Human Rights of Women Living with HIV in the Americas

The **Joint United Nations Programme on HIV/AIDS (UNAIDS)** leads and inspires the world to achieve its shared vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS unites the efforts of 11 UN organizations—UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, UN Women, ILO, UNESCO, WHO and the World Bank—and works closely with global and national partners to maximize results for the AIDS response.

The **Inter-American Commission of Women (CIM)** is the main hemispheric policy forum for the promotion of women's rights and gender equality. Created in 1928 - in recognition of the importance of women's social inclusion to democratic strengthening and human development in the Americas – CIM was the first inter-governmental organization established to promote women's human rights and gender equality.

The **Organization of American States (OAS)** brings together the nations of the Western hemisphere to promote democracy, strengthen human rights, foster peace, security and cooperation and advance common interests. The origins of the Organization date back to 1890 when nations of the region formed the Pan American Union to forge closer hemispheric relations. This union later evolved into the OAS and in 1948, 21 nations signed its governing charter. Since then, the OAS has expanded to include the nations of the English-speaking Caribbean and Canada, and today all of the independent nations of North, Central and South America and the Caribbean make up its 35 member states.

Human Rights of Women Living with HIV in the Americas
Author: Dinys Luciano
Co-author: Martín Negrete
Editor: Marijo Vázquez

Copyright ©2015 UNAIDS and CIM/OAS
All rights reserved

UNAIDS Regional Support Office for Latin America and the Caribbean
Gonzalo Crance Street, # 166,
Ciudad Del Saber, Clayton.
Panama City, Panama
Tel: 00507 301 4600
Webpage: www.onusida-latina.org
Facebook
https://www.facebook.com/ONUSIDALATINA
Twitter
@OnusidaLatina
https://twitter.com/OnusidaLatina

Comisión Interamericana de Mujeres (CIM)
1889 F Street NW
Washington, DC, 20006
Estados Unidos
Tel: 1-202-458-6084
Fax: 1-202-458-6094
E-mail: cim@oas.org
Webpage: http://www.oas.org/cim
Facebook:
https://www.facebook.com/ComisionInteramericanaDeMujeres
Twitter:
@CIMOEA
https://twitter.com/CIMOEA

Design and layout: Celina Hernández

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the CIM or the OAS concerning the legal status of any country, territory, city or area, or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The opinions expressed are those of the authors and do not necessarily reflect the opinion of the OAS or the CIM.

Human Rights of Women Living with HIV in the Américas

Table of Contents

Introduction	12
1. Methodological aspects	14
2. Public policies: Legal framework and programmatic responses	17
3. Status of the rights of women living with HIV: Progress and challenges	23
3.1 Right to life	23
3.2 Right to non-discrimination and equality before the law	27
3.3 Right to the highest attainable standard of health	33
3.4. Right to a life free of violence	37
3.5. Right to not be subjected to cruel, inhuman, or degrading treatment	40
3.6 Right to education	44
3.7 Right to work	45
3.8. Right to social protection and an adequate standard of living	48
3.9 Right to form a family	50
3.10 Right to information	55
3.11 Right to participation	58
4. Funding to further the rights of women living with HIV	61
5. Coordination of the HIV response and participation	66
6. Information and knowledge-management systems	68
7. Conclusions and recommendations	70

List of tables

1. Legal framework and programmatic responses to discrimination, sexual and reproductive health, and gender violence	19
2. Current use of and access to ART in stigma and discrimination studies in six Latin American countries (2008-2014)	25
3. Countries that reported including stigma and discrimination against persons with HIV in their national HIV plans and that have specific programs (GARPR, 2011)	27

4. Experiences of discrimination in stigma and discrimination studies in eight Latin American countries (2008-2014) 28

5. Experiences of discrimination in dental and sexual and reproductive health services in stigma and discrimination studies in eight Latin American countries (2008-2014) 29

6. Legal framework for key populations in Latin America and the Caribbean according to 2011 and 2014 GARPR reports 32

7. Persons who report that they were forced to take an HIV test or were given the test without providing their consent or receiving counseling in stigma and discrimination studies in seven Latin American countries (2008-2014) 36

8. Experiences of various forms of psychological, physical, and sexual violence in stigma and discrimination studies in seven Latin American countries (2008-2014) 39

9. Cases of health professional coercion for sterilization in stigma and discrimination studies in seven Latin American countries (2008-2014) 42

10. Educational level of women and men interviewed in stigma and discrimination studies in five Latin American countries (2008-2014) 44

11. Discriminatory practices in the educational sphere in studies of stigma and discrimination in four Latin American countries (2008-2011) 45

12. Employment status of the participants in stigma and discrimination studies in six Latin American countries 46

13. Job loss and rejection and negative changes in employment due to HIV status in stigma and discrimination studies in six Latin American countries (2008-2011) 47

14. Food shortage rates among the population interviewed in stigma and discrimination studies in two Latin American countries 49

15. Barriers to housing access in stigma and discrimination studies in five Latin American countries 49

16. Situations related to reproductive rights and the right to form a family in stigma and discrimination studies in eight Latin American countries (2008-2014) 52

17. Coercion by a health professional in the past 12 months on abortion, birth, and feeding due to the mother's HIV status 53

18. Medical coverage of pregnant HIV-positive women receiving ART to prevent mother-to-child transmission (2013) 54

19. Sources of HIV financing and percent international financing by country (2007-2013) 64

List of graphics

1. Percentage of women and men from 15 to 49 years of age who took an HIV test in the past 12 months (2007-2013) 36
2. Percentage of women from 15 to 24 years of age with comprehensive knowledge of HIV (2007-2011) 56
3. Percentage of young women who used a condom in their most recent act of sexual intercourse (2009-2013) 56
4. Percentage of men and women from 15 to 19 years of age who used a condom in their most recent act of sexual intercourse (2009-2013) 57
5. Percentage of women with multiple sexual partners who used a condom in their most recent act of sexual intercourse (2003-2013) 57
6. Percentage of transgender sex workers who used a condom in their most recent act of sexual intercourse (2009-2013 58

Acknowledgements

The preparation of this document was coordinated by Hilary Anderson of the Inter-American Commission of Women of the Organization of American States (CIM/OAS). The responses to the questionnaire sent by the following OAS member states are acknowledged and appreciated: Argentina, Belize, Chile, Colombia, Costa Rica, Dominica, El Salvador, Honduras, Guatemala, Mexico, Dominican Republic, Suriname, Trinidad and Tobago, and Uruguay. The More Peace Less AIDS Foundation also returned the completed questionnaire.

The materials contributed by the regional networks ICW Latin America Chapter, Movimiento Latinoamericano y del Caribe de Mujeres Positivas [Latin American and Caribbean Positive Women's Movement] (MLCM+), the Network of Women Sex Workers from Latin America and the Caribbean (RedTraSex), Red de Jóvenes Positivos de Latinoamérica y el Caribe [Network of HIV-Positive Young People from Latin America and the Caribbean] (Red J+LAC), and the Latin America and Caribbean Network of Trans Persons (REDLACTRANS) in connection with the online course "Strengthening the human rights of women living with HIV in Latin America" are appreciated. These materials were used in the preparation of this report.

The comments made on the preliminary draft of this report by the following individuals are acknowledged and appreciated:

• Ana Cristina C. Santos	Universida de Federal de Alagoas/Campus do Sertão. Núcleo de Estudos e Pesquisas sobre Diversidades e Educação no Sertão Alagoano (NUDES/UFAL)
• Andrea Mariño	RedTraSex (Central Office, Argentina)
• Arely Cano	ICW Latina (Regional Office)
• Elena Reynaga	RedTraSex (Central Office)
• Eugenia López	Balance – Mexico
• Jimena Avalos Chapín	Balance – Mexico
• Sandra Patricia Arturo de Vries	María Fortaleza Foundation – Colombia
• Shirley Eng	UNAIDS Latin America
• Susana Chávez	PROMSEX [Center for the Promotion and Defense of Sexual and Reproductive Rights] – Peru

Abbreviations and acronyms

3TC	lamivudine
AIDS	Acquired Immune Deficiency Syndrome
ANICP+VIDA	Asociación Nicaragüense de Personas Positivas Luchando por la Vida [Nicaragua Association of HIV-Positive Persons Fighting for Life]
ART	Antiretroviral therapy
ARVs	Antiretrovirals
ATV/r	Ritonavir-boosted atazanavir
AWID	Association for Women's Rights in Development
AZT	Zidovudine
CAPSIDA	Centro de Atención Profesional para Personas con SIDA [Center for Professional Care of Persons with AIDS]
CCM	Country coordinating mechanism
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CENEP-CONICET	Centro de Estudios de Población [Center for Population Studies]-Consejo Nacional de Investigaciones Científicas y Técnicas [National Scientific and Technical Research Council]
CENSIDA	Centro Nacional para la Prevención y Control del VIH-SIDA[National Center for the Prevention and Control of HIV/AIDS]
CIM/OAS	Inter-American Commission of Women/Organization of American States
CNEGYSR	Centro Nacional de Equidad de Género y Salud Reproductiva [National Center for Gender Equality and Reproductive Health]
CONADEH	Comisionado Nacional de Derechos Humanos [National Commission on Human Rights]
CONASIDA	Consejo Nacional para la Prevención y Control del VIH/SIDA [National Council for the Prevention and Control of HIV/AIDS]
EFV	Efavirenz
ENADIS	Encuesta Nacional sobre Discriminación en Mexico [National Survey on Discrimination in Mexico]
FEIM	Fundación para Estudio e Investigación de la Mujer [Foundation for the Study and Investigation of Women]
FELC-C	Fuerza Especial de Lucha Contra el Crimen [Special Crime-Fighting Forces] (a section of the Bolivian National Police)
FTC	Emtricitabine
GAO	Grupo de Autoayuda de Occidente [Self-Help Group of the West]

GARPR	Global AIDS Response Progress Reporting
GIPA	Greater involvement of people living with HIV/AIDS
HIV	Human immunodeficiency virus
IACHR	Inter-American Commission on Human Rights
ICW	International Community of Women Living with HIV/AIDS
IEC	Information, education, and communication
IESSDAH	Instituto de Estudios en Salud, Sexualidad, y Desarrollo Humano [Institute for Health, Sexuality, and Human Development Studies]
ILO	International Labor Organization
IOM	International Organization for Migration
LAC	Latin America and the Caribbean
LPV/r	Lopinavir/ritonavir
MEXFAM	Fundación Mexicana para la Planeación Familiar [Mexican Foundation for Family Planning]
MLCM	Movimiento Latinoamericano y del Caribe de Mujeres Positivas [Latin American and Caribbean Positive Women's Movement]
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NNRTI	Non-nucleoside reverse transcriptase inhibitor
NRTI	Nucleoside reverse transcriptase inhibitor
NVP	Nevirapine
OAS	Organization of American States
PAHO/WHO	Pan American Health Organization/World Health Organization
PENSIDA	Plan Estratégico Nacional de Respuesta al VIH y Sida [National Strategic HIV/AIDS Response Plan]
PI	Protease inhibitor
PI/r	Ritonavir-boosted protease inhibitor
PLHIV	Persons living with HIV
PLWHA	Persons living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PPM	Postpartum morbidity
PROMSEX	Center for the Promotion and Defense of Sexual and Reproductive Rights
REDLACTRANS	Latin America and Caribbean Network of Trans Persons
RedTraSex	Network of Women Sex Workers from Latin America and the Caribbean

STIs	Sexually transmitted infections
TDF	Tenofovir
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

Introduction

Most Latin American and Caribbean (LAC) countries recognize that human rights violations and gender inequalities are significant barriers to progress in the national responses to HIV, and that they inflict severe damage on individuals living with or affected by HIV while creating a social and political environment that restricts their life choices and development, as well as their access to services and resources. In many countries, the social and legal context is characterized by high levels of criminalization of specific groups of women, stigma, discrimination and violence, a lack of legal and social protection, and systematic violations of the human rights of women living with or affected by HIV. Discrimination in the justice, health, education, work, and social protection systems, limited access to information, and the scant social participation of women living with HIV tend to exacerbate the social exclusion faced by these women, which is in turn transferred to their children. Factors involved in inequality like socioeconomic status, ethnicity, gender identity, and residence in urban or rural areas, among others, interconnect and influence these violations in specific ways.

Although only limited information is available, certain human rights violations that have been documented in the region serve as a basis for identifying information gaps while progress is made in responding to the needs that have already been noted. Guaranteeing the exercise of the rights of women who live with or are affected by HIV requires an effective response to HIV across sectors from a human rights and gender equality perspective, supported by decision-makers at all levels, with an assigned budget and significant social participation. In order to achieve such a goal, it is imperative to identify and raise awareness of the specific human rights violations suffered by these women as well as the impact of the epidemic, the needs derived from such violations, and the best national and regional strategies for addressing them.

Pursuant to Resolution AG/RES. 2802 (XLIII-O/13) on the "Promotion and Protection of the Human Rights of People Vulnerable to, Living with or Affected by HIV/AIDS in the Americas," which was adopted by the General Assembly of the Organization of American States (OAS) in June 2013, as well as to the collaboration agreement signed between the OAS and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in January 2014, the CIM/OAS has prepared this report on the "Human Rights of Women Living with HIV in the Americas," which will serve to inform discussions among OAS member states and their allies of the challenges that gender inequalities represent for the response to HIV, and of the actions that must be implemented at scale and that are necessary in order to create strategies that will enable HIV-positive women to exercise their rights to decent work, education, housing, healthcare, social protection, information, and social and political participation, and to live free from stigma, discrimination, and violence. This report complements the "Manual for Strengthening the Exercise of the Human Rights of Women Living with HIV in Latin America" published by the CIM/OAS and UNAIDS in 2014.[1]

1 Luciano D and Iacono M (2014). Manual para fortalecer el ejercicio de los derechos humanos de las mujeres que viven con VIH en América Latina [Manual for Strengthening the Exercise of the Human Rights of Women Living with HIV in Latin America]. UNAIDS and CIM/OAS. http://dvcn.aulaweb.org/manualparafortalecer.pdf

1. Methodological aspects

1.1 Objectives

a. To analyze the available information on the human rights situation of women living with HIV, emphasizing the aspects associated with access to support resources and services, institutional practices and initiatives, cross-sector coordination, social participation, and the financing of issues related to gender equality and HIV.

b. To identify advances in and challenges to the protection and exercise of the human rights of all of the diverse women living with HIV.

c. To examine the implications of the available information for the development of regional and national strategies for the promotion, protection, and fulfillment of the rights of women living with HIV.

1.2 Sources of information

Several different sources of information were used in preparing this report:

- **Questionnaires** sent by the CIM/OAS in November 2014 to the National Machineries for the Advancement of Women in all countries of the region through the Permanent Missions of the OAS member states. The questionnaires were also sent by email to regional networks that work to promote the rights of HIV-positive women: ICW Latina, *Red de Mujeres Positivas de América Latina y el Caribe* [Network of Positive Women from Latin America and the Caribbean], Jóvenes Positivos de América Latina y el Caribe [Positive Young People from Latin America and the Caribbean], and the Network of Women Sex Workers from Latin America and the Caribbean. Completed questionnaires were received from: Argentina, Belize, Chile, Colombia, Costa Rica, Dominica, El Salvador, Honduras, Guatemala, Mexico, Dominican Republic, Suriname, Trinidad and Tobago, and Uruguay.
- **UNAIDS global database (AIDSINFO),** which includes data from the UNGASS country reports and the GARPR (Global AIDS Response Progress Reporting) reports.
- **Studies on stigma and discrimination** from 11 countries: Argentina (2011)[2], Bolivia (2011)[3], Colombia (undated)[4], Ecuador (2010)[5], El Salvador (2010)[6], Guatemala (2011)[7], Honduras (2014)[8], Mexico (2008)[9], Nicaragua (2013)[10], Paraguay (2010)[11]; and Dominican Republic (2009)[12].

2 Mónica Petracci and Martín Romeo (2011). Índice de estigma en personas que viven con VIH Argentina [People Living with HIV in Argentina Stigma Index]. Huésped Foundation, Red de Personas Viviendo con VIH/Sida de Mar del Plata [Mar de Plata Network of Persons Living with HIV/AIDS]. http://www.stigmaindex.org/sites/default/files/news-attachments/PLHIV%20Stigma%20Index%20Argentinaacbf.pdf

3 Bolivia Ministry of Health and Sports (2011). Estudio sobre Estigma y Discriminación en Personas que viven con VIH Bolivia [Study on Stigma and Discrimination against People Living with HIV in Bolivia] http://www.stigmaindex.org/bolivia-plurinational-state

4 Red Colombiana de Personas que Viven con el VIH [Colombian Network of Persons Living with HIV], IFARMA (undated). El Índice de Personas que Viven con VIH. Resultados del índice de estigma en personas que viven con VIH en Colombia [Index of Persons Living with HIV. Results of the persons living with HIV in Colombia stigma index]. https://www.fundacionnuestrosjovenes.org.ec/documentos/BibliotecaVIH/8.%20Voces%20positivas.%20Resultado%20del%20%C3%ADndice%20de%20estigma%20en%20personas%20que%20viven%20con%20VIH%20en%20Colombia..pdf

5 Coalición Ecuatoriana de Personas que Viven con VIH/SIDA [Ecuadorian Commission of Persons Living with HIV/AIDS] (2010). Resultados del estudio sobre Estigma y Discriminación en Personas que Viven con VIH/sida en el Ecuador [Results of the study on stigma and discrimination against persons living with HIV/AIDS in Ecuador]. http://www.stigmaindex.org/sites/default/files/reports/INFORME_FINAL_INDICE_ESTIGMAPVVS_ECUADOR_10-2010.pdf

6 UNDP (2010). Estudio de Estigma y Discriminación en Personas con VIH [Study of Stigma and Discrimination against Persons with HIV]. San Salvador. http://www.stigmaindex.org/sites/default/files/reports/El%20Salvador%20-%20Stigma%20Index%20Estudio_de_Estigma_y_Descriminacion_en_personas_con%20HIV%20-2010%20Spanish.pdf

7 Fernández, Victor (2011). Índice de Estigma y Discriminación en Personas con VIH [Persons with HIV Stigma and Discrimination Index]. Fernando Iturbide Foundation. Guatemala. http://www.stigmaindex.org/sites/default/files/reports/Guatemala%20%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%20%20%20Spanish%20FINAL200512.pdf

8 Ciudad, Juan M (2014). Indice de Estigma en Personas que Viven con VIH en Honduras [Persons Living with HIV in Honduras Stigma Index]. Executive report. Llaves Foundation. http://www.stigmaindex.org/sites/default/files/reports/Honduras%20Informe%20Ejecutivo%20PDF.pdf

9 Red Mexicana de Personas que Viven Con VIH/SIDA [Mexican Network of Persons Living with HIV/AIDS] and MEXFAM [Mexican Foundation for Family Planning] (2008). Indice de Estigma en Personas que Viven con VIH en Mexico [Persons Living with HIV in Mexico Stigma Index]. http://www.stigmaindex.org/sites/default/files/reports/Mexico%20People%20Living%20with%20HIV%20Stigma%20Index%20Report%202010-%20spanish.pdf

10 Maricela Larios Cruz (2013). Estudio Índice de Estigma y Discriminación en Personas con VIH-Nicaragua [Persons Living with HIV Stigma and Discrimination Index Study – Nicaragua]. ANICP+VIDA [Nicaragua Association of HIV-Positive Persons Fighting for Life] and GAO [Self-Help Group of the West]. http://www.stigmaindex.org/nicaragua

11 Vencer Foundation (2010). Perspectiva comunitaria sobre estigma y discriminación en personas que viven con VIH y sida en Paraguay [Community perspective on stigma and discrimination against persons living with HIV and AIDS in Paraguay]. http://www.stigmaindex.org/paraguay

12 Cáceres F (2009). República Dominicana: Estigma y discriminación en Personas que Viven con el VIH [Dominican Republic: Stigma and Discrimination against Persons Living with HIV]. Profamilia. http://www.stigmaindex.org/dominican-republic

A total of 7,822 individuals living with HIV were surveyed in the 11 studies conducted between 2008 and 2014. Of these, 55.1% were men, 40.3% were women, and 4.6% were transgender women. The total number of individuals surveyed by country was: Argentina (N=1,197), Bolivia (N= 420), Colombia (N=1,000), Ecuador (N=497), El Salvador (N=500), Guatemala (N=500), Honduras (N=720), Mexico (N=931), Nicaragua (N=801), Paraguay (N=256), and the Dominican Republic (N=1,000). Of the 55 studies available and accessible during the preparation of this report, 11 had been conducted in Latin America (20%), and 16% of the almost 50,000 people living with HIV who have been interviewed since 2008 live in the region[13]. Specific studies on stigma and discrimination interventions were also reviewed.[14]

- **Literature review.** Articles, technical reports, and position documents from the following two sources were reviewed:

  - Scientific journal databases. Searches were performed in Pubmed, Scielo, and Redalyc using the descriptors "HIV and gender," "HIV and women," "sex workers," "transgender women," "young women," and "HIV and women drug users"

  - Web pages of the regional networks ICW Latina, Red de Mujeres Positivas de América Latina y el Caribe [Network of Positive Women from Latin America and the Caribbean], the Network of Women Sex Workers from Latin America and the Caribbean, Red de Mujeres Trans [Network of Transgender Women], Jóvenes Positivos LAC [Positive Young People from LAC], as well as of international agencies: UNAIDS, CIM/OAS, IACHR, UN Women, UNDP, PAHO/WHO, UNFPA, UNICEF, IOM, and ILO.

