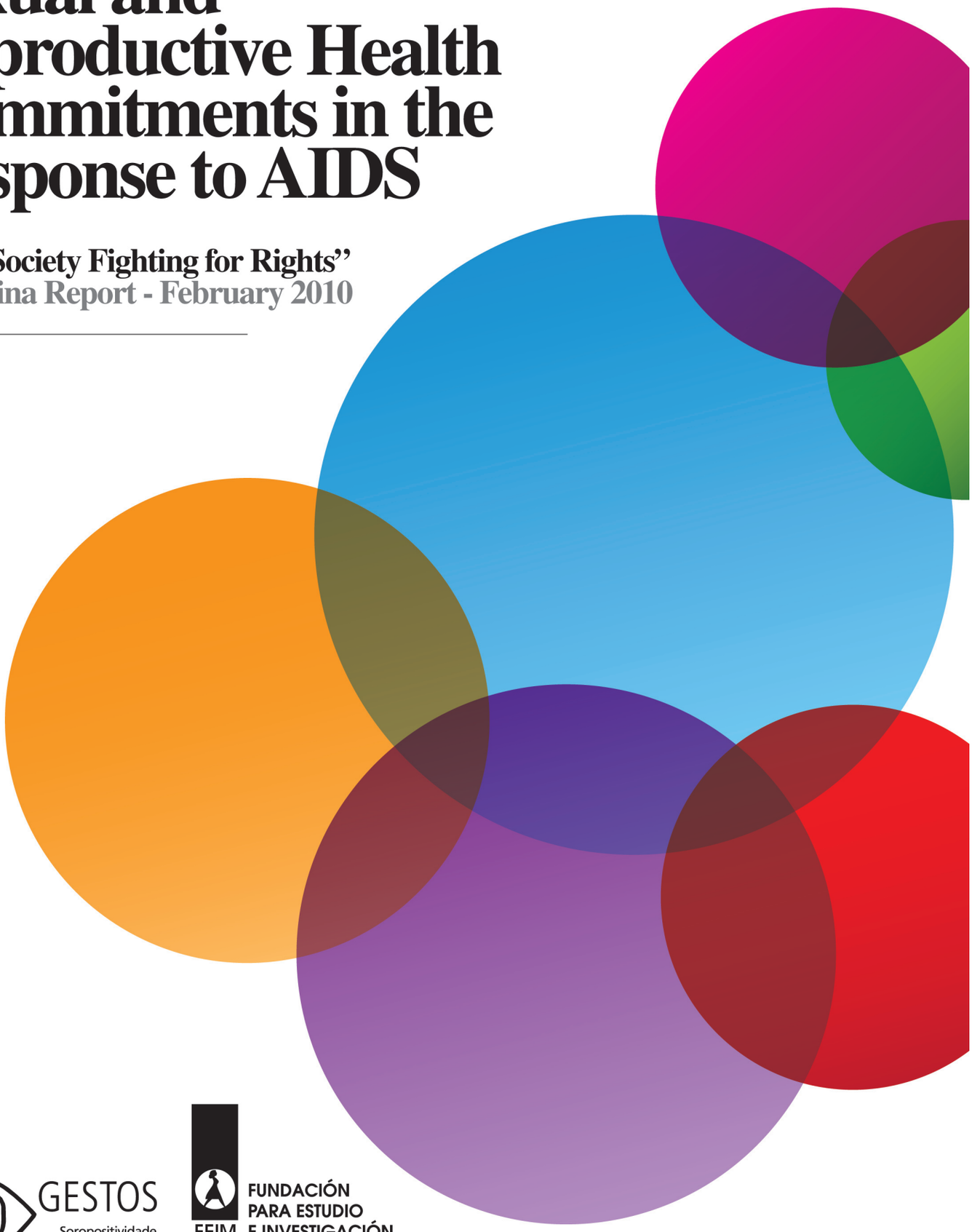
UNGASS *

Monitoring the

Sexual and Reproductive Health Commitments in the Response to AIDS

"Civil Society Fighting for Rights"

Argentina Report - February 2010



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UNGASS

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Sexual and Reproductive Health Commitments in the Response to AIDS

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This report was prepared under the project titled Monitoring UNGASS Goals on Sexual and Reproductive Health: "Civil Society Fighting for Rights", coordinated by GESTOS Brazil and supported by the Ford Foundation.

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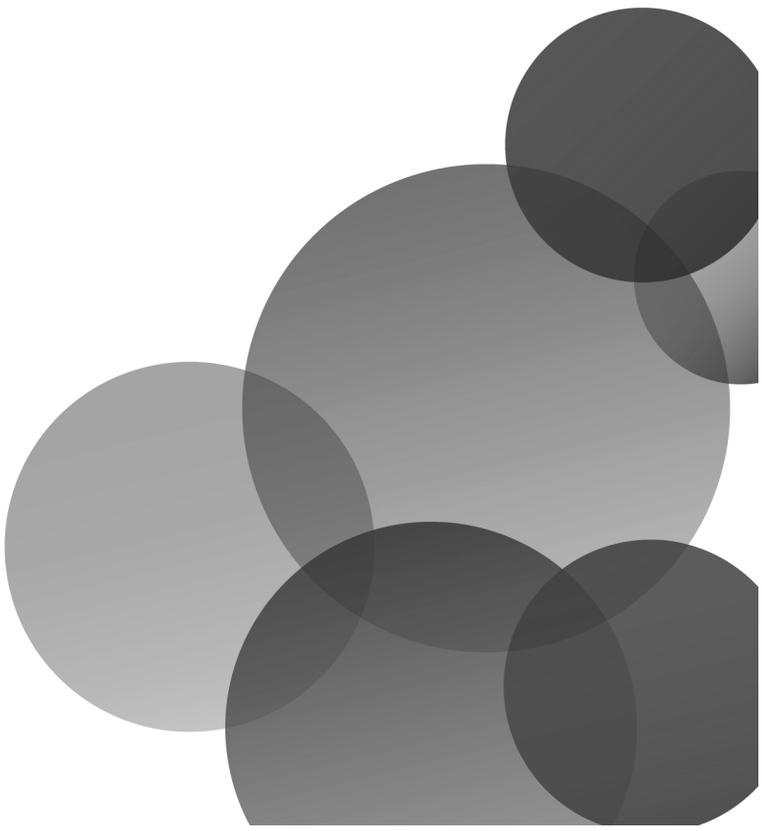

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Introduction

This is the second monitoring and evaluation report by the Argentine civil society on the goals related to HIV/AIDS and women's sexual and reproductive health, which the country committed to fulfill at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS), held in 2001.

The report was prepared by the **UNGASS Forum Argentina**, coordinated by the **Foundation for Study and Research on Women (FEIM)** within the framework of the international project "MONITORING THE UNGASS GOALS IN SEXUAL AND REPRODUCTIVE HEALTH," coordinated by GESTOS Brazil and comprised of thirteen non-governmental organizations from the fields of health, women's movement, sex workers, trans, gays and lesbians, women living with HIV/AIDS, youth, and incarcerated women. The second stage of this international project is conducted in nine countries: Argentina, Belize, Brazil, Chile, Nicaragua, Peru and Uruguay in Latin America; South Africa, Kenya and Uganda in Africa; India, Indonesia and Thailand in Asia; and Ukraine in Eastern Europe.

The monitoring results in Argentina, which will be incorporated into the government official report delivered to the Joint United Nations Program on HIV/AIDS (UNAIDS), **shows little progress and many situations unchanged from the first monitoring** conducted in 2008 and submitted to UNAIDS as a shadow report to the one submitted by the government.

The lack of integration, coordination and/or articulation between Sexual and Reproductive Health and HIV/AIDS policies and services in all provinces **is the country's main outstanding debt** to fulfilling UNGASS goals.

About half of all people living with HIV/AIDS worldwide are women and the feminization of the epidemic is a growing phenomenon. However, plans for combating HIV/AIDS do not incorporate specific actions for women. In turn, the policy on women´s sexual and reproductive health does not include specifically the prevention of the epidemic, although the Law 25.673 which created the National Program on Sexual and Reproductive Health incorporates it, nor does it specify the promotion of sexual and reproductive rights of women living with HIV. For these reasons, this monitoring focuses on the specific goals that involve the sexual and reproductive health of girls, adolescents and adult women.

The central objective of this report is to advocate for governments at national and provincial level to implement the proposals recommended by civil society organizations, to address the feminization of HIV/AIDS and ensure the sexual and reproductive rights of all people.

Further, this monitoring indicates the outstanding debts and recommendations to fulfill the commitments as well as provides data from participating civil society organizations that are otherwise scattered and inaccessible. It is also a strategy to help women to know their rights; reclaim them in cases where they have been disregarded, and to fully exercise their citizenship.

Each goal was closely evaluated by the organizations involved through requests for reports, qualitative and quantitative studies, and especially from the experiences of its members as users of different public services.

Argentina has an appropriate regulatory framework regarding access for all people to their right to health. However, in practice the country fails to ensure broad-scale provision of care. Monitoring once again showed serious problems in the response to the epidemic, especially a strong dominance of the medicalized response, delays and problems in the distribution of supplies from the nation to the provinces, delay in implementing the Comprehensive Sexual Education Law; lack of participation of adolescents and youth who are still not considered as rights holders, the vulnerability of many children and adolescents living with HIV/AIDS and/or are orphaned by AIDS, whether they are living or not with HIV/AIDS, the absence of a comprehensive approach on violence against women as a risk factor to HIV, among other aspects.

Within this context, some progress has been achieved in reduction of the vertical transmission of the virus and in the recent drafting of a National

Protocol for the care of victims of sexual violence (not yet complete).

This report is organized into three sections: Section I includes an overview of the country's health system and Sexual and Reproductive Health and HIV/AIDS policies, with statistical information about the epidemic and women`s Sexual and Reproductive Health.

Section II identifies the thirteen UNGASS goals monitored in this report, specifying the indicators used to evaluate the policies and actions implemented by the country to reduce the epidemic and its impact on women, and contrasting them to the contributions of participatiing organizations.
Section III identifies the strengths, gaps and deficiencies in Argentina to promote women`s sexual health, especially those living with HIV, and to prevent the epidemic among women. Finally, we propose recommendations towards a more comprehensive response to the epidemic, including placing sexual and reproductive health as a central unifying goal.

SECTION I

Country overview of the health system and policies on Sexual and Reproductive Health and HIV/AIDS

The overall situation and the health sector in Argentina

The population in Argentina grew to 39,745,613, according the INDEC estimates for 2008, with a distribution of 51% (20,280,308) females and 49% (19,465,305) men.[1] Age structure resulting from the 2001 Census[2], shows that people under 15 years of age reached 28.3% of the total population, the age group between 15 and 64 years comprise 61.8%, and groups of 65 years and over totaled 9.9%. 89.5% of the country's population resides in urban areas.[3]

A considerable income inequality persists, with the highest income decile topping out about 30 times greater than the lowest. The population below the poverty line in urban areas reached 13.9% in 2009, while the population below the indigence line reached 4.0% in the same period.[4]

Unemployment, one of the fastest growing problems during the decade of structural reforms from 2004 onwards, showed a progressive decrease. The current unemployment rate stands at 9.1%.[5] The unemployment rate by sex indicates the presence of persistent gender inequalities in the labor market: in the first quarter of 2009 the female unemployment rate was 9.8%, surpassing the male unemployment rate of 6 3%.[6]

Health and a healthy environment were incorporated to the National Constitution in 1994[7]. However, there is little demand or monitoring of health services by the population.

The different provinces and the City of Buenos Aires are mandated with the responsibility to care and protect the population`s health. With the goal of coordinating health policies, which involve such a diversity of actors and scenes at the country level, from 2002 the Ministry of Health strengthened the role of the Federal Health Council (COFESA), composed by the Ministries or Departments of Health of all provinces and the City of Buenos Aires, which is still running.

The national government is empowered to sanction norms for the health sector. Because of this competition, for example, in 1995 the Mandatory Medical Program (PMO for its Spanish acronym) was regulated by national decree[8], which includes the minimum benefits that different sectors of the national health system are obliged to provide.

The Argentine health system consists of three subsectors: public, social security and private; showing a significant fragmentation and overlapping of services that tends to deepen.

The public health sector provides health coverage to nearly half the population[9]. Its functions include the regulation and direct provision of services of the national state and the provincial and municipal states. It ensures basic services and essential care through free services. It is funded by federal, provincial and municipal taxes.

The social security subsector, consisting of several health insurance entities associated to different working areas, is intended to serve: employees (including military and law enforcement personnel), retirees, and independent workers who opt for the system, and their family groups, whose contributions, coupled with state subsidies, finance the system.

Finally, the private sector is financed by the contributions of associates to health insurance plans. It is worth noting that their activity has no specific health regulations, settling disputes over coverage in the frame of the Associations and consumer rights.

In response to the country's adoption of the United Nations Millennium Declaration (2000), the public health sector is the one more involved to achieve the Millennium Development Goals (MDGs) related to the health sector: reducing child mortality, improving maternal health and combating HIV/AIDS, Tuberculosis, Malaria, Chagas disease and other diseases.

The status of Sexual and Reproductive Health in Argentina

The estimated total fertility rate for 2005-2010 is 2.3 children per woman.[10]

The birth rate was 18.8% for 2008.[11] In that year,

the total number of births was 746,460, 15.5% corresponded to mothers under 20 years of age. Almost all of these births (99.4%) occurred in a health facility and were attended by trained personnel (doctors or midwives), 56.1% were attended in public hospitals.[12]

The maternal mortality rate had a slight decrease compared to 2006 reaching 4.0 per 10,000 births in 2008. 21.0% (62) of all maternal deaths in 2008 was the result of unsafe abortions. Despite the development of public and private health services and the high institutional level recorded since more than three decades, the maternal mortality rate in the country is still high. The leading causes of maternal deaths in Argentina could be reduced through preventive actions and adequate care during pregnancy and childbirth.[13]

Cervical cancer accounts for approximately 10% of the female mortality from cancer. According to 2008 [14], data, there were 2,514 deaths in Argentina from uterine cancers, of which 41% (1013) correspond to cervical cancer. Cervical cancer could be higher because a high proportion of uterine cancer is still not specifically assigned.
The infant mortality rate at the country level was 12.5% in the year 2008, the same as reported in 2006; 8.3% corresponding to neonatal deaths and 4.2% to postneonatal deaths.[15]

HIV/AIDS in Argentina

The HIV/AIDS epidemic in Argentina has evolved in very different forms since the first case in 1982, however "we now know that in Argentina we have a concentrated epidemic, (...) which means that the prevalence of HIV in the general population is less than 1%, and that there are some groups where the prevalence is equal to or greater than 5%. Several studies have found these figures: transvestites-transsexuals (34%), homosexuals and other men who have sex with men (12%), drug users (5%) and sex workers (5%).[16]

The estimates based on information collected up to 2008 jointly by UNAIDS, WHO and the Program of AIDS and STIs show that approximately 134,000 (128,000 to 140,000) people are living with HIV/AIDS in Argentina, of which 50% are unaware of their HIV status.[17]

75,009 HIV/AIDS cases were recorded since 1982 till December 2008[18], of which 37,998 (51%) had at least one AIDS-defining event, either at diagnosis or at a later stage[19]. An estimated 56,000 people are under treatment or follow-up in the health sectors, of whom 69% are under the coverage of the public subsector. 28,168 people received antiretroviral treatment provided by the National Program of AIDS and STIs in 2008.[20]

The incidence rate of AIDS cases, probably due to the incorporation of the highly effective antiretroviral therapy in 1996, has steadily declined since then to 4 per 100,000 inhabitants in 2007. The incidence rate of HIV infection[21] was 10.2 cases per 100,000 inhabitants[22] by the year 2008, with the notification of 4,067 new infections in that year. Annually between 5,000 and 6,000 new diagnoses of HIV infection are reported.[23]

The main route of transmission is unprotected sexual intercourse for both men and women. For men, the analysis of the notifications of HIV infection for 2005-2008 indicates that 48% acquired the infection through heterosexual sex and 34%, through sex with other men, establishing a relative weight of 82% of infections acquired through sexual transmission. Among men the last two years there has been an increase of unprotected sex with other men as a route of transmission. For women, 87% of infections are due to unprotected sex with men. In all regions, women infected with HIV have less education than boys.[24]

In recent years the epidemic showed a feminization. The first female with AIDS was diagnosed in 1987, and the male/female ratio was 92/1. For 2008, the ratio is 1.6 men for every woman in HIV cases. The male/female ratio presents differences in age groups, in the age group of 15 to 24 years the ratio is 0.9, while in the group of 35 to 44 years is 2.2.

