

***UNESCO REVIEW OF HIGHER EDUCATION INSTITUTIONS'
RESPONSES TO HIV AND AIDS***

BRAZIL - THE CASE OF THE UNIVERSITY OF BRASILIA

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ACRONYMS

ARV	Anti-retroviral
GDP	Gross Domestic Product
HDI	Human Development Index
HUB	Hospital Universitário de Brasília
IDU	Intravenous Drug Users
IBGE	Brazilian Institute of Geography and Statistics
MSM	Men who have Sex with Men
NEAMCES	Nucleo de Estudos e Acoes Multilaterais de Cooperacao em Educacao e Saude
NGO	Non-Governmental Organization
OECD	Organization for Economic Co-operation and Development
PMTCT	Prevention of mother to child transmission
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infections
SUS	Sistema Único de Saúde
UN	United Nations
UnB	University of Brasilia
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drug and Crime
USAID	United States Agency for International Development
WHO	World Health Organization
WTO	World Trade Organization

NATIONAL CONTEXT OF HIV/AIDS

Brazil's population is approximately 182 million, which makes it the 5th most populous country in the world. Although it still shows positive population growth rates, the Brazilian population is expected to grow at a slower pace in coming years. The population growth rate, at 3% between 1950 and 1960, dropped to 1.4% in 2004 and is projected, according to the Brazilian Institute of Geography and Statistics (IBGE) to be reduced to 0.2% in 2050. According to IBGE projections, Brazil's population shall reach 229 million in 2025 and 260 million in 2050.

Brazil displays not only major regional disparities, but also marked social, economic and cultural heterogeneity. The urban population accounts for 81.3% of the total population and presents considerable diversity in population density. For example, the Northern region, where the Amazon Forest sits, accounts for 45% of the national territory, but is home to only 8% of the population, whereas the Southeast is responsible for the highest population density, concentrating 44% of the population.

Looking at the latest IBGE demographic surveys, as a result of increasing life expectancy and plummeting mortality rates, population ageing is a phenomenon that has already set foot in the demographic profile of the country. Whereas in 1940 an average Brazilian lived 45.5 years, in 2003 life expectancy reached 71.3 years.¹ For women, life expectancy is of 75.2 years, whereas men lag behind at 67.6 years. However, population ageing has not been able to overcome the prevalence of youth population in the Brazilian society. In 2000 as many as 29.6% of the population was within the 0-14 year-old age group (compared to 38.2% in 1980). Table 1 on the following page presents some general data on Brazil (see Annex 1 for additional information).

¹ IBGE/DPE/COPIS.

Indicator	Value	Year	Average for lower-middle income countries	Source
GDP growth rate (%)	4.9	2004	3.9	IBGE and World Bank
Gross National Income <i>per capita</i> (US\$ Atlas Method)	2,720	2003	1,480	World Bank
Population below national poverty line (%)	22	2003	...	World Bank
Human Development Index (0 to 1)	0,775	2004	...	UNDP
Infant Mortality rates (per 1,000 live births)	33	2003	32	World Bank
Access to an improved water source (% of population)	87	2003	81	World Bank
Child malnutrition (% of children under 5)	6	...	11	World Bank

Note: (...) means data not available.

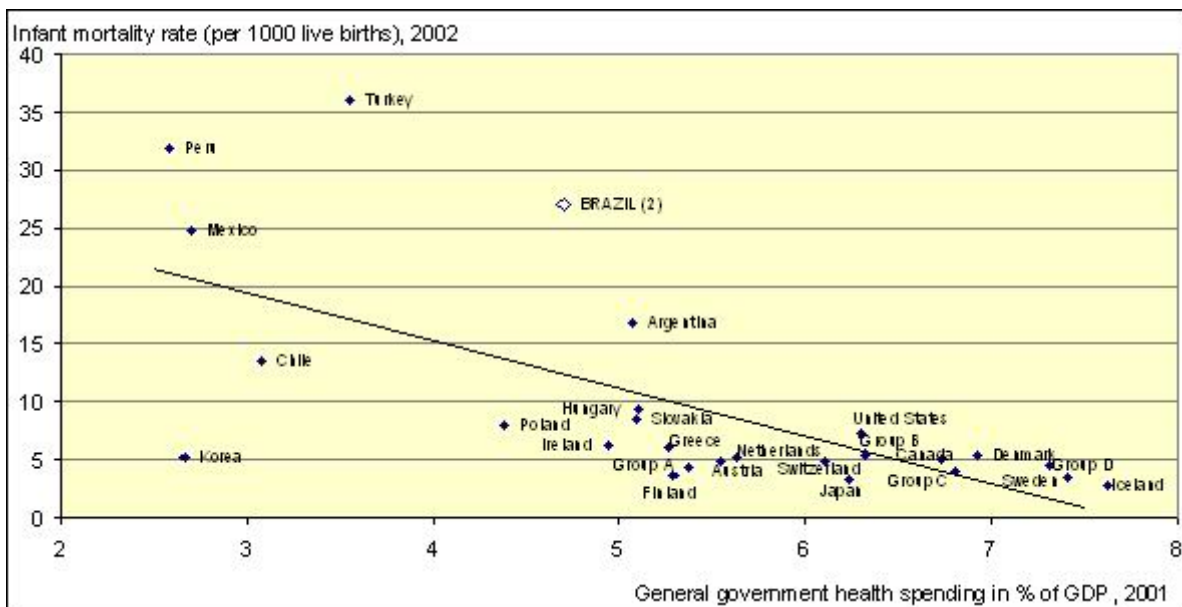
Gross Domestic Product (GDP) growth was of 4.9% in 2004 (IBGE), a yearly peak in a recent trajectory much influenced by international and domestic ebbs and flows. In 2003, gross national income *per capita* was US\$2,720.² Besides the highs and lows of output growth in recent years, poor wealth distribution and poverty also pose challenges to the country. The Human Development Index (HDI) in 2004 was 0.775, placing Brazil at the 72nd position in the world ranking out of 177 territories (175 countries, plus Hong Kong and the Palestine Occupied Territories), in the intermediate group of countries of medium development.³ As of 2003, an estimated 22% of the population lived below the national poverty line.⁴

As far as health services are concerned, the Brazilian government counts on the Unified Health System – known nationwide as SUS (Sistema Único de Saúde) - which was established in the 1988 Constitution. The SUS is guided by the principle of universal and egalitarian access to services for health promotion, protection and care, based on a regionally and hierarchically-established network of service-rendering. In 2002, health expenditures matched 3.5% of the GDP, or US\$ 15.8 billion.

² World Bank: *Brazil at a Glance*. http://www.worldbank.org/data/countrydata/aag/bra_aag.pdf

³ UNDP. *Human Development Index 2004*. New York: UNDP, 2004.

⁴ World Bank: *Brazil at a Glance*. http://www.worldbank.org/data/countrydata/aag/bra_aag.pdf



Source: OECD. *Economic Survey of Brazil 2005*.

Despite recent improvements, such as the institutionalisation of the SUS and the increased funding for health services, the country still provides inefficient and insufficient health services to its population, especially the poorer ones. For example, despite of unequivocally falling since the 1940s, child mortality rates remained as high as 33 per 1,000 in 2003, a considerably high figure when compared to other South American countries, as the chart above shows. Child malnutrition, as such, affects 6% of the children between 0-5.

