

Vera Paiva^I

Ligia Rivero Pupo^{II}

Renato Barboza^{II}

The right to prevention and the challenges of reducing vulnerability to HIV in Brazil

ABSTRACT

The study evaluates the Brazilian response to the targets established by UNGASS for the prevention of HIV/AIDS. The analysis was based on national research, documents and information from the National Program for STD/AIDS and on state-level action plans and targets. Brazil relies on various prevention policies to attain the UNGASS targets proposed for 2005. These include: addressing discrimination issues, promotion of HIV testing, distribution of condoms, needle exchange programs, discussion of sexuality in schools, prevention initiatives for sex workers and homosexuals and prevention in the workplace. These have resulted in increases in testing and condom use. Various challenges are discussed, including: overcoming discontinuity in action plans (particularly with more vulnerable groups), training prevention teams, increasing monitoring of quantity and quality of preventative actions and overcoming regional, racial and gender inequalities. It is concluded that the *right to prevention* is not a priority for entities of social control, nor is it on the social movement agendas. This contrasts with the *right to better HIV treatment*. In order to increase the efficacy of these programs, it is suggested that they be understood and incorporated based on the promotion and guarantee of human rights, thereby advancing the ethical/political debate at local and national levels.

KEYWORDS: HIV. Acquired immunodeficiency syndrome, prevention & control. Sexually transmitted diseases, prevention & control. AIDS serodiagnosis. Condoms, supply & distribution. Human rights. Review. Brazil.

^I Núcleo de Estudos de Prevenção da Aids. Instituto de Psicologia. Universidade de São Paulo. São Paulo, SP, Brasil

^{II} Instituto de Saúde. Secretaria Estadual da Saúde. São Paulo, SP, Brasil

Correspondence:

Vera Paiva
Núcleo de Estudos de Prevenção da Aids
Instituto de Psicologia - USP
Av. Prof. Mello Moraes, 1721
05508-030 São Paulo, SP, Brasil
E-mail: veroca@usp.br

Received: 12/4/2006.

INTRODUCTION

Universal access to free antiretroviral (ARV) medication and HIV testing in Brazil has substantially reduced mortality and morbidity by AIDS, including its vertical transmission.⁸ This is also a result of initiatives for prompt responses to the epidemic, to combat prejudice, and involve the general population, non-governmental organizations (NGOs), and the historically more vulnerable groups.^{10,11}

Although a predominantly Catholic country, sexual topics are discussed openly in Brazilian media and school. In addition to the distribution of millions of condoms, the government is actively involved in STD/AIDS programs with sex workers, it sponsors a gay pride parade in São Paulo (the largest in the world) and distributes clean needles to drug users.

A critical analysis of the Brazilian response has highlighted the importance of the integration of prevention, care and treatment by the Brazilian Unified Health System (*Sistema Único de Saúde - SUS*), with consideration to human rights.^{5,9,15,21} The reference to human rights permits the analysis of vulnerability to HIV/AIDS^{3,20} at the individual, social and program levels with respect to the relationships between gender and power, sexism and homophobia and racism and poverty. These can also guide the planning, organization and evaluation of services.

In this context, health indicators have frequently been pointed to as indices of protection, promotion or of the violation of human rights.²⁰ An example of this is

the incorporation of the language of human rights and of informed choice in normative definitions of sexual health.^{16,*} As a whole, the work in the field of rights still suffers because it is *ad hoc*, single-agency and reactive, when it should be strategic, multi-agency and proactive.¹⁶

The strategic initiative inaugurated in 2001 with the Declaration of Commitment on HIV/AIDS of the Special Session of the United Nations General Assembly (UNGASS) addresses topics relating health to human rights.^{13,26} This agreement established indicators and targets to be monitored by signatory countries. The present work concentrates on indicators and targets number 49, 50, 52 and 53, which concern the prevention of HIV/AIDS in Brazil (Table 1). The first difficulty of this international effort is the ideological polarization of the debate on prevention, which hampers human rights progress. Decisions are made without consideration to rigorous scientific evaluation, such as the insistence on “abstinence-only” policies** or of the dismissal of successful strategies addressing intravenous drug use.⁹

In this debate, for example, defenders of abstinence propose a “just say no” policy (to drugs and sex), based on values (chastity, monogamy, and “ignorance until the first sexual encounter”) not always shared among all citizens.

In Brazil and various other countries, a second difficulty results from the lack of an established forum to discuss national consensuses, theory-based action planning, definitions and agreed principles.^{9,*}

Table 1 - UNGASS targets for 2005.

Target number	UNGASS targets for 2005
49	Reinforce the response to HIV/AIDS in the workplace, establishing and executing prevention and care programs in the public, private and informal sectors, and taking steps to create work environments that support persons living with HIV/AIDS.
50	Create and execute national, regional and international strategies that facilitate access by migrant and itinerant workers to HIV/AIDS prevention programs, including social and health programs.
52	Guarantee the existence in all countries, and particularly those most affected, of a series of prevention programs, which address the circumstances, ethics and local cultural values, that include information, education and communicate in language that the community understands, and respect cultures, meant to reduce high risk behaviors and encourage responsible sexual behavior including abstinence and fidelity; better access to essential items, namely male and female condoms and sterilized needles; measures to reduce damage related to the consumption of drugs; better access to psychological support services and voluntary and confidential analyses; uncontaminated blood banks; and preventative and efficient treatment of sexually transmitted diseases.
53	Guarantee that at least 90% of young persons 15 to 24 years of age in 2005 (and 95% in 2010) of both sexes have access to information, education (including education for couples), education directed specifically to young persons and to the necessary services to acquire life experience needed to reduce their vulnerability to HIV infection, in partnership parents, teachers and health professionals.

