AGE OF CONSENT: LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW

BRAZIL COUNTRY REPORT
FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine. The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
ACKNOWLEDGEMENT

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SAT also wishes to thank Civil Society Organisations and partners who attended the Age of Consent Validation Meeting that met to discuss and validate the draft Advocacy Toolkit. The meeting critically reviewed the draft reports, analysing the data collected for its accuracy and merits.

SAT is grateful to UNICEF for co-funding the review of the Age of Consent laws, policy frameworks, Ethical, Social and Cultural (ESC) impacts on sexual reproductive health and rights and HIV.

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BRAZIL

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL
AND SOCIAL REVIEW
## ACRONYMS

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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>EHP</td>
<td>Essential Healthcare Package</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papillomavirus</td>
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<td>MMC</td>
<td>Medical Male Circumcision</td>
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<td>MPR</td>
<td>Multiple-perpetrator Rape</td>
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<td>MSM</td>
<td>Men having sex with men</td>
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<td>MSP</td>
<td>Multiple Sexual Partners</td>
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<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
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<td>PLWHIV</td>
<td>People Living with HIV</td>
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<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
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<td>PrEP</td>
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<td>SRHS</td>
<td>Sexual and Reproductive Health Services</td>
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EXECUTIVE SUMMARY

Age of sexual consent is 14 years in Brazil. Sexual intercourse with an individual younger than fourteen 14 years old is illegal. The definition of statutory rape is sexual intercourse practiced by one individual with another individual younger than fourteen 14 years old.

There is no age restriction in the law for males or females to have access to contraceptives. There is no law requiring parental consent for access of contraceptives. Although there is no law establishing a minimum age for access to contraceptives, the policy of the public health system provides contraceptives to females in childbearing age, every woman of childbearing age (10 to 49 years old) has access to contraceptives in the Basic Health Units. Although not established by law, in practice, prior consultation with healthcare professionals is required for the prescription of a birth control pill to be issued. While condoms are freely distributed in public hospitals and clinics, birth control pills can be acquired for an affordable price in any pharmacy participating in the Brazilian Government program “Farmacia Popular”.

In Brazil a 12 years old, a young person is considered an adolescent. At this age, Brazilian legislation and policies preserve the right of privacy and confidentiality of the adolescent. No disclosure of information to parents or guardians is allowed, unless expressly approved by the adolescent or in case the circumstances fall within the exceptions described below.

There are no age restrictions on access to emergency contraceptives so parental consent is not a legal requirement. Young person are allowed access to emergency contraceptive services such as the day after pill, without any parental consent.

The policy framework does not provide restrictions or legal requirements to obtain parental consent in order to administer Antiretroviral Therapy (ART) to a child or adolescent. The “HIV/STI Program” is a Brazilian public policy which provides wide support and access to ART for AIDS patients.

In Brazil any individual, at any age, is legally entitled to access Post-exposure Prophylaxis (PEP). The CPTG on PEP does not restrict access to the PEP, and current legislation does not require a specific age for an individual to be assisted by a physician.

Access to Ante Natal Care is assured by Law 9,263/1996, as part of family planning. According to such Law, each State has the duty, through the Brazilian United Health System, to offer conditions that promote family planning, including Ante Natal Care.

There is no exception on Pre-exposure Prophylaxis (PrEP) and parental consent is not necessary for young persons to be assisted with ANC at the Brazilian Unified Health System. Were it offered access to PrEP by young people would likely be handled similarly as other services offered by the SUS to HIV patients.

 Abortions are illegal, except in very limited circumstances. Even in such limited circumstances, if the mother is under 18 years the consent of her legal representatives must be obtained.

Access to ANC is assured by law. No parental consent is necessary for young persons to be assisted with ANC at the Brazilian Unified Health System.

The Human Papilloma Virus (HPV) vaccine is part of the public immunisation program. Girls ages 9 years to 15 years only require parental consent when the vaccine is provided via a school campaign.

In Brazil a 12 years old, a young person is considered an adolescent. At this age, Brazilian legislation and policies preserve the right of privacy and confidentiality of the adolescent. No disclosure of information to parents or guardians is allowed, unless expressly approved by the adolescent or in case the circumstances fall within the exceptions described below.
Chapter One: Introduction

The world’s attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have therefore explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15 - 24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘All In To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts at globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility and acceptability. Adherence and quality must inform these services.
The SRHR Africa Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth attitudes survey

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / policies and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

**Methodology**

The Brazil legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by KLA Koury-Lopes Advogados Law firm and the ethical, cultural and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations and policies exploring the ages for girls and boys separately where relevant, including where contradictions exist in laws, policies and regulations on these issues.

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives with and without parental consent
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent with and without parental consent
9. Age of Consent to access HIV testing without parental consent

Brazil's ethical, cultural and social analysis was conducted through a desk review of publically accessible sources in English, including works published by international agencies such as UNICEF, WHO, UNAIDS, UNESCO, UNFPA, and the World Bank.

The research highlights social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. Age of Consent for sex and sexual debut.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.

