UNGASS

MONITORING THE UNGASS GOALS ON SEXUAL AND REPRODUCTIVE HEALTH

"Civil Society Fighting for Rights"

ARGENTINA REPORT

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(PARTICIPATING ORGANIZATIONS)

AMMAR – Argentine Association of Sex workers – Paraná (Entre Rios Province)
AMMAR – Argentine Association of Sex workers - Santiago (Santiago del Estero Province)
Civil Society of Committed and Active Adolescents (Jo.A.CyA) – Posadas (Misiones Province)
Civil Association Trama - Links for development – Vicente López (Buenos Aires Province)
Association for the Struggle of Transvestite and Transsexual Identity (ALITTT)
Catholics for Choice – Córdoba (Córdoba Province)
International Gay and Lesbian Human Rights Commission (IGLHRC)
Conciencia Joven – Azul (Buenos Aires Province)
Desalambrando – Buenos Aires
Fundación Huésped -Buenos Aires
FEIM – Foundation for Research and Studies on Women
Argentine Women's Group, member of the Argentine Prison Observatory
Latin American and Caribbean Movement of Positive Women (MLCM+) – Argentina
Argentine Network of Women Living with HIV/AIDS
National Network of Adolescents for Sexual and Reproductive Health (REDNAC)

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PRESENTATION

This report was produced within the framework of the project "Monitoring the UNGASS Goals on Sexual and Reproductive Health: **Civil Society Fighting for Rights**." It was coordinated by GESTOS Brazil with the support of the Ford Foundation and UNAIDS.

In studying the advancements made on the UNGASS goals on sexual and reproductive health we gain the tools to continue advocating nationally, regionally and internationally for the need for integral and comprehensive sexual and reproductive health care in response to HIV/AIDS.

The fragmentation of services and the lack of attention paid to the issue by sexual and reproductive health (SRH) and HIV/AIDS services is a constant in Argentina that is repeated in the majority of countries in the region. In this appeal we stand together as women who are living with HIV, affected by HIV, sex workers, young people, LGTTTB populations, and people in situations of incarceration. Unity among these groups is key to be more effective in our advocacy work on HIV/AIDS and SRH. To achieve this we must review our agendas and priorities.

This study is an example of joint work between these groups and organizations, which helps build unity among us and strengthen collaboration in our advocacy.

Mabel Bianco, M.D., M.P.H., Epidemiologist
President FEIM

THE CURRENT HIV/AIDS SITUATION IN ARGENTINA

The HIV/AIDS epidemic in Argentina has evolved unevenly since the first HIV case was registered in 1982. It reached very high levels of incidence and prevalence in 1998 and cases have increased 40% overall since 2001.[1] The estimates for 2007 show that approximately 134,000 (128,000 to 140,000) people are living with HIV/AIDS in Argentina, 50% of which are unaware of their serostatus.[2]

In October of 1997, the number of people with AIDS and aware of their status was 34,214. Taking into consideration the delay inherent in notifying the newly infected, it is estimated that the real number is closer to 36,570. Of these cases, women make up 25.1% of those infected and men make up 74.6%.[3] According to the estimates, the rate of incidence for 2007 will be 41 cases per one million habitants; a reduction of approximately 50% in comparison to 1996.

The most prevalent means of transmission is unprotected sex. In the year 2006, 62.9% of infections were through heterosexual sex, 13.9% by men who have sex with men and 17.6% by intravenous drug users.[4] **Since the year 2004, new infections in the 15 to 24 year-old age group have occurred predominantly in women. And if you look at the prevalence of infection in girls between the ages 13 and 19 in comparison to boys from the same age group, the rate is higher still.**

In the last few years the epidemic has shown a tendency toward feminization. The first infected woman was diagnosed in 1987 and the male/female ratio was 92/1. In 2006 it was 2.6 men for every woman and for HIV it was 1.5 men for every woman. In women, transmission rates decrease as a result of injectable drug use (IDUs) and increase as a result of unprotected heterosexual sex. In 2006, 88% of new AIDS infections were in women who had had unprotected heterosexual sex.[5]

