

Thirty years of confronting the Aids epidemic in Brazil, 1985-2015

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Abstract *The Brazilian response to AIDS started in 1985, with government, civil society and academic community coming together with common goals. This was strengthened with the establishment in 1988 of an universal public health system (SUS), pivotal to a comprehensive and human rights-based national STD/AIDS programme, aiming at achieving equality, integrality, inclusion and fighting prejudice and discrimination. In 1996 Brazil was a pioneer in providing treatment free-of-charge to all PLHA. This article depicts achievements and setbacks that occurred in these 30 years and the perspectives for controlling and eventually eliminating HIV/AIDS. It is fair to affirm that it is possible to defeat prejudice and discrimination and to confront the unacceptable levels of disparity, fertile ground for dissemination of HIV/AIDS and other epidemics. Tools to eliminate transmission, to adequately treat PLHA, to protect their rights, to eliminate discrimination and to end AIDS are already at hand. However, the needed changes for this to happen involve expansion of access to education, including sexual education and to quality public health care to all. It is also necessary to constant confront conservatism and to combat violence and discrimination. Brazil's track record in the confrontation of AIDS is an invaluable asset to achieve these goals.*

Key words *AIDS confrontation, Brazil, Perspectives*

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Introduction

*A vida é curta,
O conhecimento é vasto
As oportunidades passageiras,
A experiência enganosa
O julgamento difícil*
Hipócrates (460-370 BC)

Commemorative dates are always a good moment to review the past, evaluate the present and plan the future. The Brazilian response in confronting Aids was and has been exemplary, with major advances, and a few, indefensible setbacks, over these three decades.

The 1st decade (1980-1989) was set against the background of a re-democratization process in Brazil.

‘The “appearance” of AIDS’ - in 1981, the Centers for Disease Control (CDC USA)¹ made the first report on opportunistic diseases among young, previous healthy, homosexual people. The emergence of this serious and deadly epidemic, involving the diverse aspects of human relations (sex, death, discrimination and prejudice) revealed the great difficulty of implementing prevention, developing effective medication at an accessible cost and, furthermore, of making efficacious vaccines available, as well as drawing attention to the disparities within and between countries.

In a contradictory yet positive manner, the spread of AIDS brought about beneficial by-products e.g. the involvement of civil society demanding access to information, to research grants and new medicines, besides the expansion of the discussion about complex themes (sexual rights, human rights, death issues, illegal drug use, confidentiality).

Fear was the easiest sentiment to understand and, theoretically, to combat. The worst part was that the fear felt by the public was reinforced by the health professionals who refused to care for people living with HIV/Aids (PLWHA) and by the health institutions that refused to hospitalize them. This led to Resolution (nº 1.359) in 1992² by the Federal Council of Medicine (CFM) *on the duty of doctors to care for people at risk of or infected by HIV/AIDS*, which was followed by a more complete resolution, 1665/2003³, which included the prohibition of doctors from mandatorily requesting serological tests for HIV.

In the 1970s and 80s, Brazil was going through complex and challenging situations,

with the intensification of pressure by progressive entities and civil society against the dictatorship, demanding direct elections for president (“*Diretas Já* – Rights Now”) and the public health movement fighting for access to healthcare for all. Besides this, the struggle for amnesty of the persecuted, exiled and banished by the military was getting increasingly intense.

In the 1970s, in Minas Gerais, as in other Brazilian states, the *Renovação Médica* (Medical Renewal) movement began with the goal of improving public health, reducing disparities and combating violence. I participated in the *Comitê Brasileiro pela Anistia, Minas Gerais section* (Brazilian Committee for Amnesty, CBA-MG), presided over by Mrs. Helena Greco, in the Belo Horizonte Doctors’ Union and the State Medical Council (CRMMG). In 1979, amnesty was promulgated albeit a lot less broad and unrestricted than what we had proposed, but nevertheless it resulted in the return of many of those who had been banished or exiled, among them the tireless human rights activist, Herbert de Sousa, ‘*Betinho*’, honored by Aldir Blanc and João Bosco in the song *O Bêbado e a Equilibrista*⁴, magnificently performed by Elis Regina (*meu Brasil, que sonha com a volta do irmão do Henfil, com tanta gente que partiu num rabo de foguete*). And finally, there was the indirect presidential election of Tancredo Neves, his unexpected death and the ascension of those who had previously aligned themselves with the military. The rest of this story is too long to go into here but the fall of the dictatorship undoubtedly opened the way for positive changes in Brazilian public health.