Brazilian Government reports, and non-Governmental research outputs.
Country overview

Brazil is the largest country in Latin America and the fifth most populous country in the world.¹ Brazil is home to approximately 190 million people.² Of these, 61 million are children and adolescents.³ Boys and girls respectively constitute 51% and 49%, of this population. A significant proportion (84%) of the population stay in urban areas and a minority, (16%) in rural areas.⁴ The country is divided into five regions i.e. North, Northeast, Southeast, South and Center-West.⁵ The 2010 census indicated that 91 million people identified as white, 82 million as mixed ethnicity, 15 million as black, 2 million identified as Asians, and 817 000 as indigenous.⁶ Afro-Brazilians make up 50.7% of the population.⁷ The composition of ethnic groups amongst adolescents and children is 51.2% white, 42.7% mixed-ethnicity, 5.7% black, 0.5 indigenous, and 0.3% yellow (Asian origin).⁸ Brazilian society is deeply religious, with 65% of the population identifying as Catholics, 22% as Protestants, 8% as unaffiliated and 5% as other religion.⁹

Country context

● Brazil is classified as upper middle income country with an estimated GDP of $2.346 trillion.¹⁰
● Children and adolescents account for 35.9% of the total population.¹¹
● Brazil accounts for 47% of people living with HIV in Latin America.¹²
● Brazil is home to an estimated 734,000 PLWHIV.¹³
● The South-east region has the highest number of cumulative HIV cases (56%), followed by the South region, the North, the Mid-west, and the North-east having the least number of HIV cases.¹⁴
Chapter Two: Age of Consent to sexual intercourse

In Brazil there is no express definition of consenting age for sexual intercourse. However, based on the definition of statutory rape as described below, it may be understood that sexual intercourse may take place if both individuals are aged 14 or older. The age is the same for males and females, and for any type of sexual intercourse as definition of rape was broadened by an amendment to the Criminal Code in 2009.

Legislation on Age of Consent to sexual intercourse

There is a clear definition of statutory rape which is sexual intercourse practiced by one individual with another individual younger than fourteen (14) years old.

In Section 217-A of the Brazilian Criminal Code, Decree Law 2848, of December 7, 1940, as amended by Law 12,015 of August 7, 2009 (“Criminal Code”):

Section 217-A. To have sexual intercourse or perform other lewd acts with an individual younger than 14 years old: Imprisonment of 8 to 15 years.

As well as a Federal Supreme Court decision HC 111.159/BA: The majority of the case law of the Supreme Court has reaffirmed the absolute nature of the crime of rape against a victim younger than 14 years old [...], being irrelevant to the crime, the victim’s consent or physique.

Age of Consent for sex and sexual debut

The Age of Consent for sexual activity (regardless of sexual orientation) in Brazil is 14 years of age, while the minimum age for marriage for both males and females is 16 years of age, even with parental consent. Although religion has normative regulations which serve to deter sexual activities, adolescents are still debuting sex at an early age in the country. Both Catholics and Protestants prohibit premarital sexual activity. Brazil’s National Adolescent School-based Health Survey (PeNSE) conducted among 13-15 year old’s in 2009 and 2012 observed that 20.5% females and 28.7% males had already initiated their sexual life. There has been a decline in the value placed on virginity among Brazilian youth. Virginity has lost its social value among the middle and upper class cultures, but it is relatively important in more rural areas and lower socio-economic classes. There is also loss of moral significance in preserving virginity for marriage. The decline in age at first intercourse may be attributed to Brazil’s religious landscape, marked by the decline in Catholic dominance, growth of evangelical Protestantism, and the growth of people who identify as having no religion. Gender, region and type of school have been cited as being determining factors on how early one debuts sex.

Sexuality in Brazil

Adolescents’ early sexual debut in Brazil can be partly attributed to Brazilian values and norms of being a sexualized culture. Brazil is presented both locally and internationally as a sexually uninhibited society, free from sexual restraints. Brazilian society has undergone a process of liberalization of social norms. Sexual activities are no longer controlled and adolescent sexual life is not as restricted as before. Television programs broadcast in Brazil showcase this change. To this end, soap operas openly deal with sexual issues. However, it has been argued that adolescents in Brazil have not received proper information about sexuality to instill responsibility. Dialogue about sexuality is fragmented or absent. Thus, adolescents mostly get their sexuality information from peers, movies, magazines, television, internet and they get little information from parents, teachers and health professionals.

Machismo

Machismo is the dominant ideology that defines males in Latin America, including Brazil. The male role in Latin society is characterized by a man’s sexual prowess and virility, invulnerability, and dominion. Machismo encourages males to be polygamous, sexually experienced, and unfaithful. Adolescent boys grow up learning that they are strong and they generally dominate woman. A man is defined by what differentiates him from women and homosexual men. Heterosexuality is a key component for one to be a macho man. Men are
expected to be experienced in sex before marriage. Furthermore, sex is viewed as an uncontrollable instinct for boys such that when they feel the urge to have sex they are not supposed to resist the sexual impulse. On the other hand, females are expected to control their urges.

**Structural inequalities**

Structural inequality – where one category of people are attributed an unequal status in relation to other categories of people – is a major problem in Brazil. There are huge income disparities across regions, metropolitan centers, nonmetropolitan urban centers, and rural areas in the country. The country has one of the highest levels of inequality in the world and it is ranked second on the world ranking of countries with income inequalities. Social inequalities have been shown to negatively affect risky sexual behavior amongst Brazilian adolescents.

