Brazilian Ministry of Health
Health Surveillance Secretariat
STD, AIDS and Viral Hepatitis Department

Targets and Commitments made by Member-States at the United Nations General Assembly Special Session on HIV/AIDS
UNGASS – HIV/AIDS

Brazilian Response
2008-2009
Country Progress Report

Brazil, March 2010

The Federative Republic of Brazil
Ministry of Health
Health Surveillance Secretariat
STD, AIDS and Viral Hepatitis Department

Technical Index of the Brazilian Progress Report:

Institutional authorship of this document is attributed to the National STD and AIDS Commission - CNAIDS

General Coordination:
Mariângela Batista Galvão Simão (Director of the STD, AIDS and Viral Hepatites Department); Eduardo Luiz Barbosa (Joint Director of the STD, AIDS and Viral Hepatites Department)

Organization:
Ângela Pires Pinto (STD, AIDS and Viral Hepatites Department)

Report writer:
Fernando Seffner (Consultant)

Working group designated by CNAIDS for data gathering and producing this report:
Mariângela Simão (Director of the STD, AIDS and Viral Hepatitis Department and Coordinator of the Working Group); Ana Maria de Oliveira (Federal Medical Council); Euclides Ayres Castilho São Paulo University); Felipe Krause Dornelles (Ministry of Foreign Affairs); Jacqueline Côrtes (Joint United Nations Programmme on HIV/AIDS - UNAIDS); Jaime Marcelo Pereira (AIDS NGO Forum – Southeast Region); Jair Brandão Filho (UNGASS Forum/Gestos - Seropositivity, Communication and Gender); José Carlos Veloso (UNGASS Forum/GAPA/SP); Maria Clara Gianna (STD/AIDS Actions Management Commission- COGE); Mariza Gonçalves Morgado (Oswaldo Cruz Foundation - FIOCRUZ); Nélio José de Carvalho (National Network of People Living with HIV/AIDS); Ximena Pámela Diaz Bermudez (Pan American Health Organization PAHO/WHO).

Ministry of Health team involved in data gathering and desk review of this document:
Alessandro Ricardo Cunha, Ana Roberta Pascom, Ana Paula Prado Silveira, Andressa Bolzan, Ângela Pires Pinto, Barbara Graner, Caio Gonçalves, Carlos Passarelli, Cristina Possas, Dario Noleto, Dulce Ferraz, Eduardo Luiz Barbosa, Emília Ramos do Valle, Érika Fazito, Flávia Moreno, Gerson Fernando Pereira, Gilvam de Almeida, Gilvane Casimiro da Silva, Gustav Liliequist, Ivo Brito, Josué Ferreira, Juliana Vallini, Juliana Machado Givisiez, Karim Sakita, Lilian Amaral Inocêncio, Marcelo Araújo de Freitas, Marcelo Barbosa, Maria do Socorro de Oliveira, Maria Etelvina Barros, Mariângela Simão, Mauritânia Pereira, Mirtha Sudbrack, Mônica Bulhões, Nádia Paranaíba, Rachel Baccarini, Rogério Scapini, Romina do Socorro M. de Oliveira, Rosângela Ribeiro, Rubens Duda, Ruy Burgos, Samia de Albuquerque, Sérgio D'Ávila, Thaisa Lima, Valdir Pinto.

Editing, revision, diagramming: Communication Unit (STD, AIDS and Viral Hepatitis Department) Angela Gasperin Martinazzo, Alexsandro de Brito Almeida, Dario Noleto, Myllene Müller Nunes.

English version: Martin Charles Nicholl
Spanish version: Javier Martínez

Acknowledgements

We wish to thank:

The members of the STD and AIDS Commission – CNAIDS who contributed to the discussions of the report at their regular meetings in 2009 and 2010;

The institutions that make up the UNGASS/Brazil Forum for disseminating the UNGASS commitments and for the debates that were held in the various regions of the country;

Participants in the meeting to validate NCPI Part A (Government), especially the members of the STD/AIDS Actions Management Commission - COGE (*vide* appendix II).

Participants in the meeting to validate NCPI Part B, referring to Civil Society, notably the members of the Commission for Articulation with Social Movements – CAMS (*vide* appendix II).

Participants in the meeting to validate NCPI Part B, referring to the United Nations Agencies, especially the UNAIDS WG (*vide* appendix II).

To all health staff, managers, members of social movements and NGOs and others that took part in the Public Consultation via Internet;

To those who took part in the meeting to validate the final document: Alessandro Ricardo Cunha (STD, AIDS and Viral Hepatitis Department), Ana Maria de Oliveira (Federal Medical Council), Ana Roberta Pati Pascom (STD, AIDS and Viral Hepatitis Department), Ângela Pires Pinto (STD, AIDS and Viral Hepatitis Department), Antonio Ernandes Marques da Costa (Northern Region, GRUPAJUS/Pará), Carlos Passarelli (STD, AIDS and Viral Hepatitis Department), Cristiane José (CENAIDS, Philips do Brasil), Dirceu Greco (Brazilian Tropical Medicine Society), Eduardo Barbosa (STD, AIDS and Viral Hepatitis Department), Elias Nobre Almeida (Northeast Region, Rede de Solidariedade Positiva/Ceará), Jacqueline Cortes (UNAIDS WG, UNAIDS), Jaime Marcelo Pereira (AIDS/NGO Forum – Southeast Region), José Carlos Veloso (UNGASS Forum, Gapa/SP), José Roberto Pereira (Southeast Region, Bem-Me-Quer Project), José Valdez Ramalho Madruga (Brazilian Infectious Diseases Society), José Wilter Ferreira Ibiapina (Viral Hepatitis Social Movement), Luisa Guimarães Queiroz (STD, AIDS and Viral Hepatitis Department), Maria Clara Gianna (STD/AIDS Actions Management Commission – COGE), Maria de Fátima Alencar Fernandes D'Assunção (Ministry of Labour), Maria Inês Costa Dourado (São Paulo University), Maria de Fátima Simas Malheiro (Ministry of Education), Mariângela Simão (STD, AIDS and Viral Hepatitis Department), Mauritânia Pereira (STD, AIDS and Viral Hepatitis Department), Nélio José de Carvalho (National Network of People Living with HIV/AIDS), Nereu Henrique Mansano (National Council of Health Secretaries), Newton Sérgio de Carvalho (Brazilian Sexually Transmitted Diseases Society), Patrícia Santana Santos (National Anti-drugs Secretariat - SENAD), Paulo César do Nascimento (Southern Region, Bom Viver), Rafael Theberge de Viveiros (Ministry of Defence), Regina Maria Lancellotti (Viral Hepatitis Social Movement), Roberto Pereira (Southeast Region, Sexual Education Centre - CEDUS), Ronildo Lima e Silva (National Network of People Living with HIV/AIDS), Rosa Mari Guimarães Godinho (Mid-west Region, CADS), Sandra Catarina Rolim Gomes (STD/AIDS Actions Management Commission – COGE), Sandro Oliveira da Rosa (Mid-west Region, Mato Grosso NGO/AIDS Forum), Sérgio D'Ávila (STD, AIDS and Viral Hepatitis Department), Tânia Ferreira (STD, AIDS and Viral Hepatitis Department), Valdiléa Gonçalves Veloso dos Santos (FIOCRUZ), Ximena Pámela Diaz Bermudez (UNAIDS WG, OPAS).

And the collaboration of Arthur Braz, Beatriz Proença, Cláudia Medeiros, Cleber Ricardo, Elaine Ramos, Ieda Fornazier, Juliana Monteiro da Cruz, Laís Garcia, Lilian Melo, Lúcio Costa, Renato Girade, Sandra Cynthia Conçalves, Silvia Reis, Wanderson Gontijo.

Contents

Acronyms 4

Introduction 6

Chapter 1 – The process of elaborating the report 8

Chapter 2 – The Brazilian AIDS response and the National Health System 10

Chapter 3 – The AIDS epidemic in Brazil 12

3.1 – Epidemiological scenario 12

3.2 – Programmatic and organisational context 22

3.2.1 – Governance 22

3.2.2 – Prevention and reducing vulnerabilities 27

3.2.3 –STD/HIV/AIDS research and surveys 35

3.2.4 – Human Rights 38

3.2.5 – Care, support and treatment 39

Chapter 4 – Brazil's participation in international cooperation in the fight against AIDS 47

Chapter 5 – Prospects, challenges and lessons learned 51

References 54

6.1 – Bibliography 54

6.2 – Internet sites 58

Appendix I – Indicator 1: Spending 59

Appendix II – Indicator 2: National Composite Policy Index (NCPI) 77

Appendix III – Indicators 3 to 25 136

Acronyms

ANRS – French National AIDS and Viral Hepatitis Research Agency
CAMS – National Commission for Articulation with Social Movements
CAPDA – STD and AIDS Policies Monitoring Committee
CENAIDS – National Corporate Council for HIV/AIDS Prevention
CEP – Research Ethics Committee
CICT – International Centre for Technical Cooperation in HIV/AIDS
CIPA – Internal Accident Prevention Committee
CNAIDS – National STD and AIDS Commission
CNS – National Health Council
COGE – STD/AIDS Actions Management Commission
CONEP – National Research Ethics Commission
COPRECOS LAC - Commission for Prevention and Control of HIV/AIDS in the Latin American Armed Forces
CPLP – Community of Portuguese-speaking Nations
CTA – Voluntary Testing and Counselling Centre
DATANHS – National Health System IT Department
DFID – Department for International Development of the United Kingdom
DST – Sexually Transmitted Diseases
FIOCRUZ – Oswaldo Cruz Foundation
FUNASA – National Health Foundation
GCTH – Horizontal Cooperation in HIV/AIDS Group
GTZ – German Technical Cooperation Agency
IAVI - International AIDS Vaccine Initiative
IBAS – India, Brazil and South Africa Consortium
IDU – Injecting drug users
LGBT – Lesbians, Gays, Bisexuals, Transvestites and Transsexuals
LOAS – Organic Social Assistance Law
MEGAS – Health Expenditure Measuring System
MERCOSUL – Southern Cone Common Market
MONITORAIDS – System Monitoring STD, AIDS and Viral Hepatitis Department Indicators
MSM – Men that have sex with men
MRG – Genotyping reference doctors
MS – Ministry of Health
NGO – non-governmental organization
ONG – non-governmental organization
PAHO – Pan American Health Organization
PAISM – Integral Women's Health Assistance Programme
PCAP – Knowledge, Attitudes and Practices Survey of the Brazilian Population
PREVINI – Prevention Commodities Monitoring System
PSE – Health in Schools Programme
PSF – Family Health Programme
PLHA – People living with HIV and AIDS
QUALIAIDS – Self-evaluation of AIDS outpatient services quality in the NHS
RDS – Respondent Driven Sampling
SAE – Specialised Services
SES – State Health Department
SICLOM – Medication Logistics Control System

SIM – Mortality Information System
SINAN – Notifiable Disease Information System
SISCEL – Laboratory Tests Control System
SMS – Municipal Health Departments
SPE – Health and Prevention in Schools Programme
SPM – Special Secretariat for Policies for Women
SUS - National Health System (*Sistema Único de Saúde)*
SVS – Health Surveillance Secretariat of the Ministry of Health
TARV – Antiretroviral Therapy
UBS – Primary Health Care Unit
UDM – Medication Dispensing Units
UNE – National Students Union
UNITAID – International Centre for the Procurement of AIDS, Tuberculosis and Malaria medicines
WHO – World Health Organization

Introduction

This progress report presents indicators and other relevant information on the Brazilian response to AIDS for the period 2008/9. It has been constructed in alignment with UNGASS guidelines set out in the document 'Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on construction of core indicators: 2010 reporting' available for consultation at www.unaids.org in the section referring to Brazil.

An important feature of the report is its continuity in regard to Brazil's two previous country reports: "Brazilian Progress Report 2005/2007" and "UNGASS Goals–HIV/AIDS: the Brazilian Response 2001-2003' both available for consultation at www.aids.gov.br. To facilitate comparisons with those earlier documents part of their structure has been preserved. Other informative documents produced by Brazil for the United Nations such as the Brazilian reports on the Millennium Development Goals, reports related to National AIDS Spending Assessments and other documents providing general information on the Brazilian health situation to the World Health Organization (WHO) have also been taken into consideration and they are identified and referred to in the body of the text.

In terms of domestic references this document has drawn from Brazilian scientific production in all fields that have to do with HIV/AIDS (Social Science, Exact Sciences, Natural Sciences and Health Sciences) as well as the country's information and surveillance systems. Those systems are the source of most of the data set out in this report and they are complemented by the information obtained by specific scientific research and surveys designed to construct data for some of the indicators which were only partially informed or insufficiently informed in previous reports. Data gathering enjoyed the collaboration of civil society and of AIDS programme managers in the Brazilian states and municipalities and much data was supplied by current health monitoring and evaluation systems already in place and by other Brazilian ministries.

Chapter 1 portrays the process of constructing the progress report with details of the various stages right up to the approval of the final document and lists the main social actors and stakeholders involved.

Chapter 2 analyses the Brazilian response from the policy and programmatic point of view. The main aim of the chapter is to discuss the central axis of the Brazilian AIDS response and its insertion in the National Health System – NHS (*Sistema Único de Saúde* – SUS).

Chapter 3 delineates the profile of the AIDS epidemic in Brazil. In the first part there is a description of the epidemiological scenario complemented by the indicators of compliance with commitments, which are set out in detail in item 6.3. The second part of the chapter deals with the programmatic and organisational situation with special attention devoted to the progress achieved in governance, prevention and reduction of vulnerabilities as well as information on STD/HIV/AIDS research and surveys, care, assistance and treatment, and Human Rights.

Chapter 4 describes Brazil's performance in the fight against AIDS on the international scene, highlighting the various horizontal technical cooperation processes.

Chapter 5 sets out the challenges and prospective scenarios for the future of the epidemic in Brazil as well as lessons learned in the Brazilian response to AIDS. The narrative part of the report closes with a list of bibliographic references and a list of the sites that were consulted during the process of elaborating it.

Attached to the narrative report are the 25 progress indicators divided into three Appendices : I) National and international spending on AIDS by spending categories and by funding sources; II) the National composite policy index which presents the visions of government agents, international bodies and bilateral agencies, and civil society based on the administration of three distinct questionnaires; and III) data associated to 23 indicators that provide a quantitative description of programme functioning, population knowledge and behaviour, and the impacts of AIDS.

A list of acronyms is set out at the beginning of the report to facilitate reader consultation.

Chapter 1 – The process of elaborating the report

The preparation of this document was coordinated by the STD, AIDS and Viral Hepatitis Department of the Brazilian Ministry of Health and began in April 2009 when meetings were held between technical staff from various areas of the Ministry and representatives of partner institutions, to evaluate the elaboration process of previous reports. The main points that were identified in that evaluation and which have been implemented in the writing of the present report were: expanding the participation and involvement of social actors in the elaboration of the progress report; data collection that reflects Brazil's considerable regional diversity; expanding data gathering processes to complete information in regard to all 25 indicators requested; an analysis of the situation of the Brazilian response to AIDS to be achieved through an intensive dialogue with the Brazilian National Health System (NHS).

The National STD and AIDS Commission (*Comissão Nacional de DST e AIDS – CNAIDS*), one of the Department's consultative committees is made up of 42 members representing government institutions, civil society, corporations and research institutions, and it took control of the construction of the document starting in June of the same year

A Working Group was set up (UNGASS WG) and it coordinated a network of collaborators to carry out data gathering, administering questionnaires, filling in forms, writing the successive versions of the document and generally coordinating the progress of the process

There was an intense mobilisation of managers and representatives of civil society in the months from July to December 2009 for the purpose of evaluating the Brazilian response over the period stipulated for the report. To provide support and facilitate contributions, a 'questions and answers' document on the issue was made available on the Internet and various discussions and debates were held at events, which were known as the "UNGASS Forums". Over that period data gathering for the narrative report was finalised and all the questionnaires were completed and returned.

The National Composite Policy Index (NCPI) was widely disseminated and debated. The various social actors involved (agents of state and municipal governments, civil society, international and bilateral bodies and agencies) buckled down to the work of filling out the NCPI form and answering the set of questions it contained to evaluate the Brazilian response for the biennial period 2008/2009. A reading of the final text of that document clearly reveals the strong differences in emphasis there were in the assessments of the Brazilian response according to the different understandings of the three distinct groups of actors.

Part A of the NCPI was discussed and filled in by STD/AIDS Actions Management Commission - COGE, which has representatives of the federal, state and municipal STD/AIDS programmes among its members.

Part B was discussed in two spheres and the two versions of the result are presented here. During the course of constructing the present progress report the discussion participants agreed that it would be impossible to arrive at a common denominator that would integrate the visions of civil society and those of the international and bilateral bodies and agencies in a single document. Accordingly one of the forms was filled in by the UNAIDS Working Group and a second one was left in the charge of an expressive group of Brazilian civil society organizations mobilised by means of the articulation forums already referred to.

The contributions made went far beyond those made to any previous report. In the form dedicated to civil society for example the number of institutions sending in completed forms

jumped from 2 to 37. Representatives of civil society participating in the UNGASS Working Group consolidated the answers of civil society bodies and the final version of the form was validated by the National Commission for Articulation with Social Movements – CAMS. The list of forums, networks NGOs and Activists that collaborated to inform the document appears in the consolidated version of the form itself.

The first version of this report was concluded at the end of January 2010 and made available on the Internet for public consultation from February 2–23. The contributions sent in by Internet users were then incorporated to the report and the present final version was analysed and approved by CNAIDS at a special session at the beginning of March and forwarded for translation and subsequent delivery to the United Nations.

Chapter 2 – The Brazilian AIDS Response and the National Health System

The main thread of connection running through the Brazilian response to AIDS throughout its 25 year-long existence is the structuring of its actions as a part of the Brazilian National Health System – NHS). The Constitution of the Federative Republic of Brazil of 1988 declares that health is the right of all and a duty of the State's to be guaranteed through social and economic policies that seek to reduce the threat of sickness and disease and offer universal egalitarian access to actions and services designed to promote, protect and recuperate it. The basic principles of the NHS are universality, equality and integrality. The system is organised in a decentralised manner with health actions articulated among the three spheres of administration: Federal, State and Municipal.

The reason we can talk about prevention as a right in Brazil (the right to prevention and to those commodities that are necessary for it), and the reason that we have managed to structure and maintain a programme of universal access to treatment, is because our national response to AIDS is inserted into a wider notion of health as the right of every individual. That idea is firmly anchored in the broader concept of Human Rights and formally guaranteed by the NHS and by the permanent mobilisation of civil society to ensure its effective implantation.

The reason we can talk about a National Response to the epidemic within a framework of vulnerability and Human Rights in Brazil, is because it has been structured in direct connection with the Human right to health. The 1998 Brazilian Constitution, popularly known as the "Citizen" constitution is the first Brazilian *Carta Magna* ever to formally declare the right to health as a fundamental Human Right and in that aspect it is entirely consonant with the precepts of the World Health Organization, which has reiterated, in a series of resolutions, that the right to health is a fundamental right of every single human being.

The reason we have been able to guarantee the necessary financial and other resources to sustain the fight against AIDS, including the acquisition and distribution of antiretroviral drugs, and meeting the costs of laboratory examinations and other procedures; is largely because this particular demand on resources is part of a wider struggle to maintain and expand sources of public funding. The reason that in Brazil, the number of people living with HIV/AIDS receiving care and attention shows how widespread coverage, even when compared to the estimated number of Brazilian people infected with HIV, has to do with the huge numbers of people the NHS regularly handles in its health care offer to the Brazilian population with an even more widespread coverage.

From the programmatic and policy point of view, that is the single most important characteristic of the Brazilian AIDS response. The Brazilian response to AIDS holds that if it is to be lasting and efficient, capable of maintaining itself and of innovating, then it must address the question of health in all its aspects and have a well-structured public health system. Strategic issues involving the maintenance of the Brazilian AIDS programme, as for example, the question of compulsory licensing of antiretroviral medicines, could only be addressed at all because of other similar initiatives unfolded by the Brazilian public health system in its broader dimension, increasingly concerned to guarantee access to essential medicines to the populace as a whole.

Accordingly, one of the outstanding challenges facing the Brazilian AIDS Programme is how to combine the maintenance of high levels of investment in facing the disease with the simultaneous strengthening of the public health system. That also means combining the fight against AIDS with

state policies directed at expanding citizenship and rights and strengthening democracy, all explicitly expressed in the principles of the national public health system.

In close collusion and connection with those principles, not only in the fight against AIDS but also in the public health system as a whole, there is a growing practice of designing AIDS-related actions within a reference framework of vulnerability and Human Rights, involving the extensive participation of civil society at all levels and valuing the diversity of identities as a way of intensifying and extending social inclusion in health policies.

Chapter 3 – The AIDS epidemic in Brazil

3.1 – Epidemiological scenario

A. General statistics of the AIDS epidemic in Brazil:

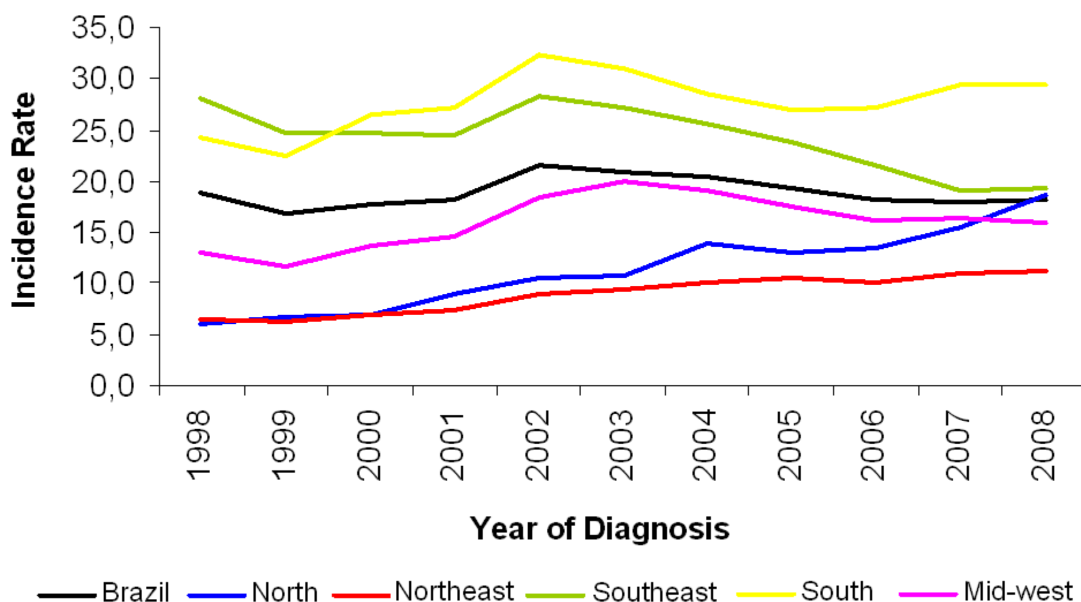
- Estimated number of HIV-infected individuals in 2006: 630,000
- HIV prevalence in the 15 to 49 age group: 0.61% (females: 0.41%, and males: 0.82%)
- New cases of AIDS in 2008: 34,480
- AIDS incidence rate in 2008: 18.2 per 100,000 inhabitants
- Accumulated number of AIDS cases for the period from 1980 to June of 2009: 544,846
- Number of deaths from AIDS in 2008: 11,523
- AIDS mortality coefficient in 2008: 6.1 per 100,000 inhabitants
- Total number of deaths from AIDS in the period from 1980 to 2008: 217,091

It is believed that there are 630 thousand individuals in the 15 to 49 age group in Brazil infected with HIV/AIDS. According to the parameters established by the World Health Organization, the epidemic in Brazil is of the concentrated type with a prevalence of HIV infection of less than 1% among parturient women in urban areas and over 5% in sub-groups of the population most-at-risk in regard to HIV infection. The prevalence of HIV infection in the population at large has remained stable at around 0.6% since 2004. Among women it is 0.4% and among men, 0.8% (SZWARCWALD *et al*., 2008). Among young males in the 17 to 20 age group HIV prevalence was estimated at 0.12% in 2007, showing a slight increase compared to the figure for 2002 (0.09%), although it was not statistically significant (SZWARCWALD *et al*., 2005, 2010). Among young females in the 15 to 24 age group, estimated prevalence for 2006 was similar to the figure obtained for 2004, around 0.28% (SZWARCWALD *et al.*, 2008).

In regard to most-at-risk sub-groups of the population, studies carried out in 10 Brazilian municipalities (Manaus, Recife, Salvador, Belo Horizonte, Rio de Janeiro, Santos, Curitiba, Itajaí, Campo Grande and Brasília), in 2008 and 2009, estimated HIV prevalence rates at 5.9% among illicit drug users (BASTOS, 2009), 12.6% among men that have sex with men (MSM) (KERR, 2009) and at 4.9% among female sex workers (SZWARCWALD, 2009).

In regard to numbers of AIDS cases, from 1980 up until June 2009, the accumulated total of identified cases was 544,846. ON average 35 thousand new cases are identified every year. AIDS incidence figures have shown a tendency to stabilise at high levels over recent years and in 2008, stood at 18.2 per 100,000 inhabitants. However, there are great differences according to geographic distribution among the Brazilian macro-regions, with incidence rates on the decline in the south-eastern and Midwest regions for the period 2000 to 2008, and on the increase in the northern, northeastern and southern regions (see Figure 1). The southeastern region still has the highest percentage of all notified cases in Brazil with 59.3%; southern region, 19.2%; northeastern region, 11.9%; mid-western region, 5.7%; e, and northern region, 3.9%.

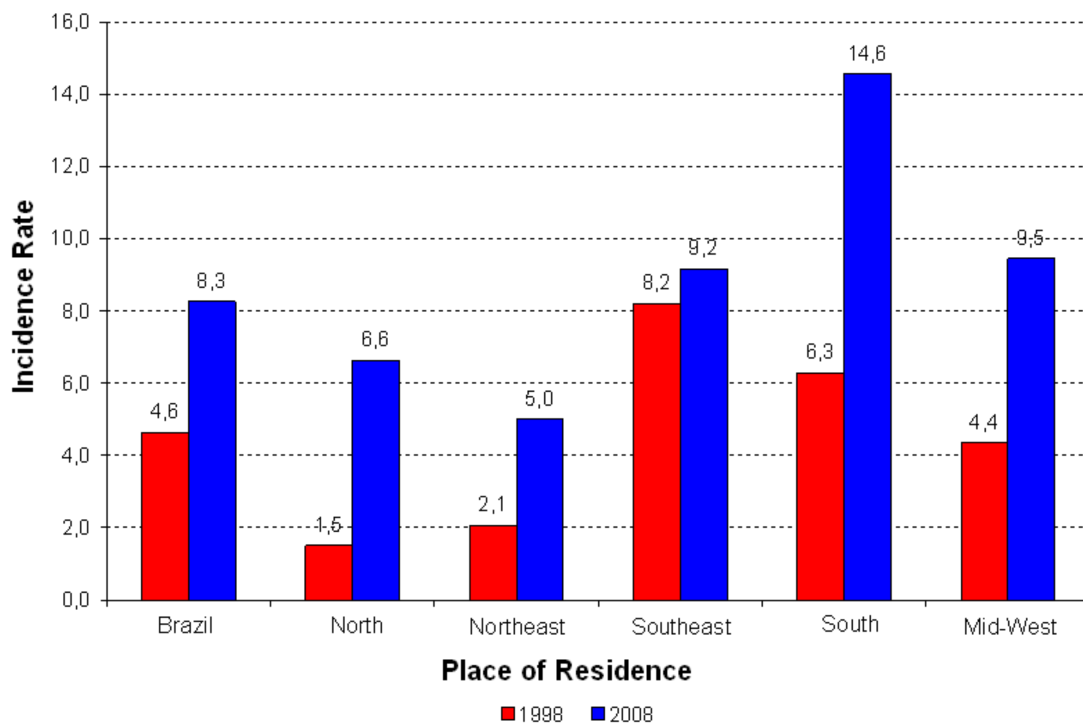
Figure 1: AIDS Incidence rates[1] (per 100,000 inhabitants) by region of residence and by year of diagnosis. Brazil, 1998 to 2008



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
POPULATION MS/SE/DATASUS at <www.datasus.gov.br> in the menu option 'Informações em saúde > Demográficas e socioeconômicas', consulted on October 20, 2009.
(1) Cases notified to the SINAN and registered in the SISCEL/SICLOM up until June 30, 2009. Preliminary data for the last five years.

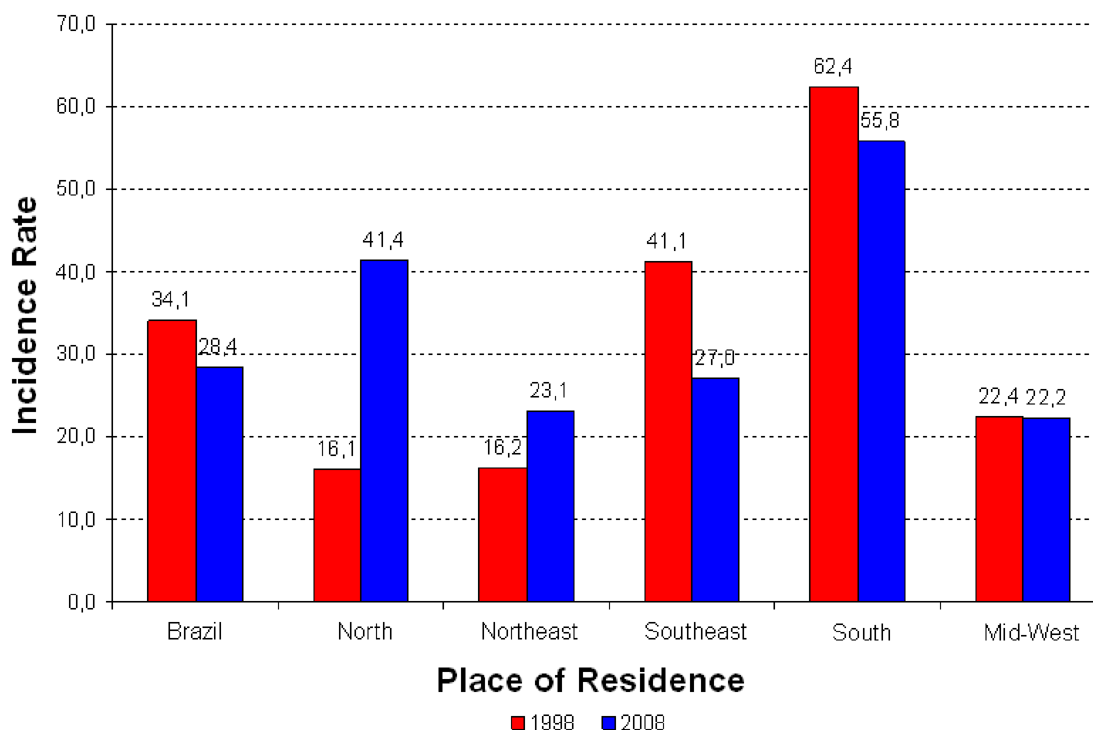
In an analysis considering the factor 'municipal population size', it can be seen that in municipalities with over 500 thousand inhabitants there has been a decline in incidence rates. Comparing the figures for the years 1998 and 2008 the incidence figure went from 34.1 cases per 100,000 inhabitants to 28.4. In municipalities with less than 50 thousand inhabitants however, AIDS incidence figures rose from 4.6 cases to 8.3 over the same period. That tendency to an increase of AIDS in the smaller municipalities and a decrease in the big ones is confirmed in the south-eastern and southern regions, but in the northern and northeastern regions, the epidemiological profile is different and there is an overall increase in the incidence rates in a comparison between the figures for 1998 and 2008, in both small and large municipalities (See Figures 2 and 3).

Figure 2. Incidence rates of AIDS cases[1] (per 100,000 inhabitants) in municipalities with fewer than 50,000 inhabitants, by region of residence and by year of diagnosis. Brazil, 1998 to 2008



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
(1) Cases notified to the SINAN and registered in the SISCEL/SICLOM up until June 30, 2009 and declared in the SIM from 2000 to 2008. Preliminary data for 2007.
POPULATION MS/SE/DATANHS at <www.datasus.gov.br> in the menu option 'Informações em saúde > Demográficas e socioeconômicas', consulted on October 20, 2009.

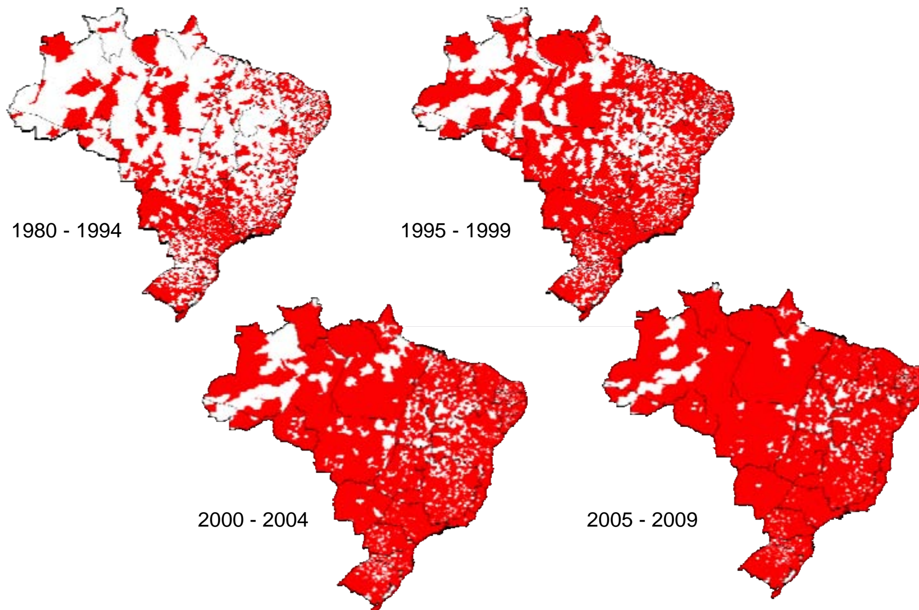
Figure 3. Incidence rates of AIDS cases(1) (per 100,000 inhabitants) in municipalities with 500,000 inhabitants or more, by region of residence and by year of diagnosis. Brazil, 1998 to 2008



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department.
(1) Cases notified to the SINAN and registered in the SISCEL/SICLOM up until June 30, 2009 and declared in the SIM from 2000 to 2008. Preliminary data for 2007.
POPULATION MS/SE/DATANHS at <www.datasus.gov.br> in the menu option 'Informações em saúde > Demográficas e socioeconômicas', consulted on October 20, 2009.

The number of Brazilian municipalities with at least one registered case of AIDS has increased over the years (Figure 4), going from 57.5% in 1998 to 87% in 2008. Ninety percent (4,981) of Brazilian municipalities have fewer than 50 thousand inhabitants and consequently are home to just 34% of the total Brazilian population and 11% of all the cases of AIDS identified in Brazil. On the other hand only 0.7% of Brazilian municipalities have over 500 thousand inhabitants. They alone hold 30% of the entire population and more than half (51.5%) of all identified AIDS cases.

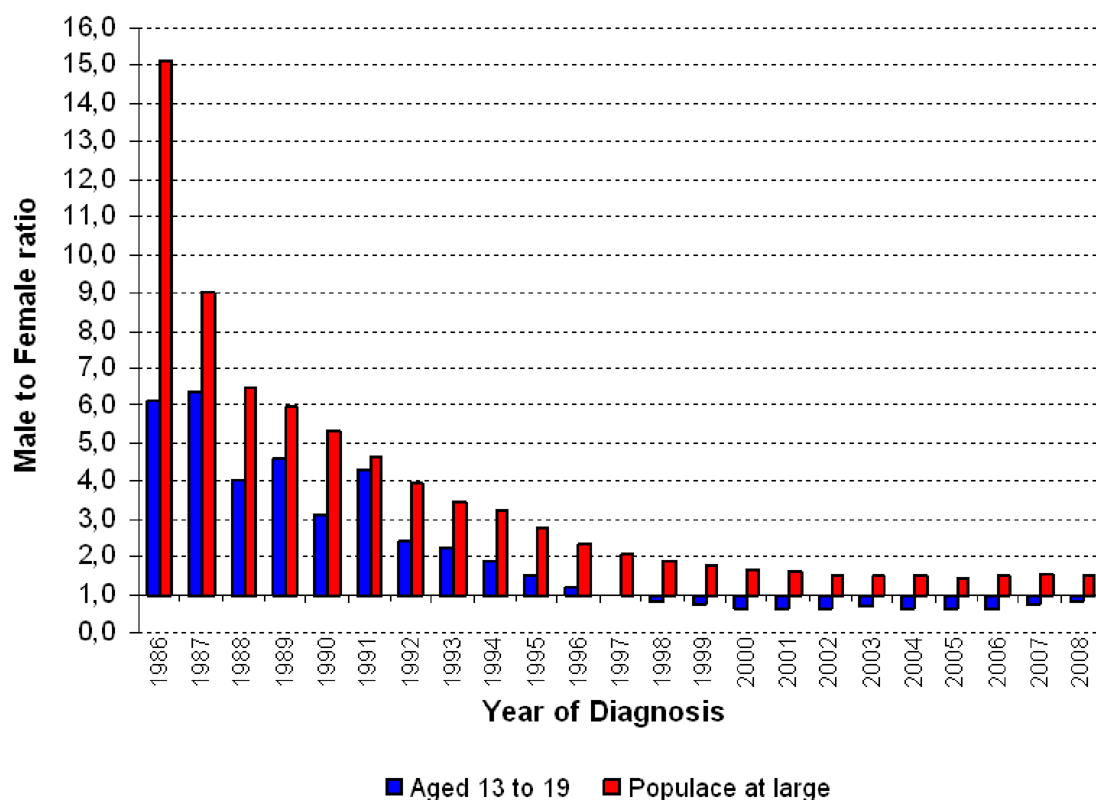
Figure 4. Municipalities reporting at least one case of AIDS, by year of diagnosis. Brazil, 1980 to 2009(1)



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
(1) Cases notified to the SINAN and registered in the SISCEL/SICLOM up until June 30, 2009 and declared in the SIM from 2000 to 2008. Preliminary data for the last five years.

An analysis of AIDS cases according to the sex of the individual shows that in 2008, AIDS incidence among men was 22.3 cases per 100,000 inhabitants and among women, 14.2 cases per 100,000 inhabitants. In both sexes the highest incidence figures are found in the 25 to 49 age group, and among people over 40 there has been a tendency for the figure to increase over the last ten years. The male:female ratio among AIDS cases in Brazil has gone down considerably from the beginning of the epidemic to the present day. In 1986 it was 15.1 to 1 but from the year 2002 on, that ratio levelled out at 1.5:1. However in the 13 to 19 age group, the number of AIDS cases is higher for girls than for boys. That reversal of the ratio has been observable since 1998 and now stands at s 0.8:1 (Figure 5).

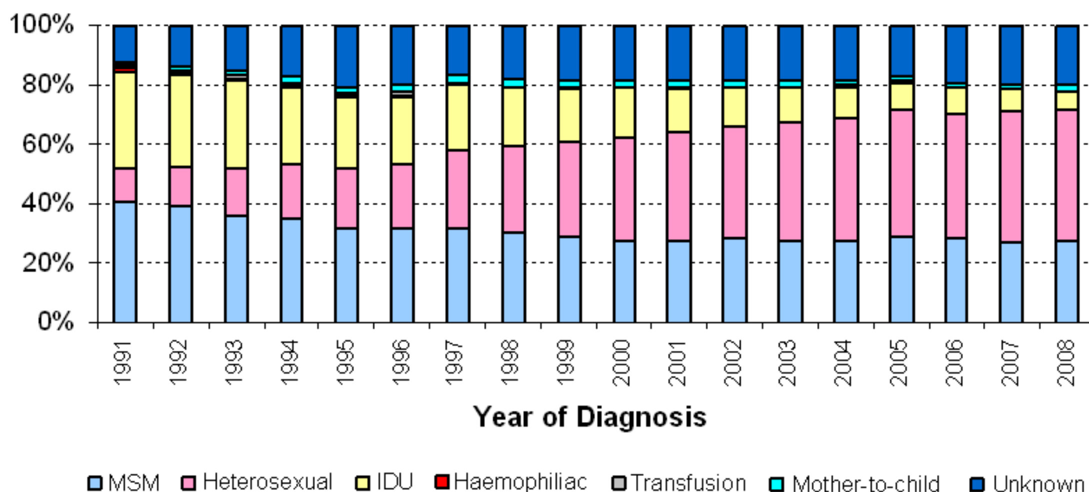
Figure 5. Ratio of AIDS cases between the sexes (M:F)[1] by year of diagnosis. Brazil, 1986 to 2008



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
(1) Cases notified to the SINAN and registered in the SISCEL/SICLOM up until June 30, 2009 and declared in the SIM from 2000 to 2008. Preliminary data for the last five years.

