

Overview

As a major international player in the response to the HIV epidemic, Brazil has strived to meet the Sustainable Development (SDG) Goal 3.3 on ending the AIDS epidemic by 2030, and is thoroughly committed with the 90-90-90 goals, the first step in this journey. As a result, Brazil established, in its multiannual plan for years 2016 to 2019 (an instrument created by the 1988 Federal Constitution designed to organize public activities and make them viable), the goal of maintaining at 90% minimum, the percentage of people living with HIV, who have been on therapy for at least 6 months, with suppressed viral load.

In 2017, over half a million people (547,000) were on antiretroviral therapy (ART) in Brazil and, of these, 70,516 started on ART in that same year. This expanded number of people on ART has allowed Brazil to come closer to reaching the second 90-90-90 goal. At the end of 2017, 75% of people diagnosed with HIV were already on ART. In relation to the first target, it is estimated that 87% of all people living with HIV (PLHIV) had been diagnosed. Furthermore, the main therapy quality indicator – and the third 90-90-90 target, related to suppressed viral load – was 92% among individuals on ART for at least 6 months, at the end of 2017.

In an effort to reduce side effects, have greater efficacy, decrease the possibility of transmissible resistance, and offer greater dosing convenience, Brazil announced in 2016, the adoption of Dolutegravir as part of the preferential regimen to start ART (except for young people under the age of 12, pregnant women, and co-infected patients), complementing its previous and exclusive indication as rescue therapy. In 2017, the offer of Dolutegravir was scaled up and Raltegravir was indicated as part of the preferential antiretroviral regimen for people aged between 3 and 12, as well as the initial therapeutic scheme for pregnant women.

These and other innovations are described in the 2017 update of the Clinical Protocols and Therapeutic Guidelines (CPTG), including management of HIV infections in adults; prevention of mother-to child transmission of HIV, syphilis and viral hepatitis; post-exposure prophylaxis to HIV, STIs and viral hepatitis infections (PEP); and management of HIV infection in children and adolescents.

In the context of scaling up combination prevention technologies, Brazil has also launched its HIV guidelines for PrEP (pre-exposure prophylaxis). This prophylaxis targets sex workers, gay men and other men who have sex with men (MSM), trans people and serodiscordant couples. The offer of PrEP began in January 2018 in 36 healthcare units, distributed along 10 states and the Federal District. In April 2018, 29 new healthcare services of the remaining 16 states were trained and are expected to start offering PrEP in June 2018. The

Brazilian Ministry of Health (MoH) intends to have at least one healthcare unit offering PrEP in every state of the country, by the end of 2018.

Considering the HIV epidemiological profile in Brazil, which highlights the vulnerability of young people, the MoH has developed strategies to promote HIV prevention for this segment, mainly young gay people, MSM, and travestis. In 2017, the MoH launched the “HIV Combination Prevention Workshop for Young People from Key and Priority populations.” Six workshops were conducted with the participation of 380 young people from all over the country, qualifying them to conduct peer education and combination prevention in their communities. Also in 2017, the ‘Hackathon’ – an IT coding marathon, resulting from the combination of the words “hack” (program) and “marathon” – was promoted by the MoH. The project, in the context of “Hack Health”, occurred as a 24-hour side event during the 11th Congress of HIV/AIDS and the 4th Congress of Viral Hepatitis, held on September 26-29 in Curitiba, Paraná. The project delivered innovative healthcare devices and tools, with a focus on combination prevention, and it also served as a strategy to discuss technology, communication, and health topics.

Last year, the MoH launched a certification process for municipalities that achieve the elimination of HIV vertical transmission, an important step to encourage and strengthen local actions to respond to this event. The certification guidelines were published in 2016, and, in 2017, Curitiba was the first certified city. The indicator that monitors the number of new AIDS cases in children under the age of 5 – used as a proxy of vertical transmission – was included in the Federal Pact of Indicators as a national health priority, in effect for the period between 2017 and 2021.

In relation to viral hepatitis, the publication of the CPTG for Hepatitis B and Co-infections as well as the PCTG review of Hepatitis C and Co-infections need to be underlined. It expanded access to treatment to all patients, regardless of the degree of liver damage, and increases treatment time for patients with genotype 3 and cirrhosis, from 12 to 24 weeks. It was in this context of international leadership in the area of viral hepatitis that Brazil was chosen to host the “2017 World Hepatitis Summit”. This event is known as a historical landmark for the country. In its opening ceremony, the MoH announced the National Plan to Eliminate Hepatitis C by 2030 with the offer of treatment to everyone. The event gathered representatives from several countries, specialists in public health, and NGOs to discuss the elimination of viral hepatitis worldwide.

The 10 commitments to scale up the response to the HIV epidemic, agreed upon at the 2016 United Nations High-Level Meeting on Ending Aids, represent a step forward to meet the

3.3 goal of the SDG. The HIV and viral hepatitis advances described above confirms Brazil's commitment to the 2030 agenda.

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

Regarding the first 90-90-90 target, the laboratory area of the Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis (DIAHV) concentrated, in 2017, its efforts to expand HIV diagnosis through the distribution of rapid tests. In that year, nearly 12 million rapid tests to diagnose HIV infection were distributed, an increase of about 60% when compared to 2016. It is estimated that 84% of all PLHIV had already been diagnosed by December 2017. Still in relation to the diagnosis target, it is important to mention that, in November 2015, the National Health Surveillance Agency (ANVISA), through its Collegiate Board Resolution (RDC) number 52, dated November 27, 2017, authorized the registration of HIV self-tests to be made available in pharmacies, drugstores, drug dispensing units, healthcare services, or public health programs. In 2017, ANVISA registered three HIV self-tests, one of which uses blood samples and the other two, oral fluids. The HIV self-test provides one more testing option to individuals who wish to use it, and takes into account the various factors that may hinder their access to diagnosis, such as HIV-related stigma and prejudice. These measures aim at guaranteeing that all PLHIV have access to diagnosis, in compliance with the first of the 90-90-90 targets. Besides scaling up access to diagnosis, Brazil has been increasing investments to reduce the gap between HIV diagnosis and treatment (ART). Universal and free-of-charge access to ART has been ensured since 1996. In December 2013, Brazil was the first developing country, and third country of the world, to expand the indication of treatment to everyone, regardless of their CD4 count. This change in the HIV treatment recommendation was followed by the nationwide adoption of the fixed dose combination in 2015. These two interventions resulted in a substantial increase of people on ART in the country. In 2016, the country announced the adoption of Dolutegravir as a preferential first-line regimen to start ART (except for children under the age of 12, pregnant women, and co-infected patients), complementing its previous and exclusive indication as rescue therapy. The decision to include Dolutegravir in first-line treatment was based on this drug having less side effects, greater efficacy, better dosing convenience, and reduced probability of transmissible resistance. In 2017, the offer of Dolutegravir was scaled up and Raltegravir was indicated as the preferential antiretroviral

scheme for patients aged 3 to 12 as well as part of the initial therapeutic scheme for pregnant women due to the same benefits (less side effects and toxicity, quicker reduction of HIV viral load, reduced probability of transmissible resistance, and better dosing convenience). Still in 2017, 80,592 patients were on Dolutegravir, 54,175 of these being new patients.

All these innovations were included in the 2017 CPTGs updates: Management of HIV Infections in Adults; Prevention of HIV, Syphilis and Viral Hepatitis Vertical Transmission; Post-Exposure Prophylaxis for People at Risk of HIV, STIs, and Viral Hepatitis Infections; and Management of HIV Infections in Children and Adolescents. In March 2017, CPTG of PrEP was launched. In order to improve healthcare professionals' access to the CPTGs nationwide, smartphone apps have been developed, containing all the protocols as well as some additional clinical tools. The CPTGs are also available online on DIAHV's official website.

As a result of the CPTGs updates, Didanosine (DDI) and Stavudine (D4T) were removed from the list of available antiretroviral drugs to patients of all ages, especially due to their known adverse effects and toxicity, the small number of people using them, and the possibility of their replacement by more modern and safer drugs. The use of pro-viral DNA to diagnose children aged between one day and 18 months was also incorporated. Finally, the recommendation of using PEP for HIV-exposed children – especially those breastfeeding – was reinforced.

90-90-90 Targets

Brazil monitors HIV clinical indicators monthly through the programmatic data registered in its databases. Most of these monitored indicators are viewed as key data to inform the Brazilian and the world's response to the HIV epidemic, and to comply with the World Health Organization's recommendations published in the 2017 *Consolidated Guidelines on Person-Centred HIV Patient Monitoring and Case Surveillance*. Since 2016, the results of the monitoring processes have been made available through a national publication – the *HIV Clinical Monitoring Report* – with the purpose of subsidizing HIV-response actions grounded on strategic and updated information. Also, in 2017, these indicators were made available to all municipalities with over 50,000 inhabitants through www.indicadoresclinicos.aids.gov.br

As a result of this clinical monitoring, it was possible to verify that, up to December 2017, over half a million people were on ART (547,000), and that 70,516 had started ART in the same year. This increase in the number of people on ART brings Brazil closer to reaching the second 90-90-90 target: in 2017, 75% of all diagnosed PLHIV were on antiretroviral therapy. The medium time between the request for the first CD4 count (which means the start of infection

follow-up) and the beginning of ART was 39 days in 2017, and the main therapy quality indicator, viral suppression, ended the year of 2017 at 92% for individuals on ART.

