

1 November 2004

TERMINAL EVALUATION REPORT

AD/BRA/99/E02 Drug Abuse and STD/HIV/AIDS Prevention
Project

Thematic Area: HIV/AIDS

Brazil

Report of the Evaluation Team

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LIST OF ACRONYMS

ABC – Agência Brasileira de Cooperação (Brazilian Agency for Cooperation)
ANVISA – Agência Nacional de Vigilância Sanitária (National Agency for Sanitary Surveillance)
ARV – Anti-Retroviral (drugs)
CAPS – Centro de Atenção Psicossocial (Center for Psycho-Social Care)
CAPS-ad – Centro de Atenção Psicossocial (Center for Psycho-Social Care) – Alcohol and Drugs
CCO – Committee of Co-sponsoring Organizations (CCO)
CDR – Combined Delivery Report
CONAD – Conselho Nacional Antidrogas (National Anti-Drugs Council)
COSAM – Coordenação de Saúde Mental (Mental Health Coordination Unit)
CSO – Civil Society Organization
CSW – Commercial Sex Worker
CTA - Centro de Testagem Anônima (voluntary counseling and testing center)
DU – Drug Users
FUNAD – Fundo Nacional Antidrogas (National Anti-drugs Fund)
IAEA – International Atomic Energy Organization
IDU – Injecting Drug Users
NGO – Non-governmental Organization
NP-STD/AIDS – National Program for STD/AIDS
MOH - Ministry of Health
MSM – Men who have Sex with Men
PLWHA – People living with HIV/Aids
SAE - Serviço Ambulatório Especializado (Specialized Outpatient Service)
SENAD – Secretaria Nacional Antidrogas (National Anti-Drugs Secretariat)
STD – Sexually Transmitted Disease
SUS - Sistema Único de Saúde (Unified Health System)
UAP/ABC – Administration Unit of the Brazilian Agency for Cooperation
UBW – Unified Budget and Work
UN – United Nations
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNDP – United Nations Development Programme
UNDCP – United Nations Drug Control Program
UNODC – United Nations Office on Drugs and Crime
VCT – Voluntary Counseling and Testing

EXECUTIVE SUMMARY

Project title, number:	Drug Abuse and STD/HIV/AIDS Prevention Project, AD/BRA/99/E02
Region:	Latin America and the Caribbean
Project budget:	US\$46,608,360
Project duration:	21 December 1998 to 30 December 2004
Executing agency:	Ministry of Health, National Program for STD/AIDS (NP-STD/AIDS)
Associated agency:	none
Type of evaluation:	terminal
Date of evaluation:	1 November 2004

Project description:

1. Drug abuse is a growing phenomenon in Brazil, especially severe in the southeastern and southern regions but also widespread in the other regions. Only partial information is available, but the information is sufficient to demand action, especially since the data on HIV/AIDS mortality indicate that injecting drug use is still practically tied with homosexual exposition as the second most frequent transmission mode in Brazil (after the heterosexual transmission mode). Analyzing the tendencies in the AIDS epidemic, the project has identified four trends that underlie the formulation of objectives and achievement indicators: femininization: increasing incidence among women; heterosexualization: increasing heterosexual exposure; interiorization: geographic expansion of the AIDS epidemic; and pauperization: low income groups are increasingly affected. The development objective is to be a part of the Brazilian Government's efforts to reduce the incidence of HIV/AIDS infections and other STD, to broaden access and to improve the quality of diagnosis, treatment and health care in the area of STD, HIV and AIDS, and to strengthen public and private institutions responsible for the prevention and control of STD, HIV, and AIDS. The (drug) control objective is to reduce the incidence of HIV/AIDS and other diseases of blood-related transmission among vulnerable populations, with special emphasis on the prevention of drug abuse. The project aimed to promote (1) prevention of STD/HIV/AIDS and other diseases of blood transmission and drug abuse within more vulnerable populations; (2) strengthening of prevention and health care services for STD, HIV, AIDS and chemical dependency; and (3) institutional building of governmental and non-governmental organizations in the area of drugs and AIDS; and to foster, at the national and international levels, (4) the development of knowledge and technology to improve actions in the drug abuse and STD/AIDS field; as well as (5) to strengthen the National Program for STD and AIDS and (6) institutions for undertaking actions for health care services, human rights protection and prevention of STD/HIV/AIDS, other diseases of blood-related transmission and drug abuse.

Findings and conclusions of the evaluation team:

Concept and design

2. The annual evaluation for 2002 of the Brazilian Pluri-Annual Plan for 2000-2003 states, "One of the most important aspects of the national response to AIDS has been the increased number of prevention actions directed at the groups most vulnerable to the epidemic.... Harm reduction is an

alternative for combating the transmission of the disease among drug users, based on the principle that drug users should be protagonists of their own history, having, as protagonists, control over the use they make of the drug.... The project is much broader [than just exchange of syringes].... The Brazilian Anti-Drugs Program (SENAD) includes and recommends its adoption as a priority line of action for reducing the impact of HIV/AIDS and the hepatitis among injecting drug users (IDU).... In those cities in which it has been implemented, HIV infection rates [in this group] are already declining. As for UNODC priorities, the Declaration on the Guiding Principles of Demand Reduction states that activities should cover all areas of demand reduction, from discouraging initial use to reducing the negative health and social consequences of drug abuse for the individual and the society as a whole. HIV/AIDS constitutes one of the serious potential harms of drug abuse. The ACC-approved UN System Position Paper recommends a comprehensive package of prevention and care for IDU's, which could include outreach services, HIV/AIDS education, access to clean needles and syringes, condoms, drug dependency treatment (including substitution treatment and, where appropriate, rehabilitation), voluntary HIV testing/counseling, and psychosocial support). The June 2001 UNGASS Declaration of Commitment on HIV/AIDS sets out general targets for Member States on HIV prevention and specific targets for groups with high or increasing rates of infection, including IDU's. The Commission on Narcotic Drugs Resolution E/CN.7/2002/L.3/Rev.1 calls "...upon UNODC to continue to cooperate with the Joint United Nations Programme (UNAIDS) and other relevant United Nations entities in introducing and strengthening programmes to address HIV/AIDS."

Project implementation and management

3. The successful implementation and management of this project may be considered a model for HIV/AIDS programs in other countries. In the original project document, the National Program for STD/AIDS (NP-STD/AIDS) is specified as the executing agency and one of the two implementing agencies (along with the Brazilian Cooperation Agency - ABC, under the Ministry for External Affairs). In Brazil, the national execution modality,¹ adopted for practically all international projects, has come to be seen by some as implying limited involvement of the respective international organization in project affairs. Backstopping, in the sense of UNODC or ABC (on behalf of the Government) being ready to step in if there were a lapse on the part of the executing agency, has never been an issue in this project, because of the recognized efficiency of the NP-STD/AIDS. As to project impacts, the well known limits to evaluation for attribution at the national and subproject levels, and the large degree of overlapping with efforts under other United Nations agencies, make it difficult to assess the accomplishment of impact objectives at the level of this one project, however

¹ General Assembly resolution 47/199 (22 December 1992) reiterates that "national execution should be the norm for programmes and projects supported by the United Nations system, taking into account the needs and capacities of recipient countries." Governing Council decision 93/25 (17 June 1993) "welcomes the increased use of national execution in UNDP-assisted programmes and projects in pursuance of General Assembly resolution 47/199 [...]; calls upon recipient countries, with the assistance of UNDP as requested by the countries concerned, to assess carefully national capacities for carrying out execution responsibilities before approval of such programmes and projects; encourages greater use of UN specialized agencies in the design, technical appraisal and backstopping of nationally executed projects."

The UNDP book, *National Execution: Promises and Challenges*, points out that "The Governing Council and the General Assembly clearly intended that UN Agencies should continue to provide important technical guidance and resources to UNDP-assisted programmes, but that they should cede the overall management role to national entities in most instances" (www.undp.org/ea/documents/necl.htm). Such has generally been the case in this project (see below).

positive one's general impressions may have been; as for capacity development objectives, see below. In spite of the change of federal administration in 2003, external factors seem not to have presented any major obstacles to project execution.

Project results

4. Among project outputs were 15 important research studies; a large number of materials of a promotional, informative, educational and capacity building nature; and extensive international technical cooperation provided to other countries in the region and in Africa. As for the attainment of immediate objectives, understood as outcomes related to capacity development, there is an up-to-date monitoring system; widespread teaching about STD, HIV/AIDS and drugs in the public schools; greatly expanded coverage of IDU through harm reduction programs, specialized outpatient services, and counseling and testing, as well as efforts directed at drug users in general; expanded coverage of prison inmates and personnel; strengthening of state and municipal health secretariats and NGO's for dealing with STD/HIV/AIDS and drug abuse; and substantial Brazilian participation in national and international events on the topic. There has been a major long term effort for political networking and advocacy of adoption of harm reduction policies, alongside treatment and other forms of prevention of HIV/AIDS, as well as social mobilization and structuring of harm reduction networks. The project is a part of a long-term effort that is reducing seroprevalence and AIDS cases, particularly among IDU's, as well as increasing knowledge about prevention, promoting safe sex among students and vulnerable populations, and reducing the sharing of syringes. Considering that considerable dependency has been generated at all three levels of government and among NGO's, the issue of sustainability is a very real one. It is the government's intention to transform the NP-STD/AIDS into a regular department of the MOH by the end of the next loan agreement and projects. Efforts have begun to get underway to encourage the health and educational authorities in the states and municipalities to take responsibility for fighting AIDS, STD and drug abuse, but this is a major challenge; and the response is likely to vary widely from place to place. In particular, if the government no longer were to distribute free male and female condoms and syringes, many people would probably not buy any, or not buy enough to meet their needs, for financial or other reasons. Only a few of the NGO's supported by subprojects seem willing or able to go after their own funding. Furthermore, with the trend to "interiorization" of the epidemic, municipalities with little or no experience in the area or interested local NGO's will face new challenges.

Recommendations and lessons learned

5. The following are the recommendations and lessons learned:
 - Train project and subproject personnel in evaluation methodology, and compile and disseminate the results of subproject evaluations. Submit all annual project progress reports and project or program evaluations to critical analysis and meta-evaluation.
 - Increase activities of international exchange and cooperation at the level of the United Nations, and foment the establishment and definition of collaborative mechanisms with other international partners involved in HIV/AIDS prevention in Brazil, in order to create
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synergetic effects and to avoid overlapping. Through the NP-STD/AIDS and the UN Thematic Group on HIV/AIDS in Brazil, sponsor program outcome and impact evaluations not limited in time or by the respective agency responsibilities.

- Consider attempting to increase the proportion of subprojects targeting the traditional groups of interest to UNODC, in accordance with its mandate. Specific technical assistance in the form of training in drug abuse matters for organizations that implement harm reduction projects is needed, mainly focusing on secondary and tertiary prevention. It may be possible to expand the involvement of the Mental Health Coordination Unit of the Ministry of Health in this endeavor, along with other governmental and nongovernmental organizations, in order to see to it that the harm reduction approach is embedded, as it should be, in a network of services for drug addicts.
- Strive to provide coverage of areas of action not yet sufficiently included (geographical areas as well as areas of activity). Further action is particularly recommended with regard to the trend of “feminization” of the HIV/AIDS epidemic. Organizations should be enlisted that are able to address women, including married women, with specific prevention activities.
- UNODC is advised to seek out possibilities for technical assistance for Brazil, in order to guarantee that the successful harm reduction approach is embedded, as it should be, in a network of services for drug addicts.
- Promote large-scale nationwide efforts on behalf of youth protagonism and peer counseling on HIV/AIDS, STD and drugs, in the public and private schools and elsewhere.

Follow-up

6. As the project is still underway, the question of follow-up may be considered premature, except as it relates to negotiations for a new loan agreement and UNODC project.

INTRODUCTION

7. The HIV/AIDS epidemic in Brazil was showing clear signs of stabilization by the end of the nineties, and HIV prevalence appears to be stabilizing across all sentinel surveillance studies conducted in the country (UNAIDS, Epidemiological Fact Sheet Brazil, 2002 Update). The country can present impressive data. Condom use, for instance, increased 15 times in 10 years, which is probably largely due to the public distribution of condoms by the numerous health agents working in communities in all 27 states. Brazil has established an impressive system of diagnosis, care and support services throughout the country and access to anti-retroviral (ARV) therapy is guaranteed to all people living with HIV/AIDS (PLWHA). Primary resistance to treatment is 6.6%, which is lower than in the UK (14%) or the USA (15 to 26%)².

8. Such success is certainly largely due to the Brazilian government's efforts in HIV/AIDS prevention and care for PLWHA. The HIV/AIDS epidemic has been on the government's agenda at least since the late eighties. Joint efforts with UNODC began in 1994, when the government launched the project, “Drug abuse prevention with special emphasis on prevention of HIV infection among intravenous drug users,” together with UNDCP (the name of the agency at that time). The total budget of that project was US \$10,020,300, with 77

per cent government counterpart contribution (\$7,720,300) and 23 per cent from UNDCP sources (\$2,300,000). The Brazilian government had negotiated a US \$160 million World Bank loan to address issues related to HIV/AIDS, and was able launch several projects, AD/BRA/94/851 being one of them.