Camus (The Plague)⁵ claimed that wars and epidemics, even when pre-announced, always take people by surprise, and AIDS was no exception. And this occurred at the end of the twentieth century when industrialized societies were boasting of their capacity to control all infectious diseases through immunization or treatment.

The Brazilian State’s response

Brazil, in an unconventional manner, if compared to other disease control programs, confronted and continues to confront Aids head on in a resolute defense of human rights, with local production and distribution of contraceptives and antiretrovirals (ARVs), and the implementation of a public network of laboratories and services to care for PLWHA, and research financing.

An example: Confronting the epidemic in Minas Gerais

With the spread of AIDS, the Ministry of Health (MS) established the National STD/AIDS Program (PNDSTAIDS) and recommended the creation of inter-institutional state committees to combat the disease. In Minas Gerais, this took place in 1985. As coordinator of the Infectious and Parasitic Diseases Service (SDIP) of the UFMG *Hospital das Clínicas* (HC – University Hospital) and with the understanding that the university must be the center disseminating knowledge to the community, I proposed that the SDIP establish a reference structure (prevention, treatment, laboratory, education and research) for PLWHA or those at risk of infection. As such, the HC would assume the dignified, ethical and competent care of people already marginalized by their sexual orientation, their activity (sex workers), use of intravenous drugs or by a base disease (hemophilia).

This argument met with many obstacles:

- The rule in HC was not to hospitalize anyone with an infectious disease and they used a variety of fallacious arguments to prevent the admittance of PLWHA: lack of beds for isolation, even though they actually accepted other infectious diseases; lack of technical knowledge, of material and of specialized staff;

- Fear, prejudice and discrimination, especially against homosexuals, who were the main “risk group” in the popular imagination.

Having failed to convince HC on the hospitalization issue, I took charge of out-patient care for people living with or at risk of HIV and on August 13, 1985 the Immunodeficiency Clinic was opened. The word AIDS was not used to avoid prejudice and discrimination and, for the same reason, the new clinic was set up alongside the general out-patient Infectious and parasitic diseases clinic. On the eve of its opening, HC communicated that the proposed activity would not be permitted since there was no back-up for hospitalization. The hospital’s error would be “corrected” through the non-functioning of the clinic. Fortunately, this threat did not materialize and care began to be provided in the out-patient facility.

On the first day of the clinic, a popular Belo Horizonte radio station asked a gentleman’s opinion of the HC caring for *aidéticos* (sic – a pejorative way of naming PLWHA). The short answer was: “I’ll never bring my kids to that place!”

The clinic began functioning with one psychologist (Edison Oliveira), one social worker (Maria Alice), three MDs: Roberto Pedercini, Luiz

Loures (currently Deputy Executive Director of UNAIDS-Switzerland) and me, apart from medical students, including Marco Vitória, now also at WHO in Geneva, and two nurses, Ms. Zuleica Souza Silva and Mr. Raimundo Rezende.

The battle continued to allocate beds in the HC. The arguments against continued to be the same and the undertone was one of fear, prejudice, and the lack of a humanitarian, scientific and academic view. In 1986, thanks to the efforts of Dr. Luiz Loures, Dr. Francisco das Chagas Lima e Silva and supporters, we managed to get four beds in Hospital João XXIII, a public hospital renowned in the state for emergency care.

It is worth describing the surrealism of the process: patients that required hospitalization were isolated, regardless of the reason for admittance: visits were prohibited, disposable plates were used and all the staff used masks, caps, gowns and boots. On discharge from the hospital, as if by miracle, everything went back to normal: the patient used the regular elevator and returned to the world of the common people. This was the conduct required to enable hospitalization. That was Belo Horizonte in 1987 (AD or BC?).

In 1987, the first sign of encouragement came when there was a decrease in mortality with the use of zidovudine (AZT), opening up the path for the specific treatment of HIV⁶.

