

Ten commitments - 2016 United Nations General Assembly High Level Meeting on Ending AIDS

Guiding Questions (*Prevención Combinada del VIH Bajo La Lupa - PAHO*)

In response to the invitation of the Ministry of Health of Brazil (MoH), civil society organisations representatives participated in the technical consultation on the preparation of Brazil's "2017 Global AIDS Monitoring Report (GAM)", held in Brasília, Brazil, on 28 March 2017.

Following an explanation of the AIDS epidemic scenarios in Brazil and in Latin American and the Caribbean, participants were divided into four working groups to give suggestions for the country to achieve the 10 commitments made at the 2016 United Nations General Assembly High Level Meeting on Ending AIDS. Due to limited time (1 day meeting) for the representatives to contribute to all 10 commitments, it was proposed for more contributions to be sent later by e-mail.

The result of the civil society representatives' participation in the meeting is presented below. It's also written in this document, the names of every organization that made their contributions online, as well as the names of each representative of the civil society organisations present at the meeting in Brasilia.

It is worth mentioning that this report was separated by groups, regarding the response to each commitment. However, the recommendations are interrelated among the aforementioned commitments, i.e., in some cases the recommendations apply to various commitments.

Group 1

1. National Network of Trans People in Brazil (Trans Brazil Network) - **Tathiane Araújo**
2. National Movement of PositHive Women (MNCP) - **Silvia Aloia**
3. UFRGS (Federal University of Rio Grande do Sul) - **Fernando Seffner**
4. National Lai Lai Apejo Network - Black Population and AIDS - **Michely Ribeiro da Silva**
5. AIDS Pastoral Care Network - **Luiz Carlos Lunardi**

Commitment 1 - Ensure that 30 million people living with HIV have access to treatment by meeting the 90-90-90 targets by 2020.

Commitment 10 – Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.

Guiding Questions (La Lupa):

- ✓ **What are the main barriers to meeting commitments 1 and 10?**
 - Stigma and prejudice (gender, sexual orientation and gender identity, racism, people living with HIV, etc.).
 - Independent services and need for intersectoral collaborative action.

- High cost of medicines.
- ✓ **What actions have already been taken and what actions could be taken to encourage/increase the demand for (or supply of) combination prevention services?**
 - Provide funding for civil society, with a view to encourage dialogue between governments and civil society.
 - Seek collaborative and integrative AIDS response in all health areas, in order to provide comprehensive healthcare, promoting HIV debate in environments where people living with HIV live.
 - Ensure civil society participation in the definition of HIV/AIDS public policies.
 - Carry out different communication strategies in health for different populations and age groups, in the most diverse social settings.
 - Implement and offer integrative and complementary practices in health services in the daily treatment of HIV/AIDS, thus improving the quality of life of women living with HIV/AIDS in all life cycles (National Movement of PositHIVE Women).

Commitment 1

- Ensure access to health care, focusing on user-friendly testing and treatment services.
- Ensure there is integration between health systems, scientific knowledge and pharmacological industry, while ensuring ARV is available in sufficient quantities at reduced costs and with minimal side effects.
- Ensure federal investment in antiretroviral research and development, taking into account the different co-morbidities caused by the virus and side effects caused by the drugs on People Living with HIV/AIDS (PLWHA), especially on Women Living with HIV/AIDS (National Movement of PositHIVE Women).
- Invest in strategies to raise awareness and reduce stigma, prejudice and discrimination (gender, sexual orientation and gender identity, racism, people living with HIV, etc.) by connection discriminated populations to the construction of policies, as a way to guarantee access to health services.
- Promote strategies for choosing antiretroviral drugs, taking into account the individuality, vulnerability, specificity, gender, and life cycles of PLWHA, thus improving adherence (National Movement of PositHIVE Women).
- Ensure that public policies are defined based on scientific evidence rather than on religious standards.
- Identify, in a timely manner and within the scope of the International Decade for People of African Descent, the investment in this population required to achieve the 90-90-90 goal by 2020 – not forgetting that the UN General Assembly proclaimed 2015-2024 as the International Decade for People of African Descent.

- Invest in research in alternative treatments, including research of medicinal cannabis in HIV/AIDS treatment (Brazilian Network of Harm Reduction and Human Rights - REDUC).
- To achieve this commitment it's relevant to overcome institutional barriers, bearing in mind the important role of the civil society and the peer-to-peer methodology to increase diagnosis and treatment. (REDUC).

Specificities for the Brazilian context

The Brazilian HIV/AIDS response has been based on a partnership between the government, NGOs and academy, in this way improving the response to HIV/AIDS.

- Ensure the Unified Health System (SUS) as a public health policy with universal and equitable access to the Brazilian population, as a way to ensure the access of people living with HIV to diagnosis and treatment.
- Establish a flow of responsibilities between the three federal levels to ensure a structure for the national response to HIV/AIDS, including penalties for noncompliance with commitments established in every levels (Federal, State and municipal).
- Increase the national production of medicines and promote the production and development of health technologies in the country, in order to decrease the cost of drugs, guaranteeing the effectiveness of treatment and reducing side effects.
- Invest in communication strategies with the intention to inform the population in regards of the draft bill that criminalizes the HIV transmission.
- Face the challenge of upsurge of the minimal state debate.
- Provide funding for civil society, in order to encourage dialogue between governments and civil society (National Movement of PositHIVe Women).
- Provide flexibility in schedules and for required documents, at least at the beginning of treatment (REDUC).
- To achieve this commitment, it's important to fund civil society participation, due to their proximity with the most affected population, and their expertise and experience (National Movement of PositHIVHIV-Positive Women).

Commitment 10

- Strengthen and ensure civil society participation in the development of public policy for the response to HIV/AIDS.
- Recognize people's background and ensure that they have access to health care strategies in different life cycles.
- Ensure that health policies are where people are.
- Stigma and discrimination around people living with HIV not only prevent them from accepting the fact that they have other infectious diseases but also hinders treatment.

- Seek collaborative and integrative AIDS response in all health areas, in order to provide comprehensive healthcare, promoting HIV debate in environments where people living with HIV live.
- Think about collaborative actions among different health areas as a way to take AIDS out of isolation.
- Include civil society in the training of the national, state and municipal's workforce in health, education and social participation, taking into account their expertise and experience in HIV/AIDS, racism, violence against women, transphobia, lesbophobia, the abuse of alcohol and other drugs, disabilities, and youth, among other topics.
- Improve public information systems on gender identity, race/colour, violence against women and their relation to the infection (as well as in all data reports), and cross data between co-related HIV/AIDS diseases to better support the development of HIV/AIDS response strategies.