**Geography**

Geographic regions in Brazil tend to shape adolescents sexual decision-making. The country’s North and Northeastern regions are the poorest and characterized by vast, sparsely populated areas. Adolescents living in these regions report initiating sex early, more frequently. One study highlighted that the country’s Northern regions had the highest percentage of adolescents who had debuted their sexual life before 15 years of age. More than half of poor Brazilians live in the Northeast area. Adolescent girls who reside in the Northeast region of Brazil are more likely to get pregnant during adolescence than their Southeast counterparts. Data from 2009 shows that adolescents from these regions presented 22% of total births, while the rest of the country presented 17% or less. Adolescent girls from poorer backgrounds, who have a lower level of education, debut sex earlier. However, in the GRAVAD survey there were no significant differences between adolescent boys who lived in poor communities and those who lived in rich communities. Furthermore, adolescents who stay in urban areas are at a higher risk of early sexual debut than those who live in rural or small town.

**Poverty**

In Brazil, approximately 16 million people live in extreme poverty. Such communities typically experience social exclusion, especially those who live in disadvantaged neighborhoods. Racial inequalities in Brazil makes Afro-Brazilian adolescents susceptible to poverty. Studies have indicated that when income inequality is high, getting pregnant is viewed as an opportunity for a better life and as an enhancement to one’s social position. Adolescents who live in poverty stricken communities are also prone to initiate sex early so as to get pregnant because motherhood is viewed as a central element of femininity. Adolescent girls are also vulnerable to sexual exploitation, abuse, and pornography. Studies have shown that living in high poverty neighborhoods is associated with a 50% increase in sexual initiation. On the other hand, adolescents from affluent backgrounds can also debut sex early, because economic development promotes secularism, individualism and self-expression values which may lead to more permissive attitudes towards premartial sex.

**Ethical implications and recommendations**

Given that poverty is an indicator of early sexual debut, the Brazilian Government should continue its successful poverty-alleviation measures. Furthermore, more should be done to educate adolescents in poverty-stricken communities about the socio-economic and health implications of early sexual debut and pregnancy, with the goal of encouraging deferring sexual debut.

**Country experiences in addressing barriers**

Brazil has many progressive policies on paper. However, most of these have not been translated into action. In an effort to educate adolescents about sexual health the Brazilian Ministry of Health included sex education in the National School Curriculum. However, most schools focus on biomedical discourse, such as reproductive aspects, fertility, pregnancy and contraception. Schools neglect sexual health and relationships discourse. Such initiatives also only focus on adolescents in school, accordingly sideling a huge number of adolescents who are out of the school system.
In 2011, the Federal Government of Brazil launched the Brazil without Poverty Plan (Brasil Sem Miseria, BSM) which is divided into three pillars.66 These pillars focus on income guarantee, relief of extreme poverty, access to public services to improve education, health and citizenship of families, and productive inclusion to increase the capabilities and work opportunities for income generation among poor families.67 To date, such initiatives, and earlier ones, have yielded impressive results. Since 2002, more than 36 million people have been lifted out of extreme poverty in Brazil.68

Exceptions for gay sex

Brazil does not have Age of Consent exceptions in the law for gay sex. Under Section 217- A of the Criminal Code. To have sexual intercourse or perform other lewd acts with an individual younger than 14 years old: Imprisonment of 8 to 15 years.

Homosexuality and transgender expression

Under Portuguese rule, sodomy was a crime in Brazil, punishable by death or hard labour.69 In 1830, eight years after independence from Portugal, Brazil’s Imperial Penal Code was signed into law. Despite the country’s strong Catholic roots, the new Penal Code eliminated all references to sodomy,70 thus ushering in a relatively liberal era in Brazil’s history, in regard to homosexuality. In 2011, a judicial hearing established that same-sex ‘civil unions’ were legally permissible in Brazil, thus conferring equal status and rights to homosexual couples in the country. Today, Brazil is recognized as one of the global leaders in advocating for progressive domestic and global LGBTI rights.

While Brazil’s legislative framework has been tolerant towards homosexuality, cultural constructions of sexuality determine how homosexuality is viewed. To this end, the cultural construction of sexuality enables self-described heterosexual men to engage in homoerotic sexual activity without explicitly identifying themselves as homosexuals or publicly acknowledging these activities.71 The males who play an active role in a homosexual relationship are not labeled homosexuals, because they will be playing an active role of penetrating which goes hand in hand with masculinity.72 However, males who play a passive role in a homosexual relationship are labeled homosexuals because they are not exercising penetration and are deemed to be practicing femininity.73 Brazil has one of the largest Catholic populations in the world. Catholics in Brazil follow the religious rhetoric of hating the sin not the sinner. Conservative groups are, however, against people of the same sex kissing in public. These groups have mobilized to criminalize such acts. In 2008, conservative Evangelical and Catholic religious groups had media campaigns against the draft bill that would criminalize homophobia.74 The campaigns claimed that the bill would restrict religion and promote homophobia which did not exist before. In a survey conducted in 2007, 46% of Brazilian Catholics supported civil union between same sex couples.75 Despite the country’s liberal stance in regard to homosexuality, homophobia and aversion towards homosexual men still exist in Brazil.76 A nationally representative study by the Brazilian Ministry of Health revealed that 80% of the population expressed opposition to male and female homosexuality.77 Another public opinion survey indicated that 63% of Brazilians oppose homosexuals entering into civil union.78 Despite apparently liberal mores in Brazil, MSM face violence, stigma and discrimination.79 Internal agencies indicated that 50% of transgender murders in 2014 were committed in Brazil.80 Approximately 326 LGBT people were murdered in 2014.81 The Brazilian Government tries to promote access to health services to MSM as it is a fundamental human right for all.82 In Latin America, including Brazil, more than 50% of MSM have access to sexual reproductive services.83 Homophobic bullying is also prevalent in Brazilian schools, with 40% of gay men reporting having been bullied at school.84 Religious groups have also protested homosexuality being portrayed on television.85 These groups have also protested against sex-education with homosexual themes.