The extent of HIV infection among women, especially of childbearing age, carries the risk of transmission of the virus by vertical transmission to their children. The notification

of cases of infection through this route fell from the biennium 1995/1996 due to the impact of the implementation of protocol ACTG076. For 2008 113 cases of HIV infection were reported through perinatal transmission, representing 2.8% of all notifications.[25]

The evolution of the AIDS mortality rate is similar to the evolution of the incidence rate of AIDS diagnosis, with a peak in 1996 that fell with the incorporation of the highly effective ARV treatment and stabilized by 1999. In 2007, the mortality rate from HIV/AIDS was 36.2 per million of inhabitants, registering an increase of 2 points compared to 2005.

There are big differences of sexual and reproductive health including HIV/AIDS indicators between the provinces in Argentina. This difference shows the relation of inequality as related to income and access to social services. Northeast and Northwest regions of the country are those with the most critical health indicators altogether with the highest concentration of poor people.

Sexual and Reproductive Health and HIV/AIDS policies

With the creation in 2003, under the National Ministry of Health, of the National Program of Sexual Health and Responsible Parenthood, through the law 25673/02, Argentina advanced to overcome the pro-natalist tradition deeply rooted in the country that still maintains a significant presence.[26]

The free provision of contraceptives with counseling at the request of all the beneficiaries is a breakthrough in universal access to protection methods for fertility regulation, so far only guaranteed to those who could access them in the market.

The law provides that the services, including provision of contraceptives should be covered by the social security and the private sectors in the same conditions as the minimum benefits set out in the Mandatory Medical Plan.

The objectives of the National Program of Sexual Health and Responsible Procreation are to: a) Reach for the population the higher level of sexual health and responsible procreation so that people can make decisions free of discrimination, coercion or violence; b) Reduce maternal and infant mortality; c) Prevent unplanned pregnancy d) Promote adolescent sexual health; e) Contribute to the prevention and early detection of sexually transmitted diseases, HIV/AIDS and genital and breast diseases; f) Ensure to all people access to information, counseling, methods and services related to sexual health and responsible procreation; g) Enhance women's participation in the decision making process regarding their sexual health and responsible procreation. It also establishes that the program is aimed at the general population, without any discrimination.

Although the Law No. 25,673 excluded surgical contraception and sex education was raised only for the schools of the public system, the following years laws were passed that recognized surgical contraception (August 2006), and comprehensive sexuality education in all public and private educational institutions (October 2006).[27]

Due to Argentina´s federal structure, the provinces are primarily responsible for implementing the program. Most provinces have enacted laws similar to the Law 25673, but their contents are dissimilar. Some of them have joined the national law and others have enacted specific laws. It is also dissimilar their commitment in the implementation of the program, which is reflected, among other indicators, in the availability and access to all contraceptive methods provided by the current legal framework.

During the period, the National Program of Sexual Health and Responsible Procreation went from having autonomous entity within the Ministry of Health of the Nation to be incorporated again as a program of the Maternal and Child area. This passage reaffirms the dominant trend in health care services and in the health sector in general, which prioritizes the reproductive aspects over the exercise of sexuality not linked to procreation.

The legislation on abortion is restrictive and its interpretation is even more restrictive. Although

abortion is legal in cases of risk to the health and lives of women and in rape cases since 1922, there are no reported cases in which abortions were performed in public hospitals. For about five years, there are many cases that fall as non punishable, however, if a woman asks for an abortion in public hospitals there is a tendency to seek legal authorization and there is a systematic refusal to practice it.

Argentina is one of the first Latin American countries to have legislation to address the epidemic and protect the rights of people living with HIV/AIDS. In 1990, the National Law 23798 to Fight against AIDS was sanctioned.

In 1992, according to the Law No. 23798, the National Program to Fight AIDS and STIs (PNLRHS in Spanish) was created. In 2007, the program acquired the hierarchy of Office within the structure of the Ministry of Health, under the name of National Office of AIDS and STIs.

Two national laws state[28], as part of the services and procedures recognized in the Mandatory Medical Plan, that providers from the social security and private services should cover comprehensive care for HIV infection, including the provision of ARVs.

The National Office of AIDS and STIs, in the frame of the law 23798, manages 100% of the ARV treatments[29] (including those for the prevention of vertical HIV transmission), medication for opportunistic diseases[30] and covers the monitoring studies of infection (Viral Load Measurement, CD4 count and Resistance Testing), to the people living with HIV who are under care in the public health system.

It also includes the provision to the provinces and the City of Buenos Aires of: condoms, reagents for HIV and syphilis screening for pregnant women, medication for the STIs treatment and breast-milk substitute for the children of women living with HIV. The provision of these medical supplies is the result of complex institutional arrangements, which started with the first agreements signed in 1997, which promoted shared responsibility for care of people living with HIV, but gave the National Ministry of Health larger responsibilities.

Epidemiological surveillance of HIV/AIDS is also under the National Ministry of Health. In 2001, the country incorporated the notification of HIV infection cases to the epidemiological surveillance, up to that moment mandatory notification only included AIDS cases

As regards the provision of ARV drugs, since 2002 Argentina has led the renegotiation of prices of medicines for HIV/AIDS in the region[31]. Moreover, in 2001 and 2003 important resolutions were passed in the National Ministry of Health on mandatory bioequivalence tests and bioavailability of ARV drugs

Both the National Program to Fight AIDS and STIs and the National Office of AIDS and STIs encouraged the development and dissemination of standards, guidelines and therapeutic recommendations related to various aspects of the epidemic. Currently there are standards, therapeutic recommendations and/or Guidelines for: Perinatal Transmission of HIV/AIDS (1997, updated in 2002), Antiretroviral Treatment-(2007), Health, HIV/AIDS and trans sexuality: Health care for transvestite and transsexual people (2008), Treatment and Prophylaxis of Opportunistic Infections and other relevant infections in people living with HIV/AIDS (PLWHA), Syphilis Treatment in pregnant women and newborns; STI Care and Comprehensive Care of Women living with HIV (2009).

Currently, the country has a National Strategic Plan for the period 2008-2011 (updated strategic response to HIV and AIDS in Argentina: towards universal access to prevention, treatment, care and support), produced in 2007 and revised in 2008. The development of this plan included the participation of government agencies, civil society, academia and international agencies associated with UNAIDS operating in the country.

Interaction among HIV/AIDS, SRH and STI programs

There is no interaction between these national programs. Although the National Program of

Sexual Health and Responsible Procreation has among its objectives and actions the diagnosis and prevention of HIV/AIDS and other STIs, and the National Office of AIDS and STI has among its strategic guidelines the need for articulation with the SRH program, the **fragmentation between SRH and HIV/AIDS services is confirmed in most jurisdictions.**

At the national level, joint initiatives are still incipient. **In mid-2009 both programs began to work together in the development of a care protocol for sexual violence victims and in prevention activities, but still no progress has been made. The protocol still is not published and disseminated, and there is not yet joint training for professionals.**

The association between contraception and HIV is recognized in a recent publication (August 2009) by the National Office of AIDS and STI, dedicated to the comprehensive care of women living with HIV. It is the first document with recommendations for health professionals who deals specifically with this theme. However, it has not been sufficiently widespread among those responsible for HIV/AIDS provincial programs, and among providers of the National Program of Sexual Health and Responsible Procreation, key aspect to achieve its effective incorporation into healthcare services.

In public health care services, there is a distance between those for infectious diseases, focusing on the care and treatment of people living with HIV, and those addressing SRH. These do not work in a coordinated manner, therefore they do not address the issue comprehensively, even though it has been recognized the need to work jointly.

SECTION II
UNGASS goals

Goal 37 - *Leadership by Governments facing the HIV/AIDS Epidemic*

"By 2003, ensure the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that address the epidemic in forthright terms; confront stigma, silence and denial; address gender and age-based dimensions of the epidemic; eliminate discrimination and marginalization; involve partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people (…)"

The review of the this goal's fulfillment analyzed the situation and the advances in women's and young people's effective participation in decision making processes on national policy related to HIV/AIDS. It also included a review of the participation of representatives of women's, young people's and adult's, women living with HIV/AIDS, lesbian women and transgender collectives in planning and monitoring actions aimed at reducing their vulnerability to HIV.

Civil Society Participation in designing public policies on HIV

With regard to the 2008 Report, the systematic participation of civil society organizations in decision-making processes on government policy is still not seen; except for their presence in the Technical Advisory Committee.[32]

"The participation of women's movements or women's groups is limited to specific instances in the National AIDS Program planning, which is the only space for dialogue between the government and civil society in which it is possible to influence policies specific to HIV/AIDS and women; young people are not included in the planning. (…) a multisectoral body where the government and civil society are able to reach consensus that allows for the inclusion of civil society in decision-making spaces has not yet been effectively created, which means that the only space for this is exclusively under the government agency." (Buenos Aires Network of PLWHA). It is worth clarifying that this situation affects women who are members of the networks and CSOs of WLWHA.

The National Strategic Planning (NSP) Processes which began in 1999 are the meeting place for government and civil society actors to build consensus for action. The current NSP was developed in 2007 and was revised in 2008 and 2009.[33]

> **"Without participation."** *"Inclusion of civil society in decision making spaces has not been achieved"* Buenos Aires Network of PLWHA"

Toward the end of 2008, the National Office of AIDS and STIs, with the support of multilateral cooperation agencies, encouraged annual operational programming processes related to the NSP in some provinces where the epidemic has a larger presence. Government organizations and civil society participated in these processes at the local level. **The call for participation did not specifically take into account women's or young people's groups but rather organizations with local presence related HIV care. In all cases, representatives of people living with HIV participated in these meetings.**

The process of developing the "Guide for Comprehensive Care for Women with HIV Infections"[34] promoted by the National Office of AIDS and STIs, is recognized as an opportunity for the participation of women living with HIV. The Guide constitutes the first set of recommendations developed specifically regarding care for women living with HIV, whose primary basis is not only prevention of vertical transmission, and which include matters related to reproductive rights. The consultation process was developed in 2008 with regional meetings in which representatives of provincial and municipal HIV programs, scientific societies, healthcare teams and CSO representatives participated.

"HIV+ women actively participated, as did women sex workers. We were not invited in designing the project, but we were invited to the regional workshops in different parts of the country; we validated what was the most adequate and least stigmatizing vocabulary. What was important was the opportunity we had to express the poor care we received as women receiving services facing the healthcare teams (…)" (RedAR+).

The Country Coordinating Mechanism (CCM), implemented in the country in 2002 upon approval of the Global Fund Program, did not include women's organizations.[35]

❇ Women and youth from outside. The HIV/AIDS epidemic is increasingly younger and more female, but the opinions and experiences of women's and young people's organizations are excluded from the design, planning and monitoring of policies and actions on HIV/AIDS. And the gender perspective as a cross-cutting focus is missing.

With regard to other government structures at the national level and the possibility for designing and monitoring actions and policies, Civil Society Forums were created in the National Institute against Discrimination, Xenophobia and Racism (INADI for its Spanish acronym)[36]. Along these lines, Forums dedicated to Gender, HIV/AIDS and Sexual Diversity, among others, have also been created.

With regard to transgender people, no possibilities were observed for influencing the design or for systematically participating in monitoring policies so as to help reduce their vulnerability.[37]

Compared to the 2008 Report, even though CSOs were incorporated into specific actions, the broad and systematic inclusion of women's and young people's organizations in the discussions and consensuses on HIV/AIDS has not been found. Based on the diagnosis of affected people with higher prevalence of HIV infection, transgender people and sex workers were convened for some aspects of planning, designing recommendations for care and/or programmatic actions. The inclusion of a gender perspective as cross-cutting action on HIV/AIDS is a challenge that is still pending.

Goal 52- *Prevention*

"By 2005, ensure: that a wide range of prevention programs which take account of local circumstances, ethics and cultural values, is available in all countries particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behavior and encouraging responsible sexual behavior, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm-reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections."

The review of advancements analyzed: prevention components of the national HIV/AIDS policy related to sexual and reproductive health; the implementation of strategies to reduce HIV prevalence in young people between the ages of 15-24, including coverage and effectiveness, with special emphasis on informational and educational strategies and campaigns; access to and availability of condoms (male and female) and lubricants for adult women and young people; obstacles for women in accessing prevention services and supplies; availability and accessibility of STI diagnosis and treatment services in primary health care centers, and availability of statistics and campaigns about women; and the existence of regular government monitoring of actions carried out in relation to SRH, HIV/AIDS and STIs and the creation of reliable and available information in this regard.

Prevention Components of the National HIV/AIDS Policies and SRH

Among its strategic objectives, the NSP 2008-2011 establishes the following: *guarantee and increase access to HIV prevention aimed at the general population with emphasis on populations with greater vulnerability to infection: people living in poverty, people who use drugs, men who have sex with men, gays, sex workers, people in prison, transgender people, migrants, refugees, boys and girls, adolescents, young people, women and indigenous people.*

In developing the strategic points, actions and content related to sexual and vertical HIV transmission are identified. Among them are: intensify the prevention of vertical transmission of HIV and congenital syphilis; implement and support sexuality education programs and STI and HIV prevention programs in populations that are socially and economically vulnerable; establish joint programs and projects on sexual health and HIV and STI prevention for boys, girls, adolescents and young people, in an effective partnership between Health and Education; guarantee the periodicity of mass, targeted communications on HIV prevention, taking into account different people's situations and singularities and guarantee accessibility of condoms to the population, taking into account the diverse specificities to improve condom distribution policy and strategies.

It is worth noting that in the strategic objective related to comprehensive care for people living with HIV, not even one strategic point refers to sexual and reproductive health, even though links to other government areas are considered, specifically prevention and treatment for tuberculosis.

Moreover, among its strategic areas, national policy related to HIV/AIDS includes promotion and accessibility of condoms and prevention tools; in this particular case, it mentions articulating with reproductive health and maternity and childhood policies, among others. About condoms, only male condoms are distributed.

❇ **Low level of articulation.** The only initiative that articulating actions between programs to fight HIV and sexual and reproductive health programs was the development and drafting of the National Care Protocol for Victims of Sexual Violence, which is still not yet implemented.

The search for articulating with reproductive health policies is new compared to previous formulations of the National HIV/AIDS Policy. During 2009, both programs worked on drafting the National Care Protocol for Victims of Sexual Violence, which was reviewed in 2010 but not yet implemented. However, beyond such specific activities, no comprehensive linkage connecting the actions developed by the two programs exists at national level nor at health care services.