Specificities for the Brazilian context

The federal sphere is better structured to think about intersectoral collaborative responses, mainly because it receives demands from other countries and international agreements. However, states and municipalities, which do not experience these demands, have less incentive to pursue this collaborative intersectoral relationship.

- Ensure that states and municipalities have institutionalized structures to provide a response to HIV/AIDS.

Group 2

1. Unified Centre of Sex Workers (CUTS) - **Monique Prada**
2. Brazilian Association of Harm Reduction (ABORDA) - **Álvaro Mendes**
3. Brazilian Network of Harm Reduction and Human Rights (REDUC) - **Vera da Ros**
4. National Network of Adolescents and Young People Living with HIV/AIDS (RNAJVHA) **Deivisson de Souza**
5. Brazilian Association of Lesbian, Gay, Bisexual, Transvestite and Transsexual People (ABGLT) - **Carlos Magno Silva Fonseca**

Commitment 2 - Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018.

Commitment 3 - Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations – gay men and other men who have sex with men, transgender people, sex workers and their clients, people who use injecting drugs and prisoners.

Commitment 5 - Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year.

Guiding Questions (La Lupa):

- ✓ **What barriers would you highlight in the access of key populations between the time of diagnosis and the start of ART?**
- ✓ **Are STI tests offered in the HIV diagnosis? And is ARV offered after diagnosis?**
- ✓ **Are there specific actions to facilitate access to combination prevention in population segments and/or in specific contexts, e.g. crack cocaine users, indigenous peoples, *quilombolas* and persons with disabilities?**
- ✓ **What actions have already been taken and what actions could be taken to encourage/increase the demand for (or supply of) combination prevention services?**

Commitment 2

- Strengthening and development of new strategies and public policies to combat mother-to-child transmission.
- Humanize the public health system for children with HIV/AIDS by promoting psychosocial support for those who are already on treatment seeking adherence and improving their quality of life.
- Promote HIV debate in in schools in order to work with families and communities.
- Strongly support the access of every woman to prenatal care and offer treatment during this period, if necessary (REDUC).
- Prioritize health care to pregnant women, living on the street who use drugs and alcohol, in other to prevent mother-to-child transmission. (REDUC)

Specificities for the Brazilian context

- Ensure the rights of key populations are fully guaranteed, especially mothers in situation of social vulnerability. They cannot yet access health services due to the great prejudice that still exists, they fear having the custody of their children taken away from them due to pauperization.
- Ensure equity in care, especially in the context of social vulnerability. It has a big impact on mortality rate among black people living with AIDS, thus raising the number of orphan black children and it increases children vulnerability (National Lai Lai Apejo Network).
- Rapid tests should be available for pregnant women's partners and offered throughout pregnancy and breastfeeding, thus protecting mother and child from infections during those periods (National Movement of HIV-Positive Women).

Commitment 3

- Seek greater knowledge about the realities of each group and their respective specific demands.
- Facilitate access to prevention and harm reduction measures for people who use drugs, prioritizing not only people using crack cocaine and injection drugs.

- Fight for the total decriminalization of sex work, also aiming to guarantee human rights in the fight against prejudice and discrimination.
- Reaffirm the fundamental rights to public health, ensuring universal access to every person.
- Talk about testing, because it is also a prevention tool. We would include the word “prevention” everywhere and report everything that is available - testing, medication, PEP, PrEP (REDUC).
- Particularly in Commitment 3, the most vulnerable people are those who abuse of alcohol and other drugs and not only people who inject drugs. It’s important to emphasize the vulnerability of people in street situation who use drugs and abuse of alcohol (REDUC).
- Provide comprehensive care for women victim of violence, providing the necessary supplies for contraception and HIV/AIDS prevention (National Movement of HIV-Positive Women).

Specificities for the Brazilian context

- One of the greatest barriers to reach key populations is the unequal social treatment of these populations, i.e., they get to the service already stigmatised by prejudice.
- Use the racial and ethnic dynamics in the identification of access networks of prevention supplies, considering their environments as strategic spaces for delivering supplies (National Lai Lai Apejo Network).
- Due to social inequalities, the formula distributed to newborns is shared with other family members. This requires carrying out a socioeconomic evaluation of families and extending the distribution of the formula until the child’s first birthday (National Movement of PositHIVE Women).

Commitment 5

- Invest in new campaigns that appeal to the young population, seeking to empower adolescent and young women for HIV/AIDS testing and treatment.
- Develop an agenda with youth social movements to talk about campaigns and ways of communication with this population.
- Ensure the participation of adolescents and young people in decision-making at government level, taking into consideration the reality of multiple youth groups, and focusing, especially, on those from key populations (National Lai Lai Apejo Network).
- Develop new appealing prevention strategies and youth friendly services for young people. The young population need to have access to information in settings other than schools and health services, for example, places where the young population usually meet or vocational training centres focused on the empowerment of adolescents and young people (REDUC).
- Ensure the sexual and reproductive rights of people living with HIV, with respect for the autonomy of adolescents and young people, including by: offering positive prevention (beyond

condom use); ensuring access to HIV testing and protecting the confidentiality of the test result; combating obstetric violence against pregnant women living with HIV, ensuring them access to HIV/AIDS testing during prenatal care and respect for the right to humanized childbirth; combating forced sterilization or sterilization without free and informed consent; ensuring access to assisted reproductive technologies; promoting dissemination of and access to the contents of comprehensive sexual education in prevention supplies - condoms, contraceptive methods, etc. (Mangueiras Collective – Youth for Sexual and Reproductive Rights).