National HIV/AIDS Vaccine Centers (1992-1993) were established as well as prospective cohort studies of homosexual men not infected by HIV (1994)⁷:

In 1992, the WHO Global AIDS Program proposed the creation of vaccine centers in four developing countries (Uganda, Rwanda, Thailand and Brazil) as part of the worldwide effort to confront AIDS. The National STD/AIDS Program (PNDSTAIDS) defined three centers: one in São Paulo, another in Rio de Janeiro, while UFMG was chosen by an ad hoc commission as the third center. The initial objective was to obtain reliable estimates of HIV incidence. To this end, one priority was to create open cohorts to assess the impact of educative interventions in reducing vulnerability to infection and, with the information gathered, decide on participation in future vaccine trials. As such, in 1993-1994, three projects were set up, which were considered strategic by the Ministry of Health (MoH): Bela Vista (SP, coordinated by Prof. José Carneiro), Horizonte (MG) and Rio (RJ, coordinated by Dr. Fritz Suttmoller). The Horizonte Project, the only one still ongoing, has admitted approximately 1,200 people since 1994, with 133 cases of HIV

up to 2015, with an incidence rate of 2.5/100 person-years, a relatively low rate, although showing a preoccupying increase in recent years. In 2015, approximately 500 volunteers are on follow up. An initial multidisciplinary team was set up: Socio-behavioral: Edison Oliveira, Júlio Andrade, Marília Greco, Roberto Chateaubriand, Juliana Nahas, Maria José Utsch; Clinical: Unai Tupinambás, Antonio Toledo, Carmelita Rabelo; Epidemiological: Carlos Maurício Antunes, Mariângela Carneiro, Fabíola Cardoso; Administrative: Mauro Jerônimo, Magda Aires, Jerre Camargos.

From 1994 to 1996, the first Brazilian trial of a phase I study with candidate vaccine against HIV/AIDS took place in two vaccine centers: in SDIP UFMG and in Fiocruz (Dr. Fritz Suttmoller, Dr. Marisa Morgado). It contained synthetic peptides similar to the V3 loop of HIV, developed by *United Biomedical* (USA). Although at the time most phase I trials were carried out in developed countries, this one was approved, after scientific and ethical scrutiny, in Brazil, China and Thailand, with healthy volunteers at low risk of HIV being recruited to assess safety and immunogenicity. These peptides induced neutralizing antibodies against laboratory strains of HIV-1 but subsequent trials showed that this response was not sufficient for effective immunization and the rest of the story behind the search for a vaccine can be found elsewhere^{8,9}.

The 2nd Decade – 1990-1999

In 1991, Brazil began distributing AZT through SUS, manufactured locally from 1993 onwards. This initial access to medication confirmed the social and human rights policy set out in the 1988 Constitution and in SUS precepts. Shortly after, under pressure from social movements and supported by academia, Brazil adopted the policy of direct access to medication through SUS and enacted Law 9313/1996¹⁰.

Combined antiretroviral therapy as turning point in the treatment of PLWHA

In 1996, research disclosed at the IX International Aids Conference (Vancouver, Canada) demonstrated the efficacy of combined ARV therapy^{11,12}. The number of pills to be taken daily was quite high, which hindered adherence and produced many side effects; its high cost restricted access to industrialized countries. Brazil was the first, exemplary exception with its enactment

of the abovementioned Law 9313 in the same year.

The first Brazilian consensus on the treatment of AIDS – Still in 1996, PNDSTAIDS invited specialists and representative from civil society to set out the first Brazilian guidelines for the treatment of HIV/AIDS. This contributed to creating a Brazilian ‘system’ for treatment that also included the establishment of a national network for tracking the circulating strains, which later led to the National Genotyping Network (RENAGENO) and a network of CD4 and viral load laboratories.

The 3rd decade – 2000-2009 – complex period, start of a new millennium. The concentration of capital intensified and there was a banking crisis that almost exclusively affected the populace, with perverse reflections on access to healthcare. And perhaps just as serious as this, there was a worldwide expansion of conservatism.