Adolescents

As was observed in the 2008 Report, no specific strategies for working with adolescents and young people promoted by the public health sector were found. Even though young people are included as a target group of HIV prevention actions, the prevention strategies undertaken do not consider the specificities of working with them. "In terms of national policies, there is a clear omission by the State since it has no strategy for addressing (…) adolescents and young people between the ages of 14 and 30" (JOACYA). A large part of the prevention work with adolescents and young people is sustained by CS groups, including regular provision of male condoms and lubricant in friendly places.

As reported in 2008, the National Ministry of Education, Science and Technology and the Ministries of Education in the provinces and in the City of Buenos Aires still have not implemented the National Comprehensive Sexuality Education Program created by the National Law 26150, sanctioned in 2006.[38]

✻ **Absence of sexuality education.** The government's failure to effectively implement the Comprehensive Sexuality Education Program keeps girls, boys and young people from accessing information on a priority issue for them, thereby violating their rights to information.

"There are no strategies to reduce the increases in HIV among young people. Although the Comprehensive Sexuality Education Law exists since 2006 so that (…) young people can have access to information and education about HIV, it still has not been effectively implemented in all the provinces, and therefore the fulfillment of this goal is not guaranteed" (RedNAC).

It should be pointed out that in some parts of the country, such as the City of Buenos Aires, some joint actions with CSOs were initiated in 2007, aimed at adolescents enrolled in school, but in 2008, with the change of government, these actions were cut back and since 2010 a reduction in the budget for developing these activities existed.

The government's failure to effectively implement the Comprehensive Sexuality Education Program keeps girls, boys and young people from accessing information on what is a priority issue for them, thereby violating their rights to information.

✻ **"Insufficient, sporadic, limited."** This is what organizations think of the HIV/AIDS prevention campaigns targeting young people.

There is consensus among organizations; all of them consider the campaigns to be insufficient, sporadic and limited in reach. The work of dissemination/awareness is primarily based on handing out flyers and condoms, be it continually and systematically or at mass events held on commemorative dates. *"The specific campaigns ended up being based on the distribution of flyers, in specific places, but they were not able to implement them through different means of communication, which meant that the messages transmitted is not in the reach of many young people (…)"* (RedNac). *"The communication campaigns for disseminating the policy of the National Office of AIDS and the prevention tools are nonexistent. The dissemination is done through a website and/or by the organizations that are familiar with the resources. We have not identified campaigns in the provinces or at the local level that have an impact."* (RedAR+).

Prevention Supplies

Male condoms and lubricants are available for free distribution in health care centers and hospitals belonging to the public health system. The National Office of AIDS and STIs, and the National Program of Sexual Health and Responsible Procreation, are the main sources providing these supplies. The provision is mainly done through the respective provincial HIV/AIDS and SRH programs.

The National Office of AIDS and STIs provides condoms to CSOs and networks for them to distribute for free. The organizations involved in the distribution are quite different, including organizations of sex workers, trans, gays, women, young people, people living with HIV/AIDS, as well as community kitchens, development associations, clubs, among others. This strategy responds to one of the central goals: condom accessibility. The government promotes distribution networks based in places where people can have regular access to male condoms.

A study[39] done by the National Office of AIDS and STIs showed that only six provinces acquired condoms for distribution to the populations; the majority of the provincial HIV/AIDS programs only have the supplies that are provided by the National Office of AIDS and STIs, and the National SRH Programs.

✻ **Condoms.** There were missing supplies and delays in delivering condoms in the provinces; especially outside the capital cities.

Logistical difficulties in distribution to the provincial programs and health centers in the different districts have been reported; especially by those located outside the capital cities and for (short) periods with no supplies available. In addition, based on the variation in the demand, the condoms received from the National Ministry of Health are sometimes not enough for some districts.

*"Young and adult women are **able to access** male condoms and lubricants in the primary health care centers and at some civil associations. During the course of the year there is a lack of supplies but not for very long. But what is not available is **easy access** to acquiring these supplies."* (Fundación Huésped- testimony of an Infectologist in Jujuy).

Female condoms are not available for distribution in public health centers in the whole country.[40] One of the proposals that was made is that they be included with the prevention supplies for free distribution. *"Taking into consideration the effects of gender violence on the growth of the epidemic among women and thinking about promoting actions that would allow women not to depend on men's decisions for prevention, we believe that free distribution of female condoms is necessary"* (AMMAR).

In this sense, from the National Office of AIDS and STIs a project on use of female condoms has started to be discussed. *"With the support of UNFPA, the National Office of AIDS is planning a pilot test related to female condom use; and civil society organizations and the Sexual and Reproductive Health Program have been convened to participate. The SRH Program has had weak participation due to the difficulties that the different Programs of the National Ministry of Health have in articulating joint actions."* (RAMVIHS)

Although male condoms (and other contraceptive methods, including surgical contraception) are available and guaranteed by law, multiple obstacles for accessing them are reported, especially for adolescents and young people (15-24 years old).

Access to condoms and other contraceptive methods is hampered by the predominance of moral values and the prejudice and prescriptive attitudes of health care personnel regarding people exercising their sexuality.

✻ **Identify yourself.** Some services called for people requesting condoms to present their national identity document. In Buenos Aires Province, Fundación Huésped made a formal request to the provincial and national sexual and reproductive health programs to stop this practice and, as a result of the request, a resolution was established avoiding this requirement.

In a survey done in Entre Ríos Province, in the framework of monitoring the reproductive health services, the young people consulted responded that they *"never or almost never go to the health center because they do not like how they are treated there; (…) they said the personnel does not respect their privacy and accuses them of being promiscuous and irresponsible."* (RedNac). Young people from other localities have the same feeling about the care they received. Another main obstacle for young people in accessing condoms and other contraceptive methods is rooted in the force of the custodial paradigm over minors (which attributes the possibility of deciding about questions regarding their development to the State and the parents) in the practices of a large number of health centers and health personnel and their lack of knowledge about the current legal framework.

The Law 25673 (National Program of Sexual Health and Responsible Procreation) specifically defines that **adolescents ages 14 and over can access a doctor's appointment and the provision of contraceptives without the presence of an adult.** Nonetheless, *"even though coverage of male condoms and lubricants is free through the public system, young women still face restrictions in obtaining the sufficient quantity of male condoms and lubricants for free at the health services, since they are still asked to be accompanied by their parents or guardian despite*

their right to attend freely once they are 14 years old, as guaranteed by Law 25.673" (RedNac).

> **"For three condoms.** *"I don't use the hospital or clinic services because every time that I have gone to ask for contraceptive pills, they interrogated me as if I were committing a crime". "(in the hospital) they even ask for your name and your mom's national ID number, or if you have a lot of sex every month, just so they can give you three condoms"* – ICW"

Programmatic and bureaucratic issues linked to resource management in the programs are clearly an obstacle for access not just by young people but also by all populations that use these services.

One of the first issues is the requirement demanded in some services (although for no reason or programmatic explanation) of **presenting one's national ID card and, in the case of the male condoms distributed by the National Program of Sexual Health and Responsible Procreation, signing the list of people who have received supplies.**[41] Although the National Program of Sexual Health and Responsible Procreation has determined, since 2007, that condoms should be distributed freely, upon demand and without keeping a list of names, this practice continues in the large majority of health centers, especially in primary care.

One example of the actions needed to guarantee free access: *"In October of 2009, the Fundación Huésped submitted a formal request to the Sub-Program of Reproductive Health and Responsible Procreation of the Ministry of Health of Buenos Aires Province and to the National Sexual Health Program so people can receive condoms without having to leave their name. The request was resolved with an agreement by which, as of that moment, only the amount of condoms given out would be recorded, but not the person who received them. This resolution was communicated at a meeting with regional representatives of Reproductive Health, who were also given a clarification note on this issue. This agreement will facilitate access to and distribution of condoms for whoever requests them, especially for adolescents and young people since they can do it anonymously"* (Fundación Huésped).

Sexually transmitted infections

The availability of STI diagnosis and treatment in the first level of care is different according to the zone of the country and its territories. The National Office of AIDS and STIs provides supplies for diagnosing syphilis and blennorrhagia and treatment for the majority of STIs; it provides recommendations for treating syphilis in pregnant women and newborns. The prescription of the test for detecting syphilis in pregnant women is included as part of prenatal controls.

There are no massive campaigns addressing STI prevention. The National Office of AIDS and STIs offers materials on STIs for dissemination only through its website and includes information on STIs in the materials about HIV/AIDS.

Health centers should have the obligation to notify some of the STIs to the National System of Epidemiological Vigilance (SINAVE for its Spanish acronym); and in the case of syphilis, they should also notify the National Office of AIDS and STIs. **Nonetheless, not all professionals and centers fully comply with the notifications.**

Regarding the effectiveness actions for HIV and other STI prevention, reports from studies with different reaches[42] show that, among young people, there is still a remarkable lack of knowledge about HIV/AIDS and other STIs transmission as well as uneven levels of using condoms for prevention.

Regular monitoring of the actions related to SRH, HIV/AIDS and STIs was not found. In the case of HIV/AIDS and STIs, there is epidemiological information that registers delays and underreporting.

Goal 53- *Prevention*

"By 2005, ensure that at least 90 per cent,

and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers."

The review of this goal's fulfillment analyzed: the existence of specific prevention services for Young women and also formal and informal barriers to providing prevention services (including information and supplies) to adolescent minors; the availability of trained health personnel to provide prevention counseling for women and the existence of training initiatives for health teams on this task and the availability of EC[43] and ARV treatment for post-exposure prophylaxis for sexual exposure to HIV.

Prevention Services

As in 2008, in the public sphere, there are very few hospitals that have adolescent health services; and among those that do, very few of them dedicate part of their work to providing HIV/AIDS prevention services. The gynecology/obstetrics services rarely incorporate prevention-promotional activities into their actions.

It is primarily the CSOs that develop this task, sometimes in the framework of health institutions based on agreements with a varying level of formality made with health teams.

✻ Delegating prevention.
The prevention services aimed at women and young people are mainly run by civil society organizations.

The barriers related to providing prevention services to adolescents and young people are similar to those found in access to prevention supplies. The obstacles found come into play with variations found in different districts, prejudices and discrimination, interventions based on gender stereotypes, the lack of specific technical and legal knowledge, and moral values found in the practices of some members of the health teams. *"The majority of existing sexual and reproductive health services have not looked after large part of the SRH needs of adolescents as a group. The health centers do not have counseling services available for adolescents or special spaces to provide them with care. The majority of adolescent women that gave birth in public hospitals did not receive specialized treatment"* (RedNac)

The existence of trained health teams to work specifically with women and Young people is a deficit. Although some efforts to advance in training members of health teams on counseling were observed, these are unsystematic and insufficient.

"Keep health personnel up to date and trained is a pending debt in health policy, and even more so when it comes to WLWHA, who are still stigmatized by health personnel and counseling services, sometimes even feeling like they don't have the right to have a full sexual life since they live with HIV. (…) It is noteworthy that in some health services there is a strong prejudice about the sexuality of women living with HIV" (Buenos Aires Network of PLWHA).

The strategy that is used most by the organizations is to identify and strengthen relationships with trained and sensitized professionals and with friendly services, and referring the population that they work with to them. This strategy has proved to be limited, both because of the scarcity of such professionals and services and because of the limited reach to populations and districts. **The effective enjoyment of one's rights depends exclusively on the personal commitments of the members of the health teams; without being able to take forward inclusive strategies for the promotion and effective exercise of one's rights; and even less so in universal, non-discriminatory public policies.**

❝ Unfriendly services for adolescents: *"The health centers do not have counseling or special spaces for care adolescents. Most adolescent women that gave birth in a public hospital did not received specialized treatment"* - RedNac ❞

Care protocols for victims of sexual violence

At the date of this report's publication, Argentina still does not have a national protocol that establishes norms for care for women victims of sexual violence and that specifies the provision of Emergency Contraception –EC- for prevention of pregnancy, of Post-exposure prophylaxis for HIV prevention and psycho-social care. Nonetheless, as was mentioned, during 2009 the National Program of Sexual Health and Responsible Procreation and the National Office of AIDS and STIs developed a version of a national protocol on which some CSOs have expressed their opinion. In 2010 a review was done but still the protocol was not adopted/implemented.

The EC is supplied by the National Program of Sexual Health and Responsible Procreation as part of the contraceptive methods provided by the program. Its distribution was approved in 2007, but its availability in the health services is unequal due to myths and prejudices about its abortive nature. The logistical problems that affect the availability of condoms in the health centers outside capital cities also happen in the case of the contraceptive methods supplied by the National Program of Sexual Health and Responsible Procreation. It is worth noting that the alternative offered by the Yuspe method is not commonly used either, with oral contraceptives being available in the health centers.

> **"Lack of training:** *"In some health services there are strong prejudices about the sexuality of women living with HIV/AIDS"* – Buenos Aires Network of PLWHA **"**

Regarding ARV prophylaxis, based on the regulation of what was the National Program to Fight AIDS and STIs in 2001, the health centers should have a prevention kit for one month of treatment. Generally this kit, when it is actually available, is found in hospitals but not in primary health care centers. In some places in the country, accessing the hospitals means having to travel great distances.

The application of the post-exposure prophylaxis would seem to have a greater presence in situations of sexual violence that in care for accidents (when the condom breaks or in cases of unprotected sex) that expose women, men and trans.

Post-exposure prophylaxis *"is not available for women or young people when they go to the doctor's appointment to request it after having had unprotected sex" (Buenos Aires Network of PLWHA). "We identified isolated cases of post-exposure prophylaxis protocols in some localities which have done a great job articulating and creating a reference system of sexual abuses; these networks are generally intersectoral and are led by militant women"* (RedAr+).

Goal 54- *Prevention*

"By 2005, reduce the proportion of infants infected with HIV by 20 per cent, and by 50 per cent by 2010, by ensuring that 80 per cent of pregnant women accessing antenatal care have information, counseling and other HIV-prevention services available to them, increasing the availability of and providing access for HIV-infected women and babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counseling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care."

The review of this goal's fulfillment analyzed: availability of information, counseling and tests for detecting HIV in public and private care services for pregnant women; offer and availability of treatment to prevent vertical transmission, psychosocial support and orientation for feeding their children and breast milk substitutes. Orientation to contraceptives for women with HIV; national policy on abortion and the perception of public opinion regarding the right of a women living with HIV to terminate a pregnancy.

Vertical Transmission

Since 1996, the country has established that testing for pregnant women and ARV treatment for preventing perinatal HIV transmission must be offered. The national law 25543 ratifies that health professionals are obligated to offer the HIV test to pregnant women, following counseling and confidentiality standards. Treatment and formula milk are available for the children of mothers living with HIV until they turn six months old.

Inequalities and disparities are found between different provinces in regards to the availability of timely diagnoses that are accompanied by counseling. These differences are associated to the uneven spread of networks of laboratories, the capacity of processing their samples and the scarce development of counseling activities.

The absence or low level of development of counseling related to diagnostic tests is a problem that was found not only for pregnant women but also for other users. *"The only case in which offering an HIV test to women is prioritized is when the woman is pregnant, following the 'container' model of women and trying to avoid vertical transmission"* (RAMVIHS).

