

# The Brazilian Response to HIV and AIDS

Global AIDS Response  
Progress Reporting (GARPR)

*Narrative Report*

Brasília, DF - June, 2015



## INDEX

Acronyms

Index of images

### Foreword

#### 1. Introduction

- 1.1. Post-2015 commitment
- 1.2 Social participation and addressing stigma and discrimination

#### 2. Brazilian epidemiological scenario

- 2.1 Stable and concentrated epidemic
- 2.2 Youth
- 2.3 Pregnant women and mother to child transmission
- 2.4 Exposure category
- 2.5 Race and colour
- 2.6 Mortality

#### 3. Brazil: commitment to ending the AIDS epidemic

- 3.1 Scaling up access to HIV diagnosis: 90% of people living with HIV knowing their HIV status
- 3.2 New diagnosis technologies: rapid testing

#### 4. Prevention and diagnosis among key populations

- 4.1 “*Viva Melhor Sabendo*” project
- 4.2 Other mobilization initiatives for access to diagnosis
  - 4.2.1 “*A Hora é Agora*” pilot project
  - 4.2.2 “*Quero Fazer*” project
  - 4.2.3 Prevention and diagnosis among youth
- 4.3 Prevention and testing mobilization and campaigns
  - 4.3.1 “*#PartiuTeste*” campaign

#### 5. Combination prevention: new technologies, new challenges

- 5.1 Pre and post-exposure prophylaxis (PrEP and PEP)
- 5.2 Condoms and gel
- 5.3 PrEP feasibility studies in course

#### 6. Universal access to treatment: test and offer

- 6.1 Test and offer: 90% of people living with HIV receiving treatment
- 6.2 Shared management: primary care and specialized HIV and AIDS care services
- 6.3 Enhancement of information and clinical monitoring systems
- 6.4 Triple fixed-dose combination and adherence to treatment: 90% of people on ART virally suppressed

#### 7. Funding

#### 8. Final considerations

Bibliography and sources

Appendices

## **Acronyms**

AIDS – Acquired Immunodeficiency Syndrome

ANVISA - National Health Surveillance Agency

ARV - Antiretroviral

ARVT – Antiretroviral therapy

CAMS – Commission for Articulation with Social Movements

CDC – Centres for Disease Control

CNAIDS – National AIDS Commission

CPTG – Clinical Protocol and Therapeutic Guidelines

DATASUS – SUS / MoH Information Technology Department

DDAHV – Department of STI, AIDS and Viral Hepatitis

HIV – Human Immunodeficiency Virus

HSS – Health Surveillance Secretariat

ILO – International Labour Organization

INSS – National Social Security Institute

LGBT – Lesbians, Gays, Bisexuals and Transvestites

MoH – Ministry of Health

MSM – Men who have Sex with Men

PAB – Primary Care Ceiling

PAHO - Pan American Health Organization

PEP – Post-Exposure Prophylaxis

PrEP – Pre-Exposure Prophylaxis

PLHA – People living with HIV and AIDS

PUD – People who use drugs

SICLOM – Medication Logistics Control Information System

SINAN – Notifiable Diseases Information System

SISCEL – Laboratory Examination Information System

STI – Sexually Transmitted Infections

SUAS – Unified System for Social Assistance

SUS – Unified Health Service (*Sistema Único de Saúde*)

SW – Sex workers

TasP – Treatment as Prevention

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNO – United Nations Organization

VH – Viral Hepatitis

WHO – World Health Organization

## Index of Images

### Graphs

- Graph 1 – Continuum of care. Brazil, 2013.
- Graph 2 – AIDS detection rates, by State. Brazil, 2013.
- Graph 3 – AIDS prevalence rates in key populations. Brazil, 2009-2013.
- Graph 4 – AIDS detection rate (per 100,000 inhabitants) by sex and sex ratio per year of diagnosis. Brazil, 2004-2013.
- Graph 5 – Percentage distribution of AIDS cases in males aged 13 or over by exposure category and year of diagnosis. Brazil, 2004-2013.
- Graph 6 – Proportion of PLHA with late HIV infection diagnosis (CD4<200 cells per mm<sup>3</sup>), by year of collection. Brazil, 2003-2014.
- Graph 7 – Percentage of positive HIV tests in key populations covered by the “*Viva Melhor Sabendo*” project. Brazil, 2014.
- Graph 8 – Individuals aged 15-64 who agree with the statement “using a condom is the best way of avoiding HIV infection”.
- Graph 9 – Sexually active individuals, aged 15-64, who used condoms in the last 12 months.
- Graph 10 – Sexually active individuals, aged 15-64, by indicators of sexual practices.
- Graph 11 – Evolution of ARV treatment in Brazil – 1999-2014.
- Graph 12 – Offer to and inclusion of new patients on ARV treatment. Brazil, 2009-2014.
- Graph 13 – Percentage of people living with HIV receiving treatment, by viral load, 6 months after starting ARVT. Brazil, 2009-2014.

### Figures

- Figure 1 – AIDS mortality rates, by State. Brazil, 2013.
- Figure 2 – “*Viva Melhor Sabendo*” project logo.
- Figure 3 – “*A Hora é Agora*” project logo.
- Figure 4 – Integrants of the “*Quero Fazer*” project during an HIV test action in the city of São Paulo.
- Figure 5 – Young leaders’ capacity building course, 2014.
- Figure 6 – Printed material, 2014 Carnival campaign.
- Figure 7 – Poster with footballer David Luiz, from the “Protect the Goal” campaign

Figure 8 – President Dilma Rousseff and Michel Sidibé, UNAIDS Executive Director, at the launch of the “Protect the Goal” campaign.

Figure 9 – “#PartiuTeste” campaign poster, 2014.

Figure 10 – CNBB Campaign – 2014: “Take good care of yourself and your loved ones”, on the internet.

Figure 11 – Combination prevention “mandala”.

## **Tables**

Table 1 – Tests performed by the “*Viva Melhor Sabendo*” project. Brazil – March 2014 to January 2015.

Table 2 – Female condom purchases and distribution. Brazil, 2014.

Table 3 – Lubricant gel purchases and distribution. Brazil, 2014.

Table 4 – *DDAHV*/HSS/MoH Budget. 2003-2014.

## Foreword

This document is part of Brazil's contribution to the UNAIDS Global AIDS Response Report 2015 and presents the main progress and challenges regarding actions and policies developed in 2014 by the Department of STI, AIDS and Viral Hepatitis (*DDAHV*), located within the Ministry of Health's (MoH) Health Surveillance Secretariat (*HSS*). Its contents highlight complementary aspects of information already reported in the form of indicators using the GARPR 2015 on-line reporting tool, available on the following website: <https://aidsreportingtool.unaids.org/>.

In order to prepare GARPR 2015, *DDAHV* organized a working group comprised of 18 specialists from different technical areas involved in the national response to HIV (monitoring and evaluation, epidemiological surveillance, prevention, care and treatment, laboratory, international cooperation, among others). A multisectoral effort involving several different professionals in a series of meetings was made, not only to organize the information provided in this narrative part of the report, but also to collect and report on the specific indicators contained in the GARPR 2015 on-line tool.

In addition to internal mobilization, the work process also involved dialogue between *DDAHV* and representative of civil society, local service managers and UN system agencies. An in-person meeting with 53 participants from these sectors was held in Brasília on March 17<sup>th</sup> 2015, with the aim of gathering additional information for preparing this narrative report. The meeting's agenda, as well as its final minutes, are attached. Excerpts from the final minutes have been highlighted in boxes throughout this document to emphasize the contributions provided by the meeting participants.

By presenting the results of the joint efforts to produce GARPR, the Brazilian Government informs its country's citizens and the international community about the main actions undertaken in 2014, in view of the finalization in 2015 of the commitments taken on by Brazil under the 2011 Political Declaration on HIV/AIDS; and publicizes Brazilian proposals in the field of HIV/AIDS to meet the new 90/90/90 targets for the year 2020.



# 1. Introduction

## 1.1. Post-2015 commitment

In May 2014, during the *1st Latin American and Caribbean Forum on the HIV Care Continuum*, held in the City of Mexico, Brazil and other countries of the region established the so-called “90/90/90” targets, namely: 90% of people living with HIV/AIDS (PLHA) knowing their HIV status; 90% of PLHA receiving antiretroviral therapy (ARVT); and 90% of people receiving ARVT virally suppressed by the year 2020.

Throughout the remainder of 2014, Brazil supported and also sought to promote adherence to the “90/90/90” targets in the international forums in which it participated. In November, the *Mercosul* Health Ministers endorsed this commitment in a meeting held in Buenos Aires. The same occurred in the meeting of the BRICS Health Ministers (Brazil, Russia, India, China and South Africa), held in Brasilia in December 2014.

On the World AIDS Day, December 1st 2014, Brazil<sup>1</sup> took part in a meeting held in France, at the invitation of the Joint United Nations Programme on HIV and AIDS - UNAIDS, and signed the “Paris Declaration to end the AIDS epidemic”, committing to the fast track strategy, which aims to accelerate the response to the HIV and AIDS epidemic, including through the participation and commitment of cities.

In Brazil, achieving the 90/90/90 targets is in keeping with the framework of universal access to health. The Unified Health

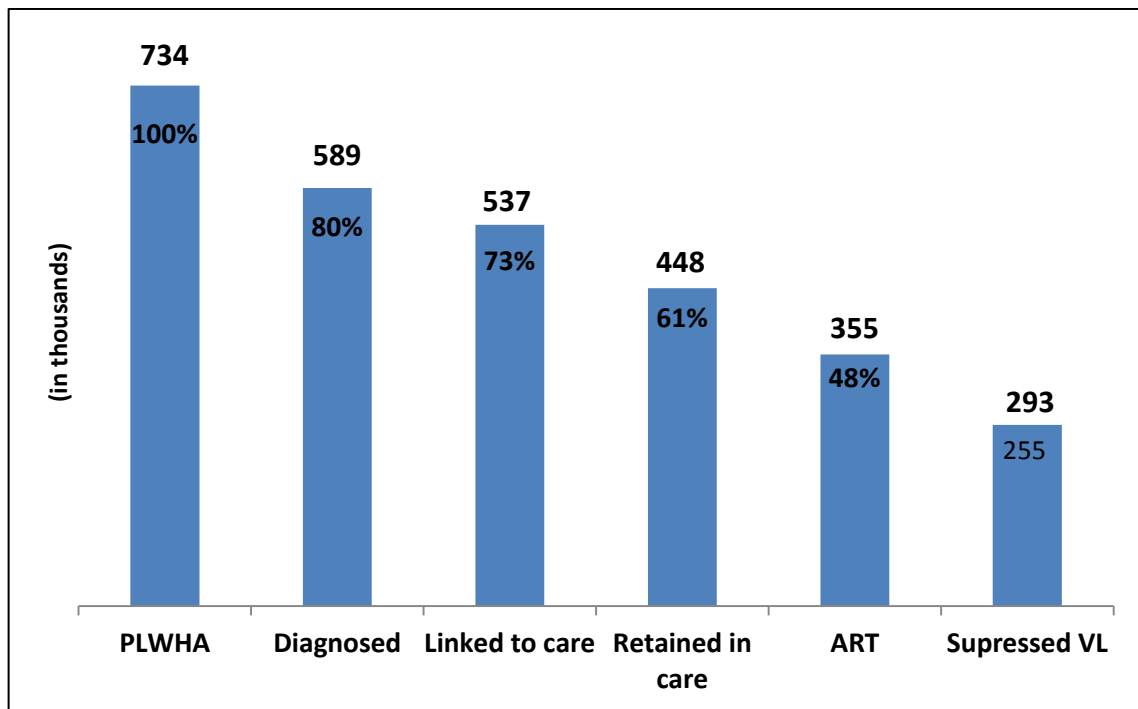
---

<sup>1</sup> The Brazilian delegation was comprised of the City Governments of Curitiba (State of Parana) and Salvador (State of Bahia), as well as the president of the Association of Municipalities of the State of Bahia, which represents 417 of that State’s municipalities.

System (*Sistema Único de Saúde - SUS*), based on the principles of universality, equity, integrality and social participation, establishes the fundamental mainstays of the Brazilian response to HIV and AIDS. It is within this context that Brazil has been implementing innovative actions and policies, by scaling up access to prevention, diagnosis and treatment; combating stigma and discrimination; and promoting human rights, especially towards those of the epidemic's key populations and people living with HIV.

Graph 1 shows the HIV continuum of care in Brazil. It establishes the baseline and enables the progress towards achieving the targets to be monitored. In 2013, some 734,000 people were estimated to be living with HIV and AIDS in Brazil, 80% of whom (589,000) had already been diagnosed. Approximately two thirds (537,000) of PLHA had been linked to health services and 448,000 (61%) continued in follow-up. Of the 355,000 PLHA receiving antiretroviral therapy, 293,000 (82.5%) had undetectable viral load (less than 1000 copies/ml, following WHO standards). With regard to the targets for the year 2020, according to the 2013 continuum of care, 80.2% of the estimated number of PLHA knew their HIV status and 61.0% of these were receiving ARVT. With regard to viral load, 82.5% of those receiving ARVT were virally suppressed, accounting for 88% of adults in this category.

**Graph 1** – Continuum of care. Brazil, 2013



**Source:** Ministry of Health/Health Surveillance Secretariat/Department of STI, AIDS and Viral Hepatitis. Cases identified on the SINAN system as at epidemiological week 26 – December 2014.