Ethical implications and recommendations

Notwithstanding objections to LGBTI-expression on moral and religious grounds from some quarters in Brazil, the Brazilian Government must continue to function as a secular democracy. Furthermore, the Government must uphold its human rights obligations. To this end, the country must protect, and promote the rights of, the country’s LGBTI community. The Government should also continue to counter homophobia.
Country experiences in addressing barriers

Annually, Brazil hosts the “biggest and best gay parades” in the world. Enjoying Government support, these parades are aimed at fighting against discrimination and violence towards the LGBT community the parades are coupled with discussions and debates on gay themes. In 2004, the Brazilian Government implemented the Brazil without homophobia campaign, which aimed at promoting rights, combat violence and impunity and promote values with respect to peace and non-discrimination against the LGBTI population. The Ministry of Education also implemented the Schools without homophobia program in an effort to eradicate homophobia in schools. This program focuses on regional discussions between state leaders and social movements about ways to combat homophobia in schools. The program also develops training kits on homophobia for both educational professionals and students.

Although there are many drives to promote tolerance of the LGBTI community, schools are still lagging behind in providing students information about homosexuality and issues of discrimination based on sexual preference are not discussed. Sex education in schools is considered as a possible means of correcting or controlling sexual identities and behaviors deemed immoral or abnormal. In spite of homosexuality topics not being discussed in class, learners are not necessarily opposed to the discussion of homosexuality. In one initiative aimed at exploring learners’ beliefs towards homosexuality, graffiti in a public school in Petro Alegre, South Brazil portrayed students’ beliefs and concerns about homosexuality. All forms of sexuality were accepted, both by the graffiti artists and those who commented on the graffiti. This indicates that some Brazilian students may be willing to have discussions on these issues.

In Brazil, approximately 50,000 LGBT people are able to access good quality healthcare. Organisations such as ‘Bridging the gaps’ have trained staff at health facilities to provide LGBTI-friendly services. Furthermore, 60% LGBTI people access to HIV/STI services in Rio de Janeiro, Fortaleza, and Porto Alegre. However, the existence of prejudicial and discriminatory behavior by health professionals towards the LGBT population is still apparent. Due to discrimination in health facilities, LGBT people only seek healthcare in situations of greater illness.

The country’s Ministry of Health has implemented two major initiatives to scale up testing and prevention among key population. The ‘A Hora e Agore’ project (‘The time is now’), which was implemented in 2014, works with gay men and MSM, offering rapid HIV tests in mobile units which are equipped with counseling rooms. The ‘Quero Fazer’ project (‘I want to do it’) focuses on increasing coverage and quality of HIV/STI prevention and testing activities, improving the care provided to LGBTI people, ensuring access to health services for the LGBTI community, and enhancing knowledge about the needs of LGBT community.
Chapter Three: Access to contraception services and commodities

There is no age restriction in the law for males or females to have access to contraceptives. There is no law stating that parental consent to access such methods is required.

Although there is no law establishing a minimum age for access to contraceptives, the policy of the public health system is to provide contraceptives to females in childbearing age. As provided in the Government website ‘the Brazilian Portal,’ every woman of childbearing age (10 to 49 years old) has access to contraceptives in the Basic Health Units. This is part of the Brazilian family planning policies, provided by the Brazilian Federal Constitution and by Law 9,263 of January 12, 1996 (Law 9,263/1996).

Although not established by law, in practice, prior consultation with healthcare professionals is required for the prescription of a birth control pill to be issued. While condoms are freely distributed in public hospitals and clinics, birth control pills can be acquired for an affordable price (less than BR 6.00) in any pharmacy participating in the Brazilian Government program ‘Farmacia Popular.’

Access to emergency contraceptives

In Brazil, every woman of childbearing age (10 to 49 years old) has access to contraceptives in the Basic Health Units. There is no law providing that parental consent to access such methods is required. Therefore, a young person is allowed to have access to emergency contraceptive services (e.g. day after pill), without any parental consent. Sections 3 and 4 of Law 9,263/1996 provide all citizens with general health assistance and preventative measures.

Legislation and policy framework

Section 3. Family planning is part of a set of actions towards women, men and couples with the mission of providing them with general and global health assistance.

Sole Paragraph: In the performance of the actions described in the heading of this Section, all levels of the Brazilian Unified Health System undertake to assure full healthcare program, in all its services network, concerning woman, man or couples health, in all their life cycles, including, as basic activities, among others:

1. assistance to conception and contraception;
2. access to Antenatal Care;
3. labour puerperium and new-born assistance;
4. control of sexually transmitted diseases; and
5. control and prevention of cervical, breast, prostate and penis cancers.

Section 4. Family planning is guided by preventive and educational actions and by ensuring equal access to information, means, methods and techniques available for fertility control.