9. Project AD/BRA/99/E02, "Drug Abuse and STD/HIV/AIDS Prevention Project," which started up in December 1998, is a follow-up project to AD/BRA/94/851. The initial project budget was US\$33,000,000 with a UNODC contribution of \$2,500,000. After three lessons learned-based revisions, the budget had been increased to a total of \$46,608,360, and the closing date extended to 30 December 2004.

10. Projects AD/BRA/99/E02 and AD/BRA/94/851 have certainly contributed to Brazil's success in containing the AIDS epidemics and contributed to the development of a national strategy to that end. The question of attribution is difficult to determine, since the Brazilian government, through the National Program for STD and HIV/AIDS (NC-STD/HIV/AIDS) at the Ministry of Health, has also executed other projects on HIV/AIDS in cooperation with other international partners (some of which have also targeted drug users to some extent). It is likewise hard to say whether the current project's main contribution has been to decrease HIV/AIDS infection among drug users and injecting drug users in Brazil or among other populations at risk, such as street children and commercial sex workers (CSW). Nevertheless, project AD/BRA/99/E02, the focus of this evaluation, has already been favorably judged in the annual reviews³ as having been very successful, and as having made an important contribution to the development of a nationwide strategy for dealing with drugs and the HIV/AIDS epidemic.

11. The follow-up project, AD/BRA/99/E02, was considered necessary because in 1998, when the first project on drug abuse prevention was closed, the infection rate among IDU's was still high in Brazil. Drug users in general, in addition to injecting drug users (the traditional high risk group for HIV/AIDS), were included as a target group in the project, since it had become evident in many countries, through numerous studies, that those who take drugs, whether injecting or not, risk HIV/AIDS infection because of a higher probability of exposure to unsafe sex. The other vulnerable groups were included as target groups, because Brazilian studies had found similar profiles and behavioral tendencies among drug users and these populations.

12. The project formulated a strategy consisting mainly of promotion of so-called harm reduction intervention, accompanied by the further establishment of care, support and treatment facilities for PLWHA. Non-governmental organizations and other civil society organizations (CSO) were included among the main agents of decentralization, since they are able to reach out to the direct beneficiaries, i.e., PLWHA and the different vulnerable groups. Such organizations were consequently strongly supported by the project. In a sense they became "implementing agencies," in that they developed and executed the lion's share of the 1430 subprojects signed since 1999. The strategy is to achieve sustainability of all these efforts by linking up the non-governmental actors to public actors, at mainly state and municipality levels. These public actors are also "implementing agencies," and by the end of the project they were to be able to assume responsibility for HIV/AIDS prevention and care in order to guarantee their institutionalization. NP-STD/AIDS was expected then be able to pull out and take an advisory role.

13. A further follow-up project (AD/BRA/03/H34 – Drug Abuse, HIV/AIDS, and STD Prevention Project) has already been planned. The government and UNODC have requested an evaluation of project AD/BRA/99/E02, and particularly an analysis of lessons that can be learned from it regarding further

² Sources: Ministry of Health, Apresentação UEPI, 2004; and UNAIDS Epidemiological Fact Sheet Brazil, 2002 Update).

improvement of project strategies, activities, outcomes and impacts. For the Terms of Reference of this evaluation see the annex.

Evaluators are:

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I. PROJECT CONCEPT AND DESIGN

A. Overall assessment of the project strategies on prevention of HIV/AIDS and drug abuse

14. The project strategy for prevention of HIV/AIDS aims at promoting, decentralizing and institutionalizing prevention activities. Decentralization and institutionalization are considered the two guiding principles. Among the key actors in the decentralization process are civil society organizations: 65 % of the subprojects are executed by non-governmental organizations (NGOs). Institutionalization, and therefore sustainability, are to be achieved through collaboration between state and municipal government agencies and nongovernmental organizations, with the support of the project. After termination of this present project, most funding for local initiatives is to pass through the state health secretariats, which are to distribute funds to the municipalities in accordance with subcontracts monitored by the national program. In addition, a few strategic projects will be under the direct responsibility of the NP-STD/AIDS and UNODC, in collaboration with selected organizations.

15. The project strategy on prevention of drug abuse focuses on harm reduction, in order to promote a reduction of STD/HIV/AIDS incidence among vulnerable populations, with special emphasis on drug users (DU) and injecting drug users (IDU). For the UN agencies, the term “harm reduction” is meant to cover activities aimed at reducing the health-related and social consequences of drug abuse. Harm reduction is an integral part of the comprehensive approach to demand reduction, as acknowledged in the Declaration on the Guiding Principles of Drug Demand Reduction, adopted by the United Nations General Assembly at its twentieth special session, in 1998. This pioneer project was signed before that UN resolution was passed, so in the project documents the term “harm reduction” is not defined. However, the strategy adopted refers mainly to the following harm reduction principles:

- reaching out to injecting drug users;
- discouraging the sharing of contaminated equipment by providing sterile injecting equipment and, to a much lesser extent now, disinfectant materials;
- encouraging safe sex practices among drug users and injecting drug users by providing condoms; and

³ Tripartite meetings held by NC-STD/HIV/AIDS, UNODC and ABC (the Brazilian Agency for Cooperation), at the Ministry of Foreign Relations).

- encouragement of testing and counseling, as well as referral to health services offering HIV/Aids treatment.

16. The strategy does not include provision of substitution treatment, a key principle of many other harm reduction approaches. Encouraging safe sex practices also among non-injecting drug users is a principle of harm reduction, since numerous studies have found that they, like injecting drug users, are disproportionately likely to be involved in high risk sexual activity.

17. Of the 1430 subprojects signed since 1999, 347, or 24.3%, target DU's or IDU's. Many of the remaining 75.7% address vulnerable groups such as commercial sex workers (CSW), prison populations, etc., that are considered groups at risk for drug use and for HIV/AIDS. There is some evidence for this from Brazilian studies that have found similar "profiles and tendencies" (Project Document AD/BRA/99/E02) among drug users and other vulnerable groups for HIV/AIDS.

B. Problem analysis, objectives and achievement indicators

18. There is a detailed description in the project document of the problem distribution or prevalence among the target populations. Drug abuse is a growing phenomenon in Brazil, especially severe in the southeastern and southern regions, but also widespread in other regions. Only partial information is available; but the information is sufficient to demand action, especially since the data on HIV/AIDS mortality indicate that injecting drug use is still practically tied with homosexual exposition as the second most frequent transmission mode in Brazil (after the heterosexual transmission mode). Analyzing the tendencies in the AIDS epidemic, the project has identified four trends that underlie the formulation of objectives and achievement indicators:

- femininization: increasing incidence among women;
- heterosexualization: increasing heterosexual exposure;
- interiorization: geographic expansion of the AIDS epidemic;
- pauperization: low income groups are increasingly affected.

19. The objectives provide a logical rationale for the project. They are formulated at three levels:

1. The development objective is to be a part of the Brazilian Government's efforts to reduce the incidence of HIV/AIDS infections and other STD, to broaden access and to improve the quality of diagnosis, treatment and health care in the area of STD, HIV and AIDS, and to strengthen public and private institutions responsible for the prevention and control of STD, HIV, and AIDS.
2. The (drug) control objective is to reduce the incidence of HIV/AIDS and other diseases of blood-related transmission among vulnerable populations, with special emphasis on the prevention of drug abuse.
3. From the very beginning, data collection and analysis played an important role, making it possible to refine and update the interventions during the course of the project, on the basis of lessons learned. Two of the specific or immediate objectives (4 and 5) of the project were re-defined, and a new immediate objective (6) was added in the first revision of the project (Revision B):
 - Objective 1: To promote actions for the prevention of STD/HIV/AIDS and other diseases of blood transmission and drug abuse within more vulnerable populations.
 - Objective 2: To promote actions for the strengthening of prevention and health care services for STD, HIV, AIDS and chemical dependency.

- Objective 3: To promote actions for the institutional building of governmental and non-governmental organizations in the area of drugs and AIDS.
- Objective 4: To foster, at the national and international levels, the development of knowledge and technology to improve the actions in the drug abuse and STD/AIDS field.
- Objective 5: To strengthen the National Program for STD and AIDS to manage actions in the field.
- Objective 6: To strengthen institutions for the development of actions for health care services, human rights protection and prevention of STD/HIV/AIDS, other diseases of blood-related transmission and drug abuse.

20. The objectives are not precise from a quantitative point of view. This may be partly due to the complexity of the task: Brazil is the fifth largest country of the world, and to reach out to vulnerable populations in remote areas (see “interiorization”) in a territory of eight and a half million square kilometers requires enormous efforts. The objectives are, nonetheless, appropriate and also verifiable, within the limits of time and resources. Direct and indirect beneficiaries are different target groups, such as people living with HIV/AIDS (PLWHA), injecting drug users, commercial sex workers (CSW), etc. as well as children and adolescents and teachers, health agents, NGO personnel and other professionals, in all 27 states of Brazil.

21. Main expected achievements are:

- 27 prevention programs reaching 54,000 schools, 270,000 education professionals and 1,620,000 students;
- Outreach to 40,000 injecting drug users;
- Assisting nine regional reference centers and training 2,000 professionals;
- Assisting non-governmental organizations;
- Establishing 27 state networks for HIV/AIDS projects;
- Establishing 2,000 health teams for the treatment of sexually transmitted infections among drug users.

22. The immediate objectives and achievement indicators refer implicitly to the four trends in the AIDS epidemic in Brazil that have been identified: to a larger extent to “heterosexualization,” “interiorization” and “pauperization,” and to a lesser extent to “feminization.” A more explicit reference to this would add some clarity for the reader who is not familiar with the political, organizational, geographical, epidemiological and other conditions in Brazil. It could also be useful as a “best practice” contribution from Brazil to an international public, as the trends identified in Brazil can currently be observed in many other countries; and Brazil’s way of responding to these phenomena might be a model for others.

C. Outputs, activities and inputs

23. Budgeted inputs include international consultancy, support personnel, mission costs (monitoring and evaluation), national project personnel (technical staff and consultancies by product), subcontracts, training, expendable material, sundries and support cost. The final budget is US\$ 46,608,360.00, broken down as follows:

UNODC Contribution (US\$)		Government Cost-sharing (US\$)	
	2,500,000		30.500.000
		Budget increase Revision B	3,800,000
		Budget increase Revision C	4,000,000
		Budget increase Revision D	5,808,360
	—————		—————
Total	2,500,000	Total	44,108,360

24. Expected outputs are mostly stated in the project document as “To have [performed some action].” With regard to the first objective (“prevention of STD/AIDS and other diseases of blood-related transmission and drug abuse within more vulnerable populations”), the outputs were “To have reached”... children and adolescents in public schools, drug users (2 outputs), prison populations, sex workers, truck drivers and prospectors. The second objective had the following outputs: “To have strengthened a reference network for prevention and health care services of STD/AIDS in order to identify, expand and reinforce health care for drug users, particularly injecting drug users infected with HIV and AIDS patients”; “To have supported the reference network for chemical dependency treatment regarding the inclusion of HIV/AIDS-related issues”; and “To have promoted access to diagnosis of HIV infection in a confidential and gratis system, followed by counseling activities, in the VCT centers”. The third objective refers to production of properly evaluated educational materials, an information network, NGO projects, state networks, support for 9 reference centers, and participation in national and international events. Objective 4 sought “To have collected and systematized... data related to”... STD/AIDS and drug abuse prevention among adolescents in school, injecting drug users, sex workers, the networks of prevention and health care services for STD/AIDS and the centers for treatment of chemical dependency, and drugs and the AIDS epidemic, as well as to have developed a monitoring and evaluation system. Objective 5 had just one expected output: “To promote actions aiming at international technical cooperation....” Numerous activities were specified under each output.

D. Executing modality and managerial arrangements

25. The overall institutional framework seems complex, but is actually quite simple.

- According to the Project Document, the executing agency is the Ministry of Health - National Program Office for STD and AIDS (NP-STD/AIDS).
- Also according to the original Project Document, the implementing agencies are the NP-STD/AIDS and the Project Administration Unit of the Brazilian Agency for Cooperation (UAP/ABC) of the Ministry of External Relations. Under Title II, Article 2 of the Complementary Obligations and Prerequisites, Item G of the project document, "The Brazilian Government appoints... "ABC" as the institution responsible for the follow-up and evaluation of activities carried out within the framework of the actions described in the present Project Document." However, the UAP/ABC (a UNDP project) was de-activated in 2002-03, and most of its bureaucratic functions were transferred to the respective

international agencies.⁴ At the invitation of UNODC, a representative of the ABC Program for Multilateral Technical Cooperation accompanied this evaluation mission to Rio de Janeiro and Porto Alegre.

- Under Title V, Article 8, "The Implementing Agency" [NP-STD/AIDS (and ABC?)] shall indicate to the Executing Agency [MOH/NP-STD/AIDS], to UNDCP [UNODC] and to ABC the respective names of the Director and Coordinator..."; Revision B rewords this provision. The NP-STD/AIDS, as executing agency, carries out project activities in collaboration with UNODC; ensures that financial contributions are deposited according to the agreements; provides adequate premises, information and facilities for implementation of activities; draws up the annual work plans and progress reports; and monitors, supervises and controls implementation. In practice, this gives the NP-STD/AIDS practically full operational control of the project.
- UNODC performs the tasks foreseen in the project document and the annual work plans, in collaboration with NP-STD/AIDS. At the request of the executing agency, it carries out the administrative activities need to achieve the project objectives.