Still in relation to the quality of antiretroviral therapy, in December 2016, the National Committee for Health Technology Incorporation (CONITEC) published a report which recommends scaling up the exam to typify allele HLA-B among PLHIV treated with Abacavir (ABC) in order to evaluate hypersensitivity to this antiretroviral drug and possible adverse reactions, thus ensuring its safe use.

In order to confirm its commitment with the 90-90-90 targets, Brazil included, in its Federal Government multiannual plan, in effect for the years of 2016 to 2019, the goal of maintaining at 90% minimum, the percentage of PLHIV who have been on ART for at least 6 months, with suppressed viral load.

It should also be mentioned that the MoH has a Clinical Monitoring System for PLHIV (SIMC), an important tool that integrates data on PLHIV's continuous care and generates data to inform the development of monitoring activities, the surveillance of new cases, and the qualification of HIV healthcare services in states and municipalities. The SIMC database encourages the follow-up of sentinel events that are relevant to meeting the 90-90-90 targets. Among others, this tool provides information about PLHIV who (1) have been diagnosed but are not on ART ("Treatment gap"); (2) have abandoned treatment (> 100 days without ARV dispensing); and (3) are on ART without suppressed viral load (HIV virological failure). In 2017, SIMC database was improved and its reports are now updated monthly. The MoH periodically promotes video-conferences, meetings and workshops with the participation of states, municipalities, and healthcare services to strengthen the use of this tool and to monitor the goals of reducing the number of PLHIV who have not started

ART, who have abandoned treatment, and who, after 6 months on ART, still present detectable viral load. By monitoring and following up action plans in priority states and municipalities which concentrated 90% of the treatment gap in the period between January and December 2017, there was a reduction of 58.9% in the treatment gap, if the entry of new diagnosed patients is not taken into account, or 18.2% when new diagnosed patients are considered. This translates into 30,950 PLHIV leaving the treatment gap in this period.

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 country of PAHO/WHO's pact to eliminate the vertical transmission of HIV and syphilis in the American continent. During the 50th Directing Council held in 2010,

PAHO's member states adopted the Strategy and Plan of Action to Eliminate Mother-to-Child Transmission of HIV and Congenital Syphilis (Resolution CD50.R12).

The strategies to eliminate HIV and other STIs vertical transmission are being strengthened in prenatal and sexual and reproductive health services, as well as other related services, with the aim of scaling up HIV prevention, diagnosis, assistance, treatment, and surveillance. In relation to the year of 2017, the following actions are highlighted:

a) Update of the CPTG of Prevention of Vertical Transmission of HIV, Syphilis, and Viral Hepatitis, to include changes in the preferential initial regimen for pregnant women. This update introduces a new integrase inhibitor, Raltegravir, which speeds up the reduction of viral load when compared to Efavirenz, thus positively benefiting women diagnosed with HIV in the third trimester of pregnancy. It is expected that this alteration will improve adherence to ART, as this medication presents less side effects and less drug interactions. These updates also include a chapter on sexual and reproductive health of HIV+ women, specifically addressing the context of serodiscordant couples. Also, this updated document emphasizes testing and immediate treatment of pregnant women with syphilis;

b) Increased number of investigation committees to prevent vertical transmission of HIV, syphilis, and viral hepatitis B and C in states, regional health centers, capital cities, and municipalities, in order to improve prevention interventions, propose measures to correct flaws in prevention, assistance and surveillance during prenatal exams, childbirths, and puerperium, and eliminate vertical transmission of these;

c) Performance of situational analysis on the offer of milk formula to HIV-exposed children and the adoption of Cabergoline to inhibit lactation in new mothers living with HIV, in all states, in order to subsidize strategies and action plans to ensure access to inputs and prevention of late HIV vertical transmission, besides specific and individualized interventions in states that have experienced difficulties in the procurement and distribution flow.

d) Start of situational analysis of prophylaxis actions to prevent the vertical transmission of HIV, syphilis, and gonorrhea in Brazilian maternities in order to develop an intervention proposal to scale up access;

e) Certification, by the MoH, of municipalities that achieve the elimination of HIV vertical transmission, in order to encourage and strengthen local actions to respond to this event. The certification guidelines were published in 2016 and, in 2017, Curitiba was the first certified city. The indicator that monitors the number of new AIDS cases in children under the age of 5 was

included as a national health priority in the Federal Pact of indicators, in effect for the period between 2017 and 2021.

It is expected that the implementation of these actions will contribute to the elimination of HIV and syphilis vertical transmission in the country, specifically improving the quality of management, surveillance and assistance.

It should also be noted that testing and treatment of pregnant women in Brazil are core pillars of the national policy of HIV combination prevention. The volume of rapid testing of HIV+ pregnant women is growing yearly, having increased from 86,000 HIV tests in 2012 to 497,000 in 2017.

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 – gays and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs and prisoners.

Brazil has been striving to ensure access of its population, more specifically key-populations, to all HIV combination prevention strategies, universally and free-of-charge, in compliance with the principles of the Unified Health System (SUS). The national policy to respond to the HIV epidemic has maximized the offer of classic prevention strategies through the distribution of condoms and expansion of testing. In 2017, the MoH distributed approximately 460 million male condoms, 10 million female condoms, 45 million lubricating gel sachets, and about 12 million HIV rapid tests.

Besides leveraging classic prevention strategies, the country has also endeavored to improve and implement biomedical HIV prevention technologies. Since 2013, the MoH has increased investments to expand the healthcare network that offers PEP. The intra-sectoral articulation between the 24-hour service network and emergency and urgency units, has allowed key-populations greater access to the post-exposure prophylaxis. An evidence of this upscaled access is the 202% growth in the number of dispensed PEPs between 2013 and 2017. Over 87,000 PEPs were dispensed in 2017; of these, 70,000 had complete dispensations data (24% were dispensed to gay people and other men who have sex with men; 1.3% to people who use drugs; 3.4% to sex workers; and 0.6% to transsexual people).

With the purpose of expanding biomedical combination prevention technologies, the MoH started implementing pre-exposure prophylaxis (PrEP) in 2017. This prophylaxis targets sex workers, gay men and other MSM, transgender people, and serodiscordant couples. In January 2018, 36 healthcare units, in 10 states and the Federal District, started dispensing PrEP. In April, 2018, 29 new healthcare services in the remaining 16 states were qualified and are expected to start offering PrEP in June 2018. The MoH's goal is to have at least one healthcare service dispensing PrEP in every state of the country by December 2018.

The growth in combination prevention strategies has required the development of new guidelines for Testing and Counseling Centers (CTA), to allow them to become reference of matrix support to primary health care. To this end, a Working Group (WG) was created in 2016, with the participation of workers, managers, and civil society. This WG elaborated and delivered the "Guidelines for CTA Organization within the Scope of Combination Prevention and the Healthcare Network" and developed a strategic project to offer technical support to state coordination to reorganize CTAs.

Still concerning the implementation of combination prevention, the MoH resumed, in 2016, a working group, with participation of civil society, and whose purpose was to strengthen prevention strategies focusing on qualifying counseling practices, harm reduction actions, and the expansion of male and female condom distribution. This group developed strategies relative to: ensuring fundamental human rights; responding to racism, stigma, and discrimination; and promoting social and gender equality. One of the deliveries of this group was the elaboration of a reference document for sex workers, published in 2017, entitled "HIV Combination Prevention: Conceptual bases for healthcare professionals, workers, and managers."

Within the scope of commitment 3, it is noteworthy to mention the community-based strategy to scale up HIV diagnosis among key-populations: Live Better Knowing (VMS - *Viva Melhor Sabendo*). This strategy, implemented in 2014, is conducted by the MoH in partnership with civil society organizations through public edicts and in collaboration with local health managers. The VMS strategy uses peer-education methodology and consists on offering HIV rapid tests using oral fluid, and linking people with positive test results to healthcare services. Between January 2014 and December 2017, over 160,000 HIV tests were carried out. Almost 50% of these individuals had never been tested for HIV before and 1.6% of them had a positive result. The percentage of tests with positive results ranged from 0.5% among cis women who did not use drugs nor were sex workers to 8.4% among transgender people who reported being sex workers who used drugs.