Access to sexual and reproductive health services [SRHS], including autonomous HIV counselling and testing [HCT] and contraception access

The PNDS-2006 study indicated that the most adopted contraceptives among Brazilian youth were the male condom and the pill. In Brazil, young people are the most frequent users of condoms and mostly access condoms via the National Health System. Public schools are the second largest distributors of condoms to adolescents. In a study conducted by UNESCO in Brazil, two third of surveyed parents supported the distribution of condoms and sexuality education in schools.
There have been clashes between the Catholic Church and the Government in regards to condom safety and distribution.\textsuperscript{109} The Catholic Church prohibits the use of modern contraceptives of any form.\textsuperscript{110} In 2004, after a Brazilian Catholic Bishop’s Conference, the convening Bishops released a statement stating that condoms were not 100% safe.\textsuperscript{111} The Government then ran a media campaign with the message that ‘nothing gets through a condom’.\textsuperscript{112} Although the Church is against use of contraceptives, congregates either discreetly use them or make it known that they are using them because such decisions affirm freedom of choice.\textsuperscript{113}

Youth in Brazil face a lot of barriers in accessing accurate reproductive health information and care.\textsuperscript{114} A study conducted in Northeastern Brazil indicates that adolescents considered oral contraception to be harmful to health, aesthetics and fertility.\textsuperscript{115} Furthermore, adolescents in this study believed that contraception negatively interferes with effective sexual relations.\textsuperscript{116} Women are expected to take full responsibility on contraception and their partners have minimal contributions.\textsuperscript{117}

In some areas in Latin America, Brazil included, due to societal norms, standard family planning services are not readily available to many communities. Access to affordable access to contraception, sexual education regarding contraceptive methods and sexually transmitted diseases, and healthcare for stigmatized or marginalized communities are in tragically short supply. This is not because of lack of ability to deliver such services, but due to lack of political will and coordination. Some policymakers in the region believe that dissemination of information or provision of contraception is a form of encouragement to indulge in sexual activities.

**Social vulnerability**

Data from surveys on factors associated with the use of health services have indicated that socioeconomic inequalities in Brazil limit access to healthcare services.\textsuperscript{118} Some adolescents cannot access SRHS because of their social vulnerability.\textsuperscript{119} There are prevalent socioeconomic inequalities between different races in Brazil.\textsuperscript{120} Typically non-white adolescents demonstrate higher fertility than whites, which is indicated by the number of children they have before the age of 20.\textsuperscript{121} Adolescents may not be able to access sexual reproductive health services due to racial discrimination perpetrated by the health professionals.\textsuperscript{122} Such prejudices have become obstacles for adolescent to use health services.\textsuperscript{123}

**Ethical implications and recommendations**

Despite Brazil being a multi-cultural society with rich ethnic diversity, discrimination based on ethnicity, colour, and social class persist. Authorities should do more to facilitate SRHS services to adolescents from lower socio-economic communities. Authorities should remind health workers that they have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values.

**Country experiences in addressing barriers**

Mass media has played a significant role in breaking down the stereotype that sexual health services such as family planning, is taboo.\textsuperscript{124} Family planning is now widely known among the Brazilian communities. DHS data showed that 100% of sexually experienced adolescents knew at least one method of contraception.\textsuperscript{125} Approximately 63% of Brazilian schools tackle STI and AIDS themes in class. Although adolescents are knowledgeable about contraceptive methods, this has not translated into actual use.\textsuperscript{126} This is indicated by the high fertility rates and HIV prevalence among this age group.\textsuperscript{127} Contraceptive use has been found to be associated with ones level of education, marital status and contraception use at first intercourse.

USAID has expanded social marketing for condoms, promoted HIV rapid testing and increased diagnosis among the most at risk populations through a comprehensive voluntary counseling and testing program.\textsuperscript{128} Implementation of programs such as Quero Fazer has led to increased testing opportunities.\textsuperscript{129}
Chapter Four: Age of Consent and HIV testing

In Brazil the Statute of the Child and Adolescent specifically states that childhood ends at 12 (twelve), starting adolescence at this age. When it comes to children, despite the fact that we have not found specific legislation requesting parental consent for children, we have found a technical opinion ("Parecer Técnico do PN-DST-AIDS") issued by a technician of the ‘HIV/STI Program’ on May 7, 1997, which recommends that HIV testing and the related report to children should be made with the presence/authorization of the parents or guardians (please note that it is a recommendation).

On the other hand, the researchers also learnt about the existence of an opinion issued by the Brazilian Federal Council of Medicine (Ofício CFM n° 1.865/96) stating that for underage people - encompassing persons under the age of 18 – no parental consent should be requested for HIV testing, provided that the young person has capacity to evaluate his/her condition (no copy of such opinion was found, only references from the official webpage of the Brazilian HIV/STI Program).

The two available opinions contradict each other, and it would appear that the determination as to whether parental consent is required for children is a matter of practice rather than policy or law.

Legislation and policy framework on HIV testing

Parecer Técnico do PN-DST-AIDS states: For these reasons, the guidance is provided in order to adopt the age parameters recognized by the medical and legal fields, i.e. for young children (between 0 and 12 years old), HIV tests to be conducted only in the presence of the young child’s parents or legal guardian; in the case of adolescents (from 12 to 18 years old), only after their required ability to discern the circumstances relating to testing has been established, divulging information to third parties about the testing and results of the HIV test is subject to in the adolescent’s sole discretion.

Section 2 of Law 8,069/1990 (The Statute of the Child and Adolescent) Art. 2 For the purposes of this Act, child is the person up to twelve years old, not complete, and adolescents the person between twelve and eighteen years old.