The current number of AIDS cases annually diagnosed in women has continued to increase and is combined with the increased concentration of cases appearing in women who are of a sexually active age. This entails a double risk, since the probability of mother-to-child transmission of the virus already exists. Currently, the prevalence of HIV in pregnant women is 0.32% with spikes of 1% or more in some public hospitals in the city of Buenos Aires and the Greater Buenos Aires area. It is important to emphasize the decrease of infection in the 15 to 24 year-old age group (historically the group with the highest risk of infection). Likewise, since the application of Protocol 076 and the triple ARV therapy, the probability that the child of an HIV+ mother will be born with HIV has decreased from 30% to 2%.[6]

Mother-to-child transmission makes up 94.7% of infection in children of both sexes under 13 years of age. The rate of HIV infection by mother-to-child transmission from 1991 to 1995 was between 4.2-4.7 out of every 10,000 live births. In 2005 it was 2.5, 50% less than in 1996 and lower than the overall incidence rate (3 out of every 10,000 live births)[7]

UNGASS GOALS AND PROPOSED INDICATORS

GOAL 37 – Government leadership in facing the HIV/AIDS Epidemic

"By 2003, to ensure the development and implementation of multi-sector 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 most vulnerable groups and people at risk, particularly women and young people(...)"

Proposed Indicators:

• Effective participation of women and young people with HIV in HIV/AIDS programs, including participation in decision making spaces and in UNGASS monitoring activities.

(1) As of 2001, mandatory HIV notification was incorporated into the AIDS registry. The National Program began to work together with provincial programs and informant doctors to reconstruct the historical register.
(2) The National Program to Fight Human Retrovirus AIDS and STIs of the Ministry of Health "Bulletin" on AIDS in Argentina Year XII, Number 25, December 2007, Buenos Aires, Argentina.
(3) Ibid.
(4) Ibid.
(5) Ibid.
(6) Ibid.
(7) Ibid.

• Participation by groups of women and young people who are to benefit from the design, implementation and evaluation of the programs created for them.

Even though some formal and informal collaboration exist between PLWHA and government institutions, the participation of women and specifically the inclusion of a gender perspective and the thematic inclusion of HIV into SRH, is extremely limited. Participation is not reflected in planning and policy decisions about program management, but sometimes WLWHA are given space to participate on a consultative level. For women not living with HIV/AIDS, they only have the possibility of submitting proposals for financing. There is no participation by young people.

GOAL 52 - Prevention

"By 2005, guarantee that all countries, particularly the most affected, have a broad range of prevention programs that take into consideration the circumstances, ethical and local cultural values. This should mean information and communication activities in the languages they understand best, and respect for their cultures, with the objective of reducing risky behavior and promoting responsible sexual conduct, including abstinence and faithfulness; more access to essential items such as male and female condoms, and sterilized syringes; activities to reduce the harm of drug consumption; increased access to psychological support services as well as voluntary and confidential testing services; access to non contaminated blood, and quick and efficient treatment of sexually transmitted diseases;"

Proposed Indicators:

• Adequate, effective and far reaching preventative education programs for women and young people, lesbians and transgendered people;
• Availability of both male and female condoms at health services, schools and associations;
• Easy access and orientation to the use of the aforementioned methods for young people;
• Adequate, effective and far reaching programs oriented toward harm reduction and drug consumption for women, young women, women living with HIV/AIDS, lesbians and transgendered people.

There is an absence of public policy addressing HIV/AIDS in a comprehensive way, specifically as it relates to sexual and reproductive health. HIV/AIDS is addressed from a perspective of transmission, which is an attitude replicated in health facilities. **The public health system does not have any specific strategies to reduce the prevalence of HIV in young people between the ages of 15 and 24 , except condoms distribution.** Prevention and promotion activities are generally carried out by NGOs and PLWHA associations. They are also carried out through the various instances of collaboration and joint activities by official, financing and international bodies.[8] Public health services accept and value projects that include the participation of groups of PLWHA, especially because these groups can provide necessary services for free that public health services cannot. For example, they give counseling to those who ask to be tested or they support those whose results are positive; they accompany them to take care of paperwork, they guide them in the administrative procedures necessary for obtaining medication and other assistance. These groups provide services that the healthcare professionals appreciate because it means they don't have to "waste their time" on tasks they feel they shouldn't have to do. Their participation is largely seen as "cheap or free labor" and not as joint action between health services and organizations. This attitude greatly devalues these activities.

The increase in the incidence of HIV/AIDS in adolescents could signify that the implementation of these actions is still ineffective and their reach is still insufficient. *"Although prevention activities have increased in the last few years, their reach continues to be relatively weak as a result of the scarce human resources dedicated to these activities and lack of exclusive attention to the issue. The demand for direct care – considered to be the only variable of service productivity – always leaves prevention as second priority"* (Civil Association Trama)

There are no national prevention programs for women (young or not) just as there is no space for promoting the rights of women living with HIV.

