



**STRENGTHENING NETWORKS OF PEOPLE LIVING  
WITH HIV/AIDS PROGRAM**

**Annual Report  
October 2008 – September 2009**

**Cooperative Agreement 512-A-00-03-00054-00**

**December 2009**



**Annual Report – Strengthening Networks of People Living with HIV/Aids Program**

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# C O N T E N T S

<b>ACKNOWLEDGEMENTS</b> .....	<b>4</b>
<b>LIST OF ABBREVIATIONS AND ACRONYMS</b> .....	<b>5</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>6</b>
<b>ACTIVITIES AND RESULTS</b> .....	<b>8</b>
▪ <b>ADMINISTRATIVE AND FINANCIAL MANAGEMENT</b> .....	<b>8</b>
▪ <b>MONITORING AND EVALUATION</b> .....	<b>8</b>
▪ <b>PROGRAMMATIC COMPONENTS</b> .....	<b>14</b>
<b>NEXT STEPS</b> .....	<b>15</b>
<b>PHOTO GALLERY</b> .....	<b>16</b>
<b>ATTACHMENT</b> .....	<b>18</b>

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## LIST OF ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>APA</b>	Agents of Accession Partners
<b>ARV</b>	Antiretroviral Therapy
<b>CA</b>	Cooperative Agreement
<b>CDC GAP</b>	Centers for Disease Control – Global AIDS Program
<b>E&amp;S</b>	Employability and Sustainability
<b>FY</b>	Fiscal Year
<b>GIPA</b>	Greater Involvement of People Living with HIV and AIDS
<b>GPAS</b>	Grantee Performance Assessment Scale
<b>HAART</b>	Highly Active Antiretroviral Therapy
<b>HIV</b>	Human Immunodeficiency Virus
<b>IEC</b>	Information, Education and Communication
<b>LAC</b>	Local Advisory Committee
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MERL</b>	Monitoring, Evaluation, Reporting, and Learning
<b>MoH</b>	Ministry of Health
<b>NAP</b>	Brazilian National STD and AIDS Program
<b>NCE</b>	No Cost Extension
<b>NGO</b>	Non Governmental Organization
<b>NOTIVISA</b>	National Adverse Events Reporting System
<b>NSC</b>	National Steering Committee
<b>PEPFAR</b>	President’s Emergency Plan for AIDS Relief
<b>PLHIV</b>	People Living with HIV and AIDS
<b>REACH</b>	Rapid and Effective Action Combating HIV and AIDS
<b>RFP</b>	Request for Proposals
<b>RNP+</b>	National Network of People Living with HIV and AIDS
<b>S&amp;D</b>	Stigma and Discrimination
<b>SSO</b>	Strategic Support Objective
<b>STI</b>	Sexually Transmitted Infections
<b>SUS</b>	Unified Health System of Brazil ( <i>Sistema Único de Saúde</i> )
<b>TA</b>	Technical Assistance
<b>USAID</b>	United States Agency for International Development
<b>WHOQOL-BREV</b>	World Health Organization Quality of Life – Abbreviated Version

## EXECUTIVE SUMMARY

This program is implemented as an Associate Award under the Community REACH (Rapid and Effective Action Combating HIV and AIDS) Leader with Associate Award and focuses on HIV prevention, support for people living with HIV and AIDS (PLHIV), and strategic support to HIV and AIDS monitoring and evaluation (M&E) activities. The methodology and strategies designed for the program's implementation are in line with the United States Agency for International Development (USAID) and the Centers for Disease Control – Global AIDS Program (CDC GAP) priorities in Brazil, and aligned with the current directives of the Brazilian Ministry of Health's (MoH) National STD and AIDS Program (NAP) for confronting the HIV and AIDS epidemic in Brazil.

The objective of the program is to improve the quality of life for PLHIV in conditions of social vulnerability. The program's strategy is comprised of three key components: strengthening governmental HIV and AIDS M&E initiatives; implementation of pilot projects to support PLHIV in partnership with Non Governmental Organizations (NGOs); and the development of an information system to report the adverse effects of anti-retroviral (ARV) therapies. Pact Brasil provides direct technical and financial support for the activities related to these components. Program activities are consistent with USAID/Brazil Strategic Objective: "Transmission of selected communicable diseases reduced in target areas" and its Intermediate Result "Increased use of HIV/STI prevention and care practices among high-prevalence groups."

This program was originally scheduled to end in September 2009. In April 2009 Pact submitted a request for a cost extension in order to support a new NAP strategy by implementing activities directed at young people living with HIV and AIDS in all Brazilian states, as well to extend the life of current pilot projects developed in partnership with local NGOs. USAID/Brazil approved a one year no-cost extension (NCE) in July 2009, extending the program's activities until September 30<sup>th</sup>, 2010.

This program has been particularly effective at integrating the participation of various actors in the development of the program's goals and activities, in sensitizing strategic local partners, and in its M&E processes. In addition to the partnerships with NGOs, the program has formed a National Steering Committee (NSC) and Local Advisory Committees (LAC) at both the federal and local level with representatives from various entities including, but not limited to: Government, National Network of People Living with HIV and AIDS (RNP+), Positive Citizen Movement and, NGO/AIDS Forum. Additionally, this program has developed a specialized technical, administrative and financial process that replaces the need for formalized sub-agreements with NGO partners.

During the period of this report, Pact supported three pilot projects in São Paulo, Brasília, and Salvador targeted at increasing the quality of life for PLHIV. The pilot projects implemented a number of training activities to build the capacity and skills of PLHIV and increase their employability. Recognizing the need of an integrated and holistic approach to health and well-being for PLHIV, this program features a broad-based strategy to promote improved quality of life through physical activity courses, psychosocial support groups on living successfully with HIV/AIDS, and proper nutrition education to complement the economic empowerment component.

In addition to providing technical and financial oversight to the pilot projects, Pact reviewed the data from the World Health Organization Quality of Life Survey Abbreviated Version (WHOQOL-BREV). The baseline survey was conducted with PLHIV reached by the pilot projects to monitor the results of the health promotion and quality of life improvement activities implemented through this program.

This report provides consolidated information regarding program activities and related results throughout the program's second year of implementation, emphasizing the accomplishments during

the second half of FY2009 which were not covered by the semi-annual report (October 2008 to April 2009). These results are based on data from two sources: monitoring, evaluation, reporting and learning (MERL) systems developed by Pact and the information provided by the program's partner organizations. The information provided thus includes data previously reported and new information which combined provides an update of the program strategies and achievements during FY09.