Specificities for the Brazilian context

- Seek new ways of HIV/AIDS prevention through up-to-date training in schools and social environments including in the discussion gender issues, themes related to the "The Brazilian Child and Adolescent Act" (ECA in the Portuguese acronym) and sexual and reproductive health of the young population, focusing not only on adolescents but also on young people of 20 to 29 years old.
- Strengthen strategies for comprehensive sexual and reproductive education at all educational levels in a cross-cutting manner, in order to promote health, gender equality and the deconstruction of violence (Mangueiras Collective – Youth for Sexual and Reproductive Rights).
- Develop actions to ensure access by adolescents and young people to good sexual and reproductive health services, with respect for confidentiality, privacy and guarantee of free and informed choices, including: reproductive planning services; prenatal services, humanized childbirth and maternal and child health; legal and safe abortion; prevention, detection and treatment of HIV/AIDS and sexually transmitted infections; prevention and treatment of infertility, breast cancer, infections, and cancer of the reproductive system, among others (Mangueiras Collective – Youth for Sexual and Reproductive).
- Ensure respect for all sexual and reproductive rights in health services, beyond safe sex, pregnancy and maternity and assisted human reproduction (National Movement of PositHIVE Women).
- Ensure the participation of adolescents and young people in decision-making at government level, taking into consideration the reality of multiple youth groups, and focusing, especially, on those from priority populations (National Lai Lai Apejo Network).

Group 3

1. HIV/AIDS Coordinator of the State of Santa Catarina - **Dulce Brandão Quevedo**
2. National AIDS Articulation (ANAIDS) - **Veriano Terto**
3. National Association of Transvestites and Transsexuals (ANTRA) - **Keila Simpson**
4. Brazilian Network of Prostitutes - **Leila Barreto**
5. Brazilian Institute of Transmasculinities (IBRAT) - **Lam Matos**

Commitment 4 - Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

Commitment 6 - Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV sensitive social protection by 2020.

Commitment 9 - Empower people living with, at risk of and affected by HIV to know their rights to access justice and legal services to prevent and challenge violations of human rights.

Guiding Question (La Lupa):

- ✓ **About discrimination against key populations: Are there laws or resolutions criminalizing discrimination? Are there actions to raise awareness of, or reduce/eliminate stigma and discrimination in health services and reduce violence, including institutional violence?**
 - Yes, general protective laws - it is necessary to focus on the contexts of each key populations.
 - There are (sporadic) initiatives in the health services but they need to be evaluated, innovated and enhanced.

Commitment 4

- In the context of violence and discrimination against women and girls, attention should be drawn beyond cisgender people.
- Give visibility to all forms of violence experienced according to gender identities and their contexts.
- Promote equal rights through intersectoral and interdisciplinary efforts.

Specificities for the Brazilian context

- Give visibility to key populations beyond their HIV 'risk' potential and consider their vulnerability in political, social and economic terms.
- Advertise existing protective laws in campaigns, public spaces, schools and other information and education strategies.

- Promote training that allows interaction and joint agendas with other women's movements, with the aim to empower women and reduce vulnerabilities considering, *inter alia*: gender violence, discrimination, racism, and sexism (National Movement of PositHIVE Women).

Commitment 6

- meet the target established in commitment 6, given the scenario of vulnerability for people of African descent around the world, requires ensuring the active, free and meaningful participation of all groups of individuals regardless of their diversity, including Afro-descendants, in development and decisions related to them as well as in the fair distribution of the benefits resulting from them(National Lai Lai Apejo Network).
- Recognize that poverty is both a cause and a consequence of racial discrimination, therefore states must adopt or strengthen national programmes to eradicate poverty and reduce social exclusion that take into account the specific needs and experiences of people of African descent, so as to guarantee HIV sensitive social protection by 2020 (National Lai Lai Apejo Network).

Specificities for the Brazilian context

- Provide information and access to legal rights and HIV sensitive social protection in intervention, testing and treatment initiatives

Commitment 9

- Explain terminologies (HIV-sensitive social protection) and promote understanding (information/training/access) of these terminologies among the populations represented as well as of actions related to them.
- Ensure specific funding for HIV/AIDS initiatives.
- Ensure lines of credit that meet the realities of NGOs.
- Invest in artistic and cultural initiatives in order to disseminate a friendly culture in relation to AIDS issues by promoting events (theatre plays, music, dance, poetry, etc.) that talk about prejudice empower people, and promote prevention and care (REDUC).

Specificities for the Brazilian context

- Implement new laws or resolutions, at the same time guaranteeing the rights already achieved.
- Promote funded advocacy strategies.
- Provide information about legal rights and access to HIV sensitive social protection in intervention, testing and treatment initiatives.
- Provide for continuous training in public health services.
- There is a need to promote and expand civil society work in Harm Reduction, which has already been extremely strong and consistent in our country (REDUC).

- Intensify efforts (social movements, UNAIDS, Ministry of Health of Brazil) to repeal and eradicate criminalizing laws such as the draft bill 198/2015, which make the deliberate transmission of HIV a heinous crime, based on the understanding that these laws cause setbacks as they contribute to further stigmatise PLWHA and negatively affect the sexual and reproductive rights of Women Living with HIV/AIDS (National Movement of PositHive Women).

Group 4

1. National Health and Human Rights Coordination Unit (ANSDH) - **Renato da Matta**
2. National Network of People Living with HIV/AIDS (RNP+) - **Francisco Erdivando**
3. Brazilian Gay Articulation (ARTGay) - **José Felipe de Santos**
4. HIV/AIDS Coordinator of the Municipality of Curitiba - **Deisy Rodrigues Felicio de Souza**

Commitment 7 - Ensure that at least 30% of all service delivery is community-led by 2020.

Commitment 8 - Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers.

Guiding Questions (La Lupa):

- ✓ **How do CSOs, particularly those comprised of key populations, participate in public health management in the country at all stages, from planning to evaluation of actions?**
 - In Conferences, Councils and Commissions in the three spheres of government.
- ✓ **Should any special mention be made of this civil society participation regarding the offer (provision) of combination prevention services? If this participation exists, is it supported with financial resources?**
 - Call for proposals should support prevention, care and human rights events.
 - Call for proposals to support continuing education actions for civil society's work with populations in contexts of greater vulnerability, thus generating links in the communities (National Movement of PositHive Women).

Commitment 7

- Encourage and provide training to communities about information on HIV/AIDS
- Monitor and evaluate government's activities through social control bodies.
- Take into consideration urban and rural outskirts and strengthen the process to increase community participation, ensuring methodologies that are both appropriate and capable of promoting the community decision-making process (National Lai Lai Apejo Network).

Specificities for the Brazilian context

- Ensure resources for participation in joint actions with local governments based in an agreement between public health decision makers and the community.