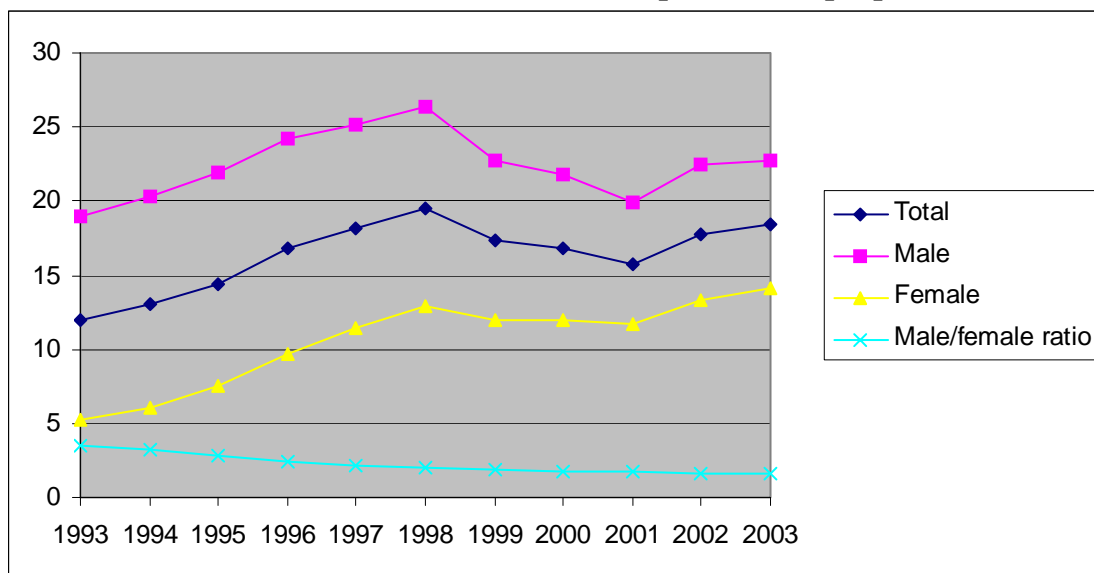
HIV/AIDS

The first HIV/AIDS cases in Brazil were identified in the 1980s in the largest urban centres of the Southern and Southeast states and were concentrated in specific social groups. By 1985, 76% of the cases were detected among men who had sex with men (MSM), 12.7% among users of intravenous drugs (IDUs), and 95.9% of the infected individuals were men. In its second wave, the epidemic spread in medium-sized urban centres and there was an increase in the number of heterosexual cases. By 1994, a drop in the number of MSM cases was witnessed, and their share in the total was reduced to 37.8% of all cases. For its turn, the number of cases of IDUs increased by 21.4%, while the proportion of infected women raised 28.4%.

Over the last years, stabilisation – although at high levels – has been the verifiable trend in the HIV/AIDS epidemic. In 2003, 32,247 new HIV/AIDS cases were registered in Brazil, an incidence rate of 18.2 cases for every 100,000 people. For adults (15-49), the HIV/AIDS prevalence rate was 0.7% in 2003. From 1980 through 2004, 362,364 people have developed AIDS in the country.

Today, an estimated 600,000 people live with HIV/AIDS in Brazil. Out of this total, 240,000 are estimated to be women. Whereas the number of men infected has stabilised, women have been falling more and more vulnerable to infection, reaching its pinnacle in 2003 with 14 cases in every 100,000 women. According to the Ministry of Health, the epidemic remains largely concentrated amongst white rather than afro-descendant or indigenous people.

Incidence of HIV/AIDS in Brazil (per 100,000 people)



Source: BRASIL. Ministério da Saúde. *Boletim Epidemiológico AIDS e DST*. Brasília: Programa Nacional de DST e AIDS, jan/jun 2004.

As a consequence of the increased transmission of the virus among women, the number of infected children has also increased. Preventive actions have brought mother to

child transmission to 7% as of 2002. Prevention of mother to child transmission (PMTCT) included anti-retroviral (ARV) treatment for 26% of pregnant women in 2003.⁵

AIDS-related death rates increased 2% from 2002 to 2003, reaching a total 11,276 persons. Again, whereas the number of male fatalities kept steady, the number of female victims increased, supporting the suggested gender bias.⁶

Brazilian responses to the epidemic

Amongst the actions Brazil has undertaken against HIV/AIDS, one should highlight the STD/AIDS National Programme, which was created in 1986 and has been working in prevention, diagnosis, treatment, research, human rights and social organization in the field of sexually transmitted infections (STIs) and in particular HIV/AIDS. The Brazilian programme was created rather prematurely, back in the first wave of the epidemic and has become a worldwide reference in preventive action and access to the ARV treatment. Brazil's response to AIDS has benefited from consistently strong political support from the highest level of government, which has led to regulatory policies as well as a very clear and permanent allocation of financial resources at national, state and local levels.

In the field of prevention, information dissemination and condom distribution have been the priorities. The programme has pursued partnerships with private institutions in order to strengthen the distribution of condoms and to cut down prices to consumers. Some 600 million condoms are distributed freely nationwide each year, according to the Ministry of Health. The programme also targets specific groups, fostering special prevention policies for workers of sex-related industries, prison inmates, drug abusers, armed forces and indigenous populations. Special campaigns towards adolescents, women and men who have sex with men are also common. An important feature of all these preventive policies, most especially the informative campaigns, is their clear language and non-prejudicial approach. International organizations, media vehicles, NGOs, private firms, as well as local teachers and health agents have been actively engaged in these actions, thanks to a very pro-active and pro-partnership approach from the National STI/AIDS Programme. As the epidemic

⁵ BRASIL. Ministério da Saúde. *Boletim Epidemiológico AIDS e DST*. Brasília: Programa Nacional de DST e AIDS, jan/jun 2004.

⁶ *Idem*.

moves inland to smaller towns in the countryside, higher poverty and less information tend to pose tougher challenges in terms of both prevention and treatment. An extraordinarily large network has thus been created, bringing together local authorities, firms and NGOs to act on a decentralised fashion.

Concerning disease diagnosis, the programme has been actively engaged in communication campaigns to stimulate people to undertake free HIV tests, given that out of the 660,000 appraised number of HIV cases, only an estimated 250,000 are aware of the disease. Various HIV test centres have been opened throughout the country, where users can be tested in full anonymity. The Ministry of Health, seeking a more premature diagnosis of the virus, has produced television-broadcasted campaigns – one of them in partnership with the “Ação e Cidadania” (Action and Citizenship) NGO, aiming to promote the HIV test among heterosexuals. The HIV test is offered by the public health system, and in 2004 the test coverage was reckoned in 28.1% of the sexually active population.

Brazil is one of the few developing countries that offer universal access to ARV treatment, which since 1996 has been offered freely through the public health system. The government action has been guided by the pressure of health-related NGOs, health and medical authorities and human rights groups. In 1996, such pressure resulted in the promulgation of an act that stipulates that medicine is to be handed out freely to HIV-positive persons. The number of patients receiving ARV treatment reached 125,168 in 2003, according to the World Health Organization (WHO). ARV therapy has contributed to a significant decrease in the hospitalisation/patient rate, which dropped from 63% in 1998 to 30% in 2003. Due to the positive results of the treatment, the Brazilian government expects a reduction of US\$ 2.2 billion in hospital care – a much smaller amount than the \$400 million to be spent in the drugs procurement and distribution in 2005.

Nonetheless, the cost of medication has made difficult to maintain universal provision of ARVs. In 2002, US\$ 179 million out of the US\$ 274 million HIV/AIDS budget was dedicated to purchasing ARVs. Since 1999, the Brazilian government has invested in reducing the cost of medication, through the production of generic products in state-owned laboratories, which has cut down prices and increased the bargaining power of the federal government to negotiate lower prices with foreign drug producers. Brazil has also played a leading role in negotiations carried out under the World Trade Organization

(WTO), especially during the Cancun Meeting of the Doha Round, to tackle the selective flexibility of WTO rules regarding patents in order to allow generic drugs to be exported to least developing countries unable to produce them locally.

The Brazilian government has also invested in technology transfer cooperation agreements with other countries, envisaging the local production of medications. In addition, the Brazilian Cooperation Agency has established agreements with Portuguese-speaking and Latin American countries in order to share Brazilian experiences in reproductive health and prevention/treatment of STI/AIDS. For example, in Mozambique, it has been three years now that a project has been executed in partnership with UNESCO, UNFPA, UNICEF, USAID, and a handful of NGOs and bilateral partners, to improve the quality of information on reproductive health for youth. Brazil has also established similar cooperative partnerships with Bolivia, Colombia, the Dominican Republic, El Salvador and Paraguay.

The National STD/AIDS Programme has also made significant efforts towards working alongside civil society organizations, pursuing social control mechanisms over AIDS policies, and engaging them throughout the policy cycle (design, implementation, monitoring and evaluation). Since 1992, the National Coordination of STD/AIDS has taken charge of establishing partnerships with the civil society organizations, starting with an agreement between the Brazilian government and the World Bank – AIDS I (1994-1998). AIDS I handed financial support to civil society organizations to develop original initiatives, particularly in the field of prevention. Following the first agreement, Brazil signed AIDS II (1999-2002), which financed 1,780 civil society organizations' projects. In terms of foreign funds and support, the World Bank has been the single largest contributor, committing US\$325 million from 1988 through 2004 in HIV/AIDS-specific loans to Brazil. Smaller financial contributions have also poured in from UN agencies and international NGOs and foundations.

