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Department of STD, AIDS and Viral Hepatitis

Progress Report on the Brazilian Response to HIV/AIDS

(2010-2011)

Brazil, 2012

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Acronyms

APAC – *Autorização de Procedimentos Ambulatoriais de Alta Complexidade/Custo* (Authorization for High Complexity/Cost Outpatient Procedures)
ARV – Antiretroviral
ARVT – Antiretroviral Therapy
BPO – *Boletim de produção ambulatorial* (Outpatient Production Bulletin)
CAMS – *Comissão Nacional de Articulação com Movimentos Sociais* (National Commission for Articulation with Social Movements)
CNAIDS – *Comissão Nacional de DST, Aids e Hepatites Virais* (National STD, AIDS and Viral Hepatitis Commission)
CTA – *Centro de Testagem e Aconselhamento* (Testing and Counselling Centre)
DATASUS – National Health System Information Technology Department
DDAHV - Department of STD, AIDS and Viral Hepatitis
HSS – Health Surveillance Secretariat - Ministry of Health
IDU – Injecting Drug User
ILO – International Labour Organization
MDG – Millennium Development Goals
MDS – Ministry of Social Development and Combat against Hunger
MDU – Medication Dispensing Units
MEC – Ministry of Education
MoH – Ministry of Health
MONITORAIDS – Department of STD, AIDS and Viral Hepatitis Indicator Monitoring System
MRG – *Médicos de Referência em Genotipagem* (Genotyping Reference Doctors)
MSM – Men who have Sex with Men
NCPI – National Commitments and Policy Instrument
LGBT – Lesbians, Gay men, Bisexuals, Transvestites and Transsexuals
NGO – Non-Governmental Organization
NHS – National Health System
NOAS – *Norma Operacional da Assistência à Saúde* (Healthcare Operational Norm)
PAHO – Pan American Health Organization
PLWHA – People Living With HIV and AIDS
QUALIAIDS – Evaluation and Monitoring of the Quality of AIDS NHS Outpatient Care
RDS – Respondent Driven Sampling
SAE – *Serviço de Atendimento Especializado* (Specialized Care Service)
SEDH – Human Rights Secretariat of the Office of the President of the Republic
SES – State Health Department
SICLOM – *Sistema de Controle Logístico de Medicamentos* (Medication Logistics Control System)
SIM – *Sistema de Informação de Mortalidade* (Mortality Information System)
SINAN – *Sistema de Informação de Agravos de Notificação* (Communicable Diseases Information System)
SISCEL – *Sistema de Controle de Exames Laboratoriais* (Laboratory Tests Control System)
SMS – Municipal Health Department
SPM – Women's Policy Secretariat
STD – Sexually Transmitted Diseases
UNAIDS – Joint United Nations Programme on HIV and AIDS
UNFPA – United Nations Population Fund
UNGASS – United Nations General Assembly Special Session on HIV/AIDS
UNICEF – United Nations Children's Fund
UNITAID – International Facility for the Purchase of Drugs against AIDS, Tuberculosis and Malaria
WHO – World Health Organization

Presentation

This progress report presents relevant indicators and information on the Brazilian response to AIDS during the period 2010/2011, based on the guidelines of the Joint United Nations Programme on HIV and AIDS - UNAIDS *("Global AIDS Response Progress Reporting 2012. Guidelines: construction of core indicators for monitoring the 2011 Political Declaration on HIV/Aids"*)[1].

Ten years after the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), progress on the global response to AIDS was discussed again in June 2011 in New York, at the United Nations General Assembly High Level Meeting on AIDS. The result of the meeting was a new Political Declaration of commitment by the Member States, including Brazil, and the definition of six new targets to be achieved by 2015:

1. Halve sexual transmission of HIV;

2. Reduce transmission of HIV among people who inject drugs by 50%;

3. Ensure that no children are born with HIV;

4. Increase access to antiretroviral therapy to get 15 million people on life saving Treatment;

5. Reduce tuberculosis (TB) deaths in people living with HIV by 50%;

6. Close the global resource gap for AIDS and work towards increasing funding to between US$ 22 and US$ 24 billion per year and recognized that investments in the AIDS response is a shared responsibility.

The Political Declaration also clearly draws attention to the urgent need to enhance access to health services by vulnerable populations, such as men who have sex with men (MSM), people who use drugs (IDU) and sex workers, as well as the need to eliminate gender-based iniquities and abuse.

Following on from the previous reports, this document portrays the current situation of the epidemic in Brazil and the response to it in terms of policies, programmes and strategies adopted by the government in partnership with other stakeholders. It is important to emphasize that the Brazilian response to the AIDS epidemic is embedded in the National

[1] UNAIDS. Global AIDS Response progress reporting: monitoring the 2011 political declaration on HIV/AIDS: guidelines on construction of core indicators: 2012 reporting. 2011. Document available at: http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/globalaidsprogressreport/

Health System (NHS), the principles of which are universality, equity and integrality, as well as regarding health as a fundamental human right.

The process of preparing this document was assisted by the contributions of the National STD, AIDS and Viral Hepatitis Commission and the Commission for Articulation with Social Movements, both of which are advisory bodies to the Ministry of Health's Department of STD, AIDS and Viral Hepatitis; the United Nations Agencies, under UNAIDS coordination; and state-level managers of the HIV/AIDS policy. The document also presents the discussions that took place in the UNGASS Forum, a civil society initiative supported by the government.

Chapter 1 provides a brief introduction to the context of the Brazilian response to HIV/AIDS, a description of how the progress report has been prepared, as well as providing summary tables of the indicators.

Chapter 2 presents the profile of the AIDS epidemic in Brazil, including updated HIV/AIDS epidemiological surveillance information, sentinel surveillance studies with parturient women and armed forces conscripts, as well as special studies with vulnerable populations: sex workers, men who have sex with men and people who use drugs.

Chapter 3 describes the Brazilian response from the political and programmatic perspective. Its main aim is to discuss the core elements of the Brazilian response to AIDS embedded in the National Health System. The chapter details the response in terms of prevention, diagnosis, care, support and treatment, human rights and international cooperation.

Chapter 4 presents the monitoring and evaluation system adopted and implanted by Brazil.

Chapter 5 presents the current challenges and perspectives of the response to the epidemic in Brazil.

The narrative part of the report ends with the bibliography and the list of websites consulted. The appendices to the report contain the progress indicators divided into three sections:

- Appendix I: Targets 1 to 5. Quantitative data relating to programme operation, the population's knowledge and behaviour and the impact of AIDS;

- Appendix II: Target 6. Domestic and international AIDS spending by categories and financing sources; and

- Appendix III: Target 7. National Commitments and Policy Instrument (NCPI) which, based on three forms, presents the perspectives of government officials, international agencies and Brazilian civil society.

- Appendix IV: UNGASS Forum letter (2011).

Chapter 1 Introduction

Brazil is a federative republic comprised of 26 states and a federal district, divided into 5,565 municipalities. The country has an area of 8,511,925 square kilometres. This is equivalent to 47% of the South American territory and represents the planet's fifth largest territorial area, as well as having the world's fifth largest population. Brazil's population, according the 2010 Demographic Census performed by the Brazilian Institute of Geography and Statistics (IBGE), had reached 190,755,799 inhabitants, with 84.4% of the population being defined as urban. In 2008 the total rate of illiteracy was 11.48%, whilst among the young (15-19 years old) it was 1.74%.

With regard to health, the National Health System (NHS), created in Brazil with effect from the promulgation of the new Federal Constitution in 1988, made access to health a right of the entire population and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other complaints, as well as being aimed at achieving universal and equal access to actions and services for health promotion, protection and recovery (Article 196 of the Federal Constitution). Its basic principles are universality, equity and integrality. The NHS is organized in a decentralized manner involving articulation between the three levels of the Federation: Union, States and Municipalities.

In relation to AIDS, 30 years into the epidemic it is stabilized and concentrated in certain vulnerable population sub-groups. According to the most recent Epidemiological Bulletin (base year 2010), there were 608,230 cumulative AIDS cases between 1980 and June 2011, of which 397,662 (65.4%) were male cases and 210,538 (34.6%) were female cases. These cases were reported on the Communicable Diseases Information System (*Sistema de Informação de Agravos de Notificação - SINAN*), the Mortality Information System (*Sistema de Informação de Mortalidade - SIM*) and the Laboratory Tests Control System / Medication Logistics Control System (*Sistema de Controle de Exames Laboratoriais - SISCEL*) / *Sistema de Controle Logístico de Medicamentos - SICLOM*).

The rate of HIV infection prevalence in the population aged 15 to 49 has been stable at 0.6% since 2004, being 0.4% in females and 0.8% in males. With regard to more vulnerable population groups aged over 18, studies conducted in 10 Brazilian municipalities between 2008 and 2009 estimated HIV prevalence rates of 5.9% in IDU, 10.5% in MSM and 4.9% in female sex workers.

The Brazilian response to the AIDS epidemic is based on the principle that all people have the right to health. This human rights-based principle is guaranteed by the NHS and counts on the permanent mobilization of civil society for its effective implantation, thus enabling the structuring of a programme to provide universal access to prevention, treatment and care, this being the most important characteristic of the Brazilian response to AIDS. An aspect of this response is that for it to be efficient, long-lasting and capable of maintaining and innovating itself, it must contemplate healthcare in all its dimensions within a well-structured public health system.

Given that 2010-2011 is the period covered by this report on the commitments taken on by Brazil with regard to HIV/AIDS, it has been compiled from data collected from a variety of different areas. The Ministry of Health's Department of STD, AIDS and Viral Hepatitis coordinated the preparation of this Progress Report, which received contributions from the National STD and AIDS Commission, the Commission for Articulation with Social Movements, United Nations Agencies (coordinated via UNAIDS) and state-level HIV/AIDS policy managers. In addition, the social movement has a specific forum for discussing the aforementioned decisions established at the 2011 United Nations General Assembly High Level Meeting on AIDS.

The process of preparing the indicators, the results of which are shown in Appendices 1-3, was undertaken by the Department of STD, AIDS and Viral Hepatitis. With regard to the indicators relating to the first five strategic targets of the 2011 Political Declaration (Appendix 1; Summary tables 1-5) several different information systems managed by the Department of STD, AIDS and Viral Hepatitis, the Health Surveillance Secretariat and the Ministry of Health were consulted, as were data from behaviour and epidemiological surveillance studies. The Block 6 indicators (Appendix 2; Summary table 6) on expenditure were compiled using the National AIDS Spending Analysis (*Medição do Gasto em Aids - MEGAS*) method, based on 2009 and 2010 spending.

With regard to the National Commitments and Policy Instrument (NCPI) (Appendix 3), part A was applied by the Department of STD, AIDS and Viral Hepatitis with contributions from the state-level STD, AIDS and Viral Hepatitis Programmes, which are responsible for coordinating the AIDS response in the Brazilian states. Part B of the NCPI has been divided into two, in the same way as the previous report: B1, coordinated by UNAIDS and answered jointly by the United Nations Agencies in Brazil; B2, coordinated by the Commission for Articulation with Social Movements.

Finally, the descriptive report was prepared with the participation of all the Programmes, the Monitoring and Evaluation Unit, the International Cooperation Support Unit, with overall coordination by the Directorate of the Ministry of Health's Department of STD, AIDS and Viral Hepatitis.

Summary Table 1. Target 1 Indicators: Halve sexual transmission of HIV by 2015.

Indicator No.	Sub-indicator	Total %	Male %	Female %
1.1	Percentage (%) of respondents aged 15-24 who gave the correct answer to all five questions.	**51.7**	**52.97**	**27.05**
	Percentage (%) of respondents aged 15-24 who answered question 1 correctly: "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	**75.61**	**79.34**	**71.82**
	Percentage (%) of respondents aged 15-24 who answered question 2 correctly: "Can a person reduce the risk of getting HIV by using a condom every time they have sex?"	**96.98**	**97.51**	**96.38**
	Percentage (%) of respondents aged 15-24 who answered question 3 correctly: "Can a healthy-looking person have HIV"?	**92.6**	**92.6**	**92.59**
	Percentage (%) of respondents aged 15-24 who answered question 4 correctly: "Can a person get HIV from mosquito bites?" (or country-specific question).	**96.1**	**95.82**	**96.3**
	Percentage (%) of respondents aged 15-24 who answered question 5 correctly: "Can a person get HIV by sharing food with someone who is infected?" (or country-specific question).	**75.01**	**72.43**	**77.54**
1.2	Percentage (%) of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	**35.46**	**40.85**	**29.45**
1.5	Percentage (%) of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	**14.18**	**10.72**	**17.62**
1.6	Percentage (%) of young women aged 15-24 who are living with HIV.	-	-	**0.26**
1.7	Percentage (%) of female sex workers who replied "yes" to both questions.	-	-	**46.81**
	Percentage (%) of female sex workers who replied "Yes" to question 1: "Do you know where you can go if you wish to receive an HIV test?"	-	-	**56.76**
	Percentage (%) of female sex workers who replied "Yes" to question 2: "In the last 12 months, have you received condoms?"	-	-	**77.09**
1.8	Percentage (%) of sex workers (women and men) reporting the use of a condom with their most recent client.	-	-	**90.09**
1.9	Percentage (%) of sex workers who received an HIV test in the past 12 months and know their results.	-	-	**17.52**
1.10	Percentage (%) of sex workers who are living with HIV.	-	-	**4.91**
1.11	Percentage (%) of MSM who replied "Yes" to both questions	-	**38.74**	-
	Percentage (%) of MSM who replied "Yes" to question 1: " Do you know where you can go if you wish to receive an HIV test?"	-	**40.47**	-
	Percentage (%) of MSM who replied "Yes" to question 2: "In the last 12 months, have you received condoms?"	-	**70.16**	-
1.12	Percentage (%) of men reporting the use of a condom the last time they had sex with a male partner.	-	**59.73**	-
1.13	Percentage (%) of MSM who received an HIV test in the past 12 months and know their results.	-	**19.11**	-
1.14	Percentage (%) of MSM who are living with HIV.	-	**10.51**	-

Indicator No.	Sub-indicator	Total %	Male %	Female %
1.15	Percentage (%) of general health services offering HIV counselling and testing services.	**0.8**	-	-
1.17	Percentage (%) of women accessing antenatal heath care services tested for syphilis at their first antenatal appointment.	-	-	**86.47**
	Percentage (%) of women accessing antenatal heath care services who received a positive syphilis test result.	-	-	**1.1**
	Percentage (%) of women accessing antenatal heath care services who received a positive syphilis test result and received treatment.	-	-	**80.55**
	Percentage (%) of sex workers with active syphilis.	-	-	**2.5**

Summary Table 2. Target 2 Indicators. Reduce transmission of HIV among people who inject drugs by 50% by 2015

Indicator No.	Sub-indicator	Total No.	Total %
2.2	Percentage (%) of people who inject drugs reporting the use of a condom the last time they had sexual intercourse.	-	40.67
2.3	Percentage (%) of people who inject drugs reporting the use of sterile injecting equipment the last time they injected.	-	54.31
2.4	Percentage (%) of people who inject drugs who received an HIV test in the past 12 months and know their results.	-	15.0
2.5	Percentage (%) of people who inject drugs who are living with HIV.	-	5.92
2.6	Estimated number of opiate users (injecting and non-injecting).	472,700	-

Summary Table 3. Target 3 Indicators. Ensure that no children are born with HIV by 2015 (and substantially reduce AIDS-related maternal deaths).

Indicator No.	Sub-indicator	Total No.	Total %
3.1	Percentage (%) of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	-	**50.23**
3.2	Percentage (%) of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth.	-	**35.24**
3.3	Percentage (%) of child HIV infections from HIV-positive women delivering in the last 12 months.	-	**6.8**
3.6	Percentage (%) of HIV-positive pregnant women assessed as to their eligibility for ARVT, either by their clinical stage or CD4 count.	-	**37**
3.7	Percentage (%) of infants born to HIV-positive women (children exposed to HIV) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first six weeks of life (i.e. early postpartum transmission at around 6 weeks of age).	-	**61.5**
3.11	Number of pregnant women who had at least one antenatal consultation during the reporting period.	**2,795,278**	**93.3**
3.12	Number of health services offering antenatal care.	**48,741**	-
	Number of health services offering antenatal care which also perform CD4 counts at the same place or have a system for the collection and transportation of blood samples for CD4 counts in HIV-positive pregnant women.	**250**	-
	Number of health services offering paediatric ARVT.	**451**	

	Percentage (%) of health services offering virological tests (e.g. PCR) to diagnose HIV in newborn babies at the same health service or using drops of dry blood.	-	**26.2**

Summary Table 4. Target 4 Indicators. Increase access to antiretroviral therapy to get 15 million people on life saving treatment by 2015.

Indicator No.	Sub-indicator	Total No.	Total %
4.1	Percentage (%) of eligible adults and children currently receiving antiretroviral therapy.	**215,676**	**72***
4.2a	Percentage (%) of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (out of those starting therapy in 2010).	-	**93.03**
4.2b	Percentage (%) of adults and children with HIV still alive and on treatment 24 months after initiation of antiretroviral therapy (out of those starting therapy in 2009).	-	**75.6**
4.2.c	Percentage (%) of adults and children with HIV still alive and on treatment 60 months after initiation of antiretroviral therapy (out of those starting therapy in 2006).	-	**74.3**
4.3	Number of health services offering antiretroviral therapy (ARVT) (i.e. prescribe and/or provide clinical monitoring).	**737**	-

* Of the estimated 540,000 PLWHA, 215,000 are on treatment and another 100,000 on follow up but yet not eligible to treatment. Of the remaining 225,000 not yet diagnosed, it is estimated that 33% of them have CD4 below 350 and should be on treatment. Thus, 72% of the 299,250 eligible are on treatment.

Summary Table 5. Target 5 Indicators. Reduce tuberculosis (TB) deaths in people living with HIV by 50% by 2015.

Indicator No.	Sub-indicator	Total No.	Total %

Note: in the report none of the target 5 indicators have been filled in.

Summary Table 5: Expenditure distribution by category, Brazil, 2009 and 2010.

Category	2009	%	2010	%
Prevention	265,170,632	20.2	264,700,268	19.9
Care and treatment	871,399,850	66.3	933,417,719	70.2
Programme management and administration strengthening	104,205,312	7.9	72,202,450	5.4
Incentives for human resources	2,065,958	0.2	3,801,414	0.3
Social protection and social services	31,778,810	2.4	37,097,417	2.8
Enabling environment and community development	35,253,348	2.7	16,559,990	1.2
Research	3,823,820	0.3	1,017,343	0.1
TOTAL	**1,313,697,730**	**100.0**	**1,328,796,601**	**100.0**

DDAHV/HSS/MoH, 2012.

Chapter 2 The Brazilian Epidemiological Scenario

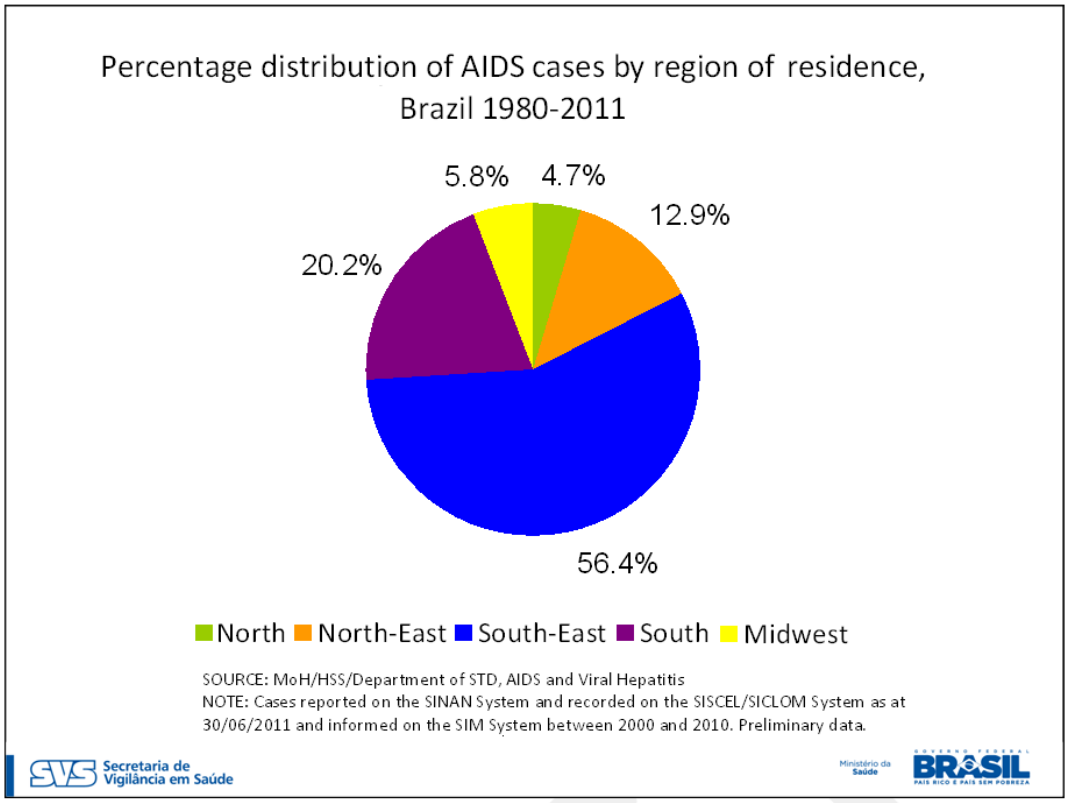
The AIDS epidemic is stable and concentrated in certain vulnerable population sub-groups. The national HIV infection prevalence rate in this age group has been stable at approximately 0.6% since 2004, being 0.4% in females and 0.8% in males. These estimates are obtained through the Parturient Women Sentinel Study, which also estimates syphilis prevalence (1.6%), as well as evaluating the quality of healthcare during the antenatal period and childbirth throughout the country's entire public health network. It is important to note that the population of parturient women has been monitored since the 1990s because its HIV prevalence rate is similar to that of the general female population. Brazil conducted a new parturient sentinel study in 2011, the data of which will be published in 2012. In the case of young women aged 15-24, the HIV prevalence rate estimated in 2006 was similar to the rate of approximately 0.26 found in 2004 (Szwarcwald CL, 2008).

Brazil also periodically conducts surveys with Armed Forces Conscripts, these being young men aged 17-20 enlisting for compulsory military service. This population is quite heterogeneous as far as its socio-economic characteristics are concerned and is representative of young men in this age group in Brazil. The principle objectives of the survey are to identify HIV and syphilis prevalence among these young men and their behaviour in terms of the risk of HIV and other STD transmission. In 2007 the HIV prevalence rate in this population was estimated at 0.12% whilst the syphilis prevalence rate was 0.5% (Szwarcwald CL, 2005, 2007).

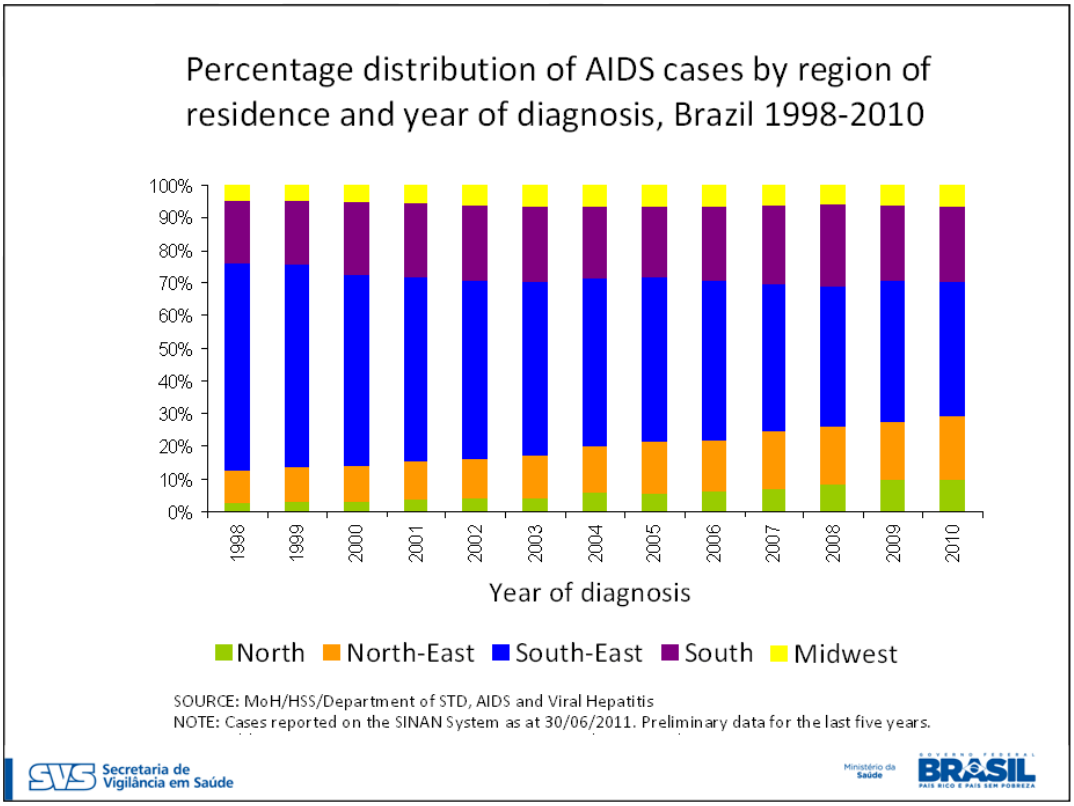
With regard to population subgroups most at risk, studies conducted in ten Brazilian municipalities (Manaus, Recife, Salvador, Belo Horizonte, Rio de Janeiro, Santos, Curitiba, Itajaí, Campo Grande and Brasília) between 2008 and 2009 estimated HIV prevalence rates of 5.9% among drug users (Bastos FI, 2009), 10.5% among men who have sex with men (Kerr L, 2009) and 5.1% among female sex workers (Szwarcwald CL, 2009).

Regarding AIDS in Brazil, between 1980 and June 2011, 608,230 AIDS cases were reported on the *SINAN*, *SIM*, *SISCEL* and *SICLOM* systems, with 56.4% in the South-East Region; 20.2% in the Southern Region; 12.9% in the North-East Region; 5.8% in the Midwest Region; and 4.7% in the Northern Region (Graph 1).

Graph 1.



Graph 2.

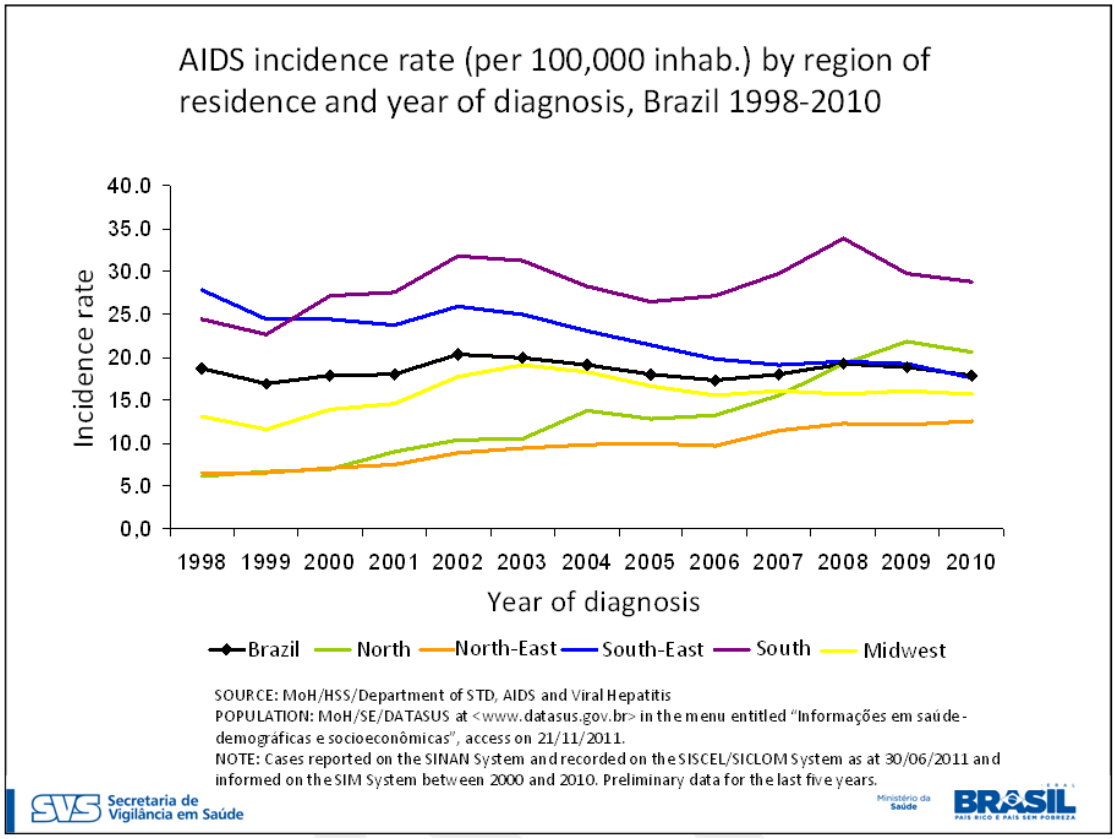


In 2010, 34,218 AIDS cases were reported on the *SINAN*, *SIM* and *SISCEL*/*SICLOM* systems. 14,142 (41.3%) of these occurred in the South-East Region; 7,888 (23.1%) in the Southern Region; 6,702 (19.6%) in the North-East Region; 3,274 (9.6%) in the Northern Region; and 2,211 (6.5%) in the Midwest Region. With regard to the percentage distribution of AIDS cases reported on the *SINAN*, *SIM* and *SISCEL*/*SICLOM* systems between 1998 and 2010, a reduction of 34.7% can be seen in the proportion of cases in the South-East Region (from 63.31% in 1998 to 41.33% in 2010), whereas the proportion of cases in the other regions increased in the same period (Graph 2).

In terms of absolute numbers in the country's regions, the highest number of cases is found in the Northern Region state of Pará (12,532); in the North-East it is found in the state of Bahia (19,290); in the South-East Region it is found in the state of São Paulo (207,077); in the Southern Region it is found in the state of Rio Grande do Sul (60,512) and in the Midwest Region the highest number of cases is found in the state of Goiás (12,588).

