This action is funded by the European Union

**ANNEX I**

of the Commission Implementing Decision on the financing of the multiannual action programme in favour of Central Asia for 2019 and 2020 part 1

**Action Document for ‘Central Asia Drug Action Programme (CADAP) – Phase 7’**

**ANNUAL PROGRAMME/MEASURE**

This document constitutes the annual work programme in the sense of Article 110(2) of the Financial Regulation and action programme/measure in the sense of Articles 2 and 3 of Regulation N° 236/2014.

| 1. Title/basic act/CRIS number | Central Asia Drug Action Programme (CADAP) – Phase 7  
| CRIS number: ACA/2019/041-702  
| Financed under the Development Cooperation Instrument |
| 2. Zone benefiting from the action/location | Central Asia  
| The action shall be carried out at the following location: Kazakhstan (KZ), Kyrgyzstan (KG), Tajikistan (TJ), Turkmenistan (TM) and Uzbekistan (UZ) |
| 4. SDGs | Goal: 3 Health  
| Goal 16: Peace, Justice and Strong Institutions  
| Goal 5: Gender equality  
| Goal 10: Reduced inequality |
| DEV. Aid: YES |
| 6. Amounts concerned | Total estimated cost: EUR 7 000 000  
| Total amount of EU budget contribution EUR 7 000 000 |

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| 7. Aid modality(ies) and implementation modality(ies) | Project Modality
Indirect management with FIIAPP (International and Ibero-American Foundation for Administration and Public Policies) |
|---|---|
| 8 a) DAC code(s) | 12330 (Control of harmful use of alcohol and drugs): 70%
16063 (Narcotics control): 30% |
| b) Main Delivery Channel | Third Country Government (Delegated Co-operation) – 13000 |
| 9. Markers (from CRIS DAC form)² | General policy objective
Not targeted | Significant objective | Principal objective |
| Participation development/good governance | ☐ | ☐ | x |
| Aid to environment | ☐ | ☐ | ☐ |
| Gender equality and Women’s and Girl’s Empowerment ³ | ☐ | x | ☐ |
| Trade Development | ☐ | ☐ | ☐ |
| Reproductive, Maternal, New born and child health | ☐ | x | ☐ |
| RIO Convention markers | Not targeted | Significant objective | Principal objective |
| Biological diversity | ☐ | ☐ | ☐ |
| Combat desertification | ☐ | ☐ | ☐ |
| Climate change mitigation | ☐ | ☐ | ☐ |
| Climate change adaptation | ☐ | ☐ | ☐ |
| 10. Global Public Goods and Challenges (GPGC) thematic flagships | N/A |

**SUMMARY**

²When a marker is flagged as significant/principal objective, the action description should reflect an explicit intent to address the particular theme in the definition of objectives, results, activities and/or indicators (or of the performance / disbursement criteria, in the case of budget support).

³Please check the Minimum Recommended Criteria for the Gender Marker and the Handbook on the OECD-DAC Gender Equality Policy Marker. If gender equality is not targeted, please provide explanation in section 4.5.Mainstreaming.
The proposed action aims to develop integrated, balanced and evidence-based drug policies, taking into account best practices in order to increase the access to quality demand-reduction interventions, which will lead to improved citizens' health in Central Asia. There will be a strong focus on sharing EU best practices (e.g. EU Action Plan on Drugs 2013-2020, the EU-Central Asia Action Plan on Drugs (2014-2020) including through the portal and publications of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The action will support Central Asian partners in improving their capacity in drug demand reduction interventions, including new psychoactive substances, the spread of HIV and Hepatitis C, migrants' health and alternatives to coercive sanctions. The Action will pursue the overall objective to reduce drug use in Central Asia and the specific objective to improve access to quality drug demand reduction interventions, while promoting universal access to health, especially for vulnerable groups.

1. CONTEXT ANALYSIS

1.1 Context Description

Opiate trafficking along the so-called ‘northern route’, from Afghanistan to neighbouring States in Central Asia (CA), has started to resurge after the decline observed during the period 2008-2012. Trafficking to the Russian Federation is carried out predominantly along the northern route via Central Asia, or via the Caucasian route, to destination markets in the Russian Federation and, to a very small extent, for trafficking onwards to Belarus and Lithuania. In 2016, the main transit countries for heroin seized in the Russian Federation continued to be countries in Central Asia and Transcaucasia (notably Tajikistan (TJ), Kazakhstan (KZ) and Azerbaijan). Data on drug use in CA is scarce, however the data provided by different researches has shown an important prevalence (from 0.6% to 1% of adult population) of opiate users in all five CA countries. According to the data obtained in the latest studies, the number of people dependent on drugs in KZ is 1.7% of the total population (31.6% are dependent on opioids (mainly heroin), 81.3% on cannabis, and 15.5% on other drugs). In KG the number of registered people who use narcotic drugs and psychotropic substances is increasing every year. It has been reported a steady increase of injecting drug use, particularly heroin, which involves a growing dependency problem and increased numbers of overdoses and health risks of spreading blood borne infectious diseases (HIV, hepatitis B and C, syphilis, etc.). The estimates of the number of drug users vary, but the available data points in the direction of around 9,000 to 10,000 registered problem drug users of which 6,000 to 7,300 are injecting drug users. In TJ the number of injecting drug users was estimated to be 25,000, with a possible range of 20,000 to 30,000. In UZ, according to the more recent estimations performed by the Republican AIDS Centre, the number of

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1 UNODC World Drug Report 2018
3 Central Asia (0.9 per cent), UNODC world report 2018
4 Republican Scientific and Practical Centre of Medical and Social Problems of Drug Abuse (RSPC MSPDA)
5 National Drug Addiction Centre of the Ministry of Health of Kyrgyz Republic (MoH)
drug users has been reduced to 49,000 in 2011. In TM it is difficult to accurately assess the situation, because reliable figures on the current situation are not available. There are at least 300,000 heroin users and 60,000 opium users in Central Asia, with the highest increase in prevalence worldwide. Heroin is mostly injected (70-95%), and in Central Asia, injecting opiates is linked to nearly 60-70% of all HIV infections. The HIV prevalence among Injecting Drug Users in Central Asia is estimated between 10-20%, where the prevalence of injecting drug use is also high, with nearly 0.9% use-rate among the population aged 15-64. In the region, other blood-borne infections are also strongly associated with injecting drug use. Central Asia is one of the few regions with a continued increase in the incidence of HIV. While states in the region are taking efforts to raise awareness on the risk of infection through shared needle use and other drug injecting paraphernalia, heightened awareness on HIV prevention and public health policies is still necessary.