UN agencies have been particularly engaged in cooperative arrangements with the Brazilian government, universities, NGOs and even private firms when it comes to combating HIV/AIDS. Their actions have been coordinated by UNAIDS, but they have also marshalled various initiatives in their own mandate areas. Whereas, UNODC and UNESCO have been directly involved in the actions carried through by the National

STD/AIDS Programme of the Ministry of Health and has been a co-executor of that Programme. It has also sought to support local NGOs and university efforts focused on AIDS – as is the case of the University of Brasilia (UnB) – and has acknowledged best practices through its annual UNESCO Awards.

BRIEF NOTES ON HIGHER EDUCATION IN BRAZIL⁷

In Brazil, university education is a benefit exclusive to a small share of the population. Brazil falls behind OECD (Organization for Economic Co-operation and Development) and other Latin American countries with regard to the proportion of university students in the population and within university age. Brazil will not find its leap into the future unless it settles the scores of the country's educational deficit. Despite these dismal figures, there have been remarkable advancements in the field of university education in Brazil in the last decade. Such evolution can be observed in the public policies of the three government levels – municipal, state and federal -, arguably more pre-eminently in the last two. In Brazil the right to a public university education is granted in the National Constitution of 1988 and in the Education Guidelines Law (Lei de Diretrizes e Bases da Educacao).

Figures show that whereas in 1960 only 95,000 people were enrolled in an higher education institution, in 2002 as many as 3.56 million students were attending university, which represents up to 15 % of the population in university age (18-24 year-olds) – yet, still lower, for instance, than Argentina (36%) and the OECD average (52%), but much higher than the Brazilian average of 1980-1994 (10%). The trend of expansion of university enrolment can be attributed to the growing demand by students resulting from the soaring number of those finishing secondary education (high school), the adaptation of undergraduate courses to fit labour market demands, and public policy incentives. The trend can be seen in the following data: as of 2001, out of the 1,855 million students finishing high school, 1,591 million found their way to enter university (85.7%), as opposed to the 0.574 million of 1994 (74% of the 0.749 million).

In 2002, as many as 3,479,913 students were enrolled in undergraduate courses. Only between 1998 and 2002, 1,353,956 students were added to the number of university students in Brazilian institutions, amounting to a 63.6% increase in this period alone. In 1998, there were 2.1 million students attending 973 centres of higher education, 47 of which were federal institutions, 74 state, 78 municipal, and 764 private. In 2002, the number jumped to 3.5 million students in 1,637 education centres, of which 73 were

⁷ Data available at www.inep.gov.br (INEP – National Institute of Educational Research and Studies). Further data from SOUZA, P.R. *Ensino Superior: Maior, Melhor e Mais Competitivo*. Chapter 8 (yet to be published).

federal, 65 state, 57 municipal, and 1,442 private schools or universities. Worth noting, 57% of students registered in 2002 were women.

The number of master and doctorate students has also grown in the 1994-2002 period: 41% between 1994 and 1998 and 84% between 1998 and 2002 for master students and 58% (1994-1998) and 74% (1998-2002) for doctorates.

As a result of expanding enrolments in institutions of higher education, the universities' faculty board/teaching staff has also witnessed a significant enlargement. Between 1998 and 2002, 38% more professors were hired, which followed an improvement in the student/professor rate – from 12.9 to 15.3.⁸ In 2002, a total 227,884 professors were working in the field of university education, of which 61% were in the private sector. In municipal and private institutions, the student-professor rate (17 and 18.5, respectively) is higher than those of state (12.8) and federal universities (11.6), given the latter propensity to develop research and carry out post-graduate courses. As a reference, the OECD student/professor rate is 17.

The professional and academic qualifications of university faculty board/teaching staff has also made relevant improvements: between 1998 and 2002, the rate of professors holding master and doctorate degrees in the boards raised respectively from 27.5% and 19% (36.5% combined) in 1998 to 34% and 21.6% (55.6% combined) in 2002. The fact that the proportion of master holders in private institutions has soared from 34% to 50% between 1994 and 2002 is also telling of the trend of the private sector to meet the legal requirements and its public demands. In 2002, the number of professors holding master and doctorate degrees in federal universities increased respectively 70% and 40%.

Federal funding for higher education has experienced contradictory trends. On the one hand, the Ministry of Education, despite maintaining the rhetoric of higher education as a priority, has attempted to streamline funding and has continuously stimulated federal universities to find new sources of funding. To a great extent, the eventual freezing of the amounts of federal transfers to universities in recent years has been able to free resources that have helped expand coverage in elementary schooling. On the other hand, by doing so, the Ministry of Education has seen the amount of universities' budget expand on personnel

⁸ That is, an improvement in efficiency, because this rate is still below OECD countries' rates, at 17 students/professor.

and social security time and again, due to inequitable and inefficient legal provisions that provide annually increasing benefits for personnel on an almost automatic basis. As a result, actual spending on research, investments in books and infrastructure, technology and so on may have suffered in recent years. Be that as it may, this policy might have prompted some managerial improvements in federal universities and has certainly pushed them towards more active fundraising activities.

To conclude, the following trends with regard to university education in Brazil: a general expansion of the supply of university education in the country, ballooning demand for university education from students finishing high school, significant enlargement of private education (in number of institutions, professors, students, and investments), increasing diversity of undergraduate courses, increasing proportion of institutions and courses functioning in non-capital cities (countryside and coastal towns), and the understanding that the growth of the public education network is limited due to fiscal constraints, unlike what takes place in the private education sector.

Case study: the University of Brasilia (UnB)

Established in 1962, the University of Brasília (UnB), despite its innovative programme, soon fell victim to the hardships of the military rule in Brazil. The campus was invaded by Army troops in 1968, students and professors were arrested, and some were sent to exile in foreign countries, others were forced to retire. The academic life restricted by censorship and close surveillance from the Armed forces. Nonetheless, the UnB grew to become one of the larger Brazilian universities, both in number of courses and students.

In recent years, from 1994 through 2003, the University of Brasília has witnessed a major growth both in the number of courses and in the number of admissions, in tune with the growth of higher education in Brazil in that period. Whereas the number of undergraduate courses grew 15% in the period, the number of students jumped 74%. Figures for masters and doctorate candidates and courses reveal an even more significant increase, as the table below shows.

Courses and Students – University of Brasília

	1993	2004	Growth 1993-2004 (%)
Undergraduate courses	52	60	15
Masters courses	39	12	31
Doctorate courses	14	30	114
Undergraduate students	12,758	22,281	74
Masters students	1,184	2,600	119
Doctorate students	288	1,186	311

Source: UNB. *Relatório Anual de Gestão 2004*. Brasília: UnB, 2004.

The academic board/teaching staff raised in a considerably slower pace in the same period: it has only increased from 1,274 professors in 1994 to 1,297 in 2003, which resulted in a higher student/professor rate, though still much lower than that observed in OECD countries or even in private institutions in Brazil.

In 2003, the University of Brasilia managed a R\$ 475.6 million budget (61% from federal transfers, 27% own resources, and 12% from partnerships and donations). Spending was chiefly concentrated in personnel and pensions (87.6%). The student cost per year was calculated in US\$2,100, according to an internal survey. Notably, the medical courses showed the highest figures of student cost/year due to maintenance needs of the Hospital of the University of Brasilia (“Hospital Universitário de Brasília” – HUB).

INSTITUTIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC – THE UNIVERSITY OF BRASILIA

The University of Brasilia (UnB), located a few minutes away from the Ministry of Health and from the National STD/AIDS Programme premises, lacks an institutional policy towards the HIV/AIDS epidemic, be it directed to its own university community or to the community beyond its invisible walls. Nevertheless, various initiatives have been developed and implemented since 1996, especially in its Medical, Social Services and Psychology schools. Furthermore, the University's Hospital (HUB) is a reference centre for treatment and care of people living with HIV/AIDS in Brasilia and its surrounding towns. Most of these initiatives have reached out to the larger community even before focusing on faculty, staff and students of the UnB.