For this report, special emphasis was placed on the collection of information on women in all of their diversity, and to that end data was gathered from secondary sources and the countries were requested to include, whenever possible, disaggregated or specific data in the questionnaires on various groups within the female population, namely, young people, adults, the elderly, women of African descent and indigenous women, transgender women, sex workers, women with disabilities, migrants, residents of urban or rural areas, lesbians and/or bisexuals, drug users, women deprived of liberty, and other country-relevant categories. The sources used show that for most of these populations, there is only limited information available, and for others, there is none at all.

13 The People Living with HIV Stigma Index. http://www.stigmaindex.org/ (Accessed on July 17, 2015)

14 ZUCCHI, Eliana Miura; PAIVA, Vera Silvia Facciolla; FRANCA JUNIOR, Ivan. Intervenções para reduzir o estigma da Aids no Brasil: uma revisão crítica [Interventions to reduce the stigma of AIDS in Brazil: a critical review]. Trends in Psychology, Ribeirão Preto, v. 21, no. 3, December 2013. http://pepsic.bvsalud.org/scielo.php?pid=S1413-389X2013000300017&script=sci_arttext

2. Public policies: Legal framework and programmatic responses

According to the 2011 GARPR reports, the regulatory frameworks in 20 Latin American and Caribbean countries include national strategies on gender equality: Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela. These countries affirmed in their reports that the "women's" sector, as well as equality and gender empowerment, are included in the national HIV strategies, while the other countries, except for El Salvador and Honduras, confirmed that women and girls were included in their strategies.[15] . It should be noted that not all of the aforementioned countries explicitly spell out actions specifically focused on the various categories of women in their national plans.[16] Although most countries in the region do have HIV-related laws, strategic plans and programs, regulations, and protocols, the approaches and scopes thereof are varied. Furthermore, although a significant number of countries have laws in place to protect and promote the rights of women overall, very few have made progress towards recognizing the specific rights of women living with HIV.

15 UNAIDS. AIDSINFO. Reportes GARP 2011. http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx

16 T. Kendall & E. López-Uribe (2010) Improving the HIV response for women in Latin America: Barriers to integrated advocacy for sexual and reproductive rights and health. Global Health Governance 4 (1) www.ghgj.org

Some national strategic plans on HIV have progressively incorporated references to gender equality as a guiding principle as well as certain interventions focused on preventing perinatal transmission and transmission in female sex workers and transgender women. In Mexico, Article 4 of the Law for the Prevention and Comprehensive Care of HIV/AIDS of the Federal District specifies that *"The authorities will follow a human rights and gender perspective approach in designing, executing, monitoring, and evaluating the prevention and care actions referred to herein"*. [17]

In some cases, the act of placing the spotlight on perinatal transmission and on women sex workers propagates the idea that women are vectors of the disease rather than whole persons with specific vulnerabilities and needs in dealing with HIV.

Currently, there is very little documentation of the differential impact of gender equality policies on women in all of their diversity. For example, with regard to the movement of persons, other than Belize, Nicaragua, and Paraguay, the countries of the region have no restrictions on entry, stay, or residence for people living with HIV, despite the lack of available information on the impact of the legal status of migrant women on their living conditions in the origin, transit, and destination countries, which can lead, for example, to their increased vulnerability to HIV. [18] Of the 20 countries included in the 2011 GARPR reports, six reported that they had laws to protect sex workers: Argentina, Bolivia, Colombia, Ecuador, Guatemala, and Uruguay. Furthermore, in some countries HIV testing is mandatory for sex workers, but not free or confidential, meaning that a positive result could land them in jail.[19]

17 Legislative Assembly of the Federal District, VI Legislature. Law for the Prevention and Comprehensive Care of HIV/AIDS of the Federal District. Mexico. http://www.aldf.gob.mx/archivo-12b28d9460f66f93a0268e3ed29bbe9d.pdf

18 Avert. HIV and AIDS in Latin America. http://www.avert.org/hiv-aids-latin-america.htm#sthash.svd2DSj9.dpuf

19 UN News Centre. Trabajadoras sexuales promueven campaña sobre el VIH/Sida en América Latina [Sex workers promote HIV/AIDS campaign in Latin America]. August 22, 2014 http://www.un.org/spanish/News/story.asp?NewsID=30272#.VSE-RFwfxJ0

Table 1: Legal framework and programmatic responses to discrimination, sexual and reproductive health, and gender violence

Countries	Legal framework (policies, laws, resolutions)				Programmatic response (plans, programs, projects, protocols)		
	HIV	Anti-discrimination	Sexual and reproductive health/ sexual education	Domestic/ gender violence	HIV	Gender equality	Protection of women/women's health (sexual and reproductive health)
Argentina	Yes	Yes	Yes	Yes	Yes	ND	Yes
Belize	Yes	ND	ND	Yes	Yes	ND	ND
Chile	Yes	Yes	Yes	Yes	Yes	ND	Yes
Colombia	Yes	Yes [20]	Yes	Yes	Yes	Yes	Yes
Costa Rica	Yes [21]	Yes	Yes	Yes		Yes [22]	Yes
Dominica	Yes	Yes [23]	ND	Yes [24]	Yes	Yes	ND
El Salvador	Yes	Yes	ND	Yes	Yes	ND	ND
Guatemala	Yes	ND	Yes	Yes	Yes	ND	Yes
Honduras	Yes	ND	ND	Yes	Yes	Yes	Yes
Mexico	Yes	Yes [25]	Yes	Yes	Yes	Yes	Yes
Dominican Republic	Yes	ND	ND	Yes	Yes	Yes	ND
Suriname	Yes	ND	ND	ND	Yes	ND	Yes
Trinidad and Tobago	Yes	Yes	ND	Yes	Yes	Yes	ND
Uruguay	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Source: Country questionnaires sent to the CIM/OAS. ND=no data

Some countries, like Argentina, Brazil, and Uruguay, and Mexico's Federal District, have also passed gender identity laws. In Colombia, the Constitution includes the principles of respect and recognition, specifically in Judgment C-481/98 on the right to sexual identity/sex-based discrimination, which establishes that sexual preference and the adoption of a given sexual identity are core parts of

20 Senate of the Republic. Law 1482 of 2011. Colombia. http://wsp.presidencia.gov.co/Normativa/Leyes/Documents/ley148230112011.pdf
21 General Law on HIV/AIDS of the Republic of Costa Rica. Law No. 7771 published in the official gazette La Gaceta on May 20, 1998. http://www.hsph.harvard.edu/population/aids/costarica.aids.98.pdf
22 National Policy for Gender Equality and Equity (PIEG) 2007-2017 and the Action Plan thereof for the 2008-2012 period.
23 In the country's constitution.
24 Protection against Domestic Violence Act No. 22 of 2001 passed in Dominica in December of 2001.
25 National Council to Prevent Discrimination. Federal Law to Prevent and Eliminate Discrimination. March 20, 2014 Amendment. Mexico. http://www.conapred.org.mx/userfiles/files/LFPED_web_ACCSS.pdf

the fundamental right to the free development of personality. The Court has affirmed that sexual orientation is an issue that falls within the sphere of individuals' personal autonomy, allowing individuals to take on their desired life projects without outside pressure, as long as by doing so they do not violate the law or the rights of others[26].

The 14 countries that completed the CIM/OAS questionnaire reported that, within their respective legal frameworks, they have specific laws in place for the control of HIV and other STIs, [27] as well as other related laws on, for example, sexual and reproductive health,[28,29] , domestic violence, or violence against women/gender violence[30] and, to a lesser degree, laws against all forms of discrimination. There are also other complementary laws on access to healthcare, social protection, work, education, and information, among others. Specifically, Uruguay's regulatory and legal framework decriminalizes abortion (Law 18,987) and includes aspects like gender equality, sexual orientation, and gender identity in the majority of the laws specified in the questionnaire. In that same country, the General Law on Education (Law no. 18,437) sets forth the core crosscutting priorities of the national education system, such as education on human rights, education for health, and sexual education, while at the same time imposing criminal sanctions (up to 18 months imprisonment) for actions that incite hate, violence, and contempt (Law no. 17,677). In Mexico, the National Youth Program 2014-2018 includes "Promoting timely and quality care in health centers for young people living with HIV/AIDS" among its lines of action. [31]

They did not report particular laws or policies that specifically address women living with HIV, since this population is considered to be included within the categories of "residents," "persons," "persons living with HIV," "women," "vulnerable groups," and other similar groups that are included in the various instruments referenced. It is thus assumed that the overall legal framework in general applies to women with HIV in particular. Currently, only Brazil has a public policy instrument specifically focused on women living with HIV, called the "Plan to Address the Feminization of AIDS and other STIs." [33]

26 Colombia. Judgment C-481/98 on RIGHT TO SEXUAL IDENTITY/SEX-BASED DISCRIMINATION.

27 Belize and Trinidad and Tobago have specific policies and programs for responding to HIV in the workplace.

28 Argentina has a National Sexual Education Law and Colombia has a National Policy on Sexuality, Sexual Rights, and Reproductive Rights 2014-2024.

29 Uruguay is the only country that has reported having a law on elective abortion (Law 18,987) and one of the few that has reported an Assisted Reproduction Law.

30 Guatemala and El Salvador report that they have specific laws against violence against women or gender-based violence. Guatemala has Decree 7-99, Law to Comprehensively Advance and Dignify Women, and Decree 22-2008, Law against Femicide and Other Forms of Violence against Women. El Salvador reports that it has the Special Comprehensive Law for a Violence-Free Life for Women. Mexico has two policy instruments that include HIV interventions associated with gender-based violence: i) Official Mexican Regulation NOM-046-SSA2-2005, which considers them health care in situations of sexual violence; and ii) the General Law to Prevent, Punish, and Eradicate Human Trafficking-related Crimes and to Protect and Assist the Victims of such Crimes.

31 Mexican Youth Institute. National Youth Program 2014-2018. Mexico. http://www.imjuventud.gob.mx/imgs/uploads/ProJuventud_2014.pdf

32 Universal Declaration of Human Rights; American Declaration of Human Rights; CEDAW; Convention on the Rights of the Child; International Covenant on Economic, Social, and Cultural Rights; International Covenant on Civil and Political Rights and its Optional Protocol, among others.

33 Ministry of Health. Department of Health Surveillance. National STI and AIDS Program: Integrated Plan to Address the Feminization of the Epidemic of AIDS and other STIs, Brasilia, March 2007. Cited by FEIM (Fundación para Estudio e Investigación de la Mujer, Foundation for the Study and Investigation of Women). http://www.feim.org.ar/pdf/doscaras2010.pdf

According to the principle of non-discrimination, all human beings are born free and equal in dignity and rights. However, in practice, and particularly in the case of women living with HIV, this does not occur, since the fact that this principle may be recognized in national laws does not necessarily guarantee that it will be fully enforced. In Mexico, Chapter II of the Federal Law to Prevent and Eliminate Discrimination states that *"All discriminatory practices that aim to hamper or void the recognition or exercise of rights and true equality of opportunity are prohibited. For the purposes of the foregoing, the following are considered discriminatory behaviors: VI. Denying or restricting information on reproductive rights or preventing the free determination of the number of children and their spacing."*[34] For this reason, women living with HIV have been advocating for the enforcement of the international doctrine on human rights to be reviewed and for the language thereof to be revised in order to specifically include the rights of these women.

In the 2011 GARPR reports, 28 Latin American and Caribbean countries stated that they had educational programs in place on the rights of persons living with HIV and key populations: Antigua and Barbuda, Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Jamaica, Mexico, Nicaragua, Panama, Peru, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, and Uruguay. [35] It is unknown whether these programs specifically address issues related to the rights of women living with HIV.

In terms of programs, the 14 countries that responded the CIM/OAS questionnaire stated that they had national HIV programs that take into account the four lynchpins of universal access: a) prevention, b) treatment, c) care, and d) support, in compliance with the commitments undertaken by the countries in the UNGASS principles and the Millennium Development Goals. However, just as with the legal frameworks, there were no programs that specifically target women living with HIV, since these women are usually included under the category of "persons living with HIV" and are therefore considered to be subjects of the rights, guarantees, interventions, and services recognized for all persons with HIV.

With regard to the content, focus, and scope of the national HIV plans and programs, the Dominican Republic indicates that the cross-cutting gender focus of these instruments and of the country's policies aims to "identify HIV-related gender inequalities, placing emphasis on the

34 National Council to Prevent Discrimination. Federal Law to Prevent and Eliminate Discrimination. March 20, 2014 Amendment. Mexico. http://www.conapred.org.mx/userfiles/files/LFPED_web_ACCSS.pdf

35 UNAIDS. AIDSINFO. B.III.11.a Has programmes to educate concerning rights of PLHIV and key populations. http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx

historic inequalities between men and women and the need for special measures to compensate for these disadvantages and guarantee women's participation in formulating HIV response plans and programs" (Law 135-11). Guatemala's National HIV/AIDS Strategic Plan includes differentiated strategies that take gender inequalities and gender identity into account: *"Development of women's skills and women's empowerment to recognize and defend their sexual and reproductive rights," "Emphasis on modifying the gender-based approach and masculinities that increase vulnerability to acquiring STIs, HIV, and AIDS," "Differentiation of the interventions in IEC that target gender identities, gender equity, and social disparities in access to prevention services," "Differentiated treatment for victims of sexual violence based on gender or gender identity."*

Barriers to the full exercise of the rights of women living with HIV

The countries that completed the questionnaire sent by the CIM/OAS and provided information on the barriers to the full exercise of the human rights of women living with HIV tend to agree that the main obstacles are the stigma and discrimination associated with HIV status, gender-based violence, the lack of empowerment of women living with HIV, their inadequate knowledge of their human rights, and their limited access to employment, and that these obstacles are closely associated with the disparities caused by gender inequalities themselves. Violence and difficulties in getting and keeping a job and being promoted at work are associated with gender-based discrimination, and when the condition of living with HIV is added to these pre-existing inequalities, the disparities can be exacerbated. Gender and HIV status thus intersect and increase vulnerability, and are compounded by other social determinants like ethnicity, age, social class, educational level, etc. Few countries identified "poverty" as a significant, structural, and cross-cutting factor in vulnerability (in this case only Trinidad and Tobago did so), even though national and regional statistics clearly demonstrate that women have access to considerably fewer resources, since on average they earn less than men and it is more difficult for them to enter the formal labor market.

3. Status of the rights of women living with HIV: progress and challenge

3.1 Right to life

The States guarantee this right to the extent that they respond to the needs of all of the diverse women living with HIV, eliminate discrimination, and create an atmosphere favorable to the exercise of rights. This right also entails access to the services and resources necessary for prolonging an active, healthy life, as well as respect for the dignity and integrity of the bodies of women living with HIV.

- **Access to treatment:** Significant progress has been made in Latin America and the Caribbean in access to antiretroviral therapy (ART). It was estimated that in the year 2013, around 71% of individuals with HIV knew their HIV status, 56% of patients who fulfilled the criteria for treatment were receiving antiretroviral therapy, and in 77% of the individuals in treatment, the viral load had become undetectable. Furthermore, 35% of new diagnoses had a first CD4 count of <200 cells/mm3[36] , and around 71% of patients undergoing ART received a first-line treatment

36 Advanced HIV (disease) infection case reporting is defined as the identification of persons with advanced HIV (only including those in clinical stages 3 or 4, or with a CD4 count of <350 cells/mm3). AIDS case reporting is defined as the identification and registration of patients when they are first found to be in clinical stage 4 or to have a CD4 count of <200 cells/mm3. Source: Vigilancia de la infección por el VIH basada en la notificación de casos: recomendaciones para mejorar y fortalecer los sistemas de vigilancia del VIH [Case-reporting-based HIV surveilllance: recommendations for improving and strengthening HIV surveillance systems]. Washington, D.C.: PAHO, 2012.

regimen,[37] 24%, a second-line regimen, and 5%, a third-line regimen. This indicates that around 29% of patients had already experienced treatment failure.[38] Despite this progress, several countries have identified the challenges in providing treatment to a larger number of persons with HIV than currently have access thereto.[39]

Furthermore, the failure to provide treatment and follow-up care is a frequent problem in some countries. In Peru (2009) the national rate of vertical transmission was calculated in a cohort of children born exposed to HIV in 2007 as a point estimate of 9.1%, although it was noted that approximately 50% of the babies born exposed that year did not continue with follow-up monitoring and their serological status could not be determined. In Lima and Callao, on average more than 35% of pregnant HIV-positive women and newborns are not monitored. [40]

The studies of stigma and discrimination against persons living with HIV reveal differences in access to ARVs, with lower percentages found for transgender women in Honduras (72.7%) and the three populations analyzed in Ecuador: men (65.7%), women (63.2%), and transgender women (60.7%). [41]

37 According to WHO recommendations, first-line treatment should consist of 1 NNRTI + 2 NRTIs, one of which should be zidovudine (AZT) or tenofovir (TDF). The different countries should introduce measures to reduce (and eventually eliminate) the use of stavudine in first-line regimens due to the recognized toxicity thereof. Second-line treatment should consist of a ritonavir-boosted protease inhibitor (PI/r) + 2 NRTIs, one of which should be zidovudine (AZT) or tenofovir (TDF), depending on what was administered in the first-line regimen. Ritonavir-boosted atazanavir (ATV/r) and lopinavir/ritonavir (LPV/r) are the preferred PIs. While the current options have made advancements possible with ART, there has been a considerable cost in terms of side effects. PLHIV and health service providers both call for phasing in less toxic antiretrovirals while maintaining simplified fixed-dose combinations. According to the evidence available, the initial ART should contain an NNRTI (NVP or EFV) combined with two NRTIs, one of which must be 3TC or FTC and the other AZT or TDF. The countries are advised to choose a second-line regimen for patients for whom first-line ART has failed. Source: WHO, Antiretroviral therapy for HIV infection in adults and adolescents. Recommendations for a public health approach. 2010 revision. Geneva 2010. http://apps.who.int/iris/bitstream/10665/44379/1/9789241599764_eng.pdf