There are two main drug policy models in the region. The first one is more comprehensive and evidence-based, oriented towards public health, and based on international recommendations of the United Nations General Assembly Special Session on Drugs (UNGASS) of 2016 and EU standards. The second one is a more criminalised model, which is used to exert increased influence on drug policy in the region on the basis of security and safety. Given the "security" approach certain CA Governments still have toward drug policies, a switch to public health approach is needed in CA, offering a wide range of integrated pharmacological services as well as psychosocial services and social protection interventions (such as counselling, cognitive behavioural therapy and social support), which are evidence-based and focused on the process of prevention, risk and harm reduction, treatment, rehabilitation, recovery and social reintegration. These methods have proven to both improve the drug user quality of life and to reduce HIV and incidence of infectious diseases among drug users. Afghanistan remains a very strong external factor influencing the situation and policy in CA countries, placing an emphasis on the supply reduction side of the drug policy. Thus, ‘control’ is a priority and the demand reduction part of the drug policy has (traditionally) adopted part of this control function. Russia’s drug policy (which is mainly focused on supply reduction) still significantly influences the decision-making process in CA especially in demand reduction, as such the EU has been the only positive external factor and opportunity for CA countries to strengthen and develop their drug policies and capacities using EU best practices.

1.2 Policy Framework (Global, EU)

The United Nations General Assembly Special Session on Drugs (UNGASS) adopted in 2016 was a major change in the international drug policy by calling for more comprehensive and balanced drug policies. UNGASS effectively rebalanced global drug policy: with its seven chapters, the Outcome Document better reflects the complexities of the drug situation and enables all countries to address a broader range of policy issues. The focus on the health side of the drugs problem, including prevention, treatment, and risk and harm reduction, on vulnerable members of society, on human rights, on proportionate sentencing for drug related offences, and the strong link with the relevant Sustainable

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9 UNODC World Drug Report 2018
10 Evaluation Report CADAP 6, 2018
Development Goals rebalanced global drug policy. At the same time, the Outcome Document reaffirms the unwavering commitment to supply reduction and related measures, including effective law enforcement, countering money-laundering and promoting judicial cooperation.

The UNGASS Outcome Document served also as a step towards the preparation of the Ministerial Segment of the Commission on Narcotic Drugs (CND) of March 2019 in Vienna. The recommendations of the UNGASS Outcome Document should be implemented in the CA countries.

Development of EU and international drug policies standards is not a common standard in the CA countries. There is limited experience with the needs assessment approach, learning from best practices, applying international standards and monitoring and evaluation of results. However, with the support of the latest two phases of CADAP, CA drug policy makers have been increasingly familiarised with EU standards. The whole approach and principles of the EU Action Plans on Drugs and EU policy in Central Asia clearly reflect: shared responsibility, multilateralism, integrated, balanced and evidence-based policy recommendations, the mainstreaming of development, respect for human rights and human dignity, respect for international conventions and encouragement of political stability. The EU policy in CA also reaffirms the importance of good governance, in particular the need to strengthen the capacity of public administration and local authorities to promote social development in Central Asia. Inclusive development that promotes the well-being of all layers of society, including the empowerment of women, is an essential component of longer-term stability and resilience of the countries, and the EU is committed to supporting its partners in this regard. This involves not only promoting respect for human rights in the region, including through the human rights dialogues with the five countries but also in even further prioritising the Rule of Law cooperation in the EU Strategy for Central Asia\(^1\). In addition, the newly adopted Enhanced Partnership and Cooperation Agreement (EPCA) with KZ, as well as the renewed EPCCAs with UZ and KG (now under negotiation) represent important policy documents for the next programme. The geo-political situation in the region with, for instance, a prominent presence of Russia, may indirectly influence the development of national drugs policies based on ‘evidence and best practices’. Nevertheless, some significant progress in evidence-based policies has been made. For example, Kazakhstan passed new regulations on Opioid Substitution Treatment (OST) following the completion of an 8-year study pilot, when it was ready for up-scaling and further rollout.

1.3 **Public Policy Analysis of the partner country/region**

National Drug Strategies and Action Plans have been prepared and adopted in KG, UZ and TJ. TM has also adopted an overall 2016-2020 plan on combatting drugs. With EU support, the national authorities of KG, KZ, TJ and UZ have prepared annual drug reports (ADR) and country situation summaries (CSS), in line with EU standards. However, the national anti-drug legislations in all CA countries still contain legal gaps and conflicts. While countries in the CA have signed and support the international drug-related treaties to address the drug situation in their countries with a package of drug supply and drug demand measures, and have committed to the United Nations General Assembly Special Session on Drugs

\(^{11}\) Council conclusions on the EU Strategy for Central Asia, 19 June 2017.
(UNGASS) Outcome Document, adopted in April 2016, there is a need to put into better practice the international/EU standards and the recommendations of the UNGASS Outcome Document. The latest assessment shows some improvement on drug policies. Examples of best practices and progress made in particular areas include the Opioid Substitution Treatment (OST) regulation and provision in KZ, prison health services in Kyrgyzstan and increased civil society involvement in Tajikistan and Kazakhstan. However, significant challenges still exist, especially because some countries do not even aim at adopting European standards. In Turkmenistan and Uzbekistan, for example, drug policies are still based on traditional approaches, with limited political room for external collaborations. Despite this, there is space for enhanced cooperation in the sphere of public health and drug policies, as demonstrated by the fact that Uzbekistan and Turkmenistan have changed their approach to the CADAP programme during the last two years.