Source: United Nations.²⁶

*Paiva V, Ayres JRCM, Franca-Jr I. Expanding the flexibility of normative patterns in youth sexuality and prevention programs. *Sexuality Research & Social Policy*. J NCRRC. 2004;1(1). Disponível em <http://nsrc.sfsu.edu> [acesso em 4 mai 2006]

**Kirby D. Do Abstinence-Only Programs Delay the Initiation of Sex Among Young People and Reduce Teen Pregnancy? (EUA), 2002. Washington (DC): National Campaign to Prevent Teen Pregnancy. Disponível em https://www.teenpregnancy.org/resources/data/pdf/abstinence_eval.pdf [acesso em 10 fev 2006]

Table 2 - Percentage of condom use among persons sexually active during the last 12 months according to sex, year of study and age category, in 1998 and 2005.

Use	Total	Age category			
		16 to 25	26 to 40	41 to 55	56 to 65
Condom					
1998	23.87	44.41	23.73	8.68	1.33
2005	35.37	61.46	36.25	21.06	8.93
Men					
1998	26.06	52.79	23.94	10.70	1.47
2005	38.10	71.40	34.77	22.22	12.76
Women					
1998	21.43	35.35	23.53	6.38	1.05
2005	32.64	50.00	37.53	19.89	3.97

Source: Berquó E, Koyama M. Notas preliminares sobre o uso de preservativo entre pessoas sexualmente ativas nos últimos doze meses teste do HIV e seus diferenciais por sexo, idade, escolaridade, raça, e região. Análise comparativa entre 1998 e 2005. São Paulo: CEBRAP; 2005.

The third difficulty involves the need to address Brazil's health policies in the context of the decentralization of the SUS, which should be undertaken in accordance with the principles of completeness, equity and universality. This has been particularly relevant since the creation of the Incentive Policy and of the Action and Targets Plan (*Plano de Ações e Metas* - PAM) in 2003,* which were developed in conjunction with states, municipalities and NGOs.¹⁰

The present work aims to evaluate the Brazilian response to the AIDS epidemic in relation to the targets established for 2005 in the chapter concerning prevention of the "United Nations Declaration of Commitment on HIV and AIDS".

Administrative documents from the National Program for STD/AIDS (PN-DST/AIDS) of the Ministry of Health, information from members of the technical team and data available from the Institution's webpage** were consulted to analyze the following: counseling and the availability of HIV testing, sex education for young persons, access to male and female condoms, control of STDs, prevention for intravenous drug users and prevention in the workplace (Table 1).

Also the action plans and targets for STD/AIDS for 2003 and 2004 from the states of Rio Grande do Sul, São Paulo, Pará, Pernambuco and Mato Grosso do Sul were analyzed. The criteria used in choosing these states were based in the evaluation of the 100 municipalities with the highest incidence of AIDS in each administrative region of Brazil according to cases reported until 2003.⁷

The initiatives planned and implemented by PAM for STD/AIDS prevention were identified and categorized in light of the decentralization process of the SUS.

ACTION PLAN AND TARGETS

The five states studied planned prevention initiatives during 2003-2004 directed to the populations considered most vulnerable to HIV/AIDS. Conspicuous here were the state programs without a prevention team (2/5) or with a team consisting of a single person (1/5). The discontinuity of prevention initiatives was notable for indigenous groups, truck drivers, rural settlers, elderly, military personnel, and industry and company workers. The group most cited in the allocation of resources were adolescents attending school.

Prevention initiatives conducted by the states concentrate primarily on elaborating, producing and distributing education material or the training of health professional that work in the basic healthcare network. In relation to initiatives to increase access to HIV, Syphilis and Hepatitis testing, training was offered in the basic health care network and new Testing and Counseling Centers (CTA) were implemented in epidemiologically strategic municipalities of Pará and Pernambuco states.

All states programmed inter-agency initiatives that prioritized the secretariats of Education and of Justice. Only in Pernambuco the partnership with Tutoring Councils was cited. Despite the agenda of state coordinators indicating the incorporation of inter-agency initiatives, no mention was made of activities directed to municipal health or education councils in the PAM*** for 2003 and 2004. This suggests there is little interaction between managers in the formulation, consensus and social control of health policies.

Data on the monitoring and evaluation of initiatives

*Ministério da Saúde. Portaria Ministerial nº 2.313, de 19/12/2002, Diário Oficial da União, Seção 1, nº 55, de 20/3/2003, instituindo Incentivo para estados, Distrito Federal e municípios no âmbito do Programa Nacional de HIV/AIDS e outras DST. Disponível em <http://www.aids.gov.br/incentivo/> [acesso em 25 abr 2006]

**Programa Nacional de DST e Aids. Ministério da Saúde. Disponível em <http://www.aids.gov.br> [acesso em 25 abr 2006]

***Ministério da Saúde. Portaria Ministerial nº 2.314, de 20/12/2002, Diário Oficial da União, Seção 1, nº 250, de 27/12/2002, aprovando a Norma Técnica - Incentivo HIV/Aids e outras DST - nº 01/2002. Disponível em <http://www.aids.gov.br/incentivo/> [acesso em 25 abr 2006]

Table 3 - Percentage of sexually active young persons and those using contraception in their first encounter, according to age and sex, 1998 and 2005.