In order to achieve the 90/90/90 targets, Brazil has committed to scaling up rapid testing and making available oral fluid tests at drugstores in the near future, along with the policy of offering treatment as prevention (TasP/Test and Treat), ensuring people’s right to make the choice to begin treatment, regardless of their viral load.

With the aim of collaborating with scaling up timely access to treatment, *DDAHV/MoH* has been promoting the shared management of care for patients with HIV with the primary health care network; the incorporation of new pharmaceutical formulations of ARV drugs; and the enhancement of information systems for monitoring care. These initiatives have contributed to both scaling up access to prevention, diagnosis and treatment services and commodities, as well as to an increase in adherence to treatment, these being fundamental aspects for controlling the epidemic.

Among its prevention actions, Brazil has adopted combination prevention, a strategy that involves post-exposure prophylaxis (PEP); mass campaigns to encourage condom use and testing; distribution of prevention commodities (condoms and gel lubricant) within the realm of the Unified Health System (*Sistema Único de Saúde - SUS*); and specific HIV prevention actions with key populations (gay men and other MSM, transgenders, sex workers and people who use drugs, with emphasis on crack users).

All these actions are based on dialogue with different stakeholders (federal, state and municipal governments, academic experts, civil society organizations, members of parliament, religious communities, the media, international organizations, blocs of countries and bilateral and multilateral agencies) as well as on the recognition of the singular contexts in addressing the epidemic (people living with HIV/AIDS, key populations and hot spots). This broad dialogue is one of the distinctive characteristics of the Brazilian response to HIV and AIDS.

Other characteristics of the Brazilian response also include permanent technological innovation and actions based on scientific evidence. In this respect, Brazil has accompanied global progress and has contributed to the debate, preparation and implementation of proposals and policies, always based on the commitment to the right of all people to live a full, productive and dignified life. This has led the country to implement a series of impacting measures related to the human rights of PLHA and key populations, as well as to adhere to international initiatives, such as the UNAIDS *Zero Discrimination* strategy.

## **1.2 Social participation and addressing stigma and discrimination**

The Brazilian Ministry of Health makes continuing efforts to create mechanisms which involve, encourage and broaden social participation in several spaces of discussion and formulation of HIV and AIDS policies. Way back in the early years of the Brazilian response, the Commission for Articulation with Social Movements (CAMS) and the National AIDS Commission (CNAIDS) were set up via Ministerial Ordinances with the aim of forming consultative forums on technical and political aspects necessary for formulating guidelines for proper response to HIV, AIDS and viral hepatitis. Although both Commissions are spaces of dialogue with different sectors of society, CAMS represents HIV and AIDS-related social movements and most vulnerable populations, in order to enhance discussion and follow-up in relation to specific demands; whilst CNAIDS ensures the participation of representatives as a forum similar to a coordinating body that works on the management of the national response, and includes state and city governments, academia, social movements, NGO networks, among other partners. In 2014 the 118<sup>th</sup> and 119<sup>th</sup> CNAIDS Meetings and the 40<sup>th</sup> CAMS Meeting were held in Brasília.

Between 2013 and 2014, six regional public consultation forums were held involving the participation of a variety of social stakeholders to discuss and enhance the guidelines of the Brazilian policy on STI, AIDS and viral hepatitis. In 2014 alone, four regional dialogue forums were held in Brazil: the *4<sup>th</sup> Regional Forum: the Southeast Forum* - February 4-5<sup>th</sup> in Belo Horizonte (MG); the *5<sup>th</sup> Regional Forum: Northeast Forum I* - March 26-27 in Fortaleza (CE); the *National Forum on STDs* - April 14-15<sup>h</sup> in Brasília (DF); and the *6<sup>th</sup> Regional Forum : Northeast Forum II* - April 28-29 in Aracaju (SE).

In addition, a variety of working groups (WG) have notable social participation, such as the WG on mother-to-child transmission, lipodystrophy, adherence to treatment and harm reduction. The purpose of these spaces is to inform and recommend to the Department of STI, AIDS and Viral Hepatitis technical actions in specific areas of knowledge on HIV and AIDS.

Four public calls for proposals were also made in 2014 to select projects to be developed by civil society organizations with emphasis on early diagnosis, community mobilization, legal aid and human rights actions aimed at most vulnerable populations. These projects, made available through the Ministry of Health (MoF), totalled more than US\$ 10,5 million of transfers to civil society.

As part of its efforts to encourage social participation in Brazil's HIV and AIDS policy, *DDAHV*/MoH supports civil society representation in a variety of national and international forums and conferences. As example of this kind of support was the participation in 2014 of 17 representatives of different sectors as part of the Brazilian official delegation during the 20<sup>th</sup> International AIDS Conference, held in Melbourne, Australia, in July.

On December 1<sup>st</sup> 2014, the seminar on "Media, AIDS and Technological Innovation" was also held, bringing together media stakeholders and opinion leaders in an up to date debate on the response to the HIV/AIDS epidemic 30 years after its inauguration in Brazil (1985). Despite technological innovations and progress with the scope of the policy, addressing stigma and discrimination continues to be a pressing issue, and the role of the media is crucial in this respect.

It is impossible to dissociate human rights from the fight against HIV and AIDS. As such, actions undertaken in 2014 were marked by

close dialogue with the specificities of the most affected populations. HIV and AIDS-related stigma and discrimination generally come hand in hand with other forms of prejudice and can compromise progress in the response to the epidemic.

Standing out among the most recent progress made in the field of the rights of people affected by the AIDS epidemic in Brazil is the enactment of Law No. 12,984, dated June 2<sup>nd</sup> 2014, which criminalizes, with the possibility of imprisonment, discriminatory conduct against people with HIV and AIDS. Moreover, in September 2014, the Ministry of Health published Technical Note No. 18, which provides guidance for health service managers and system operators responsible for registering *SUS* users on the procedure for filling in the form for the use of the “social name<sup>2</sup>” on the *SUS* user card. This measure aims to avoid a trans person being exposed to the humiliation and embarrassment they would face by being identified by a name in disagreement with their physical appearance and gender identity. This right has been guaranteed since 2009 by the *SUS* Users’ Charter of Rights (Ordinance No. 1,820).

In connection with International Labour Organization (ILO) Resolution 200, another fundamental achievement was the publication by the Ministry of Labour and Employment of Ordinance No. 1,927, dated December 10<sup>th</sup> 2014, which sets guidelines for combating discrimination against people with HIV and AIDS in the workplace. The Ordinance determines that it is a discriminatory practice to require that workers, including migrants, people looking for employment and job applicants provide a recent HIV test result. HIV tests must be voluntary and free from coercion: and no worker can be forced to disclose their HIV status. Workers cannot be discriminated or stigmatized - in particular people who are looking for or applying for a job – because of their HIV

---

<sup>2</sup> Translator’s note: “*nome social*” - name chosen by transgender persons, which best reflects their gender identity, as opposed to the name they were registered with at birth.

status, whether real or presumed; nor by the fact of coming from regions of the world or population segments considered to be at greater risk or greater vulnerability to HIV infection.

On World AIDS Day 2014 new recommendations were released by the National Social Security Institute (*INSS*) for granting social security benefits to people living with HIV/AIDS, in the publication entitled “Support Guidelines for Specialized Technical Medical Decisions”. The new guidelines have broadened the concept of a “symptomatic” person and now take into consideration not only the syndrome and the occurrence of opportunistic diseases, but also chronic and degenerative complications, sequels, adverse effects of medication for comorbidities and antiretroviral drugs (such as anatomical alterations arising from lipodystrophy), as well as the important consideration given to psychosocial factors, especially those involving stigma and discrimination, which can lead to temporary or even permanent disability. As such, the use of T-CD4+ cell counts, on their own, is no longer adequate for the purposes of assessing eligibility for social security benefits.

In this way, in order for the 90/90/90 targets to be fully achieved by Brazil, the need exists to continue to respond to the epidemic’s different social contexts, always ensuring the right to individual choice of the methods used to withstand HIV, although never ignoring the collective nature of health actions, which inspires and is the cornerstone of *SUS*.

It is the Ministry of Health’s understanding that these collective efforts should be reiterated in all actions to combat HIV and AIDS, and to help in inspiring the global context of the response. As such, Brazil acts in an articulated and fraternal manner with other countries, international organizations and cooperation agencies, through international cooperation programmes and projects that the



country is developing, exchanging successful experiences and sharing difficulties so that more effective responses become possible.

*DDAHV/MoH* also plays an outstanding role in Brazilian cooperation policies with blocs of countries, such as the Portuguese-Speaking Countries Bloc and the *Mercosul* Bloc. Another relevant historic relationship is Brazil's cooperation within the Horizontal Technical Cooperation Group (HTCG), which involves all the Latin American countries and the Spanish speaking countries of the Caribbean.

In 2014, the BRICS Health Ministers meeting was held in Brasília and on that occasion the ministers jointly committed to the Global "90/90/90" Target. This commitment further increased the repercussion of Brazil's efforts as well as this agenda on a global level.

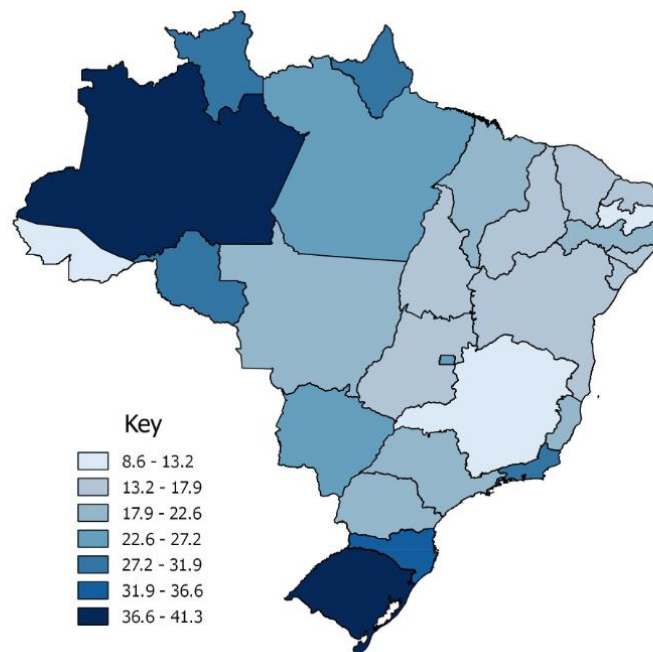
In addition, Brazil's international activities involve partnerships with United Nations agencies and programmes, in particular its participation on the UNAIDS Programme Coordinating Board (PCB) and representation on WHO technical advisory committees on STI, AIDS and Viral Hepatitis, among others.

## 2. Brazilian epidemiological scenario

### 2.1 Stable and concentrated epidemic

The HIV and AIDS epidemic is currently considered to be nationally stable in Brazil, in view of the relatively constant detection rate of around 20 cases per 100,000 inhabitants over the last five years. Nevertheless, in some of the country's states the epidemic's detection rates are more accelerated (the so-called hot spots). In order to address these regional disparities, the Department of STI, AIDS and Viral Hepatitis is focusing specific actions and policies on these regions, by means of interfederative cooperation (task forces involving civil society and the three levels of government: federal, state and municipal). As at the end of 2014 interfederative cooperation had been developed with the states of Amazonas and Rio Grande do Sul, where detection and mortality rates due to HIV/AIDS are more striking.

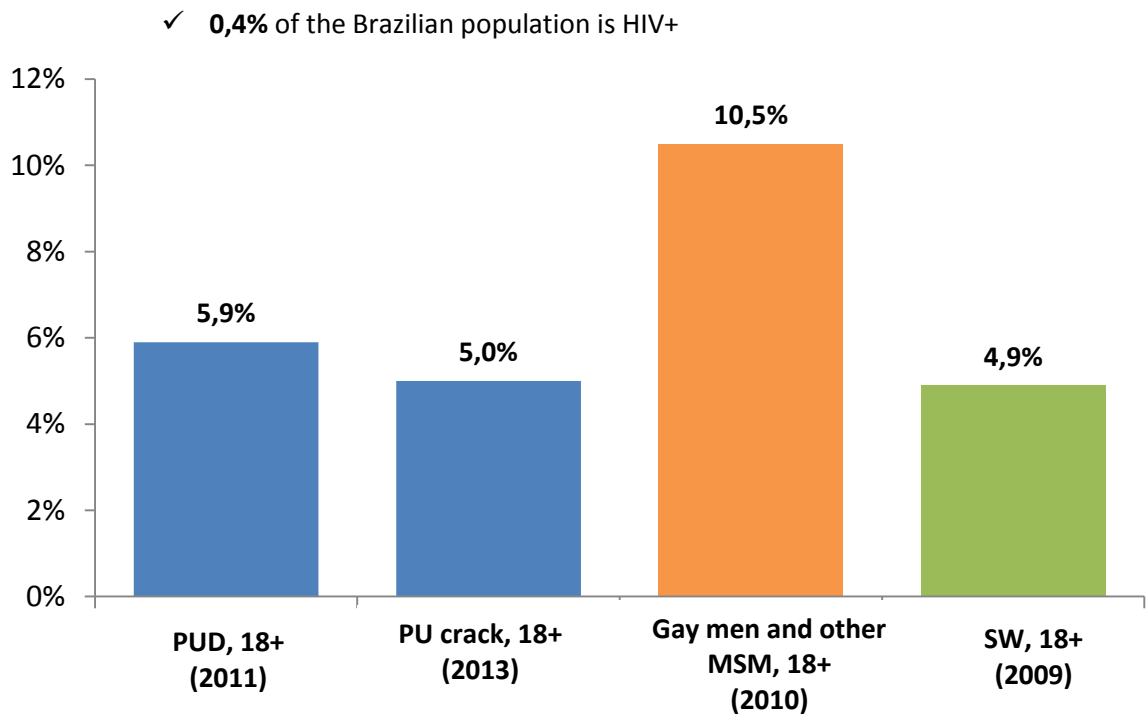
**Graph 2** – AIDS detection rates, by State. Brazil, 2013



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

There are estimated to be some 734,000 people living with HIV/AIDS in Brazil. This corresponds to a prevalence rate of 0.4% in general population. The epidemic is concentrated in key populations, with HIV prevalence rates of 5.9% among people who use drugs- (PUD)<sup>3</sup>, 10.5% among men who have sex with men – (MSM)<sup>4</sup> and 4.9% among female sex workers (SW)<sup>5</sup> Moreover, HIV prevalence is 5.0%<sup>6</sup> among crack users.

