

HIV/ Aids among adolescents in Brazil and France: similarities and differences¹

Epidemia de HIV/Aids em adolescentes no Brasil e na França: semelhanças e diferenças

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Resumo

Com objetivo de analisar a epidemia de Aids na França e no Brasil, especialmente entre adolescentes, realizou-se revisão crítica de literatura, documentos oficiais e verificação *in loco* de serviços de saúde sexual e reprodutiva para adolescentes. Utilizaram-se as categorias que compõem o conceito de vulnerabilidade como base teórica da análise. O Brasil em relação à França tem o triplo do número de casos de Aids, proporcionalmente à sua população. Na França houve declínio ininterrupto da incidência a partir de 1998 e, no Brasil, a redução iniciou somente em 2002, voltando a aumentar em 2008. O acesso universal ao tratamento antirretroviral (ARV) e a tendência de pauperização, feminização e heterossexualização da epidemia está presente em ambos os países. Entre adolescentes brasileiros, o número de casos é proporcionalmente 3,5 vezes mais elevado e estes vivem em contextos de maior vulnerabilidade: têm iniciação sexual mais precoce, usam menos preservativos e a escolaridade é menor. Na França a educação sexual nas escolas é prevista em lei, a notificação da Aids e do HIV são obrigatórias, o acesso a serviços para adolescentes com confidencialidade é facilitado, e há disponibilidade de exames para DST e interrupção voluntária da gravidez oportunizando prevenção e tratamento de agravos sexuais.

Palavras-chave: HIV/Aids; Adolescência; Saúde sexual e reprodutiva; Educação sexual; Doenças sexualmente transmissíveis.

Abstract

In order to analyze the Aids epidemic in France and Brazil, particularly among adolescents, a critical review of literature, official documents and on-site verification of services for sexual and reproductive health for adolescents was held. The concept of vulnerability and its categories were used as theoretical basics of analysis. In comparison to France, Brazil has three times the number of Aids cases in proportion to its population. In France there was a continuous decline in the incidence of this disease from 1998 onwards; in Brazil, the decline started in 2002, but there was a rise in cases in 2008. Both countries offer universal access to ARV treatment and the epidemic shows a trend of impoverishment, feminization and heterosexualization. Among Brazilian adolescents, the number of cases is proportionally 3.5 times higher; they have an earlier sexual initiation, use condoms less frequently and schooling is shorter. In France schools are obliged by law to offer regular educational activities on sexuality, the notification of Aids and HIV are mandatory; the access of adolescents to health services with confidentiality is facilitated, there is availability of tests for STDs and of voluntary interruption of pregnancy, which offer conditions for prevention and treatment of sexual disorders.

Keywords: HIV/Aids; Adolescence; Sexual and Reproductive Health; Sex Education; Sexually Transmitted Diseases.

Introduction

Since 1990, the Brazilian Ministry of Health has participated in the Brazil-France Technical and Scientific Cooperation Program on AIDS; through this program professionals from both countries exchange knowledge on facing the epidemic to address the programming needs of national AIDS policy.

Through this cooperation, a study titled "Prevention of STD - AIDS and their impacts on adolescence" was conducted at the Centre Régional de Ressources d'Information et de Prévention sur le VIH/SIDA (CRIPS: Regional Resource Center for Information and Prevention of HIV-AIDS) in Paris; this association was created in 1988 by an initiative by the *Île-de-France* regional counsel with the support of the French Ministry of Health (CRIPS ILE-DE-FRANCE, 2010). The objective of this institution, which is financed by public government, is to support and carry out activities to prevent and fight AIDS in youth. Since 1992 CRIPS has coordinated health education programs aimed at students in secondary and supplemental education programs. The general objective of these programs is to allow adolescents to reflect on the situations they encounter, so that they can implement the information offered to them in order to protect their health.

The Project from which this cooperation originated was intended to verify the manner in which France faced the AIDS epidemic in adolescents and analyze the differences in cultural contexts and their influences on vulnerability to the disease in order to supplement Brazilian political policies. With regard to adolescent sexuality, the subjects were asked about: average age of first sexual relations, frequency of condom use, presence or lack of gender inequality, education policies in sexual and reproductive health adopted by the French government, among others. In the area of public policy, the objective was to understand the health services offered to adolescents and analyze how these services were offered, if there was autonomy, respect, and confidentiality, and if there were policies targeting the adolescent gay public, among others.

The present scenario of AIDS among adolescents in Brazil indicates that there is a more intense feminization than in other age groups, as well as

an increase in cases among men who have sex with other men. Therefore, there is a need to develop strategies for education and health communication directed at the most vulnerable population groups, as well as STD/AIDS prevention policies at all levels: local, state, and federal.