26. NP-STD/AIDS, ABC and UNODC are to conduct tripartite meetings twice a year (or annually, under Revision B), in order to analyze progress reports presented in advance of the meeting. These meetings are to discuss future developments, work plans and corresponding budgets, as well as to ensure accountability for project activities. The UN Thematic Group on HIV/AIDS provides cooperation and supports the National Aids Program.

27. The project, through NP-STD/AIDS, collaborates with the Ministries of Justice, Education and Communication, as well as the following relevant federal offices: the National Anti-Drugs Secretariat (SENAD), the executing secretariat of the National Anti-Drugs Council (CONAD) and the National Anti-Drugs Fund (FUNAD). Within the Ministry of Health, it works closely with the Mental Health Coordination Unit (COSAM) and the National Sanitary Surveillance Agency (ANVISA). These are partnerships built up in the course of project implementation, generating additional spillover effects and products.

28. Implementing agencies at the state and local levels are non-governmental and governmental organizations that are selected according to well-defined criteria: the epidemiological relevance of the intervention region, the relevance and consistency of the proposed activities, and the technical and administrative capabilities of the organizations.

II. PROJECT IMPLEMENTATION

A. Overall assessment

29. The successful implementation and management of this project may be considered a model for HIV/AIDS programs in other countries.

30. HIV/AIDS and drug abuse prevention projects must be based on a thorough, continuing assessment of local community needs. Implementing organizations must participate in developing subproject ideas and proposals, and direct beneficiaries must be involved. The effectiveness and impact of the subprojects must be

⁴ Since 2001, ABC has maintained a General Coordinating Unit for Project Monitoring and Administrative Planning (CGAP). According to the ABC homepage, the CGAP is responsible for administrative, budgetary, financial, accounting and patrimonial follow-up and supervision of international technical cooperation projects conducted under the modality of national execution (as is the case of this project). CGAP's sole bureaucratic responsibility at the present time is to administer the payrolls of the international agency projects in Brazil.

regularly assessed. Project implementation is very complex, considering that the number and nature of the subprojects have changed in the course of the project.

31. In accordance with established procedures, regular review and revision of project activities, with preparation of annual progress reports and annual work plans and implementation schedules, in collaboration with the co-funding agency, has taken place. Reports and work plans are subject to approval during the tripartite meetings.

32. Collaboration mechanisms between NP-STD/AIDS and the state and local implementing organizations have not been well defined, as might have been expected given the importance of their active participation in the project. As the evaluators were able to observe during their field visits to Rio de Janeiro and Porto Alegre, such collaboration mechanisms vary widely. NP-STD/AIDS is always the final instance, but some of the organizations, probably the older and more experienced ones, appear to be proactive, collaborative and even independent in their project-related activities; whereas others rely heavily on NP-STD/AIDS inputs in many areas, particularly the organizational and institutional ones. A definition and fine-tuning of collaboration mechanisms in this area – and training in organizational matters and institution building for the organizations in need of the same – might enhance the decentralization efforts. Some organizations are indeed decentralized from a geographical point of view, but still centralized in the sense of being largely dependent on the executing agency in organizational matters. Of course, collaboration mechanisms are continually under construction, and vary widely, depending on the institutional capacity of the benefited organization and on the development of the state, region or municipality in question.

B. Delivery of inputs

33. Project AD/BRA/99/E02 is a Non-UBW project on the agenda of the Brazilian government. UNODC is in charge of administration and of input delivery. The partners were able to rely on prior cooperation experience, since the project was a follow-up project to Project AD/BRA/94/851, "Drug abuse prevention with special emphasis on prevention of HIV infection among intravenous drug users."

34. Project AD/BRA/99/E02 has been revised and expanded three times (Revisions B, C and D). Revision B was a revision on the basis of lessons learned. Two of the immediate objectives were re-defined, a third one was added, and the budget was increased. Revision C mainly consisted of an expansion of activities that was required in order to accomplish the objectives set out in the project document, with the necessary budget increase. Revision D was necessary in order to adjust the budget, reflecting the corrections introduced in the CDR (Combined Delivery Report) by UNDP headquarters in New York,⁵ to expand project activities and to revise the project duration, changing its closing date to 30 December 2004.

35. There were 1430 subprojects, with a total budget of R\$ 59,635,862.31 (approximately US\$ 19,878,621).⁶ Of these, 334, with a total budget of R\$ 19,603,726.33 (32.9% of the project total, by far the largest category), focused on IDU; 13, with a total budget of R\$ 525,592.00 (0.9%), focused on other drug users. Numerically, the most frequent target group was CSW, with 41 subprojects (R\$ 1,743,643.15) focusing

⁵ UNODC's financial data are consolidated by UNDP headquarters in New York, through a CDR (Combined Delivery Report). UNODC had observed discrepancies between the data presented in the CDR and the data presented in the financial reports issued by ABC and UNDP Brazil; these were formally reported to the UNDP in New York, with a request for corrections. The reasons for the differences were clarified and the corrections in the CDR were made.

⁶ Assuming an exchange rate of 3 reals to the dollar.

on male sex workers and 353 (R\$ 71,765.32) focusing on CSW in general or female CSW. The total budget for CSW subprojects was just 3.0% of the project total, however. The other target groups were truck drivers; children, adolescents and young adults, except those living on the street; children, adolescents and young adults living on the street and/or in institutions; those in poverty or living on the street; adhesion groups; fellowship groups; women; the population of prospecting areas and extractive reserves; rural settlers and squatters; urban housing project settlers and squatters; confined adult populations; PLWHA; (education and) health professionals; the mentally ill; the general population; and other target populations.

36. Of the subprojects, 35.1% were located in the southeastern region (which includes Sao Paulo and Rio de Janeiro); 21.8% in the southern region (which includes Porto Alegre); 21.6% in the populous, poorer northeast; 11.0% in the vast northern region, which includes the Amazon forest; and 10.6% in the centerwest, which is being rapidly opened up to agricultural activities.

37. Subcontract expenditures from 1999 to 2003 are shown below.

Table 1
Total Subcontract Expenditures, 1999-2003 (US \$)

	Before 2002	2002	2003	Total	%
1 School Projects	599,458	-32,529	34,502	601,431	2.5
2 Harm Reduction	1,375,550	1,873,982	1,123,014	4,372,546	18.2
3 Specific Populations	1,687,162	1,756,905	1,423,097	4,867,164	20.2
4 Health Care Projects	657,429	102,609	28,822	788,860	3.3
5 Testing and Counseling Centers	377,017	79,126	20,242	476,385	2.0
6 Non-Governmental Organizations	2,803,566	1,087,869	812,914	4,704,349	19.5
7 Reference Centers	244,799	-2,456	-6,833	235,510	1.0
8 Subproject Grants	533,185	243,281	41,930	818,396	3.4
9 Research and Studies	762,592	-18,637	136,469	880,424	3.7
10 International Cooperation Projects	0	14,677	0	14,677	0.1
11 Educational and Instructional Material	3,225,607	2,387,356	562,316	6,175,279	25.6
12 Monitoring and Evaluation Contracts	98,473	39,725	6,961	145,159	0.6
Total	12,364,838	7,531,908	4,183,434	24,080,180	100.0

38. Under the new strategic management system, all 26 states and the Federal District, as well as 400 of the 411 qualified municipalities, were receiving funding every month (data from April 2004). Of the programmed funding for this system, 99.54%, or 102.8 million reals (approximately 34 million U.S. dollars), had already been committed (5.1.1, 2003 report).

C. Management and implementation of activities

39. In Brazil, the national execution modality (often with very significant cost sharing contributions), adopted for practically all international agency projects, has been generally successful and particularly appropriate, given the country's size and level of development. However, it has come to be seen by some as implying rather limited involvement of the respective international agency in project affairs. As the evaluators

perceived during the field mission, NP-STD/AIDS is seen by some of the NGO's as the agency in charge not only of control of implementation (in collaboration with UNODC), but, in some ways, as the only organization that counts. This may be partly due to NP-STD/AIDS' simultaneous involvement in other international agency projects. A few of the local implementing organizations visited, perhaps with little experience in project administration, did not know or recall that they had signed their contracts with UNODC. At the same time, UNODC has played an important role in national policy promotion and implementation.

D. Monitoring and backstopping

40. For a discussion of monitoring systems, see section III. B.

41. Backstopping, in the sense of UNODC or the ABC (on behalf of the Government) being ready to step in if there were a lapse on the part of the implementing-executing agency, was never an issue, given the recognized managerial competence of the NP-STD/AIDS. The UNDP book, *National Execution: Promises and Challenges*, points out that "The Governing Council and the General Assembly clearly intended that UN Agencies should continue to provide important technical guidance and resources to UNDP-assisted programmes, but that they should cede the overall management role to national entities in most instances." While this has generally been the case in this project, the evaluators observed certain indications of a need for somewhat more technical guidance on the part of UNODC. Whether such orientation is transmitted through the NP-STD/AIDS, other federal agencies, state or municipal governments or civil society organizations is not the main point here.

E. Circumstances affecting the project

42. The project has been implemented under the aegis of the "Basic Agreement of Technical Assistance between the Government of Brazil and the United Nations Organization, its Specialized Agencies and the International Atomic Energy Organization – IAEA." UNODC has been guaranteed the privileges and immunities granted under international agreements signed by the Brazilian government.

43. Prerequisites such as specific objectives, formulation of the expected main outputs, appointment of participating institutions, definition of implementation procedures, and definition of duties and obligations, etc., have been met. Further prerequisites regarding budget, personnel, facilities, etc. have likewise been defined and fulfilled.

44. The central role of the NP-STD/AIDS has undoubtedly had a very positive effect on project performance. Brazil has made extraordinarily successful efforts to decrease the incidence of HIV/AIDS infection in the country. A strong and highly committed central authority was needed to achieve this in a country with more than 120 million inhabitants. It is certainly true that civil society has exerted constant pressure on the government to become more proactive in the field of HIV/AIDS prevention, as an evaluator mentioned in 2002 (Thematic evaluation of HIV/AIDS activities of UNDCP, Kroll). But it is also true that NP-STD/AIDS, acting on behalf of the government, has encouraged and empowered representatives and organizations of civil society, and helped them to become proactive and to take over project responsibilities and execute project activities. Such a pattern, a governmental organization that encourages and supports non-governmental organizations to work at the grass-root level and in the communities, is rare and definitely outstanding.

45. It has been likewise positive that the other participating institutions, UNODC and ABC, have been able to cope with this central role of NP-STD/AIDS and to maintain collaboration throughout the whole project. The Brazilian office of UNODC has made an outstanding contribution to project performance by engaging, as early as in 1994 and even before, in HIV/AIDS related activities, where it was clear from the very beginning that interventions related to HIV/AIDS among drug users would almost exclusively be so-called harm reduction interventions. With this, the country office has played a pioneering role within UNODC.

III. PROJECT RESULTS

A. Outputs

1. Research

46. The numbers of published research studies produced under the project, by topic, and the respective targets, are given below. Many of these studies are cited in the footnotes to this report.

Table 2

Research Studies					
Target Report)	Number	(2003	Topic	Target	Studies Produced
4.1.1			Children and adolescents in school	2	2
4.2.1			UDI in harm reduction programs	6	5
4.3.1			CSW (STD, AIDS, drug abuse)	2	1
4.4.1			Prevention and assistance (STD, AIDS, drug abuse)	2	3
4.5.1			AIDS epidemic and drug abuse (STD, AIDS, drug abuse)	3	4
Total				15	15

2. Instructional, educational and social communication materials

47. In the year 2003 alone, "a large number of materials of a promotional nature (12 materials, including stickers, pins, t-shirts, caps, bags and a calendar), informative (6 posters and 8 folders), for training (12 technical manuals and 21 videos... and educational (4 workbooks), as well as 15 other printed documents" were produced (data from April, 2004). Many other materials were produced between 1999 and 2002.

3. International technical cooperation provided to other countries, and norms and recommendations

48. According to the 2003 report, in Latin America and the Caribbean, cooperation activities from 1998 to 2003 have reached almost all the countries in the region, both through bilateral cooperation and within the sphere of the Latin America and the Caribbean Horizontal Technical Cooperation Group on HIV/AIDS. Specific projects for border regions were conducted with Argentina, Paraguay, Venezuela and Uruguay, in partnership with UNAIDS. In 2002, Brazil launched the Program of International Cooperation with Other Developing Countries, which will send anti-retroviral medication produced in Brazil to one hundred patients in ten countries of Latin America, the Caribbean and the African continent. The project is already underway and producing good results in Kenya and Mozambique. As the evaluators noted in their interviews with informants, Brazilian experts sometimes may tend to underestimate the contribution they can make to international

HIV/AIDS work, in part because of the language problem. Asked about their interchange with other countries, most referred to Portuguese-speaking African countries they had visited.

49. There were four publications in cooperation with other countries, on the UNGASS goals, the Eleventh Brazil-France Annual Seminar (access to ARV medication), and manuals for adolescents and youth protagonists and for sex worker protagonists (of which 2000 copies of the former and 1000 copies of the latter were sent to Mozambique) (4.3.1, 2003 report).