Also in 2017, the MoH developed the strategic agenda to scale up access of key-populations to comprehensive health care. This agenda was motivated by the disproportionate levels of viral load counts found in key-populations when compared to the general population, requiring a differentiated and articulated response as well as the participation of all key players involved in the fight against HIV, STIs, and viral hepatitis, with the purpose of guaranteeing universal and egalitarian access to HIV health care. This network comprises: state and municipal health offices; the primary care network; urgency and emergency units; the National Tuberculosis Control Program; MoH's Strategic and Participatory Management Secretariat; Ministry of Human Rights; Special Secretariat to Promote Racial Equality; Interagency Councils – CONASS and Conasems; National Health Council; Ministry of Justice – National Secretariat for Drug Policy ; Ministry of Education; Ministry of Social Development; National Secretariat for the Youth; National Secretariat of Policies for Women; Federal Universities of Rio Grande do Norte, Rio de Janeiro, and Brasilia; international agencies (UNAIDS, UNESCO, PNUD, UNODC, UNFPA, UNICEF, PAHO and CDC/USA); and civil society's national networks of key-populations (sew workers, gay people, transgender people, people who use alcohol or other drugs, and PLHIV). This strategic agenda will be implemented within the next four years and is based on seven core axis: HIV integral care and continuous assistance; the response to stigma and discrimination; health communication; society's participation; strategic information; management; and governance.

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.

Brazil not only recognizes the issue of gender inequality, but also of racial inequality. As a result of these disparities, black women suffer much greater hardships that place them at extreme social vulnerability. Data published in 2017 show that the non-black women's mortality rate from AIDS (white, Asian, and indigenous women) decreased 7.4% from 2005 to 2015, while the mortality rate from AIDS among black women rose 22% in the same period. Regarding HIV cases among women, in the period 2007 to 2017, 55.9% of the cases were among black women.

With the intention of contributing to the response to gender and racial inequalities, and to the fight against violence and discrimination, several action plans were implemented in 2017. Among these actions, the promotion of female condom use – to increase women's autonomy in choosing their prevention method – must be highlighted. In this context, training workshops were conducted countrywide, involving healthcare workers and representatives from the civil society. In parallel, the government invested in the dissemination of information and

communication regarding this topic. During 2017, the DIAHV distributed about 10 million female condoms.

Also targeting the reduction of inequities and improving access of other key-populations and transgender people to healthcare services, two web documentaries entitled “POPTRANS” were produced,. These documentaries approaches key concepts around gender identity and sexual orientation, presenting the personal experiences of transgender people and their demands in relation to health care. The two chapters are available on <https://www.youtube.com/watch?v=-rRdCadJwVE> .

A workshop about combination prevention for transgender men was carried out and resulted in the publication of a guidebook on sexual and reproductive health as well as a special issue related to STIs, HIV/AIDS and viral hepatitis, specifically written for transgender men. This booklet was developed by the Ministry of Health in partnership with social movements organized by transgender men, and aims at providing information about their specific health-related needs to society in general.

Brazil is also committed to overcoming the scarcity of information about transgender people. In 2018, public HIV information systems will include the following variables: social name, sexual organ at birth, gender identity, and sexual orientation. This will allow the breaking down of data and the development of specific HIV clinical monitoring of the transgender population.

In relation to cisgender female sex workers, the MoH has consistently invested in and contributed to socially articulation of this key-population, ensuring that their leaderships participate in the political arenas that promote sexual health and HIV prevention. In 2017, the “6th National Meeting of Prostitutes: 30 years of memories, history and struggles”, sponsored by the Brazilian Government, was held with the participation of 100 sex workers and representatives from civil society organizations from all over the country. The main product delivered in this meeting was a strategic agenda to empower cisgender female sex workers to participate in the Brazilian response to HIV, other STIs and viral hepatitis as well as towards ending the violence they experience daily.

Another effort by the DIAHV to fight stigma and discrimination against PLHIV, was the endeavor to remove, from National Congress, Project of Law (PL) 198, proposed in 2015, which intended to categorize as heinous crime the deliberate transmission of HIV. In partnership with the Joint Parliamentary Front to Fight HIV/AIDS, DIAHV took action in National Congress to reject and shelve PL 198. On that occasion, the DIAHV reaffirmed that the Brazilian Penal Code already has legislation addressing the intentional transmission of STIs and that the PL was not only unnecessary but also potentially harmful to the advances achieved by Brazil in the fight against HIV. PL 198 was shelved in 2017.

Finally, Brazil has sponsored nationwide research studies, using the *Respondent Driven Sampling* (RDS) methodology, on behaviors, attitudes, practices, and prevalence of HIV, syphilis, and hepatitis B and C among (1) transsexual and travesti women; (2) female sex workers; and (3) gay men and other men who have sex with men. The studies were conducted in 12 municipalities: Belém, PA; Belo Horizonte, MG; Brasília, DF; Campo Grande, MS; Curitiba, PR; Fortaleza, CE; Manaus, AM; Porto Alegre, RS; Recife, PE; Rio de Janeiro, RJ; Salvador, Ba; and São Paulo, SP. In relation to violence, preliminary findings show that:

- i. In the study conducted among transsexual and travesti women, 27.5% reported having suffered some type of discrimination in healthcare services in the previous 12 months.
- ii. In the study conducted among gay men and other men who have sex with men, 65% reported having suffered some type of discrimination due to being gay; 24% said they had suffered some type of sexual violence; 21% reported having been forced to have sexual intercourse.
- iii. In the study conducted among sex workers, 34.8% reported having suffered some type of discrimination due to their occupation. In the 12 months prior to the research, 41.4% were verbally offended, humiliated or despised; 21.1% were physically assaulted; 27.9% reported having been forced to have sexual intercourse unwillingly (by their partners in 18.2% of the cases, 30.6% by clients, 11.4% by a family member, and 16.9% by an acquaintance). In 72% of the forced sexual intercourses, the perpetrators did not use condoms.

The findings in these studies will allow planning of specific policies for these key-populations and are expected to strengthen the fight against gender inequalities.

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

Compelled by the HIV epidemic profile which points to the vulnerability of young people, the MoH has developed strategies to promote HIV prevention targeting this segment, especially young gay men, other MSM, and travestis. In 2017, the MoH launched the “HIV Combination

Prevention Workshop for Young People from Key and Priority populations”, training them to provide peer education and promote combination prevention. Six workshops were conducted with the participation of 380 young people from all over the country. In this strategy, the MoH, in partnership with STIs and HIV/AIDS municipal managers, was in charge of conducting the activities, which were designed to promote social participation and to build a local intervention agenda for combination prevention, focusing on the specificities and needs of each region. These workshops allowed increasing knowledge, and promoted acceptance of combination prevention by the young participants, paving the way to the development of viable approaches, coherent with their specificities and vulnerabilities. Besides the exchange of knowledge, this strategy also helped young people to deconstruct biases and discriminatory attitudes associated with sexual orientation, gender identity, use of alcohol and other drugs, prostitution, skin color, race or culture, HIV stigma, and people with special needs, among others. Another benefit obtained is that the young participants are now capable of replicating the information in their communities.

Also in 2017, the ‘Hackathon’ – an IT coding marathon resulting from the combination of the words “hack” (program) and “marathon” – was promoted by the MoH. Hackathons have become a popular dynamic activity among institutions and are being applied in various knowledge fields, such as health (hack health). The project, in the context of “Hack Health”, occurred as a 24-hour side event during the 11th Congress of HIV/AIDS and the 4th Congress of Viral Hepatitis, held on September 26-29 in Curitiba, Parana. The hackaton was conducted by a team of specialists and received MoH’s technical support to build the conceptual bases related to combination prevention. The project delivered innovative healthcare devices and tools, with a focus on combination prevention, and also served as a strategy to discuss technology, communication, and health topics. One of the features of a hackathon is the stimulation of creativity which results from its competitive nature and can be used to encourage reflection and discussions among the youngsters and the groups.

Another action specifically addressing young people is the partnership signed in 2014 between UNICEF and the MoH to develop a strategy to minimize the growing trend of new HIV cases and mortality from AIDS among young people and adolescents. The decision was to use the same name and the same guidelines of the Live Better Knowing (*Viva Melhor Sabendo*) strategy (see details under commitment 3), making some adjustments such as using a mobile unit to offer testing and inviting a young person to act as peer navigator to help linking people to healthcare services, specially treatment. The name of the strategy was also adapted to “Young Live Better Knowing” (*Viva Melhor Sabendo Jovem – VMSJ*) to take into account the specific

focus on adolescents and young adults. Initially, two pilot-projects were implemented in the cities of Fortaleza and Porto Alegre. In 2017, the project was rolled out to the cities of Belém, Recife, São Paulo and Manaus, offering HIV testing, counseling, and referral to healthcare services, whenever necessary. In the VMSJ strategy, the cases with positive results for HIV are automatically linked to healthcare services and, from then on, adherence to ART is closely monitored. This strategy also stands out due to its articulation with young people, who are empowered to take important content to municipal and state schools, fostering citizenship education for adolescents and young people, and also scaling up HIV testing among 14 to 29-year-old people in the cities where the project has been implemented.

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

Brazil has strived to construct, along the past few decades, a legal framework to protect PLHIV. This social protection is also viewed as one of the factors for the success of the Brazilian response, considering that the mere distribution, free-of-charge, of antiretroviral drugs, important as it may be, is not capable of providing the integral care that PLHIV need. It is important to point out – as may be seen in the list below – that sometimes the legislation is broader and does not explicitly cite PLHIV. This, however, does not prevent them from benefiting from the provided protection.