The study is based on an analysis of the pertinent literature for both countries, including legislation and official documents about epidemiological data for HIV/AIDS and the government plans for addressing the epidemic; furthermore, an *in loco* visit was paid to services serving adolescents and youth, educational activities in schools were observed, and interviews were conducted with French health professionals involved with both prevention and treatment in sexual and reproductive adolescent health as well as in treatment of patients living with HIV and AIDS. The categories which made up the concept of vulnerability as a theoretical base for analysis were used (Ayres et al., 2003).

AIDS in France

France is the largest country in the European Union, with a total population of 62,616,488 inhabitants in 2009 (Banque Mondiale, 2009a). Life expectancy is 77.8 years for men and 84.5 years for women; this latter figure is the highest in Europe. School attendance between ages six and 16 is obligatory under the law.

The total number of cases of AIDS diagnosed from the beginning of the epidemic until December 31, 2009 was 65,279 (0.1% of the total population), and around 80% of these are men (Institut de Veille Sanitaire, 2009). Starting in 1998, incidence has been progressively diminishing. Among men, the main means of infection is by homosexual/bisexual contact (described as men who have sex with men, or MSM), and in women, heterosexual contact. There was a proportional increase in the number of cases of heterosexual transmission among them. In period I (until 1997), homosexual/bisexual contact represented 54.6% of male infection, which fell to 36.1% in period II (from 1998 to 2009). On the contrary, heterosexual transmission represented 13.1% in period I and 36.1% in period II; in other words, it almost tripled. In 2009 the number of cases of

heterosexual transmission among men was larger than those of homosexual/bisexual transmission. For women, in period I heterosexual transmission accounted for 47% of all cases, and injection drug users (IDU), 34%. In period II, the percentage of heterosexual transmission rose to 78% and IDUs fell to 11.6% (Institut de Veille Sanitaire, 2009).

With regards to sex distribution, a reduction in the proportion of cases between men and women was observed starting in 1998. In period I, the number of cases in men accounted for 82% of the total, and women represented 18%, with a proportion of 4.5 cases in men for every 1 case in women. In period II, there was a decrease in the total number of cases and also in the male/female proportion. The percentage of cases in men for this period was 71.3% and in women this number was 28.3%, in other words, 2.5 cases in men for every case in women (Institut de Veille Sanitaire, 2009).

Analysis of the nationalities of patients with AIDS in France indicates that the largest number of cases, after French citizens, occurred in people of sub-Saharan African origin, with a gradual increase in cases among this latter group. In distribution of nationality regrouped by sex, it was seen that the feminization of the epidemic comes mainly at the cost of people from sub-Saharan Africa, who present 2.5 times more cases than French women (Institut de Veille Sanitaire, 2009).

Age distribution of AIDS cases shows a much lower percentage of diagnoses in the adolescent age bracket (10-19 years): 0.6%. It is notable that in this age group there are proportionally more cases among females, 40.4% of the total. This is more significant when keeping in mind that in the overall numbers, the percentage of cases in women is 20.7%.

In France, the health system is public and accessible to all. For adolescents, the state offers health services specifically oriented to their specific needs ("*Espace Santé Jeune*"). Services are free, unencumbered by bureaucracy, and anonymity and confidentiality are guaranteed. Consultants are offered for obstetrics/gynecology, psychology, dentistry, and nutrition. Laboratory examinations are available to diagnose STDs (syphilis, hepatitis B and C, chlamydia, HIV), as is voluntary termination of pregnancy in the first ten weeks of gestation,

which has been permitted by law for minors since 1975 without obligatory parent or guardian consent, only consent by a representative above 18 years of age (Assemblée Nationale de France, 1975).

The *in loco* visits to three adolescent health services confirmed the availability and quality of the services offered. Laurence Levy is the joint advisor to the first service we visited, MGEN CS (Mutuelle Générale de l'Éducation Nationale), Center for Family Planning; in this center various activities are conducted, among them family planning, obstetric and gynecological care, laboratory exams to diagnose pregnancy and STDs (HIV, hepatitis B and C, chlamydia, syphilis) and ultrasounds.

In the second service we visited, "Espace Santé Jeune" located in Nanterre, nurse in charge Geneviève Dogbé stated that it served youth between ages 12 and 25, also without cost, anonymously and confidentially for any health need. The clinic provides doctors (general clinicians and obstetricians/gynecologists), psychologists, a dentist, a nutritionist, as well as laboratory examinations, ultrasound and distribution of preventative resources (condoms and contraceptives). Consults can be scheduled or spontaneous, with a maximum wait time of one week for psychological services. Educational activities are routinely carried out in these spaces. This service also responds to requests for educational activities related to health and prevention in the schools and in the community itself.

The third service we visited, which was under the direction of Michelle Orbach Roulière, the "Centre Municipal de Santé" in Issy-Les-Moulineaux, was similar in nature to the other services already described. It can be noted that in the three centers which were visited, adolescents have no difficulty whatever in receiving care. What stands out among the proposals for educational projects we saw is that increasing self-esteem in adolescents makes them capable of making safer and healthier choices. This work is mainly conducted by the teams' psychologists.