Despite clear support from the Dean's Office, and despite generally lacking personnel, resources, or even basic materials, these initiatives have been able to develop a large set of far-reaching partnerships with government agencies, international organizations, NGOs and private firms. Their actions have helped to increase awareness of the HIV/AIDS epidemic, stimulate prevention and HIV testing, train students and teachers (university, elementary and high school), improve treatment and care for people living with HIV/AIDS. Some have been so successful that they have caught the attention of foreign institutions, which have visited the campus to learn from their experiences. The following will be presented in greater detail:

- Com-Vivência – Acoes Integradas de Atencao e Atendimento a Pessoas Portadoras de HIV/AIDS e Familiares;
- NEAMCES – Nucleo de Estudos e Acoes Multilaterais de Cooperacao em Educacao e Saude;
- HUB – Hospital Universitário de Brasilia;

1. Com-Vivência – Psychological Care to people living with HIV/AIDS and Education on HIV/AIDS

Established in 1996, the Com-Vivência is a multidisciplinary project of the UnB that brings together faculties and students from the Medical, Psychology and Social Services colleges. It is as much a research and a training spot in the University as it is a help centre for people living with HIV/AIDS. Spreading itself through three small adjacent rooms made available by the University Hospital, the Com-Vivência staff is comprised by one part-time professor (a doctorate psychology professor at the UnB, which acts as Coordinator), two Social Services graduates, one administrative assistant, and three volunteers (two of which are undergraduate students at the UnB, and the third a former postgraduate student). This permanent staff is complemented by 3 trainees per semester. Eight undergraduate and postgraduate students are also currently doing field or document research at the Com-Vivência facilities.

Its budget comes from a project that has to be annually updated with the Department of Community Affairs of the University, and basically finances the scholarships of the trainees and the purchase of office material. It has also been able to receive small grants (US\$ 1,000) from the University in the last three years, which have been used to purchase two computers and some furniture for the rooms.

The Com-Vivência has four main areas of activity:

- Psychological and social assistance support and counselling;
- HIV/AIDS prevention;
- Training and education;
- Research.

Psychological and Social Assistance Support and Counselling and HIV/AIDS Prevention

In its community services, Com-Vivência has developed a wide range of activities. This provides pre- and post-test counselling for all of those who take HIV tests at the HUB. Additionally, it hosts regular (individual and group) meetings with people living with HIV/AIDS. These meetings are conducted by the Coordinator and are based on a cognitive-

affective behavioural approach towards the group, through which a better comprehension of the infection and its side effects is sought in an environment conducive to collective understanding and affection. Similar meetings bring together relatives of people living with HIV/AIDS, during which the same approach is applied but with different goals, chiefly in order to provide them information regarding HIV/AIDS and counselling on how to provide caring for loved ones with HIV. These meetings use audio-visual resources, such as videos donated by the Ministry of Health or the Federal District's Health Secretariat. Leaflets and other information material regarding prevention methods are also freely distributed in the Com-Vivência site to anyone wishing to take them.

Specific meetings were designed for pregnant women with HIV/AIDS to address their different feelings and reactions to the disease as well as to prevent HIV transmission from mother to child. As a direct or indirect result of such services, no case of vertical transmission has been registered in the HUB since 2001. Another special group brings together people who are suffering from HIV-caused lipodystrophy. This group has been singled out not only because its members may witness distinct features from other groups, but also because the Com-Vivência staff has detected a higher treatment abandonment rate among them. These meetings, therefore, serve also as an attempt to ensure people's continuous adherence to the treatment. They are also useful for patients to be provided with information on nutritional supplements and dietary changes that help reduce the symptoms of lipodystrophy.

Although the HUB treats very few children and teenagers with HIV/AIDS, Com-Vivência staff has witnessed a slow increase in the demand in recent months and expects it to increase even further, as children who were infected at birth grow older and start to develop AIDS. More important, the staff see the act of telling their children about their infection as one of the most pressing and difficult tasks for parents. Thus, Com-Vivência is developing a new strategy to deal with this group, which will require not only different approaches but also some changes in the infrastructure of the rooms, so that the facilities can be more attractive and child-friendly.

Besides free distribution of condoms (including female condoms), Com-Vivência has delivered countless workshops and lectures on safe sex, contraceptive methods and other STI/HIV prevention methods to students, mostly adolescents, of public schools in Brasilia since its creation back in 1996. These workshops and lectures are *pro bono* and are usually delivered by the Coordinator of the project, although the interns have been trained to deliver them as well. Furthermore, it receives material from the state Secretariat of Health and distributes them largely to anyone visiting the Com-Vivência premises and to the university community in general.

The number of people living with HIV/AIDS which receive treatment and ARV drugs at the HUB is a figure that revolves around 280 and 340. The chart below brings data from 2004 regarding services provided by the Com-Vivência within the HUB:

Type of service/group	Number of people
Admittance of new inpatients	112
Social assistance/orientation services	225
Individual psychological support	460
Couples' and/or relatives' meetings	49
Psychological support to parents' of children and adolescents living with HIV/AIDS	25
Individual psychological support to children/adolescents with HIV/AIDS	30
Pre- and post-test/visit to doctor counselling	114

Source: COM-VIVÊNCIA. *Relatório Final – Projeto de Extensão de Ação Contínua*. Brasília, UnB, 2004. mimeo.

Training and Education

As an education spot, the Com-Vivência has served as a privileged opportunity for on-site learning for undergraduate students in the fields of Social Services and Psychology. It usually hosts eight undergrads from Social Services and Psychology per semester in tutored on-site education internships.

The Com-Vivência staff has also provided training for health professionals (physicians, nurses, psychologists, health technicians and so on), elementary school teachers, social workers, NGO professionals, prison staff, and other private workers and civil servants.

Most of these activities, either short courses or one-day lectures, have been contracted by the Federal District Government's Health Secretariat.

From 1997 through 2000, Com-Vivência trained 250 public health professionals in counselling on PMTCT in Brasilia, under a project financed by the National STD/AIDS Programme. Medical, including ARVs, and psychological treatment was offered to inmates at the Papuda Prison (Brasilia's main detention facility), and its staff were trained in HIV/AIDS prevention methods. Various short courses for both health professionals and technicians were also carried out under the UNIVERSIDAIDS project of the National STD/AIDS Coordination and UNESCO, from 2001 to 2003. These courses, typically 20-hours each, focused on the qualification of HIV/AIDS preventive actions in Brasilia, and were attended by around 150 people. According to Com-Vivência staff, the courses were positively evaluated, but once funding ceased, they were discontinued.

Com-Vivência was also engaged, from 1999 through 2001, in a multidisciplinary education project financed by the National Anti-Drugs Secretariat and the Ministry of Education aimed at training school teachers about alcohol and drug abuse. It was responsible for producing a volume (out of a series) on the inter-relation of HIV/AIDS and drug abuse. The materials were distributed nationwide to some 26,000 people, who were then trained at distance with the support of information and communication technologies, such as online tutoring on the Internet, telephone help lines, and videos. Interns and volunteers from the UnB were specially trained to act as tutors for this initiative.

Apart from the aforementioned projects, Com-Vivência has also delivered short courses and lectures for youth on sexuality and safer sex practices, drug use and HIV/AIDS, and a number of other issues. As a result, more than 32,000 people have been either trained or qualified by Com-Vivência's education and training actions. Further evaluation of Com-Vivência's activities is necessary to determine their impact on knowledge, skills, and behaviours related to HIV/AIDS.

Research

Despite its various projects targeting groups outside the University, Com-Vivência has not neglected scientific research. Three doctorate thesis and six master's dissertations have been written by candidates involved in the Com-Vivência Project or using data collected at the project, while two others are currently being written. Moreover, professors associated directly or indirectly with Com-Vivência have written and published various articles or presented lectures at national and international scientific symposia based on the Com-Vivência experience (see Annex 2 for a partial listing of these materials).

Research has ranged from bioethics to social policies, from psychological treatment to health care and counselling, from gender-related aspects of HIV/AIDS to anthropological explorations of the consequences of HIV/AIDS. Although all of the theses and dissertations are available at the University's Library, Com-Vivência has not been able to publish or distribute them due to lack of resources.

Final Comments on Com-Vivência

Although seated on campus at the University Hospital, the main activities of Com-Vivência have been directed at the community outside the university since its inception. Although the decision to do so may be due to the fact that HIV/AIDS has reportedly had little impact on the university community (professors, staff, students), it is more likely due to its initial design in 1996. At that time, professors were inclined to implement a project to provide psychological services for people living with HIV/AIDS; thus, more connected to the reality of the University hospital than to the university community itself.