- Federal Law 7,713/1988 guarantees exemption from paying income taxes to “people with acquired immune deficiency, based on specialized medical conclusion, even if the disease occurred after retirement or reform.” This was an important measure (especially in relation to that period of time), providing PLHIV, who would otherwise have to pay income taxes, an additional income to invest in their quality of life;
- Federal Law 11,052/2004 alters paragraph XIV of Law 7,713, dated December 1988, incorporating the provisions of Law 8,541, dated December 23, 1992, to include, among the exemptions from income tax payment, the revenues received by people with severe hepatopathies.
- Federal Law 7,670/1988 extended to PLHIV the right to: sick leave to undergo health treatment; retirement; military reform; special pension; and “illness benefit or retirement, regardless of grace periods, to the insured people who, after having been registered in the National Social Security Institute, present the disease, as well as pension for death to their dependents.” This law also allows “withdrawing the amounts

deposited in the Employees Severance Guarantee Funds (FGTS), regardless of the termination of work-related contracts, and any other type of benefits to which the patients are entitled”;

- Clauses 274 to 287 of the Normative Instruction 45/2010 of the National Social Security Institute (INSS) provides for any insured Brazilian who, due to illnesses, cannot work for over 15 consecutive days. An HIV+ person or anyone with severe hepatopathy will have the right to the benefit without the need to comply with the minimum contribution time, as long as they have been insured. This illness benefit is interrupted when insured individuals recover their capacity and resume work or when the beneficiary becomes entitled to disability retirement.
- Inter-ministerial Ordinance 769/1992 established that “compulsory serological testing requirement is unjustified and cannot be demanded prior to admission or enrollment of students, teachers, and professors, including the conduction of tests to maintain enrollment, attendance, and provision of services in public and private education institutions at all levels;”
- Organic Social Welfare Law (LOAS) 8,742/1993, in accordance with the 1988 Federal Constitution, regulated the Continuing Benefit Conveyance (BPC), which ensures minimum wage to the elderly over 65 years of age and to people with disabilities, regardless of age, who prove having an income per capita inferior to ¼ of the national minimum wage. The beneficiary must undergo evaluation every two years and the benefit may be suspended or terminated according to the conditions of the beneficiary.
- Federal Law 9,313/1996 “regulates the free-of-charge distribution of drugs to people with HIV/AIDS;”
- INSS/PRES Normative Instruction 45/2010, paragraph 152, states that “regardless of the grace period, the following benefits are provided: I – pension for death, reclusion aid, family allowance, and accident aid; II – paid maternity leave to insured female employees, domestic servants, and temporary workers, including those who are unemployed and maintain the insured condition due to exercising the activities in the respective categories; III – illness aid and disability retirement, in cases of accidents of any nature, including work-related accidents, as well as those cases in which the insured, after affiliating to General Service Welfare Service (RGPS)”, presents Acquired Immune Deficiency Syndrome (AIDS). The PLHIV are entitled to the benefit without the need to fulfil the minimum contribution time, as long as they are registered with INSS. The illness

aid benefit will be terminated when the beneficiary recovers their capacity and resume work or when the beneficiary becomes entitled to disability retirement;

- The Ministry of Labor's Ordinance 1,927/2014 establishes guidelines to fight discrimination against people with HIV in the workplace, complying with Recommendation 200 – HIV and the world of work – approved by the International Labor Organization on June 17, 2010. This legislation addresses the discriminatory practice of demanding workers (including migrants, people seeking jobs, and job candidates) to be tested for HIV or to disclose their HIV serological status. Also, workers cannot be coerced to provide HIV-related information of third parties;
- Federal Law 12,984/2014 “defines discrimination against carriers of the Human Immune Deficiency Virus (HIV) and AIDS patients as a crime;”
- Presidential Decree 8,727/2016 “provides for the use of the social name and the recognition of gender identity of travestis and transsexual in Federal, State, the Federal District, or municipal governments as well as autarchies and foundations;”
- Several state and municipal laws provide PLHIV with free-of-charge access to public transportation. You will need to access state and municipal transportation offices to obtain further information about this right.

Commitment 7 – Ensure that at least 30% of all HIV services delivered are community-led by 2020.

The Ministry of Health makes continuous efforts to create mechanisms that involve, encourage and scale up the participation of communities in discussion forums as well as STIs, HIV and viral hepatitis policy-formulation arenas. In this context, the National STIs, AIDS and Viral Hepatitis Commission (CNAIDS) and the Articulation with Social Movements Commission (CAMS) were created in 1986 and 2005, respectively. Although these two bodies promote dialogue with different social sectors, CAMS represent the social movements concerned with HIV and vulnerable populations and has the purpose of encouraging in-depth discussions and channeling their specific demands. CNAIDS, on the other hand, ensures the participation of representatives of institutions involved with the national response such as national, state, and municipal managers, social movements, and NGO networks, among other partners. The 123rd and 124th CNAIDS Meeting, and the 45th CAMS Meeting were held in 2017.

These two commissions also involve the participation of: NGO representatives; Work Groups on Prevention, Adherence, Lipodystrophy, Retention and Linkage, and PrEP; the Technical Advisory Committees on Managing HIV infections in Adults, Managing HIV Infections

in Children and Adolescents, Preventing Vertical Transmission, and Providing Integral Assistance to People with STIs; National Validation Committee on the Elimination of HIV Vertical Transmission; and the Partners of the Strategic Agenda Action Plan to Reduce Syphilis. The purpose of these institutions is to provide advisory services to DIAHV on their respective areas of expertise.

In relation to civil society funding, two bidding processes were launched in 2017:

- Selection process of civil society organizations to strengthen, promote and defend human rights actions related to STIs, HIV and viral hepatitis. 19 projects were approved totaling an investment of U\$ 251,537.48;
- Selection process of civil society organizations to conduct STIs, HIV and viral hepatitis combination prevention. 14 projects were approved totaling an investment of U\$ 1,043,599.92.

Finally, it is important to point out that, as part of the incentives for society's participation in formulating STIs, HIV and viral hepatitis policies in Brazil, DIAHV sponsors civil society representatives' participation in national and international events.

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

This report comprises the financial information related to the Brazilian response to the HIV/AIDS epidemic, conducted at various government levels. Therefore, it is not limited to the budget of the Ministry of Health's Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis, linked to the Health Surveillance Secretariat. Data provided by the direct federal administration as well as sub-national organizations, such as STIs/HIV/AIDS and VH state and municipal coordination units, are included in this report.

The information in this documents was obtained from the composition of the Health Surveillance Secretariat (SVS) budget, DATASUS database, Transparency Brazil Portal database, and data from STI/AIDS/VH state and municipal programs.

The budget of the DIAHV has the following structure: a) surveillance, promotion, and prevention account whose purpose is to ensure resources for epidemiological and prevention surveillance actions, and maintenance of management and technical structure of the

central nucleus of the Department; b) transfers to states and municipalities account which finances decentralized actions; c) procurement of ARV drugs account; and d) account for the procurement, storage and distribution of inputs for viral hepatitis prevention and control; and procurement of HIV prevention inputs, diagnosis tests, and patients' clinical monitoring.

In 2017, the approved budget for all the accounts totaled U\$ 533,744,880.67. In this report, the composition of national expenditures also contemplates other financial sources allocated to the health sector related to outpatient and medium/high complexity hospital actions, such as financial coverage of actions and procedures related to hospital admissions, clinical monitoring of HIV patients, control of opportunistic infections, and other high-cost control measures.

The total expenditures of the Brazilian Government with STIs/HIV/AIDS and viral hepatitis include both direct and indirect costs. Among the indirect costs, the following categories are highlighted: *Prevention, promotion of testing and linkage to care programs targeting young women and adolescent girls (high-prevalence countries); Gender programs; Programs for children and adolescents; Key human rights programs*. These costs derive from specific programs carried out by other Federal Government ministries, among which are the human rights and gender violence programs.

Brazil's total expenditures in this field totaled U\$ 668,212,053.00 in 2017. Among the main expenditures we point out the following categories: treatment – US 416,410,860.00; governance and sustainability – US 86,004,108.00; critical enablers – U\$ 15,796,659.00; communication for social and behavioral change – U\$ 13,061,029.00; children and adolescents – U\$ 4,123,872.39; and opportunistic infections – U\$ 5,470,049.07 (this amount refers to state and municipal contributions). We also highlight the inclusion of the category *Other essential programs outside the suggested framework of core HIV and AIDS programs* which reports the amount of U\$ 103,696,957.00 invested in syphilis and viral hepatitis prevention, assistance, and treatment actions.

Regarding disaggregated data for key populations, the only information available relates to the funding of civil society projects. Therefore, data related to what was actually spent on tests and condoms for key populations are not available. Still in relation to condoms, it is important to clarify that the difference (smaller when compared to 2016) is due to the fact the number of condoms purchased in 2016 was enough to partially cover the demand for 2017.

Concerning information relative to pre-exposure prophylaxis (PrEP), expenditures occurred during capacitation programs. Disaggregated data by key-populations will probably be reported in the year of 2019.