Other health services we visited were the Hospital Trousseau, which is specialized in children's care, and the Hospital Tenon, which provides general care; the head of its department of infectious diseases, Dr. Guillaume Le Loup, stressed France's policy for facing HIV/AIDS. In the former hospital, Dr. Cath-

erine Dollfun, who is responsible for the HIV/AIDS clinic, talked to us about caring for patients up to 15 years of age who contracted HIV through vertical transmission. Dr. Dollfun called attention to the feminization of the AIDS epidemic in France, especially among adolescents of African descent. These adolescents have relations with men of the same culture and origin; AIDS is much more prevalent in African countries than in France, so the chances of infection are much greater. The more precarious socio-economic situation as well as the lower levels of education of this population were also stressed.

We also visited the office of Dr. Athéa, gynecologist and author of the book "*Parler de sexualité aux ados. Une éducation à la vie affective et sexuelle*" (2006). According to Athéa, French adolescents generally receive their first gynecological exam at age 17, generally in order to seek orientation about contraceptives before beginning their first sexual relations.

With regards to prevention among adolescents, one of the regular activities which has been established by law since 2001 is education on sexual and affective health in the schools; this is conducted in three annual sections, and linked to distribution of condoms (Jourdain-Menninger and Albin, 2009). In visits to schools and the educational activities which took place in the *Lycées Auguste Renoir, Louis Armand and École Nationale Chimie-Physique Biologie*, various lively techniques were observed, such as: drama groups presenting comedies about AIDS followed by debate, psychodrama and extemporaneous theater, lectures on the topic of affective and sexual life, etc.

In France, the average age of first sexual encounter has been stable since 1965, around 17.5 years for men and 18 years for women. 87.6% of men and 84.2% of women used contraceptives in their first sexual encounter. This preventative norm is strongly established in younger generations, although not in the same way in all social classes. Contraceptive use in the first sexual encounter is less frequent among women with lower levels of education and among those women who are more concerned with religion (Moreau et al., 2007).

AIDS notification has been obligatory since 1986. With the advent of anti-retroviral (ARV) thera-

py in 1996, the disease's prognosis has changed and, in consequence, the change in the number of AIDS cases no longer reflects the dynamics of the epidemic. Based on this verification, it was determined that also notifying HIV cases for epidemiological purposes was pertinent as well. In 2003, reporting of HIV also became obligatory and ARV therapy is advocated today in cases where the number of CD4 cells is less than or equal to 500 cells/mm³ (Institut de Veille Sanitaire, 2009).

The main activity of The National AIDS Plan 2010-2014 is to carry out national tracking of HIV in all people between ages 15-80 for the diagnosis and early treatment of HIV. According to the *Ministère de la Santé*, approximately forty to fifty thousand people are infected with HIV without knowing it; one in four diagnoses are advanced cases. This plan seeks to radically change the course of the epidemic in five years, through actions which include, besides tracking HIV in the general population, publicizing information regarding exposure to risk and reinforcement of directives aimed at the most vulnerable groups, namely MSM populations, who have an annual incidence 200 times greater than that of the heterosexual population (France, 2010).

With relation to the specific public of adolescents and youth, the Plan establishes that preventative information should be offered to them from the beginning of their sexual lives in order to encourage preventative behaviors at the time that affective and sexual relationships are learned. Knowledge of STDs is stressed, principally with respect to the frequency of infection by asymptomatic chlamydia, in the most modern communication networks (internet, social networks). The Plan also outlines special attention for those youth under judicial protection who exhibit a more precocious entrance into sexuality.

AIDS in Brazil

According to data from the Banque Mondiale (2009b), Brazil had 193,733,795 inhabitants. According to the Instituto Brasileiro de Geografia e Estatística (Brazilian Institute of Geography and Statistics, IBGE), the average life expectancy is 69.4 years for men and 77 years for women. As for level of education, it is noted that the educational

system does not yet grant access to all, as the large part of the population does not reach high school. For the age group 15-17, 50.9% show an inequality between age and educational level. In 2009, the average number of years of schooling for persons 15 years or age or older was 7.5 years, less than the eight years required to conclude obligatory primary education. (IBGE, 2010).

The number of AIDS cases reported between 1980 and June 2011 was 608,230, according to the 2011 Boletim Epidemiológico Aids - DST (AIDS/STD Epidemiological Bulletin) from the Ministry of Health. In 2010, the incidence rate was 17.9/100,000 inhabitants. Cases are predominantly masculine, although the epidemic is moving towards feminization: in 2010 there were 1.7 new cases in men for each case in women. The incidence rate in Brazil is stable, with reduction in the southeast region and increase in other regions (Boletim Epidemiológico, 2010/2011). The most common and increasing category of exposure is heterosexual, followed by homosexual/bisexual. A trend towards increase in the young population can be seen. A survey conducted among youth ages 17-20 conscripted in the army reveals that the prevalence in this population rose from 0.09% in 2002 to 0.12% in 2007 (Szwarcwald et al., 2011).