It is worth mentioning some defining dates:

1. 1994 - TRIPS (Agreement on Trade Related Aspects of Intellectual Property Rights) emanated from the World Trade Organization (WTO)¹³ had a negative impact on access to essential medication and not only in relation to the treatment of HIV/AIDS. It set out parameters for patents, with a term of 10 years for each country to adapt. Unfortunately, the Brazilian government signed it prematurely, complicating the preparation of national production sector for the transition. Other countries, e.g., India and Thailand, used a longer time period to facilitate the local production of generic medication and supplies.

2. 2000 – Millennium Development Goals (UN)¹⁴: The eight goals for 2015 included combating the AIDS epidemic (Goal 6) and, in my opinion more importantly, they incorporated a broad vision in relation to the struggle against disparities (goals 1 to 5).

3. 2001 – The DOHA Declaration on Public Health¹⁵ counterpoints the rigidity of the TRIPS, allowing for the use of the patented object without the authorization of its holder in situations involving a risk to public health. This easing of restrictions was used by Brazil in the compulsory licensing of Efavirenz.

4. In 2001, for the first time in its history, the United Nations held a Special Session dedicated to the specific problem of public health. In a General Assembly they passed the Declaration of Commitment on HIV/AIDS (UNGASS HIV/AIDS)¹⁶, considering the epidemic a real threat to the world, and included the preparation of plans to control and eventually eradicate it. Brazil had a fundamental role in this UNGASS.

5. 2003- The “3 by 5” initiative from the WHO/UNAIDS¹⁷, implemented in 2003 during the mandate of Dr. Paulo Teixeira as director of the WHO’s HIV/Aids Department aimed at providing ARV access to three million PLWHA in low and middle income countries by 2005 to show that everyone has a right to HIV/AIDS prevention and treatment. Yet again, the Brazilian example was used to demonstrate that these goals could be achieved.

6. 2007 – Compulsory licensing of Efavirenz (EFZ).

In 2007, for the first time, the Brazilian government decided to compulsorily license a drug, permitting its local production. The estimate was that this would result in a reduction in drug procurement of US\$30 million in 2007 alone, rising to \$236 million by 2012. The licensing process was conducted by the MS (Minister José Gomes Temporão) with the active participation of PNDSTAIDS, under the decisive direction of Dr. Mariângela Simão. This sovereign and courageous decision reflected President Lula’s declaration that: “Between our commerce and our health, we are going to take care of our health”¹⁸.

The 4th decade – 2010 – 2019

Over the course of these 30 years confronting AIDS in Brazil, it is worth addressing some of the lessons learned:

– 1. *The initial mark of combining forces with a common goal*: The State, Civil Society and Academia, structured a combined national response based on human rights and SUS principles. In my opinion and metaphorically speaking, the Brazilian response took place in a manner opposite to that of a plane crash, in which small events add up to finally bring the airplane down. Here, people, groups and institutions overcame their problems with working together and united forces to confront the issue and they are co-responsible for the Brazilian response.

– 2 *The Brazilian State* mobilized itself early to confront Aids.

2.1. In 1985-1986, before the creation of SUS, PNDSTAIDS was set up, coordinated by the firm and expert hand of Dr. Lair Guerra de Macedo Rodrigues, an example of public spirit, competence and determination. The Brazilian state mobilized itself, proposed inter-institutional state commissions, and established a national policy to confront AIDS, with emphasis on human rights protection.

2.2. SUS (*Sistema Único de Saúde* – Brazilian National Health Service): It is highly unlikely that

the Brazilian response would have advanced in the manner it did without SUS, which was genuinely a major factor in changing Brazilian public health, having been created in 1986 at the *8th National Health Conference (CNS)*. This CNS established the bases for the *Health* section of the 1988 Brazilian Constitution, defining it as *everyone’s right and the duty of the State*. Law 8.080/1990¹⁹ founded SUS, based on the principles of *Universality, Equality and Integrity in healthcare for the Brazilian public*, with social control and user participation playing a decisive part.

2.3. Still in 1986, PNDSTAIDS created the National AIDS Commission (CNAIDS), an internal instance of social control, with the participation of civil society, academia and government, to discuss and recommend actions for the continuous enhancement of program policies. In its 100th meeting, an evaluation of its history and role was commissioned, and then published in 2003. It was coordinated by Prof. Mary Jane Spinks and is well worth reading²⁰.