1.4 Stakeholder analysis

The main state partners in Kazakhstan are the Department for Combatting Drug Trafficking and Drug Control under the Ministry of Interior and the Ministry of Healthcare and Social Development. The Department for combatting drug trafficking and drug control is the state coordinating body in charge of drug control policies. The Ministry of Healthcare and Social Development of the Republic of Kazakhstan was divided into two ministries: Ministry of Healthcare (MoH) and Ministry of Labour and Social Protection. Both centres are key for future CADAP actions. During CADAP 6 the KZ stakeholder have been dynamically and actively cooperating with the programme and with all components of the project, showing how KZ is interested in adopting most advanced EU drug policies. The main stakeholders in Kyrgyzstan are the Ministry of Foreign Affairs and the Ministry of Internal Affairs, the State Executive Service attached to the Government (GSIN), penitentiary services, and the Ministry of Health (MoH); previously the main stakeholder coordinating with CADAP was the State Drug Control Service attached to the Government (SDCS) (abolished in July 2016). Other partners include the main Counter-Drug Department (SBNON) of the Ministry of Internal Affairs (MIA) involved mainly on drug policies, drug data collection and prevention activities. NGOs in Kyrgyzstan are a very important and effective partner for the programme and they will keep being an important link between the Government and the project also for CADAP 7. The main stakeholders in Tajikistan are the Drug Control Agency under the President of the Republic of Tajikistan (DCA), the Ministry of Health and Social Protection and the Ministry of Justice. Representatives from Drug Control Agency are in charge of the national drug policies and of the improvement of drug data collection and analysis and play an important role in drug prevention actions. Representatives from the DCA have participated in regional and country level actions with CADAP 6 and have actively contributed to the effective implementation of CADAP actions. The Ministry of Health and Social Protection, operates through two main structures: National Centre for Monitoring and Prevention of Drug Use and Republican Clinical Centre of Narcology. Those are key stakeholders in coordinating interventions on drug Policy. CADAP 7 will keep cooperating with those actors, who were positively involved during the whole implementation of CADAP 6.

The main stakeholders in Turkmenistan are the Ministry of Interior and the Ministry of Public Health and Medical Industry; both institutions are dealing with the approval and coordination of drug actions in the country; all activities are being approved at the high governmental level and even by the President of
the country. During CADAP 6 it was observed a good participation in the trainings and in the regional events, while on the other hand it was challenging to get approvals for implementing prevention programmes. There is a newly formed Department of Drug Control, which has been very active in the activities of CADAP. The Department of Treatment is a partner for the current phase of CADAP and coordinates the work of narcological clinics, narcological centres, the newly opened rehabilitation centre as well as the training of narcologists by the Turkmen Medical University.

The main stakeholders in Uzbekistan are the National Information-Analytical Centre on Drug Control (NCDC) under the Cabinet of Ministers of the Republic of Uzbekistan, the National Coordinating Unit of the European Union’s Technical Assistance Programme (NCU), the Ministry of Foreign Affairs, the Ministry of Interior, the Ministry of Health, the Ministry of Higher and Secondary Special Education and the Ministry of Public Education. The NCDC is the major executive body for control and coordination of activities of all ministries, agencies and organisations involved in drug related issues nationwide. The main institutions are the Ministry of Health and National Centre for Combating HIV/AIDS, the Ministry of Public Education as well as non-governmental organisations do play a very important role. CADAP 7 will keep cooperating with the all the institutions involved in CADAP 6, after trustful working relations have been established during the CADAP 6 implementation.

Finally, the level of leadership, commitments and ownership of the partners’ countries stakeholders and decision makers created by previous CADAP actions is sufficient for a sustained engagement of key players in the new programme. The most vulnerable groups are people who inject drugs (PWID), HIV positive individuals, drug using prisoners, migrants, youth population, users of new psychoactive substances and women. In Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, substantial parts of the population work abroad part of the year and migrants are often PWID, and are vulnerable to infectious diseases through high-risk behaviours such as unprotected sex or sharing injection material. It is worth mentioning insufficient resources and lack of institutional solutions dedicated to these groups.

1.5 Problem analysis/priority areas for support

Drug policy in CA is still mainly focused on supply reduction; it is mostly seen as a security issue, (i.e. drug agencies are based mainly in law enforcement institutions and not in health-oriented institutions). However, with EU assistance, CA has adopted more coherent and balanced drug policies. KZ, KG, TJ and UZ, have been committed to integrating specific drug demand reduction strategies and projects into their national plans. CADAP has been the main driving instrument to support drug policy-making and developments in CA through discussions, sharing/demonstrating of best EU practices and lobbying.

With the support of CADAP and EU expertise, CA countries should continue adapting the methodologies of the EMCDDA, such as information maps, a National Action Plan for the Drug Information System, country situation summaries and drafting national reports on a common basis. Drug demand reduction and drug policies will remain the focus of the programme, with special emphasis on the spread of HIV and hepatitis C, migrants’ health, new psychoactive substances users, alternatives to coercive sanctions, and

12 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4487482
13 Strategic evaluation of CADAP 2018
promotion of universal access to health. Although prevalence levels of new psychoactive substances use remain low among the general CA population, EU can support CA in the formulation and implementation of effective public health responses to this new phenomenon. In this context, CADAP support may play a significant role in achieving tangible results on drug-demand reduction actions and drug policies through wider regional cooperation and stronger focus on data collection, evidence-based policies, research and evaluation of drug policies as envisaged by the EU-Central Asia Action Plan on Drugs 2014-2020. As regards data collection, CADAP should contribute to the work conducted by UNODC on the improvement of the quality and effectiveness of the annual report questionnaire (ARQ). Strengthening and streamlining the existing data-collection and analysis tools, including improving the quality and effectiveness of the Annual Report Questionnaire with reliable and comparable data on drugs is necessary.

The regional approach of the programme will continue to be reinforced. Such an effort would be a guarantee for maintaining coherence with what has been done so far in the previous programme phases, as well as ensure the overall concept of CADAP, which is regional cooperation in the sphere of drug policies. The Action fully matches with the principle "Partnering for Resilience" of the new EU-CA Strategy, and it reflects the overall strategy of the EU in Central Asia for what it concerns security, organized crime and drug policies. CA countries shall keep their commitment in adopting drug policies in compliance and consistency with EU and international standards (EU Drugs Strategy 2013-2020) and its EU Action Plan on Drugs 2017-2020 and EU-Central Asia Action Plan on Drugs (2014-2020).

From this Action EUMS will enhance their cooperation with CA ministries of interiors, anti-drug trafficking and antinarcotics agencies in line with the new Strategy and with the recently signed EPCAs. EU will highly benefit in terms of inter-institutional relations with its counterparts in CA to the extent the EU will be in a better position to exert influence on the development of societies in CA, to promote the strengthening of civil society in CA, to build stronger partnerships and working alliances with CA countries and build a strong reputation becoming a key partner in support of common objectives.

The main components of the next phase of CADAP will directly address and complement the beneficiary governments’ national strategies for drug control and their international commitments and thereby ensure the ownership and sustainability of this initiative.