KEY ACCOMPLISHMENTS
<ul style="list-style-type: none"> <li>▪ Three NGOs provided with financial support for specific activities related to the improvement of quality of life for PLHIV and network strengthening.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Seven meetings with the Steering Committee and LAC to share results and challenges of pilot projects.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Six supervisory visits to monitor the pilot projects and to discuss adjustments for their strategies.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Nine financial reports and 12 activity reports analyzed and feedback provided to the NGO partners.</li> </ul>
<ul style="list-style-type: none"> <li>▪ One WHOQOL survey baseline conducted and its results disseminated.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Additional Synovate database purchased and provided to NAP.</li> </ul>
<ul style="list-style-type: none"> <li>▪ 182 PLHIV reached by the pilot projects supported through the program.</li> </ul>
<ul style="list-style-type: none"> <li>▪ 251 workshops and training courses provided by the pilot projects for PLHIV.</li> </ul>
<ul style="list-style-type: none"> <li>▪ US\$ 174.600,00 invested in three pilot projects supported by the program.</li> </ul>
<ul style="list-style-type: none"> <li>▪ 13 partnerships formed by the NGOs and local businesses to improve the pilot projects activities.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Seven meetings held to evaluate the pilot projects performance, strategies and results, including the analysis of Grantee Performance Assessment Scale (GPAS).</li> </ul>
<ul style="list-style-type: none"> <li>▪ One National Seminar held to discuss the effects of Lipodistrophy.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Three M&amp;E workshops held for the NGO partners.</li> </ul>
<ul style="list-style-type: none"> <li>▪ Seven PLHIV from the pilot projects participated in the "XIV Brazilian PLHIV Summit".</li> </ul>
<ul style="list-style-type: none"> <li>▪ Four program abstracts submitted and approved for presentation at the Latin America HIV/AIDS Forum and IAPAC Conferences.</li> </ul>
<ul style="list-style-type: none"> <li>▪ 48 documents related to program implementation were produced and disseminated (briefings, activity reports, media releases, research reports, abstracts, papers, RFA, etc).</li> </ul>
<ul style="list-style-type: none"> <li>▪ Four meetings held with different partners to define a new strategy for young people living with HIV/AIDS.</li> </ul>
<ul style="list-style-type: none"> <li>▪ One Request of Proposal (RFA) launched to select 27 young people living with HIV/AIDS to participate in this pilot project.</li> </ul>

## ACTIVITIES AND RESULTS

### • ADMINISTRATIVE AND FINANCIAL MANAGEMENT

During FY09, Pact Brasil led discussions with CDC, NAP and Synovate regarding the database needs, issuing a contract with Synovate to purchase an additional data set covering the last two periods of 2008. Between December 2008 and June 2009, NAP received all Synovate deliverables as set-out in both Synovate contracts (December 2007 and January 2009). From July to October 2009, Pact assisted the NAP team to analyze and consolidate the Synovate data with other National data.

As part of the second program component, during FY09 Pact monitored and negotiated adjustments to each partner NGO's work plan. Pact also continues to provide overall programmatic management support to the pilot projects. Partners are required to submit quarterly reports that detail their activities and any changes to their action plan. Pact reviews and approves these reports before providing additional in-kind support for project activities. In addition, Pact conducted the following key activities: (i) processed modifications to each in kind agreement with the NGOs to adjust the pilot projects activities and purchases; (ii) oversaw the contracting and monthly remuneration for the local teams (tutors, project coordinators, instructors, consultants); (iii) purchased materials and equipment to support field activities; and, (iv) administered monthly advances to partner institutions to cover expenses related to PLHIV participation in field activities and trainings. From January to March, Pact and NAP conducted mid-year reviews of the pilot projects, resulting in revised program activities and strategies for the remainder of Year One and future Year Two programming. To complement this process, Pact Brasil and NAP conducted multiple technical supervisory visits to each pilot project to observe the field activities, reinforce aspects of the incorporation of new strategies for the next months, and participate in the Local Advisory Committee meetings.

The third program component of providing technical/operational support to NAP for implementation of a notification system of the adverse events and complaints related to ARVs (NOTIVISA) faced implementation difficulties and delays due to the necessary arrangements and partnerships between NAP and NOTIVISA/ANVISA. During FY08 Pact Brasil led a range of meetings and discussions with USAID, CDC and NAP teams to identify possible solutions to the challenges, however, these attempts were unsuccessful. In January and February 2009 the component was revised by USAID, CDC and Pact Brasil, resulting in a program financial, administrative and technical realignment, with the exclusion of NOTIVISA from the program strategies. This program realignment was presented and discussed with NAP allowing the identification of a new initiative to be supported by the program with the NOTIVISA's funds: a leadership formation program involving young people living with HIV/AIDS.

### • MONITORING AND EVALUATION

The program's MERL activities in FY09 were focused on three areas: (1) application of the WHOQOL – BREF; (2) Technical assistance (TA) to pilot projects on data collection and reporting; (3) annual evaluation of pilot project activities.

Due to the innovative nature and pilot element of the program, Pact ensured that MERL plans focused on data quality and indicators, as well as establishing clear goals to be reached during project implementation to be able to effectively measure project success. This was initially challenging as the NGOs were not implementing the same activities (in particular, physical activities and nutrition) and therefore was challenging to agree on indicators that reflected the diverse range of NGO activities. Similar challenges were faced with regards to the income generation activities. However the

establishment of clear goals was absolutely critical to evaluating the projects' successes in addition to being able to compare results across pilot projects. The comparison between projects was also facilitated by the socio-demographic data collected as part of the baseline application of the WHOQOL-BREF.

The WHOQOL was designed by a specialized committee in the WHO (WHOQOL Group) in 1991 to evaluate the quality of life of PLHIV with an international standard. It was used within the context of this program to construct a baseline for monitoring the results of the Program. Specifically, the MERL Plan established six outcome indicators for the program to be monitored through the application of the WHOQOL-BREF: Level of satisfaction with one's quality of life; Level of satisfaction with one's health; Level of satisfaction with one's current level of energy; Level of satisfaction with oneself; Level of satisfaction with one's capacity for work; and, Level of satisfaction with the availability of information that one needs.

The survey was conducted from September-October 2008 with 121 PLHIV, including 39 men and 82 women who participated in the pilot projects implemented by the NGOs in Salvador, São Paulo and Brasília. The data was analyzed using SPSS 16.0 and in accordance with the instructions provided by the WHOQOL Group for the coding, filtering and cleaning the data. The sample included more women (67.8%) and a higher concentration of PLHIV between the ages of 30 and 49. Of all the respondents, 36% identified themselves as black, which was the same percentage of people who identified as brown<sup>1</sup>. The majority of PLHIV interviewed reported being unemployed. In the self-evaluation of their quality of life, 42.1% of PLHIV defined it as "neither poor nor bad" and 30.6% as "good", 3% of the PLHIV reported that their quality of life was "very poor". Only 5% of the PLHIV interviewed were "very unsatisfied" with their health, 37.5% defined themselves as "satisfied" and 22.5% "unsatisfied". In terms of work, the majority reported being satisfied with their ability to work (29.8%) or very satisfied (28.1%).

Through the results of the study, it was possible to summarize the socio-demographic profile of the people reached through the NGO activities and services: older age bracket; strong presence of blacks and women; high level of satisfaction with oneself; high level of satisfaction with ability to work coupled with a high percentage of people who are not employed. At the time, the results were used to refine the pilot project activities, results frameworks, and MERL plans. Specifically, the program sought to identify and implement strategies to expand access to activities for the younger population; incorporate topics to attract the male population into the income generation and employability activities; and to implement awareness raising activities with the private sector to address the question of the employability of PLHIV. The report of the baseline analysis was shared with all of the program local partners, the WHOQOL-Group in Brazil and the São Paulo Ethical Review Board.