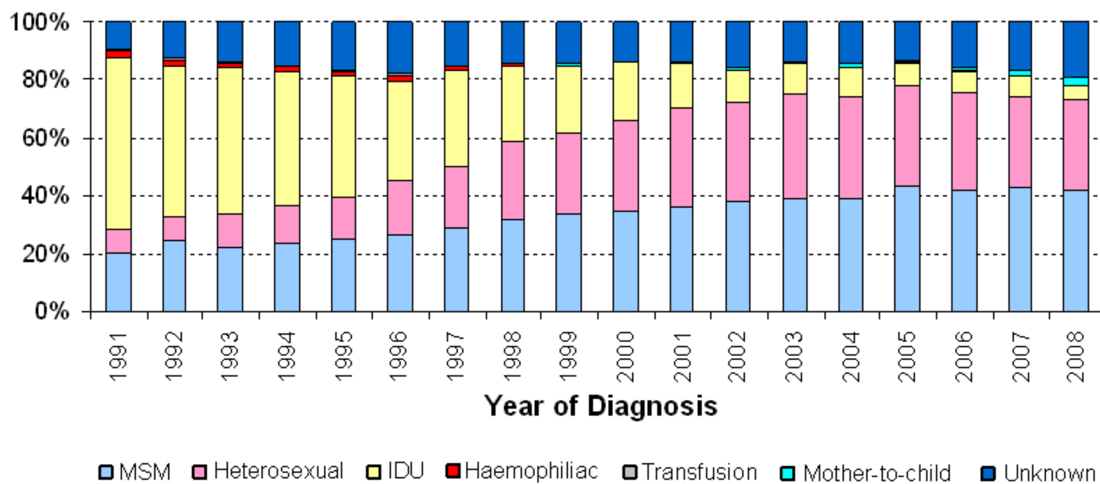
In spite of the observable growth in the numbers of cases among women over recent years, a recent study has shown that men who have sex with men and male injecting drug users continue to be the groups most at risk of HIV infection in comparison with the populace at large with incidence rates 15 times higher than those for heterosexuals in general (BARBOSA JR. *et al.,* 2009). When the analysis is made by exposure categories, it can be seen that in 1998 sexual exposure was responsible for 91.3% of all cases and in 2008 that percentage was up to 97%. Among males there was a proportional increase in the number of AIDS cases among heterosexuals, which went from 30.3% in 1998, to 45.2%, in 2008 (Figure 6). There is also a noticeable tendency to stabilisation of the proportion of AIDS cases among MSM starting from the year 2000. In the 13 to 24 age group however, there was a proportional increase in AIDS cases, going from 35% in 2000, to 42.7% in 2008 (Figures 6 and 7). In the exposure category ‘blood’, there has been a sharp drop in the proportion of cases corresponding to injecting drug users. The proportion of cases fell from 16.3% in 1998 to 4.9% in 2008.

Figure 6. Percentage distribution of AIDS cases[1] among males in the 13 plus age group, by exposure category and by year of diagnosis. Brazil, 1991 a 2008



SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
NB: (1) Cases notified to the SINAN up until June 30, 2009. Preliminary data for the last five years.

Figure 7. Percentage distribution of AIDS cases[1] among males in the 13 to 24 age group by exposure category and by year of diagnosis. Brazil, 1991 to 2008



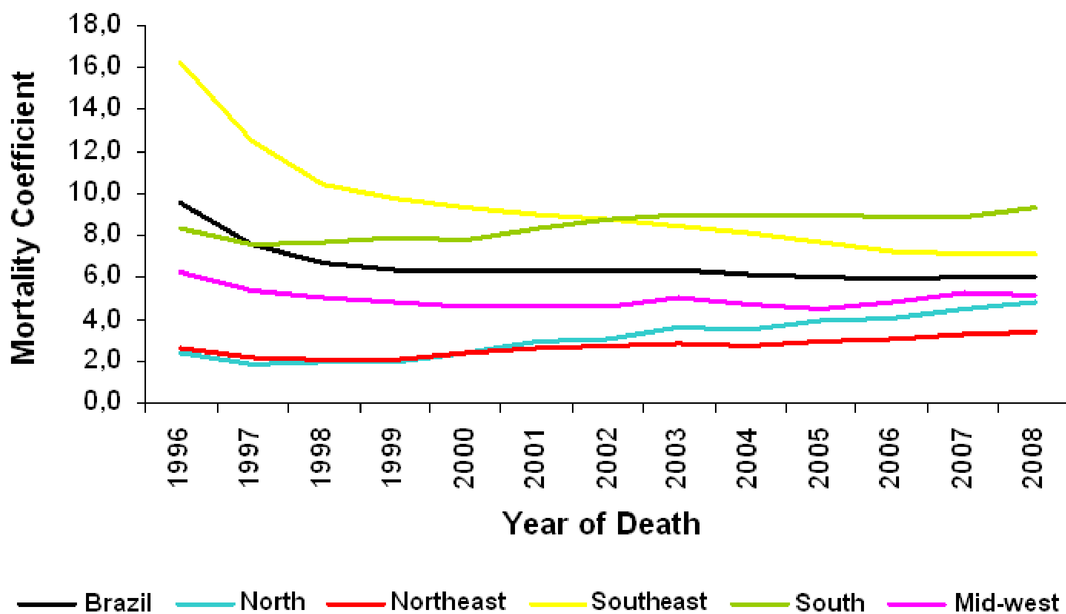
SOURCE: Ministry of Health/Health Surveillance Section/STD, AIDS and Viral Hepatitis Department
NB: (1) Cases notified to the SINAN up until June 30, 2009. Preliminary data for the last five years.

In the period before the introduction of ARV therapy in Brazil, the rate of mother-to-child transmission of HIV was estimated at 16% in a study carried out in São Paulo (TESS *et al.,* 1998). In 2008 it was possible to detect a clear tendency to reduction of the mother-to-child transmission rate, which was estimated to be 6.8% (SUCCI et al., 2007). The exposure category 'mother-to-child' transmission is the main form of transmission in almost all cases in children under five. Accordingly the incidence of AIDS cases in that age group has been used as a proxy in Brazil for the mother-to-child transmission rate of HIV. Corroborating earlier findings, in the period from 1998 to 2008, Brazil reduced the incidence of cases of AIDS in children under five by 49% and it went from 5.9 per 100,000 inhabitants in 1998 to 3.0 in 2008.

In regard to prophylaxis for the reduction of mother-to-child transmission of HIV during childbirth, in 2009 coverage of this treatment was estimated as 50% confirming a tendency to increase that began in 2003 (46.6%).

As for AIDS mortality, in the last decade Brazil has been registering an average of 11 thousand deaths a year. The mortality coefficient for deaths from AIDS varied from 9.6 per 100,000 inhabitants in 1996 to 6.0 in 2006, and since then it has remained stable. Among children under five, the mortality coefficient for deaths from AIDS has shown a drop of 62.5%, going from 1.6 per 100,000 inhabitants in 1998 to 0.6 in 2008. An analysis by regions shows that the AIDS mortality coefficient has gone up in the southern, northern and northeastern regions, stabilised in the Midwestern region and gone down in the southeast (Figure 8).

Figure 8. AIDS mortality coefficient (per 100,000 inhabitants) standardised for age[1], by region of residence and by year of death. Brazil, 1996 to 2008



SOURCE: Mortality Information System – SIM.
N.B.: (1) Use of Direct method Based on the Brazilian Population.
POPULATION: MS/SE/DATANHS at <www.datasus.gov.br> in the menu option Informações em saúde > Demográficas e socioeconômicas, consulted on October 20, 2009. Preliminary data for 2008.

In the last few years there has been an increase in the survival period for AIDS patients. The probability of survival for children 60 months after being diagnosed, which was 58.3% among those diagnosed in 1995 and 1996 (MATIDA, 2007) went to 86.3% for those diagnosed in 1999 and 2002 (MATIDA, 2008). Among adults the average survival time after diagnosis from 1982 to 1989 was just 5.1 months (CHEQUER, 1992), but increased to 58 months for patients diagnosed from 1995 to 1996 (MARINS, 2003). A recent study conducted with patients diagnosed in 1998 and 1999 revealed an average survival expectancy of over 108 months (GUIBU, 2008).

From 2003 to 2008, the average percentage of previously untreated HIV-positive patients arriving in the health services with CD4 counts of less than 200 cells/mm^3 was 32.5%; those that arrived in the health services with CD4 counts higher than 350/mm^3 represented around 47%. The trend over the period 2003 to 2008 among HIV-positive patients in general was to a slight increase in the percentage of patients with CD4 counts of less than 200/mm^3, which went from 32.9% in 2003 (SOUZA JR. *et al*., 2007) to 34.9% in 2008.

Presently 190 thousand HIV-positive patients are in ARV therapy in Brazil and almost 35 thousand began therapy in 2008. Among the latter, 98,7% were still taking the treatment 12 months later which shows there is good adherence to treatment.

In regard to the diagnosis of HIV infection, the Survey of Knowledge, Attitudes and Practices of the Brazilian Population (PCAP) that was done 2008, when compared to the one conducted in 2004 showed an increase in the coverage of diagnostic testing for HIV infection given that in 2004, around 28% of the sexually active population in the 15 to 54 age group declared that they had already taken the test at least once in their lives, while in the 2008 survey this figure was up to 38.4%.

Similarly, a periodic study conducted among parturient Brazilian women revealed an increase in the coverage of HIV testing during pregnancy. The percentage of those that had undergone testing and had the results revealed as part of antenatal care service went from 52% in 2002 to 62% in 2004 and remained at that level through 2006. There was also a 50% increase in the number of anti-HIV tests carried out by the National Health System – NHS from 2002 to 2008.

The PCAP survey shows that in 2008, the proportion of people in the 15 to 49 age group that had taken the anti-HIV test in the previous 12-month period and knew the result was 13.1%: 10.1% of the men and 15.9% of the women. Coverage was even higher among groups most-at-risk of HIV infection: 17.5% among female sex workers; 19.1% among MSM and 13.2% among illicit drug users.

As for prevention activities, the results of the section of the School Census – 2007 dedicated to 'Health Care and Preventive Education' showed that 63% of Brazilian basic education facilities addressed the issue of STDs. That is a higher figure than the one for 2005, which was 60,4%. If the analysis is restricted to those schools offering only primary and lower secondary education then the figures are higher, going from 67.8% in 2005 to 72.7% in 2007. Among schools offering higher secondary education the proportion goes from 96.2% to 97.5% for the same period.

There was also a notable tendency to an increase in the number of basic schooling establishments that replied to the Health Survey questionnaire and reported condom-distribution as one of the STD and AIDS-related activities undertaken in their school. In 2005 that figure stood at 5.7% and was up to 7.9% in 2007.

Still in connection with prevention activities, in 2009, 47% of women sex workers received assistance from prevention programmes, 57% of them stated that they knew where they could

take the anti-HIV test free of charge and 77.2% had received free condoms in the previous 12-month period (KERR, 2009). Among injecting drug users, 40% had had access to prevention programmes; 48.6% knew where they could take the anti-HIV test free of charge but only 28.6% had received free condoms (BASTOS, 2009).

In regard to awareness of forms of HIV transmission, most (98%) of the Brazilian population in the 15 to 54 age group declared that condom use was the best way of preventing HIV infection, a similar figure to the one for 2004. On the other hand there was a drop in the number of individuals with accurate knowledge of forms of transmission, that is to say, those who answered correctly all five transmission–related items agreeing that: a person may have a healthy appearance and yet be infected with HIV; having a partner that is faithful and not infected reduces the risk of HIV infection; condom use is the best way of avoiding HIV infection; a person cannot be infected by insect bites; infection cannot be acquired by using the same cutlery as an infected person. In the case of the last item the proportion of people answering correctly went down from 67.1% in 2004, to 57.5% in 2008.

Among youngsters in the 15 to 24 age group, the proportion of them with correct knowledge regarding forms of transmission was almost 52%; that is, 52.9% among males and 50.4% among females. Almost 76% of the young people agreed that the risk of HIV transmission could be reduced if the individual only had sexual intercourse with a non-infected faithful partner; 92.6% agreed that a person may have a healthy appearance and yet be infected with HIV; 96.1% that a person cannot be infected by an insect bite; and 74.9% that infection cannot be acquired by using the same cutlery as an infected person.

The proportion of MSM correctly identifying forms of protection against sexual transmission of HIV and rejecting the main mistaken beliefs concerning transmission of the virus was 62.3% (KERR, 2009), among injecting drug users, 31.7% (BASTOS, 2009), and among female sex workers, 42.3% (SZWARCWALD, 2009).

Regarding sexual practices related to HIV infection, in 2008, 90% of the population in the 15 to 54 age group had had sexual intercourse at least once in their lives, and 79% had had sexual intercourse at some time during the 12-month period prior to the survey. Those figures are very similar to the ones obtained by the survey for 2004. Over the same period there was an increase in the percentage of individuals that had initiated their sex lives before they were 15 years old, going from 25.2% in 2004 to 27.7% in 2008 for that age group. Among youngsters in the age group 15 to 24 the figure was 35.4% in 2008, similar to the one for 2004. Among the young males it was 41% and among the young females 29.5%.

On the question of multiplicity of sexual partners there was a slight increase in the proportion of individuals in the 15 to 49 age group that declared that they had had more than one partner in their lifetimes, going from 63.8% in 2004 to 66.1% in 2008. In the latter year the proportion for the same item was 75.7% among men and 56.6% among women. Approximately 9% of the Brazilian population in the 15 to 54 age group had had more than five casual partners in the previous 12-month period, twice the amount detected in the 2004 survey, which was 4%.

The analysis of the indicators associated to protected sex showed a reduction in condom use from 2004 to 2008 except among those that regularly used condoms with any partner, stable or casual. The declaration of condom-use in the most recent sexual intercourse with a casual partner went down from 67% to 60%, and regular condom use with casual partners, from 51.5% to 46.5% over that period. Regular condom use with a stable partner also dropped from almost 25% in 2004, to 20% in 2008.

Among those declaring they had had more than one partner in their lifetimes, condom use in the last sexual intercourse with any category of partner was 39.2%, a 10% drop when compared to the figure for 2004, which was 43.1%. Although condom use with casual partners was more frequent than with any category of partner, it also went down over the period in question going from 70.4% in 2004 to 60.2% in 2008.

90% of female sex workers declared that they had used a condom with their last client but only 55.2% reported using condoms in all sexual intercourse with clients (SZWARCWALD, 2009). Approximately 48.3% of MSM reported condom use in their last sexual intercourse with casual male partners in the previous 12-month period (KERR, 2009). Among illicit drug users, 70.1% mentioned condom use in their last sexual intercourse with a casual partner in the previous 12-month period (BASTOS, 2009).

In 2009, around 54% of IDU reported not having shared syringes in the previous 12-month period (BASTOS, 2009).

3.2 – Programmatic and organisational context

3.2.1 – Governance

National health policy in Brazil is headed by the Ministry of Health responsible for multi-sector articulations to further its interests. The health system is decentralised with a single command for each sphere of government. At the Ministry of Health, the STD, AIDS and Viral Hepatitis Department is responsible for coordinating the national policy for confronting the epidemic. As part of their administrative structures, states and municipalities maintain their own local policy coordination and mobilization bodies in alignment with national policy. In 2009 the Ministry structurally formalised the National STD and AIDS Programme by elevating it to the administrative status of "Department" (Decree Nº 6.860 of the Presidency of the Republic) thereby underscoring the political importance of the issue for the nation as a whole. The STD, AIDS and Viral Hepatitis Department is responsible for establishing the guidelines of the national policy for fighting AIDS and for providing support to state and municipal authorities for the planning, implementation, monitoring and evaluation of the associated actions. In addition to funding STD/AIDS prevention, diagnosis and care activities, since 2002 the Ministry of Health has made use of a mechanism whereby financial resources to be used in controlling the epidemic are transferred directly to the Health Departments of the Brazilian states and to the health departments of 480 priority municipalities. That policy referred to as the "Policy of Incentives for STD/AIDS Actions" and is designed to reinforce the management of local programmes increasing their autonomy in planning and implementing actions with social participation. Furthermore, the Ministry of Health promotes and articulates inter-sector government policies to promote the Human Rights of people living with HIV/AIDS and those of vulnerable populations.

Participative management

Social participation in the elaboration of public policies has contributed towards the exercise of citizenship and social control. The latter expression, now widely used in the sphere of the National Health Services (NHS) refers to the need for social participation in the processes of elaborating and following up on public policies. To that end, the National Health Council, a permanent deliberative body and a mandatory structural element of the Ministry of Health, includes among its members,

representatives of government bodies, service providers, health workers and service users and in 2003 it set up a specific sub-group specifically dedicated to the question of AIDS and known as the STD and AIDS Policies Monitoring Committee - CAPDA. This committee meets four times a year to formulate and evaluate Ministry of Health strategies. In the last few years it has proved to be an important space for dialogue on issues that directly concern people living with HIV/AIDS and the fight against the penalisation of HIV transmission; and also for tracking financial resources for HIV/AIDS actions transferred directly to state and municipal authorities. In turn, the National STD and AIDS Commission – CNAIDS, a multidisciplinary, consultative body, is made up of representatives of NGOs and people living with HIV/AIDS (elected by their peers in national events, academics and state health managers as well as representatives of other ministries, religions and the corporate sector. CNAIDS functions as an advisory body to the national policy coordinating body and has been integrated to the structure of the Programme/Department since 1986. It collaborates in AIDS control actions involving medical, scientific, social, legal aspects and the administration of national policy. In October 2009 CNAIDS held its 100th meeting. All its meetings are for the purpose of proffering advice and counsel on the formulation, elaboration and monitoring of public policies and to confront and combat the epidemic. In recognition of its importance and plurality of representation, the Brazilian government has entrusted the elaboration of the present report to CNAIDS.

Two other consultative committees have also been set up with a view to enhancing social participation in the Brazilian response:

I. The National Commission for Articulation with Social Movements – CAMS, for the purpose of articulating with, consulting, and ensuring the participation of those civil society social actors that are active in the fight against the AIDS epidemic (elected by their peers at national meetings). It seeks to promote better ways of integrating the actions of the STD, AIDS and Viral Hepatitis Department with those of its social movement partners, to perfect public policies directed at prevention and care in STD/HIV/AIDS, and to promote the Human Rights of people living with HIV/AIDS. Currently CAMS is composed of 10 representatives of AIDS/NGO Forums in the 26 Brazilian states and the Federal District and 10 representatives of national networks and movements (people living with HIV/AIDS, prostitutes, women, homosexuals, transvestites and transsexuals students, harm reducers and drug users, Afro-descendents, Indigenous people and grass roots organizations).

II. STD/AIDS Actions Management Commission – COGE: aimed at articulating the discussion of AIDS policies with representatives of State and Municipal Programmes in order to stimulate and reinforce the process of decentralising health actions. It is made up of 10 representatives of municipalities and 10 of states with an even balance as regards regional representation.

Setting up state and municipal STD and AIDS committees in the 26 states and Federal District and in the 450 municipalities most severely affected by the epidemic is also strongly encouraged. In most government spaces dedicated to the construction of public policies there are formal or informal guarantees of a place for the representation of Civil Society Organizations. Another form of stimulating social participation is by means of meetings, seminars and working groups.

As an example, in 2008 and 2009 there was a “National Consultation on STD, AIDS, Human Rights and Prostitution” and the “National Consultation on HIV in Prisons”. Both consultations enjoyed widespread participation and as a result, produced valuable documents setting out recommendations on the respective issues. In the period April 6 to May 6 2009 the STD, AIDS and Viral Hepatitis Department promoted a virtual STD and AIDS forum entitled “Prevention in the Network” to debate prevention-related issues. The forum registered over 10 thousand accesses

going far beyond the number of people that originally registered for it (1,200). Thirteen discussion 'rooms' were organised covering a wide range of subjects related to priority prevention issues. In addition to being a methodological innovation, the Forum was also a political landmark in the debate on STD/AIDS prevention in Brazil as it proposed to all participants that the reference frame for prevention should be prevention as a right and that fair, equal and universal access to that right must be guaranteed. The unabridged report on the discussions and participations is available at: http://sistemas.AIDS.gov.br/forumprevencao_final. Other spaces where dialogue took place that foster participative management are the National AIDS/NGO Articulations, the Social Movements National Articulations and the State and Municipal AIDS/NGO Forums (spaces for articulation among NGOs, networks and social movements that are engaged with the question of HIV/AIDS). An outstanding challenge in this respect is how to strengthen the participation of such representations in the consultative and deliberative entities dedicated to the construction of public policies.

There are other outstanding examples of leadership as for example the National Parliamentary Front for the Fight against AIDS, which was set up as a non-party alliance in 2001. During the term of the 2007 to 2010 legislature, the number of congressional members affiliated to the Front has risen from 192 to 198. There are also parliamentary fronts in eight state legislative assemblies: Amazonas, Ceará, Rio de Janeiro, Rio Grande do Norte, São Paulo (2008), Rio Grande do Sul (2009), Minas Gerais (2009) and several municipalities around the country. The actions of these parliamentary groups have been highly important in debating and proposing draft legislation especially in impeding the approval of legislation that runs contrary to Brazilian policy for confronting the epidemic. In the corporate sphere, the most notable body is the National Corporate Council for HIV/AIDS Prevention – CENAIDS, which has the mission of mobilising the corporate sector for the fight against the AIDS epidemic by promoting the exercise of social responsibility and sustainability by companies.

Reduction of the social and economic impacts of AIDS

The social and economic impacts of AIDS on the country's development has been amply portrayed in many Brazilian studies, in those of other countries, and in United Nations documents. A good example of that is the 2008 UNAIDS report. One of the commitments made by countries participating in the 2001 UNGASS-AIDS was to reduce such impacts although at the time no specific direct indicators to serve that end were defined. In Brazil's case a set of social protection policies has been directly or indirectly contributing towards achieving a reduction in AIDS' social and economic impacts. In addition to the associated health policies, the country's social assistance and social insurance policies have played an outstanding role. The National Social Insurance Policy makes a set of provisions to protect any worker that has contributed to the Social Insurance System should he or she become temporarily or permanently sick or unable to work and among the benefits foreseen are sickness and disability allowances and the promotion of professional rehabilitation. In turn the National Social Assistance Policy based on legislation known as the "Organic Social Assistance Law", foresees the concession of benefits in the case of unfitness for work and/or sickness in situations of extreme poverty.

In the same sphere, the '*Bolsa Familia'* programme (family allowance) deserves a special mention. It is a programme designed to transfer income to benefit families living in poverty or extreme poverty (for further details access http://www.mds.gov.br/bolsafamilia/). It is currently the government's largest and most important social programme.

However, the considerable increase in the longevity of seropositive individuals and the increase in their capacity for work is increasingly demanding that strategies be adopted to ensure the re-insertion and of people living with HIV/AIDS in employment. That has posed a considerable challenge in regard to addressing the AIDS epidemic's social impacts in Brazil.

Accordingly, in addition to the aforementioned policies, pilot projects were implanted in 2008 with a view to improving the quality of life, and propensity for employment and gaining an income of people living with AIDS, in two Brazilian state capital cities, Salvador and São Paulo, and in the Federal District. The partial results of that initiative obtained so far confirm the great difficulties encountered by people living with HIV/AIDS to get access to the formal labour market or keep themselves in employment, and that is especially true for those in situations of poverty. The low professional qualifications of the initiative's target public combined with the stigma and discrimination associated to HIV reinforce the urgent need to seek for alternatives for the social inclusion of people living with HIV/AIDS.

Global economic-financial crisis

The most important event in the two-year period under analysis from the point of view of its impacts on the development of nations and on the scenario of the AIDS epidemic, was the global economic and financial crisis that started to develop in the period from March to June of 2008 and even today is still making itself felt in all countries around the world and so it fully affected the period addressed by the present report. From the outset, global health authorities were concerned about the impacts the crisis might have on national responses to AIDS and one of the fruits and evidences of that concern is the UNAIDS document 'The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact' published in June 2009 and another is the inclusion of the same issue on the agenda of the 25th meeting of the UNAIDS Coordinating Council held in Geneva, Switzerland, on December 8–10, 2009. On that occasion the following five questions were formulated for discussion and to evaluate the impacts of the global crisis on each country's AIDS response:

a) Has the global economic slow down had an effect on the outreach and coverage of funding for AIDS prevention, assistance and care activities?

b) If the answer is affirmative, how serious are the effects and which programmes (prevention, treatment, orphans and other vulnerable children, legal and social services) have been hardest hit?

c) What other negative effects are expected in the coming months?

d) What has been done so far and what could be done in the future to confront those negative effects and enable the AIDS programmes to make progress towards their goals of universal access and materialise the important benefits they envisage?

e) What can the various actors – especially governments, civil society organizations and external partner organizations– do to implement measures to mitigate the adverse effects of the global economic slow-down on the AIDS programmes?

In Brazil's case the impact of the crisis has been considerably less than in many other countries due to a series of structural factors like: a strong and expanding internal/domestic market; long-term economic stability; high volume of exports to a diversified set of client countries; self-

sufficiency in petroleum; low risk-level banking system; considerable hard currency reserves and other factors.

In a more specific aspect associated to the Brazilian response to AIDS and the efforts to provide better quality of life to people infected with HI, there have been the governments initiatives to promote development in the form of large-scale housing development plans and measures to stimulate consumption that have eased up the unemployment rate and kept the GNP up to a high level. The indicators show that the process of diminishing poverty has continued in spite of all the diverse effects of the crisis and those factors must have certainly combined to attenuate the impacts of AIDS especially remembering the epidemic in Brazil is on the increase among the poorest sectors of the population, which are always hardest hit by economic crises. In any event, clear evidence of the effects of the global economic and financial crisis on the epidemiological situation of AIDS in Brazil will only eventually be perceptible in the medium to long term.

Communication strategies

Communication is an extremely important area in ensuring that the question of AIDS is always present on the media agenda and in the minds of society at large. A variety of strategies has been employed and among them are: two mass media campaigns a year; mobilization activities; social marketing and a press advisory group that ensures ample space in the media. The very importance of the theme justifies the existence of a sector within the STD, AIDS and Viral Hepatitis Department dedicated to communication and active in four areas: press (interface with newspapers, radios, and television networks, press relations body to supply information on AIDS to journalists, etc.); publishing (coordinates the publication of printed material such as booklets, books and magazines as well as educational videos and cataloguing reference material); publicity (responsible for articulating with advertising agencies, civil society and the federal government for the elaboration of mass campaigns and specific actions related to the question of HIV/AIDS); and managing the Department's internet page (gathering presenting and disseminating technical-scientific production, information for the public at large and activities related to STD/HIV/AIDS).

There is also more specific communication activity directed at vulnerable populations such as transvestites, transsexuals, men that have sex with men, prostitutes and other target publics that are still discriminated in the ordinary mass media. In spite of all the efforts that have been made, themes related to living with HIV and prevention are still generally taboo and the mass media is no exception to the rule. However, after almost 30 years of epidemic and 20 years of mass media campaigns in AIDS some signs of society's progress are perceptible and most of them can be attributed to communication efforts. Today, on open TV channels homosexuality is a common topic in the soap operas, the condom is almost an obligatory mention any discussions or programme inserts involving sexual relations; the figure of the prostitute has become acceptable to the point of occupying prime time on the country's biggest TV channel. Such progress is clearly essential but there was a time when those very issues were extremely polemical in Brazilian homes.

As a result of all those efforts, today *the great majority* of Brazilians, almost 97%, recognises that condom use is the best way to avoid HIV infection and 95.7% are aware that there is a risk of infection in sexual intercourse where the condom is not used (PCAP, 2008).

Monitoring and Evaluation systems

Institutionalising monitoring and evaluation in all three spheres of government is a top priority for the STD, AIDS and Viral Hepatitis Department. They are seen as management tools that inform the decision making process and make social control feasible and provide the means of adjusting and improving programmes. In the period covered by this report the continuation of that process is visible strengthening investment in capacity building in monitoring and evaluation for staff human resources, in the consolidation of monitoring systems and in undertaking specific studies for the purpose of monitoring and evaluating the AIDS epidemic in the country.

In regard to capacity building, two new classes were formed for the Masters course in Monitoring and Evaluation and the short-term workshops continued to be run and offered to STD, AIDS and Viral Hepatitis Department's partner organizations. Two computer-based distance-learning monitoring and evaluation courses were also developed and administered, one a short term course and the other at the level of postgraduate specialisation.

Among other actions designed to reinforce monitoring of the epidemic were: the updating and reformulation of the system of monitoring indicators used by the Department, - MONITORAIDS, which presently comprises 90 indicators; the definition of a methodology for estimating HIV incidence; the development of system for monitoring the costs of outpatient treatment for people living with HIV/AIDS and the creation of a monitoring system to accompany the project 'Health and Prevention in Schools'. In regard to monitoring studies, nine cohort studies of knowledge, attitudes and practice surveys among the general public were done and studies were carried out to estimate syphilis prevalence among parturient women and Brazilian army conscripts. Three other probabilistic sampling studies were conducted in this same period among populations most-at-risk of HIV infection: MSM, female sex workers and drug users.

One of the outstanding monitoring and evaluation systems that have been implemented in Brazil is the SIS-Incentive system. It is designed track the financial execution of the funds that are regularly transferred to 27 state health departments and 480 municipal health departments to accompany the achievement of annual programmed targets and basic STD and AIDS indicators, and to verify the fulfilment of formal commitments and the partnerships established with civil society organizations. All those systems can be accessed and accompanied by the ordinary citizen.
However, in spite of all the advances Brazil has achieved in this area there are still at least two outstanding challenges to be met and overcome: how to effectively decentralise monitoring and evaluation activities; and how to stimulate their use as management tools in all spheres of government.

3.2.2 – Prevention and reducing vulnerabilities

In Brazil, vulnerability to HIV of individuals and population groups stems from a combination of many factors linked to questions of gender, race and ethnicity, sexual orientation, income, schooling level, geographic region of residence and age group among others, and it is aggravated by the severe inequality that marks Brazilian society so strongly. Given that the Brazilian epidemic is one that is concentrated in vulnerable populations, it is natural that preventive actions should involve a combination of strategies specifically directed at those populations with others directed at the populace at large.

There is a considerable range of social programmes designed to prevent and reduce specific vulnerabilities and most of those that have already been portrayed and analysed in the previous

report are still fully functional and in some cases have expanded their outreach. Among them we can mention: the Health and Prevention in Schools programme; the Integrated Plan to Combat the Feminisation of AIDS and other STDs, the National Plan for the Combat of the AIDS and STD Epidemic among gay men, other men who have sex with men and transvestites; the various harm reduction programmes for drug users; the Integrated Programme of Affirmative Actions for Afro-descendant People, and the Programme of Strategic Actions among Indigenous Populations. Actions designed to combat the sexual exploitation of girls come under the aegis of the National Plan to Combat Sexual Violence against Girls and Young Women and care services provided to such girls and their families come under the 'Sentinel' Project. All of those programmes appeared in the previous report and have been maintained and/or expanded. The principal actions designed to ensure continuity are set out below.

STD prevention

Sexually transmitted diseases (STD) are still a very serious public health problem in spite of all the progress achieved with new diagnosis methods and new treatments, and they continue to generate severe socio-economic and psychological impacts all over the world (HOLMES, 1999), as well as being great facilitators of HIV transmission. Accordingly, prevention of STDs is an important strategy for combating the AIDS epidemic in Brazil.

In the middle of the 1990s the Ministry of Health adopted a syndrome-based approach strategy in regard to STDs with the aim of achieving early diagnosis and timely treatment thereby avoiding serious sequels and reducing the risk of dissemination. Studies demonstrated that it was easy to apply flow chart techniques to the main syndromes and that they offered a high rate of cure especially in the case of urethral discharge and genital ulcers. In keeping with that strategy, the three spheres of government undertake actions for the prevention and treatment of STDs. In the last ten years, the STD, AIDS and Viral Hepatitis Department has been unfolding capacity building activities in partnership arrangements with state and municipal STD/AIDS programmes with a view to qualifying health staff in regard to the syndrome-based approach and it has been making educational and informative material available, carrying out research into the main STD, and monitoring for the appearance of possible resistance to microbicides.

Capacity building events for NGOs were held in all five Brazilian macro-regions with the intention of furnishing them with information on the signs and symptoms associated to STDs and on government health policies regarding those diseases, including the mutual commitments made between states and municipalities concerning the need to undertake advocacy activities in regard to this issue.

Broadening access to prevention commodities

By means of a set of administrative and educational actions the Ministry of Health has sought to promote the access of the population to prevention commodities with special emphasis on male condoms, female condoms and lubricant gel. In its new systematised work using Prevention Commodity Needs Plans that are elaborated by the states, commodities in are distribute in accordance with the said plans, which means that the real needs of each state are better assessed and the distribution of the commodities to vulnerable populations is more effective. All the plans and distribution spreadsheets are made available for inspection on the internet (www.aids.gov.br/previni), by means of the PREVINI system with the object of offering useful information, fostering exchanges of information on strategic prevention commodities involving the three spheres of government and enabling follow up on the distribution.

In 2008, 410 million male condoms were distributed and in 2009 the biggest ever distribution in the country was made - 466.5 million units. It has also proved possible to maintain the continuous distribution of female condoms and lubricant gel. In 2008, 3 million female condoms were distributed and in 2009, 2.06 million units. 1.8 million units of lubricant gel were distributed in 2008 and that was increased to 2.17 million in 2009. Priority populations for receiving female condoms are women living with HIV/AIDS, women with STDs, women attending Counselling and Testing Centres, drug users, female sex workers, women receiving attention in the prison system, and women receiving attention in the primary health care network. Priority populations for lubricant gel distribution are people living with HIV/AIDS, sex workers, gays, MSM, transvestites and women.

In October 2008, the first batch of male condoms produced by the factory in Xapuri (the first ever state run factory for condom manufacture, inaugurated in 2007) in the State of Acre was launched. Current production is 8 million units/month and it meets 100% of the male condom demand of the entire northern region.

Still with a view to expanding access, the Ministry of Health announced recommendations for expansion of male condom distribution in the National Health Services network stimulating direct access to the commodity without any need for the user to register or identify himself or herself (Technical Note nº 13/2009/GAB/PN-DST-AIDS/SVS/MS, dated January 15, 2009). The integrated decentralisation of strategic commodities to the seats of municipal authorities was the subject of another technical note that set out recommendations designed to improve logistics flows (Technical Note nº 094/2009/GAB/PN-DST-AIDS/SVS/MS, dated April 15, 2009).

Combating the feminisation of the epidemic

The Integrated Plan to Combat the Feminisation of AIDS and other STDs launched in 2007 had important repercussions in the biennial period 2008/2009. Workshops in the states were held to elaborate the State Plans to Combat the Feminisation of the Epidemic of AIDS and other STDs. The number of states with specific plans elaborated rose from five in 2007 to 26 in 2009 and they are the basis for addressing the need to combat the feminisation of the epidemic at local level

Another important action was the review of the National Plan based on articulation with the women's social movements which led to a re-definition of specific objectives and the inclusion of four affirmative agendas for the more vulnerable segments: women living with HIV/AIDS, prostitutes and sex workers; lesbians and other women that have sex with women; and women living in trans-sexuality situations.

The work agenda reinforced the inter and intra-sector partnerships especially with Special Secretariat of Policies for Women and the Technical area of Women's Health at the Ministry of Health which dealt with actions related to violence and other actions that had been the object of previous agreements with a variety of social actors and which now as a result of the articulation include the question of AIDS.

Presently the main focus of activities is on executing and monitoring the State Plans. Plan contents are on display in the Internet at (www.aids.gov.br/feminizacao) to make it easy for the population to accompany them and create an opportunity for states to exchange information on original and innovative experiences.

Among the important actions associated to priorities defined in the plans are: support for the project to strengthen national networks of prostitutes and women living with HIV/AIDS; the holding of a National Consultation on STD, AIDS, Human Rights and Prostitution which took place

in February 2008; and the development of a Prevention Campaign associated to the '*Bolsa Família*' family allowance programme (which provides social benefits to low-income populations).

Combating the epidemic among gay men, other MSM and transvestites

Since 2007 the National Plan for the Combat of the AIDS and STD Epidemic among gay men, other men who have sex with men and transvestites which was designed against the background of the 'Brazil without Homophobia' Programme (involving a wide range of actions designed to guarantee the citizenship and rights of such populations within a Human Rights framework) has established guidelines and actions associated to the theme. In 2008 and 2009, working meetings and workshops were held in the states and the results of those efforts were the State Plans elaborated by 25 states. They have been formalised and are now available for inspection on the Internet (www.aids.gov.br).

An outstanding feature of the implementation of the Plan has been the inter-sector collaboration and partnerships with other non-health areas such as Human Rights, education, the legal system and social movements. Among the achievements are the launching of the Health Care Policy for LGBTs; a campaign on identity and respect designed to promote transvestite rights and reduce their vulnerability; the intensification of support for LGBT visibility activities like the LGBT Pride Parades; and the implementation of network projects to strengthen advocacy activities of gay and transvestite organizations.

Health actions among young people

The Health and Prevention in Schools project continues to be a benchmark for health and prevention actions in STD and AIDS in the school environment. During the period being reported this project was expanded and a Health in Schools programme was created. The original government programme was created by Presidential Decree in 2007 and is under the joint management of the Ministries of Health and Education. It integrates a series of health actions in the school environment and promotes the strengthening of relations and interactions among schools and health care services.

Outstandingly the project has included the theme of living with HIV/AIDS among the various subjects it addresses and the actions it unfolds with the active participation of the movement of adolescents and young people living with HIV/AIDS. In 2008 the 3rd National Exhibition of Health and Prevention in Schools took place and over a thousand youngsters, education and health professionals and managers, researchers and representatives of international organizations took part. The exhibition took place in Florianopolis in the state of Santa Catarina, immediately before the 7th Brazilian Congress on STD and AIDS Prevention, and it succeeded in bringing together schools with successful experiences in preventive education and in integrating with health services.

Over the two-year period 2008/2009, the Health and Prevention in Schools project tried out a new strategy to boost the decentralisation of its actions. In a partnership arrangement with FIOCRUZ it contracted people selected by regions to act as agents with the function of boosting and supporting actions in the states designed to structure the programmes there, and that strategy has led to a considerable increase in the number of actions.

For the purpose of gaining better knowledge of the Brazilian school population and informing decisions on activities in Health and Prevention in Schools, for the fourth year running a special questionnaire-insert dedicated to health issues was included in the 2008 School Census. That

traditional data-gathering instrument collects information on the Brazilian schools network and the health insert posed questions as to how the schools were addressing issues like STD/AIDS, sexual diversity, teenage pregnancy, alcohol and other drugs, environmental education and a healthy diet.

99,316 valid questionnaires were sent in by schools and their geographic distribution was 50.9% urban and 49.1% in rural areas. Among those that responded, 94% of the establishments in activity declared that they had carried out some kind of activity relating to health promotion and preventive education. The outstanding challenge is posed by the teaching strategies being used. The most common tactic employed was inserting the theme into certain study disciplines and 80% of the schools referred to it with no notable differences in the proportions between urban and rural schools. Among the occasional activities identified were lectures, mentioned by 70% of schools followed by the distribution of educational material mentioned by a little over 40%.

In 2008 an agreement between the Ministry of Health and the National Union of Students made it possible to conduct prevention activities and a total of 1,600 rapid tests for HIV were done among young people in 41 universities by a mobile team that travelled around the whole country.

Another important action that targets young people was begun in 2009 and was the object of a partnership arrangement among the Ministries of Health and of Tourism and the Brazilian Youth Hostel Federation. Special material promoting prevention was produced to target young people that frequent youth hostels and furnishing them with information on modes of HIV transmission and making condoms available to them.

Harm Reduction strategies

A big step forward in addressing in harm reduction was achieved by strengthening the integration of the Technical Areas for Mental Health and those for STD, AIDS and Viral Hepatitis for the purpose of elaborating and implementing strategies.

In 2008, with the participation of civil society, they elaborated educational and informative material for the use of those involved in promoting harm reduction (harm-reducers). In 2009 an integrated public selection of projects for civil society and health services was launched aimed at: broadening access to health for people using alcohol and other drugs; improving the service-offer and attention dispensed to such service-users by the NHS; reinforcing community actions undertaken by harm-reducers among alcohol and drug users; and intensifying and expanding the articulation of the various actions undertaken by the different programmatic areas and those involving government and civil society.

In October 2009 the Seminar 'Drugs, Harm Reduction, Legislation and Inter-sector Approaches' was held through a partnership arrangement with the Brazilian National Congress. During the event there were discussions on drugs in general but with a particular emphasis on 'crack' and cocaine and an analysis of domestic and international public policies on drugs. The seminar also examined existing Brazilian legislation and the impacts of drugs on health. The seminar produced a report that will be used as a supporting element in the respective discussions of the issue with local bodies representing the areas of health, social action, Human Rights, the legal system, education and organised civil society. One of the next steps will be to set up a working group to undertake a review of the legislation in keeping with the recommendations of the seminar report, and establish a technical cooperation project on the theme.

Prevention of mother-to-child-transmission of HIV and syphilis

The Ministry of Health has been carrying out prevention actions against the mother-to-child transmission of HIV since the 1990s through the introduction of ARV therapy for HIV-infected pregnant women and the children exposed to the risk of transmission, in alignment with the procedures set out in Protocol ACTG 076. Those actions were boosted by the institution of Edict 2.104/GM, dated November 19, 2002, which was associated to the project "*Nascer-Maternidades*" designed to expand the use of various prophylactic commodities in maternity wards and maternity clinics located in municipalities classified as epidemiological priorities, to reduce mother-to-child transmission of HIV and syphilis in. The materials being supplied include rapid tests for HIV, syphilis tests, antiretroviral medicines (for parturient women and exposed children), lactation inhibitors (oestradiol and cabergoline) and formula milk for infants. Data produced by the Multi-centric study conducted by the Brazilian Paediatric Society estimated the mother-to-child transmission rate of HIV in Brazil (2004) at 8.5%, varying from 13.8% in the northern region to 3,5% in the mid-western region (SUCCI, 2003).

Over the years the Ministry of Health has been supporting the continuation and expansion actions for the prevention of mother-to-child transmission of HIV and syphilis in that part of the services network (primary health care, reference centres, maternity wards and clinics) that is administered directly by state and municipal authorities.

Presently the Federal Government takes responsibility for funding the procurement of all commodities destined for prevention of mother-to-child transmission of HIV and syphilis. In Brazil the protocols specifically recommend that HIV infected women should not breast-feed their newborn babies and accordingly the Federal Government makes provision of funds to enable state and municipal health authorities to acquire lactation inhibitors (at the moment cabergoline is the only one officially recommended) and formula milk for infants. To ensure the sustainability of formula milk distribution the respective funding has been included in the Incentives scheme (foreseen in Edict 2.313/GM, dated November 19, de 2002), thereby enabling states, municipalities and the Federal District to acquire the product themselves.