38 PAHO/WHO (2014). Antiretroviral Treatment in the Spotlight: A Public Health Analysis in Latin America and the Caribbean. Washington, DC. http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=23710&Itemid

39 Avert. HIV and AIDS in Latin America. http://www.avert.org/hiv-aids-latin-america.htm#sthash.svd2DSj9.dpuf

40 Red Peruana de Mujeres Viviendo con VIH [Peruvian Network of Women Living with HIV] (2014). Determinantes Psicosociales en la Transmisión Vertical del VIH. Diagnóstico Comunitario Red Peruana de Mujeres Viviendo con VIH [Psychosocial Determinants in the Vertical Transmission of HIV. Peruvian Network of Women Living with HIV Community Diagnostic]. Lima. http://dvcn.aulaweb.org/determinantes_psicosociales_transmision_vertical_VIH.pdf

41 Legend applicable to all data tables from the studies on stigma and discrimination: M=Men, W=Women, T=Transgender women

Table 2: Current use of and access to ART in stigma and discrimination studies in six Latin American countries (2008-2014)

Use of and access to ART	Bolivia 2011 (N= 420) %		Mexico 2008 (N= 931) %			Honduras 2014 (N= 720) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %		
	H	M	H	M	T	H	M	T	H	M	T	H	M	T	H	M	T
Currently taking ARVs	55,3	43,5	83,9	90,1	85,7	89,9	93,3	90,9	88,4	87,5	82,8	74,8	77,9	60,7	71,2	67,6	ND
Has access to ARVs	ND	ND	97,9	98,4	98,6	88	90,7	72,7	96,6	97	100	65,7	63,2	60,7	90,5	88,4	ND

Source: Studies of stigma and discrimination against persons living with HIV

- **Killings of transgender persons:** Gender-identity-associated discrimination also endangers the lives and safety of transgender persons, as they are victims of violence and physical and sexual hate crimes. Around 80% of the killings of transgender persons reported globally occurred in Latin America. [42] The perpetrators of these crimes are not usually brought to justice. The impunity that allows violations of the rights of activists and other transgender women to occur is not only caused by the overall climate of impunity that exists in several Latin American countries, but rather, to a large extent results from transphobia.[43]

- **Killings of sex workers:** In the past few years, RedTraSex member organizations have registered the murders of female sex workers. For example, in Honduras 16 killings were noted; in El Salvador, 27; in Bolivia, 9; and in Chile, 16.[44] The cases compiled and the information provided by national organizations of sex workers in 13 countries of the region suggest that sex workers as such are murdered for the following reasons: i) they have refused to work or to continue working for a pimp; ii) they have refused to pay "fees" to mafias, gangs, or law enforcement forces in order to be able to work; iii) they have made official complaints against certain powerful sectors seeking to benefit from their sex work; iv) simply because they are sex workers who suffer stigma and discrimination; and v) because they work in completely unsafe areas known as "zonas liberadas"

42 UNAIDS, Gap Report 2014, http://www.unaids.org/sites/default/files/media_asset/08_Transgenderpeople.pdf, http://cerodiscriminacion.onusida-latina.org/personas-trans/las-violaciones-a-los-derechos-humanos-de-las-personas-trans-aumentan-su-vulnerabilidad-al-vih.html

43 REDLACTRANS (2012). Impunity and violence against transgender women human rights defenders in Latin America. http://www.aidsalliance.org/assets/000/000/405/90623-Impunity-and-violence-against-transgender-women-human-rights-defenders-in-Latin-America_original.pdf?1405586435

44 Human rights situation of female sex workers in 15 countries of the Americas. http://www.redtrasex.org/Human-rights-situation-of-female.html Available in Spanish at: http://www.redtrasex.org/Situacion-de-derechos-humanos-de.html

or "no man's lands," which are areas without a police presence. The level of impunity of these crimes is high because rarely does the justice system identify the perpetrators and many of the investigations are left unfinished.[45]

Access to condoms for adolescents and young people: Condoms have been proven to effectively prevent HIV transmission in men and women if used correctly in every act of intercourse, and the female condom is the only method for preventing HIV and other STIs that is controlled by the woman. However, legal, cultural, and social barriers restrict access to male and female condoms, particularly in the adolescent and youth populations, and above all, for women. The legal age for purchasing male condoms varies by country, with policies that allow open access at any age in Brazil, Costa Rica, Ecuador, El Salvador, and Guatemala; at 10 years of age in Honduras, Mexico, Nicaragua, and Paraguay; at 12 years in Bolivia and Colombia; at 13 years in Uruguay; and at 14 years in Argentina, Chile, and Venezuela. In the legal frameworks of most of these countries, the legal age for purchasing condoms is generally the same as the age of sexual consent or older, except for in Argentina, where the age of sexual consent is 13 years and contraception may be purchased without parent or guardian permission from 14 years of age. In Chile, the legal age for purchasing condoms is 14 years and the age of sexual consent for homosexual relationships is 18 years.[46]

HIV and armed conflict: There is very little documentation on the effects of the high levels of social violence and armed conflict on women's vulnerability to HIV. A study conducted in Colombia from 2002 to 2008 found that the HIV epidemic tended to spread in regions where heterosexual contact was the predominant mode of HIV transmission and where the armed conflict was more intense. Equally, this study emphasized that it should be kept in mind that extreme rates of underdiagnosis could be hiding behind the data on departments that seem to have high rates of armed violence and a low incidence of HIV and AIDS.[47]

Furthermore, in disaster situations, people living with HIV may be affected by interruptions in the supply of ARVs, which could cause them to develop resistance to the medications. Food scarcity

45 RedTraSex (2015). Violación de los derechos humanos a las mujeres trabajadoras sexuales en catorce países de las Américas [Human rights situation of female sex workers in 15 countries of the Americas]" available at http://www.redtrasex.org/IMG/pdf/cidh_resumenejecutivo_disenado.pdf

46 UNFPA (2015). Análisis de la legislación y políticas que afectan el acceso de las y los jóvenes a la salud sexual y reproductiva en América Latina y el Caribe. Versión preliminar [Analysis of the legislation and policies that affect youth access to sexual and reproductive health in Latin America and the Caribbean. Preliminary version].

47 NEVARDO MALAGÓN J. Influencia del conflicto armado en el aumento de la incidencia de VIH/sida en Colombia, durante el periodo 2002-2008 [Influence of the armed conflict on the incidence of HIV/AIDS in Colombia in the 2002-2008 period]. http://med.javeriana.edu.co/publi/vniversitas/serial/v52n1/INFLUENCIA%20DEL%20CONFLICTO%20ARMADO.pdf

in emergency situations also has grave implications for some individuals living with HIV, since malnutrition can accelerate the progress of the infection [48]

3.2 Right to non-discrimination and equality before the law

The guarantee of this right entails the prevention of discriminatory acts, the protection of persons living with HIV, and their integration into public policies on development. HIV-related stigma and discrimination persist as major obstacles to furthering an effective HIV response in the region, and they have a bearing on multiple facets of life for persons living with HIV.[49]

In the 2011 GARPR reports, 29 Latin American and Caribbean countries reported that stigma and discrimination were addressed in their national HIV plans, and 12 stated that they had programs in place to target them. [50]It is not known whether these plans and programs specifically address the gender aspects of stigma and discrimination.

Table 3: Countries that reported they have included stigma and discrimination against persons with HIV in their national HIV plans and that have specific programs (GARPR, 2011)

Stigma and discrimination included in national HIV plan	Have programs on stigma and discrimination against persons with HIV
Antigua and Barbuda, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uru-guay, and the Bolivarian Republic of Venezuela.	Argentina, Belice, Brasil, Colombia, Ecuador, El Salvador Guatemala, Guyana, Mexico, Nicaragua, Perú y Surinam. Argentina, Belize, Brazil, Colombia, Ecuador, El Salvador, Guatemala, Guyana, Mexico, Nicaragua, Peru, and Suriname.

Source: UNAIDS. AIDSINFO

48 International Federation of Red Cross and Red Crescent Societies. Natural disasters: the complex links with HIV. http://www.ifrc.org/PageFiles/99874/2008/WDR2008-English-6.pdf

49 UNAIDS. Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf 50 UNAIDS. AIDSINFO. A.I.2.2 Reduction of stigma and discrimination included in plan. http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx

50 UNAIDS. AIDSINFO. A.I.2.2 Reduction of stigma and discrimination included in plan. http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx

The existence of programs or actions to reduce stigma and discrimination does not automatically transform institutional and social practices. Studies on stigma and discrimination in Latin America reveal high levels of social exclusion, with differences among men, women, and transgender women. The percentage of individuals who state that they have been excluded from social activities ranges from 31.4% of transgender women in Mexico to 6% of women in Ecuador and Honduras. The percentage of women who state that they have experienced some kind of discrimination reaches 40.7% in El Salvador, 17.1% in the Dominican Republic, 55% in Paraguay, and 4% in Guatemala.

The percentage of women who state that they have been excluded from family activities ranges from 20.3% (Nicaragua) to 3% (Guatemala), and the percentage of transgender women, from 28.5% (Paraguay) to 11.1% (Nicaragua). The percentage of women who report that they have been excluded from religious activities was 3.5% in Mexico, 5.8% in Honduras, 3.7% in the Dominican Republic, and 5.5% in Paraguay.

Between 65.7% of women in the Dominican Republic and 20.4% in Guatemala reported that they have been the subject of gossip, while 100% of transgender women in Paraguay and 77.8% in Nicaragua did so. The percentage of women who reported experiencing discrimination from other persons with HIV was 14.3% in Nicaragua, 6.7% in Mexico, 6.5% in the Dominican Republic, and 9.5% in Paraguay. For transgender women, the percentages were 29.6% in Nicaragua, 20.7% in Mexico, 39.3% in Ecuador, and 14.2% in Paraguay.

Table 4: Experiences of discrimination in stigma and discrimination studies in eight Latin American countries (2008-2014)

Forms of discrimination	Nicaragua 2013 (N= 801) %			Mexico 2008 (N= 931) %			Honduras 2014 (N= 720) %			Guatemala 2011 (N=500) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
Exclusion from social activities	15,1	14,5	22,2	11,3	12,5	31,4	8,4	6,7	ND	ND	ND	ND ND	ND	ND	ND	11,1	6,1	ND	7,6	7,3	ND	12,1	12,6	14,2
Some form of discrimination	ND	ND	ND	ND	ND	ND	ND	ND	ND	4,1	4,3	ND	23,2	40,7	34,5	ND	ND	ND	12,8	17,1	ND	55,3	55	100
Exclusion from family activities	14,9	20,3	11,1	8,6	8,7	21,4	4,1	5,4	ND	4,2	3,1	ND	ND	ND	ND	ND	ND	ND	9,7	13,1	ND	15,4	16,6	28,5
Exclusion from religious or worship activities	ND	ND	ND	2,1	3,5	9,3	5,4	5,8	ND	ND	ND	ND	ND	ND	ND	3,3	2,9	ND	2,3	3,7	ND	3,2	5,5	ND
Subject of gossip	43,1	46,7	77,8	62,8	53,8	94,3	ND	ND	ND	18,2	20,4		21,5	37,4	31	ND	ND	ND	58,6	65,7	ND	55,2	55,5	100
Discrimination by other persons with HIV	11	14,3	29,6	14,4	6,7	20,7	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	39,3	7,4	6,5	ND	8,1	9,5	14,2

Source: Studies of stigma and discrimination against persons living with HIV

Discriminatory practices have also been noted in dental and sexual and reproductive health services. In stigma and discrimination studies in five countries in Latin America, the percentage of individuals who stated that they had been denied a health service over the past 12 months due to their HIV status, including dental care, ranges from 8.8% in Mexico to 13.8% in Paraguay for men and from 10.2% in Mexico to 20% in Paraguay for women; for transgender women, the percentages were 37.9% in Mexico and 39.3% in Ecuador, the two countries with information available on this group. The percentage of women who reported that they had been denied family planning services in the past 12 months due to their HIV status was 4.2% in Mexico, 3.3% in Guatemala, 6% in Ecuador, and 2.7% in the Dominican Republic. In the 12 months prior to the study, 3.8% in Mexico, 1.3% in Guatemala, and 1.8% in the Dominican Republic had been refused sexual and reproductive health services because of their HIV status.

Table 5: Experiences of discrimination in dental and sexual and reproductive health services in stigma and discrimination studies in eight Latin American countries (2008-2014)

Discriminatory practices	Mexico 2008 (N= 931) %			Guatemala 2011 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	H	M	T	H	M	T	H	M	T	H	M	T	H	M	T
In the past 12 months was refused some health service, including dental care, due to HIV status	8,8	10,2	37,9	5,6	7,5	ND	12	12,7	39,3	6,8	10	ND	13,8	20,6	ND
In the past 12 months was refused family planning services due to HIV status	1	4,2	0,7	2,1	3,3	ND	4,9	6	39,3	2,1	2,7	ND	ND	ND	ND
In the past 12 months was refused sexual and reproductive health services due to HIV status	0,4	3,8	1,4	2,1	1,3	ND	ND	ND	ND	1,2	1,8	ND	ND	ND	ND

Source: Studies of stigma and discrimination against persons living with HIV

Other sources have documented the discrimination in health services against women living with HIV. The *Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica* [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica] found that 41% of the women interviewed in Mexico, 35% in Nicaragua, 54% in Honduras, and 46% in El Salvador reported having noted a discriminatory attitude on the part of the healthcare staff. The following situations illustrate these attitudes: the staff are reproachful or "rub in" the fact that the women have the disease; the women are blamed for getting pregnant or for transmitting the virus vertically before they even knew they had it; their identity is tied up with the disease (i.e. being "AIDS"); and they are fired without justification, among others.

Likewise, the interviewees reported that they are sometimes refused medical/surgical procedures (e.g., they were not given gynecological check-ups; a spine surgery was not performed; staff did not want to attend a delivery). They further reported other practices through which medical personnel exclude women because of their HIV status, such as forcing them to be seen last or speaking to them from the office door. The most extreme expression of discrimination is the involuntary sterilization of women living with HIV, which was reported in the four countries studied[51]

Likewise, in Peru, a study revealed the unequal treatment given by health professionals to persons living with HIV, with approximately 5% of the interviewees indicating that they had been refused some type of family planning or reproductive health service and more than 25% reporting that they had never been offered any such services. More than a quarter of the participants stated that they had been treated differently from the other patients.[52] Similar situations were reported in 2013 by a significant portion of the 386 women with HIV from the 18 Latin American countries in which ICW Latina has a presence who participated in the Monitoring of Sexual and Reproductive Health Services for Women with HIV, which found that in terms of treatment and average office wait times, 34% of these women were seen in less than one hour and 27% in less than two hours, while 38% had to wait more than two hours. The latter group reports discrimination because they have to wait much longer to be seen than other women requesting sexual and reproductive health services do.[53]

In the case of sex workers, stigma plays an important role in health services use patterns. In a 2013 study conducted by RedTraSex with the participation of 1,006 female sex workers, the interviewees reported that they have to see doctors far from where they live in order to prevent being found out as sex workers in their neighborhoods or homes, or use health services far from where they work so that the providers will not know what type of work they do. The purpose of these service-seeking strategies is to avoid potential situations in which they would be discriminated against by people close to them and/or by healthcare providers. Thirty-three percent reported that they did not want to go to the hospital or use health services because they did not want to have to give explanations about their work; one-third reported having experienced discrimination and violence at the hospital, including hostility on the part of the administrative staff, or that they had to change hospitals or services; and 13% stated that they had been directly refused services. Sometimes, it is

51 Avalos Capín J. (2013). Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica]. Balance Promoción para el Desarrollo y Juventud A.C. [Balance Promotion for Development and Youth, Non-Profit Organization], Mexico. http://dvcn.aulaweb.org/mod/data/drx.php?ID=223

52 IESSDAH (2012). "... and I realized that AIDS is not a synonym for death." Diagnóstico del acceso a servicios y programas de prevención de salud sexual y reproductiva por parte de las personas viviendo con VIH [Evaluation of access to services and sexual and reproductive health prevention programs for persons living with HIV].

53 ICW Latina (2013). Resultados de aplicación de herramienta de monitoreo de Servicios de Salud Sexual y Reproductiva en Mujeres con VIH – 2013 [Results of applying the sexual and reproductive health services for women with HIV monitoring tool – 2013] http://dvcn.aulaweb.org/mod/data/drx.php?ID=222

not strictly speaking the health professionals who discriminate or obstruct access, but rather the context of persecution and the stigma of sex work that do so. [54]

The organizations of female sex workers in the countries included in the study reported that most female sex workers never file complaints when their rights are not respected. The main reason why is fear, followed by a lack of trust in the process, discrimination by those who register the complaint, and threats and a lack of knowledge about the legal process. Among other reasons cited was the fear that their families would find out about their *"double lives."* This makes it clear that, for female sex workers, the act of keeping their economic activity a secret constitutes a vulnerability factor that also perpetuates the impunity of the crimes committed against them. Women who have taken legal action describe it as *"a bitter experience,"* in which they experienced "*mistreatment and abuse by the police,"* stating that it was *"very hard, since the doors close on us when they find out that we are sex workers."* Furthermore, women who have been defendants in these proceedings report other types of violations of their rights. Examples of specific cases include the complaints received in countries like Bolivia and Colombia: *"The police hit me and put me in a jail with fellow prisoners and crazies who stole everything from me even my shoes and one of them raped me and the police turned a blind eye [. . .] after the guy raped me I got an STD and the police didn't do anything"* (Nancy, sex worker in Colombia). In Bolivia, in October 2014, a police operation in underground brothels and bars ended up detaining 20 sex workers in FELC-C cells for the alleged crime of endangering public health. *"The girls were verbally assaulted by law enforcement officers and others were physically assaulted: when it was time to be transferred many of us were asked to present our health credentials, but the documents were not shown to the health authorities, which caused lots of problems for the sex workers because however much we insisted that we had the health credentials, they accused us just the same."*

In the case of transgender women, many countries do not issue identity documents that accurately reflect gender identity as opposed to biological sex. This situation can hamper access to employment, to medical care, to the possibility of traveling outside the country, and to participation in the various spheres in which citizenship is exercised. Transgender persons also encounter discrimination from their families, communities or ethnic groups, police officers, and organized crime.[55] Other barriers to medical treatment that they face include being mistreated and discriminated against by professionals and staff members at healthcare facilities; the lack of customized, comprehensive care; and professionals' limited technical capacities for treating individuals while taking into account

54 RedTraSex (2015). Five reasons why sex work must be regulated. Argentina. http://www.redtrasex.org/Five-Reasons-Why-Sex-Work-Must-Be.html

55 REDLACTRANS (2014). Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean. http://www.redlac-trans.org.ar/site/wp-content/uploads/2015/03/Report%20on%20DESC%20trans.pdf

their sexual diversity. A study on the sexual, reproductive, and mental healthcare needs, barriers, and demands in the transgender, lesbian, and gay population in Peru found that the vast majority of the interviewees call for fair and respectful treatment and for their particular needs to be addressed, and that they prefer to be seen in healthcare facilities where they are guaranteed to be treated well, warmly, and without discrimination rather than in facilities that may be fully outfitted in terms of equipment, infrastructure, and medications but cannot guarantee good treatment and non-discrimination.[56]

In Brazil, there are few interventions designed to reduce the stigma associated with HIV, and they are carried out at the community level through HIV-prevention projects. [57]

According to the 2011 and 2014 GARPR reports, in Latin America and the Caribbean, 14 countries prohibit sex work, 20 have laws that protect young people, and four have laws that protect injection drug users.