(8) Within the framework of the Second Generation AIDS Vigilance Project financed by the Global Fund and carried on in 2005 in a study on behavior and information in relation to HIV/AIDS and STIs in the adolescent population (14-19). In the Global Fund call for projects oriented toward HIV/AIDS prevention in specific populations and the improvement of quality of life for PLWHA, financing for actions for uneducated and educated children and young people was included; also they were financed to promote care for children and adolescents affected by HIV/AIDS, among others.

In October of 2006, National Law Number 26.150 was approved. This law establishes obligatory participation by schools all over the country in a Comprehensive Program for Sexual Education for students at all levels. **However, this law has still not been implemented and there is still no access to and education on HIV/AIDS in schools. The National Ministry of Education does not comply with the mandatory implementation of sexual education.** *"Young people between the ages of 15 and 18 and 18 to 24 do not have the relevant information to prevent STIs, unwanted pregnancies...those who have more in depth knowledge are those who have gone to health care providers for various reasons...the health system has a prevention strategy that does not present policies accessible to the community, their strategies tend to be limited to the inside of the health care system"* (Conciencia Joven).

NGOs emphasize that campaigns alone are not sufficient because they are non recurrent, intermittent and short reaching. Also, they tend to focus on very limited problems and are subject to the availability of financing. They do not have the reach of public policy and in many cases campaigned are limited to handing out condoms and leaflets. Coverage at the national level is very heterogeneous; it may have greater impact in the big cities, but not in the provinces. *"Even if prevention campaigns are carried out, they do not have a lasting impact, rather, they are carried out on specific dates and events"* (Jo.A.CyA Misiones).

Male condoms and lubrication are available and free of cost in the public health system. They are distributed by public health providers according to demand and also through community organizations, such as community centers and clubs, among others. However, there are neither records nor planning about which groups are the principal beneficiaries of these services. There are also difficulties in accessing services as a result of the socioeconomic, cultural and geographic barriers faced by women and young people. These difficulties are related to problems within the healthcare institutions: inconsistency in the organization and management of distribution, restricted office hours, lack of human resources for distribution and inadequate training for doctors and health teams. At the same time, **at many healthcare centers condoms are not being distributed to women and young people**.[9]

Keeping in mind that prevention and health promotion are components of the Primary Health Care (PHC) strategy, **there are regional disparities in the role that these components play. Hospitals continue to be the principal healthcare environment for the majority of the population, yet they are lacking in sustained efforts to promote sexual and reproductive health and HIV/AIDS prevention.**

There are currently no national campaigns on STIs, although, the policies for addressing STIs are contemplated in the National Program to Fight the Human Retrovirus, AIDS and STIs (NPFHRAS), which proposes to decrease STI infection in the general population. The NPFHRAS provides diagnostic services for syphilis, blenorragia and treatment for the majority of STIs. Each province is responsible for providing all levels of care, which means that the degree of implementation depends on the abilities of each provincial program.

STI statistics are included in the illnesses that must be reported by each jurisdiction to the Argentine National Epidemiological Surveillance System (SINAVE). In the case of Syphilis, for example, the NPFHRAS has a specific record for monthly updates. However, not all healthcare professionals participate, leading to largely underreported cases of STIs.

The NPFHRAS participates in the "Drug Abuse and HIV/AIDS Prevention Program for the Southern Cone" together with other organizations and NGOs. Its objective is to decrease drug user vulnerability to HIV. However, the program itself is not directed specifically to women but to the general population, and its scope is limited.

In creating HIV/AIDS and SRH programs, comprehensive care and joint action are necessary, but these programs continue to be fragmented. **On the national level, work is disjointed, as evidenced by the lack of collaboration between policies, sexual and reproductive health and HIV/AIDS services.** The disconnect between SRH and HIV/AIDS services is a national problem. Both ignore certain responsibilities they view as belonging to the other: NPFHRAS does not address contraception for PLWHA and the National SRH Program does not address HIV/AIDS.