**Graph 3** – AIDS prevalence rates in key populations.  
Brazil, 2009-2013



**Sources:** Specific studies conducted between 2009 and 2013

<sup>3</sup> 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*. Technical report presented to the Department of STD, AIDS and Viral Hepatitis, 2009.

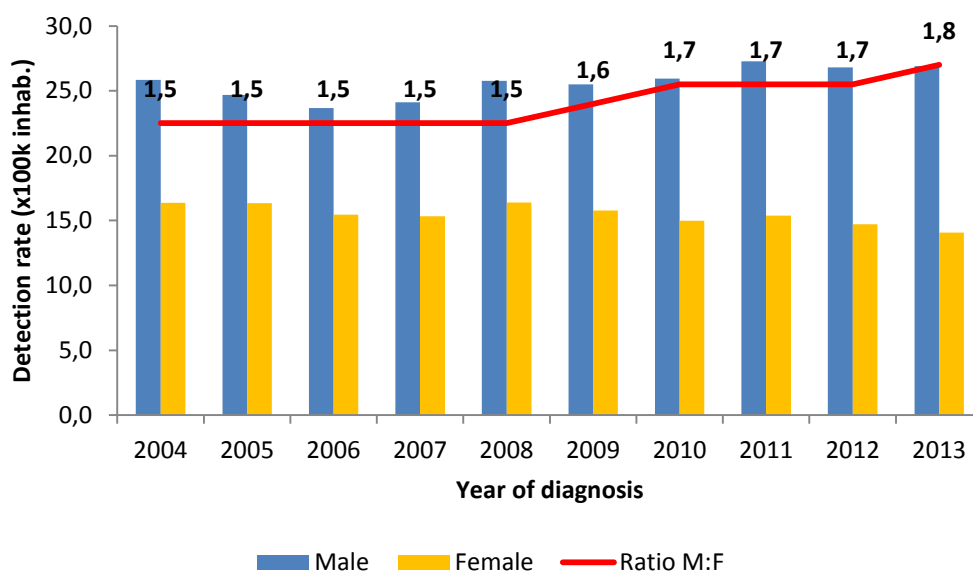
<sup>4</sup> KERR, L. *Comportamento, atitudes, práticas e prevalência de HIV e sífilis entre homens que fazem sexo com homens (HSH) em 10 cidades brasileiras*. Technical report presented to the Department of STD, AIDS and Viral Hepatitis, 2009.

<sup>5</sup> SZWARCOWALD, C. L. *Taxas de prevalência de HIV e sífilis e conhecimento, atitudes e práticas de risco relacionadas às infecções sexualmente transmissíveis nos grupos das mulheres profissionais do sexo, no Brasil*. Technical report presented to the Department of STD, AIDS and Viral Hepatitis, 2009.

<sup>6</sup> BASTOS, F. I.; BERTONI, N. (Org.). *Pesquisa Nacional sobre o uso de crack: quem são os usuários de crack e/ou similares do Brasil? Quantos são nas capitais brasileiras?* Rio de Janeiro: Editora ICICT/FIOCRUZ, 2014.

From the beginning of the epidemic until June 2014, 757,042 AIDS cases were registered in Brazil, with 65.0% among males and 35.0% among females. With effect from 2009, a reduction can be seen in female cases and an increase in male cases. This is reflected in the sex ratio, which changed to 18 male AIDS cases for every 10 female cases in 2013.

**Graph 4** – AIDS detection rate (per 100,000 inhabitants) by sex and sex ratio per year of diagnosis. Brazil, 2004-2013<sup>(1)</sup>



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

## 2.2 Youth

The highest concentration of AIDS cases in Brazil is found among individuals aged 25 to 39 in both sexes. In relation to total cases between 1980 and June 2014, this age group accounts for 54.0% of male cases and 50.3% of female cases.

Over the last ten years a statistically significant increase can be seen in the detection rate among males aged 15-19, 20-24 and 60 or over. In particular there is an increase in young males aged 15-

24. Between 2004 and 2013, there was an increase of 53.2% among those aged 15-19 and 10.3% among those aged 20-24.

The detection rate among women by age group during the same period showed a significant trend towards increasing among those aged 15-19, 55-59 and 60 or over, with an increase of 10.5%, 24.8% and 40.4%, respectively.

### **2.3 Pregnant women and mother-to-child transmission**

Based on estimated HIV prevalence among parturient women, the expected number of pregnant women with HIV in Brazil is approximately 12,000 cases per annum. Between the years 2000 and 2014 (June), 84,558 pregnant women with HIV were notified nationwide. Over the last ten years the detection rate among pregnant women has shown a statistically significant trend of increasing: in 2004 the rate was 2.0 cases per 1,000 live births, increasing to 2.5 in 2013.

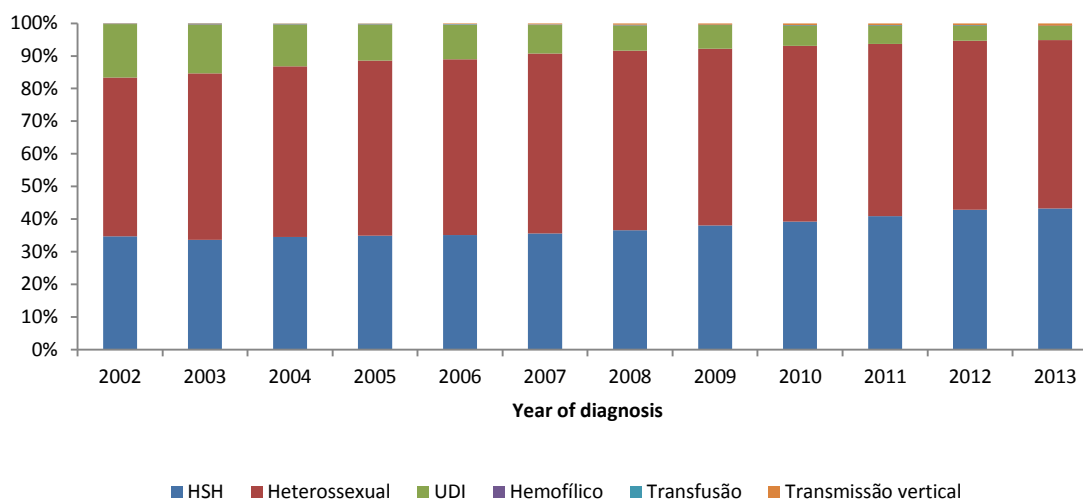
The AIDS detection rate in children aged under five has been used as a proxy indicator for assessing mother-to-child HIV transmission. In Brazil as a whole there has been a statistically significant decreasing trend of 35.7% over the last ten years.

### **2.4 Exposure category**

The main transmission route among individuals aged 13 and over is sexual intercourse, both among males and females. In 2013, this category accounted for 94.9% of cases among males and 97.4% among females. Among males, the predominant exposure category was heterosexual, although there has been an increasing trend in

the proportion of cases among MSM in the last ten years, going from 34.6% in 2004 to 43.2% in 2013. The proportion of people who inject drugs has been reducing over the years throughout Brazil, with a statistically significant decreasing trend, as can be seen in Graph 5.

**Graph 5** – Percentage distribution of AIDS cases in males aged 13 or over by exposure category and year of diagnosis. Brazil, 2004-2013<sup>(1)</sup>.



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

Note: (1) Cases notified on the SINAN system as at 30/06/2014

## 2.5 Race and colour

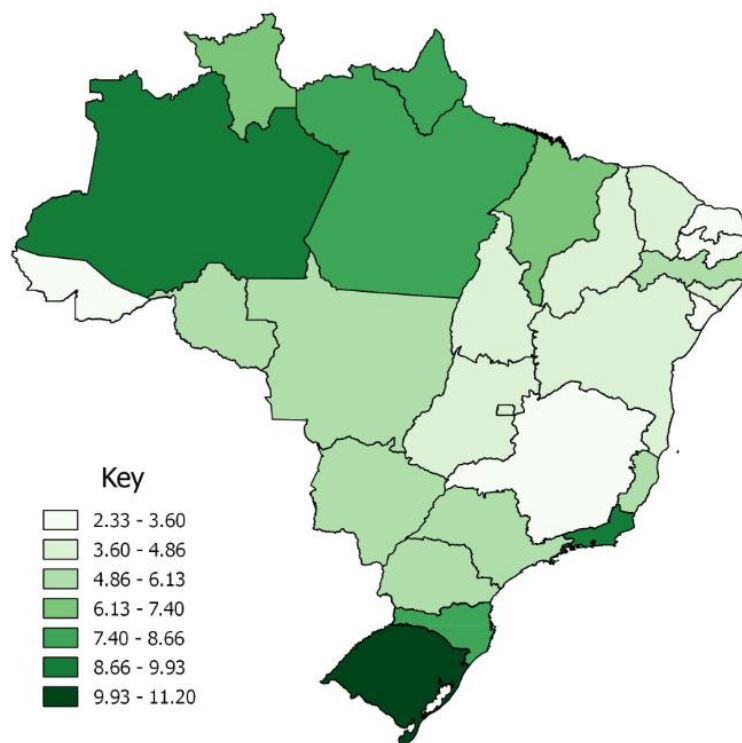
When comparing the proportional distribution of AIDS cases by race/colour according to sex from 2004 to 2013, there is no statistically significant difference in the proportions of people who state their race/colour is white, yellow, brown and indigenous, by sex, except among people with black skin colour, where the proportion of men is lower than that of women. In 2013, 9.7% of AIDS cases notified on the SINAN system related to men with black skin colour, whereas among women it was 11.7%. In the same year the proportions of white, yellow, brown and indigenous race/colour, in

relation to the total number of cases, were 44.5%, 0.4%, 44.3% and 0.3%, respectively. Furthermore, there has been a significant increase in the proportion of people who state their colour is brown and a significant fall in the proportion of those of white colour.

## 2.6 Mortality

278,306 deaths having AIDS as their basic cause (ICD:B20-B24) were identified between the beginning of the epidemic and December 2013, with 71.3% among males and 28.6% among females. There has been a reduction in the coefficient of AIDS deaths in Brazil over the last decade or so – from 6.4 per 100,000 inhabitants, in 2003, to 5.7 in 2013.

**Figure 1** – AIDS mortality rates, by State. Brazil, 2013



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

The results of a study published in *The Lancet*<sup>7</sup> showed a higher decrease in the annual rate of deaths related to HIV/AIDS in Brazil than the global average: between the years 2000 and 2013 the annual reduction rate of AIDS deaths was 2.3%, whereas the global average decline during the same period was 1.5%.

The regional differences indicated by Brazil's AIDS mortality rates, emphasize the importance of the actions that are being undertaken focused on "hot spots" currently located in the states of Rio Grande do Sul and Amazonas.

---

<sup>7</sup> MURRAY, C. et al. Global, regional, and national incidence and mortality for HIV, tuberculosis, and malaria during 1990-2013: a systematic analysis for the Global Burden of Disease Study, 2013. *Lancet*, [S.l.], v. 384, n. 9947, p. 1005-1070, 13 set. 2014.



### **3. Brazil: commitment to ending the AIDS epidemic**

HIV and AIDS has affected the world for the last three decades, but it is only recently that the end of the epidemic has appeared on the horizon of researchers, governments, civil society organizations and international organizations as a feasible proposed global target for the year 2030, as advocated by UNAIDS.

The agreement reached regarding the so-called “90/90/90 targets” has mobilized efforts and Brazil has sought to take on new initiatives to achieve them. One of the first challenges is understanding and articulating new prevention and treatment actions in an integrated manner. Standing out among these efforts is the adoption of the strategies of “Test and Treat”, Treatment as Prevention (TasP) and “combination prevention”, which will be described below.

This section will also cover the actions aimed at scaling up diagnosis and treatment; strategies focused on key populations; mobilization and communication strategies; and the financial sustainability of the Brazilian response to HIV and AIDS.

#### **3.1 Scaling up access to HIV diagnosis: 90% of people living with HIV knowing their HIV status**

It is estimated that some 150,000 of the more than 700,000 people living with HIV in Brazil do not know their HIV serostatus. According to the epidemiological data presented above, the epidemic is concentrated in the following key populations: gay men and other MSM, transgenders, sex workers and people who use drugs, with emphasis on the use of crack.