> **"Container Women.** *"The only case in which offering an HIV test to women is prioritized is when the woman is pregnant, following the 'container' model of women and trying only to avoid vertical transmission"* - RAMVIHS"

"Since 1997, a protocol has been applied for pregnant women that go to the doctor for the first time, offering then an HIV test after first receiving counseling. If the result is positive then the prophylaxis protocol is implemented to prevent vertical transmission. (…) this has improved in the last years and **we should recognize that it is one of the strongest methods implemented in all levels of care nationally;** *the problem is when the mother does not come in for the controls and goes directly to have her child, and doesn't find out her diagnosis until childbirth"* (Buenos Aires Network of PLWHA).

Regarding the provision of breast milk substitutes, logistical problems in their distribution from central provincial health services to those outside are sometimes found.

Sexual and Reproductive Health of WLWHA

The contraceptives offered to women living with HIV and approach to sexual health care in general is found to be a highly conflictive issue, sometimes due to prejudices and stigmatizing and discriminatory attitudes of personnel and health services, on top of the unnecessary suffering of women who experience this situation in "silence" due to the difficulty of finding someone who can negotiate for them in consideration of their needs and desires.

The only advance recognized in this sense is the development of the "Guide for Comprehensive Care for Women with HIV Infections" mentioned earlier; which included, for the first time, aspects linked to clinical-gynecological monitoring and care for women with HIV, contraceptive options for people with HIV, pre-conception consultation for women with HIV, treatments recommended for STIs, reproduction in the framework of HIV infection and legal aspects[44].

Nonetheless, the impact of these recommendations still have not taken shape in health care services, where **condom use is persistently suggested as the only method for PLWHA and double protection is not promoted or worked on regularly.** A study developed by FEIM (2009)[45] indicates that out of 65 WLWHA interviewed who use some contraceptive method, only 13 of them use double protection—primarily condoms and contraceptive pills; while almost all of the WLWHA only use condoms. *"In this group condom use is dominant because it is the method that is suggested to WLWHA for having sex, due to its ability to prevent HIV more than as a contraceptive. For this reason, in this variable differences are also recorded with regard to the tendency observed in other studies of the general population (…)"* (FEIM: 2009).

Therefore, it is observed that the medical counsel does not contemplate the diversity of PLWHA's needs, which can have to do with wanting to having children or the real difficulties (which many WLWHA express) in getting their partners to accept always using a condom. *"In general, there is still rejection of talking about contraceptive methods (except for condoms) or about the sexual and reproductive health of women living with HIV. Any consultation made to the Family Planning service, be it for protection or to get pregnant, is immediately referred to Infectology. (…) They suggest that you abstain from having children and often strongly judge the decision to have them. (…) The concept of double protection is not talked about. Little is explained about correct condom use and they do not inform you about reinfection".* (Buenos Aires Network of PLWHA)

✻ Sexuality and HIV. The sexuality of women living with HIV is a highly conflictive issue for health personnel and is influenced by prejudices and stigmatizing and discriminatory attitudes.

"In terms of recommendations about contraceptive methods, there are not many opportunities to be able to talk openly about the sexual life of positive women, not even a doctor specialized in gynecology so that he/she can give you a general checkup (…)". (RedAR+)

"The orientation provided by health professionals on contraceptives for WLWHA is limited to the use of the male condom every time you have sex. (…) From the Argentine Network of Women Living with HIV/AIDS we promoted double protection since many women are not able to negotiate condom use with their partners or the women themselves decide not to use them. It is not looked on positively by health services when WLWHA ask for contraceptive pills or an IUD. They tell us, for example, that the IUD lowers our defenses or that the pill has counter indications for ARV medication. There is institutional violence against WLWHA in gynecological and obstetric services when asking for other contraceptive methods and when expressing the desire to have children (…). As WLWHA, we want family planning programs to consider not only the woman but also her partner. (…) Some of our colleagues and friends have been offered sterilization to avoid having children" (RAMVIHS).

In the National Nutrition and Health Survey in 2007, it is found that out of the total sample, 23% of the women use condoms as a contraceptive method, 17.5% use the pill and 8% use an IUD. *"Only one of the women surveyed uses an IUD, which may be due to the resistance of the health professionals to suggest this method for WLWHA based on the erroneous belief that IUDs in WLWHA can produce co-infections and/or possible infections. (UNGASS 2008, IPAS 2006). (…) Regarding sterilization, two women refer to it, reflecting a greater proportion using this method than in the general population, which coincides with established facts (Bianco, Ré and Acerbo 2000) and evidence that among WLWHA there is a tendency of professionals from the health sector to suggest sterilization as a form of preventing HIV transmission to children, which is something unconceivable with the reduction of vertical transmission with prevention using antiretrovirals. (…)"* (FEIM, 2009)

It is evident that **there is an implicit prejudice: it is not considered reasonable that WLWHA have children, and therefore, there is a tendency (not declared but real) to discourage WLWHA from pregnancy and in some cases from being sexually active** (FEIM 2006). **Therefore, the development of the "Guide for Comprehensive Care for Women with HIV Infections" is recognized by WLWHA as progress in installing the issue in the agenda on HIV/AIDS care.**

❝ Maternity. *"They suggest that you abstain from having children and often strongly judge the decision to have them."* –Buenos Aires Network of PLWHA **❞**

Access to assisted fertilization is still restrictive. *"In the case of serodiscordant couples, there is only one hospital in the City of Buenos Aires with a protocol for assisted insemination and sperm washing."* (RAMVIHS)

"(…) also, the legal ignorance of the health teams is important, although the lack of adequate information can operate as a possible cause of the problem, since correct and full knowledge of the ethical and legal tools should facilitate the true enjoyment of the right to family planning and free and responsible reproduction" (Fundación Huésped).

Abortion

Regarding abortion, the country continues to have its restrictive policy. *"There are many women living with HIV who cannot negotiate for their partners to use a condom and they do not have access to any contraceptive method, having unwanted pregnancies; without knowing where to go, they begin a pilgrimage looking for a clandestine service to have an abortion" (Buenos Aires Network of PLWHA). This situation has a negative impact on the health of women, especially WLWHA: "(criminalization) obligates women in poverty to use homemade practices to induce the abortion, putting their life at risk. In the case of WLWHA, the risk is greater depending on the CD4 count"* (RAMVIHS)

> **❝ Abortion and risking one's life.**
> *"There are many cases of women for whom carrying a pregnancy to term means risking their life and/or health and, despite the fact that this circumstance is also a case in which legal abortion is permitted by law, it is almost impossible to access health services that will perform it."* (CDD) **❞**

Performing abortions that are not considered punishable by law meets resistance in the field of public health services and the health team members still appeal to unnecessary judicial authorization when women submit their requests.[46]

"(…) in Argentina the difficulties found in the medical and legal sectors' continue to be found (…), which, on many occasions, has led many women to be taken to court or prevented from accessing abortion permitted by law". "The difficulties in accessing legal abortion are not suffered only by women with disabilities who have been raped. There are many cases of women for whom carrying a pregnancy to term means risking their life and/or health and, despite the fact that this circumstance is also a case in which legal abortion is permitted by law, it is almost impossible to access public health services that will perform it." (CDD)

As found in 2008, regarding post-abortion care, it is important to note that WLWHA have the same luck as the rest of the women in Argentina. Humanized post-abortion care, based on current regulation, should be provided to all women, whether or not they live with HIV/AIDS. This means that, in general, all women should demand this care in public hospitals, but in reality it is not provided in all.

During this period, Santa Fe Province adopted a law adhering to the national post-abortion care protocol, which adds to the already existing protocols in the City of Buenos Aires and Buenos Aires Province since mid 2007. The existence of these protocols did not ensure they are performed in public hospitals.

Likewise, the National Ministry of Health developed a Guide for care which it disseminated in January 2008 and which has not yet been implemented. *"With regards to the legal abortion cases in the framework of the National Program of Sexual Health and Responsible Procreation, in December 2007 a Ministerial Resolution worked on distribution of the Technical Guide for Non-punishable Abortion Care in the health sector, which indicates the clinical and surgical procedures recommended by the WHO for termination of pregnancy, including medical abortion. The document aims to clarify the application of the penal law, "legal authorization is not necessary" in cases where women request an abortion that is permitted by law. It should be noted that due to the management change in the Ministry, this document never became a Ministerial Resolution (…)."* (CDD)

Goal 59- *Human Rights*

"By 2005, bearing in mind the context and character of the epidemic and that, globally, women and girls are disproportionately affected by HIV/AIDS, develop and accelerate the implementation of national strategies that promote the advancement of women and wom en's full enjoyment of all human rights; promote shared responsibility of men and women to ensure safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection."

The review of the fulfillment of this goal: the existence of government policies and programs aimed at promoting women's rights, including analysis of effectiveness, strengths and weaknesses of their implementation, actions to strengthen women developed jointly with the HIV/AIDS program or the Reproductive Health program and barriers and facilitators to their implementation. Strategies to promote shared responsibility of men and women regarding safer sex, including assessment of coverage, effectiveness and suitability in the context of gender relations. Specific government strategies to strengthen the capacity of women in decision making in regards to sexuality and HIV and other STIs prevention. Specific strategies to protect the rights of women workers and to protect women workers with HIV from workplace harassment.

Policies and programs aimed to the promotion of women's rights.

In formal terms the country has fragmented initiatives, isolated and sometimes even contradictory as regards the promotion of women's rights. **These initiatives have not reached many districts or people and have little public visibility.**

As in 2008, the country continues with little progress on the effective implementation of policies and actions related to the promotion and protection of women's rights. Although the country has a normative-legal framework that theoretically protects the rights of women and girls, through the ratification of agreements, treaties and international conventions, their incorporation with constitutional status to the Constitution in 1994 and the legal sanction of initiatives generated at the national level, **its effective implementation is still an outstanding debt.**

❇ **Women's rights.** Care and promotion services for women's rights are still scarce and institutional practices that violate their rights continue to exist.

The characteristics of the national and provincial contexts, the availability of tangible and intangible management resources, the presence of criteria not always shared and especially the level of political commitment regarding the institutionalization of improvements in the situation of women, result in an uneven progress in the country regarding the effective enjoyment of rights by women. **A shortage or lack of care and promotion services that effectively work with women on how to exercise their rights was observed. Sometimes the institutional practices are viewed as violations of these rights.** *"(...) the few success stories of friendly care are linked to the awareness raising activities carry out by civil society and which often result in agreements with special professionals but rare times in institutional arrangements that will endure over time."* (AMMAR)

Promotion of women's rights and HIV/AIDS and Reproductive Health programs.

Fragmentation and sometimes overlapping actions related to the promotion of women's rights can be also observed in some of the actions implemented by the National Program of Sexual Health and Responsible Procreation and the National Office of AIDS and STI, especially in matters concerning joint work. In

this sense, little seems to be the advancement or improvement compared to 2008.

> **"Isolated.** *"The lack of coordination between SRH and HIV/AIDS services is a constant in all provinces and at all levels: municipal, provincial and national"* – Buenos Aires Network of PLWHA"

As it was stated in **GOAL 52**, the intention of coordinating actions with the National Program of Sexual Health and Responsible Procreation is part of the formulation of the HIV/AIDS policy, at least in the contents related to the promotion of safer sex, but the "lack of coordination between SRH and HIV/AIDS services is a constant in all provinces and at all levels: municipal, provincial and national, and is difficult to obtain a space for participation in the planning of actions" (Buenos Aires Network of PLWHA). "In Argentina there is limited information regarding the main risk and factors of women's vulnerability to HIV. This is mainly due to the lack of HIV prevention strategies based on gender within the government program for HIV prevention, instead, the messages and interventions carried out are common to all people" (RAMVIHS)

Shared responsibility of women and men as regards safer sex.

As observed in 2008, there is a lack of work strategies that promote shared responsibility of men and women as regards safer sex. Nevertheless, these strategies are viewed as necessary from youth and WLWHA.

"There are no work strategies that promote shared responsibility of men and women as regards to safer sex. There are several publications and programs at local and national level that address the topic of safer sex but in practice we continue observing women's higher vulnerability and their subordination." (Buenos Aires Network of PLWHA). "It's key to incorporate men so they can learn to respect women's self-determination and share with them the responsibility in all aspects concerning sexuality, procreation, and family planning. In order to achieve changes it is necessary to break the myth that considers reproduction and its processes as an exclusive issue of women and emphasize the role of men as authors and key actors along with women. In reproductive and sexual health services, this change has to begin with creating a space for couples, since talking about "shared responsibility" is meaningless if men are excluded and women are considered as the only responsible for the pregnancy, taking into account, that existing reproductive services have been reproducing this conception of providing a space exclusively to women." (RedNac)

Strengthen women's decision making ability in regard to their sexuality and HIV and STI prevention.

The limited actions carried out to strengthen women for the exercise of their rights, do not include strategies or actions to strengthen their ability to make decisions in regard to their sexual health in a comprehensive perspective (contraception and HIV and STI prevention). This omission is worrying, since it is women who usually must face alone the decisions as regards safer sex. *"**The decision-making** concerning safer sex or not, was in charge of the women in 58,4% of the cases, only 22,8% of the women made the decisions together with their partners (…)."* (FEIM: 2009).

"There are some strategies that the Ministry of Health and the National AIDS Program are carrying out, as a specific publication for women, brochures and some idea of introducing the female condom as another prevention method, but these strategies fail to reach the entire population and as we know HIV and STI usually affect the poorest and most vulnerable". (Buenos Aires Network of PLWHA).

The same study conducted by FEIM on WLWHA and gender based violence, reveals the need for urgent action to strengthen and support the decision-making power of women: *"Partner violence is also evident in the control and barriers imposed by partners as regards the exercise of women´s sexual and reproductive rights. Even*

if a woman can have access to information about condoms and contraceptive methods (birth control), she will not be able to negotiate or request its use within a violent relationship; in many cases even the attempt of negotiation triggers physical, verbal and sexual abuse from their partner. " (FEIM: 2009)

The situation is exacerbated by the fact that *"None of the respondents reported using condoms as a method of protection prior to their HIV/AIDS diagnosis. (...) The majority of respondents never received advice or counseling about condom use prior to their diagnosis (...). The lack of information or guidance about the routes for HIV transmission, sexuality and condom use (...) was identified by women as the main reason for their lack of protection." Even when they manage to advance in adopting protective practices based on condom use, there are obstacles: "Many of the women noted the difficulties encountered when implementing condom with their partners, showing that condom use depends not only on the access to information but also on the possibility of appropriating these information through the empowerment of women and awareness about their sexual and reproductive rights "* (FEIM: 2009)

Women´s Labor Rights

The protection of labor rights recognizes men and women equally, in line with international guidelines provided by ILO to encourage non-discrimination and equal treatment and opportunities. As noted, under the Ministry of Labor, Employment and Social Security works the CIOT. **The law, that organizes labor rights for formal workers, recognizes specific protections for women at childbearing** (during pregnancy and breastfeeding); economically penalizing employers in cases of dismissal and contemplating the mandatory reserve of jobs.

Nevertheless, a large majority of women workers is not contemplated in this labor system, since many women work in the informal sector and especially in domestic service.

> **"At risk from stigma.** *"During the epidemic of influenza A, leave was given to pregnant women and immuno-suppressed persons, but unfortunately the vast majority of women living with HIV, that have jobs, could not enjoy this benefit because they do not reveal their diagnosis in their workplaces for reasons related to stigma and discrimination."* - RAMVIH"

There are no instruments for the protection of women living with HIV (or for men). The prohibition to include non-consensual diagnostic test by prospective employers is a protection as it seeks to promote the incorporation of people living with HIV into the labor market, the existence of an anti-discrimination law protects workers living with HIV in their jobs. Both measures are general, applicable to an employment situation and not always respected by employers, many times the government as an employer has failed to comply with this legislation.