In 2007 the Ministry of Health launched its "Operational Plan for the Reduction of Mother-to-Child transmission of HIV and Syphilis" which sets out scheduled, regional targets for mother-to-child transmission reduction throughout the country. Syphilis prevalence among parturient women is to the order of 1.6%, almost 4 times that of HIV infection. In 2004 an estimated 50,000 pregnant women were infected with syphilis. Congenital syphilis is a clear indicator of the quality of health care and assistance and on average 4 thousand new cases are notified every year with an incidence rate of 1.6 cases to every thousand live-born babies. The Ministry of Health has been integrating its work in this field with the work of states and municipalities in a drive to ensure that the targets set out in the plan are effectively met. These joint prevention efforts of federal, state and municipal authorities against the mother-to-child transmission of HIV and syphilis have been underway since the 1990's and have been largely responsible for the gradual reduction in the number of AIDS cases among children in the 0 to 5 age group. The incidence rate in 1998 was 5.9/100,000 inhabitants but by 2008 it had fallen to 1.3/100,000 inhabitants. The outstanding challenges still to be faced: increasing the coverage of HIV and syphilis testing (for pregnant women and their partners) in the antenatal care services; and increasing the number of maternity units (wards, clinics or hospitals) that effectively carry out all the prophylaxis procedures recommended to prevent mother-to-child transmission of HIV and syphilis during labour, childbirth and the post-birth period, with special attention to those regions where conditions make it very difficult to implant actions that have any effective impact on the mother-to-child

transmission of HIV and syphilis. In those regions where the services have shown sensitivity in regard to the issue and have made serious efforts to address it and reduce the impact of this form of transmission, the statistics are similar to those found in the developed countries.

Indigenous populations

Brazil has an indigenous population of around 488 thousand Indians distributed among 215 ethnic groups that speak 180 different languages. It has been estimated that an additional 150 thousand Indians are living in state capitals and metropolitan areas. There are 633 officially recognised and demarcated Indigenous reserves and altogether their areas add up to 14% of Brazil's total area. Most of these indigenous lands are located in what is known as the 'Legal Amazon". 405 such areas occupy 20.7% of the Amazon and account for 98.6% of the total area of all indigenous lands in Brazil. The remaining areas are scattered around the northeastern, southeastern and southern regions of the country and there are some in the state of Mato Grosso do Sul.

Towards the end of the 1990s, changes in the profile of the AIDS epidemic began to appear in the form of an increasing interiorization, feminisation and pauperisation. Those tendencies were also reflected in the notifications of cases among indigenous peoples. The notification data shows an increase in STD and AIDS incidence among indigenous people residing in or frequenting urban areas or living in frontier areas; and a similar situation among the inhabitants of villages located in reserves near to highways, mining ventures, or large ventures involving soy production, or cattle raising or tourism areas in the coastal regions.

A special sub-system of the National Health System NHS is dedicated to providing health care for indigenous populations coordinated by a foundation linked to the Ministry of Health – the National Health Foundation – FUNASA. Integrated actions between FUNASA and the National STD, AIDS and Viral Hepatitis Department have implanted various programmes of prevention against STD and AIDS in 26 of the Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*), 76% of the total number of districts. The main actions rolled out by the Ministry of Health directed at these populations are: a) provision of HIV rapid test diagnosis in all special indigenous health districts representing a coverage of around 36% of that population; b) access to treatment for STD and syndrome-based diagnosis; c) inclusion of amounts destined for indigenous populations in the "Plan of condom distribution needs"; d) control of mother-to-child transmission of HIV; e) capacity building for indigenous health agents on themes associated to STD and AIDS prevention.

STD/AIDS and disability

In the Brazilian legislation AIDS is not classified as a disability. In 2007 the question of STD/AIDS and disability received a considerable boost as a result of the 1st Technical Meeting of Specialists in HIV/AIDS and Disabilities, which took place in November 2006 in Santiago, Chile. Brazil has been working in two perspectives in regard to this issue: prevention, diagnosis and treatment of STD/HIV/AIDS for disabled people and those with special needs; and care for people living with HIV/AIDS that have become disabled as a result of AIDS.

In the course of 2007, workshops for health managers aimed at integrating the work being done by the areas of STD/AIDS and those involved with health care for the disabled and those with special needs were held in all 5 Brazilian macro-regions. That led to the inclusion and strengthening of actions related to the issue by various states and municipalities around the country. In 2008 an informative publication for health staff was launched and the 1st Forum on STD/AIDS and Disability was held. Advocacy activities on this theme, with the intense participation

of People Living with HIV/AIDS have produced a strong mobilisation among the various health areas for the implementation of actions that include making informative material available and media campaigns. In 2009 the document "Sexual and reproductive rights in the integrality of health care for disabled persons", which defines specific actions in the field of STD/AIDS and Disability and for the promotion of inclusion of people with disabilities and special needs. Such actions are presently being implemented in all three spheres of government.

Armed Forces

Although in general terms they fit into the epidemiological scenario that has already been described, members of the Armed Forces do have some peculiarities in regard to vulnerability to HIV/AIDS. Accordingly, the Ministry of Defence has sought to undertake actions of prevention against STD among the troops and the Ministry of Health has been supporting its efforts ever since 1996 when the Brazilian Army launched the Sentinel Programme for Conscripts (*Programa Sentinela Conscrito*). On March 24, 2004, the Ministry of Defence signed a partnership protocol with the Ministry of Health and UNAIDS for the purpose of unfolding a series of actions designed to reinforce the programme 'Prevention and Control of STD/AIDS in the Armed Forces' with special attention devoted to youthful military personnel (recruits and students in the Military Academies and Training Schools) and those professionals designated to participate in the UN Peace Missions or demobilised from them.

The Programme seeks to train and qualify peer educators and prepare military personnel with good interpersonal communication skills, ease of expression, leadership qualities and interested in health issues, for that function. The idea is to stimulate an exchange of experiences among people in the same age group and disseminate information in STD/HIV/AIDS prevention. Lectures designed to enhance the sensitivity of military leaderships in regard to the issue are also given and they consist mainly in guidance and orientation for future military commanders on HIV/AIDS prevention in the various military organizations of the three branches of the armed forces. Since programme activities began in 2004 there have been 37 Capacity building Courses for Peer Educators qualifying a total of 1,267 educators: 307 from the Navy, 679 from the Army and 281 from the Air force. Every year prevention actions involving the educators are promoted to reach out to 125,000 young military personnel (recruits and students in military schools and academies) and 5, 028 career personnel engaged in United Nations Peace Keeping Missions.

Prevention in the workplace

The Ministry of Labour has determined that companies must include prevention measures against STD and AIDS on the agendas of the training promoted by their Internal Work Accident Prevention Committees. In 2009 the Ministry of Labour published a regulatory document (Normative Instruction nº 80, issued by the Work Inspection Department) concerning inspection of the workplace, which sets out provisions regarding the inspection of discriminatory practices in the workplace and the inspection of the training provided by the Internal Accident Prevention Committees. The document enables 3 thousand fiscal auditors to inspect prevention actions against HIV/AIDS and defend Human Rights in the workplace.

Since 1998, the National Corporate Council for the Prevention of HIV/AIDS (CENAIDS) has been mobilising the corporate sector to promote actions to combat AIDS. Presently CENAIDS is made up of 18 companies representing various sectors. Every year CENAIDS makes awards to associated companies as a form of incentive for them to undertake prevention activities among their

employees. The challenge that needs to be addressed is how to engage small and medium-sized businesses in a similar way.

Congresses and seminars on prevention

An intense debate on prevention of STD and AIDS is in progress in Brazil. Innumerable congresses and seminars are being held in states and municipalities to exchange practical and technical-scientific knowledge with a view to making actions more effective. Such events bring together administrators and managers, members of civil society organizations and health professionals, professionals from other areas and other partners in the fight against AIDS.

Brazil considers that learning about prevention is not the mere accumulation of information but a dialectic and dialoguing process of collective construction; one that must necessarily be based on the defence of rights and which can only be guaranteed by permanent mobilisation to that end in all spheres. The practice of prevention only effectively materialises in the cultivation of spaces of sociability, and of the meaning, values and ideology associated to it. It is in such spaces that need becomes apparent to include decentralising management, inter-sector approaches, network strengthening, technological development and universal access to prevention, diagnosis and treatment in public health policies.

On the national scene the largest event associated to this question is the "Brazilian Congress on Prevention of STD and AIDS" which will be held for the 8th time in 2010. Each edition of the Congress has endowed it with increasing visibility and importance as a forum for the debates on AIDS and other STDs in Brazil. Its proposals have had a strong influence on the formulation of public policies insofar as it discusses tendencies of the AIDS epidemic, the question of Human Rights and local actions under the aegis of the Brazilian response to the epidemic, thereby contributing to the progressive strengthening of the National Health System.

3.2.3 – STD/HIV/AIDS research and surveys

In the period 2008/09 Brazil achieved a quality upgrade in regard to the goals concerning science and technology and innovation in STD/HIV/AIDS established in the Declaration of Commitment The Ministry of Health's STD. AIDS and Viral Hepatitis Department played an outstanding role in stimulating research and technological development in Brazil, considerably strengthening its information management in regard to STD/HIV/AIDS. In that strategic perspective, the Department focussed its actions on innovation, investigation of priority themes and areas with poor data coverage and on studies of the epidemiological, behavioural and social situations of the populations being investigated. Several technological actions and projects were implemented (vaccines, medicines, microbicides, and diagnosis kits) with a view to strengthening national capacity and the technology transfer contemplated in Brazil's policy on technology and industry.

To that end, several scientific and technological partnership agreements with national and international, public and private organizations like universities, research institutes, corporations and non-governmental organizations were set up and/or reinforced.

In regard to funding, the Brazilian Technological Research and Development Policy received financial support not only from governments own sources and from the loan negotiated with the World Bank (AIDS III) but other support stemming from the considerable participation of international partners (World Health Organization – WHO, Pan-American Health Organization – PAHJO, France's National AIDS Research Agency – ANRS, the International AIDS Vaccine Initiative -

IAVI, Global HIV Vaccine Enterprise, and others). As a consequence the STD, AIDS and Viral Hepatitis Department was able to finance 240 research projects and launch 14 Public Calls for Research under the aegis of AIDS III covering different areas (biomedical, epidemiological, clinical e socio-behavioural) which led to an expressive increase in Brazilian scientific and technological production (presence in reviews and journals of international importance, books and other publications), with a total of almost 900 scientific papers or other forms of production concerning those areas, stimulating the effective dissemination and diffusion of knowledge. The projects themselves and the scientific knowledge have been made available for public consultation on the Department's internet site (www.aids.gov.br) under the heading *Informe de Ciência e Tecnologia* thereby offering a further demonstration of transparency associated o the actions undertaken in this area.

Many of the projects led to the creation of Research Networks associated to: Respondent Driven Sampling, Mental Health and STD/AIDS, Afro-descendent Populations and HIV/AIDS, Mother-to-child Transmission of HIV, Anti-HIV Therapeutic Vaccines; and there were many activities like seminars and support given to Masters and Doctorate students, and overseas training and studies with the participation of researchers as well as collaboration in some multi-centric studies

To make an adequate implementation of that science and technology policy feasible certain knowledge governance mechanisms were reinforced that involved:

1. Holding regional seminars to negotiate agreements with the scientific and technological community, managers and civil society based on joint identification and attribution of priorities to items on the research agenda;

2. Implementing preventive and adaptive monitoring systems for the various stages of project development to ensure a proper fulfilment of contract objectives and the proper scientific quality of the results according to internationally recognised criteria;

3. Strategies to stimulate publication in internationally important reviews and journals including capacity building in writing scientific articles, live and distance training on quantitative and qualitative research methodology for different field of knowledge (clinical, clinical-epidemiological, social and behavioural, including Respondent Driven Sampling methodology for use in populations that are hard to access for sampling purposes);

4. Expansion of the Science and Technology component of the MONITORAIDS indicators, which are the most important structural components of all the STD, AIDS and Viral Hepatitis Department's monitoring and evaluation activities. The corresponding database can be accessed at: www.aids.gov.br.

In addition to the strategies intended to strengthen governance of knowledge and information, operational and evaluative research projects selected by public process received support to conduct research and surveys that would furnish supporting information for prevention and assistance actions related to HIV/AIDS and STDs. To that end the Calls for Operational Research were launched to finance projects in multi-centric research networks. Three multi-centric projects using Respondent Driven Sampling methodology among vulnerable populations (MSM, sex workers and drug users) were funded in 10 Brazilian municipalities and the results obtained on the prevalence of the epidemic among those populations filled in important gaps in knowledge in that area. Other thematic lines related to Human Rights (living conditions and quality of life of people living with HIV/AIDS – children, adolescents and adults) were included in the Calls for research as well as questions concerning the impacts of the use of new ARV and their side effects.

In regard to policy on technology and industry, strenuous efforts were made over the reporting period to boost national competence and capacity in regard to strategic materials and they were directed at local capacity building and the transfer of technology related to antiretroviral medicines. It should be mentioned that such efforts were redoubled after the compulsory licensing of Efavirenz (Merck, Sharp & Dome). Similar efforts were made respecting the rapid test for HIV diagnosis. Those strategies coupled with the negotiation for more favourable prices, achieved a substantial reduction in the price paid by the Brazilian government to purchase those commodities. The Department took an active part and supported the elaboration of a variety of scientific products discussing the issue of the price of strategic materials and commodities (drugs, vaccines and microbicides) and their relationship to questions of Intellectual Property Rights as for example: (i) the article "Contributions to the Development Agenda on Intellectual Property Rights", in Economic Review (vol. 10, nº 2, 2008); (ii) the chapter on intellectual property rights and the compulsory licensing of ARV drugs in Brazil in the book 'The Political Economy of HIV/AIDS in developing countries: Trips, Public Health Systems and Free Access', by Edward Elgar, 2008; (iii) the book on intellectual property and health in Portuguese–speaking countries, to be published by the Brazilian Ministry of Health, now going to press.

Anti-HIV vaccine research came strongly to the fore during the two-year period with the Ministry of Health's decision to prioritise funding for that area. In 2008 the International Seminar on anti-HIV Vaccines was held and enjoyed the support of WHO, PAHO and IAVI and the Ministry of Health launched its 'Brazilian anti-HIV Vaccine Plan 2008-2012'. In 2009 the Strategic Operational Plan designed to implement the anti-HIV vaccine plan was elaborated. One of the consequences of the latter plan was a process that began to map Brazil's installed capacity in the field of anti-HIV vaccine research with view to identifying research groups with potential in that field and delineate data and knowledge gaps that need to be addressed to make future anti-HIV vaccine development feasible. The support given to anti-HIV vaccine research has a large international cooperation component in the form of: a partnership with IAVI and the insertion of Brazil as a member of its Advisory Committee; and a partnership with Global HIV Vaccine Enterprise and a place for Brazil on its coordinating committee and a partnership arrangement enabling vaccine research to be included on the 'Brazilian Research Site' of France's ANRS.

In spite of all the efforts made to date, and especially those of the Ministry of Health and its STD, AIDS and Viral Hepatitis Department, currently responsible for 75% of all research in the area of STD/AIDS and 95% of the research on anti-HIV vaccines; there is still an outstanding need to expand funding of this area and ensure its sustainability by seeking to involve other agencies that provide support for research in a coordinated inter-institutional articulation for the purpose of invigorating and strengthening scientific activity and the associated technology.

One of the outstanding challenges in regard to research and development that has to be addressed is the need to project scenarios in order to estimate the impacts of the epidemic on the different regions over the next ten years. To that end, there must be a system of knowledge governance that can integrate all the indicators and research results and facilitate their use to structure and inform inter-sector strategies that will be effective in combating the epidemic and at the same time provide support for operational and evaluative studies and research projects investigating the social and economic impacts of the epidemic in Brazil's different regions.

3.2.4 – Human Rights

The Human Rights policy is one of the main pillars of the Brazilian response to AIDS and is a crosscutting theme of all its actions. In addition to promoting the right to health, it actively and effectively fights all forms of discrimination and stigma, especially those directed at people living with HIV/AIDS. In the federal sphere, as early as the year 2000 a specific division was created within the structure of the STD, AIDS and Viral Hepatitis Department with the specific mission of fostering articulation with and among civil society organizations and promoting the Human Rights of people living with HIV/AIDS and the most vulnerable populations. The division plans strategies, implements actions and provides guidance to states and municipalities in their fight against stigma and discrimination and help to ensure that their actions to face up to the epidemic do not violate Human Rights in any way. Most of the states have a designated focal point person or area for such matters and support or carry out activities specifically intended to promote Human Rights.

Government and organised civil society are both making a strong effort to inform the population about the anti-discrimination laws and have them implemented. As a result it is possible to identify some important advances in the fight against racism, homophobia, the 'macho' culture and other kinds of discrimination that tend to aggravate vulnerability of the individuals and populations that they target. In regard to discrimination associated to HIV it is clear that in spite of all the legislation and other mechanisms to combat discrimination, it is still a major harassment in the lives of people living with HIV/AIDS. The results of the PCAP show that 13% of those interviewed believe that a teacher that has the virus should not be allowed to give classes in ordinary schools; 22.5% declare that they would not buy greens or vegetables in a place where a person with HIV was working; and 19% believed that if a family member gets sick with AIDS, he or she should not be looked after in the family home.

Partnerships with Civil Society have shown themselves to be absolutely fundamental to the success of strategies to promote and guarantee Human Rights. One example of such work carried out jointly by the STD, AIDS and Viral Hepatitis Department and civil society organizations is the legal advisory service offered to people living with HIV/AIDS and those belonging to vulnerable populations as part of the fight against discrimination. In 2007 the Department provided online access to a database containing data on Denunciations of Human Rights violations where legal aid services and activist groups handling the issue can register cases of HIV-related discrimination occurring anywhere in Brazil. Up to December 2009 1,447 cases had been registered. The database makes it possible to trace the outline of discrimination and devise specific public policies to address and redress the situations. Human Rights is one of the axes of all plans to fight the epidemic and they always address the question of combating violence and other forms of discrimination in a Human Rights perspective.

The National Plan to promote the Citizenship and Human Rights of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals and the National Human Rights Plan elaborated with wide-ranging social participation and launched in 2009, both have strategies to combat HIV-related stigma and discrimination. Also, the Brazilian Constitution in its endeavour to guarantee the rights of the population, such as the right not to be discriminated, provides formal mechanisms for such, attributed to the Offices of the Federal Public Prosecutor and the Federal Public Defender. There are also Reference Centres for Women, and Reference Centres for the Fight against Homophobia, Women's Rights Councils and Councils to Promote the Defence of Human Rights in various state capitals and municipalities around the country. All of these bodies receive denunciations and forward them to the respective authorities. In the period 2008 – 2009 there were isolated actions attempting to penalise the transmission of HIV as a criminal offence in spite of there being no

Brazilian legislation in place to that effect. The Ministry of Health, based on the principles of Human Rights and confidentiality feels that legal actions that envisage the sexual transmission of HIV as a crime to be legally penalised could set in train a series of decisions and generalised understanding that would certainly jeopardise the response to the epidemic. Accordingly, in close collaboration with the Parliamentary Front on HIV/AIDS and organised civil society, the Ministry has promoted debates and conducted advocacy activities in various spheres of the legal system, courts and the judiciary to discourage it.

The work of promoting Human Rights is mainly directed at strengthening the protagonist role and citizenship of people living with HIV/AIDS and vulnerable groups. To that end, in 2008 and 2009 the federal, state and municipal governments continued to sustain lines of support already in place by promoting various social mobilisation activities such as the meetings held to articulate with the social movements, and broad-based, participative Human Rights events. In 2009 a pilot programme to qualify youthful 'HIV positive' leaderships was launched designed to foster the participation of young people all over the country in the various spaces where AIDS policies are constructed, especially in the spheres of management, testing services and assistance for people living with HIV/AIDS. The great challenge now facing the country is how to expand the number of such actions into the northern and northeastern regions of the country and strengthen them in other regions where they are ongoing.

3.2.5 – Care, support and treatment

The set of commitment goals and targets established in the UNGASS 2001 concerning care, support and treatment is accompanied by means of three indicators; the quality of the efforts made in promoting universal access to antiretroviral treatment; the quality of health care services provided to people living with HIV/AIDS; treatment dispensed for the co-infection – tuberculosis/HIV. In regard to constitutional guarantees of the right to health and the duty of the State to ensure universality, equality and integrality of health actions mediated by the National Health System – NHS, there are still innumerable obstacles in the path of promoting the early diagnosis of HIV infection.

Access to diagnosis

In view of the aforementioned obstacles, Brazil has adopted several health policies designed to broaden access to diagnosis among which are: decentralisation; structuring networks of testing and follow up laboratories; political incentives for testing and social mobilisation to stimulate the populace to present itself for testing and early diagnosis; the elaboration of national norms and protocols; articulation with organised civil society; guaranteeing funding for the procurement of diagnostic tests by means of negotiated agreements and commitments among the three spheres of government, and additional funding for specific commitments like the reduction of mother-to-child transmission. Testing in the public health services is not mandatory and according to the service users wishes, it can be anonymous. The public offer of diagnostic testing has increased tenfold over the last decade. In 1999 just 440,215 immuno-enzymatic HIV screening tests were carried out while in 2008 4,659,610 tests were done.

The most recent review and revision of the regulations determining the testing algorithm to be used for diagnosing HIV infection allowed for enhanced flexibility in the choice of collecting and testing and included the possibility of using the most modern methodologies thereby reducing the number of intermediary stages in the diagnosis process and speeding up the delivery of results

without sacrificing the reliability or quality of the diagnoses in any way. That has increased the handling capacity of the laboratories and led to considerable financial savings. The new document also opens up the innovative possibility of conducting tests on dried blood using filter-paper collecting method. The great advantage of that is that samples can be sent in by post, so that diagnosis can extend its outreach from the urban centres to include the most far away locations where there are no laboratory services available.

Another important step forward embodied in the revised version of the diagnosis norms and regulations of 2009 was the inclusion of molecular biology methodology as an auxiliary diagnostic technique for use in children less than 18 months old born to HIV-positive mothers. The same methodology can be applied in antenatal care in the cases of pregnant women with undefined serum status in order to reduce the risk of mother-to-child transmission of HIV. In the previous version of the protocol the diagnosis was finalised after twelve months of follow up on the child.

The Rapid Test

The sustainability of actions related to HIV diagnosis and treatment is one of the outstanding features of Brazilian health policy. The rapid test is a good example of the kind of investment that is made. Brazilian pharmaceutical companies attached to research institutions manufacture two brands of rapid test and their entire production is purchased by the Ministry of Health. The implantation of rapid testing in the health services began in 2004 when 150 thousand tests were distributed. The total number of tests distributed including those distributed in the various testing mobilisations went steadily up over the years and in 2009 2,446,380 rapid tests were distributed in the whole of Brazil, 28% more than in 2008.

The implantation of rapid anti-HIV testing was an extremely important step that facilitated the access of the most vulnerable segments of the population to diagnosis. Presently this methodology fosters and facilitates diagnosis especially among men that have sex with men, injecting drug users, sex workers, riverside dwellers, Indians, low-income populations, truck drivers, gold prospectors and prisoners. Furthermore it is useful in the diagnosis of co-infections associated to high morbidity/mortality rates of AIDS patients like the HIV/Tuberculosis co-infection. All those facts have conspired to ensure that the offer of diagnostic testing has reached out to a far greater numbers of people and ensured efficacious and timely diagnosis.

The Ministry of Health has a social mobilisation project associated to rapid testing, the “You Gotta Know” (*Fique sabendo*) project which seeks to stimulate the diagnosis of HIV and syphilis infection. The main point put over by the mobilisation activities is the importance of early diagnosis and they also provide information on prevention and offer referral to treatment and follow-up services. The “You Gotta Know” project has made an appearance in fashion events, Arts Fairs, congresses, typical Brazilian folk festivals (like the June festivals, Carnival and the Winter Festival) and in universities around the country it has reached out to students by means of the ‘flying column’ of the National Union of Students-UNE. It was also in evidence during the World AIDS Day when many municipalities took part in action designed to take testing into the heart of the population. Among the most important the *Fique Sabendo*’s mobilisation activities are the LGBT Pride Parades at which testing is promoted among gays, lesbians, transvestites, transsexuals and transgender people. In addition, the Ministry of Health and the National Conference of Brazilian Bishops joined together in a historical and absolutely unprecedented action: the Catholic Church mobilised all of its social welfare and religious personnel, communication media and health network to raise sensitivity and awareness of the faithful in regard to the importance of testing.

Access to ARV treatment

In the 1990s Brazil was a pioneer among the developing nations in adopting a public policy of universal access to antiretroviral treatment. Currently there are around 197,000 HIV positive individuals receiving free treatment in the Brazilian public health services and that accounts for 95% of all patients diagnosed as HIV positive in Brazil and eligible for treatment. The need to establish norms and officialised procedures for such complex and controversial situations as those associated to antiretroviral therapy, led the STD, AIDS and Viral Hepatitis Department to set up special Working Groups to conduct discussions and elaborate documents that would reflect the National Consensus surrounding treatments. It was against that background that the Advisory Committee on Antiretroviral Therapy for HIV-infected Adults was set up in 1996 and in 2005, the Advisory Committee on Antiretroviral Therapy for HIV-infected Children and Adolescents. In the same year the Advisory Committee on Antiretroviral Therapy for Pregnant Women was also constituted. The three Advisory Committees all have representatives of civil society and of medical associations among their members.

Over the years the process of elaborating national guidelines conducted by the Advisory Committees has gradually been perfected. At the end of 2007 the Advisory Committee on Antiretroviral Therapy for HIV-infected Adults was restructured and introduced new approaches concerning conflicts of interests, which is a very crucial issue insofar as it affects the recommendations for the inclusion of new drugs in the NHS. Similarly the documents produced by the Committees have widened their outreach and include various aspects related to integral care for people living with HIV and AIDS and not just the question of ARV therapy. Nowadays the recommendations are founded on the best scientific evidence available and their elaboration is coordinated by the STD, AIDS and Viral Hepatitis Department in a perspective of rational use of medicines and technical-scientific alignment with the presupposition and principal of universal access to antiretroviral medicines in Brazil.

To make those recommendations widely known in the Brazilian context, regional seminars for doctors and other medical professionals that deal with AIDS patients were organised on an annual basis as well as other strategies that the geographical vastness of Brazil demands. Thus in 2010 a course on the Consensual Recommendations for the Treatment of Adults has been elaborated and it is designed to reach out to professionals in distant locations identified in the regular seminars. The procurement of antiretroviral medicines is centralised in the Ministry of Health and governed by Law nº 9.13/96. Presently the range of antiretroviral drugs used in Brazil is made up of 19 basic substances in 32 different commercial formulations for adult and paediatric use. In 2009 the Department began to discuss cost-benefit aspects with a view to making consistent decisions on the inclusion or non-inclusion of new drugs in the range of drugs being made available.

The antiretroviral drugs that have been most recently incorporated into the group of ARVs used in Brazil are: enfuvirtide (2005, fusion inhibitor), darunavir (2008, protease inhibitor) and raltegravir (2009, integrase inhibitor). In December 2008, 70% of all patients were using first line drugs (according to WHO classification), and among them 47.8% used the efavirenz, lamivudine and zidovudine regimen (EFZ+3TC+AZT), which is the officially recommended first line regimen in Brazil. Roughly 15% of patients in ARV therapy use second line medicines, which include alternatives like the protease inhibitors.

In Brazil there are individuals among the population of people living with HIV/AIDS that have already tried many different ARV therapy regimens and 5% of them are cases of therapeutic failure. Such patients are obviously in need of more recently discovered ARVs or new classes of drugs to make up more powerful viral repression schemes. The available options are evaluated by

specialised physicians that are references for questions of genotyping in the different regions of the country and those individuals act as references for other doctors offering guidance on questions of management and the principles of salvage therapy.

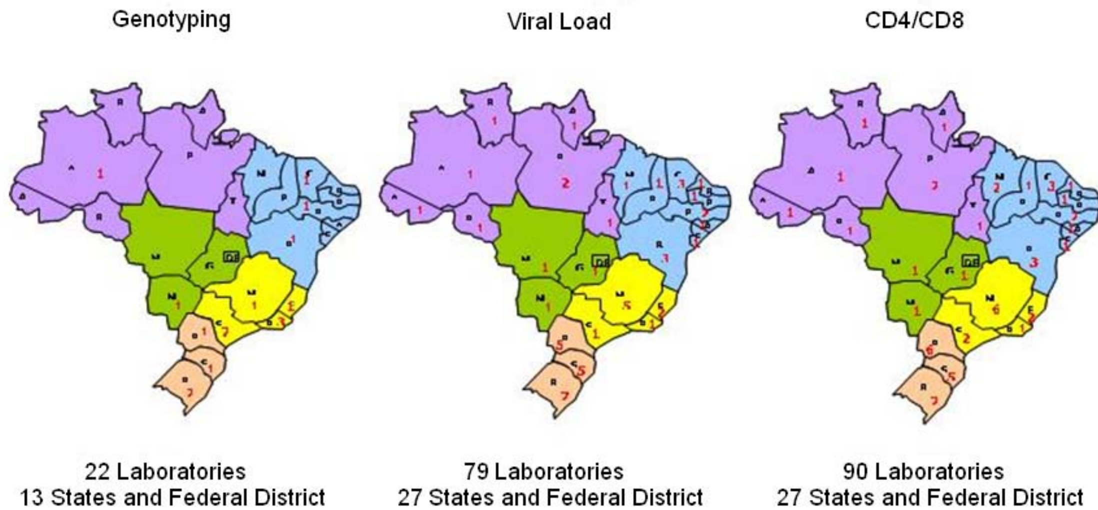
A system to control the dispensing of antiretroviral medicines was conceived in 1997, the Logistics Control of Medicines System (SICLOM) designed to analyse and control doctors' prescriptions in alignment with the technical recommendations of the Ministry of Health and to control the dispensing of antiretroviral medicines in the Public Health network. The dispensing of antiretroviral medicines actually takes place in "pharmacies" in those primary health care units that provide assistance to HIV/AIDS and are referred to as Medicine Dispensing Units - UDM. 675 UDM are involved in dispensing activities such as conservation, control, and stocking of medications, and others that are more directly linked to the patient like dispensing, and offering guidance as to medicine use which basically means that they provide integral pharmaceutical assistance, and 80% of them make use of the SICLOM.

Laboratory networks

From 1994 on the installation of a national network of laboratories carrying out T CD4+/CD8+ counts and viral load assays began for the purpose monitoring the clinical evolution of people living with HIV/AIDS and providing orientation for the beginnings of antiretroviral treatment and also to make it possible to adopt preventive therapy to avoid opportunistic infections. Presently that network is made up of 90 T CD4+/CD8+ count laboratories. In 2009 the Ministry of Health distributed 544,350 T CD4+/CD8+ count tests and 542,632 viral load assay tests. The laboratories have a computerised laboratory test control system that stores and associates clinical data and generates a set of computerized reports on all HIV-infected patients. Thus it is possible to obtain strategic information classified by age group, gender, symptomatic or non symptomatic, $CD4^+/CD8^+$ count and viral load assay results, and that in turn, makes individual, global or administrative management at federal and state levels feasible.

Brazil also has a network of laboratories dedicated to the detection of genotypic resistance that is, to detecting HIV mutations in people using antiretroviral drugs. The implantation of a network of genotyping laboratories began in 2001 and presently the network is made up of 22 laboratories and they received 5,665 tests distributed by the Ministry of Health in 2009. There is also a computerized control system for genotyping which is designed to store clinical, therapeutic and laboratorial data as well as information on HIV DNA sequences to provide guidance to doctors in their choices of the best possible therapeutic regimes and to assist the Brazilian government in the administration of its medicines policy.

Maps of the National Laboratory Networks



Another aspect of Brazilian policy is the monitoring and evaluation of the quality of laboratory diagnosis, the identification of problems and the assessment of the quality of laboratorial diagnoses as well as the standardisation of the methodologies used in the laboratories that make up the network. To provide advice on those processes the Ministry of Health set up three Technical Laboratorial Diagnosis Advisory Committees composed of representatives of government, the scientific community and society at large drawn from public and private institutions involved in the diagnosis and follow up of HIV infection in Brazil.

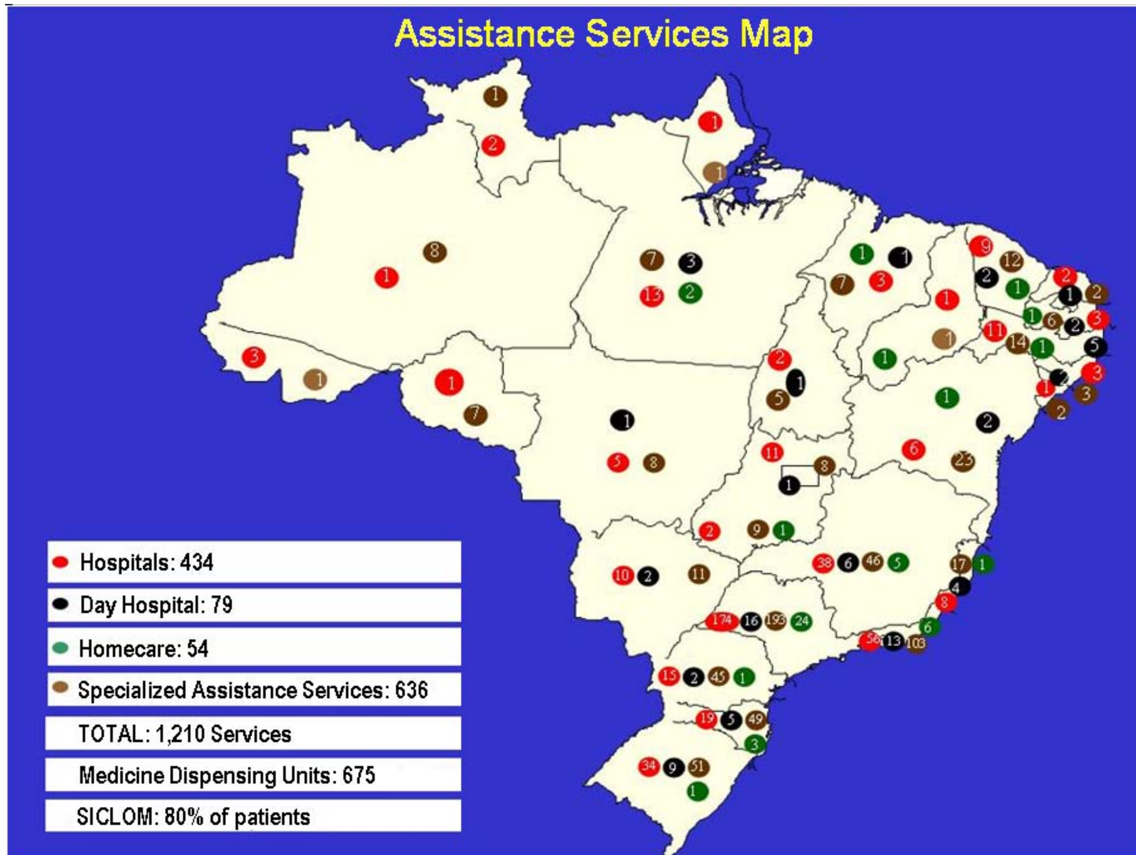
HIV-1 Isolation and characterisation network (RENIC)

In a study of primary resistance carried out by the Ministry of Health in 2009. Three levels of resistance were considered for analysis purposes: low (less than 5%); intermediate (from 5 to 10%) and high over 15%). Data gathering was undertaken in the five large urban centres in which more than 70% of all Brazilian AIDS cases are to be found, namely: São Paulo, Rio de Janeiro, Salvador, Porto Alegre, Brasilia and Belém. It was concluded that primary resistance is low in most of the regions studied.

The study was not actually designed to define the distribution of HIV sub-types in Brazil but it did prove possible to identify some patterns: sub-type B, for example is the most prevalent type (72%) in all of the cities that were surveyed except Porto Alegre, where the prevalence of 69% of sub-type C was identified.

Assistance for people living with HIV/AIDS

The response to HIVAIDS centred on organising a network of reference services has played a historical role in the clinical management of HIV infection and has had a huge impact on the lives of patients. The network of assistance services in AIDS is made up of 675 Medicine Dispensing Units, 636 treatment referral units (the so-called "SAE", Specialised Assistance Services), 434 reference hospitals, 79 day-care hospitals and 54 home care units, amounting to 1,210 services altogether. As it is an integral part of the NHS, it inevitably interacts with all the other services that fall under the aegis of the System.



SAE teams are multidisciplinary and are basically composed of doctors, nurses, social assistants and psychologists. The management of the network and any eventual expansion is undertaken by the state and municipal authorities.

The Ministry of Health in partnership with the research and survey institutions seeks out ways of evaluating the quality of those services and on the basis of the evaluations, takes steps to improve their quality. The "QualiAIDS" monitoring and evaluation instrument evaluates the quality of AIDS-related outpatient services of the National Health Service - NHS and over the last few years has evolved into a valuable management and diagnosis tool. In 2009 several workshops were held in the various states and municipalities with the technical support of the Ministry and they made use of data collected by the QualiAIDS instrument to highlight crucial aspects that needed to be addressed in the organizational sphere.

New challenges for the care and assistance services have sprung up in the second decade of universal access to antiretroviral therapy in Brazil and consequently many of them have been diversifying their activities and adopting approaches focussed on prevention of adverse events, mental health, adherence, human reproduction and health promotion.

A decree was issued in 2009 regulating the accreditation of hospitals and health services for the administration of treatment for lipodystrophy and it made provisions not only for restorative surgery but also for facial contour restoration using methacrylate; a service that is already being

offered in several services around the country. Seven reference hospitals were duly accredited in 2009 and over 8,000 surgical procedures to treat facial lipoatrophy have been carried out in outpatient services since 2006. In 2009 the Department sought to obtain a technical consensus in collaboration with a technical chamber specifically constituted for that purpose to enable it to elaborate the Facial Atrophy Treatment Handbook.

In regard to guaranteeing the reproductive rights of people living with HIV and AIDS, Brazil has been discussing recommendations to minimise the risks of mother-to-child HIV transmission between serodiscordant couples or serodiscordant individuals that wish to have children in several different contexts.

As regards the HIV/Tuberculosis co-infection, after the implantation of rapid testing for HIV in the reference services for tuberculosis, in an effort to ensure early diagnosis, the Department, in a coordinated action with the National Tuberculosis Control Programme began a process designed to implant tuberculosis testing in the HIV reference services, by first providing capacity building to nurses in priority municipalities and subsequently expanding the action to encompass all the Brazilian states. Also in the same year, prophylaxis based on isoniazide was implanted in the STD/AIDS services and the substance was made available in the Medicine Dispensing Units and included in the SICLOM.

PostitHIVe prevention

Almost 20 years after the Law (nº 9,313) that guaranteed universal access to antiretroviral medicines in the National Health System – NHS came into force and of extensive use of highly potent therapeutic regimens, Brazil is faced with the considerable challenge finding ways to alert and treat a significant proportion of patients living with AIDS that suffer from the adverse effects of using antiretroviral drugs. Similarly there is an urgent need to find innovative and effective ways of addressing the question of prevention among patients living with HIV and of putting them into practice.

Recent studies that have demonstrated the reduction in the risk of virus transmission associated to undetectable viral loads have stimulated public policies to direct their attention to the question of adherence to treatment. In 2008 studies were begun with focal group patients being treated in STD/AIDS outpatient services with the intention of identifying factors that might be determinant in regard to good adherence to ARV therapy. The results that the focal groups presented in regard to issues like the organization of the services, the multi-disciplinary teams, the timetables established for service use and other issues have gradually transformed themselves into management tools in the sense that they offer an opportunity to improve the reception of such patients and the service offer with the aim of achieving a better level of adherence to the treatment. In 2009 a series of videos was produced to be displayed in the waiting rooms of the specialised services with the intention of providing orientation and stimulating the sharing of life experiences among the patients As regards the prevention of adverse events, the STD, AIDS and Viral Hepatitis Department has been working to promote the correct use of methods that base themselves on the evidence of national and international studies and are effectively capable of retarding the appearance of alterations in the overall distribution of body-fat such as physical exercise and a diet especially created to meet the needs of people living with HV/AIDS That is why the constitution of a discussion group made up of specialists, technical personnel belonging to the department and people living with HIV/AIDS has brought with it such good results planning of actions for the services including the elaboration of technical handbooks offering technical guidance to the health teams.

Support shelters

The Ministry of Health has been channelling technical-financial support to institutions that provide shelter and multi-disciplinary assistance to adults living with HIV/AIDS in administrative collaboration with state and municipal authorities. The number of shelters benefited in the period 2005 to 2009 has remained stable. (19 states and 107 shelters are involved offering 1,841 accommodations). The same strategy is used for adolescents and young people living with HIV and AIDS. In 2008 and 2009 support for the 44 homes was provided directly by the state and municipal authorities.

One of the most important challenges that is posed in regard to people living with HIV/AIDS, is the strengthening of family ties and the social inclusion of children and adolescents living with HIV/AIDS.

Chapter 4 – Brazil's participation in international cooperation in the fight against AIDS

Brazilian policy in regard to confronting the STD/AIDS epidemic, which is founded on the integration of prevention, assistance and the promotion of Human Rights has strengthened the country's participation in the international discussions insofar as it represents an intransigent defence of the Human Right to health in its broadest sense. Accordingly, Brazil has adopted a stance of insisting on the importance of adopting an integrated approach to the epidemic involving the participation of civil society and guaranteeing respect for Human Rights especially the rights of people living with HIV/AIDS and those belonging to vulnerable population groups.

Among the actions on the international scene that are directed at eliminating obstacles to universal access are the negotiations in international forums of measures that seek to endow the present system of intellectual property rights with greater flexibility and to conduct advocacy actions against the restrictions imposed on entering, leaving or remaining in countries that are linked to the question of serum status for HIV and against any attempt to classify HIV transmission or infection, sexual orientation or gender identity as crimes.

The Brazilian response is typified by an intense participation of civil society, which is reflected in Brazil's performance the international sphere. Governmental and non-governmental bodies work together in close alliance in the various multilateral forums and technical cooperation projects established among the nations. In addition, there is an intense dialogue in course with international bodies and bilateral agencies especially involving the UNAIDS thematic group dedicated to the execution of international cooperation actions in the national sphere.