The Brazilian response has thus sought to intensify actions aimed at diagnosis, by facilitating the priority access of these key populations to HIV testing (without leaving to one side prevention and diagnosis actions directed towards the general population).

### **3.2 New diagnosis technologies: rapid testing**

Since 2005 the Ministry of Health has been distributing rapid tests through the Unified Health System (*Sistema Único de Saúde - SUS*) in all regions of Brazil. These tests have evolved over the years, becoming more accessible and affordable. They have been made available in places where conventional laboratory tests are not feasible, as well as for key populations. This enables swifter referral to medical care and starting treatment in a timely manner.

Rapid tests can be performed using blood samples or oral fluid and do not require the structure of a laboratory, different to conventional HIV tests which are operationally more complex, require specialized laboratory professionals and appropriate physical and technological infrastructure. Rapid tests significantly reduce the time in which the result is given, thus reducing the loss of people in follow-up.

In order to monitor the rapid tests it distributes, the Ministry of Health has implemented SISLOG-LAB, a system for controlling the capillarity of the tests distributed to the states and municipalities. The purpose of this system is to provide information on the availability and quality of rapid tests at health centres, so that the population can accompany the control of the tests performed.

In December 2013, the oral fluid test was regulated by Ordinance No. 29 and since 2014 it has been available nationwide. This is an

important step in scaling up testing. In Brazil two algorithms are recommended for diagnosing HIV infection when only rapid tests are used.

In the event of a positive diagnosis obtained using a rapid test, the patient is advised to go to their health centre to have a viral load examination in preparation for treatment. In this way diagnosis of people living in hard to reach places has been facilitated, in the same ways as migrant populations and those with increased vulnerability.

In 2014 the “New Technical Manual for Diagnosing HIV Infection in Adults and Children” was revised, whereby the original text was enhanced and the glossary definitions were altered to include terms that facilitate the understanding of them. In addition, the Manual presents the Department’s policies aimed at scaling up diagnosis and getting diagnosed people onto treatment. Also in 2014, in the area of laboratory distance learning projects, the new TELELAB internet course included contents on rapid testing, including oral fluid tests, so that by means of these on-line lessons professionals in the field can learn to perform the test safely and with quality.

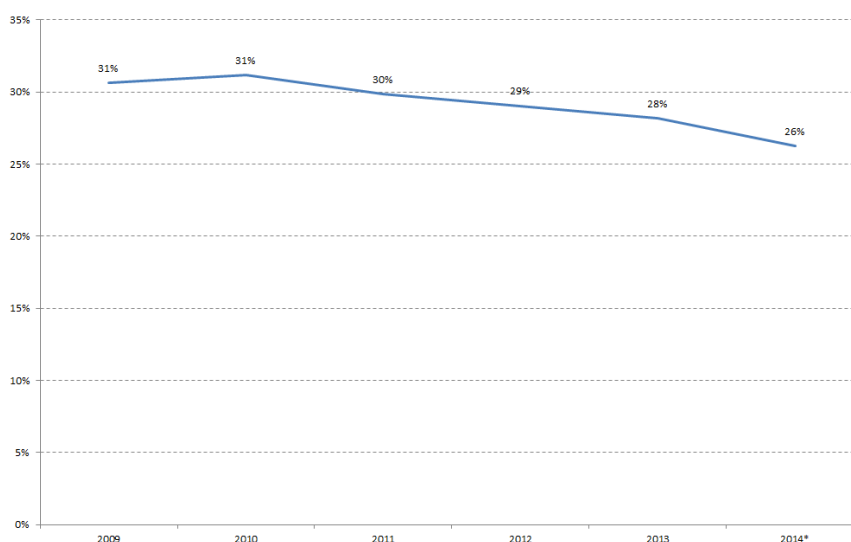
The policy of scaling up access to diagnosis also has self-testing on its horizon. By making oral fluid tests available in drugstores, the expectation is that diagnosis will increase, given that it contributes to empowering individuals in having control over their health. The process for regulating the sale of oral fluid tests in drugstores was submitted to the appreciation of the National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária – ANVISA*) in May 2014 and is currently under public consultation.

The incorporation of rapid tests for self-testing in drugstores assumes the existence of a support network to ensure access to complementary information, as well as linkage to services for treatment.

**Conclusions of the meeting with representatives of civil society about rapid HIV test**

The scaling up of diagnosis is monitored by accompanying the proportion of PLHA who have not started treatment and reach health services with immunological impairments, these being measured by their CD4 counts (PAHO/WHO<sup>8</sup>, 2014). In Brazil, there is a tendency towards a decrease in the proportion of PLHA reaching health services with CD4 counts below 200 cells per mm<sup>3</sup>, from 31% in 2009 to 26% in 2014 (October).

**Graph 6** – Proportion of PLHA with late HIV infection diagnosis (CD4<200 cells per mm<sup>3</sup>), by year of collection. Brazil, 2003-2014\*



**Note:** (\*) October 2014.

**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

It is expected that by scaling up access to new diagnosis technologies, more people living with HIV will be able to know their status, begin antiretroviral therapy and thus improve their quality of life and contribute to reducing the transmission of the virus.

From this same perspective and also taking into account the epidemic's trends in Brazil, DDAHV has undertaken actions and projects aimed at promoting diagnosis among key populations, so that available resources

<sup>8</sup> WHO 2014 [http://www.paho.org/hq/index.php?option=com\\_docman&task=doc\\_view&gid=25746&Itemid=](http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=25746&Itemid=)

are fully used. Recent initiatives include “*Viva Melhor Sabendo*” project (Live better knowing), mobilization of civil society, as well as prevention and testing campaigns, as described below.

## **4. Prevention and diagnosis among key populations**

### **4.1 “*Viva Melhor Sabendo*” project**

In the second semester of 2013, the Department of STI, AIDS and Viral Hepatitis launched its strategy for rapid HIV testing with oral fluid, in partnership with civil society organizations, focusing on key populations and work between peers. The name of the project is “*Viva Melhor Sabendo*” (Live better knowing), in an allusion to the benefits of diagnosis, and involved grass roots organizations closely linked to key populations and HIV and AIDS. The scaling up of voluntary testing takes place in the communities which the participating organizations represent. In the first stage of the project 36 cities in all five regions of the country were involved.

As at the end of 2014, the “*Viva Melhor Sabendo*” project was being carried out in partnership with 48 NGOs from four key populations of Brazil’s concentrated epidemic: gay men and other MSM; transgenders; people who use drugs; and sex workers. The Ministry of Health developed the NGO Project Monitoring and Evaluation System (SIMAV-pro) to accompany the project, enabling the identification of the carrying out of the activities proposed and any necessary corrections during implementation.

**Figure 2 – “Viva Melhor Sabendo” project logo**



The strategy adopted by the “*Viva Melhor Sabendo*” (Live better knowing) has enabled people to be reached in alternative places and at alternative times, with tests being offered outside of health service structures, by NGOs linked to the respective key populations. The use of the peer strategy both facilitates and multiplies the initiative: peers conduct the activities and spread information in the most adequate manner for the given context. The peer strategy is the “sharing of knowledge between equals, i.e., between people or groups having the same profile and sharing the same experiences, thus facilitating the exchange of knowledge and practices.” (UNICEF, 2013). TELELAB technical distance learning resources are used for training in oral fluid testing. The project is one of the Ministry of Health’s main recent initiatives to promote the scaling up of testing, since it enables HIV testing to be offered by non-professional members of partner NGOs.

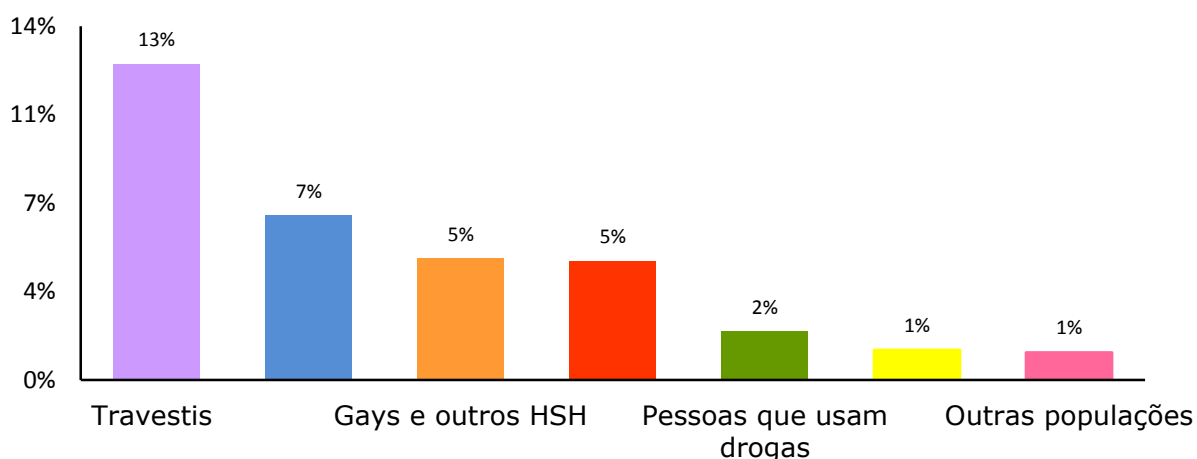
**Table 1** – Tests performed by the “*Viva Melhor Sabendo*” project. Brazil – March 2014 to January 2015

Key populations*	Number of people tested	Number of positive cases	Percentage of positive cases
Transvestites	626	80	12.8%
Transsexuals	435	29	6.6%
Male sex workers	504	21	4.1%
Female sex workers	3,418	40	1.2%
People who use drugs	2,697	47	1.7%
Gay men and other MSM	3,011	142	4.7%
Other populations	5,142	52	1.0%
<b>Total</b>	<b>15,833</b>	<b>411</b>	<b>2.6%</b>

**Source:** SIMAV-pro

Note:\* The database was filtered so that each key population could be analyzed separately

**Graph 7** – Percentage of positive HIV tests in key populations covered by the “*Viva Melhor Sabendo*” project. Brazil, 2014



**Source:** SIMAV-pro - MoH/Department of STI, AIDS and Viral Hepatitis

Testing is offered and performed in spaces where key populations socialize, such as brothels, bars, night clubs, saunas, etc., involving both oral fluid rapid testing and guidance on prevention. According to the information held on SIMAV-pro, 43.3% of those tested via the “*Viva Melhor Sabendo*” project between March 2014 and January 2015 tested for the first time. 29% of positive cases had never tested before.

Testing strategies must be focused on key population under a territoriality conception (key-territories) (...) Not being “friendly” continues to be a barrier to key population access to health services, including structural and bureaucratic barriers.

**Conclusions of the meeting with representatives of civil society about rapid HIV test**

## **4.2 Other mobilization initiatives for access to diagnosis**

Other initiatives aiming at scaling up testing and prevention among key populations are “*A Hora é Agora*” project (The time is now) and the “*Quero Fazer*” project (I want to do it), as described below.

### **4.2.1 “*A hora é Agora*” pilot project**

The pilot project “*A Hora é Agora: Testar nos Deixa Mais Fortes*” (The time is now: testing makes us stronger) was implemented at the end of 2014. The project is undertaken in partnership between the City of Curitiba, DDAHV, the United States Centers for Disease Control and Prevention (CDC), the Oswaldo Cruz Foundation, the NGO *Grupo Dignidade*, the Federal University of Paraná and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The project works specifically with gay men and other MSM, offering finger-stick rapid HIV tests in mobile units equipped with counselling rooms and rooms where the test result is given. The same occurs at the offices of *Grupo Dignidade*, a human rights NGO.



**Figure 3** – “A Hora é Agora” project logo



The project also has an on-line “e-testing” platform which enables the oral fluid test to be sent by post to people at their homes. Alternatively, they can ask for the test kit to be delivered to a self-service post office box or obtain it at the Public Health Pharmacy, so called People’s Pharmacy. This is yet another HIV testing option, enabling people to choose when and where they feel more at ease to find out their HIV status.

The project’s communication strategy involves the dissemination of information in places where the key populations socialize, such as bars, night clubs, saunas and social networks on the internet. For those who use the project’s website, a telephone service is available to answer questions and provide specialized support. In the event of a positive test result, website service users are referred to Curitiba’s Voluntary Counselling and Testing Centre for confirmation of the test result and to make an appointment for follow-up with a doctor.

According to CDC, as at the end of January 2015, 440 HIV tests had been performed at the mobile unit, with 15 positive results, 10 of which occurred in the project’s key populations. This reinforces the importance of the strategy of scaling up testing among specific

populations. The next stages of the project are intended to go beyond Curitiba and to be extended to other sites in Brazil.

#### 4.2.2 “Quero Fazer” project

During 2014, another important project, “*Quero Fazer*” (I want to do it), continued to be implemented. It follows similar principles to the “*Viva Melhor Sabendo*” project: scaling up access to HIV diagnosis and voluntary testing for gay men, other MSM, transvestites and transsexuals in places where they socialize, on alternative days and at alternative times, focusing its services on the specific needs of LGBT people. The project’s main objectives are: to increase the coverage and quality of HIV and STI prevention and testing activities; improve the care provided to LGBT people; ensure integral and universal access to health services for gay men, other MSM, transvestites and transsexuals; and enhance knowledge about the needs of LGBT people.