As previously mentioned, the results of the WHOQOL-BREF informed a revision of the pilot projects strategies and goals. The MERL Plans of GAPA/BA (Salvador), MAPA (São Paulo) and Grupo Arco-Iris (Brasília) were all also revised accordingly in close partnership with USAID and NAP. Based on the changes in the pilot projects' MERL plans, the overall program M&E Plan was also adjusted and carefully reviewed by both USAID and NAP. Moreover, Pact provided TA through on-site visits, telephone meetings and email throughout the year to the pilot projects. Each NGO submitted quarterly reports, which Pact analyzed and provided detailed feedback on with the goal of improving the effectiveness of their actions. During FY09 a total of nine reports were submitted by the NGOs that included success stories, detailed descriptions of the workshop methodologies, quantitative indicators, and the results of brief evaluations applied in the workshops to measure the satisfaction of participants.

An evaluation of the all of the pilot project activities was conducted in July, 2009. The evaluation entailed comparing what was originally established in terms of goals and activities in the pilot project

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<sup>1</sup> In Brazil, the socio-demographic questions regarding race followed the example of the Brazilian Statistical Institute (IBGE) which literally asks people what color they consider themselves. In Portuguese, there are three different words to refer to people with darker skin color– *pardo*, *negro*, and *preto* (more negative connotations), yet the IBGE only includes "preto" and "pardo" and considers that "negro" is equivalent to the sum of the two previous categories.

results frameworks and MERL plans, comparing it with final project results. Thus, the data used to conduct the evaluation included the project activity reports, supervisory visit reports, indicator tables from the project reports, and documentation from communication between Pact Brasil and the respective NGOs. Table I presents data with regards to the goals reached in comparison to those established and Table II presents the indicators from the Pact MERL Plan. The results from the GPAS analysis – Pact’s tool to measure grantee performance over time – are also presented.

Table I shows the goals reached by the pilot projects during the year of activities. The results reflect in many ways the experience of the NGOs: they were quite positive in terms of implementation of activities, offering 100% of the professional development courses planned for the year and meeting with many small businesses to discuss the project. Yet, they faced challenges when it came to organizing meetings with the formalized private sector business councils and expanding participation in all of the activities offered.

As Table II illustrates, none of the pilot projects were able to meet their established goals for the number of people reached in their positive prevention activities that included nutrition, physical activity, and sexual and reproductive health activities. Of the three pilot projects, the project in Brasília had the most positive results, followed by São Paulo, and Salvador. The highest percentages reached in terms of the number of participants were in the workshops for sexual and reproductive health rights, in which São Paulo achieved 84.0% of their goal, Brasília 72.0% and Salvador 54.0% of their goal. All of the NGOs had previously worked in this area, which may be part of the reason for the more positive results on this indicator. It is important to note that in São Paulo and Brasília the activities reached a wider audience than in Salvador where nearly all of the pilot project activities were restricted to a small group of participants. These differences can best be observed in the participation percentages presented in Table II.

In comparing the percentages of goals reached (Table II), it can be observed that none of the pilot projects achieved all of the goals set in their results framework: São Paulo reached 58.33%, Brasília 44% and Salvador 9%. The primary reasons for the low percentage of goals reached are related to the challenges all three NGOs faced in expanding access to PLHIV, the high level of social vulnerability of the participants which affected the income generation goals, and stigma and discrimination encountered in the private, formal job sector. As the table shows, there was also variance across the groups in terms of the activities that attracted the highest number of participants. For example, for Salvador and Brasília, the highest percentages were in the income generation activities, whereas for São Paulo the sexual and reproductive health rights activities attracted the highest portion of participants (followed closely by the physical activities).

To better contextualize the results, it is important to note the difficulties faced by the population reached through the NGO activities, in particular when it comes to the area of Employability and Sustainability (E&S). As Table II shows, only 15% of those participating in the E&S strategies increased their income by at least ¼ of the Brazilian minimum wage during a quarter of the project, however 49% were able to earn some additional income through selling some of the products produced through the workshops. Pact found that the informal market strategies were more successful than the formal markets largely due to the high levels of stigma and discrimination (S&D) in the formal market, combined with the extremely vulnerable socio-demographic profile of the pilot project participants and their often poor health conditions. Indeed, particularly for the pilot project in Brasília, the weak health of the PLHIV brought difficulties for their participation in the physical activities.

In addition to comparing the results achieved with the goals established, Pact also evaluated each institution’s performance using the GPAS. The tool is comprised of seven categories, each with five separate indicators. The composite GPAS scores showed that São Paulo achieving a score of 76%, Brasília 88% and Salvador 60.0%. The graphs (page 13) of each institution illustrate the separate scores per category. In comparing the graphs it can be observed that each institution improved during implementation in terms of the budgetary, management, and M&E procedures. São Paulo and

Brasília greatly improved from the first semester to the second semester in terms of activity execution, the quality of their activities, and potential for sustainable actions. The Salvador pilot project focused its activities on sustainability and income generation for a small group of PLHIV, working with individuals and not with a work group. This made it more difficult for them to meet the originally established goals and target numbers during FY09.

TABLE I: GOALS REACHED IN THE FIRST YEAR OF PROGRAM IMPLEMENTATION JUNE 2008-JUNE 2009		
GOALS	NUMBER REACHED	
	#	%
By March 2008, 3 NGOs selected in São Paulo, Bahia and the Brasília to develop the project	3	100,0%
By July 2008, 3 action plans developed with the NGOs selected	3	100,0%
A monitoring and evaluation plan developed for each pilot project by the middle of the program	3	100,0%
By August 2008, at least 1 professional contracted per project to support the nutrition, physical education, and health activities	9	100%+
By the end of the project, each NGO will have reached at least 50 PLHIV with nutritional monitoring	27- MAPA	54,0%
	36 - GAI	72,0%
	28 GAPA	56,0%
By the end of the project, each NGO will have reached at least 50 PLHIV with physical activity monitoring	40 - MAPA	80,0%
	36 - GAI	72,0%
	20 - GAPA	40,0%
By the end of the project, workshops will have been conducted with at least 50 PLHIV on sexual and reproductive health rights	42 - MAPA	84,0%
	36 - GAI	72,0%
	27 - GAPA	54,0%
By the end of the project, 12 professional development courses with PLHIV* will have been conducted	12	100,0%
By the end of the project, at least 80% of PLHIV will have finished a professional development course*	96*	52,0%
By the middle of the project, a Talent and Opportunities Database will have been developed	0	0,0%
By the middle of the project, a needs assessment for health promotion, quality of life, and social inclusion actions will have been conducted in the three target cities	1	100,0%
By the end of the project, at least two meetings with CEN and AMCHAM will be undertaken to present the initiative	1	50,0%
By the end of the project, at least three meetings with the local business councils will have been held to present the initiative	0	0,0%
By the end of the project at least three meetings per pilot projects with businesses will have been conducted to discuss the themes of the program	19	100%+