For purposes of comparison with the French indices through 2009, we stress the epidemiological data from the Ministry of Health, which are consolidated until June of 2009 (Brasil, 2012) and show a total of 544,846 cases since the beginning of the epidemic, with 65.2% in men and 34.8% in women. In period I, from 1980 to 1997, these percentages were 75.9% and 24.1% for men and women, respectively. In the second period, from June 1998 to June of 2009, the numbers were 61.7% and 39.9%, in other words, there was an increase in cases in women. As for exposure, the predominance of heterosexual transmission is highlighted throughout the entire timeline, tending to become more accentuated over time. In period I these cases measured 31%, and in period II, 45.7%. Nevertheless, despite the decrease in cases among homosexuals and in the increase in other categories of exposure, when the rates of contraction are compared it is evident that the major risk is to MSM individuals. According to a study by Barbosa Júnior et

al. (2009), the dynamics of the AIDS epidemic in Brazil show that MSM individuals present higher risk.

In overall analysis of the epidemic, it can be seen that the number of AIDS cases continued to increase until 2002, when incidence tended to decline until 2007; there was a slight increase in 2008 and 2009. Transmission by IDU represented 12.3% of the total epidemic in 1998, but has been decreasing in incidence since that time, accounting for only 2.6% of cases in 2008. Vertical transmission fell from 2.3% of all cases to 1.1% in 2008. All these percentages, however, are affected by the high rate of infections in which the means of exposure was not accounted for. Over the entire epidemic, the number of cases where this item was ignored represented 25.3% of cases, and in 2008 this number was 52.7%; in other words, more than half of notified cases (Brasil, 2012).

With relation to incidence by age group, the data show an increase in the percentage of cases in the age group 17-20, which over the last five years grew from 0.09% to 0.12% (Brasil, 2012). For the overall total of the epidemic, from 1980 to 2009, 2.1% of cases were diagnosed between 13 and 19 years of age, 50.3% in males and 49.7% in females. In this age group, the ratio between cases in men and women is the smallest. In the city of Rio de Janeiro, since 1996 there have been more cases in female adolescents, and in 2009 there were almost two cases in women for one case in men (Taquette et al., 2011).

The age of first sexual activity in Brazil has fallen over time and there is a relationship between years of education, age of first sexual encounter and condom use. The lower the age and level of education are, the lower the chances that condoms will be used. A study by Teixeira et al. (2006) in three Brazilian state capitals revealed that the first sexual encounter with penetration occurred at up to 14 years of age in 53% of the sample. A survey published by the Ministry of Health in 2007 verified that sexual activity begins at an average age of 15.3 years and approximately 36% have their first sexual relation before age 15. Other studies (Abramovay et al., 2004; Taquette et al., 2004) show an average age of 14.5 years for boys and 15 years for girls for first sexual relations.

Comparing the epidemiological data from France and Brazil, it can be seen that Brazil, proportional

to its population, has three times the percentage of cases in France, with more cases diagnosed in period II, 382,030, against 162,816 in period I. This contrasts with France, which from period I to II reduced its number of cases by almost a third - from 48,509 to 16,770. In both countries, a trend towards involvement of the poorest segments of the population was observed, and towards heterosexualization and feminization of the epidemic, although it was more intense in Brazil. The larger percentage of cases among adolescents in Brazil also stood out: this number is 3.5 times higher than that of France. These data can be seen in Tables 1 and 2.

The Brazilian notification system shows a high number of cases in which the means of exposure was neglected: this could be a sign of gaps in the process between diagnosis and official communication with health authorities. In period I, from 1980 to 2009, the percentage of cases with unknown means of transmission was 25.3% of the total number of cases in Brazil and only 6.9% of French cases.

The policies for facing the AIDS epidemic in Brazil have two main objectives: reduce the transmission of HIV, sexually transmitted diseases and viral hepatitis, and improve the quality of life in people who are already infected. To reach these objectives, six large areas are being pursued: strengthening the network of health services and lines of care for STDs, AIDS and viral hepatitis; prevention, early diagnosis of infection for HIV and viral hepatitis, and reduction of risk and vulnerability; promotion of human rights and connection with social networks and movements; improvement and development of vigilance, information and research; improvement of governance and management; and universal access to medications, condoms and other strategic materials. Besides these strategic areas, the Ministry of Health's Department of STDs and AIDS utilizes international cooperation programs which allow real possibilities for the sharing of experiences between countries (Brasil, 2012) and specific Plans and Programs aimed at priority populations such as the Plano de Enfrentamento da Epidemia de Aids e das DST (Plan for Addressing the Epidemic of AIDS/STDs among gays, MSM and transvestite populations), the Programa Saúde e Prevenção nas Escolas (Health and Prevention in the Schools Program), the

Table 1 - Distribution of the number of Aids cases in France and Brazil, according to diagnosis time period, exposure way and gender