"There is no formal space that exists in either of the programs for integrating both issues; neither can they find a place for collaboration in building records. Of the surveys done, it is clear that the National SRH Program is concerned mostly, if not exclusively, with contraception, while the National AIDS Program is concerned with

(9) CoNDeRS monitoring reports of the provinces, 2006, http://www.conders.org.ar/monitoreo.asp

HIV/AIDS prevention and care" (IGLHRC). *"At the moment there has been only one joint condom purchase and training exchange, but there is no other collaboration (...) There are differences in management and timing to achieve concrete objectives; differences in methodology for working with people"* (Desalambrando).

Health services have a difficult time collaborating on the SRH of WLWHA. There have been no resources for distribution created specifically on these issues. Training for professionals is scarce and collaborative initiatives seem to come more from the resolve of personnel than government decisions. This means groups often restrict themselves to purchasing and distributing condoms. It is certain that there is a perceived distance between what is theoretically proposed by government programs and what happens at healthcare centers. On one hand, those who direct government programs declare and promote positions that respect the rights of WLWHA. On the other hand, according to some of the statements made by users and professionals of direct care services, there are roadblocks to achieving those rights.[10]

GOAL 53 – Prevention

"By 2005, guarantee that at least 90% of youth of both genders, 15 to 24 years old, and by 2010 at least 95% of them will have access to information, education, including peer education and specific education for youth about HIV. They will also have the necessary services to develop the required abilities to reduce their vulnerability to the HIV infection; all of this will be done in collaboration with young people, mothers and fathers, families, educators and health care professionals;"

Proposed Indicators:

- Reach, adequateness and efficacy of sexual health programs for youth.
- Access to unsafe sex post-exposure prophylaxis.

The National Program for Sexual Education of the Ministry of Education has still not been implemented in schools, although there are a few isolated programs being run in some provinces. In the city of Buenos Aires there is the program "Our Rights, Our Lives," which was developed by the National Council for the Rights of Girls, Boys and Adolescents as well as NGOs in 2000. It only ran in 20% of schools, however, and was cancelled in 2008.

The public health system does not have special services for young women. The services that young women do have access to for information and HIV prevention components *"are offered only within health services that exist for the general population"* (Civil Association Trama).

Prevention policies that are implemented concentrate mainly on the overall population. There are no specific and effective policies directed toward women and young people in particular, least of all to WLWHA or trans people. It has been mainly Civil Society Organizations (CSO) that have developed preventative activities in this sense. *"The joint prevention strategies developed among peers and by groups and organizations involved in planning improve the population's access to information and knowledge on issues related to sexual and reproductive health"* (Fundación Huésped).

There are no formal barriers for adolescents and young people in accessing services, but there are some informal barriers. In the case of prevention for those under 18, we must highlight that care without the accompaniment of an adult continues to be problematic, even though there are rules that specifically mandate health teams provide care without an adult present. Also, the National Sexual and Reproductive Health Law specifies that there is no age limitation for care and that everyone must have access, including adolescents. *"Those who are under 14 need authorization from their families to receive contraception or condoms. The majority do not go with parents, so once they've become sexually active they are then asked to bring authorization from a parent later on, but at that same visit they are provided with contraceptive methods anyway, in order to prevent a worse situation like an unwanted pregnancy, or they are given condoms to prevent STIs, although the majority of adolescents don't use them"* (Conciencia Joven).

The lack of sufficient resources and time dedicated to care for young people means a failure to address sexuality and HIV/AIDS and young people. Also, there is limited knowledge of legislation by healthcare teams that provide support to professionals in carrying out their obligations on these issues.

(10) Bianco, M.; Re, M.I. and Acerbo, M. "The Sexual and Reproductive Rights of Women Living with HIV/AIDS in Argentina," DeSIDAmos Magazine, YEar XIII, Nº1, September 2005

Training for healthcare teams shows that it is necessary to continue elaborating on and addressing comprehensive prevention for women. From a formal perspective, prevention is included, but the question of "how" remains outside of the scope of commitment of healthcare personnel and professionals. Respecting the rights of PLWHA is very inconsistent. Even within the same health center, care can be disparate depending on the characteristics of each professional. For this reason, carrying out those rights not only has to do with the existence of publications, documents and formal adherence to the principles established, but also with the creation of public policy promoting training for personnel.

Hospitals in general do not provide prevention and promotion services, these are carried out by CSOs and associations of PLWHA. PLWHA who are trained on these issues seem to be the ones who are in the best position to develop prevention activities, to explain and solicit informed consent, as well as to give test results.