Section 100 of Law 8,069/1990 (The Statute of the Child and Adolescent): Section 100. For the implementation of the measures the pedagogic needs shall be observed, being preferable those which strengthen the familiar and communitarian bounds. (…) Sole Paragraph: The following are also principles to rule the implementation of the measures: (…) V – privacy: the promotion of the rights and the protection of the child and the adolescent must observe their rights to privacy, to image and preservation of their private lives; (…).

Section 4 of Ministry of Health Ordinance 23 of December 17, 2013: Section 4. An official document of the individual to be submitted to the sample collection shall be requested and verified (…). Sole Paragraph: Anonymous testing is assured, however, the individual must be aware, in such case, during the sample collection that no written result will be provided.
Section 74 of Medical Code of Ethics approved by Federal Council of Medicine Resolution 1,931, of September 17, 2009:

Section 74. To disclose professional secrecy and confidentiality related to an underage patient, including his/her parents or guardians, provided that the underage patient has judgmental capacity, unless such non-disclosure may entail damage to the patient.

Available at: http://portal.cfm.org.br/index.php?option=com_content&view=category&id=9&Itemid=122

Age of consent to report HIV status directly to adolescents

With respect to adolescents' persons aged 12-18 years, the Brazilian legal framework, states that they can be tested for HIV without parental consent. HIV testing is not only free of charge in Brazil - through the Brazilian Unified Health System, but may also be anonymous, at the patient's sole discretion. Sexual and reproductive rights have been increasingly incorporated to the Brazilian legislation, since the country is a signatory of basically all the relevant instruments related to sexual and reproductive rights. In this sense, Brazilian legislation also guarantees the right to privacy to adolescents, ensuring their right to receive medical assistance without parental consent and also free and anonymous HIV testing.
Chapter Five: Age of Consent and access to Anti-retroviral Therapy (ART)

The Brazilian Constitution guarantees free and universal health assistance to all Brazilian citizens. The ‘HIV/STI Program’ is a Brazilian public policy which provides wide support and access to ART for aids patients. Generally, the Brazilian legislation does not request parental consent for aids treatment of children and adolescents (anyone under 18 years of age), as the ‘HIV/STI Program’ is understood as a strategic national policy. With respect to ART specifically, there are no age restrictions or requirements to obtain parental consent in order to administer ART to a child or adolescent.

Legislation and policy framework on access to ART

Sections 196 and 198 of the Brazilian Constitution: Section 196. All individuals have the right to access health services and the State has to guarantee such access through social and economic policies aimed at reducing the risk of diseases and other health problems and the universal and equal access to actions and services. (…). Section 198: Health public actions and services integrate a regionalized and hierarchical network and constitute one universal system, structured according the following directives: (…); II – integral care, prioritizing prevention, without prejudice to assistance care.

The system known as Sistema Único de Saúde – SUS (Brazilian Universal Health System, created by Law 8,808/1990) Section 2). Implemented through several legal instruments - provides free and universal consultation and treatment for all Brazilian citizens, being the ‘HIV/STI Program’ one of the most developed and well-structured health public policies in the country, internationally recognized. Law 8,808/1990). Section 2. Health is a fundamental right of the human being and the State has the duty to assure the conditions to its full exercise.

Sections 7 and 11 of Law no. 8,069 of July 13, 1990 (Law 8,609/1990):
Section 7. The child and the adolescent have the right to protection of their life and health, through effective implementation of social public policies which allow a healthy birth and harmonious development in dignified conditions of existence. (…).

Section 11. Children and adolescents are guaranteed a comprehensive healthcare through the Brazilian Universal Health System, with universal and equal access to actions and services for the promotion, protection and recovery of health”.

Section 1 of Law 9,313/1996 Art. 1 People living with HIV (human immunodeficiency virus) and AIDS patients (Acquired Immunodeficiency Syndrome) must receive from Brazilian Universal Health System, free of charge, all the medicines necessary to their treatment.

Ministry of Health Ordinance 21 of March 21, 1995:

Considering the need to guide and organize access and distribute drugs for HIV, according to the studies developed by the HIV/STI Program, this Secretariat establishes that: (…). II - Access to Medicines: a) all patients under treatment in the public system have free access to medicines provided that the technical rules are observed; b) patients not being treated in the public system must be evaluated by trained public units to receive the adequate medication, so that existing technical indications are respected.

Sections 196 and 198 of the Brazilian Constitution:

Section 196. All individuals have the right to access health services and the State has to guarantee such access through social and economic policies aimed at reducing the risk of diseases and other health problems and the universal and equal access to actions and services. (…). Section 198: Health public actions and services integrate a regionalized and hierarchical network and constitute one universal system, structured according the following directives: (…); II – integral care, prioritizing prevention, without prejudice to assistance care.
Available at: http://www.planalto.gov.br/ccivil_03/constituicao/ConstituicaoCompilado.htm

Section 2 of Law 8,080 of September 19, 1990 (Law 8,808/1990):

Section 2. Health is a fundamental right of the human being and the State has the duty to assure the conditions to its full exercise.
Available at: http://www.planalto.gov.br/ccivil_03/leis/L8080.htm

Sections 7 and 11 of Law no. 8,069 of July 13, 1990 (Law 8,609/1990):

Section 7. The child and the adolescent have the right to protection of their life and health, through effective implementation of social public policies which allow a healthy birth and harmonious development in dignified conditions of existence. (…).