With regard to the incidence of AIDS cases reported on the *SINAN*, *SIM* and *SISCEL*/*SICLOM* systems, a rate of 17.9/100,000 can be seen in the year 2010, indicating stabilization over the last 12 years. The incidence rates in the country's regions in the year 2010 were: 28.8/100,000 inhabitants in the Southern Region; 20.6 in the Northern Region; 17.6 in the South-East Region; 15.7 in the Midwest Region; and 12.6 in the North-East Region (Graph 3).

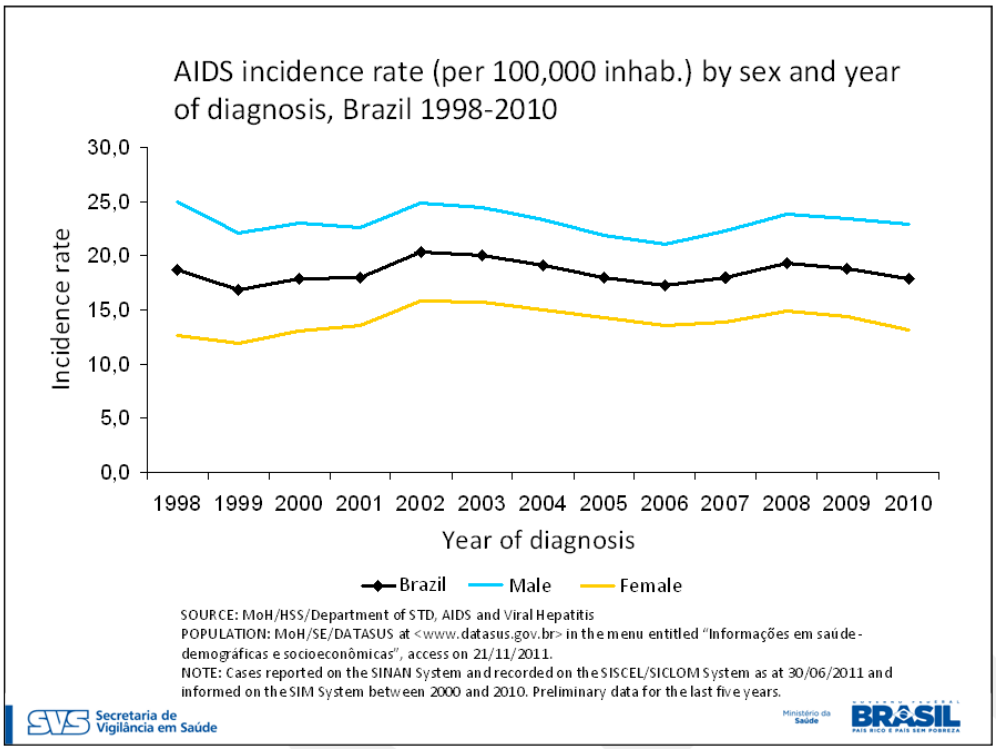
Graph 3.



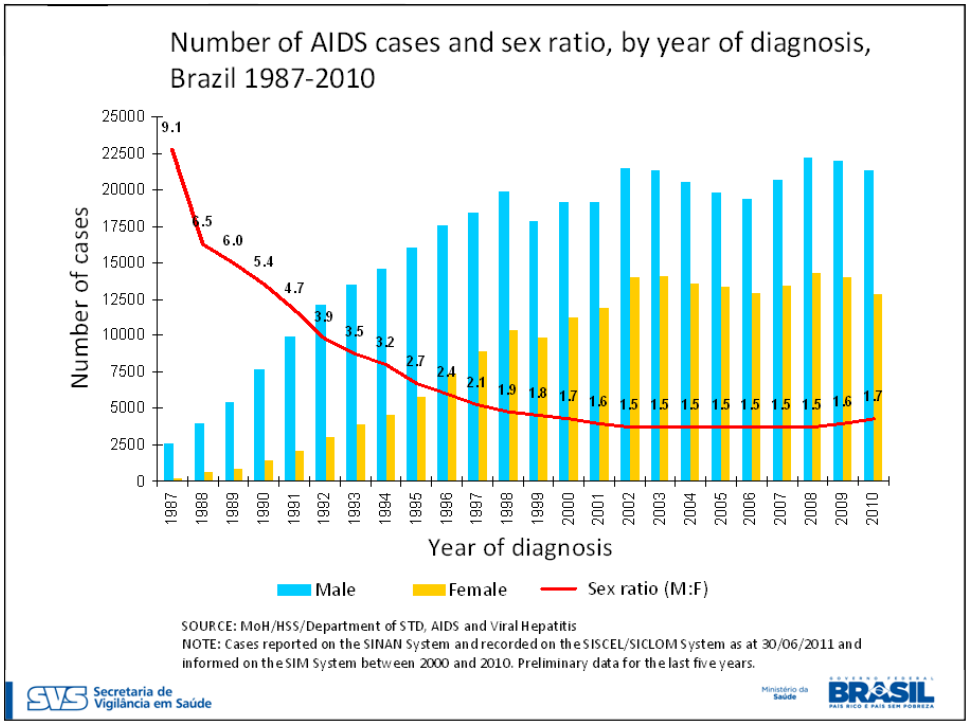
With regard to the country's five regions during the period 1998 to 2010, a decrease of 30.9% in the incidence rate can be seen in the South-East Region, which accounts for 56.4% of national cumulative cases, whilst there is an increase in the other regions. In 2010, eight of the country's 27 Federative Units had incidence rates above the national average (17.9/100,000 inhab.): Amazonas (30.9), Roraima (35.7) and Pará (19.5) in the Northern Region; Espírito Santo (20.4) and Rio de Janeiro (28.2) in the South-East Region, and all the states in the Southern Region. Analysis of the ranking of the Federative Units over time shows that since the year 2000 the state of Rio Grande do Sul has had the highest AIDS case incidence rate.

Between 1980 and June 2011, 397,662 (65.4%) male AIDS cases and 210,538 (34.6%) female AIDS cases were reported on the *SINAN*, *SIM* and *SISCEL*/*SICLOM* systems. In 1998 the incidence rate was 25.0/100,000 inhabitants in men and 12.6 in women, whereas in 2010 the rate in men was 22.9/100,000 inhabitants and 13.2 in women. The sex ratio, which was 40 men to 1 woman in 1983, was 1.7 men to 1 woman in 2010 (Graphs 4 and 5).

Graph 4.

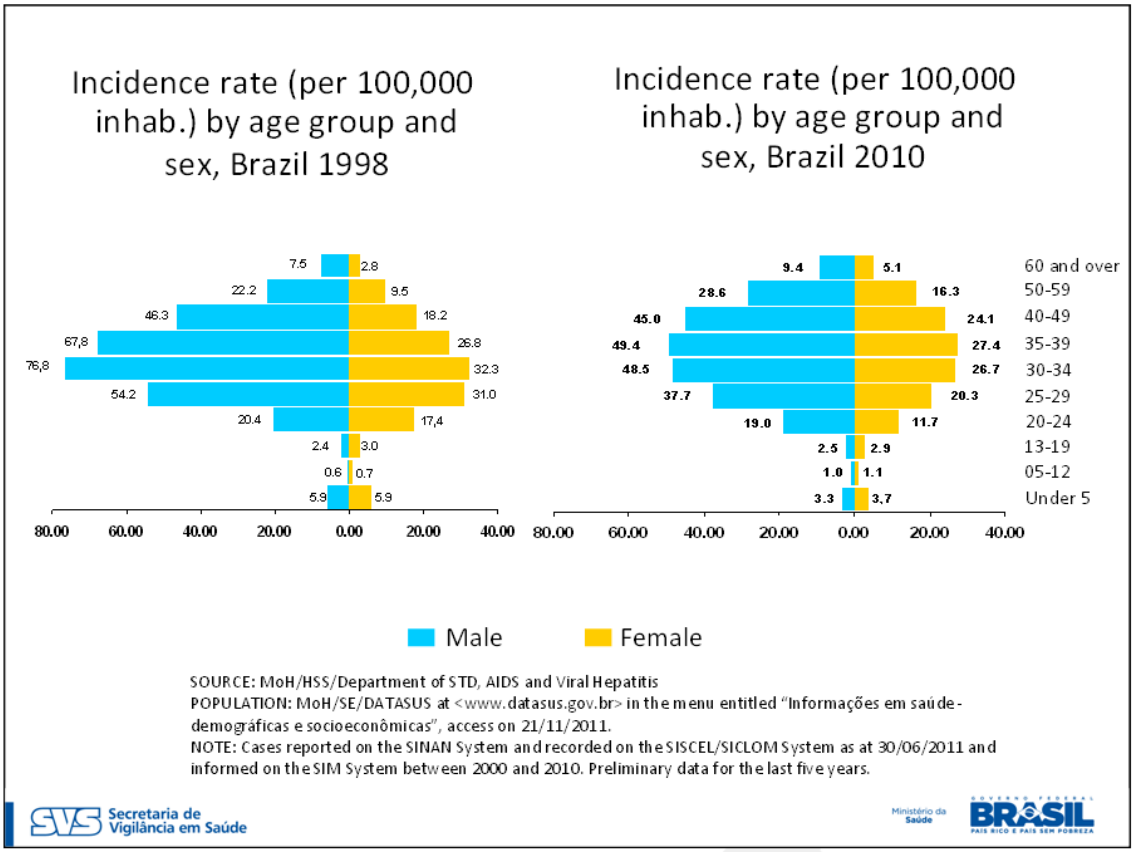


Graph 5.



In 2010, the 35-39 age group has the highest incidence rate in the country (38.1 cases/100,000 inhab.). Between 1998 and 2010 an increase in AIDS cases can be seen in the 05-12, 50-59 and 60 and over age groups (Graph 6).

Graph 6.



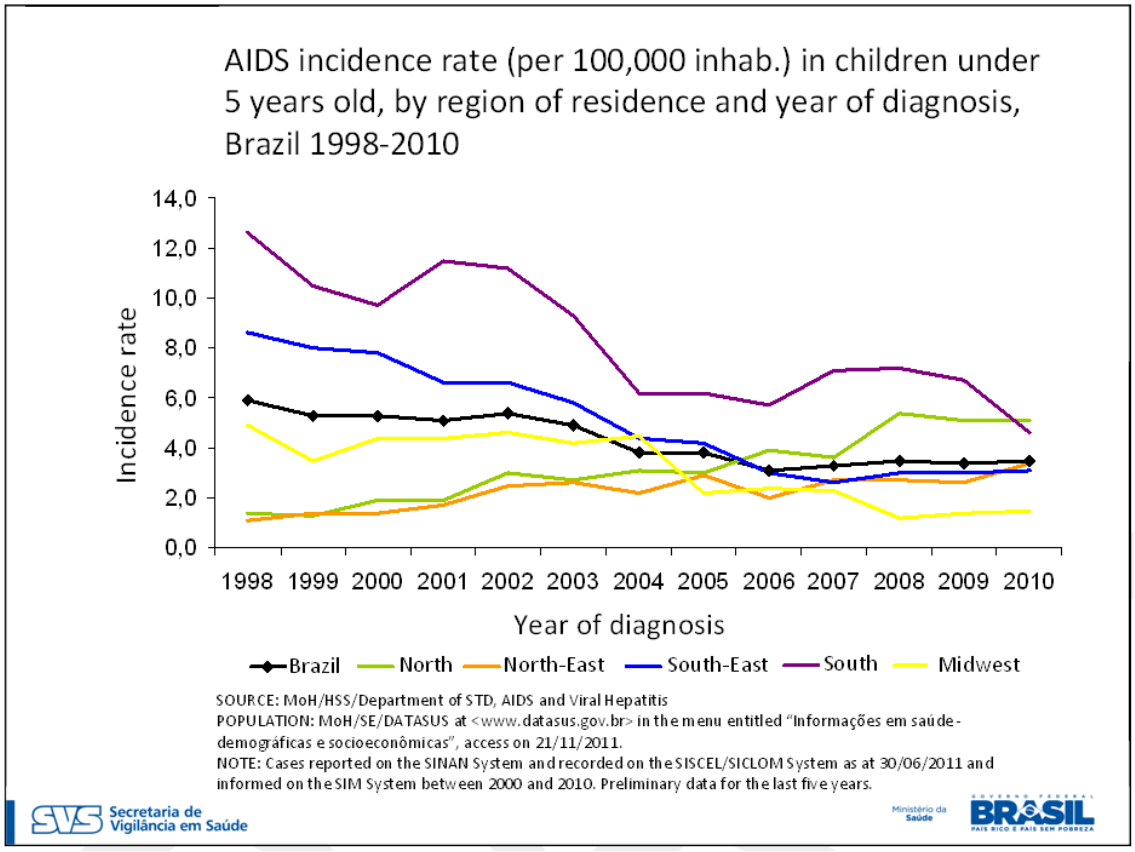
The AIDS incidence indicator in children aged under five is important because it is a proxy indicator which is used to monitor progress with the control of mother-to-child HIV transmission. Targets for the reduction of this form of transmission have been agreed with the state and municipal health authorities.[2]

[2] Mendes Pereira GF, Caruso da Cunha AR, Rocha Moreira MB et al. *Perspectivas para o controle da transmissão vertical do HIV no Brasil [Prospects for control of HIV vertical transmission in Brazil]*. Saúde Brasil 2010. An analysis of health situation and of selected evidence of the impact of the health surveillance actions.

14,127 AIDS cases were reported in children aged under five between 1980 and June 2011. In terms of the country's regions in the same period, 7,383 (52.3%) cases were diagnosed in the South-East Region, 3.499 (24.8%) in the Southern Region, 1,750 (12.4%) in the North-East Region, 771 (5.4%) in the Northern Region, and 723 (5.1%) in the Midwest Region.

482 cases were reported in 2010. This corresponds to an incidence rate of 3.5/100,000 inhabitants. In 1998 there were 947 cases and the incidence rate was 5.9/100,000 inhabitants. In the period between 1998 and 2010 there was a 49.1% reduction in the absolute number of cases and a 40.7% reduction in the incidence rate. Nevertheless, in the same period an increase in the incidence rate can be seen in this age group in the North and North-East regions, whereas there is a significant reduction in the South-East, South and Midwest regions (Graph 7).

Graph 7.

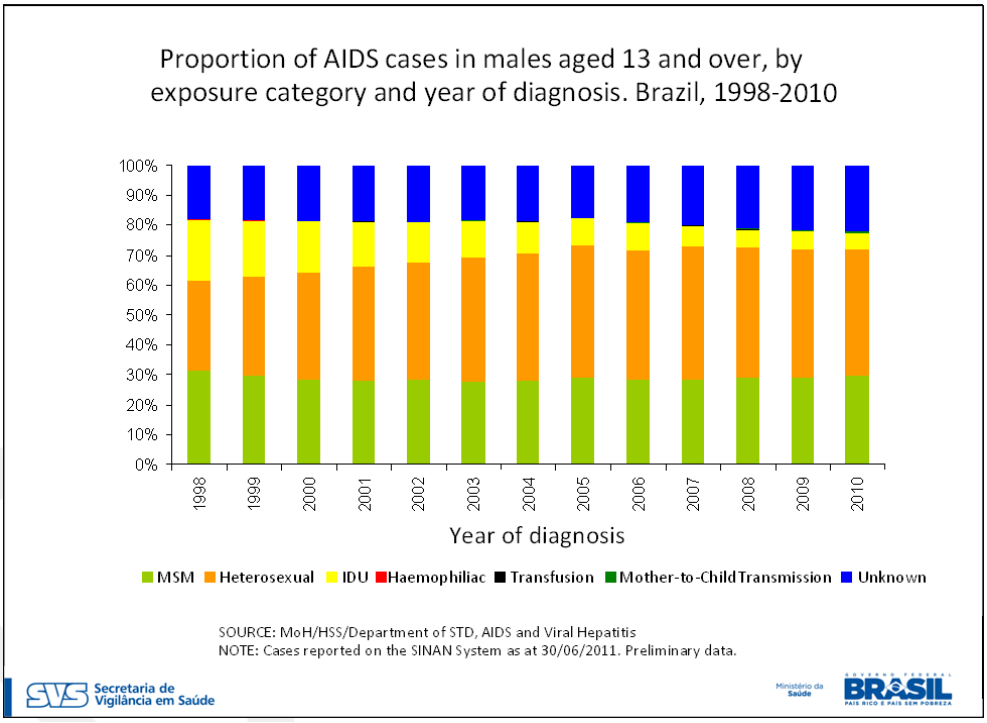


When considering the Federative Units between 1998 and 2010, there was an increase in the AIDS incidence rate in children aged under five in all the Northern Region states, with the exception of the state of Acre. The same occurred in all the North-East region states and also in the state of Espírito Santo in the South-East Region. In 2010, the states of Amazonas (8.,1/100,000 inhab.), Roraima (4.2), Pará (5.4), Rio Grande do Norte (4.7), Paraíba (5.2), Alagoas (5.1), Espírito Santo (10.2), Rio de Janeiro (5.8) and Rio Grande do Sul (7.8) had incidence rates above the national average (3.5).

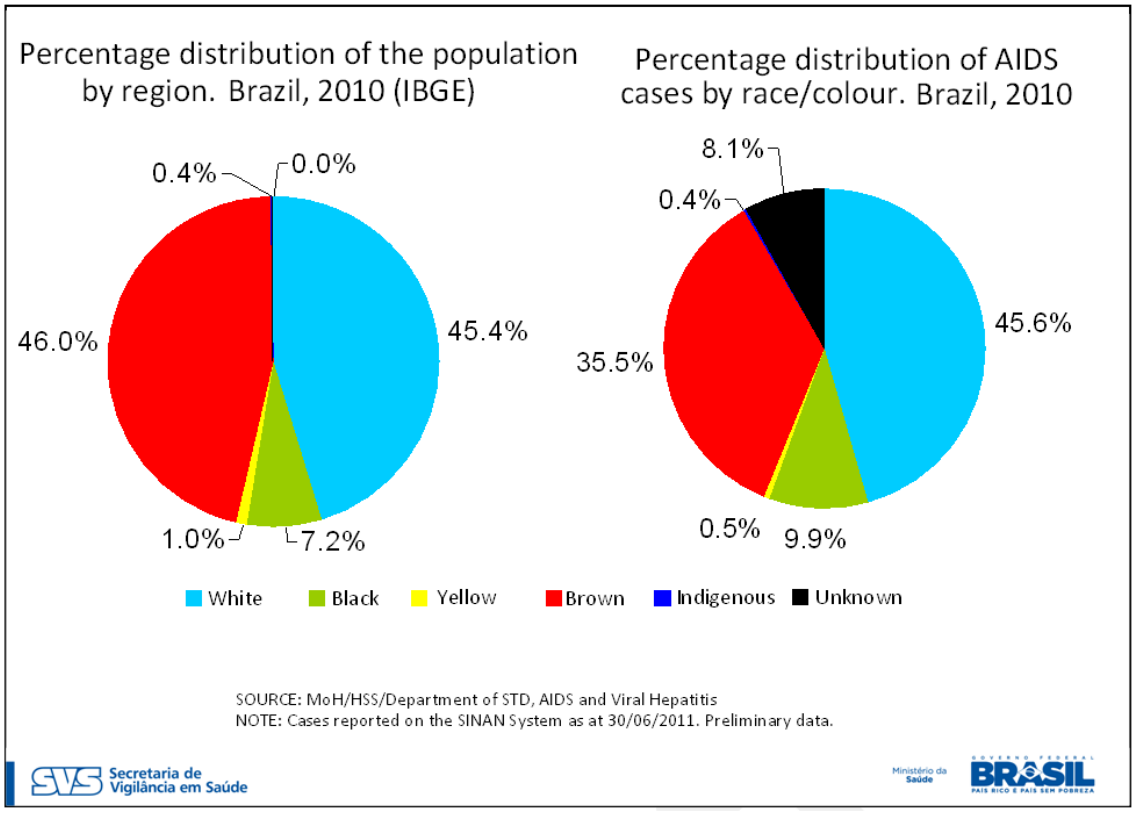
With regard to AIDS cases reported on the *SINAN* system in children aged under 13 by exposure category, out of the total of 15,775 reported cases between 1980 and June 2011, 13,540 (85,8%) fell into the category of exposure owing to mother-to-child transmission.

In the 13 and over age group, 15,026 male AIDS cases were reported on the *SINAN* system in 2010. Of these, 22.0% are homosexual, 7.7% bisexual, 42.4% heterosexual, 5.0% IDU, 0.6% mother-to-child transmission and 22.1% are unknown. With regard to the 8,210 female cases reported on the *SINAN* system in 2010, 83.1% are heterosexual, 2.2% IDU, 0.9% mother-to-child transmission, whilst the exposure category of 13.8% of these cases is unknown (Graph 8).

Graph 8.



Graph 9.



Analysis by race/colour in 2010 reveals that 49.6% of cases reported on the *SINAN* system are white, 10.8% are black, 0.5% are yellow, 38.6% are brown, 0.4% are indigenous and 8.1% are unknown. With regard to gender, in 2010, 51.2% of male cases were white, 9.8% were black, 0.5% was yellow, 38.2% were brown, 0.3% was indigenous and 8.2% were unknown. 46.7% of female cases were white, 12.7% were black, 0.7% was yellow, 39.4% were brown, 0.5% was indigenous and 7.8% were unknown with regard to race/colour (Graph 9).

In terms of education, in 2010, 14.2% of reported cases on the *SINAN* system had studied for up to four years or less at school (5.9% had completed four years); 27.4% had studied for between five and eight years at school (9,8% had completed eight years); 20.1% had studied at sixth form level (13.3% had completed sixth form); and 8.2% had studied at higher education level (5.3% had completed higher education); 2.4% were illiterate; no information was available for 26.5% of cases.

Still with regard to education, in 2010 it can be seen that among females the proportion of AIDS cases in the literate and those who studied at middle school, whether they finished middle school or not, is higher than among males. The proportion of AIDS cases

among males who completed sixth form education or who studied at higher education level, whether they completed it or not, is higher than among females.

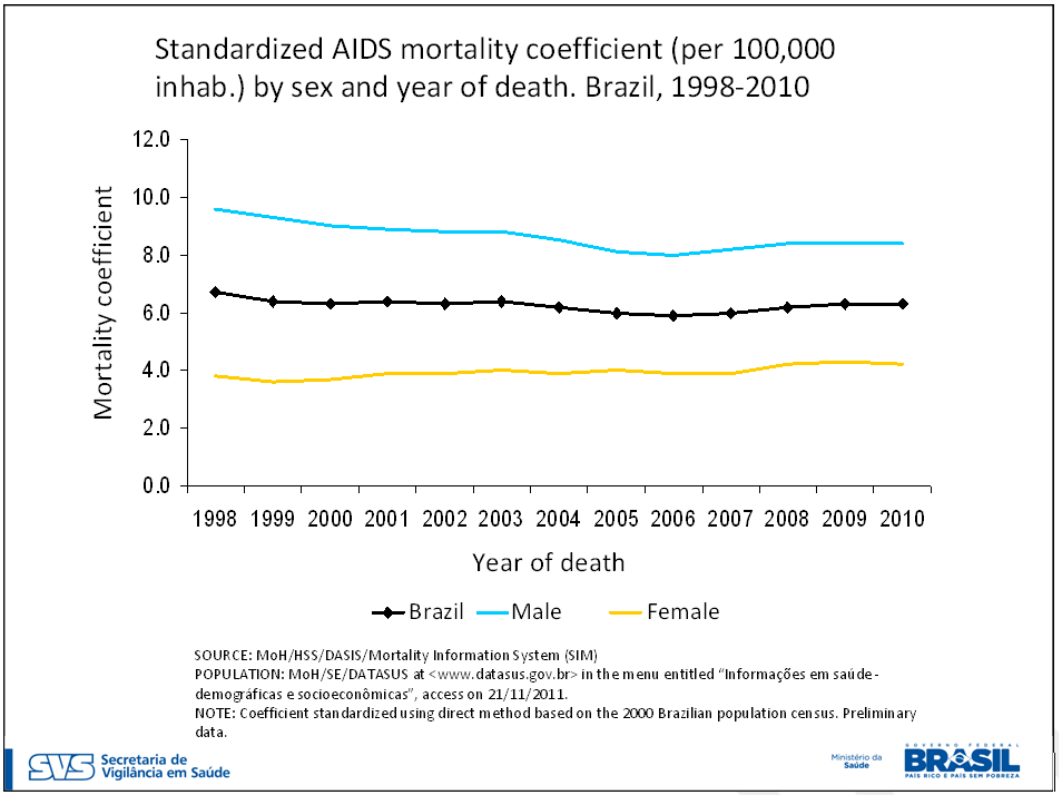
There were 241,469 deaths attributed primarily to AIDS in Brazil between 1980 and 2010. Of these, 155,088 (64.2%) occurred in the South-East Region, 40,414 (16.7%) in the Southern Region, 26,172 (10.8%) in the North-East Region, 11,639 (4.8%) in the Midwest Region, and 8,154 (3.4%) in the Northern Region. There were 11,965 deaths in Brazil in 2010, of which 5,687 (47.5%) occurred in the South-East Region, 2,574 (21.5%) in the Southern Region, 2,020 (16.9%) in the North-East Region, 923 (7.7%) in the Northern Region, and 761 (6.4%) in the Midwest Region.

The gross AIDS mortality coefficient in Brazil in 2010 was 6.3/100,000 inhabitants. Taking the Brazilian population in the year 2000 (IBGE) as a basis, the standardized mortality coefficient for 2010 was 5.6/100.000 inhabitants, corresponding to an 11.1% reduction in the last 10 years. In 2010 the mortality coefficient by gender was 8.4/100,000 inhab. in males, and 4.2/100,000 inhab. in females (Graph 10).

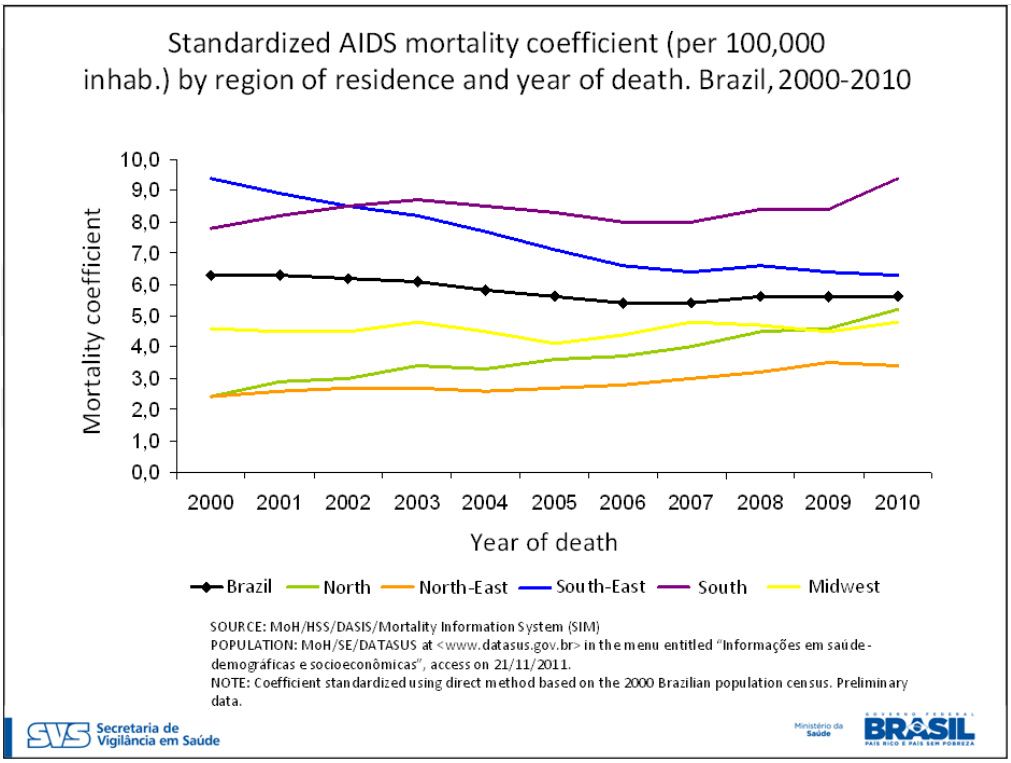
In terms of the country's regions, the mortality coefficient in 2010 was 9.4/100,000 inhabitants in the Southern Region, 7.1 in the South-East Region, 5.8 in the Northern Region, 5.4 in the Midwest Region, and 3.8 in the North-East Region. Analysis of the standardized mortality coefficient between 2000 and 2010 shows that there was an increase in AIDS mortality in the North, North-East and Southern regions, a decrease in the South-East Region and stabilization in the Midwest Region (Graph 11).

In 2010, seven of the 27 Federative Units had mortality coefficients above the national average, as follows: Amazonas (8.0/100,000 inhab.), Roraima (7.1), Rio de Janeiro (10.3), São Paulo (7.2), Santa Catarina (9.0), Rio Grande do Sul (13.6) and Mato Grosso (7.0). Between 2000 and 2010, 19 states had an increase in the standardized AIDS mortality coefficient. The biggest reduction in the AIDS mortality coefficient occurred in the state of São Paulo, from 11.3/100,000 inhabitants in 2000 to 6.4 in 2010.

Graph 10.



Graph 11.



Reducing mother-to-child transmission of HIV and syphilis is an important component of the Ministry of Health's Health Pact (2006) on the policy regarding the prevention of maternal and infant mortality. Access to antenatal care, early diagnosis of HIV and syphilis in pregnant women, as well as to the adequate treatment of both diseases, is essential for controlling mother-to-child HIV and syphilis transmission.

Mother-to-child HIV transmission was assessed in 2004 by means of a Ministry of Health multicentre study conducted by the Brazilian Paediatrics Society. The study found an estimated mother-to-child HIV transmission rate of 6.8% in Brazil (unpublished DDAHV data). It is relevant to note that in the state of São Paulo, where antenatal health care coverage is high (97%) and antiretroviral prophylaxis for mother-to-child transmission has attained 85.5%, a mother-to-child transmission rate of 2.7% was observed in 2004 (Matida, 2010).