FRANCE	Total time period 80 – 2009 (until Dec. 09) n (%)	Period I 80 – 97 n (%)	Period II 98 – 2009 (until Dec. 09) n (%)	BRASIL	Total time period 80 – 2009 (until Jun. 09) n (%)	Period I 80 – 97 n (%)	Period II 98 – 2009 (until Dec. 09) n (%)
Cases	65,279 (100)	48,509 (100)	16,770 (100)	Cases	544,846	162,816	382,030
Exposure way							
Homo/bi	26,057 (39.9)	21,722 (44.8)	4,335 (25.8)	Homo/bi	98,502 (18.2)	46,300 (28.4)	52,202 (13.7)
Straight	17,344 (26.6)	9,304 (19.2)	8,040 (47.9)	Straight	224,913 (41.3)	50,443 (31)	174,470 (45.7)
Injectable Drugs Addicts	13,484 (20.6)	11,351 (23.4)	2,133 (12.7)	IDA	67,009 (12.3)	38,097 (23.4)	28,912 (7.6)
Not known	4,508 (6.9)	2,552 (5.3)	1,956 (11.7)	Not known	138,081 (25.3)	19,989 (12.3)	118,092 (30.9)
Gender							
Male	51,795 (79.3)	39,775 (82)	12,020 (71.7)	Male	377,604 (65.2)	123,947 (75.9)	235,657 (61.7)
Female	13,484 (20.7)	8,734 (18)	7,750 (28.3)	Female	201,774 (34.8)	39,453 (24.1)	152,321 (39.9)

Table 2 - Distribution of the Aids cases in France and Brazil according to age and gender

FRANÇA	1980 – 2009			
Age	n (%)	Men n (%)	Women n (%)	Total n (%)
10 – 19	361 (0.6)	215 (59.5)	146 (40.4)	361 (100)
20 – 29	11,110 (17)	7,902 (71.1)	3,208 (28.9)	11,110 (100)
Other	53,808 (82.4)	43,678 (81.2)	10,130 (18.8)	53,808 (100)
Total	65,279 (100)	51,795 (79.3)	13,484 (20.7)	
BRASIL	1980 – 2009			
Age	n (%)	Men n (%)	Women n (%)	Total n (%)
10 – 19	12,456 (2.1)	6,269 (50.3)	6,187 (49.7)	12,456 (100)
20 – 29	154,023 (6.6)	95,415 (61.9)	58,608 (38.1)	154,023 (100)
Other	412,911 (71.3)	275,920 (66.8)	136,991 (33.2)	412,911 (100)
Total	579,390 (100)	377,604 (65.2)	201,786 (34.8)	

Plano Integrado de Enfrentamento da Feminização da Aids /outras DST (Integrated Plan for Addressing the Feminization of AIDS/other STDs), the Plano de Redução da Transmissão Vertical do HIV e da Sífilis (Plan to Reduce Vertical Transmission of HIV and Syphilis), the Plano Nacional de Controle das Hepatites (National Hepatitis Control Plan), the Plano Nacional de Saúde do Sistema Penitenciário (National Prison System Program), the Programa Integrado para Ações Afirmativas para Negros - Afroatitute (Integrated Program for Affirmative Actions for Blacks - Afroatitute), the Projeto Redução de Danos para UDI (Project for IDU Harm Reduction), Povos

Indígenas (Indigenous Peoples), Profissionais do Sexo (Sex Workers), among others. An important result of the Brazilian initiative has been the large decrease of AIDS infection rates in IDUs, which is related mainly to the national harm reduction policy which increased practices for safe use of injected drugs and migration from these types of drugs to others (Barbosa Júnior et al., 2009).

The Health and Prevention in the Schools Program (Programa Saúde e Prevenção nas Escolas: SPE) targets the specific public of adolescent students. One of its objectives is to conduct activities promoting sexual and reproductive health in

adolescents and youth, connecting the health and education sectors in order to contribute to the reduction of infection by HIV/STDs as well as dropout rates caused by pregnancy in the 10-24 year old population (Brasil, 2006). The SPE is administered in a decentralized manner through working groups made up of members of the three levels of government (federal, state and municipal). These groups also benefit from participation by civil society, universities, and other local partnerships, bringing together different regional initiatives which contribute to the strengthening of the national response to the HIV/AIDS epidemic. In 2008, all Brazilian states had state management groups at their disposal, but SPE activities were conducted by only 600 municipalities (around 10% of all Brazilian municipalities). The SPE is the main public policy which prevents the consequences of unprotected sexual activity among adolescents and youth and is a fundamental strategy towards reducing this population's vulnerability to HIV/AIDS.

Discussion

Analyzing the AIDS epidemic from the concept of vulnerability, it can be stated that in relation to individual factors, in France adolescents are less vulnerable, since they have a later onset of sexual activity and use condoms more frequently. For several years the rate of condom use at the first sexual encounter has been 85%. In other words, the risk which depends on the individual is low, even considering that older adolescents have higher levels of education, which increases understanding of the risks; consequently, the individual has a greater chance of protecting himself or herself.