- Recognize and strengthen dialogues with multiple African descent's living and recreational places (suburbs, slums, traditional black and *quilombola* communities and African-origin religions centres), in order to empower and ensure the rights of this population are met.(National Lai Lai Apejo Network).

Commitment 8

- Maintain the financial support and resources already existing in the public and private sectors.
- Find new public or private partners.
- Invest in marketing to raise funds within the community in general.

Rapporteurs: Silvia Aloia and Michely Ribeiro da Silva.

April 17, 2017.

Overview

In 2016, the first full year of the Sustainable Development Goals (SDGs), a new challenge was set for countries on HIV/AIDS, as goal 3.3 of the SDGs establishes that the world must end the AIDS epidemic by 2030.

Brazil has established in its multiannual plan, an instrument provided by the Federal Constitution of 1988 to organise and enable public policies over the four-year period from 2016 to 2019 - the goal of increasing to at least 90% the proportion of people living with HIV/AIDS (PLWHA), who have been receiving treatment for at least six months and with suppressed viral load. Although the target was reached in 2016, the challenge to maintain this indicator remains in the coming years. To this end, the Brazilian government has implemented the Clinical Monitoring System. The system identifies and actively seeks out PLWHA who have been already diagnosed but have not yet started antiretroviral therapy (ART), as well as people who had started or changed treatment at least 6 months prior to the search but still had a detectable viral load.

The number of PLWHA receiving ART gained significant momentum in 2013, when the country began to implement ART for all PLWHA regardless of the CD4 count. Brazil was the 3rd country worldwide and the first in development to do so, reinforcing its leading position in the area.

Respect for human rights, constant fight against stigma and discrimination, as well as an ongoing dialogue with civil society organisations CSOs are also salient features of Brazil's HIV/AIDS policy and have greatly contributed to the efficiency, efficacy and effectiveness of HIV public policies. In this context, it is worth mentioning the Law N. 12,984/2014, which defines the crime of discrimination against PLWHA, and the presidential decree N. 8,727/2016, which provides for the use of the social name and recognition of the gender identity of transgender people within the public administration. In Brazil, transgender women and transvestites both have a male birth sex and female social expression. However, they differ in their political and/or subjective self-identification.

In line with the scientific evidence, the Ministry of Health of Brazil (MoH) has endeavoured to consolidate combination prevention in the country. This strategy includes antiretroviral therapy for all PLWHA; treatment of sexually transmitted infections (STIs) and viral hepatitis; immunization against viral hepatitis A and B; harm reduction for people who use drugs; distribution of prevention supplies (male and female condoms; lubricant); regular testing for HIV, other STIs and viral hepatitis; and post-exposure prophylaxis (PEP) and pre-exposure prophylaxis for HIV (PrEP).

Some of the biggest challenges of the national HIV/AIDS policy are the increased rate of HIV detection rate among young people aged 15 to 24 (especially gay men); late diagnosis, although timely testing and treatment are improving; TB/HIV co-infection, since tuberculosis remains one of the main causes of death among PLWHA; stigma and discrimination against PLWHA (in particular key populations, i.e. female commercial sex workers, gay men and other men who have sex with men - MSM, people who use alcohol and other drugs, and transgender).

In order to expand testing among key populations based on combination prevention, the MoH launched in the second half of 2013 the rapid oral fluid HIV testing strategy, called "*Viva Melhor Sabendo*" (Live Better Knowing), in partnership with CSOs. So far, more than 50 NGOs have been funded by this strategy. Testing is offered in public places where these key populations commonly meet. Within the project, NGOs offer HIV oral fluid rapid testing, prevention education, counselling, prevention supplies, patients' referral to PEP and monitoring of their linkage to health services. Testing is free and is carried out confidentially and based on peer-to-peer methodology. Community-based rapid HIV testing delivered by peers reached key populations that had not previously accessed HIV testing.

Regarding hepatitis, which are mentioned in commitment 10, it is important to note that since 2016 hepatitis B vaccination has become universal in Brazil. It is also important to highlight that last year the MoH negotiated 30 percent reduction in the price of new hepatitis C drugs. Nevertheless, the high cost of hepatitis C treatment remains a challenge for the Unified Health System (SUS).

The 10 commitments to accelerate the response to the AIDS epidemic agreed at the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS represent a firm step towards reaching goal 3.3 of the SDGs. Brazil welcomes all efforts towards this goal, aware of its responsibility.

Commitment 1 – Ensure that 30 million people living with HIV have access to treatment through meeting the 90-90-90 targets by 2020.

In recent years Brazil has stepped up its efforts to increase access to ART for PLWHA, including by: increasing HIV testing in primary care units; offering combined fixed-dose; recommending treatment for all, and including (2017) dolutegravir for therapy-naïve patients and as salvage therapy (except for pregnant women, patients co-infected with TB-HIV and children under 12 years of age).

Some Brazilian states with the highest HIV burden in the country have started the process of extending HIV care to primary care through a cooperation, in which the three spheres of government (federal, state and municipal) agree on extra technical and financial efforts to overcome the local HIV epidemic. This strategy aims at building a line of HIV and AIDS care that includes prevention, care and treatment, epidemiological surveillance, clinical monitoring, and continuing education. Currently, this is an ongoing strategy in the states of Amazonas, Rio Grande do Sul and Santa Catarina. It has already boasted positive results since its inception in 2014, not only from the point of view of management but mainly regarding the quality of life of PLWHA, who are increasingly benefiting from health services that provide comprehensive care.

In 2016, 498,000 PLWHA were on ART in Brazil. Out of these, approximately 70,000 were new patients. In addition, 90 percent of PLWHA who had been receiving ART for at least 6 months had a suppressed viral load. Moreover, in the same year the SUS incorporated dolutegravir to the third line of treatment, with a subsequent recommendation to extend its use (in 2017) to the preferred initial treatment regimen as well as to salvage therapy. Currently, the national HIV treatment guidelines for adults and for children and adolescents are under review.

Brazil also has a Clinical Monitoring System (SIMC), which is an important tool to monitor the progress towards the 90-90-90 targets. This system provides clinical monitoring of PLWHA through the identification and active search of diagnosed PLWHA who have not yet started ART, as well as people who had started or changed treatment at least 6 months prior to the search but still had a detectable viral load. The work carried out locally in states and municipalities has enabled reducing the ART gap by 43% from June to November 2016.

Commitment 2 – Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018.