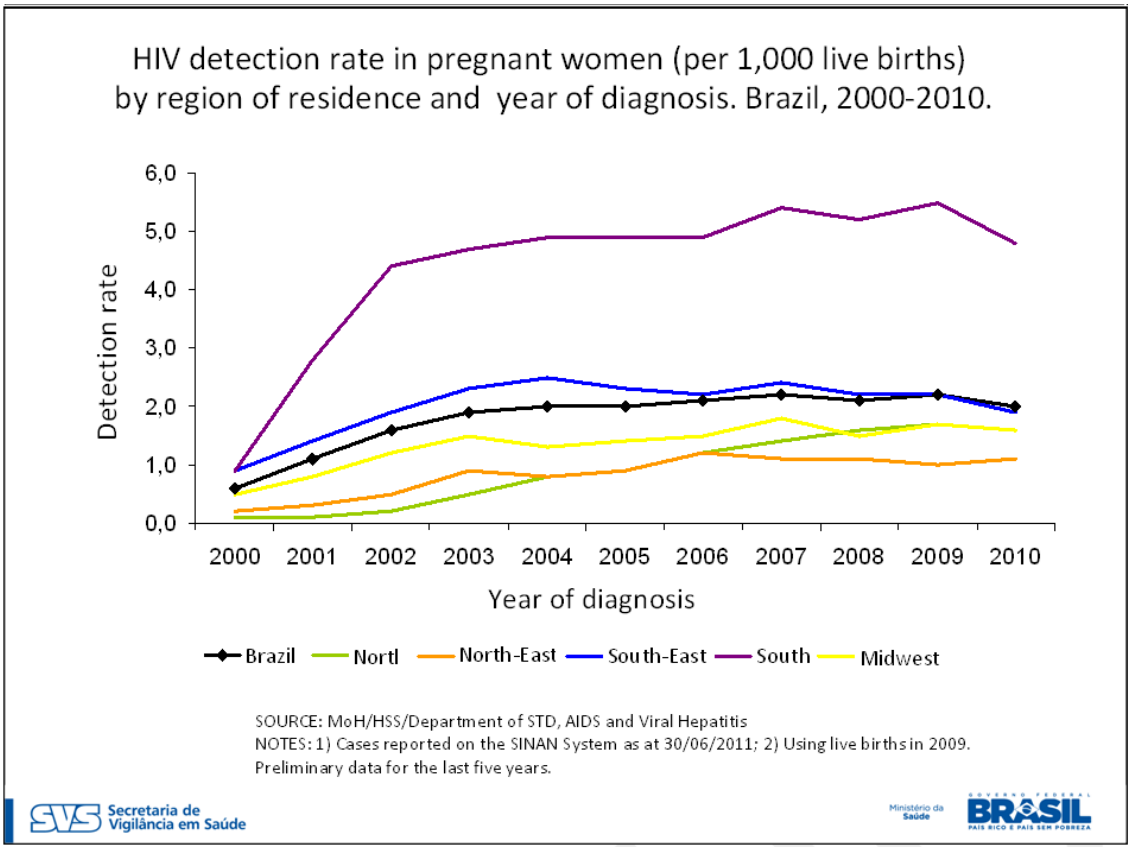
The 2006 Parturient Sentinel Study found HIV prevalence of 0.41%, corresponding to an estimated 12,456 HIV-positive pregnant women. Comparing estimated data with 2006 reported cases (6,137 HIV-positive), HIV surveillance in pregnant women has reached 49.3% of expected cases.

Between 2000 and June 2011, 61,789 cases of HIV infection in pregnant women were reported on the *SINAN* system. 26,772 (43.3%) of these cases occurred in the South-East Region, 19,625 (31.8%) in the Southern Region, 8,493 (13.7%) in the North-East Region, 3,485 (5.6%) in the Midwest Region, and 3,378 (5.5%) in the Northern Region. In 2010, there were 5,666 cases of HIV infection in pregnant women in Brazil, of which 2,136 (37.7%) occurred in the South-East Region, 1,774 (31.3%) in the Southern Region, 909 (16.0%) in the North-East Region, 499 (8.8%) in the Northern Region, and 346 (6.1%) in the Midwest Region.

In 2010 the detection rate of HIV cases among pregnant women was 2.0 cases per 1,000 live births. The only region with a detection rate above the national average was the Southern Region which had 4.8 cases/1,000 live births. The states with the highest levels of detection in 2010 were Rio Grande do Sul (7.3/1,000), Santa Catarina (5.6), Amazonas (2.4), Rio de Janeiro (2.4), Espírito Santo (2.3), Paraná (2.2) and Mato Grosso (2.2) (Graph 12).

As a rule the highest proportions of HIV-positive pregnant women are concentrated in the 20-29 age group (51.4%), in two levels of formal education – incomplete middle school education (26.9%) and complete secondary school education (12.8%) –, as well as being concentrated in the white (42.7%) and brown (37.3%) race/colour.

Graph 12.


HIV detection rate in pregnant women (per 1,000 live births)
by region of residence and year of diagnosis. Brazil, 2000-2010.
Detection rate
6,0
5,0
4,0
3,0
2,0
1,0
0,0
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
Year of diagnosis
Brazil
Nortl
North-East
South-East
South
Midwest
SOURCE: MoH/HSS/Department of STD, AIDS and Viral Hepatitis
NOTES: 1) Cases reported on the SINAN System as at 30/06/2011; 2) Using live births in 2009.
Preliminary data for the last five years.
Secretaria de Vigilância em Saúde
Ministério da Saúde
BRASIL

Chapter 3 The National Response to HIV/AIDS

The Brazilian response to the AIDS epidemic follows the principles of the National Health System, i.e., health is a right of all people and a duty of the State and is subject to the principles of universality, equity and integrality. It is organized in a decentralized manner, with actions articulated between the three levels of the Federation: Union, States and Municipalities. In addition, social participation is one of the key elements for the elaboration, implementation, monitoring and evaluation of public health policies. The Brazilian response to the AIDS epidemic is also characterized by the balance between prevention, care and treatment actions and the prioritization of the public interest in relation to economic and market interests as will be shown below.

3.1 Prevention and Diagnosis

Promoting prevention and diagnosis in Brazil takes place based on intense mobilization and articulation between the three levels of health management, as described below.

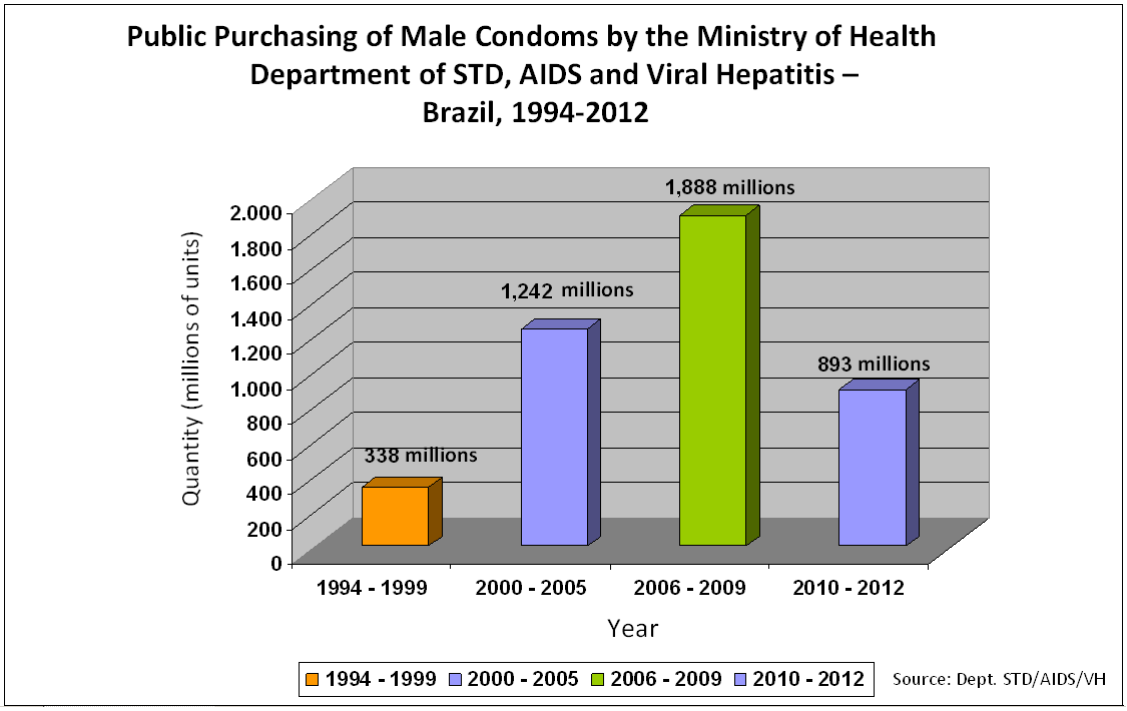
Access to diagnosis

During 2010-2011 Brazil enhanced its testing strategy with the aim of scaling up diagnosis coverage in the country. In addition to being offered by the health services, the strategy is also supported through an important partnership with civil society which has collaborated intensely in mobilizing vulnerable populations. Rapid testing is now being used on a large scale and thus provides access to effective and early diagnosis by more vulnerable segments of the population, such as men who have sex with men, injecting drug users, sex workers, river bank dwellers, indigenous populations, pregnant women, low-income populations, truck drivers, precious metal prospectors and people deprived of liberty. In addition there have been increased efforts to diagnose coinfections, such as tuberculosis, which have great impact on the morbidity and mortality of patients with AIDS.

Prevention

The actions undertaken include making available the necessary prevention commodities, with emphasis on the free of charge distribution of male and female condoms and lubricant gel by the health services and civil society partner organizations. In 2010 (and in previous years), the country took the decision to request PAHO and UNFPA intermediation

with the purchase of 20 million female condoms, in order to overcome the monopolistic contexts relating to the production and commercial representation of female condoms which prevented them from being purchased at fair prices. During the period 2010-2012, the Federal Government purchased 893 million male condoms, as per the following graph. Of these, 100 million were produced in Brazil at a government owned plant, with latex correctly extracted from the Amazon Region.



During 2010-2011 plans to fight the epidemic among specific populations continued to be implemented. These are: the National Plan to Fight the AIDS Epidemic and STDs among Gay Men, other MSM and Transvestites, and the Integrated Plan to Fight the Feminization of the STD and AIDS Epidemic.

With regard to adolescents and young adults, the partnership between the Ministry of Health and the Ministry of Education via the Health and Prevention in Schools project continues to be a reference for health and STD/AIDS actions in the school environment. During the period in question training courses were held for multidisciplinary teams in the States and Municipalities, in addition to involving the National Network of Young People Living with HIV and AIDS. Even though this initiative involves several partnering institutions at federal, state and municipal levels, there is always a risk of changes in some teams due to local political arrangements, constituting a challenge to the continuity of planned activities.

In relation to universal access to diagnosis, Brazil has adopted the following strategies:

- Decentralization of testing actions;
- Structuring of laboratory networks for the purposes of patient testing and monitoring;
- Political incentives for testing;
- Social mobilization to encourage the population to seek early diagnosis;
- Preparation of national norms and protocols;
- Articulation with organized civil society;
- Guaranteeing financial resources through agreements with the different service management levels for the purchase of tests for diagnosis;
- Increased funding for specific commitments, such as the reduction of mother-to-child transmission.

Indigenous populations

Following the increase in the number of AIDS cases among the country's indigenous population, as per data recorded on the *SINAN* system in the last decade, an Action Plan for HIV/AIDS and STD Interventions in Indigenous Communities has been prepared and implemented in collaboration with the Special Secretariat for Indian Health of the Ministry of Health (SESAI). These actions involve three strategic areas: enhancing the surveillance system, scaling up diagnosis and reducing mother-to-child transmission. It should be noted that most part of this population inhabits isolated, hard to access, areas of the Brazilian territory and there is a need of knowledge of their costumes, languages and beliefs, making it much harder to implement prevention strategies.

Armed Forces

By means of a partnership between the Ministry of Health, the Ministry of Defence and UNAIDS, STD/AIDS prevention and control actions are undertaken with the members of the country's Armed Forces, with emphasis on the young (recruits and students at Military Colleges and Training Centres) and Peace Mission personnel, including those on active service and the demobilized. The actions consist of training peer educators and holding informative and mobilizing lectures.

Since the Programme's activities began in 2004, 37 Peer Educator Training Courses have been held and 1,267 educators have been trained, distributed as follows: 307 from the

Navy, 679 from the Army and 281 from the Air Force. Every year the educators undertake prevention actions with 125,000 young military personnel (recruits and students) and 5,028 military personnel deployed in UN peacekeeping forces.

Prevention in the workplace

Following the approval in 2010 of ILO Recommendation 200 on HIV and the world of work, the Ministry of Health in partnership with the Ministry of Labour, ILO, trade unions and the National Business Council on HIV/AIDS Prevention have started publicizing and implementing the Recommendation in the country.

During 2010-2011, the Department of STD, AIDS and Viral Hepatitis and the São Paulo State and Municipal STD/AIDS Programmes, in partnership with trade unions, ILO, the Ministry of Labour and the CSA, gave courses for workers with the aim of training STD/HIV/AIDS prevention agents in the workplace, in accordance with ILO "Recommendation 200". The first Module of the "Train the Trainers Course on HIV/AIDS in the Workplace" took place on December 8-10 2010 and 50 workers were trained. The second Module was held in São Paulo on August 15-17 and 35 workers were trained.

Prevention among drug users

In 2011, the Brazilian President Dilma Rousseff launched the "Plan for the confrontation of the use of crack and other drugs". This programme, with an investment of U$ 2 billion, has among its objectives to provide adequate care to drug dependent individuals and their families, to tackle drug trafficking and to prevent the use of addictive substances. The Ministry of Health will qualify professionals and establish specialized wards in public hospitals in Brazil´s main cities, and also the creation of "street outpatient clinics".

3.2 STD and AIDS care and treatment

Access to treatment

The Brazilian Government has guaranteed universal and free of cost access to antiretroviral treatment since 1996. The antiretroviral drugs are purchased by the Ministry of Health and distributed exclusively via the public health system Medication Dispensing Units (MDU), also meeting the needs of private health service patients. Drugs for the treatment of opportunistic infections and other STDs are purchased by the state-level governments, in accordance with agreements between the three levels of government that form the NHS. The

Ministry of Health has various committees that advise the Department of STD, AIDS and Viral Hepatitis on procedural norms in relation to antiretroviral therapy for HIV-positive adults, children and adolescents and pregnant women.

In 2010 some 200,000 people received antiretroviral treatment on the NHS via 737 Specialized Care Service units located in municipal or state polyclinics, reference hospitals, primary healthcare centres, STD clinics, specialized STD/AIDS outpatient services, etc. The care network also includes 707 Medication Dispensing Units, 418 hospitals accredited to treat AIDS, 92 day hospitals and 91 home care units, totalling 1,556 services.

The range of antiretroviral drugs available in Brazil is comprised of 19 active ingredients and one fixed-dose combination which are available in 38 pharmaceutical formulations for adult and paediatric use (Table 3). Ten antiretroviral drugs are currently produced in Brazil by several public laboratories and one private laboratory.

Table 3. ANTIRETROVIRAL DRUGS (Brazil, 2012)

TYPE OF PRODUCTION	
NATIONAL	**IMPORTED**
Didanosine (ddI) 4g powder for oral solution	Abacavir (ABC) 300mg
Efavirenz (EFZ) 600mg	Abacavir (ABC) 20mg/ml oral solution
Stavudine (d4T) 30mg	Atazanavir (ATV) 200mg
Stavudine (d4T) 1mg/ml powder for oral solution	Atazanavir (ATV) 300mg
Indinavir (IDV) 400mg	Darunavir (DRV) 75mg
Lamivudine (3TC) 150mg	Darunavir (DRV) 150mg
Lamivudine (3TC) 10mg/ml oral solution	Darunavir (DRV) 300mg
Nevirapine (NVP) 200mg	Didanosine (ddI) EC 250mg
Saquinavir (SQV) 200ml	Didanosine (ddI) EC 400mg
Tenofovir (TDF) 300 mg	Efavirenz (EFZ) 200mg
Zidovudine (AZT) 100mg	Efavirenz (EFZ) 30mg/ml oral solution
Zidovudine (AZT) 10mg/ml injection solution	Enfuvirtide (T-20)
Zidovudine (AZT) 10mg/ml oral solution	Etravirine 100mg
Zidovudine (AZT) 300mg + Lamivudine (3TC) 150mg (fixed-dose combination)	Fosamprenavir (FPV) 700mg
	Fosamprenavir (FPV) 50mg/ml oral solution
	Lopinavir/Ritonavir (LPV/r) 100/25mg
	Lopinavir/Ritonavir (LPV/r) 200/50mg
	Lopinavir/Ritonavir (LPV/r) 80/20mg/ml oral solution
	Nevirapine (NVP) 50mg/5ml oral suspension
	Raltegravir 400mg
	Ritonavir (RTV) 100mg
	Ritonavir 80mg/ml oral solution
	Tipranavir 250 mg
	Tipranavir 100mg/ml oral solution

Source: DDAHV

Antiretroviral drug dispensing has been managed by the Medication Logistics Control System (*Sistema de Controle Logístico de Medicamentos - SICLOM*) since 1997. Apart from controlling the distribution, dispensing and stock levels, the system assists the analysis of the medical prescriptions in accordance with Ministry of Health technical recommendations. The National Network of Genotyping Laboratories (*Rede Nacional de Laboratórios de Genotipagem - RENAGENO*) was created in 2002 and helps doctors to choose the best treatment regimen. If a doctor prescribes third-line drugs, such as Indinavir or Stavudine, the Technical Committees in the states analyse the case and emit a report either favourable or contrary to the drug being indicated.

In 2009 the Department introduced tools for analysing the impact on public health, economic evaluation and evidence-based practices, with the aim of establishing more precise parameters to estimate the impact of changes in treatment strategies, as well as the incorporation of new interventions and medications into the range available, thereby strengthening the sustainability of universal access to treatment. In the same year Raltegravir (integrase inhibitor) was incorporated into the treatment recommendations, followed in 2010 by Etravirine (second generation non-nucleoside reverse transcriptase inhibitor) and Tipranavir (protease inhibitor) for exclusive use in children and adolescents in 2011. All these drugs are part of third-line treatment.

According to a survey done in December 2008 as to the Brazilian treatment recommendations, approximately 83.2% of patients on ARVT were using first-line drugs, including protease inhibitor alternatives, 13.5% were using second-line drugs and 3.3% were using third-line drugs. The regimen recommended as the first treatment option, comprised of Efavirenz, Lamivudine and Zidovudine (EFZ+3TC+AZT), was being used by 47.8% of these patients.

Coinfections

HIV/TB coinfection is estimated as being 8.8% and tuberculosis is currently the principal cause of death among patients with AIDS – the death rate is as much as 20%.

Joint actions undertaken by the DDAHV and the National Tuberculosis Control Programme are being scaled up. They include: the implementation of tuberculin testing in the Specialized Care Service units and Isoniazid chemoprophylaxis for patients with PPD ≥ 5 mm, radiologic scarring or a history of contact with TB bacillus carriers, after active infection has been discarded; scaling-up access to early diagnosis of HIV infection in people with

tuberculosis. Also, it is important to acknowledge the significant contribution of the Global Fund (Global Fund Programme TB/Brazil) where social mobilization actions contributed to raise awareness in relation to the risks of TB infection among PLWHA.

Viral hepatitis coinfections, principally hepatitis B and C, also have great magnitude and impact on AIDS mortality. Hepatitis C coinfection has high prevalence among patients with AIDS and can be as high as 54%. The National Viral Hepatitis Programme has been integrated into the Department of STD and AIDS since November 2009, with the aim of optimizing the prevention, diagnosis and treatment actions related to these diseases.

National Guidelines

All the complex issues of patient management are guided by clinical protocols prepared by expert committees and based on available scientific evidence. The treatment recommendations are widely publicized among medical professionals through seminars, workshops and, recently, also by distance learning courses, with the aim of broadening their reach. Recent studies indicate that the medical professionals are using the National Guidelines on Antiretroviral Treatment in their daily practice.

The recommendations are updated annually. The criteria for starting treatment have been revised recently, so that starting ARVT is now recommended for patients with lymphocyte counts of CD4 < 350 cells/mm³ and should be considered for those with CD4 lymphocyte counts between 350 and 500 cells/mm³. The committees also advise on decisions as to the incorporation of new antiretroviral drugs by the NHS. This indication is assessed by the National Commission on Technology Incorporation (CONITEC) which, if approved, recommends its incorporation to the Ministry of Health. In this way, Darunavir was incorporated in 2008, Raltegravir in 2009 and Tipranavir for children and Etravirine in 2010. The incorporation of third-line ARVs enables the adequate and effective rescue of multiresistent patients, resulting in their increased survival time and improved quality of life.

With regard to the guarantee of the reproductive rights of people living with HIV and AIDS, Brazil has established recommendations to minimize the risk of HIV transmission between seroconcordant or serodiscordant couples who want to have children with greater safety and in different situations.

Adherence

Treatment adherence is extremely important for the durability of the established treatment regimen. A very positive statistic that can be related to adherence is that data

available on 166,000 patients on treatment showed that 78% had viral load counts below 1,000 copies and 67% of these had undetectable viral load.

In 2008 a study was conducted with focal groups of patients using STD/AIDS outpatient services. The results relating to issues such as service organization, multidisciplinary teams, opening hours, are being used to improve the service provided to these patients with the aim of improving treatment adherence, among others. In 2009 a series of videos was produced for use in the waiting rooms of the specialized services, with the aim of providing information and guidance, as well as encouraging patients to share experiences. In 2010 and 2011 informative materials were also produced based on the results of the focal groups.

Lipodystrophy

Lipodystrophy can be the cause of interrupted or abandoned treatment, as a result of low self-esteem or even states of depression caused by the physical alterations it can produce. Treating lipodystrophy is, therefore, one of the biggest challenges to the quality of life of people living with HIV/AIDS (PLWHA).

A Ministerial Ordinance was published in 2009 establishing the criteria for the accreditation of hospitals and services providing surgery and outpatient treatment for this adverse effect, as well as defining that the following reparative procedures can be performed on the NHS: facial filling using polymethylmethacrylate (PMMA), liposuction of the lower jaw region, the back of the neck and shoulders or the abdominal wall, breast surgery or gynaecomastia and surgical treatment of buttock lipoatrophy by means of implanting prostheses.

Ten hospitals are currently accredited and qualified to perform reparative surgery and facial filling, as well as a further thirteen outpatient services authorized to perform facial filling to treat facial lipoatrophy. Between 2005 and 2010, 222 dermatologists and plastic surgeons from most of the Brazilian states were trained and more than 9,500 facial fillings using PMMA were performed during the period. In 2009 and 2010 some 120 reparative operations were performed in the accredited hospitals.

Prevention of mother-to-child HIV and syphilis transmission

The strategies for preventing the mother-to-child transmission of HIV and syphilis implemented by the Brazilian Government include the holding of informative campaigns, training courses, the scaling up of the specialized network and the provision of prevention

commodities, such as rapid HIV tests, tests for syphilis, antiretroviral medication (for parturient women and exposed children), lactation inhibitors (Cabergoline) and infant formula. All these commodities are provided by the NHS.

The strategies adopted have contributed substantially to the reduction of AIDS cases in children aged under 5 (the incidence rate, which was 5.9/100,000 inhabitants in 1998, dropped to 3.5/100,000 inhabitants in 2010). Even so there are still currently many challenges to be overcome.

In 2010 a project was implanted in partnership with UNICEF to enhance the mother-to-child transmission healthcare services in the Brazilian Amazon and in North-East Brazilian states, with the aim of scaling up the coverage of HIV and syphilis diagnosis in primary healthcare and antenatal services for infected pregnant women and children exposed to HIV.

The “Stork Network” initiative was established by the Ministry of Health in 2011, with the objective of guaranteeing to all Brazilian women, through the Public Health System (SUS), adequate and safe care, from the beginning of pregnancy through all the antenatal period and delivery, and in the first two years of the new-born. The “Stork Network” will receive U$ 4.5 billion from the Ministry of Health budget for investments through 2014. All PMTCT strategies are integrated into the “Stork Network”.

3.3 Human Rights

The Brazilian response to the AIDS epidemic is based on the principle that health is a right of all people and on total respect for human rights. This commitment is reflected in its institutional structure. Since the year 2000 the Department of STD, AIDS and Viral Hepatitis has specific sectors to foster articulation with civil society and promote the human rights of people living with HIV/AIDS and more vulnerable populations. States and municipalities also work on this issue.

The initiatives undertaken as part of the Brazilian response have always been based on guaranteeing the rights of vulnerable populations, in particular the right to confidentiality, non-discrimination and equal access to health services. The Ministry of Health considers that AIDS is a disease associated with inequality and not just with poverty – it is inequality that increases the vulnerability of poor populations – e.g. gender inequality, inequality in relation to sexual orientation and racial inequality. Specific actions have been developed aimed at

eliminating possible obstacles to universal access by vulnerable populations, such as gay men, lesbians, transvestites and transsexuals, sex workers and drug users.

Actions to combat stigma and discrimination include campaigns, supporting civil society organizations in providing legal aid, supporting social mobilization actions, such as events and meetings in which social movement articulation occurs.

3.4 International Cooperation

The Brazilian policy sees public health as a fundamental element for the social and economic development of countries. As such Brazil is committed to providing aid and knowledge sharing with other countries with the aim of promoting the health of all people, especially through actions that improve access to medication and prevention commodities in an equitable and sustainable manner, in addition to promoting human rights in addressing the HIV/AIDS epidemic.

In international negotiations Brazil has always defended the need to guarantee universal access to treatment and to prevention commodities and other human rights relating to the fight against the epidemic, the adoption of measures that enable greater flexibilization of the current intellectual property system, as well as the institutional strengthening of national health systems and South-South cooperation.

The Brazilian experience in responding to the HIV/AIDS epidemic has contributed to progress in addressing the AIDS epidemic in other developing countries, especially in Latin America, the Caribbean and Africa. This collaboration takes place through the sharing of Brazilian experiences by means of technical cooperation projects and other partnerships with countries and international organizations.

In order to achieve this aim, the Ministry of Health works together with the Ministry of External Relations, through the Brazilian Cooperation Agency and other Ministries, in addition to other Brazilian governmental and non-governmental institutions. It also works very closely with United Nations organizations – such as UNAIDS, PAHO/WHO, UNESCO, UNICEF, UNODC, ILO, UNFPA and UNIFEM – and bilateral cooperation agencies.

As such, Brazil's main initiatives regarding international cooperation in the fight against AIDS can be divided into two main areas: a) Technical Cooperation and b) Advisory Services, Negotiation and Representation in International Fora, as described below:

Technical Cooperation

The Department of STD, AIDS and Viral Hepatitis is responsible for coordinating and carrying out, in partnership with the institutions mentioned above, international technical cooperation activities undertaken between Brazil and Latin American and African countries with which it has bilateral or multilateral cooperation agreements.

The Department's International Cooperation Support Unit has taken on the functions of the International Centre for Technical Cooperation in HIV/AIDS (ICTC). The carrying out of its attributions is based on the respect for human rights, equality between States, cooperation between nations for the progress of humanity, as stipulated by the Brazilian Federal Constitution (article 4).

The cooperation undertaken by Brazil promotes interventions from a perspective of exchanging experiences, learning together and sharing results and responsibilities. The initiatives conducted by the Brazilian Government in this area are horizontal, based on the needs of the countries, seeking to maximize the benefits to both sides and strengthen the processes of integration.

Brazil currently has 14 formal HIV/AIDS technical cooperation projects with Barbados, Bolivia, Colombia, Congo, Guinea Bissau, Kenya, Peru, Surinam, Tanzania, Uruguay and Zambia. The negotiation and execution of these projects receive the political and financial support of the Brazilian Ministry of External Relations' Cooperation Agency. Brazil also undertakes a large number of cooperation and collaboration activities and initiatives, including:

- *Laços Sul-Sul* (South-South Ties): Created in 2004, the *Laços Sul-Sul* Network supports efforts aimed at universal access to prevention, care and treatment by means of technical cooperation and supplying first-line ARV drugs produced by public laboratories in Brazil, with logistical support by UNICEF. The Network involves Bolivia, Brazil, Cape Verde, Guinea Bissau, Nicaragua, Paraguay, São Tomé and Príncipe and East Timor, as well as UNAIDS, UNFPA, UNESCO and UNICEF. Under this initiative between 2003 and 2011 Brazil provided approximately 31,100 antiretroviral treatments and undertook 57 technical cooperation

activities through missions, training courses and technical visits relating to epidemiological surveillance, information systems, prevention, monitoring and evaluation, logistics, laboratories, human rights, care and treatment. In December 2008 this initiative won a United Nations award at the Exposition on Global/South-South Cooperation.

- Brazil-France Cooperation: Collaboration between the two countries is defined by the Brazil-France Technical and Scientific Cooperation Agreement, which has been in force since 1968. This is a bilateral cooperation agreement included under the Brazilian foreign policy on science and technology as defined by the Ministry of External Relations. This cooperation takes place through: technical training of Brazilian and French professionals (Internships in governmental and non-governmental organizations working with HIV/AIDS, STDs and viral hepatitis); seminars (exchange of experiences and dissemination of information); scientific cooperation (research programmes on HIV/Aids, STDs and viral hepatitis; cooperation on the frontier between Brazil and French Guiana, involving the implementation of the French Guiana/Brazil Transfrontier Action Plan to Fight STD, AIDS and Viral Hepatitis.

- MERCOSUL Frontiers: When considering regional actions in response to the AIDS epidemic, one of the principal concerns of the countries that form the MERCOSUL economic community (Argentina, Brazil, Paraguay and Uruguay) relates to the organization of prevention and care services in the frontier regions, in the light of the flow of people and goods in this area, as well as the fragile local structures. Since mid-1990s, actions to integrate the fight against STD/AIDS in this economic bloc have been promoted. The progress achieved in the dialogue within the MERCOSUL Intergovernmental Commission on HIV has enabled the creation of a joint project focussing on the frontiers of the four countries. The project's objective is to scale up the response to HIV, AIDS and STDs in the frontier regions by forming health and HIV committees in frontier towns. The project's thematic areas are prevention, epidemiological surveillance, monitoring and evaluation, training and management.