There are no focalized counseling services that address care for families, parents and young people. This kind of care *"exists in some health centers under general care by doctors"* (Civil Association Trama), without considering the possibility of creating specific and focalized strategies that allows for addressing the differing needs of the people who use the services. According to the experience of working in the greater Buenos Aires , the Fundación Huésped points out that *"In relation to counseling for adolescents and young people of both sexes, general health centers are too unfriendly to these groups, especially for boys. This deficit is compensated for by the work of peers: women give counseling in their own homes and groups of young people trained in workshops have done these prevention activities"* (Fundación Huésped).

It is necessary to point out **the lack of national protocol that regulates care for women victims of sexual violence and that specify provision of Emergency Contraception (EC) to prevent pregnancy, Post Exposure Prophylaxis to prevent HIV, and psychological care and legal support.** EC is a method recognized and provided by the National SRH Program; **its distribution began in 2007.** However, its distribution depends on the decision of health care providers, some of whom refuse because they consider it to be abortive.

It is important that women have information about their right to obtain EC and how to do so. This is generally information women do not have and it is necessary in case of rape or broken condoms, when women do not arrive at a medical consultation in time to prevent the pregnancy.

Although in 2001 the NPFHRAS established rules with respect to PEP, including requiring that all hospitals have available a care kit providing one month of prophylactic treatment in emergency services, this measure is not always carried out. It is often only used in cases where exposure is a result of a work accident, as long as the worker has worker's compensation. There are few centers that provide services for rape cases and other forms of exposure to HIV. Rosario and the city of Buenos Aires are the places with the best access to these services.

GOAL 54 – Prevention

"By 2005, to reduce the number of HIV infected breast fed babies by about 20%, and by 2010 by about 50%, by offering to 80% of all pregnant women prenatal services with information, psychological support, and other HIV prevention services, and by growing the availability of efficient treatment to reduce the transmission of the virus from mother to child and by giving access to treatment for HIV infected women and babies, and offering access to treatment for HIV infected women that are breast feeding, as well as efficient interventions for HIV infected women that should include psychological support and the voluntary and confidential testing services, access to treatment, particularly the antiretroviral therapy and, when appropriate, the substitution of breast milk, and a continuous series of attention services;"

Proposed Indicators:

- Breadth, quality and care of services for HIV infected pregnant women.
- Access to adequate treatment for pregnant women.
- Availability of appropriate detection testing.
- Quality of counseling for HIV detection testing in pre-natal services.
- Access to detection of syphilis in the maternity attention services.
- Access to treatment of identified syphilis cases during pregnancy.
- Nutritional support for pregnant HIV+ women.

- Anti- HIV prophylaxis during delivery.
- Breadth, adequateness and efficacy of programs that guarantee breast milk substitutes.

Since 1997 the Law on Prevention of Mother-to-Child Transmission of HIV with AZT has been in effect, by means of which the HIV test is offered along with counseling prior to pregnancy. The law was updated in 2002 according to the international recommendations on alternative diagnostics, treatment and types of delivery, and was accompanied by training activities for personnel involved in these practices. In the event of positive test results, Protocol 076 was instated. However, these practices are still not generalized in all health services. Their implementation is uneven and their quality varies. However, its application is improving. This is evidenced by a reduction in mother-to-child transmission rates. The PNLRHS guarantees free HIV testing of pregnant women who are cared for in the public services, as well as the medication necessary for treatment and/or prevention of an HIV+ mother and her newborn. This includes the intravenous AZT component for delivery, the drugs for the newborn and the formula to substitute breastfeeding by an HIV+ mother for the first six months.

Some NGOs do testing and counseling, or divert public services that are have previously been identified as friendly. Some public services are created with the participation of PLWHA. The implementation depends on the type of management of each health care provider or professional, or sometimes on each municipality and/or province.

For pregnant women, there is higher predisposition toward the test, although it is not always accompanied by an adequate level of counseling. Even if access to HIV testing is theoretically guaranteed, the results are still not always given quickly in order to facilitate treatment. This varies not only because the delayed consultation for many pregnancies, but also because of "difficulties in access as a result of charges for these services" (Catholics for Choice). Services vary also because of the delays in the process of drawing blood, analysis and sending the result to the health care provider in order to begin treatment.