Variable	Men		Women	
Year of research	1998	2005	1998	2005
Sexually active				
16-19	67.8	67.4	54.3	55.2
20-24	97.6	92.4	86.5	84.7
Used contraception during first sexual encounter				
16-19	45.1	68.3	51.0	62.5
20-24	44.0	57.5	30.0	52.4

Source: Berquó E. Comportamento Sexual e Percepções da População Brasileira sobre o HIV/Aids [apresentação]. Brasília (DF): Programa Nacional de DST e Aids; 2005.

at the state level are not always available in an organized and systematic form, thus hampering the evaluation of the STD/AIDS management policy by the state secretariats. This suggests a disjointed relationship exists between the production of these data and decision-making within state STD/AIDS programs, a factor which can reduce the effectiveness of political negotiation in the municipalities and health councils, in inter-institutional forums with non-health sectors and in NGOs.

Access to condoms

Policies designed to increase access to male condoms in Brazil involve the allocation of financial resources from national, state and municipal levels of government.

Male condoms distribution by the Brazilian government increased from 13 million in 1994 to 260 million in 2003.* The significant drop in the quantity distributed by the Ministry of Health from 2004 to 2005 was attributed to operational problems. These include administrative and legal impediments that slowed the certification process for condoms acquired from international purchases (in cases where Brazilian legislation is more rigorous than that of the exporting countries). It was not possible to obtain information on the fulfillment of agreements of the national condom policy by state.

Access to condoms in Brazil has been monitored in various national studies.^{6,24,25,*,**,* **} These reveal an increase in the use of condoms by the population. Between 1998 and 2005, the use of condoms increased significantly in all age groups (Table 2). In research conducted in 2005, use of condom was

greater among young persons having completed elementary schooling and lower among women, black men and in residents of the Central-Western region. The lowest rates of use continue to be seen among illiterate persons.***

Two positive initiatives coincided with the UNGASS targets: the ongoing construction of a national condom factory in Acre State and the distribution of four million female condoms by the federal government in the period leading up to 2004. Brazil is one of the principal buyers of this product in the world.

Concerning youths

The proportion of persons below the age of 20 that use condoms increased from 47.8% in 1998 to 65.8% in 2005, this rate being higher among males (Table 3).

A national study conducted in 2004²⁵ indicated that 57.3% of persons 15-24 years-old used condoms during their last sexual encounter, 58.5% always used condoms with a casual partner and 38.8% used this method with a regular partner.

Another study^{****} indicated that 60.2% of schools in Brazil provide STD/AIDS prevention programs. In high schools this represents 96.2%, in contrast to only 29.7% of elementary schools undertake prevention initiatives. These percentages are reflected in the proportion of teachers qualified to teach such topics: 62.4% in high schools and 29.3% in elementary schools.

Since August 2003, the ministries of Health and of Education have advanced STD/AIDS prevention initiatives, including the availability of condoms for

*Relatório Técnico apresentado na Reunião do Population Council.- Rapid Needs Assessment for Condom Programming: technical report (Brasil), 10 e 11 de março, 2003.

**Ministério da Saúde. Secretaria de Vigilância Saúde/Programa Nacional de DST/Aids. Pesquisa sobre conhecimento, atitudes e práticas na população brasileira de 15 a 54 anos- PECAP. Brasília (DF): Ministério da Saúde; 2005. Disponível em http://www.aids.gov.br/data/documents/storedDocuments/%7BB8EF5DAF-23AE-4891-AD36-1903553A3174%7D/%7BF17DC2BC-C60E-4C6A-96BC-02371A870406%7D/PCAP_2004.pdf [acesso em 10 fev 2006]

***Paiva V, Venturi G, França Jr I, Lopes F. Uso de preservativos. Pesquisa MS/IBOPE 2003. Ministério da Saúde, Programa Nacional de DST/Aids. Disponível em http://www.aids.gov.br/final/biblioteca_ibope/artigo_preservativo [acesso em 10 fev 2006]

****Berquó E, Koyama M. Notas preliminares sobre o uso de preservativo entre pessoas sexualmente ativas nos últimos doze meses teste do HIV e seus diferenciais por sexo, idade, escolaridade, raça, e região. Análise comparativa entre 1998 e 2005. São Paulo: CEBRAP; 2005.

*****Ministério da Educação e Cultura. Censo Escolar, INEP. 2005. Dados não publicados.

Table 4 - Percentage of HIV tests undertaken, according to sex, age, region, and race, in 1998 and 2005.

Variable Research	Men		Women	
	1998	2005	1998	2005
Age				
16-25	18.7	14.6	14.8	38.8
26-40	39.1	39.4	21.1	48.5
41-55	23.2	30.9	9.7	28.5
56-65	3.4	21.8	1.0	12.2
Region				
North	15.6	18.0	4.4	19.6
Midwest	29.5	39.2	10.6	34.0
South	29.7	29.6	20.4	40.6
Race				
White	30.0	29.6	15.9	40.5
Black	22.6	26.4	14.1	31.5

Source: Berquó E, Koyama M. Notas preliminares sobre o teste do HIV e seus diferenciais por sexo, idade, escolaridade, raça, e região. Análise comparativa entre 1998 e 2005. São Paulo: CEBRAP; 2005.

students aged over 14.* The School Census indicated that 9.1% of schools made condoms available for their students.