\*Including the craft workshops conducted by MAPA

**TABLE II: INDICATORS FROM THE PROGRAM MONITORING AND EVALUATION PLAN  
JUNE 2008-JUNE 2009**

<b>INDICATORS</b>	<b>SÃO PAULO (MAPA)</b>	<b>BRASILIA (ARCO-IRIS)</b>	<b>SALVADOR (GAPA)</b>	<b>TOTAL</b>
Number of PLHIV enrolled in the program*	81	67	34	182
Number of PLHIV receiving nutritional services / Number of PLHIV reached by the NGO*	33,00%	53,73%	82,35%	50,00%
Number of PLHIV participating in physical activities/Nº of PLHIV reached by the NGO*	49,38%	53,73%	58,82%	48,35%
Number of PLHIV participating in sexual and reproductive rights workshop / Number of PLHIV reached by the NGO*	51,85%	53,73%	79,41%	53,30%
Number of PLHIV participating in income generation activities / Number of PLHIV reached by the NGO	28,40%	67,16%	82,35%	52,75%
% of goals established reached by the pilot project	58,33%	44,44%	9,09%	N/A
% of PLHIV who have participated in the professional development courses and/or income generation workshops that obtained a salary increase of at least ¼ of minimum wage during at least one quarter of the project	0%	13,00%	36,00%	15,00%
Number of PLHIV participating in productive activities and earning an income*	19	19	11	49
Number and type of professional development courses conducted, both within and outside the NGO	3	4	5	12
Number of partnerships formed between NGOs and local businesses to conduct activities related to the Program	7	4	2	13
Number of meetings held with AMCHAM and CEN to present the project	0	0	0	0
Number of meetings held with local business councils to present the initiative and seek partnerships	0	0	0	0
Number of meetings held with businesses to discuss themes related to the program	11†	6	2	19
Number of projects provided with specialized TA in strategic information**	1	1	1	3
Number of organizations provided with specialized TA in the management and implementation of their activities***	1	1	1	3
Final score in the Grantee Performance Assessment Scale	76,00%	88,00%	60,00%	N/A

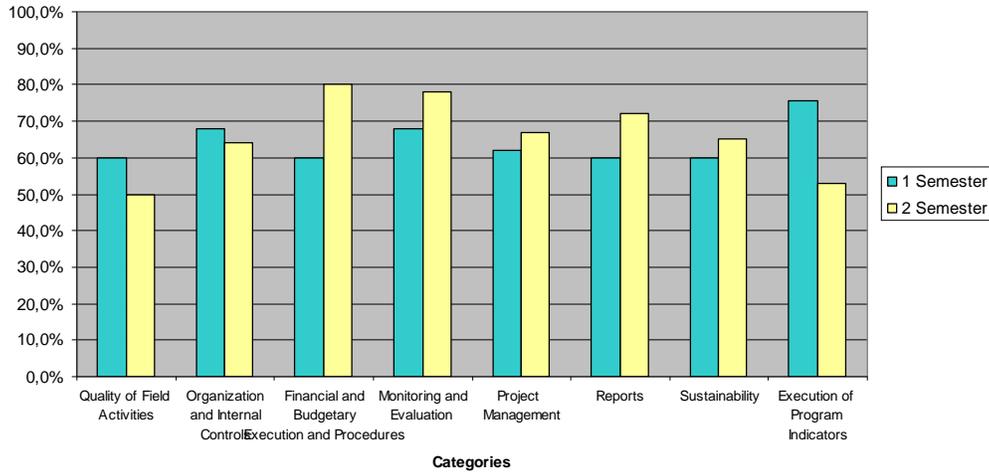
†From the Indicator, "Nº of meetings held with organizations."

\*Related to PEPFAR Indicator: Number of individuals receiving palliative care services.

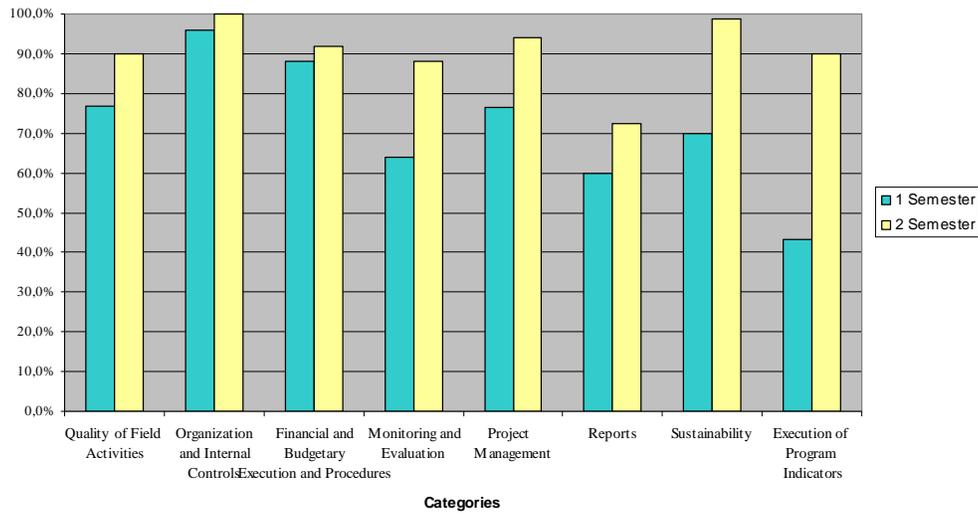
\*\*Related to PEPFAR Indicator: Number of organizations receiving technical assistance in strategic information.

\*\*\*Related to PEPFAR Indicator: Number of local organizations provided with technical assistance to increase their institutional capacity in HIV.

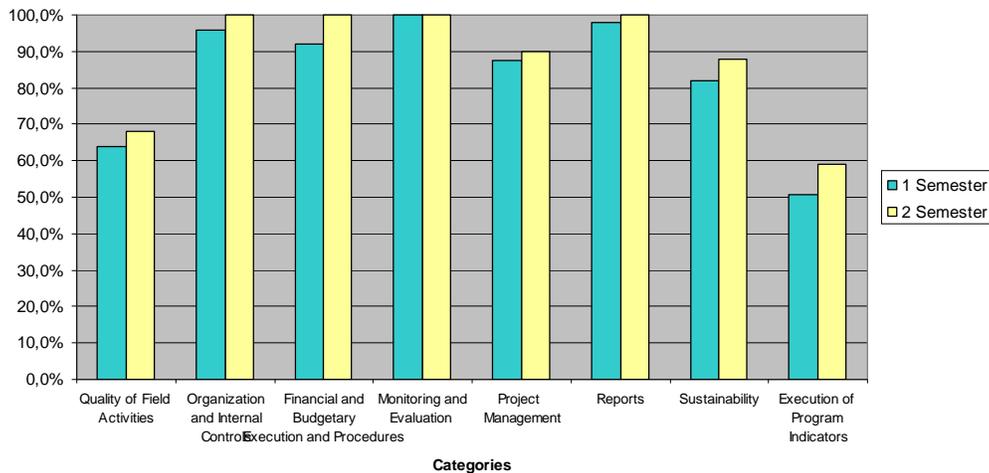
**Grantee Performance Assessment Scale - Salvador - June 2008 - June 2009**



**Grantee Performance Assessment Scale - Brasilia - June 2008 - June 2009**



**Grantee Performance Assessment Scale - São Paulo - June 2008 - June 2009**



## • PROGRAMMATIC COMPONENTS

From the beginning of the program to October 2009, Pact procured the 2002, 2003, 2004, 2006, 2007 and 2008 Synovate data sets allowing NAP to aggregate this data with data generated by the different information systems of the Brazilian MoH (MONITORAIDS system). The program support for the NAP M&E systems helped to facilitate public policies on treatment and care of HIV/AIDS. An example of a paper generated with data from the Synovate database is included as an attachment to this report<sup>2</sup>.