Table 6: : Legal framework for key populations in Latin America and the Caribbean according to 2011 and 2014 GARPR reports

18 countries that report they have laws that protect persons deprived of liberty (GARPR 2011)	14 countries where sex work is illegal (GARPR 2014)	20 countries that report they have laws that protect young people (GARPR 2011)	4 countries that report they have laws that protect injection drug users (GARPR 2011)
The Bahamas, Bolivia, Brazil, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Dominican Republic, Venezuela, Panama, and Uruguay.	Antigua and Barbuda, The Bahamas, Barbados, Dominica, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, and Trinidad and Tobago.	Antigua and Barbuda, Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Ecuador, El Salvador, Grenada, Guatemala, Jamaica, Nicaragua, Peru, Dominican Republic, Venezuela, Saint Lucia, and Uruguay	Colombia, Ecuador, Guatemala, and Uruguay

There are significant information gaps on certain populations that to some extent result from the stigma and social exclusion that render these populations invisible in first- and second-generation epidemiological surveillance studies. For example, most Latin American countries have an indigenous population, and the absence of studies showing the factors, including gender

56 Velarde Ramírez, Chaska T (2011). La igualdad en lista de espera: necesidades, barreras y demandas en salud sexual, reproductiva y mental en poblacion trans, lesbiana y gay [Equality on the waiting list: Sexual, reproductive, and mental health needs, barriers, and demands in the transgender, lesbian, and gay population]. Centro de Promoción y Defensa de los Derechos Sexuales y Reproductivos [Center for the Promotion and Defense of Sexual and Reproductive Rights] (PROMSEX). http://promsex.org/images/docs/Publicaciones/LaigualdadenlistadeesperaNecesidades.pdf

57 ZUCCHI, Eliana Miura; PAIVA, Vera Silvia Facciolla; FRANCA JUNIOR, Ivan (2013).

factors, that impact the dynamics of the HIV epidemic in those communities and the conditions of indigenous women living with HIV, accurately reflects the social marginalization in which they live their lives and the limited progress that has been made towards addressing ethnicity-related issues.[58] Equally worrisome is the lack of information on HIV in female drug users, women deprived of liberty, migrant women, and women with disabilities, among other groups.

3.3 Right to the highest attainable standard of health

Access to sufficient, quality healthcare and to living conditions that ensure physical and mental well-being are key aspects for guaranteeing the right to health.

Health insurance and coverage: Women living with HIV have to face significant barriers in order to reach a satisfactory state of physical and mental health, including limited access to health insurance. A study conducted in Argentina found that 70% of HIV-positive women had no health coverage beyond the government system. Only 23% had publicly funded health insurance through their own employment or through their spouse or a family member (known as obras sociales), and a small percentage belonged to an emergency service or had private coverage.[59]A study on adherence to treatment in Colombian women with HIV found that the principle barriers thereto are structural, created by the current healthcare system based on the insurance market. Women find that their rights to timely and continuous treatment, to confidentiality, to non-discrimination, and to comprehensive care with a gender-based approach, are violated, and this affects their adherence to the treatment[60]. In some countries, the high prices of medications for preventing and treating associated opportunistic infections constitute one of the challenges in HIV care and treatment.[61]

The RedTraSex regional study (2014) found that the public health system offered by the State, which in many countries is totally or partially free of charge, covers almost eight of every 10 individuals surveyed. Ten percent have publicly funded health insurance (obra social), social security, or union-

58 Volkow, P. et al. La vulnerabilidad femenina frente al VIH en América Latina [Women's vulnerability to HIV/AIDS in Latin America]. Actualizaciones en SIDA [AIDS Updates]. Buenos Aires, November 2012. Volume 20, number 78:111-119. http://www.huesped.org.ar/wp-content/uploads/2014/11/ASEI-78-111-119.pdf

59 Binstock G, Manzelli H, Hiller R, Bruno M (2012). Caracterización de las mujeres recientemente diagnosticadas con VIH en Argentina [Characterization of women recently diagnosed with HIV in Argentina]. Red Argentina de Mujeres viviendo con VIH/sida [Argentine Network of Women Living with HIV/AIDS], Red Bonaerense de Personas viviendo con VIH/sida [Buenos Aires Network of Persons Living with HIV/AIDS], CENEP-CONICET, Gino Germani Institute (University of Buenos Aires), UNAIDS. http://publicaciones.ops.org.ar/publicaciones/publicaciones%20virtuales/MujeresVIHPV/pdf/informeFinalMujeresVIH.pdf

60 Arrivillaga-Quintero M. Análisis de las barreras para la adherencia terapéutica en mujeres colombianas con VIH/sida: cuestión de derechos de salud [Analysis of the barriers to adherence to treatment in Colombian women with HIV/AIDS: a question of health rights]. Salud pública Méx [Mexican Public Health] vol. 52 no. 4 Cuernavaca Jul./Aug. 2010. http://www.scielosp.org/scielo.php?pid=S0036-36342010000400011&script=sci_arttext

61 UNAIDS, PAHO/WHO, and UNICEF (2009). Challenges Posed by the HIV Epidemic in Latin America and the Caribbean 2009. http://new.paho.org/hq/dmdocuments/2010/CHALLENGES-hiv-epidemic-INGLES-2010.pdf

based insurance; eight percent pay out of pocket to see their personal physicians, and three percent use pre-paid private medical plans. In some cases, women prefer to pay for services and/or go to private clinics in order to ensure that they are treated well, in keeping with the patient-as-consumer paradigm; in others, they are forced to pay for private care in order to avoid situations of hostility and stigma. Furthermore, the reasons why sex workers undergo health tests are influenced by whether or not such tests are mandatory; 32% of sex workers state that they have had a health consultation in the past year "because they had to undergo tests for their health card or due to another legal regulation" and a similar percentage states that they did so "because at work they were forced to take a test." These percentages are much higher in countries with regulations that mandate testing.

The healthcare systems in Latin America and the Caribbean suffer from systemic problems that limit the coverage of services for the general population as well for specific groups such as, for example, women living with HIV. PAHO/WHO (2014) has suggested that this lack of adequate coverage and universal access has a considerable social cost, with catastrophic effects on the most vulnerable population groups[62]; this is especially notable in persons living with HIV. When access to comprehensive services is not guaranteed, women living with HIV incur higher costs and lose a significant portion of their incomes while their key rights, such as the right to the highest attainable state of health, to life, or to work, among others, are violated. At the same time, this situation creates a vicious cycle that links HIV infection with poverty among HIV-positive women. It should be noted that 30% of the region's population does not have access to healthcare due to financial reasons and 21% cannot even seek treatment due to geographical barriers. [63]

With regard to access to healthcare services and treatment, the ICW Latina study Resultados de aplicación de la herramienta de monitoreo de servicios de salud sexual y reproductiva en mujeres con VIH [Results of applying the monitoring tool on sexual and reproductive health services for women with HIV] (2013) revealed that there are countries in which women living with HIV have to pay to access treatment. Barriers to access were identified, and were associated with the distance to health facilities, the wait times of more than two hours to be seen, and the discrimination the women face in the services. Ninety-three percent of the interviewees stated that they had access to antiretrovirals. Their most common issues were with the time they have to put in to their care and how they are treated by the healthcare professionals when they are seen. Moreover, the service is

62 PAHO/WHO. Strategy for Universal Health Coverage. 154th Session of the Executive Committee. CE154/12, May 12, 2014. Washington, D.C. http://iris.paho.org/xmlui/bitstream/handle/123456789/4186/CE154-12-e.pdf?sequence=1&isAllowed=y

63 PAHO/WHO. Strategy for Universal Health Coverage. 154th Session of the Executive Committee. CE154/12, May 12, 2014. Washington, D.C. http://iris.paho.org/xmlui/bitstream/handle/123456789/4186/CE154-12-e.pdf?sequence=1&isAllowed=y

limited to the prescription of medication and does not include any exploration of possible adverse reactions or other associated pathologies[64]

In addition, although mental health problems in women living with HIV are a significant issue that affects their overall well-being and that can make it difficult for them to comply with specific medical and pharmacological treatments, they are hardly addressed. [65]

Access to HIV testing: In order to expand access to treatment, it is necessary to facilitate access to HIV testing and to counseling. In 17 countries, the percentage of women between 15 and 49 years of age who had taken an HIV test in the 12 months prior to the survey ranges from 2% in Bolivia to 47% in Chile. For men in the same age group, the range was from 2% in Bolivia to 51% in Ecuador. In six of the 17 countries, five or more percentage points more women than men took the test: Peru (38.9% vs. 5.3%), Chile (47% vs. 22.4%), Brazil (17.6% vs. 10.7%), Haiti (20.6% vs. 13.4%), and Cuba (19.8% vs. 13.7%). Substantially increasing the demand for HIV testing in key vulnerable populations of the region is essential, and this increase must be accompanied by steady improvements in quality in, for example, the organization of services, the strength and comprehensiveness of surveillance systems, and the adequacy of infrastructure and the available human, material, and financial resources. [66]Barriers to HIV testing access lead to a build-up of late diagnoses.

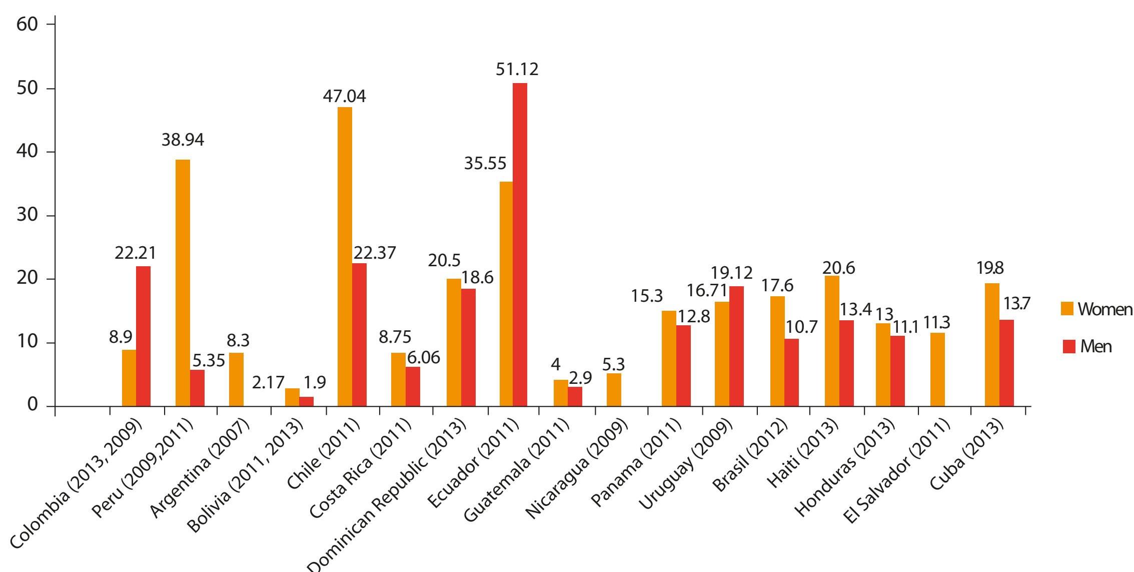
In stigma and discrimination studies in seven countries, the percentage of individuals who reported that they had been tested without having given their consent ranges from 5.3% (Guatemala) to 13.4% (El Salvador) for women and from 2.9% (Mexico) to 14.2% (Paraguay) for transgender persons. Between 19.7% (El Salvador) and 37.5% (Mexico) of women stated that they had not received counseling, as did between 21.4% (Mexico) and 37.9% (El Salvador) of transgender persons.

64 ICW Latina (2013). Resultados de aplicación de herramienta de monitoreo de Servicios de Salud Sexual y Reproductiva en Mujeres con VIH – 2013. http://dvcn.aulaweb.org/mod/data/drx.php?ID=222

65 Obiols, M. Julieta; Stolkiner, Alicia I.Importancia de la inclusión de la salud mental en la atención integral de mujeres que viven con vih/Sida. Ciencia, Docencia y Tecnología, vol. XXIII, núm. 45, noviembre, 2012, pp. 61-80 Universidad Nacional de Entre Ríos, Concepción del Uruguay, Argentina. http://www.redalyc.org/articulo.oa?id=14525317003

66 UNAIDS. Treatment 2015. http://www.unaids.org/sites/default/files/sub_landing/files/JC2484_treatment-2015_es.pdfONUSIDA.

Graph 1: Percentage of women and men aged 15-49 that have had an HIV test in the last 12 months (2007-2013)



Fuente: UNAIDS, Treatment 2015

RedTraSex has indicated that the existence of testing without consent, forced testing, and the failure to keep test results confidential is reported by sex workers in almost all countries. A high percentage of the women surveyed were forced to take a test because they were sex workers: 37.3% of the total sample and 60.1% (a very high percentage) of those in the Andean region. We can thus see how a right is arbitrarily transformed into an obligation. In terms of pre- and post-testing care: seven of every 10

Table 7: Persons who report that they were forced to take an HIV test or were given the test without providing their consent or receiving counseling in stigma and discrimination studies in seven Latin American countries (2008-2014)

HIV testing		Mexico 2008 (N= 931) %			Honduras 2014 (N= 720) %			Guatemala 2011 (N=500) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
		M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
My decision to take the test was:	I was forced to take the test	2,9	4,5	2,9	ND	ND	ND	2,3	3,8		2,3	3	3,4	ND	ND	ND	6	3,7	ND	ND	ND	ND
	The test was performed without my consent	8,8	10,9	2,9	ND	ND	ND	5	5,3		17,8	13,4	3,4	13,5	12,9	ND	6,2	8,6	ND	7,3	10	14,2
I did not receive counseling		41,3	37,5	21,4	25,3	23,8	0	23,1	22,5		22	19,7	37,9	30,2	34,3	ND	23,9	30	ND	ND	ND	ND

Source: Studies of stigma and discrimination against persons living with HIV

female sex workers surveyed who had at some point taken an HIV test received some type of orientation or counseling before the test. Somewhat over a quarter of them never received this type of pre-test guidance, while approximately a third of the women surveyed who took an HIV test did not receive any guidance or counseling whatsoever when they were given the results (whether negative or positive).[67]

UNAIDS and the WHO (2012) have suggested that national policies and practices should be reviewed to eliminate all non-voluntary tests, and that testing should not be compulsory or mandatory for anyone, not even for members of groups at higher risk of HIV infection and of other vulnerable populations, such as pregnant women, people who inject drugs and their sexual partners, men who have sex with men, sex workers, prisoners, migrants, refugees and internally displaced persons, and transgender people. The five key components of testing and counseling programs are: consent, confidentiality, counseling, correct test results, and connection/linkage to prevention, care, and treatment.[68]

Some comprehensive healthcare initiatives have been developed in LAC for women living with HIV, for example, Mexico City's Condesa Clinic, which offers treatment to highly vulnerable women, including: detection and treatment of HIV, human papilloma virus, and other STIs, support for the detection of breast cancer through Inmujeres D.F. [Women's Institute of the Federal District] and uterine cervical cancer, emergency contraception, legal termination of pregnancy, and pregnancy monitoring and management. The clinic has an inter-agency panel on affirmative actions for women with HIV that facilitates the implementation of a care model incorporating referrals and counter-referrals. This model promotes access to programs for self-employment, housing, domestic violence assistance, and rural populations, among others. In addition, there is a food assistance program for all women at the clinic. [69]

3.4. Right to a life free from violence

Measures targeted at the following are required in order to guarantee this right in the context of HIV: preventing and responding to the many forms of violence against women, ensuring access to justice, creating a policy environment to protect the rights of women with HIV in all their diversity and eliminate institutional violence, including violence exercised or tolerated by the State. In Latin

67 REDLACTRANS (2014). Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean. http://www.redlactrans.org.ar/site/wp-content/uploads/2015/03/Report%20on%20DESC%20trans.pdf

68 WHO. Statement on HIV testing and counseling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing. November 28, 2012. http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/

69 Clínica Especializada Condesa [Condesa Specialized Clinic]. Mexico. http://condesadf.mx/mujeres.htm

America and the Caribbean, all 32 countries have laws that punish sexual and physical violence, and of those, only seven countries (Antigua and Barbuda, Barbados, Brazil, Honduras, Jamaica, Nicaragua, and Peru) explicitly include women with HIV in their polices and/or plans on violence against women. [70]

Several studies have been conducted in the region on violence against women living with HIV[71, 72,73] transgender people, and sex workers[74] These studies reveal the systemic, persistent nature of violence in all its forms and in the multiple spheres of these women's lives.

At the same time, the studies on stigma and discrimination against people living with HIV make it possible to compare the different forms of violence in population subgroups in the countries where the data was disaggregated by sex and gender identity. Transgender persons experienced higher levels of aggression and/or verbal threats than did women in all seven countries except for El Salvador (6.9% of transgender persons vs. 17.4% of women), with the percentages for transgender people ranging from 57% in Paraguay to 72.1% in Mexico, and for women, from 9.9% in Guatemala to 32% in Nicaragua and Ecuador.

The percentage of women who reported having experienced threats or physical harassment ranged from 9.5% in Paraguay to 22% in Nicaragua, and of transgender women, from 3.4% in El Salvador to 42.8% in Paraguay. The percentage of women who reported physical assault ranged from 4.3% in El Salvador to 23.1% in Nicaragua, and of transgender women, from 3.4% in El Salvador to 42.8% in Paraguay.

The percentage of women who stated that their partner had manipulated or put psychological pressure on them ranged from 9.2% (Guatemala) to 19% in Nicaragua and Paraguay, while the percentage of transgender women ranged from 11% in Mexico to 18% in Nicaragua.

70 UNDP and UN Women (2013). The Commitment of the States: Plans and Policies to Eradicate Violence against Women in Latin America and the Caribbean. Panama. http://www.tt.undp.org/content/dam/trinidad_tobago/docs/DemocraticGovernance/Publications/Gender%20Violence%20Plans%20&Policies_LAC.pdf

71 Red Guatemalteca Mujeres Positivas en Acción [Guatemelan Network of Positive Women in Action] (2007). VIH/sida y violencia contra las mujeres [HIV/AIDS and violence against women]. http://www.actionaidguatemala.org/textos/VIH-SIDA.pdf. Referenced in: Modelo de Políticas y Programas Integrados de VIH y Violencia contra las mujeres en Guatemala [Integrated policy and program model for addressing HIV and violence against women in Guatemala]. CIM/OAS, 2012. Washington, D.C.

72 Study of the Movimiento Latinoamericano de Mujeres Positivas [Latin-American Positive Women's Movement] (2012). Nuestras historias, nuestras palabras: Situación de las mujeres que viven con VIH en 14 países de América Latina [Our Stories, our words: The situation of women living with HIV in 14 Latin American countries]."

73 Bianco, Mabel and Mariño, Andrea (2010). Dos caras de la misma realidad: Violencia hacia las mujeres y VIH/sida en Argentina, Brasil, Chile y Uruguay [Two sides of the same coin: Violence against women and HIV/AIDS in Argentina, Brazil, Chile, and Uruguay]. FEIM [Foundation for the Study and Investigation of Women]. Argentina.

74 Ross Quiroga, Violeta (2013). Huellas de la violencia y el sida en la corporeidad e identidad de las mujeres viviendo con VIH, las trabajadoras sexuales y las mujeres trans de tres ciudades de Bolivia [Footprints of violence and AIDS in the bodily nature and identity of women living with HIV, sex workers, and transgender women in three cities in Bolivia]. RedBol [Network of Persons Living with HIV in Bolivia]. Bolivia. http://www.onusida-latina.org/images/2013/04-abril/138328495-Estudio-Violencia-en-Tres-Poblaciones-de-Mujeres-en-Bolivia.pdf

The percentage of women who stated that they had been rejected sexually on account of their HIV status was 6.7% in Guatemala, 9.5% in Paraguay, 11% in Nicaragua, Ecuador, and the Dominican Republic, and 15% in Mexico; among transgender women, the percentages were 11.1% in Nicaragua, 14.2% in Paraguay, 20.7% in Mexico, and 39.3% in Ecuador.