2.4. The enactment of law 9313, supported and pressured by organized civil society, transformed universal ARV access through SUS into a right. This decision went against common sense, clearly vocalized by the World Bank, which declared that developing countries should concentrate their efforts on prevention, since the complexity of the treatment schemes would hinder adherence, increasing the risk of resistant strains. From 1996 to 2002, Brazilian investment reached approximately US\$ 1.6 billion, which in addition to the invaluable social impact of reducing mortality, morbidity, hospitalizations and retirements, also provided estimated savings of US\$2 billion. Today, the results of this vital decision are internationally recognized, and it has also been demonstrated that the percentage of resistant viruses in Brazil has remained equal to or even lower than in central countries.

In providing universal ARV access and suitable health care for PLHA, it was unequivocally shown that a developing country could, even in the face of so many inequalities, treat people equally regardless of race, sex, sexual orientation or economic power.

– 3. *Participation of civil society*: the participation of citizens and groups involved in the struggle for human rights has been indispensable in the establishment and maintenance of a Brazilian policy in response to HIV/AIDS²¹.

It is clear that in order to offset the use of power in the definition and financing of public health policies, the emancipation of people/cit-

izens is necessary. One example is the participation of PLWHA in the struggle for their rights in all forums, especially in Health Councils and regulatory agencies. On the other hand, the participation of people exposed to, for example, schistosomiasis or Chagas Disease at decision making tables is much smaller, despite millions of people suffering from them. There is a lot of talk of the need to “empower” people. However, “empowerment” should be substituted by *Emancipation*, in the sense of Paulo Freire²², who uses the word with a broader meaning of liberation and autonomy in his work on education for freedom, exactly as it should be when we discuss citizenship, rights or the struggle against inequality. Power is never granted, it is always seized. According to Freire, emancipation will not happen by chance, or by concession, but will be a conquest carried out by the human praxis, which calls for uninterrupted struggle.

4. *The universities/health secretariats/academia*: the participation of public health institutions and *sensu lato* academia was and is also an important factor in the response. It allowed for the establishment of quality services, with technical and academic support for specific policies involving diagnosis, care, virologic and immunologic assessment, as well as research.

Scientific, economic, social and ethical impact

Science

The knowledge gained about HIV/AIDS since the first reported cases in 1981 is admirable. Fifteen years later (1996) the positive results ARV combination brought hope to millions of PLWHA; however, this scientific victory was not used to worldwide benefit, but remained mainly restricted to central countries for many years, highlighting the urgent need to ethically discuss the right of access to scientific progress for all of the people who need it.

Ethics, research and access

The AIDS pandemic amplified the need for effective international collaboration and WHO/UNAIDS has had an unquestionable role in this process. Non-governmental institutions were also created, such as, the Global Fund to Fight Malaria, Tuberculosis AIDS and UNITAID, as well as private foundations, e.g., *Clinton Health Access Initiative (CHAI)*, *Bill and Melinda Gates Foundation*. While this increases financial resources, it also tends to reduce the pressure on the countries

to assume their role in public health, apart from the risk that the setting of the agenda might be at the discretion of the financier, with all the associated political and ideological implications. Besides this, the reduction or interruption of these external funds, which has already been happening, can lead to difficulties in maintaining adequate treatment and care for PLWHA²³.

Collaboration in AIDS research has entailed a re-examination of legal and particularly ethical aspects. Some points are worth highlighting:

- It is vital that we develop universally respected ethical principles and the UNESCO Universal Declaration of Bioethics and Human Rights²⁴ should serve as reference;
- Research project participants must be ensured of post-study access to medication, vaccines, interventions and prevention strategies, which must be extended to universal public health access.

The urgency in controlling the AIDS epidemic, in addition to the increase in the incidence of other illnesses (e.g., hepatitis, malaria, dengue, cholera) has been used as an argument for the easing of ethical requirements in research, especially in developing countries.