- HTCG – Horizontal Technical Cooperation Group: This group was created in 1995 and is comprised of representatives of Latin American and Caribbean AIDS Programmes and representatives of regional community networks. Its aim is to promote an integrated regional response to the HIV/AIDS epidemic. This initiative has lead to important advances in universal access to prevention, treatment, care and support through the holding of

regional consultations, training courses and technical and scientific events, thus promoting the scaling-up and diversification of the exchange between the region's countries.

- Technology Transfer: The Brazilian Government is financing the installation of an antiretroviral drug factory in Mozambique. This involves the transfer of all the technology necessary for production.

- COPRECOS: Since 1995 Brazil has been part of the Committee for the Prevention and Control of HIV/AIDS in the Armed Forces and National Police Forces of Latin American and the Caribbean (*Comitê de Prevenção e Controle de HIV/Aids das Forças Armadas e Polícia Nacional da América Latina e Caribe - COPRECOS LAC*). The Committee operates as a regional platform in response to the HIV epidemic in the area of defence and security. In order to achieve its objectives, *COPRECOS LAC* has adopted the following strategies: a) establish equal, bilateral and multilateral relations, developing technical cooperation projects that offer mutual benefits and have shared costs with the countries involved; b) promote the exchange of experiences and technologies aimed at joint solutions to the AIDS and other sexually transmitted diseases epidemics. *COPRECOS LAC* is comprised of the *COPRECOS* of the various Latin American and Caribbean countries. Brazil, through its Defence Ministry, was one of the founders and chaired the Committee between 2005 and 2007. *COPRECOS LAC* received support from the Ministry of Health's Department of STD, AIDS and Viral Hepatitis, among other organizations, in the preparation of its proposal for funding submitted to the Eighth and Ninth Rounds of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- Young People Living on the Streets and HIV/AIDS: In 2008 a partnership involving the Brazilian Ministry of Health, UNICEF, UNAIDS and the Dutch Embassy in Brazil began the project entitled "Addressing the Vulnerabilities of Young People Living on the Streets to HIV/Aids: South-South Cooperation as an axis of articulation". This cooperation initiative involves Bolivia, Brazil, Colombia and Peru. This initiative has taken into consideration the common reality shared by these countries relating to the context of violence and exclusion of young people living in the streets, so as to work on actions and policies aimed at this population's needs, especially in the area of STD/AIDS. This exchange has served to open perspectives and suggest changes within each country.

- Collaboration with the UN Integrated Plan

  Defined jointly with the DDAHV and complying with the "Three Ones", the UN Integrated Plan was established in late 2008 under the UNAIDS TG platform. Based on the national

priorities, the UNAIDS TG has agreed to pioneer an integrated work plan, to strengthen local responses to the epidemic and to face regional inequalities.

This Integrated Plan on HIV/AIDS focuses on two States of Brazil: Amazonas (North Region) and Bahia (Northeast Region), both presenting great challenges in respect to burden of disease and to treatment delivery for the affected populations.

- *The Integrated Plan in the State of Amazon- AMAZONAIDS initiative:* aimed at supporting, systematizing, harmonizing and expanding activities related to HIV in a particular area of Amazon, boundary with Peru and Colombia (Alto Solimões Region). The enormous geographical distances, the population dispersion, the growing influence of foreign evangelical fundamentalist groups, plus the believes and practices of indigenous population may be additional hurdles for the implementation of scientific practices of STI/HIV prevention.

The involvement of local authorities, public servants and grass root communities in identifying the needs and expectations have been indispensable to attain the objectives of the *Amazonaids* Initiative.

Political mobilization at federal, state and municipal levels with the participation of community leaders and of the incipient civil society groups are positive aspects of the initiative. Education materials to raise awareness of HIV modes of transmission and scientific ways of prevention were elaborated in Portuguese and indigenous languages to be used in the health services and public schools.

Training of health professionals in several areas were carried out including STI syndromic approach, HIV and Syphilis rapid test procedures and AIDS diagnoses and treatment. Appropriate approach to drug users management and capacity building on governance to strengthen skills, competencies and abilities of public servants are among key activities developed.

Training of inmates as peer educators also had a positive impact - They were selected and moved away from their cell's environment to learn and replicate their learning to the rest of the prison population, helping health professionals who deliver services to other inmates. At the end of training, they received their Health Agent Diplomas, an important tool to increase self-steam.

For the next biennium four main areas were defined and approved a) prevention in schools; b) promotion of health in prisons; c) support integration of all people living with AIDS in Alto Solimões to establish a local network; d) and strengthening women's support system against violence).

In the research area, a study coordinated by the DDAHV and UNAIDS is planned, in partnership with Fiocruz Foundation and CDC/Brazil to evaluate the use of CD4 rapid test technology in the Amazon.

- *The Integrated Plan in Support to the AIDS Response in the State of Bahia – Laços SociAids Initiative (LSI)* – UNAIDS-led in association with the DDAHV and local stakeholders, was implemented in 2008 to strengthen local capacities to improve the response to the AIDS epidemic in the State, as well as to harmonize the actions undertaken by the UN Agencies and other partners, optimizing the use of technical and financial resources and supporting local government priorities.

  Following strategic directions from the State of Bahia, LSI focuses three priority areas: a) PMTCT; b) promotion of health and prevention in schools; c) and addressing the feminization of the epidemic.

  Situation analysis was carried out in all of the 28 municipalities encompassed by the initiative (two Micro-Regions of the State, with a population of around 1,000,000 inhabitants).

  For the 2012-2013 biennium, there is a plan to include three new geographical areas in Bahia State, covering an additional 1,000,000 people.

- "Learn to react in the Portuguese language"

  The "Learn to React" is a partnership UNAIDS, DDAHV in the cooperation CPLP (community of Portuguese-speaking people) Brazil-Africa Project. Undertaken by the National Movement of "Posithive" Women Citizens (MNCP), includes the partnership with UNESCO, UNICEF, UN-Women and UNFPA. Its objectives include the strengthening of activism and citizen participation in human rights, violence against women, gender and watch dogging of local public policies in Portuguese-speaking countries participating in the initiative (Angola, Brazil, Cape Verde, Guinea-Bissau, Mozambique, and São Tomé and Príncipe.).

  Five workshops have occurred in Brazil, Angola and Mozambique, aimed at strengthening local capacities of community positive women leaders and focal points in the fight against the epidemic, as well as to strengthen their social and political linkages in these countries, establishing operational parameters for horizontal cooperation. As part of the activities, local political authorities participated in the discussion of these issues and gaps on local public policies for women living with HIV/AIDS.

Advisory Services, Negotiation and Representation

Brazil maintained an outstanding position during the negotiations of the WHO Intergovernmental Working Group as to the formulation of the Global Strategy on Public Health, Innovation and Intellectual Property, which culminated in the approval of the wording of the strategy by the World Health Assembly in May 2008. Supported by the delegations of various developing countries, Brazil proposed that a chapter of principles be included in the strategy, reaffirming the Doha Declaration and the primacy of health over intellectual property rights. Brazil has been supporting the implementation of the Global Strategy through technical

meetings and the exchange of experiences between countries, as well as through the consolidation of a regional platform for Latin American and the Caribbean in partnership with PAHO.

Also noteworthy is the Brazilian participation in the UNAIDS Programme Coordinating Board, not only through the sharing of the results Brazil has achieved over the years with the implantation of a consistent policy in response to the HIV epidemic, but also because it is the only South American country with a seat on the Board. The Brazilian position, always based on human rights, reinforces the global efforts to advance with the international policies on universal access, and the Brazilian depositions are always awaited with great expectations because they are backed by concrete examples of the Brazilian experience.

Chapter 4 Monitoring and Evaluation

The institutionalization of monitoring and evaluation at the three levels of government continues to be one of the priorities of the Brazilian response to the AIDS epidemic. Monitoring and Evaluation (M&E) is used as a management tool to inform decision making and make social watch practicable, with focus on programme improvement.

The national STD/AIDS monitoring system, which is managed by the Ministry of Health's Department of STD, AIDS and Viral Hepatitis, is seen as a system in permanent development. An example of this is the continuous restructuring of the information technology systems such as the "Monitoraids" system. In addition to responding to the need to monitor the effects of the HIV/AIDS, STD and viral hepatitis prevention and control strategies, the system seeks to accompany the operational implementation of the pertinent actions. The system is organized in layers of information (sub-systems), taking into consideration accessibility and complexity, and is based on three models.

The first model is the Programme's Logical Model and was built based on the Department's organizational structure, in accordance with its strategic and operational priorities, as well as combing two implementation analysis techniques: forward mapping and backmapping. Forward mapping follows the planning logic, i.e. first of all the problem is defined and, based on the problem, the related inputs, activities, products, outcomes and impacts are then defined.

Backmapping starts with the effect (impact, outcome and/or product) in order to analyse the organizational conditions and the external context, based on three basic questions: a) what organizational competencies (knowledge, skills, technologies) are needed to modify the effect observed?; b) what resources are needed to achieve the effect; and c) what is the action plan for this? This combined process has more likelihood of contemplating the interactions between the central and decentralized levels of management, in addition to increasing the possibilities of including the interests and needs of the target audience.

The second model is the Performance Evaluation Model and is part of the systemic evaluation perspective. Under this perspective, policies and interventions are seen as organized social systems and sets of actions which have four basic functions or domains: a) achieving objectives; b) adaptation (governance); c) production and coordination; and d) maintaining and creating values. The success of these systems is determined by the balance between these four functions (Contandriopoulos et al., 2008). The analysis and operationalization of this model are being developed.

The final model that comprises the Department's Monitoring and Evaluation Plan is the Utilization/Influence Model. This model seeks to use monitoring information and evaluation findings proposed by the Department. In addition it places emphasis on the accompaniment and encouragement of utilization/influence in line with the NHS principles which are seen as an indispensable tool for innovation and results-based participative management. Therefore, as a result of using this model the aim is to strengthen learning and results-based participative management, as well as reinforcing an efficient and effective innovation agenda.

The Utilization Model is comprised of three operational domains: documentation; analysis and evaluation; and dissemination. Documentation includes the routine monitoring that covers the accompaniment of the logistics of the Department's operations, with emphasis on strategic inputs and integrated management (forward and backmapping). In addition it includes the creation of a cost centre which involves the accompaniment of actions financed through public funds and also actions financed through other types of partnership. During the documentation process findings from quick studies and situation assessments are also summarized. Tendencies are also monitored, including studies of the effects of different strategies over time.

The analysis and evaluation domain comprises: the periodical analysis of routine monitoring information and intermediate results; the continuous analysis of evaluation studies; systematic reviews and meta-analyses; trend evaluation (intermediate results of the strategic government agenda, triangulation); and impact evaluations.

Finally, the third domain is referred to as dissemination and comprises the creation of a learning agenda on decentralized utilization and innovation involving traditional diffusion strategies, such as workshops and seminars. It also involves the preparation of bulletins and less traditional strategies, such as awards for good practices and innovation fairs, for example.

The Department's Monitoring and Evaluation System is being implanted gradually. At the beginning emphasis was placed on the documentation and development of data analysis methods. At the moment priority is being given to its utilization to reorient decision making, in addition to disseminating the M&A findings.

Finally, it is extremely important that the monitoring and evaluation findings be increasingly used and incorporated into the development of the prevention and control policies.

Chapter 5 Challenges and Perspectives

As described in the preceding chapters, the Brazilian epidemic has demanded a strong commitment by the government and its partners to guaranteeing the right to health in order to, through intra and intersectoral articulation, respond to its complexity. Challenges remain in several different areas in relation to commitments taken on.

- **Halve sexual transmission of HIV**

As one of its STD/AIDS prevention strategies, Brazil provides free of charge female and male condoms. However, the Brazilian Government's demand for purchasing condoms has been hindered by the lack of supply on the international market. In the case of male condoms, the procurement process to purchase 1.2 billion units (in 2009) resulted in the purchase of only 788 million units.

Furthermore, considering that the epidemic is a concentrated one, the country has worked to facilitate access to diagnosis by the priority populations where they are located and at unconventional times. As such, the national targets are:

- increasing rapid HIV test purchasing and distribution from 3 million to 6 million;
- increasing the number of rapid test multipliers in the states;
- increasing testing for vulnerable populations;
- increasing testing for the general population;
- increasing testing in states that have Testing and Counselling Reference Centres established to serve MSM and transvestite populations in the state capitals in the south and south-east regions;
- Increasing HIV testing in primary healthcare facilities.

- **Reduce transmission of HIV among people who inject drugs by 50%**

Guaranteeing universal access to people who inject drugs has been a constant challenge in concentrated epidemics. Whilst there has been a reduction in injecting drug use, the importance of interventions with people who use alcohol and other drugs has been identified. As such, in 2011 there were 24 projects aimed at people who use alcohol and other drugs and the process of agreeing a minimum agenda has been started with the country's states for intervention with this population.

- **Reduce tuberculosis (TB) deaths in people living with HIV by 50%**

The actions to combat tuberculosis within the context of HIV/AIDS are undertaken by the Department of STD, AIDS and Viral Hepatitis and by the National Tuberculosis Control Programme.

One of the main challenges with regard to HIV/TB coinfection is the need to organize coinfection care services, including articulating the network of specialized outpatient care with primary healthcare services and reference hospitals, so as to achieve intervention agility and timeliness taking into consideration the referral and counter-referral flows in the early diagnosis of the two diseases, as well as adequate clinical management and timely treatment.

In addition, the country is preparing to scale up the availability of anti-TB in the HIV/AIDS network (Specialized Care Services), so that these services can become reference centres for coinfection treatment.

Rapid HIV testing is currently being implemented in the primary healthcare network and this will contribute towards a significant increase in the coverage of HIV diagnosis in people with tuberculosis over the coming years.

- **Ensure that no children are born with HIV (and substantially reduce AIDS-related maternal deaths)**

Even with the reduction in the AIDS incidence rate among children aged under five in the last decade, the country has been strengthening its activities to reduce mother-to-child HIV transmission and its target is to eliminate it by 2015.

In 2011 the Ministry of Health launched the “Stork Network” initiative. This is a care network that ensures that women have the right to reproductive planning, humanized care during pregnancy, childbirth and the postnatal period and that children have the right to a safe birth and healthy growth and development.

- **Increase access to antiretroviral therapy to get 15 million people on life saving treatment**

Universal and free of charge treatment has been available on the Brazilian National Health System since 1996, funded exclusively with national resources. ARV drug purchases account for approximately 70% of the total budget for STD/AIDS and Viral Hepatitis actions. As such the use of price negotiation mechanisms and TRIPS flexibilities have been important strategies for ensuring the sustainability of access to treatment by all who need it.

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Appendix 1 Progress Report Indicators on the Brazilian Response to HIV/AIDS (2010-2011): targets 1 to 5.

The indicators of this Report on the Brazilian Response to HIV/AIDS (2010-2011) are divided into six blocks, in accordance with the overall targets of the 2011 Political Declaration on HIV/AIDS to be achieved by 2015:

1. Halve sexual transmission of HIV;

2. Reduce transmission of HIV among people who use drugs by 50%;

3. Ensure that no children are born with HIV;

4. Increase access to antiretroviral therapy to get 15 million people on life saving treatment;

5. Reduce tuberculosis deaths in people living with HIV by 50%;

6. Close the global resource gap for AIDS and work towards increasing funding to between US$22 and US$24 billion per year and recognize that investments in the AIDS response are a shared responsibility (the results of the indicators related to target 6 are presented in Appendix 2).

The process of preparing the report indicators was undertaken by the Department of STD, AIDS and Viral Hepatitis (DSAVH) between January and March 2012. A working group was responsible for gathering the data from the DSAVH coordinating areas (Surveillance, Information and Research; Care and Quality of Life; Sustainability, Management and Cooperation; Human Rights, Risk and Vulnerability) as well as from its Monitoring and Evaluation Unit and its International Cooperation Support Unit.

Various different information systems managed by the Ministry of Health were consulted in order to prepare the indicators relating to the first five strategic targets of the 2011 Political Declaration on the global response to HIV/AIDS (block 1-5 indicators). These systems are: the Medication Logistics Control System (*Sistema de Controle Logístico de Medicamentos – SICLOM*); the Laboratory Tests Control System (*Sistema de Controle de Exames laboratoriais – SISCEL*); the National Communicable Diseases Information System (*Sistema de Informação Nacional de Agravos de Notificação – SINAN*); the Live Births Information System (*Sistema de Informação de Nascidos Vivos – SINASC*); and the National Register of Health Establishments (*Cadastro Nacional de Estabelecimentos de Saúde – CNES*). Data was also considered from behavioural studies (2008 Study on Knowledge, Attitudes and

Practices), epidemiologic surveillance studies (2006 Parturient Women Sentinel Studies), and special studies with most-at-risk populations (2009 Respondent Driven Sampling studies with sex workers, drug users and men who have sex with men).

The complete results of the indicators are presented in Tables A-1-5.

Table A-1. Target 1 Indicators: Halve sexual transmission of HIV by 2015.

Indicator n.	Indicator	relevance	source	additional information	Data collection period	subindicator	N. tot	% tot	N	D	% male	N	D	% female	N	D
1.1	Young People: Knowledge about HIV Prevention. Percentage of women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Topic relevant, indicator relevant, data available	Behavioural Surveillance Survey - Knowledge Attitudes Practice (KAP)	KAP performed in general population, 15-64 years of age.	2008	Percentage (%) of respondents age 15-24 who gave correct answers to all 5 questions	-	51,7	1285	2485	52,97	659	1244	27,05	336	1242
						Percentage (%) of respondents age 15-24 who gave a correct answer to question 1 "Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?"	-	75,61	1879	2485	79,34	987	1244	71,82	892	1242
						Percentage (%) of respondents age 15-24 who gave a correct answer to question 2 "Can a person reduce the risk fo getting HIV by using a condom every time they have sex?"	-	96,98	2410	2485	97,51	1213	1244	96,38	1197	1242
						Percentage (%) of respondents age 15-24 who gave a correct answer to question 3 "Can a healthy-looking person have HIV" ?	-	92,6	2301	2485	92,6	1152	1244	92,59	1150	1242
						Percentage (%) of respondents age 15-24 who gave a correct answer to question 4 "Can a person get HIV from mosquito bites ?"	-	96,1	2388	2485	95,82	1192	1244	96,3	1196	1242
						Percentage (%) of respondents age 15-24 who gave a correct answer to question 5 "Can a person get HIV from sharing food with someone who is infected ?"	-	75,01	1864	2485	72,43	901	1244	77,54	963	1242
1.2	Sex Before the Age of 15	Topic relevant, indicator relevant, data available	Behavioural Surveillance Survey - Knowledge Attitudes Practice (KAP)	KAP performed in general population, 15-64 years of age.	2008	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	-	35,46	683	1926	40,85	415	1016	29,45	268	910
1.3	Multiple sexual partners	Topic relevant, indicator relevant, data not available.		The national behavioural survey performed in 2008 (Knowledge, Attitudes and Practice) in the general population (15-64 years of age) assesses the % of respondents "who have had sexual intercourse with more than five partners in the last 12 months": 9,48% (all respondents aged 15-49 = 491/5175); males 14,5% (378/2606); females 4,39% (113/2569).		Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	-	-	-	-	-	-	-	-	-	-
1.4	Condom Use During Higher Risk-Sex	Topic relevant, indicator relevant, data not available.		The national behavioural survey performed in 2008 (Knowledge, Attitudes and Practice) in the general population (15-64 years of age) assesses the % of respondents " who have been sexually active (>0 sexual partners) in the last 12 months and who also reported that a condom was used the last time they had sex ". KAP indicator: % of respondents aged 15-49 who have been sexually active in the last 12 months and who also reported that a condom was used the last time they had sex: 38,0% (1986/5230) tot; 44,1% (1166/2642) males; 31,7% (820/2588) females.		Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months who also reported that a condom was used the last time they had sex	-	-	-	-	-	-	-	-	-	-

1.15	Health facilities that provide HIV testing and counselling services	Topic relevant, indicator relevant, data available.	Ministry of Health, Audit Department/health service research on VCT sites (2010)	Besides 517 VCT sites, a greater number of public sectors facilities provide HIV testing, but the exact number of sites is not currently available.	2011	Percentage of health facilities that provide HIV testing and counselling services	64858	0,8	517	64858	-	-	-	-	-	-
1.16	HIV Testing in 15+ (from programme records)	Topic relevant, indicator relevant, data not available.		No programme records on HIV testing are available in Brazil.		Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results	-	-	-	-	-	-	-	-	-	-
						Number of women and man aged 15 and older received testing and counselling in VCT sites in the past 12 months and know their results	-	-	-	-	-	-	-	-	-	-
						Number of pregnant women aged 15 and older who received testing and counselling in the past 12 months and received their results	-	-	-	-	-	-	-	-	-	-
1.17	Sexually Transmitted Infections (STIs): Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	Topic relevant, indicator relevant, data available.	ANC Sentinel Surveillance	The indicator was calculated using data from the last antenatal care (ANC) sentinel surveillance study performed in 2006, and considering the percentage of ANC attendees who were screened for syphilis at least once during antenatal care and with result recorded on the ANC card. Updated results from the ANC sentinel surveillance 2010-2011 will be available later this year. The implementation of SIS-PRÈ-NATAL started in 2011 will provide routine programatic data to calculate this indicator in the future.	2006	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit	-	-	-	-	-	-	-	86,47	12137	14036
	Sexually Transmitted Infections (STIs): Percentage of antenatal care attendees who were positive for syphilis	Topic relevant, indicator relevant, data available.	ANC Sentinel Surveillance	The indicator was calculated using data from the last antenatal care (ANC) sentinel surveillance study performed in 2006, and considering the percentage of women with positive VDRL at delivery. Update from the ANC sentinel surveillance 2010-2011 will be available later this year. The implementation of SIS-PRÈ-NATAL started in 2011 will provide routine programatic data to calculate this indicator in the future.	2006	Percentage of antenatal care attendees who were positive for syphilis	-	-	-	-	-	-	-	1,1	146	13267
	Sexually Transmitted Infections (STIs): Percentage of antenatal care attendees positive for syphilis who received treatment	Topic relevant, indicator relevant, data available.	Data taken from the National Disease Notification System (SINAN).		2010	Percentage of antenatal care attendees positive for syphilis who received treatment	-	-	-	-	-	-	-	80,55	8123	10084
	Sexually Transmitted Infections (STIs): Percentage of sex workers (SWs) with active syphilis	Topic relevant, indicator relevant, data available.	Special RDS Study	Female sex workers only. Data colleted in ten municipalities in Brazil (Manaus, Recife, Salvador, Brasilia, Campo Grande, Belo Horizonte, Santos, Itajai, Rio de Janeiro e Curitiba).	2009	Percentage of sex workers (SWs) with active syphilis	-	-	-	-	-	-	-	2,5	63	2521
	Sexually Transmitted Infections (STIs): Percentage men who have sex with men (MSM) with active syphilis	Topic relevant, indicator relevant, data not available.				Percentage men who have sex with men (MSM) with active syphilis	-	-	-	-	-	-	-	-	-	-

Table A-2. Target 2 Indicators. Reduce transmission of HIV among people who inject drugs by 50% by 2015.

Indicator n.	Indicator	relevance	source	additional information	Data collection period	subindicator	N. tot	% tot	N	D
2.1	People who inject drugs: Prevention Programmes	Topic relevant, indicator relevant, data not available.		Harm reduction programs are decentralized at state level, therefore data is not available at MOH level.			-	-	-	-
2.2	People who inject drugs: Condom Use	Topic relevant, indicator relevant, data available.	Special RDS Study	Data collected in ten municipalities in Brazil among hard drug users - DU (crack, cocaine, injectable cocaine, etc).	2009	Percentage of injecting drug users reporting the use of a condom the last time they had sex	-	40,67	1235	3037
2.3	People who inject drugs: Safe Injecting Practices. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected drugs	Topic relevant, indicator relevant, data available.	Special RDS Study	Data collected in ten municipalities in Brazil among hard drug users - DU (crack, cocaine, injectable cocaine, etc). This indicator was calculated only considering the respondents who reported use of injectable drugs (418).	2009	Percentage of injecting drug users who report using sterile injecting equipment the last time they injected drugs	-	54,31	227	418
2.4	People who inject drugs: HIV Testing	Topic relevant, indicator relevant, data available.	Special RDS Study	Data collected in ten municipalities in Brazil among hard drug users - DU (crack, cocaine, injectable cocaine, etc).	2009	Percentage of injecting drug users who received an HIV test in the last 12 months and who know their results	-	15	512	3414
2.5	People who inject drugs: HIV Prevalence	Topic relevant, indicator relevant, data available.	Special RDS Study	Data collected in ten municipalities in Brazil among hard drug users - DU (crack, cocaine, injectable cocaine, etc).	2009	Percentage of injecting drug users who test positive for HIV	-	5,92	202	3412
2.6	Opiate Users	Topic relevant, indicator relevant, data available.	Behavioural Surveillance Survey - Knowledge Attitudes Practice (KAP)	KAP performed in general population, 15-64 years of age.	2008	Estimated number of opiate users (injectors and non-injectors)	472700	-	-	-
		Topic not relevant		Harm reduction program in Brazil does not include OST.		Number of people on opioid substitution therapy (OST)	-	-	-	-
2.7	NSP and OST sites	Topic relevant, indicator relevant, data not available.		NSP are decentralized at state level and data are not available at MOH.		Number of needle and syringe programme (NSP) sites	-	-	-	-
		Topic not relevant		Harm reduction program in Brazil does not include OST.		Number of substitution therapy (OST) sites	-	-	-	-

Table A-3. Target 3 Indicators. Eliminate mother-to-child a transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths.

Indicator n.	Indicator	relevance	source	additional information	Data collection period	subindicator	N. tot	% tot	N	D
3.1	Prevention of Mother-to-Child Transmission	Topic relevant, indicator relevant, data available.	National information system for ARV drug logistics (SICLOM)	The estimated number of HIV positive pregnant women in previous 12 months was calculated based on number of livebirths in Brazil in 2009 (2.881.581) + 10% to account for abortions and stillbirths (3.169.739) and ANC HIV seroprevalence of 0,41% (ANC sentinel surveillance in 2006). Data on antiretrovirals are taken from the National Information System for ARV drug logistics (SICLOM) which represents a 91% coverage of national data.	2011	Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	-	50,23	6528	12995
3.2	Early Infant Diagnosis	Topic relevant, indicator relevant, data available.	National database of Lab Results Information System - SISCEL	The numerator was calculated using results of HIV RNA viral load which is used to confirm HIV infection in exposed infants born from HIV positive mothers (National Lab Results Information System - SISCEL). The denominator was estimated based on number of livebirths in 2009 (2.881.581) and HIV prevalence in pregnant women from last ANC sentinel surveillance study in 2006 (0,41%).	2011	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	-	35,24	4163	11814
3.3	Mother to Child transmission rate (modelled)	Topic relevant, indicator relevant, data available.	Estimates from ANC serosurveillance and vertical transmission studies	The estimated number of HIV positive women who delivered in previous 12 months was calculated based on number of livebirths in Brazil in 2009 (2.881.581) and ANC HIV seroprevalence of 0,41% (ANC sentinel surveillance in 2004). Updated results from ANC serosurveillance 2010/2011 will be available later this year. Vertical transmission at national level is based on results from a national study performed in 2004 (STD/AIDS and Hepatitis Department, Ministry of Health - unpublished data).In Brazil, the "incidence of AIDS in children <5 years of age" is used as proxy indicator for vertical transmission. In 2010, the incidence of AIDS in <5 years of age was 3,5/100.000 persons.	2011	Percentage of child infections from HIV-infected women delivering in the past 12 months	-	6,8	803	11814
3.4	Pregnant women who know their status	Topic relevant, indicator relevant, data not available.		The estimates of HIV prevalence and HIV testing coverage in pregnant women (ANC, delivery) are taken from National ANC based Sentinel Surveillance studies usually performed every 4 years. The 2006 data showed that 62,3% of pregnant women (N=16.158) has HIV result available from diagnostic test performed before delivery. Updated results from the ANC sentinel surveillance 2010-2011 will be available later this year. The implementation of SIS-PRÉ-NATAL started in 2011 will provide routine programatic data to calculate this indicator in the future.		Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	-	-	-	-
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	Topic relevant, indicator relevant, data not available.				Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	-	-	-	-
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	Topic relevant, indicator relevant, data available.	SICLOM/SISCEL	The numerator is calculated considering the number of pregnant women registered in the SISCEL and SICLOM.The estimated number of HIV positive pregnant women in previous 12 months was calculated based on number of livebirths in Brazil in 2009 (2.881.581) + 10% to account for abortions and stillbirths (3.169.739) and ANC HIV seroprevalence of 0,41% (ANC sentinel surveillance in 2006). Updated results from ANC serosurveillance 2010/2011 will be available later this year.	2011	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	-	37	4829	12995
3.7	Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission	Topic relevant, indicator relevant, data available.	SICLOM	The number of infants receiving ARV prophylaxis is taken from the national ARV drug losgistics information system (SICLOM). The estimated number of HIV positive women who delivered in previous 12 months was calculated based on number of livebirths in Brazil in 2009 (2.881.581) and ANC HIV seroprevalence of 0,41% (ANC sentinel surveillance in 2006). Updated results from ANC serosurveillance 2010/2011 will be available later this year.	2011	Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age)	-	61,5	7264	11814

3.8	Infants born to HIV-infected women who are provided with ARVs to reduce the risk of HIV transmission during breastfeeding	Topic not relevant				Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.	-	-	-	-
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	Topic relevant, indicator relevant, data not available.				Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	-	-	-	-
3.10	Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	Topic not relevant				Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit	-	-	-	-
3.11	Number of pregnant women attending ANC at least once during the reporting period	Topic relevant, indicator relevant, data available.	National Livebirth Information System (SINASC)	Data taken from the National Livebirth Information System.	2009	Number of pregnant women attending ANC at least once during the reporting period	2795278	-	-	-
3.12	Health Facilities	Topic relevant, indicator relevant, data available.	SICLOM/SISCEL	The number of Health facilities providing pediatric ART was taken from the Logistic Control Information System (SICLOM) for ARV drugs. Sites were included if at least 1 dispensation of pediatric ARV drugs was registered in the system during the reporting period. The number of sites providing virological tests for HIV diagnosis is taken from the Lab Exam Information System (SISCEL) and is based on sites performing HIV RNA viral load confirmatory test in exposed infants. The number of ANC sites is taken from Qualiaids System Indicators I-2c e I-2d: 1/3 of ART sites (SAE) in the country provide ANC services. Considering 750 SAEs in 2010, an estimate of 250 sites provide ANC services.	2011	Number of health facilities providing ANC services	48741	-	-	-
						Number of health facilities providing ANC services that also provide CD4 testing on site, or have a system for collecting and transporting blood samples for CD4 testing for HIV-infected pregnant women	250	-	-	-
						Number of health facilities that offer paediatric ART	451	-	-	-
						Percentage of health facilities that provide virological testing services (e.g. polymerase chain reaction) for diagnosis of HIV in infants on site or from dried blood spots	305	26,2	80	305

Table A-4. Target 4 Indicators. Have 15 million people living with HIV on antiretroviral treatment by 2015.