Regarding workplace, RAMVIHS explains: *"During the winter of 2009 and due to the epidemic of influenza A in our country, leave was given to pregnant women and immuno-suppressed persons, but unfortunately the vast majority of women living with HIV, that have jobs, could not enjoy this benefit because they do not reveal their diagnosis in their workplaces for reasons related to stigma and discrimination."*

Additional protection that comes from joining the formal labor market is the possibility of social medical coverage from the social security sector by joining a health insurance entity. According to the law passed in 1995, they are required to cover the ARV treatment and opportunistic events at no cost for people living with HIV. They are also obliged to maintain confidentiality regarding the HIV status of their members.

There are no data on workplace harassment for WLWHA, however the stories of people with HIV, including WLWHA, account for situations of employment discrimination based on their HIV status, these include: non-consensual test and non-

incorporation with HIV positive results as well as layoffs when finding out theirs HIV status. *"(...) We find that the majority of women work in places where their rights are violated and exploited, with low wages, no social security coverage and if the HIV diagnosis is known WLWHA have to endure abuses in different ways since employers argue that it is the only work that may be able to have. Physical, sexual, and verbal abuses have been reported by WLWHA, as has been being fired from their job without being paid for their work.* "(Buenos Aires Network of PLWHA)

Goal 60- *Human Rights*

"By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender-sensitive framework."

The review of the advancements analyzed: the existence of government education policies that seek to promote gender equality and its effectiveness. The existence of government educational programs for HIV/AIDS that address gender inequalities. The existence of legal and traditional barriers that limit young women´s access to SRH services and ARV treatment.

Comprehensive Sexuality Education

Although since 2006 the country has the Law 26,150 that established the Comprehensive Sexuality Education Program, it has not been implemented nationally yet so the impact of its actions cannot be assessed. While the National Ministry of Education has developed the program and the contents, the provinces are not implementing it yet. The City of Buenos Aires that had started to conduct actions in 2007, in 2009 has suffered a major setback. In 2008, in Mexico, the ministers of Education and Health of the countries of the region signed an agreement to implement sex education. In Argentina, progress has been limited. The lack of political will of the national government and most provincial governments coupled with strong pressure from conservative religious sectors or not, is the main obstacle.

✻ **On hold.** After nearly four years since being enacted, the country still has not effectively and sustainably implemented the Law 26150 that created the Comprehensive Sexuality Education Program, and for this reason its impact still cannot be evaluated.

If in education there was no significant progress in relation to the promotion of gender equality and consideration and respect for diversity, in the field of SRH and HIV programs and health services progress was limited too, particularly in the area of health system practices. *"The gender perspective is more an individual position on the part of some professionals, although they recognize that there have been some recent actions that address gender inequalities."* (CDD)

Barriers to access SRH and HIV/AIDS services

There is consensus in recognizing, as raised in **GOALS 52, 53 and 54**, that barriers to access to prevention, advocacy and care services in HIV/AIDS and SRH are not derived from legal frameworks. The country has laws that protect rights in relation to access to medicines, contraceptive supplies, sterilization, diagnosis and HIV and other STDs treatment; the country also adhered to and/or enacted laws and other legal norms that guarantee rights (civil, social, political, human and even fourth generation rights as identity, among some of them).

✻ **Rejection and criminalization.** These are the principal barriers that keep trans people from accessing HIV/AIDs and sexual health prevention, promotion and care services.

"The laws guarantee young women's access to sexual and reproductive health care but socio-cultural norms, rooted in health services and health care providers, often impose limits on such access" (Fundación Huésped)

The obstacles are related to issues of prejudice, stigma and discrimination, administrative and bureaucratic issues of programs and effectors; supplies logistics, poor training of health teams on issues pertaining to their disciplines and legal issues; confluence of different levels of government, lack of systematic controls and monitoring to correct the restrictive aspects of health and educational services, among others.

❝ **Transphobia.** *"Trans people do not finish secondary school as a result of the transphobia that exists in those environments"* - ATTTA ❞

An important part of them were listed in the analysis of the goals 52, 53, 54 and 59. In addition to them, "transphobia" or rejection of trans people was reported in the field of education[47] and *"regulations that criminalize women sex workers; infringement codes and codes of living are based on stigma and discrimination (...)"* (AMMAR). The criminalization also reaches transgender people. As regards to infringement codes, a study of IGLHRC about provincial legislation revealed that in eight provinces[48] transvestism is penalized by the Infringement Code or Contravention.

Goal 61- *Human Rights*

"By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering and trafficking in women and girls"

✻ **HIV+Violence.** Nine out of every ten women living with HIV suffered some type of violence (generally several associated types of violence) throughout their life, based on a study done by FEIM. The research showed the greater vulnerability to HIV/AIDS of women victims of violence.

The review of the advancements analyzed: coverage and effectiveness of government efforts to prevent gender violence, availability of protocols and resources for the care of victims of sexual violence, the existence of campaigns (including its effectiveness and contents) and the implementation of actions by government and civil society to monitor the actions for preventing violence against women and girls and sexual exploitation.

Violence against women

As it was mentioned in the **Goal 59**, the country has a new legislative Framework that promotes the eradication of gender violence, protects and promotes the rights of women and girls, penalizes human trafficking and assists and protects trafficking victims. However, **its implementation at the national level is still an outstanding debt.**

The legal framework described in the 2008 Report, was expanded in March 2009, with the enactment of the National Law 26485 for the Comprehensive Protection to prevent, sanction and eradicate violence against women in any area in which they develop interpersonal relationships. This law establishes the National Women's Council as the entity responsible for the design of public policies to make effective the dispositions of the law, and the design and monitoring of a National Plan for Action to prevent, address and eradicate violence against women, through the development of preventive and care services, recording and monitoring of the situations of violence against women and actions implemented. It also creates, an Observatory on Violence against women.

The care and preventive programs currently in place are insufficient; as well as the campaigns[49] to raise awareness and install the theme in the public agenda. Civil society organizations, particularly those incorporated into the women's movement, have achieved to incorporate and maintain the magnitude of violence against women in the public agenda, as regards injuries as well as women´s deaths due to gender violence.

Although the **National Women´s Council** implements some technical assistance and training activities to organizations of provincial and municipal governments, **it has failed to achieve leadership on the issue or work on the design of proactive polices to eradicate gender violence or at least mitigate its impact.**

There is a lack of actions to address the links between violence against women and HIV/AIDS. Since 2008, FEIM developed a study to explore the existence of situations of violence in women living with HIV/AIDS and the links between them[50]; the main findings indicate that 9 out of 10 WLWHA suffered some form of violence (in general, various forms of violence) during their life, and that 80% experienced violence prior to their HIV diagnosis, **revealing the condition of greater vulnerability to HIV/AIDS for women victims of violence.**

✻ **Without data.** The lack of registers/information on violence against women and for monitoring actions has gone unchanged.

Policy development, availability of prevention and care services and other resources as regards this issue are uneven in the country, even within provincial jurisdictions; large cities tend to concentrate the scarce existing resources. In 2008, the Office for Victim Assistance of the Supreme Court of the Nation began to operate, but its services extend only to Buenos Aires City. Some provinces have: police stations to receive complaints related to gender violence, ministerial departments, programs and offices for addressing violence against women, as well as some municipalities. The reality, coverage and quality of services are very uneven, with low reach.

The absence of a system to register episodes of violence against women and for the monitoring of actions remains unchanged.

Civil society, especially organizations working with the women's movement and WLWHA, has conducted monitoring actions of the situation and response actions.

A central aspect concerning the protection of women and girl victims of sexual violence is exposure to pregnancy and HIV infection and other STI, is the provision of the adequate and timely treatment in health care services. As mentioned above, **so far there is no national protocol for Post-Exposure Prophylaxis to unify the standards of care.**

The difficulties in the implementation of the existing protocols, when available, are similar to those described in **Goal 54**. Although the Emergency Contraception is incorporated by ministerial resolution among the methods distributed for free provision by the National Program for Sexual Health and Responsible Procreation and the ARV medication is available (under the norms emanating from the National Program in 2001), their use in health care services is not uniform. However progress can be identified in the number of services that provide post exposure prophylaxis, **its effective and timely implementation still depends on factors such as training of health teams, resource availability and proper functioning of the health care networks to ensure the provision of supplies in a timely manner.**

Human Trafficking

One issue that recently entered the public agenda, through the actions of mothers, families of victims and social leaders, is human trafficking and sexual exploitation. Well-known cases that occurred in the country have brought to light the existence of child prostitution networks and sex tourism with children and adolescents.

Government actions in this regard are recent and are being progressively included in the agendas of various government agencies. During the

monitored period, the Law 26,364 was passed which legislates on the prevention and punishment of human trafficking and the assistance of victims.

The government agencies responsible to address this problem (the National Women´s Council, the National Ministry of Justice, Security and Human Rights, the National Secretariat for Children, Youth and Family), have not developed active policies at the national level. Since mid-2009 an anti-trafficking Brigade operates under the Ministry of Justice, Security and Human Rights, but has not made an impact in identifying traffickers and in the recovery of victims.

Although the Program "Victims against Violence"[51] continues operating (within the Ministry of Justice, Security and Human Rights of the Nation), which includes among its objectives the fight against abuse, exploitation and child prostitution, its actions are conducted only in the City of Buenos Aires.

Goal 62-
Reducing Vulnerability

"By 2003, in order to complement prevention programmes that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behavior and injecting drug use, have in place in all countries strategies, policies and programmes that identify and begin to address those factors that make individuals particularly vulnerable to HIV infection, including underdevelopment , economic insecurity, poverty, lack of empowerment of women, lack of education, social exclusion, illiteracy, discrimination, lack of information and/or commodities for self-protection , and all types of sexual exploitation of women, girls and boys, including for commercial reasons. Such strategies, policies and programmes should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement."

The review of the advancements made examined the situation and progress related to specific programs and actions against trafficking in women, women's participation in areas of design and evaluation of initiatives to promote the inclusion of women from vulnerable groups and the existence of transparent and public mechanisms for the monitoring of government actions aimed at the inclusion of women from most vulnerable groups.

> **"Times of participation.** *"The participatory meetings many times have good intentions, but the demand of groups is urgent and the bureaucratic times are endless, especially when the policy to be designed do not have the necessary resources"* - RedAr +"

In line with what was described in **Goal 61**, the enactment of Law 26364 is one of the specific actions related to the punishment of trafficking in women. It sets out the criminal and procedural measures against human trafficking; distinguishing when the victim is over or under 18 years old (age limit set by the Convention on the Rights of the Child and the National Law for the Comprehensive Protection for the Rights of Children and Adolescents).

The recent inclusion of the issue in the public agenda and the still pending task of giving visibility and properly characterizing the problem as well as the national and jurisdictional responses, do not allow assessing the effectiveness of the implemented measures.

Regarding the inclusion of women from vulnerable groups in HIV policies, as stated in **Goal 37**, the incorporation of the gender perspective in the design of development strategies is a task to be faced. This low level of development, due to the absence of policies and programs that effectively promote the inclusion of women from vulnerable groups, impacts in the absence of committees and/or areas of design and evaluation of such policies and programs, while that it does not promote monitoring of the impact of current policies and programs on women and girls.

"Actions are limited and there is no public

monitoring, much less the creation of a committee for planning and evaluation." (JOACYA)

Regarding the inclusion of vulnerable groups, RedAR+ considers:

"As regards the inclusion of vulnerable groups in the planning of the actions, there are many national initiatives from provincial and municipal sectors; but generally this inclusion is an achievement of the militant groups. Sometimes we can identify that some groups are used by the governments as an emblem to show inclusion. We are not aware of transparent monitoring actions of the resources used. The participatory meetings many times have good intentions, but the demand of groups is urgent and the bureaucratic times are endless, especially when the policy to be designed do not have the necessary resources " (RedAr +).

Goal 63- *Reducing Vulnerability*

"By 2003, develop and/or strengthen strategies, policies and programmes which recognize the importance of the family in reducing vulnerability, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good-quality, youth-friendly information and sexual health education and counseling services; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programs, to the extent possible".

✻ **Excluded.** The multicultural perspective does not exist in the formulation of social programs; including HIV/AIDS or sexual health programs.

The review of this goal analyzed: adequacy of the concept of family used in family strategies to the reality of most vulnerable groups, inclusion of a multicultural perspective in social programs and adequacy to an inclusive perspective and respect for differences in HIV educational programs.

Different family models are recognized, but these are not always consistent with the realities of the families of most vulnerable groups (families torn apart, single parents, grandparents or other relatives as caregivers for children and adolescents, blended families).

The most neglected aspect is the difficulty and little support that adults from vulnerable family groups face in matters concerning their sexuality and sexual and reproductive health care. Several studies, including the one developed by FEIM regarding WLWHA, reveal misinformation, misconceptions, difficulties to access to information, preventive services and supplies and inefficient practices in relation to the prevention of HIV/AIDS and pregnancy reported not only by youth but also by adults. In this context, the possibility of adults to become actively involved in promoting healthy practices in relation to children and teenage members of their family groups are more complex, since it gives them responsibilities to face with few tools and little or no social support from social, education and health services.

The multicultural perspective is an outstanding debt in the design of social programs, including those relating to HIV/AIDS prevention and SRH promotion. **In Goal 64** the findings concerning the actions aimed at members of indigenous communities are presented.

The analysis of **Goals 52 and 60** indicates **little or no incorporation of the inclusive perspective and respect for the differences in education programs, particularly in relation to sexual diversity.** The little or no inclusion of the gender perspective in educational, health and social programs impedes the full inclusion of young and adult women.

Goal 64- *Reducing Vulnerability*

"By 2003, develop and/or strengthen national strategies, policies and programs, supported by regional and international initiatives, as appropriate, through a participatory approach, to promote and protect the health of those identifiable groups which currently have high or increasing rates of HIV infection or which public health information indicates are at greatest risk of and most vulnerable to new infection as indicated by such factors as the local history of the epidemic, poverty, sexual practices, drug-using behavior, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise"

The review of this goal included the analysis of programs or specific actions to protect the sexual and reproductive health of WLWHA and/ or members of the groups most vulnerable to HIV infection (women prisoners and members of ethnic minorities) and identification of barriers that restrict the access of women from vulnerable groups to sexual and reproductive health care and ARV treatment. Additionally, the government's performance in relation to budget contributions for working with vulnerable populations to HIV was also analyzed.

The review of **Goals 37, 53 and 59** provided significant information regarding actions or programs aimed at protecting the sexual and reproductive health of WLWHA and/or women members of vulnerable groups.

❝ NGOs making up for the state.
"We have seen that in our community there is a high percentage of immigrant women workers and women workers belonging to indigenous people such as the Wichi community, that has made us see the need to develop materials in Wichi and Guarani as many of them speak little or no Spanish, let alone read it" – AMMAR❞

In relation to the real possibility to exercise their sexual and reproductive rights, WLWHA and women members of vulnerable groups (including women sex workers) find more obstacles than positive actions from public health and service providers. The design of programmatic actions in sexual and reproductive health and children's and adolescents' care do not fully consider the protection and promotion of rights and care in most vulnerable groups.

Regarding women and young members of indigenous communities, the implementation of actions to protect sexual and reproductive health are described as limited and hampered by socio-cultural reasons, including language.