**Figure 4** - Integrants of the “*Quero Fazer*” project during an HIV test action in the city of São Paulo



“*Quero Fazer*” began in 2008 as a pilot programme in three cities - Rio de Janeiro, Recife and Brasília -, through a partnership between Pact

Brazil (with USAID funding), DDAHV, state and municipal STI and AIDS programmes and NGOs (NGOs include *EPAH - Associação Espaço de Prevenção e Atenção Humanizada*, which has been coordinating the project since 2011). Owing to the positive results of the first stage, the project extended its activities to other cities.

The project uses strategies for scaling up diagnosis by means of offering rapid testing in mobile units (trailers) and the offices of LGBT NGOs, with counselling focused on the target populations. The peer strategy enables the participation of the key populations in all the work undertaken, including working as peer educators.

The project has dissemination and communication strategies directed towards LGBT people, through social networks (Facebook, Twitter and Flickr); the project's website ([www.querofazer.org.br](http://www.querofazer.org.br)); a partnership with a gay dating website called [disponivel.com.br](http://disponivel.com.br); as well as sending SMS with counselling and voluntary testing messages to registered users.

#### **4.2.3 Prevention and diagnosis among youth**

The AIDS epidemic figures in Brazil make the vulnerability of young people evident. This has led the Ministry of Health to develop strategies for scaling up opportunities of HIV diagnosis aimed at this group, especially young gay men, MSM and transvestites; based on the experience of previous projects such as “*Quero Fazer*”, making the most of its methodology; and “*Fique Sabendo*” (You gotta know), following a critical evaluation and adjustments based on lessons learned. As such, the aim has been to ensure open and direct dialogue with young people, so that they debate HIV-related issues they consider important and urgent and design jointly with the Ministry of Health strategies to combat the epidemic.

To this end, on August 5<sup>th</sup> and 6<sup>th</sup> 2014, the first workshop with young leaders was held, also involving university researchers specialized in the theme, civil society representatives (STI and AIDS organizations, LGBT groups, among others), United Nations agencies, state STI and AIDS programme managers, as well as members of the Department's technical team. The objective of the meeting was to define strategies for prevention, testing and adherence to treatment. The themes covered by the workshop included: combination prevention actions; scaling up testing and adherence to treatment; communication; and increasing the number of young gay, MSM and transvestite leaders.

**Figure 5** – Young leaders' capacity building course, 2014.



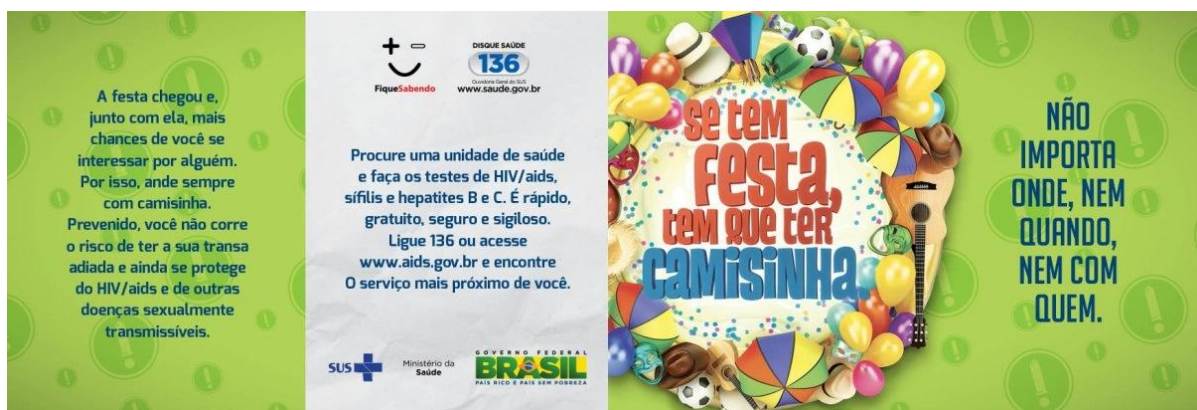
The new proposal seeks to promote the combination prevention strategy in accordance with the reality of young people, offering prevention commodities and possibilities of choice at meeting points, both on-line and off-line. The guidelines for the implementation of this initiative are: 1) investing in the validation of new methods, outreach and prevention with young gay men, MSM and transvestites in places most frequented by them (places where they socialize); 2) investing in mobile testing units in places where young gay men, MSM and transvestites socialize; 3) using new digital technologies and other efficient channels to reach young people and link them to a reliable source of Ministry of Health information – forming partnerships with other federal government bodies and opinion leaders; and 4) building the capacities of young gay

men, MSM and transvestites in 27 municipalities. Each one of these guidelines has a corresponding scope of actions. It was through this contact with young people that the Ministry of Health developed the “#PartiuTeste” campaign, which will be featured in the next section.

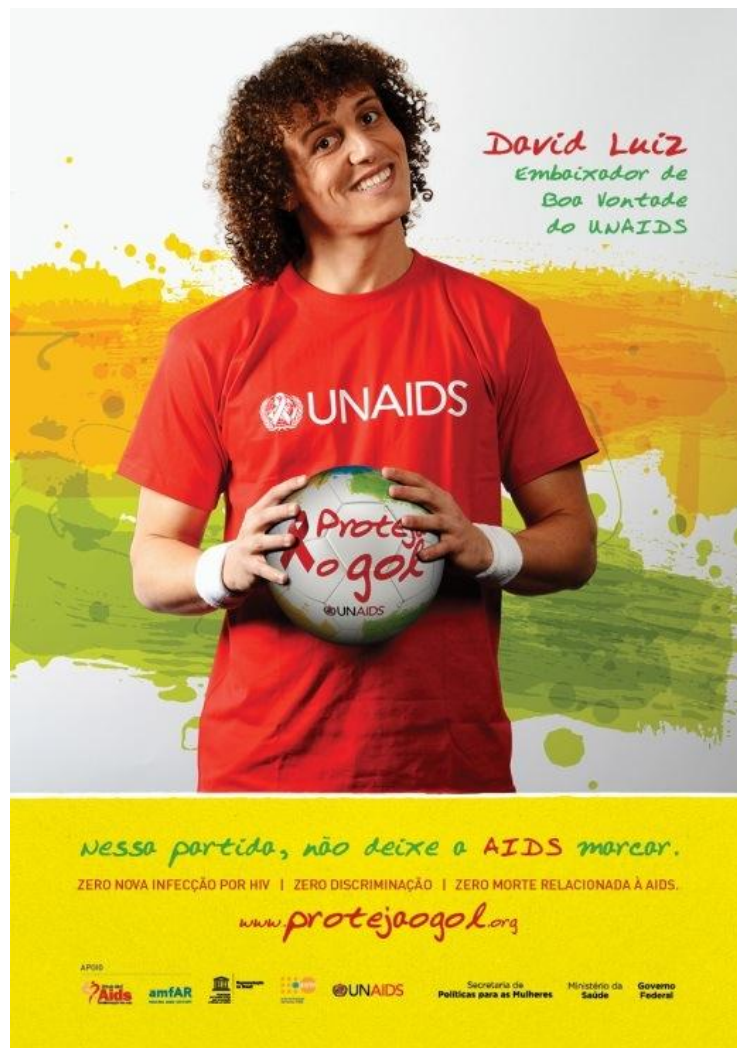
### 4.3 Prevention and testing mobilization and campaigns

In Brazil, Carnival and World AIDS Day (December 1<sup>st</sup>) are two unique opportunities within the country’s cultural context for approaching the issue of STI and AIDS prevention with the general population. The campaign held during the Carnival 2014 period highlighted testing and prevention and encouraged condom use with the theme “*Se tem festa, festaço ou festinha tem que ter camisinha*” (whatever the size of the party, there must be condoms). It was a national campaign and prioritized people aged 15 to 49. In 2014 a prevention and testing campaign was also held at the time of the football World Cup. The “Protect the Goal” project was a UNAIDS initiative in partnership with the Ministry of Health to prevent HIV and AIDS and mobilize young people to get tested.

**Figure 6** – Printed material, 2014 Carnival campaign



**Figure 7** – Poster with soccer star David Luiz, from the “Protect the Goal” campaign



The main objectives of the “Protect the Goal” campaign were to increase young people’s knowledge about HIV, AIDS and STI, their causes and forms of prevention; to encourage and mobilize the population, especially youth, to get tested; to promote protected sex and to fight against AIDS-related discrimination in Brazil. During the *fan fests* in the 12 host cities a variety of actions in these areas took place, such as rapid HIV testing in mobile units. During the period of the World Cup games, some 4 million male and female condoms were distributed and around 6 thousand rapid HIV tests were performed. Following the

launch of the campaign in Salvador (June 9<sup>th</sup>), President Dilma Rousseff autographed the football that symbolized the campaign, following the example of several other Heads of State worldwide.

**Figure 8** – President Dilma Rousseff and Michel Sidibé, UNAIDS Executive Director, at the launch of the “Protect the Goal” campaign



#### **4.3.1 “#PartiuTeste” campaign**

With the aim of combating the HIV and AIDS epidemic among young people, the Ministry of Health has been developing specific communication actions in partnership with young people themselves, promoting campaigns not just using conventional media (radio, TV and press), but also alternative media, such as applications (apps) directed towards young people (Tinder and Hornet), especially on the internet. As such, the #PartiuTeste campaign was launched on December 1<sup>st</sup> 2014, with the aim of alerting young people to protect themselves from HIV. Whilst also mentioning the importance of using condoms, the message focused on HIV testing and starting treatment early, thus reinforcing the combination prevention strategy. The campaign began on World AIDS Day 2014 and is continuing throughout 2015.

**Figure 9** – “#Partiu Teste” campaign poster, 2014



Also as part of the 2014 World AIDS Day activities, the Ministry of Health supported the proposal of the National Conference of Brazilian Bishops (*Conferência Nacional dos Bispos do Brazil - CNBB*), via its AIDS Pastoral, to hold a campaign to encourage testing in all Brazilian parishes and dioceses.

**Figure 10** – CNBB Campaign – 2014: “Take good care of yourself and your loved ones”, on the internet.



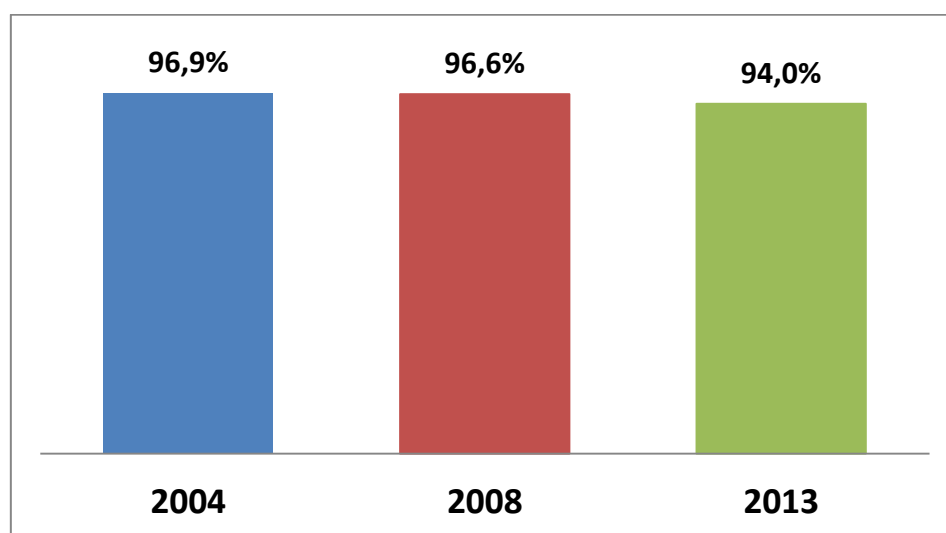


The AIDS Pastoral, through its agents and the work done with communities and health centres, has been developing awareness raising activities as to the need to test for HIV in the places where it operates. The aim is to encourage HIV diagnosis and to collaborate with achieving the 90/90/90 targets.

## 5. Combination prevention: new technologies, new challenges

According to the time series of the Knowledge, Attitudes and Practices (KAP) survey, around 95% of the Brazilian population aged 15-64 knows about the importance of using condoms.

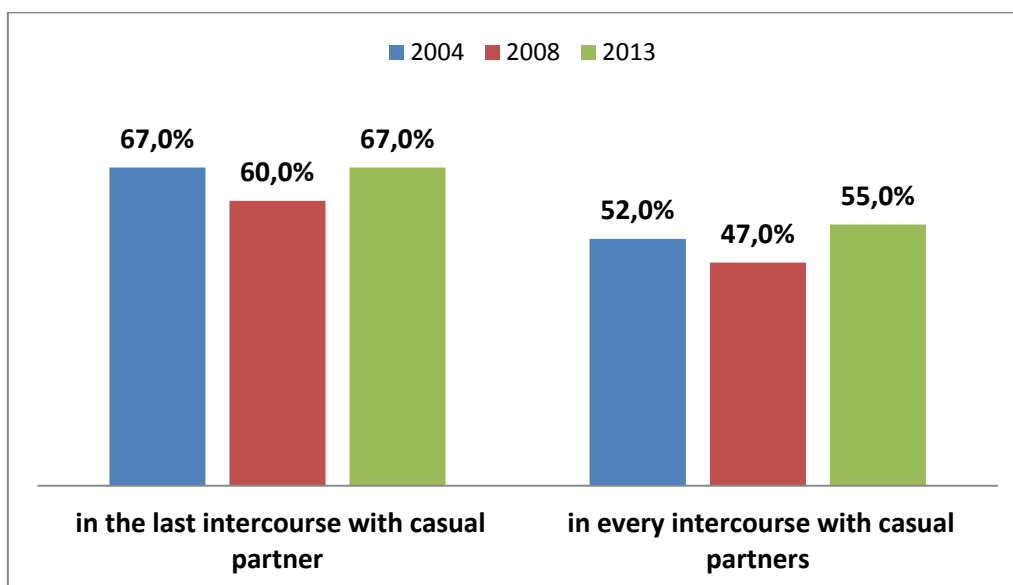
**Graph 8** – Individuals aged 15-64 who agree with the statement “using a condom is the best way of avoiding HIV infection”



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

Despite this high level of knowledge, constant use of condoms in all sexual intercourse with casual partners is reported by only 55% of the population.