B. Immediate objectives / outcomes

1. Monitoring systems

4.6.1 (renumbered 5.2.1 in the 2003 report). "Proportion of projects with a monitoring system installed and issuing reports by the deadline set, in relation to the total number of projects supported."

50. The Project Monitoring System (SIMOP) is now fully operational, making available continually updated information on the implementation of the "physical-financial execution" of the subprojects.⁷ The present project evaluators have made extensive use of this system in preparing this report. However, although the subprojects do regularly render financial accounts (in order to continue receiving payments), by August 2004 only 56.2% of the 1430 subprojects had submitted one or more progress reports (although the 2002 progress report of the National Program, citing ASIP, July, 2003, reports **70%** of the executors issuing reports by the deadline).⁸ Progress reports are filed separately from the dossiers containing the subproject proposal and the reports of expenditures. Some are filed at the Project Control Unit and some at the program units (mostly Prevention and Human Rights). Some of the older dossiers and progress reports are stored in the basements at the building housing the National Program (twice hit by flooding). No information from the progress reports is recorded in the SIMOP. Of the 81 subproject progress report portfolios (a 10% simple random sample) requested for this evaluation, 59 were provided, apparently with some difficulty. Four had been lost to flooding. Several of the portfolios actually did not contain any progress reports.

2. Schools

*1.1.1 (renumbered 6.1.1 in the 2003 report). Proportion of elementary and secondary public schools conducting continual activities for prevention of STD and AIDS and drug abuse, in relation to the universe of public elementary and secondary schools = **70%**. Expected situation = 25.6%.*

51. In the 2003 report, the expected situation is given as 80% for STD/AIDS prevention and 68% for drug use. The source of the 70% figure is Rua and Abramovay (2001).⁹ Table 7 of that study shows that in 1999 (the year the project got underway), 70% of the 2339 teachers questioned in 14 of the 27 state capitals (in a sample of 340 schools) reported that such activities occurred in the schools where they taught. Comments: besides being a baseline survey as far as this project is concerned, the sample cannot be considered representative of the public schools in Brazil.

52. In the second half of 2003, the federal government, bringing together the NP-STD/AIDS and the Ministry of Education (and with the support of this project), initiated a pilot experiment aimed at disseminating

⁷ Considering that in the not too distant past, the "physical" part of the monitoring was reportedly often done by dividing expenditures by unit prices, this is a major advance.

⁸ Note that a subproject executor may have more than one subproject.

⁹ Rua, M.G. and Abramovay, M. (2001). *Avaliação das ações de prevenção das DST/Aids e uso indevido de drogas nas escolas de ensino fundamental e médio em capitais brasileiras* (Evaluation of actions of prevention of STD/AIDS and drug abuse in elementary and secondary schools in Brazilian capitals). Brasília, Edições Unesco.

the role of the school in health promotion and prevention of AIDS and STD.¹⁰ In Brazil's decentralized educational system, where public preschool and elementary education are mainly the responsibility of the municipalities, and secondary education of the states, participation in this pilot experience is at the initiative of each individual school. To date, 42 municipalities in 15 of the 27 states are participating in phase 1 of the Health and Prevention in the Schools initiative, 27 municipalities in 14 states in phase 2, and 106 municipalities (including 92 in one initiative in the state of Rio de Janeiro) in 8 states in phase 3.¹¹

1.1.4. Proportion of students enrolled in elementary and secondary public schools covered by continuing activities of prevention of STD, AIDS and drug abuse, in relation to the universe of students enrolled in the public elementary and secondary schools = 8,800,000 / 52,200,000 = 16.9%.¹²

53. The target group for Health and Prevention in the Schools is the 14.7 million students aged 15-19 in Brazil (83.5% of the universe of youth in this age range). According to NP-STD/AIDS data, 37.3% of the 1,800,000 public elementary and secondary school teachers in December, 2002 had been trained for prevention of STD, AIDS and drug abuse through distance education (1.1.3); 10,000 had been trained face-to-face (1.1.2).

54. With regard to target 1.1.5, the 2002 progress report states that "With the priority given to integration of activities in the pedagogical plans of the schools, **activities of peer education stopped being encouraged for this segment, and the indicator is no longer calculated.**"

55. Comments: The incorporation of AIDS and drugs¹³ into the transversal item "Health" of the curriculum, in the Parâmetros Curriculares Nacionais (PCN) (Ministry of Education, 1997), was meant to be an important step in the direction of sustainability. The idea that the schools would work closely with nearby public health facilities with regard to AIDS was to be an important aspect of this strategy. However, the Brazilian educational system is not as well integrated as the health system; and the PCN never really took hold as a comprehensive nationwide curriculum (although individual schools or state and municipal offices of education may well make use of the federal government publication of that name that they still may have on their bookshelf). The result is that AIDS prevention activities in the schools, although apparently widespread, depend largely on the whims of the political and educational authorities who happen to be in office at the moment in any particular locality.¹⁴ The pilot experiment mentioned above holds promise, but is just now getting underway. In the light of these considerations, the wisdom of the suspension of target 1.1.5 may be questioned. Peer education is known to be an effective strategy worldwide, but is not likely to be often spontaneously generated in individual municipalities and schools.¹⁵ Alternative channels, such as nationwide youth associations, do exist, and have been enlisted in AIDS prevention campaigns in the past. Publication in 2003 (with project funding) of 5000 copies of the *Manual do Multiplicador Adolescente* was a step in the right direction, but how it will be utilized to mobilize large numbers of adolescents all over the country remains to be seen. Of course, responsibility for this area may well be assigned to the UNESCO project.

¹⁰ Ministry of Education and Ministry of Health (May, 2004). *Saúde e prevenção nas escolas* (Health and prevention in the schools). Brasília.

¹¹ Expanded draft version of the above report.

¹² NP-STD/AIDS (July, 2003). Data refer to December, 2002.

¹³ The section of the PCN on the transversal theme of health contains one paragraph each on AIDS and drugs, without attempting to impose any particular way of dealing with the issues: "The degree to which practical measures for prevention of STD/AIDS are gone into in depth depends in a significant way on the interest of the group. The period of sexual initiation with partners is quite variable among different people and social groups.... Initiation into consumption of drugs is a risk factor, in determined localities, already among students in the first through fourth grades. Reconnaissance of the local situation is of fundamental importance."

¹⁴ The comments up to this point take off from points raised by consultant Marina Marcos Valadão in a telephone interview, based in part on her masters thesis in public health, which she was about to defend as this evaluation was being drafted.

¹⁵ Although the Health and Prevention in the Schools pilot experiment does foresee the possibility of federal support for "training youth as health promoters," peer education is not explicitly included as a strategy for AIDS prevention.

3. IDU and other drug abuse, specialized outpatient services, and counseling and testing

56. There has been a major long term effort for political networking and advocacy of adoption of harm reduction policies, alongside treatment and other forms of prevention of HIV/AIDS, as well as social mobilization and structuring of harm reduction networks. The project reports a 700% growth in coverage of IDU from 1999 to 2002, and that the different harm reduction programs accessed 155,200 injecting drug users in the course of the project.¹⁶ Nineteen harm reduction associations were formed. Efforts are underway to integrate harm reduction efforts with the health services (in spite of the many difficulties involved, as noted in Greater Porto Alegre, and concerns about the appropriateness of working through the health services, vs. community-based work) and the Centers for Psycho-Social Care (CAPS). The project, in partnership with the Mental Health Coordination Unit of the MOH, reportedly participated in the installation of 75 CAPS, of which 50 are specifically in the area of alcohol and drugs (CAPS-ad). The reported number of general drug users involved in ongoing prevention and assistance activities by the subprojects is **155,201**, vs. a target of 100,000 (1.3.2). The proportion of health care services for STD/HIV/AIDS that include care for drug users is **50%** for the specialized outpatient services (SAE) and **15%** of the voluntary counseling and testing (VCT) services (2.1.1). All HIV positive IDU's reportedly have access to a SAE (2.1.2). The goal of 191 VCT centers was surpassed: there are now **220** (2.3.2), meeting 20% of the demand for laboratory examinations in the Unified Health System (SUS). Although a 200% increase in the number of people doing their HIV testing in VCT centers was expected beginning in 1997, "there has been an important, growing yearly reduction in the past four years," according to the 2003 report (2.3.3, renumbered 6.4.1 in the 2003 report). It was expected that 71% of the people who take an examination for HIV in a VCT center would return to get the result and be counseled, but the figure is actually **40%** (2.3.4). It was expected that 44% of the VCT centers, in 14 states, would be installed in regions of relevance for HIV transmission via sharing of syringes; research conducted in October 2001 showed the percentage to be **16%** (2.3.1).¹⁷ Centers of reference provided training in counseling to 1,140 health units, including STD clinics, women's health centers, and STD/AIDS outpatient services (3.5.1), as well as **76,461** community health agents and **957** professionals of the Family Health Program (3.5.5), who were also trained in harm reduction.

4. Prisons

57. The 2003 progress report states that 130,000 prisoners (**45%** of the total inmate population) were covered by prevention and care programs for STD, AIDS and drug use (vs. an expected situation in 2003 of 80% of the prison population). The National Plan for Health in the Penitentiary System was launched by the ministries of Justice and Health on August 17, 2004. In Article I, paragraph V, it provides for the "implementation of actions for the prevention of tuberculosis..., hepatitis, AIDS, STD, and mental and psychosocial disturbances, including distribution of condoms and inputs for harm reduction associated with drug use."¹⁸ The project now acts through direct support to 34 projects integrated into the National Plan.

5. State and municipal health secretariats, NGO's, networking, forums and social movements

¹⁶ The figures given are 12,000 in 1999, 31,450 in 2000, 65,467 in 2001 and 84,000 in 2002. The sum of these figures is 192,917 (37,717 greater than the total given in the text), indicating that some effort may have been made to avoid counting the same individuals more than once. To the evaluators' knowledge, more recent figures have not yet been published.

¹⁷ DISQUE AIDS / DISQUE SAÚDE. *Diagnóstico Situacional dos CTA*. Telemarketing research study conducted by Disque Saúde.

58. Of the 1430 subprojects with government and nongovernmental organizations supported under the project, 65% were executed by NGO's and 35% by state and municipal governments. **435** institutions (27 state health secretariats, 150 municipal secretariats and 258 NGO's) had their personnel trained in prevention of STD, HIV/AIDS and drug abuse and implemented subprojects. Although the original plan called for just 54 NGO subprojects for prevention of HIV/AIDS and drug abuse, as well as STD, **287** subprojects have been supported (71 for drug users, 124 for CSW, 20 for prospectors, 15 for prison inmates and 57 for other categories) (3.3.1). Of the 250 NGO professionals that were to have been trained in project management and to put into practice what they learned, **180** were actually trained (3.3.2). Instead of creating statewide networks for exchange of project experiences (3.4.1 and 3.4.2), the national program gave priority to strengthening forums and social movements. In the drug field, 2 nationwide associations and 17 state associations were created.

6. Participation in events

59. The project promoted the participation of 3,350 Brazilian specialists in national and international events in the areas of AIDS and drugs (3.6.1).

C. Control objective

60. To reduce the incidence of STD/AIDS and other diseases of blood-related transmission among vulnerable populations, with special emphasis on the prevention of drug abuse. The project sought to produce four kinds of impacts: knowledge, safe sex, harm reduction and reduced seroprevalence. The indicators reported in the 2002 and 2003 progress reports are critically analyzed below (the results claimed in the progress report are highlighted in boldface). In addition, a random sample of subprojects and their respective progress reports (in those few cases in which impact evaluation was reported) are assessed.

1. Knowledge

1.4.2. Proportion of prison inmates involved who correctly state the forms of prevention of STD's and AIDS (expected situation: 50%). 1.4.4 The same, for prison guards (expected situation: 60%) and 1.4.5 for "intimate visitors" (expected situation: 80%).

61. For prisoners (1.4.2), the reported percentage is **70%** to **90%**, but no source is cited; for the other groups, no results are reported. There were 34 subprojects and "integrated actions" in the prisons. "The activities directed to confined adult populations reach 122,000 persons in all the states and the federal district, corresponding to 42% of the total confined population in the national penitentiary system."¹⁹ National Program personnel mentioned the difficulties involved in working with the state prison authorities.

- Subproject TC-364/02 (continuation), "Project Citizenship IV," executed by the Service of Hope and Encouragement to Life Now, in the city of Ilha Solteira, São Paulo, promoted prevention of HIV/AIDS and other STD's in the local jails. Results include **70%** of the inmates being able to list ways to prevent DTD/HIV/AIDS; **50%** of those who received condoms adopting utilization, even in their intimate visits; and **60%** of the professionals trained in STD/HIV/AIDS implementing the service.²⁰

¹⁸ <http://intranet.ensp.fiocruz.br/descentralizar/anexos/Plano%20Sistema%20Penitenci%C3%A1rio.ppt>

¹⁹ According to Ministério da Saúde (2002), "The confined population of the national penitentiary system is estimated to be ca. 216,780 individuals, of whom 146,564 are distributed among the prisons of the 26 states and the Federal District." 122,000 is 56.3% of 216,780.