The same problem is true in relation to the disaggregation of expenditures with PEP by key-populations, because the current database only registers whether the exposure was sexual, occupational or violence-motivated.

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

Respecting human rights and fighting prejudice and discrimination have been cornerstones of the Brazilian response from the beginning and are essential for scientific advances to effectively reach people living with, at risk of and affected by HIV. Brazil's adherence to the "Zero Discrimination" strategy, proposed by UNAIDS in 2013, and the approval of the Brazilian law 12,984 in 2014, which criminalized discriminatory attitudes against PLHIV, are examples of the Brazilian commitment with this topic.

Below is a list of the national legislation establishing a legal framework to protect the rights of people most affected by HIV:

- Law 7,716/1989 defines race or color-related prejudice as a crime. Law 12,288/2010 establishes the Statute of Racial Equality;
- Law 12,984/2014 criminalizes any discrimination against carriers of the Human Immune Deficiency Virus (HIV) and AIDS patients;
- Decree 4/2010 creates the National Day Against Homophobia;
- Law 11,340/2006 creates mechanisms to curb domestic and family violence against women, under the provisions of article 226, paragraph 8, of the Federal Constitution and in accordance with 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; the law alters the Code of Criminal Procedure, the Penal Code and the Law of Criminal Enforcement; it also makes other provisions;
- Law 13.104/2015 alters article 121 of Decree Law 2,848/1940 – Penal Code, to qualify femicide as a heinous crime, and article 1 of Law 8,072/1990 includes femicide in the list of heinous crimes;

- Law 4,898/1965 regulates the Right to Representation and the legal procedures related to Administrative, Civil and Penal Responsibility in cases of abuse of authority;
- Law 7,853/1989 regulates the National Policy for the Integration of People with Disability, in their multiple aspects;
- Law 10,216/2001 regulates the protection and rights of people with mental diseases and provides new guidelines for the mental health assistance model;
- Decree 7,388/2010 establishes the composition, structure, competencies and functions of the National Council for Combating Discrimination (CNCD);
- Decree 8,727/2016 provides for the use of the social name and the recognition of gender identity of travestis and transsexual people in Federal, State, municipal governments, and the Federal District, as well as autarchies and foundations;
- The Brazilian Internal Revenue Agency issued Normative Instruction 1,718/2017 establishing guidelines to include and exclude social names from the Taxpayers Registry Card (CPF), in order to comply with Decree 8,727/2016. The interested party must go to an Internal Revenue unit and apply for the inclusion of their social name in their CPF. The inclusion will be immediately processed and the social name will appear in the CPF card along with the civil name;
- Recommendation 14/2017, issued by the National Education Council/Ministry of Education, dated September 12, 2017, approves the national norms on the use of the social name in basic education institutions. On January 17, 2018, the Ministry of Education ratified the recommendation, which came into effect immediately.

The creation of the Human Rights Hotline, known as “Dial 100”, must also be pointed out. It is a public service offered by the Ministry of Human Rights, linked to the National Human Rights Ombudsman, and which receives demands related to human rights violations, such as racism, homophobia, lesbophobia, and transphobia.

This service also disseminates human rights information as well as information about action plans, programs, campaigns, and human rights assistance, protection, defense and accountability services available at federal, state and municipal levels.

The Human Rights Hotline – Dial 100 – is available 24x7, including holidays. Direct calls can be made from any place in Brazil, from landlines or mobile phones, and are free-of-charge. Anonymous reports and complaints can be made and, when requested by the claimant, confidentiality of information is ensured.

After registration, these claims are analyzed and referred to protection, defense and liability offices within 24 hours, respecting their competencies and specific attributions, prioritizing the institutions that are able to intervene immediately in order to break the cycle of violence and provide protection to the victim.

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

As a result of the 2013 recommendation to provide treatment to all PLHIV, the assistance model for people living with HIV was reorganized and became a national priority. This new context required HIV services to function in a multidisciplinary and continuous manner to ensure integral assistance to PLHIV. This integrality cannot be achieved in specialized services only, but needs the articulation of network services to allow the meeting of the various needs of the population. This feature is found in the proposal of primary healthcare services which include actions to promote health, prevention and treatment, viewing each individual as unique. This integration between services of different assistance complexities is the major Brazilian response to minimize healthcare gaps and scale up access to HIV diagnosis and treatment in order to achieve the 90-90-90 targets. This innovation in HIV care follows international recommendations of shared assistance management and upscaled offer of HIV management services.

In order to promote greater integrality, the reorganization of the HIV care model needs to take into account a better articulation with the fields in charge of treating tuberculosis, cervical cancer, and hepatitis B and C, a somewhat complex activity that has already been started, but that needs to be further implemented. To illustrate some of the steps already taken, we highlight the HIV/AIDS notification form that includes other variables such as tuberculosis co-infection at the time of diagnosis. The viral hepatitis notification form also requires information about HIV/AIDS co-infection and the tuberculosis notification form requires data related to HIV/AIDS co-infection and ART.

In relation to cervical cancer, DIAHV and the *Associação Hospitalar Moinhos de Vento* (Windmills Hospital Association) in Porto Alegre, RS, have jointly conducted, since the first semester of 2015, a research project entitled “Epidemiological Study on the National Prevalence of HPV Infection”, whose purpose is to verify HPV prevalence and types in the different regions of Brazil, among women aged between 16 and 25, as well as to identify HPV-related demographic, socio-economic, regional and behavioral factors, specially focusing on types 6, 11,

16 and 18 which are covered by the quadrivalent vaccine adopted by the National Immunization Program.

Preliminary findings show an estimated HPV prevalence of 54.6%; 38.4% of participants at high-risk of developing HPV-related cervical cancer. The study has also indicated that 16.1% of young people had had at least one previous STI or a positive result for HIV or syphilis. As soon as the data analysis of the study is concluded, findings will be used to refine the scientific foundations that informs the formulation and improvement of public policies to combat STIs.

In relation to hepatitis B and C, Brazil has provided assistance and care through SUS since 2002. From 2011 to 2017, the MoH distributed approximately 30 million hepatitis B and C rapid tests, demonstrating the country's efforts to scale up diagnosis.

HIV treatment protocols include testing for hepatitis B and C to every PLHIV before they start ART as well as an annual test repeat. Hepatitis A and B immunization for PLHIV and the offer of timely treatment in cases of co-infection are indicated.

In 2015, Brazil started offering new hepatitis C treatment by incorporating direct-acting antivirals (DAA) and by providing priority access of patients co-infected with HIV/HCV to treatment, regardless of the degree of liver damage. In 2017, a revision of the antiretroviral drugs logistics control system's (Siclom) registration form allowed the inclusion of the variable HIV/HBV and HIV/HCV co-infections, permitting better monitoring of these patients and qualifying data on these co-infections. From 2015 to 2017, 65,000 people infected with hepatitis C were treated with the new DAA with cure rates of over 95%.

In 2017, the CPTG for hepatitis B and co-infections was published. It was developed based on most recent scientific evidence for the treatment of hepatitis B as well as Delta, hepatitis C and HIV co-infections. By the end of 2017, over 31,000 patients were treated for hepatitis B and Delta. It is still important to mention that, in 2016, universal access to hepatitis B vaccination was introduced in Brazil.

The CPTG for hepatitis C and co-infections, revised in 2017, provided several updates: incorporation of one more drug to the therapeutic arsenal for the treatment of hepatitis C; scaled-up access to all patients with F2 fibrosis stage, regardless of how long the liver damage had been in place; and an increase, from 12 to 24 weeks, in the time of treatment for patients with genotype 3 and cirrhosis. In that same year, treatment of all patients, regardless of the degree of liver damage, was announced. From 2016 on, in the second procurement of antivirals, a 30% reduction in the cost of medications was achieved, although the high cost of drugs still remains a challenge for SUS.

It is also relevant to point out that, in 2017, the MoH, in partnership with PAHO/Washington and CDA (Center for Diseases Analysis), elaborated a mathematical model to update the epidemiological data related to hepatitis C in Brazil. This has helped to improve assistance, prevention, surveillance, and treatment action plans for viral hepatitis in the country. It is estimated that, in 2016, the prevalence of people aged 15 to 69 with anti-HCV seropositivity was 0.7%, which corresponds to about 1,032,000 hepatitis C seropositive people (exposed to the C virus). Among them, it is estimated that 656,000 are viremic cases requiring treatment.

Finally, Brazil was chosen to host the “2017 World Hepatitis Summit” in recognition of the country’s on-going national initiatives and its international leadership in the field of viral hepatitis. The Summit is considered a major landmark for the country and, during the event, the National Plan to Eliminate Hepatitis C by 2030 was announced, including treatment to everyone. The goal was presented by the MoH during the opening ceremony which gathered representatives from several countries, specialists in public health as well as representatives from NGOs to discuss the elimination of viral hepatitis worldwide.