Table 8: Experiences of various forms of psychological, physical, and sexual violence in stigma and discrimination studies in seven Latin American countries (2008-2014)

Variables	Nicaragua 2013 (N= 801) %			Mexico 2008 (N= 931) %			Guatemala 2011 (N=500) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Repblic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
Verbal abuse/threats	26,5	31,8	66,7	28,4	26,9	72,1	10	9,9	ND	7,3	17,4	6,9	26,5	30,5	ND	24,3	28,8	ND	25,2	25,3	57,1
Physical harassment/ threats	17	22	37	15,2	10,9	51,4	ND	ND	ND	4,2	7,5	3,4	17,1	17,5	ND	12,1	15,1	ND	11,3	9,5	42,8
Physical assault	15,8	23,1	25,9	13,6	16	38,6	2,3	4,3	ND	2,3	4,6	3,4	ND	ND	ND	9,1	11,8	ND	7,3	8,7	42,8
Psychological pressure/ manipulation by spouse or sexual partner in which HIV status is used against you	11,3	19,6	18,5	9,2	11,9	11,4	6,5	9,2	ND	ND	ND	ND	13,3	13	ND	8	11,6	ND	18,6	19	14,2
Sexual rejection on account of HIV status	17	15,9	11,1	21,5	15,4	20,7	8,1	6,7	ND	ND	ND	ND	12	11,1	39,3	15,6	11,2	ND	19,5	9,5	14,2

Source: Studies on stigma and discrimination against persons living with HIV

The RedTraSex regional study (2014) found that 18% of the individuals surveyed stated that they had gone to the doctor or to health services in the past year because they had had been victims of blows or violence. Twenty-seven percent of sex workers in Central America and the Caribbean–10% more than in the region overall–stated that they had done so for the same reason, which motivated RedTraSex to draw up the Guía de Buenas Prácticas para el Personal del Sistema de Salud [Guide to Good Practices for Healthcare Personnel](RedTraSex, 2015).[75] The lack of legislation regulating sex work in some countries creates a framework within which, backed by unconstitutional administrative regulations, law enforcement officers pursue, arbitrarily arrest, extort, and threaten sex workers, and even break into and close off their homes.

The International HIV/AIDS Alliance and the WHO have noted that since sex work is illegal and/ or stigmatized in many countries, sex workers are often marginalized, which puts them at greater

risk of suffering violence: they may work alone, in unfamiliar areas without police protection; they may be unable to develop supportive networks that could help them avoid dangerous clients or settings; and they may seek out the protection of gangs or other groups operating outside the law, leading to further risk of exploitation and abuse. Likewise, sex workers may come up against barriers, such as a lack of awareness of their rights or limitations in recognizing the various forms of violence exercised against them, that decrease their likelihood of reporting violence, which in turn limits their ability to prevent future acts of violence. [76]

It should be stressed that women fearing violence are less able to protect themselves from HIV infection since they have less power to negotiate safe sex or refuse unwanted sex, they do not get tested for HIV, and they fail to seek treatment after infection.[77] In the Dominican Republic, the study *Nuevas evidencias del vínculo entre violencia contra la mujer y VIH* [New evidence of the linkages between violence against women and HIV] (2011) found that the experience of violence at an early age is directly associated with risky behaviors, including substance use to cope with abuse, mental illnesses due to abuse, riskier social networks, and an increased probability of engaging in unprotected sex. Furthermore, women with less education have less information on HIV-prevention methods and also feel less empowered to refuse sex, in comparison with their more educated peers.[78]

3.5. Right to not be subjected to cruel, inhuman, or degrading treatment

The guarantees for the exercise of this right include the criminalization of acts of torture as well as the investigation, prevention, and punishment thereof. In Latin America and the Caribbean, many key populations face barriers to accessing information, prevention, and treatment resources, are refused services, and suffer hostility and other forms of discrimination in various spheres of their lives.

Coercive or forced sterilization: This has been one of the violations of women's rights that has most generated interest in and mobilized the region. Forced sterilization entails the violation of a number of internationally protected rights, including the right to physical and mental integrity

75 RedTraSex (2015). "Ponte en nuestros zapatos" Guía de Buenas Prácticas para el Personal del Sistema de Salud ["Put yourself in our shoes" Guide to Good Practices for Healthcare Personnel] http://www.redtrasex.org/IMG/pdf/guia_de_buenas_practicas.pdf

76 UN Women. Sex workers. http://www.endvawnow.org/en/articles/687-trabajadoras-sexuales.html

77 Kata Fustos (2011). Gender-based violence increases risk of HIV/AIDS for women in Sub-Saharan Africa. Population Reference Bureau. http://www.prb.org/Publications/Articles/2011/gender-based-violence-hiv.aspx

78 UNAIDS and UNFPA. Nuevas evidencias del vínculo entre violencia contra la mujer y VIH Informe Final [New evidence of the linkages between violence against women and HIV Final Report], October 2011. http://countryoffice.unfpa.org/filemanager/files/dominicanrepublic/nuevas_evidencias_mujer_y_vih.pdf

and the right to live free from cruel, inhuman, or degrading treatment: Article 5 of the American Convention on Human Rights, Article 7 of the International Covenant on Civil and Political Rights, Article 16 (1) of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Article 6 of the Inter-American Convention to Prevent and Punish Torture. The Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica] found that of a total of 337 women interviewed, 20 in Mexico, seven in Nicaragua, six in Honduras, and 10 in El Salvador reported having been pressured or forced to be sterilized; these cases range from insistence and intimidation to forced sterilization.[79] In 2015, a judgment was handed down in a case brought in El Salvador for constitutional relief against the forced sterilization of women living with HIV on the grounds that their rights had been violated. [80]

Among the individuals interviewed in stigma and discrimination studies in seven Latin American countries, the percentage of women who reported having felt coerced by a health professional on some occasion to undergo sterilization was 26.1% in Colombia, 50% in Mexico, 20.6% in Guatemala, 14.4% in El Salvador, 11.1% in Ecuador, and 19.8% in the Dominican Republic. These percentages are higher for women than for men in all countries except Ecuador, where 13.6% of men, two percentage points more than the 11.1% of women, had this experience.

Forced or coercive sterilizations

"The nurses made me sign. They asked me more than three times and threatened that if I didn't, they wouldn't do the cesarean. Due to the pressure I had no other choice but to sign…."- Salvadoran, 19 years old, separated, 1 child.

"They forced me to accept sterilization, saying that if I didn't they wouldn't help me get milk for my children." - Salvadoran, 35 years old, married, 3 children.

"During the C-section and while she was under the effects of the anesthesia they forced her to be sterilized so she wouldn't have any more children. She did not sign her consent. When she was in recovery from the anesthesia she saw that her finger was stained with ink."

- Mexican, 27 years old, domestic partnership, 2 years.

"She had a problem with her abdomen, but instead of operating to relieve her pain they sterilized her without her consent."

- Salvadoran, 39 years old, married, 2 children.

Source: Avalos Capín J (2013). Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica]. Balance Promoción para el Desarrollo y Juventud A.C. [Balance Promotion for Development and Youth, Non-Profit Organization]

79 Avalos Capín J (2013). Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica. Balance Promoción para el Desarrollo y Juventud A.C. Mexico. http://dvcn.aulaweb.org/mod/data/drx.php?ID=223

80 AIDSMAP. http://www.aidsmap.com/org/7983/page/1868839/

Table 9: Cases of health professional coercion for sterilization in stigma and discrimination studies in seven Latin American countries (2008-2014)

	Colombia (N=1000) %			Mexico 2008 (N= 931) %			Honduras 2014 (N= 720) %			Guatemala 2011 (N=500) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
On some occasion you felt coerced by a health professional to undergo sterilization	3,3	26,1	1,6	24,4	50	8,6	1,9	17,6	ND	11,8	20,6	ND	2	14,4	ND	13,6	11,1	ND	2,5	19,8	ND

Source: Studies on stigma and discrimination against persons living with HIV

Criminalization of HIV transmission: In the 2014 GARPR reports, The Bahamas, Bolivia, Colombia, Honduras, Nicaragua, Saint Lucia, Panama, and the Dominican Republic reported that they had laws criminalizing the transmission of HIV.[81] This situation contravenes international regulations that establish that neither criminal nor health legislation should include specific crimes against the deliberate and intentional transmission of HIV, since the epidemic is spread through transmission in the case of undiagnosed infection and not by persons who know they are HIV-positive; furthermore, in many countries, criminalization puts women at risk of imprisonment and of losing custody of their children, among other dangers. A prime example of this took place in Bolivia, where a 25-year-old female sex worker and mother of two children who worked in Sucre and Potosí was sentenced to house arrest for having continued to work after being diagnosed HIV-positive, despite the fact that she used condoms. The Departmental Health Services reported her and, through the Chuquisaca Department Court of Justice, under the authority of Judge Ximena Mendizábal, imposed a precautionary measure against her, in the consideration that she was a danger to public health. The judge decided that she was guilty of a crime against public health, that she had to undergo medical treatment, and that she had to appear at the Office of the Prosecutor General every two weeks in order to sign the record book. In the ruling, the judge also ordered that she be put under house arrest with a police escort. This situation clearly violates the right to confidentiality of the woman diagnosed with HIV and, furthermore, is a clear example of discrimination.[82]

Violation of confidentiality: Several international instruments establish that the unauthorized public or private disclosure of an individual's HIV diagnosis is a violation of their rights. Although progress has

81 UNAIDS. AIDSINFO. 2014 GARPR reports. http://www.aidsinfoonline.org/devinfo/libraries/aspx/dataview.aspx
82 Network of Women Sex Workers from Latin America and the Caribbean. Information sent by email on July 14, 2015.

been made on this right in some countries, the laws of other countries have prohibited adolescents from privately accessing public services, thereby depriving them of their right to confidentiality.[83] In Chile, although the law on HIV stipulates confidentiality, almost half of the women interviewed in the study *Violaciones de los derechos de las mujeres VIH positivas en establecimientos de salud chilenos* [Violations of the rights of HIV-positive women in Chilean health facilities] reported that this right had been violated in the healthcare context. These violations included cases in which "HIV-positive" was written in giant letters, and often highlighted or in red ink, on the covers of their medical charts, as well as cases in which the health providers' name tags identified them as HIV-care professionals and the hospital signs identified the department in question as an HIV-treatment ward.[84] EThe *Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en Mesoamérica* [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica] found that in Mexico, one-third of the women interviewed felt that the confidentiality of their diagnosis had not been respected, as did one-third of the women interviewed in Nicaragua. In Honduras, 26% of women, and in El Salvador, 36% of women felt that the confidentiality of their diagnosis was not respected. [85]

Threats to physical integrity and violence: In the REDLACTRANS study "Impunity and violence against transgender women human rights defenders in Latin America," around 80% of the transgender activists interviewed reported having been subjected to violence or threats to their physical integrity, allegedly from State actors. One factor impeding progress in the criminal investigation and prosecution of cases is the fact that the violence that transgender women experience on a daily basis inhibits them from filing complaints about abuses perpetrated against them, thereby creating a culture of silence.[86]

For sex workers, the lack of clear regulations on sex work encourages a breach of legitimacy in which State institutions are able to institute repressive practices, and at the same time results in a lack of control over the conditions in which sex work is performed. The fact that it is impossible to give a statement or report an incident to the justice system as a sex worker–given that sex work is not formally recognized as an occupation–is also detrimental to the existence of reliable, complete, and official records on situations of violence and cruel treatment. According to a study conducted in Costa Rica, almost 30% of sex workers reported that the police demand bribes or payments and that the police also commit sexual

83 Ester Valenzuela Rivera, Lidia Casas Becerra. Derechos sexuales y reproductivos: confidencialidad y vih/sida en adolescentes chilenos [Sexual and reproductive rights: confidentiality and HIV/AIDS in Chilean adolescents]. Acta Bioethica [Bioethics Report], vol. XIII, no. 2, 2007, pp. 207-215, University of Chile. http://www.redalyc.org/articulo.oa?id=55413208 84 Centro por los Derechos Reproductivos. DIGNIDAD NEGADA: VIOLACIONES DE LOS DERECHOS DE LAS MUJERES VIH-POSITIVAS EN ESTABLECIMIENTOS DE SALUD CHILENOS. http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/DignidadNegada_0.pdf

84 Center for Reproductive Rights. Dignity Denied: Violations of the rights of HIV-positive women in Chilean health facilities. http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_single_FIN.pdf

85 Avalos Capín J, Balance Promoción para el Desarrollo y Juventud A.C. [Balance Promotion for Development and Youth, Non-Profit Organization], 2013.

86 REDLACTRANS (2012). The night is another country. Impunity and violence against transgender women human rights defenders in Latin America. http://www.aidsalliance.org/assets/000/000/405/90623-Impunity-and-violence-against-transgender-women-human-rights-defenders-in-Latin-America_original.pdf?1405586435

violence against them in exchange for not arresting them for not having a work permit or health card. In the Dominican Republic, 95% of sex workers reported that violence had been inflicted upon them by law enforcement officers or agents of justice. Of these, 95% indicated that this violence was verbal or psychological, while 60% reported physical violence and 35%, sexual violence. [87]

3.6 Right to education

Guaranteeing the exercise of this right entails eliminating economic, cultural, geographical, and social barriers to education, including the barriers associated with HIV status. HIV is also a consequence of inadequate education in women, since a lack of information about transmission and about their sexual rights limits their ability to protect themselves from the virus. Stigma and discrimination studies in five countries show that a significant portion of the interviewees, around 13% of both women and men in the Dominican Republic, had not attended school. A higher percentage of women than men was illiterate, 23.9% vs. 15.2% in Honduras, 12% vs. 3% in Mexico, and 4% vs. 0.8% in Paraguay. The percentage of women who had finished primary school ranged from 35.4% in Ecuador to 51.4% in the Dominican Republic. For men, the figures ranged from 15.4% in Paraguay to 58% in Honduras and the Dominican Republic.

Table 10: Educational level of women and men interviewed in stigma and discrimination studies in five Latin American countries (2008-2014)

Educational level	Dominican Republic (2009) %		Honduras (2014) %		Ecuador (2011) %		Mexico (2008) %		Paraguay (2010) %	
	M	W	M	W	M	W	M	W	M	W
None	13	12,4	15,2	23,9	SD	SD	3	12	0,8	4
Primary school	58,8	51,4	58	50	15,5	35,4	17	41	15,4	44,4
Secondary school	23,5	29,2	24,6	23,9	55,6	50,9	27	31	52,8	35
University	4,7	6,7	2,2	2,2	26,9	10,7	31	7	31	16,7

Source: Studies on stigma and discrimination against persons living with HIV

87 RedTraSex (2015). Violación de los derechos humanos a las mujeres trabajadoras sexuales en catorce países de las Américas [Violation of the human rights of female sex workers in fourteen countries of the Americas].

The studies on stigma and discrimination in four countries also explored exclusionary practices in the educational sphere and found that in Guatemala, in the previous 12 months, 9% of the men interviewed and 12% of the women reported that they had been rejected or expelled from, or prevented from attending, some educational institution due to their HIV status. Also in Guatemala, 14.6% of men and 19% of women indicated that in the past 12 months their children had been rejected or expelled from, or prevented from attending, some institution.

Table 11: Discriminatory practices in the educational sphere in studies of stigma and discrimination in four Latin American countries (2008-2011)

Practices	Mexico 2008 (N= 931) %			Guatemala 2011 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %		
	M	W	T	M	W	T	M	W	T	M	W	T
In the past 12 months you have been rejected or expelled from, or prevented from attending, some educational institution due to your HIV status.	0,4	1,6	0,7	9,2	12,2	ND	0,7	0,6	ND	3,1	2,4	ND
In the past 12 months, your children have been rejected or expelled from, or prevented from attending, some educational institution due to your HIV status.	0,6	1,9	0	14,6	19	ND	2,9	2,3	ND	1,6	2,2	ND

Source: Studies on stigma and discrimination against persons living with HIV

It should be emphasized that in the RedTraSex study (2014), most of the women sex workers interviewed had completed or attended some primary school, almost 20% did not finish primary school, and 8% had never attended school at all, while 18% managed to complete secondary school and almost one of every 10 interviewees had started higher-level studies, while one of every ten is still a student.[88] Furthermore, most transgender people in Latin America have not completed their basic education, which goes against the guarantee of universal primary education.[89]

3.7 Right to work

Guaranteeing this right entails eliminating barriers to access associated with HIV status, job security, social security, and fair pay. The studies of stigma and discrimination conducted in six countries of the region reveal high levels of unemployment. At the time of the survey, 58.2% of women with

88 RedTraSex (2013). Study on stigma and discrimination against women sex workers in access to health services in Latin America and the Caribbean. http://www.redtrasex.org/Study-on-Stigma-and-Discrimination.html

89 REDLACTRANS (2014). Report on the economic, social and cultural rights of the transgender population of Latin America and the Caribbean. http://www.redlac-trans.org.ar/site/wp-content/uploads/2015/03/Report%20on%20DESC%20trans.pdf

HIV in the Dominican Republic, 35.7% in Guatemala, 67.1% in Honduras, 46.1% in Ecuador, 45.8% in Mexico, and 45% in Paraguay were unemployed. For men with HIV, the unemployment rates were as follows: 27.6% in the Dominican Republic, 16.1% in Guatemala, 52.7% in Honduras, 29.4% in Ecuador, 21.7% in Mexico, and 15% in Paraguay. The percentage of women with HIV who were unemployed was double or more than the percentage of men in four of the countries analyzed: the Dominican Republic, Guatemala, Mexico, and Paraguay.

Table 12: Employment status of the participants in stigma and discrimination studies in six Latin American countries

Employment status	Dominican Republic (2009) %		Guatemala %		Honduras (2014) %		Ecuador (2011) %		Mexico (2008) %		Paraguay (2010) %	
	M	W	M	W	M	W	M	W	M	W	M	W
Full time	23,3	12,4	44,7	21,4	22,5	11,9	27,3	17,9	31,3	18,3	31	12
Unemployed	27,6	58,2	16,1	35,7	52,7	67,1	29,4	46,1	21,7	45,8	15	45
Other	49,1	29,4	39,2	42,9	24,8	21	43,3	36	47	35,9	54	43

Source: Studies on stigma and discrimination against persons living with HIV

The stigma and discrimination studies also document the experiences of job loss and rejection and discrimination in the occupational sphere. The percentage of women interviewed who reported that they had lost their jobs at least once in the 12 months prior to the survey was 24.5% in Colombia, 26.5% in Mexico, 18.7% in Guatemala, 19.3% in Ecuador, 17.3% in the Dominican Republic, and 9.5% in Paraguay; for transgender women, the percentages were 68% in Colombia and 21.3% in Mexico.

The percentage of women who reported having been rejected from a job in the past 12 months due to their HIV status was 6.6% in Mexico, 1.1% in Guatemala, 6.2% in Ecuador, and 10% in the Dominican Republic; for transgender women, the percentages were 3.9% in Mexico and 39.3% in Ecuador. Likewise, the percentage of women who indicated that in the past 12 months the characteristics or nature of their job had been changed, or that they had been refused promotion due to their HIV status, was 15.7% in Mexico, 16.7% in Ecuador, and 12.3% in the Dominican Republic.