Despite initial reservations from the HUB staff, fear of an overload in HIV/AIDS-related demand stimulated by the activities of the Com-Vivência, the project has established itself as the most visible response of the University of Brasilia to the HIV/AIDS epidemic. Throughout the 11 years since its creation, it has provided direct counselling, psychological support and care to thousands of people living with HIV/AIDS or their relatives. Moreover,

it has engaged in various training and education initiatives which have reached more than 30,000 public and private professionals and students, adult and young, throughout the country. It has been able to build partnerships with private firms and local NGOs, with state and central-level governmental agencies, and has improved its relationship with the managerial structure of the University itself. Anecdotal evidence points out that, given the close relationship eventually established between the Com-Vivência and the medical staff of the HUB, the University Hospital is home to the best treatment and care services for people living with HIV/AIDS in town.

Nonetheless, limited resources and lack of personnel continue to be a major constraint for Com-Vivência's activities. Funding is required to adapt the infrastructure (e.g., to better welcome children and adolescents living with HIV/AIDS) and to replace obsolete equipment (computers, printers, etc.), as well as to publish and distribute more materials for visitors and registered users of the services. Resources could also be used to, not to mention to develop and implement a more reliable and timely data system in order to track programme activities and monitor progress.

Interesting enough, Com-Vivência has not been widely used by the university community – only 2 staff members and 2 students were said to be regular users, and only at individual sessions – perhaps as a result of the low incidence of HIV/AIDS on campus. Be that as it may, university users – even interns, trainees and researches – have reported to suffer from the stigma which still clouds discussions about the disease on campus. The decision of those living with HIV/AIDS to participate only in individual sessions – sometimes off work hours – may reinforce that perception. Whatever the reason might be, the fact is that, if the University has been using it mostly as a spot for on-site education and training, community outside the University – usually much poorer – is benefiting from a range of services that have helped give a more humane face to HIV/AIDS prevention, treatment, care and support.

2. NEAMCES – Núcleo de Estudos e Ações Multilaterais em Educação e Saúde (Centre of Studies and Multilateral Actions in Education and Health)

The Multilateral Centre of Studies and Actions of Cooperation in Education and Health (NEAMCES-UnB), based in the Department of Social Services of the University of Brasilia, develops research activities, multilateral cooperation projects, and facilitates the exchange of experiences in the fields of education and health. The centre was created as a result of the workshop “*Training of Agents for the Promotion of Health and Prevention of STD/AIDS*”, in the framework of the 1st Extension Course “*Quality of Life, Health and Policies to Fight the Global HIV/AIDS Epidemic*”, held in Brasilia from September 16 to October 4, 2002.

The centre assembles professors and students from Brazil, Cape Verde, Guinea-Bissau, Senegal, Angola, Mozambique, and Peru, with the spirit of strengthening international cooperation in health-related themes. The list of the NEAMCES’ main partners and supporters includes UNESCO, UNAIDS, USAID, the Brazilian Ministry of Health STD/AIDS Programme and several NGOs.

The main objective of NEAMCES is to become an academic reference in international cooperation programmes in the fields of education and health, particularly as far as the HIV/AIDS epidemic is concerned. To reach that objective, the centre outlines specific goals including: i) to serve as a space of integration and exchange of experiences for Brazilian and foreign students and professors of the University of Brasilia and other education institutions; ii) to provide technical and scientific education on health, prevention, training of human resources, and HIV/AIDS assistance, by offering courses, promoting research activities, disseminating information, and rendering consulting services; iv) to organise conferences on the “global epidemic of HIV/AIDS” for Brazilian and foreign students; v) to consolidate and publicise databases of documents, research material, public policies records, and international agreements on education, health and HIV/AIDS.

The lines of action put forward by the NEAMCES including planning routine activities, organising thematic seminars, establishing permanent contacts with partners and supporters, conducting routine meetings with the associated embassies, and promoting the

aforementioned extension programme - “*Quality of Life, Health and Policies to Fight the Global HIV/AIDS Epidemic*”.

The University of Brasilia’s NEAMCES initiative embraces a pioneer and distinguished concept of education on health themes, inasmuch as other universities and foreign scholars are encouraged to engage in its activities. Notably, most of the foreign participants come from African countries – the region most severely affected by HIV/AIDS. In addition, the centre is based on a model of horizontal cooperation, which aims to reunite diverse experiences and to foster community participation by establishing permanent channels of dialogue.

The actions carried out by NEAMCES to date are guided by enhancing experience-sharing mechanisms, articulating civil society actions, undertaking pedagogical activities, expanding human resources, and laying ground for HIV/AIDS preventive education. Furthermore, NEAMCES has been struggling to integrate foreign students into the Brazilian academic community. At the same time, it has been devoting efforts to improve quality of life on campus – especially, in regard to the HIV/AIDS epidemic.

Public demonstrations, collaborations with NGOs, surveys to assist people living with HIV, promotion of cultural activities, and participation in health-related conferences also fill the NEAMCES’ workplan.

1st Brazilian Meeting for Mozambican Students

In order to mobilise Mozambican students living in Brazil and to deepen the discussion on the HIV/AIDS epidemic, the city of Curitiba hosted the *1st Brazilian Meeting for Mozambican Students*, which took place from December 4-7, 2003. During thirty hours of activities in the capital of Paraná State (Brazil), 46 undergraduate and graduate Mozambican students living in Brazil pursued the development of a network of technical and scientific exchange to respond to the HIV/AIDS epidemic in Mozambique – where, according to the country’s government officials, as many as 1,300 people are infected every day.

Participants attended workshops on the global outlook of HIV/AIDS, public policies, human rights, and national experiences in combating HIV/AIDS, among other seminal issues. In addition, the meeting marked the foundation of the partnership between

the University of Brasilia/NEAMCES and the Eduardo Mondlane University of Mozambique, envisaging to create thematic disciplines focused on the HIV/AIDS epidemic in their local, regional and global dimensions and to enshrine both institutions as references for university policies and programmes of international cooperation in health education, chiefly for African Portuguese-speaking countries. UNESCO, the Brazilian Ministry of Health's STD/AIDS Programme, the Brazilian Ministry of Foreign Affairs, the Embassy of Mozambique and the Parana's Health Secretary granted the institutional support for the conference. As a direct result of the conference, more than 100 students were trained to work on HIV/AIDS prevention policies in Mozambique.

HIV/AIDS Prevention Unit

The HIV/AIDS Unit is a branch of the Multilateral Centre of Studies and Actions of Cooperation in Education and Health (NEAMCES-UnB), functioning in the Department of Social Services of the University of Brasilia. The Unit aims at providing counselling services in HIV/AIDS themes for students, professors, staff, and other community members. Founded in May 2004, the HIV/AIDS Prevention Unit hosts "safe sex" workshops, lectures and courses, distributes male and female condoms, provides information, and hands out informative material. According to NEAMCES Coordinator, the Unit's target to create permanent bonds with its users has been met with success. Currently, the HIV/AIDS Unit serves 100 people. Students and staff can volunteer to join the NEAMCES and they may also enrol for the courses at the Prevention Unit. It is open during business hours and in the night time.

Courses

For the third time, the Extension Course "*Quality of Life, Health and Policies to Fight the Global HIV/AIDS Epidemic*" was organised with remarkable success. In July and August 2004, around 50 participants attended the 60-hour course, which resulted in the publication of projects and articles – including academic pieces developed in undergraduate and graduate programmes. Papers focused on the issues of health care procedures, management and public policies.

Courses and workshops on sexuality and on the training of health agents, as well as the organization of cultural activities such as art exhibitions and theatre plays, have been carried out regularly by the NEAMCES and its Prevention Unit.

Conclusions

The Multilateral Centre of Studies and Actions of Cooperation in Education and Health (NEAMCES-UnB) has been successful in performing its mission on a permanent basis and on a planned schedule, as opposed to implementing isolated activities of limited reach. Apart from the results already mentioned in this report as consequence of the centre's programmes, the NEAMCES can be proud to have transformed students into health agents and awareness-builders in the field of prevention of the HIV/AIDS epidemic.

However, in order to continue to achieve positive outcomes, the centre needs continuous support mechanisms that ensure the steady provision of human resources and proper funding. In this regard, UNESCO's support has been vital from the outset for the initiative to thrive.

3. Hospital Universitário de Brasília – University of Brasilia Hospital – HUB

The University of Brasilia's Hospital was inaugurated in 1972 as a federal hospital and was only completely donated to the University in 1990. It is mainly used by lower-middle and low-income segments of Brasilia's population, though patients coming from surrounding towns and other Brazilian states often also use the available services. It covers 33 distinct medical areas, from paediatrics to oncology, from neurosurgery to HIV/AIDS care. It has its own laboratories and is almost fully equipped to Brazilian standards, lacking only magnetic resonance scanning equipment.