Brazil went against this trend and, in 2008, in a sovereign and courageous manner, through CONEP/National Health Council Resolution 404/2008²⁵ decided that at the end of clinical trial, all participants must be ensured of access to the best proven prophylactic, therapeutic and diagnostic methods identified by the study. This decision was incorporated into Resolution 466/2012²⁶, which sets out the guidelines and regulatory norms for research involving human beings. This protects research participants and could serve as leverage so that this access extrapolates the controlled research environment and is established in public health for all those who can benefit from the products.

Challenges

There are several challenges for the sustainability of the Brazilian program:

- a. The greatest of them is confronting inequality, poverty and discrimination, since these increase the vulnerability of people in relation to HIV/AIDS and hinder access to the necessary prevention and medical care, as well as affecting treatment adherence.
- b. The increase in the number of PLWHA beginning treatment, besides the need for new medication for those that already failed the ini-

tial regimen. In 2015 there were app. 700,000 PLWHA in Brazil, with 455,000 of these receiving antiretroviral therapy, and 150,000 of whom had begun treatment in the last two years (2014 and 2015)²⁷. With the expansion of diagnosis and the expected need for imported, patent protected 2nd and 3rd line treatment regimens, investment will continue to rise.

c. The mistaken perception, accentuated by pharmaceutical industry propaganda that intellectual property is no longer relevant. This occur in the treatment access expansion programs (e.g., Global Fund, PEPFAR, Gates Foundation), where the opportunity to begin treatment affects the long-term discussion about local production, including generic medication, and hinders the transition of responsibility to the local health system. It does not directly affect Brazil, but could hinder the use of TRIPS flexibilities, including compulsory licenses and production or importation of generics.

d. Another misconception, both by the general public and the media is that the epidemic under control, which complicates the necessary and continuous discussion on prevention and diagnosis, especially with population in a vulnerable situation and younger people, who did not witness the outbreak of the epidemic.

Perspectives

The prevention and combating of prejudice and discrimination

Prevention: The positions generally taken by the Brazilian state are based on respect for human rights, non judgmental of individual attitudes, and with a policy of producing and distributing male and female contraception, lubricating gel, disposable syringes/needles for IV drug users, as well as universal access to prevention and ART.

On the other hand, sexual abstinence was proposed by the US government in a fire brimstone manner. It is important to remember the clear and sovereign decision by the Brazilian government, through PNDSTAIDS, to return US research funding of US\$ 40 million, since studies involving prostitution were restricted²⁸. This took place in 2005 during the term of Dr. Pedro Chequer at the helm of the PNDSTAIDS board. Those were good times.

Nevertheless, prejudice and discrimination persist while the instruments to impede or punish them are known and it is the duty of the State to use them. Hence, the urgent need to enact a law that criminalizes homophobia.

Unfortunately, the role assumed by the Department of STDs, Aids and Viral Hepatitis (DDAHV) in the defense of human rights has regressed in recent years. Pressure from conservative groups resulted in the Health Ministry (MS) suspending campaigns, impeding the distribution of educative material through in schools and cancelled support material for the International Prostitute' Day. The decisions were made to align with retrogressive forces with a view to possible and intangible gains.

It is worth mentioning three episodes that took place between 2012 and 2013.

Firstly, I would to take a moment to better situate myself in this process. After years spent as a human rights activist, physician, university professor and researcher, I became Director of the DDAHV in July 2010, appointed by the then Minister José Gomes Temporão, with Dr. Gerson Penna as Secretary of Health Surveillance. I succeeded experienced people with whom I had closely worked for 30 years, and accepted the responsibility of following on from Mariângela Simão, who managed department policy firmly and competently. I was requested from the Ministry of Education where I held and continue to hold the position of Full Professor in UFMG's Medical School. I was now metaphorically in the glasshouse. I applied the same vision and coherence from my personal and professional history to the new mission in an impartial, honest, transparent and republican manner. I will not go into detail here about my three years as Director but I would like to state that I worked alongside competent and engaged people, in a department with more than 200 staff. It would be impractical to name them all here. The Board was composed of Eduardo Barbosa and Ruy Burgos Filho - serious, skilled, experienced and dedicated professionals and I learned a lot from them. I would also like to mention Ieda Fornazier, the executive secretary of the board and an exemplary public servant, a mainstay in the department since the term of Lair Guerra, as I pay tribute to all those who shared responsibility with me.