Indicator n.	Indicator	relevance	source	additional information	Data collection period	subindicator	N. tot	% tot	N	D
4.1	HIV Treatment: Antiretroviral Therapy	Topic relevant, indicator relevant, data available.	National information system for ARV drug logistics (SICLOM)	Data Taken from National ARV drug logistics Information System (SICLOM).	2011	Percentage of eligible adults and children currently receiving antiretroviral therapy	215676	-	215676	-
4.2a	HIV Treatment: 12 Months retention	Topic relevant, indicator relevant, data available.	SICLOM	The denominator refers to individuals starting ART between January and December of 2010 (12 months prior to the reporting period).	2011	Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy	-	93,03	36631	39376
4.2b	HIV Treatment: 24 Months retention	Topic relevant, indicator relevant, data available.	SICLOM	The denominator refers to individuals starting ART between January and December of 2009 (24 months prior to the reporting period).	2011	Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2009)	-	75,6	23698	31371
4.2.c	HIV Treatment: 60 Months retention	Topic relevant, indicator relevant, data available.	SICLOM	The denominator refers to individuals starting ART between January and December of 2006 (60 months prior to the reporting period).	2011	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2006)	-	74,3	18710	25172
4.3	Health facilities that offer antiretroviral therapy	Topic relevant, indicator relevant, data available.	SICLOM	Treatment and care for people living with HIV is provided through a network of 737 Specialized Care sites (Serviços de Atendimento Especializados). ARVs are dispensed through a network of 707 Drug Dispending Units (Unidades Dispensadoras de Medicamentos).	2011	Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	737	-	-	-
4.4	ART Stock-outs	Topic relevant, indicator relevant, data not available.		The National ARV drug logistics information system (SICLOM) includes the information required to calculate this indicator, but it is not yet programmed to generate it.		Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months	-	-	-	-
4.5	HIV Care	Topic relevant, indicator relevant, data not available.				Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis	-	-	-	-

Table A-5. Target 5 Indicators. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015.

Indicator n.	Indicator	relevance	source	additional information	Data collection period	subindicator	N. tot	% tot	N	D
5.1	Co-Management of Tuberculosis and HIV Treatment	Topic relevant, indicator relevant, data not available.		In 2012, anti-TB drugs will be included in the national information system for drug logistics control (SICLOM), and this indicator will be available in the future.		Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	-	-	-	-
5.2	Health care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control	Topic relevant, indicator relevant, data not available.		TB infection control SOPs currently being implemented in selected ART sites. This indicator will be available in the future.		Number of health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control	-	-	-	-
5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	Topic relevant, indicator relevant, data not available.		In 2012, anti-TB drugs will be included in the national information system for drug logistics control (SICLOM), and this indicator will be available in future reports.		Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	-	-	-	-
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Topic relevant, indicator relevant, data not available.				Percentage (%) of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	-	-	-	-

Note: in the report none of the target 5 indicators have been filled in.

Appendix 2 Progress Report Indicators on the Brazilian Response to HIV/AIDS (2010-2011): strategic target 6.

Strategic target 6 of the 2011 Political Declaration refers to HIV/AIDS-related expenditure: reach annual global spending levels of between 22 and 24 billion dollars in low and middle income countries.

The appendix presents a statement of HIV/AIDS-related expenditure in Brazil, by expenditure category and source of funding, in 2009 and 2010.

DESCRIPTION OF THE METHODOLOGY

The National Funding Matrix is used to measure AIDS-related expenditure by source of funding. The Matrix is a calculation spreadsheet that enables the countries to record their AIDS-related expenditure by spending categories and sources of funding. The Matrix has two basic components:

- AIDS spending categories (how funds allocated to the national response to the HIV/AIDS epidemic are spent).
- Financing sources (where funds allocated to the national response to the HIV/AIDS epidemic are obtained)

There are eight AIDS spending categories: prevention; care and treatment; orphans and vulnerable children; programme management and administration strengthening; incentives for human resources; social protection and social services (excluding orphans and vulnerable children); enabling environment and community development; and research. These categories have 79 different classification types, distributed between 11 types of financing sources, thus generating 869 information cells. In this report the financing sources are divided between: public (national and subnational) and international.

The National AIDS Spending Analysis (*Medição do Gasto em Aids - MEGAS*) method was used to gather the information for the funding indicator, since it is a tool having activity classification similar to that requested for UNGASS reporting. The *MEGAS* method provides indicators on the national HIV/AIDS response that enable the monitoring of resource mobilization and is a tool that helps with the installation of continuous processes of financial information within the national monitoring and evaluation framework. It also enables the comparison of information with that of previous years.

The stages involved in producing this report were:

- Data collection;
- Processing and estimates of amounts;
- Classification of the information by spending categories and funding sources;
- Analysis of the information.

This report covers the years 2009 and 2010. It was not possible to report on 2011, as expenditure relating to that year had not yet been finalized by the different bodies involved as at the period when the data was collected.

In relation to public spending, financial and budgetary information derived from the Federal Government information systems was considered: Integrated Financial Management System (*Sistema Integrado de Administração Financeira – SIAFI*); Single Social Security Benefits Information System (*Sistema Único de Informações de Benefícios–SUIBE*). Specific Ministry of Health systems information was also used: NHS Hospital Information Systems (*Sistemas de Informações Hospitalares-SIH-SUS/DATASUS*) and NHS Outpatient Information Systems (*Sistemas de Informações Ambulatoriais-SIA-SUS/DATASUS*); NHS Procedure Chart Management Information System (*Sistema de Informações Gerenciais da Tabela de Procedimentos do SUS-SIGTAB*); STD/AIDS Information System (*Sistema de Informação em DST/aids – SIAIDS*); Medication Logistics Control System (*Sistema de Controle Logístico de Medicamentos –SICLOM*); Laboratory Tests Control System (*Sistema de Controle de Exames laboratoriais – SISCEL*); STD/AIDS Incentive Policy Monitoring System (*Sistema de Monitoramento da Política de Incentivo no Âmbito das Ações em DST/Aids-SIS-INCENTIVO*). Furthermore, additional national and international information was obtained from management reports provided by the Department of STD, AIDS and Viral Hepatitis, the UNAIDS Office in Brazil and the State-level STD/AIDS Programmes. Owing to the inexistence of specific AIDS-related classification on some data which is relevant for this report, this data was obtained by means of estimates and added to the categories, such as expenditure on outpatient consultations (classified in 2.01.02) which was estimated based on the number of requests for viral load and CD4 tests made by public health infectious disease doctors for patients with HIV/AIDS on treatment and registered on the *SISCEL* system and by taking the average cost of a specialized outpatient consultation as established by the *SIGTAB* system.

Considering the difficulties in gathering information on public sources of the 5,565 Brazilian municipalities, the option was to include in this report only the expenditure of state-level Health Departments. It was defined for the purposes of this report that these

Departments would provide expenditure data relating to the purchase of medication for the treatment of opportunistic infections (OI) and STDs, the purchase of male condoms and the costs of human resources involved in the management of the state programmes. This information was obtained through a questionnaire sent by the Ministry of Health and which was answered by 16 state Health Departments (60%).

Once it had been collected, this information was classified under the financing categories and consolidated in the Funding Matrix at actual cost (not deflated). The US Dollar exchange rate used was the average rate for the year studied (Source: Brazilian Central Bank).

It is important to emphasize that the National Funding Matrix, although it increases the ability to analyse the information, does not represent the totality of public financing in Brazil, given that there exists autonomy and decentralized management at federal, state and municipal level. In addition, information systems that enable expenditure to be identified in the categories established by the Funding Matrix do not exist. It must therefore be taken into account that some of the amounts recorded in some of the categories may underestimate actual expenditure. An example of this is expenditure on prevention, principally expenditure aimed at more vulnerable populations which takes place both directly by government bodies and also by non-governmental organizations funded with public resources.

ANALYSIS OF THE EXPENDITURE CATEGORIES - 2009 and 2010

According to the data gathered, expenditure on AIDS for the years 2009 and 2010 reached around R$ 1.313 billion and R$ 1.329 billion, respectively. A small increase of around 1.0% can be seen from one year to the other, as well as in relation to previous years. Table 6-A shows expenditure distribution.

Highest expenditure was concentrated in 2009 and 2010, respectively, on care (66.2% and 70.2%), prevention (20.2% and 19.9%) and management (7.9% and 5.4%). The amounts relating to social protection and community development, which influence the reduction of social and programmatic vulnerability, jointly accounted for expenditure of 5.1% (2009) and 4% (2010). Expenditure on research maintained the same proportions as in previous years. Furthermore, difficulties exist in establishing mechanisms to measure more precisely all the studies and research performed in the years in question owing to the way this expenditure is classified on the information systems used.

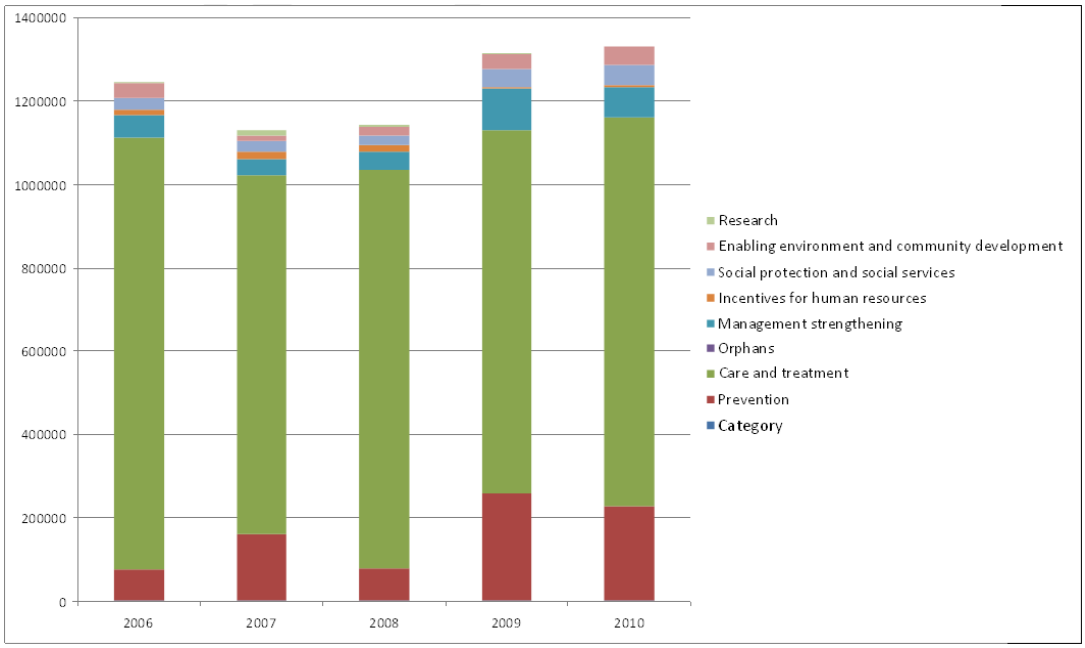
Table 6-A. Expenditure distribution by category, Brazil, 2009 and 2010.

Category	2009	%	2010	%
Prevention	265,170,632	20.2	264,700,268	19.9
Care and treatment	871,399,850	66.3	933,417,719	70.2
Programme management and administration strengthening	104,205,312	7.9	72,202,450	5.4
Incentives for human resources	2,065,958	0.2	3,801,414	0.3
Social protection and social services	31,778,810	2.4	37,097,417	2.8
Enabling environment and community development	35,253,348	2.7	16,559,990	1.2
Research	3,823,820	0.3	1,017,343	0.1
TOTAL	**1,313,697,730**	**100.0**	**1,328,796,601**	**100.0**

Department of STD, AIDS and Viral Hepatitis/HSS/MoH, 2012.

The graph below compares the distribution of resources over the different categories in the five-year period from 2006 to 2010:

Graph 1-A: Expenditure distribution by category, Brazil, 2006-2010.



Department of STD, AIDS and Viral Hepatitis/HSS/MoH, 2010.

FINAL CONSIDERATIONS

Owing to the difficulties encountered in some classification processes in the preparation of this report, there may be distortions in some categories. As such, the lack of information regarding some activities does not necessarily mean that there was no expenditure, but rather that because of the sources that provided this data, classification was not possible.

Furthermore, in order to obtain amounts for some categories estimates had to be made such as, for example, expenditure on outpatient consultations by patients with HIV/AIDS and expenditure on social security benefits.

The impossibility of gathering total expenditure of own funds by the state and municipal governments, which are the principal implementers of health actions and account for half the country's health expenditure, demonstrates the need to adapt the methodology to the national characteristics. In addition, consideration must also be given to private sector expenditure which still requires enhancement with regard to the information collection processes in the various information sources and systems.

Appendix 3 National Commitments and Policy Instrument (NCPI) National Commitments and Policy Instrument (NCPI) PART A administered to government officials.

Representatives of institutions contributing to the completion of NCPI – Part A

Organization	Name/Position	Interviewed for Part A – by section					
		A.I	A.II	A.III	A.IV	A.V	A.VI
Department of STD, AIDS and Viral Hepatitis, Ministry of Health	Dirceu Greco, Director; Eduardo Barbosa, Deputy Director; Ruy Burgos, Substitute Director; Ângela Pires Pinto, Consultant for International Cooperation; Gerson Fernando, Consultant for Surveillance, Information and Research	X	X	X	X	X	X
Department of STD, AIDS and Viral Hepatitis, Ministry of Health	Ivo Brito, Consultant for Human Rights, Risk Reduction and Vulnerability; Gilvane Casimiro, Consultant for Human Rights, Risk Reduction and Vulnerability; Lucas Seara, Consultant for Human Rights, Risk Reduction and Vulnerability; Rubens Duda, Consultant for Human Rights, Risk Reduction and Vulnerability	X	X	X	X	X	
Department of STD, AIDS and Viral Hepatitis, Ministry of Health	Ronaldo Hallal, Consultant for Care and Quality of Life					X	
Department of STD, AIDS and Viral Hepatitis, Ministry of Health	Ana Roberta Pascom, Consultant for Monitoring and Evaluation						X
Department of STD, AIDS and Viral Hepatitis, Ministry of Health	Renato Girade, General Coordinator of Sustainability, Management and Cooperation; Maria Alice Lipparelli Tironi, Consultant for Sustainability, Management and Cooperation; Cynthia Batista, Management of the Process of Universal Access to Medication, Condoms and other Commodities	X	X				
Federal District STD, AIDS and Viral Hepatitis Management Division	Luiz Fernando Marques, Manager	X	X	X	X	X	X
São Paulo State STD/AIDS Department, Planning Division	Vilma Cervantes, Technical Aide	X	X	X	X	X	X
São Paulo State STD/AIDS Department	Maria Clara Gianna Garcia Ribeiro	X	X	X	X	X	X
Amazonas State STD, AIDS and Viral Hepatitis Management Division	Noaldo Oliveira de Lucena	X	X	X	X	X	X

I. <u>STRATEGIC PLAN</u>

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes X	No

IF YES, what was the period covered?

With effect from 1986

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. ***IF NO or NOT APPLICABLE,*** briefly explain why:
Since 1986 Brazil has developed multi-sectoral strategies aimed at responding to the epidemic, including strategic plans, operational plans, annual actions and goals.

IF YES, complete questions 1.1 through 1.10; ***IF NO***, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies [write in]:

Ministry of Health

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

SECTORS	**Included in Strategy**		**Earmarked Budget**	
Education	Yes X	No	Yes X	No
Health	Yes X	No	Yes X	No
Labour	Yes X	No	Yes X	No
Military/Police	Yes X	No	Yes X	No
Transportation	Yes X	No	Yes X	No
Women	Yes X	No	Yes X	No
Young People	Yes X	No	Yes X	No
Other *[write in]* = Prison Administration Departments	Yes X	No	Yes X	No
Human Rights Secretariat – Office of the President of the Republic	Yes X	No	Yes	No X**
Welfare and Social Development Departments	Yes X	No	Yes	No X**
Justice Departments	Yes X	No	Yes	No X**
Science and Technology Departments	Yes X	No	Yes X	No
Sport and Tourism Departments	Yes X	No	Yes	No X**
Women's Policy Secretariat – Office of the President of the Republic	Yes X	No	Yes	No X**
Ministry of Justice/National Drugs Secretariat (SENAD)	Yes X	No	Yes	No X**
Ministry of Culture	Yes X	No	Yes	No X**

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities.
** Ministry of Health budget resources are not reallocated to other ministries. However, when joint intersectoral actions are to take place, full financing of these actions may occur through resources from this source. An example is the implementation of plan to fight the feminization of the epidemic which is budgeted in the 2012-2015 Pluriannual Plan. Moreover, resources from other government areas are also allocated to jointly developed activities, even if they do not have a specific budget line.

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Men who have sex with men	Yes X	No
Migrants/mobile populations	Yes X	No
Orphans and other vulnerable children	Yes X	No
People with disabilities	Yes X	No
People who inject drugs	Yes X	No
Sex workers	Yes X	No
Transgendered people	Yes X	No
Women and girls	Yes X	No
Young women/young men	Yes X	No
Other specific vulnerable subpopulations[31] = population deprived of liberty, the over 50s, indigenous population, Black population, people living with HIV/AIDS, truck drivers, industrial workers, psychoactive substance abusers	Yes X	No
SETTINGS		
Prisons	Yes X	No
Schools	Yes X	No
Workplace	Yes X	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes X	No
Gender empowerment and/or gender equality	Yes X	No
HIV and poverty	Yes X	No
Human rights protection	Yes X	No
Involvement of people living with HIV	Yes X	No

[31] Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection [e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees].

IF NO, explain how key populations were identified:

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country *[write in]**?***

KEY POPULATIONS
The key populations are: women, young people (of both sexes), injecting drug users, gay men, other men who have sex with men, transvestites, sex workers, orphans and other vulnerable children, migrants, the landless, transsexuals, population deprived of liberty, people aged over 50, indigenous population, Black population, people with disabilities, people living with HIV/AIDS.

Ever since the beginning of the epidemic, the individual epidemiological records have provided information on gender, place of residence, age, level of education and exposure categories. In the year 2000, information on race/colour was also included. Prior to the year 2000 information relating to the indigenous population was reported in the epidemiological bulletin classified by ethnic group and indigenous territory. Following the creation of the indigenous health subsystem in 1989, the development of a specific information system for indigenous health (*SIASI*) and the changes proposed to the Communicable Diseases Information System (*Sistema de Informação de Agravos de Notificação - SINAN*), the data on the epidemic in this segment have been obtained by collating the information from the two systems.

The analysis of this data has shown the principal trends and has informed the definition of actions. Management forums and forums of intersectoral articulation and articulation with civil society, in addition to population-based studies and surveys, are additional needs assessment mechanisms. Studies have also been conducted since the 1990s. At that time, given the lack of population-based studies, Demography and Health Study information was used instead. The first of them was conducted in 1986, followed by others in 1989, 1992 and 1996. The information enables comparison with other countries. The last compared analysis was regarding the context of women's health and was published in 2006, taking the previous studies as a reference. The following studies are currently considered as references for preparing strategies:

BRASIL. Ministério da Saúde. Departamento de DST, Aids e Hepatites Virais. PCAP - Pesquisa de Conhecimento, Atitudes e Práticas na População Brasileira. Brasília, 2009. (Study of Knowledge, Attitudes and Practices in the Brazilian Population).

BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. Programa Nacional de DST e Aids. Pesquisa entre Conscritos do Exército Brasileiro, 1996-2002: Retratos do comportamento de risco do jovem brasileiro à infecção pelo HIV. Brasília, 2006. 128 p. Série Estudos, Pesquisas e Avaliação, n. 2. (Brazilian Army Conscripts Study, 1996-2002: Portraits of HIV infection risk behaviour in young Brazilians).

BRASIL. Ministério da Saúde. Programa de DST/Aids. Bela Vista e Horizonte: estudos comportamentais e epidemiológicos entre homens que fazem sexo com homens. Brasília, 2000. Série Avaliação, n. 5. (*Bela Vista* and *Horizonte*: behavioural and epidemiological studies with men who have sex with men).

BRASIL. Ministério da Saúde. Programa de DST/Aids. A contribuição dos Estudos Multicêntricos frente à epidemia de HIV/Aids entre UDI no Brasil: 10 anos de pesquisa e redução de danos. Brasília, 2003. Série Avaliação, n. 8. (The contribution of the Multicentre Studies in the face of the HIV/AIDS epidemic among IDU in Brazil: 10 years of research and harm reduction).

BRASIL. Ministério da Saúde. Coordenação Nacional de DST e Aids. Comportamento sexual da população brasileira e percepções do HIV/aids. Brasília, 2000. Série Avaliação, n. 4. (Sexual behaviour of the Brazilian population and perceptions of HIV/AIDS).

BRASIL. Ministério da Saúde. Coordenação Nacional de DST e Aids. Comportamento sexual da população brasileira e percepções do HIV/aids. Brasília, 2005. Vários artigos de autoria derivados do estudo e publicados na Rev. Saúde Pública, São Paulo, vol. 42, suppl. 1, jun. 2008. (Sexual behaviour of the Brazilian population and perceptions of HIV/AIDS).

BRASIL. Ministério da Saúde. Programa Nacional de DST e Aids. Avaliação da efetividade das ações de prevenção dirigidas às profissionais do sexo, em três regiões brasileiras. Brasília, 2003. 104 p., Il. cor. Série Estudos, Pesquisas e Avaliação. (Evaluation of the effectiveness of prevention actions aimed at sex workers in three Brazilian regions).

FRANÇA JR., I; CALAZANS, G.; ZUCCHI, E. M. Mudanças no acesso e uso de testes anti-HIV no Brasil entre 1998 e 2005. Artigo não publicado, submetido à Revista de Saúde Pública. (Changes in access and use of HIV testing in Brazil between 1998 and 2005).

SZWARCWALD, C. L.; SOUZA JR., P. R. B. Estimativa da prevalência de HIV na população brasileira de 15 a 49 anos, 2004. Boletim Epidemiológico AIDS/DST, Brasília, Ano III, n. 1, p. 11-15, 2006. (Estimated HIV prevalence in the Brazilian Population aged 15 to 49, 2004).

SZWARCWALD, C. L.; CARVALHO, M. F. Estimativa do número de indivíduos de 15 a 49 anos infectados pelo HIV, Brasil, 2000. Boletim Epidemiológico AIDS/DST, Brasília, Ano XIV, n. 1, 2001. (Estimated number of individuals aged 15 to 49 infected with HIV, Brazil, 2000).

SZWARCWALD, C. L.; CASTILHO, E. A. Estimativa do número de pessoas de 15 a 49 anos infectadas pelo HIV, Brasil, 1998. Cadernos de Saúde Pública, Rio de Janeiro, v. 16, Supl. 1, p. 135-141, 2000. (Estimated number of individuals aged 15 to 49 infected with HIV, Brazil, 1998).

SOUZA JR., P. R. B de; SZWARCWALD, C. L.; BARBOSA JR., A. et al. Infecção pelo HIV durante a gestação: Estudo Sentinela Parturiente, Brasil, 2002. Revista de Saúde Pública, São Paulo, v. 38, n. 6, p. 764-772, 2004. (HIV infection during pregnancy: Parturient Sentinel Study, Brazil, 2002).

1.5. Does the multisectoral strategy include an operational plan?

Yes X	No

1.6. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?	Yes X	No	N/A
b) Clear targets or milestones?	Yes X	No	N/A
c) Detailed costs for each programmatic area?	Yes X	No	N/A
d) Indication of funding sources to support programme implementation?	Yes X	No	N/A
e) A monitoring and evaluation framework?	Yes X	No	N/A

1.7. Has the country ensured "full involvement and participation" of civil society[32] the in development of the multisectoral strategy?

Active involvement X	Moderate involvement	No involvement

[32] Civil Society includes among others networks and organizations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith based organizations; AIDS service organizations; workers organizations; human rights organizations. Etc. Note: The private sector is considered separately.

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
The Civil Society Organizations are longstanding partners of the Ministry of Health's Department of STD, AIDS and Viral Hepatitis, which accordingly has ensured their full participation and involvement in fighting the epidemic. In 1986, the Ministry of Health set up a National STD and AIDS Commission (*CNAIDS*), representing civil society organizations, universities, state and municipal health service managers. By October 2009, *CNAIDS* had held 100 meetings, all of them with the aim of assisting in the formulation and monitoring public policies in response to the epidemic. Civil society participation in formulating public policies contributes to the exercising of citizenship and social watch (*controle social*). This latter expression, originating in the National Health System (NHS), indicates the need for control over government by society, especially at local level, in the definition of targets, goals and action plans. It is for this reason that in 2003 the National Health Council, a Ministry of Health body which guarantees the participation of representatives of health service users, workers and service providers, created a specific subgroup on AIDS, namely the STD and AIDS Policy Accompaniment Commission. The Commission meets four times a year and collaborates directly with

the formulation and evaluation of strategies developed by the Ministry of Health.

The formation of state and municipal STD and AIDS Commissions is strongly encouraged in the 26 states, the Federal District and the 450 municipalities that receive Ministry of Health resources to respond to AIDS and which together account for 98% of the country's AIDS cases. Civil Society Organization representation is ensured, formally or informally, in the majority of governmental Public Policy building spaces, such as Commissions, Working Groups, Technical Boards and Forums. Participation is also encouraged in spaces of formulation, analysis, planning and monitoring of actions, strategies and plans built through meetings, gatherings, seminars, working groups, formation of commissions, etc.

Since August 2000 there has existed within the structure of the Ministry of Health's Department of STD, AIDS and Viral Hepatitis a specific division for developing articulation with civil society and promoting the human rights of people living with HIV/AIDS and more vulnerable groups. At state and municipal level there are also focal points for articulation with civil society.

The strengthening of Civil Society Organization actions is one of the priorities of the Department of STD, AIDS and Viral Hepatitis and in addition to technical support (provision of advice and the holding of courses/seminars) includes the funding of projects. Moreover, at state and municipal level there is a systematic and specific line of funding for actions developed by these organizations which is guaranteed by law.

This model is singular to the Department and has guaranteed the implementation of article 196 of the Federal Constitution, which establishes that health is a right of all people and a duty of the State.

In addition to *CNAIDS*, civil society also has direct participation on the National Health Council, an NHS decision making and social watch body, as well as on the Commission for Articulation with Social Movements, a Department of STD, AIDS and Viral Hepatitis consultative body.

IF NO or MODERATE INVOLVMENT, briefly explain why this was the case:

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes X	No	N/A

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners X	Yes, some partners	No	N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2. Has the country integrated HIV into its general development plans such as in: a) National Development Plan; b) Common Country Assessment / UM Development Assistance Framework; c) Poverty Reduction Strategy; and d) sector-wide approach)?

Yes X	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN development Assistance Framework	Yes X	No	N/A
National Development Plan	Yes X	No	N/A
Poverty Reduction Strategy	Yes X	No	N/A
Sector-wide approach	Yes X	No	N/A
Other *[write in]:*	Yes	No	N/A

2.2. IF YES, are the following specific HIV-related areas included in one or more of the development plans?

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	Yes X	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes X	No	N/A
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	Yes X	No	N/A
Reduction of stigma and discrimination	Yes X	No	N/A
Treatment, care and support (including social security or other schemes)	Yes X	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes X	No	N/A
Other [write in below]:	Yes	No	

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes X	No	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW					**HIGH**
0	1	2	3	X 4	5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, Police, peacekeepers, prison staff, etc.)?

Yes X	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?[33]

[33] Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES:63/277, 10 June 2011

Yes X	No

5.1 Have the national strategy and national HIV budget been revised accordingly?

Yes X	No

5.2 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs X	Estimates of Current Needs Only	No

5.3. Is HIV programme coverage being monitored?

Yes X	No

(a) ***IF YES,*** is coverage monitored by sex (male, female)?

Yes X	No

(b) ***IF YES,*** is coverage monitored by population groups?

Yes X	No

IF YES, for which population groups?
Women, young people, injecting drug users, men who have sex with men, sex workers, people deprived of liberty, migrant/mobile populations.
Briefly explain how this information is used:
The estimates are made based on the information on colour, age, sex and exposure category, obtained from the individual epidemiological records, or are obtained from specific population-based studies.

(c) Is coverage monitored by geographical area?

Yes X	No

IF YES, at which geographical levels (provincial, district, other)?
State and municipal levels.
Briefly explain how this information is used:
The information provides knowledge as to adherence to treatment, adverse effects and clinical monitoring by cross-referencing the available databases, as well as enabling the calculation of the amount of medication needed to be purchased and dispensed.