Section 11. Children and adolescents are guaranteed a comprehensive healthcare through the Brazilian Universal Health System, with universal and equal access to actions and services for the promotion, protection and recovery of health.
Available at: http://www.planalto.gov.br/ccivil_03/leis/L8080.htm"
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

Pre-Exposure Prophylaxis (PrEP)

PrEP is not expressly prohibited in Brazil but there is yet no policy framework or authorized PrEP drug available. Therefore, the use of any drugs for PrEP treatment (except for test purposes) is currently prohibited because no such drugs were approved by the Brazilian National Health Surveillance Agency.

Although there is currently no policy framework on PrEP nor a PrEP drug approved by the Ministry of Health relating thereto, the Brazilian public scientific institution for research and development in biomedical sciences, Fiocruz, is conducting a Clinical Trial on PrEP. Only gay men, transvestites and transgender women above 18 years old are eligible for participating in this research.

Young people’s access to PrEP

Once the policy and the respective drugs are approved, we would expect PrEP to be available to any individual at any age, since there is no age restriction nor a requirement for parental consent for a young person to have access to (i) contraceptive and emergency contraceptive, (ii) PEP treatment; (iii) Ante Natal Care, and (iv) HIV testing. This is our expectation based on the current legislation scenario on similar regulated issues, however, once PrEP is authorized, the law may provide otherwise.

Legislation and policy framework on PrEP

There is no legislation or policy specifically enabling PrEP use in Brazil.

Post-Exposure Prophylaxis

There is no prohibition of PEP in Brazil. The Ministry of Justice recently approved the Clinical Protocol and Therapeutic Guidelines on PEP (“CPTG”) through Ordinance 34 of July 22, 2015, that states that the PEP must be available to any individual, of any age, who suffered any 'sexual accident', including the failure to use a condom or a problem when using a condom. Under the CPTG, the choice for the use of PEP treatment is based on a risk assessment relating to the exposure and not in the type of exposure (e.g., occupation or sexual violence).

As per Section 1 of Law 9,313/1996 and Law 8,080/1990, HIV and AIDS patients shall receive from the Brazilian Universal Health System, free of charge, all medication necessary for their treatment. PEP treatment is included such legislation, as PEP and other methods to reduce the risks of infection of HIV and the impacts of such infection (i.e. the Treatment as Prevention - TASP) are considered part of the “Comprehensive Prevention” strategies, a new approach of the HIV/STI Program, which has been discussed, developed and implemented by the Brazilian Ministry of Health (MoH).
Legislation and policy framework on access to PEP

Ordinance 34 of July 22, 2015: Approved the Clinical Protocol and Therapeutic Guidelines on PEP.
Section 1 of Law 9,313/1996 “Art. 1 - People living with HIV (human immunodeficiency virus) AND AIDS patients (Acquired Immunodeficiency Syndrome) must receive from Brazilian Universal Health System, free of charge, all the medicines necessary to their treatment.” Ordinance 34 of July 22, 2015 contains several binding recommendations on PEP therapy.

NB: A literal interpretation of Art. 1 suggests that someone seeking PEP would not come within its scope since he/she would not be a confirmed AIDS or HIV patient. However, PEP treatment is considered part of the “Comprehensive Prevention” strategies, a new approach of the HIV/AIDS/ Program, which has been discussed, developed and implemented by the Brazilian Ministry of Health (MoH).

The CPTG is divided in four sections, specifically (a) risk assessment relating to the exposure, (b) antiretroviral regimen for PEP, (c) other assistance measures for the exposed individual, and (d) clinical and laboratorial monitoring. The ‘risk assessment relating to the exposure’ involves the following conditionals: type of biological material involved, type of exposure, timeframe between exposure and care and serologic condition of infection by HIV of the exposed individual and the source individual. The ‘antiretroviral regimen for PEP’ section indicates the drugs to be prescribed. The third section describes additional measures that must be considered during assistance to the PEP patient, for example, prophylaxis of other sexually transmitted infections and tetanus immunization. The last section specifies certain measures that must be considered during clinical and laboratorial monitoring, for example, toxicity of antiretroviral and HIV testing.
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

Abortion in Brazil is illegal and implies in severe penalties to the consenting woman or legal representatives and the person performing the abortion. There are currently only three exceptions in which abortions may be legally performed in Brazil:

a. Rape;
b. Pregnancy representing a danger to the woman’s life; and
c. Fetus with anencephaly.

Even under these 3 situations the consent of the pregnant woman must be obtained, or if she is under the age of 18, the consent of her legal representatives.

Legislation and policy framework on safe abortion and post care

According to Law 12,845 of August 1, 2013, a woman was no longer required to prove her allegation of rape before having access to abortion services. The definition of non-consensual sex was also expanded by the Maria da Penha Law (Law 11.340 of August 7, 2006). This Law included in the definition of rape, “marital rape”, and therefore, wives who are raped by their husbands have the right to legally terminate their pregnancy.
Chapter Eight: Age of Consent on access to Antenatal Care (ANC)

Access to Antenatal Care is assured by Law 9,263/1996, as part of family planning. According to such Law, each State has the duty, through the Brazilian United Health System, to offer conditions that promote family planning, including Ante Natal Care.