During FY09 the pilot projects continued activities to improve the quality of life for PLHIV; such activities included, but were not limited to: conducting positive prevention trainings; facilitating ARV treatment adherence and nutrition counseling; organizing group therapy sessions; advocating for increase human rights for PLHIV; and providing professional skills development trainings to PLHIV to increase their income generating opportunities. The Pact Brasil team and Tutors supported the pilot project activities and assisted problem solving ways to overcome the difficulties faced by the NGO teams. Approximately US\$ 174.600,00<sup>3</sup> was invested during FY2009 in the three pilot projects to cover the costs of the team, supplies and equipment, transport and meals for participants (PLHIV), Tutor remuneration and specialized consultancy in E&S area.

As previously described, the mid-year review of the pilot projects highlighted the need to realign project strategies and the need to increase the number of PLHIV reached in each city. Pact Brasil and NAP provided TA and political support for the pilot projects to launch partnerships with public health services, allowing the implementation of NGO activities at key HIV/AIDS service locations and thus increasing access to a larger number of PLHIV (including young people).

Due to the elimination of the NOTIVISA component, USAID, CDC, NAP and Pact Brasil held meetings to develop new activities targeted at young people living with HIV/AIDS (Youth+). This new program strategy was also presented and discussed with the National Steering Committee in March 2009. The strategy includes program support for the national public policy on HIV/AIDS and to increase the geographic and population coverage of the NAP program. The Youth+ strategy aims to identify, train, and encourage the closer engagement of young people living with HIV/AIDS in the implementation of government and non governmental HIV/AIDS activities. This strategy also supports the recent Brazilian Affirmative Action policy which requires a greater involvement and participation from different and excluded population groups in government and non-governmental programs, in this case specifically linked to the Brazilian response to the AIDS epidemic. This strategy was originally designed by NAP and is also supported by USAID/CDC and UN's agencies in Brazil.

Youth+ required the identification of youth aged 16 to 24 years, one in each Brazilian state, to participate in the pilot project. In FY09 Pact was responsible for launching a public RFP and conducting a selection process to identify these young people from the 50 proposals submitted from 21 Brazilian states. In addition, Pact and NAP defined the key stages and activities of the 11-month Youth+ program that focuses on building leadership capacity of young PLHIV. Twenty two young people were selected in September 2009 by USAID, NAP, UN agencies, State HIV/AIDS Programs and Pact to serve as Youth+ representatives. The first Youth+ training workshop was held in October 2009 and served as the formal launch of this program. Pact developed 11-month contracts following Brazilian labor laws to employ the Youth+ participants for four hours/day to ensure their participation in program activities and to provide them with mentoring and leadership development training. During the fourth quarter of FY09 Pact's team was involved in the administrative, legal and financial processes related to the contracts and monthly remuneration for the Young+ participants.

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<sup>2</sup> The example included in this report was produced by M&E area team from NAP and it is not to be disseminated without permission. This document was originally written in Portuguese and it was not translated by Pact Brasil to English for this Report.

<sup>3</sup> Tax rate = R\$ 1,87

## NEXT STEPS

The program's current end date is September 2010. Pact Brasil will focus its efforts on the implementation of the following key activities, during the period of October 2009 to September 2010:

- ✓ Review, adjust and accompanying new work plans for a second phase of the two pilot projects.
- ✓ Provide technical support to the pilot projects in the implementation of field activities and M&E.
- ✓ Implement and manage the administrative and financial components of the 22 Youth+ contracts.
- ✓ Identify, in partnership with USAID and NAP, five young people living with HIV/AIDS to fill the remaining vacancies in the leadership formation program.
- ✓ Provide technical support and mentoring to the Youth+ participants to building their leadership skills.
- ✓ Develop and implement M&E systems and tools for the Youth+ strategy.
- ✓ Conduct a mid-term evaluation and final evaluation of the pilot projects.
- ✓ Identify and support new NGO initiatives associated with quality of life and social inclusion of PLHIV.
- ✓ Disseminate the program results at the Brazilian National Conference on HIV and AIDS.
- ✓ Provide technical assistance to NAP on the development of articles and a publication on HIV and AIDS treatment in Brazil.
- ✓ Finalize the contractual, financial, and programmatic activities related to program closeout.

# PHOTO GALLERY



PLHIV participation at a Bazaar – São Paulo



MAPA Physical Activity



Folder - Lipodystrophy Seminar – Grupo Arco Íris - Brasília



Customization of Clothing Workshop Salvador



Nutrition Workshops – Brasília



Physiotherapy Workshop - Salvador



Waitress formed – Brasília



Computer Training Course - Salvador



Sewing Course – Brasília



T-Shirts Production - Salvador



Crafts Workshops – São Paulo



Hands Crafts Products –Brasilia



Nutrition Workshops – São Paulo

## VIVA A VIDA!...POSITIVAMENTE...!

Programa Viver+



Hands Crafts Products – São Paulo



PLHIV Monthly Meetings – Brasília



Ceramics' Workshop - Salvador



Physical Exercises – São Paulo

# ATTACHMENTS

## **Análise exploratória dos resultados do estudo "HIV Monitoring" de 2008<sup>4</sup>**

*Elaborado por: Marcela Rocha de Arruda*

O objetivo do presente relatório é o de apresentar uma análise exploratória das informações são referentes ao período entre julho e setembro 2008 (segundo corte).

### **Metodologia**

No segundo corte de 2008, foram selecionados 50 médicos e a estratificação foi baseada na distribuição dos casos de aids no período 1980-2008. Foram escolhidos médicos em centros de tratamento em cada região, nos quais não são recrutados mais do que dois médicos por centro. Cada médico preencheu aos seguintes critérios de elegibilidade: atender pelo menos 15 pacientes HIV+ por semana, gerenciar informações de pelo menos 50 pacientes HIV+ por mês e ser qualificado em sua especialidade há pelo menos dois anos. Os médicos selecionados preencheram um formulário contendo informações retrospectivas sobre o tratamento de 20 de seus pacientes HIV+. Os pacientes foram escolhidos aleatoriamente durante um período entre duas ou três semanas. A amostra de 2008 foi de 1.060 pacientes HIV+.

As informações coletadas nesse estudo foram: as características demográficas básicas dos pacientes; as condições concomitantes - tais como, co-infecções por HBV/HCV; os marcadores de carga viral e de imunodeficiência (CD4) - no diagnóstico, no início da terapia, no início do tratamento atual e na visita atual; o esquema de tratamento atual; a opinião do médico sobre aderência do paciente ao tratamento atual; a história de tratamento; e os efeitos colaterais sofridos durante toda essa história.

### **Principais Resultados**

#### **1.1. Características do Paciente**

Foram analisadas as informações de 1060 formulários preenchidos no segundo corte do estudo de 2008. Dentre os pacientes selecionados, 84,3% estavam em tratamento com ARV; 78,9% em continuação, 2,6% no início e 2,8% em troca de esquema. Quase 18% dos pacientes não estavam em tratamento no momento. (tabela 1).