Professors and staff tend not to use the University Hospital because their contracts with the University provide them with private health insurance, allowing them to refer to private medical institutions. Naturally, private hospitals and health centres provide them with

easier access – though not necessarily with better care. Most students also have private insurance, according to socio-economic data available at the University.

The hospital is the major on-site training and education spot in the city: it hosts in more than 500 undergraduate and postgraduate internships, as well as 20 different medical residency programmes accredited by the Ministry of Education.

Its staff is comprised by UnB professors and students, doctors, nurses and other technical and administrative personnel, civil servants as well as private professionals. It has currently 289 beds, 121 outpatient facilities, and executes some 36,000 procedures monthly. In 2004, it managed to stay within its budget of approximately US\$10 million, an unusual situation for a highly demanded public hospital in Brazil. Although budgetary constraints are common, usually the Ministry of Health provides institutions that overspend with supplementary allotments. According to a users' satisfaction survey conducted by the Ministry of Health in 2000, the HUB ranked top among public hospital and health centres in Brasilia.

When it comes to HIV/AIDS, the HUB is certainly the branch of the University most directly involved in the epidemic. Besides hosting the Com-Vivência on its premises, the HUB also treats between 280 (permanent) and 340 (60 occasional) patients monthly, either for medical consultations, ARV and other drugs distribution or exams. It has an average of 7 inpatients with HIV/AIDS and conducts hundreds of HIV-tests monthly. Its Drugs Distribution Facility provides people with AIDS with free drugs, including ARVs. Beneficiaries have to be registered to be eligible for receiving the drugs, but their names and other personal data are strictly kept confidential. No disclosure whatsoever of medical records can be made available.

The medical staff directly involved with HIV/AIDS in the Hospital comprises 4 doctors, 6 residents, as well as a number of other nurses and other support personnel. Research conducted at the HUB, however, does not include or relate to hard (basic) science, for Brasilia does not have any P-4 laboratory, that is, a laboratory where virus such as the HIV

can be manipulated. Therefore, most of the research is related to diagnosis, treatment alternatives and organic reaction to drugs and HIV/AIDS- related diseases.

No further data was made available by the hospital on its services rendered to people living with HIV/AIDS. These data are protected with confidentiality under the Brazilian Law, except for the highly general and aggregated figures presented here.

LESSONS LEARNED

The primary lesson learned from the UnB experience is that individual schools and/or departments of the University can develop and implement HIV/AIDS initiatives even in the absence of explicit support from the Dean's Office. As previously indicated, when Com-Vivência was created, even the doctors and medical staff at the University of Brasilia Hospital (HUB) displayed reservations towards the project. Through a careful and gradual approach, Com-Vivência staff was later able to convince the medical staff, and today all medical visits to patients with HIV/AIDS at the HUB are accompanied by a psychologist from Com-Vivência.

Professors and staff involved with HIV/AIDS at the UnB have also learned that internal and external cooperation is an important element for the reach and sustainability of their initiatives. Both Com-Vivência and NEAMCES members reported that the partnerships they were able to establish within the University – with other Departments, with the HUB etc – and outside it – with the National Programme on STD/AIDS, the Federal District Health Secretariat and UNESCO, to name a few – were important not only in terms of direct funding for specific activities. According to them, these partnerships paved the way for other opportunities, and have thus contributed to increase their outreach. For example, Com-Vivência has done projects nationwide and NEAMCES is beginning talks for an international partnership with Caribbean countries.

A third important lesson learned by Com-Vivência is that flexible arrangements are necessary to provide assistance for those uncomfortable with exposing their condition. Special hours, such as after work, and individual meetings have proved to be important to obtain adherence to treatment of University staff and professors, who feared to be seen by colleagues at Com-Vivência premises. According to one of the interviewees, *'anonymity may be a first step towards acceptance and later disclosure of their condition as HIV-positive people, at least while the stigma surrounding the disease doesn't go away'*.

Another noteworthy experience highlighted by the UnB is that scientific research can be facilitated when there is an assistance project on campus. Given the paucity of resources for

field research and data collection, most graduate and post-graduate candidates are inclined to define the subject-matters of their dissertations taking into account the availability, reliability and timeliness of data. Since Com-Vivência was created, the number of HIV/AIDS dissertations increased, and most of them used data collected at Com-Vivência, according to its coordinator. Research in medical sciences related or not to HIV/AIDS, are also facilitated by the existence of the University Hospital. Therefore, investments in community assistance initiatives, even when professors, students or staff are not their primary users, might serve as an important boost to research.

Both Com-Vivência and NEAMCES also show that HIV/AIDS-related academic projects can be good on-site learning opportunities for graduate students. Internships have allowed students to improve their knowledge on matters related to HIV/AIDS, to develop teamwork and entrepreneurial skills, and to exercise their solidarity. According to the coordinators of these projects, intern students tend to increase their chances of finding a job when they leave the university.

RECOMMENDATIONS FOR ACTION

The most important recommendation for the UnB is for the Dean's Office to propose an *ad hoc* commission to develop a University HIV/AIDS policy plan. This commission may bring together professors and staff involved with the already existing HIV/AIDS-related initiatives on campus. Close cooperation with government agencies, multilateral organizations, NGOs and private enterprises should be sought in order to implement such a policy.

The modernisation of record-keeping for HIV/AIDS projects remain a task to be fulfilled. Medical records at the Drugs Distribution Facility at the HUB, for instance, still use papersheet files to keep track of patients' adherence to ARV treatment. Resources should be directed towards the procurement of computers, printers and servers, needed to process local data banks and integrate them with outside databases. This would help keep track of the progress of the projects, and would be a useful tool for students and researchers in need of reliable and timely data.

Com-Vivência, HUB and NEAMCES coordinators have complained about the lack of personnel. In most cases, they said, personnel are needed to perform administrative duties and to assist in project implementation and monitoring. Although they mentioned to be in need of more professors and experienced professionals, in their opinion more internship scholarships – a relatively low-cost solution – would fill most of the blanks. UNESCO has contributed resources for hiring consultants for NEAMCES in the past; perhaps it might do so again, now for Com-Vivência. Other agencies, both national and multilateral, could also commit resources.

One must also recommend regular monitoring and in-depth evaluation of the actions carried out by the abovementioned projects. No independent evaluation has been produced about them and, in most cases, one has to rely on the reports given by those directly involved in the rendering of services. User satisfaction surveys could become a powerful tool for policy

fine-tuning and redesign. Also, they could be used by students and professors when conducting research about HIV/AIDS or the projects themselves.

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ANNEXES

ANNEX 1 - BRAZIL – KEY INDICATORS

Basic Indicators	Year	Figures	Source
HIV/AIDS			
Adults and children (ages 0-49) living with HIV/AIDS	2003	660.000	UNAIDS, 2004
Adults (ages 15-49) living with HIV/AIDS	2003	650.000	UNAIDS, 2004
Women (ages 15-49) living with HIV/AIDS	2003	240.000	UNAIDS, 2004
Adults and child AIDS deaths (ages 0-49)	2003	15.000	UNAIDS, 2004
Adult (ages 15-49) HIV prevalence (%)	2003	0.7	UNAIDS, 2004
Percent of adults receiving VCT in last year (I-1)	2003	0.1	WHO Health Services Coverage, 2004
Number of VCT clients per year (I-2)	2003	84.700	WHO Health Services Coverage, 2004
Number of VCT sites (I-2)	2003	220	WHO Health Services Coverage, 2004
Percent of pregnant women offered PMTCT services (I-3)	2003	56	WHO Health Services Coverage, 2004
Percent o HIV + pregnant women receiving ARV prophylaxis	2003	26	WHO Health Services Coverage, 2004
Number of sites offering PMTCT services (I-3)	2003	938	WHO Health Services Coverage, 2004
Estimated coverage of antiretroviral therapy (est. %) (I-4)	2003	100	WHO Health Services Coverage, 2004
Number of public sector patients receiving antiretroviral therapy (I-5)	2003	125.168	WHO Health Services Coverage, 2004
Number of sites offering antiretroviral therapy services (I-5)	2003	438	WHO Health Services Coverage, 2004
Percentage of population living in areas with DOTS coverage (I-6)	2002	25	WHO TB Control Report, 2004
Number of TB cases registered for treatment under DOTS (I-7)	2001	1,394	WHO TB Control Report, 2004
HUMAN DEVELOPMENT INDICES			
Human development index (rank) (I-8)	2002	72	UNDP, 2004
Gini index (I-9)	2002	59.1	UNDP, 2004
Gender-related development index (GDI) (I-10) (rank)	2002	60	UNDP, 2004
Gender-related development index (GDI) (I-11) (value)	2002	0.768	UNDP, 2004
MORTALITY			
Life expectancy at birth (I-12) (years)	Various Years	71	PRB Data Sheet, 2004
Infant (Ages 0-1) mortality rate (I-13) (per 1,000 live births)	2003	33	UNICEF, 2005
Under-five mortality rate (I-14) (per 1,000 live births)	2003	35	UNICEF, 2005
Maternal mortality ratio (I-15) (per 100,000 live births)	2000	260	UNFPA, 2004
Probability at birth of surviving to age 65, female (I-16) (% of cohort)	2000-2005	76.5	UNDP, 2004
Probability at birth of surviving to age 65, male (I-16) (% of cohort)	2000-2005	59.7	UNDP, 2004
GENERAL POPULATION			
Total population (millions)	2004	182	IBGE
Total projected population - 2025 (millions)	2004	229	IBGE
Total projected population - 2050	2004	260	IBGE

