evaluation Question 2. What best practices emerged from the programme implementation?

The Global Programme has done a commendable job in addressing the needs of women and key populations. Intervention models that have proven effective at national and regional levels (The Federal Democratic Republic of Nepal/The Republic of India/Brazil) should be replicated considering adaptations to the local epidemiology and the broader UNODC country strategy.

The instrumental mechanisms developed by projects to coordinate actors in the approach to solve PWID challenges at national level are worth sharing among different regions in order to cross-fertilize different types of joint solutions among a wide range of partners.

Evaluation Question 3. Can these best practices be realistically replicated?

The replication is potentially always possible but there are two steps that have to come first. A proper and systematic way to recognize and identify best practice, the means to transfer the experience and knowledge to the place where is required within a reasonable time span, and partnership with the

country on its implementation. This would be the kind of services that a knowledge management system could provide for the Global Programme and would also serve the dual purpose of improving country relations with UNODC.

Evaluation Question 4. What lessons can be drawn from unintended results?

Unintended results of the programme have been mainly positive, and there are examples of collaboration of national government counterparts that are usually impossible to see in a real collaboration in many national contexts. In particular, this occurs between the law enforcement and health authorities. The main lesson learnt here, is to take this unintended result and include it in every intervention as a systematic way to create strong bonds among these two types of administrations. In this way, they can engage together in providing a comprehensive response to the problems affecting key populations.

Evaluation Question 5. What lessons can be drawn from the working arrangements with partners (global, regional, and national), including working as a Cosponsoring agency of the Joint United Nations Programme on HIV/AIDS (UNAIDS)?

Harmonization is not a luxury; it is a necessity. The example of the collaboration of the UN family in the Federative Republic of Brazil where UNHCR, ILO, UNWOMEN, PAHO, UNDP, UNAIDS, UNESCO, UNFPA, UNICEF and UNODC jointly designed and implement an integrated plan that coordinate the agencies' interventions based on identified needs operating through the UN team on HIV/AIDS needs to be followed and expanded.

Evaluation Question 6. What lessons can be drawn from the engagement with civil society and private sector stakeholders?

CSOs are a key partner for UNODC success in its contribution to stop the HIV/AIDS epidemic in key targeted populations. The good working relations and partnerships identified at national level should guide the future of the relations with CSO in international arena.