5.4. Has the country developed a plan to strengthen health systems?

Yes X	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	X **7**	8	9	10

Since 2009, what have been key achievements in this area?
With effect from 2007 Strategic Plans have been developed to respond to the epidemic among women, gay men, MSM and transvestites, the control of mother-to-child transmission, the elimination of congenital syphilis and the scaling up of early diagnosis. In this process the Department has been able to count on the direct collaboration of local programme coordinators and the involvement of civil society, as well as the participation of other health sector programmatic areas and other social areas covered by the government at all three levels (federal, state and municipal). There has also been a significant commitment to establishing financial resources (Incentive Resources) in the Municipal Actions and Goals Plans for the development of activities. Also noteworthy are: the activities undertaken in fighting stigma and discrimination; the implementation of rapid testing in a larger number of municipalities thus enabling the availability of diagnosis to be scaled up; the incorporation of Monitoring and Evaluation instruments in the work processes; the implementation of the strategies to Reduce Mother-to-Child Transmission; the work of the National and State-level Parliamentary Fronts on HIV/AIDS.
What challenges remain in this area?
Considering the broader concept of health and the importance of the response to the epidemic involving the integrality of people living with HIV, a challenge that remains is implementing actions that take into consideration not only the integration of HIV/AIDS strategies with other areas of health but also multisectorality. Another challenge that remains is the orientation and alignment of strategies to respond to the epidemic among more vulnerable populations, which requires the scaling up of access to diagnosis and increased coverage of actions.

II. <u>POLITICAL SUPPORT AND LEADERSHIP</u>

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do the following high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

A. Government ministers	Yes X	No
B. Other high officials at sub-national level	Yes X	No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example: promised more resources RO rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes X	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
The Minister of Health has emphasized the Brazilian response to the epidemic as part of the agenda of priorities and during 2011 there was a series of media reports and advertising campaigns directly related to the issue of AIDS prevention or care. In addition to expressing his opinions in the press and other media, the Minister of Health has raised issues of interest to people living with HIV/AIDS with the Parliamentary Front on AIDS and the Council of Magistrates.

2. Does the country have an officially recognized national multisectoral HIV coordination body (i.e., National HIV Council or equivalent)?

Yes	No X

IF NO, briefly explain why not and how HIV programmes are being managed:
The Brazilian Federal Constitution establishes that health is a right of all people and a duty of the State (article 196). For this reason the entire national health policy in Brazil is lead and coordinated by the Ministry of Health, which is responsible for making effective the multisectoral articulations of interest to the area. Within the Ministry of Health it is the Department of STD, AIDS and Viral Hepatitis (formerly called the National STD and AIDS Programme) which coordinates the national policy in response to the epidemic. Given that one of the characteristics of the National Health System is the decentralization of actions (distribution of responsibilities between the three levels of government), at state and municipal levels there are STD and AIDS Sectors within the Health Departments which coordinate the STD/AIDS policy at the local level. The Department of STD, AIDS and Viral Hepatitis is responsible for establishing the guidelines of the national policy in response to AIDS, guiding states and municipalities on action planning and implementation, directly funding actions related to STD/AIDS prevention, diagnosis and care, as well as promoting and articulating intersectoral government policies to defend the human rights of people living with HIV/AIDS and more vulnerable groups. Of all the ministries, the Ministry of Health has the largest budget within the federal government. The Ministry of Health maintains important spaces of participation (social watch) such as the National Health Council, which involves the representation of diverse sectors of society, both governmental and non-governmental, which appraise and discuss the country's health policy, as well as maintaining a Commission to Accompany STD and AIDS Policies. The Ministry of Health's Department of STD, AIDS and Viral Hepatitis also receives advice from the National AIDS Commission which, as a consultative body, brings together representatives of civil society organizations, universities, state and municipal health service managers and the ministries of Policies for Women, Human Rights, Education, Racial Equality, Labour, Social Security and Defence.

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes X	No	N/A

IF YES, briefly describe the main achievements?
The National STD and AIDS Commission (*CNAIDS*) is the Ministry of Health's consultative body on HIV/AIDS, the principal characteristic of which is plurality – in that it brings together representatives of the government, civil society and universities. It was officially created on April 25th 1986, by means of Ministerial Ordinance No. 199. The joining of forces – the government responsible for public policies and *CNAIDS* as a consultative and political body – is one of the reasons why Brazil is a reference in the response to the epidemic. The composition of the Commission is currently defined by Ministerial Ordinance No. 43, dated September 28th 2005. The Commission has 41 seats, divided between two Ministry of Health representatives, ten from other federal government ministries and secretariats, seven from non-governmental organizations and networks of people ling with HIV, as well as three Municipal and State Health Departments. There are also seven seats for representatives of universities and research institutes, nine for medical associations and three for worker networks and religious institutions. Included among the important issues that have been on the Commission's agenda are the admission of HIV positive people to the Armed Forces and the fight against restrictions on people with HIV entering the country. For the Commission it was inadmissible that a positive diagnosis could be used as a

criterion for excluding people from the job market or from entering Brazil. The stance taken against compulsory testing was registered in a motion of repudiation approved in its 77th meeting in 2005. In 2006 *CNAIDS* set up a subcommission to prepare a document as a basis for the discussions on "Consented tracing". A year and a half later the Ministry of Health produced regulations on the procedures for the consented tracing of people who use health services to test for HIV but do not return to get the result or fail to attend medical appointments when in treatment. In 2007 *CNAIDS* also contributed to the strategy for the compulsory licensing of Efavirenz, which was issued in 2007 and re-issued May 2012. The Ministry of Health's Department of STD, AIDS and Viral Hepatitis also has other consultative bodies. Standing out among them is the Commission for Articulation with Social Movements comprised of 20 representatives of diverse social movements and NGOs from the country's five regions; the Service Managers' Commission, comprised of representatives of state and municipal STD/AIDS service managers; and the National Business Council on STD/AIDS, currently comprised of eighteen companies from various areas of industry and commerce.
What challenges remain in this area:
CNAIDS faces the constant challenge of reconciling its members' different viewpoints so as to contribute to the construction of strategies to fight the epidemic.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the last year?

1.5%

Note: The Federal Government transfers (fund to fund) annually approximately US$ 90 million to the state health departments, plus a further US$ 9 million to support national projects. This accounts for 1.5% of the Department of STD, AIDS and Viral Hepatitis' global budget and around 7.2% of the budget for prevention actions.

5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Capacity-building	Yes X	No
Coordination with other implementing partners	Yes X	No
Information on priority needs	Yes X	No
Procurement and distribution of medication or other supplies	Yes X	No
Technical guidance	Yes X	No
Other: Project funding	Yes X	No
Political support for interlocution between civil society organizations and state and municipal governments and parliamentarians.	Yes X	No

6. Has the country reviewed national policies and laws to determine which, if any, are consistent with the National HIV Control policies?

Yes X	No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?

Yes X	No

IF YES, name and describe how the policies / laws were amended:

The National Plan to Promote Lesbian, Gay, Bisexual, Transvestite and Transsexual Citizenship and Human Rights was launched in 2009. The Plan is the result of joint Federal Government and Civil Society efforts and was prepared by a Technical Interministerial Commission comprised of representatives of 18 Ministries. The Plan contains 51 guidelines and 180 actions based on proposals approved by the I National LGBT Conference. These will be implemented by the Government to guarantee the equal rights and full citizenship of the LGBT segment of the Brazilian population, including the response to the STD/AIDS epidemic.

The third version of the National Human Rights Programme was also launched in 2009. The Programme includes commitments on promoting access to health services and combating stigma and discrimination.

With regard to education, the launch of the Federal Government's "*Pró-Jovem*" (Pro-Youth) Programme has enabled greater capacity-building and more information for teenagers and young adults, as well as their increased access to the School Health Programme and the Health and Prevention in Schools Programme.

In addition, efforts have been made in the National Congress to prevent the approval of bills inconsistent with the national policy on combating AIDS, including measures that aimed to criminalize HIV transmission or restrictions relating to sexual orientation and sexual education.

The following regulations also stand out: Decree No. 6860, dated May 28th 2009, which institutionalized the Department of STD and AIDS; Ordinance No. 2561, dated October 28th 2009, which approved the Clinical Protocol and Treatment Guidelines for Chronic Viral Hepatitis B and Co-infections; Decree No. 7135, dated March 29th 2010, establishing that the Department of STD and AIDS will also coordinate the National Viral Hepatitis Programme. This lead to the institution of the Department of STD, AIDS and Viral Hepatitis.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Some cases of criminalization because of HIV transmission, without the intention to transmit, have been reported. Nevertheless, there is no specific law in Brazil that criminalizes HIV transmission. As a result, the Brazilian Judiciary has used various articles of the Brazilian Criminal Code, ranging from the crime of bodily injury to attempted murder. In response to this, the Ministry of Health's Department of STD, AIDS and Viral Hepatitis and civil society organizations have undertaken a variety of actions, including advocacy, with the Judiciary. In November 2009, the Department of STD, AIDS and Viral Hepatitis released a technical note explaining the transmission routes and stating that criminalization is an obstacle to the actions to combat AIDS.

In addition, a considerable growth in conservative movements can be observed and this is making difficult or even preventing the development of HIV/AIDS actions in the country. This is a phenomenon that hinders the promotion of universal access by people particularly vulnerable to the epidemic, especially psychoactive substance abusers and the LGBT population (Lesbians, Gay men, Bisexuals, Transvestites and Transsexuals).

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	X **7**	8	9	10

Since 2009, what have been key achievements in this area?

The elaboration of strategic plans for more vulnerable populations and to eliminate congenital syphilis; the creation of a Technical Board for dispensing medication susceptible to intervention by the Judiciary (writs of mandamus); the use of TRIPS flexibilities to ensure access to medication.

What challenges remain in this area?

Improving the human resources policy and implementing prevention actions that ensure access by more vulnerable populations.

III. <u>HUMAN RIGHTS</u>

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Circle yes of the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS		
People living with HIV	Yes X	No
Men who have sex with men	Yes X	No
Migrants/mobile populations	Yes	No X
Orphans and other vulnerable children	Yes X	No
People with disabilities	Yes X	No
People who inject drugs	Yes	No X
Prison inmates	Yes X	No
Sex workers	Yes	No X
Transgendered people	Yes	No X
Women and girls	Yes X	No
Young men/young women	Yes X	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No X

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes X	No

IF YES to Questions 1.1 or 1.2, briefly describe the content of the laws:
The Federal Constitution guarantees full rights of diversity and expressly condemns all forms of discrimination, whether it be racial, ethnical or religious and, therefore, confers full rights to all citizens, whether these be political, social or individual rights. The Organic Law of the National Health System ratifies these principles and defines health as a right of citizenship, it being the State's duty to provide the means for individual and collective well-being. Access to public health services is universal and free to all Brazilian citizens. Examples of specific legislation include: State Law (State of São Paulo) No. 11,199, dated July 12th 2002: prohibits discrimination against people with HIV or AIDS, in addition to other provisions. State Law (State of São Paulo) No. 10,948, dated November 5th 2001: provides penalties to be applied to the practice of discrimination on the grounds of sexual orientation, in addition to other provisions.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
The areas and bodies of the government, at all three levels (federal, state and municipal), are oriented to plan and implement public policies that respect the needs of each population. Affirmative actions are also implemented to promote the rights of populations which, unfortunately, are still targets of discrimination. Within the National Health System the principles of universality and equity, established by law and which orient its actions, seek to promote access to health by the entire population. As such, health promotion policies for vulnerable populations have been formulated and are implemented in the states and municipalities (e.g.: the National Policy on the Health of the Black Population, the National Policy on Women's Health, the National Policy on the Health of Lesbians, Gay men, Transvestites and Transsexuals, the National Policy on the Health of People with Disabilities, among others). Moreover, the Brazilian Federal Constitution provides for mechanisms to ensure that the population's rights are

guaranteed, such as the right to not be discriminated against, by means of bodies such as the Public Prosecution Service and the Office of the Public Defender.

Other mechanisms include the creation of Reference Centres for Women, Reference Centres to Combat Homophobia, Women's Rights Councils and Human Rights Promotion and Defence Councils based in the state capitals and several of the country's municipalities. These bodies receive and refer complaints, as well as counselling and guiding victims of discrimination.

Combating stigma and discrimination is one of the Ministry of Health's priorities in response to the HIV/AIDS epidemic. To this end, the Department of STD, AIDS and Viral Hepatitis has a Human Rights Division which plans and implements actions and provides guidance for the states and municipalities on combating stigma and discrimination. The participation of civil society organizations has been fundamental for these strategies. An example of this is the partnership between the Department of STD, AIDS and Viral Hepatitis and civil society organizations in providing legal aid to combat discrimination against people living with HIV/AIDS and other vulnerable populations.

Briefly comment on the degree to which they are currently implemented:

With effect from 1988, following the return of democracy to Brazil and the new Federal Constitution, the country has sought to ensure equal rights for all, and several laws and strategies have been implemented in this respect. The government and civil society have made strong efforts to inform the population about anti-discrimination laws and to implement them. As a result of these efforts, important progress can be seen in the fight against racism, homophobia, *machismo* and other types of discrimination.

With regard to HIV-based discrimination, it can be seen that despite the existence of laws and mechanisms to combat discrimination, it continues to be a significant obstacle in the lives of HIV positive people. An example of this are the results of a national survey with 8,000 people from all over the country undertaken between September and November 2008, according to which 13% of those interviewed believe that a teacher with HIV cannot teach in any school; 22.5% stated that vegetables cannot be bought in a place where a HIV positive person works; and 19% believed that if a family member becomes ill with AIDS they should not be cared for in the family home.

In 2007, the Ministry of Health's Department of STD, AIDS and Viral Hepatitis implanted its Human Rights Violations Complaints Database on which cases of discrimination throughout Brazil can be recorded. To date 1,871 complaints have been recorded.

These figures indicate the constant presence of cases of discrimination and also that victims are more inclined to formalize complaints. Furthermore, the campaigns have provoked an in-depth discussion in society, driving changes in attitudes, behaviours and practices.

Despite the diverse strategies developed over the years (campaigns, seminars, legal aid) and the progress identified, HIV-related stigma and discrimination continue to be constant challenges in the fight against the epidemic.

2. Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes	No X

[42] These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have included: "laws that criminalize same sex relationships", "laws the criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure"; "inheritances laws/rights for women"; "laws that prohibit provision of sexual and reproductive health information and services to young people"; etc.

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable populations[35] [write in below]	Yes	No

[35] Other specific vulnerable populations other than those above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees).

Briefly describe the content of these laws, regulations or policies:
Briefly comment on how they pose barriers:

IV. <u>PREVENTION</u>

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population?

Yes X	No

1.1. IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	No X
Avoid commercial sex	Yes	No X
Avoid inter-generational sex	Yes	No X
Be faithful	Yes	No X
Be sexually abstinent	Yes	No X
Delay sexual debut	Yes	No X
Engage in safe(r) sex	Yes X	No
Fight against violence against women	Yes X	No
Greater acceptance and involvement of people living with HIV	Yes X	No
Greater involvement of men in reproductive health programmes	Yes X	No
Know your HIV status	Yes X	No
Males to get circumcised under medical supervision	Yes	No X
Prevent mother-to-child transmission of HIV	Yes X	No
Promote greater equality between men and women	Yes X	No
Reduce the number of sexual partners	Yes	No X
Use clean needles and syringes	Yes X	No

Use condoms consistently	Yes X	No
Other *[write in]*: Fighting STDs	Yes X	No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes X	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes X	No

2.1. Does the country have a policy or strategy to promote life-skills based HIV education for young people:

Is HIV education part of the curriculum in:		
Primary schools?	Yes	No X
Secondary schools?	Yes X	No
Teacher training?	Yes	No X

2.2. Does the strategy use age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes X	No

2.3. Does the country have an HIV education strategy for out-of-school young people?

Yes X	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?

Yes X	No

Briefly describe the content of this policy or strategy:
The policy considers key populations to be key stakeholders in the national response to HIV and therefore, with the active participation of these populations, develops strategies aimed at them. The IEC policies also take into consideration the various regional and specific realities of the key populations.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

Check which specific populations and elements are included in the policy strategy:

	IDU[36]	MSM[37]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations*[38] [*write in*]
Condom promotion	X	X	X	X	X	X
Drug substitution therapy	N/A	N/A	N/A	N/A	N/A	N/A
HIV testing and counselling	X	X	X	X	X	X
Needle and syringe exchange	X	N/A	N/A	N/A	N/A	N/A
Reproductive health, including sexually transmitted infections prevention and treatment	X	X	X	X	X	X
Stigma and discrimination reduction	X	X	X		X	X

Targeted information on risk reduction and HIV education	X	X	X		X	X
Vulnerability reduction (e.g. income generation)	N/A	N/A	X	N/A	N/A	X

* Truck drivers, indigenous population, street population, people with disabilities, young people, migrant populations, people living with HIV/AIDS, psychoactive substance abusers.

_____

[36] IDU = People who inject drugs

[37] MSM = Men who have sex with men

[38] Other specific vulnerable populations other than those above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees).

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	X **7**	8	9	10

Since 2009, what have been key achievements in this area?
Key achievements include: the formulation of the Plan to Fight the Feminization of the Epidemic and the Plan to Fight the Epidemic among Gay Men, Transvestites and MSM; the scaling-up of strategic commodities purchases (condoms and rapid tests for diagnosing HIV and syphilis); the integration of the actions of the Health and Prevention in Schools project into the Government programme aimed at country's school children and other young people; programmatic articulation with the Tuberculosis programme and the promotion of measures that ensure the access of people living with HIV/AIDS to assisted reproduction; the implantation of the protocol for HIV post-exposure prophylaxis.
What challenges remain in this area?
The remaining challenges are: scaling up the coverage of actions for vulnerable populations; restructuring the network of counselling and testing centres so that they can meet the needs of the vulnerable populations; the implementation and use of new prevention technologies to address concentrated epidemics.

4. Has the country identified specific needs for HIV prevention programmes?

Yes X	No

IF YES, how were these specific needs determined?
They were determined based on the analysis of the epidemiological and sociodemographic data, in addition to information from key stakeholders and intervention activities.

IF NO, how are HIV prevention programmes being scaled-up?

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	4 X	N/A
Condom promotion	1	2	3 X	4	N/A
Harm reduction for people who inject drugs	1	2	3 X	4	N/A

HIV prevention for out-of-school young people	1	2	3 X	4	N/A
HIV prevention in the workplace	1	2	3 X	4	N/A
HIV testing and counselling	1	2	3 X	4	N/A
IEC[39] on risk reduction	1	2	3 X	4	N/A
IEC on stigma and discrimination reduction	1	2	3 X	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4 X	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3 X	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4 X	N/A
Risk reduction for sex workers	1	2	3	4 X	N/A
School-based HIV education for young people	1	2	3 X	4	N/A
Universal precautions in health care settings	1	2	3 X	4	N/A
Other *[write in]*:	1	2	3	4	N/A

[39] IEC = information, education and communication

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	X **7**	8	9	10

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes X	No

If YES, briefly identify the elements and what has been prioritized:
The federal law on universal access to treatment was enacted in 1996, guaranteeing access to all those with medical indication to be on treatment. Some 20 ARV drugs are available for 215,000 people living with HIV. There is a network comprised of Counselling and Testing Centres, more than 700 Specialized HIV and AIDS Outpatient Clinics and more than 700 ARV Medication Dispensing Units, in addition to laboratories that perform viral load counts, LT-CD4 and genotyping tests, as part of universal access to treatment. The national clinical guidelines on treatment are reviewed annually. The Specialized Clinics are located in large and medium-sized urban centres and are comprised of complete health teams, including social workers and psychologists. The Medication Dispensing Units are comprised of middle-level teams and pharmacists. The country's most vigorous action occurs in the service network: due in particular to the impact of the policy on universal access to treatment the need for injected treatment is reducing, resulting in a decrease in the use of day hospital services for this purpose, whilst the demand remains for palliative care and treatment adherence. Some home care services still exist. Brazil uses the strategy of "Consented Tracing" to reduce treatment abandonment.

Priorities: a) establishment of up to date guidelines aimed at the rational and simplified use of ARV regimens; b) earlier indication for starting treatment; c) monitoring of the information systems with the aim of treatment being started in patients with LT-CD4 levels that indicate the need to start treatment; d) incorporation and control of the use of 3rd-line ARVs; e) timely management of TB-HIV co-infection, using AIDS services for reference purposes; f) making available fixed-dose combination formulations; g) guidance on lifestyles to reduce adverse cardiovascular effects, including encouraging the use of alternative strategies such as fitness academies; h) prioritization of vulnerable populations' access to diagnosis.

Currently the priority of the Brazilian response consists of scaling up access to diagnosis, promoting prevention actions for more vulnerable populations and the organization of care schemes focused on people living with HIV (reduction of infectiousness) and vulnerable populations, identifying health needs and linking them with the health services.

Briefly identify how HIV treatment, care and support services are being scaled-up:

More than 700 HIV services have already been implanted. A call for proposals was published in 2004 to fund new HIV services. Large and medium-sized municipalities implement services in accordance with increases in demand, using incentive policy funds.
As a result of the change in the epidemic's profile, the demand for home care and day hospitals is also changing, and new care situations are emerging.

A network has been formed for performing surgical procedures to treat lipodystrophy. Since 2009, 10 hospital services have been accredited and offer both facial filling and reparative surgery. A further 13 outpatient services perform only facial filling. The network is therefore comprised of 23 accredited services.

1.1 To what extent have the following HIV treatment, care and support services been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	4 X	N/A
ART for TB patients	1	2	3	4 X	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4 X	N/A
Early infant diagnosis	1	2	3	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	3 X	4	N/A
HIV testing and counselling for people with TB	1	2	3 X	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3 X	4	N/A
Nutritional care	1	2	3 X	4	N/A
Paediatric AIDS treatment	1	2	3 X	4	N/A
Post-delivery ART provision to women	1	2	3	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3	4 X	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3	4	N/A
Psychosocial support for people living with HIV and their families	1	2	3 X	4	N/A
Sexually transmitted infection management	1	2	3 X	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3 X	4	N/A
TB preventive therapy for people living with HIV	1	2	3 X	4	N/A
TB screening for people living with HIV	1	2	3 X	4	N/A
Treatment of common HIV-related infections	1	2	3	4	N/A
Other *[write in]*:	1	2	3	4	N/A

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?

Yes X	No

Please clarify which social and economic support is provided:
Social and economic support occurs based on the country's current social protection system. Low-income people living with HIV/AIDS have the right to the Continuing Payment Benefit (under the social security organic law) which ensures per capita income of one minimum wage. However, in order to access this benefit, people living with HIV/AIDS have either to prove that their income is less than ¼ of the minimum wage or prove disability. Examples of other benefits ensured include the right to withdraw contributions made to the Government Severance Indemnity Fund for Employees (*FGTS*), sick pay and retirement pension if the person is formally employed. In addition, with effect from 2004, under the terms of Ministerial Ordinance (GM No. 1,824/2004), 12 million Real are transferred to states, the Federal District and municipalities qualified to receive incentive for funding actions undertaken by Support Homes for Adults Living with HIV/AIDS; with effect from 2011 Ministerial Ordinance GM No. 2,555/2010 also enables Support Homes for Children and Teenagers to receive this funding.

3.Does the country have a policy or strategy for developing/using generic medications or parallel importing of medication for HIV?

Yes X	No	N/A

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms and substitution medications?

Yes X	No	N/A

IF YES, for which commodities?
When necessary the Brazilian Government purchases medication and commodities for HIV/AIDS treatment and prevention via PAHO and UNICEF. This form of purchasing occurs for a variety of reasons, such as: price, products not produced by national laboratories and lack of registration with the National Health Surveillance Agency (*ANVISA*). Only Brazilian Government financial resources are used to make purchases in this way.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	X 8	9	10

Since 2009, what have been key achievements in this area?
1) The creation of technical boards on medication, 2) the holding of seminars and studies on adverse events, 3) the creation of the lipodystrophy/lipoatrophy network, and 4) strengthening the availability of tests.
What challenges remain in this area?
The following continue to be challenges: 1) early HIV diagnosis, 2) death investigation, and 3) increasing the number of hospital beds available for inpatient care.

6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes X	No	N/A

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes X	No

6.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes X	No

6.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes X	No

6.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	X **7**	8	9	10

Since 2009, what have been key achievements in this area?
Since 2011 Ministerial Ordinance GM 2,555/2010 has enabled Support Houses for Children and Teenagers to receive federal financial resources, thus increasing support in this area.
What challenges remain in this area?
The de-institutionalization of children and teenagers, by returning to their families of origin or being adopted by replacement families.

VI. <u>MONITORING AND EVALUATION</u>

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?

Yes X	In Progress	No

Briefly describe any challenges in development or implementation:
The principal challenges include: a) in a results-based management environment, linking planning with M&E, as well as the emphasis on accompanying results, has reduced the concern with planning; b) the creation of permanent mechanisms for the timely use of information generated by the M&E systems.

1.1. IF YES, years covered *[write in]:*

Since 2003

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners X	Yes, some partners	No	N/A

Briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include:

A data collection strategy?	Yes X	No
IF YES, *does it address*:		
Behavioural studies?	Yes X	No
Evaluation / research studies?	Yes X	No
HIV Drug resistance surveillance?	Yes X	No
HIV surveillance?	Yes X	No
Routine programme monitoring?	Yes X	No
A strategy for evaluating data quality? (i.e. validity, precision)	Yes X	No
A data analysis strategy?	Yes X	No
A data dissemination and use strategy?	Yes X	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	Yes X	No
Guidelines on tools for data collection?	Yes X	No

3. Is there a budget for implementation of the M&E plan?

Yes X	In Progress	No

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?

%

Note: This is not applicable since the budget for the evaluation area is not specific, but rather diluted among the Department's activities, such as expenditure on human resources and research, for example.

4. Is there a functional national M&E Unit?

Yes X	In Progress	No

Briefly describe any obstacles:
Although in recent years M&E has increasingly become necessary for maintaining the activities of all programmes, a lack can still be perceived of a national M&E culture that really establishes it as a reflexive management tool, rather than considering it as a means of scrutinizing work processes and the meeting of targets.

4.1. Where is the national M&E Unit based:

In the Ministry of Health?	Yes X	No
In the National HIV Commission (or equivalent)?	Yes	No X
Elsewhere? *[write in]*	Yes	No X

4.2. How many and what type of Professional staff are working in the national M&E Unit?

POSITION	Fulltime	Part time	Since when?
Permanent Staff [Add as many as needed]			
Statistician	X		2003
Statistician	X		2008
Statistician	X		2010
Psychologist, with postgraduate qualifications in M&E	X		2010
Dentist, with postgraduate qualifications in epidemiology and experience in M&E	X		2011
Nurse, with postgraduate qualifications in epidemiology and experience in M&E	X		2011

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes X	No

IF YES, briefly describe the data-sharing mechanisms:
A timetable exists for submitting the information necessary for completing the reports.
What are the major challenges in this area?
1) Consolidating decentralized M&E reports; 2) harmonizing the different interests in relation to the National Evaluation Plan, especially with regard to process indicators and indicators of effects on the target population; and 3) use of evaluation results as a management tool.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

Yes X	No

6. Is there a central national database with HIV-related data?

Yes X	No

IF YES, briefly describe the national database and who manages it:
MONITORAIDS – The Department of STD, AIDS and Viral Hepatitis' Indicator System. The System is currently comprised of a set of 90 indicators. The indicators selected are those that: a) characterize socioeconomic status, making it possible to analyse the inequalities that influence the dissemination of the disease and the effectiveness of the response; b) are relevant for monitoring the evolution of HIV/AIDS and other STDs; and c) are useful for accompanying programmatic actions and for indicating evaluations that need to be undertaken. The indicators have been divided into three areas: External Context Indicators, Programme-Related Indicators and Impact Indicators. The External Context indicators have been established based on the context in which the AIDS epidemic occurs in the country. They are represented by demographic and socioeconomic characteristics of the population, as well as by national health system indicators. Department-Related indicators are output and outcome indicators and are divided into sub-areas established according to: expenditure; the incorporation of new knowledge and technologies; individual vulnerability; prevention strategies; care provided; HIV/AIDS surveillance; STD prevention and control. Finally the Impact indicators enable the analysis of the impact on morbidity and mortality owing to the actions undertaken to control AIDS and other STDs.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organization?

Yes, all of the above X	Yes, but only some of the above	No, none of the above

IF YES, but only some of the above, which aspects does it include?

6.2. Is there a functional Health Information System[40]?

At national level	Yes X	No
At subnational level ***IF YES,*** at what level(s)? [write in] National Communicable Diseases Information System (*Sistema de Informação de Agravos de*	Yes X	No

Notificação - SINAN): Subnational and national Mortality Information System (*Sistema de Informação sobre Mortalidade - SIM*): Subnational and national Medication Logistics Control System (*Sistema de Controle Logístico de Medicamentos - SICLOM*): Subnational and national Laboratory Tests Control System (*Sistema de Controle de Exames Laboratoriais - SISCEL*): Subnational and national Live Births Information System (*Sistema de Informações sobre Nascidos Vivos - SINASC*): Subnational and national Note: All these systems provide information for Brazil as a whole and also for the states and municipalities.		

[40] Such as regularly reporting data from health facilities which are aggregated at district level and sent to the national level; data are analysed and used at different levels?

7. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?

Yes X	No

8. How are M&E data used?

For programme improvement?	Yes X	
In developing / revising the national HIV response?	Yes X	
For resource allocation?	Yes X	
Other *[write in]*		No X

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
The Department of STD, AIDS and Viral Hepatitis' policies on controlling the HIV/AIDS epidemic are based on evidence obtained through M&E. To give an example, the data is used in the definition of epidemic prevention and control strategies. With regard to care, the data obtained on clinical monitoring helps in the definition of the treatment consensus for people living with HIV/AIDS. Currently the main challenge is that of establishing a monitoring system which, in addition to monitoring the epidemic based on epidemiological indicators, also integrates the monitoring of the Department's performance using outcome and process indicators.

9. In the last year, was training in M&E conducted:

At national level?	Yes X	No
IF YES, what was the number trained: 10		
At subnational level?	Yes X	No
IF YES, what was the number trained: approximately 200 technical staff trained		
At service delivery level including civil society?	Yes X	No
IF YES, how many: approximately 50 technical staff trained		

9.1. Were other M&E capacity-building activities conducted other than training?

Yes X	No

IF YES, describe what types of activities:
Postgraduate Courses (Postgraduate Specialization and Professional Master's Degree) in the Evaluation of Endemic Process Control Programmes, with emphasis one STD/HIV/AIDS Postgraduate Specialization Course in Health Evaluation (distance course) - The courses are conducted and coordinated by the National School of Public Health /FIOCRUZ, in partnership with the

Department of STD, AIDS and Viral Hepatitis.