²⁰ The questionnaires were administered by project staff. No details were provided as to the manner in which they were applied.

1.5.2. Proportion of sex professionals involved in projects supported by the MOH that correctly state the forms of prevention of STD and AIDS and regarding drug abuse (30% increase).

62. The progress reports refer to **98.7%**. This is the percentage of the treatment group sample of 1,399 women in three of the five regions of Brazil, questioned in 2000, who responded affirmatively when asked whether AIDS could be transmitted through vaginal sex (Ministério da Saúde, 2003,²¹ also referred to as NESP/UnB, 2002); among the 1,313 members of the comparison group, the percentage was 98.2%. Had the baseline percentage for the treatment group been 75.9%, a 30% increase would have yielded 98.7%. Although no baseline group for roughly the same population is reported, research by the state program in the northeastern state of Piauí is cited (Piauí, 1995), to the effect that the percentage there in the mid-nineties was 66.8%. A study in the southern port city of Itajaí is also cited (NESP/UnB, 2002), showing a percentage of 89.4% in 1996. Comments: it is hard to believe that ignorance of the fact that AIDS can be transmitted through vaginal sex is an important problem in Brazil today, particularly among sex workers. The NESP/UnB study shows a certain prevalence of erroneous beliefs regarding other possible means of transmission. At any rate, a study conducted in 2000, the year after the project began, cannot be considered an adequate source of information on project impacts.

- Subproject TC 685/01, “BR116 – the Highway of Prevention,” was conducted by the Association for Supporting the Needy of Pacajus, in the northeastern state of Ceará. Pretests and posttests were administered to 200 female sex workers.²² On the pretest, the percentage of correct answers ranged from 25% to 40%; on the posttest, from 50% to 75%. There was also a practical component of the post-test: the sex workers were asked to demonstrate the correct placement of the condom. Of the 200, 50 correctly showed how to put it on “in all four ways,” 55 in two ways and 6 in one way. Seventeen erred in putting on the condom in all the ways, and 18 refused to demonstrate putting it on. (Obs.: It is not clear whether this refers to the male or female condom. The subproject reported offering workshops on both.)

*1.7.2. Number of prospectors involved in the projects supported by the MOH that correctly state the forms of prevention of STD and AIDS and regarding drug abuse (70% of the target population of the projects). The figure of **320,501** is cited, with no explanation and without giving the source.²³*

2. Safe Sex

*1.1.6. Proportion of public elementary and secondary school students reporting adoption of safe sex practices in the last relationship, in relation to the number of students covered by the project (**between 50% and 61%**).*

63. Table 63 in Rua and Abramovay (2002) provides the basis for this claim. This table relates reported frequency of condom use to exposition to STD/AIDS prevention activities in the schools among sexually active students in four state capitals (three in the Northeast and one in the South), as well as the national capital Brasilia, which is in the Centerwest region. A stratified random sample of students in 340 schools in 14 capitals had been taken. The number of questionnaires returned ranged from 853 in the Federal District to 1,838 in Sao Paulo. In the schools in the five capitals included in Table 63, the self-reported percentage of sexually active students ranged from 11% of girls aged 11-14 in Fortaleza (in the Northeast) to 79% of boys aged 18 and over in the southern state of Rio Grande do Sul. The percentage of sexually active students in schools where there were STD/AIDS prevention activities who reported condom use in all sexual intercourse over the past year

²¹ NP-STD/AIDS (2003). Avaliação das ações de prevenção dirigidas às profissionais do sexo, em três regiões brasileiras.

²² The questionnaires were administered by project staff. No details were provided as to the manner in which they were applied.

ranged from 50% in Brasilia (n=121) to 61% in the northeastern city of Recife (n=145). In four of the five capitals, the percentage was higher where activities were reported (the difference was 21 percentage points in Recife and 7 to 9 points in the other capitals). In Porto Alegre, in the South, 60% of students where there were activities, vs. 65% where there were none, reported regular condom use.²⁴ Comments: Although no target was set ("expected situation"), it may be assumed that substantial and statistically significant differences between responses related to the existence or intensity of STD/AIDS prevention activities in the schools might have been considered evidence of project impact. Considering the paucity of such evidence, the limited sample size and representativeness, and the fact that the data were gathered in 2000 (shortly after project start-up the previous year), no claim of project impact in this area may be said to have been supported.

1.2.5 (renumbered 6.3.1 in the 2003 progress report). Percentage of injecting drug users tied to the harm reduction programs who state that they adopted safe sex practices at last intercourse (70%).

64. The progress reports refer to reported practice over the past six months, giving the percentages of reported condom use "always" with the regular partner (**39%**) and occasional partners (**62.9%** or **63%**). A research study conducted by the Federal University of Minas Gerais in six cities in the South, Southeast and Northeast (UFMG, 2002) is cited. The total sample size was 599 clients of harm reduction programs and 252 non-clients. Reported condom use was 42.3% among clients and 31.1% among non-clients. For heterosexual use, the percentage reporting condom use "every time" ranged from 28.3% to 63.5%. Six of twelve men who have sex with men reported condom use with regular partners "most of the time or every time" (50.0%); with occasional partners the fraction was 18 out of 34 (52.9%). Comments: While the section on "Material and Methods, Population Studied" states that subjects were to be recruited in four cities in 1999-2000, some of the data were apparently gathered over a four year period, in six cities. Considering that no dates are specified for the reported data, it is unclear which should be considered baseline data for this project and which might reflect early impacts. Barring major unforeseen project impacts on safe sex and syringe exchange (or less injecting drug use related to the spread of crack and reported drug gang bans on this highly risky practice in some cities), sexual infection of partners of injecting drug users, particularly regular partners, likely remains a significant problem in Brazil, and one which certainly merits further study.

1.3.3. Proportion of drug users who report adoption of safe sex practices at last intercourse.

65. The progress reports refer to reported practice over the past six months, giving the percentages of reported condom use "always" with regular partners (**27%**) and occasional partners (**50.7%**). The source is the same as above. In this case, the calculated sample size is 505, apparently all participants in harm reduction programs. Reported frequency of condom use "every time" over the past six months ranged from 21.1% to 38.9%, with regular partners, and from 28.3% to 63.5% with occasional partners. Comments: similar to the above. It is claimed that drug use in general reduces inhibitions about unsafe sex and sometimes makes it hard to correctly use the male condom.

*1.5.5. Proportion of sex professionals reporting condom use in all sexual relations with clients, in relation to the number of sex professionals covered by the project = **73.8%**. Expected situation = 100%...*

66. This is the percentage in the treatment group claiming to have consistently used a condom with clients over the past six months (same source as in 1.5.2, above – NESP/UnB, 2002); the percentage in the comparison

²³ According to UNODC, this figure refers to the number of participants in subprojects directed toward these specific populations.

²⁴ For some reason, Table 64, which relates reported condom use to intensity of exposition to prevention activities, includes data on 8 capitals, including 3 of those included in Table 63. Frequency of reported regular condom use was always greater where there was "intense exposition" than where there was "low or no exposition (percentage point differences ranged from 4 to 16).

group was 60.3%, a difference that is highly statistically significant. The progress reports note that this result falls short of the 100% target. Comments: as noted under 1.5.2, above, a study conducted in 2000 cannot be considered an adequate source of information on project impacts (although it might be expected that the difference would tend to increase over time). Nor do projects in 14 localities necessarily reflect the current or potential situation nationwide. Of even greater concern is the much lower frequency of reported consistent condom use by CSW with regular partners: 23.9% for those involved in intervention efforts and 15.8% for the comparison group. Activist commercial sex workers in Porto Alegre report that the female condom is considered a second line of defense. The NESP/UnB data show 39.0% of the treatment group and 18.2% of the of the comparison group having used one by 2000. In Rio de Janeiro, one prevention agent expressed concern that some CSW leave it in for three relations, creating a risk of infection for the latter two clients; in Porto Alegre, the informants insisted that this was not the case.

- Subproject TC-583/02 (continuation of 504/00), "Project PREVINA in Prostitution," was executed by the Group of Support and Prevention of AIDS (GAPA) in Belo Horizonte, Minas Gerais. Contact was made with 3,465 female sex workers and 5,916 clients. Questionnaires were administered to 100 men and 165 female sex workers in 2003; unfortunately, the baseline data gathered in 2000 were damaged, and there was no time or manpower to recover them for analysis.²⁵ Although 97% of the female sex workers claimed to use condoms in all their sexual relationships, 7.8% said they had not protected themselves in the past 30 days, or didn't recall having done so. In a validity check, it was found that the number of condoms used corresponded to the number of daily "programs" engaged in by the sex workers. All stated that they never failed to require condom use for anal sex. Only 12.7% stated that the condom had never burst during their work; inappropriate lubricants seem to be the main cause of breakage. Further, many reported buying condoms from street vendors, with no quality guarantee (just 28.1% of the condoms they were carrying during the interview were from a secure source). Just 2.4% of the women said they acquired their condoms in health posts, and 6.1%, in community projects. As for the clients, 13% reported not having used any protection in intercourse with prostitutes. Numerous inconsistencies were found in the clients' responses about condom use. Although the interviews were done in houses of prostitution, before having sex, 55% of the men were not carrying a condom at the time. The main excuses for not using a condom were that the partner is reliable (23%) and that when under the influence of alcohol or drugs they themselves sometimes forget (15%).
- Subproject TC 880/02, "Stars of the Night" was executed from March to July 2003, in the city of Julio de Castilhos, Rio Grande do Sul, by the NGO "VHIVA MAIS – Group for Supporting the Seropositive and Preventing AIDS." Eighty sex workers, of whom 72 were women and 8 transvestites, were trained. Another 20 community members who participated in the "network of social insertion of the city's prostitution territories" were also approached. Of the 80 sex workers, 72.5% reported always using condoms with clients, 21.5% not always, and 6.25% never. As for drug use, 18.75% reported not using drugs, 27.5% using marijuana, 22.5% using cocaine, 28.75% using alcohol and 2.5% using other drugs (for a total of 100%, indicating that use of more than one drug was not considered). Of the 45% who reported having taken an examination, 36 mentioned the result; 27.8% (10/36) were seropositive. Just 15% of the sex workers (12/80) reported not having an STD. After nine meetings, all 80 participants reported having

²⁵ The questionnaires were administered by project staff. No details were provided as to the manner in which they were applied.

adopted safer sex practices with their partners, and maintained their affiliation with the new sex workers' association.

3. Harm Reduction²⁶

1.2.4. Proportion of syringes collected by the harm reduction projects, in relation to the number of syringes supplied to the injecting drug users = from 5 to 80%. Expected situation = 80%.

67. Source: progress reports with reference to 2001 by 8 harm reduction projects that had been in operation for at least one year and which provided the required data. Comments: informants in Rio de Janeiro and Porto Alegre stated that strict numerical control of the return of used syringes is only maintained for research purposes. In Porto Alegre, because of the risk of infection involved in handling used syringes, control is by weight. At any rate, there seems to be no strict requirement that the user hand in all his used syringes in order to receive an identical number of new ones. Instead, collection boxes are left at key distribution points. Even this is a problem, as police officers may not understand what used condoms are doing on the premises (report by a shop manager in the Jacarezinho slum of Rio de Janeiro). In Porto Alegre, there is reported to be receptivity on the part of waste management authorities to the proposal to include recipients for syringes alongside recipients for organic and inorganic refuse. One municipal harm reduction agent reported suspending two plastic bottles (just out of reach of children), one containing new syringes and one for depositing used ones, at a place known to be frequented by a couple of anonymous users. At any rate, the above target seems no longer to be considered universally valid; perhaps for this reason there is such a great variation among projects.

1.2.6. "Proportion (%) of injecting drug users linked to the harm reduction projects who state that they did not share needles and syringes the last time they used injecting drugs - 40.6%. Expected situation = 60%..."

68. Reduction in rates of sharing of material for injection (from 70%, in 1999, to **66.4%**, in 2002) and intensified demand for testing [HIV] (from 52% in 1999 to **66.4%**, in 2002) and for treatment for chemical dependence and increased condom use (from 42.1% in 1999 to **62.9%**, in 2002) among injecting drug users accessed by the harm reduction projects." Comments: these data are apparently not to be found in the footnoted study (UFMG 2002) published in September, 2002, in which injecting drug users were interviewed in six cities in the South, Southeast and Northeast. To be sure, there are data indirectly related to target 1.2.6: the respondents were asked whether in their lifetimes they had ever given used needles or syringes for another person to use or received used needles or syringes from another person. The percentages of negative responses were 47.2% (n=842) and 55.0% (n=837), respectively. Successive filters reduced the numbers responding to the next two questions, referring to the past six months (56.6% of 380, and 62.0% of 324, respectively, said no) and to the past month (43.6% of 163 and 37.5% of 120, respectively, said they had not given or received used needles or syringes). No data related to the claimed impacts (reductions and increases) could be located in the footnoted report. See, however, the discussion of target 1.2.5 on reported condom use among injecting drug users, above.