**Tabela 1: Total de paciente e respectiva distribuição percentual, segundo condição de tratamento do paciente. Brasil, 2008.**

<b>Tratamento</b>	<b>N</b>	<b>%</b>
Início do tratamento	28	2,6
Troca de tratamento	30	2,8
Continuação do tratamento	836	78,9
Não tratamento	166	15,7
<b>Total</b>	<b>1060</b>	<b>100,0</b>

Fonte: HIV Monitor 2008.

A tabela 2 mostra a distribuição proporcional do total de pacientes e daqueles em TARV segundo o sexo e a faixa etária. Dos Pacientes que se encontravam em TARV, em torno de 64% eram homens e 36% mulheres. Por faixa etária, aproximadamente de 44% tinham entre 25 a 29 anos de idade e em

<sup>4</sup> NAP document produced with Synovate database.

torno de 35% entre 40 a 49 anos. Na faixa etária menor de 24 anos 4,4% se encontravam em tratamento com ARV.

**Tabela 2: Características demográficas do total de pacientes e dos pacientes em TARV. Brasil, 2008.**

Características demográficas		Pacientes		Pacientes em tratamento ARV	
		N	%	N	%
Sexo	Homens	660	62,3	569	63,9
	Mulheres	397	37,5	322	36,0
Faixa etária	Até 24 anos	59	5,6	39	4,4
	Entre 25 e 39 anos	487	45,9	394	44,1
	Entre 40 e 49 anos	338	31,9	308	34,5
	Mais de 50 anos	176	16,6	153	17,1

Fonte: HIV Monitor 2008

A tabela 3 mostra que, dos pacientes em TARV, 24,2% são observados em intervalos de 61 a 90 dias, 0,1% com intervalos maiores de 90 dias e 46% com intervalos menores de um mês.

**Tabela 3: Pacientes em TARV, total e respectiva distribuição percentual, segundo frequência em que são observados a cada dia. Brasil, 2008.**

Dias	N	%
Abaixo de 30	408	46,0
Entre 31 e 60	263	29,7
Entre 61 e 90	215	24,2
Mais de 90	1	0,1

Fonte: HIV Monitor 2008

A tabela 4 mostra a distribuição dos pacientes segundo a classificação do estadiamento clínico da aids, 23,8% dos pacientes em TARV eram assintomáticos, 10,4% sintomáticos não aids e 65,8% eram aids (tabela 4). Dentre os pacientes classificados por esse critério como aids, 75,3% já tinha apresentado algumas das doenças definidoras de aids.

**Tabela 4: Pacientes em TARV, total e respectiva distribuição percentual, segundo classificação fase do CDC. Brasil, 2008.**

Fase CDC	Pacientes em TARV	
	N	%
Assintomático	213	23,8
Sintomático não AIDS	93	10,4
AIDS	588	65,8

Fonte: HIV Monitor 2008

A principal via de transmissão do HIV foi a sexual, totalizando 91,4% dos pacientes HIV+ participantes do estudo (tabela 5). Dentre os homens, a via provável de infecção foi a homossexual/bissexual em torno de 57% e a heterossexual em 32,2% dos pacientes. Entre as mulheres, a via provável de infecção foi a heterossexual em quase 96% dos pacientes. O uso de drogas injetáveis foi a via de infecção provável de 7,0% desses pacientes, variando de 9,3% entre os homens e a 2,8% entre as mulheres.

**Tabela 5: Pacientes em TARV, por sexo, total e respectiva distribuição percentual, segundo via de infecção provável. Brasil, 2008.**

Via de infecção provável	Pacientes		
	Homem	Mulher	Total
Homossexual/ bissexual	323	0	323
Heterossexual	183	306	491

Usuário de drogas injetáveis	53	9	62
Outras *	9	5	15
<b>%</b>			
<b>Via de infecção provável</b>	<b>Homem</b>	<b>Mulher</b>	<b>Total</b>
Homossexual/ bissexual	56,9	0,0	36,3
Heterossexual	32,2	95,6	55,1
Usuário de drogas injetáveis	9,3	2,8	7,0
Outras *	1,6	1,6	1,7

Fonte: HIV Monitor 2008. Nota: (\*) Incluem a transmissão vertical do HIV.

### 1.2. Contagem de CD4 e carga viral

Em termos da contagem de linfócitos T CD4+ no diagnóstico, 38,3% dos pacientes foi diagnosticado CD4 menor que 200 células por mm<sup>3</sup> de sangue, 23,9% entre 200 e 349 por mm<sup>3</sup> de sangue e em torno de 38% tinha o CD4 maior do que 350 por mm<sup>3</sup> de sangue no diagnóstico (tabela 6).

**Tabela 6: Pacientes, total e respectiva distribuição percentual, segundo faixa de CD4 no diagnóstico. Brasil, 2008**

CD4 (mm3)	N	%
Menor que 200	352	38,3
Entre 200 e 349	219	23,9
Mais de 350	347	37,8

Fonte: HIV Monitor 2008.

A contagem do número de linfócitos T CD4+ mediana no diagnóstico foi de 215 células por mm<sup>3</sup> de sangue e a carga viral mediana foi 75.000 cópias/ml. No início da 1ª linha de terapia com anti-retroviral o valor do CD4 mediano foi 186 por mm<sup>3</sup> de sangue e com carga viral mediana de 100.000 cópias/ml. Na última visita ao médico o valor mediano do CD4 foi 428,5 por mm<sup>3</sup> de sangue e carga viral de 49 cópias/ml (tabela 7).

**Tabela 7: Mediana da contagem do CD4 e carga viral, segundo a fase de terapia em que se encontrava. Brasil, 2008**

Fase de terapia	Mediana	
	Contagem do CD4 (mm3)	Carga Viral (cópias/ml)
No diagnóstico	215	75.000
No início da 1ª linha da terapia	186	100.000
No início da terapia atual	236	20.647
Na visita atual	428,5	49

Fonte: HIV Monitor 2008.

### 1.3. Condições Concomitantes

Dos pacientes que estavam em TARV, 48,6% apresentavam pelo menos uma condição concomitante. Pode-se observar na tabela 8 que, desses pacientes, 22,5% tinham a presença da hiperlipidemia e, desses, 93,5% estavam sendo tratados. Com respeito à lipodistrofia, 11,3% apresentavam essa condição concomitante e, desses, 42,9% estavam fazendo algum tratamento. A depressão estava presente em 15% dos pacientes, dos quais 97,5% estavam sendo tratados para tal. Com relação às hepatites, 4,8% tinham hepatite B e 7,9% de hepatite C, dos quais, quase 84,4% e 51,6% estavam sendo tratados para cada uma dessas doenças, respectivamente.