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	8	9	10

Since 2009, what have been key achievements in this area?
1) Institutionalization of monitoring as a management tool 2) Establishment of priority studies for accompanying the Brazilian response 3) Monitoring of key indicators 4) Implantation of a performance evaluation model
What challenges remain in this area?
1) Mismatch between M&E and planning 2) Strengthening the institutionalization of monitoring as a management tool 3) Standardization of the information systems used in monitoring 4) Prioritization of monitoring indicators 5) Assimilation of M&E in work routines

National Commitments and Policy Instrument (NCPI) PART B1 administered to representatives from UN agencies.

Representatives of institutions who contributed to the completion of NCPI – Part B.1:

Organization	*Name/Position*
1) UNICEF	Carla Perdiz, HIV/AIDS Programme Coordinator
2) UNODC	Bo Mathiasen, Regional Representative; Nara Santos, Technical Advisor on HIV/AIDS
3) UNAIDS	Pedro Chequer, UNAIDS Coordinator Brazil; Jacqueline Côrtes, Programme and Project Advisor
4) OPAS/OMS	Pamela Ximena Bermudez, HIV/AIDS Focal Point
4) UNFPA	Ângela Donini, HIV/AIDS Advisor
5) UNESCO	Maria Rebeca Gomes Otero, HIV/AIDS Programme Officer; Mariana Braga Alves de Souza
6) ACNUR	Luiz Fernando Godinho, Public Information Officer Cintia Sampaio, HIV Focal Point
7) PNUD	Joaquim Roberto Fernandes, Programme Official

I. CIVIL SOCIETY[41] INVOLVEMENT

[41] Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					**HIGH**
0	1	2	3	✓ **4**	5

Comments and examples:
Civil Society representation is guaranteed in social watch ("*controle social*") bodies provided for under Brazilian legislation, such as Health Councils (national, state and municipal) and other participation mechanisms, such as the UNAIDS Working Group, the National AIDS Commission and the Commission for Articulation with Social Movements, among others. Brazilian Civil Society, through a variety of organizations, has exercised considerable social watch over HIV-related prevention, counselling and treatment programmes and projects.

2. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and receiving drafts)?

LOW					**HIGH**
0	1	✓ **2**	3	4	5

N.B.: The most recent National Strategic Plan was written in 2004.

Comments and examples:
Brazilian Civil Society, through a variety of organizations, has exercised due social watch over HIV-related prevention, counselling and treatment programmes and projects. Its participation is constant in the Ministry of Health's Department of STD, AIDS and Viral Hepatitis and in other consultation, discussion and monitoring forums, such as the UNAIDS Working Group. Nevertheless, this participation is very differentiated and unequal in the various states and municipalities that go to make up the country. With regard to the issue of funding and budget, participation is much less effective.

3. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					**HIGH**
0	1	2	✓ **3**	4	5

b. The national HIV budget?

LOW					**HIGH**
0	1	✓ **2**	3	4	5

c. The national HIV reports?

LOW					**HIGH**
0	1	2	✓ **3**	4	5

Comments and examples:
Brazilian Civil Society, through a variety of organizations, has exercised due social watch over HIV-related prevention, counselling and treatment programmes and projects. Its participation is constant in the Ministry of Health's Department of STD, AIDS and Viral Hepatitis and in other consultation, discussion and monitoring forums, such as the UNAIDS Working Group. On the other hand, this participation is very differentiated and unequal in the various states and municipalities that go to make up the country.

4. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response:

a. Developing the national M&E plan?

LOW					**HIGH**
0	1	✓ **2**	3	4	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					**HIGH**
0	1	2	✓ **3**	4	5

c. Participate in using data for decision-making?

LOW					**HIGH**
0	1	✓ **2**	3	4	5

Comments and examples:
Overall, Civil Society participates through the Social Watch ("*Controle Social*") bodies. Specifically, we can cite the country progress reports on AIDS, in which civil society has had broader and more effective participation.

5. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, and faith-based organizations)?

LOW					**HIGH**
0	1	2	✓ **3**	4	5

Comments and examples:
Diversity is present through Civil Society representation on the country's various deliberative and consultative bodies on the issue of HIV/AIDS.

6. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW					**HIGH**
0	1	✓ **2**	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					**HIGH**
0	1	2	3	✓ **4**	5

Comments and examples:

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations				
People living with HIV	**<25%** ✓	25-50%	51-75%	>75%
Men who have sex with men	<25%	**25-50%** ✓	51-75%	>75%
People who inject drugs	**<25%** ✓	25-50%	51-75%	>75%
Sex workers	<25%	**25-50%** ✓	51-75%	>75%
Transgendered people	<25%	**25-50%** ✓	51-75%	>75%
Testing and counselling	<25%	**25-50%** ✓	51-75%	>75%
Reduction of stigma and discrimination	<25%	**25-50%** ✓	51-75%	>75%
Clinical services (ART/OI)*	**<25% (Zero)**	25-50%	51-75%	>75%

	✓			
Home-based care	**<25% (Zero)** ✓	25-50%	51-75%	>75%
Programmes for OVC**	**<25%** ✓	25-50%	51-75%	>75%

*ART = Antiretroviral Therapy; OI: Opportunistic infections
**OVC: Orphans and other vulnerable children

N.B. Civil Society contributes with prevention actions for key populations and stigma and discrimination reduction, although this takes place in an articulated manner with public services at the three levels of government.

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor										Excellent
0	1	2	3	✓ **4**	5	6	7	8	9	10

Since 2009, what have been key achievements in this area?
Increased support to the National Network of Teenagers and Young Adults Living with HIV can be seen.
What challenges remain in this area?
Most at risk populations, such as MSM (especially young MSM), young women, indigenous populations, traditional Black communities (*quilombolas*) and riparian communities have not yet reached the necessary and desired degree of participation. Low level of financial support for these populations at grassroots level.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

✓ **Yes**	No

IF YES, describe some examples of when and how this has happened:
• Social Watch (*Controle Social*) Bodies (Councils, Commissions, Committees, etc.) • Consultations • Working Groups

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle "Yes" if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	✓ Yes	
Men who have sex with men		✓ No

Migrants/mobile populations		✓ No
Orphans and other vulnerable children		✓ No
People with disabilities		✓ No
People who inject drugs	✓ Yes	
Prison inmates	✓ Yes	
Sex workers		✓ No
Transgendered people		✓ No
Women and girls	✓ Yes	
Young women/young men	✓ Yes	
Other specific vulnerable subpopulations *[write in]*:		

N.B.: Laws providing protection cover the general population. A more in-depth assessment of the contents in relation to previous years revealed the absence of specific protection legislation for specific populations.

Comment briefly on the current level of the implementation of this legislation:
The proposed law to criminalize homophobia (Bill No. 122/2006) has still not been approved by the National Congress.

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

✓ Yes	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Adequate legal mechanisms are in place at all levels of government. The main challenge is the enforcement and fulfilment of these laws in all circumstances. Some states and municipalities have laws that prohibit discrimination on the grounds of sexual orientation. In addition to national legislation and policies, there are also specific policies, such as the Integrated Programme of Affirmative Actions for Black People, the Integrated Plan to Fight the Feminization of AIDS and other STDs, the Statute for the protection of children and adolescents and the *Maria da Penha* Law on domestic violence against women and their protection, as well as the Operational Plan to Reduce Mother-to-Child Transmission of HIV and Syphilis. Laws also exist on Harm Reduction for people who use drugs. Below are the most relevant mechanisms: **LGBT** The objective of this programme is to promote the citizenship of gay men, lesbians, transvestites, transsexuals and bisexuals, based on equal rights and combating homophobic violence and discrimination, respecting the specificities of each of these population groups.

In order for the programme to achieve its objective, four main actions must be implemented.

1. Support for projects to strengthen public and non-governmental institutions that work to promote LGBT citizenship and/or to fight homophobia;
2. Building the capacity of professionals and representatives of LGBT movements involved in defending human rights;
3. Dissemination of information on rights and promotion of LGBT self-esteem;
4. Encouraging the reporting of the violation of the human rights of the LGBT segment.

There are around 50 LGBT Reference Centres providing legal support in cases of reported discrimination.

Children and teenagers

The Statute on Child and Teenage Rights (Law No. 8,069, dated July 13th 1990) provides for the integral protection of children and teenagers, including against all forms of discrimination, negligence, exploitation, violence, cruelty or oppression.

Drug users

Law No. 11,343/06 created the National System of Public Policies on Drugs, with the purpose of articulating, integrating, organizing and coordinating prevention, treatment and social reintegration activities for drug users and those dependent on drugs, as well as fighting drug trafficking, in line with the National Policy on Drugs.

Among its general guidelines, the National Policy on Drugs promotes harm reduction strategies and actions directed towards public health and human rights, to be undertaken in an articulated inter and intra-sectoral manner, with the aim of reducing the risks, adverse consequences and harm associated with the use of alcohol and other drugs for individuals, family and society.

Prison population

Interministerial Ordinance No. 1,777/03 (Ministry of Health and Ministry of Justice) created the National Health Plan for the Prison System and provides for the inclusion of the prison population within the National Health System (NHS), ensuring that the right to citizenship effectively happens within the perspective of human rights. This population's access to health actions and services is legally defined by the 1988 Federal Constitution; as well as by Law No. 8,080/90, which regulates the NHS; Law No. 8,142/90, that provides for community participation in the management of the NHS; and the Law of Criminal Code Enforcement (Law No. 7,210/84).

The National Health Plan for the Prison System was prepared based on a perspective of care and inclusion of people deprived of liberty and on basic principles that guarantee the effectiveness of health promotion, prevention and integral care actions. The principles on which the Plan is based include the promotion of citizenship, from the perspective of civil, political and social rights as well as the promotion of human rights as a benchmark for a life with dignity, without discrimination and without violence.

Refugees/migrants:

With regard to men, women and children seeking refuge or recognized as refugees in Brazil, this population has guaranteed access to the country's health services, including HIV/AIDS prevention commodities, counselling and treatment.

Specific legislation does not exist for migrant/mobile populations, but their access to services is guaranteed by existing norms, regulations and legislation.

Briefly comment on the degree to which they are currently implemented:

LGBT

The programme was created in 2004, and is still in the implementation phase. It has been monitored by the Human Rights Secretariat of the Office of the President of the Republic, the Ministry of Health, the Ministry of Education, the Ministry of Justice, the Ministry of Culture, the Ministry of Labour and Employment, among others.

Drug users

The harm reduction strategy has been adopted by the Ministry of Health's Department of STD, AIDS and Viral Hepatitis since 1994. Harm reduction is a highly relevant strategy in changing the profile of the AIDS epidemic. In the 1990s there was a point when 25% of reported AIDS cases were associated directly or indirectly with injecting drug use, whereas currently they have fallen to 9%.

In 2009, the Ministry of Health, through its Mental Health Coordination, launched its Emergency Plan to Scale Up Access to Alcohol and Other Drug Treatment and Prevention on the National Health Service. The main objective of the Plan is to intensify, scale up and diversify health prevention and promotion actions and actions for the treatment of the risks and harm associated with the prejudicial consumption of psychoactive substances. Among its guidelines, the Plan proposes respect for and promotion of human rights and social inclusion. The Plan's actions include support for actions to combat stigma and promote social inclusion by raising the awareness of public service managers, professionals and the general population about the rights of people who use alcohol and other drugs.

Prison population

23 of Brazil's 27 states are currently qualified under the National Health Plan for the Prison System.

All populations under the UNHCR mandate (the Office of the United Nations High Commissioner for Refugees in Brazil) are benefitted by this guarantee.

2. Does the country have laws, regulations of policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	✓ No

[42] These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

2.1. IF YES, for which subpopulations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No

Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations[43]:	Yes	No

[43] Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
Briefly comment on how they pose barriers:

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

✓ **Yes**	No

Describe briefly the content of the policy, law or regulation and the population included:
Law No. 11,340 (*Maria da Penha* Law) dated August 7th 2006 This law creates mechanisms to curb domestic and family violence against women, in accordance with the Federal Constitution (paragraph 8, article 226), the Convention on the Elimination of All Forms of Violence Against Women and the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women. The law provides for the creation of Courts to judge domestic and family violence against women; it alters the Code of Criminal Procedure, the Criminal Code and the Law of Criminal Code Enforcement; and makes other provisions. Article 9. "Assistance to women in situations of domestic and family violence shall be provided in an articulated manner and in accordance with the guidelines contained in the Organic Law of Social Welfare, the National Health System, the Public Security System, among other protection norms and public policies, as well as on an emergency basis when necessary. Paragraph 1. The judge shall determine, for a defined period of time, the inclusion of women in situations of domestic and family violence on federal, state and municipal welfare programmes. Paragraph 3. Assistance to women in situations of domestic and family violence shall include access to the benefits arising from scientific and technological development, including emergency contraception services, prophylaxis for sexually transmitted diseases (STD) and the Acquired Immune Deficiency Syndrome (AIDS) and other medical procedures necessary and appropriate in cases of sexual violence."

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

✓ **Yes**	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Human rights are clearly mentioned and incorporated in all the policies, strategies and programmes that sustain the Brazilian response to HIV/AIDS. It is the country's understanding that the response to HIV is based on the indissociability of prevention and care, having human rights as its mainstay.

Civil society and specific groups of populations vulnerable to HIV/AIDS have ample participation in the programmes developed by the three levels of government (federal, state and municipal), principally through activities of the Ministry of Health's Department of STD, AIDS and Viral Hepatitis, the State and Municipal STD/AIDS Departments and projects implemented by international agencies.

Although human rights are reflected in HIV policies and strategies, the National LGBT Council is concerned that there should be a stronger link between media campaigns against violence against the LGBT population or which deal with this group's human rights, as a factor of vulnerability and increased risk of HIV infection.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

✓ **Yes**	No

***IF YES*, briefly describe this mechanism:**

The Department of STD, AIDS and Viral Hepatitis has a complaints database – the HIV/AIDS Human Rights Violations Monitoring and Evaluation System (www.aids.gov.br, in the item "*Leis e Normas*").

There are also juridical and legal mechanisms such as the public prosecution services, the Brazilian Law Society, the small claims courts and legal aid provided by NGOs. These services and support are free of charge.

Nevertheless, these mechanisms need to be enhanced, given that the various government systems like the Health Line, Dial 100 and Dial 180 are not yet linked to the records of discriminatory violence controlled by the Ministry of Justice and its police stations.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "Yes" or "No" as appropriate).

	Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Antiretroviral treatment	✓		
HIV prevention services[44]	✓		
HIV-related care and support interventions	✓		

[44] Including blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counselling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

✓ **Yes**	No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

✓ **Yes**	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support.

✓ **Yes**	No

IF YES, briefly describe the content of this policy/strategy and the populations included:
As mentioned above, the country has a range of policies and programmes aimed specifically at more vulnerable populations. Access to the public health system is universal and non-discriminatory.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

✓ **Yes**	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
There are legal instruments referred to as Plans to Fight the Epidemic, aimed at, for example: • Women • MSM and Transvestites • Prison population • Indigenous population

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

✓ **Yes**	No

IF YES, briefly describe the content of the policy or law:
Ministry of Labour and Employment Ordinance No. 1,246, dated May 28th 2010, prohibits companies from submitting workers to HIV tests, directly or indirectly, for admission, change of position, periodic assessment, return to work, dismissal/resignation or any other procedure related to the employment relationship. The Ordinance is based on Law No. 9,029, dated April 13th 1995, which prohibits all discriminatory and restrictive practices regarding admission to or permanence in employment. The text is also based on Interministerial Ordinance No. 869, dated August 12th 1992, which prohibits the requirement to test for HIV as part of pre-employment or periodical examinations in the federal civil service. Nevertheless, the Ordinance is not contrary to the encouragement of testing, with proper counseling,

through health prevention campaigns or programmes, as long as workers voluntarily agree to it.

MINISTRY OF LABOUR AND EMPLOYMENT ORDINANCE No. 1,246, DATED MAY 28th 2010 – PUBLISHED IN THE OFFICIAL GAZETTE ON MAY 30th 2010

THE MINISTER OF LABOUR AND EMPLOYMENT, in the use of the attributions conferred upon him by article 87, paragraph 1, subsection II of the Federal Constitution;

Whereas International Labour Organization Convention 111, enacted through Decree No. 62,150, dated January 19th 1968, prohibits all forms of discrimination in respect of employment and occupation;

Whereas Law No. 9,029, dated April 13th 1995, prohibits all discriminatory and restrictive practices regarding admission to or permanence in employment;

Whereas, in consideration of the provisions of programmatic action contained in item j, Strategic Objective VI. Guideline III, of the National Human Rights Programme, approved by Decree No. 7,037, dated December 22nd 2009;

Whereas Interministerial Ordinance No 869, dated August 12th 1992, prohibits the requirement to test for the Human Immunodeficiency Virus – HIV in the Federal Civil Service, both as part of pre-employment or periodical health examinations;

Whereas Federal Council of Medicine Resolution No. 1,665, dated May 7th 2003, prohibits compulsory HIV testing,

Hereby determines:

Article 1 – The provision of guidelines for companies and workers with regard to human immunodeficiency virus – HIV testing.

Article 2 – The testing of workers for HIV shall not be allowed, directly or indirectly, as part of medical examinations for admission, change of position, periodic assessment, return to work, dismissal/resignation or other examinations relating to the employment relationship.

Paragraph 1. The provisions of this article do not prevent health prevention campaigns or programmes from encouraging workers to find out their HIV status through counselling and testing proven to be voluntary, unrelated to their employment relationship, whereby the results are always confidential.

Article 3 – This Ordinance comes into effect on the date of its publication.

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work.

✓ **Yes**	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts.

✓ **Yes**	No

IF YES on any of the above questions, describe some examples:

1. The National Council to Combat Discrimination; 2. The National AIDS Commission; 3. The Commission for Articulation with Social Movements (Department of STD, AIDS and Viral Hepatitis); 4. The Technical Committee on Gay, Lesbian, Bisexual, Transvestite and Transsexual Health (Ministry of Health); 5. The Human Rights Commission of the National Congress; 6. The Human Rights Secretariat of the Office of the President of the Republic; 7. The Parliamentary Front on HIV/AIDS – National Congress; 8. The Parliamentary Front for LGBT Citizenship – National Congress.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[45]?

✓ **Yes**	No

[45] Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008).

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

✓ **Yes**	No

[46] Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners.

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework.

✓ **Yes**	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV.

✓ **Yes**	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

✓ **Yes**	No

IF YES, what type of programmes?		
Programmes for health care workers	✓ **Yes**	No
Programmes for the media	✓ **Yes**	No
Programmes in the work place	✓ **Yes**	No
Other *[write in]*: • Frequent pronouncements by people in prominent positions • Specific Carnival and December 1st Campaigns • Programme to fight violence and discrimination against	✓ **Yes**	No

LGBT and to promote homosexual citizenship		

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	✓ 6	**7**	8	9	10

Since 2009, what have been key achievements in this area?
• Intense progress with intersectoral actions, e.g. the presidential decree that created the School Health Programme in 2007; • The creation of a national network of teenagers and young adults living with HIV in 2008 is giving greater visibility to the issue; • The development of integrated plans to fight the feminization of the AIDS epidemic and other STDs and to fight the AIDS epidemic and other STDs among gay men, other MSM and transvestites; • The holding of the 1st National Lesbian, Gay, Bisexual, Transvestite and Transsexual Conference (LGBT) on May 5th 2008; • Leadership in the Regional Consultation on HIV and Sex Work and the National Consultation on HIV, Prostitution and Human Rights in 2008; • Leadership in the Latin American and Caribbean Regional Consultation on HIV in the Prison System, held in São Paulo in May 2008, followed in 2009 by the National Consultation on HIV in the Prison System; • Increase in universal health care, improvement in the collection/analysis of epidemiological data and new strategies for access by more vulnerable populations.
What challenges remain in this area?
• People with HIV continue to suffer discrimination and stigma. Greater attention needs to be paid to children and teenagers living with HIV, in particular those living in institutions. • Greater presence of the Department of STD, AIDS and Viral Hepatitis in frontier areas, with greater distribution of relevant information (on prevention, counselling and treatment in frontier and migration control posts. • Need to strengthen the School Health Programme and increase the participation of adolescents in the Programme as peer educators. • Need to increase the participation of girls living with HIV in existing forums • Need for greater articulation between the Department of STD, AIDS and Viral Hepatitis and the Human Rights Secretariat of the Office of the President of the Republic in joint actions.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	3	4	5	✓ 6	7	8	9	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area?

The implementation of laws providing protection and the systematic refusal of the federal legislative branch in the National Congress to support specific laws to protect certain more vulnerable populations.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

✓ **Yes**	No

IF YES, how were these needs determined?
Through recommendations made by the national, state and municipal councils; behaviour studies; prevalence studies; establishment of National Plans. Other measures include scientific and technological development in the area of prevention commodities, the enhancement of strategies for the social marketing of condoms and the scaling up of actions by partners outside the health sector such as, for example: education, labour, women's policies, social action, youth, among others. Such measures enable improved data collection/analysis and more precise identification of the evolution of the epidemic and the social groups more vulnerable to HIV/AIDS.
SE NÃO, how are HIV prevention programmes being scaled-up?

1.1. To what extent has HIV prevention been implanted?

HIV prevention component	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety			✓		
Condom promotion				✓	
Harm reduction for people who inject drugs		✓			
HIV prevention for out-of-school young people		✓			
HIV prevention in the workplace			✓		
HIV testing and counselling			✓		
IEC[47] on risk reduction			✓		
IEC on stigma and discrimination reduction			✓		
Prevention of mother-to-child transmission of HIV			✓		
Prevention for people living with HIV			✓		
Reproductive health services including sexually transmitted infections prevention and treatment			✓		
Risk reduction for intimate partners of key populations			✓		
Risk reduction for men who have sex with men			✓		
Risk reduction for sex workers			✓		
School-based HIV education for young people			✓		

Universal precautions in health care settings				✓	
Others *[write in]*:					

[47] IEC = information, education and communication

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	✓ **5**	6	7	8	9	10

Since 2009, what have been key achievements in this area?
• Scaling up of rapid testing for pregnant women; • Scaling up of testing for young adults and teenagers; • National Plan to Fight the AIDS and STD Epidemic among Gay Men, Other MSM and Transvestites.
What challenges remain in this area?
• Universal access to testing by pregnant women has not yet been achieved; • Many teenagers and young adults still do not have access to condoms; • Out-of-school teenagers continue to be excluded in relation to prevention and treatment services; • Large regional differences (North and North-East Regions) in relation to prevention services; • The policy to fight the feminization of HIV has not yet been successfully incorporated in the Brazilian states; • There has been no progress in the Legislative Branch with regard to the rights of LGBT people in Brazil. Expressive political presence of fundamentalist parliamentarians in the National Congress has caused notorious backtracking of the traditional evidence-based Brazilian policy.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

✓ **Yes**	No

IF YES, briefly identify the elements and what has been prioritized:
The elements have been defined through studies and research on adherence, diagnosis; by scientific medication protocol committees; and by health information systems in the country.
Briefly identify how HIV treatment, care and support services are being scaled-up:

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A

Antiretroviral therapy	1	2	3	4	
ART for TB patients			✓		
Cotrimoxazole prophylaxis in people living with HIV			✓		
Early infant diagnosis			✓		
HIV care and support in the workplace (including alternative working arrangements)		✓			
HIV testing and counselling for people with TB			✓		
HIV treatment services in the workplace or treatment referral systems through the workplace					✓
Nutritional care		✓			
Paediatric AIDS treatment			✓		
Post-delivery ART provision to women			✓		
Post exposure prophylaxis for non-occupational exposure (e.g., sexual assault)			✓		
Post exposure prophylaxis for occupational exposures to HIV			✓		
Psychosocial support for people living with HIV and their families			✓		
Sexually transmitted infection management			✓		
TB infection control in HIV treatment and care facilities			✓		
TB preventive therapy for people living with HIV			✓		
TB screening for people living with HIV			✓		
Treatment of common HIV-related infections			✓		
Other [*write in*]:					

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	✓ **7**	8	9	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area?
True universal access: regional iniquities and structural problems in health services and local political scenarios are factors that hinder the achievement of universal access.

2. Does the country have a policy and strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	✓ **No**

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

2.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	**2** ✓	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area?
The national plan to ensure the right to family and community life makes some mention of children living with HIV.
What challenges remain in this area?
Several challenges remain: • Lack of information at state and national level on the number of children affected by HIV; • Lack of information on the types of violence suffered by these children and teenagers; • Lack of a national strategy effectively implemented to ensure that children and teenagers with HIV and living in institutions have the right to family and community life; • Lack of psychosocial support for children and teenagers living with HIV – focus only on medical aspects; • Lack of a specific policy with options for teenagers in care once they are 18.

National Commitments and Policy Instrument (NCPI) PART B.2 administered to Civil Society Organizations

Representatives of institutions who contributed to the completion of NCPI – Part B2.

Organization	*Name/Position*	Interviewed for Part B.2 – by section				
		B.I	***B.II***	***B.III***	***B.IV***	***B.V***
Movimento de Promoção da Mulher (Women's Promotion Movement)	Maria Luiza Barroso Magno/President	X	X	X	X	X
Rede Nacional de PVHA núcleo Belém (National Network of PLWHA – Belém branch)	Maria Elias Sarmento Silva/ Executive Coordinator	X	X	X	X	X
Colegiado Regional de Cidadãs Positivas do Norte (Positive Women Citizens – North Brazil Regional Collegiate)	Alzemira Santarém Guerreiro	X	X	X	X	X
Movimento dos Atingidos por Barragens (Movement of People Affected by Dams)	Judith da Rocha/National Management	X	X	X	X	X
AMAR-Associação de Mulheres do Acre Revolucionárias (State of Acre Association of Revolutionary Women)	Anagila Bomfim/President	X	X	X	X	X
AREDRAC-Associação de Redução de Danos do Acre (State of Acre Harm Reduction Association)	Leazar Haerdrich /Director	X	X	X	X	X
ATRAC-Associação das Travestis do Acre (State of Acre Transvestite Association)	Raissa Rios/President	X	X	X	X	X
AVIVER-PR	Amauri Ferreira Lopes/President	X	X	X	X	X
Grupo União Pela Vida	Edna Soares da Silva/Secretary	X	X	X	X	X
PROJETO AMMOR – FÓRUM MINAS	Rose Souza	X	X	X	X	X

I. CIVIL SOCIETY[41] INVOLVEMENT

[41] Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					**HIGH**
0	1	2	3	4	5
(01)*	(02)*			(04)*	(02)*

* Number of respondants

Comments and examples:
Yes, although some organizations consider themselves to be excluded from the process in the states and

municipalities, whilst others think they have little participation and others consider very positive civil society's participation – as members of State-level AIDS Service NGO Forums, Advisory Committees, Networks of PLWHA, the Network of Positive Women Citizens etc. – in spaces of social watch (Health Councils), the Commission for Articulation with Social Movements, the National AIDS Commission when their representatives are elected in a fair manner. In relation to HIV/AIDS, the target population is involved in public policies on prevention, through partnerships, in the development of prevention projects. Nevertheless, more involvement of some segments is lacking, activists have low educational qualifications and financial dependence often prevents these activists from being more active. Criticism exists as to the differentiated treatment the Government has dispensed to religious segments in the National Congress which has been prejudicial to the movement and has disqualified it. Another complaint is the fact of the Department hear suggestions but implementing few of them, given the limitation of the social movement that has a consultative role in these spaces. Civil society needs more support for the greater development of knowledge and greater dedication of its activists.

2. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and receiving drafts)?

LOW					**HIGH**
0	1	2	3	4	5
(02)		(01)	(01)	(01)	(04)

Comments and examples:
Social organizations took part in the planning processes, in the construction of the Plans to fight epidemic among MSM and women and the plan to eliminate syphilis in 2009 and 2010. At state and municipal level (some state capitals) and other municipalities including capitals in the northern region have still not adopted a democratic way of working, either in building the plans or executing them. Generally this depends on the stance of the health service manager both in the states and the municipalities (capital). In relation to more effective planning, such as the Pluriannual Plan and the Law of Budgetary Guidelines, civil society is not called on to discuss this, although it has raised this demand in some states and municipalities and with the Federal Government. A minority of the organizations think that they take part in the planning process in an indirect manner.

3. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					**HIGH**
0	1	2	3	4	5
	(02)	(01)	(02)	(01)	(03)

b. The national HIV budget?

LOW					**HIGH**
0	1	2	3	4	5
(01)	(04)		(02)	(02)	

c. The national HIV reports?

LOW		**HIGH**

0	1	2	3	4	5
(01)	(03)		(03)	(02)	

Comments and examples:
As part of the national strategy, the proposal of decentralization promoted by the Ministry of Health/Department is very positive with regard to resource management and medication with the aim of facilitating the agility of the actions. However, in practice it has not worked. The Social Organizations have undertaken their activities with great difficulty, many of them out of their commitment to the segments to which they belong and in which they are militants, given that the resources for projects have reduced considerably and, as a result, so have the actions undertaken by the NGOs. Resources have reduced considerably. The documentation required in order to receive funding and the onus of social security and other contributions have been a barrier for the NGOs and have generated a certain discomfort and resulted in discontinued actions. The low commitment of private companies to support the actions of the movement in this area is also an obstacle.

4. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response:

a. Developing the national M&E plan?

LOW					**HIGH**
0	1	2	3	4	5
(02)	(01)			(04)	

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					**HIGH**
0	1	2	3	4	5
(01)		(01)	(02)	(04)	(01)

c. Participate in using data for decision-making?