The testimony from MLCM+ is very telling, *"Thanks to the pressure and monitoring by civil society, the decentralization of testing and an increase in number of lab appointments, among other things, have been achieved."* All the same, it is important to point out that HIV testing as a routine part of pregnancy care will be for many young women and young people, their first encounter with the health care system, and specifically with the HIV test. *"Increased access to the HIV test for adolescents has been observed, particularly with respect to young men," "the majority of women who request the HIV test do it during pregnancy, at the suggestion of health care personnel. This shows why there is a disparity in testing between men and women"* (Fundación Huésped).

Health care professionals in the city of Azul stated, *"What we are trying to do is ask for HIV testing not only for pregnant women, but for their partners as well. HIV testing has to be voluntary, with signature and consent by the patient, which makes it very difficult to carry out. We decided to implement this policy because men are difficult to test, they do not visit health centers, they come for consultations, but only when they have a problem"* (Conciencia Joven).

Pre and post test counseling is available in prenatal services, but different services show different levels of compliance and quality. *"Often they do not understand the basic information that they receive, it is just handed to them in a leaflet for them to read, the doctors' visits are generally very quick as a result of the quantity of women that need to be attended. The paperwork to get an appointment is bureaucratic and consists of long waiting periods" (MLCM+). "The quality of information and counseling is not systematized among members of the health care team, which means that quality and fairness of information and counseling is not guaranteed"* (Civil Association Trama).

Currently, the NPFHRAS includes free distribution of formula for the newborns of women with HIV until the sixth month of life. The provision of a sufficient quantity in a timely manner is subject to the management and internal obstacles of the health system's management.

Basic diagnostic tests for syphilis are provided via free testing done during pregnancy in all health services. Many professionals do not interpret the results of these tests as a reason to start appropriate treatment. The timely return of results is subject to the same circumstances as those that affect the return of HIV test results: delays in the process of drawing blood, analysis or in sending test results to the health care provider, among other things delay treatment. It was revealed that many WLWHA *"do not take all the tests because not all the health centers have access to all the necessary reagents and so they are transferred to other health clinics, resulting in the loss of the continuity of care" (MLCM+). "No. There are different causes, a woman is given orders for a blood test and she does not show up at the lab. She goes, they*

give her an appointment and then she never comes back. The results do not come back or the patient does not come back. Many arrive for delivery without the result of the VDRL, they draw her blood right there, and again, many time the results never leave the hospital" (Catholics for Choice).

GOAL 59 - Human Rights

"By 2005, taking in consideration the epidemic context and specificity, and that women and girls are disproportionately affected by HIV/AIDS, we must elaborate and accelerate the application of national strategies that promote women's progress and the respect for their human rights; and to promote the shared responsibility of men and women to secure safe sexual relations; as well as to train women to freely and responsibly control and decide the issues related to their sexuality with the objective of increasing their capability to protect themselves against the HIV."

Proposed Indicators:

- Adequacy, effectiveness and breadth of government's policies and programs directed towards the promotion, security, and reparation of women's rights;
- Interrelated policies directed towards women's rights with the HIV/AIDS National Programs;
- Adequacy, effectiveness and breadth of government's policies and programs directed towards men's responsibility in sexual and reproductive health issues;
- Adequacy, effectiveness and breadth of the policies and programs of protection for vulnerable women's sexual and reproductive rights;
- Access to assisted reproductive services.

From 2001 to 2006, the Optional Protocol of CEDAW was halted in the National Congress. Enacting the rights of women and girls is not only connected to the implementation of rules, programs, documents and the formal adherence to the principles that are established, but to the creation of public policy that promotes those rights, including health care personnel training. The National Women's Council (NWC) is the national government organization responsible for the public policy of gender equality among men and women. However, it is limited in its powers, the scope of its activities, its hierarchy and its allocated budget.

The government policies and programs that must respect and applied the international declarations and conventions on the human rights of women[11] and adopt them as rules to work by do not always have the management tools to guarantee that health care services will effectively comply. These documents are not always accompanied by conceptual frameworks and criteria for addressing and creating pertinent mechanisms of intervention. There are no specific public policies to decrease gender inequality and strengthen the rights of women and girls. With respect to policies for promoting the rights of girls, in 2005 the National Law for the Comprehensive Protection of the Rights of Girls, Boys and Adolescents was passed, but it was slow and uneven in its implementation.