**Tabela 8: Distribuição percentual dos pacientes em TARV, por presença de condição concomitante e se estão sendo tratados devido a essa condição, segundo doenças concomitantes. Brasil, 2008.**

Condição concomitante	Condição atual	Tratamento
<b>N</b>		
Hepatite B	43	27
Hepatite C	71	16
Hiperlipidêmica	201	131
Doenças cardiovascular	61	48
Lipodistrofia	101	24
Diabetes	40	29
Depressão	134	117
<b>%</b>		
Hepatite B	4,8	84,4
Hepatite C	7,9	51,6
Hiperlipidêmica	22,5	93,5
Doenças cardiovascular	6,8	98,0
Lipodistrofia	11,3	42,9
Diabetes	4,5	93,5
Depressão	15,0	97,5

Fonte: HIV Monitor 2008

#### 1.4. Adesão do paciente ao tratamento

As informações quanto à adesão dos pacientes ao TARV, foram obtidas segundo a percepção do médico. A tabela 9 mostra que, na percepção do médico, 17,4% dos pacientes tiveram menos de 90% de adesão ao tratamento e 55,8% tiveram uma adesão maior que 95%. Dos homens, 55,5% possuíam adesão maior que 90% segundo o médico, e 56,7% das mulheres. De acordo ainda com a tabela 9, dentre os pacientes assintomáticos, 64,9% tiveram adesão à TARV maior que 90% na percepção do médico e, dentre os sintomáticos não aids e os classificados como aids, a proporção comparável foi de 55,1,2% e 52,7%, respectivamente. A adesão na visão do médico foi maior para pacientes sem condições definidoras de aids; 60% com adesão maior do 90%.

**Tabela 9: Distribuição percentual de pacientes, por percentual de adesão, segundo sexo, classificação fase do CDC e condição definidora de AIDS. Brasil, 2008.**

Características demográficas		Adesão segundo informação do médico		
		Menos que 90%	Entre 90 e 95%	Maior que 95%
<b>Total</b>		17,4	26,7	55,8
Sexo	Homem	16,2	28,3	55,5
	Mulher	19,9	23,5	56,7
Fase CDC	Assintomático	12,9	22,3	64,9
	Sintomático não AIDS	22,5	22,5	55,1
	AIDS	18,3	29,0	52,7
Condição definidora AIDS	Sim	17,9	30,2	51,9
	Não	16,8	23,1	60,0

#### 1.5. Testes de resistência

Quase 12% dos pacientes em TARV fizeram algum teste de resistência, dos quais a maioria fez genotipagem. A genotipagem foi feita por 9,5% dos pacientes (tabela 10). Dos pacientes que fizeram algum tipo de teste de resistência, 72,3% apresentaram resistência alta ao medicamento efavirenz, 70,2% ao AZT (zidovudina), 68,1% ao nevirapine, 66% ao 3TC (lamivudina), e 54,3% ao d4T e nelfinavir.

**Tabela 10: Distribuição absoluta (N) e percentual (%) dos pacientes em TARV que fizeram teste de resistência e dentre os que fizeram algum teste para quais medicamentos apresentaram resistência de nível alto. Brasil, 2008.**

Teste de resistência		
	N	%
Algum teste	104	11,6

<i>nenhum</i>	790	88,4
genótipo	101	9,5
fenótipo	0	0,0
feno-virtual	5	0,5
geno-feno combinado	4	0,4
<b>Dentre os que fizeram algum teste, para quais medicamentos apresentaram resistência de nível alto</b>		
	<b>N</b>	<b>%</b>
efavirenz	68	72,3
AZT	66	70,2
nevirapine	64	68,1
3TC	62	66,0
d4T	51	54,3
nelfinavir	51	54,3
ABC	42	44,7
ddl	39	41,5
indinavir	38	40,4
ritonavir	35	37,2
saquinavir	33	35,1
atazanavir	31	33,0
fosAmprenavir	28	29,8
Lopinavir	24	25,5
TDF	16	17,0
tipranavir	14	14,9
etravirine	3	3,2

Fonte: HIV Monitor 2008.

### 1.6. Tempo decorrido entre o diagnóstico e o tratamento

O tempo mediano entre o diagnóstico e o início do tratamento é de três meses e média de 14,6 meses (tabela 11). O tempo mediano decorrido entre o diagnóstico e o início do tratamento foi de um mês entre os pacientes com número de linfócitos T CD4+ menor que 200 células por mm<sup>3</sup> de sangue, de quatro meses em pacientes com CD4 entre 200 e 349 por mm<sup>3</sup> de sangue e 23 meses nos pacientes com CD4 de 350 ou mais por mm<sup>3</sup> de sangue.

**Tabela 11: Tempo médio e mediano (meses) decorrido entre o diagnóstico e o tratamento, segundo faixa de CD4 no diagnóstico. Brasil, 2008**

CD4 (mm <sup>3</sup> )	Média	Mediana	Máximo	Mínimo
Menor que 200	3,6	1,0	91,0	0
Entre 200 e 349	13,1	4,0	114,0	0
350 ou mais	30,1	23,0	168,0	0
Total	13,1	2,5	168,0	0

Fonte: HIV Monitor 2008.

### 1.7. Características do tratamento atual

Em relação ao esquema atual de tratamento, tabela 12 mostra que 27,6% dos pacientes usavam na terapia atual o esquema "AZT + 3TC + efavirenz" e 13% utilizavam "AZT + 3TC + Kaletra". O esquema "AZT + 3TC + atazanavir + ritonavir" era usado por 6,8% dos pacientes, 6% usavam "3TC + TDF + Kaletra" e 5,8% "3TC + TDF + efavirenz".

**Tabela 12: Pacientes, total e respectiva distribuição percentual, segundo terapias atuais. Brasil, 2008.**

Terapias atuais	N	%
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AZT + 3TC + efavirenz	247	27,6
AZT + 3TC + Kaletra	116	13,0
AZT + 3TC + atazanavir + ritonavir	61	6,8
3TC + TDF + Kaletra	54	6,0
3TC + TDF + efavirenz	52	5,8
AZT + 3TC + nevirapine	49	5,5
3TC + TDF + atazanavir + ritonavir	27	3,0
AZT + 3TC + atazanavir	26	2,9
AZT + 3TC + TDF + Kaletra	13	1,5
d4T + 3TC + efavirenz	12	1,3

Fonte: HIV Monitor 2008.

Nota: (a) Proporção menor que 1%: d4T + 3TC + Kaletra; FTC + TDF + efavirenz;

d4T + 3TC + nevirapine; d4T + 3TC + atazanavir + ritonavir;

3TC + TDF; ddl + 3TC + Kaletra; ABC + 3TC + Kaletra;

ddl + TDF + Kaletra; AZT + 3TC + indinavir; ddl + 3TC + efavirenz;

ddl + TDF + atazanavir.

A duração mediana da terapia atual dos pacientes em TARV foi de quase dois anos. Pode-se verificar que a duração mediana que utilizaram o esquema "AZT + 3TC + indinavir" foi em torno de nove anos. Os que utilizaram o esquema "d4T + 3TC + nevirapine" aproximadamente seis anos e o esquema "AZT + 3TC + efavirenz" em torno de dois anos medianos. O esquema "AZT + 3TC + Kaletra" teve duração mediana de menor que um ano. (Tabela 13).

**Tabela 13: Duração mediana (em meses) da terapia atual. Brasil, 2008**

Terapias atuais	Mediana
Total	19,0
AZT + 3TC + indinavir	119,0
d4T + 3TC + nevirapine	77,0
ddl + 3TC + Kaletra	72,0
AZT + 3TC + nevirapine	61,0
AZT + 3TC	50,0
AZT + 3TC + TDF + efavirenz	42,0
AZT + 3TC + efavirenz	25,0
d4T + 3TC + atazanavir + ritonavir	23,5
ABC + 3TC + Kaletra	23,0
3TC + TDF + fosamprenavir + ritonavir	21,5
FTC + TDF + efavirenz	19,5
3TC + TDF + nevirapine	17,5
FTC + TDF + nevirapine	17,0
AZT + 3TC + atazanavir + ritonavir	15,0
ddl + 3TC + efavirenz	15,0
3TC + TDF + efavirenz	14,5
3TC + TDF + Kaletra	12,0
AZT + 3TC + Kaletra	11,0
AZT + 3TC + fosamprenavir + ritonavir	3,0

Fonte: HIV Monitor 2008.