10 commitments to scale up the HIV response, agreed upon at the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS

2018 GAM Report – Civil Society Contributions

In response to an invitation made by Ministry of Health of Brazil through its Secretariat of Health Surveillance; its Department of Surveillance, Prevention and Control of STIs, HIV/AIDS and Viral Hepatitis; and UNAIDS, Brazilian civil society organizations participated, on March 20-21, 2018, in Brasília, Brazil, in a technical consultation to civil society to develop the Brazilian “Global AIDS Monitoring – GAM 2018” report.

After a presentation followed by a debate about the HIV/AIDS scenario in Brazil, Latin America and the Caribbean, participants were asked to divide into three groups, according to the adopted methodology, to provide contributions to meet the 10 commitments and scale up the response to the HIV epidemic, as agreed upon at the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS.

Civil society representatives discussed the 10 commitments in order to establish a methodology to address the topics. One of the methodologies used was a general debate about all the commitments and an assessment of the Brazilian context, as well as of the paths that will lead to those goals. Other discussions were carried out about how to ensure access of certain key populations whose health service provision is still limited or inexistent, as is the case of people deprived of freedom or the homeless.

It is crucial to understand Brazil as a continental country, with diverse regional features (Legal Amazonia), its social, political, economic, and cultural contexts, its pluralities – and to recognize and take into account its many dimensions as to gender, sex, sexual orientation, identities and expressions of gender,

generation, race, color, and ethnic groups, by observing traditions and habits of socially vulnerable groups that belong to the forest, to the water (riverside dwellers and people affected by dams), to rural (*quilombolas*) or urban areas (traditional African-Brazilian communities and populations), as well as indigenous populations.

It is also important to highlight the contributions made by social movements at the forefront – building bridges toward new prevention technologies to increase access and linkage, always adapting to regional specificities. Some examples are the Legal Amazonia and the semi-arid Northeast regions, among other areas in which access is limited or inexistent.

The fact that public health resources will be frozen for 20 years has led to huge losses to Brazil's public health system, and has demanded management strategies to maximize resources allocated to addressing the HIV/AIDS epidemic.

The document deals with global commitments; however, when they are translated, they include certain inadequate terms and/or make certain populations invisible. We believe that whenever trans people are mentioned, one must always specify whether they are *travestis*, transsexual men and women.

Concerning key populations, we believe that they should always be named and described so as to ensure that their specificities and the reason why they are highlighted among other populations which are equally affected by the epidemic (such as the increasing number of HIV+ women in epidemiological reports, according to databases from the last 10 years). Special attention should be paid to the term "people in prisons"; it should be replaced by the more comprehensive "people deprived of freedom." Similarly, "people living on the streets" refers to those who lack social assistance policies that assure them minimum citizenship rights.

The GAM report must emphasize the Brazilian political context, presently taking a step backwards concerning human rights, and marked by inequality, social vulnerabilities, and violence (which has become trivial in current relationships), and also see these commitments from the perspective of gender identity.

We consider that the challenges and issues referring to the 10 commitments are transversal and should be viewed in an articulated manner.

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

Ensure that the public health system works in line with the principles of integrality and universality, prioritizing prevention activities based on human rights. The cost of new drugs needs to be reduced and new technologies must be quickly incorporated to guarantee access of 30 million people by 2020, thus improving their quality of life and maintaining adherence. Integrality and universality include: low cost of medication; a public health system that works; and assurance of integral and universal access. In this context, the patent system needs to be reviewed to prevent abuses by medication patent owners. The entry of drugs – which have been pre-qualified by and purchased through PAHO or WHO – should be authorized with no opposition from ANVISA. This has happened to Darunavir, for example, which no longer has a patent in Brazil. Another example is the additional demands made by the European Union in the field of intellectual property (Trips-Plus goals) to sign a treaty with Mercosur. Constitutional Amendment 95, which establishes an expense ceiling, has caused a decrease in the allocation of resources to healthcare, and the mechanisms available to get lower drug prices are not being used. This happens not only to HIV and AIDS funding, but also regarding associated infections such as Hepatitis C and Tuberculosis, mainly in relation to drug-resistant TB.

According to the World Bank, in 2014, Brazil's total health expenditure (as a percentage of total expenditures) was 46% (for a public and universal system), compared to 83% in the United Kingdom (universal system), 78.2% in France, 71% in Uruguay, and 60% worldwide. In other words, Brazil's health policy, with its principles of integrality and universality, needs a substantial increase in resources in order to be comparable to other countries with the same policy, that is, an increase of 33% to reach the world's average.

Promote federal investments in antiretroviral drugs (ARVs) research and development, taking into account the various comorbidities caused by the HIV virus and drugs, while enhancing strategies for and alternatives to ARV regimens. These need to respect the singularities, vulnerabilities, specificities, gender, color, race, age, and the life cycles of People Living with HIV/AIDS (PLWHA), contributing to improved adherence by and better qualification of this population.

Ensure assistance and scale up access of populations in need of humanized and friendly services. We understand that there are still great challenges to comply with this commitment, mainly in defining and clarifying processes to improve the quality of services offered to persons deprived of freedom.

Ensure and scale up universal access to testing, diagnosis, treatment, and therapeutic regimens, as a fundamental principle of the right to prevention, promotion and access of key populations (gays and other MSM, bisexual people, *travestis* and transsexual people, people who use alcohol and other drugs, people deprived of freedom and sex workers). However, other initiatives need to be strengthened and services offered throughout the healthcare network. Innovative strategies need to be developed and made visible, according to the reality of each key population (gays and other MSM, bisexual people, *travestis* and transsexual people, people who use alcohol and other drugs, people deprived of freedom, and sex workers) as well as priority populations (the black population, indigenous populations, adolescents and young adults, and the homeless), thus reaching a larger number of people. To this end, we need to understand the social, political and cultural aspects

underlying the definition process of prevention activities. To illustrate this, we point out the the SAMPACENTRO study, carried out in 2011-2012, among MSM in downtown São Paulo which showed a prevalence of 15%. In 2017, the RDS study for MSM, sponsored by the Ministry of Health, showed a prevalence of 25% in the city of São Paulo. That is, an increase of 66% in five years over an incidence that was already high. These results exemplify the inappropriateness of the prevention policies implemented for this population and this place. The Ministry of Health has not yet released the data obtained in this study for other cities and key populations. A major increase is expected, though.

Promote discussion forums with different leaderships, with a focus on the priority to protect the right to health, from the perspective of the 90-90-90 goals.

When working in partnership with civil society, the education network directly contributes to overcoming institutional barriers, reinforcing the importance of access, diagnosis and treatment. It should be highlighted that the testing policy cannot be the core axis of prevention. We also point out the difficulties of making initial appointments once a positive test is received. Furthermore, HIV+ individuals without symptoms do not immediately get a CD4 count in order to assess the need to be started on ART or other prophylaxis treatments. That is, the test has become an end in itself, and people are left on their own to obtain assistance and inclusion in healthcare services. This shows missed-out opportunities and disrespect towards PLWHA's health.

Improve ARV dispensing services. There are great challenges to continue treatment as some dispensing units offer medication for up to 30 days only. Ensuring supply can guarantee drug distribution for longer periods of time, reducing the risk of non-adherence. These challenges also extend to the provision of access to diagnosis for everyone.

Invest in communication and information strategies through closed and open media; printed materials; bold advertisement; mass-communication campaigns outside the calendars already established (e.g. carnival and December 1) to disseminate new technologies for combination prevention (e.g. PrEP and PEP); and use of virtual applications (e.g. Tinder), in addition to other media.

Conduct awareness-raising programs to sensitize the population towards reducing stigma, prejudice and discrimination (gender, race, sexual orientation, gender identity, being HIV+, among others); and to link users to services, mainly key populations (gays and other MSM, bisexual people, *travestis* and transsexual people, people who use alcohol and other drugs, people deprived of freedom, and sex workers) and priority populations (the black population, indigenous populations, adolescents and young adults, and the homeless).

Promote continuous education within SUS in the 3 spheres of government, prioritizing the elimination of stigma and discrimination barriers among healthcare professionals.

Ensure that public policies are defined based on scientific evidence only and not on religious principles. Exercise state secularism in defining policies. For example, invest in research of alternative treatments, including the use of medicinal cannabis (this example does not apply to HIV, Hepatitis C or TB treatment).

The Ministry of Health must develop campaigns focusing on the 90-90-90 goals, defining access as a duty of the State and the right of users. Also, these goals must be viewed as nationwide objectives and take into account the continental and plural features of the country; however, compliance must be planned and monitored from SUS's perspective and include aspects related to reception and humanized care.

Address the trivialization of condom use and, in the same light, prevent the trivialization of other technologies and of AIDS itself, which started with the availability of drugs and is becoming increasingly common in different social groups, especially among young people. We also need to advance discussions about prevention beyond medicalization, incorporating risk-management issues. Different HIV prevention options must be offered, from the use of condoms to PrEP, treatment as a prevention strategy, and PEP, regardless of healthcare professionals' personal beliefs.

Reinforce the transversality of Health Education in public and private high schools in an attempt to expand the Education curriculum. Investments in School Health Programs are important.