A study** of Municipal STD/AIDS Programs analyzed the project described above and found that 67.5% of Municipal Health Secretariats allocate resources for prevention in their PAM for school networks. Despite 88.4% of municipal programs addressing prevention initiatives in partnership with education, the majority do not include condom distribution programs to municipal schools (88.3%). The lack of human resources is one of the primary reasons indicated by the program coordinators for the failure to execute prevention initiatives with young persons in schools, with 35% stating they do not possess the appropriate technical know-how.

The availability of condoms in schools is still low in Brazil. The students that these programs reach are primarily of high school age, despite the presence of students over 14 years of age in elementary schools. Ninety-six percent of municipal programs concentrate their actions in the distribution of education material to schools, 95% conduct lectures, 71% train teachers and 68% conduct prevention workshops,** the same categories seen in 1999.***

The focus on information and seminars, although necessary, is insufficient to promote safer sex and

strengthen students' understanding of their own sexuality, which depends on a forum promoting the effective participation of students, as is established by UNGASS target 53. In another study, young persons aged 15-24 were those proportionally worse at identifying the causes HIV transmission (62%, compared to 71% of adults 25-39 years of age and 67.1% of adults over 40).^{25.****}

In order to reach young persons not formally enrolled in the school network, the PN-DST/AIDS initiated pilot projects in 2005 with homeless boys and girls from state capitals and other metropolitan regions with large numbers of such children. In addition, regulations were passed to address the health of incarcerated youths, which include the components of STD/AIDS prevention and assistance.

Offer of HIV testing and counseling

The percentage of persons tested increased significantly during recent years, from 20% in 1998 to 32.9% in 2005.***** Nevertheless, the majority of those tested were women in the age range from 25 to 39 (Table 4), a proportion that is explained by the inclusion of HIV testing in prenatal care. These data reveal an important advance in the access of the female population to early HIV/AIDS diagnosis,***** but also suggest that men are not being reached by these efforts. Women that are not pregnant probably

*Projeto Saúde e Prevenção nas Escolas. Dados não publicados.

**Ministério da Saúde. Levantamento sobre o Projeto Saúde e Prevenção nas Escolas, 2005. (relatório não publicado).

***Ministério da Saúde. Coordenação Nacional de DST/AIDS/UNESCO. Levantamento nacional sobre prevenção de DST/AIDS e de uso indevido de drogas em escolas. Série Avaliação 3; 2000. Disponível em <http://www.aids.gov.br/avalia3/home.htm> [acesso em 10 fev 2006]

****Ministério da Saúde. Secretaria de Vigilância Saúde/Programa Nacional de DST/AIDS. Pesquisa sobre conhecimento, atitudes e práticas na população brasileira de 15 a 54 anos- PECAP. Brasília (DF): Ministério da Saúde; 2005. Disponível em http://www.aids.gov.br/data/documents/storedDocuments/%7BB8EF5DAF-23AE-4891-AD36-1903553A3174%7D/%7BF17DC2BC-C60E-4C6A-96BC-02371A870406%7D/PCAP_2004.pdf [acesso em 10 fev 2006]

*****Berquó E, Koyama M. Notas preliminares sobre o teste do HIV e seus diferenciais por sexo, idade, escolaridade, raça, e região. Análise comparativa entre 1998 e 2005. São Paulo: CEBRAP; 2005.

*****Ministério da Saúde. Secretaria de Vigilância Saúde/Programa Nacional de DST/AIDS. Pesquisa sobre conhecimento, atitudes e práticas na população brasileira de 15 a 54 anos - PECAP. Brasília (DF): Ministério da Saúde; 2005. Disponível em http://www.aids.gov.br/data/documents/storedDocuments/%7BB8EF5DAF-23AE-4891-AD36-1903553A3174%7D/%7BF17DC2BC-C60E-4C6A-96BC-02371A870406%7D/PCAP_2004.pdf [acesso em 10 fev 2006]

*****Ministério da Saúde. Sistema de Monitoramento de Indicadores do Programa Nacional de DST/AIDS. MONITORAIDS. Versão 1.0. Brasília (DF); dezembro 2005. Disponível em <http://www.aids.gov.br/monitoraids> [acesso em 10 fev 2006]

also do not benefit from these policies. Inequalities were observed in relation to schooling level, geographic regions and race, with black men being the demographic category least tested since the end of the 1990s (22 % in 1998 and 26% in 2005).

There are today 322 CTAs in Brazil and the process of decentralizing HIV diagnosis from federal to local healthcare networks is ongoing. This is driven partly by the "You Should Know" (*Fique Sabendo*) campaign launched in 2003 by the federal government,* a program that has increased requests for HIV testing by 30%.** However, because Brazilian policies have developed based on assistance services specialized to AIDS (such as STD/AIDS Reference Centers and CTAs), the incorporation of initiatives related to HIV/AIDS in the basic healthcare network has been relatively slow. HIV testing is considered by technicians difficult to assimilate into the routine of basic healthcare networks and counseling is not well established theoretically, which hampers its expansion.