- Subproject TC-482/00, "Solidarity in Foz," was executed by the NGO "Núcleo de Ação Solidária a AIDS," in the city of Foz de Iguaçu, Paraná, site of the famous waterfalls and of the border with Paraguay and Argentina. In that municipality, epidemiological data show very high seroprevalence due to sharing of needles and syringes, as well as high rates of drug abuse, especially of crack. Reported results of this one year subproject (March 2001 to March 2002) show use of clean syringes among just 5% of the IDU served,

²⁶ Following project usage, safe sex is considered separately from harm reduction, even when unsafe sex is associated with drug abuse.

and just 10% of the crack users covered by subproject activities using condoms in their sexual relations. In addition, 10% of the drug users were reportedly using less risky drugs (a hoped-for project result).²⁷

4. Reduced Seroprevalence

"Maintenance of the trend of declining seroprevalence for HIV (from 52% in 1999 to 36.5% in 2001, among injecting drug users linked to harm reduction programs), and persistence of elevated seroprevalence for HCV (from 60% in 1999 to 56.4% in 2001)."

69. Comments: the later data only are reported in the footnoted source (UFMG, 2001). Of 853 injecting drug users tested for HIV using the Abbott and Sanofi-Pasteur tests, 310 tested positive; disregarding the single indeterminate case, the percent positive is 36.4%; including it, it is 36.3%. For Hepatitis C, the given percentages of 839 are 56.4% positive, 35.3% negative and 8.3% indeterminate. The source of the earlier data and respective sampling procedures could not be identified. With regard to one key aspect of the research, the UFMG researchers state that "It will therefore not be possible, within the scope of this present proposal, to demonstrate the effectiveness of the harm reduction programs in reducing rates of incidence of HIV among their clients *through reduction of prevalence of HIV in the circulating syringes...*" (our italics). Behavioral and biological studies among UDI in selected municipalities were conducted in 1998 and 2000-2001; no reports are available to date on the studies reportedly planned for 2003 and 2004.²⁸

70. AIDS cases in Brazil involving injecting drug users rose from 1,992 in the year 1992 to 2,131 in 1996. By 2002, the number had fallen to 560; for 2003, the preliminary figure was 228.²⁹ Obviously, these data reflect declining rates of infection prior to the present project (1999-2004), no doubt due in part to the efforts of the National STD-AIDS Program, with the support of UNODC and others. Bastos, Telles and Hacker (2003)³⁰ state that "More recently [apparently the authors are referring here mainly to the late nineties], cocaine traffic and consumption and dissemination of HIV and other infections of blood transmission have shown themselves to be especially relevant along the southern coast, with extensive epidemics and accelerated propagation of HIV among injecting drug users, especially in certain municipalities located on the coast of Santa Catarina and Rio Grande do Sul (Bastos, 2000). In some municipalities, more than 50% of all cases of AIDS have been recorded among injecting drug users...(Bastos, 2000)... [Several studies have shown that] injecting drug users are concentrated in the richest socioeconomic regions of Brazil, although a vast majority of them belong to the poorest social strata, with the lowest levels of schooling."³¹

²⁷ As explained above, this particular subproject was selected using a random sampling procedure. It is possible to select other subprojects to portray much more favorable results. A case study of a successful subproject in Salvador, Bahia, distributed by UNDCP on 4 November 2002, is a case in point. The subproject had been coordinated since 1994 by the Center for Studies and Therapies of Drug Abuse (CETAD), of the Federal University of Bahia. The report (available in English from the UNODC country office) states that "After more than 70,000 appointments with drug users since 2001, CETAD claims that the sharing of syringes, for instance, has declined from 60% to 18% in Salvador. Additionally, condom using has increased from 3% to 30% when it is related to usual partners and from 15% to 30% for casual sexual intercourse. If 28% of IDU had contact with any kind of HIV prevention methods in the beginning of the programme, nowadays 68% of the interviewees respond affirmatively to this question." The UNDCP paper concludes as follows: "In 1991, IDU represented about 25% of all HIV/AIDS cases in Brazil. For 2001, figures from Brazilian government show that this percentage is now around 11% annually. Moreover, the projects have produced an infrastructure of high-quality services for drug users, with trained professionals and volunteers, as well as a wide range of services. For all this, it is possible to say that Brazil is a good example of how the issue of HIV/AIDS amongst injecting drug users can be addressed."

²⁸ See DataShow in Portuguese supplied by the UNODC office, entitled "Technical inf2."

²⁹ Ministério da Saúde (2004). Boletim Epidemiológico AIDS.

³⁰ In Ministério da Saúde (2003). A contribuição dos estudos multicêntricos frente à epidemia de HIV/AIDS entre UDI no Brasil: 10 anos de pesquisa e redução de danos (The contribution of multi-centric studies in the face of the HIV/AIDS epidemic among injecting drug users in Brazil: 10 years of research and harm reduction). Brasília.

³¹ These authors continue, "Rio de Janeiro, where cocaine is typically sniffed, has a quite dynamic situation with regard to drug consumption. Interestingly, the HIV/AIDS epidemic in that state has not been strongly influenced by the relatively small proportion of the population that uses injecting drugs (compared with the situation in Sao Paulo, for example)... The city of Rio

D. Other results – field visits

71. The evaluators made a short mission to Rio de Janeiro and Porto Alegre and were accompanied during the interviews, group discussions and field visits by representatives of NP-STD/AIDS (both Rio de Janeiro and Porto Alegre), UNODC (Rio de Janeiro only) and ABC (both). The organizations and places visited had been chosen by NP-STD/AIDS. For the names of the organizations and places visited and the persons met, see the Annex.

72. The evaluators visited:

Non-governmental organizations	7
Non-governmental organizations exclusively working with DU / IDU	2
State and municipality-run health units	2
Harm reduction projects	5
HIV/AIDS prevention projects for CSW	2
Health centers / VCT	2
Harm reduction “life” – field visits with personnel of harm reduction projects	3
Training projects	1
A facility not supported by the project, but important for project beneficiaries ³²	1

73. The field visits with the harm reduction project personnel (“health agents,” in part volunteers) were an opportunity for participative observation. The following is a narrative report of findings and observations.

Overall findings

74. One overall finding is that all people the evaluators met, qualified professionals as well as health agents working on a volunteer basis in communities, employees of public institutions as well as NGO staff, are highly professional and impressively committed. They are dedicated to their work and to the direct beneficiaries of the project. Many appear driven by enthusiasm, ideas, a sense of responsibility and duty, and also personal courage, which is, if not indispensable, at least highly valuable and precious in a field of work as

de Janeiro may be the Brazilian city with the largest number of studies conducted among the population of drug users (especially among users of injecting drugs)... The studies conducted by our research group in Rio de Janeiro had, up until then, been recording prevalences of HIV infection in the injecting drug user population of around 27%³¹... and substantially higher prevalences (above 55%) for hepatitis B and C... in the successive cross sectional studies conducted in this population. To our surprise, we ran across, in the WHO Phase II study of evaluation of prevalence and risk factors for HIV and viral hepatitis among injecting and non-injecting drug users, a prevalence of HIV infection of approximately 8-9%... along with equally substantial reductions in prevalences of hepatitis B and C. The data seem to be consistent with prior results showing a declining epidemic in this population in [the city of] Rio de Janeiro, as it is possible to demonstrate through triangulation of data from different sources.... In summary, two risk factors central to parenteral transmission, frequencies of injection and sharing, had their frequencies considerably reduced [between the WHO I and WHO II projects].” Note that the WHO II project was just prior to the present UNODC project. In a personal interview, one of the researchers (Paulo Telles, coordinator of the harm reduction project at NEPAD, State University of Rio de Janeiro, which is supported by the present project) expressed reservations about attributing epidemiological trends to project interventions. According to him, the big drug gangs in the city of Rio de Janeiro have a rule against injecting drug use. Of course, this does not apply nationwide. Furthermore, there seems to be no evidence of drug gangs interfering with syringe exchange programs in Brazil; indeed, it seems to be in their own interest to promote, or at least tolerate, different forms of “harm reduction,” in order to keep their clients alive. Note also that this high seroprevalence among IDU in the city of Rio was not inconsistent with the fact that the a relatively small proportion of the state was reportedly injecting drugs, nor that their impact on the HIV/AIDS epidemic in the state was not great. These data are quoted here at length because of their relatively good quality and comprehensiveness, and because they seem to confirm (at least for the city of Rio de Janeiro) the basic premise stated in the progress reports.

³² This visit was organized ad-hoc in Porto Alegre by the colleague from NC-STD/HIV/AIDS, responding to a wish expressed by the evaluators. The facility was a CAPS (Centro de Atenção Psicossocial) for street children. The question had arisen where drug addicts who want to quit drug use can find assistance. A visit in one of the recently established specialized CAPS for alcohol and drugs (CAPS-ad)

difficult and challenging as HIV/AIDS. None of these people has become a “health bureaucrat,” not even those who have been working ten years or longer in the area of HIV/AIDS and who are, as mentioned in Chapter I, more experienced and capable in organizational matters than the personnel of the younger organizations. It is probable that the strong commitment of the NP-STD/AIDS has contributed to this rather unique performance and is a model for its partners.

75. Another observation is more an assumption than a finding, yet is nonetheless worth mentioning. This refers to the general atmosphere surrounding HIV/AIDS – possibly not only in Rio de Janeiro and in Porto Alegre, but also in other places in Brazil (at least in the big cities of the Southeast, South and Centerwest): HIV/AIDS and condom use seem to be an accepted topic of public discussion, and less embarrassing than elsewhere. Prejudices and stigma seem to be fewer in Brazil than in other countries with a similar development profile. This may be partly an effect of the public campaigns launched by this and other projects of the NP-STD/AIDS. Some examples may help to clarify or explain this hypothesis.

- The team and its driver had a hard time finding a VCT center in a hospital in Rio de Janeiro. They asked several people, always using the name of the hospital. Nobody could help, not even a group of young males. Then a team member had the idea to ask not for the hospital, but for “the place where people can test for AIDS” – and the young men were immediately able to point the way.
- The men who received condoms from male and female health agents in slums and other neighborhoods were not embarrassed at all, but even seemed to be proud to receive their “dose,” laughing and joking with their colleagues and the health agents.
- The team visited two VCT centers, in Rio de Janeiro and in Porto Alegre; and in both centers the staff reported that 780 to 820 persons come in for testing each month – and that only around 40 to 50 want to test anonymously. Both teams also reported that people who come for testing and are sitting together to hear a lecture on HIV/AIDS, which is given in the pre-counseling phase, usually do not mind encountering people they know. They would often start talking with each other almost immediately, apparently without embarrassment.

Harm reduction projects

76. The evaluators were able to observe during the field visits that the health agents are not only well accepted by the communities, but that people even seem to expect them. Indeed, they are part of the communities and have created impressive networks of collaborators. Clients also serving as informal collaborators range from a barkeeper in a slum in Rio de Janeiro to an addict’s sister in a neighborhood in Porto Alegre. The latter give their customers the harm reduction kit they receive from the health agents, containing syringes, disinfectant material and condoms, together with the drugs they sell (chemicals in the cases observed).

77. The projects visited work with the poor, in slums mainly. According to a recent publication of the Ministry of Health,³³ injecting drug use is indeed more common in the poorer segments of Brazilian society. However, many drug users can also be found among the rich. As the staff of harm reduction projects in Rio de

could not be organized ad-hoc. However, the visit to a CAPS for street children, all of them drug users or at least drug-experienced, could give some orientation.

³³ Ministério da Saúde, NC-STD/AIDS (2003). "A Política do Ministério da Saúde para a Atenção Integral a Usuários de Álcool e Outras Drogas" (The policy of the Ministry of Health for comprehensive care of users of alcohol and other drugs), Brasília.

Janeiro and in Porto Alegre reported, access to these people is difficult, if not impossible. Participants in a training project that was supported by the project until 2002 (and who work in organizations or projects not necessarily under the umbrella of the current project, but in harm reduction matters) reported that the rich youth take advantage of the harm reduction kits that are distributed. They could afford the expenses for syringes and condoms themselves, but are afraid of being discovered by their parents and hide among the poor drug users. However, it is very difficult to build up a real contact with such youth.

78. Health agents and other staff from harm reduction projects reported that “many” drug addicts ask for help, wanting to quit. The health agents often feel helpless, because they cannot really refer them services where they can get assistance (except for hospitals in some cases, which is almost never an adequate solution). “For many of them this is a miserable life, and they would be happy they could stop taking drugs” (a psychologist in Porto Alegre).

79. Except for one project the evaluators observed, the harm reduction projects visited did not arise out of work with drug users. Instead, HIV/AIDS prevention work evolved into harm reduction for drug users. Most of the people working in the field are recruited for their experience and close contact with drug users, which make it possible to reach this specific population. However, some of the problems the projects and organizations have are due to their lack of experience with addiction. Many prevention strategies that work for other vulnerable groups do not work for addicts. Work with addicts requires training, specific knowledge and experience. Addicts tell lies, steal and do other unpleasant things when they need their drugs and are at risk of a withdrawal syndrome. Most are highly experienced in “playing games” with helpers. Helpers who are unaware of the problem and do not know how to deal with it risk a personal burnout and many professional problems.

80. The knowledge about addiction the health agents and their colleagues have may well be sufficient for what they are doing: harm reduction. But problems arise as soon as they want to do more, to go beyond outreach and, for example, organize group meetings with active drug users in a clinic or a doctor's office.