Legislation and policy framework

In 2006, the Ministry of Health issued a Technical report on antenatal and After Childbirth Care – Qualified and Humanized Attention, which establishes that States and Municipalities, through their healthcare units, are responsible for providing Ante Natal and After Childbirth Care, according to specific criteria, such as: material and human resources; treatment to all pregnant women seeking health services; additional tests; laboratory tests; vaccine application; treatment to all women in labor and to their newborns, with guarantee of the necessary hospitalization, guarantee of the presence of a companion during labor, encouragement of normal birth instead of caesarean section and removal of pregnant women or newborns in adequate transportation to a healthcare unit.

No parental consent is necessary for young persons to be assisted with ANC at the Brazilian Unified Health System. Under Section 3 of Law 9,263/1996: Section3. Family planning is part of a set of actions towards women, men, and couples, with the mission of providing them with global health assistance.

Sole Paragraph: In the performance of the actions described in the heading of this Section, all levels of the Brazilian Unified Health System undertake to assure full healthcare program, in all its services network, concerning woman, man or couples health, in all their life cycles, including, as basic activities, among others:

i. access to Ante Natal Care;
ii. labor, puerperium and new-born assistance.
Chapter Nine: Age of Consent and access to HPV vaccine, and cervical cancer screening and treatment

Since 2014, the Brazilian Ministry of Health included the Human Papillomavirus (HPV) vaccine in the Public Health Immunization Calendar. Currently, all girls, aged 9 to 15 may be immunized with the quadrivalent vaccine (efficient against types HPV 6, 11, 16 e 18), recommended by the World Health Organisation. No parental consent is necessary for young persons to receive the vaccine through the Brazilian Unified Health System, provided that the young person presents her immunization record and any ID. In the event of public immunization campaigns at schools, however, the parents need to be previously informed of the date of the campaign and, in the event that they do not wish their daughters to participate, may send a Refusal Term, which draft will be delivered by the school.

Legislation and policy framework

The Ministry of Health Ordinance 54 of November 18, 2013 states it's the decision to incorporate in the quadrivalent vaccine against HPV in the prevention of uterus cancer in the Brazilian Universal Health System. In accordance with Law 12,401 of April 28, 2011 the Ministry of Health, assisted by the National Commission of Incorporation of Technologies – CONITEC, is responsible for defining the criteria and terms for the incorporation of Technologies within the scope of the SUS. As per such legislation, the Ministry of Health has the power, with the assistance of CONITEC, to include, exclude or change new medications, products and procedures, as well as create or change clinical protocols.

Article 1: The quadrivalent vaccine against HPV in the prevention of cancer of the uterus is hereby incorporated to the Brazilian Universal Health System.

Section 2: The recommendation report of the National Commission of Incorporation of Technologies – CONITEC.
Chapter Ten: Conclusion

In some respects, Brazil offers a good example of a developing country that has made valiant strides in addressing the sexual and reproductive health needs of its adolescent population. To this end, the country has effected laudable policies in regard to especially vulnerable adolescents, including LGBTI adolescents and those that hail from low-economic communities. However, in light of attempts by religious bodies to influence legislative reforms aimed at enhancing the rights of LGBTI individuals, vigilance needs to be maintained to ensure that health gains in respect of LGBTI adolescents, do not regress. Given the link between poverty and early sexual debut, the Brazilian Government must continue its poverty-alleviation campaigns. Furthermore, authorities need to do more to sensitize health workers regarding the impact of discriminatory behavior towards vulnerable adolescents, especially in relation to race, colour, socio-economic class, and sexual orientation. Health workers should be reminded that they have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values.

A limitation of this work is that data sources were limited to publicly-accessible documents in English, and not based on original qualitative or quantitative research. Relevant studies may have been missed if they were not included in the databases reviewed for this report.
## Chapter Eleven: Recommended intervention on legal and policy framework

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References


Gupta GR. Vulnerability and resilience: gender and HIV/AIDS in Latin America and the Caribbean.


63 Silva DQ, Guerra OU and Sperling C. Sex education in the eyes of primary school teachers in Novo Hamburgo, Rio Grande do Sul, Brazil. Reproductive Health Matters 2013; 21(41) 114-123.
64 Silva DQ, Guerra OU and Sperling C. Sex education in the eyes of primary school teachers in Novo Hamburgo, Rio Grande do Sul, Brazil. Reproductive Health Matters 2013 21:41 114-123.
105 Department of STD, AIDS and Viral Hepatitis/SVS/MS. Available: www.aids.gov.br
107 Oliviera-Campos M, Nunes ML, Maderia FC et al. Sexual behavior among Brazilian adolescents, National Adolescents School-based Health Survey (PeNSE 2012). Revista Brasileira de Epidemiologia 17 2014
Annex 1

KEY QUESTIONS IN ESC REVIEW

i. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents (males and females).

ii. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

iii. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

iv. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

v. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

vi. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?
2. Is there a definition of statutory rape? Please define.
3. Are there exceptions to question (1)? For example gay sex?
4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.
5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’) At what age? Please specify if there are different ages with and without parental consent.
6. Policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART), including Age of Consent with and without parental consent.
7. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent with and without parental consent.
8. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
9. Is there any legislation or policy specifically enabling PEP use in country? Please specify if it deals with Ages of Consent and give details.
10. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent with and without parental consent.
11. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
12. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.
13. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent with and without parental consent.
14. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent with and without parental consent.
15. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent with and without parental consent.
16. What is the Age of Consent to access HIV testing without parental consent?
17. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/ policy requirements to report this status to her/his parents?
18. Please explain any inconsistencies between the answers above.