This more protected sexual behavior observed in France, according to Rudelic-Fernandez (2002), is the result of a cultural shift provoked by AIDS: due to the necessity of preventing the disease, discussions about sexuality came to take place in institutions where they did not take place previously, such as schools. Speaking about sexuality became easier. AIDS allowed people to reveal their sexual distresses and opened the door for new erotic art. Sexuality came to occupy a space in dialogue which included the erotization of sexual relations

and also "one-on-one" management of pleasure and risk. On the other hand, in Brazil, discussion of sexuality in society and in the spaces where youth and adolescents live, for example schools, still has not advanced sufficiently to provoke relevant cultural changes. The situations which occur in the reality of their lives, and the anguish they provoke, are not debated. The discussion remains stalled at standardizing behavior, which stands alongside the erotization which is intensely touted in new means of communication. Adolescents live in a paradox where they are encouraged to exercise their desires precociously, yet at the same time receive messages that having sex in adolescence is precocious and improper (Taquette, 2009).

As for social factors, in France the educational system's wide offerings along with the obligation to attend school until age 16, and ample publicized information and freedom of expression reduce vulnerability, since the consciousness of risk is greater. However, some situations of vulnerability similar to those in Brazil were observed, such as homophobia, gender inequality and violence against women (Bousquet, 2009; Laborde, 2010; Sida Info Service, 2010).

In the field of programmed actions and public policy, every four years the French Ministry of Health revises its new plan of action and goals for addressing the AIDS epidemic. Some differences in comparison with Brazilian programs stand out, such as obligatory notification for HIV as well as AIDS, and policies which encourage early tracking of HIV with ARV treatment in all HIV+ cases where the level of CD4 is less than or equal to 500 cells/mm³. The objective is to reach an estimated 50,000 people in France who are seropositive but unaware of their status. The goal is to reach all people between age 15 and 70, regardless of exposure risks, beyond systematically serving patients in determined circumstances, such as suspicion or diagnosis of STDs, hepatitis C, tuberculosis, pregnancy, abortion, first prescription of contraceptives, sexual violence, and incarceration. When seropositive status is recognized, there is an improvement in behavior which prevents AIDS and reduces transmissibility. A 2008 study demonstrated that 81% of patients with HIV who were treated for at least six months with a com-

combination of ARVs had a viral load of <50 copies/ml (France, 2010). This aspect, besides improving the prospects for these patients' lives, encourages better control of the epidemic, as there is a connection between the level of plasmatic viremia and the risk of transmission. Accordingly, tracking and treatment of HIV-positive patients are important preventative measures, complemented by condom use. On the other hand, the probability of modifying sexual behavior by adopting preventative measures is much greater in individuals who recognize their seropositive status than in those who ignore it (ORS, 2010).

Obligatory HIV notification has been emphasized by other authors. Today, with prophylactic and therapeutic interventions available which considerably increase the asymptomatic period, interpretation of data based on AIDS cases alone is insufficient (Paixão, 2000). In Brazil, treatment of asymptomatic adults infected with HIV is suggested by the Ministry of Health when the CD4 level is less than 350 cells/mm³ (Brasil, 2010a).

Other activities to be stressed are those carried out in sexual and reproductive health services for adolescents and youth, legal voluntary termination of pregnancy by women of any age up to twelve weeks of gestation, and requiring all high schools to conduct educational activities about sexuality at least three times per year with homogenous groups of students, as well as access to condoms. There also is a phone line available for information on AIDS (in 2004, 21.5% of calls were made by youth, the majority between age 20 and 24). This service was created in 1990 and unites various telephone and internet services which work in the field of health (HIV, STDs, sexuality, patients' rights, social and health emergencies). It is anonymous, confidential, free, and can be accessed 24 hours per day, seven days a week (IFOP, 2007).

In Brazil, obligatory AIDS notification through the Sistema Nacional de Notificação de Doenças (National Disease Notification System: SINAN) began in 1993 and, starting August 31, 2010, acquired syphilis and male urethral discharge syndrome were also classified as diseases requiring compulsory notification. HIV notification is only obligatory for pregnant women and newborns (Brasil, 2010a). Conversely, availability for public sexual and re-

productive health services for adolescents is low, as shown in some studies (Taquette, 2009; Pereira and Taquette, 2013). Furthermore, exams to diagnose STDs, principally for chlamydia, are not routine in the majority of services. This may explain the intensity of the feminization of AIDS in the adolescent age group, a population in which there is a great prevalence of asymptomatic STDs.

Supports to public policies

Based on the French experience facing the AIDS epidemic and the reality in Brazil, some viable measures could contribute to the reduction of infection rates in Brazil, especially for the adolescent age group.