Table 13: Job loss and rejection and negative changes in employment due to HIV status in stigma and discrimination studies in six Latin American countries (2008-2011)

Experiences of discrimination in the employment sphere	Colombia (N=1000) %			Mexico 2008 (N= 931) %			Guatemala 2011 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
Job loss at least once in the past 12 months	19,6	24,5	68	19,8	26,5	21,3	16,2	18,7	ND	10,8	19,3	ND	17,1	17,3	ND	14,6	9,5	0
Job rejection due to HIV status at least once in the past 12 months	ND	ND	ND	5,4	6,6	3,9	2,4	1,1	ND	12,8	6,2	39,3	9,5	10	ND	ND	ND	ND
In the past 12 months, the nature/characteristics of your job have changed or you have been denied a promotion due to your HIV status.	ND	ND	ND	10,3	15,7	6,3	ND	ND	ND	7,7	16,7	ND	13,4	12,3	ND	ND	ND	ND

Source: Studies on stigma and discrimination against persons living with HIV

Violations of the right to work of persons living with HIV have been documented in several meetings on HIV and human rights. Specifically, in El Salvador, the Office of the Ombudsman recognized that dismissal on the grounds of HIV status is a common practice that also reflects the weakness of existing legal frameworks and enforcement mechanisms.[90] The study Nuestras historias, nuestras palabras [Our stories, our words], of the *Movimiento Latinoamericano de Mujeres Positivas* [Latin American Positive Women's Movement] (2012), found that all 57 of the women interviewed reported post-diagnosis changes in their financial situation associated with treatment and care expenses, and that the cost of transportation relative to their schedules, routines, and temporary interruption in their jobs was a deciding factor in whether or not they would continue treatment. Added to these costs were the expenses for purchasing medicine to treat opportunistic infections and high-quality food. Women who had financial support from their families and inner circles did not report changes in their financial situations. Many of the women with HIV who were interviewed had been forced to leave their jobs or were fired. Most of the interviewees left their jobs or were fired and did not seek another job because they feared rejection, stigmatization, or discrimination.[91] In the study

90 HIV and the Law, UNDP and Office of the Ombudsman. Report on the El Salvador National Dialogue on HIV and the Law.

91 Movimiento Latinoamericano de Mujeres Positivas [Latin American Positive Women's Movement] (2012). Nuestras historias, nuestras palabras: Situación de las mujeres que viven con VIH en 14 países de América Latina [Our stories, our words: the situation of women living with HIV in 14 Latin American countries]. http://www.onusida-latina.org/images/2012/junio/INVESTIGACION.20MLCM.2B.202011.pdf

Caracterización de las mujeres recientemente diagnosticadas con VIH en Argentina [Characterization of women recently diagnosed with HIV in Argentina], less than half of the women were working at the time of the survey (46%), although most of them reported that they were participating in the labor market through unstable jobs without social benefits or coverage (70%).[92]

3.8 Right to social protection and an adequate standard of living

The social protection of women with HIV in all of their diversity is a fundamental mechanism for fulfilling their economic and social rights. In particular, social protection should ensure a sufficient level of welfare to sustain living standards that are considered basic for a person's development, while also facilitating access to social services and promoting decent work.[93] It is necessary to take into account employment policies and sectoral policies on education, health, and housing, since they are essential components for understanding challenges to social protection access and the "welfare gaps" between different population groups. It is also imperative to consider a society's capacity for generating income through the labor market to sustain its members as well as the governments' capacities for providing sustenance and protection to those who lack or have insufficient income, which is the case for many women living with HIV. A significant number of women with HIV fall into the category of dependents, since although they are in the productive age bracket, they do not participate in the labor market, or they do so in a precarious manner and with low incomes. Given the high levels of social exclusion they experience, women living with HIV do not necessarily benefit from the initiatives aimed at increasing social protection coverage, namely: retirement benefits, pensions, and other income transfers to older adults, monetary transfers to families with children, access to health insurance and services, and finally, worker protection (insurance against illness and unemployment, together with labor rights policies like severance pay, overtime, leave periods, etc.).

The studies on stigma and discrimination only partially reveal the lack of social protection experienced by persons living with HIV, and especially by women. The percentage of interviewees who experienced food shortages for one to two days, three to four days, or five or more days, was around 35% for men and 46% for women in the Dominican Republic, and 12.3% for men and 21.6% for women in Honduras.

92 Binstock G, Manzelli H, Hiller R, Bruno M (2012). Caracterización de las mujeres recientemente diagnosticadas con VIH en Argentina [Characterization of women recently diagnosed with HIV in Argentina]. Red Argentina de Mujeres viviendo con VIH/sida [Argentine Network of Women Living with HIV/AIDS], Red Bonaerense de Personas viviendo con VIH/sida [Buenos Aires Network of Persons Living with HIV/AIDS], CENEP-CONICET, Gino Germani Institute (University of Buenos Aires), UNAIDS. http://publicaciones.ops.org.ar/publicaciones/publicaciones%20virtuales/MujeresVIHPV/pdf/informeFinalMujeresVIH.pdf

93 Cecchini S, Filgueira F, and Roble C (2014). Social protection systems in Latin America and the Caribbean: A comparative view. ECLAC.

Table 14: Food shortage rates among the population interviewed in stigma and discrimination studies in two Latin American countries

Food shortage	Dominican Republic (2009) %		Honduras (2014) %	
	M	W	M	W
None	64,6	53,9	87,7	78,4
1 to 2 days	9,1	10,8	6,9	11,3
3 to 4 days	12,8	15,3	4,7	6
5 or more days	13,6	20	0,7	4,3

Source: Studies on stigma and discrimination against persons living with HIV

The stigma and discrimination studies also show the barriers to accessing a permanent place of residence and the inability to rent housing. The percentage of women who stated that they had been forced to change their place of residence or had been unable to rent housing in the past 12 months was 17% in Mexico, 12.9% in Guatemala, 10.5% in Ecuador, 22.5% in the Dominican Republic, and 27.7% in Paraguay. Among transgender women, the percentages were 19.3% in Mexico and 42.8% in Paraguay. The percentages of men and women were similar in Mexico, Guatemala, and Ecuador.

Table 15: Barriers to housing access in stigma and discrimination studies in five Latin American countries

	Mexico 2008 (N= 931) %			Guatemala 2011 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
In the past 12 months how often have you been forced to change your place of residence or been unable to rent a place to stay?	18,4	17	19,3	13,8	12,9	SD	10,5	10,5	SD	18,5	22,5	SD	17,8	27,7	42,8

Source: Studies on stigma and discrimination against persons living with HIV

Slightly more than half of the individuals interviewed in the Caracterización de las mujeres recién diagnosticadas con VIH en Argentina [Characterization of women recently diagnosed with HIV in Argentina] study live in overcrowded homes: 22% in critically overcrowded homes (that is to say, three or more persons per room) and an additional 30% in moderately overcrowded homes (that is to say, an average of 2 to 3 persons per room).[94] In Guatemala, 33.7% of men and 42.5% of women living with HIV do not have their own homes.[95] In the transgender population, the principal obstacle to gaining access to housing, land, or credit is that it is impossible for them to prove financial solvency, since as a rule they are not formally employed.[96] According to the National Survey on Discrimination in Mexico (ENADIS 2010), three of every ten individuals in Mexico are unwilling to let persons with HIV live in their homes.[97]

3.9 Right to form a family

In order for this right to be guaranteed, there must be legal frameworks in place, in addition to the services and protection measures necessary for the comprehensive development of women living with HIV and their children. With the progress that has been made in access to treatment, more HIV-positive women are deciding to get pregnant and have children; however, many of them do not receive information about their reproductive options. Some health service providers do not believe that people with HIV can or should have children. Pregnant HIV-positive women should receive all standard prenatal care services, including screening and treatment for STIs as well as nutritional counseling and monitoring. Prenatal care should also include the appropriate ART for the situation. [98, 99, 100, 101, 102, 103]

94 Binstock G, Manzelli H, Hiller R, Bruno M (2012) Caracterización de las mujeres recientemente diagnosticadas con VIH en Argentina [Characterization of women recently diagnosed with HIV in Argentina]. Ibid

95 Stigma and Discrimination Index. Guatemala.

96 REDLACTRANS (2014).

97 National Council to Prevent Discrimination (2011). National survey on discrimination in Mexico (ENADIS). Enadis 2010. Overall results. Mexico. http://www.conapred.org.mx/userfiles/files/Enadis-2010-RG-Accss-002.pdf

98 Mexico National Commission on Human Rights (2012). Mujeres, embarazo y VIH [Women, pregnancy, and HIV]. http://www.cndh.org.mx/sites/all/fuentes/documentos/cartillas/11%20cartilla%20mujeres%20embarazo%20VIH.pdf

99 FEIM [Foundation for the Study and Investigation of Women]. DECISIONES REPRODUCTIVAS Y EMBARAZO EN LAS MUJERES QUE VIVEN CON VIH/SIDA. Recomendaciones para el equipo de salud [REPRODUCTIVE DECISIONS AND PREGNANCY IN WOMEN LIVING WITH HIV/AIDS. Recommendations for the healthcare team]. http://www.feim.org.ar/pdf/publicaciones/Opciones_Reproductivas_Recomendaciones.pdf

100 Huésped Foundation (2006). Sexualidad, embarazo y VIH/SIDA [Sexuality, pregnancy, and HIV/AIDS]. http://www.huesped.org.ar/wp-content/uploads/2014/11/Sexualidad-Embarazo-y-SIDA.pdf

101 Global Network of People Living with HIV/AIDS (2009). Advancing the Sexual and Reproductive Health and Human Rights of People Living with HIV. http://www.unfpa.org/sites/default/files/resource-pdf/guidance_package.pdf

102 IPAS (2012). Reproductive choice for women living with HIV. http://www.ipas.org/~/media/Files/Ipas%20Publications/HIVPREABOS12.ashx

103 Center for Reproductive Rights and Vivo Positivo [I live positive] in Chile (2011). Dignity denied: Violations of the rights of HIV-positive women in Chilean health facilities. http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/chilereport_single_FIN.pdf

Furthermore, the fact of having HIV does not constitute a limitation for raising and caring for one's children, since people may not be deprived of these rights because they have HIV. HIV-positive mothers have the right to legal custody of their children. Likewise, they have the right to appoint their desired guardian if they are unable to take responsibility, as well as to have due institutional protection to that end.

The stigma and discrimination studies show that a significant percentage of women living with HIV are mothers: 90% of the women interviewed in the Dominican Republic, 87% in Colombia and Paraguay, 85% in Mexico, 84% in Guatemala, and 67% in Ecuador. In other words, between seven and nine of every ten women interviewed are mothers. The percentage of HIV-positive men who have children is 24.6% in Colombia, 17.7% in Mexico, 51% in Guatemala, 59.7% in Ecuador, 68.7% in the Dominican Republic, and 45.4% in Paraguay, which is between two and seven of every ten men interviewed. The percentage of HIV-positive women who have children with HIV is 28.7% in Colombia, 7.2% in Guatemala, 10.5% in Ecuador, and 58% in the Dominican Republic while for men, the percentages are 10.4% in Colombia, 6.8% in Guatemala, 13.2% in Ecuador, and 56.7% in the Dominican Republic.

The percentage of women living with HIV who report having received counseling on their reproductive choices varies from 14.2% in Mexico to 54.9% in Honduras, and the percentage of men ranges from 15.3% in Mexico to 50.3% in Ecuador.

The percentage of women living with HIV who report having been advised on some occasion by a health professional to not have children was 42.2% in Colombia, 30.7% in Honduras, 35.6% in Guatemala, 33.2% in El Salvador, 32.6% in Ecuador, and 29.6% in the Dominican Republic. Except for in Ecuador, the percentage of women who reported this was higher than the percentage of men who did so, and in Colombia, Honduras, El Salvador, and the Dominican Republic, it was two to three times higher.

Of the women interviewed, 8% in Colombia, 36.5% in Mexico, 25.5% in El Salvador, 6.6% in Ecuador, and 21% in the Dominican Republic stated that they had been forced to use certain contraceptives as a condition for receiving antiretroviral therapy.

The percentage of women who reported having received information on healthy pregnancy and maternity as part of the prevention of mother-to-child transmission (PMTCT) program was 88.3% in Colombia, 93% in Mexico, and 39.6% in Paraguay.

Table 16: Situations related to reproductive rights and the right to form a family in stigma and discrimination studies in eight Latin American countries (2008-2014)

	Colombia (N=1000) %			Mexico 2008 (N= 931) %			Honduras 2014 (N= 720) %			Guatemala 2011 (N=500) %			El Salvador 2010 (N=500) %			Ecuador 2010 (N=497) %			Dominican Republic 2009 (N=1000) %			Paraguay 2010 (N=256) %		
	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
Have children	24,6	86,7	3,1	17,7	85,3	3,6	ND	ND	ND	51	84	ND	ND	ND	ND	59,7	67	ND	68,7	90	ND	45,4	87,3	ND
% of children who are HIV+	10,4	28,7	ND	ND	ND	ND	ND	ND	ND	6,8	7,2	ND	ND	ND	ND	13,2	10,5	ND	56,7	58	ND	ND	ND	ND
% that received counseling on reproductive options	30,7	59,4	6,3	15,3	14,2	0	45,1	64,9	42,9	ND	ND	ND	47	54,3	41,7	50,3	45,1	100	46,1	59	ND	ND	ND	ND
On some occasion was advised by a health professional to not have children	14,7	42,2	ND	ND	ND	ND	15,1	30,7	16,7	33,3	35,6	ND	18,9	33,2	28,6	32,4	32,6	39,3	16,7	29,6	ND	ND	ND	ND
Access to antiretroviral therapy is conditional upon use of certain contraceptives	ND	8	ND	9.4	36.5	2.9	ND	ND	ND	ND	ND	ND	27.8	25.5	36.8	10.4	6.6	21.3	21.2	2,1	ND	ND	ND	ND
Was given information on healthy pregnancy and maternity as part of a PMTCT program	ND	88,3	ND	ND	93	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	39,6	ND

Source: Studies on stigma and discrimination against persons living with HIV

In the stigma and discrimination studies that were analyzed, the percentage of women who reported having been pressured by a health professional to have an abortion ranged from 1% to 3% in Colombia, Bolivia, Nicaragua, Mexico, and Honduras to 59% in Guatemala.

Less than 10% of women in Bolivia and Mexico, between 11% and 20% in Colombia, Nicaragua, and Paraguay, and 42% in Guatemala reported having been forced to choose a specific method of giving birth.

Less than 15% in Colombia, Bolivia, Nicaragua, Mexico, and Paraguay, and 18.4% in Honduras and 40.4% in Guatemala, had been pressured on how to feed their babies.

Table 17: Coercion by a health professional in the past 12 months on abortion, birth, and feeding due to the mother's HIV status

In the past 12 months has been forced by a health professional on any of the following practices due to HIV status		Colombia (N=1000) %			Bolivia 2011 (N= 420)			Nicaragua 2013 (N= 801)			Mexico 2008 (N= 931)			Honduras 2014 (N= 720)			Guatemala 2011 (N=500)			Paraguay 2010 (N=256) %		
		M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T	M	W	T
	Abortion	ND	2	ND	ND	3	ND	ND	2,2	ND	ND	1	ND	ND	1,2	ND	ND	59,1	ND	ND	0	ND
	Method of delivery	ND	14	ND	ND	8	ND	ND	16,5	ND	ND	6,1	ND	ND	18,6	ND	ND	42,1	ND	ND	11,1	ND
	Method of feeding baby	ND	14	ND	ND	10	ND	ND	8,3	ND	ND	7,1	ND	ND	18,4	ND	ND	40,4	ND	ND	9,6	ND

Source: Studies on stigma and discrimination against persons living with HIV

Complete avoidance of breastfeeding is efficacious in preventing mother-to-child transmission of HIV, but this intervention has significant associated morbidity (e.g., diarrheal morbidity if formula is prepared without clean water). If breastfeeding is initiated, two interventions are efficacious in preventing transmission: i) exclusive breastfeeding during the first few months of life; and ii) extended antiretroviral prophylaxis to the infant (nevirapine alone or nevarapine with zidovudine).[104] However, the countries do not offer counseling on the baby feeding options that would enable women with HIV to choose the most suitable method for their circumstances in accordance with PAHO/WHO recommendations[105]

On the other hand, elective cesarean section is an efficacious intervention for the prevention of mother-to-child transmission among HIV-1-infected women not taking ARVs or taking only zidovudine. The risk of postpartum morbidity (PPM) with elective cesarean section is higher than the risk associated with vaginal delivery but lower than with non-elective cesarean section. More advanced maternal HIV-1 disease stage and concomitant medical conditions (e.g., diabetes) are independent risk factors for PPM. More evidence is required in order to clarify the risk of mother-to-child transmission according to mode of delivery among HIV-1-infected women with low viral loads (low either because the woman's HIV-1 disease is not advanced, or because her HIV-1 disease is well-controlled with ARVs).[106]

104 Horvath T, Madi BC, Iuppa IM, Kennedy GE, Rutherford G, Read JS. Interventions for preventing late postnatal mother-to-child transmission of HIV (Review) Cochrane Database of Systematic Reviews, 2009, Issue 1. Art. No.: CD006734. DOI: 10.1002/14651858.CD006734.pub2. http://apps.who.int/rhl/reviews/CD006734.pdf

105 T. Kendall & E. López-Uribe (2010) Improving the HIV response for women in Latin America: Barriers to integrated advocacy for sexual and reproductive health and rights. Global Health Governance 4 (1) http://blogs.shu.edu/ghg/2010/12/20/476/

106 Read JS, Newell ML. Efficacy and safety of cesarean delivery for prevention of mother-to-child transmission of HIV-1. Cochrane Database of Systematic Reviews 2007, Issue 4, Art. No.: CD005479. DOI: 10.1002/14651858.CD005479. http://apps.who.int/rhl/reviews/CD005479.pdf

LThe medical coverage of pregnant women living with HIV varies significantly in 15 countries in Latin America and the Caribbean, ranging from less than 30% of women covered in Guatemala (22%) and Venezuela (28%); between 30% and 50% in El Salvador and Honduras (47%), The Bahamas (45%), and Paraguay (48%); between 51% and 80% in Bolivia (66%), Belize (63%), Jamaica (60%), Mexico (75%), Peru (70%), and Trinidad and Tobago (80%); to more than 80% in Ecuador (95%), Haiti (93%), and Panama (93%).

Table 18: : Medical coverage of pregnant HIV-positive women receiving ART to prevent mother-to-child transmission (2013)

Countries	Estimated percentage (%)
The Bahamas	45
Belize	63
Bolivia	66
Ecuador	95
El Salvador	47
Guatemala	22
Haiti	93
Honduras	47
Jamaica	60
Mexico	75
Panama	93
Paraguay	48
Peru	70
Trinidad and Tobago	80
Venezuela	28

Source: UNAIDS Spectrum Estimates

It should be noted that HIV transmission rates during pregnancy, birth, or breastfeeding range from 15% to 45% in the absence of any interventions, and can be reduced to levels below 5% with effective interventions.[107] Moreover, the region's policies on adoption by HIV-positive individuals are very restrictive, particularly in Honduras, where the law expressly prohibits it. Likewise, policies that give HIV-positive individuals access to assisted reproduction services and counseling for the

107 WHO. Mother-to-child transmission of HIV. http://www.who.int/hiv/topics/mtct/en/108 T. Kendall & E. López-Uribe (2010)

prevention of transmission in serodiscordant couples or from the mother to her child are not included in national legislations.[108]

3.10 Right to information

The guarantees of access to information, health services and resources, education, and work, economic empowerment, and the mechanisms of social participation are key factors in HIV prevention.