Brazil is a signatory of the PAHO/WHO commitment for the elimination of mother-to-child transmission of HIV and syphilis in the Americas. At the 50th Directing Council meeting in 2010, PAHO Member States approved the Strategy and Plan of Action for the Elimination of Mother-to-Child Transmission of HIV and Congenital Syphilis (Resolution DC50.R12).

The Brazilian “Stork Network” was established in 2011, as a MoH strategy designed to ensure the right to humanized care in reproductive planning as well as in antenatal care, childbirth and postnatal care in health services. The strategy emphasises the prevention and treatment of STIs and HIV/AIDS during antenatal care and provides rapid HIV and syphilis tests.

The strategies for the elimination of mother-to-child transmission of HIV are being strengthened in primary, medium and high complexity care in prenatal and sexual and reproductive health services, among other related services, with the aim of improving prevention, diagnosis, care, treatment, and surveillance.

We highlight some actions carried out in 2016 in this field: implementation of the national guidelines for the prevention of mother-to-child transmission of HIV, syphilis and viral hepatitis; increase of rapid testing (HIV and syphilis) in primary care for pregnant women and their sexual partners within the Stork Network; launch in December 2016 of the Certification of Elimination of Mother-to-Child HIV Transmission (for municipalities with 100,000 or more inhabitants; detection rates equal to or less than 0.3 for each 1,000 live births; and a proportion of no more than 2% of children up to 18 months old exposed or infected by HIV, who are being monitored in the public network); increase in the number of “Investigation Committees for Prevention of Mother-to-child Transmission of HIV, syphilis and viral hepatitis B and C in the states. The purposes of these committees are to support interventions and propose measures that can correct failures in prevention, surveillance and care in antenatal care, childbirth and postnatal periods, aiming at eliminating these diseases as a major public health problem.

Commitment 3 – Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm reduction and condoms, to at least 90% of people by 2020, especially young women and adolescent girls in high-prevalence countries and key populations - gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.

The combination prevention strategy in Brazil covers antiretroviral therapy for all PLWHA; treatment of STIs and viral hepatitis; immunization against viral hepatitis; harm reduction for people who use drugs; distribution of prevention supplies; regular testing for HIV, other STIs and viral hepatitis; post-exposure (PEP) and pre-exposure prophylaxis (PrEP) for HIV (the latter not yet implemented nationally).

PrEP

PrEP incorporation has recently been approved as an HIV prevention public policy and will be implemented countrywide still in 2017.

In addition, the MoH is currently implementing two research projects related to PrEP: I- With UNITAID, the Latin American project in partnership with INI/Fiocruz/Fiotec a study for

implementation of PrEP in adult MSM and trans population as a mean of prevention against HIV infection, initially in some cities in Brazil, Mexico and Peru (2017-2019); and II - acceptance of and adherence to PrEP among sexually active adolescents (aged 16 - 19 years) at substantial risk of HIV infection, in three cities in Brazil.

Testing in key-populations and young people (VMS project)

One of the greatest challenges for the national HIV/AIDS policy is late diagnosis. Brazil is committed to expanding testing and ensures people the right to choose whether to uptake treatment or not, regardless of the CD4 count. In the effort to increase testing among key populations based on the combination prevention paradigm, and in accordance with the guidelines of the national HIV/AIDS policy, in the second half of 2013 the MS launched the rapid oral HIV test strategy in partnership with NGOs, focusing on key-populations and peer education methodology, "Live Better Knowing" (VMS), as mentioned in the overview of this document. Since its beginning, a total of 120,224 tests were administered by the VMS. Approximately 52 percent of all people tested had never been tested before, demonstrating the importance of the strategy in reaching populations that have little access to traditional health services. The strategy to increase testing and diagnosis has also been designed to facilitate access of key populations to health services, diminishing barriers such as stigma and discrimination and limitations related to testing sites and schedules. Thus the VMS, which also provides services at hours and locations other than those offered by traditional health services, innovates in two fundamental aspects: the use of the oral fluid rapid HIV test and the fact that for the first time in Brazil tests are being administered by members of civil society, who do not necessarily have a university degree in healthcare. Social participation through community-based organizations is fundamental since it applies the tacit knowledge of the reality of these populations to the actions offered by SUS, increasing the potential for achieving effectiveness.

PEP

Post-exposure prophylaxis is part of the combination prevention effort and is already implemented within SUS. The Clinical Protocol and Therapeutic Guidelines for PEP, currently under review, main goal is to simplify the prescription, in order to expand the combination prevention strategy by recommending a single antiretroviral regimen for all PEPs (occupational, unprotected consensual intercourse and sexual violence exposures). Considering the need to establish recommendations and guidelines for the organisation of this network of PEP services, in 2016 the MoH published a book for healthcare managers entitled "Guidelines for the Organisation of the Network of Antiretroviral Post-Exposure Prophylaxis After risk of Exposure

to HIV – PEP”. Also as a way of contributing to this institutional improvement, the training of health workers directly involved with PEP was established as one of the main actions for consolidating the prophylaxis. As a way to broaden the scope of this alternative of prevention to the population, a list of healthcare services that offer PEP it is posted on the website of the Department of Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis (DIAHV) and in an app. Currently, there are 626 services registered in 268 municipalities (all capitals in the country have at least one service). In 2016, the number of PEPs provided totalled 57,464, an increase of nearly 39% in comparison to 2015.

Commitment 4 – Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations by 2020.

In line with Resolution 200 of the International Labour Organization (ILO), the Ministry of Labour and Employment of Brazil has published in 2014, the Ordinance No. 1,927 establishing the guidelines for fighting discrimination against PLWHA in the workplace. The Ordinance states that it is a discriminatory practice to require compulsory HIV testing of workers, including migrant workers and any job applicants. Testing must be voluntary and free of any coercion, and no worker should be required to disclose HIV related information. There should be no discrimination against or stigmatization of workers. In particular, job applicants, based on HIV status or on the fact that they are part of groups most at risk of, and affected by HIV, or that they come from regions of the world with high HIV burden.

In Brazil, some of the legal frameworks (laws and bills) deemed essential for achieving this commitment include:

- Federal Law No. 9,313 of 13 November 1996 - ensured free and universal access to ART through the Brazilian Unified Health System (SUS).
- Law No. 12,984 of 2 June 2014: Art. 1 - Discriminatory behaviours against PLWHA patients by virtue of their status as such are crimes punishable by imprisonment of one to four years and fine; also to refuse or delay health care.