LOW					**HIGH**
0	1	2	3	4	5
(02)	(02)		(04)	(01)	

Comments and examples:
At national level some Monitoring and Evaluation actions take place at the Macro-Regional meetings that take place every year in all the regions and in which civil society takes part. At state and local level, Monitoring and Evaluation should be more effective but does not happen because of the lack of political and democratic commitment of the health service managers who in the majority of cases consider the social movement as an enemy, given that the application of resources (health fund) does not happen in a harmonious manner, and only with considerable effort does the elaboration of the Actions and Goals Plans take place. In relation to the statistical data, it is very difficult to monitor given the low level of execution of intersectoral policies and the huge difficulty in implementing articulated information systems that guarantee the quality of the monitoring and evaluation of the health services and policies. This difficulty occurs at federal level. At state and municipal level it is even worse as the system is not fed with information in a systematic manner as the Ministry/Department recommends. Apart from this, we need to create M&E mechanisms so that all planning, all actions, all funded projects are monitored and evaluated. However, the government does not perform this monitoring and civil society does not have access to the data, thus making social watch more difficult, social watch being to a certain extent an instrument that contributes to the improvement of services and public policy.

5. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organizations and networks of people living with HIV, of sex workers, and faith-based organizations)?

LOW					**HIGH**
0	1	2	3	4	5
	(01)		(01)	(04)	(03)

Comments and examples:
Yes, at the federal level all the segments: women, Black women, MSM, LGBT, prostitutes, young people and other segments are represented on the various Committees where strategies to fight the epidemic are discussed, such as the Commission for Articulation with Social Movements, the National AIDS Commission and other Committees such as the vaccine advisory committee. At state level the same practice does not happen, or when it does it is nothing more than a few meetings held as a result of civil society pressure. In the municipalities it is much more difficult, because the health service managers do not understand the policy, do not execute the policy and do not accept civil society participation.

6. To what extent (on a scale of o to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW					**HIGH**
0	1	2	3	4	5
(02)	(02)	(01)	(01)	(03)	

b. Adequate technical support to implement its HIV activities?

LOW					**HIGH**
0	1	2	3	4	5
(02)	(01)	(02)		(01)	

Comments and examples:
Civil society is having increasing difficulty in accessing financial resources and has to compete in national and state-level calls for proposals, which in the majority of cases have been insufficient to implement actions with quality. The Department has not been very sensitive about regional differences in Brazil. Our regions are very diverse in size, population density, number of HIV/AIDS cases, numbers of co-infections, whereas the organizations compete in the calls for proposals under the same criteria. Those who are different should be treated differently. The states continue to retain the resources of the Actions and Goals Plan for long periods, do not execute the policy, do not support the movements. Technical support should be provided by the state and municipal governments more frequently, but this does not happen in a pacific and efficient manner. When the movement accesses the Federal Government it obtains information and support. Before decentralization these practices were better, more frequent and more accessible.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations				
People living with HIV	<25%	25-50%	51-75%	>75% (09)
Men who have sex with men	<25% (01)	25-50% (04)	51-75% (03)	>75% (01)
People who inject drugs	<25% (03)	25-50% (04)	51-75% (02)	>75%
Sex workers	<25% (01)	25-50% (04)	51-75% (03)	>75% (01)
Transgendered people	<25% (04)	25-50% (04)	51-75%	>75% (01)

Testing and counselling	**<25%**	**25-50%**	**51-75%**	**>75%**
Reduction of stigma and discrimination	<25%	25-50% (02)	51-75% (03)	>75% (04)
Clinical services (ART/OI)*	**<25%**	**25-50%**	**51-75%**	**>75%**
Home-based care	**<25%**	**25-50%**	**51-75%**	**>75%**
Programmes for OVC**	<25% (08)	25-50%	51-75%	>75% (01)

* ART = Antiretroviral Therapy; OI: Opportunistic infections

** OVC: Orphans and other vulnerable children

Suggest removal from this questionnaire

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
			(01)	(01)	(02)	(03)	(02)			

Since 2009, what have been key achievements in this area?
• For some organizations there has been no progress. For others there has been progress with greater participation of society in spaces of social watch and in working groups, public consultations, discussion and construction of Plans to fight the epidemic among MSM, women and other vulnerable populations; • Creation of branches of the National Network of People Living with HIV/Aids (NRN+); • Civil society participation in the Actions and Goals Plan workshops; • Greater participation of the movements in the State AIDS Service NGO Forums; • Support with the holding of Local, Regional and National Articulation and Qualification Events.
What challenges remain in this area?
• Better qualified leaders; • Support for knowledge production; • The difficulty in identifying and training new leaders committed to the movement; • Little structure for implementing actions and activities; • Little respect on the part of some government authorities for the execution of what has been planned in the Actions and Goals Plans; • More support from the government and private companies in the development of prevention and treatment actions; • Respect on the part of society and the governments; • Correct application of the Actions and Goals Plans; • Civil society is a partner, but the responsibility for executing public policies is the Government's. • More strictness on the part of the Federal Government in inspecting and monitoring the application of federal resources by the state and municipal governments.

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes (07)	No (02)

IF YES, describe some examples of when and how this has happened:
The majority answered yes. The Federal Government has hired as civil servants technical staff and

leaders from all segments of organized civil society: LGBT, homosexuals, PLWHA, and has supported events promoted by PLWHA and other segments of organized civil society and this has contributed greatly to progress with policies, because of the understanding, experience and knowledge of the cause of those involved. State governments have not implemented the same practice, and if they do it is for other motives.
The Government has provided financial support to projects, although this support has been insufficient;
Support to the National Network of Young People Living with HIV/AIDS;
Support for local, state and national events;
Support with drawing up the Actions and Goals Plans;
Support with the Macro-Regional Meetings.
On the other hand, the population that uses drugs indicates that it needs this involvement and feels excluded.

III. HUMAN RIGHTS

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle "Yes" if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes (09)	No
Men who have sex with men	Yes (08)	No (01)
Migrants/mobile populations	Yes (08)	No (01)
Orphans and other vulnerable children	Yes (09)	No
People with disabilities	Yes (09)	No
People who inject drugs	Yes (01)	No (08)
Prison inmates	Yes (01)	No (08)
Sex workers	Yes (01)	No (08)
Transgendered people	Yes (01)	No (08)
Women and girls	Yes (09)	No
Young women/young men	Yes (09)	No
Other specific vulnerable subpopulations: Elderly, Indigenous, Black men and women, Gypsies	Yes (08)	No (01)

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination)?

Yes (09)	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

The sanctioning of the "*Maria da Penha*" Law in 2006 has contributed a great deal to encouraging women to report domestic and family violence, sexual violence and harassment. In many cases and places these practices have been repressed, however women are facing a big battle with the National Congress which is attempting to alter clauses of this law. Nevertheless, women have organized themselves and have sought mechanisms that guarantee the defence of sexual rights and reproductive rights that truly meet women's integral health needs. As to the right to abortion, this has been a hard and unequal struggle with the Brazilian Congress, marked by huge prejudice, principally on the part of evangelical members of parliament.
The Youth Statute has been being analysed by the Constitution, Justice and Citizenship Commission since 15/01/2012
The Statute of the Child and Adolescent is another instrument, as is the Statute of the Elderly, the Statute of Racial Equality, the law which criminalizes racism.
In the majority of the Brazilian states, trans people have the right to use their "social name" (preferred name instead of registered name).
In the state of Pará an ordinance of the Penitentiary System Superintendent's Office allows "intimate

visits" between inmates and their same sex long-term partners.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Support from the Brazilian Law Society, Public Prosecution Service, mobilization and denouncements by the social movement itself.
Briefly comment on the degree to which they are currently implemented:
In Brazil there is a very large number of Laws, Norms and Acts. What is difficult is their enforcement. As such, the enforcement of the laws for these populations is no different to the rest. Much progress needs to be made. The Judiciary branch tends to operate to the contrary. Another impediment is political will: the Brazilian Government submits to pressure brought principally by religious groups or those linked to them. As a result Brazil has made successive retrograde steps in policies which today should already have been consolidated, including from a Human Rights perspective.

2. Does the country have laws, regulations of policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No (09)

[42] These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

2.1. IF YES, for which subpopulations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations: Precious metal prospecting populations, former landless in settlements, dam workers, indigenous populations in native villages or not.	Yes	No

[43] Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
Although it is boasted that there is no prejudice in Brazil, that we are a democracy and we do not have legislation that does not allow prevention or which prohibits HIV and other STD treatment and support, some facts can be identified, such as: homosexuals are prohibited to donate blood, there is no policy for people deprived of liberty, the same applies to people living in the streets and who are extremely vulnerable both to STDs and to drugs, without access to health and welfare services and other public policies.
Briefly comment on how they pose barriers:
The Ministry/Department has attempted to implement some policies in a cross-cutting manner in

partnership with other Ministries, such as: Human Rights, Women, Education. It can be perceived that this has not worked very well, as is the case of the following plans: Plan to fight the feminization of the AIDS epidemic and other STDs, Plan to fight the epidemic among MSM, Plan to eliminate syphilis, the Health and Prevention in Schools programme, the National plan to fight sexual violence against children and teenagers, this latter plan involving several Parliamentary Committees of Inquiry in several states. However, few of these plans have been put into practice and some states have not so much as written the Plans, never mind execute them. In this sense there is a lack of political will on the part of the public service managers.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes (09)	No

Describe briefly the content of the policy, law or regulation and the population included:
The "*Maria da Penha*" Law and other laws mentioned above.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes (09)	No

***IF YES*,** briefly describe how human rights are mentioned in this HIV policy or strategy:
Furthermore, Brazil has a Ministry of Human Rights.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes (08)	No (01)

***IF YES*,** briefly describe this mechanism:
There used to be a project funded by the Department using Actions and Goals Plan resources that ensured the provision of legal aid services by some NGOs, some of which referred cases to the Public Prosecution Service, the Brazilian Law Society, the Human Rights Society (*SDDH*). However, these services are no longer available. Other services are provided by the Special Police Stations for Women.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "Yes" or "No" as appropriate).

	Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Antiretroviral treatment	X		
HIV prevention services[44]	X		
HIV-related care and support interventions	X		

[44] Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counselling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes (09)	No

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes (09)	No

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes (08)	No (01)

IF YES, briefly describe the content of this policy/strategy and the populations included:
The Brazilian Government attempts to guarantee these services at the three levels of government (federal, state, municipal) through financial support, for care and support both for men and for women. In the specific case of prevention for women, there is care for some specific groups such as prostitutes and positive women citizens and for other women organized in other segments. The policy on services for the general population is deficient. Not all women are contemplated in the way mentioned above and furthermore this is contrary to the regulations of the National Health System. In truth, low performance and inefficiency in state and municipal management are prejudicial to the federal strategy. As for treatment, it is made available to everyone who needs it, although in the last two years we have noticed the systematic shortage of some medications. According to UNAIDS, coverage of HIV treatment in the country varies between 60% and 79%.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes (07)	No (02)

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
Brazil has the world's best health plan – the Federal Constitution and the National Health System guarantee access. The Ministry of Health's strategy, involving large-scale civil society participation, in creating the Department of STD and AIDS has resulted in it making a tremendous effort to ensure universal and equal access by women, MSM, PLWHA, by all people. However, at grassroots level access is not universal. In other cases, policies need to be scaled up to include other populations such as those living in frontier regions and precious metal prospectors. Testing campaigns and mobile testing units are directed towards the general population, but need to be aimed at vulnerable populations and need to occur more in interior regions of the country. The high rate of late diagnosis is a reality.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes (09)	No

IF YES, briefly describe the content of the policy or law:
Owing to its response to the epidemic based on the respect for human rights, among many other considerations, the Brazilian programme has been recognized as an example for the world. The concept of human rights in the fight against the AIDS epidemic is far-reaching, ranging from the promotion of the citizenship of historically marginalized populations to guaranteeing the human rights of people living with HIV and/or AIDS. One of these rights is the right not to be submitted to compulsory HIV testing, this being a fundamental guarantee provided for in the Federal Constitution (Article 5, item X): "people's… intimacy, private life

are inviolable". Based on this understanding, Interministerial Ordinance No. 869, dated August 11th 1992 (attached), prohibits testing to detect HIV as part of employment admission examinations and periodical health checks for federal civil servants. Federal Council of Medicine Report No. 05, dated February 18th 1989 (attached), on the obligation to test for HIV as part of employment admission, concluded that "performing serological tests for AIDS on workers under these circumstances is a violation of their rights, it is also in contravention of the Consolidated Labour Laws and, in the case of a positive result, contributes to their marginalization as citizens." Similarly, Federal Council of Medicine Report No. 15, dated April 9th de 1997 (attached), refers to the performance of serological tests for HIV without the prior consent of candidates in civil and military entrance examinations, as well as referring to such candidates being disqualified in the event of a positive result, and determines that "the obligatory serological tests required by Army Ministry regulations are a violation of Human Rights, are in contravention of the Federal Constitution and are unethical". Unfortunately there are still some Brazilian states and municipal governments that attempt to include in their Public Service Entrance Examinations the requirement to test for HIV, in the same way as the Armed Forces, as is currently the case of the entrance examination for military police officers and soldiers in the State of Minas Gerais, as can be seen in the following link in the item "*Exames Complementares de Saúde*", http://www.dsconto.com/768650-concurso-pmmg-2012-soldado-cfo-feminino-interior-e-mais/ "blood: immunofluorescence for *Trypanosoma Cruzi*, complete blood count, blood sugar level, anti-HIV, HBS Ag, anti-HCV, glutamic pyruvate transaminase, gamma-glutamyl transferase and creatinine".

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work.

Yes (09)	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts.

Yes (08)	No (01)

IF YES on any of the above questions, describe some examples:
Brazil has high Social Capital and, therefore, has many organizations, Networks of PLWHA, Youth Network, Network of Positive Women Citizens, State AIDS Service NGO Forums, National AIDS Articulation, Brazilian Network of Prostitutes, Trans Network, Transvestite Association, Gay Association, Brazilian Harm Reduction Network. With regard to item b, the Brazilian Law Society provides support through its Human Rights Commission, and the Public Prosecution Service provides support through its Human Rights Division.

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[45]?

Yes (08)	No (01)

[45] Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008).

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

Yes	No (02)

Not aware of any such programmes (07)

_____

[46] Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners.

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework.

Yes (09)	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV.

Yes (09)	No

In addition to universities, we also highlight the "S System" (*Sistema S*). (A wide range of social and other services the existence of which is determined by the Federal Constitution)

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes (08)	No (01)

IF YES, what type of programmes?		
Programmes for health care workers	Yes (07)	No
Programmes for the media	Yes (07)	No
Programmes in the work place	Yes (07)	No
Other: Advocacy actions.	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
					(01)	(01)	(04)	(03)		

Since 2009, what have been key achievements in this area?
The most significant achievement was the integration of the HIV/AIDS and Viral Hepatitis policies into one single policy; Co-infection care, principally TB; In the last two years little progress has been made with free public transport for PLWHA and part of this population still does not have access to it. In the northern region, these policies are still lacking implementation because of the lack of commitment of certain public service managers who are not even capable of applying the Fund-to-Fund Incentive resources (Actions and Goals Plans).
What challenges remain in this area?
The biggest challenge is to make agreements on HIV/AIDS/STD policies between state and municipal governments a priority once more, to ensure that the resources of the Actions and Goals Plans are used

correctly. The Ministry having the courage to apply the penalties provided for and to monitor efficiently and efficaciously the application of the resources. Women are not having their rights guaranteed, neither their Human Rights nor the right to be able to use free of charge female condoms as previously publicized. Brazil has been remiss in purchasing and promoting the use of female condoms. The Ministry of Health has been systematically reducing the purchase of these condoms since 2008. Lack of availability of these condoms in public health services and in organizations that work specifically with women.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
		(01)		(04)	(04)					

Since 2009, what have been key achievements in this area?
No progress has been made. 2011 was a very negative year and this continues to apply. The policies are not being implemented, so much so that AIDS cases are increasing in the Northern region and globally women and girls are still the most affected by the epidemic. The ability of women and girls to protect themselves from HIV continues to be hindered by several factors such as gender inequalities, including unequal legal, economic and social conditions, difficult access to health services, including with regard to sexual and reproductive health, as well as all forms of discrimination and violence, including sexual violence and exploitation. How can the fulfilment of the policies be ensured if the funding to guarantee actions in response to HIV/AIDS is insufficient. A further aggravating circumstance is the cut in health resources, for the first time international aid resources for the development of these policies have not increased and we continue with the same level of resources as in 2008 and 2009.
What challenges remain in this area?
Little political will on the part of state and municipal-level public service managers to implement these policies. Effective monitoring actions by the Ministry/Department.

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes (08)*	No (01)*

* number of respondants

IF YES, how were these needs determined?
They have been indicated by civil society in events, seminars, meetings of the Commission for Articulation with Social Movements and the National AIDS Commission. We must state that although they are identified, these actions are not implemented.
IF NOT, how are HIV prevention programmes being scaled-up?

1.1. To what extent has HIV prevention been implanted?

HIV prevention component	The majority of people in need have access to...				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2 (01)	3	4 (08)	N/A

Condom promotion	1	2 (01)	3 (07)	4 (01)	N/A
Harm reduction for people who inject drugs	1 (01)	2 (07)	3 (01)	4	N/A
HIV prevention for out-of-school young people	1 (01)	2	3 (07)	4 (01)	N/A
HIV prevention in the workplace	1	2 (03)	3 (04)	4	N/A
HIV testing and counselling	1	2 (04)	3 (04)	4 (01)	N/A
IEC[47] on risk reduction	1	2 (07)	3	4	N/A
IEC on stigma and discrimination reduction	1 (08)	2	3	4 (01)	N/A
Prevention of mother-to-child transmission of HIV	1 (01)	2 (04)	3 (03)	4 (01)	N/A
Prevention for people living with HIV	1 (01)	2	3	4 (08)	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2 (01)	3 (07)	4 (01)	N/A
Risk reduction for intimate partners of key populations	1 (01)	2 (08)	3	4	N/A
Risk reduction for men who have sex with men	1 (01)	2 (02)	3 (03)	4 (03)	N/A
Risk reduction for sex workers	1 (01)	2 (2)	3 (03)	4 (03)	N/A
School-based HIV education for young people	1 (01)	2 (06)	3 (01)	4 (01)	N/A
Universal precautions in health care settings	1 (01)	2	3 (03)	4 (05)	N/A
Other: Harm reduction for crack and alcohol users, dam area, forest and precious metal prospecting populations	1 (08)	2	3	4 (01)	N/A

[47] IEC = information, education and communication

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
		(01)			(05)		(02)	(01)		

Since 2009, what have been key achievements in this area?
PEP – Post Exposure Prophylaxis, greater availability of rapid testing, although some movements do not agree with the way it is being applied; Policies for Youth, support, guarantee of the participation of young people in spaces of social watch and in some spaces where the policy is formulated; The unification of the HIV and Viral Hepatitis policies.
What challenges remain in this area?
Agreements between society and Government need to be respected. The Department needs to move forward, retrogression can be seen in the current Brazilian context, respect for society's decisions regarding AIDS campaigns, correct application of Fund-to-Fund Incentive resources; ensure access to female condoms; the interface between women, violence and AIDS; increase support to the Brazilian NGOs, ensure the systematic supply of medications, guarantee treatment for lipodystrophy and liposuction for PLWHA. Guarantee the implementation of the Plans to Fight the Feminization of the Epidemic by the Federal

Government and by the Brazilian states, as women are suffering sexual violence right from their teenage years and the Ministry has not created a mechanism that identifies the types of violence that these women with HIV have suffered.

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes (07)	No (02)

IF YES, briefly identify the elements and what has been prioritized:
Even though the answer is yes, there are some restrictions. The size of the country implies a series of differences, both in terms of commitment and in terms of management. Good standards of service need to be guaranteed in Specialized Care Services, Testing and Counselling Centres, Alcohol and Drugs Psychosocial Care Centres. Services for women need to improve. The Care and Treatment Units need to be scaled up.
Briefly identify how HIV treatment, care and support services are being scaled-up:
The lipodystrophy services need to be scaled up. Data collection needs to be standardized, especially with regard to women and the monitoring of HIV and violence against women.

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2 (01)	3 (08)	4	N/A
ART for TB patients	1 (01)	2 (03)	3 (05)	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1 (01)	2 (03)	3 (05)	4	N/A
Early infant diagnosis	1	2 (01)	3 (08)	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1 (01)	2 (07)	3 (01)	4	N/A
HIV testing and counselling for people with TB	1 (01)	2 (05)	3 (02)	4 (01)	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1 (01)	2 (06)	3 (02)	4	N/A
Nutritional care	1 (01)	2	3	4 (08)	N/A
Paediatric AIDS treatment	1	2	3	4	N/A
Post-delivery ART provision to women	1	2 (01)	3 (08)	4	N/A
Post exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2 (04)	3 (04)	4 (01)	N/A
Post exposure prophylaxis for occupational exposures to HIV	1	2 (01)	3	4 (08)	N/A
Psychosocial support for people living with HIV and their families	1	2 (05)	3 (03)	4 (01)	N/A
Sexually transmitted infection management	1	2 (04)	3 (04)	4	N/A
TB infection control in HIV treatment and care facilities	1 (02)	2 (03)	3 (03)	4 (01)	N/A

TB preventive therapy for people living with HIV	1 (01)	2 (04)	3 (02)	4 (02)	N/A
TB screening for people living with HIV	1 (01)	2 (04)	3 (02)	4 (02)	N/A
Treatment of common HIV-related infections	1 (01)	2 (04)	3 (02)	4 (02)	N/A
Other: Dam area populations, Lesbians, Transgendered people.	1 (04)	2 (03)	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10
				(06)	(02)		(01)			

Since 2009, what have been key achievements in this area?
There has been little progress, on the contrary there have been setbacks in some aspects such as the guarantee.
What challenges remain in this area?
The commitment of public service managers to implementing the policies, to fulfilling the agreement made with society, respect for the Fund-to-Fund Incentive resources, the correct application of these resources, respect of the planning of the Actions and Goals Plans. Greater technical capacity of health workers in relation to the management of the treatment of PLWHA, ensuring an adequate number of hospital beds, principally for women.

2. Does the country have a policy and strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No (09)

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No (01)

Unaware of such a plan=08

2.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

Unaware of such an estimate =07

2.4. IF YES, what percentage of orphans and vulnerable children is being reached?

%

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?

Very Poor									Excellent
0	1	2	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area?
What challenges remain in this area?
Commitment of the Governments to the people's lives, identify, monitor AIDS orphans; Guarantee specific policies for children and adolescents living with HIV/AIDS that ensure their placement on the formal and informal labour market. Support and strengthen families responsible for looking after orphaned children.

Appendix 4 Political Letter of the VII BRAZILIAN UNGASS AIDS NGO FORUM

Recife – Pernambuco, Brazil, 2011

Held on October 23rd and 24th 2011 with the participation of 84 representatives of Networks of People Living with HIV and AIDS, the National Movement of Posithive Women Citizens, the National Network of Young People Living with HIV and AIDS, LGBT Organizations, the Brazilian Partnership Against Tuberculosis, the Latino Tuberculosis Observatory, AIDS Service NGOs, AIDS Service NGO Forums and the GAPA Brazil Network, the VII Brazilian UNGASS AIDS Forum provided an important moment for reflection on the global, regional and national contexts of responses to HIV and AIDS, exploring greater dialogue between these levels which, despite being diverse, converge on important issues.

The global and regional challenges, ten years after the Declaration of Commitments to overcome AIDS signed at the United Nations in 2001, are now more complex and the epidemic continues to be driven by an explosive combination of socio-economic iniquities, gender violence and recurring Human Rights violations, especially violations of sexual rights. The current situation is, however, much more adverse, and the targets of the recently approved 2011 Declaration "*Intensifying our Efforts to Eliminate HIV and AIDS*", require more constant technical and political monitoring, since addressing HIV and AIDS is no longer a priority for governments, cooperation agencies[1] and, clearly, no longer occupies a place on the agenda of the Brazilian Government's priorities.

In the face of this scenario, we identify that our greatest challenge is to guarantee the conditions for strengthening the organizations of the National Movement to Fight AIDS so that we can act locally and globally with adequate structure and in an articulated manner, influencing the spaces in which public policies are decided. The diverse voices of this historical movement are increasingly necessary to demand that public service managers and parliamentarians exclude fundamentalist positions from consideration and fulfil their role of defending a truly secular State, impeding the violation of the sexual rights and reproductive rights of all people, in particular gay men and young girls; punishing the persecution and murder of transsexuals and transvestites, sex workers and human rights defenders and supporting the social organizations that, legitimately, defend the agenda of sustainable human development. The strengthening of a secular and equitable State is vital to banish the culture of discrimination and prejudice against the LGBT population, poor people and Black people in Brazil, especially if they are also living with HIV and AIDS.

Another considerable challenge to be overcome on the global/regional public health agenda is that the AIDS epidemic is occurring in a context of the privatization of other strategic areas such as education, energy production, transport, communication and security; the dispute between public and private assets is at the centre of the issues that demand urgent attention – a recent example is Decree No. 7,508, dated June 22nd 2011[2], that is contrary to the National Health System principles of universality and equality.

In the face of a critical context of large changes in the geopolitical world, it also concerns us that the interests of a few countries and those of business corporations are undermining the legitimate multilateral bodies and forcing the regression of already conquered rights, supported by political cultures still based on relations that seek financial, personal and partisan advantages and which, invariably, result in a high level of corruption. We therefore consider that the Brazilian Government should continue with and strengthen its active role in the defence of global health, guaranteeing, for example, transparency and social participation in the current reform of the World Health Organization.

Nationally we are also concerned by the frailty of the few existing intersectoral policies and the great difficulty in implementing articulated information systems capable of guaranteeing the quality of the monitoring and evaluation of health services and policies.

Finally, it is a cause of concern to us to observe the considerable governmental leadership crisis both globally and locally – it is a fact that in Brazil many public service managers still lack the technical capacity and political skill needed to eradicate AIDS and this requires urgent attention by the Ministry of Health.

Therefore, it is within a context of multiple challenges that we reaffirm:

- That the interventions to overcome HIV and AIDS must be based on the understanding that public health is a human right, and that public services must be of quality and effective at one and the same time. In order for this to happen it is fundamental to ensure innovative strategies, with multisectoral actions, strengthen social watch and urgently guarantee the effectiveness of the institutional control structure provided for in the Federal Constitution.
- The defence of the guarantee of the full efficacy and administrative accountability in the public management of social policies, ensuring that the instruments of social protection – principally in the fields of health, human rights and development – are not treated like private consumer goods, accessed by few.
- That the advance of the human rights agenda to respond to AIDS in Brazil is directly related to the decision making processes created based on collective construction, in a transparent manner and with effective participation of the AIDS movement in the design, allocation of resources, monitoring and evaluation of federal, state and municipal public policies.

Therefore, we request of the Ministry of Health:

- The inclusion of qualitative indicators in the strategies for monitoring, collecting data and evaluating the country's health actions, programmes and services;
- A national up to date diagnosis of the situation of children living with HIV and AIDS – we consider to be serious the absence of relevant data on this population which requires better access and care strategies;
- The creation of an effective *Posithive Prevention* programme, to improve the quality of life of People Living with HIV and AIDS (PLWHA), focused on adherence to HIV and AIDS treatment and Tuberculosis co-infection treatment, with strategies that ensure that PLWHA have access to quality care from the support network;
- Increased efforts to fight Tuberculosis, improving prevention, early diagnosis and treatment and the integration of HIV and TB services, in accordance with the Global Plan to Stop TB (2011-2015), in accordance with the Millennium Goals and in accordance with the "*Intensifying our Efforts to Eliminate AIDS*" Declaration, all of which have been ratified by Brazil;
- Greater emphasis on the articulation and attention of the state and municipal governments and increased resources allocated to the *National Plan to Fight the AIDS and STD Epidemic among Gay Men, other Men who have Sex with Men and Transvestites* and the *National Integrated Plan to Fight the Feminization of the AIDS Epidemic and other STDs*; as well as full compliance with the Ministerial Ordinance on Lipodystrophy[3];
- Greater national investment in research and development of products and commodities to prevent, diagnose and treat HIV and AIDS, including therapeutic vaccines for PLWHA;
- Establishment of dialogue and transparent mechanisms to accompany the ARV (anti-retroviral drugs) production, purchasing and distribution processes, making detailed and up to date information available on: a) suppliers meeting delivery commitments and stock status; b) the criteria for adopting and funding Public-Private Partnerships, and Technology Transfer agreements under negotiation for the national production of ARV drugs within the context of the current policy on the establishment of the Medical-Industrial Complex; c) the determinants of ARV drug prices, the risk of creating demand and the risk of stockouts arising from the creation of a temporary monopoly.
- We request the incorporation[4] and use of the public health protection flexibilities provided for in the World Trade Organization's TRIPS Agreement that make it possible to purchase medication at affordable prices and would counter the monopolistic practices of the

pharmaceutical companies, including not only the use of compulsory licensing, the Bolar exception and other alternatives, but also the reestablishment of the National Health Surveillance Agency (*ANVISA*) Prior Agreement. Furthermore, that efforts be made to prevent the adoption of TRIPS-plus type measures in the Legislative, Judiciary and Executive branches, in a manner coherent with the Brazilian Government's position in international negotiation forums in defence of the protection of public health in the face of commercial interests.

- Involvement in the processes and debates for the creation of taxes on international financial transactions, currently being discussed by the G20 group of nations, so that they may also be used for Health;
- Immediate action by the Ministry of Health and the Public Prosecution Service against local health service managers to ensure the transparent and effective allocation and expenditure of resources. We consider it to be a criminal act that R$ 139,000,000.00 (one hundred and thirty nine million Real) transferred under the Fund-to-Fund Incentive scheme for care actions with PLWHA and HIV and AIDS prevention actions are stationary in the bank accounts of state and municipal governments. We demand the immediate investigation of the case and the punishment of those responsible.

In solidarity,

VII Brazil UNGASS-AIDS Forum

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Associação Brasileira de Lésbicas, Gays, Bissexuais, Travestis e Transexuais – ABGLT
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GAPA/PA
GAPA/SP
GAPA/RS
GAPP e HIV e AIDS/MS
GESTOS – Soropositividade, Comunicação e Gênero
GRUPAJUS
Grupo Apoio a Diversidade (GAD)
Grupo Cactos/PE
Grupo de Amigos na Luta Contra SIDA, Pela Qualidade de VIDA – ASQV/PE
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Movimento Nacional das Cidadãs Posithivas – Ponta Porã/MS
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