Access to comprehensive sex education for adolescents and young people: Seventeen Latin American countries have comprehensive sex education laws, plans, or programs managed by various agencies. The majority of these (8) are run by the educational system or by the education, health, and/or other sectors.[109] Among the persistent obstacles to effectively preventing HIV in adolescents and young people are the failure to distribute condoms in schools, insufficient access to sexual and reproductive health services and the failure to integrate them with HIV services and to adapt them to the needs of young people, and the high rates of sexual violence committed against girls, teenagers, and young women. Furthermore, the ability of some young people to access essential services is restricted due to the lack of confidentiality and to violations of their right to privacy. Inadequate access to comprehensive sex education negatively impacts efforts to protect girls, adolescents, and young women from HIV and other STIs.

Access to information in health services: : In the Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica], 56% of participants reported having received information on preventing mother-to-child transmission, 43% on safe pregnancy with minimal risks for the mother, her partner, and their baby, 36% on pregnancy while reducing the risk of partner transmission, and 21% on safe conception: treatments like prevention, prophylaxis prior to exposure, insemination, and antiretrovirals.[110]

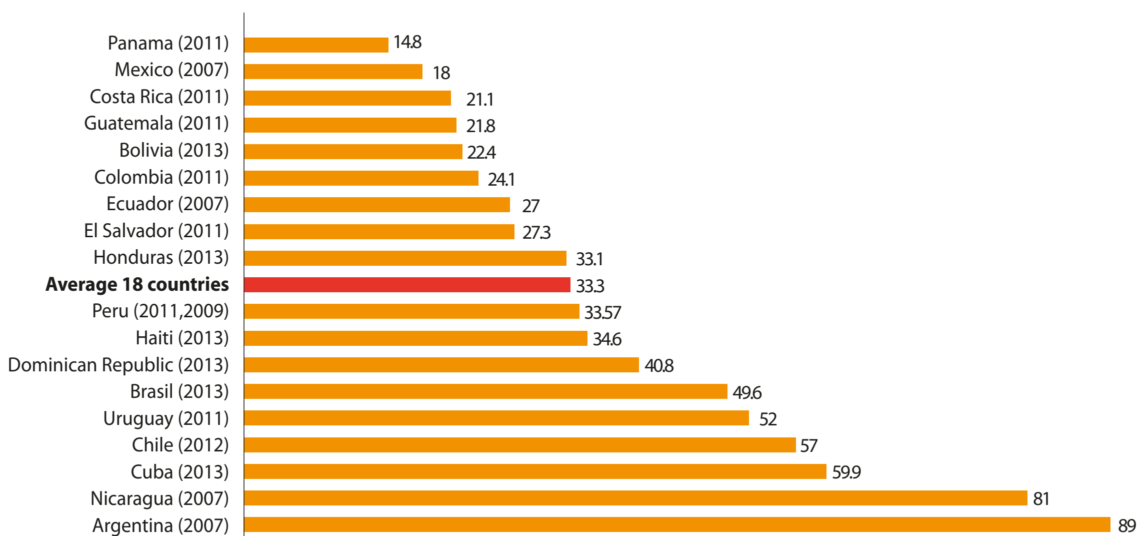
Knowledge of HIV, forms of transmission, and condom use in young and adult women: In 10 Latin American countries, an average of 40% of women 15 to 24 years of age had knowledge of HIV and how to prevent it, with extremes of 14.8% of these women in Panama and 89% in Argentina. In six of the 10 countries analyzed, fewer than 40% of women possessed such knowledge.

108 T. Kendall & E. López-Uribe (2010) Improving the HIV response for women in Latin America: Barriers to integrated advocacy for sexual and reproductive health and rights. Global Health Governance 4 (1) http://blogs.shu.edu/ghg/2010/12/20/476/

109 UNFPA, 2015.

110 Avalos Capín J, Balance Promoción para el Desarrollo y Juventud A.C. [Balance Promotion for Development and Youth, Non-Profit Organization], 2013

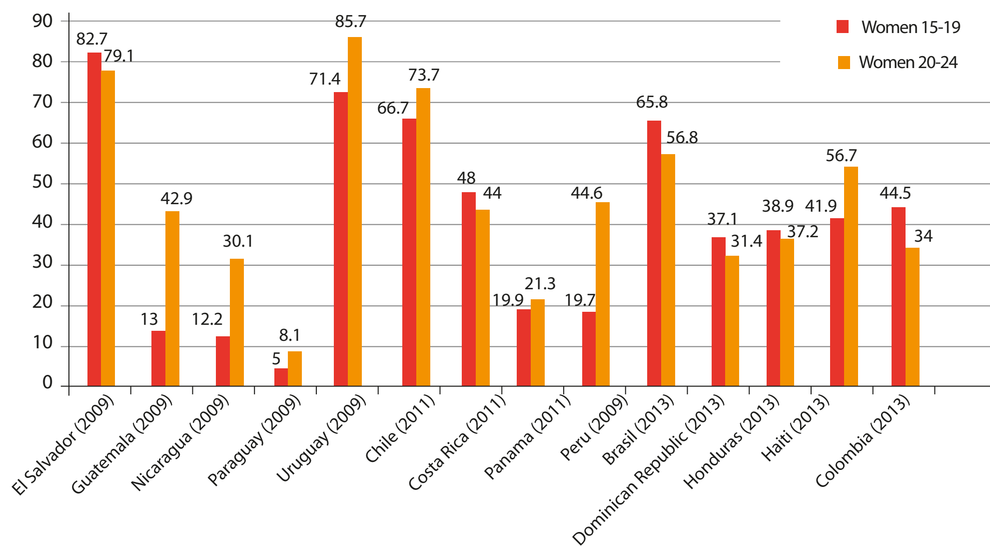
Graph 2: Percentage of women 15-24 years of age with comprehensive knowledge of HIV (2007-2011)



Fuente: UNAIDS, Treatment 2015

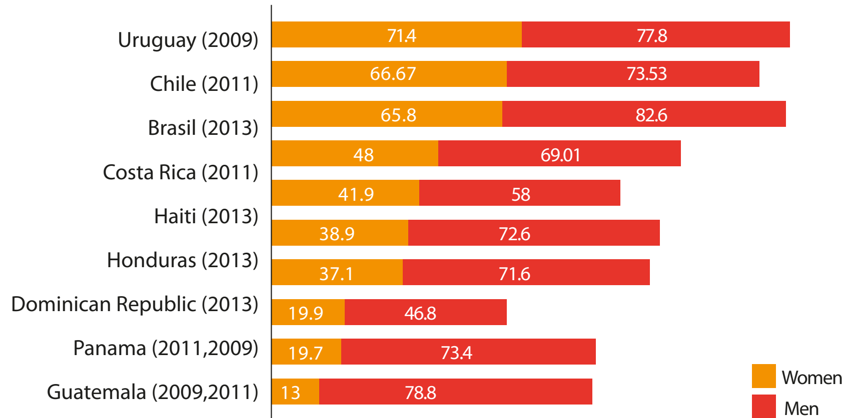
Examining the information contributed by young women in 14 countries reveals that in only four of them (El Salvador, Chile, Brazil, and Uruguay) did 50% or more women in both subgroups (15-19 years old and 20-24 years old) report having used a condom in their most recent act of sexual intercourse. In Haiti, 56.7% of women aged 14 to 20 years old reported having used a condom in their most recent act of sexual intercourse.

Graph 3: Percentage of young women that used a condom during their last sexual relation (2009-2013)



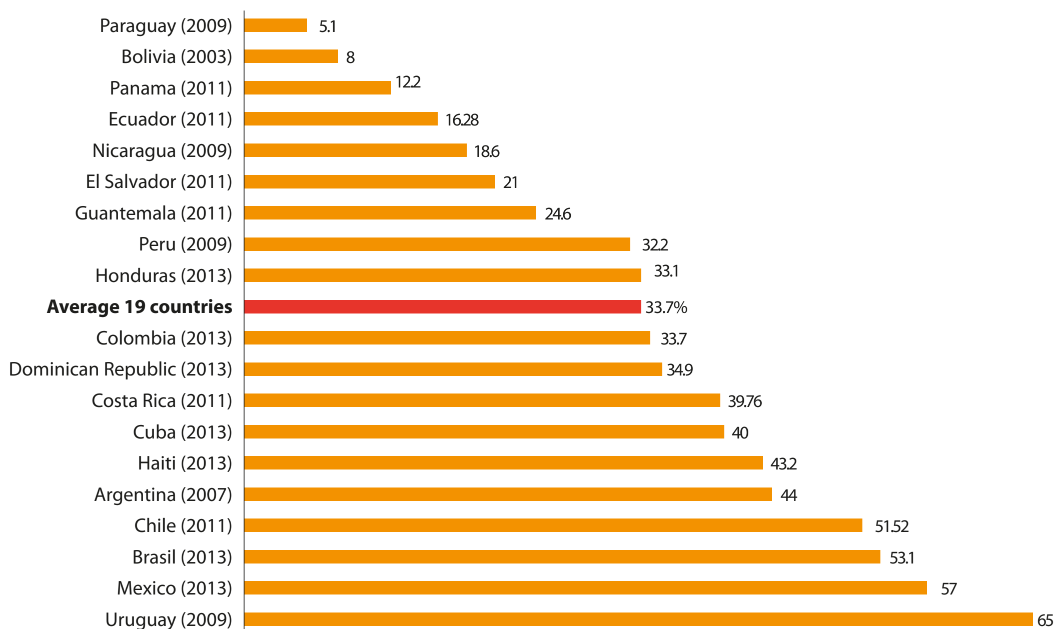
Comparing the percentages across all countries of men and women from 15 to 19 years of age who used a condom in their most recent act of sexual intercourse, we see that in eight of the 10 countries analyzed, more men than women (by differences of more than 20 percentage points) did so.

Graph 4: Percentage of men and women from 15 to 19 years of age that used a condom during their last sexual relation (2009-2013)

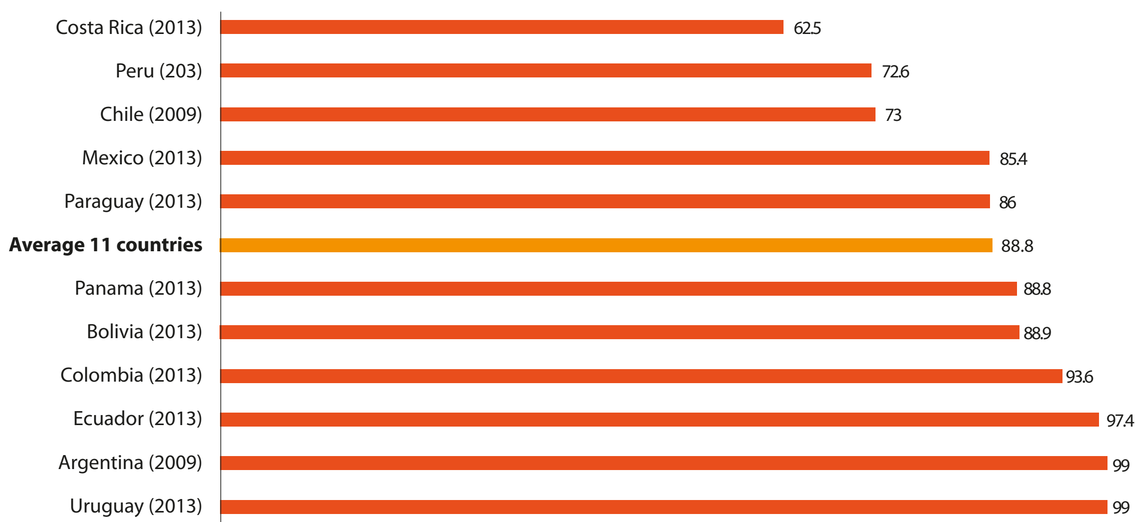


Condom use in the most recent sexual encounter is also low among women with multiple sexual partners, at an average of 33% in 19 countries, or one of every three, with the rates in Bolivia, Ecuador, El Salvador, and Peru coming in below this average.

Graph5: Percentage of women with multiple sexual partners that used a condom during their last sexual relation (2003-2013)



Graph 6: Percentage of Transgender Sex Workers that used a condom during their last sexual relation (2009-2013)



In 11 countries, an average of 86% of transgender sex workers had used a condom in their most recent act of sexual intercourse, with only Mexico and Peru having rates below this average.

3.11 Right to participation

In order to guarantee this right for all of the diverse women living with HIV, it is necessary to further their capacities to freely assemble without facing discrimination, to participate in decision-making mechanisms with regard to HIV, gender equality, and development, and to participate in all social and political bodies, while providing resources to ensure that they are adequately involved therein.

The study Participation of women and transgenders in Global Fund Processes in Latin America and the Caribbean (2010) found that 13 of 15 country coordinating mechanisms (CCMs) include an HIV-positive woman among their members, but only in one of these mechanisms does she specifically represent women living with HIV; in the other 12 CCMs, the women represent the broader sector of all persons living with HIV, not just HIV-positive women. This has made it more difficult for women with HIV to position their specific needs, since the issues prioritized by the broader group tend to focus on access to ART. The effective participation of women and transgender persons in the

CCMs is also affected by issues of legitimacy and accountability, since election processes are not necessarily democratic and the sectors they represent may be limited to an organization rather than a broad population group. [111]

In the RedTraSex study (2014), 40% of the women surveyed stated that they participated in some organization or network of sex workers. The women sex workers surveyed in the Southern Cone are those who most participate in organizations of sex workers (47%). The countries with the highest percentages of surveyed individuals who participate in some organization or network of sex workers are Paraguay (73%), the Dominican Republic (66%), and Panama (65%), and those with the lowest percentages are Uruguay (8%) and Colombia (12%).

Barriers to participation for young Latin American and Caribbean women living with HIV include their limited knowledge of their rights, their burden of unpaid domestic labor, the high levels of stigma and discrimination against young women in general and HIV-positive women in particular, the lack of opportunities for them to develop leadership abilities, social norms and laws that restrict their autonomy in the public and private spheres, the limited opportunities for addressing the varied situations faced by young HIV-positive women in all of their diversity, the violence to which they are subjected in their communities, families, and various public spaces, and the prevailing perceptions in the development of public policies and programs that tend to see young women as objects of intervention rather than protagonists of change.[112]

UNAIDS (2012) has identified some challenges to the participation of civil society organizations and networks in the HIV context that similarly affect organizations of women living with HIV:

- **Token representation in processes:** representatives do not have the power to negotiate or speak in a meaningful way;
- **Cherry picking:** certain civil society representatives are invited to participate because they are easy to work with while more controversial ones, who may raise challenging viewpoints, are excluded;
- **Inauthentic representation:** civil society representatives do not have sufficient legitimacy to represent a specific or general community group or nongovernmental organization;

111 AIDS for AIDS (2010). Participation of women and transgenders in Global Fund Processes in Latin America and the Caribbean. http://www.icaso.org/media/files/9600-ParticipationOfWomenandtransgendersinGFrocessesEN.pdf

112 Development Connections (2015). Barreras a la participación social de las mujeres jóvenes que viven con VIH en América Latina [Barriers to social participation for young women living with HIV in Latin America]. http://dvcn.aulaweb.org/Infografia.Barreras.a.la.participacion.jovenes.positivas.Marzo2015.4.pdf

- **Inauthentic processes of consultation:** where civil society input is not carried into decision-making processes;
- **Inadequate support and resources, in particular a lack of funds:** civil society representatives cannot participate in processes authentically because they lack human or financial resources, information, or preparation time;
- **Limited capacity in terms of skill sets:** civil society representatives do not have the ability to access information and actively participate on a long-term basis in, for example, meetings and consultations.[113]

113 UNAIDS (2012). UNAIDS guidance for partnerships with civil society, including people living with HIV and key populations. Geneva. http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2236_guidance_partnership_civilsociety_en.pdf

4. Funding to further the rights of women living with HIV

Making progress on the respect, protection, and fulfillment of the human rights of all of the diverse women living with HIV depends on several factors, including political commitment, leadership, changes in public policy processes and contents, and the financial resources to implement priorities and address the current gaps in the HIV response associated with these rights.

Financing, gender and human rights, and participation: From the beginning of the HIV epidemic, the funding of gender mainstreaming in the HIV response and of women's organizations has been an issue of particular concern. In 2006, AWID [Association for Women's Rights in Development] conducted a global survey that was answered by almost 1,000 women's rights organizations worldwide and that brought to light the difficulties that prevent those organizations from receiving adequate funding. The 512 respondents that declared they work on HIV-related issues reported that it is very challenging for them to obtain sufficient resources to further the work they do in these areas as related to women's rights. Furthermore, the sense of scarcity is even more evident when it comes to specifically rights-based approaches. This same survey reported that education and information dissemination are among the easiest activities to finance, along with the distribution of condoms, whereas in terms of gender-based violence, changing high-risk practices and advocating for legislative and policy changes are considered activities for which it is difficult to get funding. [114]

114 AWID [Association for Women's Rights in Development]. Funding to fight HIV/AIDS 2008. http://www.awid.org/sites/default/files/atoms/files/funding_to_fight_hiv-aids_through_the_promotion_of_womens_rights_a_case_study_from_south_africa.pdf

The ICW Latina analysis (2015) found that:

- In most countries, the most significant spending category was Care and Treatment (40% or more), especially Outpatient Care and Antiretroviral Therapy.
- Until 2012, no National AIDS Spending Assessment (NASA) included analyses disaggregated by sex/gender or age (apart from the child population), which meant that in most cases the population of people living with HIV/AIDS was categorized as "adults or young people 15 years of age or older living with HIV."
- In most countries, the Enabling Environment spending category is targeted at human rights actions or programs but does not specify the prioritized populations or rights. Only Peru and Bolivia establish programs targeted at women or gender-based violence.
- No specific programs or activities on sexual and reproductive health or violence were identified for women living with HIV. It is not clear which women are targeted with the Violence Prevention program in Bolivia.[115]

Resources, support, and commitment are essential in order to make it possible for people living with HIV, including women in all of their diversity, to meaningfully participate. Successful implementation of the GIPA principle requires leadership and strategic planning within organizations, as well as the individual and collective empowerment of members in order to ensure sustainable and sustained participation. [116] POf particular importance for women living with HIV is addressing the cultural, social, geographical, economic, and institutional barriers to participation, including discriminatory policies and procedures, and ensuring the availability of financial, technical, and human resources that facilitate participation and help strengthen their skills and organizations. Even though most projects in Latin America and the Caribbean include activities for working with women living with HIV, women sex workers, and transgender women, the organizations of these groups of women rarely receive grant funding as sub-recipients and in most cases, resources are allocated for carrying out specific activities. Recently some progress has been made in terms of funding for regional networks, since the Global Fund has approved ICW Latina's concept note and the grant is expected to be signed shortly[117]. Likewise, RedTraSex is carrying out a multi-country project (2012-2015) with Global Fund support in the amount of US$11,175,184.[118]

115 Salazar, Ximena (2015). Brechas de financiamiento [Funding gaps]. ICW Latina. Working Document No. 1.

116 International HIV/AIDS Alliance and the Global Network of People Living with HIV (2010). Greater involvement of people living with HIV (GIPA). Good Practice Guide. http://www.aidsalliance.org/assets/000/000/411/464-Good-practice-guide-Greater-involvement-of-people-living-with-HIV-(GIPA)_original.pdf?1405586730

117 http://lacfondomundial.org/noti/notas-conceptuales-de-icw-latina-y-redlactrans-recomendadas-por-el-prt/