Additionally, in September 2014 the MoH issued a Technical Note instructing health professionals to respect the use of the "social name" on the health ID card, protecting transvestites and transgender people from embarrassment and shame. This right has been guaranteed since 2009. In addition, Decree No. 8,727/2016 provides for the use of the social

name and recognition of the gender identity of transvestites and transgender people within the federal public administration.

Besides, Ordinance No. 2,836 of 1 December 2011 established the National Policy for Integral Health of the Lesbian, Gay, Bisexual, Transvestites and Transgender People (LGBT); and MoH Ordinance No. 992 of 13 May 2009 established the National Policy for Integral Health of the Black Population.

Commitment 5 – Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100 000 per year.

We observed a statistically significant increase in the AIDS detection rates among men aged 15 to 19 and 20 to 24 between 2006 and 2015. The highest increase was found among young people aged 15 to 24 years, with an increase in the detection rate from 2.4 to 6.9 (cases/100,000 inhabitants) in young men aged 15 to 19, and from 15.9 to 33.1 (cases/100,000 inhabitants) among youngsters aged 20 to 24. These age groups represent about 25 percent of the total number of HIV cases reported in 2016. In Brazil, young men who have sex with men are being disproportionately affected by the HIV/AIDS epidemic.

Driven by the scenario of the HIV/AIDS epidemic in Brazil, which highlights the vulnerability of young people, the MoH has developed strategies to increase HIV testing and diagnosis among key populations, especially gay young men, MSM and transgender people, such as the "Live Better Knowing" strategy developed in partnership with NGOs.

Another strategy was developed for young leaders' education to monitor and debate public policies of SUS and to share the knowledge for prevention, diagnosis and improvement of the quality of life of young PLWHA, from the perspective of peer methodology. The training was performed in partnership with UNAIDS, UNICEF and UNESCO, with the support of UNFPA for youngsters aged 18 to 26, who were in some way involved in HIV/AIDS-related activism.

Actions of this nature are based on the assumption that the training of new social actors will result in the multiplication of agents of change, who will have political influence in spaces of participation and social control, thus enriching, from different perspectives and angles, the Brazilian response to HIV/AIDS.

Another important strategy implemented in 2016 was the "Close Certo" pilot project ("The Right Close-up"), an information and communication technology initiative developed during the Rio

2016, Olympics and Paralympics in partnership. For 49 days, 18 young gay volunteers chatted on the dating App Hornet about HIV and other IST (prevention, diagnosis and treatment). They exchanged over 1,000 with the app users geolocated in 15 Brazilian cities (10 capitals). Also 4 inbox messages were sent to the over 1 million Brazilian Hornet users, approaching issues such as locations of free condom distribution, provision and access to PEP and testing for HIV and other STIs, as well as information aimed at combating HIV-related stigma and discrimination. The project was a partnership with the DIAHV, UNAIDS, UNESCO and Hornet. Currently, a Working Group is being organized to improve the project and inspire new on-line initiatives.

Commitment 6 – Ensure that 75% of people living with, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2020.

Over the last decades, Brazil has strived to develop a regulatory framework to protect PLWHA. This social protection is also considered one of the key factors for the HIV response in the country, since the universal access to ARVs alone, would not be able to provide the comprehensive health care that PLWHA need. It will be seen in the list below, that sometimes the legislation is broader and does not explicitly mention PLWHA. This, however, does not preclude them from receiving protection.

- Federal Law No. 7,713/88 - provides for tax exemption on the income of PLWHA, based on the conclusion of specialized medicine, even when one was infected after retirement. This is an important step as it provides PLWHA an additional income to invest in quality of life.
- Federal Law 7,670/88 - extends to PLWHA rights such as paid sick leave, retirement, military reserve, special pension and "sickness benefit or retirement, regardless of the grace period, for the insured person who develops the disease after being enrolled in social security, as well as bereavement allowance to their dependents." It also enables "collecting the amounts corresponding to the FGTS (Government Severance Indemnity Fund for Employees), regardless of termination of the individual employment contract, or any other types of funds to which the patient is entitled".
- Interministerial Ordinance No. 769/92 – establishes that "compulsory serological testing prior to the admission or enrolment of a student, employee and teacher, and tests for the guarantee of enrolment, attendance and provision of services in public and private education networks at all levels are unjustified and should not be required".
- Organic Law of Social Assistance (LOAS - No. 8,742/93) – regulates, in line with the Federal Constitution of 1988, the Continuous Cash Benefit (BPC), which guarantees a

minimum wage for elderly people aged 65 years and over and persons with disabilities, regardless of age, with a proven per capita income of less than ¼ of the minimum wage. The beneficiary must undergo an evaluation every two years, and the benefit may be suspended or terminated based on the results of the evaluation.

- Federal Law 9,313/96 - “provides for the free distribution of medicines to PLWHA”.
- Normative Instruction INSS/PRES No. 45/2010, article 152 - states that "the following benefits shall be granted independent of the grace period: I – bereavement allowance, reclusion aid, family allowance and accident aid resulting from an accident of any sort; II - maternity pay for insured employed women, female domestic employees and self-employed women, including those who are in the period of maintenance of their status as an insured employee as a result of performing activities in their respective categories; III - sickness benefit and disability retirement, in cases of accidents of any sort, including occupational accidents, and in cases in which the insured, after enrolment in the General Social Security System (RGPS) contracts AIDS. PLWHA will be entitled to the benefit without the need to comply with the minimum contribution period, provided that they are registered with the National Social Security Institute (INSS). The sickness benefit shall be terminated when the insured regains capacity and returns to work or when the benefit turns into disability retirement.
- Ordinance No. 1,927/2014 of the Ministry of Labour – establishes guidelines to combat discrimination against people with HIV/AIDS in the workplace, in compliance with Recommendation 200 on HIV/AIDS and the world of work approved by the International Labour Organization (ILO) on June 17, 2010. The Ordinance states that it is a discriminatory practice to require HIV testing of workers (including migrant workers and job applicants).
- Federal Law No. 12,984/2014 - defines the crime of discrimination against PLWHA.
- Presidential Decree No. 8,727 of 28 April 2016 - provides for the use of the social name and recognition of the gender identity of transgender people within the public administration.