(millions)			
YOUTH			
Population ages 10-24 (millions)	2000	50.9	PRB Youth Data Sheet, 2000
Percent of total population ages 10-24	2000	30	PRB Youth Data Sheet, 2000
Percent of total population under 15	mid-2004	30	PRB Data Sheet, 2004
GENERAL ECONOMY			
Gross national income (I-17) (US\$ per capita)	2002	7,450	World Bank/ WDI – 2004
Gross domestic product (R\$, per capita)	2004	9.014	IBGE, 2005
POVERTY			
Population below poverty line (I-19) (%)	1990-2001	17.4	UNDP, 2004
Population below US\$1/day (I-20) (%)	1990-2001	8.2	UNDP, 2004
GENERAL HEALTH			
Health expenditure, private and public (I-21) (US\$ per capita)	2001	573	UNDP, 2004
Physicians per 100,000 people (I-22)	1990-2003	206	UNDP, 2004
Births attended by skilled health staff (I-23) (%)	1995-2002	88	UNDP, 2004
Malaria cases per 100,000 people (I-24)	2000	344	UNDP, 2004
Prevalence of child (ages 0-5) malnutrition (I-25) (%)	1995-2003	6	UNDP, 2004
TB treatment success rate, new smear-positive cases-DOTS (I-26) (% of cases)	2001	67	WHO TB Control Report, 2004
Child (ages 0-1) immunization rate, measles (%)	2003	99	UNICEF, 2005
Child (ages 0-1) immunization rate, DPT (I-27) (%)	2003	96	UNICEF, 2005
FERTILITY			
Total fertility rate (I-28) (number of children)	2000-2005	2.21	UNFPA, 2004
EDUCATION			
Gross primary school enrollment ratio, male (I-29)	1998-2002	153	UNICEF, 2005
Gross primary school enrollment ratio, female (I-29)	1998-2002	144	UNICEF, 2005
Gross secondary school enrollment ratio, male (I-29)	1998-2002	102	UNICEF, 2005
Gross secondary school enrollment ratio, female (I-29)	1998-2002	113	UNICEF, 2005
Adult literacy rate (%) (I-30)	2000	86.4	World Bank/ WDI – 2004
Adult literacy rate, Female (%) (I-30)	2000	86.5	World Bank/ WDI – 2004
Adult literacy rate, Male (%) (I-30)	2000	86.2	World Bank/ WDI – 2004
Indicator Notes			
I-1.	Voluntary counselling and testing refers to services providing pre-test counselling, testing for HIV infection, and post-test counselling for anyone wanting to know their HIV status. It does not include testing done on hospital patients for medical purposes. Although the entire adult population may not be in need of VCT, statistics from VCT programmes indicate that clients represent a mix of risk behaviours. While VCT may be "needed" by those engaging in risky behaviour, in practice it is also used by people with little or no risk. Thus a simple ratio of the number of VCT clients to those with risky behaviours would not provide a true indication of coverage. For this reason coverage is presented as a percentage of the adult population, but it is recognized that the goal would not be 100% coverage.		
I-2.	Voluntary counselling and testing refers to services providing pre-test counselling, testing for HIV infection, and post-test counselling for anyone wanting to know their HIV status. It does not include testing done on hospital patients for medical purposes.		
I-3.	Prevention of mother-to-child transmission refers to services that provide voluntary counselling and testing for		

	pregnant women and provide prevention services to those who are HIV positive. Prevention services should include treatment with zidovudine, nevirapine or other antiretroviral drugs and may also include breastfeeding counselling and supplemental feeding.
I-4.	Antiretroviral therapy refers to the treatment of HIV-positive adults or children with a combination of at least three antiretroviral drugs. The number needing antiretroviral therapy is estimated as all adults with HIV who are within 2 years of dying from AIDS without antiretroviral therapy. This number is estimated to be twice the number of deaths from AIDS in 2003.
I-5.	Antiretroviral therapy refers to the treatment of HIV-positive adults or children with a combination of at least three antiretroviral drugs.
I-6.	The percentage of the population living in geographic areas nominally serviced by health facilities implementing DOTS (Directly Observed Treatment, Short-course).
I-7.	The number of new smear-positive cases registered for treatment under DOTS (Directly Observed Treatment, Short-course) in 2001.
I-8.	Measures average achievements in three basic dimensions of human development: life expectancy at birth; adult literacy and combined primary, secondary, and tertiary gross enrollment ratios; and GDP per capita.
I-9.	Measures the extent to which the distribution of income (or consumption) among individuals or households within a country deviates from a perfectly equal distribution. A value of 0 represents perfect equality, a value of 100 perfect inequality. Because the underlying household surveys differ in method and in the type of data collected, the distribution data are not strictly comparable across countries.
I-10.	Reflects inequalities between men and women using unweighted average of three component indices: life expectancy, education index, and income index.
I-11.	Reflects inequalities between men and women using unweighted average of three component indices: life expectancy, education index, and income index. Values range from 0 (lowest gender equality) to 1 (highest gender equality).
I-12.	The average number of years a newborn infant can expect to live under current mortality levels. For countries with complete registration of births and deaths, rates are those most recently reported. For more developed countries, nearly all vital rates refer to 2002 or 2003, and for less developed countries, to some point in the late 1990s or early 2000s.
I-13.	Probability of dying between birth and exactly one year of age, expressed per 1,000 live births.
I-14.	Probability of dying between birth and exactly five years of age, expressed per 1,000 live births.
I-15.	Number of deaths to women per 100,000 live births that result from conditions related to pregnancy, delivery, and related complications. These are consensus estimates of WHO, UNICEF, and UNFPA.
I-16.	The probability of a newborn infant surviving to age 65 if subject to prevailing patterns of age specific mortality rates. Data refer to estimates for the period specified.
I-17.	The gross national income (GNI) converted to international dollars using purchasing power parity (PPP) rates. An international dollar has the same purchasing power over GNI as a U.S. dollar has in the United States
I-18.	GDP is the sum of gross value added by all resident producers in the economy plus any product taxes and minus any subsidies not included in the value of the products. It is calculated without making deductions for depreciation of fabricated assets or for depletion and degradation of natural resources. Data are in current U.S. dollars. Dollar figures for GDP are converted from domestic currencies using single year official exchange rates. For a few countries where the official exchange rate does not reflect the rate effectively applied to actual foreign exchange transactions, an alternative conversion factor is used.
I-19.	The percentage of the population living below the poverty line deemed appropriate for a country by its authorities. National estimates are based on population-weighted subgroup estimates from household surveys. Data refer to the most recent year available during the period specified.
I-20.	The percentage of the population living below \$1 a day--at 1985 international prices (equivalent to \$1.08 at 1993 international prices), adjusted for purchasing power parity. Data refer to the most recent year available during the period specified.
I-21.	The sum of public and private expenditure (in US\$ adjusted for purchasing power parity), divided by the population. Health expenditure includes the provision of health services (preventive and curative), family planning activities, nutrition activities and emergency aid designated for health, but excludes the provision of water and sanitation.
I-22.	Includes graduates of a faculty or school of medicine who are working in any medical field (including teaching, research and practice). Data refer to the most recent year available during the period specified.
I-23.	The percentage of deliveries attended by personnel (including doctors, nurses and midwives) trained to give the necessary care, supervision and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on their own and to care for newborns. Data refer to the most recent year available during the period specified.
I-24.	The total number of malaria cases reported to the World Health Organization by countries in which malaria is endemic. Many countries report only laboratory-confirmed cases, but many in Sub-Saharan Africa report clinically diagnosed cases as well. Data refer to malaria cases reported to the World Health Organization (WHO) and may