The understanding that the right to health takes precedence over intellectual property rights coupled with international initiatives that contemplate a development perspective like the global strategy to fight hunger and poverty have also assisted Brazil in its strong drive to implement innovative funding mechanisms and establish international references for reducing prices to guarantee the availability of prevention and treatment commodities to all. An outstanding example is Brazil's participation in 2004, in setting up the network of Technical Cooperation in HIV and AIDS dedicated to researching and developing strategic commodities. Other examples are its ongoing funding of UNITAID – the International Centre for the Procurement of Medicines for AIDS, Tuberculosis and Malaria; cooperation in the development of an anti-HIV vaccine through its participation in the IBAS consortium (India, Brazil and South Africa); Brazil France cooperation; and the stimulus of regional research networks in Latin America and the Caribbean. Added to those are Brazil's activities in the sphere of the World Health Organization, participation in the coordinating body of UNAIDS and more recently, on the Human Rights Council at the United Nations.

Brazil played a leading role in the negotiations conducted by the WHO Intergovernmental Working Group (task force) formulating the Global Public Strategy for Public Health, Innovation and Intellectual Property, which culminated with the approval of the text it produced by the 61st World Health Assembly in May 2008. Brazil, with the support of several other developing countries, proposed that the strategy should include a chapter of principles reaffirming the terms of thee Doha Declaration and the precedence of public health considerations over commercial interests. Brazil has given integral support to the implementation of the strategy in the global sphere and the consolidation of a regional platform for Latin America and the Caribbean in close collaboration with PAHO.

Bearing in mind that the Brazilian epidemic transcends national borders and that consequently there is a need to join forces to face up to it, ever since the 1990s Brazil has been investing in international technical cooperation in HIV/AIDS. Such cooperation is horizontal insofar as it takes place among developing countries in the southern hemisphere and is referred to as South-South Cooperation. Horizontal cooperation is understood to be a process in which the relationships among the countries are based on mutual respect and the actions are defined by joint agreement with all stage being discussed and defined by a consensus arrived at by the cooperating parties in a bid to safeguard the autonomy of countries and the sustainability of the processes involved.

Brazilian cooperation has been expanding its outreach and now includes various themes related to the epidemic. In 2004, the International Centre for Technical Cooperation in HIV/AIDS was instituted (CICT) – a joint initiative of the Brazilian Government and the United Nations Joint Programme for HIV/AIDS with the support of the German Technical Cooperation Agency – GTZ, and the Department for International Development of the United Kingdom (DFID). Currently the centre is responsible for mobilising technical and financial resources of the Brazilian government, international bodies and bilateral agencies to support activities in more than 20 countries in South and Central America, the Caribbean, Africa and Asia.

In 2004 the 'South-South Links' network was set up to support national efforts to achieve universal access to prevention, care and treatment by providing technical cooperation and supplying first-line ARV drugs produced by Brazilian government-owned laboratories and rapid tests supplied by UNICEF. The network brings together 8 Portuguese and Spanish-speaking countries: Bolivia, Brazil, Cape Verde, Guinea Bissau, Nicaragua, Paraguay, São Tomé and Principe and East Timor. The International Centre for Technical Cooperation in HIV/AIDS (CICT), UNAIDS, UNFPA, UNESCO and UNICEF are all actively supporting the Network. At first the network focussed mainly on reducing mother-to-child transmission of HIV and prevention for women, children and young people but it has now expanded into other areas. In recognition of its contribution towards expanding care, treatment and prevention through the mechanism of South-South Cooperation the Network received a United Nations Award on the occasion of the Global South-South Exhibition in December 2008.

Since 1995 Brazil has had a seat on the Commission for Prevention and Control of HIV/AIDS in the Latin American Armed Forces (COPRECOS LAC), which acts as a regional platform for the response to the HIV epidemic in the areas of defence and security. To achieve its object, COPRECOS LAC has adopted the following strategies: a) establish equitable bilateral and multilateral relations in the development of technical cooperation projects that offer mutual benefits with costs being shared by the countries involved; b) promote the exchange of experiences and technology with a view to finding joint solutions for the epidemic of AIDS and other sexually transmitted diseases. The COPRECOS LAC is formed by the COPRECOS of the various Latin American and Caribbean countries. The Brazilian Ministry of Defence was one of the founders of the Commission and presided over it from 2005 to 2007. The CICT and other organizations supported COPRECOS LAC in the elaboration of a funding proposal for the 8th and 9th rounds of the Global Fund for the Fight against AIDS, Tuberculosis and Malaria. The proposal received a positive review from the Fund's Technical Revision Committee and funding should be forthcoming in 2010.

In view of the need to foster and strengthen regional integration initiatives involved in the response to HIV/AIDS, since 1995 Brazil has been participating in the Group for Horizontal Technical Cooperation in HIV/AIDS (GCTH) which congregates Latin American and Caribbean AIDS Programmes and representatives of regional community networks. The initiative has contributed towards important advances that have occurred in universal access to prevention, treatment, care

and support by means of its regional consultations, capacity building activities, and technical-scientific events and by promoting the expansion and diversification of exchanges among the countries in the region. Another important forum for Brazil is the Intergovernmental Commission on HIV/AIDS of the Southern Cone Common Market –MERCOSUL which established regional strategies in 2008 directed at the prevention and control of the epidemic among vulnerable populations in view of the fact that the regionally, the epidemic is of the concentrated type.

In regard to regional performance in the fight against the AIDS epidemic, the countries that make up the Mercosul block have shown that their main concern is to organise prevention and care services along their borders because of the intense flows of goods and people across international frontiers and the fragility of local health structures. Activities began in the mid-90s in the form of isolated actions but in recent years they have become more integrated and embraced the proposal put forward by the MERCOSUL Intergovernmental Commission on HIV/AIDS to develop specific projects addressing the issue. A project was prepared by the International Centre for Technical Cooperation in HIV/AIDS (CICT), MERCOSUL representatives and the GTZ and it was approved at the Meeting of MERCOSUL Health Ministers in 2008 thereby ensuring greater political sustainability and greater integration of the envisaged actions in contrast to the former situation of sporadic, isolated actions.

Based on the project, regional HIV/AIDS Committees/working groups were either set up in frontier areas or reinforced where they already existed and they in turn elaborated sub-projects and work plans at the local level. The role of the HIV/AIDS Committees/working groups is to propose and follow up on actions for the control and prevention of STD/HIV/AIDS in their areas. There are now HIV/AIDS Committees/working groups on the frontiers between Brazil and Argentina, Bolivia, Colombia, Guyana, Paraguay, Uruguay and Venezuela. In 2009 the project was evaluated and the results were disseminated to all the countries to enable a strategy to be devised to ensure the continuity and sustainability of the actions in course. In the same year planning was begun of actions to be developed on the border between Brazil and French Guyana.

More recently Brazil has been encouraging the cooperating nations to concentrate on specific themes. On the basis of the demands identified among the countries the focus of activities will be on: confronting the feminisation of the epidemic, epidemiological surveillance, qualification of information and production of knowledge.

In 2008 the CICT in a partnership arrangement with UNICEF, UNAIDS, the Ministry of Health and the Dutch Embassy in Brazil initiated a cooperation project entitled “Addressing the vulnerability to HIV/AIDS of Youngsters Living in the Streets: South-south cooperation as an axis for articulation” involving Bolivia, Brazil, Colombia and Peru. The initiative takes into account a reality that these countries have in common in regard to violence and the exclusion of youngsters dwelling in the streets and the fragility or total absence of policies or actions to address the needs of those population groups (boys and girls living in the streets), factors that strongly heighten their vulnerability to STD/AIDS. The initiative has promoted and/or strengthened partnerships and the integration of actions in the areas of health and social protection for children and adolescents in the countries involved and work plans for fighting the epidemic specifically tailored to the reality of that population group are now being elaborated.

Another aspect of cooperation is reflected in the projects designed to harmonise public policies on sexual education and HIV/AIDS prevention in schools and to support the social welfare network *Rede Pastoral da AIDS* and other thematic initiatives involving the Community of Portuguese-speaking Nations (CPLP).

In all those ways the technical cooperation and dialogues promoted by Brazil's international performance are contributing towards strengthening the national response.

The process of identifying good practices among governmental and non-governmental organizations in Brazil and the other cooperating countries has revealed a series of different ways of addressing similar problems in the fight against HIV/AIDS. This has been an added stimulus to creativity in designing and implementing strategies to confront the epidemic and has provided an important opportunity to strengthen alliances to face the common enemy.

Chapter 5 – Prospects, challenges and lessons learned

In the many forums and seminars that have been held over the years, government, civil society and academic institutions have been evaluating the trajectory of the Brazilian response to date and seeking to improve it. In this chapter attention will be given to concerns with the future scenario of the epidemic in Brazil and lessons learned so far in the context of an epidemic that is concentrated in population groups that traditionally have had a poor reception at the hands of the health services. The challenges facing the Brazilian response to AIDS for the medium long term are:

I. Diminishing the numbers of new cases especially among vulnerable populations;

II. Increasing inter-sector actions for risk and vulnerability reduction taking regional inequalities into account;

III. Expanding access to early diagnosis of HIV infection and of other STDs;

IV. Promoting universal access to prevention activities in a perspective of equality by expanding access to prevention commodities and stimulating consistent condom use;

V. Increasing the number of actions for reducing mother-to-child HIV transmission and congenital syphilis;

VI. Improving the quality of life of people living with HIV and AIDS by integrating HIV/AIDS strategies in the Health sector and other sectors;

VII. Expanding access to and improving the quality of health care and social support services including primary health care;

VIII. Promoting the sustainability of universal access to treatment;

IX. Effectively executing all the STD/AIDS actions that have been formally negotiated and agreed to in the NHS, guaranteeing technical and financial resources for the three spheres of government and ensuring social participation;

X. Expanding Human Right guarantees for people living with HIV/AIDS especially those concerning access to the labour market and maintenance of employment; and for populations socially marginalized by poverty or discriminated on the grounds of sexual orientation, race or gender.

To address all the challenges listed above, geographical, and institutional obstacles have to be overcome as well as obstacles in the field of Human Rights. The geographic obstacles consist of the distances (typical of a country with continental dimensions) to be travelled to get to services especially in the northern and northeastern regions of Brazil, and the low incidence of specialised services that are created on the basis of updated epidemiological and demographic information. There is a whole set of obstacles associated to the question of Human Rights like the question of stigma that makes a person seek out the health services in a municipality other than the one of residence for fear of being identified and discriminated. Finally there are the institutional obstacles. Even after three decades of the epidemic's existence there are still health professionals in the services that refuse to handle individuals belonging to most vulnerable population groups or patients affected by AIDS. The groups most jeopardised by this latter aspect are street dwellers, and alcohol and drug users.

In order to overcome those barriers and enhance the possibilities of achieving success in the Brazilian response to AIDS it is fundamental to take advantage of lessons learned. In view of the huge numbers of qualified experiences considered to have produced good results that have been accumulated in the long trajectory of the fight against the epidemic and the broad outreach of the national response in such a vast country it would be difficult to choose specific experiences to relate and so it has been decided to give a description in general terms of the lessons learned and the way they mirror the complexity of the Brazilian response to AIDS and the size and diversity of the country.

I. The involvement of civil society, health professionals and other sectors of society that play a role in the social control exercised over public policies and in the elaboration, implementation, monitoring and evaluation of the strategies to confront the epidemic is a good practice. Those categories are represented on the consultative and decision making councils and committees of the health sector. One challenge associated to this good practice is to find a way to extend this form of social control to embrace the new partners of public policies for the prevention of AIDS which would mean thinking about the participation of civil society in the decision making and evaluation spheres of other federal bodies like the Ministry of Education, the Ministry of Justice and the Ministry of Defence and the same goes for state and municipal spheres of government.

II. From the beginning the Brazilian response has managed to strike a balance between the single national authority constituted in the Federal sphere with ample power of decision and large volumes of resources to administer (formerly the National STD and AIDS Programme and now the STD, AIDS and Viral Hepatitis Department) and the decentralisation process that is the hallmark of the Brazilian National Health System, the NHS. In the context of a concentrated epidemic with uneven distribution among regions and populations, the institutionalisation of prevention and assistance actions in health services routines must inevitably be achieved through negotiation between the national authority and the respective state and municipal entities. The Operational Plans have proved to be an example of a good practice in maintaining a rational equilibrium between the national authority and the state and municipal health departments. The plans correspond to strategies for consolidating and negotiating commitment to actions that are actually being implemented but in a dispersed and irregular manner. The aim of the plans is to boost the actions to give them national scale and guarantee their consolidation and maintenance. What guarantees success in this case is the dialogue established between the national authority and the local authorities as part of the process of elaborating the Plans. Among the Plans presently in execution are: the Integrated Plan to Combat the Feminisation of AIDS and other STDs, the Operational Plan for the Reduction of the Mother-to-Child Transmission of HIV and Syphilis, and the National Plan for the Combat of the AIDS and STD Epidemic among gay men, other men who have sex with men and transvestites;

III. Giving priority to health assistance and prevention actions that are on the same level of intensity and are understood to be fundamental rights in the field of health is a good practice.

IV. The most notable feature of the Brazilian response to AIDS is that it addresses the epidemic in a framework of Human Rights and Vulnerability.

That means valuing the identities of groups and populations, respecting differences and valuing diversity. One example of this good practice is the plurality evident in the Calls for Research, intervention and advocacy issued by the STD, AIDS and Viral Hepatitis Department

and by the state and municipal AIDS programmes which contemplate the diversity of regions, contexts, and populations based on an understanding that prevention and assistance need to respect the consent of their subjects, cultural contexts and cultural values.

V. Emphasising Human Rights and universal access to treatment has led to: a growing concern about the quality of life of people living with HIV/AIDS that is mirrored in the actions designed to combat discrimination in the community; the expansion of the legal protection framework surrounding the question of anonymity in the workplace; guaranteeing anonymity in the treatment process; guaranteeing the right to social welfare and assistance benefits; guaranteeing access to vaccines and prevention procedures against diseases; increasing the number of procedures that seek to minimise the side effects of ARV therapy (facial atrophy correction, treatment for lipodystrophy and hepatic diseases; physical exercises, etc.); follow up conducted by multi-disciplinary health teams (doctor, psychologist, nurse, pharmaceutical assistant, oral health care person etc.); a multi-disciplinary approach and other measures to ensure better quality of life for seropositive people. Such follow up on a person that is HIV+ is an increasingly complex matter and is part of the effort being made to avoid early deaths and late diagnoses. The efforts to improve the quality of life of people living with HIV means there must be strategies to ensure broader access for the patient and strengthen the bond between the patient and the services.

VI. The establishment and stabilisation of a democratic regime in Brazil, the heavy investments made in social inclusion programmes and the general raising of schooling levels in the population at large are factors that have contributed towards reducing structural social vulnerability and programmatic vulnerability.

VII. The Public Health System firmly rooted in the doctrinal and organisational principals that are responsible for the quality of the results it obtains, is characterised by: universality (health is the right of all); integrality (health care encompasses preventive measures just as much as curative ones and individual health just as much as collective health); equality (all individuals must enjoy equal opportunity to make use of the health care system); community participation (social control exercised by service users by means of conferences and councils in all spheres of the system); political-administrative decentralisation (the NHS is implanted and active in the federal, state and municipal spheres of administration); hierarchy and regional adaptation (Health services form a hierarchy based on levels of complexity).

References

6.1 – Bibliography

ALL PARTY PARLIAMENTARY GROUP ON AIDS. *The Treatment Timebomb*. London, 2009.

BARBOSA JR., A. et al. Tendências da epidemia de AIDS entre subgrupos sob maior risco no Brasil, 1980-2004. *Cad. Saúde Pública*, [S.l.], v. 25, n. 4, p. 727-737, 2009. ISSN 0102-311X.

BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros*. Relatório técnico entregue ao Departamento de DST, AIDS e Hepatites Virais, 2009.

BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de DST, AIDS e Hepatites Virais. *Boletim Epidemiológico AIDS e DST*, Ano III, n. 1. Brasília, 2007.

______. *Boletim Epidemiológico AIDS e DST*, Ano IV, n. 1. Brasília, 2008.

______. *Boletim Epidemiológico AIDS e DST*, Ano V, n. 1. Brasília, 2009.

______. *AIDS: Leia antes de escrever*. Brasília, 2009.

______. *Prevalência da sífilis, do HIV e do HTLV e Fatores Comportamentais Associados:* Estudo Transversal com Conscritos das Forças Armadas. Relatório técnico. Brasília: 2010.

______. *Pesquisa de Conhecimento, Atitudes e Práticas na População Brasileira de 15 a 64 anos*. Relatório técnico. Brasília, 2010.

BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. Programa Nacional de DST e AIDS. *Metas da UNGASS – HIV/AIDS*: Resposta Brasileira, 2001-2003. Brasília, 2003.

______. *Direitos humanos e HIV/AIDS*: avanços e perspectivas para o enfrentamento da epidemia no Brasil. Brasília, 2008. Série Parcerias e Mobilização Social, n. 6.

______. *Metas e compromissos assumidos pelos Estados-Membros na Sessão Especial da Assembléia Geral das Nações Unidas em HIV/AIDS*: UNGASS HIV/AIDS - Resposta Brasileira 2005/2007, Relatório de Progresso do País. Brasília, 2008.

BRASIL. Presidência da República. *Objetivos de desenvolvimento do milênio: principais iniciativas do governo federal*. Brasília, 2007.

BRASIL. Secretaria Nacional de Direitos Humanos. *Plano Nacional de Enfrentamento da Violência Sexual Infanto-Juvenil*. SNDH, Comitê Nacional de Enfrentamento à Violência Sexual contra Crianças e Adolescentes, Brasília, 2006.

CHEQUER, P.; HEARST, N.; HUDES, E. S. et al. Determinants of survival in adult Brazilian AIDS patients, 1982-1989. *AIDS*, [S.l.], v. 6, n. 5, p. 483-7, 1992.

GUIBU, I. A.; BARROS, M. B. A.; CORDEIRO, M. R. D. et al. Estudo de Sobrevida de Pacientes de AIDS no Brasil, 1998 a 1999: Fase I, Regiões Sul e Sudeste. In: BRASIL. Ministério da Saúde. Secretaria de Vigilância em Saúde. Programa Nacional de DST e AIDS. Boletim Epidemiológico AIDS/DST, ano V, n. 1, 2008. Disponível em: <http://www.aids.gov.br/data/documents/storedDocuments/%7BB8EF5DAF-23AE-4891-AD36-1903553A3174%7D/%7B31A56BC6-307D-4C88-922D-6F52338D0BF4%7D/Boletim2008_vers%E3o1_6.pdf>. Acesso em 20 mar. 2009.

HOLMES, K.; SPARLING, P. F.; MARDH, P. A. et al. *Sexually Transmitted Diseases*. [S.l.]: McGraw-Hill, 1999. 3 ed.

INOCENCIO, L.; PEREIRA, A.; SUCUPIRA, M. C. et al. et al**.** Brazilian Network for HIV Drug Resistance Surveillance: a survey of individuals recently diagnosed with HIV. Journal of the International AIDS Society*, [S.l.],* 2009, v. 12, n. 20, p. 10.1186-1758-2652. Disponível em <http://www.jiasociety.org/content/12/1/20>.

KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras*. Relatório técnico entregue ao Departamento de DST, AIDS e Hepatites Virais, 2009.

MARINS, J. R.; JAMAL, L. F.; CHEN, S. Y. et al. Dramatic improvement in survival among adult Brazilian AIDS patients. *AIDS*, [S.l.], v. 17, p. 1675–1682, 2003.

MATIDA, L. H.; GRUPO BRASILEIRO DE ESTUDO DA SOBREVIDA EM CRIANCAS COM AIDS. AIDS by mother-to-child transmission: survival analysis of cases followed from 1983 to 2002 in different regions of Brazil. *Cad. Saúde Pública*, [S.l.], v. 23, n. 3, p. S435-S444, 2007.

MATIDA, L. H.; RAMOS JR., N. A.; MONCAU, J. E. C. et al. AIDS by mother-to-child transmission: survival analysis of cases followed from 1983 to 2002 in different regions of Brazil. *Cad. Saúde Pública (FIOCRUZ)*, [S.l.], v. 23, n. S3, p. 435-44, 2007. Disponível em: <http://www.scielo.br/pdf/csp/v23s3/11.pdf>. Acesso em 20 mar. 2009.

MATIDA L. H.; MARCOPITO, L. F.; SUCCI, R. C. et al. Improving survival among Brazilian children with perinatally-acquired AIDS. *Brazilian Journal of Infectious Diseases*, [S.l.], v. 8, n. 6, p. 419-423, 2004.

MATIDA L. H.; RAMOS JR., A. N.; HEUKELBACH, J. et al. Continuing Improvement in Survival for Children With Acquired Immunodeficiency Syndrome in Brazil. *The Pediatric Infectious Disease Journal*, [S.l.], v. 28, n. 10, p. 920-922, 2009.

MAYAUD, P.; MABEY, D. Approaches to the control of sexually transmitted infections in developing countries: old problems and modern challenges. *Sexually Transmitted Infections*, [S.l.], v. 80, n. 3, p. 174-82, 2004.

NILO, A.; VELOSO, J. C.; VILLELA, W. V. *Monitoramento das metas da UNGASS-AIDS em saúde sexual e reprodutiva das mulheres*: avanços e desafios para a resposta brasileira. Fórum UNGASS AIDS Brasil, Gestos: Recife, 2008.

ORGANIZACIÓN PANAMERICANA DE LA SALUD (OMS). *Definición de la OMS de caso de infección por el VIH a efectos de vigilancia y revisión de la estadificación clínica y de la clasificación inmunológica de la enfermedad relacionada con el VIH en adultos y niños*. Washington D.C., 2009.

SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil*. Relatório técnico entregue ao Departamento de DST, AIDS e Hepatites Virais, 2009.

SZWARCWALD, C. L. et al. HIV Testing During Pregnancy: Use of Secondary Data to Estimate 2006 Test Coverage and Prevalence in Brazil. *The Brazilian Journal of Infectious Diseases*, [S.l.], v. 12, n. 3, p. 167-172, 2008.

______. Práticas de risco relacionadas à infecção pelo HIV entre jovens brasileiros do sexo masculino, 2007. *Cad. de Saúde Pública*, [S.l.]. Submetido em 2010.

SZWARCWALD, C. L.; CARVALHO, M. F.; BARBOSA JR. et al. Temporal trends of HIV-related risk behavior among Brazilian Military Conscripts, 1997-2002. *Clinics*, [S.l.], v. 60, n. 5, p. 367-74, 2005.

SOUZA JR., P. R. B.; SZWARCWALD, C. L.; CASTILHO, E. A. Delay in introducing antiretroviral therapy in patients infected by HIV in Brazil, 2003-2006. *Clinics*, [S.l.], v. 62, n. 5, p. 579-84, 2007.

SUCCI, R. *Protocolo colaborativo multicêntrico brasileiro para avaliar as taxas de transmissão materno-infantil do HIV em filhos de mulheres com diagnóstico da infecção pelo HIV realizado antes, durante ou até três meses após o parto*. [S.l.]: Sociedade Brasileira de Pediatria, 2003.

SUCCI, R. C. M.; Grupo de Estudos da Sociedade Brasileira de Pediatria para Avaliar a Transmissão Materno-Infantil do HIV. Mother-to-child transmission of HIV in Brazil during the years 2000 and 2001: results of a multi-centric study. *Cad. Saúde Pública*, [S.l.], v. 23, Supl. 3, p. S379-S389, 2007.

TESS, B. H. et al. Breastfeeding, genetic, obstetric and other risk factors associated with mother-to-child transmission of HIV-1 in Sao Paulo State, Brazil. São Paulo Collaborative Study for Vertical Transmission of HIV-1. *AIDS*, [S.l.], v. 26, n. 12, p. 513-20, 1998.

THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS). *Joint Action for Results*: UNAIDS Outcome Framework 2009-2011. Geneva, 2009.

______. *The HIV Epidemic in the Portuguese Speaking Countries*: current situation and future perspectives towards universal access for prevention, treatment and care. Geneva, July 2008.

______. *Dialogue on Universal Access:* A summary of consultations with key stakeholders. Geneva, 2009.

______. *Monitoring the Declaration of Commitment on HIV/AIDS*: guidelines on construction of core indicators : 2010 reporting. Geneva, 2009.

THE JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS (UNAIDS). *UNAIDS' Terminology Guidelines*. Geneva, February 2008.

______. *Annual report 2008*: towards universal access. Geneva, 2009.

______. *The Global Economic Crisis and HIV Prevention and Treatment Programmes*: Vulnerabilities and Impact. Geneva, 2009.

______. *UNAIDS Action Framework*: Universal Access for Men who have Sex with Men and Transgender People. Geneva, 2009.

______. *Medição de Gastos em AIDS/SIDA (MEGAS)*: Classificações e Definições. ONUSIDA Brasil, 2009.

______. *The Global Economic Crisis and HIV Prevention and Treatment Programmes*: Vulnerabilities and Impact Executive Summary, BRAZIL. October 2009.

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO). *Culture, HIV and AIDS*: an annotated bibliography. Paris, 2006.

UNITED NATIONS (UN). *Towards universal access scaling up priority HIV/AIDS interventions in the health sector, 2009*. New York, 2009.

UNITED NATIONS (UN). General Assembly. *Resolution adopted by the General Assembly 60/262*. Political Declaration on HIV/AIDS. New York, 2006.

UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP). *Objetivos de desarrollo del milenio*: una mirada desde América Latina y Caribe. Santiago de Chile, 2005.

WORLD HEALTH ORGANIZATION (WHO). *Sustainable health financing, universal coverage and social health insurance*. The Fifty-eighth World Health Assembly, WHA58.33, 2005.

______. *Global prevalence and incidence of selected curable Sexually Transmitted Infections:* overview and estimates. Genève, 2001.

______. *The Global Strategy for Intervention and Control of Sexually Transmitted Infections: 2006-2015*. Geneva, 2006.

6.2 – Internet Sites

www.aids.gov.br

www.who.int/tb/country/en

http://apps.who.int/globalatlas/dataQuery/default.asp

http://www.measuredhs.com/

www.unaids.org

http://regional.bvsalud.org/php/index.php

http://conselho.saude.gov.br/

http://www.fiocruz.br

http://portal.saude.gov.br/portal/saude/default.cfm

http://www.cenaids.com.br/

http://www.abiaids.org.br/

http://www.theglobalfund.org/en/

http://www.unodc.org/brazil/index.html

http://www.unfpa.org.br/novo/index.php

http://www.unesco.org/pt/brasilia/

http://www.mds.gov.br/bolsafamilia/

http://www.presidencia.gov.br/estrutura_presidencia/sepm/

http://sistemas.aids.gov.br/prevencao2010/

http://sistemas.aids.gov.br/congressoprevencao/2008/index.php

http://sistemas.aids.gov.br/forumprevencao_final

http://www.datasus.gov.br/

http://www.aids.gov.br/main.asp?Team={2AC6957D-CD5D-4D96-901D-6947A6D2059D} (for information on the situation of indigenous peoples)

APPENDIX I – INDICATOR N.1: SPENDING

DEMONSTRATION OF SPENDING ON HIV/AIDS IN BRASIL, BY SPENDING CATEGORIES AND BY FUNDING SOURCES IN 2007 AND 2008

Methodology

The National Funding Matrix is used to measure AIDS spending according to Funding Source. It is a spreadsheet that enables countries to record AIDS spending by expenditure categories and by funding sources. This indicator provides critical information that is valuable at both national and global levels of the AIDS response.
The Matrix has two basic components:

- AIDS Spending Categories (How funds allocated to the national response are spent)
- Financing Sources (Where funds allocated to the national response are obtained)

There are eight AIDS Spending Categories: 1) Prevention; 2) Care and Treatment; 3) Orphans and Vulnerable Children; 4) Programme Management and Administration Strengthening; 5) Incentives for Human Resources; 6) Social Protection and Social Services (excluding Orphans and Vulnerable Children); 7) Enabling Environment and Community Development; and 8) Research. Across the spending categories there are a total of 79 subcategories distributed among eleven funding sources thereby generating 869 information cells on the matrix. In the present report the funding sources have been divided into public (national and sub-national) and international.

The National AIDS Spending Assessment (NASA) was the tool used to collect data for the AIDS spending by funding source indicator because it is a tool that classifies activities in similar way to the one recommended by UNGASS. The NASA system monitors the flow of resources involved in the Brazilian response to HIV/AIDS and facilitates the installation of continuous financial information processes in compliance with the directives of the Brazilian national monitoring and evaluation reference framework. The fact that the same strategy was used for the 2006 report will facilitate a temporal comparison of data.

The present report covers the years 2007 and 2008. It was not possible to complete the survey for 2009 because some of the spending associated to that year had not yet been finalised by the various bodies and executing entities at the time when data was being collected for this document.

Based on the priorities established by UNGASS, the collected data was classified according to funding sources considering the categories: public (national and sub-national) and international (bilateral agencies, multilateral agencies and private international foundations). Due to the great difficulty associated to compiling data on private spending undertaken for the upkeep of private health insurance plans and other private spending on health, and in keeping with previous reports, such information has not been included.

In the category of national public spending, information was gathered from the various areas of the Ministry of Health: procurement of commodities, equipment, ARV drugs and hiring technical staff; purchasing of laboratory commodities (for viral load assay, CD4/CD8 counts, anti-HIV testing, and genotyping) and prevention commodities (male condoms, female condoms and lubricant gel); financing outpatient and in-patient procedures; support for prevention activities directed at vulnerable populations and the general public, conducted by Civil Society Organizations; social communication actions; production of educational material; direct transferral of funds from the National Health Foundation to funds under the administration of the states and municipalities (Policy of Incentives for Actions in the sphere of the STD, AIDS and Viral Hepatitis Department); and transferral of funds to the United Nations system's international cooperation agencies with which the Ministry of Health has formal technical and financial agreements covering this area. Information was also obtained on related spending in other areas of federal government: social welfare and education. Data was obtained directly from the information systems of the Ministry of Health and other governmental bodies.

The intense process of decentralising public health funding now in course has inevitably led to difficulties in obtaining information in the sub-national spheres and the inclusion of such information on public funding of health and other governmental areas like social welfare and education. In an effort to set in motion a process that could gradually install capacity for obtaining such information in future studies and surveys, a questionnaire was designed and forwarded to the STD/AIDS programmes run by State Health Departments destined to register spending on the procurement of medicines for the treatment of Opportunistic Infections. Even though it only represents part of the total spending done by decentralised spheres of government in Brazil, that information does increase our knowledge about it and offers supporting elements for the identification of the extent of local involvement with the formal mutual commitments made by the three spheres of government. 24 (88%) State Health Departments supplied information by returning completed questionnaires to the Ministry of Health.

With the completion of the data gathering process the information was classified into the respective funding categories and the data consolidated in the Funding Matrix using current currency values (no inflation-related adjustments). The basis adopted for the calculation of dollar equivalents was the average annual exchange rate for the Brazilian real against the US dollar for the corresponding year[2].

The information respecting international spending was obtained from the international organizations that had technical cooperation agreements with Brazil in place (governmental international agencies, private foundations and organizations of the UN System). This information was likewise obtained by administering a questionnaire to the respective organizations with the assistance of the UNAIDS office in Brazil.

It must be stressed that however much it may facilitate the analysis of information, it was very difficult to adapt the classification of spending adopted for the National Funding Matrix to the reality of the structure of public funding in Brazil. For most of the recommended categories there

[2] The values to be used for the present survey are: R$ 1.96 for the year 2007 and R$ 1.83 for the year 2008 (Source: Brazilian Central Bank, 2009).

are no specific information systems in place that make it possible to identify specific spending. This means that the registration of amounts for some categories may fail to realistically represent spending that was effectively done for them. As an illustrative example, spending on prevention, especially expenditure directed at most vulnerable populations, is actually done as much in the form of direct spending by government bodies as it is by non-governmental organizations, both national and international.

Evolution of AIDS-related spending in Brazil (1998-2008)

The Brazilian National Health System (*Sistema Único de Saúde* – SUS), has been institutionalised in Brazil since 1988. It has a hierarchical structure with interdependence of the Federal, State and Municipal spheres and funding it depends mainly on public sources stemming from various forms of federal taxation as well as financial resources applied by state and municipal governments stemming from the levying of local taxes. A network of public and private services formally associated to, or contracted by the system executes health actions at all levels of complexity. According to the respective legislation, the private health network is complementary to the system and is chiefly financed by individual expenditure and private health insurance schemes. 20% of the Brazilian population is estimated to have private health insurance even though they also make use of the public health network.

In recent years there has been a gradual increase of state and municipal government participation in such funding as can be seen in Table 1 below.

Table 1: Percentage of health revenue by government sphere – Brazil, 2005-2008

YEAR	UNION	STATES	MUNICIPALITIES
2005	38.5	31.0	30.5
2006	46.7	22.1	27.2
2007	47	26	27
2008	50.6	24.4	25

Source: CARVALHO, 2007 and 2009[3]

In regard to AIDS, most of the health expenditure in Brazil is done with public financing whether it be in the federal, state or municipal sphere. The table below shows the amounts allocated from 1998 to 2009 to the National STD, AIDS and Viral Hepatitis Department responsible for conducting the Brazilian STD and AIDS Programme. The annual budgeted amounts reflect their adaptation to estimated expenditure needs per year over the period.

[3] CARVALHO, Gilson. Gasto Público em Saúde – Brasil, IBSAUDE, 2007 (disponível em: < www.ibsaude.org.br>) e Financiamento da Saúde no Brasil, ABRASCO, 2009.

Table 2: Budget allocations for the STD, AIDS and Viral Hepatitis Department of the Ministry of Health – 1998 to 2009.

In R$ millions

Year	Budgeted (*)
1998	271.21
1999	593.41
2000	713.10
2001	654.50
2002	802.45
2003	689.00
2004	880.28
2005	941.54
2006	1,305.36
2007	1,362.39
2008	1,340.75
2009	1,430.16

Source: SIAFI. Expenditure on hospitalisation, outpatient consultations and laboratory examinations paid for by the SUS are not included.
(*) Current values. The average annual currency exchange rate for the year 2009 was taken to be R$ 2.00 (Brazilian Central Bank – BACEN, 2009).

In the same way as other government spending on health, expenditure on AIDS makes use of the financial resources of state and municipal spheres of government and most of the spending is actually done by the state and municipal health departments.

The present study did not make a survey or inventory of spending financed by state and municipal government sources. The absence of such information will most certainly affect the possibility of knowing the effective total public outlay. In a previous study[4] for the year 2004 the total AIDS-related spending of 16 state health departments and 129 municipal health departments was found to have been around $R201 million[5], which represented a considerable impact on the total spending for the same year.

In 2009, the Department of Health of the Government of the State of São Paulo provided additional information to the effect that in addition to spending on the purchasing of medicines for the treatment of opportunistic diseases and other expenditure, in 2007 and 2008, the state spent R$ 36.6 million and R$ 40.6 million respectively to ensure the sustainability of the state STD/AIDS Programme (human resources, infrastructure, service providers and so on).

The federal resources that the Ministry of Health dedicates to AIDS are spent on human resources, payment for in-patient, outpatient and laboratory services, purchase of antiretroviral drugs, the

[4] BRASIL. Ministério da Saúde. Contas em HIV/AIDS - estimativas do gasto público - 2003 e 2004 (Condensed version), Brasília, 2006.
[5] Current values. For currency exchange calculations use the average annual exchange rate against the US dollar in 2004 of R$ 2.93 (Brazilian Central Bank - BACEN, 2009)

procurement and distribution of prevention commodities as part of prevention actions (male condoms, female condoms, lubricating gel), nationwide mass publicity campaigns and fostering various lines of research, surveys and studies. Furthermore, other federal financial resources are decentralized to state and municipal health departments for the control of HIV/AIDS and other STDs. These last are designed to reinforce the decentralised response to the epidemic in those local spheres by financing various actions undertaken by the public network and others carried out by civil society organizations.

The first attempt to provide formal accounts of AIDS-related spending in Brazil[6] were made in 1997 and enjoyed the cooperation of the SIDALAC (Regional initiative for AIDS control in Latin America and the Caribbean) and the *Fundación Mexicana de Salud* (Mexican Health Foundation). Brazil continued its accountability efforts by promoting biennial spending analysis studies conducted by means of a partnership agreement involving *ad hoc* collaborators and technical staff of the Ministry of Health.

The most recent of such surveys was conducted in 2007 in regard to spending in 2006. The survey sought to establish a classification in alignment with NASA methodology and the National Funding Matrix proposed by UNAIDS for UNGASS purposes.

It must be underscored that over the years there have been significant changes in the methodology used for such studies, which make it difficult to make comparisons of years and establish a temporal series of in-country spending information or to make comparisons with other countries.

Spending Analysis for the years 2007 and 2008

According to the survey that was made, total AIDS-related spending was stable in relation to the level detected in the previous survey[7] and in the years 2007 and 2008 totalled R$1.14 billion and R$ 1.40 billion respectively. Public funding was responsible for 99.5% and 96.4% of total spending for each year. According to the methodology previously described, the only state resources included here are those of 24 state health departments spent on the procurement of medicines for the treatment of opportunistic diseases. These last amounted to R$ 10 million in 2007 and R$ 12.8 million in 2008.

Spending based on international funding in 2007 was to the order of R$ 5.55 million (0.49% of the total). In 2008 that rose to the amount R$ 11.44 million and accounted for 1.01% of the financial resources spent in the Brazil. In spite of that increase, international participation remains at a low level, which demonstrates the sustainability of the Brazilian response in HIV and AIDS as it is largely based on its own national funding sources. It must be pointed out, however, that in spite of their low percentage participation, international resources are still important in financing actions especially technical cooperation designed to foster activities directed at: the most vulnerable

[6] The first studies/surveys produced were: Cuentas Nacionales em VIH/SIDA, Estimación de Flujos de Financiamento y Gasto em VIH/SIDA – Brasil: Cuentas em Sida, 1997-1998, Fundación Mexicana de Salud, 2000 e Sistemas de Información de Respuestas Nacionales Contra el SIDA: flujos de financiamento y gasto em VIH/SIDA, Cuentas Nacionales em SIDA, Brasil: 1999 e 2000, Fundación Mexicana de Salud, 2002.

[7] Brasil, Ministério da Saúde, *Ibid*.

populations; and perfecting intervention strategies in the field of prevention and strengthening management of the Brazilian Programme.

Spending on prevention in 2007 and 2008 amounted to R$ 160.77 million and R$ 75.93 million respectively, corresponding to 14.7% and 6.7 % of total spending. The highest levels of spending registered for 2007 were those related to condoms (43%) and communication (19%); while in 2008 they were communication (40%) and voluntary testing (20%).

It should be noted that the municipalities carry out most prevention actions and they also bear the brunt of the costs for them. This means that such spending does not appear in the present survey report.

There was a significant increase in the percentage of total spending represented by spending on prevention and that was accounted for by the large-scale procurement of male condoms. As the condom purchasing process in 2008 was only finalised in 2009, the figure presented here has reverted to the level registered for 2006 (6%). From 2009 on, with the due finalisation of that condom acquisition, spending on prevention will show an increase once more.

Now that annual procurement processes to acquire 1 billion male condoms/year are in place Brazil has become the world's largest purchaser. It also purchases female condoms and lubricant gels.

In 2007 and 2008, spending on AIDS-related health care totalled R$ 860.12 million and R$ 951.7 million respectively. This category was the object of the greater part of national outlays on AIDS (76% and 84%), and within the category itself, the purchase of antiretroviral drugs accounted for 82% of all spending. Other important categories are in service testing (6%) and HIV-related laboratory monitoring (4% and 6%). In-patient and outpatient-related spending showed the same percentage participation in overall spending as in previous years (around 2.5%). Spending on medicines to treat opportunistic diseases undertaken by state health departments accounted for 1.2% and 1.3% of total spending in this category in 2007 and 2008.

It should be stressed that spending on the procurement and distribution of antiretroviral drugs, one of the mainstays of Brazilian policy on AIDS, has dropped considerably in recent years. That means that in spite of the annual increase in the numbers of patients with HIV/AIDS that need such medicines, the average expenditure per patient has hardly increased at all and accordingly the proportion of the total Ministry of Health budget represented by this particular spending category has gradually diminished as has its percentage calculated against the total GNP as the table below clearly demonstrates:

Table 3: Average expenditures on ARV per patient and as a percentage of the Brazilian GNP and of the total budget of the Ministry of Health, 2003-2009

Year	Nº Patients	Spending on ARV in US$ /Patient/Year	ARV spending as a % of the GNP	ARV spending as a % of the total Ministry of Health Budget
2003	139,868	1,377.62	0.038	1.92
2004	156,670	1,554.84	0.033	1.73
2005	164,547	1,750.79	0.031	1.63
2006	174,270	1,830.35	0.027	1.47
2007	180,640	1,767.75	0.025	1.30
2008	191,244	1,566.49	0.019	1.08
2009*	197,000	1,435.00	0.020	1.03

(*) Preliminary data subject to alteration.
Source: Brazilian Ministry of Health, 2009

By means of successive negotiations and measures such as the compulsory licensing of Efavirenz in 2007, the country has managed to ensure the sustainability of universal access to ARV therapy. According to a Ministry of Health study, the average annual expenditure on AIDS patients has dropped by about 25% in the period from 2003 to 2009. In 2003, Brazilian government spending on medicines represented 0.038 of the GNP while in 2009 it was down to 0.020%. It is estimated that the impact of that reduction on the procurement of medicines in 2010 will be savings to the order of R$ 118 million.

Such savings in no way jeopardise the quality of the treatment being offered. The World Health Organization (WHO) made an assessment of the technical document containing Antiretroviral Therapy recommendations for Adults infected with HIV elaborated by the Brazilian Ministry of Health, and considered that the recommendations were in alignment with international recommendations and that included the incorporation of new drugs that have made it possible to maintain the treatment of patients already in therapy and provide treatment for 25 thousand new cases every year. Presently 19 different drugs are purchased in 32 different presentations of which 13 are produced in Brazil and 19 are imported for the 190 thousand patients now receiving treatment.