2 RISKS AND ASSUMPTIONS

<table>
<thead>
<tr>
<th>Risks</th>
<th>Risk level (H/M/L)</th>
<th>Mitigating measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>The national institutions and organisations may not adopt and incorporate the initiatives under the project into their regular operations despite the</td>
<td>H</td>
<td>Policy dialogue at high governmental level</td>
</tr>
</tbody>
</table>

14 Ibidem.
15 Idem.
<table>
<thead>
<tr>
<th>Preliminary endorsement</th>
<th>M</th>
<th>The programme will take into account countries’ absorption capacities in order to adequately implement the proposed interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of planned activities may be delayed due to internal dynamics of the partner institutions</td>
<td>M</td>
<td>Policy dialogue with Central Asian governments and constant liaising as regards the technical and timely implementation of the programme</td>
</tr>
<tr>
<td>Low levels of communication among governments and absence of regional institution/authority entailing weak incentive for joint efforts to tackle drug demand issues regionally</td>
<td>L</td>
<td>Strengthening of mutual contacts and cooperation on local, national and regional level</td>
</tr>
<tr>
<td>Lack of political will to fully embrace European best practices and embark on necessary reforms</td>
<td>H</td>
<td>Raising awareness of the benefits of the promoted European good practices among society and local communities</td>
</tr>
<tr>
<td>Tailor-made approach of the programme to each country in Central Asia may lead to limited results in forming a regional approach to drug demand reduction;</td>
<td>L</td>
<td>By means of relevant and objective sources and materials, provision of justification and argumentation for the beneficial effect of a regional approach on drug demand reduction;</td>
</tr>
</tbody>
</table>

**Assumptions**

The programme aims to build the capacity of national experts and institutions through the implementation of effective and evidence-based programmes on drug demand reduction. This will encompass working with different national ministries, institutions and individuals with their own priorities and dynamics. Therefore, in the context of an increasing need to encourage ownership and commitment of governments for the sake of self-initiated reforms in the field of drug demand reduction, the following assumptions and risks need to be taken into consideration during programme implementation: The national counterparts in each country endorse the next programme phase and assign relevant institutions as implementation partners with the necessary authorisation of action; Government and implementation teams provide resources to ensure the smooth and consistent transition to a new phase of CADAP, building on the results and efforts of previous phases; Inter-ministerial/agency coordination mechanism is sufficiently operational; each of the participating departments and organisations remains fully committed and allocates sufficient and relevant human resources for participation in the programme’s implementation, which are to provide sustainability and continuation of the expertise in the hosting institution. Non-state actors (rehabilitation centres, psychologists' associations, local community organisations, etc.) are given sufficient permission and flexibility to participate effectively in various activities.
LESSONS LEARNT AND COMPLEMENTARITY

3.1 Lessons learnt

Some of the lessons learnt from previous phases of CADAP to be taken into consideration in the new programme are the following:

Political and institutional commitment of CA governments is key to the successful implementation of all the activities of CADAP; Support in developing legislation and national programmes in the fight against drugs was well received by CA countries in previous CADAP phases, but political risk surrounding the full implementation and adoption of such recommendations still persists; therefore, to ensure sustainability, implementation has to be tailor-made and to focus on each country’s specific needs and requirements; the programme should be more flexible and address country-specific needs without locking countries into regional programmes that propose the same activities for all CA countries. A potential consideration for the next phase could be to develop two or clusters of countries, in order to re-define the type of intervention. On the basis of what it was observed and assessed during CADAP 6, the following recommendations are made:

Programme budget and financial management should be transparent and balanced between administrative costs and funds for concrete activities; establishment of a better programme coordination mechanism and better programme adaptation to the beneficiaries’ absorption capacities; improvement of the project management roles pertaining to planning, coordination and decision-making issues to increase programme efficiency; ensure enhanced presence and proactivity of key experts in CA region in order to increase the EU’s commitment and improve the efficiency and effectiveness of the programme; revision and adjustment of the functions and roles of key and non-key experts in line with the actual needs of the programme.

3.2 Complementarity, synergy and donor coordination

The new CADAP phase is aimed to logically complement the EC-funded assistance programme BOMCA, as well as other EC-funded interventions in Central Asia, notably a rule of law programme and the EU Action against Drugs and Organised Crime (EU-ACT).

Along with the EU, USA, Japan, Russia and Turkey continue to stand out as the most prominent donors, providing support to projects and Technical Assistance (TA) in the region. Some EU Member States (mainly Germany) have projects in all five Central Asian countries. Additionally, UK, Italy, France and Czech Republic contribute to the activities of CARICC (Central Asian Regional Information and Coordination Centre). The common understanding (according to the Dublin Group's regional report on Central Asia) is that more efforts have been dedicated to the drug supply control side of narcotics control. This trend has been justified by the transnational character of the drug supply nexus and the pressing need of a consolidated response to Illegal Trafficking through the ‘Northern Drug Route’. CADAP will focus on drug policies, data collection and demand reduction actions, complementing other donor interventions: UNODC programmes, WHO, GIZ, the Global Fund and USAID/INL interventions. Mechanisms for close cooperation and communication with relevant national authorities have been well established by CADAP teams in all CA countries during previous phases, such as the National and Regional Steering Committee meetings.
4 DESCRIPTION OF THE ACTION

4.1 Overall objective, specific objective(s), expected outputs and indicative activities

Overall objective: Contribute to the reduction of drug use and support CA Government drug policies.
Specific objective: Improved access to quality drug demand reduction interventions

Expected outputs:
O1 Integrated, evidence-based and balanced drug policies
O2 Integrated data collection systems
O3 The countries’ capacity on prevention policies is improved
O4 Strengthened treatment methods

The foreseen activities related to expected outputs may include inter alia:

O1 Integrated, evidence-based and balanced drug policies

This output should continue enriching national authorities’ knowledge about international drug policies implemented in EU countries and internationally and support the implementation and drafting of drug legislation in CA based on evidence-based drug policies.

Activity 1.1. The implementation of integrated, balanced and evidence-based drug policies
The specific objective of this activity is to provide advisory support and assistance to the five countries in the drafting, monitoring and evaluation of national drug policies and legislation in CA based on EU and recognised international standards. This activity will consist of technical assistance (TA), ad hoc interventions, twinning with EUMS to provide policy/legislative recommendations to support the CA Governments in: developing and implementing evidence-based policies, drafting prevention and treatment protocols, norms, etc. within the respect of EU human rights and gender standards.