	represent only a fraction of the true number in a country.
I-25.	Percentage of children under five whose weight for age is below minus two standard deviations from median weight for age of reference population. Data refer to the most recent year available during the period specified.
I-26.	Percentage of new, registered smear-positive (infectious) cases that were cured or in which a full-course treatment was completed. TB case notifications represent only a fraction of the true number of cases arising in a country because of incomplete coverage by health services, inaccurate diagnosis, or deficient recording and reporting.
I-27.	Percentage of infants that received three doses of diphtheria, pertussis (whooping cough) and tetanus vaccine.
I-28.	The number of children a woman would have during her reproductive years if she bore children at the rate estimated for different age groups in the specified time period.
I-29.	The number of children enrolled in a level (primary or secondary), regardless of age, divided by the population of the age group that officially corresponds to the same level. This is a standard indicator of the level of participation in education. The goal is to be as close to 100% as possible. In countries with gross enrollment ratios of less than 100%, there are not enough schools or slots for students, and children may not be taking the slots that are available because they are kept out of school. In countries with gross enrollment ratios over 100%, there is much under- and/or overaged enrollment, meaning that many students are above or below the official age for the grade; this may be the result of having to repeat grades or entering school late because of work and/or inability to afford school fees. Data refer to the most recent year available during the period specified.
i-30.	The percentage of people ages 15 and over who can, with understanding, read and write a short, simple statement about their everyday life.

ANNEX 2 - RESEARCH BY/AT/ON COM-VIVÊNCIA

Approved Doctorate Thesis involving Com-Vivência

Terror e Aids: um estudo etnográfico de uma comunidade de portadores do HIV/AIDS - Pedro Paulo Aguiar. Doctorate Thesis, Anthropology School, University of Brasília, 2000.

Pessoas vivendo com HIV/AIDS: configurando relações entre enfrentamento, suporte social e qualidade de vida - Eliane Maria Fleury Seidl. Doctorate Thesis. Brasília, Psychology School, University of Brasília, 2001.

Desconstruindo o preconceito em torno do HIV/AIDS na perspectiva da bioética de intervenção. Herli H. Gonçalves. Doctorate Thesis. Brasília, Health Sciences School, University of Brasília.

Approved Masters' Dissertation involving Com-Vivência

Prevenção e assistência a detentos portadores do HIV/aids - Leonardo Guirao Jr., Masters in Social Policies, University of Brasília, 2001.

Aids e gestação: construção de uma relação - Wania E.S. Carvalho, Masters in Social Policies, University of Brasília, 2001.

Convivendo com a diferença: proposta de avaliação da dinâmica relacional de casais sorodiscordantes para HIV/aids - Larissa Polejack, Masters in Psychology, University of Brasília, 2001.

Treinando respostas de adesão ao tratamento em portadores do aids hospitalizados: um estudo exploratório - Juliana B. Barletta - Masters in Psychology, University of Brasília, 2003.

O auto-cuidado e a subjetividade em mulheres portadoras de HIV e mulheres profissionais de apoio. Maria Helena Guerra Gomes Pereira. Masters in Psychology, University of Brasília, 2003.

Religiosidade, enfrentamento e bem-estar subjetivo em pessoas vivendo com HIV/Aids -Juliana Bernardes de Faria. Masters in Psychology, University of Brasília, 2004.

Book Chapters written by Com-Vivência professors

OLIVEIRA, Maria José de; GUÉRCIO, Cíntia Rios; SEIDL, Eliane Maria Fleury. Consentimento esclarecido de mulheres soropositivas no uso de leites adaptados: reflexões à luz da bioética. In: GIRALDI, Nilson; GARRAFA, Volnei. (Orgs.), **Cadernos de bioética: estudos e reflexões**. Londrina. (no prelo).

SEIDL, Eliane Maria Fleury; MUSSI, Marinez; FAUSTINO, Quintino de Medeiros (2003). Oficina sobre sexualidade e práticas sexuais seguras: trabalhando a prevenção às DST/HIV/Aids com adolescentes em medidas socioeducativas. In: SUDBRACK, Maria Fátima de Olivier; GANDOLFO, Maria Inês Conceição; SEIDL, Eliane Maria Fleury; SILVA, Maria Terezinha (Orgs.), **Adolescentes e drogas no contexto da Justiça** (p. 215-235). Brasília: Editora Plano

Articles published in Symposia Annals

SEIDL, Eliane Maria Fleury; CARVALHO, Wania Espírito Santo; ROSSI, Walnicéia; MENEZES, Ana Karenine F de; VIANA, Keylla F; ALVES, Adriene; MEIRELES, Everson (2003). Aspectos psicossociais de crianças e adolescentes vivendo com HIV/Aids e seus cuidadores: resultados preliminares. In: **II FORO EN VIH/SIDA/ITS EN AMERICA LATINA Y EL CARIBE, Memorias Foro 2003 (CD ROM)**, Havana.

SEIDL, Eliane Maria Fleury; MACHADO, Ana Cláudia (2003). Impacto psicológico da lipodistrofia em pessoas vivendo com HIV/Aids: um estudo exploratório. In: **II FORO EN VIH/SIDA/ITS EN AMERICA LATINA Y EL CARIBE, 2003, Memorias Foro 2003 (CD ROM)**. Havana.

Lectures in Scientific Events

SEIDL, Eliane Maria Fleury; CARVALHO, Wania Espírito Santo; ROSSI, Walnicéia; MENEZES, Ana Karenine F de; VIANA, Keylla F; ALVES, Adriene; MEIRELES, Everson (2003). Aspectos psicossociais e enfrentamento de cuidadores primários de crianças e adolescentes vivendo com HIV/Aids. In **XXXIII REUNIÃO ANUAL DE PSICOLOGIA DA SOCIEDADE BRASILEIRA DE PSICOLOGIA**, Belo Horizonte. Resumos de Comunicação Científica. v. 1 (p. 76)

SEIDL, Eliane Maria Fleury; MACHADO, Ana Cláudia (2003). Aspectos psicossociais e lipodistrofia em pessoas vivendo com HIV/Aids: estudo preliminar [Resumo]. In: **VII CONGRESSO BRASILEIRO DE SAÚDE COLETIVA**, in: Livro de Resumos I (p. 323). Brasília: Abrasco.

SEIDL, Eliane Maria Fleury; MUSSI, Marinez; FAUSTINO, Quintino de Medeiros (2003). Crenças, conhecimentos, atitudes e frequência de uso da camisinha em adolescentes antes e após ação educativa [Resumo]. In: **XXXIII REUNIÃO ANUAL DE PSICOLOGIA DA SOCIEDADE BRASILEIRA DE PSICOLOGIA**, Belo Horizonte. Resumos de Comunicação Científica (p. 306). Belo Horizonte: SBP.

SEIDL, Eliane Maria Fleury; CARVALHO, Wânia Espírito Santo; ROSSI, Walnicéia; MENEZES, Ana Karenine F de; VIANA, Keylla F; ALVES, Adriene; MEIRELES, Everson (2003). Crianças e adolescentes vivendo com HIV/Aids e suas famílias: aspectos psicossociais [Resumo]. In: **VII CONGRESSO BRASILEIRO DE SAÚDE COLETIVA** Livro de Resumos I (p. 761). Brasília: Abrasco.

SEIDL, Eliane Maria Fleury; MUSSI, Marinez; FAUSTINO, Quintino de Medeiros (2003). Prevenção das DST/Aids junto a adolescentes de escola pública: avaliando mudanças de conhecimentos, atitudes e crenças sobre sexualidade e práticas seguras [Resumo]. In: **VII CONGRESSO BRASILEIRO DE SAÚDE COLETIVA**, Livro de Resumos I (p. 495) Brasília: Abrasco.

ANNEX 3 - LIST OF PERSONS INTERVIEWED

COM-VIVÊNCIA

Eliane Seidl
Coordinator

Letícia Ferreira
Social Assistant

Wania Carvalho
Social Assistant

NEAMCES

Mário Ângelo Silva
Coordinator

Alexandra Trivellino
Assistant

Edison Oliveira Alves
Volunteer

HUB

Anonymity preserved.