HIV/AIDS prevention for other vulnerable groups

81. The subprojects dealing with prevention for sex professionals³⁴ are well organized and can count on the active participation of the direct beneficiaries. Sex professionals involved in the subprojects generally use condoms with their clients - in some cases, as reported by informants, mostly female condoms. The female condom protects the women themselves, but not their customers, in the likely case that they have more than one per evening (if they neglect to replace it every time). Sex professionals in Porto Alegre reported that they “educate” their customers to use the condom, usually with good success, but the men rarely use a condom when having intercourse with their wives. This is culturally rejected, and the women might well suspect their men of having affairs if they offered condom use (or the men might project this suspicion on the women).

82. The sex professionals the evaluators met did not have much to say about drug use. They said yes, there are other CSW who use drugs, but they were not in touch with them. The evaluators could not determine whether the women referred to were real sex professionals, or whether they were addicts prostituting themselves to get money for drugs.

83. Street children were reported to be almost all users of crack or inhalants. The CAPS visited in Porto Alegre (see footnote above) does not deal specifically with addiction, but the personnel pointed out that it would be necessary to do so.

³⁴ Brazilian terminology avoids the term “commercial sex workers” and prefers “sex professionals.”

Health centers and VCT

84. The facilities visited are very well organized and highly professional. An average of around 800 tests per month, with the related counseling, is high; and the personnel said they are overloaded with work. They seemed to be highly committed, however.

E. Sustainability of project results

85. The national STD/AIDS program has depended on loan agreements and nationally executed international projects since the early nineties, particularly in the areas of institutional strengthening and prevention and health promotion.³⁵ The loan agreement and technical cooperation projects currently under negotiation are expected to be the last. Considering that considerable dependency has been generated at all three levels of government and among NGO's, and assuming that the AIDS epidemic and related STD and drug abuse are not likely to disappear soon, the issue of sustainability is a very real one. It is the government's stated intention to transform the NP-STD/AIDS into a regular department of the MOH by the end of the next loan agreement and projects. Efforts have begun to get underway to encourage the health and educational authorities in the states and municipalities to take responsibility for fighting AIDS, STD and drug abuse; but this is a major challenge; and the response is likely to vary widely from place to place. In particular, if the government no longer were to distribute free male and female condoms and syringes, many people would probably not buy any, or not buy enough to meet their needs, for financial or other reasons.³⁶ Only a few of the NGO's supported by subprojects seem willing or able to go after their own funding.³⁷ Furthermore, with the trend to "interiorization" of the epidemic, municipalities with little or no experience in the area or interested local NGO's will face new challenges.

IV. OVERALL CONCLUSIONS

86. Brazil has made an enormous and largely successful effort to contain the spread of the HIV/AIDS epidemic in the country. The project under discussion has contributed to this success, although it may be impossible to determine to what extent such success can be attributed to this particular project. Parts of the project could be (and in fact already are, to some extent) a best practice contribution of Brazil to an international audience, as evidenced by materials forwarded to the evaluation team. Particularly outstanding and certainly interesting for an international public are the achievements in the development of outreach or community-based activities in HIV/AIDS prevention, along with the mobilization and the involvement of civil society organizations. Sustainability has not yet been achieved and must be a main goal of the planned follow-up project.

³⁵ A DataShow presentation by the then director, Alexandre Granjeiro, shows that in 2000, 81.4% of federal expenditures were in the areas of medication and diagnosis and treatment, and 88% of all federal expenditures were funded out of the regular government budget (the remaining 12% being from the World Bank loan agreement).

³⁶ Trend studies of condom sales in Brazil are urgently needed.

³⁷ One, in Rio de Janeiro, has received free assistance from a marketing firm to enable it to raise funds with no strings attached, in order to meet its regular obligations (salaries, rent, utilities, etc.). Another, in a smaller town, has done local marketing to increase contributions. Non-volunteer workers for NGO's are generally in an irregular situation, because the organizations have no way to commit themselves to regular payment of salaries, with the attendant heavy obligations for social security and other payroll deductions.

V. RECOMMENDATIONS

A. Issues resolved during evaluation

87. One issue could not really be resolved: it became clear that it would be impossible to attribute the overall positive developments in HIV/AIDS matters in Brazil, or well-defined parts of them, exclusively to Project AD/BRA/99/E02. The government, through NP-STD/AIDS, works with other partners on similar and even identical issues; and there seems to be insufficient information exchange among these international partners, in spite of the UN Thematic Group on HIV/AIDS in which they all participate. The important thing is that through partnerships between NP-STD/AIDS, the World Bank, UNODC and UNESCO, it has been possible to change the course of the epidemic in Brazil.

B. Actions/decisions recommended

88. The following is recommended:

- Train project and subproject personnel in evaluation methodology, including impact analysis (with no arbitrary dictums about how long one must wait to do impact evaluation) and outcome monitoring and evaluation (of capacity development).
- Compile and disseminate the results of subproject evaluations.
- Identify best practices and encourage similar projects and subprojects to examine them for possible adoption.
- Subject all annual project progress reports and project or program evaluations to critical analysis and meta-evaluation.
- Promote further decentralization, in administrative as well as other areas.
- Increase activities of international exchange and cooperation at the level of the United Nations.
- Foment the establishment and definition of collaborative mechanisms with other international partners involved in HIV/AIDS prevention in Brazil, in order to create synergetic effects and to avoid overlapping.
- Increase of the proportion of subprojects targeting the traditional groups of interest to UNODC, in accordance with its mandate.
- Provide specific technical assistance in the form of training in drug abuse matters for organizations that implement harm reduction projects, possibly through the mental health department of the Ministry of Health.
- Strive to provide coverage of areas of action not yet sufficiently included (geographical areas as well as areas of activity). Further action is particularly recommended with regard to the trend of “feminization” of the HIV/AIDS epidemic. Organizations should be enlisted that are able to address women, including married women, with specific prevention activities.
- Promote large-scale nationwide efforts on behalf of youth protagonism and peer counseling on HIV/AIDS, STD and drugs, in the public and private schools and elsewhere. These efforts should be coordinated by the NP-STD/AIDS and assisted by the international organizations, with the support of the mass media and the health and educational authorities whenever possible. While it is important to enlist the cooperation of educators and the educational authorities, and the pilot experiment currently underway is of major significance, the slow pace of diffusion of innovations in the public schools in Brazil cannot be allowed to retard this vital initiative.

89. One recommendation concerns the co-funding agency, UNODC, and the Brazilian government, but not NC-STD/HIV/AIDS: Drug use is a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence. Harm reduction, by definition, forms a part of a so-called comprehensive approach, meaning that it is just one solution in a package of assistance for drug addicts. Project AD/BRA/99/E02, the Drug Abuse and STD/HIV/AIDS Prevention Project, belongs to the Drug Demand Reduction sector. From an ethical point of view, harm reduction is the last resort, for those who are severe abusers and for whom assistance aiming at total or near abstinence does not work. In most countries that have adopted harm reduction strategies, such as the Netherlands and Switzerland,³⁸ harm reduction has also been the last solution in a chronological sense, and includes the provision of substitution treatment. These countries have offered many other services for drug users before introducing harm reduction, and continue to offer them, as part of a comprehensive approach. Brazil appears to be a country where harm reduction is often not the last solution, but the first one. In any event, it should not be the only one. The evaluators were not able to thoroughly assess services for drug users in the given time frame and under their mandate. However, it seems that there are very few services available where drug addicts can find other than harm reduction or detoxification assistance. In particular, secondary and tertiary prevention services seem to be lacking. UNODC is advised to seek out possibilities for technical assistance for Brazil, in order to guarantee that the successful harm reduction approach is embedded, as it should be, in a network of services for drug addicts. The Brazilian strategy of inserting harm reduction approaches within the national AIDS program has been largely successful, and may point the way for other countries. NP-STD/AIDS is not directly responsible for other aspects of demand reduction, but could further assist UNODC by backing up agency initiatives within the Ministries of Health and Justice.

C. Project revisions

90. With over one thousand subprojects to be concluded, one more project revision is expected to be necessary.

VI. LESSONS LEARNED

A. Lessons about the importance of the project

91. One lesson learned is that it is impossible to determine the importance and impact a project has if it does not concentrate mainly on the traditional target populations of the UN agency involved, and if it is just one project among many other similar ones, with considerable overlapping among the groups addressed by the different projects.

92. It is, nonetheless, possible to conclude that it makes sense to invest heavily in community-based activities when it comes to HIV/AIDS prevention, and to seek partnerships with civil society organizations. This lesson has been learned theoretically by all the co-sponsors of UNAIDS, and has already been put into practice by some of them, including UNODC in Brazil.

93. Despite the above-mentioned obstacles to the assessment of project impacts, it may be concluded that the project is, indeed, of outstanding importance to the co-funding agency. UNODC worldwide encountered certain difficulties in conceptualising issues related to HIV/AIDS when it became a co-sponsor of UNAIDS in 1999. The agency has chaired the Committee of Co-sponsoring Organizations (CCO) of the Joint United

³⁸ Brazilian authors arguing for harm reduction approaches often refer to these countries. See for instance “Drogas, Dignidade & Inclusão

Nations Programme on HIV/AIDS (UNAIDS) since 1 July 2004. As the Executive Director, Mr. Costa, said in a special message to all divisions and field offices at the beginning of this chairmanship,³⁹ UNODC will focus its attention on the areas of injecting drug use, prisons, trafficking in persons, and conflict and post-conflict situations. This project has dealt already with two of these areas, i.e., HIV/AIDS prevention for injecting drug users and in prisons, and can well provide important inputs to UNODC headquarters in this regard.

94. The project is likewise important to the Brazilian government, which can be proud of its achievements in HIV/AIDS prevention, as well as diagnosis and treatment. Another important lesson for the government is that it should speed up its efforts to develop and implement a comprehensive approach to drug addiction, assisted if possible by the agency that has the most technical knowledge in this area, i.e., UNODC.

B. Project performance

95. Project performance is difficult to assess in detail. However, the evaluators' overall judgment is positive. And an important lesson learned is that it makes sense to have a strong and powerful central authority, in order to initiate and administer a very complex project tackling a difficult issue. A further lesson learned is that the central authority should try not to miss the best moment to relinquish this responsibility, change its the role and take over other functions; and that major efforts will be required to enable the more than 1000 states, municipalities and NGO's already involved, as well as others, to take the lion's share of the responsibility themselves.

C. Project efficacy in using financial resources

96. The up-to-date database and data management system now in place make it possible for the NP-STD/AIDS to better control project and subproject *efficiency*, in the sense of keeping down the financial costs of project and subproject inputs (what in Brazil is called "physical-financial monitoring") and outputs. However, there is little solid evidence at the project or subproject level of outcomes and impacts; and what evidence there is is not included in the data management system. Thus, outside of praising the project for its apparent efficiency and the general impression one has of the *efficacy* of the various approaches adopted, little can be said specifically about project efficacy in employment of the substantial financial resources the NP-STD/AIDS has administered (cost-effectiveness, cost-benefit or cost-impact analysis).

Social" (Drugs, Dignity and Social Inclusion), published by the Associação Brasileira de Redutores de Danos, Rio de Janeiro, 2003.

³⁹ E-mail to the Brazilian Office. The office brought the message to the attention of the evaluators.

Annexes

1. Terms of reference

UNITED NATIONS OFFICE ON DRUGS AND CRIME

PROJECT EVALUATION

TERMS OF REFERENCE

Project Title: Drug Abuse and STD/HIV/AIDS Prevention Project
 Project Number: AD/BRA/99/E02

BACKGROUND

1. Project AD/BRA/99/E02 is part of the National Programme for the Control and Prevention of the Aids epidemic in Brazil. This programme counts with the support from the World Bank second Loan Agreement # 4392-BR to the Federal Republic of Brazil in the amount of US\$ 300 million. The Project aims at covering all federal states and supporting the development of activities at state and municipal levels. The main objective of the project is the reduction of the incidence of STD/Aids and other diseases of blood-related transmission among vulnerable populations, with special emphasis on drug abuse prevention.

Project AD/BRA/99/E02 represents a second generation of drug abuse and HIV/STD/Aids prevention project, continuing the prior cooperation between the Brazilian Ministry of Health and UNODC Brazil through Project AD/BRA/94/851 "Drug Abuse Prevention with Special Emphasis on Prevention of HIV Infection among Injecting Drug Users in Brazil", signed in 1994 and which had a duration of four years.

Project AD/BRA/99/E02 was signed in December 1998 and had two Project Document Revisions. The original project document had 5 Immediate Objectives and was expected to be implemented in 4 years (until December 2002), with a total budget of US\$ 33,000,000 (US\$ 30,500,000 from Government Contribution and US\$ 2,500,000 from UNODC contribution).

The Project Document Revision B, besides increasing the total budget up to US\$ 36,800,000, reorganized the Project objectives, outputs and activities, included new target groups previously not addressed and extended the duration until 31 December 2003. According to Revision B the first three Project Immediate Objectives were considered fully completed until December 2002, Objectives 4 and 5 were adapted to the new epidemic context in Brazil and an Objective 6 was added to the document. Objectives 4, 5 were reformulated and an Objective 6 was created.