The episodes:

- The 2012 carnival campaign – the Ministry of Health used a technicality to prohibit a video clip showing two young gays hugging each other²⁹. It had already been approved by the minister, and publically launched at a lively event in the Rocinha district in Rio. There was speculation that the suspension (censorship) of the clip had come directly from the Chief of Staff, under the obviously spurious influence of the conservative

evangelical movement. The social pressure to revert this censorship, as evidenced by the questioning of Federal Deputy Jean Wyllys of the government's apparent homophobia, was answered by the communication department (ASCOM) from the MS. The enlightened response of the ASCOM coordinator was that "the government is not homophobic since there are even gays on the board of the Aids department" – it was genuinely unbelievable and even more incredible was that it went without censure.

– The distribution of comic books (2013), developed by MS, MEC, UNESCO, UNICEF and UNFPA, in the Sphere of Health and Prevention in Schools (SPE).

This material was to be part of health week in schools, an annual MEC activity. It is worth noting that the school is a privileged place to discuss topics such as sexuality, diversity, violence prevention and the struggle against discrimination³⁰. Distribution was suspended and the material withdrawn with the technical justification that it had not been approved by the editorial commission, even though it had already been approved and launched publically under the previous management by Minister Temporão during the Brazilian Congress on the Prevention of STDs/AIDS (Brasília, 2010).

- 3rd episode: International Sex Workers' Day (June 02, 2013), the DDAHV posted virtual pamphlets on social networks, prepared in a workshop with emancipated, activist citizens. The photo of one participant with the phrase "I am happy being a prostitute" stood out and was criticized by conservative groups. On the same day, the Ministry of Health stated that no-one would convince him that such a comment had anything to do with the MS. I don't know what world he was living in, when the vulnerability of this and other populations is directly and intrinsically linked to health. The real difficulty in their access to health services and the manner in which they are (mis)treated could be counterbalanced by reinforcing their rights and self-esteem. The MS also stated that campaigns under his administration would be exclusively on the prevention of STDs, reiterating the distancing of human rights issues. There is hope that there will be a change in this position, which fortunately is not a State position.

The MS decision was celebrated by conservative forces and an example is in the "*Blog do Garotinho*" online in June 2013³¹. It was also openly supported by deputy Marco Feliciano who tweeted about a phone call he received from the

minister of health, in which the former says the latter is a good man but advised him to be careful with consultants³². Obviously these are not progressive forces, whether from social movements or academia.

The release of this material on June 02, 2013 resulted in the immediate dismissal of the DDAHV's director, without addressing the problem. On the other hand, there was an intense backlash against these decisions³³.

Diagnosis in timely manner

Around 1/4 of the PLWHA diagnosed in Brazil have a CD4 count of less than 200, which indicates an advanced stage of infection. Therefore, it is necessary to expand access to serology for HIV, especially for high vulnerability groups but also for the general public. Availability of testing through the family health program is another way to achieve this expansion.

Timely diagnosis will reduce morbidity, mortality and will act as secondary prevention, as long as treatment is provided and adherence achieved. In this sense, in January 2016, Recommendation 02/2016 of the CFM was passed, in which doctors are encouraged, when appropriate, to offer non-compulsory serology for HIV, syphilis and hepatitis B and C to patients in consultations. This is an excellent moment to talk about sexuality and will enable the health professional to give advice on prevention for those whose results are negative, and begin treatment for those who are diagnosed with a given disease.

Treatment and adherence

There is an urgent need to reinforce the "rational use" of ARVs, including robust scientific evidence policies before the adoption of new medication to the Brazilian treatment consensus. Pharmaceutical industry pressures to introduce new ARVs must be offset by operational research, using the enviable quantity of information gathered from the 400,000+ people currently in treatment.