Invest in communication strategies that highlight the escalation of legislation aimed at criminalizing PLWHA. Proposed Bill 198 has been removed from the agenda, but two other Bills are in course in Congress.

Conduct qualification programs about the rights of PLWHA for healthcare professionals who dispense medications at UDMs and all those who are in contact with service users (ACS, technicians, receptionists, and other healthcare professionals).

Implement the HIV/AIDS attention and lines-of-care model by analyzing those viewed as “innovative” in order to evolve towards an “Integral Healthcare Policy for PLWHA”. This can be achieved by observing the approaches that examine the Cascade of Care and positively impact the PLWHA population; by interconnecting activities relative to STIs and AIDS in Primary Care; by following the logical order of activities: prevention, diagnosis, assistance, and treatment; and by using the “*PositHIVa* Prevention” approach with a focus on improving the quality of life of PLWHA.

Guarantee the supply of ARVs and laboratory exams. In 2017 and 2018, the lack or fractioning of some ARVs were reported in different states, leading to disputes among the Ministry of Health, States, Municipalities, and contracted logistics services. In 2017, the offer of viral load count was interrupted and, for several months, it was limited to priority groups and pregnant women, compromising the treatment of PLWHA. The only one who is affected is the user.

Promote racial equality. The state and the municipality of São Paulo have produced data about the racial inequality of HIV and AIDS (there are no nationwide studies in this area). In the municipality, the research shows that the

death rate from AIDS among black women is 3-fold that of white women, and black men's death rate from AIDS is twice that of white men.

Improve early diagnosis rates. Late diagnosis (first CD4 count<200) is still a reality. For the last 3 years, the rate of late diagnosis has remained at 25%. Among indigenous populations, late diagnosis is growing (currently it is at 32%), according to data from the 2017 HIV Clinical Monitoring Report by the Ministry of Health.

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

Ensure assistance and integral care for women living with HIV/AIDS, focusing on their reproductive and sexual health and improving access to longer-lasting contraception methods such as IUDs, birth control implants, subdermal contraception, and monthly or quarterly injections.

Incorporate aspects of family planning for unplanned pregnancies in women living with HIV/AIDS as well and ensure prenatal exams, thus preventing late diagnosis and low number of medical appointments.

Strengthen and create new public policy strategies to fight “vertical transmission”. The need for policies directed at pregnant women using alcohol or other drugs, and/or living in the streets should be highlighted. Rapid testing of pregnant women's partners must be conducted whenever requested and be offered at all phases of pregnancy and breastfeeding, in order to prevent HIV mother-to-child transmission in these phases. It is important to guarantee linkage of women who have just given birth, as well as their babies, to the healthcare network, and, whenever possible, involve the spouse in the pregnancy monitoring process.

Ensure integral and humanized assistance to HIV+ children, with a focus on improving both adherence and their quality of life. Guarantee that they not only receive all the needed drugs during the first 18 months of clinical follow-up, including formula milk, but also that breastfeeding inhibition procedures are adopted immediately after delivery, as determined in specific protocols. Also, provide integral attention to HIV-exposed children.

Extend the offer of PrEP to women in the protocols. The great majority of women are excluded from the Brazilian protocol for PrEP, which restricts the method to four population groups, considered key populations (gays and other MSM, bisexual people, *travestis* and transsexual people, people who use alcohol and other drugs, people deprived of freedom, sex workers, and serodiscordant couples). This may have a negative impact on vertical transmission because it denies women of reproductive age, who are at high risk of acquiring HIV during pregnancy or breastfeeding, access to PrEP. According a WHO report, PrEP should be a prevention option both for pregnant woman and for nursing mothers.

Important considerations:

Improve access of socially vulnerable mothers (homeless and/or those who use alcohol or other drugs) to healthcare services. These mothers stay away from healthcare services because of prejudice and the fear of having their children taken away from them through legal interventions, as they are in a context of poverty and/or lack the capability to assume civil responsibility for their care. Their rights must be protected in their totality.

Ensure that families are included in social security protection programs, with the purpose of reducing social inequalities and guaranteeing universal and egalitarian access to public health policies, social assistance and security.

Ensure assistance and integral care to the general public as well as key populations, with a focus on their sexual and reproductive health. Different HIV

prevention options should be offered, from condoms to PrEP, prevention treatment, and PEP, regardless of healthcare workers' beliefs.

Commitment 3 – Ensure access to combination prevention options to at least 90% of people by 2020

Ensure the participation of civil society in the development of combination prevention strategies, especially through communication strategies.

Offer integral assistance to women who suffer abuse, making contraceptive inputs available to prevent HIV, syphilis, viral hepatitis, and other STIs.

Install services free from prejudice, discrimination and judgements, reaffirming the guarantee of fundamental rights to public health and universal access to everyone.

Promote greater communication about combination prevention to civil society, educators, healthcare and social assistance professionals, emphasizing the three dimensions of the strategy. We must raise healthcare professionals' awareness about the secularity of the state and the assurance of rights, protected by the 1988 Federal Constitution, especially in relation to prevention and health promotion.

Guarantee assistance and integral care to key populations and the population in general, with a focus on their sexual and reproductive health. Different HIV prevention options should be offered, including condoms, PrEP, prevention treatment, PEP, regardless of healthcare professionals' personal beliefs.

Think about the challenges to guarantee access to combination prevention, observing the differences in sexual practices within the perspective of sexual and reproductive rights. To illustrate this point, we point to the SAMPACENTRO study, carried out in 2011-2012, among MSM in downtown São Paulo which showed a prevalence of 15%. In 2017, the RDS study for MSM, sponsored by

the Ministry of Health, showed a prevalence of 25% in the city of São Paulo. That is, an increase of 66% in five years over an incidence that was already high. These results exemplify the inappropriateness of the prevention policies implemented for this population and this place. The Ministry of Health has not yet released the data obtained in this study for other cities and key populations. A major increase is expected, though.

Develop access strategies to combination prevention for people who use injectable drugs as well as other legal and illegal drugs. Intersectorality with harm reduction programs is also important.

Provide people deprived of freedom access to combination prevention. Establish social interventions and discussion forums with the homeless, schools, and various existing religious institutions.

Develop strategies to prevent unprotected sexual practices among sex workers. There is growing concern in relation to the use of combination prevention technologies in the context of commercial sex practices: negotiations to increase the price of sex with PrEP and no condoms.

Expand the offer of PrEP. The restriction of PrEP to specific populations exclude a great number of people who are at high risk of acquiring HIV and could benefit from the method, especially women.

Improve data collection systems to include gender identity information. The Ministry of Health's HIV/AIDS Epidemiological Bulletin is based on an information system that does not collect data about gender identity. Therefore, *travestis*, transsexual men and women are classified according to the sex attributed to them at birth, a fact that does not allow breaking down these data and hides the epidemiological reality of these populations, who depend on specific research.

Invest in HIV/AIDS prevalence studies among transsexual men and the specific groups of trans men. Data in this area are scarce and existing studies show an

epidemiological profile – including mortality – similar to cis, gay and bisexual men.

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.

Promote better communication, especially about the structural dimension of combination prevention, to civil society, educators, healthcare professionals, and social assistance workers.

Fight obstetric violence during pregnancy as well as forced, unconsented, and uninformed sterilization of women living with HIV/AIDS.

Invest in efforts to promote discussions about gender and, through that, measure how stigma and discrimination affect this health topic.

View the issues of inequality and violence within the social determinants and structural aspects of health Along with discussions about gender inequalities and the social-cultural differences in the territories, issues related to racism, LGBT phobia, and the social and legal limitations to access services must also be discussed.

The recent loss of funds allocated to AIDS – which have become immersed in the general account to transfer funds from the Federal Government to States and Municipalities – may mean compromising actions to address this issue. It was thought, planned and decided upon by national councils of health secretariats, without the participation of civil society's control mechanisms.

Strengthen discussion forums on gender inequality in the education system including themes such as gender, sexual rights, and prevention technologies. This debate must also include the issue of masculinity beyond the way that males behave (who are these men – cis/trans – who have sex with men?).

Forms of discrimination and violence, whose discussion is currently restricted to cisgender, heterosexual women and girls, must also include *travestis* and transsexual women and girls.

Carry out research about stigma and discrimination against PLWHA. We still have alarmingly high rates of violence against women and LGBT.

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.

Promote objective, clear and open debates in schools for young people, families, and communities to reduce stigma and discrimination, grounded on personal experiences (based on Paulo Freire's methodology – Popular Health Education).

Invest in alternative and appealing language for young people, using social media as well as other media used by this population.

Provide varied peer-based education on prevention and assistance options to young people, utilizing new languages and messages. The School Health Program and other social programs must integrate prevention activities. Educators, healthcare professionals and social assistance workers must be prepared for this theme. It is important to overcome institutional barriers in schools which must become spaces for behavioral change and democracy, through teaching and learning. Education practices must be based on the cognizant subject and not on financial education.

Promote and provide, in the family context, a dialogue around the topic of sexual and reproductive health as well as risk management during the manifestation of sexuality. Sex-related taboos in the family circle increase the need for prevention strategies for adolescents and young adults.