"There are programs in which health care providers go to the community and visit from house to house to check the health of the family, especially children. On these occasions condoms are provided to women as a contraceptive method. Condoms are given to moms who have just had babies, they say 'take them, do not get pregnant again'. "(Fundación Huesped-testimony of members of the Ava Guarani community of Oran - Salta)

"Younger people have no access to condoms in health care centers due to the lack of information and shame. There is no specific care for young people (...)Young people should be informed about condoms, how to prevent ... "(Fundación Huesped-testimony of members of the Ava Guarani community of Oran - Salta)

"We have seen that in our community there is a high percentage of immigrant women workers and women workers belonging to indigenous people such as the Wichi community, that has made us see the need to develop materials in Wichi and Guarani as many of them speak little or no Castilian, let alone read it " (AMMAR).

The finding including in the 2008 report regarding the care of indigenous people remain almost unchanged. "The health system dos not have in all cases social and health intervention approaches that take into account the representations and cultural practices specific to the communities involved. There are no

strategies for health education that take into account the cultural construction of the health-disease process, which results in difficulties in accessing the system for these populations. "

This exclusion and/or difficult contact wit health services further aggravates the health situation found in most of the groups and communities belonging to indigenous peoples. During the period, no specific actions were designed at the prevention and care level with communities belonging to indigenous peoples, expected after the completion of the behavioral study conducted in 2005.[52]

Regarding incarcerated women, during the period (July 2008) the Agreed Framework for Health in Prisons[53] from the Ministry of Justice, Security and Human Rights and the Ministry of Health was signed, and the supplementary agreements relating to the implementation of actions in addiction prevention, HIV/AIDS and STD prevention and care, sexual health and responsible parenthood in the maternal and child are and women`s, children`s and adolescents' health.

This framework and its supplementary agreements promote the responsibility of the Ministry of Health for the health care of detainees in the orbit of the Federal Prison Service, separating it from the prison care, in line with international recommendations.

> **"Unhealthy prisons.** *"Incarcerated women not only suffer the confinement itself but also the lack of medical care, which is a human right. HIV/AIDS has spread quickly in prisons in recent years"* - Argentine Women's Group"

A survey implemented by CSOs in 2007 and 2008, in prisons for men and boys and women of the Federal Penitentiary Service and the Correctional Services from Santa Fe, Buenos Aires, Mendoza and Cordoba, states: *"(...) [it is necessary] to propose joint work between ministries as the ones proposed to be extended and replicated to all provinces in the country, promoting an increasingly active participation of the public health system in medical and health care of prisoners."* (UNAIDS 2008).[54]

The same study and other previous studies conducted with the participation of CSOs recognize the restrictive nature of access to health care services in the field of prison units, which is worse in the case of women`s prisons. **These restrictions reach both preventive and care services related to sexual and reproductive health as HIV infection and they remain during the years.**

"The prevention activities developed were identified as partial and difficulties were found as regards the access to specific supplies: condoms, diagnosis under rules of confidentiality, voluntary test and results notification, and supply of chlorine to disinfect injection and tattooing equipment. Risk situations were identified that needed to be addressed: not allowed sex, forced or voluntary, practiced clandestinely with visits or with others prisoners and staff, use of drugs that reduce the ability of self-care, tattoos with unsterilized precarious elements and difficulties in the access and availability of medical and psychological care to work with prisoners, the promotion of care practices and early diagnosis." (UNAIDS 2003)[55]

"Incarcerated women not only suffer the confinement itself but also the lack of medical care, which is a human right (…), HIV/AIDS has spread quickly in prisons in recent years (…) the lack of psychological care to address the situation of the children living wit HIV and give support to their mothers in prison, and finally, the lack of social assistance..." (Argentine Women's Group)

During the period, a law[56] was passed which expands the conditions under which prisoners can request house arrest. These include the situation of pregnant women, mothers of children under 5 years of age and /or women who are responsible for a disabled person.

The initiative specifically considered the situation reported by CSOs and monitoring entities about the prison situation regarding the living conditions of women in prison and children up to 4 years staying with them.[57] Reports of the Committee

against Torture from the Province of Buenos Aires, reveal the seriousness of the situation.

Some CSOs have been the ones who have developed preventive activities, with great difficulties since prisons are not very open to respecting and promoting rights.

The rules[58] governing life in Argentine prisons are restrictive and have negative impact on the health of the prisoners, by administratively penalizing drug use and unauthorized sex attempts, they impede detainees from consulting when they are exposed to risky situations, and the Administration from implementing risk reduction measures as regards HIV, including expanded provision of condoms. No other legal obstacles to access SRH and HIV/AIDS care were reported by the women from vulnerable groups.

The legal obstacles to access SRH and HIV/AIDS care reported by women from vulnerable groups have been described in the **GOALS 52, 53, 54, 59, 60 and 61.** They take particular forms for certain groups of women but generally have common origins.

Goal 65- *Orphans*

"By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS, including by providing appropriate counseling and psychosocial support, ensuring their enrolment in school and access to shelter, good nutrition and health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse ,violence ,exploitation ,discrimination, trafficking and loss of inheritance."

EThe review of the advancements in this goal explored: coverage, adequacy and effectiveness of specific support programs for orphans and children infected and affected by HIV and of educational programs aimed at the same population.

As regards the care of children affected by HIV, the situation remained unchanged from the previous report. The national government, either through HIV/AIDS agencies and the National Secretariat for Children, Youth and Family (SENNAF), continues without implementing support strategies for children with HIV/AIDS or children affected by the epidemic. **Among the outstanding debts is the development of studies to measure and characterize the universe of children and adolescents affected directly or indirectly by HIV.**

✻ **Boys and girls.** Among the pending debts is an analysis that allows us to understand the dimension of and characterize the universe of children and adolescents affected directly or indirectly by HIV.

The available epidemiological information allows suggesting that most of them, who acquired the infection through vertical transmission, belong to poor sectors. In this sense, their specific problems and the possibility of access and enjoyment of benefits and social services are subject to the conditions of care for the population living in situation of social vulnerability.

The trend toward deinstitutionalization of care for children promoted by the Law for the Comprehensive Protection of the Rights of Children and Adolescents, and the fact that children orphaned or with absent parental figures are often raised and cared by relatives, **indicate the need to extend and deepen the lines of monetary and nonmonetary support to these extended family groups, considering other lines of work to strengthen the family and the community.**

The assumption of parenting and care responsibilities from these family groups finds, in many cases, legal and programmatic obstacles in order to ensure access to social benefits[59]. The absence of parental figures requires the application for the "guardianship" of the children and adolescents via the judicial authorities. The difficulties in accessing the judicial system, delays in resolving procedures, hamper the possibility of accessing a number of social benefits.

In practice, this situation overburdens families with care and rearing responsibilities, keeping these groups, which are already in situations of vulnerability and exclusion, from important opportunities for support.[60] Among them, especially elderly men and women in poverty, in the majority of cases it is the grandparents of the children and adolescents who take on or actively participate in the care and rearing responsibilities. Although in recent years advances have been achieved regarding inclusion of elderly adults in social security and there have been relative improvements in the amount of retirement and other pensions, these are clearly insufficient for guaranteeing that they can support themselves and the children and adolescents under their care. Additionally, the health conditions of elderly adults in this situation, be it those that come with age or with their daily living conditions, make it more difficult to carry out extensive proceedings and application processes. In this sense, specific support for accompanying the inclusion of girls, boys and adolescents in programs and services have not been found; some forms of support are provided, generally by social services in health centers, municipal agencies and other government agencies and CSOs, with differing levels of development.

Even when the issue of access has been resolved and the services are available, the fragmentation of health and social interventions, managed by different government agencies generally on more than one governmental level and occasionally by CSOs, make it more complex and difficult for children and their caretakers to appropriate and make use of them. Therefore, the management of medications and controls refers to the health centers; local government agencies obtaining food allowances; management of cash benefits to agencies pertaining to the social area of the central government.

For the situations of children and adolescents in which containment and rearing in the family and community environment is not possible, the legislation establishes petition of alternative care such as foster families or external caretakers, institutionalization in public homes and/or homes that are managed by CSOs, and adoption.

The disputes between the old "child welfare" paradigm, which was in place until enactment of the Law 26061, and the propositions adapted to the Convention on the Rights of the Child from the current legal framework, still generated judicial interventions based on prejudice, stigma and discrimination related to HIV/AIDS; which considers its presence in children and in parent figures or family members as a situation of "material or moral risk".

In the scarce incorporation of HIV/AIDS in school curriculum and teacher training, one aspect receiving little attention is the **promotion of non discriminatory practices in the school environment toward children living with HIV and the creation and maintenance of school environments that favor their inclusion.** One still frequently hears mothers, fathers, grandparents or family members of children living with HIV express their doubts regarding the compulsory nature of revealing children's serological status and the obstacles they face when looking for support from adult figures in the school to accompany the situation of their children.

In the health field, some CSOs recognize the need for research and development of pediatric ARV formulas as a pending debt. The work of health centers and CSOs regarding diagnoses and support for children and adolescent living with HIV is also limited.

In this regard, even more serious is the scarce or inexistent development of prevention/promotional and assistance actions related to sexuality-HIV/AIDS with adolescents, as was already analyzed in **GOALS 52 and 53.** So it is necessary to include and strengthen actions for advising on and promoting protected sex to avoid reinfection, infecting others as well as unplanned pregnancy.

Goal 68- *Alleviating Social and Economic Impact*

"By 2003, evaluate the economic and social impact of the HIV/AIDS epidemic and develop multisectoral strategies to address the impact at the individual, family, community and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact of HIV/AIDS on household income, livelihoods and access to basic social services, with special focus on individuals, families and communities severely affected by the epidemic; review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers, and in families affected by HIV/AIDS, and address their special needs; and adjust and adapt economic and social development policies, including social protection policies, to address the impact of HIV/AIDS on economic growth, provision of essential economic services, labor productivity, government revenues, and deficit-creating pressures on public resources."

The review of the advancements analyzed: the availability of data and studies about the socioeconomic impact of HIV on women.

No modifications have been made to the inexistence of studies implemented by the national government and the provincial or municipal governments about the socioeconomic impact of the HIV epidemic.

The development of studies on the population affected by HIV focuses especially on the epidemiological observation of first and second generations. Along these lines, information that is disaggregated by age and sex is available; with the bias, in the epidemiological observation based on the notification of new cases, based on the inclusion of the trans population in the male group according to their civil identity and in the group of men who have sex with men when grouped by transmission routes.

A look at the situation of WLWHA that reflects their lower participation the job market indicates that: *"studies developed by the ECLAC calculate that women are those most affected by unemployment due to the face that the activities that suffer the effects of economic recession most are those with high female participation rates (ECLAC 2008). Nonetheless, based on this study and considering women with living with HIV, we can hypothesize that the lower level of participation in the job market as compared to the total female population is linked to the high levels of discrimination in the workplace that people living with HIV suffer in Argentina; living with the virus is still a reason for dismissal or for not being hired* (FEIM: 2009).

In 2007, in the framework of the Argentina Project of the Global Fund to Fight AIDS, Tuberculosis and Malaria, a National Study about the Social Situation of People Living with HIV/AIDS was developed. It analyzed quantitative and qualitative information about 841 people living with HIV, in treatment due to the infection, from all regions of the country.

The absence of systematic studies about the socioeconomic impact of HIV on the lives of women (and men and trans) seems to be an effect of two difficulties or obstacles that operate on different levels: the difficulty of incorporating the gender perspective in analyses of the socioeconomic situation and in the interventions designed to mitigate the impacts of poverty and exclusion in the lives of people, families and communities; and the difficulty of interpreting the HIV/AIDS epidemic and other chronic ailments as complex and multidimensional problems, not only tied to the sphere of health.

Goal 72- *Research and Development*

"Develop and evaluate suitable approaches for monitoring treatment efficacy, toxicity, side effects, drug interactions and drug resistance, and develop methodologies to monitor the impact of treatment on HIV transmission and risk behaviors".

The review of this goal continued to focused on analyzing: the existence of specific studies about the natural history of HIV in the female body, the sufficient inclusion of women in clinical trials and protocols for developing new ARV drugs, the existence of incentives for favoring the free, informed and consent-based participation and incorporation in clinical studies; and review the participation of women in Ethics Committees.

In the monitored period no studies dedicated to the natural history of HIV in the female body that had been encouraged by the National Office of AIDS and STIs or by other government agencies were found.

"Dr. Maglio[61] points out that, to date, no specific research about the natural history of HIV in the female body has been evaluated, even though women are frequently included in clinical studies" (Fundación Huésped).

"No studies have been done to determine the number of women included in clinical studies; nonetheless, we have evaluated a large number of studies where women living with HIV/AIDS have been included, this would allow us to assume that there is enough information to develop a sex-diseaggregated analysis. But this is not the case in behavioral studies, to date, the COB has not evaluated behavioral studies related to HIV infection which include women living with HIV". (Fundación Huésped).

The criteria for selecting and including subjects in the framework of clinical studies appear in the studies' protocol, which must always be approved by the National Administration of Medicine, Food and Medical Technology (ANMAT for its Spanish acronym) and by an Ethics Committee, in regard to inclusion and exclusion criteria, such as sex and age, among others.

In this period, the inexistent participation of WLWHA representatives in the Ethics Committees which should participate in the approval of protocols continued to be the case.

"Despite the fact that Fundación Huesped's Bioethics Committee (COB) has women members, there no people living with HIV as members, this also happens on other ethics committees of similar characteristics". (Fundación Huésped)

The inexistence of both clinical and behavioral studies applied only to women is attached to the inexistence of special incentives for including them.

"In clinical studies, women are not treated any differently than the rest of the subjects in the study and no special incentives for women who participate in clinical trials are found" (Fundación Huésped).

In regard to consent-based, free and informed incorporation, the recognized tool is consent. *"In our country all potential participants in clinical studies must sign a free and informed consent form prior to being incorporated. The ethics committees have the obligation to approval, supervise and even suspend studies in order to guarantee the protection, integrity and rights of the subjects involved. Likewise, the national regulation agency (ANMAT) also supervises and inspects the study sites to guarantee the safety and effectiveness of the studies' medicines and procedures"* (Fundación Huésped).

Nonetheless, in practice this has become a bureaucratic procedure; women sign the consent forms without receiving sufficient information about the scope and consequences of the clinical studies.

The perception of this situation pointed out to the ANMAT in 2008 the need to review the procedure and the tool used for signing free and informed consent forms.

As in 2008, it should be mentioned that the provisions mentioned are fulfilled as long as a laboratory adapts its work to the current regulations, complies with international criteria, respects international and national audits, and controls and monitors its research centers. For this, the responsibility falls on the government agencies in charge of monitoring these actions.

SECTION III

Strengths identified to promote women's sexual health, especially women living with HIV, and the prevention of the epidemic among women.

The review of the progress made in achieving the UNGASS GOALS on SRH and HIV/AIDS allows the recognition of some strengths, understood as facilitators and/or achievements in relation to their scope.

*** The existence of a legal framework, oriented to guarantee human, social and civil rights.** It includes: covenants, conventions and protocols ratified by the country which have constitutional status, the constitutional recognition of the right to health, AIDS laws, the National Program on Sexual Health and Responsible Procreation, the Comprehensive Sexuality Education Law, the law on tubal ligation and vasectomy, the Law for the Comprehensive Protection of the Rights of Girls, Boys and Adolescents, the Law for the Comprehensive Protection of Women to prevent, sanction and eradicate violence against women, the Law against trafficking that includes the assistance of trafficking victims, among others.