In the short term, the strategy defined by the SPE program should be amplified to offer adolescent students information about the prevention of consequences of sexual activity, and to carry out activities promoting health such as, for example, large-scale free distribution of male condoms. School is the ideal place to teach how to think, and also to teach people to think about sexuality. Sexual education is an obligatory component of education for life, and school is seen as an appropriate location for this. However, the proposed activities should not be only informative, but should also serve as moments to listen and dialog about real experiences in the students' affective/sexual relations, which provoke reflection, encouraging broadened emotional competency and bringing about changes in behavior.

From a point of view of informative strategies, greater diffusion of information about STDs is fundamental, especially about asymptomatic STDs, which tend to have later diagnoses. Other forms of publicity to be intensified include: television campaigns and a toll-free phone line for information and answers about HIV/STDs/AIDS.

Compulsory HIV notification should be implemented, along with the establishment of a free quick test in all municipalities in the country, with training of health professionals in collecting samples and pre- and post-testing counseling, as well as in the area of anonymity. The need for investments in improving and amplifying access to sexual and reproductive health services for adolescents is evi-

dent, not only to diagnose and treat STDs, but also to make contraceptive information and preventative supplies available, including in this category better-quality prenatal care. In the long term, reduction of inequalities and injustices (in other words, of the structural violence in Brazilian society) is a goal which should be pursued to guarantee all people the right to health, and to bring about a change in the current profile of AIDS, which so clearly exhibits social injustices.

References

- ABRAMOVAY, M.; CASTRO, M. G.; SILVA, L. B. (Org.). *Juventudes e sexualidade*. Brasília, DF: Unesco, 2004.
- ASSEMBLÉE NATIONALE DE FRANCE. *Loi du 17 janvier 1975 relative à l'interruption volontaire de grossesse*. France, 1975. Disponível em: <<http://www.assemblee-nationale.fr/histoire/interruption/sommaire.asp>>. Acesso em: 29 nov. 2010.
- ATHÉA, N. *Parler de sexualité aux ados: une éducation à la vie affective et sexuelle*. Paris: Groupe Eyrolles, 2006.
- AYRES, J. R. C. M. et al. O conceito de vulnerabilidade e as práticas de saúde: novas perspectivas e desafios. In: CZERESNIA, D. (Org.). *Promoção da saúde: conceitos, reflexões, tendência*. Rio de Janeiro: Fiocruz, 2003. p. 117-139.
- BANQUE MONDIALE. *Données*: France. [S.l.], 2009. Disponível em: <<http://donnees.banquemondiale.org/pays/france>>. Acesso em: 29 nov. 2010.
- BANQUE MONDIALE. *Données*: Brésil. [S.l.], 2009. Disponível em: <<http://donnees.banquemondiale.org/pays/bresil>>. Acesso em: 29 nov. 2010.
- BARBOSA JUNIOR, A. et al. Tendências da epidemia de Aids entre subgrupos sob maior risco no Brasil, 1980-2004. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 25, n. 4, p. 727-737, 2009.
- BOLETIM EPIDEMIOLÓGICO - AIDS E DST. Brasília, DF: Ministério da Saúde. Departamento de DST, AIDS e Hepatites Virais, ano VIII, n. 1, 2010/2011.
- BOUSQUET, D. *Rapport d'information fait au nom de la mission d'évaluation de la politique de prévention et de lutte contre les violences faites aux femmes*. [S.l. ; s.n.], 2009. Disponível em: <<http://www.assemblee-nationale.fr/13/rap-info/i1799-t1.asp>>. Acesso em: 4 nov. 2010.
- BRASIL. Ministério da Saúde. *Diretrizes para implantação do Projeto Saúde e Prevenção nas Escolas*. Brasília, DF, 2006.
- BRASIL. Ministério da Saúde. Portaria nº 2.472 de 31 de agosto de 2010. *Diário Oficial da União*. Brasília, DF, 01 de setembro de 2010a.
- BRASIL. Ministério da Saúde. Departamento de DST, Aids e Hepatites Virais. *Recomendações para terapia antirretroviral em adultos infectados pelo HIV*. Brasília, 2010b. Disponível em: <http://www.AIDS.gov.br/sites/default/files/suplemento_II_web.pdf>. Acesso em: 11 fev. 2011.
- BRASIL. Ministério da Saúde. Departamento de DST, Aids e Hepatites Virais. *A Aids no Brasil*. Brasília, DF, 2012. Disponível em: <<http://www.aids.gov.br/pagina/aids-no-brasil>>. Acesso em: 29 nov. 2012.
- CRIPS ILE-DE-FRANCE. *Qui sommes nous?* Disponível em: <<http://www.lecrips-idf.net/rubrique36.html>>. Acesso em: 25 set. 2010.
- FRANCE. Ministère de la Santé et des Sports. *Plan national de lutte contre le VIH/sida et les IST 2010-2014*. [S.l. : s.n.], 2010. Disponível em: <http://www.sante.gouv.fr/IMG/pdf/plan_national_lutte_contre_le_VIH-SIDA_et_les_IST_2010-2014.pdf>. Acesso em: 15 nov. 2010.
- IBGE - Instituto Brasileiro de Geografia e Estatística. *Síntese de indicadores sociais 2010*. [S.l. ; s.n.], 2010. Disponível em: <http://www.ibge.gov.br/home/presidencia/noticias/noticia_impressao.php?id_noticia=1717>. Acesso em: 8 fev. 2011.
- IFOP - INSTITUT FRANÇAIS D'OPINION PUBLIQUE. *Les jeunes face au sida: représentations et comportements face à l'épidémie*. [S.l.], 2007. Disponível em: <www.ifop.com/media/poll/jeunes_sida.pdf>. Acesso em: 20 out. 2010.