Expenditure on strengthening management, providing incentives for human resources, studies, research and surveys was responsible for 5.88% and 5.31% of total spending in 2007 and 2008 respectively with a large part being spent on administration, planning, systems and supervision of states and municipalities. An important part of the spending was on capacity-building for human resources which is fundamental for strengthening and improving decentralised administration in all regions of the country and such spending accounts for 26% of the total within these categories, every year. In regard to studies and surveys which account for 11.7% of spending in those categories, it must be observed that they are not funded exclusively by the sources considered in the present survey but receive additional support from other public and international sources.

Spending in the category ‘social protection, orphans and other vulnerable children’ together with spending on community development represented 3.55% and 3.95% of the total spending

registered for the two years with a notable participation of spending on social welfare benefits (social insurance sickness allowance, disability pension and social support for the mentally deficient) accounting for 64.5% and 55% of total spending in this category during 2007 and 2008, respectively. It must also be underscored that public spending on orphans – which according to Brazilian national criteria and parameters has no significant social impact on the epidemic – has not been included in the present inventory because the sources in the sphere of public social assistance have no installed capacity enabling them to disaggregate the specific information. The same problem occurred with consolidation of the social insurance spending because not all of the benefits granted are registered under the heading 'AIDS' but are associated to other diseases which makes it impossible to make a more specific data collection.

Final Remarks

Because of the difficulties posed by some of the classificatory processes there may well be distortions present in regard to the information registered for some of the categories. One example is that some of the expenditure on 'surveys and studies' may actually have been compiled under other headings (prevention, care or even management) just as some of the spending associated to prevention actions (especially among vulnerable populations) may have been included in the category 'community development'. Furthermore, in the case of some categories, the fact that no data has been registered does not necessarily mean that there was no spending associated to them but rather that it proved impossible to access any sources that could provide the information.

The work of gathering and compiling the information contained in the present inventory stimulated a process of more meticulous and minute investigation of the origin and final destination of the funds spent on AIDS in Brazil. On the other hand the impossibility of obtaining all the data and information on AIDS-related spending in the state and municipal spheres of government (which presently account for half of all public spending on health nationwide) show the urgent need to adapt the methodology to the characteristics of the Brazilian reality.

In addition there is the question of spending done by the private sector where the process of collecting data from a considerable variety of sources and systems still needs to be improved. The short space of time available between initiating the survey process and presenting the results contributed towards the decision made to reduce the period under investigation, the categories, and the national funding sources. Finally, the use of this methodology also needs to adapt itself to previous processes of inventorying spending, in order to maintain a degree of compatibility that will make it possible to conduct analyses of a temporal series of comparable data.

Even though the amounts registered in the present inventory do not register all public and private spending on AIDS in Brazil, the significant amounts registered here do express the extent of the commitment to constructing the national response to HIV/AIDS effectively constituting, as it does, one of the most efficient health policies implanted in Brazil.

National Funding Matrix

AIDS Spending Categories by Financing Sources

YEAR: 2007

Fiscal Year: YES:.X NO:.....

Average exchange rate for the year: R$1,96 (US$, 2007)

AIDS spending Category	TOTAL (local currency)	Public (subtotal)	Public Sources: National	Public Sources: Sub-national	Public Sources: Dev. Bank (Reimbursable)	Public Sources: All other public	International (subtotal)	International Sources: Bilateral	International Sources: Multilateral: UN Agencies	International Sources: Multilateral: Global Fund	International Sources: Multilateral: Dev. Bank (non reimbursable)	International Sources: Multilateral: All other International multilateral
TOTAL(local currency)	**1,127,271,494**	**1,121,720,607**	**1,084,654,372**	**10,048,773**		**27,017,463**	**5,550,887**	**760,194**	**4,301,068**			**489,625**
1. Prevention (sub-total)	**160,772,680**	**158,895,183**	**157,695,183**			**1,200,000**	**1,877,497**		**1,754,897**			**122,600**
1.01 Communication	**29,834,802**	**29,676,364**	29,676,364				**158,438**		158,438			
1.02. Community mobilization	**10,324,440**	**10,229,628**	10,229,628				**94,812**		94,812			
1.03. Voluntary counselling and testing	**17,436,693**	**17,436,693**	17,436,693									
1.04. Risk educations for vulnerable and accessible populations	**8,189,819**	**7,692,473**	7,692,473				**497,346**		497,346			
1.05 Prevention-youth in school	**2,494,672**	**1,970,318**	770,318			1,200,000	**524,354**		524,354			
1.06 Prevention – youth-out-of-school	**936,957**	**936,957**	936,957									
1.07 Prevention of HIV transmission aimed at people living with HIV	**1,422,791**	**1,422,791**	1,422,791									
1.08 Prevention programmes for sex workers and their clients												
1.09 Programmes for men who have sex with men												
1.10 Harm-reduction programmes for injecting drug users	**43,683**						**43,683**		43,683			
1.11 Prevention programmes in the workplace												

1.12 Condom social marketing												
1.13 Public and commercial sector male condom provision	**67,991,988**	**67,987,138**	67,987,138				**4,850**		4,850			
1.14 Public and commercial sector female condom provision	**6,321,585**	**6,321,585**	6,321,585									
1.15 Microbicides												
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	**3,579,523**	**3,579,523**	3,579,523									
1.17 Prevention of mother-to-child transmission	**7,239,892**	**6,808,478**	6,808,478				**431,414**		431,414			
1.18 Male circumcision												
1.19 Blood safety	**1,250,520**	**1,250,520**	1,250,520									
1.20 Safe medical injections												
1.21 Universal Precautions												
1.22 Post-exposure prophylaxis												
1.98 Prevention activities not disaggregated by intervention	**3,705,315**	**3,582,715**	3,582,715				**122,600**					122,600
1.99 Prevention activities not elsewhere classified												
2. Care and treatment (sub-total)	**860,151,173**	**860,051,673**	**850,002,901**	**10,048,773**			**99,500**					**99,500**
2.01 Outpatient care												
2.01.01 Provider-initiated testing and counselling	**52,871,560**	**52,871,560**	52,871,560									
2.01.02Opportunistic infection outpatient prophylaxis and treatment (IO)												
2.01.03 Antiretroviral therapy	**710,841,824**	**710,841,824**	710,841,824									
2.01.04 Nutritional support associated to ARV therapy												
2.01.05 Specific HIV-related laboratory monitoring	**37,625,416**	**37,625,416**	37,625,416									
2.01.06 Dental programmes for people living with HIV	**426,787**	**426,787**	426,787									
2.01.07 Psychological treatment and support services												
2.01.08 Outpatient palliative care												
2.01.09 Home-based care												

2.01.10 Traditional medicine and informal care and treatment												
2.01.98 Outpatient services not disaggregated by intervention	**21,226,588**	**21,127,088**	21,127,088				**99,500**					99,500
2.01.99 Outpatient services not elsewhere classified												
2.2 In-patient Care												
2.02.01 In-patient treatment of opportunistic infections	**10,048,773**	**10,048,773**		10,048,773								
2.02.02 Inpatient palliative care												
2.02.98 In-patient services not disaggregated by intervention	**27,110,226**	**27,110,226**	27,110,226									
2.02.99 In-patient services not elsewhere classified												
3. Orphans and vulnerable children (sub-total)	**70,690**						**70,690**					**70,690**
3.01 OVC Education												
3.02 OVC Basic health care												
3.03. OVC Family/home support												
3.04. OVC Community support												
3.05 OVC Social services and administrative costs												
3.06 Institutional Care												
3.98 OVC services not disaggregated by intervention												
3.99 OVC services not elsewhere classified	**70,690**						**70,690**					70,690
4. Programme management and administration	**38,595,690**	**35,629,931**	**35,629,931**				**2,965,759**	**760,194**	**2,168,123**			**37,442**
4.01 Planning, coordination and programme management	**12,859,736**	**11,117,361**	11,117,361				**1,742,375**		1,742,375			
4.02 Administration and transaction costs associated with managing and disbursing funds	**5,958,734**	**5,901,605**	5,901,605				**57,129**	57,129				
4.03. Monitoring and evaluation	**4,456,167**	**3,753,102**	3,753,102				**703,065**	703,065				
4.04 Operations research												
4.05 Serological surveillance	**726,188**	**726,188**	726,188									

4.06 HIV drug-resistance surveillance												
4.07 Drug supply systems	**5,178,461**	**5,178,461**	5,178,461									
4.08 Information technology	**339,660**	**339,660**	339,660									
4.09 Patient tracking												
4.10 Upgrading and construction of infrastructure	**286,811**	**286,811**	286,811									
4.11 Mandatory HIV testing (not voluntary counselling)												
4.98 Programme management and administrative strengthening not disaggregated	**1,041,937**	**1,004,495**	1,004,495				**37,442**					37,442
4.99 Programme management and administrative strengthening not elsewhere classified	**7.747.997**	**7.322.249**	7.322.249				**425.748**		425.748			
5. Human resources (sub-total) **	**16,851,202**	**16,691,809**	**16,691,809**				**159,393**					**159,393**
5.01. Monetary incentives for human resources	**159,393**						**159,393**					159,393
5.02 Formative Education to build up an HIV workforce	**16,691,809**	**16,691,809**	16,691,809									
5.03 Training												
5.98 Incentives for human resources not disaggregated by type												
5.99 Incentives for human resources not elsewhere classified												
6. Social protection and social services (excluding orphans and vulnerable children)	**25,817,463**	**25,817,463**				**25,817,463**						
6.01 Social protection through monetary benefits	**25,817,463**	**25,817,463**				25,817,463						
6.02 Social protection through in-kind benefits												
6.03 Social protection through provision of social services												
6.04 HIV-specific income generation projects												
6.98 Social protection services and social services not disaggregated by type												

6.99 Social protection services and social services not elsewhere classified												
7. Enabling Environment and Community Development (sub-total)	**14,164,775**	**13,846,680**	**13,846,680**				**318,095**		**318,095**			
7.01 Advocacy and strategic communication	**2,331,168**	**2,123,962**	2,123,962				**207,206**		207,206			
7.02 Human rights programme	**982,572**	**982,572**	982,572									
7.03 AIDS-specific institutional development	**10,663,024**	**10,663,024**	10,663,024									
7.04 AIDS-specific programmes focussed on women	**110,889**						**110,889**		110,889			
7.05 Programmes to reduce Gender Based Violence												
7.98 Enabling Environment and Community Development not disaggregated by type												
7.99 Research not elsewhere classified	**77,122**	**77,122**	77,122									
8. Research, excluding operations research	**10,847,821**	**10,787,868**	**10,787,868**				**59,953**		**59,953**			
8.01 Biomedical research												
8.02 Clinical research	**1,663,425**	**1,663,425**	1,663,425									
8.03 Epidemiological research	**2,367,857**	**2,367,857**	2,367,857									
8.04 Social science research	**59,953**						**59,953**		59,953			
8.05 Vaccine-related Research	**4,012,786**	**4,012,786**	4,012,786									
8.98 Research not disaggregated by type	**1,305,613**	**1,305,613**	1,305,613									
8.99 Research not elsewhere classified	**1,438,187**	**1,438,187**	1,438,187									

(*)Lack of data for some categories does NOT necessarily mean there was no expenditure but that it was not possible to collect the respective data.

National Funding Matrix

AIDS spending categories by financing sources

YEAR: 2008

Fiscal Year:	YES:.X	NO:.....										
	Financing Sources											
Average exchange rate for the year: R$ 1.83 (2008)	TOTAL (local currency)	Public (sub-total)	Public Sources				International (sub-total)	International Sources				
								Bi-lateral	Multilateral			
AIDS spending categories			National	Sub-national	Dev. Bank Reimbursable	All other public			UN Agencies	Global Fund	Dev. Bank (non reimbursable)	All other Multilateral International
TOTAL (local currency)	**1,140,334,333**	**1,128,891,440**	**1,091,349,174**	**12,757,466**		**24,784,800**	**11,442,893**	**985,483**	**5,609,216**			**4,848,194**
1. Prevention (sub-total)	**76,419,285**	**73,846,026**	**73,846,026**				**2,573,259**	**49,750**	**2,451,315**			**72,194**
1.01 Communication	**29,720,864**	**29,553,118**	29,553,118				**167,746**		167,746			
1.02. Community mobilization	**10,092,046**	**9,892,187**	9,892,187				**199,859**		199,859			
1.03. Voluntary counselling and testing	**14,579,160**	**14,579,160**	14,579,160									
1.04. Risk educations for vulnerable and accessible populations	**4,728,571**	**4,445,772**	4,445,772				**282,799**		282,799			
1.05 Prevention-youth in school	**1,763,579**	**539,671**	539,671				**1,223,908**		1,223,908			
1.06 Prevention – youth-out-of-school	**25,108**						**25,108**		25,108			
1.07 Prevention of HIV transmission aimed at people living with HIV												
1.08 Prevention programmes for sex workers and their clients	**35,820**						**35,820**		35,820			
1.09 Programmes for men who have sex with men	**99,500**						**99,500**		99,500			
1.10 Harm-reduction programmes for injecting drug users	**47,760**						**47,760**					47,760
1.11 Prevention programmes in the workplace	**127,378**						**127,378**		127,378			
1.12 Condom social marketing												
1.13 Public and commercial sector male condom provision	**167,497**	**167,497**	167,497									
1.14 Public and commercial sector female condom provision												

1.15 Microbicides												
1.16 Prevention, diagnosis and treatment of sexually transmitted infections	**4,418,474**	**4,413,351**	4,413,351				**5,123**		5,123			
1.17 Prevention of mother-to-child transmission	**6,952,792**	**6,618,968**	6,618,968				**333,824**	49,750	284,074			
1.18 Male circumcision												
1.19 Blood safety	**1,080,340**	**1,080,340**	1,080,340									
1.20 Safe medical injections												
1.21 Universal Precautions												
1.22 Post-exposure prophylaxis												
1.98 Prevention activities not disaggregated by intervention	**2,580,395**	**2,555,961**	2,555,961				**24,434**					24,434
1.99 Prevention activities not elsewhere classified												
2. Care and treatment (sub-total)	**956,379,023**	**951,702,523**	**938,945,056**	**12,757,466**			**4,676,500**					**4,676,500**
2.1 [2.01]Outpatient care												
2.01.01 Provider-initiated testing and counselling	**56,214,564**	**56,214,564**	56,214,564									
2.01.02 Opportunistic infection outpatient prophylaxis and treatment (IO)												
2.01.03 Antiretroviral therapy	**782,798,604**	**782,798,604**	782,798,604									
2.01.04 Nutritional support associated to ARV therapy												
2.01.05 Specific HIV-related laboratory monitoring	**53,984,417**	**53,984,417**	53,984,417									
2.01.06 Dental programmes for people living with HIV												
2.01.07 Psychological treatment and support services												
2.01.08 Outpatient palliative care												
2.01.09 Home-based care												
2.01.10 Traditional medicine and informal care and treatment												
2.01.98 Outpatient care services not disaggregated by intervention	**23,857,404**	**23,857,404**	23,857,404				**4,676,500**					4,676,500
2.01.99 Outpatient Care services not elsewhere classified												
2.2 In-patient Care												
2.02.01 In-patient treatment of opportunistic infections	**12,757,466**	**12,757,466**		12,757,466								
2.02.02 Inpatient palliative care												

2.98 In-patient services not disaggregated by intervention	**22.090.067**	**22.090.067**	22.090.067									
2.99 In-patient services not elsewhere classified												
3. Orphans and vulnerable children (sub-total)												
3.01 OVC Education												
3.02 OVC Basic health care												
3.03. OVC Family/home support												
3.04. OVC Community support												
3.05 OVC Social services and administrative costs												
3.06 Institutional Care												
3.98 OVC services not disaggregated by intervention												
3.99 OVC services not elsewhere classified												
4. Programme management and administration	**42,907,394**	**40,066,595**	**40,066,595**				**2,840,799**	**935,733**	**1,905,066**			
4.01 Planning, coordination and programme management	**9,893,444**	**9,893,444**	9,893,444				**1,201,692**		1,201,692			
4.02 Administration and transaction costs associated with managing and disbursing funds	**20,093,830**	**20,093,830**	20,093,830				**78,553**	78,553				
4.03. Monitoring and evaluation	**3,346,132**	**3,346,132**	3,346,132				**906,930**	857,180	49,750			
4.04 Operations research							**1,570**		1,570			
4.05 Serological surveillance	**248,133**	**248,133**	248,133									
4.06 HIV drug-resistance surveillance												
4.07 Drug supply systems		**4,329,940**	4,329,940									
4.08 Information technology	**1,166,847**	**1,166,847**	1,166,847									
4.09 Patient tracking												
4.10 Upgrading and construction of infrastructure												
4.11 Mandatory HIV testing (not voluntary counselling												
4.98 Program Management and Administration Strengthening not disaggregated by type												
4.99 Programme management and administrative strengthening not elsewhere classified	**988,269**	**988,269**	988,269				**652,054**		652,054			

5. Human resources (sub-total) **	**15,655,902**	**15,556,402**	**15,556,402**				**99,500**					**99,500**
5.01. Monetary incentives for human resources	**99,500**						**99,500**					99,500
5.02 Formative Education to build up an HIV workforce	**15,556,402**	**15,556,402**	15,556,402									
5.03 Training												
5.98 Incentives for Human Resources not specified by kind												
5.99 Incentives for human resources not elsewhere classified												
6. Social protection and social services (excluding orphans and vulnerable children)	**24,784,800**	**24,784,800**				**24,784,800**						
6.01 Social protection through monetary benefits	**24,784,800**	**24,784,800**				24,784,800						
6.02 Social protection through in-kind benefits												
6.03 Social protection through provision of social services												
6.04 HIV-specific income generation projects												
6.98 Social protection services and social services not disaggregated by type												
6.99 Social protection services and social services not elsewhere classified												
7. Enabling Environment and Community Development (sub-total)	**20,220,329**	**19,012,790**	**19,012,790**				**1,207,539**		**1,207,539**			
7.01 Advocacy and strategic communication	**10,284,018**	**10,284,018**	10,284,018				**61,920**		61,920			
7.02 Human rights programme	**1,978,140**	**1,978,140**	1,978,140									
7.03 AIDS-specific institutional development	**6,750,631**	**6,750,631**	6,750,631				**891,520**		891,520			
7.04 AIDS-specific programmes focussed on women							**254,099**		254,099			
7.05 Programmes to reduce Gender Based Violence												
7.98 Enabling Environment and Community Development not disaggregated by type												
7.99 Research not elsewhere classified												

8. Research, excluding operations research	**3,967,601**	**3,922,305**	**3,922,305**				**45,296**		**45,296**			
8.01 Biomedical research												
8.02 Clinical research												
8.03 Epidemiological research	**232,742**	**232,742**	232,742				**45,296**		45,296			
8.04 Social science research												
8.05 Vaccine-related Research												
8.98 Research not disaggregated by type	**1,181,865**	**1,181,865**	1,181,865									
8.99 Research not elsewhere classified	**2,507,699**	**2,507,699**	2,507,699									
(*) Lack of data for some categories does NOT necessarily mean there was no expenditure but that it was not possible to collect the respective data.												
(**) Acquisition of male condoms referring to the year 2008 was only finalised in 2009.												

APPENDIX II - National Composite Policy Index (NCPI)

Part A
[to be administered to government officials]

To fill Part A of NCPI, we received contributions from representatives of States and Municipalities that coordinate STD/AIDS police at local level. The final version was discussed and validated at STD/AIDS Actions Management Commission (COGE), comprised of representatives of the National, State and Municipal STD/AIDS Programmes.

		Respondents to Part A [indicate which parts each respondent was queried on]				
Organization	**Name/Post**	***A.I***	***A.II***	***A.III***	***A.IV***	***A.V***
STD, AIDS and Viral Hepatitis Department – Ministry of Health	Eduardo Barbosa, Assistant Director; Ângela Pires Pinto, Technical Officer; Sérgio D´Ávila, Head Planning Advisory; Ana Roberta Pascom, Head Monitoring and Evaluation Advisor; Gerson Fernando, Head of Information and Surveillance Unit; Rogério Scapini, Head of Logistics Unit	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Maria Clara Gianna, Executive Secretary of the Management Committee (COGE), DST/AIDS Prograsmme Coordinator for the State of São Paulo	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Jacqueline Voltolini de Oliveira (Boa Vista/RR)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Maria Auxiliadora da Paixão Aire, (Gurupi/TO)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	José Eudes Barroso Vieira, (Aracajú/SE)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Marlene Lopes Plaster (Cuiabá/MT)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Neusa Maria Pereira (Ponta Porã/MS)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Mariuva Valentin Chaves (Rondonópolis/MT	X	X	X	X	X

Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Maria da Consolação Lavagnoli (Colatina/ES)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Zenaide Cadette dos Santos Dutra (Belford Roxo/RJ)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Josana Aparecida Dranka Horvath (Cascavel/PR)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Francisco Carlos dos Santos (Curitiba/PR)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Maricélia Morais Macedo (Salvador/BA)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Marta Evelyn (Maringá/PR)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Vilma Cervantes (São Paulo/SP)	X	X	X	X	X
Management Committee (COGE), STD, AIDS and Viral Hepatitis Department, Ministry of Health	Sandra Catarina Rolim Gomes (Tramandaí/RS)	X	X	X	X	X
Epidemiological Surveillance Group of the Registro/SP region	Maria Cecília Rossi de Almeida,	X	X	X	X	X
Epidemiological Surveillance Group of the Campinas/SP region	Márcia Regina Pácola	X	X	X	X	X
Epidemiological Surveillance Group of the Araraquara/SP region	Marco Antonio	X	X	X	X	X
Epidemiological Surveillance Group of the São José do Rio Preto/SP region	Zumira da Rocha Meireles	X	X	X	X	X
Epidemiological Surveillance Group of the Diadema/SP region	Tania da Costa	X	X	X	X	X
Epidemiological Surveillance Group, Taboão da Serra/SP	Iris Bandeira Roquim	X	X	X	X	X
Epidemiological Surveillance Group, Itaquaquecetuba/SP	Lucille Mary Loureiro Soares	X	X	X	X	X
Epidemiological Surveillance Group, Cajamar/SP	Marta Possani	X	X	X	X	X
Epidemiological Surveillance Group, São Paulo/SP	Maria Cristina Abbate	X	X	X	X	X

Epidemiological Surveillance Group, **C**araguatatuba/SP	Aurélio Candido do Nascimento Filho	X	X	X	X	X
Epidemiological Surveillance Group, Praia Grande/SP	Dorian Rojas	X	X	X	X	X
Epidemiological Surveillance Group, Registro/SP	Aparecida Perin de Oliveira	X	X	X	X	X
Epidemiological Surveillance Group, Jacareí/SP	Marisa De Carvalho Braga	X	X	X	X	X
Epidemiological Surveillance Group. Taubaté/SP	Renata F. de Oliveira	X	X	X	X	X
Epidemiological Surveillance Group, Piracicaba/SP	Moisés Francisco Baldo Taglietta	X	X	X	X	X
Epidemiological Surveillance Group. Campinas/SP	Maria Cristina Feijó Januzzi Ilário	X	X	X	X	X
Epidemiological Surveillance Group, Itu/SP	André Navarro	X	X	X	X	X
Epidemiological Surveillance Group, Itapeva/SP	Rosani Aparecida de Pontes	X	X	X	X	X
Epidemiological Surveillance Group, Mogi-Mirim/SP	Bárbara Fernanda de Freitas	X	X	X	X	X
Epidemiological Surveillance Group Bragança/SP	Tânia Maria Guelpa Clemente	X	X	X	X	X
Epidemiological Surveillance Group, Sertaozinho/SP	Renata Abduch	X	X	X	X	X
Epidemiological Surveillance Group, São Joaquim da Barra/SP	Márcia Valéria Coelho	X	X	X	X	X
Epidemiological Surveillance Group, Olimpia/SP	Marli Maria M. Belucci dos Santos	X	X	X	X	X
Epidemiological Surveillance Group, Araraquara/SP	Sonia Maria Molan Gaban	X	X	X	X	X
Epidemiological Surveillance Group, Paraguaçu-Paulista	Sonia Maria Coppio Siqueira	X	X	X	X	X
Epidemiological Surveillance Group, Araçatuba/SP	Sandra Margareth Exaltação	X	X	X	X	X
Epidemiological Surveillance Group, Votuporanga/SP	Léa Cristina Bagnola Macedo	X	X	X	X	X
Epidemiological Surveillance Group, Marilia/SP	Helena Regina Guelpa Q. Schwitzky	X	X	X	X	X
Epidemiological Surveillance Group, Bauru/SP	Eliane Regina Catalano Monteiro	X	X	X	X	X
Epidemiological Surveillance Group Laranjal Paulista/SP	Joelma Alexandra R. de Medeiros	X	X	X	X	X
Epidemiological Surveillance Group, Jales/SP	Ana Cláudia Lisboa Campaneri	X	X	X	X	X
Epidemiological Surveillance Group, Presidente Epitácio/SP	Claudia De Melo	X	X	X	X	X

I. STRATEGIC PLAN

1. Has Brazil 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

Period covered: Ever since the National STD and AIDS Programme was officially constituted in 1986, Brazil has been developing multisectoral strategies to combat the epidemic including strategies, plans, operational plans, actions and annual goals.

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

1.1 How long has Brazil had a multisectoral strategy?
Number of years: 23 years.

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

Sectors	Included in the strategy	Specific budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	Yes
Transportation	Yes	Yes
Military/Police	Yes	No**
Women	Yes	Yes
Young people	Yes	Yes
* Other = Special Secretariat for Prison Administration	Yes	Yes
Special Human Rights Secretariat	Yes	No**
Special Secretariat for Social Assistance and Development	Yes	No**
Secretariats of the Justice System	Yes	No**
Science and Technology Secretariats	Yes	No**
Sport and Tourism Secretariats	Yes	No**
Special Secretatiat of Policies for Women	Yes	No**
Ministry of Health / Drugs National Secretariat	Yes	No**

* Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

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?
**Financial resources stemming from the Ministry of Health are not re-allocated to other Ministries. However, when there are joint intersectoral actions to be undertaken, there may be cases of integral financing of the actions using funds from that source alone. Furthermore, other areas of government may also use their own resources to finance such joint actions even if the funds were not originally specifically allotted for the purpose in question.

1.3. Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations	
a. Women and girls	a. Yes
b. Young women/young men	b. Yes
c. Injecting drug users	c. Yes
d. Men who have sex with men	d. Yes
e. Sex workers	e. Yes
f. Orphans and other vulnerable children	f. Yes
g. Other specific vulnerable subpopulations*	g. Yes
Migrants, landless people, transsexuals, prisoners, people over 50, indigenous populations, Afro-descendant populations, people living with HIV/AIDS, truck drivers, industry workers	
Settings	
h. Workplace	h. Yes
i. Schools	i. Yes
j. Prisons	j. Yes
Cross-cutting isues	
k. HIV and poverty	k. Yes
l. Human rights protection	l. Yes
m. Involvement of people living with HIV	m. Yes
n. Addressing stigma and discrimination	n. Yes
o. Gender empowerment and/or gender equality	o. Yes

* Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

1.4. Were target populations identified through a needs assessment?
Yes

IF YES, when was this needs assessment conducted?

Year: 1983

Since the epidemic broke out in 1983 the index cards used for epidemiological investigation have included information on sex, area of residence, age, schooling level and exposure category. Since 2000 the item race/colour has been included on the cards. Prior to the year 2000, information on indigenous populations was published in the Bulletin and classified according to ethnic groups and indigenous area. In 1989, with the creation of the Indigenous health sub-system, the development of a specific information system for Indigenous health (SIASI) and certain modifications made to the Notifiable Diseases Information System (SINAN), data on the epidemic among this population segment began to be extracted by cross-referencing the information in the two systems.

The analysis of the data has revealed the main tendencies and provided the information needed to determine the actions to be undertaken. Other mechanisms for evaluating needs are the spaces for intersectoral articulation and articulation with civil, society, the spheres of management, and population studies and surveys. Furthermore, formal studies have been conducted ever since the 90s. At that time there was little data available from population-based studies and the information had o be obtained from Demographic Surveys and Health Surveys the first of which were conducted in 1986 followed by others in 1989, 1992 and 1996. Currently, the elaboration of strategies is based on information available in the following reference studies:

• BRASIL. Ministério da Saúde. Departamento de DST, AIDS e Hepatites Virais. *PCAP - Pesquisa de Conhecimento, Atitudes e Práticas na População Brasileira*. Brasília, 2009.
• 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, nº 2.
• 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.
• BRASIL. Ministério da Saúde. Coordenação Nacional de DST e AIDS. *Comportamento sexual da população brasileira e percepções do HIV/AIDS*. Brasília, 2000. Série Avaliação, nº 4.
• 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. 01, p. 11-15, 2006.
• 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, nº 01, 2001.
• 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.
• 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.
• 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.

1.5. What are the identified target populations for HIV programmes in Brazil?
Women, young men and young women, injecting drug users, gays, other men who have sex with men, transvestites, sex workers, orphans and other vulnerable children, migrants, landless people, transsexual people, prisoners, people over 50, indigenous populations, Afro-descendant populations, persons with disabilities, people living with HIV/AIDS.

1.6. Does the multisectoral strategy include an operational plan?
Yes

1.7. Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes
b. Clear targets or milestones?	Yes
c. Detailed costs for each programmatic area?	Yes
d. An indication of funding sources to support programme implementation?	Yes
e. A monitoring and evaluation framework?	Yes

1.8. Has Brazil ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy? (*Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately).
Active involvement

IF active involvement, briefly explain how this was organised:
Civil society organizations are the historic partners of the Brazilian Ministry of Health's STD, AIDS and Viral Hepatitis Department and accordingly have ensured their full participation and involvement in combating the epidemic. In 1986 the Ministry of Health set up the National STD and AIDS Committee (CNAIDS) and it included representatives of civil society organizations, the academic world, and state and municipal health administrators. In October 2009, the CNAIDS held its 100th meeting. The purpose of those meetings has always been to contribute advice and suggestions to the process of elaborating and monitoring public policies to combat the epidemic.

The participation of civil society in the elaboration of public policies contributes towards the exercise of citizenship and social ("watchdog") control. The expression social control has been adopted by the Brazilian National Health Service and is taken to mean the exercise of control over public authorities by the citizenry especially at the local level, in the definition of targets, goals and action plans. For that reason, in 2003, the National Health Council, a Ministry of Health body that guarantees the participation of representatives of health service users, health workers and health service providers, formed a sub-group specifically dedicated to the question of AIDS and entitled the 'STD/AIDS Actions Management Committee' (*Comissão de Acompanhamento das Políticas de DST e AIDS* - CAPDA). The committee meets four times a year and collaborates directly in the formulation and evaluation of strategies developed by the Ministry of Health.

There is strong encouragement for the setting up of State and Municipal STD and AIDS committees in the 26 Brazilian states and the Federal District and in the 450 municipalities that receive financial resources from the Ministry of Health, specifically for the purpose of combating AIDS. 98% of all cases of AIDS in Brazil are found in those municipalities. In most of the government spaces where public policies are constructed like Committees, Forums, Working Groups, Technical Chambers and Technical Forums, Civil Society representation is formally or informally guaranteed. There is also strong stimulus for Civil Society to participate in the formulation, analysis, planning, and follow up of actions, strategies and plans constructed by means of meetings, seminars, working groups, committees and others.

Since August 2000, the STD, AIDS and Viral Hepatitis Department has had a division specifically dedicated to fostering articulation with civil society and protecting and promoting the Human Rights of People Living with HIV and AIDS and the other most vulnerable groups. At state and municipal levels there are formally designated focal points charged with articulation with civil society.Supporting and reinforcing civil society actions is one of the STD, AIDS and Viral Hepatitis Department's top priorities and it involves providing technical support (consultancy and the holding of courses and seminars) and financing projects. There is also a specific line of systematic financing for those organizations guaranteed by the legislation in force.

This structural model is a singularity of the Brazilian Department's and corresponds to the implementation of Article 19 of the Federal Constitution that establishes Health as the right of all and the duty of the State.

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

1.10. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?
Yes, all partners

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why.
In the last few years a consensus has been arrived at with external partners that pursue different policies from those of the Brazilian government whereby the directives of Brazilian policies have come to be respected and observed in the support being provided for actions undertaken in Brazil.

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

2.1. ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a) National Development Plan	Yes
b) National Development Assessment - based on specific targets set out in the Federal Government's Multi-annual Plan	Yes
c) Inclusion in the Growth Acceleration Plan (PAC) – "More Health"	Yes
d) Sector-wide approach	Yes

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

HIV-related area included in development plan(s)	
HIV prevention	Yes
Treatment for opportunistic infections	Yes
Antiretroviral treatment	Yes
Care and support (including social security and other schemes)	Yes
HIV impact alleviation	Yes
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support.	Yes
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes
Reduction of stigma and discrimination	Yes
Economic empowerment of women (e.g. access to credit, access to land, training)	Yes

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

3.1. ***IF YES***, to what extent has it informed resource allocation decisions?

Low				*High*	
0	1	2	3	4	5

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

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes
Condom provision	Yes
HIV testing and counselling	Yes
Sexually transmitted infection services	Yes
Antiretroviral treatment	Yes
Care and support	Yes

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):
Testing is voluntary and provided free of charge by the National Health Service and it is possible to be tested anonymously in the Testing and Counselling Centres (CTA). There is legislation in force that specifically prohibits compulsory testing and makes professional confidentiality mandatory. In the case of provision for the uniformed services, efforts are being made to adapt the strategies for that specific target public to the directives of the Brazilian Policy for Combating the Epidemic so as to ensure the voluntary nature of testing, secrecy, and confidentiality.

5. Does Brazil have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?
Yes

5.1. ***IF YES***, which subpopulations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users	Yes
d. Men who have sex with men	Yes
e. Sex workers	Yes
f. Prison inmates	Yes
g. Migrants/ mobile populations	Yes
h. Other: Afro-descendant populations, people living with HIV/AIDS	Yes

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Bodies and entities of the three spheres of government (federal, state and municipal) are orientated to plan and implement public policies taking into consideration and respecting the needs of each population. Affirmative actions are also undertaken and implemented to promote and protect the rights of those populations that unfortunately are still the target of discrimination. The principles of universality and equality are established in the legal framework of the National Health System and they orientate actions that seek to ensure access to health for the entire population. To that end specific policies have been structured to promote the health of vulnerable populations and they are implemented at state and municipal levels (e.g National Health Policy for the Afro-descendant Population, National Health Policy for Women, National Health Policy for Lesbians, Gays, Transvestites and Transsexuals, National Health Policy for Persons with Disabilities, and others). Furthermore, the Brazilian Federal Constitution also foresees mechanisms to foster and protect the population's rights such as the right not to be discriminated. Such mechanisms are evident in the form of bodies like the Offices of the Public Prosecutor and the Public Defender. Reference Centres for Women, Reference Centres for Combating Homophobia, Women's Rights Councils, and Councils to Promote and Protect Human Rights have also been established based in the state capitals and in various municipalities.

Those bodies receive and process denunciations from the victims of discrimination and offer them guidance. IN the fight against the AIDS epidemic, combating stigma and discrimination is one of the Ministry of Health's top priorities. To that end, the National STD, AIDS and Viral Hepatitis Department has a Human Rights Division that plans and implements actions and provides guidance and advice to states and municipalities on combating stigma and discrimination. In the case of those strategies, the partnerships with organised civil society have been fundamental. One example is the partnership between the National STD, AIDS and Viral Hepatitis Department and civil society organizations to provide legal assistance to combat the discrimination of people living with HIV and AIDS and other vulnerable populations.

Briefly comment on the degree to which these laws are currently implemented:
Since 1988 when Brazil took up democracy once more and the new Federal Constitution was promulgated, the country has been actively affirming the principles of equality and rights and various laws and strategies have been implanted to enforce them. Government and civil society have made strenuous efforts to inform the general public about the anti-discrimination laws and to effectively implement them. As a result there has been visible progress in combating racism, homophobia, 'macho' attitudes and other forms of discrimination.

In regard to discrimination associated to HIV it can be seen that in spite of all the laws and mechanisms in place to combat discrimination, it continues to be a considerable obstacle in the lives of seropositive people. One example of that showed up in the results of a national survey where 8.000 people in all parts of Brazil were interviewed in September and November of 2008. 13% of the interviewees believed that a teacher living with the HIV virus should not be allowed to teach in any school at all; 22.5% stated that you should not buy fruits or vegetable at a store where there was a person with HIV working; and 19% believe

that if a member comes gets sick with AIDS, he or she should not be looked after in the family home.

In 2007 the Ministry of Health's STD, AIDS and Viral Hepatitis Department made a Denunciations of Human Rights Violations database available to register cases of discrimination around the country. 1,399 denunciations have been registered so far.

Those figures show not only the persistence of cases of discrimination but also that nowadays the victims are more disposed to denounce the occurrences. There have also been campaigns fostering a broader discussion of the issue by society and stimulating changes in attitudes, behaviour and practices.

However, in spite of the various strategies that have been unfolded over the years (campaigns, seminars, legal advisory services) and of the progress that can be identified, stigma and discrimination continue to be constant challenges to face in combating the epidemic.

6. Does Brazil have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?
No

6.1. ***IF YES***, which subpopulations?

a. Women	No
b. Young people	No
c. Injecting drug users	No
d. Men who have sex with men	No
e. Sex workers	No
f. Prison inmates	No
g. Migrants/ mobile populations	No
h. Other	No

7. Has Brazil followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?
Yes

7.1. Have the national strategy and national HIV budget been revised accordingly?
Yes

7.2. Have the estimates of the size of the main target populations been updated?
Yes

7.3. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?
Yes / Estimates of current and future needs

7.4. Is HIV programme coverage being monitored?
Yes

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

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

IF YES, for which population groups?
Women, Young people, Injecting drug users, Men who have sex with men, Sex workers, prisoners, migrants/mobile populations.
Briefly explain how this information is used:
Estimates are based on information respecting colour, age and exposure category available on the Epidemiological Investigation Cards.

(c) Is coverage monitored by geographical area?
Yes

IF YES, at which geographical levels (provincial, district, other)?
State and Municipal levels

Briefly explain how this information is used:
The information is used to analyse and control the flow of medicine demands for purchasing and dispensing purposes.

7.5. Has Brazil developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?
Yes

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?

2009	Very poor										Excellent
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:
Since 2007 Strategic Plans have been elaborated for combating the epidemic among women, gays, MSM, and transvestites, for eliminating congenital syphilis and for extending the coverage of early diagnosis. There was intense involvement of civil society in those processes and participation of the different health areas in the three spheres of government (federal, state and municipal). There was also serious commitment to establishing the necessary financial resources (Incentive resources) in the Municipal Actions and Targets Plans for the development of the respective activities. Other notable achievements have been: the implementation of fast testing in a far greater number of municipalities corresponding to an expansion in the provision of diagnosis; the incorporation of Monitoring and Evaluation instruments in the work processes; the implementation of strategies for the Reduction of Mother-to-child Transmission; and the performance of national and state parliamentary fronts on HIV/AIDS related issues.

What are remaining challenges in this area?
Bearing in mind the broader definition of Health and that the combating the epidemic must view the person living with HIV and AIDS in an integral perspective, there still some challenges outstanding in regard to ensuring that the implementation of actions does not only concern itself with integrating HIV/AIDS strategies with the various Health areas but also with their multisectoral integration. There is also the challenge of decentralizing actions within the sphere of the National Health System and guaranteeing the execution of actions in the three spheres of government (federal, state and municipal) as well as fulfilling the commitment to make full use of all financial resources allotted for the combat of the epidemic.

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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

President/Head of Government	Yes
Other high officials	Yes
Other officials in regions and/or districts	Yes

2. Does Brazil have an officialy recognised multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?
No

***IF NO*, briefly explain why not and how AIDS programmes are being managed:**
The Brazilian Federal Constitution determines that health is the right of all and a duty of the State (Article 196). Accordingly national health policy in Brazil is led and coordinated by the Ministry of Health and it is up to the Ministry to put into effect multisectoral articulation of interest to the health area. Within the Ministry the STD,AIDS and Viral Hepatitis Department (formerly known as the National STD and AIDS Programme) coordinates the national policy for combating the epidemic. Because the National Health System has a policy of decentralizing its actions (distributing responsibilities among the three spheres of government) coordinating bodies for STD/AIDS policies have been established in States and Municipalities attached to the respective Health Departments and coordinating policy at the local level. The STD, AIDS and Viral Hepatitis Department is responsible for defining national policy directives to combat AIDS, providing guidance to states and municipalities in planning and implementing their actions and providing direct financing for STD/AIDS related prevention, diagnosis and assistance actions. It is also responsible for fostering and articulating governmental intersectoral policies to promote and protect the human rights of people living with HIV and AIDS and the most vulnerable population groups. The Ministry of Health has the largest budget of all the Brazilian Ministries. The Ministry of health also maintains important social control spaces like the National Health Council which comprises the representations of various governmental and non governmental sectors of society who come together to deliberate on Health policies for the country and it in turn maintains a STD/AIDS Actions Management Commitee. The Ministry of Health's STD, AIDS and Viral Hepatitis Department is also counselled by the Brazilian National AIDS Committee, a consultative body which brings together representatives of civil society, universities, state and municipal health administrators and of other ministries like the Ministries of Education, Defence, and Labour and Social Welfare.

2.3. ***IF YES,*** does the national multisectoral AIDS coordination body:

have terms of reference?	No
have active government leadership and participation?	No
have a defined membership? ***IF YES***, how many members? include civil society representatives? ***IF YES***, how many? include people living with HIV? ***IF YES***, how many? include the private sector?	No No No No
have an action plan?	No
have a functional Secretariat?	No
meet at least quarterly? review actions on policy decisions regularly? actively promote policy decisions? provide opportunity for civil society to influence decision-making? strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	No

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

IF YES, briefly describe the main achievements:

The National STD and AIDS Committee (CNAIDS) is the main consultative body of the Ministry of Health for HIV/AIDS affairs and plurality is its most notable feature. It congregates representative of government bodies, civil society and the universities and was officially instituted by Ministerial Edict Nº 199 in 1986. The combination of the forces of government – responsible for policies and the CNAIDS, a consultative body with considerable political weight, is what has made Brazil a reference in terms of responding to the AIDS epidemic.