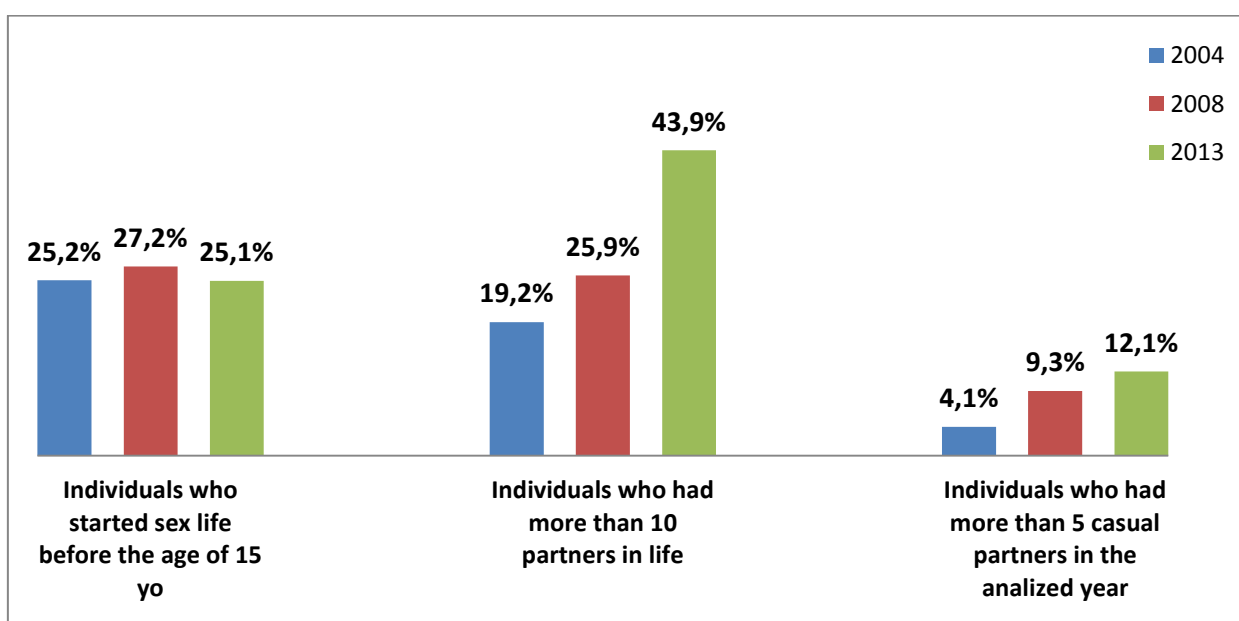
**Graph 9** – Sexually active individuals, aged 15-64, who used condoms in the last 12 months



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

Brazil has the world’s 7<sup>th</sup> youngest population (Report: State of World Population, UNFPA 2014) and, according to the KAP survey, the youngest generation (2013 data) has almost twice as many casual sex partners as previous generations.

**Graph 10** – Sexually active individuals, aged 15-64, by indicators of sexual practices



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

Until recently the prevention policy in Brazil was focused on condom use and the message “use condoms”, but data like this points to the need for more wide-ranging strategies. So now Brazil has adopted what is known as “combination prevention”, based on the incorporation of new technologies and possibilities of choice of methods according to lifestyles, acceptability and people’s assessment of their risk practices.

It is necessary to promote and strengthen the combination prevention strategy, disseminating the use of these new technologies, not leaving behind the conscious use of condom agenda; improve the quality of the prevention supplies; increase the acquisition and distribution of female condoms, promoting women autonomy.

**Conclusions of the meeting with representatives of civil society about combination prevention**

In addition to the consistent use of male or female condoms in all sexual intercourse, the following practices are also encouraged: getting tested regularly for HIV; test pregnant women in the antenatal period; treating other sexually transmitted diseases; using post-exposure prophylaxis (PEP), when necessary; in addition to making harm reduction actions available in the event of drug use, considering the specificities of using crack, given its prevalence in Brazil; and, in addition, in the event of positive HIV diagnosis, consider starting antiretroviral treatment immediately.

There is also the need for institutionalizing the harm reduction policy within the Unified Health System (SUS) and the Unified Social Services System (SUAS). The interventions on prevention and harm reduction should be carried out without the interference of moral issues and activities should incorporate all key and vulnerable populations, including the prison population, most of the time forgotten by the public policies.

**Conclusions of the meeting with representatives of civil society about harm reduction policy**

**Figure 11** – Combination prevention “mandala”



In Brazil, the combination prevention approach is a response to the epidemic’s concentrated profile, which affects in particular gay men and other men who have sex with men, transvestites and transgender persons, sex workers, young people, and people who use drugs. The Unified Health System offers a variety of prevention commodities and services and its users can choose and combine the prevention methods that best meet their situation of vulnerability, in particular those social groups most affected by the epidemic.

It is necessary to create a calendar of annual campaigns in order to maintain the subject on the agenda of the mass media throughout the year. Little progress has been made on the formal educational system on issues of sexuality, STI, HIV and AIDS prevention and the promotion of self-care. (...) It is important to facilitate the dissemination of information outside of health services, in contexts in which specific populations do not have access.

**Conclusions of the meeting with representatives of civil society about information, education and communication on STI, HIV and AIDS**

Below are descriptions of some of the technological innovations involving combination prevention that have been transforming the horizon of the fight against the HIV epidemic and scaling up access to prevention, especially through specific approaches aimed at key populations.

### **5.1 Post-exposure prophylaxis (PEP)**

Post-Exposure Prophylaxis (PEP) is part of the combination prevention efforts. In Brazil PEP has already been implanted in the Unified Health System. It is a prevention strategy that enables intervention in particular and urgent situations of high exposure to risks of infection.

Use of PEP by starting antiretroviral treatment within 72 hours is recommended following possible exposure to HIV, as provided for by the Brazilian Protocol since 2010. The Unified Health System (*SUS*) offers PEP in several different situations: accidents at work, situations of violence and what is referred to as “sexual PEP”. The recommendations on PEP were revised in December 2014 by the Antiretroviral Therapy Technical Advisory Committee<sup>9</sup>, with the aim of simplifying ARV indication, facilitating patient adherence to taking the medication and, above all, scaling up access to this prevention strategy.

The obstacles to the prevention prophylaxis may be related to prescription mechanisms, as per the 1998 ANVISA Ordinance No. 344, according to which the ARV should be prescribed only by medical doctors. This Ordinance should be revised. Issues of stigma and prejudice also continue to be barriers to incorporate this prevention technology on the health services. Our challenge is to integrate these issues with other interventions aimed at behaviour change.

**Conclusions of the meeting with representatives of civil society about prevention prophylaxis: PEP**

---

<sup>9</sup> In the process of approval by the National Commission of *SUS* Technology Incorporation (*CONITEC*)

## 5.2 Condoms and gel

Brazil is the world's biggest condom buyer.ç In 2014 alone it bought 620 million male condoms and 50 million female condoms. Moreover, Brazil encourages local production, through the Ministry of Health's condom factory in Xapuri, in the state of Acre, where condoms are produced using natural latex extracted in a sustainable manner from the Amazon forest. The factory, created in 2008, is an example of the Ministry of Health social responsibility and sustainable local development, producing on average around 150 million condoms per year.

Apart from the condoms produced at Xapuri, the Ministry of Health distributed free of charge – between 2010 and 2014 alone – 2.2 billion condoms<sup>10</sup>, alongside the social market and the private market, which is disputed by different brands and companies. Public purchasing of condoms is done by the Ministry of Health via procurement. Purchasing processes can take a long time, when compared to purchases made directly from a supplier, but the price, quality and quantity of purchases follow rigorous criteria which often cannot be met immediately by the supplier selected. Logistics is one of the most important aspects of the condom policy, with regard to ensuring that national stocks are kept at ideal levels. International companies are also encouraged to register in Brazil in order to be able to take part in the bidding process, as well as ensuring that they adopt standards of excellence in their negotiations.

In addition to increasing male condom purchases and distribution, Brazil has been investing in promoting access to female condoms. Distribution prioritizes social groups most vulnerable to HIV, such as sex workers; although the use of female condoms assumes encouragement of female autonomy in protection against HIV and other

---

<sup>10</sup> This refers solely to 52mm and 49mm male condoms.

sexually transmitted diseases, as well as avoiding unwanted pregnancies. The purchasing and distribution of gel lubricant, associated with promoting the use of condoms, also characterizes the condom policy in Brazil. 12,500,000 units were purchased in 2014 alone, to meet the demand of the states and municipalities.

**Table 2** – Female condom purchases and distribution. Brazil, 2014.

<b>YEAR</b>	<b>Amount Purchased (Units)</b>	<b>Amount Distributed (Units) <sup>(1)</sup></b>
2014	12,500,000	2,073,500

**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

**Table 3** – Gel lubricant purchases and distribution. Brazil, 2014.

<b>Year</b>	<b>Amount Purchased (Units)</b>	<b>Amount Distributed (Units)</b>
2014	35,000,000*	18,558,997

**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

\*Purchase in progress

The importance of communication actions needs to be highlighted in relation to scaling up access to condoms within the perspective of combination prevention. Although the communication actions do not mention the term “combination prevention”, the advertising and journalistic messages are becoming increasingly emphatic about the need to combine prevention methods, over and above using condoms, encouraging, for example, individual choice to test for HIV.



### **5.3. PrEP feasibility studies in course**

PrEP is characterized by the use of ARV by people who do not have HIV and who, aware of their status of exposure to the virus, choose this prevention resource by taking tablets or using gel.

In 2014, the Ministry of Health, in partnership with the Oswaldo Cruz Foundation and universities, began observational pilot studies in the states of Bahia, Minas Gerais, Rio de Janeiro, Rio Grande do Sul and São Paulo, to accompany the implementation of access to this technological innovation in Emergency Care Units, focusing on strategies for large-scale availability within the Unified Health System. Each state is responsible for ensuring the possibility of this choice.

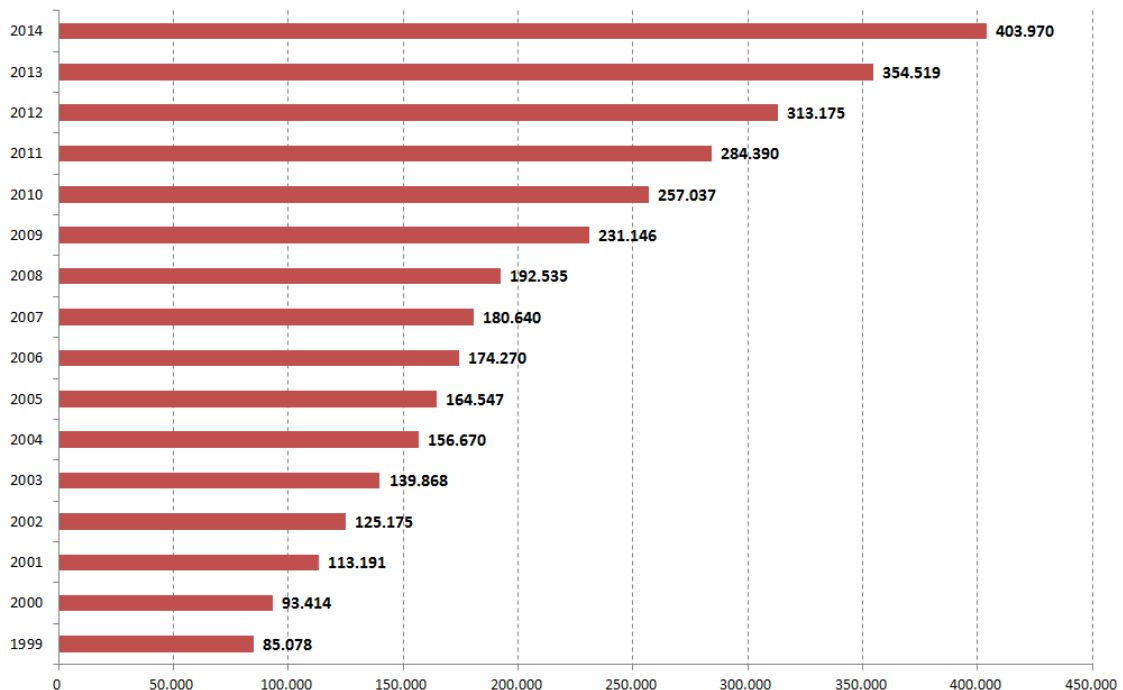
Key populations (including prison populations and young offenders on probation) are segments that must be addressed in current PEP strategies and future PrEP strategies. The challenge is not just mapping hot spots, but also identifying them, reaching them and incorporating them into health action planning, monitoring and evaluation.