Activity 1.2. Institutionalisation of the good practices
This activity will facilitate horizontal collaboration between the Consortium Leader, the Regional TA advisor and the other 3 Components, supporting drug policy reform on evidence-based data collection, prevention and treatment in the community and in the prison settings; the activity will be mainly consisting on TA advisory provided to National Policy makers, institutions and law makers; it foresees a significant level of field interventions.

O2 Integrated data collection systems
It is expected that through this output, the capacity of CA institutions for collecting comparable and harmonised data will be developed and strengthened to ensure a continuous and precise knowledge of the national and regional situation concerning drugs.

**Activity 2.1 Strengthening the regional dimension and capacity in data collection**
Technical assistance (TA) through seminars, training programmes, and working groups, will be provided to enhance the regional capacity on data collection and analysis to enhance capacity of national institutions and experts in collecting data. It is foreseen the establishment of a network for regional cooperation.

**Activity 2.2 Support to National Information Systems**
Surveys, research work and studies, with the involvement of CA institutions, will enhance the National Information Systems (NIS). The activity will include the establishment and support of Early Warning Systems (EWS), specifically to focus on new psychoactive substances (NPS), on further structuring and equipping of NIS, on the improvement and support of the Annual Drug Reports coherent with EMCDDA guidelines, etc.

**Activity 2.3 Networking of experts with EU/EMCDDA structures and working groups**
This activity will consist in EU/EMCDDA expert meetings: the activity will aim at supporting and promoting the institutionalisation of drug monitoring structures and monitoring centres (long-term structures are basic for drug monitoring). Technical assistance, trainings and study visits will facilitate stronger linkages between government authorities and NGOs working in drug policy areas to improve the knowledge of data analysis and interpretation methodology.

**O3 The countries’ capacity on prevention policies is improved**

**Activity 3.1 Support to selective/indicative evidence-based prevention programmes and strategies, and EU and international best practices**
In order to prevent drug consumption, it is necessary to have reliable and evidence-based prevention programmes. TA, seminars, trainings and twinning will continue developing selective/indicative prevention interventions in schools and in local in communities and in families at risk. Prevention will be conducted in recreational settings (i.e. mapping exercise on demand reduction activities to NPS in clubs/discotheques; outdoor events (e.g. festivals) and temporary venues. It will include, inter alia: youth at-risk programmes, improving the capacities and knowledge on evidence based prevention interventions (standards, theories, risk and protective factors), improving the skills/knowledge in motivational interviewing, screening tools development to identify youth at risk; and programmes addressed to youth using new psychoactive substances (NPS).

**Activity 3.2 Establishment and strengthening a network of professionals involved in prevention (health workers, psychologists, social workers, NGOs and other professionals dealing with prevention)**
In each country, working groups with experts specialising in prevention will be put in place. WG will be composed of health workers, NGOs, psychologists, teachers, civil servants, social workers, local educational authorities and other professionals dealing with prevention. Those actors will need to
cooperate very closely and actively in the elaboration and dissemination of prevention programmes. This activity will include, inter alia, training, workshops, study visits and technical assistance in the area of prevention. An electronic platform will be established to serve as a tool to exchange information and disseminate best practices and new methodologies in the field of prevention and in the establishment of a regional working group.

**O4 Strengthened treatment methods**

The establishment of functional and effective treatment and harm reduction programmes based on EU and international standards are essential to provide the best and cutting-edge health responses, programmes and models to CA countries’ populations. This output will focus on strengthening demand reduction models on the basis of best EU and international practices for harm reduction, rehabilitation and social reintegration, and therapeutic communities.

**Activity 4.1. Strengthening of the national working groups**

The intervention will consist of ad hoc TA activities as seminars to strengthening the national working groups already established in previous CADAP phases, and specifically those activities will initiate a regional working group network in line with UNODC and WHO standards; additionally a regional working group on treatment standards and quality improvement in OST will be established to facilitate the exchange of experiences in practice. Activity guidelines, guidebooks, and SOPs will also be elaborated.

**Activity 4.2 Establishment, strengthening and training of rehabilitation centres**

Trainings-on-the-spot will enhance rehabilitation centres implementing a comprehensive package of treatment and rehabilitation. These centres will be taken as pilot projects for further replication. The Pavlodar Republican Narcological Centre and Almaty comprehensive model approach on treating addiction problems, including (legal) alcohol, tobacco and gambling as well as problems with illicit drugs’ (heroin and cannabis) and New Psychoactive Substances (NPS) will be reviewed to assess further replication throughout the region. Trainings will focus on the principles of drug addiction treatment, diagnosis and therapy of opioid addiction, guidelines on opioid substitution, opioid substitution in special situations (pregnancy, comorbid psychiatric disorders, comorbid HIV), abstinence oriented treatment (detoxification, psychotherapy, self-help, opioid antagonists), New Psychoactive Substances (NPS) and psychopathological and somatic consequences of its use. Establishment of a rehabilitation centre, based on internationally lessons learned, which could serve as a model for other parts of CA.

**Activity 4.3 Strengthening of NGOs structures and programmes**

TA, seminars and ad hoc interventions on capacity building will focus on NGOs capacities. In countries like KG and TJ where interventions in this field are more developed, they will need to be strengthened and assessed. In other countries like UZ and KZ, these services and programmes should be introduced and developed. Furthermore e-learning courses should be developed to educate strengthen the capacities of people working with drug users. Specific support and advocacy will be offered to NGOs working with drug users living with HIV/AIDS.
Activity 4.4 Implementation of Social work programmes

Cooperation with universities and institutions working on social work in Central Asia and Europe will be developed and strengthened. The main focus of the trainings will be to familiarise the partners with European standards of social work with addictions. Based on the results of the research project elaborated under CADAP 6 Component 4 (Treatment) involving university work, a curriculum for education and trainings for social work students skilled in the work with drug dependent people will be developed, implemented and evaluated in all five CA countries.

Activity 4.5 Treatment services for drug dependent inmates introduced and strengthened

A regional Action Plan on institutionalisation of public health within the prison system and on common initiatives for alternatives to imprisonment will be introduced. The staff of the new clean zone of the women’s prison in Bishkek will be trained in after-care tools after release.

Finally, the above mentioned 4 SOs may be accompanied by "infrastructure interventions". Up to 15% of total budget will be allocated for infrastructure interventions.