Recent research with both population and HIV-positive individuals suggests that counseling is little valued as a strategic field of prevention.^{14,22}

Workplace

There is no data on the number of large companies that offer prevention programs, as requested by the UNGASS indicator. In Brazil, initiatives for prevention in the workplace began at the end of the 1980s and the federal government has created mechanisms for the protection of workers affected by the epidemic.***

Despite advances in Brazilian legislation,**** issues related to employment are the second most frequent cause of rights violations for persons living with HIV/AIDS. The illegal use of HIV testing as a condition of employment is responsible for 7.8% of tests undertaken in the country.

In 1997, the PN-DST/AIDS instituted the National Corporate Council, which comprises 25 large companies

and aims to mobilize the sector toward HIV/AIDS prevention. Since 2005, these Councils have become decentralized to state level. However, the prevention strategies adopted by the companies involved do not reach the most vulnerable workers (unemployed, those with less schooling, and those linked to the informal or undocumented economy).

In recent years, STD/AIDS programs have become increasingly affiliated with labor unions and social services for commerce, industry and transport to develop initiatives for training and execution of prevention projects. These services, whose mission is to educate, train and qualify individuals to re-enter the job market, target primarily the more vulnerable workers. Nevertheless, they have limited reach within the country and until now were primarily carried out in short and discontinuous programs.

Harm reduction among Injecting Drug Users

Studies^{17,24} indicate an HIV prevalence of 0.2% among Injecting Drug Users (IDU) sampled. Considering the relative size of the IDU population, it was possible to estimate that the rate of infection had declined.***** This reduction has been attributed to the increased use of crack and to the death of addicts.^{1,4,12} Several studies^{13,*****} indicate, however, that there was a significant increase in the percentage of IDUs that abstain from sharing needles, reaching 76% in 1999, demonstrating the efficacy of prevention programs in Brazil.

The harm reduction strategy adopted by the Ministry of Health has expanded since its enactment in 1994.¹³ Initiatives were increased to include not only IDUs, but also users of crack and alcohol. In 2000, this strategy was incorporated into the National Anti-Drug Policy and in 2005, was legislated by the federal government. Its aim is to reach drug users by incorporating needle exchange programs into the services provided by the SUS healthcare network, thus reducing the incidence of HIV and Hepatitis in this population. Five states and nine municipalities from the Southern and Southeastern regions (those most developed in

*Informações sobre o "Fique Sabendo" estão disponíveis em <http://www.aids.gov.br/data/Pages/LUMISE77B47C8ITEMIDF6588EE5C95C42E0AF705B0395961E07PTBRIE.htm> [acesso em 25 abr 2006]

**Ministério da Saúde. Sistema de Monitoramento de Indicadores do Programa Nacional de DST/Aids. MONITORAIDS. Versão 1.0. Brasília (DF); dezembro 2005. Disponível em <http://www.aids.gov.br/monitoraids> [acesso em 10 fev 2006]

***Ministério da Saúde. Legislação sobre DST e Aids no Brasil, Programa Nacional DST/Aids - Unidade de Articulação com a Sociedade Civil e Direitos Humanos (organizadores); 2000. Disponível em <http://www.aids.gov.br/final/biblioteca/legislacao> [acesso em 15 abr 2006]

****Conselho Federal de Medicina. Resolução nº 1.359/92. Dispõe sobre o atendimento a portadores do vírus da Aids. Disponível em http://www.aids.gov.br/final/biblioteca/legislacao/vol2_16.htm (14 of 18) [acesso em 15 abr 2006]

*****Ministério da Saúde. Secretaria de Vigilância Saúde/Programa Nacional de DST/Aids. Pesquisa sobre conhecimento, atitudes e práticas na população brasileira de 15 a 54 anos - PECAP. Brasília (DF): Ministério da Saúde; 2005. Disponível em http://www.aids.gov.br/data/documents/storedDocuments/%7BB8EF5DAF-23AE-4891-AD36-1903553A3174%7D/%7BF17DC2BC-C60E-4C6A-96BC-02371A870406%7D/PCAP_2004.pdf [acesso em 10 fev 2006]

*****Ministério da Saúde. Secretaria de Políticas de Saúde. Coordenação Nacional DST/Aids. A Contribuição dos Estudos Multicêntricos frente à Epidemia de HIV/Aids entre UDI no Brasil: 10 anos de pesquisa e redução de danos. Brasília (DF); 2001. [Série Estudos Pesquisas e Avaliação nº 2]

Brazil) have enacted laws specifically targeting damage reduction. This represents a step forward in the strengthening and promotion of prevention policies, but is also evidence of regional inequalities.

The ongoing decentralization of prevention programs in Brazil has made the states and municipalities responsible for the execution and monitoring of these initiatives. One-hundred thirty-four STD/AIDS prevention projects with drug users were identified in Brazil.¹² Nevertheless, the PN-DST/AIDS possesses information only on the 38 such projects that it funds.

FINAL CONSIDERATIONS

Several advances were seen relating to the targets proposed for 2005. Brazil has enacted a large number of prevention programs dedicated to the groups and situations detailed in targets 49, 52 and 53. The reduction of vertical transmission, the increase of testing and the increased use of condom are important results of the plan to reduce individual vulnerability to HIV/AIDS.^{6,9,25,*}

In this process, the effort to integrate STD/AIDS prevention initiatives into the basic healthcare network is noticeable and is a result of the decentralization policies of the SUS. The PN-DST/AIDS has sponsored descriptive studies and systems to monitor the management of the proposed initiatives and of prevention attitudes, behavior and practices. However, research that evaluates prevention strategies and practices are extremely rare.^{10,**} Likewise, the Latin-American literature concentrates primarily on the in-depth description of only a few, highly localized, projects.⁹

The discussion of local ethics and cultural values, as defined by target 52, depends on the way in which initiatives are undertaken; if groups holding traditional values are being addressed and if minorities are considered; from initial design to the evaluation of results. Men and women may or may not realize their desires and intentions within the limit of their social and cultural context and their moral options, beyond what techno-science can justify and control. The majority of prevention initiatives have some impact (or none) on cultural and symbolic aspects, and not directly on individual conduct; when they can promote important changes, programs can affect other programs, innovate cultural circumstances and change attitudes and practices.²⁰ Prevention programs, therefore, have a long maturation time.