**Conclusions of the meeting with representatives of civil society about PEP and PrEP and key populations**

## 6. Universal access to treatment: test and Treat

In order for 90% of people living with HIV to be receiving treatment by 2020, access needs to be scaled up not only to diagnosis but also to treatment. Brazil has guaranteed universal and free of charge access to antiretroviral therapy for people living with HIV/AIDS since 1996. In 2014, the country continued on the front line in adopting innovative technologies of diagnosis, prevention and care to face the challenges posed by the epidemic. Standing out among the most recent actions is the scaling up of the offering of treatment to all HIV positive adults, even when their immune system has not been compromised (CD4). This strategy is known as “Test and Treat”, whereby treatment is also used as a form of prevention (TasP). As at December 2014, more than 400,000 people were receiving antiretroviral treatment in Brazil.

**Graph 11** – Evolution of ARV treatment in Brazil – 1999-2014



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

## **6.1 Test and Treat: 90% of people living with HIV receiving treatment**

Since December 2013, when the Clinical Protocol and Therapeutic Guidelines for HIV Infection Management in Adults (CPTG)<sup>11</sup> was published, the recommendation for starting treatment regardless CD4+, and it is now recommended that it be offered to all people diagnosed with HIV. The aim of this is to provide patients with early clinical benefits and to reduce HIV transmission. Brazil was the third country in the world to adopt the Treatment as Prevention (TasP) strategy in its national recommendations. The new CPTG has enabled treatment options to be simplified, thus enabling the points of HIV and AIDS care to be scaled up.

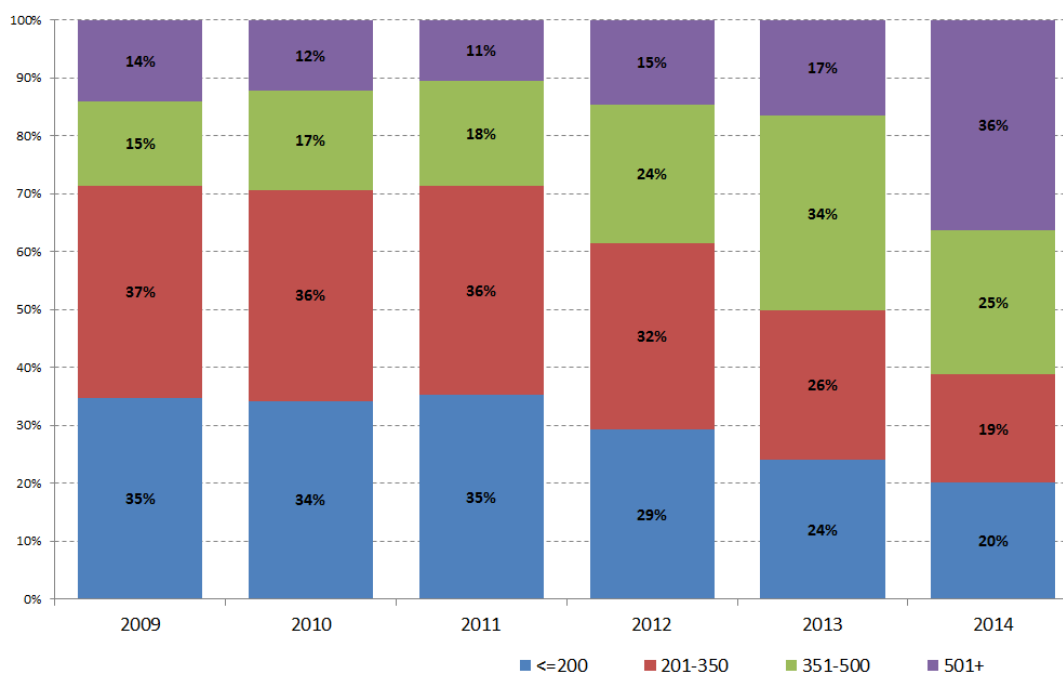
These new guidelines have significantly increased the number of PLHA receiving treatment. In 2014 alone, approximately 75,000 new PLHA started receiving antiretroviral treatment via SUS. This represents an increase of 31% when compared to the same period in 2013.

Based on clinical follow-up data, with effect from the new recommendation to “Test and Treat”, 36% of Brazilian patients who started receiving treatment in 2014 had CD4 counts above 500 cells/mm<sup>3</sup>. This data, as per the following graph, shows that the new protocol is working.

---

<sup>11</sup> Available at [www.aids.gov.br/pcdt](http://www.aids.gov.br/pcdt)

**Graph 12** – Offer to and inclusion of new patients on ARV treatment. Brazil, 2009-2014.



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

Starting treatment early is expected to reduce viral load and this brings benefits for the patient (reduction in morbidity and mortality) as well as for the community (working as a form of prevention and avoiding HIV transmission). *SUS* currently distributes 22 ARV drugs, with 40 different pharmaceutical forms, for treating AIDS, with an investment of approximately US\$ 300 million per annum. Expenditure on medication in 2015 is forecast in the sum of around US\$ 3,4 million.

## **6.2 Shared management: primary care and specialized HIV/AIDS care services**

The large-scale mobilization around diagnosis and treatment has resulted in the need to adjust health services capacity to meet this

new demand, with the aim of ensuring the right to access and to quality health care.

Also equally crucial and opportune is the involvement of the primary care service network in order to increase the availability of care and follow-up for people living with HIV/AIDS.

It should be noted that at the beginning of the AIDS epidemic and in the years that followed, the care model for people living with HIV/AIDS (PLHA) in specialized services, such as the Specialized HIV/AIDS Care Services, was the most effective and safe. As progress was made with caring for PLHA and with the simplification of antiretroviral treatment, HIV infection began to present the characteristics of a chronic condition, and the model centred solely on specialized services began to have limitations.

The need therefore arose to reorganize the health care model for the management of HIV infection at all care levels, in particular by sharing care with primary health care services.

As such, a new model has been developed within *SUS*, representing an evolution of the HIV care models based solely on specialized services, to models whereby different levels of health care take part at different points along the line of HIV and AIDS care<sup>12</sup>.

The specialized HIV and AIDS services have accumulated knowledge on managing the disease and this can and must be shared with primary health care services. These, in turn, are the preferred “way in” to the network, welcoming service users, ensuring linkage and joint responsibility for caring for their health needs. PLHA also need

---

<sup>12</sup> BRASIL. Departamento de DST, Aids e Hepatites Virais. *Cinco passos para a implementação do Manejo da Infecção pelo HIV na Atenção Básica: Guia para Gestores*. Brasília: Ministério da Saúde, 2014. Available at: <<http://www.aids.gov.br/publicacao/2014/cinco-passos-para-implementacao-do-manejo-da-infeccao-pelo-hiv-na-atencao-basica>>. Access on: April 30, 2015..

to take care of several aspects relating to their health (healthy food, physical exercise, immunization, assessment of blood pressure and capillary blood glucose, mental health, among others), in an integral, multiprofessional and longitudinal manner. Primary health care can provide this integrated care approach with the support of specialized services.

Given the magnitude of the Brazilian territory, expanding specialized HIV and AIDS care to the primary care network also enables the scaling up of care for PLHA in regions distant from large urban centres.

The new treatment guidelines and the definition of treatment lines and therapeutic regimens indicated by the adults guidelines contribute greatly to HIV management in primary care. DDAHV has been encouraging this sharing of care with primary care services by means of preparing training materials for service managers, doctors and multiprofessional teams.

### **6.3 Enhancement of information and clinical monitoring systems**

Another important measure for achieving the 90/90/90 targets, with regard to having a greater number of people receiving ARV treatment, is the implementation and enhancement of information systems that help to monitor access and outcome of treatment.

Despite all the progress made, the data showed that there was a considerable number of people not receiving treatment, even though their CD4 result in 2013 was below 500 cells/mm<sup>3</sup>. Based on this information, obtained by linking the SISCEL database (laboratory exams) and the SICLOM database (medication logistics and dispensing), a new database on the treatment gap was created.

With the aim of reducing this gap, the Ministry of Health has been providing health centres caring for PLHA with a new information system: SIMC – the Clinical Monitoring System for People Living with HIV. By means of a simple registration procedure, all health centres that provide HIV care now have automatic access to their respective treatment gaps, with nominal patient information, their CD4+ and the date on which the exam was performed. SIMC enables active tracing of patients needing to start treatment, thus increasing even more the number of people receiving ARV treatment, enabling case follow-up and contributing to a reduction in occurrences of morbidity and HIV transmission.

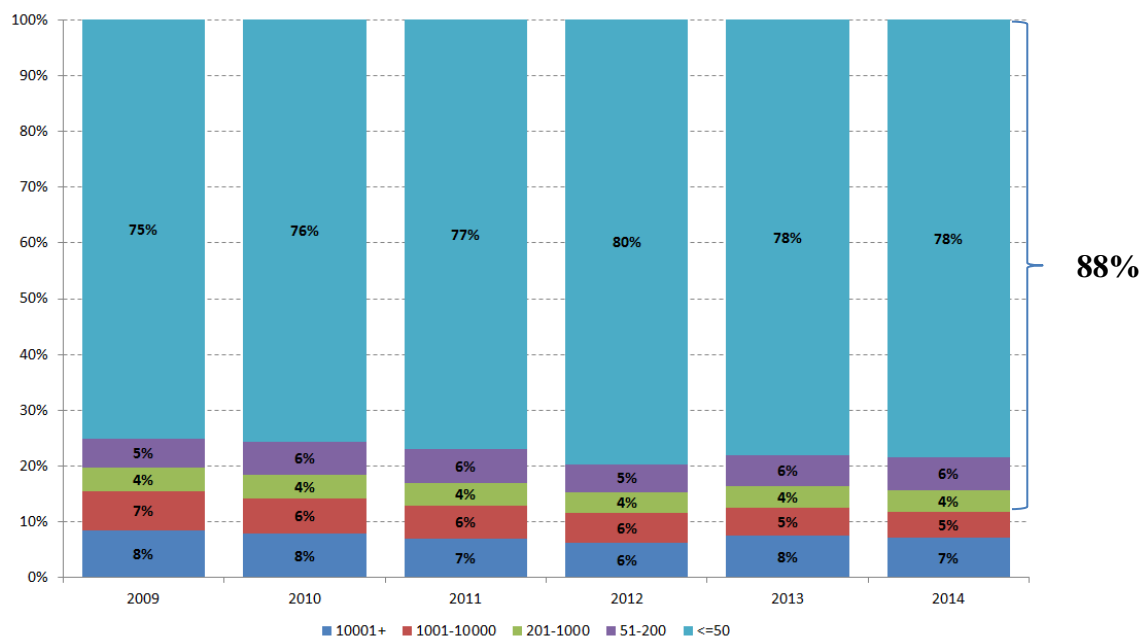
**6.4 Triple fixed-dose combination and adherence to treatment:  
90% of people on ARV virally suppressed.**

Another novelty brought by the new guidelines was the incorporation, in 2014, of the triple fixed-dose combination of the Tenofovir (TDF) + Lamivudine (3TC) + Efavirenz (EFV) regimen. In January 2015, the Ministry of Health distributed this medication to all the Brazilian states. Today it is possible to take just one tablet a day to treat HIV and AIDS, thus improving the adherence and quality of life of PLHA, with positive implications for both treatment and prevention.

Adherence to treatment takes on crucial importance in view of the prospects of PLHA living long lives with good quality of life. Scientific evidence indicates that treatment efficacy, expressed in levels of viral load suppression, requires the treatment regimen to follow as closely as possible the prescribed dosage. Through available information systems, it is possible to perceive that, taking suppressed viral load to be below 1,000 copies/ml (WHO standart), Brazil has around 88% of adults living with HIV receiving treatment with suppressed viral loads 6 months after

starting ARV therapy. This also confirms the occurrence of satisfactory adherence to treatment, as per the following graph.

**Graph 13** – Percentage of people living with HIV receiving treatment, by viral load, 6 months after starting ARVT. Brazil, 2009-2014



**Source:** MoH/Department of STI, AIDS and Viral Hepatitis

In addition, in 2014 the Ministry of Health set up a working group on adherence, with representation of different sectors involved, both governmental and non-governmental. Its aim is to advise the Ministry on the establishment of specific actions and public policies on this matter, particularly with regard to the discussion on new strategies to increase adherence to antiretroviral treatment in Brazil.

Medication distribution should not be centralized (in state capital cities or metropolitan regions); nor should the delivery of ARV drugs be restricted to the four monthly period. The need exists to ensure that those who have “dropped out” are won back, and to increase the availability of “2 in 1” or “3 in 1” for all patients.

**Conclusions of the meeting with representatives of civil society about adherence to treatment**



## 7. Funding

The budget of the Department of STI, AIDS and Viral Hepatitis is organized into four components: (1) surveillance, promotion and prevention: the purpose of which is to ensure resources for epidemiological surveillance and prevention actions, purchasing of prevention commodities, tests for diagnosis and clinical follow-up of patients, maintaining the managerial and technical structure of the Department's core hub; (2) incentives for funding decentralized actions undertaken by states and municipalities; (3) funding for purchasing ARV drugs and (4) purchasing, packaging and distribution of commodities for Viral Hepatitis prevention and control. In 2014 the amount spent on all these components was R\$ 1,251,658,785.98.<sup>13</sup>

Of this total, in 2014, around US\$ 58,330,000.00 were spent on the first component, namely promotion and prevention actions; around US\$ 59,480,000.00 were spent on component 2, through incentives for decentralized actions; and around US\$ 288,000,000.00 were spent on purchasing antiretroviral drugs (component 3). The following table shows the increase in funding over the last ten years, for each of the three components mentioned.