The Comprehensive Package (UNODC/ILO/UNDP/WHO/UNAIDS) will be the guiding tool to scale-up the HIV/AIDS and hepatitis prophylaxis and treatment for infected prisoners. An intervention will be dedicated to the implementation of the actions recommended by the Comprehensive Package. The situation of prisoners on release, at high risk of overdose, is of utmost importance in order to avoid mortality and morbidity. Pilot projects to reintegrate prisoners after release will be developed and implemented.

4.2 Intervention Logic

While Central Asia countries have improved their drug responses to drug issues with more accurate drug data and evidence-based drug policies and drug demand reduction programmes, there remains a need to have more integrated, evidence-based and balanced drug policies, data collection systems, to improve their capacity on prevention actions and to strengthen the treatment programmes. New and better responses in drug policy, data collection, health and social areas need to be improved continuously. It requires, inter alia, increases in capacity building, international and institutional cooperation, sharing comparable and reliable data information and operational coordination at all levels. Strengthening and developing these areas should lead to improved access to better quality demand reduction interventions and develop more integrated, balanced and evidence-based drug policies, which in turn contributes to the increase of citizens’ health and human rights in the region.

The project aims to achieve this by supporting the drug demand reduction and data collection at different levels:
(i) Improve data collection. Implementing and analysing effective data collection and sharing data will be vital to develop evidence-based public policies in the five countries. Accurate drug data will contribute to more effective and efficient drug policies.

(ii) Support the establishment of functional and effective treatment and risk and harm reduction programmes based on EU and international standards. Such support will consist in institutionalised treatment methods at regional level, thus establishing the bases to provide the best and cutting-edge health responses, programmes and models to CA countries’ population.

(iii) Improving prevention intervention is crucial to address drug use among the most vulnerable population and it contributes to reduce future drug users. Prevention programmes will lead to more healthy life styles.

The programme is designed to facilitate a structured, long-term capacity development process and sustainable regional cooperation amongst the five countries. The programme relies on the institutional capacities and structures of the five countries, by ensuring their ownership. Training courses will be embedded within existing national and regional institutions ensuring continuity beyond the project lifespan. Sustainability and ownership is also encouraged by building upon existing processes in previous CADAP phases and by increasing harmonisation and coordination amongst national systems. The programme will institutionalise existing methodologies and national approaches within the existing drug coordination units and structures. The programme will also improve the gender dimension of drug use in order to strengthen the capacities of the programmes dealing with drug use affecting women and girls, including in prison settings. Additionally, the programme is meant to complement on-going and future EU and donor interventions in the drug field at national and regional level.

4.3 Mainstreaming

Improving good governance by strengthening countries' capacities to deal with problematic drug use is the major crosscutting issue and objective of the next phase. Human rights and gender streamlining are other relevant crosscutting issues to be addressed in CADAP. Notably, due to their social impact, special attention should be paid to gender-related repercussions originating from drug use: drug-related diseases and health risks, domestic violence, decreased social capital and workforce, maternity and child mortality and related issues. The EU Delegation should highlight that a gender perspective is to be maintained and emphasised in national drug strategies, drug action plans and legislation drafting, treatment of drug users inside and outside prisons and in training and capacity building activities. CADAP 5 and 6 have taken the first steps by supporting Atlantis Centres and Clean Zones in women's prisons in Kyrgyzstan and Kazakhstan, and the next phase should continue in that direction, while introducing a greater gender focus in all activities. The selection of participants in trainings should also be increasingly gender-balanced.

The expected long-term impact of CADAP is to contribute to the strengthening of democracy, human rights and fundamental freedoms.

[15]
The United Nations General Assembly Special Session on Drugs (UNGASS) adopted in 2016 a major change in the international drug policy by calling for more comprehensive and balanced drug policies. It effectively rebalanced global drug policy and served as a step towards the preparation of the Ministerial Segment of the Commission on Narcotic Drugs (CND) of March 2019 in Vienna. The Ministerial Declaration adopted on 14 March 2019 insists on the need to strengthen actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem. The recommendations of the UNGASS Outcome Document should be implemented (e.g. health-centred approach, ensuring the availability of and access to controlled medicines, human rights compliance, special attention for vulnerable people, women and youth) in the CA countries.

4.4 Contribution to SDGs

This intervention is relevant for the 2030 Agenda. It contributes primarily to the progressive achievement of SDG Goal 3, which is dedicated to Health as a fundamental human right and a key indicator of sustainable development. Poor health threatens the rights of children to education, limits economic opportunities for men and women and increases poverty within communities and countries around the world. In addition to being a cause of poverty, health is impacted by poverty and strongly connected to other aspects of sustainable development, including water and sanitation, gender equality, climate change and peace and stability. CADAP will promote progress on Goal 16, promotion of peaceful and inclusive societies for sustainable development, access to justice for all, and building effective, accountable institutions at all levels; finally the programme will support Goal 5: achieve gender equality and empower all women and girls. Goal 10, reduced inequality, will be promoted by especially involving migrants and vulnerable people.

5. IMPLEMENTATION

5.1 Financing agreement

In order to implement this action, it is foreseen to negotiate financing agreements with the five partner countries: Kazakhstan, Kyrgyzstan, Uzbekistan, Tajikistan, and Turkmenistan. The implementation of activities may start only on condition that financing agreements have been signed by at least two of the partner countries concerned by the programme.

5.2 Indicative implementation period

The indicative operational implementation period of this action, during which the activities described in Section 4 will be carried out and the corresponding contracts and agreements implemented, is 56 months from the date of entry into force of the second signed financing agreement.

Extensions of the implementation period may be agreed by the Commission’s responsible authorising officer by amending this Decision and the relevant contracts and agreements.

5.3 Implementation of the budget support component

Not applicable.
5.4 Implementation modalities

The Commission will ensure that the EU appropriate rules and procedures for providing financing to third parties are respected, including review procedures, where appropriate, and compliance of the action with EU restrictive measures.16

5.4.1 Indirect management with a Member State Organisation

This action may be implemented in indirect management with FIIAPP (International and Ibero-American Foundation for Administration and Public Policies).

This implementation entails to contribute to the reduction of drug use and support CA Governments’ drug policies. In the specific, the Actions aims at improved access to quality drug demand reduction interventions. The expected outcomes of action will consist in: a) Integrated, evidence-based and balanced drug policies, b) Integrated data collection systems, c) improved countries’ capacity on prevention policies d) strengthened treatment methods.