There remain, however, several challenges:

- a) The discontinuity of initiatives and the lack of trained professionals affect every topic discussed herein, be it in the school environment or the workplace. This impedes the renovation needed to account for the new generations that are gradually maturing into sexual and reproductive life, as well as of the innumerable subjective, cultural and social local dimensions that have undergone historical changes and continuously shape the behavior of individuals and groups.
- b) There is no data on the processes that permit an analysis of the quality of governmental prevention initiatives, nor of the interpretation of changes at the individual and collective levels. The focus on information, and principally which information is valued, should be questioned, as should be the "pamphleting" approach.
- c) Counseling is not always a democratic moment of personalized discussion of doubts, risks, attitudes and social contexts; many times it is a health practice that is ignored, made banal or undertaken by specialized services or by the basic healthcare network without theoretical foundations.
- d) The available data on STDs in Brazil do not allow an estimate of the percentage of patients diagnosed and treated adequately by the healthcare services, as defined in the UNGASS indicator. There exists no information on the number of municipalities, services and professionals trained in symptomatic and etiological evaluation of STDs and there was little emphasis on STD diagnostic and treatment initiatives in the PAMs. The difficulty in controlling STDs in Brazil contrasts with successful progress in using ARVs and deserves its own research agenda, which has only recently been addressed.
- e) There is no record of studies with the migrant and itinerant populations, as defined in target 50.
- f) There is no information on initiatives developed in the private sector (education, health and companies not associated with the Corporate Council), nor on programs to regulate and monitor this sector, as defined in the UNGASS targets.
- g) The information available on prevention activities is insufficient and the decisions taken by administrators in the various governmental areas are occasionally contradictory, turning the monitoring of initiatives difficult. If decentralization is desired, there arises a corresponding challenge to monitoring and social control, a basic principle of the SUS.

There are various initiatives in the social vulnerabil-

*Paiva V, Venturi G, França Jr I, Lopes F. Uso de preservativos. Pesquisa MS/IBOPE 2003. Brasília (DF): Ministério da Saúde, Programa Nacional de DST/Aids. Disponível em http://www.aids.gov.br/final/biblioteca_ibope/artigo_preservativo [acesso em 10 fev 2006]

**Paiva V, Ayres JR, França Jr I. Expanding the flexibility of normative patterns in youth sexuality and prevention programs. Sexuality Research & Social policy. *J NCRC*. 2004;1(1). Disponível em <http://nsrc.sfsu.edu> [acesso em 4 mai 2006]

Table 5 - Governmental policies and programs relating to respect, protection and promotion of the right to prevention.

Area of STD/AIDS prevention	Respect	Protection	Promotion
Social and cultural preconditions	Government does not violate civil, political, economic and cultural rights of persons, recognizing that the negligence or violation of rights impacts the control of STD/AIDS	Government prevents violation of civil, political, economic and cultural rights on the part of private entities, recognizing that the negligence or violation of rights impacts the control of STD/AIDS	Government takes administrative, legislative, judicial and other measures directed to the promotion and protection of human rights, as well as making legal means and forums accessible to enable prevention initiatives and mechanisms for public control
Programs dedicated to prevention	Government does not violate planning, implementation and evaluation rights of STD/AIDS prevention programs, assuring that the programs be accessible, efficient and of high quality for the entire population	Government regulates private entities (associations, insurance companies, schools, companies and private organizations in general) and prevents rights violations in planning, monitoring and evaluation of prevention programs and guaranteeing conditions leading to informed and practical decisions	Government takes administrative, legislative, judicial measures to promote the equitable allocation of resources and the construction of support networks that assure prevention programs be accessible, efficient and of high quality for everyone, assuring mechanisms for the social control
Results of policies and programs for protection of persons and groups	Government assures rights without discriminating based on health, sex, race, sexual orientation, age and residence, including everyone in the planning, monitoring and evaluation of prevention programs and guaranteeing conditions leading to informed and practical decisions	Government prevents private entities (associations, insurance companies, schools, companies and private organizations in general) from violating rights based on health, sex, race, sexual orientation, age and residence, including everyone in planning, monitoring and evaluation of prevention programs and guaranteeing conditions leading to informed and practical decisions	Government takes administrative, legislative, judicial and other measures to promote and protect the rights of persons without discriminating based on health, sex, race, sexual orientation, age and residence, including everyone in planning, monitoring and evaluation of prevention programs and guaranteeing conditions leading to informed and practical decisions

Adapted from Gruskin & Tarantola¹³ (2005)

ity plan and interventions (laws, regulations and decrees) to justify the program decisions. Important initiatives against discrimination, such as the protection of sexual rights, are emblematic of the Brazilian response. Unfortunately, homosexuals, transsexuals and sex workers are not included in the UNGASS indicators or targets. On the other hand, even if the programs adopt references to vulnerability and human rights, some groups continue to be systematically under-protected. In this plan for social vulnerability remaining challenges include:

- The decrease of regional, racial, age and gender inequalities, which are also present in other Latin-American countries.⁹ These remain because of a lack of innovation in research methodologies to monitor populations that are difficult to reach, but are highly vulnerable to HIV/AIDS: homosexuals, IDUs and sex workers.
- The increase in initiatives to monitor tangible acts of discrimination in the workplace or in the specialized AIDS services, particularly of the reproductive rights of carriers and young persons.^{3,18}
- The prioritizing of prevention initiatives to addressing young persons; schooled versus non-schooled, high school students in relation to those

in elementary school; are evidence that prevention initiatives reduce the vulnerability of some groups. It is known that high school students represent the Brazilian youth demographic most protected in relation to sexual activity.*

- The increase in the monitoring of prevention initiatives related to racial inequalities. It is notable that the theme for World AIDS Day in Brazil in 2005 focused on the question of race.

Prevention as a right

The comparison between the findings herein and the UNGASS targets confirm that assistance is first instituted and is then followed by prevention.⁹ The social movement in Brazil, which is fundamental to developing an answer to the AIDS issue, began fighting for access to high-quality assistance for carriers and, in the 1990s, for the right to treatment. However, the right to prevention is still rarely addressed in the agendas of the social movement and by the entities of social control. In other words, there is little activism for the "right to prevention"; the mobilization for *access to the prevention material* (condoms and hypodermic needles), for *access to*

*Paiva V, Venturi G, França Jr I, Lopes F. Uso de preservativos. Pesquisa MS/IBOPE, 2003. Brasília (DF): Ministério da Saúde, Programa Nacional de DST/Aids. Disponível em http://www.aids.gov.br/final/biblioteca_ibope/artigo_preservativo [acesso em 10 fev 2006]

information, education, or high quality counseling; even where the interface with assistance services is higher, as is the case with *access to quality STD treatment, of sexual and reproductive health* or the *prevention of vertical transmission*.

The scarcity of administrative documents from state Health Agencies and of recent research on themes analyzed herein complicates a more in-depth analysis of the targets indicated in the "Prevention" chapter of the Declaration. Thus, creating a monitoring capacity using the network of organizations in civil society at the local level, but able to articulate at the national level, is a substantial challenge. The reference to human rights used in the present context and expounded in Table 5, can be useful to this end.

Changes in the field of prevention will also depend on the momentum of decision-making at the local level. Agreement on prevention based on the guarantee of rights is more realistic than attempting to reach a consensus on values, for example. Defining prevention as a right advances the "banking" analogy, whereby the participant is a "consumer" of pre-defined proceeds and values of behavior, leading to a dialogue that includes subjects and considers their values and sociocultural contexts.¹⁹ The "banking" concept, for example, removes from the debate the girl who "wants to marry as a virgin" and is uncomfortable with the demonstration of condom use in safe sex workshops, but is infected by her only partner after marriage. This applies similarly to a young man that, not having been taught how to protect himself in a homosexual context, will live his sexual life unprotected and uninformed.

The critical analysis of prevention programs can benefit from the global and local potential of human

rights.²³ In the context of the right to prevention, the participant is not the object of behavior modification techniques or of persuasion by marketing. She or he possesses rights and is a citizen who can, in turn, eventually propose rights (e.g. assisted fertilization for HIV carriers or distribution of condoms in school). The language of rights facilitates the continuity of programs and sustains innovation. The consensus is more robust when agreement is reached between distinct worldviews without coercion and where these visions can be shared, understood and considered in potential solutions.²

In this way, the lessons learned from long-term endeavors, which are subject to revision after each election or change of team, will endure in the face of the openly ethical-political human rights debate. Interaction and communication, in this context, permit that values, symbols and feelings (individual or of a group) find a forum in which to be expressed and debated; that in the midst of the diverse options and circumstances of life, recognition exists of the impact of inequality and the right to differences in actions of protection against HIV.

ACKNOWLEDGMENTS

We acknowledge the technicians at the National Program for STD/AIDS and those of the state programs for São Paulo, Pernambuco and Rio Grande do Sul for supplying material and information used herein; to the researchers and representatives of civil society and non-governmental organizations that participated in the seminar titled "Monitoring and Assessment Seminar on Target and Commitment Fulfillment relating to the United Nations Declaration of Commitment on HIV/AIDS", São Paulo, November 21st and 22nd, 2005.

REFERÊNCIAS

1. Andrade T, Lurie P, Medina MG, Anderson K, Dourado I. The opening of South America's first needle exchange program and an epidemics of crack use in Salvador, Bahia, Brazil. San Diego, California. *AIDS & Behavior*. 2001;5:51-64.
2. Aragão L. Habermas: filósofo e sociólogo do nosso tempo. São Paulo: Tempo Brasileiro: 2002.
3. Ayres JR, Paiva V, Franca Jr I, Gravato N, Lacerda R, Della Negra M et al. Vulnerability, Human rights, and comprehensive health care needs of young people living with HIV/AIDS. *Am J Public Health*. 2006;31
4. Bastos FI, Bongertz V, Morgado MG, Hacker MA, Teixeira SL. Is human immunodeficiency virus/acquired immunodeficiency syndrome decreasing among brazilian injection drug users? Recent findings and how to interpret them. *Mem Inst Oswaldo Cruz*. 2005;100(1):91-96.
5. Berkman A, Garcia J, Munoz-Laboy M, Paiva V, Parker R. A critical analysis of the Brazilian response to HIV/AIDS: lessons for controlling and mitigating the epidemic in developing countries. *Am J Public Health*. 2005;95:1162-72.