Today the Committee is regulated by Ministerial Edict Nº 43 dated September 28, 2005. There are 41 seats altogether. 2 are for representatives of the Ministry of health, 10 for representatives of other ministries and Federal Government departments, seven are reserved for representatives of non governmental organizations and people living with HIV, three for state and municipal health department representatives. There are seven seats for universities and research institutes, nine for medical associations and three for churches and workers networks.

Among the polemical issues addressed by the committee is the question of the admission of seropositive persons to the Armed Forces and the fight against imposing restrictions on the entry of people with HIV infection in Brazil. In the committees view it is unacceptable to use a positive diagnosis for HIV as a criterion for excluding people from the labour market or forbidding them to enter the country. That stance against mandatory testing was further underscored by a motion of repudiation approved at the 77th meeting of the committee in 2005. Under the ages of CNAIDS, a sub-committee was set up in 2006 to prepare a document that would provide supporting elements for the discussion on “Active search” (*Busca ativa)*. One and a half years later the Ministry of Health formally regulated the procedures and conducts for a consensual approach to service users that underwent anti-HIV testing but failed to return to collect the results or users that failed to show up for treatment that was already in course. In 2007, CNAIDS also contributed towards the strategy for the compulsory licensing of Efavirenz.

Briefly describe the main challenges:

CNAIDS faces the ongoing challenge of conciliating the different visions and views to contribute to the construction of strategies for combating the epidemic.

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

0,5% (2008)

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

Information on priority needs	Yes
Technical guidance	Yes
Procurement and distribution of drugs or other supplies	Yes
Coordination with other implementing partners	Yes
Capacity building	Yes
Other: Financing projects Political support for interlocution among civil society organizations and state and municipal governments and parliaments	 Yes Yes

6. Has Brazil reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes

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

Yes

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

During the period 2007 to 2009 the Ministry of Health elaborated and launched several health policies that included actions designed to combat STD/AIDS. Examples are the Health Policies elaborated specifically for: 1) Afro-descendant populations, 2) Indigenous populations, 3) Men, 4) Women , 5) Persons with Disabilities.

As a result of the joint efforts of the Federal Government and Civil Society, in 2009 the National Plan to Promote the Citizenship and Human Rights of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals was launched. Representatives of 18 Ministries composed the Technical Committee that actually elaborated the Plan.

The Plan consists of 51 directives and 180 actions and is based on the proposals resulting from the 1st Brazilian National Conference of Lesbians, Gays, Bisexuals and Transgender persons. The Public Authorities will implement the Plan as a measure to ensure equal rights and the full enjoyment of citizenship for that segment of the Brazilian population and it also addresses the issue of combating STD/AIDS.

In 2009 the third version of the Brazilian National Human Rights Programme was launched which contains commitments to promoting access to health and combating stigma and discrimination

Efforts were also made in the ambit of the National Congress to impede the approval of Draft Bills that are inconsistent with current Brazilian policy on combating AIDS.

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

There have been reports of the unintentional transmission of HIV being treated as a criminal offence in the courts but in fact, there is no specific law Brazilian law that legally penalises HIV. The Brazilian Judiciary has made use of several articles of the Brazilian Penal Code that cover 'inflicting bodily harm' and "attempted murder" when judging such cases. The Ministry of Health's STD, AIDS and Viral Hepatitis Department has reacted to those attitudes on the part of the judiciary, by unfolding various actions including advocacy directed at the judiciary. In November 2009 the Ministry of Health's STD, AIDS and Viral Hepatitis Department issued a Technical Note clarifying the various ways in which transmission can take place and stating that attempts to classify transmission as a crime merely makes actions to combat AIDS more difficult.

Overall, how would you rate the *political support* for the HIV programme in 2009?

2009	Very Poor										Excellent
	0	1	2	3	4	5	6	**7**	8	9	10

Since 2007, what have been key achievements in this area:

The elaboration of strategic plans directed at specific vulnerable populations and the plans for the elimination of Congenital Syphilis, 2) the creation of a Technical Chamber to handle the dispensing of exceptional medicines that are liable to legal intervention (warrants of stay), 3) the breaking of medicine patents.

What are remaining challenges in this area:

Improving human resources policies and implementing prevention actions that guarantee access for the most vulnerable populations.

III. <u>PREVENTION</u>

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

1.1. ***IF YES***, what key messages are explicitly promoted?

✓ Check for key message explicitly promoted:

a. Be sexually abstinent	
b. Delay sexual debut	
c. Be faithful	
d. Reduce the number of sexual partners	
e. Use Condoms consistently	X
f. Engage in safe(r) sex	X
g. Avoid commercial sex	
h. Abstain from injecting drugs	
i. Use clean needles and syringes	X
j. Fight against violence against women	X
k. Greater acceptance and involvement of people living with HIV	X
l. Greater involvement of men in reproductive health programmes	X
m. Males to get circumcised under medical supervision	
n. Know your HIV status	X
o. Prevent mother-to-child transmission of HIV	X
Other: Combat STDs	X

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

2. Does Brazil have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?
Yes

2.1. Is HIV education part of the curriculum in:

primary schools?		No
secondary schools?	Yes	
teacher training?		No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?
Yes

2.3 Does Brazil have an HIV education for out-of-school young people?
Yes

3. Does Brazil have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*
Yes

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

✓ Check which specific populations and elements are included in the policy/strategy.

	IDU	MSM	Sex workers	Clients of sex workers	Prison inmates	Other populations: truck drivers, indigenous populations, street dwellers, persons with disabilities, migrant populations, people living with HIV/AIDS
Targeted information on risk reduction and HIV education	X	X	X		X	X
Stigma and discrimination reduction	X	X	X		X	X
Condom promotion	X	X	X	X	X	X
HIV testing and counselling	X	X	X	X	X	X
Reproductive health, including sexually transmitted infections prevention and treatment	X	X	X	X	X	X
Vulnerability reduction (e.g. income generation)	N/A	N/A	X	N/A	N/A	X
Drug substitution therapy	N/A	N/A	N/A	N/A	N/A	N/A
Needle & syringe exchange	X	N/A	N/A	N/A	N/A	N/A

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?

2009 Very poor Excellent

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

Since 2007, what have been key achievements in this area:
The construction of the Plans for implementing materials supplies is an important achievement.

What are remaining challenges in this area:
The remaining challenges are: expanding harm reduction and 'positive prevention' actions in schools and prisons; employing new prevention technology; and promoting actions.

4. Has Brazil identified specific needs for HIV prevention programmes?
Yes

IF YES, how were these specific needs determined?
They were based on analyses of epidemiological and socio-demographic data and on information collected in intervention work and from key actors.

4.1. To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**	
Blood safety	Agree	
Universal precautions in health care settings	Agree	
Prevention of mother-to-child transmission of HIV	Agree	
IEC* on risk reduction	Agree	
IEC* on stigma and discrimination reduction	Agree	

Condom promotion	Agree	
HIV testing and counselling		Don’t agree
Harm reduction for injecting drug users		Don’t agree
Risk reduction for men who have sex with men		Don’t agree
Risk reduction for sex workers		Don’t agree
Reproductive health services including sexually transmitted infections prevention and treatment		Don’t agree
School-based HIV education for young people		Don’t agree
HIV for out-of-school young people		Don’t agree
HIV prevention in the workplace		Don’t agree

*IEC = information, education and communication.

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 **7** 8 9 10
Since 2007, what have been key achievements in this area: All Brazilian states now have their local strategic plans elaborated and being unfolded; b) network projects now in progress for vulnerable populations including sex workers, women living with HIV, men who have sex with men, drug users and transvestites; c) plans to combat feminisation implanted in all states and evaluation of them planned for 2010; d) studies carried out to estimate prevalence among drug users, men who have sex with men and sex workers; e) plans delineating prevention commodities demands (condoms, gel, female condoms) oriented towards local epidemiological characteristics and with an emphasis on vulnerable populations. *What are remaining challenges in this area:* Outstanding challenges still to be faced are: a) improving local responses for more vulnerable groups; b) determining parameters for evaluating prevention actions; c) expanding the prevention commodities logistics chain in order to broaden access and establish new parameters; d) establishing mechanisms for integrating management with other government programmes to obtain wider outreach for prevention actions.

IV. TREATMENT, CARE AND SUPPORT

1. **Does Brazil have a policy or strategy to promote comprehensive HIV treatment, care and support?** (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).
Yes

1.1. ***IF YES*,** does it address barriers for women?
Yes

1.2. ***IF YES*,** does it address barriers for most-at-risk populations?
Yes

2. **Has Brazil identified the specific needs for HIV treatment, care and support services?**
Yes

IF YES, how were these determined? They were determined on the basis of epidemiological and operational indicators.

2.1. 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		
Antiretroviral therapy	Agree		
Nutritional care		Don’t agree	
Paediatric AIDS treatment	Agree		
Sexually transmitted infection management	Agree		
Psychosocial support for people living with HIV and their families	Agree		
Home-based care		Don’t agree	
Palliative care and treatment of common HIV-related infections			N/A
HIV testing and counselling for TB patients	Agree		
TB screening for HIV-infected people	Agree		
TB preventive therapy for HIV-infected people	Agree		
TB infection control in HIV treatment and care facilities	Agree		
Cotrimoxazole prophylaxis in HIV-infected people	Agree		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree		
HIV treatment services in the workplace or treatment referral systems through the workplace		Don’t agree	N/A
HIV care and support in the workplace (including alternative working arrangements)		Don’t agree	

3. Does Brazil have a policy for developing/using generic drugs or parallel importing of drugs for HIV?
Yes

4. Does Brazil have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?
Yes

IF YES, for which commodities?

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?												
2009	Very poor										Excellent	
	0	1	2	3	4	5	6	7	8	9	10	

Since 2007, what have been key achievements in this area:
1) The setting up of the technical chambers for medicines, 2) seminars on the theme of adverse events, 3) creation of the lipodystrophy/lipoatrophy network, 4) strengthening the offer of examinations.

What are remaining challenges in this area:
1) Early diagnosis of HIV, 2) investigation of deaths and expansion of the number of beds available for hospital admission.

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

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

5.2 ***IF YES,*** does Brazil have a national action plan specifically for orphans and vulnerable children?
Yes

5.3 ***IF YES,*** does Brazil have an estimate of orphans and vulnerable children being reached by existing interventions?
Yes

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

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 **7** 8 9 10
Since 2007, what have been key achievements in this area: The elaboration of the Therapeutic Consensus for children and adolescents with the participation of young people living with HIV/AIDS. *What are remaining challenges in this area:* Remaining challenges are: 1) The elaboration of strategies for the social re-insertion of HIV+ youngsters living in support houses, 2) the elaboration of methodology for disclosing positive diagnosis to children.

V. MONITORING AND EVALUATION

1. Does Brazil have *one* national Monitoring and Evaluation (M&A) Plan?
Yes

1.1. ***IF YES***, years covered: 2003-2010

1.2. ***IF YES***, was the M&E plan endorsed by key partners in M&E?
Yes

1.3. ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?
No (the M&E Plan includes capacity building in M&E for NGOs and People Living with HIV/AIDS.)

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

IF YES, but only some partners or IF NO, briefly describe what the issues are: Lack of a national M&E culture, lack of integration among the various systems, failure to establish priorities which has led to an excessive number of indicators.

2. Does the National Monitoring and Evaluation Plan include:

a data collection strategy	Yes
IF YES, does it address:	
routine programme monitoring	Yes
behavioural surveys	Yes
HIV surveillance	Yes
Evaluation / research studies	Yes
a well-defined standardised set of indicators?	Yes
guidelines on tools for data collection?	Yes
a strategy for assessing data quality (i.e., validity, reliability)?	Yes
a data analysis strategy?	Yes
a data dissemination and use strategy?	Yes

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

3.1. ***IF YES***, **what percentage of the total HIV programme funding is budgeted for M&E activities?**
0,3 %

3.2. ***IF YES***, has *full* funding been secured?
Yes

3.3. ***IF YES***, are M&E expenditures being monitored?
Yes

4. Are M&E priorities determined through a national M&E system assessment?
Yes

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:
Monitoring indicators are brought up to date annually and gaps that call for new indicators to bridge them are identified. The analysis of the indicator results is used to identify which aspects need to be further evaluated.

5. Is there a functional national M&E Unit?
Yes

5.1. ***IF YES,*** is the national M&E Unit based:

in the National AIDS Commission (or equivalent)?	Yes
in the Ministry of Health?	Yes

5.2. ***IF YES,*** how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position: Head of the Unit	Full time	Since when?: 2003
Position: MonitorAIDS system management	Full time	Since when?: 2006
Position: Statistician	Full time	Since when?: 2008
Position: M&E specialist	Full time	Since when?: 2009

5.3. ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?
Yes

IF YES, briefly describe the data-sharing mechanisms:
The central area is responsible for most of the M&E information contained in the country report. States and municipal authorities forward information automatically to the central area. Periodic meetings are held with the other partners for discussions and to obtain additional information.

What are the major challenges?
1) Consolidate the currently decentralised M&E reports, 2) Harmonize the different interests surrounding the National Evaluation Plan especially those associated to process indicators and those concerning the impacts on target populations, 3) Make use of evaluation results as a management tool.

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

6.1. Does it include representation from civil society?
No

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

7.1. ***IF YES***, briefly describe the national database and who manages it.

MONITORAIDS – National STD and AIDS Programme Indicators System

A set of 90 indicators makes up the current system grouped into those: a) that typify socio-economic situation making it possible to analyse inequalities that influence the dissemination of the disease and the effectiveness of the response; b) that are relevant for monitoring the evolution HIV/AIDS and other STDs and c) that are useful for accompanying the unfolding of programmatic actions and indicating what evaluations are most needed.

The indicators are also classified into three broad areas, namely: Contextual indicators, programme indicators and action impact indicators. The indicators for the external context were established to represent the environment in which the epidemic takes place and are mainly linked to demographic and socio-economic aspects of the populations and National Health System indicators. The Programme-related indicators are those associated to programme products and results and are divided into sub-areas according to: the resources being spent; the incorporation of new knowledge and technology, individual vulnerability, prevention strategies, care provided, HIV/AIDS surveillance and STD prevention and control. Finally, the impact indicators make it possible to analyse the impacts on morbidity/mortality rates of the actions carried out to control AIDS and other STDs.

7.2. ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?
Yes, to all of the above

7.3. Is there a functional* Health Information System?
(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)

At national level?	Yes
At subnational level? ***IF YES***, at what level(s)? The following National systems are operated: Notifiable Diseases Information System (SINAN), Mortality Information System (SIM), System for Logistic Control of Drugs (SICLOM), Live Births Information System (SINASC) and others. There are also other systems in operation that make it possible to refine information by states and municipalities. Epidemiological surveillance of AIDS makes use of information on cases registered in the Notifiable Diseases Information System (SINAN) and the information on deaths registered by the Mortality Information System (SIM) but it also has two systems of its own: the Laboratory Test Control System (SISCEL) and the System for Logistic Control of Drugs (SICLOM). In the case of AIDS, the notification of cases to the SINAN obeys the criteria officially established in Brazil for defining cases of AIDS. The system also contains other relevant epidemiological information and has been used to delineate the dynamics of the epidemic and to provide supporting information to define actions for preventing and controlling the disease. The main purpose of the SIM is to provide information that can delineate the profile of mortality in Brazil. The system holds information on the basic causes of death, date and place of death, municipality of the occurrence and other personal information on the deceased such as age, sex, schooling level, occupation and municipality of habitual residence. The SISCEL has been developed to monitor laboratory procedures, particularly T CD4/CD8 counts and HIV viral load assays in order to assist the definition of antiretroviral treatment for patients and monitor those taking treatment.	Yes

The objective of the SICLOM is to facilitate the management of logistics involved in supplying antiretroviral medicines. The information helps to control stocks, distribute the medicines, and also to collect clinical/laboratorial information on AIDS patients using different therapeutic regimes. AIDS data is primarily based on cases notified to the SINAN with the assistance of additional information contained in the SISCEL and SIM and the technique of probabilistic relations id used to handle the data The system for logistic control of drugs (SICLOM) is used to validate the SISCEL information when confronted with the information in the SIM.	

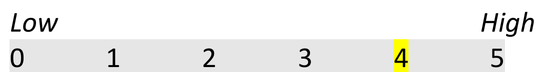
8. Does Brazil publish at least once a year an M&E report on HIV and on, including HIV surveillance data?
Yes

9. To what extent are M&E data used:

9.1. in developing / revising the national AIDS strategy?

Provide a specific example: All policies are based on data. As an example, a plan designed to expand testing known as "*Fique sabendo*" (You Gotta Know) was based on a diagnosis of poor HIV testing coverage obtained by means of a behavioural surveillance survey. What are the main challenges, if any? Use established indicators to evaluate programme performance.

9.2. for resource allocation?



Provide a specific example: The data was used to stipulate values for a policy of incentives. What are the main challenges, if any? Constructing forecasts for the procurement of prevention commodities based on usage estimates.

9.3. for programme improvement?

Provide a specific example: The data was made use of tin the campaign 'You Gotta Know' designed to expand testing. What are the main challenges, if any? Obtaining estimates of the more vulnerable populations.

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?
Yes, at all levels

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

at national level?	Yes
IF YES, number trained: 1,200	
at subnational level?	Yes
IF YES, number trained: Capacity building was provided for approximately 3,000 technical staff members	
at service delivery level including civil society?	Yes
IF YES, number trained: Approximately 400 technical personnel trained	

10.2. Were other M&E capacity-building activities conducted other than training?
Yes - Masters Degree courses in the field of Monitoring and Evaluation

IF YES, describe what types of activities:
Postgraduate courses in Evaluation of Endemic Process Control Programmes with an emphasis on STD/HIV/AIDS (Specialisation and Special Masters courses): courses developed and coordinated by ENSP/FIOCRUZ, in partnership with the STD, AIDS and Viral Hepatitis Department and the CDC/GAP. The specialisation courses are offered in modules one week a month for 12 months with an additional six months for those going on for a Masters. The aim is to qualify specialists for the work of evaluating programmes designed to control endemic processes, taking into account the social-historical and technical dimensions of assessment and supported by communication, ongoing education and knowledge reproduction processes associated to evaluation to contribute towards establishing management capable of implementing transformation.

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?		
2009	Very poor	Excellent
	0 1 2 3 4 5 6 7 8 9 10	
Since 2007, what have been key achievements in this area: 1) Institutionalising monitoring as a management tool, 2) Establishing priority studies for accompanying the Brazilian response, 3) Carrying out capacity building in M&E for states and municipalities, 4) Monitoring key indicators. *What are remaining challenges in this area:* 1) Institutionalising evaluation as a management tool, 2) Standardising the systems, prioritising the indicators and assimilating M&E in the routines.		

PART B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

Part B (1) - Bilateral agencies and United Nations organizations

The procedure for filling in the NCPI forms adopted by the agencies of the UN System was as follows:

(i) A meeting for consultation and information with the Joint UN team for AIDS at which two persons were indicated to represent the UN system before the UNGASS Work Group;
(ii) Forwarding of the NCPI forms and guidance given to the UN system representatives in Brazil and their corresponding focal points in HIV/AIDS;
(iii) Visits to the agencies to assist in completing the instrument;
(iv) Preliminary consolidation of the responses sent in by the various agencies to constitute a single document – *delivered as one;*
(v) Presentation of the preliminary consolidated version at the expanded meeting of the UNGASS Work Group;
(vi) Two meetings with the Joint UN team for AIDS to obtain consensus on the information supplied by the agencies and the suggestions made by the UNGASS Work Group;
(vii) Presentation of the UN system's final version of the NCPI to the UNGASS Work Group.

NCPI Respondents

Organization	***Name/Position***	***Respondents to Part B [Indicate which part each respondent was queried on]***			
		B.I	***B.II***	***B.III***	***B.IV***
1) UNICEF	Marie-Pierre Poirier/ Representative; Daniela Ligiéro/ HIV/AIDS Programme Coordinator	X	X	X	
2) UNODC	Bo Mathiasen/ Regional Representative; Nara Santos/ Technical Advisor on HIV/AIDS	X	X	X	X
3) UNAIDS	Pedro Chequer/ UNAIDS Country Coordinator Brazil; Naiara Costa/ Programme Officer; Jacqueline Côrtes/ Programmes and Projects Advisor; Carsten Gissel/ Programme Advisor	X	X	X	X
4) PAHO/WHO	Diego Victoria/ Representative; Luís Codina/ Family Health and Food Safety Area Manager; Pamela Ximena Bermudez/ HIV/AIDS Focal Point	X	X	X	X
4) UNFPA	Ângela Donini/ HIV/AIDS Advisor	X	X	X	X
5) UNESCO	Maria Rebeca Gomes Otero/ HIV/AIDS Programme Officer	X	X	X	X
6) UNHCR	Eva Demant/ Representative A.I; Luiz Fernando Godinho/ Public Information Officer; Rafael Rodovalho/ Senior Programme Assistant	X	X	X	X
7) UNDP	Joaquim Roberto Fernandes/ Programme Officer	X	X	X	X

I. <u>HUMAN RIGHTS</u>

1. Does Brazil (we suggest replacing "the country" with "Brazil" in all items) **have legislation and regulations that protect people living with HIV against discrimination?** (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care, etc.)
Yes

1.1 ***IF YES,*** specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

The STD/AIDS and Viral Hepatitis Department's portal (http://www.AIDS.gov.br) provides an on-line electronic version of a publication in three volumes containing the following subjects regarding national and international legislation in relation to STD/HIV and AIDS:

- The Brazilian Federal Constitution (1988);
- International Human Rights Protection Mechanisms ratified by Brazil;
- Art. 2 of the Universal Declaration of Human Rights;
- International Covenant on Civil and Political Rights;
- International Covenant on Economic, Social and Cultural Rights;
- American Convention on Human Rights;
- Legislative Decree No. 56 dated 19/04/95 (which approves the texts of the Protocol of San Salvador and the Protocol on the Abolition of the Death Penalty);
- Decree No. 1,004 dated 13/05/96 (creating the National Human Rights Programme);
- The Political and Administrative Organization of Health Services and Health Care;
- Social Services;
- Tax Benefits;
- Penal Code and Prison Legislation;
- Ethical Standards of the Federal Council of Medicine;
- State-level Legislation;
- Brazil. Ministry of Education. Ministry of Health. Interministerial Ordinance No. 796, dated May 29th 1992;
- Inter-American Convention on the prevention, punishment and eradication of violence against women – Convention of Belém do Pará (1994);
- Declaration of the fundamental rights of people living with the AIDS virus – National Meeting of Non-Governmental AIDS Service Organizations (*ENONG - Encontro Nacional de ONG que trabalham com AIDS*). Porto Alegre, 1989;
- Programme to combat violence and discrimination against LGBT people and to promote homosexual citizenship;
- The site of the Brazilian Gay, Lesbian, Bisexual and Trans Association – ABGLT (http://www.abglt.org.br), founded in 1995, also provides access to Brazilian legislation, the legislation of other countries and international legislation relating to homosexuals, HIV/AIDS, civil union, immigration, social security, sexual orientation, etc;
- The site of the National Network of People Living With HIV/AIDS (RNP+) (http://www.rnpvha.org.br). This network, founded in 1995, brings together the efforts of people living with HIV/AIDS regarding the various forms of public policy "watchdog" activities, citizenship-building, human rights, combat of discrimination. It plays a leadership role in mobilization, the provision of technical resources, information and opportunities to improve the quality of life of people living with HIV/AIDS.

2. Does Brazil have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable sub-populations?
Yes

2.1. ***IF YES,*** for which sub-populations?

a. Women	Yes
b. Young people	Yes
c. Injecting drug users (IDU)	Yes
d. Men who have sex with men (MSM)	Yes
e. Sex workers	Yes
f. Prison inmates	Yes
g. Migrants/mobile populations	Yes

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

A good juridical platform is in place at all government levels. The principal problem is the observance of these laws and their enforcement in all circumstances.

States and municipalities have laws prohibiting 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 Afro-descendant People, the Integrated Plan to Combat the Feminization of AIDS and other STDs, and the *Maria da Penha* Law on protection of women against domestic violence; and the Operational Plan for the Reduction of the Mother-to-Child Transmission of HIV and Syphilis. There are also laws on Harm Reduction for drug users.

The following are the most relevant mechanisms:

LGBT
In order for this programme to achieve its objectives, four main actions need to be implemented.

1. Support for the strengthening of governmental and non-governmental organizations that work to promote homosexual citizenship and/or to combat homophobia;
2. Building the capacity of professionals and homosexual movements working to defend Human Rights;
3. Dissemination of information about rights and the promotion of homosexual self-esteem;
4. Encouragement of the denouncement of Human Rights violations among the LGBT segment.

Children and Adolescents
Statute on the Rights of Children and Teenagers. Law No. 8.069, dated July 13th 1990, which provides for the integral protection of children and teenagers, including all forms of discrimination, negligence, exploitation, violence, cruelty or oppression.

Drug users
Law No. 11,343/06 creates the National System of Public Policies on Drugs with the aim of articulating, integrating, organizing and coordinating prevention, treatment and social reinsertion activities with drug users and dependents, as well as activities to repress trafficking, being aligned with the National Policy on Drugs.

Prison Population
Interministerial Ordinance No. 1,777/03 (Ministry of Health and Ministry of Justice) creates the National Health Plan for the Prison System, providing for the inclusion of the prison population in the National Health System (NHS), so as to ensure that the right to citizenship becomes effective within a human rights perspective. This population's access to health actions and services is legally defined by the 1988 Federal Constitution, by Law No. 8,080/90, which regulates the NHS, by Law No. 8,142/90 which provides for community participation in NHS management, and by the Law of Penal Execution No. 7,210/84.

There are around 50 LGBT reference centres which make use of this legislation in cases of complaints of discrimination.

Briefly describe the content of these laws:

LGBT

The aim of this programme is to promote the citizenship of lesbians, gay men, bisexuals, transvestites and transsexuals, by ensuring equal rights and combating homophobic violence and discrimination, respecting the specificity of each of these groups of the population.

Drug users

The National Policy on Drugs includes among its general guidelines the promotion of harm reduction strategies and actions, within a perspective of public health and human rights, to be undertaken in an articulated inter and intra-sectoral manner, aiming to reduce the risks, adverse consequences and harm associated with alcohol and drug use on users, their families and society.

Prison Population

The National Health Plan for the Prison System was prepared based on a perspective of health care and the inclusion of imprisoned people as part of basic principles that ensure the effectiveness of integral health promotion, prevention and care actions. Included among the principles on which the Plan is based are the promotion of citizenship, from a perspective of civil, political and social rights, and the promotion of human rights, as a reference for a more humane life in common, with dignity, free from discrimination and violence.

Men, women and children seeking refuge or recognized as refugees in Brazil have guaranteed access to health services, including HIV/AIDS prevention commodities, counselling and treatment.

With regard to migrant populations, there is no specific legislation, but rather access is guaranteed to the services provided for by norms, regulations and legislation already in place.

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

LGBT

This programme is relatively new, dating from 2004, and is still at the implementation stage. Monitoring has been done by the President of the Republic's Special Human Rights Secretariat, the Ministry of Health, Ministry of Education, Ministry of Justice, Ministry of Culture, Ministry of Labour and Employment, among others.

Drug users

The harm reduction strategy has been adopted by the Ministry of Health's STD, AIDS and Viral Hepatitis Department since 1994. Harm reduction is considered to be a strategy of great relevance in changing the profile of the AIDS epidemic, as in the 1990s 25% of reported AIDS cases were directly or indirectly associated with injecting drug use, whereas currently this number has fallen to 9%.

In 2009, the Ministry of Health, through its Mental Health Department, launched its Emergency Plan to Scale up Access to Alcohol and other Drug Treatment and Prevention in the National Health System (*Plano Emergencial de Ampliação do Acesso ao Tratamento e Prevenção em Álcool e Outras Drogas no Sistema Único de Saúde - PEAD*). The main objective of the Plan is to intensify, scale up and diversify the actions of prevention, health promotion and treatment of the risks and harm associated with the harmful use of psychoactive substances. Among its guidelines the *PEAD* proposes the respect for and promotion of human rights and social inclusion. The lines of action of the *PEAD* include support for actions to combat stigma and the promotion of social inclusion through sensitizing service managers, professionals and the general population about the rights of people who use alcohol and other drugs.

Prison Population

18 states have are currently qualified under the National Health Plan for the Prison System: Acre, Amazonas, Bahia, Ceará, Distrito Federal, Espírito Santo, Goiás, Mato Grosso, Mato Grosso do Sul, Minas Gerais, Paraíba, Paraná, Pernambuco, Rio de Janeiro, Rio Grande do Sul, Rondônia, São Paulo and Tocantins. These states have around 200 health teams working in 160 prison units.

All the population under UNHCR's mandate in Brazil is benefitted by this guarantee.

3. Does Brazil have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable sub-populations?
No

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

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 support the Brazilian response to HIV/AIDS. It is the country's understanding that the response to HIV is based on the perspective of the indivisibility of prevention and care with human rights as a central theme.

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

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable sub-populations?
Yes

IF YES, briefly describe this mechanism:

The Department of STD, AIDS and Viral Hepatitis has a database for denouncements, known as the HIV/AIDS Human Rights Violations Monitoring and Evaluation System (*Sistema de Monitoramento e Avaliação de Violações de Direitos Humanos em HIV/ AIDS – MS/DST/AIDS*) available at www.aids.gov.br.

There are also juridical and legal mechanisms such as the public attorney's offices, the Brazilian Law Society, small claims courts and NGO legal aid services, which provide free services and support to the population.

Law No. 11,340 (*Maria da Penha* Law)
Article 9. "Assistance to women in situations of domestic and family violence will be provided in an articulated manner and in accordance with the principles and guidelines provided for in the Fundamental Laws on Social Services, the National Health System, the National Public Security System, among other norms and public policies on protection, as well as on an emergency basis when necessary.

Paragraph 1. The judge will determine, for a defined period of time, the inclusion of women in situations of domestic and family violence on the databases of the federal, state and municipal governments' social services programmes.

Assistance to women in situations of domestic and family violence shall include access to scientific and technological development, including emergency contraception services, Sexually Transmitted Diseases (STD) and Acquired Immune Deficiency Syndrome (AIDS) prophylaxis and other medical procedures necessary and appropriate in cases of sexual violence."

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable sub-populations in government-HIV policy design and programme implementation?
Yes

IF YES, describe some examples:

Through participation in national, state and municipal councils.

The country has a National Plan for the Combat of the AIDS and STD Epidemic among gay men, other men who have sex with men and transvestites, launched in June 2007 and made available for public consultation. The plan defines HIV/AIDS prevention and care strategies for these segments, and also for the promotion of human rights and the respect for differences.

7. Does Brazil have a policy of free services for the following:

a. HIV prevention services	Yes
b. Antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

Difficulties exist with regard to prevention:

- access to condoms relating to local distribution logistics problems;
- counselling, given that the greater part of national resources are invested in antiretroviral treatment. Access to diagnosis has been late.

In addition, children and teenagers living with HIV have limited access to psychosocial support beyond the strictly medical aspect. Finally, difficulties exist in access to the treatment of opportunistic diseases.

8. Does Brazil have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?
Yes

8.1 In particular, does Brazil have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?
Yes

9. Does Brazil have a policy to ensure equal access for most-at-risk populations and/or other vulnerable sub-populations?
Yes

IF YES, briefly describe the content of this policy:
As mentioned above, Brazil has a platform of policies and programmes specifically directed towards more vulnerable populations. Access to the public health system is universal and non-discriminatory.

9.1. ***IF YES,*** does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?
Yes

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

There are legal instruments called PLANS to Combat the epidemic, such as:

- Women
- MSM and Transvestites
- Prison population
- Afro-descendants
- Indigenous population

10. Does Brazil have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?
Yes

11. Does Brazil have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?
Yes

11.1. ***IF YES,*** does the ethical review committee include representatives of civil society including people living with HIV?
Yes

IF YES, describe the approach and the effectiveness of this committee:

Brazil has a National Commission on Ethics in Research (*Comissão Nacional de Ética em Pesquisa - CONEP*) involving human beings, regulated, among others, by Resolution 196/96. This structure is reproduced at state and municipal level in the form of research ethics committees (*comitês de ética em pesquisa - CEP*).

The National Commission on Ethics in Research is a commission of the National Health Council (*Conselho Nacional de Saúde – CNS*). The *CONEP/CNS* is a national regulatory body and as such all research projects have to be approved by it.

Further details in the Table below:

YEAR	RESOLUTION	SUBJECT MATTER
2007	*CNS* Resolution 370/07	Registration and accreditation or renewal of registration and accreditation of *CEPs*
2005	*CNS* Resolution 347/05	Approves the guidelines for the ethical analysis of research projects involving the storage of materials or use of materials stored in previous research
2005	*CNS* Resolution 346/05	Multicentre projects
2004	*CNS* Resolution 340/04	Approves the Guidelines for the Ethical Analysis and Processing of Research in the Special Thematic Area of Human Genetics
2002	Regulation of *CNS* Resolution 292/99	Regulation of *CNS* Resolution 292/99 on research involving foreign cooperation (approved by the *CNS* on 08/08/2002)
2000	*CNS* Resolution 304/00	Provides a complementary norm for Research among Indigenous People
2000	*CNS* Resolution 303/00	Provides a complementary norm for the area of Human Reproduction, establishing sub-areas that must be analysed by the *Conep,* and delegating to the *CEPs* the analysis of other projects in the thematic area.
2000	*CNS* Resolution 301/00	Deals with the *CNS* and *CONEP* position contrary to the modifications of the Declaration of Helsinki.
1999	*CNS* Resolution 292/99 - *Portuguese* - *English*	Establishes specific norms for the approval of research protocols involving foreign cooperation, maintaining the requirement of final approval by the *CONEP*, following approval by the *CEPs*
1997	*CNS* Resolution 251/97 - *Portuguese* - *English*	Provides a complementary norm for the special thematic area of new pharmaceutical products, vaccines and diagnostic tests and delegates to the *CEPs* the final analysis of projects in this area, which ceases to be a special area
1997	*CNS* Resolution 240/97	Defines the representation of health service users on the *CEPs* and provides guidelines on their choice.
1996	*CNS* Resolution 196/96 - *Portuguese* - *English*	After one year's work, Resolution 196/96 was published containing the **Regulatory Guidelines and Standards for Research Involving Human Beings**, repealing the preceding Resolution 01/88

1995	*CNS* Resolution 170/95	Defines the creation of an Executive Working Group to revise the *CNS* Resolution 01/88 (the group was comprised of: researchers, representatives of the Ministries of Health and Science and Technology, Federal Council of Medicine, Brazilian Law Society, National Council of Brazilian Bishops, representative of NHS users, NGOs etc.)
1995	*CNS* Resolution 173/95	Defines the work plan for the revision of *CNS* Resolution 01/88, including the standardization of the special thematic areas
1988	*CNS* Resolution 01/88	Regulates the accreditation of Research Centres in Brazil and recommends the creation of a Research Ethics Committee (CEP) at each centre – Repealed

12. Does Brazil have the following human rights monitoring and enforcement mechanisms?

- 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

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment.
Yes

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

IF YES on any of the above questions, describe some examples:
1. National Council for the Combat of Discrimination;
2. National AIDS Commission;
3. Commission for Articulation with Social Movement (National STD/AIDS Programme);
4. Technical Committee for the Health of Gay Men, Lesbians, Bisexual and Transgender persons (Ministry of Health);
5. Human Rights Commission of the National Congress;
6. President of the Republic's Office Department of Justice, Citizenship and Human Rights;
7. Parliamentary Front on HIV/AIDS – National Congress;
8. Parliamentary Front for LGBT Citizenship – National Congress.

13. In the last two years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?
Yes

14. Are the following legal support services available in Brazil?

- Legal aid systems for HIV casework
Yes

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

- Programmes to educate, raise awareness among people living with HIV concerning their rights
Yes
(Note: services promoted by the public sector and NGOs.)

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

IF YES, what types of programmes?

Media	Yes
School education	Yes
Personalities regularly speaking out	Yes
Other: 1. Specific Carnival and December 1st campaigns 2. Programme to combat violence and discrimination against LGBT and promote homosexual citizenship	Yes

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

2009	Very poor	Excellent
	0 1 2 3 4 5 6 7 **8** 9 10	

Since 2007, what have been key achievements in this area:

- The strengthening of the joint programme between the Ministry of Health, the Ministry of Education, UNICEF, UNESCO and UNFPA (Health and Prevention in Schools Programme) to work on HIV prevention and discrimination against those living with HIV in schools;
- Intense progress with intersectoral actions such as, for example, the presidential decree that created in 2007 the Health in Schools Programme;
- The creation in 2007 of a national network of adolescents and young adults living with HIV is giving greater visibility to this issue;
- The development of integrated plans to combat the feminization of the AIDS epidemic and other STDs and to combat the AIDS epidemic and other STDs among gay men, other MSM and transvestites;
- The 1st National Lesbian, Gay, Bisexual, Transvestite and Transsexual Conference (LGBT) on June 5-8 2008;
- Leadership in the Regional Consultation on HIV and Sex Work and the holding of the National Consultation on HIV, Prostitution and Human Rights in 2008;
- Leadership in the Regional Consultation for Latin America and the Caribbean on HIV in the Prison System, held in São Paulo in May 2008, followed by the holding of the National Consultation on HIV in the Prison System in 2009;
- Increase in universal access to services, improvement in the collection and analysis of epidemiological data, new strategies for access by more vulnerable populations.

What are remaining challenges in this area?

- People living with HIV continue to suffer discrimination and stigma. More attention needs to be paid to children and adolescents living with HIV, in particular those living in institutions.
- Increase the presence of the National STD/AIDS Programme in frontier areas, with greater distribution of relevant information (regarding prevention, counselling and about treatment) at border and migration control checkpoints.

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009?

2009	Very poor	Excellent
	0 1 2 3 4 5 6 7 **8** 9 10	

Since 2007, what have been key achievements in this area:
The ever increasing participation of Civil Society in the implementation of HIV/AIDS-related programmes in Brazil has allowed better accompaniment of the results and, consequently, greater Social "Watchdog" activities on this issue – thus ensuring that the policies, laws and regulations are complied with.

What are remaining challenges in this area?

II. CIVIL SOCIETY* PARTICIPATION

*Civil society includes among other: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purposes of the NCPI, the private sector is considered separately.

1. To what extent 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 has guaranteed representativity on social "watchdog" bodies established by law in Brazil, such as health councils (national, state and municipal) and other participatory mechanisms, such as: UNAIDS Working Group, National AIDS Commission, Commission for Articulation with Social Movements, among others.

Brazilian Civil Society, through different organizations, has played a significant Social Watch role over HIV/AIDS prevention, counselling and treatment programmes and projects.

2. To what extent have civil society representative been involved in the planning and budgeting process for the National Strategic Plano n HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low *High*

0	1	2	3	4	5

Comments and examples:

Brazilian Civil Society, through different organizations, has exercised due Social Watch over HIV/AIDS prevention, counselling and treatment. Its participation is constant within the Department of STD/AIDS and Viral Hepatitis, as well as in other fora of consultation, discussion and accompaniment, such as the UNAIDS working group. Nevertheless, such participation is very differentiated and unequal in the diverse states and municipalities that go to make up Brazil.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. the national AIDS strategy

Low *High*

0	1	2	3	4	5

b. the national AIDS budget?

Low *High*

0	1	2	3	4	5

c. national AIDS reports?

Low *High*

0	1	2	3	4	5

Comments and examples:

Note: The topics above only represent actions in the area of prevention. Care services in Brazil are the responsibility of the State. Civil Society supports these services, complementing them, such as through sheltered housing for people living with HIV/AIDS, for example.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

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

c. M&E efforts at local level?

Comments and examples:
Generally speaking, Civil Society participates through the Social Watch bodies. Specifically, we can mention the UNGASS progress reports in which civil society has broad and effective participation.

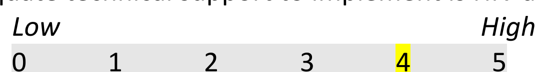
5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

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

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

b. adequate technical support to implement is HIV activities?



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

Prevention for youth	<25%
Prevention for most-at-risk populations	
- IDU	<25%
- MSM	<25%
- Sex workers	<25%
Testing and counselling	<25%
Reduction of stigma and discrimination	<25%
Clinical services (OI/ART)*	Zero
Home-based care	Zero
Programmes for OVC**	<25%

**OI: Opportunistic infections /ART: antiretroviral therapy*
***OVC: Orphans and other vulnerable children*

NOTE: Civil society contributes through prevention actions with key populations and in reducing stigma and discrimination, in a manner articulated with public services at the three government levels.

Overall, how would you rate the efforts to increase civil society participation in 2009?		
2009	Very poor	Excellent
	0 1 2 3 4 5 6 7 8 9 10 (7 highlighted)	
Since 2007, what have been key achievements in this area:		
What are remaining challenges in this area?		

III. **PREVENTION**

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

Yes

IF YES, how were these specific needs determined?

Through recommendations of the national, state and municipal councils; behaviour studies; prevalence studies; the establishment of National Plans.

Other measures include scientific and technological development in the area of prevention commodities and the enhancement of strategies for the social marketing of condoms and increased actions by partners outside the health sector such as, for example, education, labour, policies for women, social action, youth, among others.

This enables better data collection and analysis and the identification with greater precision of the evolution of the epidemic and social groups more vulnerable to HIV/AIDS.

1.1. To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**	
Blood safety	Agree	
Universal precautions in health care settings	Agree	
Prevention of mother-to-child transmission of HIV	Agree	
IEC* on risk reduction	Agree	
IEC* on stigma and discrimination reduction	Agree	
Condom promotion	Agree	
HIV testing and counselling	Agree	
Harm reduction for injecting drug users		Don't agree
Risk reduction for men who have sex with men	Agree	
Risk reduction for sex workers	Agree	
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	
School-based HIV education for young people	Agree	
HIV prevention for out-of-school young people		Don't agree
HIV prevention in the workplace		Don't agree

*IEC = information, education and communication

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?
2007 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

- Health and Prevention in Schools programme;
- Pilot STD/HIV prevention project with street kids;
- Expansion of rapid testing for pregnant women;
- Expansion of testing for young adults and adolescents;
- Integrated plan to combat the feminization of the AIDS epidemic and other STDs;
- National Plan to combat the AIDS epidemic and STDs among gay men, other MSM and transvestites.