The envisaged entity has been selected using the following criteria: 1) Nature of the action: FIIAPP is a EUMS development organisation specifically experienced in drug policies programmes. 2) Experience in the region: as for the geographical area, FIIAPP is managing EU-ACT, a thematic project - covering inter alia Kyrgyzstan - designed to contribute to the prevention and effective fight against organised crime, including the illicit trafficking. 3) Managerial/operational experience: FIIAPP has a large support structure for the experts’ team at the technical and institutional relationship level as well as at the financial and logistical level. Due to this, it has the capacity to respond efficiently to political and institutional changes and/or unforeseen requirements of another nature, which may arise during the implementation phase of the contract. 4) Technical Advisory support: FIIAPP has more than 60 active civil servants seconded in the different countries. Besides, it is one of the 20 organisations assessed and considered compliant by the EC to be a Delegated Entity for managing decentralised projects without public tendering. 5) Added value: drug policy is a very niche type of EU intervention and at the actual stage there are very few EU funded regional projects linked to drug policy sector; FIIAPP is one of the few EUMS development organisations detaining this specific development background of security and drug policies.

In case the envisaged entity would need to be replaced, the Commission’s services may select another replacement entity using the same criteria. If the entity is replaced the decision to replace it needs to be justified.

5.5 Scope of geographical eligibility for procurement and grants

The geographical eligibility in terms of place of establishment for participating in procurement and grant award procedures and in terms of origin of supplies purchased as established in the basic act and set out in the relevant contractual documents shall apply, subject to the following provisions:

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16 www.sanctionsmap.eu Please note that the sanctions map is an IT tool for identifying the sanctions regimes. The source of the sanctions stems from legal acts published in the Official Journal (OJ). In case of discrepancy between the published legal acts and the updates on the website it is the OJ version that prevails.
The Commission’s authorising officer responsible may extend the geographical eligibility on the basis of urgency or of unavailability of products and services in the markets of the countries concerned, or in other duly substantiated cases where the eligibility rules would make the realisation of this action impossible or exceedingly difficult.

### 5.6 Indicative Budget

<table>
<thead>
<tr>
<th></th>
<th>EU contribution (amount in EUR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indirect management with FIIAPP - cf. section 5.4.1</td>
<td>6 800 000</td>
</tr>
<tr>
<td>Evaluation (cf. section 5.9)/Audit (cf. section 5.10)</td>
<td>200 000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7 000 000</strong></td>
</tr>
</tbody>
</table>

### 5.7 Organisational set-up and responsibilities

#### General Coordination

EUMSA Consortium Leader (CL) will be responsible for the general coordination of the action, ensuring the cohesiveness of the action as a whole. It will ensure the required dialogue, exchange of information and coordination amongst the different stakeholders to guarantee the effective implementation of the programme and follow-up of its results. Also it will secure the necessary institutional follow-up with each EUD. The Consortium leader will coordinate with all the members of the Consortium who responds directly to the CL.

EUMSA CL will coordinate amongst the different regional structures and institutions when required. EUMSA CL will regularly engage with the EUDs in each country and relevant national services to coordinate the implementation of activities and foster the benefits of the action. The Delegation will closely work with the Component Leader, who will coordinate with the Delegation on strategic and programmatic elements of the project. The Delegation will monitor the programme and the activities with the support of the EUDs in the region.

#### Steering and supervision

A Steering Committee (SC) of the programme will be appointed. It will be in charge of providing policy guidance to ensure the accomplishment of objectives and expected results. The meetings will be arranged by the EUMSA CL and the internal rules of procedures of the Steering Committee will be established within the first three months of implementation of the project. The SC is chaired by the EUMSA Project Leader (PL) and composed of representatives of each country; the European Union and the EU MS Implementing Partners (IPs) will participate. Other interested bodies might be invited to participate when
considered necessary. The EU will normally be represented by the EUD in KG, which will consult the EU Delegations in CA.

A Technical Committee (TC) will be responsible of monitoring and supervising the implementation of the project and of ensuring coherence and creating synergies across the activities. The Technical Committee will meet three times a year. It will be composed of representatives at technical level of the EUMSA CL, IP and the European Union. Representatives of main implementing institutions of the EU (e.g., EMCDDA), CA countries and any other interested party will be invited to participate when necessary.

**Project management**

The main office (named ‘Regional Office’) will be located in Bishkek from where the team will travel regionally to monitor the implementation. Technical personnel (National Coordinators - NCs) will be assigned to KG, KZ, TJ, TM and UZ. The programme will ensure the implementation in each Country with the support of national offices.

**5.8 Performance and Results monitoring and reporting**

The day-to-day technical and financial monitoring of the implementation of this action will be a continuous process, and part of the EU implementing partner's responsibilities. To this aim, the implementing partner shall establish a permanent internal, technical and financial monitoring system for the action and elaborate regular progress reports (not less than annual) and final reports. Every report shall provide an accurate account of implementation of the action, difficulties encountered, changes introduced, as well as the degree of achievement of its results (outputs and direct outcomes) as measured by corresponding indicators, using as reference the Log-frame matrix (for project modality) or the partner’s strategy, policy or reform action plan list (for budget support). The Project Leader will be responsible for providing a consolidated CADAP 7 Consortium report to the Contracting Authority.

SDGs indicators and, if applicable, any jointly agreed indicators as for instance per Joint Programming document should be taken into account. The report shall be laid out in such a way as to allow monitoring of the means envisaged and employed and of the budget details for the action. The final report, narrative and financial, will cover the entire period of the action implementation.

The Commission may undertake additional project monitoring visits both through its own staff and through independent consultants recruited directly by the Commission for independent monitoring reviews (or recruited by the responsible agent contracted by the Commission for implementing such reviews).

**5.9 Evaluation**

Having regard to the importance of the action, mid-term and final evaluations will be carried out for this action or its components via independent consultants contracted by the Commission.
The mid-term evaluation will be carried out for problem solving and learning purposes, in particular with respect to possible adjustments/reorientation of the project if necessary. The final evaluation will be carried out for accountability and learning purposes at various levels, including for policy revision. The Commission shall inform the CL and IPs at least 30 days in advance of the dates foreseen for the evaluation missions. The CL and IPs shall collaborate efficiently and effectively with the evaluation experts, and inter alia provide them with all necessary information and documentation, as well as access to the project premises and activities. The evaluation reports shall be shared with the partner country and other key stakeholders. The CL, IPs and the Commission shall analyse the conclusions and recommendations of the evaluations and, where appropriate, in agreement with the partner country, jointly decide on the follow-up actions to be taken and any adjustments necessary, including, if indicated, the reorientation of the project.