Improve data collection systems to include gender identity information. The Ministry of Health's HIV/AIDS Epidemiological Bulletin is based on an information system that does not collect data about gender identity. Therefore, *travestis*, transsexual men and women are classified according to the sex attributed to them at birth, a fact that does not allow breaking down these data and hides the epidemiological reality of these populations, who depend on specific research.

Reintroduce Sex Education in School Curricula. In December 2017, the National Education Council and the Ministry of Education, pressured by conservatives, removed the topics of gender and sexuality from the Basic National Common Curriculum, a document that defines what every student must learn during their basic education and serves as a reference for school curricula. This change will impact the guarantee of sexual and reproductive rights and will increase the vulnerability of HIV infection among adolescents, specially girls, gay boys and bisexual youngsters, as well as *travestis* and transsexual students. Similarly, in several municipalities across Brazil, the topic of sexuality and gender is being removed from municipal education curricula.

Install healthcare services specially designed for gay people and other MSM as well as bisexual adolescents and young adults. The lack of such facilities compromises access of young people. Services especially designed for *travestis* and transsexual people are scarce and generally do not offer assistance to adolescents.

Offer free access of adolescents to healthcare services. The rights of these adolescents to access healthcare services are frequently violated and often wrongly require parental consent to offer testing, PEP, contraception, or even HIV treatment.

Expand the offer of PrEP to young people. PrEP is still unavailable to adolescents in Brazil despite the number of AIDS cases having tripled among youngsters designated as men at birth, aged 15 to 19.

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

Guarantee the expansion of policies from an integrated perspective, ensuring rights and recognizing the specific vulnerabilities that need to be prioritized. The Brazilian State must ensure PLWHA social security, protection of rights, and universal access to public services.

The labor reform has significantly reduced the rights of workers and compromised the social protection of PLWHA.

Provide special care to young people living with HIV due to vertical transmission. There are many HIV+ children and adolescents who are living in shelters, are AIDS orphans, are in potentially vulnerable situations, or are excluded from any social-educational protection and/or assistance. They must be fully provided for while in their young age and on the path to adulthood.

Commitment 7: Ensure that at least 30% of all HIV services delivered are community-led by 2020

Qualify civil society's health institutions as monitoring spaces. The principles of the Unified Health System (SUS) are universality, equity, participation, and society's control. Law 8.142/90 guarantees social participation. There are three (4) deliberative spheres for society's control: national, state, municipal, and province councils, in the three levels of government. In order to strengthen their capabilities, these spaces need to be qualified to better exercise their controlling activities.

The Brazilian State is, quintessentially, a democratic state of rights and participation, mobilization and diversity are the core cornerstones of democracy. Public managers must commit themselves to transparency and promote society's participation as control and social change instruments.

Revise the service provision model. The “service provision” model must be questioned and should function from the perspective of complementary actions, formulating social policies together with other players. Thus, more investment in basic care is needed, and physical infrastructure as well as human resources must be improved. The same is valid for high- and medium-complexity services. The poor problem-solving skills and the delays in medical appointments and exams, among other procedures, need to be re-evaluated. Also, the number of healthcare staff must be kept at optimal levels, replacing those leaving the system (whether due to retirements, dismissals, or death).

Implement programs to measure and monitor stigma and discrimination in healthcare services and invest in the development of peer-led actions.

Engage civil society in the formulation of HIV/AIDS policies. There is no monitoring plan to engage communities and civil society, both in relation to PLWHA and more vulnerable populations, in the development of HIV/AIDS policies.

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

Qualify civil society institutions. Advocacy for HIV/AIDS prevention and care currently involves people with unfavorable social-economic conditions. We need to create conditions for these populations to exercise their right to participate. To this end, we must endeavor to promote their qualification and ensure specific funding to scale up their citizenship education and political qualification, thus

allowing them to better contribute to and participate in peer debates and political articulation spaces.

The recent loss of funds allocated to AIDS – which have become immersed in the general account to transfer funds from the Federal Government to States and Municipalities – may mean compromising activities to address this issue. This is contrary to this commitment. Also, there is increasing bureaucracy to apply to funding, whether through public structures, whether through management agencies such as UNODC or UNESCO, among others. Besides, the delays in the implementation of public notices hinders civil society's activities and, in some cases, leads to the closing of institutions.

Investments must be grounded on strengthening health and human rights policies, with adequate funding to receive PLWHA, provide services and establish lines of care, at governmental and non-governmental levels, according to the realities of each region. These investments must also embrace direct support to civil society's activities offered to key populations (gays and other MSM, bisexual people, *travestis* and transsexual people, people who use alcohol and other drugs, people deprived of freedom, and sex workers) as well as priority populations (the black population, indigenous populations, adolescents and young adults, and the homeless).

Guarantee that financial investments also cover policy monitoring, such as access to medication through the Legal System and the direct participation of civil society.

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

Develop strategies to strengthen participation through the dissemination of rights and to guarantee the participation of social movements. In order to

achieve the goal of this commitment, it is necessary to recognize, as political, technical and social forces, the PLWHA National Networks (*RNP+ Brasil, MNCP, Rede de Jovens com HIV, and Rede Nacional de Travestis e Transexuais Vivendo e Convivendo com HIV e Aids*), ANAIDS, and other movements, as well as their respective representations in ENONGs (National Meeting of AIDS NGOs), where strategies to fight AIDS are developed in the various spaces provided.

Guarantee the participation of PLWHA. The different levels of government need to make efforts to create legally capable environments that will ensure the role of PLWHA. The term “role” must incorporate citizenship and rights. It is important to broaden the debate, the conditions and the opportunities to conquer rights and citizenship.

Guarantee the participation of PLWHA and the full exercise of citizenship from the perspective of joint work as well as their access to other social policies and public services. It is important to act from the perspective of intersectorality and keep matrix alignment (reference, articulation, and integration) and political articulation among civil society sectors and the Executive, Legislative, and Judiciary Powers in the various spheres of government (advocacy).

Revise the national protocol for undetectable viral loads. The federal government has not yet recognized that “undetectable = non-communicable” in its national protocol, a fact that interferes with PLWHA’s autonomy.

Implement peer education in healthcare services. Systematic peer education is not a reality in the great majority of healthcare services in the country.

Enforce rights of PLWHA’s legal rights. Violations of PLWHA’s rights continue to be the object of few legal actions. The Nucleus for the Defense of Diversity and Racial Equality of the Public Defenders’ Office of the State of São Paulo registers very few processes related to discrimination due to serological status.

Promote legal literacy to PLWHA. The health system, which physically gathers PLWHA, is not engaged in guaranteeing legal literacy for this population.

Conduct more research studies on stigma and self-esteem to provide indicators of linkage, adherence, morbidity and mortality, in order to subsidize specific policies to address the problem.

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

Strengthen the network of integral care for PLWHA. Adopt the term universal access as opposed to the notion of “universal coverage” present in the commitment. The right to health is the foundation of the Brazilian unified health system and AIDS policies must be developed based on this premise: health as integral quality of life and not as the absence of disease.

Final Considerations:

How to implement and monitor the 10 commitments in the current political situation of the country and make this document an instrument to be incorporated in public policy-making?

Sustainability cannot be viewed separately, but as a whole, englobing political, financial and programmatic aspects.

The judicial and political frailty in addressing the ongoing dismantling of the Unified Health System (SUS) in the country will negatively impact the achievement of the 10 commitments undertaken by Brazil. According to the World Bank, in 2014, Brazil's total health expenditure (as a percentage of total expenditures) was 46% (for a public and universal system), compared to 83% in the United Kingdom (universal system), 78.2% in France, 71% in Uruguay, and 60% worldwide. In other words, Brazil's health policy, with its principles of

integrality and universality, needs a substantial increase in resources in order to be comparable to other countries with the same policy, that is, an increase of 33% to reach the world's average.

Also, the current political context, marked by setbacks in the field of human rights and by conservatives' and fundamentalists' pressures, greatly impacts the response to the AIDS epidemic and the fulfillment of these commitments.

The possibility of an "alternative SUS" puts a successful policy at risk from the legal point of view. However, the present policy still faces a long journey to fulfill its purpose.

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ARTGAY - Articulação Brasileira de Gays (Brazilian Network of Gay People)

ANAIDS - Articulação Nacional de Luta Contra Aids (National Network to Fight AIDS)

ANPS - Articulação Nacional de Profissionais do Sexo (National Network of Sex Workers)

ANSDH - Articulação Nacional Saúde e Direitos Humanos (National Network for Health and Human Rights)

ABGLT - Associação Brasileira de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (The Brazilian Gay, Lesbian, Bisexual, *Travestis* and Transsexual Association)

ABORDA - Associação Brasileira de Redução de Danos (Brazilian Association for Harm Reduction)

ANTRA - Associação Nacional de Travestis e Transexuais (National Network of *Travestis* and Transsexuals)

CUTS Central Única das Trabalhadoras e Trabalhadores Sexuais (Unified Workers' and Sex Workers' Central)

CEDAPS - Centro de Promoção da Saúde (Health Promotion Center)

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