HIV/AIDS and SRH programs do not take on the task to empower and consider women at all ages. *"The focus of the national and provincial HIV programs on women and young people is centered on the prevention of mother-to-child transmission. It is rare that basic SRH services are provided, services that are considered to be universally necessary for women. Access to voluntary HIV counseling and testing, as well as promotion of these services among women, is not uniform all over the country either. It is considered much more relevant for pregnant women because of the emphasis given to vertical transmission"* (IGLHRC).

"The lack of collaboration and joint work between HIV/AIDS and other STIs with SRH are determining factors in the lack of HIV/AIDS prevention and treatment policies along with policies for the promotion of all aspects of safe sex practices. This prohibits concretely assessing and relating HIV, STIs and unwanted pregnancies to unprotected sex. This lack of a connection also results in a lack of understanding by those surveyed of the connection of the problem of SRH with HIV/AIDS. They are treated in isolation and patients go to separate services for care" (IGLHRC).

Strategies that promote shared responsibility for safe sex between men and women do not exist. *"Even if the content and message of the activities(...) are adequate, they are too scarce to have an effective impact on the relations between men and women, given their lack of continuity and scarce coverage"* (Civil Association Trama). *"Strategies that promote shared responsibility for safe sex between men and women*

(11) CEDAW was incorporated into the National Constitution during the 1994 reform.

do not exist" (AMMAR Paraná).

There are no public policy strategies to strengthen the capacity for decision-making with respect to promoting safe sex and responsible procreation along with the prevention HIV/AIDS and STIs. *"If this woman exists within a patriarchal system that keeps her unequal to her partner and everyone else and she does not have work or she is living in a situation of economic poverty, it is difficult for her to think that that a woman would be able to put herself in the position of caring for her body. 'Responsible procreation' is a great burden when the state does not assume the responsibility of providing basic services to reverse this situation of inequality, which favors submission"* (Desalambrando-Bs. As.).

The international rules of the ILO address almost all aspects of labor. Although the majority of these laws are general in nature and are applied to all workers, some contain specific rules to address the needs of women. Others refer to fundamental human rights, for example, the elimination of all forms of discrimination and the promotion of equality in job opportunities. The specific legislation for the protection of workers, the Work Accident Law, established the obligation to administer prophylactic treatment in cases of workplace accidents involving sharp objects contaminated with biological liquids.

With respect to sex work, *"The government has not developed policies and programs specifically for promoting the rights of women sex workers because they do not consider sex work to be work at all...it was a political decision repealed by article 45 section 4 of the law 3815 on violations of the province of Entre Rios, which are regulated by the police...after that, the government did not continue to create new policies to support sex workers"* (AMMAR Paraná). The effective application of the aforementioned rules is not always guaranteed, which means that the Argentine labor market is currently characterized by informality and instability in hiring, which is also affects the ability of women workers to capitalize on those rights. Even though the National HIV/AIDS law prohibits the HIV test without consent, in practice, some employers do not respect and do the test compulsory, violating the confidentiality and anonymity of the workers. There is no data on the harassment of WLWHA in the workplace.

With respect to reproductive health care and WLWHA, **the idea that condoms are the only method of safe sex is persistent and double protection is not regularly promoted.** Medical counseling tends not to address the diversity of needs of PLWHA, which can often mean interest in having children, especially for those who are undergoing ARV treatment, or the difficulties that many WLWHA have expressed in getting their partners to always use a condom. Contraception is still an unsolved problem. In recent debates, **its existence is recognized, but the institutional transformations necessary to address the problem have not been made, neither by health services nor NGOs**. Some NGOs, especially those that focus on women and young people, work on identifying services that provide adequate care and counseling because they know that these services are not provided on a wide scale.

Health services that provide WLWHA with family planning services often give women contradicting information and counseling. On one hand, the discourse of health professionals defends a woman's right to choose. On the other hand, the suggestion that they should always use condoms is present and is the main focus of the counseling. **There is an implicit prejudice: it is considered unreasonable that a WLWHA have children, so women are discouraged from getting pregnant and in some cases from having sexual activity altogether.**[12] From the perspective of WLWHA who use these health services and some NGOs, the right to choose to have children is a frequent topic of conversation and internal debate, but with little possibility of being discussed with health service providers. This indicates the **hopelessness that WLWHA feel with respect to their reproductive rights. They do not have anyone to speak with about this problem and they feel forced into silence. They believe that their rights are not being respected and their needs not met by health services.**[13] On the other hand, there is hardly any possibility of achieving assisted fertilization within public health services for couples with discordant serostatus. This is only available at private clinics and the costs are prohibitive for the majority of the population.