Commitment 7 – Ensure that at least 30% of all service delivery is community-led by 2020.

The MoH strives continually to create mechanisms that involve, stimulate and increase social participation in HIV response. Since the first years of the epidemic, the Articulation with Social Movements Commission (CAMS) and the National STD, AIDS and Viral Hepatitis Commission

(CNAIDS) have been established through a Ministerial Ordinance, with the objective of setting up advisory forums on technical and political aspects necessary for the development of guidelines to cope with HIV, AIDS and viral hepatitis. Although both are forums of dialogue with different sectors of society, CAMS represents the social movements related to HIV/AIDS and the most vulnerable populations, to deepen the discussion and referrals regarding specific demands; and CNAIDS ensures the participation of representatives of agendas related to the management of the national response, such as national, state and municipal managers, academics, social movements, and NGO networks among other partners. In 2016, the 122nd CNAIDS Meeting (06/10/16) and the 43rd (12/02/16) and 44th (07/10/16) CAMS Meetings were held in Brasilia.

In addition, several working groups have significant social participation, such as the working groups of mother-to-child transmission, lipodystrophy, adherence, harm reduction, and prevention. It is noteworthy that the working group of Combination Prevention, with the participation of SUS workers, civil society, managers and academia was reactivated in August 2016. These forums are intended to inform and recommend technical actions in specific areas of HIV and AIDS knowledge to the DIAHV.

In 2016, three public notices were issued to select projects to be developed by civil society organisations focusing on early diagnosis, community mobilisation, legal assistance and human rights actions targeted at the most affected populations:

- Call for proposals for NGOs to organise events related to STDs/HIV/AIDS and viral hepatitis;
- Call for proposals for NGOs to carry out actions related to rapid oral HIV tests among key populations;
- Call for proposals for NOGs to develop actions related to the promotion and advocacy of human rights related to STI, HIV/AIDS and/or viral hepatitis.

Between 2013 and 2016, the MoH financed 24,4 million US dollars (considering UNESCO's 3,176 exchange rate, may 2017) to NGOs' projects, research and support for the development of civil society projects. The government also financially supports NGOs representatives in various national and international forums and conferences.

Commitment 8 – Ensure that HIV investments increase to US\$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers.

The expenditure report systematises the complete financing of the Brazilian response to HIV, i.e., it consolidates the effort made by different government spheres. There is information from

the federal level and some state and municipal coordinating bodies. The information to account for the investment of the Brazilian response to the HIV epidemic in the country was obtained from the Secretariat for Health Surveillance (SVS), the DATASUS database and the *Transparência Brasil* portal (The Transparency Web-Portal), as well as from states and municipalities' STIs and HIV/AIDS programmes.

The health surveillance amount is financed by a fixed and a variable component. The fixed component is responsible for funding health surveillance actions and has universal coverage, i.e., all states and municipalities have access to these resources based on population criteria. The variable component is composed by three incentive packages and it finances public health-specific actions, it has a limited scope and is subject to epidemiological criteria. One of the SVS' incentive packages finances HIV/AIDS and viral hepatitis surveillance, prevention and control. To achieve this goal, as a way to induce specific actions for controlling the epidemic in the country, the budget of the DIAHV is organized as follows: a) a surveillance, promotion and prevention component that ensures funds for epidemiological surveillance and prevention actions, acquisition of supplies for prevention, testing and clinical monitoring of patients, maintenance of the management and technical structure of the DIAHV core centre; b) a component of the incentive to finance decentralized actions implemented by states and municipalities; c) a financing component for the acquisition of ARVs; and d) acquisition, packaging and distribution of supplies for prevention and control of viral hepatitis. In 2016, the budget for all components was 495,843,633.33 US dollars*. This amount also included the budget for viral hepatitis and the cooperation between the federal, state and municipal levels strategies which, based on epidemiological criteria, currently benefit the states of Rio Grande do Sul, Santa Catarina and Amazonas. In this report, the national spending also included the health sector-funding amount related to medium and high complexity health services, such as payment for hospitalization, opportunistic infection care and other high cost control measures.

Brazil's total spending on STI/HIV/AIDS and viral hepatitis comprises direct and indirect costs. Indirect costs include the following categories: prevention, promotion of testing and linkage to care programmes targeting young women and adolescent girls (high-prevalence countries); gender programmes; programmes for children and adolescents; key human rights programmes.

Spending in the 2016 period totalled 665,499,237.42 US dollars*, which is less than the amount spent in the previous year. Main expenses incurred include the following categories: 467,570,766.55 US dollars * on treatment and 77,019,662.47 US dollars* on prevention. Of the total amount spent on prevention, 2,669,230.58 US dollars* were intended to prevention of

mother-to-child transmission and 8,027,440.63 US dollars* to children and adolescents. Also in the prevention component, it should be noted that the 2017 GAM cost sheet excluded the blood quality category and shifted the community-based intervention category from the prevention component, thus precluding comparison of the previous expenditure reports with the 2016 report. The ideal would be to maintain the blood quality category, which is an important prevention action, and to shift the community-based intervention category back to the prevention component, thus increasing prevention expenditure in relation to total spending to 24 percent. Another relevant aspect was the exclusion of the human rights category from the 2017 GAM cost sheet. Therefore, we have reported the values spent with human resources in the *Critical Enablers* category, sub-item *AIDS-specific institutional development*.

Regarding other spending categories, 19,186,389.17 US dollars* have been invested in critical enablers, 906,801.00 US dollars* in TB/HIV coinfection and 92,626,021.33 US dollars* in governance and sustainability. In the social protection category, the amounts reported in 2016 have been maintained, due to the lack of updating of the social security database. With regard to the information in the PrEP category, the costs incurred relate to research required for evidence formulation and are included in the Governance and Sustainability item. Systematized information on PrEP will be reported next year, when this strategy will be fully implemented.

* Considering UNESCO's 3.176 exchange rate, as of May 2017.

Commitment 9 – Empower people living with, at risk of and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights.

Scientific advances in health are especially effective when guided by respect for human rights and the fight against prejudice and discrimination. Globally, Brazil joined the UNAIDS "Zero Discrimination" strategy in 2013. The 2014 law that criminalizes any discriminatory behaviour against PLWHA was a further step in that direction.