### 1.8. Efeitos colaterais relacionados ao tratamento atual

Menos de um quinto dos pacientes em TARV apresentou pelo menos um dos seguintes efeitos colaterais relacionados ao tratamento atual: elevação de lipídios (EL), problemas gastrointestinais (GI), problemas do sistema nervoso central (SNC) e icterícia (IC). Pode-se observar na tabela 14 que dos pacientes em TARV, 14,1% apresentaram elevação lipídica, 8,9% problemas gastrointestinais, 6,6% problemas no sistema nervoso central e 4,8% icterícia.

Em torno de 23% dos pacientes em uso do esquema “AZT + 3TC +efavirenz” apresentaram algum desses efeitos colaterais. Dentre os pacientes nesse esquema de tratamento, 13,7% tinham algum problema no SNC, 5,6% GI e quase 17% apresentaram EL. Com relação ao esquema “AZT + 3TC + Kaletra”, a prevalência de efeitos colaterais nesses pacientes foi de 11,2% para problemas GI e 16,4% apresentaram EL.

**Tabela 14: Pacientes em TARV, total e respectiva distribuição percentual, segundo efeito colateral apresentado. Brasil, 2008.**

Efeitos colaterais	N	%
Sistema nervoso central	59	6,6
Gastrointestinal	80	8,9
Icterícia	43	4,8
Elevação lipídica	126	14,1

Fonte: HIV Monitor 2008.

### 1.9. Motivos para troca de esquema de tratamento

A partir da história de tratamento dos pacientes em TARV que já trocaram pelo menos uma vez de esquema (N=453; 50,7% dos pacientes em TARV) pode-se verificar as razões de mudança de tratamento. A tabela 15 mostra as razões para troca em todos os esquemas e para o primeiro esquema de tratamento. As principais razões para a troca em todos os esquemas foram intolerância ao medicamento (21%) e falha virológica (19,9%). A não aderência e lipodistrofia foram motivos de troca de 7,7% dos pacientes cada, a simplificação de 6,8%, elevações lipídicas de 6,6%. Em torno de 7% trocaram o esquema por problemas gastrointestinais e 7,6% para intensificação do tratamento.

Considerando-se apenas os motivos de troca do 1º esquema de tratamento, nota-se que a intolerância medicamentosa foi motivo de troca de por 28,5% dos pacientes e falha virológica 27,4% (tabela 15). Em torno de 9% dos pacientes trocaram de esquema por causa de problemas gastrointestinais e 6,5% por causa da lipodistrofia.

**Tabela 15: Pacientes que já trocaram pelo menos uma vez de esquema, total e respectiva distribuição percentual, segundo as razões para mudanças de terapia (todos os esquemas e 1º esquema). Brasil, 2008**

Razão de mudança de terapia	Todos os esquemas		1º esquema	
	N	%	N	%
Intensificação	68	7,6	45	10,1
Falha virológica	178	19,9	122	27,4
Elevações lipídicas	59	6,6	30	6,7
Lipodistrofia	69	7,7	29	6,5
Segurança	43	4,8	25	5,6
Simplificação	61	6,8	36	8,1
Gastrointestinal	62	6,9	39	8,8
Sistema nervoso central	54	6,0	32	7,2
Intolerância ao medicamento	188	21,0	127	28,5
Decisão do paciente	55	6,2	35	7,9
Não aderência	69	7,7	46	10,3
Gravidez	17	1,9	15	3,4
Interação com outros fármacos	15	1,7	10	2,2
Outro	133	14,9	91	20,4

Fonte: HIV Monitor 2008.

### 1.10. Pacientes, atualmente, no 1º esquema de tratamento

Dentre os pacientes atualmente em TARV, quase 49% encontravam-se no primeiro esquema de tratamento. Em mediana, o número de linfócitos T CD4+ no diagnóstico foi de 216,5 células por mm<sup>3</sup> de sangue e de 181,5 células por mm<sup>3</sup> de sangue no início desse primeiro esquema. Pode-se observar na tabela 16 que, dos pacientes que estavam em 1º esquema de tratamento, 43,2% apresentaram pelo

menos uma condição concomitante. Em torno de 40% tinham presença de hiperlipidemia, 30,2% de depressão, 15,3% de hepatite C e 6,3% de lipodistrofia. A duração mediana da terapia atual dos pacientes em 1º esquema de tratamento foi de 20 meses.

**Tabela 16: Pacientes em 1º esquema de TARV, total e respectiva distribuição percentual, por presença de condição concomitante, segundo a condição concomitante. Brasil, 2008.**

Condição concomitante	N	%
Hepatite B	19	10,1
Hepatite C	29	15,3
Hiperlipidemia	74	39,9
Doença cardiovascular	26	13,8
Lipodistrofia	12	6,3
Diabetes	16	8,5
Depressão	57	30,2

Fonte: HIV Monitor 2008.

Em torno de 44% dos pacientes em primeiro esquema de TARV estavam usando “AZT + 3TC + efavirenz”, 13% utilizavam o “AZT + 3TC +kaletra” e 6,2% o “AZT + 3TC +nevirapine”.

### 1.11. História de tratamento

Em 2008, aproximadamente 9% dos pacientes em TARV encontravam-se no primeiro esquema de tratamento, 23,8% no segundo esquema e 13% no terceiro (tabela 17). Quase 8% dos pacientes estavam no quinto ou mais esquema de tratamento.

**Tabela 17: Pacientes em TARV, total e respectiva distribuição percentual, segundo o esquema de tratamento atual. Brasil, 2008.**

Nº do esquema	N	%
1º esquema	437	48,9
2º esquema	213	23,8
3º esquema	116	13,0
4º esquema	60	6,7
5º esquema e mais	68	7,6

Fonte: HIV Monitor 2008.

A história de tratamento dos pacientes analisada mostra que 86,5% deles já haviam passado ou estavam no primeiro esquema de tratamento e que a duração mediana desse esquema foi um ano (tabela 18). Com respeito ao segundo esquema, 44,3% já havia ou estavam utilizando dois esquemas de tratamento com duração mediana de dois anos no segundo esquema. Quase 24% deles passaram por três ou mais esquemas com duração mediana de dois anos no terceiro esquema e 12,2% passaram por quatro ou mais esquemas com duração mediana de dois anos no quarto esquema. Em torno de 6% deles havia ou estavam utilizando o quinto esquema de medicamentos e a duração mediana desse esquema foi de 1,5 anos.

**Tabela 18: Pacientes, total e respectiva distribuição percentual e duração mediana dos esquemas, segundo o esquema de tratamento. Brasil, 2008.**

Esquemas	Pacientes		Duração mediana (anos)
	N	%	
1º esquema	917	86,5	1,0
2º esquema	470	44,3	2,0
3º esquema	251	23,7	2,0
4º esquema	129	12,2	2,0
5º esquema	68	6,4	1,5

Fonte: HIV Monitor 2008.