The Project Document Revision C had the objective of increasing the Project total budget to US\$ 40,800,000. The development, control and immediate objectives, outputs and activities remained unchanged.

EVALUATION PURPOSE

2. The Evaluation will analyze: a) project concept and design; b) project implementation; and c) the outputs, outcomes and impact of the project. It should also ensure that lessons learnt from the project will be recorded and recommendations for the future course of the project or other follow-up activities will be made, as appropriate.

Project concept and design

3. The evaluation should assess the project concept and design, specifically:
- The project strategies on prevention of HIV/AIDS and drugs
 - The immediate objective/s and planned outputs, activities and inputs as compared to cost effective alternatives;
 - The clarity, logic and coherence of the project document;
 - The executing modality and managerial arrangements for the project;
 - Arrangements for monitoring and evaluation;
 - The appropriateness and cost effectiveness of baseline studies and achievement indicators;
 - The adequacy of the identification and assessment of risks to the project;
 - The adequacy of prior obligations and prerequisites to be met by the Government;

Implementation

4. The evaluation should assess the project implementation, specifically:
 - A. Implementation of activities specified in the project document:
 - the quality and timeliness of inputs, including counterpart participation and inputs by executing and implementing agencies;
 - the timeliness, efficiency and effectiveness of activities carried out.
 - B. Monitoring and management:
 - of the project including sub-projects
 - of interventions in the field (before the target populations)
 - technical/administrative backstopping by the Government, UNODC headquarters and the UNODC Regional Office in Brazil.
 - C. External factors:
 - the extent to which external factors (beyond the control of project management) significantly affected implementation in a positive or negative way;
 - the adequacy of the project's response to the external factors.

Project outputs, outcomes and impact

5. The evaluation should assess the project outputs, outcomes and impact, specifically:
 - the quality and quantity of outputs produced and of outcomes;
 - the achievement of the immediate objectives;
 - the contribution of the project to attaining the drug control objective;
 - the sustainability of project results, including the degree of technology appropriation by the sub-projects in the technical and project management areas, aiming at their sustainability;
 - whether the project has had any significant unexpected effects of beneficial or detrimental character.

Recommendations

6. The evaluation team shall make recommendations, as appropriate. They should constitute proposals for concrete action, which could be taken in future to improve or rectify undesired outcomes. Specifically, the evaluation may recommend abandonment, modification, or continuation of the project. Recommendations may also be made in respect of issues related to the implementations of management of the project.

Lessons learned

7. The evaluation team should record the lessons learned from the project which are valid for technical cooperation beyond the project itself. Due to the considerable number of contacts with other Aids Programs in Latin America, special attention should be paid to the concrete possibilities of horizontal cooperation among these countries.

The lessons learned may be considered relevant and contribute to the design of the new aids and drug abuse prevention project actions and strategies. They may result from identified difficulties as well as from positive aspects of the project.

The following questioning should be done: which lessons were learned about the importance of the project? What was learned in terms of project performance to achieve its objective? What was learned in terms of project efficacy in using financial resources? Are there any lessons that might suggest multiplying capacity of this kind of intervention? Which lessons might be highlighted to improve institutional strengthening capacity, mobilization and the delivery of services? Other lessons might come up from project outputs and difficulties.

DOCUMENTATION

8. Attached to the terms of reference, the evaluation team will find copies of: project document (Annex I) and revisions (Annex II and III), annual progress reports prepared for the tripartite meetings (Annex IV). Other documents will be available at UNODC Office in Brasilia and in the project coordination unit.

EVALUATION METHODOLOGY

9. The final evaluation of the project is based on document analysis and interviews with key persons. It is an external evaluation, carried out by external consultants hired to this specific purpose. The mission will evaluate the Project to provide inputs on its performance and results.

With respect to the evaluation model, a mixture of the quantitative and qualitative models should be used. The mixture model is recommended in order to cover all important aspects of both methods.

For the quantitative model, the following items should be considered:

- definition of the scope of study;
- delimitation of analysis units;
- sample;
- data collection instruments (questionnaire, structured interview);
- number of trained professionals, different populations reached, educational materials produced and distributed;
- field work; and

For the qualitative model, the following items should be considered:

- discussion with technical staff and project clients in order to identify their involvement and contribution;
- field work: mobilization of target populations, participative observations, focal groups, interviews and life stories;
- analysis of the collected information: determination of the project's effectiveness by applying the principle of "methodological mixture", quantitative and qualitative models.

RESPONSIBILITY FOR EVALUATION

10. The evaluation team will be composed by two consultants – one international and one national. They should hold expertise in qualitative and/or quantitative research evaluation methods and work experience with the United Nations. The international consultant must be fluent in oral and reading Portuguese and both the international and national consultants must have working knowledge of English for reporting purposes.

The present evaluation will require travel to different cities in Brazil and the consultants should not have any impediments that may limit their ability to engage in trips around the country.

The invitations for both consultants that will form the evaluation team will be officially signed and sent by UNODC.

The evaluation team will not act as representative of any party, but should use its independent judgment. The evaluation team was not involved in the design, appraisal or implementation of the project.

BRIEFINGS, CONSULTATIONS AND ADMINISTRATIVE SUPPORT

11. Upon arrival in Brasília, the mission will be briefed by the UNODC Representative and by the General-Coordinator of the project executing agency, who will provide the necessary substantive and operational support.

The evaluation mission will be carried out during the second half of October 2003, over a period of 2 full weeks.

The Evaluator does not have the authority to make any commitment on behalf of the project parties, i.e. UNODC, recipient countries and donors.

EVALUATION REPORT AND FOLLOW-UP

12. A meeting will be arranged by UNODC where the evaluation team will present and discuss with Project parties the main findings of the evaluation mission. Although the evaluation team should take the views expressed into account, it should use its independent judgment in preparing the final report. Within one week after the end of the mission the evaluation team will produce the draft report in English that will be circulated for comments to the Project Executing Agency and to the UNODC Brazil. The evaluation team may then incorporate any comments in the final evaluation report using his independent judgment.

13. The UNODC standard format and guidelines for the preparation of project evaluation reports will be followed by the evaluation team. The UNODC standard format for the final evaluation report (Annex V) is attached to this terms of reference. The evaluation team is also expected to fill out the summary assessment questionnaire (Annex VI) and an evaluation summary (Annex VII), according to the attached guidelines.

14. The final version of the evaluation report shall be sent to the UNODC, Brazil, in not more than 30 (thirty) days after leaving Brazil. The report should be submitted in English, not exceeding 25 pages, to the office at headquarters responsible for the project. The UNODC will distribute the final report to the other parties of the project. The report will be discussed at a project final tripartite meeting (TPR) where conclusions and recommendations on the evaluation will be made. A copy will be provided to the Senior Evaluation Officer in electronic Word format.

TIMETABLE

15. This section should specify the overall timetable for the evaluation and should, in particular, identify the starting and finishing dates of the evaluation.

08/08/04	Arrival in Brasilia
09 to 11/08/04	Meetings with UNODC, Project Executing agency
11 to 17/08/04	Field (Rio de Janeiro and Porto Alegre)
17 /08/04	Return to Brasilia
19 /08/04	Meeting with UNODC and the Executing Agency to present the Draft Evaluation Report
20/08/04	Final Consultations
20/08/04	Departure

2. Organizations and places visited and persons met

Rio de Janeiro, 11-13 August

- Programa Integrado de Marginalidade (PIM), Projeto Saúde e Educação na Prostituição (Health and Education in Prostitution Project, subproject TC-618/03). Rosângela, coordinator; Célia Sztrenfeld, executive secretary; Lourdes, administrator; Janaina, distributor.
- SEPED/NEPAD (Society for Studies and Research on Drug Addiction, Nucleo of Research on Drug Abuse), harm reduction project among IDU (subproject TC-557/03). Paulo Telles, coordinator; Nélío Zuccaro, state health secretariat, AIDS program; Aline, field supervisor; Cláudia, distributor; Rosângela, psychologist.
- Associação Carioca de Redução de Danos (Harm Reduction Association in the City of Rio de Janeiro), project for training the municipalities of the state of Rio de Janeiro in harm reduction strategies (subproject TC-552/03). Cristiane Moema, coordinator; José Carlos, field supervisor.
- CTA São Francisco, harm reduction in the VCT center (subproject TC-008/04). Sônia Batista, coordinator; Fátima Correia, nurse.
- CETAPS Health Promotion Center, Community Prevention Clusters. Vanda Lúcia Guimarães, member of the general coordinating body.

Porto Alegre, 16-17 August

- Viver, Integrated Center for Ministering to Children and Adolescents of Alvorada, harm reduction project (TC-316/99). Malova Gomes, project coordinator, STD/AIDS, Alvorada; Letícia, project coordinator, STD/AIDS, Viamão (Training People Project, TC-124/02); Dilson, project coordinator, Metropolitan Movement for Harm Reduction; Aguinaldo Pereira Ribeiro, distributor; Alexander Sandro; Maria da Graça.
- Núcleo de Estudos da Prostituição, intervention in prostitution territories project (TC-441/02). Horizontina Tabora, coordinator; Lúcia, executive secretary.
- GAPA (Group of Support and AIDS Prevention) behavioral intervention project directed at sex professionals (TC-782/02). Izete Stella; Márcia, Municipal Coordinating Body;
- Harm reduction field visit in a mobile unit

3. Summary assessment questionnaire⁴⁰

	H	S	0	1	2	3	4	5
OVERALL QUALITY AND PERFORMANCE OF PROJECT:								
I. PROJECT CONCEPT AND DESIGN:								
1. Project document (overall clarity, logic and coherence).							X	
2. Identification/analysis of problem addressed by project:		X					X	
3. Project strategy (overall assessment):	X						X	
4. Drug control objective (s) (appropriateness, obtainability):							X	
5. Immediate objective(s) (appropriateness, obtainability):						X		
6. Achievement indicators:						X		
7. Base-line study/arrangements for base-line study:						X		
8. Outputs (compared to cost effective alternatives):							X	
9. Activities (compare to cost effective alternatives):							X	
10. Inputs (compared to cost effective alternatives):							X	
11. Executing modality and managerial arrangements:		X				X		
12. Identification and assessment of risks					X			
13. Prior obligations and prerequisites:							X	
14. Workplan/planned project duration:							X	
15. Budget:							X	

⁴⁰ An assessment is provided for all categories listed (including categories constituting headings) by ticking one of the boxes ranging from 0 to 5. The ratings from 0 to 5 are based on the following standard favor-to-disfavor scale: 5 - Outstanding, highly appropriate, much more than planned/expected, certain to materialize; 4 - Very good, very appropriate, more than planned/expected, highly likely to materialize; 3 - Good, appropriate, as planned/expected, likely to materialize; 2 - Fair, less appropriate, less than planned/expected, less likely to materialize; 1 - Unsatisfactory, not appropriate, far below plans/expectations, unlikely to materialize; 0 - Cannot determine, not applicable. If a category has been significant (as a cause or effect) in relation to the overall quality and/or performance of the project, the "S" column has been ticked, or "H" if highly significant.

	H	S	0	1	2	3	4	5
II. PROJECT IMPLEMENTATION:								
1. Quality and timeliness of UNODC inputs:						X		
2. Quality and timeliness of Government inputs:							X	
3. Quality and timeliness of inputs by third parties:	X						X	
4. Equipment:						X		
5. Advisory/training services:						X		
6. Project personnel:						X		
7. Sub-contracting:	X						X	
8. Management of project:						X		
9. Project workplans:						X		
10. Implementation of activities:						X		
11. Monitoring and backstopping by UNODC HQ:			X					
12. Monitoring and backstopping by ODCCP field Office:						X		
13. Monitoring and backstopping by Executing Agency:							X	
14. Monitoring and backstopping by Government:					X			
15. Government fulfilment of prerequisites:						X		
III. PROJECT RESULTS:								
1. Timeliness of produced outputs;						X		
2. Quantity of produced outputs:							X	
3. Quality of produced outputs:							X	
4. Outcomes: achievement/likely achievement of immediate objective(s):							X	
5. Drug control impact achieved:			X					
6. Drug control impact to be expected						X		
7. Likely sustainability of project results:						X		

3. If external factors had an impact on project performance please tick the appropriate boxes: external factors impeded:___/ promoted:___ project performance. The effect on project performance of this influence was significant:___/ highly significant:_____. Please provide a short description of the nature of the external factor(s): External factors had an impact on project performance, but it is impossible to determine to which extent. The external factors are other projects in HIV/AIDS prevention in collaboration with other, also international, partners, executed by the government.

4. Did the evaluation recommend to:

- a) _____ abandon the project
- b) _____ continue/extend the project without modifications
- c) _____ continue/extend the project with minor modifications
- d) X continue/extend the project with some modifications
- e) _____ continue/extend the project with extensive modification
- f) _____ terminate the projects, as planned

(please tick the relevant category).

5. If a modification of the project was recommended did the evaluation recommend a revision of: the drug control objective(s): _____, the immediate objective(s): _____, the outputs: _____, the activities: _____ or the inputs: _____. Please tick as appropriate.

It is recommended that the project be redesigned into a new project.

6. If the evaluation recommended that the project or significant elements of it be replicated, please tick as appropriate: yes: X / no: _____