---

<sup>13</sup> The report on total expenditure submitted via the GARPR 2015 on-line tool, seeks to summarize information on the Brazilian response to the epidemic as a whole, i.e., it consolidates the efforts made by the different levels of government. It is therefore not restricted solely to the Department's budget or that of the Ministry of Health, but rather includes information provided by the Federal Administration and subnational governments such as, for example, data provided by the state governments. Further details are provided in the document on funding attached to this report.

<b>Table 4 – DDAHV/HSS/MoH Budget - 2003-2014<sup>14</sup></b>			
Year	(2) Incentive	(1) Prevention and Promotion	(3) ARV
2003	22.666.666,67	23.333.333,33	183.666.666,67
2004	38.666.666,67	46.576.933,33	208.182.652,96
2005	41.421.666,67	44.264.000,00	228.159.814,52
2006	45.166.666,67	69.952.333,33	320.000.000,00
2007	47.166.666,67	78.964.166,67	328.000.000,00
2008	48.583.333,33	60.568.622,33	337.766.666,67
2009	51.984.166,67	65.753.031,67	361.366.666,67
2010	51.984.166,67	65.639.470,67	261.366.666,67
2011	53.333.333,33	65.713.333,33	282.240.000,00
2012	56.000.000,00	75.833.333,33	262.666.666,67
2013	56.000.000,00	77.333.333,33	256.733.333,33
2014	59.479.326,67	58.394.666,67	287.979.066,67

Other details on sources and information regarding Brazilian funding can also be found on the “Global AIDS Response Progress Reporting” (GARPR) spreadsheet submitted on-line, as well as in the detailed document attached to this Narrative Report.

There is a need of optimizing the funding of the HIV and AIDS policy as part of the process of regulating the CSO Regulation Framework Law (Law 13,019/14), which will come into force in August 2015, with proactive participation and advocacy by the Ministry of Health, in articulation with civil society.

**Conclusions of the meeting with representatives of civil society about funding of the HIV and AIDS policy**

<sup>14</sup> Change rate: 1 US\$ = 3 R\$

## **Final considerations**

Recent scientific evidence shows that the instruments to end epidemic levels of AIDS are now available. This is why UNAIDS set the target of ending the HIV epidemic BY 2030. The possibility of ending AIDS as a public health problem places responsibility on governments to incorporate innovations into their public policies and brings hope in combating the epidemic. As shown throughout this report, through the 90/90/90 HIV and AIDS targets Brazil has committed to having, by the year 2020, 90% of people living with HIV/AIDS in Brazil knowing their HIV status; 90% of all people diagnosed as having HIV infection receiving antiretroviral therapy; and 90% of people receiving treatment virally suppressed.

The principles of the Brazilian Unified Health System: universal access to health, equity, integrality and social participation, are the mainstay that will enable us to make headway and make it possible to achieve the post-2015 goals, ending AIDS epidemic by 2030 as one of the Sustainable Development Goals.

Ever since the beginning of the response to AIDS, Brazil has been committed to innovation and effective interventions. In 1996, by means of a national law, universal access to antiretroviral drugs was guaranteed at a time when some international institutions argued that developing countries should concentrate their resources only on prevention and that universal access to treatment would be very expensive and could lead to an epidemic of resistant viruses. As a result of the establishment of this sustainable policy on universal access, today Brazil has more than 400,000 patients receiving ARV treatment.

In 2014, the Brazilian Government adopted new policies and strategies based on scientific evidence, focused on priority populations, incorporating new technologies and always dialoguing with all sectors of

Brazilian society. Current Brazilian guidelines recommend that antiretroviral therapy be offered to all people living with HIV, regardless of clinical or immune criteria, regardless CD4. Through “test and treat” the expectation is to scale up diagnosis; provide better quality of life for people living with HIV; as well as to achieve an important reduction in the number of new infections.

Health-related scientific progress is effective, above all, when guided by respect for human rights and combating prejudice and discrimination. Globally, Brazil has adhered to the Zero Discrimination strategy launched by UNAIDS in 2013. The enactment of Brazilian Law No. 12,984, in 2014, which criminalizes discriminatory conduct towards people with HIV/AIDS, was a step forward in this direction.

Despite the achievements, many challenges have yet to be overcome in the Brazilian response to AIDS such as, for example, strengthening and expanding combination prevention strategies; reducing the gaps in the HIV continuum of care (diagnosis, linkage, retention, treatment coverage and viral suppression); expanding the “test and treat” strategy, reducing the number of PLHA who have not started ARV therapy; implementing new forms of diagnosis and treatment, including shared HIV management in Primary Care; as well as scaling up the availability of quality health services and committing all segments of the Brazilian society in efforts to remove social and cultural barriers, in order to ensure that most vulnerable groups have access to health.

Health conditions are today one of the biggest barriers that humanity has to overcome in order to achieve healthier and longer lives. With this objective, the Brazilian response to HIV expects to be able to contribute to the new agenda for post-2015 sustainable development goals.

## **Bibliography and sources**

## **Appendices**

Meeting held on 17/03/2015

- 1- Attendance list
- 2- Agenda
- 3- Minutes of the meeting



MINISTRY OF HEALTH  
HEALTH SURVEILLANCE SECRETARIAT  
DEPARTMENT OF STI, AIDS AND VIRAL HEPATITIS  
SAF Sul, Trecho 2, Ed. Premium, Torre I, Térreo, Sala 17

70.070-600 – Brasília – DF, Brazil - Tel.: (+55) 61 3306-7146

## ***Global AIDS Response Progress Report - GARPR 2015***

**Technical Consultation - 17/03/ 2015 – MORNING: 8:30/ 13:30 (Lair Guerra Room)**

<b>Time</b>	<b>Activity</b>	<b>Responsible</b>
8:30/9:00	<b>Reception (Events) Opening and welcome</b>	<i>Dr. Fábio Mesquita</i> Director DDAHV  <i>Tatianna Meireles de Alencar</i> International Cooperation Aide DDAHV  <i>Georgiana Braga-Orillard</i> Director UnAIDS Brazil
9:00/9:20	<b>GARPR 2015: requirements and purpose</b>	<i>Georgiana Braga-Orillard</i> Director UnAIDS Brazil
9:20/9:40	<b>The Brazilian response to HIV/AIDS: progress and challenges to achieving the 90/90/90 cascade</b>	<i>Ana Roberta Pascom</i> Coordinator – Monitoring and Evaluation Sector DDAHV
9:40/10:10	<b>Debate</b>	<i>Plenary</i>
<i>10:10/10:30</i>	<i>Break</i>	<i>Coffee</i>
10:30/12:30	<b>Start of working group discussions</b> (Technique, division into groups, comment on trigger	<i>Tatianna Meireles de Alencar</i> International Cooperation Aide DDAHV

	questions)	
12:30/13:30	Break	Brunch

(Groups return to rooms - Lair Guerra, Cazuzza and Renato Russo)

Time	Activity	Responsible
13:30/16:30	<b>Working group discussions</b> (simultaneous activity - Lair Guerra, Cazuzza and Renato Russo Rooms)	<i>Moderator and Rapporteur per group</i>
16:30/16:45	Break	Coffee
16:45/17:45	<b>Presentation – contributions of the working groups</b> (Lair Guerra Room)	Plenary
17:40/ 18:00	Closure	<p><i>Dr. Fábio Mesquita</i> Director DDAHV</p> <p><i>Tatianna Meireles de Alencar</i> International Cooperation Aide DDAHV</p> <p><i>Maeve Mello</i> UnAIDS Brazil</p>

# **Global AIDS Response Report - GARPR 2015 - Brazil**

Brazilian Ministry of Health (MS)

*Minister of Health*

Ademar Arthur Chioro dos Reis

*Health Surveillance Secretary (SVS)*

Antônio Carlos Figueiredo Nardi

*Director of the Department of STI, AIDS and Viral Hepatitis (DDAHV)*

Fabio Caldas de Mesquita

## **Technical Team - DDAHV**

General coordination and preparation of the final text

International Cooperation Unit

Tatianna Meireles de Alencar (advisor), Josi Paz, Mauro Teixeira de Figueiredo and Michele Dantas

Graphic design

Communication Unit

Marcos Cleuton – Cover

Translation

David Harrad

Working Group – Indicators and narrative report

*Strategic Matters Unit (AEE)* – Ivo Brito (director) and Heloísa Vieira Curvello

*International Cooperation Unit (ACI)* – Tatianna Meireles de Alencar, Josi Paz, Mauro Figueiredo and Michele Magalhães Dantas

*Care and Treatment Unit (CAT)* - Marcelo Araújo de Freitas (coordinator) and João Paulo Toledo

*Viral Hepatitis Unit (CHV)*- Marcelo Contardo Moscoso Naveira (coordinator), Elisa Argia Basile Cattapan and Neide Fernandes



*(CIE) Strategic Information Unit* - Gerson Fernandes Mendes Pereira (coordinator) and Mariana Veloso Meireles

*(AMA) Monitoring and Evaluation Unit* – Ana Roberta Pati Pascom (coordinator), Juliana Machado Givisiez and Clarissa Habckost Dutra de Barros

*(CPAS) Prevention and Social Liaison Unit* - Ana Lúcia Ferraz Amstalden (coordinator), Ana Monica de Mello and Liliana Ribeiro

*(CLAB) Laboratory Unit* – Miriam Franchini (coordinator) and Mariana Villares Martins

*(CLOG) Logistics Unit* – Cynthia Júlia Braga Batista (coordinator) and Karim Sakita

### **External contributions to the narrative report**

*Meeting held on 17/3/2015*

#### Academia

Amilcar Tanuri; Ana Britto (UFPE); Esper Kallas (USP); Pamela Ximenes (UnB) Ricardo Kuchenbecker (UFGRS); Ricardo Sobhie Diaz (UNIFESP); Tarcisio Andrade (UFBA); Valdilea Veloso (FIOCRUZ); Jória Viana (UFPB).

#### Civil Society Organizations

ABGLT (Carlos Magno); ABIA (Salvador Correa); ABORDA (Ingrid Farias); ANTRA (Keila Simpson); ART GAY (Leo Mendes); CIDADÃS POSITHIVAS (Heliana Moura); Forum ONG AIDS RJ (Renato da Matta); GEMPAC (Leyla Suely Barreto); RNP (Jair Brandão); REDUC (Daniela Trigueiro); REDE TRANS (Tathiane Araujo); ANAJVHA (Diego Callisto); ANDH (Alexandre Cunha).

#### Health Service Managers

*State-level* – Adriano Caetano (Rio Grande do Sul), Maria Clara Gianna Garcia Ribeiro (São Paulo), Jeane Magavita (Bahia); Marco da Silva Franco (CONASEMS); Milca de Freitas Queiroz Prado (Goiás)

*Federal-level* – Andrey Roosewelt (MS/ SGEP/ DAGP); Katia Souto (MS/ SGEP/ DAGP); Lidiane Gonçalves (MS/SAS); Melquia da Cunha (MS/DAPES/SAS); Valdeeth Santos (DANT)

#### UNO System Agencies

UNAIDS Brazil - Cleiton Euzebio de Lima, Georgiana Braga-Orillard (director) and Maeve Mello

UNESCO – Gina Pancorbo

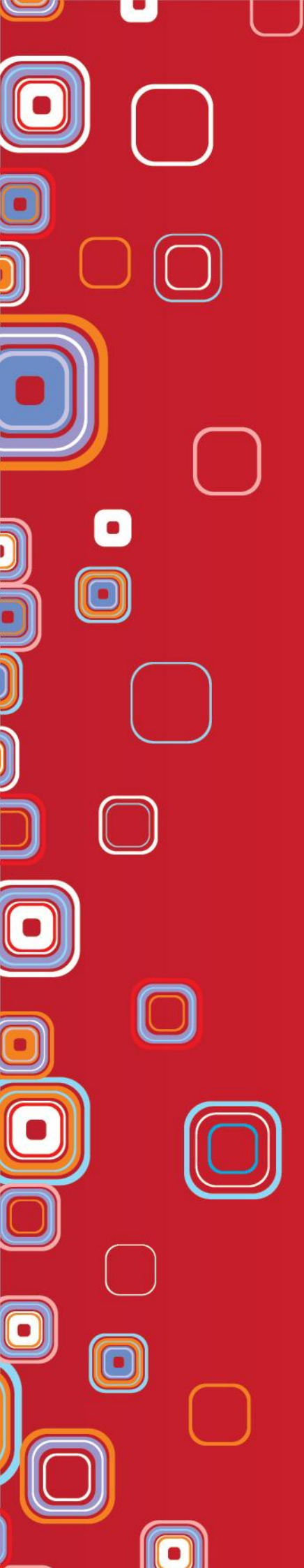
PAHO/ OPAS – Leandro Sereno

Other Agencies

USCDC - Raquel Miranda

Also present at the meeting

Fabio Sartori (ACI); Maira Taques (AMA); Rafaela Medeiros (AMA), Katia Guimarães (Nucleo de Pesquisa/ CIE)



Ministry of  
Health