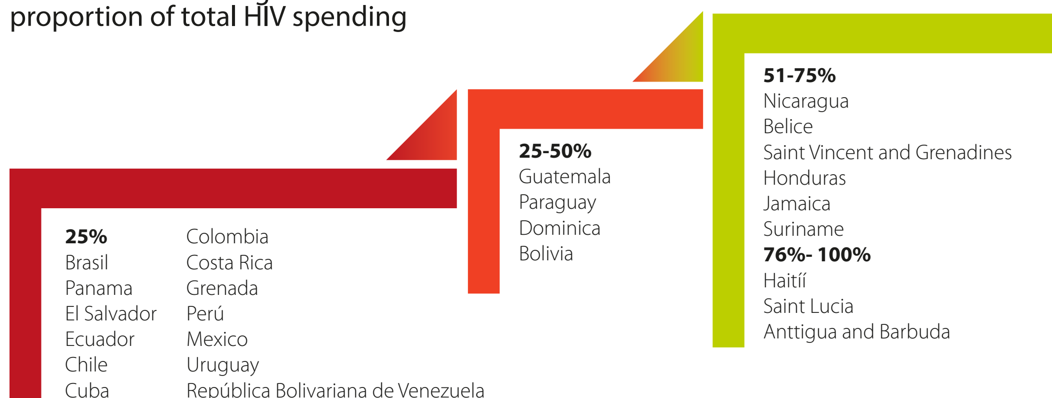
118 http://portfolio.theglobalfund.org/en/Country/Index/QMOU

A significant obstacle to receiving direct access to funds as sub-recipients is the weak organizational capacity for administering and implementing grants.[119]

Funding and spending on HIV: challenges and opportunities for investment in gender equality and human rights: On average, 75% of Latin American and Caribbean countries' budgets for HIV care and treatment is allocated to the purchase of antiretrovirals, although it must be noted that in 2012, 14 of 31 countries and territories (45%) reported at least one stock-out (shortage of ART drugs).[120] For every US$100 of international financing spent on HIV in 2011, US$73 was invested in care and treatment. According to information gathered in 17 countries, in Latin America 70% of spending was allocated to care and treatment, 18% to prevention, 6% to program management and administration, 2% to the development of an enabling environment, 2% to social protection and social services, 1% to research, and 1% to incentives for human resources.[121]

Financing sources: The international percentage of the combined domestic and international public financing varied significantly among countries. In 13 countries of the region, international financing was 25% or less than the total combined domestic and international financing, in three countries it was between 25% and 50%, in six it was between 51% and 75%, and in three it was between 75% and 100%. It bears noting that of every US$100 received in 2011, less than one dollar was spent on prevention programs for key populations.[122]

International funding as a proportion of total HIV spending



119 AIDS for AIDS (2010). Participation of women and transgenders in Global Fund Processes in Latin America and the Caribbean. http://www.icaso.org/media/files/9600-ParticipationOfWomenandtransgendersinGFrocessesEN.pdf

120 PAHO/WHO. Latin America and the Caribbean advance toward universal access to HIV treatment. Washington, D.C., November 27, 2013. http://www.paho.org/hq/index.php?option=com_content&view=article&id=9185%3A2013-latin-america-caribbean-advance-toward-universal-access-hiv-treatment&catid=740%3A-news-press-releases&Itemid=1926&lang=en

121 Aran C. Financiamiento y gasto de VIH en América Latina [Financing and spending on HIV in Latin America]. UNAIDS. March 2013.

122 Aran C Financiamiento y gasto de VIH en América Latina [Financing and spending on HIV in Latin America]. UNAIDS. March 2013.

Table 19: Sources of HIV financing and percent international financing by country (2007-2013)

Country	Year	International		Public domestic and international	Private
		Amount (US$)	% of combined domestic, public, and international		
Haiti	2011	210.000.000	100%	210.000.000	SD
Brazil	2012	9.258.557	13%	690.000.000	SD
Panama	2010	1.527.635	9%	17.229.700	7.045.659
Nicaragua	2010	14.061.971	59%	23.744.276	1.150.592
El Salvador	2013	13.764.792	23%	60.359.928	1.945.855
Belize	2012	1.886.377	69%	2.718722	118.050
Saint Vincent and the Grenadines	2012	821.178	57%	1.436.605	30.000
Ecuador	2010	2.975.540	11%	27.246.408	1.395.467
Guatemala	2012	20.625.980	43%	47.851.392	5.373.612
Paraguay	2013	2.966.599	21%	13.808.342	1.133.010
Chile	2012	227.585	2%	140.000.000	75.541.065
Cuba	2013	5.927.082	8%	69.734.376	SD
Dominica	2012	160.000	48%	336.411	SD
Honduras	2013	17.236.972	52%	33.021.402	3.692.374
Jamaica	2010	10.771.906	74%	14.620.864	45.977
Dominican Republic	2012	20.711.558	69%	29.974.062	10.755.726
Costa Rica	2012	1.701.913	8%	20.104.852	2.141.826
Saint Lucia	2007	605.638	78%	772.018	SD
Bolivia	2012	4.869.735	50%	9.656.461	2.112.301
Colombia	2013	306.020	<1%	84.249.168	34.547.857
Grenada	2013	39.398	20%	194.829	SD
Peru	2013	4.505.007	6%	74.861.272	SD
Mexico	2011	12.168.390	24%	500.000.000	39.330.686
Antigua and Barbuda	2013	1.069.122	79%	1.355.305	3.718
Suriname	2011	2.343.104	51%	4.592.708	81.800
Uruguay	2007	683.242	9%	7.534.411	6.543.398
Venezuela	2013	817.796	1%	72.603.704	SD

Source: UNAIDS and AIDSINFO

Awarding of grants to organizations of key populations: The Report on access to Global Fund resources by HIV/AIDS key populations in Latin America and the Caribbean (2009) analyzed data related to fifteen Global Fund grants in Bolivia, Colombia, Ecuador, El Salvador, Haiti, Paraguay, Peru, and the English-

speaking Caribbean. Across all the grants analyzed, over US$170 million was awarded to the sub-recipients and only 4.6% of the total has reached key population organizations in the form of sub-recipient grants. Organizations of people living with HIV received the most funds, at just over 50%, and MSM groups received 27.6%. Women living with HIV and sex workers received 16.3% and 6.1%, respectively, and organizations of transgender people were not sub-recipients of funds in any of the 15 grants.[123] The report identified four areas that affect key population access to Global Fund resources: i) lack of capacity among key population organizations, ii) access to and understanding Global Fund-related information, iii) scarce participation of key populations in related decision-making spaces such as the CCM, and iv) lack of relevant and up-to-date epidemiological data particularly among transgender people and women sex workers.

The review of current proposals conducted by ICW, in the context of the grant it was awarded by the Global Fund in 2015, showed that more than 60% are targeted at the State for national grants and that the populations that most benefit from these grants are men who have sex with men, female sex workers, and transgender individuals. Actions specifically targeted at women living with HIV center on antiretrovirals and preventing mother-to-child transmission. In the current grants, only the Dominican Republic and Colombia include specific actions for women living with HIV. Among its regional grants, the Global Fund has awarded ICW Latina US$4,333,000 to work with women living with HIV on human rights and gender-based violence issues in 11 countries of the Latin American and Caribbean region.

It must be stressed that even in a favorable context, financial resources, the level to which women's priorities are integrated, and the modes of participation that subsume the identity of women living with HIV and limit the construction of an agenda for joint mobilization are significant challenges that must be taken into account. This must be kept in mind, because even when formal progress is made in terms of levels of participation, changes to public policy, and institutional leadership, often little is known about the changes this progress brings about in the daily lives of women living with HIV. Likewise, it is unknown whether this progress can be maintained over time.

123 International HIV/AIDS Alliance (2009). Report on access to Global Fund resources by HIV/AIDS key populations in Latin America and the Caribbean. http://www.portalsida.org/repos/Report_on_Key_Populations_access_to_resources_ENG.pdf

5. Coordination of the HIV response and participation

Inter-sectoral and inter-institutional coordination mechanisms: The 14 countries that completed the questionnaires sent by the CIM/OAS indicated that they did have some type of inter-sectoral agency in charge of coordinating actions in order to further the national response to HIV and AIDS, with representatives of all vulnerable populations and sectors, including organizations of women in general and women with HIV, in particular in the countries where such grassroots organizations exist[124] Although these formal coordinating agencies provide for the participation of multiple sectors and of the most vulnerable populations[125], in practice this participation is not always effective. Uruguay did not report, Trinidad and Tobago reported that it does not have any coordinating agency, and only Honduras reported that it had a Platform on HIV and Human Rights for addressing the situation of human rights violations of persons with HIV and of the key populations, supported by UNAIDS and made up of civil society organizations, including the Red de Mujeres Positivas [Network of Positive Women], CONADEH [National Commission on Human Rights], and the Office of the Special Prosecutor for Human Rights. Belize reported that it has a National Commission on AIDS in charge of managing HIV policy and implementing the Strategic HIV Response Plan.

124 El Salvador reported that although it has forums for coordination, the country's strategies do not include nor incorporate actions for specifically targeted at women with HIV.

125 Article 22 of Law 135-11 on HIV and AIDS of the Dominican Republic establishes that the National Council on the Prevention of HIV and AIDS must include a representative of the non-profit association of women as well as of the Ministry of Women.

Participation of women with and affected by HIV in decision-making processes and mechanisms: According to the questionnaires received by the CIM/OAS from the 14 countries, the participation of grassroots organizations made up of women with HIV in monitoring the CEDAW, the Belém do Pará Convention, and/or inter-institutional mechanisms on gender equality and the rights of women, varies by country. In Chile, in connection with participation and rights, the Ministry of Health called for the formation of an Advisory Council on Gender and Health to address gender inequalities in health through State/civil society joint collaboration. Organizations of women living with HIV, of transgender persons, on sexual diversity, and of women in general all participate in this Advisory Council. Colombia's Ministry of Health and Social Protection recognizes that organizations of women living with HIV have not been participating in the forums for inter-sectoral cooperation, and consequently will adopt measures to guarantee the right of these organizations to participate in the future. Uruguay and Trinidad and Tobago did not report on this point. In Honduras, participation is limited to self-help groups and the national association of persons living with HIV; Belize reports that there is participation in planning and evaluation processes but not in the implementation and monitoring of actions. In Mexico, the Inmujeres [National Women's Institute] forms part of the CONASIDA, which has engendered several committees that aim to join forces to slow the HIV/AIDS epidemic and to follow up on actions focused on coordinating HIV/AIDS care and treatment and women's sexual and reproductive health services. Also in Mexico, the working group of the CONASIDA Prevention Committee "Women's Bureau" was created in 2009 on the initiative of the organization of HIV-positive women *Red de Mexicanas en Acción Positiva* [Network of Mexican Women in Positive Action], which chaired the Council that year. This bureau is formed by Inmujeres, CENSIDA, CNEGYSR, UNFPA, UNAIDS, the National Commission on Human Rights, *Mexicanas en Acción Positiva* [Mexican Women in Positive Action], ICW Mexico, *Balance Promoción para el Desarrollo y Juventud A.C.* [Balance Promotion for Development and Youth, Non-Profit Organization], *Movimiento Mexicano de Ciudadanía Positiva* [Mexican Positive Citizens Movement], *Salud Integral para la Mujer* [Comprehensive Health for Women], CAPSIDA, Fundar *Centro de Análisis e Investigación* [Fundar Center for Analysis and Research], *Mujer Libertad* [Women Freedom], Tamaulipas Diversidad y Vihda Trans [Tamaulipas Diversity and Trans "Lhiving"], *Centro de Investigaciones Sociales de* Comitán [Comitan Social Research Center], *Centro Ser* [Being Center], *Grupo Multidisciplinario en VIH de Veracruz* [Veracruz Multidisciplinary HIV Group], the Rainbow Foundation, and *El Clóset de Sor Juana* [Sister Juana's Closet]. The Bureau has promoted the political agenda on HIV and AIDS matters with regard to women from the gender and human rights approach in order to ensure a comprehensive response for women. This response has been presented in several different political forums and was a component of the National HIV Plan 2013-2018.

6. Information and knowledge-management systems

According to the information gleaned from the 14 countries that completed the CIM/OAS questionnaire, only Chile and the Dominican Republic have performed studies on the human rights of women living with HIV. In 2005, Chile conducted the study VIH/SIDA en mujeres, construcción de una estrategia de prevención [HIV/AIDS in women, building a prevention strategy]. The Dominican Republic, although it does not report specific studies on the human rights of women with HIV, does cite studies like Vínculos entre la violencia y VIH/SIDA entre las mujeres de República Dominicana [Links between violence and HIV/AIDS among women in the Domincian Republic] (UNAIDS, 2011), Igualdad de género y VIH en Dominican Republic [Gender equality and HIV in the Dominican Republic] (UNAIDS) and Estigma y discriminación en personas que viven con VIH [Stigma and discrimination in people living with HIV] (Profamilia [Dominican Association for Family Well-Being], 2008). On the other hand, El Salvador reported that it did not have these types of studies and acknowledges the importance of conducting them in order to raise awareness of the connection between HIV and violence against women.

In terms of strategic information on HIV, all countries except for Argentina and the Dominican Republic have reported that they disaggregate their data by sex and age, and Chile, El Salvador, and Guatemala additionally have data that has been disaggregated by gender identity and sexual orientation. In Mexico, CENSIDA has information disaggregated by sex.[126]

126 Censida. Mexico. www.censida.gob.mx

Furthermore, Honduras and Belize report that they disaggregate their data. However, the data disaggregated by sex is not available to the public in all countries, nor is all the data disaggregated in line with UNAIDS and WHO recommendations.

With regard to studies on the rights of women living with HIV, only Honduras reports the study Derechos reproductivos de las mujeres positivas [Reproductive rights of HIV-positive women], coordinated by Balance, which concludes that the right to reproductive health as set forth in international case law is not being respected[127], which concludes that the right to reproductive health as set forth in international case law is not being respected.[128]Uruguay does not report any studies of this type and Belize and Trinidad and Tobago state that they have not conducted studies in this field.

127 Main results: Sixty-three percent of women reported that they had not been consulted as to whether they wanted to take the test before it was performed on them (63). Forty-one percent did not receive pre-test counseling (41) and 36% did not receive post-test counseling (36). Seventy-one percent did not sign a certificate of informed consent. Thirty-three percent indicated that they had not been provided with sufficient information on their antiretroviral treatment. Twenty percent of the women who were interviewed (20) indicated that they had not been given information on how to protect themselves in sexual relations. Twenty-two percent stated that they had not received sufficient information on the use of condoms while 56% indicated that they had not received sufficient information on the use of the female condom. Forty percent of the women interviewed (40) stated that they had not been provided with methods of contraception. Fifty-three percent of the women (53) did not feel that they had received comprehensive care. Eleven percent of the women interviewed indicated that they had been pressured to accept contraception. Avalos Capín J. (2013). *Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en cuatro países de Mesoamérica* [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica]. Balance Promoción para el Desarrollo y Juventud A.C. [Balance Promotion for Development and Youth, Non-Profit Organization], Mexico.

128 The study results have been included in the HIV response gender assessment tool, in PENSIDA IV, and in the concept note for the Global Fund.

7. Conclusions and recommendations

Conclusions

- Some progress has been made on including key issues for women living with HIV in some national HIV strategic plans as well as in sector programs and other public policy instruments. However, there is scarce documentation to show that the results of this progress are formally used in important indicators like education, work, health, and access to social protection for women living with HIV, among others. In the current context of the increasing instability of social policies in some countries and problems with public investment in especially vulnerable population groups, such as women living with HIV, it is imperative to promote policies with allocated funding that will address their multiple needs from a comprehensive point of view.
- Women living with HIV face challenges to the exercise of their human rights that range from the lack of access to treatment in some countries and violence in the various spheres of their lives, including killings, to access to information and protection resources and high levels of discrimination in services, the family, and the community, among others.

- In particular, the right to health is significantly restricted by factors like coverage and insurance plans, access to the voluntary HIV test, the lack of confidentiality, stigma and discrimination in services, and the prevailing approaches that confine the health and development of women living with HIV to the use of medication and the prevention of HIV transmission to their babies and sexual partners. Greater efforts are required in order to further the integration of HIV services with services that address sexual and reproductive health and violence against women, including aspects like guaranteed access to contraceptives, elective abortion, fertility treatment, and the prevention of institutional, family, and partner violence, among others. Likewise, only limited progress has been made on the guarantees for safe sex-change treatments in transgender persons.
- Women living with HIV experience a high degree of violence, and the issues specific to them, such as partner violence, insults, threats, and harassment in the public sphere, as well as violence exercised by State officials (healthcare providers, police officers, educational workers), employers, etc., coincide with the high prevalence of physical, sexual, emotional, and property-related violence against women in general in Latin America and the Caribbean. Cruel, inhuman, and degrading treatment is manifested in these forms of violence and social exclusion, which notably include the criminalization of HIV transmission, forced or coercive sterilization, and threats to the physical integrity of all of the diverse women living with HIV. Transgender women and female sex workers face extremely high levels of violence.
- The exercise of the right to education is tightly tied to health, work, social protection, a life of dignity, and social participation, among other factors. The low level of access that the majority of all of the diverse women living with HIV have to formal education, and the discriminatory practices in the educational sphere, reflect the magnitude of the challenges that must be addressed in order to fully promote their rights.
- The low employment rate among women living with HIV, and the instability of the jobs that they can get and keep over time, reveal the ways in which the aspects of inequality interact, perpetuating a vicious circle of social exclusion. In turn, this situation is linked with their limited social protection coverage and restricted access to food and housing, thus generating a poor quality of life.
- The legal, social, cultural, and institutional barriers that restrict the rights of women living with HIV to form a family, to be mothers, and/or to fulfill their roles in bringing up and caring for their children, limit their right to decide about motherhood while simultaneously making their children vulnerable.

- Adolescents' and young peoples' limited access to comprehensive sex education; the low level of knowledge about HIV, how it is transmitted, and condom use; and the lack of strategies for providing condoms to teenage and young women, as well as the lack of information specifically targeted at women living with HIV in services and other spaces, all endanger the progress made on HIV and increase women's vulnerability to the virus.

- The lack of meaningful participation by women living with HIV in decision-making processes–not just for HIV-related policies and budgetary allocations, but for all human development policies–calls into question the capacity of these policies to respond to their needs and to produce sustainable changes in the structural factors that lead to violations of their rights. The lack of funding for defending these rights is one of the most significant challenges to the protection, fulfillment, and promotion thereof.

.

Recommendations

In view of the truth of the situation revealed by the information available in Latin America and the Caribbean, we recommend:

- Crafting a regional agenda led by women's groups and by diverse women living with or affected by HIV on their human rights that will make it possible to establish inter-institutional actions with key sectors like justice, education, employment, health, social protection, security, among others, with an eye to addressing the existing discrepancies in the exercise of rights.

- Mobilizing domestic and international resources for the implementation of this regional agenda, carrying out actions at scale that will produce authentic, measurable changes in the fulfillment of rights, while also ensuring the sustainability of the interventions through the meaningful participation of women living with HIV.

- Continually strengthening the capacities of women living with HIV to advocate for their rights and access justice locally, nationally, and regionally, by reinforcing the strategic alliances between regional networks, local organizations, and the sectors with links to the HIV response at the domestic and international levels.

- Generating information that makes it possible to sustain evidence-based actions and that informs the funding of the interventions aimed at protecting and fulfilling the rights of women living with HIV. This includes conducting studies on issues about which there is very little information, improving the comparability and frequency of studies on stigma and discrimination, specifically including gender-based violence and discrimination and population surveys that include sets of questions on HIV, and improving information systems by using the principles of gender analysis in epidemiological surveillance and second-generation surveillance studies. Data must be disaggregated by sex, age, gender identity, sexual orientation, and ethnicity.