What are remaining challenges in this area?

- Access to testing is still not universal for pregnant women;
- Many adolescents and young adults still do not have access to condoms;
- Out-of-school young people continue to be marginalized in relation to prevention and treatment services;
- Large regional differences (North and North East) in relation to access to prevention services;
- The policy on combating HIV feminization has not yet been successfully incorporated at state level;
- There has been no progress in legislation with regard to the rights of LGBT in the country.

IV. TREATMENT, CARE AND SUPPORT

1. Has Brazil identified the specific needs for HIV treatment, care and support services?
Yes

IF YES, how were these specific needs determined?
Through studies and research on adherence and diagnosis; by the scientific committees on medication protocols; through the country's health information systems.

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

HIV treatment, care and support service	**The majority of people in need have access**		
Antiretroviral therapy	Agree		
Nutritional care		Don't agree	
Paediatric AIDS treatment	Agree		
Sexually transmitted infection management	Agree		
Psychosocial support for people living with HIV and their families	Agree		
Home-based care	Agree		
Palliative care and treatment of common HIV-related infections	Agree		
HIV testing and counselling for TB patients	Agree		
TB screening for HIV-infected people	Agree		
TB preventive therapy for HIV-infected people	Agree		
TB infection control in HIV treatment and care facilities	Agree		
Cotrimoxazole prophylaxis in HIV-infected people	Agree		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree		
HIV treatment services in the workplace or treatment referral systems through the workplace			N/A
HIV care and support in the workplace (including alternative working arrangements)		Don't agree	

Overall, how would you rate the efforts in the implementation of HIV treatment, are and support programmes in 2009?		
2009	Very poor	Excellent
	0 1 2 3 4 5 6 **7** 8 9 10	
Since 2007, what have been key achievements in this area: What are remaining challenges in this area? Achieve complete universal access: regional inequalities and structural problems with health services and local political scenarios are factors that hinder the achievement of universal access.		

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

No

Overall, how would you rate the efforts *to meet the HIV-related needs* of orphans and other vulnerable children in 2009?		
2009	Very poor	Excellent
	0 1 **2** 3 4 5 6 7 8 9 10	
Since 2007, what have been key achievements in this area: The national plan to ensure the right to family and community life contains references to children living with HIV. What are remaining challenges in this area? There are various challenges: • Lack of information at state and national level on the number of HIV-affected children; • Lack of information on the types of rights violations suffered by these children and adolescents; • Lack of the implementation of a national strategy to ensure the right to family and community life for children and adolescents living with HIV and also living in institutions; • Lack of psychosocial support for children and adolescents living with HIV—focus only on medical aspects; • Lack of a specific policy providing options for institutionalized adolescents once they reach 18 years of age.		

Part B (2) – Civil Society Organizations

This form has been completed by the UNAIDS Work Group (GT UNAIDS) and the second version of the same form has been completed by an expressive group of civil society organizations mobilized on the basis of the various forums for articulation.

Civil society representatives participating in the Work Group GT UNGASS AIDS consolidated their answers in a single version, which was validated during the ordinary meeting of the National Committee for Articulation with the Social Movements – CAMS.

NOTE (1): *26 questionnaires were received and consolidated with the responses of 37 civil society organizations: AIDS NGO Forums, Networks of People Living with HIV and AIDS, Associations, Social Movements and Activist Movements. 4 of the completed questionnaires were from Brazil's Southern Region (11%);03 from the Southeast (9%); 12 from the Northern Region (32%); and 18 from the Northeast (48%). No questionnaire was received from any organization in the Middle-west region of Brazil.*

NOTE (2): *according to the Brazilian STD, AIDS and Viral Hepatitis Department's register of those Civil Society and Human Rights Organizations that have or have had projects supported by the Department, there are 447 Organizations in the Southeast Region (40%); 279 in the Northeast Region (25%); 164 in the Southern Region (14%); 141 in the Middle-west Region (12%); and 104 in the Northern Region (9%), making up a total of 1,135 Civil Society Organizations in Brazil. However, that register was not used as the reference by the UNGASS Forum-Brazil in the process for soliciting responses to the questionnaires and cannot serve as the numerical basis for evaluating the percentage of responses obtained.*

NOTE (3): *it must be stressed that some of the organizations that did in fact hand in completed questionnaires are not included on the Brazilian STD, AIDS and Viral Hepatitis Department's and accordingly the numbers supplied by the Department do not include them.*

Organization	Name/Post	Respondents to Part B [indicate which parts each respondent was queried on]			
		B.I	***B.II***	***B.III***	***B.IV***
GAPA/RS	Patrícia Werlang/President Carlos Duarte/Institutional Advisor Carla Almeida/Project Coordinator	X	X	X	X
Grupo Solidariedade é Vida	Wendel Alencar/Responsible for Activism and Social Control	X	X	X	X
RNP+/PI	Socorro Freitas/Executive Director	X	X	X	X
Association - Grupo Ipê Amarelo pela Livre Orientação Sexual – GIAMA	Silvânio Mota	X	X	X	X
GAPA/PA	Francisco Rodrigues Santos/Executive Coordinator	X	X	X	X
ABGLT	Toni Reis/President	X	X	X	X
AGÁ e VIDA	Janete Alves da Silva/President	X	X	X	X
NGO Juventude Nativa	Antonio Neto	X	X	X	X
Women Association - Madre Tereza de Calcutá da Amazônia Ocidental - AMATEC	Lidia Barbosa	X	X	X	X
AREDACRE	Leazar Haerdrich	X	X	X	X
Fórum de ONG/AIDS das Alagoas	Julio Daniel Silva Faria	X	X	X	X

Fórum de ONG/AIDS de Roraima	Sebastião Diniz	X	X	X	X
Fórum de ONG/AIDS do Rio Grande do Sul	Rubens Raffo/Coordinator	X	X	X	X
GAPA/SP	José Carlos Veloso/Vice President	X	X	X	X
GAPA/BA	Gladys Almeida Daiane Dultra Oséias Cerqueira Gláucia Luz Rosa Gonçalves	X	X	X	X
Grupo de Incentivo à Vida/GIV	Jorge Beloqui/Secretary	X	X	X	X
GRUPAJUS	Antonio Ernandes M. da Costa	X	X	X	X
Grupo Pela Vidda/RJ	Marcio Villard/President	X	X	X	X
Nova Vida	Luis Augusto de O. Veiga	X	X	X	X
RNP+/RS	Jaime Queiroga Berdias/State-level Representative Jose Helio Costalunga/Deputy State-level Representative	X	X	X	X
RNP+/BA	Moysés Toniolo/DH Coordinator	X	X	X	X
GRAB/CE	Adriano Caetano/Director	X	X	X	X
Fábrica de Imagens		X	X	X	X
Movimento Novo Sol		X	X	X	X
Associação Katiró	Fernando Nery Furtado	X	X	X	X
Gestos	Alessandra Nilo/Programmes Coordinator Jair Brandão Filho/Programmes Assistant Josineide de Menezes/Programmes Assistant Kariana Guérios/Lawyer	X	X	X	X
Rede de Amizade e Solidariedade às Pessoas com HIV AIDS do Amazonas	Laurinha Brelaz/President	X	X	X	X
ONG Internacional IS-Serviço Internacional	Leonardo Scalcione/M&E Officer	X	X	X	X
Missão Nova Esperança	Elizabeth de Fátima Ferreira da Silva	X	X	X	X
Espaço Vida: É Vida	Ilcélia Alves Soares/Coordinator	X	X	X	X
RNP+/PE	Roberto Brito/State Focal Point Maria Bernadete/Political Representation	X	X	X	X
Casa de Amparo Social e Promoção Humana Herbert de Souza	Carlos Antonio Lins do Nascimento/President	X	X	X	X
CENDHEC	Valéria Nepumaceno Teles Mendonça/ Coordinator	X	X	X	X
GTP+	Wladimir Cardoso Reis/Coordinator Josefa Severina da Conceição/Social Educator Diana Eugracia/Legal Advisor Sandra Cassiano Perez/Legal Advisor	X	X	X	X
Visão Mundial	Ivaldo Sales da Silva/Anglican Church Representative for the Southern Cone Countries	X	X	X	X
SOS Corpo - Instituto Feminista para Democracia	Yesone Ferreira/Educator	X	X	X	X

Miriam Fialho	Project and Research Consultant, Tutor for Specialisation Course Monographs	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Adriana Barcellos, Representative for the Harm Reduction Movement	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Antônio Pereira de Oliveira Neto, Representative for the Students' Movement	X	X	X	X
Commission for Articulation with Social Movements - CAMS	José Hélio Costalunga de Freitas, Representative for the Movement of People Living with HIV/AIDS (RNP+ Brasil)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Julio Daniel e Silva Farias, Representative for the Northeast Region (Fórum ONG/AIDS de Alagoas)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Kátia Maria Braga Edmundo, Representative for the Southeast Region (Fórum de ONG/AIDS do Rio de Janeiro)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Maiquel Fouchy, Representative for the South Region (Fórum de ONG/AIDS do Rio Grande do Sul)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Maria Noelci Teixeira Homero, Representative for the Women´s Movement	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Rejane Ferreira Soares (Negra Linda), Representative for the Movement of Afro-Descendant People	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Antonio Ernandes Marques da Costa, Representative for the North Region (Fórum de ONG/AIDS do Pará)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	João Fabrício Nunes, Representative for the North Region (Fórum de ONG/AIDS do Amazonas)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	José Raimundo Carvalho (Rafael Carvalho), Representative for the Northeast Region (Fórum de ONG/AIDS da Bahia)	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Liorcino Mendes Pereira Filho (Léo 15 Mendes), Representative for the Homossexual Movement	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Roseli Macedo Silva, Representative for the Popular Movement	X	X	X	X
Commission for Articulation with Social Movements - CAMS	Thiago Aquino de Araújo (Tathiane Araújo), Representative for the Movement of Transvestites, Transsexuals and Transgender People	X	X	X	X

I. HUMAN RIGHTS

1. Does Brazil have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes

NB: 25 answered YES; 01 answered NO.

1.1. ***IF YES***, specify if HIV is specifically mentioned and how or if this is a general non discrimination provision:

The overall perception of Civil Society is that specific laws and decrees do in fact exist but that the creation of such legislation is in the hands of individual states and municipal authorities. In São Paulo for example there is a state law in force that prohibits discrimination of people living with HIV in any environment whatever. In addition to São Paulo, other states mentioned specific legislation like: Law 7556/2003 – Espírito Santo; Law 12,595/1995 – Goiás; Law 14,582/2003 – Minas Gerais; Law 14,362/2004 – Paraná; Law 3,559/2001 – Rio de Janeiro.

Other important Inter-ministerial ordinances were also mentioned such as: Inter-ministerial Ordinance Nº796/1992; Inter-ministerial Ordinance 869/1992 and Federal Council of Medicine opinions nº 05/89 and nº 15/1997.

Lastly the civil society organizations cited some of the international conventions and treaties to which Brazil is a signatory like the Universal Declaration of Human Rights; the UNGASS Declaration; the International Covenant on Civil and Political Rights; the Convention against all Forms of Discrimination; ILO Convention nº11; the Inter-American Convention on Human Rights; and the Brazilian Federal Constitution of 1998, Article 7.

2. Does Brazil have non-discrimination laws or regulations that specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes

NB: 23 answered YES; 02 answered NO; 01 gave no answer.

2.1. ***IF YES***, for which populations?

a. Women (23 answered YES; 03 answered NO)	Yes	
b. Young people (15 answered YES; 06 answered NO; 05 gave no answer)	Yes	
c. Injecting Drug Users (07 answered YES; 11 answered NO; 08 gave no answer)		No
d. Men who have sex with men (20 answered YES; 01 answered NO; 05 gave no answer)	Yes	
e. Sex workers (10 answered YES; 09 answered NO; 07 gave no answer)	Yes	
f. Prison inmates (07 answered YES; 13 answered NO; 06 gave no answer)		No
g. Migrants / mobile populations (09 answered YES; 09 answered NO; 08 gave no answer)	Yes	No
h. Other: Afro-descendents, people living with HIV and AIDS, children and adolescents, elderly people	Yes	
Street dwellers		No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Participating organizations gave affirmative answers and identified laws and mechanisms specifically directed at these population groups. In regard to women, the Maria da Penha Act (Brazilian National Law Nº 11340/2006), which sets out provisions to curb domestic and family violence inflicted on women, was widely mentioned. It is important to mention the

Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women which took place in the city of Belém in the Brazilian State of Pará in June 1994, and to strengthen mechanisms for defending sexual and reproductive rights associated to integral health care for women.

As regards homosexuals, various state and municipal laws are cited and in that sense it is important to register the fact that almost 100% of Brazilian municipalities have specific legislation in place prohibiting discrimination based on sexual orientation and establishing formal penalties for offenders. In the case of commercial establishments, the penalties include fines and the eventual cancelling of licenses; and in the case of government bodies, the penalties involve the setting up of an administrative disciplinary process moved against civil servants that discriminate homosexuals. In the State of Amazonas, State Law 3,079 is

notable for penalizing any form of discrimination, whether it be based on sexual orientation, or on gender identity. In the city of Fortaleza, capital of the State of Ceará, the respective municipal legislation (Law n° 8,211/98) is restricted to commercial establishments and explicitly forbids any discrimination based on sexual orientation within such establishments. The Constitution of the State of Pará also outlaws any discrimination based on sexual orientation. Mention was also made of the Parliamentary Front on Sexually Transmittable Diseases and Civil Society.

The following laws and ordinances were also cited: the Statute of Rights of Children and Adolescents – Law 8,069/1990; the Statute of Rights of Elderly People – Law 10,741/2003; CF 88 – Art. 5; Chap. III Art. 12; the Law of Penal Execution – Law 7210/1984; the Penalization of Racism - Law 7.716/1989; Edict GM Nº 10, dated January 08, 2004 - Integrated Programme of Affirmative Actions for Afro-descendant People; the Statute of Racial Equality – Law 11.145/2008; ILO Convention nº 111; the Additional Protocol on Economic, Social and Cultural Rights – legislative decree 56/1995; ILO Decree 678/1992; Law nº 9.029/95 that prohibits "the adoption of any discriminatory or restrictive practice that affects access to, or maintenance of employment".

As for the population of prison inmates, only the state of Rio de Janeiro declared having any knowledge of specific decrees setting out provisions regarding their rights namely, Decree 25,685/99 issued by the Government of Rio de Janeiro. The State of Pará, through the Office of the Superintendent of the Prison System issued an act permitting conjugal visitation for Lesbian, Gay men, Bisexual and Transgender prisoners.

Briefly describe the content of these laws:

This item has been addressed in the previous paragraph.

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

The organizations that participated in the poll perceived that in spite of the existence in the international, constitutional and infra-constitutional spheres of a considerable number of regulatory norms setting out provisions concerning the rights of these populations, they are still a long way from being effectively enforced. For that to happen there needs to be a combination of political will and a heightened sensitivity of the Judiciary in regard to the issue. Organizations widely felt that those two aspects were of fundamental importance to putting into effect and guaranteeing the rights proposed in the aforementioned legal provisions.

3. Does Brazil have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?
No
NB: 09 answered YES; 17 answered NO.

3.1. ***IF YES***, for which subpopulations?

a. Women (05 answered YES, 21 answered NO)	No
b. Young people (08 answered YES, 16 answered NO, 02 gave no answer)	No
c. Injecting drug users (08 answered YES, 17 answered NO; 01 gave no answer)	No
d. Men who have sex with men (08 answered YES, 16 answered NO; 02 gave no answer)	No
e. Sex workers (05 answered YES, 18 answered NO, 03 gave no answer)	No
f. Prison inmates (05 answered YES, 20 answered NO, 01 gave no answer)	No
g. Migrants / mobile populations (06 answered YES, 18 answered NO, 02 gave no answer)	No

IF YES, briefly describe the content of these laws, regulations or policies:

Although Brazil's legal framework does not include regulations or legal provisions that hamper effective prevention, treatment, care and support in regard to HIV for most-at-risk populations and other vulnerable sub-populations, some social organizations have questioned certain measures such as:

- The regulations of the Public Health Surveillance Agency–ANVISA that forbid blood donation or donation of blood derivatives by homosexuals.

- Anti-drug laws that hinder harm reduction actions. The legislation that governs the repression of drug-use hampers harm reduction actions directed at drug users because in the present form of the law, possession of drugs is classified as a crime.

Those critics also point out the lack of any policies for confronting the epidemic among such populations and point out that among prison inmate populations there is no standardized provision of access to prevention materials or treatment. The same situation was identified in regard to street dwellers and/or drug users in terms of access to services and social assistance. As for sex workers, some municipal authorities make systematic efforts to establish norms and regulate prostitution based on public health policies and bodily control, often in the perspective of a religious ethic and with an emphasis on compulsory testing for that population. It is worthwhile highlighting the low level of government investment in care for drug and alcohol users in the context of public health policies. Furthermore, there is very little funding for either prevention or harm reduction activities made available to Non Governmental Organizations that are active in this field. It must be underscored that in Brazil there are two political schools of thought on the issue of drugs that are in mutual opposition: 1 the *Secretaria Nacional Antidrogas* – SENAD (Brazilian Anti-drugs Department) which emphasizes the aspect of National Security; and 2 the STD/AIDS and Viral Hepatitis Department that handles the issue in a human rights and harm reduction perspective.

Although there are no laws or policies in place that specifically hamper access to HIV/AIDS prevention and treatment, there are direct and indirect obstacles to it accessing them especially in the schools and prisons. There is an insufficient number of appropriately qualified staff in both systems and practice is actually guided by personal moral views and common sense. In the case of women the situation is even more complicated because the reduction of cases of HIV infection in women depends on actions directed at their sexual and reproductive health and that does not depend on the services alone because it involves the autonomy of women in regard to their own bodies.

Briefly comment on how they pose barriers:

In most Brazilian states the Integrated plan to combat the feminization of the AIDS epidemic and other STDs, the National Plan to combat the AIDS epidemic and STDs among gay men, other MSM and transvestites, and the Health and Prevention in Schools Programme are still not functioning. Civil society reported almost no results at all for the Health and Prevention in Schools Programme. The actions aimed at combating the sexual exploitation of girls are set out in the National Plan to Combat Sexual Violence against girls and young women*, and presently care and support for such girl victims and their families are provided under the aegis of the Sentinel Project. Implementation of the plan has been very limited so far and there is little dissemination of information or articulation with other government sectors especially regarding HIV/AIDS prevention.

* BRASIL. Secretaria Nacional de Direitos Humanos - Plano Nacional de Enfrentamento da Violência Sexual Infanto-Juvenil. SNDH, Comitê Nacional de Enfrentamento à Violência Sexual contra Crianças e Adolescentes, Brasília, 2006.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?
Yes
NB: 24 answered YES, 02 gave no answer.

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

Brazilian policy on HIV incorporates human rights in several perspectives as for example that of people living with HIV and AIDS, the right of universal access to prevention, care and treatment of HIV/AIDS; the rights of specific populations as set out in the National Plan to combat the AIDS epidemic and STDs among gay men, other MSM and transvestites, Integrated Plan to Combat the Feminization of AIDS and other STDs (women and female transsexuals). Respect for Human Rights is a crosscutting theme for all Brazilian public policies. Although state and municipal-level administrators do not prioritize the use of the term ‘human rights’, the construction and execution of their HIV/AIDS policies and policy promotion strategies are largely based on Human Rights principles.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?
Yes
NB: 23 answered YES, 01 answered NO, 02 gave no answer.

IF YES, *briefly describe this mechanism*:

Some equipment, protocols and mechanisms were identified and described, such as the implantation of Specialized Police Stations for Women and Specialized Police Stations against Discriminatory Offences; Registration and Documentation of the legal Advisory bodies of Civil Society Organizations; judgment of actions moved by the legal advisory bodies; denunciations to the Office of the Public Prosecutor (at state and federal levels); denunciations to the UN; Civil Society reports on International Pacts (PIDESC, CEDAW, PIDCB and others).

The legal advisory services projects financed by the Brazilian National STD, AIDS and Viral Hepatitis Department have an instrument available to them that enables them to register cases of discrimination identified in Brazil.

Another mechanism mentioned that was implanted in 2007, is the Database of the HIV/AIDS Human Rights Violations Monitoring and Evaluation System, which registers and measures situations in which the rights of most-exposed populations have been violated. It facilitates the mapping of locations where discrimination problems occur most frequently making it possible to orientate specific public policies and measures to address them. Another mechanism that was identified, more closely related to civil society participation in policy discussions was the Brazilian National Seminar on Human Rights and AIDS which produces reports that help to guide national public policies (one seminar was held in 2007 and one in 2008 as well as other outreaching and participative events at national level. It mobilized various inter-institutional and inter-sector segments to discuss the confrontation of the AIDS epidemic and combating stigmatisation.

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?
Yes
NB: 25 answered YES, 01 answered NO.

IF YES, *briefly describe some examples:*

The Brazilian government has given political and financial support to several civil society initiatives and among those mentioned were:

- Financial support for projects undertaken in the network involving People Living with HIV/AIDS and most-exposed populations;
- Financial support for prevention activities carried out during the Lesbian, Gays, Bisexuals, Transvestite and Transsexual Parades (LGBT);
- Financial support for Civil Society Organizations projects providing legal advisory services for People Living with HIV/AIDS;
- Political support to strengthen social networks of support for seropositive individuals: *Movimento Nacional das Cidadãs Posithivas* (Brazilian PositHIVe Women Citizens Movement);
- Support to strengthen the National Network of Young People living with HIV/AIDS and the National Network of People Living with HIV/AIDS (RNP+).

Official selection-process calls for the submission of action projects directed at People Living with HIV/AIDS and most-at risk and vulnerable populations were also made and people living with HIV and AIDS or belonging to most at risk populations were taken on as members of the technical staff by the government.

Although it is still incipient, there is civil society participation in the elaboration of some national programmes like Homophobia-free Brazil, the National Plan to Combat the Feminisation of AIDS and other STDs, the Integrated Plan to combat the AIDS epidemic and STDs among gay men, other MSM and

transvestites and finally, the government has been supporting events designed to strengthen networks, and the process negotiating agreements within the spheres of the Goals and Actions Plan for STDs and AIDS.

The organizations however, call attention to the lack of any clearly defined policies for riverside communities, indigenous populations or street dwellers. It must be stressed that the Ministry of Health's STD, AIDS and Viral Hepatitis Department needs to find ways of strengthening the funding for NGOs in Brazil's Northern region because coverage there is very poor and the last time there was a call for projects to be submitted, not a single one was approved for the region so that there is an urgent need to find strategies that can redress that situation and close the gap.

7. Does Brazil have a policy of free services for the following:

a. HIV prevention	Yes
b. antiretroviral treatment	Yes
c. HIV-related care and support interventions	Yes

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

Financial resources have been restricted because of the decentralization policy of the Brazilian National Health System from the federal sphere to state and municipal levels of government and insufficient levels of investment or no spending on actions directed at most-at-risk populations or those in the most vulnerable situations.

In Brazil the National Health System is responsible for providing care and attention for People Living with HIV and AIDS and the services users receive treatment and medicines paid for from the taxes levied on the Brazilian people as a whole. However the question of financing the health system is still a great challenge. Federal Law 9313/96 guarantees free universal access to antiretroviral medicines and the government has implanted an information and control system for the notification of AIDS cases and the dispensing of the medicines that enables it to estimate demand and ensure an appropriate budget provision to meet it.

Although there are clearly defined policies at national level, there are obstacles to implanting them in various states and municipalities. An example of this is the agreement drawn up with States and Municipal Authorities to ensure the supply of medicines to treat opportunistic infections. Most of the States and Municipalities fail to comply with the terms they agreed to.

IN many states, services are centralised in the State capital making universal access very difficult in the smaller cities and municipalities. There is also a lack of any policy to foster the creation of work and sources of income for People Living with HIV and AIDS. As for antiretroviral treatment, hunger continues to be a factor that makes it even more difficult and there is no prospect of social inclusion or social support for people taking the treatment (reported by the State of Maranhão - in the Brazilian Northeast macro-region).

The population has to overcome various obstacles to gain access to STD/AIDS actions and services because of the vast size of the country and the way in which policies are conducted at local level. Among specific difficulties are: spatial barriers in the form of great distances to be travelled to get to the services (continental dimension of Brazil) especially in the Macro-regions North and Northeast; the low incidence of specialized services embracing the most up to date epidemiological criteria; institutional obstacles; low level of humanization capacity among health staff (especially when handling the more vulnerable publics); discrimination practiced within the services themselves (e.g. pejorative names commonly used to designate transvestites, transsexuals or People Living with HIV/AIDS); very little inclusion or participation of service users in the administrative councils of the health system; lack of prevention materials to be made available to the public in the local primary health care units; fear of discrimination and stigmatization that leads people to seek treatment in other municipalities where they are not known. There is also the problem of no services in municipalities that have not entered on the agreements and that leads people to seek out services in the capital cities or other large urban centres; and finally there is

the fact that even after three decades of the epidemic there are still health professionals (doctors, dentists, surgeons, gynaecologists and others) in the services that refuse to handle people from vulnerable populations or those affected by AIDS. In that regard, the most neglected populations are street dwellers, users of alcohol and other drugs. When there are no day hospitals in place for emergency situations of withdrawal crises they are dealt with by psychiatric hospitals as if their problem were insanity.

8. Does Brazil have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes

NB: 23 answered YES, 02 answered NO, 01 gave no answer.

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

Yes

NB: 22 answered YES, 03 answered NO, 01 gave no answer.

By establishing agreements with national and international agencies, federal, state and municipal governments have been attempting to ensure allotments of funds to finance sexual and reproductive health actions especially at the interface with HIV infection. As a result there are some financial allotments in place and policies for working with certain groups of women in highly vulnerable situations like sex workers, HIV positive women, lesbian women, Afro-descendant women, afro-descendants, indigenous people and gypsies*. One of the directives established by the Policy on Integral Health Care for Women** is that health actions in this field must seek to such women not only in enjoying access to care but also in the respective decision-making processes. In practice the extent to which that actually takes place depends on the local administrator. There are obstacles that can vary from region to region or from service to service. In the case of women prostitutes, for example the health services tend to concern themselves only with sexual issues and the risk of disease transmission and fail to take into account the woman's integral health. In the case of prisoners, the mere fact of taking antiretroviral treatment may open the gates to discrimination in addition to the difficulty there is to get access to the medicines or to prevention materials. In that regard there is a clear need to dedicate more attention to women with a single partner because HIV infection among them is on the increase and they rarely seek out the services, whether because of authoritarianism on the part of the husband or whether because they do not feel they belong to any of the existing categories. Another factor that stands out is the low level of concern with the health of heterosexual men. Current policies are very timid in that direction and worse, such men do not seek out the primary health care units.

---

* BRASIL. Ministério da Saúde. Política Nacional de Atenção à Saúde Integral da Mulher. Brasília, 2005.

** Gabriela Leite, Rede Nacional de Prostitutas, personal communication.

9. Does Brazil have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes

NB: 22 answered YES, 04 answered NO.

IF YES, briefly describe the content of this policy:

The Brazilian Federal Constitution guarantees such access and the policy is specifically set out in the statement of principles of the National Health System. Health System services are provided free of charge at all levels of complexity and access is universal (Law 8080/1990). Various Plans have been elaborated to detail the rights involved such as the National Plan to Combat AIDS and other STDs among Gays, other MSMs, and Transvestites and the Integrated Plan to Combat the Feminisation of the Epidemic of AIDS and other STDs (women and female transsexuals). In regard to antiretroviral medicines they have been formally guaranteed in the terms of the universal access legislation (Law 9313/1996). Another aspect that is underscored is the setting up of the National STD, AIDS and Viral Hepatitis Department, which conducts

and executes a policy of combating AIDS initiated in 1986. The institutions consulted also highlighted the creation of the policy of universal access to medicines, which has been in operation since 1996.

Mention was also made of the fact that several Units of the National STD, AIDS and Viral Hepatitis Department have conducted actions specifically directed at women. There is also a person specifically designated to conduct the articulation of actions directed at the female population. The Brazilian Ministry of Health has designated a person from the technical area of women's health to work at the interface with the STD, AIDS and Viral Hepatitis Department, and within that department there is a specific body to coordinate STD issues with a primary focus on reducing congenital syphilis. Sexual and Reproductive Health policy is partially represented in the Policy of Integral Health Care for Women (PAISM) and is also present in the form of the insertion of the subject of Sexual and Reproductive Health among the Parameters specified for the National Curricula for Schools.

However, as will be explained in more detail further on, the actions of the PAISM are mainly in the form of Reproductive Health assistance and the implementation of the actions depends largely on the particular administrator. Although the National School Curriculum Policies have established the question of Sexual and Reproductive Health as cross-cutting themes, they have not guaranteed their effective insertion in the curricula themselves. Furthermore, their coverage is inevitably restricted to those youngsters actually attending schools. In 2007, the Special National Department of Policies for Women launched the Integrated Plan to Combat the Feminization of the Epidemic of AIDS and other STDs designed to be put into effect through a partnership arrangement with the National STD/AIDS Programme and the Technical Area for Women's Health. That Plan has not been duly implanted in Brazil as yet.

Brazilian legislation is very restrictive in regard to abortion and recently more conservative opinions have been gaining the upper hand in influencing public opinion on the issue. Whatever progress can be pointed to in policies directed at the sexual and reproductive health of women, the existing restrictions of the right to voluntarily interrupt a pregnancy is widely considered to be an important indication of negligence in regard to the sexual and reproductive health of women.

Another fact revealed is that although prevention is clearly affirmed in health policies it is still very much centralized on and directed towards the present tendencies of the AIDS epidemic and focuses primarily on the following social groups: Women, LGBTT people, Young people, PL, injecting drug users and rural populations. There is a need to broaden the outreach of prevention policies.

The policies currently in place are based on the principle of equality and fairness in getting access to pubic services but the services actually reveal very poor attention dispensed to adolescents, young people, Afro-descendants and LGBTT populations. Attention was particularly drawn to the great difficulties experienced by Transsexuals and Transvestites to gain access to services because of the lack of capacity building in the humanization of services for health staff. There is still a lot of prejudice and discrimination of Transvestites and Transsexual people.

9.1. ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes

NB: 20 answered YES, 04 answered NO, 02 gave no answer.

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

The National Health System, based on the fundamental principles of Equality and Universality, guarantees equal access of all segments of the population, including users of alcohol and other drugs, to all levels of assistance.

10. Does Brazil have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes

NB: 21 answered YES, 04 answered NO, 01 gave no answer.

Although there is legislation in place that specifically prohibits the requirement of HIV testing for employment purposes, there are still examples to be found of in the official documents regulating civil service entrance examinations where HIV testing is established as a pre-requisite for matriculation, as for example in the entrance exams for the Military College of Salvador and for the Uniformed Police Force of the State of Bahia.

11. Does Brazil have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes

NB: 26 answered YES.

11.1. ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

Yes

NB: 19 answered YES, 03 answered NO, 04 gave no answer.

IF YES, describe the approach and effectiveness of this review committee:

In Brazil Research Ethics Committees are regulated by a special National Commission on Ethics in research under the aegis of the National Health Council (Resolution 196) and that foresees the participation of representatives of service users on all ethics committees and without which the committees cannot exist.

12. Does Brazil have the following human rights monitoring and enforcement mechanisms?

- 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

NB: 20 answered YES, 04 answered NO, 02 did not know.

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment.

Yes

NB: 13 answered YES, 10 answered NO, 01 gave no answer, 02 did not know.

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

Yes

NB: 12 answered YES, 11 answered NO, 01 gave no answer, 02 did not know.

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

In Brazil there are many independent national institutions and networks that congregate People with and Living with HIV and AIDS such as the RNP+; Cidadãs posithivas (PositHIVe female citizens); Rede de jovens com HIV (Network of young people with HIV), AIDS NGOs and Forums and others.

There are national associations like the Brazilian Association of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals – ABGLT; the Brazilian Gay Association –ABRAGAY; the National Association of Transvestites – ANTRA; the Brazilian Lesbian League, and others.

There are also organizations of sex workers and they have set up the Brazilian Prostitutes Network.

In the case of drug users, there is the Brazilian Harm Reduction Association – ABORDA and Harm Reduction Network – REDUC both of which are active in the field of harm reduction and seek to influence national policies on drug use including the relations between drug use and HIV and AIDS.

There is also considerable organization of women's associations and networks in the national sphere increasingly addressing the question of the feminisation of the AIDS epidemic.

In most Brazilian states there are human rights committees. In terms of guaranteeing and monitoring human rights, the population can count on the Brazilian Law Association which has its own Human Rights committee and also on the office of the Public Prosecutor which also has a specific department to handle human rights issues. Other institutions mentioned were the UNGASS-AIDS Brazil Forum; and the monitoring of the PIDESC and the CEDAW.

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work?
Yes
NB (1): 15 answered YES, 06 answered NO, 04 gave no answer, 01 did not know.
NB (2): It must be stressed that such initiatives are occasional and restricted to actions undertaken by civil society and do not embrace the judiciary as whole. The discussion on the penalisation of HIV transmission now on the agenda of the Federal Supreme Court is just one example of the distortions and contradictions to be found among the judiciary and in the courts in regard to this issue.

14. **Are the following legal support services available in Brazil?**

- Legal aid systems for HIV casework.
Yes
NB: 21 answered YES, 03 answered NO, 01 gave no answer, 01 did not know.

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV.
Yes
NB (1): 16 answered YES, 08 answered NO, 01 gave no answer, 01 did not know.
NB (2): Only in a some states, among them Bahia.

- Programmes to educate, raise awareness among people living with HIV concerning their rights.
Yes
NB (1): 20 answered YES, 04 answered NO, 01 gave no answer, 01 did not know.
NB (2): Offered to alcohol and drug users by civil society organizations.

15. Are there programmes in place to reduce HIV-related stigma and discrimination?
Yes
NB: 20 answered YES, 06 answered NO.

IF YES, what types of programmes?

Media (14 answered YES, 11 answered NO, 01 gave no answer)	Yes
School Education (16 answered YES, 10 answered NO)	Yes
Personalities regularly speaking out (12 answered YES, 11 answered NO, 03 gave no answer)	Yes
Other: Human Rights for Civil Society and the Pragmatic Plans of agencies for international cooperation in HIV/AIDS and sexual and reproductive health; advocacy and political incidence activities.	Yes

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009?		
2009	Very poor	Excellent
	0 1 2 3 4 5 6 7 8 9 10	
Since 2007, what have been key achievements in this area: The organizations cited the following examples of progress: the creation of periodic communication media campaigns; the creation of the Health and Prevention in Schools Program. Another fact that was emphasized was the way the Brazilian Government involved various vulnerable segments like women, MSM, adolescents and drug users in the discussion of the plans to combat the epidemic.		

What are remaining challenges in this area?

The biggest challenge identified was to complete the implementation of the various programmes. The second was to enforce the abundant existing legislation concerning HIV and to optimize the use made of public and private financial resources to that end.

Other current challenges indicated by the organizations are related to the penalization of HIV transmission and to guaranteeing equality in public services. In spite of all the laws that guarantee that there shall be no discrimination in the workplace, putting them into effect is still a considerable challenge. The Office of the Public Prosecutor of the Labour Courts has experienced difficulty in ensuring the enforcement of those laws. Paradoxically the rights to welfare benefits/pensions/ sickness pay of People Living with HIV and AIDS have been restricted.

The organizations pointed to the creation and running of educational campaigns as being a step forward, however several challenges remain to be overcome in regard to the theme because eventual prevention campaigns in STDs and AIDS directed at young people run by the National STD, AIDS and Viral Hepatitis Department and by other state and municipal STD and AIDS programmes tend to be sporadic and occasional and furthermore, there is no regular evaluation scheme in place for such initiatives*. In addition, the continental dimensions of the country and the extensive cultural differences to be found all constitute important challenges for any educative actions in the national sphere and they must be taken into account. The organizations are convinced that such actions are of fundamental importance but they feel that every year the government is investing less in AIDS communication initiatives, and the states and municipalities, even less!

Another challenge identified was related to telephone services operated by government bodies and by non-governmental organizations offering sexual orientation to young women. They are not operational at weekends, on holidays or between the hours of 6 p.m. and 8 a.m. thereby limiting the possibility of accessing them.

The last great challenge identified was the creation of a National Harm Reduction Law for drug users as an effective state policy for that segment.

* Feres Wildney Contreras, UNIP/SP. Personal communication

Overall, how would you rate the *effort to enforce* the existing policies, laws and regulations in 2009?

2009	Very poor									Excellent
0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area:

The enactment of Law 12,008 dated July 2009, which gives priority to legal processes involving people living with HIV and AIDS and has a positive impact on the programmes providing legal advisory services and support crated by the organizations and networks of People Living with HIV and AIDS;

Other victories that the organizations cited were the implantation of free transport passes which has a positive impact on the question of treatment for seropositive people; access to formula milk for newborn babies and the setting up of a parliamentary front on STD and AIDS in the legislative branch.

The effort to put the decentralization of the health system into effect was also highlighted as an achievement. Finally some organizations referred to improvements in public health services especially in regard to the distribution of medicines which has improved visibly from last year to now; and also the implementation of the right of People Living with HIV and AIDS to receive Metacril in cases of lipodystrophy.

What are remaining challenges in this area?

One of the main challenges to overcome is to ensure that States and Municipalities fulfill their commitments to the agreements that were drawn up and another is to make sure that programmes and legislation are suitably tailored to address regional specificities.

Another issue concerns citizen participation because the organizations state that there is no broad participation of civil society in the execution of previously defined institutional programmes and that

undermines the governance that the organizations need, not only for delineating the actions but also for administering financial resources. Another aspect refers to the government programmes that are carried out by civil society organizations and programmes that have an interface with potentially violent situations, which should include safety and security guarantees and guarantee respect for labour rights. In many programmes the government does not provide for the payment of basic social security obligations and contributions thereby exposing the organizations to situations of vulnerability before the legal and fiscal authorities.

The question was also raised of the fundamental need for a broad debate on the question of the penalization of HIV transmission.

Another related aspect identified was that of guaranteeing equality in the public services because however many laws exist outlawing discrimination in the workplace, putting them into effect continues to be a serious challenge. Even the Office of the Public Prosecutor of the Labour Courts has experienced difficulty in ensuring the enforcement of those laws. The organizations stated that paradoxically, the rights to welfare benefits/pensions/sickness pay of People Living with HIV and AIDS have actually been restricted.

II. CIVIL SOCIETY PARTICIPATION*

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

1. To what extent 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:

By organizing State AIDS NGOs Forums, and national networks; by participating in social 'watchdog' bodies (municipal and state AIDS committees, municipal and state health committees and the National Health Council);and by taking part in the Consultative Committees of the National STD, AIDS and Viral Hepatitis Department (CAMS – *Comissão de Articulação com os Movimentos Sociais, Comissão Nacional de AIDS* – Committee for articulation with the Social Movements of the National AIDS Committee).

Organizations from the Northern region for example point out that most of the work in harm reduction is taken on by civil society and not government:

- Monitoring and participation in the activities of the Goals and Actions Plans (decentralization policy);
- The formulation of strategies at the National and Regional Meetings of AIDS NGO;
- The construction of the State, Regional and National Meetings of Networks of People living with HIV and AIDS for the purpose of formulating strategies to guarantee rights.

The participation of organizations in councils and committees and in the monitoring of International Pact commitments like, CEDAW, PIDESC, UNGASS.

One aspect that was brought up by the organizations was that whenever civil society is called on to participate in such events it makes a lot of proposals and observations but never manages to detect any reflection of them in the execution of the resultant policies, in the implementation of conference deliberations or the Multi-annual Plans.

Civil Society makes an effort to participate in the committees and councils formulating policies in various areas but there has not been enough capacity building done or structuring of the social movement itself to ensure that it can respond more pro-actively in those consultation processes.

2. To what extent 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 reviewing drafts)?

Low				*High*	
0	1	2	3	4	5

Comments and examples:

Organizations registered the participation of civil society in the construction of the Plan to Combat the AIDS Epidemic and in the public consultation processes.

It was also revealed that the social movements are given a hearing in regard to proposals, consultations and deliberations. Example: CNAIDS (National STD and AIDS Committee), and in CAMS and other spaces. However there has been no interlocution or call from the government to discuss the question of care for people who use alcohol and other drugs. The organizations also declare that do not know of any civil society participation in the definition of the budget for the Brazilian Strategic Plan on HIV and AIDS even though civil society participates in the health councils in the federal, state and municipal spheres. It should be stated that organizations stress that participation does not always mean that the issues raised by civil society are effectively taken into consideration at the moment of actually formulating the policies.

Finally the organizations draw attention to the fact that in the state and municipal spheres, the extent of civil society participation depends very much on the local administrator.

Under this heading it is worth highlighting one great problem of Tuberculosis/HIV co-infection (TB/HIV) is that the Tuberculosis Programme is a closed programme with very little civil society participation. Furthermore, while civil society is being actively encouraged to work with tuberculosis no funds are actually being made available for that purpose. The funds made available by the Global Fund itself are too limited for that kind of action. No financial resources have been allocated in the budget of the National Programme for Tuberculosis Control (PNCT) to be transferred to Civil Society Organizations that are actively working with the TB/HIV co-infection.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. the national AIDS strategy?

Low				*High*	
0	1	2	3	4	5

b. the national AIDS budget?

Low				*High*	
0	1	2	3	4	5

c. the national AIDS reports?

Low				*High*	
0	1	2	3	4	5

Comments and examples:

As mentioned in the response to question 7, part 1, the policy of decentralization implanted in the National Health System has resulted in insufficient investment at local level in actions directed at the most vulnerable populations. The National STD. AIDS and Viral Hepatitis Department still maintains calls for projects at the regional and national levels especially for network actions and events.

Over recent years there has been a considerable reduction in actions and funding for actions with certain specific populations like drug users, mainly due to lack of government support. Furthermore, civil society actions are not foreseen in the strategies or in the national reports and in regard to budgeting, there is no direct relation established between the NGOs and the funding sources.