Its existence brings up advocacy elements to demand for timely and respectful attention to issues related to sexuality, sexual and reproductive health and HIV/AIDS and violence against women, especially for groups particularly affected by the epidemic: women living with HIV, women, children and adolescents, sex workers, lesbians and trans.

Nevertheless, the difficulties of health, social and education services to respect the current legal framework (as described in Section II) are indicators of the difficulties due to the patriarchal and custodial paradigm on women and children and adolescents, and of deeply rooted gender stereotypes and a strong gender inequity in the country.

*** Provision, guaranteed by law, of preventive supplies such as condoms, contraceptives, breast-milk substitute and treatment exists** and is extended to all the population. This provides the necessary legal base to promote effective access and exercise of all rights related to health care.

*** The existence and development of a national health system,** in which healthcare centers of the public sector are particularly relevant as they are the most widespread. Their presence also impacts on the development of the material base to advance in prevention and care actions, particularly when health services are necessary to carry out these actions.

As regards the actors involve in building a national response:

*** The existence of a large number and diversity of civil society organizations, especially organizations, groups and networks of people living with HIV (men and women) and women's organizations, enhances the response.** Their participation (Not free of contradictions, conflicts, tensions and disjointedness), offers discussion spaces between the government bodies and people who are aware of the everyday needs of the groups they belong to, and provides leadership and support to the promotion and protection actions for the effective exercise of rights.

*** During the reporting period, small-scale progress has been found promoted by the governmental authority in HIV/AIDS.** Spaces for consultation opened to WLWHA and sex workers for the development of a Guide which for the first time includes the recommendations for comprehensive care for WLWHA, SRH issues (contraceptive care including dual protection, reproductive aspects) without focusing on HIV vertical transmission, the proposal of some actions as a pilot test of the female condom and protocol for the care of sexual violence victims that included the participation of the Sexual Health and Responsible Procreation National Program as well as CSOs and WLWHA, which are indicators of some change in the willingness to promote the relationship between HIV/AIDS and SRH. However, actions should be translated into effective actions and later extended and deepened in order to be more than rhetoric.

Regarding achievements for preventing the spread of the epidemic, **the level of development achieved in the implementation of the protocol for prevention of vertical transmission and the reduction of the number of children infected,** are recognized as the only strengths of the preventive efforts.

Nevertheless, it is noteworthy that the level of prevention of vertical transmission achieved is an indicator of a high valuation of maternal and child health care areas at the expense of other women's needs and realities, such as the effects and impact of the patriarchal and custodial paradigm over women and children.

Gaps and deficiencies identified in regards to HIV/AIDS care that includes an SRH focus

*** HIV/AIDS and the non-reproductive aspects of sexual health are not part of the priorities of the political agenda** and hence lack the political and economic support needed to be included in programs to respond to the epidemic, especially among those groups that are not included among the most affected according to diagnoses of prevalence, especially women and youth.

The unequal development of HIV/AIDS and SRH programs and actions in different provinces, the limited number of provinces that allocate budget to the purchase of health supplies such as condoms and contraceptive methods, and the uneven implementation of national and provincial legislation that incorporates human rights, including sexual and reproductive rights and children's and adolescents' rights are clear indicators in this regard.

*** The lack of integration, articulation and/ or coordination of actions developed by programs and healthcare centers and the health personnel.** This disjointedness works against building a perspective of analysis and intervention that considers the linkages between HIV/AIDS and SRH.

This fragmentation is influenced by the organizational structure of health services, the centralization of HIV/AIDS care in hospital-based specialized services (usually Infectious Diseases services), oriented to the provision, sustaining and progresses of ARV therapy and on the other side, sexual health actions basically oriented to reproductive and mother-to-child care, valued as priority actions of health services.

Reproductive bias in SRH services, low interest and support for the reproductive needs including maternity needs of WLWHA, reported as a common practice in many health services and poor incorporation of dual protection, both in HIV/ AIDS and SRH services, generates few points of contact between those two healthcare programs. This is invigorated due to the fact that hospitals and primary care centers operate under different management levels of the health care system with few points of contact between infectious diseases services functioning in hospitals and sexual health services operating at the Primary Health Care level.

The confluence of programmatic proposals related to HIV/AIDS and SRH (and their gaps in articulation) in healthcare centers, without clear and consistent procedural frameworks also strengthen this fragmentation. The establishment of bilateral administrative and bureaucratic relations between health teams and each of the programs, who have not been able to find common spaces for dialogue, articulation and/ or coordination, influences the disjointedness as well.

The limited promotion of dual protection for women and youth, especially those living with HIV/AIDS is a clear indicator of the negative impact.

*** Programmatic proposals in health, education and social development that fail to mainstream HIV/AIDS and gender equality,** promoting fragmented interventions and sometimes even contradictory actions. In some cases, there were joint bilateral actions between programs and areas, usually due to personal relations that should exist as a regular modality.

*** Health and educational practices that ignore and violate the existing legal framework, including human rights perspective.**

The review of the fulfillments of the UNGASS goals describes, among others: the lack of progress in implementing the Comprehensive Sexuality Education Program, the difficulties women face in accessing to tubal ligation due to restrictive decisions of some health professionals who add

requirements to the sole authorization needed under informed consent of women and men over 18 years old, barriers for adolescents and youth to access HIV/AIDS and SRH services and supplies by requesting authorization or the presence of a responsible adult; violation of privacy and confidentiality in care, discrimination against WLWHA in healthcare services, restrictions imposed to WLWHA in the access to contraceptive methods; restrictions in the access to supplies and services of HIV/AIDS prevention and care imposed on women and men in prisons units, and lack of attention to the requests of not punishable abortions in public health care services.

By act or omission all of them lead to the violation of the rights recognized by the existing legal framework and negatively impact on the health and the exercise of citizenship of women and youth.

*** Lack of preventive actions in the field of HIV/AIDS and other STIs as well as in sexual health in the public health sector.** These are inadequate, fragmented and unsystematic, and do not include counseling and advice on sexual health, HIV/AIDS and other STIs and also ignore the diversity of situations that fall under the category of general population used.

The assumption of this category as an organizer of epidemiological information and preventive-care actions ignore the diversity of groups and situations that gather there, especially in relation to youth and women.

*** Lack of preventive and care services for women, adolescents and youth.** The development of the epidemic as well as the advancements in relation to interventions in sexual and reproductive health, including the analysis of the unfavorable context of access to preventive care and supplies, indicate the need for services or at least health teams trained in working with women and young people considering the impact of gender inequality. **Also there is an absence of services or teams trained in working with adolescents, youth and women living with HIV.**

*** Health teams poorly trained to address sexual and reproductive health needs of WLWHA and adolescents and youth living with HIV/AIDS.** The promotion of condom use (as a protection against the infection and against infecting others rather than as a contraceptive method) as the only form of protection ignores the reality of women subordinated in social and sexual relations. The ignorance of health teams of the therapeutic possibilities as a response to the **pregnancy desire of WLWHA and MLWHA limits and restricts the exercise of the right to motherhood and fatherhood for people living with HIV.** Also, the little attention given to dual protection in the case of adolescents and youth exposes them to unplanned pregnancies and/or infection with HIV and STIs.

*** Monitoring of actions and quality of care, including the fulfillment of legal requirements and procedural rules is nonexistent.** Monitoring of programmatic actions for HIV/AIDS and other STI is done through epidemiological surveillance; this is seriously affected by under-notification and under-reporting by health teams and health services. The development of a research promoted by the Office of AIDS and STDs regarding the diagnosis of the situation in health centers and provincial programs conducted in 2008 is moving towards the local evaluation of services and actions. Evaluation or monitoring actions are focused on recording the provision of supplies sent to the provincial programs and CSO's in the case of the Office of AIDS and STDs. Monitoring and evaluation in the Sexual Health and Responsible Procreation National Program is impossible due to the diverse and insufficient record of information on the population served, services and coverage achieved.

*** Lack of systematic epidemiological information related to youth and women, about HIV/AIDS and sexual and reproductive health,** works against making decisions regarding the actions directed at them and maintain the ignorance about them.

*** Heterogeneous implementation and level of development of programs and prevention-care actions on HIV/AIDS and SRH**, result from the political criteria in provincial contexts resulting in the allocation of resources and supplies. The concentration of services trained on HIV/AIDS

and violence intervention in the provincial capital services and the logistical problems to ensure the distribution of preventive/care supplies provided by the central government to all health services, are the main causes.

*** Poor development of programs and services that address the realities and needs of the GLTTBI population.** Some few provinces have made progress in regulating the right to gender identity in relation to trans people, but compliance is uneven. In 2008, the Office of AIDS and STDs developed a document aimed at health teams focused on health care for transvestite and transsexual populations; first government document that specifically addresses the thematic. This was not reflected in norms for services. The Sexual Health and Responsible Procreation National Program is focused on women care, men care is almost non-existent, and even more for the GLTTBI population.

*** Support actions for families caring for children and adolescents affected by HIV, including orphans, are practically non-existent.** This absence seems to be secondary to the little attention paid to the situation of children and adolescents infected with HIV, as well as AIDS orphans. The economic, social and emotional impact of HIV/AIDS on the lives of children and adolescents from poor sectors is exacerbated by the difficulties in the access to goods and social services that affect a large proportion of the poor population regardless of their HIV status.

Recommendations

Monitoring reiterates the previous observation on the insufficiency and/or inadequacy of state policies and actions in the field of HIV/AIDS and SRH aimed at ensuring civil, social and human rights of the population, especially women's and youth's rights in relation to their sexuality and reproduction, as well as to provide basic services to ensure their access and opportunity for interventions. In this regard the recommendations are similar to those in 2008, expressing previous recommendations have not been considered and implemented, which is worrying.

We therefore recommend:

*** Give HIV/AIDS and sexual health care the importance required due to their impact on the exercise of citizenship and public health** and act accordingly, both in the allocation of budgetary resources as in the adequacy of policies and practices and procedures to the current legal framework in all health services.

*** Promote a multi-sectoral response to HIV/AIDS** and sexual and reproductive rights to all population groups.

*** Promote a conceptual and methodological revision of the programmatic approaches proposed by HIV/AIDS and SRH programs,** as well as the coordination of activities between both programs, especially at health services level in order to increase the efficiency, comprehensiveness and impact of their actions.

*** To promote the full enjoyment and respect for the human rights of people in health, social and educational interventions,** related to HIV/AIDS and other STIs and SRH. Including especially: the right to receive for free and timely comprehensive care and prevention and treatment supplies; the right of adolescents and youth to receive information and comprehensive sexuality education as well as preventive care and supplies without requiring the presence of adults; women's right to tubal ligation without other requirements than expressed in the law, women's right to access not punishable abortions, the right to recognition of gender identity to trans people, the right of women and children victims of violence to receive timely, comprehensive and adequate care within a framework of respect and care, among others.

*** Adopt, disseminate and implement the protocol for the care of sexual violence victims,** respectful of rights, that includes the provision of Emergency Contraception, ARV and STI prophylaxis and psycho-social care.

*** Incorporate the gender perspective into the design of health, educational and social programs,** as well as the participation of CSOs of women, adolescents and youth.

*** Develop dialogue with civil society organizations with work in HIV/AIDS and SRH in a systematic and coordinated manner** to incorporate their views and their expertise to expand and improve the response.

*** Implement the Comprehensive Sexuality Education Program in an effective and extended manner,** since it is children's, adolescents' and youth's right and an appropriate and adequate instance to prevent the spread of the epidemic and other STIs, unplanned pregnancies and unsafe abortions.

*** Address the needs of children and adolescents affected by HIV/AIDS, including orphans,** and their family groups in the design of policies for children and adolescents and in the design of social programs.

*** Expand the availability of HIV/AIDS and SRH services, creating services and/or training health teams on the care of women and youth,** including women and youth living with HIV, expanding the territorial presence in provinces with high concentration of services in capital cities and incorporating advice and counseling activities in both SRH and HIV/AIDS.

*** Build, extend, strengthen and sustain over time training activities for health teams at different levels of care on HIV/AIDS, other STIs and SRH** within a framework of conceptual and methodological integration. Training should pay special attention to incorporate the gender and human, social and civil rights perspective as part of health actions, and eliminate all forms of stigma and discrimination.

*** Improve the quality of services and health benefits.** This requires the development of regular monitoring and evaluation actions that include the perspective of the recipients.

These actions must consider the right to health based on criteria of accessibility, universality, fairness, integrity, participation, respect for diversity and realization of rights, in preventive, care and health promotion actions.

*** Create and strengthen mechanisms for citizen complaint** for the violation of rights and discriminatory practices in educational, labor and health activities, including the development of specific instances for claims and protection of sexual and reproductive rights.

*** Promote awareness and permanent training for decision makers** in charge of health services, CSOs, community networks and organizations in gender perspective, in order to promote women's access, especially WLWHA, to comprehensive care services appropriate to their needs, resources and interests. Also, promote and strengthen community outreach mechanisms, training and awareness of all women (and particularly WLWHA) on their rights.

*** Promote systematic epidemiological and comparative studies** at national level, that take into account the gender perspective, incorporating the participation of women's, adolescents' and youth's organizations and other vulnerable groups.

*** Design and implement monitoring and evaluation systems for the actions, outcomes and impacts in relation to HIV/AIDS and SRH** that include: comprehensiveness, the participation of governmental areas of different levels, civil society organizations and users themselves, the diversity of population groups and the opportunity to generate information.