The decision to make treatment available regardless of the number of CD4 lymphocytes must be carefully monitored. On the one hand, it increases the pressure on services, on budget and could result in more adherence problems in those with CD4 counts above 500 and probably asymptomatic, which may result in a need for 2nd and 3rd line regimens earlier. On the other hand, recent START research results showed that the

risk of developing a serious disease or of death was reduced by 53% among the early treatment group participants, in comparison with the late treatment group. Besides this, the rates of serious events were also lower in the early treatment group. Benefits were similar in low income countries³⁴. Despite not being mutually exclusive, the more urgent, necessary and priority effort is to find and provide appropriate care and treatment so that people can be diagnosed before becoming symptomatic or having low CD4 counts.

Local production still needs to be expanded, including better formulations of existing medication for adults and children and there is also a need for fixed combinations in a single daily dose, such as the recently released tenofovir-lamivudine-efavirenz combination.

Despite all the financial and political investment, the growing complexity and high cost of new medication protected by patents threatens available health resources. Thus, there is a need to expand local production and establish compulsory licensing when necessary. This is not a magic solution but it shows that where health is at issue, such a measure is clearly indicated. The respectability, visibility and experience accumulated by the Brazilian program enables it to be more vocal and to act according to the best interests of public health.

More research investment, including, for example, the national development of rapid-multiplatform testing to diagnose infection by HIV, syphilis, hepatitis; *point of care* tests for viral load and CD4 count; studies to assess the preventive methods available and in development.

DDAHV participation in regional and international initiatives: this is based on the defense of human rights, including universal access to treatment, combating violence and discrimination.

In this sense, Brazil has worked intensively in horizontal cooperation, where countries swap experiences and debate on equal terms. With the provision of medication manufactured in Brazil to start treatment, it is expected that this seed will transform into a policy in every partner country that includes appropriate access to treatment for all. It is worth highlighting the decision to transfer technology and manufacturing facilities for production of ARVs in Mozambique, which started its operations in 2012³⁵.

Conclusions

These three decades confirm the role that this epidemic and the fight against it meant for a new global health model³⁶.

Despite the problems and difficulties identified, the conditions do exist to overcome prejudice and discrimination, to eliminate the current state of poverty and bring about a fair distribution of wealth, which is the background to the spread of this and other epidemics (the Ebola epidemic in 2014 is a recent example). Among the viable mechanisms is the joint involvement of health professionals and civil society, for example, on the Health Boards. This can influence the enactment of a law against homophobia, in the decision on financing for the improvement of living conditions and access to quality healthcare, better epidemiological monitoring and the struggle against discrimination.

The instruments to properly treat PLWHA, eliminate HIV transmission, end discrimination and finally end the Aids epidemic are already available³⁷.

The modifications necessary for this to happen are numerous:

a) Access to education, employment, housing, healthcare, as set out in the Universal Declaration of Human Rights (articles XVIII, XXV.1, ONU 1948)³⁸;

b) The need for global involvement towards a new international order in which everyone has access to healthcare. A first step in the direction of universal access took place in 2012 in the 67th UN General Assembly to guide national health-care systems in the direction of universal health-care coverage³⁹;

However, a new international order will only be achieved if modifications are made in each nation. It is difficult to clamor for international justice when the disparity that exists in Brazil is still so evident. We need to change the paradigm of monetary and market valuation for another that respects human rights. In this manner, Brazil will be able to command respect, in opposition to the neoliberal values of the current economic order. Thucydides (465-395 BC) in the Peloponnesian War⁴⁰ affirmed that justice would only be had when those who were not wronged became as indignant as those who were. I would affirm that justice will only prevail when those affected by injustice emancipate themselves and fight for their rights.

Epilogue

The Brazilian response in confronting the epidemic was and has certainly been correct. Evidently, as underscored by the text, there is still plenty to be done for health care in general and particularly in relation to the effective control of Aids. The mentioned setback can be considered accidents along the way and show that the struggle for the necessary advances is a long one. As such, I will finish quoting Ítalo Calvino, in the last paragraph of his book *Invisible Cities* (1972), where he claims that the hell of the living is here and it is essential to discover in this hell those who are not hell, and get out together. And continue the struggle.

Acknowledgments

I would like to thank Dr. Ruy Burgos Filho for the careful revision and criticism of the text and for his relevant suggestions.

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Article submitted 03/02/2016

Approved 19/02/2016

Final version submitted 21/02/2016