INSTITUT DE VEILLE SANITAIRE. *Données issues de la déclaration obligatoire du VIH au 31 décembre 2009*. [S.l.], 2009. Disponível em: <<http://www.invs.sante.fr/surveillance/vih-sida/default.htm>>. Acesso em: 29 nov. 2010.

JOURDAIN-MENNINGER, D.; AUBIN, C. *La prévention des grossesses non désirées: information, éducation et communication: Rapport*. [S.l. : s.n], 2009. Disponível em: <lesrapports.ladocumentationfrancaise.fr/BRP/104000048/0000.pdf>. Acesso em: 4 nov. 2010.

LABORDE, F. *Rapport d'information fait au nom de la délégation aux droits des femmes et à l'égalité des chances entre les hommes et les femmes sur la proposition de loi, adoptée par l'assemblée nationale, renforçant la protection des victimes et la prévention et la répression des violences faites aux femmes*. [S.l. : s.n], 2010. Disponível em: <www.senat.fr/rap/r09-553/r09-5531.pdf>. Acesso em: 4 nov. 2010.

MOREAU, C. et al. Activité sexuelle, IST, contraception stabilisée. In : INPES - INSTITUT NATIONAL DE PREVENTION. *Baromètre Santé 2005*. Saint-Denis, 2007. p. 328-353.

ORS - OBSERVATOIRE REGIONAL DE SANTE D'ÎLE-DE-FRANCE. Suivi de l'infection à VIH/sida en Île-de-France. *Bulletin de Santé: Épidémiologie en Ile-de-France*. Paris, n.16, p. 1-20, déc. 2010.

PAIXÃO, M. T. *Metodologia para a vigilância epidemiológica da infecção pelo vírus da imunodeficiência humana em Portugal: perspectivas*. In: I CONGRESSO VIRTUAL HIV/AIDS PORTUGAL: à descoberta de desafios partilhados na luta contra a SIDA. 2000. portugal. Disponível em: http://www.aidscongress.net/Modules/WebC_AidsCongress/CommunicationHTML.aspx?Mid=30&CommID=21>. Acesso em: 29 set. 2012.

PEREIRA, S. M.; TAQUETTE, S. R. A consulta ginecológica sob a ótica de estudantes do ensino médio da cidade do Rio de Janeiro. *Revista de Saúde Pública*, São Paulo. v. 47, n. p. 2-10, 2013.

RUDELIC-FERNANDEZ, D. A sexualidade dos jovens em tempos de Aids: atos e falas. In: BORILLO, D. et al. (Org.). *A sexualidade tem futuro?* São Paulo: Loyola, 2002. p. 55-72.

SIDA INFO SERVICE. *L'homophobie, savoir et réagir*: brochure à destination des enseignants et de tous les professionnels travaillant auprès des jeunes. 5^{ème} éd. [S.l. : s.n], 2010. Disponível em: <www.lecrips.net/GED/77744.pdf>. Acesso em: 4 nov. 2010.

SZWARCWALD, C. L. et al. HIV-related risky practices among Brazilian young men, 2007. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 27, p. S19-S26, 2011. Suplemento 1.

TAQUETTE, S. R.; VILHENA, M. M.; PAULA, M. C. Doenças sexualmente transmissíveis e gênero: um estudo transversal com adolescentes no Rio de Janeiro. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 20, n. 1, p. 282-290, 2004.

TAQUETTE, S. R. O paradoxo da moral sexual na adolescência e as DST/Aids. In: _____. (Org.). *Aids e juventude: gênero, classe e raça*. Rio de Janeiro: UERJ, 2009. p. 135-154

TAQUETTE, S. R. et al. A epidemia de Aids em adolescentes de 13 a 19 anos no município do Rio de Janeiro: descrição espaço-temporal. *Revista da Sociedade Brasileira de Medicina Tropical*, Rio de Janeiro, v. 44, n. 4, p. 467-470, 2011.

TEIXEIRA, A. M. F. B. et al. Adolescentes e uso de preservativos: as escolhas dos jovens de três capitais brasileiras na iniciação e na última relação sexual. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 22, n. 7, p. 1385-1396, 2006.

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