*** Design and implement unified and consistent national records in relation to key events in HIV/AIDS and SRH, including situations of violence against women and against children, allowing to have national statistics.**

*** Develop programs for the care of LGTTBI people from a gender and human rights perspective.**

*** Promote a more active participation of the public health system in the health care of incarcerated women and men, based on a gender and human rights perspective.**

Notes

1 INDEC, "Population Estimates and Projections. The country's total population 1950-2015". Demographic Analysis Series, Num. 30. INDEC. Buenos Aires, 2004.
2 INDEC, National Census of Population, Homes and Housing, 2001.
3 The classification used by INDEC recognizes as urban zones those localities with 2,000 or more inhabitants. Information source: National Census of Population, Homes and Housing, 2001.
4 INDEC, Permanent Survey of Homes (EPH for Spanish acronym). Data consolidated for 31 urban centers from six regions of the country for the first semester of 2009.
5 INDEC, "Population Estimates and Projections. The country's total population 1950-2015". Demographic Analysis Series, Num. 30. INDEC. Buenos Aires, 2004.
6 INDEC. Permanent Survey of Homes (EPH for Spanish acronym). Data for third trimester of 2009. The EPH is regularly done in urban centers.
7 Bianco, Mabel and Mariño, A. "HIV/AIDS + VIOLENCE. Two sides of the same reality. Violence against women and HIV/AIDS feminization. Quanti-qualitative study in four MERCOSUR countries. National Report for Argentina." FEIM. Buenos Aires, 2009.
8 The same reform granted constitutional hierarchy to International Declarations, Conventions and Covenants such as the American Convention on Human Rights, the Convention on the Elimination of all forms of discrimination against women (CEDAW) and the Convention on the Rights of the Child. Likewise, in its Articles 14 bis and 75 paragraph 23 include the obligation of the State to guarantee medical social security to its citizens.
9 National Decree 492/95. The regulation was modified through decrees and resolutions of the National Ministry of Health. In 2000, Resolution 939 underwent comprehensive modifications. In 2002, the decree 486/2002 was suspended; and the Mandatory Emergency Medical Program was created through Resolution 201/2002. Through Resolution 304 in 2004 coverage was expanded again.
10 Based on data from the National Census of Population, Homes and Housing, 2001, 52% of the total population had health coverage through subsectors of health insurance entities and/or private coverage or mutual insurance; the remaining 48.1% falls under public subsector coverage.
11 INDEC, "Population Estimates and Projections. The country's total population 1950-2015". Demographic Analysis Series, Num. 30. INDEC. Buenos Aires, 2004.
12 Life Statistics. Basic Information Year 2008. Office of Health Statistics and Information, National Ministry of Health, December 2009.
13 Life Statistics. Basic Information Year 2008. Office of Health Statistics and Information, National Ministry of Health, December 2009.
14 Life Statistics. Basic Information Year 2008. Office of Health Statistics and Information, National Ministry of Health, December 2009.
15 Life Statistics. Basic Information Year 2008. Office of Health Statistics and Information, National Ministry of Health, December 2009. The deaths attributed to malignant tumors in the uterine body represent 13% of the total deaths due to malignant tumors in the uterus.
16 Life Statistics. Basic Information Year 2008. Office of Health Statistics and Information, National Ministry of Health, December 2009.
17 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
18 National Program to Fight Human Retroviruses, AIDS and STIs, Ministry of Health "Bulletin on AIDS in Argentina". Year XII, Num. 25, December 2007.
19 In 1982 the first case of AIDS was notified in the country.
20 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
21 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
22 The mandatory notification of HIV cases dates from 2001. Before that only AIDS cases had to be notified, defined by clinical criteria, by the presence of some marker diseases.
23 In this aspect, there are regional disparities which are related to the organization of the response, the social, legal and cultural contexts and the demographic and social situation. Three regions or zones of the country that present HIV rates higher than the national average are: The City of Buenos Aires (15,0 of every 100.000 inhabitants), Greater Buenos Aires (11.1 of every 100.000 inhabitants) and Patagonia (13,4 of every 100.000 inhabitants); under the national average are: the Northwest Argentina (9,5 of every 100.000 inhabitants), Central Argentina (8.9 of every 100.000 inhabitants), Cuyo (8,3 of every 100.000 inhabitants) and Northeastern Argentina (6,3 of every 100.000 inhabitants). National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina" Year XII, Num. 26, November 2009.
24 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
25 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
26 National Office of AIDS and STIs: "HIV/AIDS Bulletin in Argentina". Year XII, Num. 26, November 2009.
27 National history recognizes more prohibitions and restrictions that encourage policies and actions related to different forms of family planning. In the seventies, with the development of modern contraceptive methods, especially hormonal methods in the form of pills, activities were developed at the different levels (Public and Social Security). In 1974 the national government approved the Decree Nº 659/74 prohibiting any direct or indirect family planning act in all public hospitals and in Social Security, and establishing the sale of contraceptives with triplicate prescriptions, as are psychotropics. In 1978, the military government approved Decree Nº 3938 which reiterated and ratified what was established in Decree Nº 659/74. Not until 1986 was this last Decree repealed and reproductive rights are recognized as human rights. Still, despite the creation of the technical regulation in the late '80s, these activities are not developed.
28 National Law 26130, which guarantees surgical contraception for men and women in health establishments with the informed consent of applicants over 21 years of age. The National Law 26150 creates the National Comprehensive Sexuality Education Program in the area of the National Ministry of Education, Science and Technology, reaching the educational establishments at all levels, and both public and private.
29 Law 24455 from 1995 and Law 24754 from 1996.
30 In regard to the free provision of ARV, it should be pointed out that in late 1997, when the National Ministry of Health was not complying with the provision of medicine; eight NGOs took the case to court, defending access to treatment for PLWHA. The judge led an appeal on the grounds of unconstitutionality, establishing that within 48 hours the Ministry should cover the provision in cases of denunciation. This is still in place today. After that, the NGOs achieved a legal victory; the court decision was appealed on a second instance and later before the Supreme Court of Justice, which in 2000 repeated the sanction of the Ministry of Health.
31 In 1994, the Ministry of Health and Social Action, in its Resolution Nº169, established the "basic vade mecum for care for HIV patients", which sets out which ARV do and do not form part of the coverage provided by the public health system. With the advances in the development of new drugs and new ARV treatment proposals, new medicines are incorporated, with the approval of the Technical Advisory Committee of the National Office of AIDS and STIs.
32 The country has turned into a regional reference in the negotiation of ARV prices carried out in Peru in 2003, which allowed for 10 countries in the Latin American region to be able to Access prices up to 90% below what they were paying; since they had the lowest prices in the sub region.
33 The Technical Advisory Committee was created by the Ministerial Resolution Nº 866/02 with the purpose of providing technical advice to the Executive Management. It is made up of one representative of the Network of People Living with HIV/AIDS, Government Agencies and Scientific Societies.
34 The current National Strategic Planning (NSP) Process was convened by the National Office of AIDS and STIs together with the Pan American Health Organization and the Joint United Nations Programme on HIV/AIDS. These organizations promoted "the development of a "Process to Update the Strategic Response to HIV/AIDS and STIs in Argentina" for the 2008-2011 period, aiming to sustain and give continuity to the actions developed to date, as well as close the gaps that were observed (…), both at the national level and at the provincial and local levels in regard to the epidemic." NSP Document.
35 The "Guide for Comprehensive Care for Women with HIV Infections" came out of the consensus built in the framework of the national project implemented by the Office of AIDS and STIs and UNFPA during 2008. It includes recommendations related to: Clinical-gynecological monitoring and care of women with HIV, Vaccination of adults with HIV,Contraceptive options for people with HIV, Considerations regarding antiretroviral treatment in the female population, Recommendations for antiretroviral prophylaxis in pregnant women; and Annexes dedicated to: Pre conception consultation in women with HIV, Recommended treatments for STIs, Reproduction in the framework of HIV infection, and Legal aspects.
36 Bianco, M., Mariño, A. et al.: "Civil Society Participation in the Country Coordinating Mechanism of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Argentina", 2008. The study was done in the framework of the project "The Role of Civil Society in the Country Coordinating Mechanism", developed with the support of the International Treatment Preparedness Coalition (ITPC) in seven countries: Cambodia, Cameroon, Uganda, India, Jamaica, Romania and Argentina. In Argentina, FEIM was in charge of the study during 2008.
37 National Institute against Discrimination, Xenophobia and Racism (INADI for its Spanish acronym) is a decentralized government agency created through Law 24.515 in 1995. Since March 2005, through the Presidential Decree Nº 184, it is located in the orbit of the National Ministry of Justice, Security and Human Rights. The INADI's actions are aimed at all people whose rights are affected due to discrimination on any grounds. Its functions are oriented toward guaranteeing those people the same rights and guarantees that society as a whole enjoys; that is, equal treatment.
38 IGLHRC reports on the monitoring and advocacy actions necessary for making possible, in the area of health services, compliance with provincial

and municipal regulations that guarantee transsexuals' and transvestites' right to be called by their name of choice. An example: in 2008, an alerting action was launched due to the denial of municipal officials in Greater Buenos Aires who "has rejected an ordinance that requires municipal hospital workers and professionals to respect the gender identity by calling trans, transvestites, transsexuals or patients by their chosen names" (IGLHRC).

39 As part of the actions to achieve the implementation of the Program, the National Office of AIDS and STIs and the Ministry of Education, Science and Technology, have developed materials for the teachers to work with adolescents in middle schools. These materials consist of four sheets referencing Contraceptive Methods; Reproduction and Pregnancy; STIs; Sexuality and Young people's rights. "In all of them, emphasizing the reductionist bipolarity of men/women, and omitting the existence of other populations which, by omission and/or discrimination are some of those most exposed to HIV (sexual diversity); meanwhile, the topic of the right to say "NO" in sex is not developed." (Intilla)

40 National Office of AIDS and STIs: Where are we? Where do we want to go?. The HIV/AIDS Response from the public health system. 2008. Available in Spanish at: www.msal.gov.ar/sida/pdf/investigacion-hiv.pdf

41 The only experience of free provision of female condoms in the country was in 2004/2005, in the framework of the Argentina Global Fund Project, through delivering them to the CSOs that carried out the projects. There are no evaluations of the effects and impacts of these being handed out to the recipients of the projects.

42 The provision of condoms is equated with that of other contraceptive methods; they require registering the names of those receiving them in order to create a list of the users of the program.

43 Fundación Huésped- Profile of the population receiving the Comprehensive Sexual and Reproductive Health (SRH), HIV/AIDS and STIs Program in Greater Buenos Aires (a Program that is implemented by the Foundation). Study developed in the framework of the same Program but in the region of Northwestern Argentina. RedNac- Survey applied in sensitization and promotion campaigns on sexual and reproductive rights and HIV/AIDS and STIs prevention for youth and adolescents in the City of Villa Carlos Paz, Córdoba.

44 Emergency Contraception

45 It's worth pointing out that the content of the Legal Annex encourages a position that protects and promotes WLWHA's sexual and reproductive rights.

46 Bianco, Mabel and Mariño, A. "HIV/AIDS + VIOLENCE. Two sides of the same reality. Violence against Women and HIV/AIDS Feminiziation. Quanti Qualitative Study in Four MERCOSUR Countries. National Report on Argentina." FEIM. Buenos Aires, 2009.

47 In the period of 2008-2009 massively disseminated conflictive situations regarding the difficulty of accessing non punishable abortions in public health centers have come up; these have made visible the multiple mechanisms that operate to impede women from effectively exercising this right. These are added to situations that were already analyzed in prior years. Catholics for Choice, Cordoba, analyzed situations where access to non punishable abortions in public health centers in different parts of the country were restricted and/or refused: Buenos Aires (2005 and 2007), Buenos Aires (2007) Rosario (January 2006, 2009), Mendoza, (August 2006, 2008, 2009), Corrientes (November, 2006), Entre Ríos (2007), Mar del Plata (January 2007), and Santa Fe (May 2007, 2008, 2009), among others.

48 "Trans people do not finish secondary school as a result of the transphobia that exists in these environments" (ATTTA)

49 The jurisdictions are: La Rioja, Neuquén, Catamarca, San Juan, Santa Cruz, Formosa, Santa Fe and Santiago del Estero.

50 In 2009 the national government developed the campaign Other Life is Possible: http://www.vivirsinviolencia.gov.ar/

51 The quanti-qualitative, exploratory and descriptive study is developed in MERCOSUR countries. In Argentina it consisted of the application of a survey of 101 women living with HIV, over 18 years of age who receive care in publish health services in the City of Buenos Aires and the north and west areas of Greater Buenos Aires, in Buenos Aires Province.

52 In this implementation framework there are three mobile Brigades, of sexual violence, family violence and violence against children (against sexual exploitation), made up of psychologists and social workers that work together with police personnel. Contact with the Program to request assistance is made through a free phone line within reach in the territory of the City of Buenos Aires. The program reached its programmatic objectives, with its institutional presentation, the implementation of the mobile brigades and the adoption of the law for Comprehensive Protection to prevent, punish and eradicate violence against women in spaces where interpersonal relations are developed, and the law for Prevention and Punishment of Human Trafficking and support for victims.

53 Through the National Program to Fight Human Retroviruses, AIDS and STIs, in the framework of the project "Second Generation Vigilance System", the "Study on behavior and information regarding HIV/AIDS and STIs in the Indigenous Population" was developed in 2005. This study was qualitative and aimed to determine the tendency of the main risk factors in relation to the population, place and time, which accompany HIV transmission in Argentina.

54 The agreement was signed by the initiative of the Scientific Advisory Committee on control of illicit trafficking of narcotic drugs, psychotropic substances and complex criminality, convened by the Ministry of Justice, Security and Human Rights in 2007.

55 UNAIDS Argentina: "Prisons and HIV/AIDS. Analysis of Social and Health Resources in Selected Penitentiary Units in Argentina". Buenos Aires. 2008. The analysis was implemented by FUNDESO Buenos Aires and FUNDESO Córdoba, Women's Group of Argentina, Work in Prisons Coordination in Rosario, and a group of teachers collaborating in the young adult prison in Mendoza.

56 UNAIDS Argentina: Prisons and HIV/AIDS. Advances in prevention and improvements in HIV/AIDS care in prisons in Argentina. Buenos Aires, 2004. The document presents the systematization of HIV/AIDS prevention interventions by seven CSOs and government organizations implemented in men's and women's prisons in the Metropolitan Region of Buenos Aires, Rosario, Santa Fe and Córdoba. The document from 2008 updates the information analyzed in this project. The participating CSOs were CIPRESS (Santa Fe), CEADS (Rosario), Fundación La luciérnaga (Córdoba) among those in charge and the Argentine Women's Group, and Fundeso as part of the external evluation and monitoring committee; the participating government organizations were SEDRONAR, what was then the National Program to Fight Human Retroviruses, AIDS and STIs and the National Ministry of Justice, Security and Human Rights.

57 National Law 26472 was enacted in December 2008, which modifies both the Law of Enforcement of prison sentences Nº 24660 (which governs prison life in the majority of the country's jurisdictions) and the Penal Code. The regulatory modification came out of three legislative initiatives.

58 Among them, in 2007 in the penitentiary unit in Buenos Aires Province that holds women with children, a minor child died due to lack of medical care in the unit. The death lead to an appeal which obligated the provincial government to guarantee the living conditions and access to medical, social and education services for the children living with their mothers. The Argentine Women's Group had an important role in publicly reporting this event.

59 The Law of Enforcement of prison sentences (24660) which rules in the majority of the jurisdictions of the country and the Disciplinary Regulation regarding prison life.

60 Examples of these are: food security plans, assistance pensions, collection of family salary and inclusion in social security coverage in the case of adults responsible for child care and rearing who are employed and/or members of the provisional system, collection of Universal Allocation per child in the case of unemployed adults or those in the informal economy.

61 In consideration of the situation of social defenselessness of many family groups that include children living with HIV, the Argentina Global Fund Project, in dialogue with some CSOs that work with them, propelled in 2008 a specific field of work. This included provision of family equipment and construction materials for remodeling housing and the promotion of reading as a way of working to support affected children and adolescents.

62 Dr. Ignacio Maglio is Coordinator and member of the Bioethics Committee (COB for its Spanish acronym) of Fundación Huésped. This Committee operates since 1998 and since it began it has operated as an independent research ethics committee, where ethical and scientific aspects of pharmacological and non pharmacological clinical trials done in the institution and in other related centers are evaluated to be analyzed by the Committee.

63 Bioethics Committee (COB) of Fundación Huésped

¿Where are we? ¿Where do we want to go?. The HIV/AIDS Response from the Public Health System. 2008. Available in Spanish at: www.msal.gov.ar/sida/pdf/investigacion-hiv.pdf

Appendix I - Participating Organizations

AMMAR – Argentine Association of Sex workers – National

Argentine Women's Group, member of the Argentine Prison Observatory

Buenos Aires Network of PLWHA- Buenos Aires

Civil Society of Committed and Active Adolescents (Jo.A.CyA) – Misiones Province

Catholics for Choice – Córdoba

Fundación Huésped

ICW Argentina

IGLHRC - International Gay and Lesbian Human Rights Commission

INTILLA Civil Association - Buenos Aires

National Network of Adolescents for Sexual and Reproductive Health (RedNAC)

RAMVIHS - Argentine Network of Women Living with HIV/AIDS

RedAR+ - Argentine Positive Network

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FEIM – Foundation for Studies and Research on Women

UNGASS *

GESTOS
Soropositividade
Comunicação e Gênero

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PARA ESTUDIO
E INVESTIGACIÓN
DE LA MUJER