6. Berquó E, coordenador. In: Comportamento sexual da população brasileira e percepções do HIV/AIDS. Brasília (DF): Ministério da Saúde, Secretaria de Políticas de Saúde, Coordenação Nacional DST e Aids; 2000. [Série Avaliação nº 4]
7. Boletim Epidemiológico. Ministério da Saúde. Programa Nacional DST/Aids. Brasília (DF); 2004;16(1).
8. Brito AM, Sousa JL, Luna CF, Dourado MI. Tendência da transmissão vertical de Aids após a terapia anti-retroviral no Brasil. *Rev Saúde Pública*. 2006;40(Supl):18-22.
9. Cáceres C. Intervenciones para la prevencion de VIH e ITS em América Latina y Caribe: uma revision de la experiencia regional. [Interventions for HIV/STD prevention in Latin América and the Caribbean: a review of the regional experience]. *Cad Saúde Pública*. 2004;20(6):1468-85.
10. Camargo Jr KR. Prevenção do HIV: desafios múltiplos [HIV prevention: multiple challenges]. *Divulgação Saúde Debate*. 2003;70-80:204-14.
11. Chequer P, Marins JRP, Possas C, Valero JDA, Bastos FI, Hearst N. AIDS research in Brazil [Introduction]. *AIDS*. 2005;19(4):S1-S3.
12. Fonseca ME, Ribeiro JM, Bertoni N, Bastos FI. Os programas de redução de danos ao uso de drogas no Brasil: caracterização preliminar de 45 programas. *Cad Saúde Pública*. 2006;2(4):761-70.
13. Gruskin S, Tarantola D. Health and human rights. In: Gruskin S, Grodin MA, Annas GJ, Marks SP, editors. Perspectives on health and human rights. London/ New York: Routledge; 2005. p. 3-58.
14. Marques H, Latorre MR, Negra MD, Pluciennik A, Segurado A, Ayres JR, Buchala CM, França Jr I, Paiva V. Falhas na identificação da infecção pelo HIV durante a gravidez no Estado de São Paulo. *Rev Saúde Pública*. 2002;36(3):385-92.
15. Mesquita F, Doneda D, Gandolfi D, Nemes MIB, Andrade T, Bueno D, Piconez-Trigueiros D. Brazilian Response to the Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome Epidemic among Injection Drug Users. *Clin Infect Dis*. 2003;37:S382-S5.
16. Miller AM, Vance C. Sexuality, human rights and health. *Health Human Rights*. 2004;7(2):5-15.
17. Ministério da Saúde. Secretaria de Políticas de Saúde. Coordenação Nacional de DST e Aids. Pesquisa entre os Conscritos do Exército Brasileiro, 1996-2000: retratos do comportamento de risco do jovem brasileiro a infecção pelo HIV. Brasília (DF): Ministério da Saúde, CN DST/Aids; 2002. [Série Estudos Pesquisas e Avaliação nº 2]
18. Paiva V, Segurado A, Felipe EV, Santos N, Lima TN. Sem direito de amar? A vontade de ter filhos entre homens (e mulheres) vivendo com o HIV. *Rev Psicologia USP*. 2002;13:105-34.
19. Paiva V. Sem mágicas soluções: a prevenção e o cuidado em HIV/Aids e o processo de emancipação psicossocial. *Interface*. 2002;6(11):25-38.
20. Paiva V. Analysing sexual experiences through 'scenes': a framework for the evaluation of sexuality education. *Sex Educ*. 2005;5(4):345-59.
21. Paiva V. Beyond magic solutions: prevention of HIV and AIDS as a process of Psychosocial Emancipation. *Divulg Saúde Debate*. 2003;27:192-203.
22. Segurado A, Latorre MR, Pluciennik A, França Jr I, Ayres JRCM, Marques H, Lacerda R, Gravato N, Miranda S, Paiva V. Evaluation of the care of women living with HIV/AIDS. *AIDS Patient Care STDs*. 2003;17(2):85-94.
23. Souza Santos B. In: Reconhecer para libertar. Os caminhos do cosmopolitismo multi-cultural. Rio de Janeiro: Civilização Brasileira; 2003.
24. Szwarcwald CL, Castilho EA, Barbosa Jr A, Gomes MRO, Costa EAM, Malett BV, Carvalho RF, Oliveira SR, Chequer P. Comportamento de risco dos conscritos do Exército Brasileiro, 1998: uma apreciação da infecção pelo HIV segundo diferenciais socioeconômicos. *Cad Saúde Pública*. 2000;16 Supl 1:113-28.
25. Szwarcwald CL, Barbosa-Junior A, Pacom AR, Souza-Jr PR. Knowledge, practices and behaviors related to HIV transmission among the Brazilian population in the 14-54 years age group, 2004. *AIDS*. 2005;19(Suppl 4):S42-S50.
26. UNAIDS. Organização das Nações Unidas. Declaração de Ccompromisso sobre o VIH/SIDA. Sessão extraordinária da Assembléia Geral sobre o VIH/ SIDA. Portugal, 25-27 de junho de 2001.