Evaluation services may be contracted under a framework contract.

5.10 Audit

Without prejudice to the obligations applicable to contracts concluded for the implementation of this action, the Commission may, on the basis of a risk assessment, contract independent audits or expenditure verification assignments for one or several contracts or agreements.

It is foreseen that audit services may be contracted under a framework contract.

5.11 Communication and visibility

Communication and visibility of the EU is a legal obligation for all external actions funded by the EU. This action shall contain communication and visibility measures, which shall be based on a specific Communication and Visibility Plan of the Action and to be elaborated at the start of implementation.

In terms of legal obligations on communication and visibility, the measures shall be implemented by the Commission, the partner country, contractors, grant beneficiaries and/or entrusted entities. Appropriate contractual obligations shall be included in the financing agreement, procurement and grant contracts, and delegation agreements, respectively.

The Communication and Visibility Requirements for European Union External Action (or any succeeding document) shall be used to establish the Communication and Visibility Plan of the Action and the appropriate contractual obligations.
## APPENDIX - INDICATIVE LOGFRAME MATRIX (FOR PROJECT MODALITY)

<table>
<thead>
<tr>
<th>Impact (Overall Objective)</th>
<th>Results chain: Main expected results (maximum 10)</th>
<th>Indicators (at least one indicator per expected result)</th>
<th>Sources of data</th>
<th>Assumptions</th>
</tr>
</thead>
</table>
| Contribute to the reduction of drug use | 1. (SDG 3.5) Prevalence and patterns of drug use (by sex and age per country)  
2. (SDG 16.5) Treatment demand indicator for problem drug users in the community and in prison settings (by sex and age per country)  
3. Drug related deaths and mortality (per sex and age per country) | 1 to 3: UNODC/ Annual drug reports | Not applicable |

| Outcome(s) (Specific Objective(s)) | Improved access to quality drug demand reduction interventions | 1. Number of persons attending drug demand reduction programmes (treatment and prevention) disaggregated by sex and age  
2. Extent to which the policy framework complies with the recommendations of EMCDDA/UNODC.  
3. Extent to which internationally recognised drug policies (norms, regulations, etc.) are implemented by the governments | 1: Institutions and Ministries Reports  
2 and 3: Baseline and endline policy assessment to be commissioned by the Action Government data | Effective cooperation and coordination between all relevant institutions in the region and in the countries |
## Outputs

<table>
<thead>
<tr>
<th>Outputs</th>
<th>O1 Enhanced Integrated, evidence-based and balanced drug policies (Horizontal Component)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.1 Status of a network of regional cooperation&lt;br&gt;1.2 Number of participants to the EMCDDA meetings disaggregated by sex&lt;br&gt;1.3 Number of NGOs working with the governments thanks to support of this Action&lt;br&gt;1.4 Number of new/integrated norms and protocols drafted on drug policies&lt;br&gt;1.5 Number of norms and protocols including a gender approach, per country&lt;br&gt;1.6 Status of human rights compliances within the national legislation related to drug policies&lt;br&gt;1.7 Status of national legislation and its compliance to international norms for what it concerns data collections, prevention and treatment policies</td>
</tr>
<tr>
<td></td>
<td>1.1 to 1.3: Action Reports&lt;br&gt;Monitoring Reports&lt;br&gt;Final Implementation Report&lt;br&gt;1.4 and 1.7: National Policy Strategies; national legislation; National Gender Policies</td>
</tr>
<tr>
<td></td>
<td>1.1: Working groups’ members identified&lt;br&gt;1.2 and 1.3: Governments and their Institutions cooperate and provide the adequate staff for the interventions&lt;br&gt;1.4 and 1.7: national policy makers cooperate and integrate the recommendations into national legislations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outputs</th>
<th>O2 Integrated data collection using EU models and standards is enhanced.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.1 National drug reports improved, including a gender analysis&lt;br&gt;2.2 Number of surveys on drug use conducted per country&lt;br&gt;2.3 Status of a study on problematic drug use in women, including in prison settings&lt;br&gt;2.4 Number of indicators developed</td>
</tr>
<tr>
<td></td>
<td>2.1 to 2.4: Action Reports&lt;br&gt;Monitoring Reports&lt;br&gt;Final Implementation Report</td>
</tr>
<tr>
<td></td>
<td>2.1 to 2.4: Governments and their Institutions cooperate and provide the adequate staff for the interventions</td>
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<tr>
<td>O3</td>
<td>The countries’ capacity on prevention interventions is improved</td>
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<td>---------------------------------------------------------------</td>
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<tr>
<td></td>
<td>3.1 Number of individuals (and % of total CA population) of youth at risk reached through the programmes., including gender approach</td>
</tr>
<tr>
<td></td>
<td>3.2 Number of experts trained on prevention disaggregated by sex and country</td>
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<tr>
<td></td>
<td>3.3 Status of a regional working group including the gender composition</td>
</tr>
<tr>
<td></td>
<td>3.4 Number of teachers trained disaggregated by sex and country</td>
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<thead>
<tr>
<th>O4</th>
<th>Strengthened treatment methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.1 Number of persons reached via the Drug Demand Reduction actions (disaggregated by country, sex and prison population).</td>
</tr>
<tr>
<td></td>
<td>4.2 Status of a regional working group, including gender composition</td>
</tr>
<tr>
<td></td>
<td>4.3 Number of rehabilitation centres trained and equipped.</td>
</tr>
<tr>
<td></td>
<td>4.4 Number of NGOs strengthened with referral system, being part of the national public health network and contributing in treatment advocacy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O4</th>
<th>3.1 to 3.4: Action Reports Monitoring Reports Final Implementation Report</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>3.1 and 3.2: Government and Institutions, cooperate and provide the adequate staff for the interventions</td>
</tr>
<tr>
<td></td>
<td>3.3: Working groups’ members identified and endorsed by governments</td>
</tr>
<tr>
<td></td>
<td>3.4: Government and educational institutions, cooperate and provide the adequate staff for the interventions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>O4</th>
<th>4.1 to 4.5: Action Reports Monitoring Report Final Implementation Report</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>4.1: Government and Institutions, cooperate and provide the adequate staff for the interventions</td>
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<tr>
<td></td>
<td>4.2: Working groups’ members identified by governments</td>
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<td>4.3:</td>
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<tr>
<td></td>
<td>4.5 Number of curricula for social workers at universities developed and evaluated (one per three countries)</td>
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