Another aspect concerns the line of financing adopted for executing national budget allocations for the selection and financing of civil society projects in the field of HIV/AIDS prevention, care and support. Although they are correctly focussed on social networks, there is a clear tendency to prioritise some target segments to the detriment of others without any consultation of civil society and also to subject the Brazilian organizations to the will of the local offices of the North American agencies obliging them to form or belong to thematic/social networks for the purpose of executing the projects being funded;

The precepts embodied in the design of the funding structure for network projects presume that there is a certain homogeneity in regard to lines of action, political insertion and technical management capacity among the organizations and take little or no account of regional or local organisational specificities.

There is also a lack of sensitivity on the part of the private sector in regard to partnerships with the community sector.

The last time the National STD, AIDS and Viral Hepatitis Department issued a call for projects to finance the formation of networks or strengthening of existing ones, the process failed on both counts and in fact was actually instrumental in weakening certain existing entities.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

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

c. in the M&E efforts at local level?

Comments and examples:

In the Federal sphere, participation is at an advanced level. At the level of local (State and Municipal) coordinating bodies however, the situation is far from ideal with very little participation in monitoring and evaluation of the Goals and Actions Plans undertaken by the Health Councils or by STD/AIDS coordinating bodies.

The structure of civil society organizations does not enable them to maintain permanent activities.

In the local context, at both state and municipal levels, there are no monitoring policies in place. Accordingly, civil society participation is limited to the technical opinion issued by State Health Councils on the State Goals and Actions Plans. In the rare spaces where monitoring and evaluation actually takes place, government bodies rarely respect civil society proposals.

Civil society works alongside the councils and committees and makes strenuous efforts to evaluate the public policies in force but there is no qualitative data available on which to base any evaluation or with which to monitor the impact of local policies on the fight against the epidemic.

Monitoring and Evaluation is still a challenge for Civil Society and the Government sector. Although there is now widespread acknowledgement of how important they are, very few actions are actually implemented in partnership arrangements with Civil Society.

The State has several data gathering systems in place to enable it to monitor its own actions. Some of the systems are not mutually compatible and they have different outreaches and periodicities of collection. That makes the work of Civil Society more difficult insofar as it cannot obtain and properly analyse the

information that would enable it to suggest more effective actions for combating the epidemic to local administrators. There is a need for government to make a sustained effort to provide more support to civil society to enable, to improve its performance in exercising social control and to improve its contribution in existing spaces formally reserved for community participation especially, on the municipal, state and national health councils.

The irregular transferral (only 10%) of financial resources destined for civil society in the state and municipal STD and AIDS Goals and Actions Plans or in the calls for projects issued by the National STD, AIDS and Viral Hepatitis Department have created a huge gap in the actions carried out, because without that transferral of funds, civil society organizations do not have the means to carry out their activities.

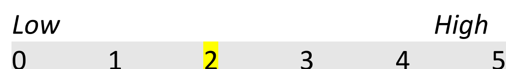
5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Comments and examples:
There are several committees in the federal sphere that concentrate the efforts to combat the epidemic and that count on the participation of civil society in all its diversity. At local (State and Municipal) levels however, such participation varies according to local government policies and in many cases those polices actually impede Civil Society participation.

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

b. adequate technical support to implement its HIV activities?



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

Prevention for youth	<25%		
Prevention for most-at-risk populations			
- IDU	<25%		
- MSM		25-50%	
- Sex workers		25-50%	
Resting and counselling	<25%		
Reduction of stigma and discrimination			>75%
Clinical Services (ART/OI)*	<25%		
Home-based care	<25%		
Programme for OVC**	<25%		

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

NB: Persons affected by the co-infection TB/HIV ought to be included in this item as they are also highly vulnerable.

Overall, how would you rate the efforts to increase *civil society participation* in 2009?			
2009	Very poor		Excellent
	0 1 2 3 4 5 6 7 8 9 10		

Since 2007, what have been key achievements in this area?
Participation in public consultations, in the discussions of plans to combat AIDS associated to specific vulnerable segments.

Actually civil society has made an effort to occupy the spaces available to it to participate in the exercise of social control. However, there has been no significant progress at the local level and that includes the aspect of adequate financing for civil society actions.

There is a proposal to increase the participation of the People Living with HIV and AIDS movement in 2010. It is expected that the women's and young people's movements will be included as well as the National Network of People living with HIV/AIDS.

What are remaining challenges in this area?
The lack of new leadership and also the fact that the existing spaces for social participation and control are merely consultative and do not necessarily absorb and/or incorporate the contributions offered by Civil Society. There needs to be progression towards a situation where the actual decision making becomes democratic and takes into account the wishes of both government and civil society.

The political qualification of Civil Society leaderships.

Another challenge identified is the funding of actions designed to provide civil society with the technical qualification needed to implement its activities. Organizations stressed that civil society actions are not intended to substitute those services that are the obligation of the state.

Lines of financing for civil society actions are constantly interrupted; they need to be more constant and less hampered by red tape.

The last monitoring process conducted by members of the CAM revealed that most of the States are over one year behind in passing over to Civil Society organization the 10% foreseen in the Goals and Actions Plan. There are some states where the delay is already over three years. There are others where the process is intensely bureaucratic: in the state of Goiás, state legislation requires that any agreement entered on, however small, must be submitted for the approval of the state legislative body and that makes the transferral of resources to NGOs extremely difficult.

III. PREVENTION

1. Has Brazil identified the specific needs for HIV prevention programmes?
Yes
NB: 20 answered YES, 04 answered NO, 02 gave no answer.

IF YES, how were these specific needs determined?
The National Plan to Combat the Epidemic of AIDS and STDs among Gays, MSM and Transvestites and the Integrated Plant to Combat the Feminisation (women and female transsexuals) of the Epidemic of AIDS and other STDs were constructed on the basis of a survey of demands carried out among the services and the social movements.

The organizations identified many necessities that in spite of being rated and awarded points, have not in fact been addressed satisfactorily, namely:

- In practice the results of the plans and policies have not been entirely satisfactory especially in the frontier areas of the Amazon.
- There are units in some municipalities implementing adolescent health programmes but that is not yet a national programmatic directive. Such programmes, when they do exist are mostly directed at the prevention of teenage pregnancies and/or the accompaniment of pregnant adolescents; there are no

specific counselling services for young women and girls in the primary health care units and the insertion of that activity in daily health care routines is still very precarious and largely dependant on the availability and/or personal interest of individuals health staff members.

- In cases of forced, non-consensual sex, emergency anti-conception and anti-HIV prophylactic services are available. However the numbers of women accessing the service are very small and government has made no special effort to extend service coverage or to make it widely known.

In 2007 the National STD, AIDS and Viral Hepatitis Department in a partnership arrangement with the Technical Area for Women's Health of the Ministry of Health elaborated the Operational Plan for Reducing Mother-to child Transmission of HIV and Syphilis*, with a view to expanding the offer of HIV and Syphilis testing for pregnant women and the provision of adequate treatment for positive cases, because although there been a continuous and consistent reduction in the numbers of cases of vertical HIV transmission and a reduction of congenital syphilis cases since 2005, the coverage of the respective actions is still not sufficient and varies considerably from region to region. In some services the staff administers the test but do not provide counselling for partners or contact them in an adequate manner. There is no control over counselling and testing in the private medical services although notification of cases of HIV and Syphilis infection is mandatory**. The fast test for HIV is done at the moment of birth if the pregnant woman is unaware of her serological status and it is available in the maternity wards and clinics of the Brazilian National health System. However there still some faults in the way the test is conducted with women in labour***.

The most urgent need for increased attention to that aspect is in the Northern Region due to its vast area and the added complication of frontier situations, and also due to the low coverage of State-level programmes in the region and that goes for all segments of the population.

* Brazil, Ministry of Health, Operational Plan for the Reduction of Mother –to-Child Transmission of HIV and Syphilis. Ministry of Health, Health Surveillance Division, National STD and AIDS Programme, Brasília, 2007.
** Edict 05 dated 21/02/2006, published in the Official Gazette of the Federal Union on 22/02/2006.
*** Monitoring the UNGASS-AIDS Goals on Women's Sexual and Reproductive Health: UNGASS-AIDS Forum/Wilza Vilela, Alessandra Cabral dos Santos Nilo, José Carlos Pereira da Silva. Recife: Gestos, 2008.

IF NO, how are HIV prevention programmes being scaled up?
Government strategies to combat the epidemic have still not managed to meet the demands and necessities due to several factors, especially the difficulty of ensuring and legitimising the participation of organised civil society and the target populations in fostering, executing and monitoring the respective policies.

There is a need to make more intensive use of the media in regard to tuberculosis prevention and treatment because currently TB/HIV co-infection is a major problem for People Living with HIV and AIDS.

1.1. To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**	
Blood safety (21 agreed, 02 disagreed, 02 gave no answer, 01 N/A)	Agree	
Universal precautions in health care settings (18 agreed, 06 disagreed, 02 gave no answer)	Agree	
Prevention of mother-to-child transmission of HIV (17 agreed, 06 disagreed, 02 gave no answer, 01 N/A)	Agree	
IEC* on risk reduction (12 agreed, 12 disagreed, 02 gave no answer)	Agree	Don't agree
IEC* on stigma and discrimination reduction (15 concordaram, 09 disagreed, 02 gave no answer)	Agree	
Condom promotion (19 agreed, 04 disagreed, 03 gave no answer)	Agree	
HIV testing and counselling (16 agreed, 07 disagreed, 02 gave no answer, 01 N/A)	Agree	
Harm reduction for injecting drug users (14 agreed, 10 disagreed, 02 gave no answer)	Agree	

Risk reduction for men who have sex with men (17 agreed, 07 disagreed, 02 gave no answer)	Agree	
Risk reduction for sex workers (18 agreed, 05 disagreed, 02 gave no answer, 01 N/A)	Agree	
Reproductive health services including sexually transmitted infections prevention and treatment (12 agreed, 12 disagreed, 02 gave no answer)	Agree	Don't agree
School-based HIV education for young people (11 agreed, 13 disagreed, 02 gave no answer)		Don't agree
HIV for out-of-school young people (08 agreed, 14 disagreed, 04 gave no answer)		Don't agree
HIV prevention in the workplace (09 agreed, 14 disagreed, 02 gave no answer, 01 N/A)		Don't agree
Other: Prevention of TB/HIV/AIDS Co-infection		Don't agree

**IEC = information, education and communication.*

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

2007	Very poor										Excellent
	0	1	2	3	4	**5**	6	7	8	9	10

Since 2007, what have been key achievements in this area?

The expansion of the *Fique Sabendo* (You Gotta Know) campaign; greater availability of fast testing; a survey of Awareness, Attitudes and Practices among most at risk populations; actions directed at implementing the National Plan for Combating the AIDS and STD Epidemic among Gays, MSM and Transvestites and the Integrated Plant to Combat the Feminization (women and female transsexuals) of the Epidemic of AIDS and other STDs; the setting up of the condom manufacturing plant in the state of Acre; the hiring of young people living with HIV and AIDS by state coordinating bodies for HIV and AIDS; and lastly, the creation of an understanding that actions directed at Hepatitis/TB and HIV/AIDS should be unfolded together.

What are remaining challenges in this area?

The organizations identified the following challenges: the need for the permanent campaigns to adapt to the realities of the Brazilian regions and use language that people can readily understand. There is also a need to create new services to overcome the enormous distance-related difficulties typical of certain regions of Brazil like the North and Northeast.

Another challenge mentioned was that in spite of the existence of specific Plans for women and MSM, prevention policies for those populations have not been satisfactorily implemented and have failed to make adequate responses to the epidemic among those populations.

In regard to young people, strategies for inserting the Health and Prevention in Schools Project in the Health in Schools programme are a challenge.

Another challenge identified was the need to overcome the idea that prevention policy must necessarily be concentrated on the positive prevention policy alone. It was also felt that it is essential to foster government programmes that meet the needs of excluded people or those that are not contemplated by other federal or state government policies like young people outside the regular school system, street dwellers, prisoners and others.

The implementation of governmental prevention programmes should not be restricted to making condoms available (with no regularity) or transferring (insufficient) financial resources to NGOs.

There is also a need to integrate other segments like afro-religious populations that have an important cultural bearing on this context and need to be supported by public policies.

Lastly, the challenge of Brazil's great cultural diversity, which impedes the adoption of homogeneous national measures to address stigma reduction and confront macho cultural attitudes that are more evident in some regions than others.

IV. TREATMENT, CARE AND SUPPORT

1. Has Brazil identified the specific needs for HIV treatment, care and support services?

Yes

NB: 19 answered YES, 03 answered NO, 03 gave no answer, 01 did not know.

IF YES, how were these specific needs determined?

Although most organizations answered 'Yes' they also stated that there is still insufficient assistance and care in the specialised services units (*Serviço de Atendimento Especializad* - SAE), the Anonymous Testing Centres (*Centro de Testagem Anônima* - CTA) , the Psycho-social Support Centres (*Centros de Apoio Psicosocial*- CAPS) , the Psycho-social Support Centres for Alcohol and Drugs (*Centro de Apoio Psicosocial para Álcool e Drogas* – CAPS/AD) especially in regard to users of alcohol and other drugs, that is, the policies for specific populations depend on local actions in the state and municipal spheres.

However the process for identifying needs and demands was conducted among People Living with HIV and AIDS and produced actions on the part of organised civil society which pressured the government bodies in all three branches of power, executive, legislative and Justice, to guarantee and enforce the Fundamental Rights of that population.

Furthermore, although there are programmes that seek to address those needs, civil society can still detect the need for a gender perspective in most of the clinical trials with anti-HIV/AIDS medicines in Brazil that would make it possible to compare the effects of medicines in men and women. There is no formal stimulus for that kind of study or for the participation of women in the trials. There also no studies on the side-effects of antiretroviral medicines on women that would provide supporting information for a surveillance system, which is a longstanding demand of the female population living with HIV and AIDS.

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

HIV treatment, care and support service	**The majority of people in need have access**	
ARV Therapy	Agree	
Nutritional care		Don't agree
Paediatric AIDS treatment	Agree	
Sexually transmitted infection management	Agree	
Psychosocial support for people living with HIV and their families		Don't agree
Home-based care		Don't agree
Palliative care and treatment of common HIV-related infections	Agree	
HIV testing and counselling for TB patients		Don't agree
TB screening for HIV-infected people		Don't agree
TB preventive therapy for HIV-infected people		Don't agree
TB infection control in HIV treatment and care facilities		Don't agree
Cotrimoxazole prophylaxis in HIV-infected people		Don't agree
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)		Don't agree
HIV treatment services in the workplace or treatment referral systems through the workplace		Don't agree
HIV care and support in the workplace (including alternative working arrangements)		Don't agree

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 **6** 7 8 9 10
Since 2007, what have been key achievements in this area: The main advances identified by the organizations is the joint (government and civil society) construction of the state-level plans for combating the epidemic together with gays, MSM, transvestites women and female transsexuals, based on the two respective national plans; the guaranteeing of universal access to ARV therapy and the increased incidence of fast testing. *What are remaining challenges in this area:* The implementation of the Plans mentioned above, especially in regard to users of alcohol and other drugs, and guaranteeing universality and access for all. Guaranteeing the Right to Health without the need to take legal action to force the state to fulfil its statutory obligations. An example of such situations is that of People Living with HIV and AIDS who need to undergo medical procedures associated to serious cases of lipodystrophy. Even when there are budget provisions for such procedures to be carried out, there is no political will to guarantee access to the treatment. Overcome the insufficient qualification of health staff for conducting the treatment of people living with HIV/AIDS and other vulnerable populations especially in municipalities in predominantly rural areas far from big urban centres; implement a policy for humanizing the handling of patients, that is, put into effect the policy of humanization of the services as part of a policy for respecting Human Rights. Foster a policy of Integral Health Care for children and adolescents living with HIV/AIDS that breaks with the traditional logic of guardianship and mere assistance policies. In regard to the vulnerability of women, it must be remembered that there is a lack of specific studies for them especially those related to the aspects of health, poverty and social support. It must also be stressed that although there are laws to protect workers with HIV in general, they are not always respected or called into play and that is particularly true in the case of women with HIV who often work as domestic help without any legal protection from the labour laws and precarious, non-formal work contracts. There are frequent denunciations of women with HIV being discriminated and excluded from the labour market, although there is no formal documentation of the fact. Those NGOs that have, or offer legal assistance services to people living with HIV and AIDS report that men seek to redress their rights violated by discrimination because of their seropositive status much more than women do.

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

No

NB: 05 answered YES, 17 answered NO, 02 gave no answer, 02 N/A

Overall, how would you rate the efforts to *meet the HIV-related needs* of orphans and other vulnerable children in 2009?
2009 Very poor Excellent
0 1 2 **3** 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: None were identified. *What are remaining challenges in this area:* To reach out to all infected children and provide total support; to create effective policies for AIDS orphans; to ensure universality and total access; to establish policies aimed at children and adolescents living with HIV/AIDS that stimulate their autonomy and to work in consonance with the doctrine of integral protection and affirmation of these children and adolescents as subjects endowed with rights; to invest in strategies that foster and strengthen family skills and responsibilities; to consolidate the implementation of inter-sector HIV/AIDS policies for this population.

APPENDIX III - INDICATORS 3 to 25

3. Percentage of donated blood units screened for HIV in a quality-assured manner.

3.1. Purpose:
To assess progress in screening of blood donations in a quality-assured manner.

3.2. Analysis:
In 2007, 3,898,398 blood units were screened for HIV. This figure refers to the National Blood Bank Network (*Hemorrede Pública Nacional*), the non-profit and private services subcontracted by the National Health System (NHS) and all completely private services. 100% of blood donated on national territory is screened and undergoes internal and external laboratory quality control, in accordance with the National Health Surveillance Agency regulations.
In Brazil, the public haemotherapy services account for 50% of collected blood, followed by National Health System (*Sistema Único de Saúde – SUS*) subcontracted services (28%) and completely private services (14%).

3.3. Data Sources:

- BRASIL. Ministério da Saúde. *Caderno de informação: sangue e hemoderivados: produção hemoterápica: Sistema Único de Saúde – SUS (serviços públicos e privados contratados) e serviços privados não contratados ao SUS/Ministério da Saúde.* Brasília, 2009. Electronic resource.
- Related legislation is available at: <http://e-legis.anvisa.gov.br/leisref/public/showAct.php?mode=PRINT_VERSION&id=11662>

4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.

4.1. Purpose:
To assess progress towards promoting access to antiretroviral combination therapy estimating the percentage of people who need and take ARV, according to criteria established in the Ministry of Health's antiretroviral therapy recommendations.

4.2. Analysis:
In 2008, around 96% of adults and children with advanced HIV infection received antiretroviral therapy, in accordance with the criteria established by the Ministry of Health's treatment recommendations.

Notes:
1. Patients with advanced infection were considered to be those who were either receiving antiretroviral therapy, or who had symptoms compatible with AIDS, or whose last CD4 count on the Laboratory Control Information System in 2008 was below 200 cells/mm^3.
2. 13,598 patients were excluded from the analysis, in relation to whom no information regarding sex or age group was recorded on the system.
3. The data reported in this section differs to that reported in Appendix 2 of the report entitled "Towards universal access: scaling up priority HIV/AIDS interventions in the health sector", published by WHO/UNAIDS/UNICEF, in September 2009, since the calculation method has been modified.

4.3. Data Sources:

- Linkage of the following databases: *SINAN/AIDS* + *SISCEL/SICLOM* +*SIM*, where: *SINAN: Sistema de Informações de Agravos de Notificação* (Notifiable Diseases Information System); *SISCEL: Sistema de Controle de Exames Laboratoriais* (Laboratory Tests Control System); *SICLOM: Sistema de Controle Logístico de Medicamentos* (Medication Logistics Control System); and *SIM: Sistema de Informações de Mortalidade* (Mortality Information System).

5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.

5.1. Purpose:
To assess progress in preventing mother-to-child transmission of HIV.

5.2. Analysis:
50.5% of HIV-positive pregnant and parturient women received antiretroviral medicines to reduce the risk of mother-to-child transmission in 2009. Between 2003 and 2006, the number of HIV-positive parturient women who received AZT injections during childbirth was reported. The percentage varied from 46.6% in 2003 to 51.9% in 2006.

5.3. Method of Measurement:
Numerator: Number of HIV-positive parturient women receiving antiretroviral medicines (*Sistema de Controle Logístico de Medicamentos – SICLOM* [Medication Logistics Control System])
Denominator: Estimated number of HIV-positive parturient women = Estimated HIV prevalence in women (SZWARCWALD et al., 2008) X Number of parturient women (*Sistem de Informações de Nascidos Vivos – SINASC* [Live Births Information System]).

5.4. Comments:
With the aim of scaling up actions to reduce mother-to-child HIV transmission, including increasing the coverage of injectable AZT for HIV-positive parturient women, the Ministry of Health has been implementing access to rapid testing for HIV diagnosis in the health service network throughout the country.
Moreover, the “Operational Plan to Reduce Mother-to-Child HIV and Syphilis Transmission” was launched in October 2007. The Plan sets goals for the reduction of mother-to-child transmission in all the country’s regions by 2011, in addition to other activities for which each of the three government levels are responsible.

5.5. Data Sources:
- *SINASC*
- *SICLOM*
- SZWARCWALD, C. L.; BARBOSA JR., A.; SOUZA JR., P. B. et al. HIV testing during pregnancy: use of secondary data to estimate 2006 test coverage and soroprevalence in Brazil. *Braz. j. infect. dis*. [S.l.]; v. 12, n. 3, p. 167-72, 2008.

6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.

6.1. Purpose:
To assess progress in detecting and treating TB in people living with o HIV.

6.2. Analysis:
The percentage of estimated HIV and TB co-infection cases receiving TB and HIV treatment was estimated to be 25.64% in 2007.

6.3. Method of Measurement:
Numerator:
Linkage of the following databases: *SINAN/AIDS* + *SIM-AIDS* + *SISCEL* + *SICLOM* + *SINAN/TB*
Denominator: WHO estimates

Notes:
1. Linkage of the following databases: SINAN/AIDS + SISCEL/SICLOM +SIM
2. Linkage of the database containing identified AIDS cases receiving antiretroviral treatment in 2007 with the SINAN/TB database, in order to identify those who began TB treatment in 2007.

6.4. Limitations:

a) The numerator was calculated, in the year reported, as being the number of adults with advanced HIV infection receiving antiretroviral treatment in accordance with the technical recommendations established by the Ministry of Health's STD, AIDS Viral Hepatitis Department, who began TB treatment in accordance with the MoH's National Tuberculosis Programme's recommendations.
b) The denominator includes incident TB cases in people living with HIV (and not just AIDS cases), which underestimates coverage.

6.5. Data Sources:

- Linkage of the following databases: *SINAN/AIDS + SISCEL/SICLOM +SIM*

7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.

7.1. Purpose:
To assess progress in implementing HIV testing and counselling.

7.2. Analysis:
Almost 13% of the Brazilian population aged 15-49 had an HIV test in the last 12 months and knew the results of their most recent test.

7.3. Method of Measurement:
Household survey representative of the Brazilian population, involving a sample of 8,000 individuals aged 15-64. The sample was probabilistic, stratified by geographical macro region (North, North-East, South-East, South and Midwest) and household location (urban/rural).
Study undertaken by the STD, AIDS and Viral Hepatitis Department.

Note:
The indicator was calculated based on the sample of people aged 15-49, totaling 6,751 of the 8,000 people interviewed.

7.4. Limitation:
As the estimates as based on samples, they are subject to sampling errors.

7.5. Data Sources:

- 2008 Study of the Knowledge, Attitudes and Practices of the Brazilian Population aged 15-64 (KAP Study).

8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.

8.1. Purpose:
To assess progress in implementing HIV testing and counselling among most-at-risk populations

Sex Workers
1. Analysis:
17.5% of female sex workers tested for HIV in the last 12 months and knew the results of their most recent test.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of female sex workers in Brazil as a whole.
b) Only female sex workers were included in the study.

3. Data Sources:

- SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Men who have Sex with Men (MSM)

1. Analysis:

Around 19% of MSM tested for HIV in the last 12 months and knew the result of their most recent test.

2. Limitations:

Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of MSM in Brazil as a whole.

3. Data Sources:

- KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Injecting drug users

1. Analysis:

Approximately 13% of drug users tested for HIV in the last 12 months and knew their result.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.

3. Data Sources:

- BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros* (Study funded by the STD, AIDS and Viral Hepatitis Department).

9. Percentage of most-at-risk populations reached with HIV prevention programmes.

9.1. Purpose:

To assess progress in implementing HIV prevention programmes for most-at-risk populations.

Sex workers

1. Analysis:

In 2009, 57% of female sex workers knew where they could get free HIV testing and 77.2% received free of charge condoms in the last 12 months.

Approximately 47% of these women were reached by prevention programmes, i.e., they knew where to get free testing and received condoms free of charge.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of female sex workers in Brazil as a whole.

b) Only female sex workers were included in the study.
c) The interviewees were asked if they knew where to get free testing, which may have influenced their replies, since they may have known where to test privately. This may have underestimated coverage.

3. Data Sources:

- SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Men who have Sex with Men (MSM)

1. Analysis:
In 2009, 47.3% of MSM knew where they could get free HIV testing and 72.4% received free of charge condoms in the last 12 months. Approximately 37.4% of them were reached by prevention programmes, i.e., they knew where to get free testing and received condoms free of charge.

2. Limitations:
Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of MSM in Brazil as a whole.

3. Data Sources:

- KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Injecting drug users

1. Analysis:
In 2009, 48.6% of illicit drug users knew where they could get free HIV testing and 28.6% received free of charge condoms in the last 12 months. Approximately 40% of them were reached by prevention programmes, i.e., they knew where to get free testing and received condoms free of charge.
Specifically in relation to IDU, 54.3% stated that they had not shared syringes in the last 12 months.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.
c) The interviewees were asked if they knew where to get free testing, which may have influenced their replies, since they may have known where to test privately. This may have underestimated coverage.
d) As the indicator was calculated for illicit drug users, only the answers to questions 1 and 2 were taken into consideration. Question 3 could not be taken into consideration because only IDU answered it and there was not a sufficient number of IDU in the sample to enable this estimate to be made.

3. Data Sources:

- BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros* (Study funded by the STD, AIDS and Viral Hepatitis Department).

10. Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.

10.1. Purpose:
To assess progress in providing support to households that are caring for orphaned and vulnerable children aged 0–17.

10.2. Analysis:
As the Brazilian epidemic is concentrated, no information on this indicator is available.

11. Percentage of schools that provided life skills-based HIV education in the last academic year.

11.1. Purpose:
To assess progress towards implementation of life-skills based HIV education in all schools.

11.2. Analysis:
In 2007, 63% of the Brazilian basic education establishments that undertook health promotion and prevention activities also incorporated the specific issue of STD and AIDS. This percentage was higher than the 60.4% observed in 2005. Considering only elementary education establishments, the percentage increased from 67.8% in 2005 to 72.7% in 2007; whilst in high schools it increased from 96.2% to 97.5% in the same period.

11.3. Limitations:
The filling in of this additional page of the School Census is optional and the number of establishments that filled it in varied considerably in the years considered, from 161,679 in 2005 to 122,491 in 2007.

11.4. Data Sources:
- Analysis of the Health element of the 2005 and 2007 School Census.

KNOWLEDGE AND BEHAVIOUR

12. Current school attendance among orphans and non-orphans aged 10-14.

12.1. Purpose:
To assess progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans.

12.2. Analysis:
As the Brazilian epidemic is concentrated, no information on this indicator is available.

13. Percentage of young 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.

13.1. Purpose:
To assess progress towards universal knowledge of the essential facts about HIV transmission.

13.2. Analysis:
In 2008, 51.7% of young people aged 15-24 correctly identified the ways of protecting themselves from the sexual transmission of HIV and rejected major misconceptions. There is a reduction in this indicator when compared to the 2004 estimate (58.4%).

13.3. Method of Measurement:
Household survey of the Brazilian population, involving a sample of 8,000 individuals aged 15-64. The sample was probabilistic, stratified by geographical macro region (North, North-East, South-East, South and Midwest) and household location (urban/rural).
Study undertaken by the STD, AIDS and Viral Hepatitis Department.

Note:
The indicator was calculated using the sample of young people aged 15-24, totaling 2,485 of the 8,000 people interviewed.

13.4. Limitations:
As the estimates as based on samples, they are subject to sampling errors.

13.5. Data Sources:
- 2008 Study of the Knowledge, Attitudes and Practices of the Brazilian Population aged 15-64.

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.

14.1. Purpose:
To assess progress in building knowledge of the essential facts about HIV transmission among most-at-risk populations.

Sex workers
1. Analysis:
In 2009, 42.3% of female sex workers correctly identified the ways of protecting themselves from the sexual transmission of HIV and rejected major misconceptions. Almost 98% of them agreed that condoms reduce HIV infection; 92.5% agreed that a healthy looking person may be infected; 77.3% agreed that it is not possible to get infected by sharing cutlery. On the other hand, only half the female sex workers agreed that they could not be infected by mosquito bites.

2. Limitations:
a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of female sex workers in Brazil as a whole.
b) Only female sex workers were included in the study.
c) Only 4 questions were taken into consideration, instead of the 5 of the original indicator, as the questionnaire did not include the question: “Can the risk of the transmission of the AIDS virus be reduced by only having sexual intercourse with an uninfected partner?”

3. Data Sources:
- SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Men who have Sex with Men (MSM)
1. Analysis:
In 2009, 62.3% of MSM correctly identified the ways of protecting themselves from the sexual transmission of HIV and rejected major misconceptions; 72% agreed that having sexual intercourse with only one faithful

and uninfected partner reduces the risk of HIV infection; 97.2% agreed that condoms reduce the risk of infection; 92.2% agreed that a healthy looking person may be infected; 72.7% agreed that they cannot be infected by mosquito bites; and 83.8% agreed that it is not possible to get infected by sharing cutlery.

2. Limitations:
Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of MSM in Brazil as a whole.

3. Data Sources:

- KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Injecting drug users (UDI)
1. Analysis:
In 2009, 31.7% of illicit drug users correctly identified the ways of protecting themselves from the sexual transmission of HIV and rejected major misconceptions. Almost 92% agreed that condoms reduce HIV infection and 83% agreed that a healthy looking person may be infected. On the other hand, only 44.3% agreed that they cannot be infected by mosquito bites and 55.7% agreed that it is not possible to get infected by sharing cutlery.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.

3. Data Sources:

- BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros* (Study funded by the STD, AIDS and Viral Hepatitis Department).

15. Percentage of young women and men who have had sexual intercourse before the age of 15.

15.1. Purpose:
To assess progress in increasing the age at which young women and men aged 15–24 first have sex.

15.2. Analysis:
In 2008, 35.4% of young Brazilians aged 15-24 reported having sexual intercourse before the age of 15, this percentage being similar to that found in 2004 (36.1%).

15.3. Method of Measurement:
Household survey of the Brazilian population, involving a sample of 8,000 individuals aged 15-64. The sample was probabilistic, stratified by geographical macro region (North, North-East, South-East, South and Midwest) and household location (urban/rural) - Study undertaken by the STD, AIDS and Viral Hepatitis Department.

Note:
The indicator was calculated using the sample of young people aged 15-24, totaling 2,485 of the 8,000 interviewed.

15.4. Limitations:
As the estimates as based on samples, they are subject to sampling errors.

15.5. Data Sources:

- 2008 Study of the Knowledge, Attitudes and Practices of the Brazilian Population aged 15-64.

16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.

16.1. Purpose:
To assess progress in reducing the percentage of people who have higher-risk sex.

16.2. Analysis:
In 2008, 66.1% of people aged 15-49 stated that they had had sexual intercourse with more than one partner in their entire life.

16.3. Method of Measurement:
Household survey of the Brazilian population, involving a sample of 8,000 individuals aged 15-64. The sample was probabilistic, stratified by geographical macro region (North, North-East, South-East, South and Midwest) and household location (urban/rural) - Study undertaken by the STD, AIDS and Viral Hepatitis Department.

Note:
The indicator was calculated based on the sample of sexually active individuals aged 15-49, totaling 5,919 of the 8,000 interviewed.

16.4. Limitations:

a) Instead of reporting the percentage of men and women aged 15-49 who had sexual intercourse in the last 12 months with more than one partner, the percentage of men and women aged 15-49 who had sexual intercourse with more than one partner in their entire life is reported here.
b) As the estimates as based on samples, they are subject to sampling errors.

16.5. Data Sources:

- 2008 Study of the Knowledge, Attitudes and Practices of the Brazilian Population aged 15-64.

17. Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last sexual intercourse.

17.1. Purpose:
To assess progress towards preventing exposure to HIV through unprotected sex with non-regular partners.

17.2. Analysis:
39.2% of people aged 15-49 who had sexual intercourse with more than one partner in their entire life reported the use of a condom during their last intercourse.

17.3. Method of Measurement:
Household survey of the Brazilian population, involving a sample of 8,000 individuals aged 15-64. The sample was probabilistic, stratified by geographical macro region (North, North-East, South-East, South and Midwest) and household location (urban/rural) - Study undertaken by the STD, AIDS and Viral Hepatitis Department.

Note:
The indicator was calculated based on the sample of sexually active individuals aged 15-49, totaling 3,556 individuals.

17.4. Limitations:

a) Instead of reporting the percentage of men and women aged 15-49 who had sexual intercourse in the last 12 months with more than one partner, the percentage of men and women aged 15-49 who had sexual intercourse with more than one partner in their entire life is reported here.

b) As the estimates as based on samples, they are subject to sampling errors.

17.5. Data Sources:

- 2008 Study of the Knowledge, Attitudes and Practices of the Brazilian Population aged 15-64.

18. Percentage of female and male sex workers reporting the use of a condom with their most recent client.

18.1. Purpose:
To assess progress in preventing exposure to HIV among sex workers through unprotected sex with clients.

18.2. Analysis:
90.1% of female sex workers reported the use of a condom with their most recent client.

18.3. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of female sex workers in Brazil as a whole.

b) Only female sex workers were included in the study.

18.4. Data Sources:

- SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil* (Study funded by the STD, AIDS and Viral Hepatitis Department).

19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

19.1. Purpose:
To assess progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.

19.2. Analysis:
48.3% of MSM reported the use of the condom the last time they had anal sex with a casual partner, in the last 12 months.

Note:
The indicator was calculated based on the 1,339 MSM who had sexual intercourse with a casual sex partner of the same sex, out of the 3,617 in the sample.

19.3. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of MSM in Brazil as a whole.

b) The indicator refers to condom use in the last sexual intercourse with a casual partner.

19.4. Data Sources:

- KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras* (Study funded by the STD, AIDS and Viral Hepatitis Department).

20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.

20.1. Purpose:
To assess progress in preventing sexual transmission of HIV.

20.2. Analysis:
70.1% of drug users reporting using a condom the last time they had sexual intercourse with a casual partner in the last 12 months.

20.3. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.
c) The indicator refers to condom use in the last sexual intercourse with a casual partner.

20.4. Data Sources:

- BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros* (Study funded by the STD, AIDS and Viral Hepatitis Department).

21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.

21.1. Purpose:
To assess progress in preventing injecting drug use-associated HIV transmission.

21.2. Analysis:
54.3% of IDU reported that in the last 12 months they had not injected drugs with a syringe/needle already used by someone else.

Note:
418 IDU were considered out of the 3,486 drug users in the sample.

21.3. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.
c) As the questionnaire did not include the question about the last time the interviewee injected drugs, the indicator below is based on the percentage of answers "NEVER" to the question: "In the last 12 months, how often did you inject yourself with a syringe/needle already used by someone else?"

21.4. Data Sources:

- BASTOS, F. I. *Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros* (Study funded by the STD, AIDS and Viral Hepatitis Department).

IMPACT

22. Percentage of young women and men aged 15-24 who are HIV infected.

22.1. Purpose:
To assess progress towards reducing HIV infection.

Men
1. Analysis:
HIV prevalence in young men aged 17-20 increased from 0.088% in 2002 to 0.12% in 2007.

2. Method of Measurement:
The study is a cross sectional one, undertaken with young men aged 17-20, reporting to the Compulsory Military Service Selection Committees (SC) in 2007. Sampling was stratified, in two stages. The selection committees were chosen in the first stage, and the conscripts were chosen in the second stage. The strata were defined according to the region in which the SC were located (North, North-East, South-East, South and Midwest) and the size of the municipality in which the SC were located (less than 50 thousand inhabitants; between 50 and 200 thousand inhabitants; more than 200 thousand inhabitants). At least one SC in each state capital was selected. For operational reasons, it was stipulated that the total number of SC in the sample would be 80. A total of 35,460 conscripts were tested for HIV.

3. Limitations:
The HIV prevalence informed for males refers to conscripts aged 17-20 and not to young people of both sexes aged 15-24.

4. Data Sources:
- SZWARCWALD, C. L. et al. *Práticas de risco relacionadas à infecção pelo HIV entre jovens brasileiros do sexo masculino, 2007. Cad. de Saúde Pública*. Publication in press, 2010.

Women
1. Analysis:
HIV prevalence in women aged 15-24 was 0.28% in 2004, and 0.26% in 2006.

2. Method of Measurement:
HIV prevalence in women is measured every four years by means of a study in maternity hospitals. The 2006 study was performed using secondary data from the antenatal cards and medical records of Brazilian parturient women. A probabilistic sample was undertaken in two stages. In the first stage 150 maternity hospitals were selected, stratified by the size of the municipality in which the were located (<50,000 inhab.; 50,000-399,999 inhab.; <400,000 inhab.). In the second stage, 100-120 women were systematically selected per maternity hospital. A total of 16,158 parturient women were included in the sample.

3. Data Sources:
- SZWARCWALD, C. L. et al. HIV Testing During Pregnancy: Use of Secondary Data to Estimate 2006 Test Coverage and Prevalence in Brazil. *The Brazilian Journal of Infectious Diseases*, v. 12, n. 3, p. 167-172, 2008.

23. Percentage of most-at-risk populations who are HIV infected.

23.1. Purpose:
To assess progress on reducing HIV prevalence among most-at-risk populations.

Sex workers

1. Analysis:

HIV prevalence in female sex workers in 2009 was 4.9%. Earlier studies found 8% prevalence in Santos (state of São Paulo) in 1998 (SZWARCWALD et al., 1998); 6.1% in 7 Brazilian cities in 2002 (BRASIL, 2004); 3.1% in Santos in 2006 (LACERDA et al., 2006); and 2.6% in Manaus in 2006 (DUTRA JR. et al., 2006). However, the difference between the methods used does not permit an analysis over time to be made.

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of female sex workers in Brazil as a whole.
b) Only female sex workers were included in the study.

3. Data Sources:

- SZWARCWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis no grupo das mulheres profissionais do sexo, no Brasil* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Men who have Sex with Men (MSM)

1. Analysis:

HIV prevalence in MSM in 2009 was 12.6%. Earlier studies found HIV prevalence rates in this population varying between 4.5% in 1999 (SZWARCWALD, 2000) and 10.8% (Ministry of Health, 2000).

2. Limitations:

Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of MSM in Brazil as a whole.

3. Data Sources:

- KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras* (Study funded by the STD, AIDS and Viral Hepatitis Department).

Injecting drug users

1. Analysis:

HIV prevalence in illicit drug users in 2009 was 5.9%, this being much lower than the prevalence found in IDUs in earlier studies, which varied between 42% in 1999 (BRAZIL, 2001) and 52.5% in 1998 (BRAZIL, 2003).

2. Limitations:

a) Study carried out in 10 Brazilian cities; as such, the indicator refers to a weighted estimate for the 10 cities and is not representative of illicit drug users in Brazil as a whole.
b) The study included illicit drug users, not just IDU.

3. Data Sources:

- BASTOS, F. I. Taxas de infecção de HIV e sífilis e inventário de conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis entre usuários de drogas em 10 municípios brasileiros (Study funded by the STD, AIDS and Viral Hepatitis Department).

24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.

24.1. Purpose:

To assess progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

24.2. Analysis:
In 2008 a total of 190,101 patients were receiving antiretroviral therapy in Brazil; 34,678 of these patients had begun ARV therapy in the same year. Of those who began ARV therapy in 2008, 98.7% continued to be on treatment 12 months after starting it. This percentage was higher than that found in patients who began ARV therapy in 2007: 81.9% were still on treatment 12 months after starting it.

Note:
The total number of patients on treatment was taken to be the number of patients on treatment in December of each year.

24.3. Additional information:
Survival time was estimated using the *Kaplan-Meier* method, with death being defined based on information on date of death recorded on the *SINAN* system and information about death on the *SIM* system. Cases of lost follow-up were considered to be individuals without any record for more than 180 days on any of the information systems used.

24.4. Data Sources:
Linkage of the following databases: *SINAN/AIDS* + *SISCEL/SICLOM* +*SIM*

25. Percentage of infants born to HIV-infected mothers who are infected.

25.1. Purpose:
To assess progress towards eliminating mother-to-child HIV transmission.

25.2. Analysis:
Mother-to-child HIV transmission was 6.8% in 2004, representing a reduction of 21% in relation to the year 2000 (SUCCI et al., 2007).

25.3. Additional information:
This indicator was not included, since the STD, AIDS and Viral Hepatitis Department does not use the UNAIDS Spectrum program to estimate mother-to-child transmission. Currently the Department monitors mother-to-child HIV transmission using the “number and rate of AIDS cases in children aged under 5” indicator. This indicator shows that between 1998 and 2008, Brazil reduced by 49.0% the incidence of AIDS cases in children aged under 5, from 5.9 in 1998 to 3.0 per 100,000 inhabitants in 2008.

25.4. Data Sources

- SUCCI, R. C. M.; Grupo de Estudos da Sociedade Brasileira de Pediatria para Avaliar a Transmissão Materno-Infantil do HIV. Transmissão materno-infantil do HIV no Brasil durante os anos 2000 e 2001: resultados de um estudo multicêntrico. *Cad. Saúde Pública*, [S.l.], v. 23, Supl. 3, p. S379-S389, 2007.