The set of existing national legislation establishing a protective legal environment for the rights of people most affected by HIV/AIDS includes:

- Law No. 7,716 of 5 January 1989 - defines the crime of racial or skin colour prejudice.
- Law No. 12,288 of 20 July 2010 - establishes the Statute of Racial Equality.
- Law No. 12,984 of 2 June 2014 - defines the crime of discrimination against PLWHA.

- Decree No. 4 of 4 June 2010 - establishes the National Day against Homophobia (May 17th).
- Law No. 11,340 of 7 August 2006 - creates mechanisms to reduce domestic and family violence against women under § 8, article 226 of the Federal Constitution, the Convention on the Elimination of All Forms of Discrimination against Women and the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women; provides for the creation of courts of Domestic Violence against Women; and amends the Code of Criminal Procedure, the Criminal Code and the Criminal Execution Law among other measures.
- Law No. 13,104 of 9 March 2015 - amends article 121 of Decree-Law No. 2,848 of December 7, 1940 - Penal Code, to provide for femicide as a qualifying circumstance of the crime of homicide, and article 1 of Law No. 8,072 of July 25, 1990, to include femicide in the list of heinous crimes.
- Law No. 4,898 of 9 December 1965 - regulates the Right of Representation and the Civil and Criminal Administrative Responsibility process in cases of abuses of authority.
- Law No. 7,853 of 24 October 1989 - provides for the National Policy for the Integration of Persons with Disabilities in their multiple aspects.
- Law No. 10.216 of 6 April 2001 - provides for the protection and rights of persons with mental disorders and redirects the mental health care model.
- Decree No. 8,727 of 28 April 2016 - provides for the use of the social name and recognition of the gender identity of transvestites and transgender people within the federal public administration.
- Decree No. 7,388 of 9 December 2010 - provides for the composition, structure, competencies and operation of the National Council for Fighting Discrimination (CNCD).

Two workshops were also held in 2016 on the comprehensive health care of women living with HIV/AIDS. The objective of the workshops was to support groups of women to disseminate information and actions related to comprehensive health care by women living with HIV/AIDS. This objective was based on the MoH's commitment to historical demands of segments of women living with HIV/AIDS and different women's movements regarding the sharing of information and technical aspects related to HIV/AIDS, STI, sexual health and reproductive health. In addition, it has also contributed to empowering women living with HIV/AIDS in the country.

Commitment 10 – Commit to taking AIDS out of isolation through people-centred systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer and hepatitis B and C.

Brazil's 1988 Constitution has guaranteed health as a right to its citizens. Therefore, the country has a public health care system called Unified Health System (SUS), based on integrality, universality and equality. In accordance with its universal access to health care, Brazil guarantees free of charge ART to PLWHA since 1996; and, in December 2013, the country has extended its treatment recommendations to all PLWHA, regardless of CD4 count. This extension of ART recommendations increased significantly the number of PLWHA on treatment, creating a need of shared management of HIV care between primary care and specialized HIV care services. The new context of treatment for all PLWHA has required a multidisciplinary and continuous approach as a way of ensuring comprehensive health care for PLWHA. This integrality cannot be achieved in a specialized service alone, but through the coordination of networked services, seeking to meet the diverse needs of the population. These characteristics are found in the primary health care scope, which offers comprehensive health care. The integration of health services of different complexities is one of the government's commitment to reduce gaps in health care and improve access to HIV diagnosis and treatment, thus contributing to the achievement of the 90-90-90 goals.

Taking the universal health access in to consideration, prevention, testing and treatment for tuberculosis, hepatitis B and C are also offered free of charge by SUS. The current clinical guidelines for the management of HIV/AIDS in adults recommends testing all patients with STIs, including those with HIV, for hepatitis B. Moreover, hepatitis B vaccine became universal in 2016.

In 2016, the MoH provided approximately 36,500 treatments for hepatitis C, achieving the highest number of patients in the past years. This accomplishment represents a milestone in the financial negotiations of Brazilian government with pharmaceutical companies to obtain over 30% discount for daclatasvir, simeprevir and sofosbuvir. Since the introduction of the new direct-acting antiviral agents for hepatitis C in October 2015 with the implementation of the new guidelines for hepatitis C and coinfections, the MoH has provided circa of 50,200 treatments for 12-week and 24-week course of treatment by the end of March 2017. The preliminary analysis of treatment effectiveness in Brazil showed that patients with hepatitis C genotype 1 achieved a cure rate of 97%. Based on results of real life clinical studies demonstrating the low effectiveness of 12-week course of treatment for hepatitis C genotype 3 with cirrhosis, the MoH

extended the treatment period for 24 weeks for these patients. According to the current hepatitis C guidelines patients with advanced chronic hepatitis C (F3 and F4) and F2 for more than 3 years, HIV/ hepatitis C co-infected patients, HIV/ hepatitis B co-infected patients, and patients with chronic diseases are eligible for treatment. Brazil has also expanded the hepatitis C testing in the country, especially for people more likely to be infected such as people who received blood or organ donation before screening standardization in 1992. Recently, the MoH introduced the 4-drug combination of ombitavir, veruprevir, ritonavir and dasabuvir in SUS. Toward the elimination of hepatitis C as a public health threat by 2030, the MoH will submit the revised guidelines for hepatitis C and coinfections for approval this year.

Regarding cervical cancer prevention, the DIAHV and the *Moinhos de Vento* Hospital Association are carrying out a research project entitled “Epidemiological study of the national prevalence of HPV infection”. The aim of the project is to assess the prevalence of Human Papillomavirus (HPV) and its types in Brazil and in the different regions of the country among men and women in age group 16 to 25 years. It also seeks to identify demographic, socioeconomic, behavioural and regional factors associated with HPV infection and its types, especially types 6, 11, 16 and 18, which are covered by the vaccine used by the National Immunization Programme. In 2017, HPV vaccination was expanded for boys aged 12 to 13 years. Until last year, this immunization was only available to girls. The age range will be gradually increased until 2020, when boys aged 9 to 11 will also be included. The vaccination scheme for boys and girls is composed by two doses. HPV vaccination has also been extended for boys, adolescents and young people aged 9 to 26 years living with HIV / AIDS. For those living with HIV, the vaccination scheme is composed by three doses. The current recommendation for HPV vaccination is: girls (9-14 years), boys (12-13 years) and PLWHA and other immunosuppressive diseases (9-26 years).