In Argentina, abortion is illegal except in cases of health risk to the mother and rape. The Penal Code establishes punishment for women who seek an abortion as well as the person who does the procedure. The two exceptions are: a) in specific situations where there is grave risk to life and health for the woman and b) in the case of rape of a woman who suffers from dementia or mental retardation. The

(12) Ibíd. 10
(13) Ibíd. 10

inexistence of a specific framework for the rules regarding abortion increases confusion and often means that health care professionals make decisions about abortion based on their own personal beliefs and criteria. *"Abortion is prohibited except in certain circumstances according to the Penal Code, and as a consequence, it is considered a crime. There is no data on public opinion of this specific issue, but surveys continue to be done on a national level. More than 60% of the population is in favor of the decriminalization of abortion"* (Civil Association Trama).

Cases of abortions that are non-punishable or permitted under the law are rarely performed in public hospitals. In October of 2004 the National Health Minister and all the provincial health ministers signed an act committing to diminish the maternal mortality rate. In this act they included: "facilitating access to non-punishable abortions in the public hospitals." However, in daily practice, doctors rarely perform legally permitted abortions in a timely manner and in many cases, ask for authorization from a judge, although this extra step is unnecessary. The penal law is restrictive and confusing and has been interpreted contradictorily in many courts. Recently, some judges have imposed administrative or economic penalization on doctors who refuse to perform the procedure. Others, on the contrary, have tried to prosecute women seeking abortions.

It is important to note that WLWHA living in Argentina have the same luck as other women with respect to post abortion care. **The lack of humanized post-abortion care affects all women living with HIV/ AIDS or not.** In both the city and province of Buenos Aires there are have been various protocols on post-abortion care enacted since mid-2007 and the National Health Minister has developed guides for care, which were distributed in January of 2008, but these procedures still have not been implemented. An unsafe abortion is a serious risk to WLWHA, the risk to a woman's health is seriously elevated. This is why it is important that there is adequate generalized care for abortion complications which recognize the specific needs of WLWHA.

GOAL 60 - Human Rights

"By 2005, to implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, mainly 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."

Proposed Indicators:

- Adequacy, effectiveness and breadth of prevention programs actions for young women.
- Adequacy, effectiveness and breadth of non-formal education programs that promote gender equality, considering aspects of maleness, heterophobia, homophobia, and misogyny.
- Adequacy, effectiveness and breadth activities on sexual and reproductive health and promoting the rights of women living with HIV.

The objective of the Education Law passed in 2006 is, among other things: "To secure conditions of equality, respecting peoples' differences without allowing for gender or any other form of discrimination." In the same year, a law was passed that created the National Program for Comprehensive Sex Education within the Ministry of Education, aimed at all students in the educational system from the youngest students to those teaching and in technical schools. One of the objectives is to obtain equal treatment and opportunities for men and women. **As stated in Goal 53, this has not been achieved.**

"In general, these norms refer only to heterosexual men and women, reinforcing the gender binary and excluding the identity of transvestites, transsexuals, and transgendered people (TTT). Although there are some educational initiatives to introduce a gender and human rights perspective into the contents of educational programs, they do not address gender identity or appearance nor is sexual or gender diversity taught in these programs. TTT are kicked out of schools at a young age as a result of explicit violence by teachers and students as well as more subtle but insidious reasons. This expulsion has grave consequences because it reinforces discrimination which confines us to prostitution and takes away our right to dignified work. At the same time, the vulnerability of our right to education creates damage that is difficult to reverse over the course of our lives" (ALITTT).

In spite of existing legislation, *"the treatment of the Gender question in the ministries is basically limited to a question of biology: anatomical differences between men and women and sexually transmitted diseases*

that include HIV treatment and prevention. During the last curriculum modification in 2005, the fundamental question of treatment for HIV infection was successfully included, and discrimination was framed within 'Respect for Diversity.' The scope or depth of the issues developed depend on the level of teacher education and the predisposition they have to talk about the issues. As a result, while the question of gender and gender diversity are technically included on a formal level, how the education on these issues is actually carried out remains in the hands of teachers and in the best of cases, the educational institution (Desalambrando-Bs. As.). *"There are no public policies for AIDS prevention at a national level that incorporate a gender perspective or specifically address the reality of the TTT"* (ALITTT).

The right to education without discrimination based on gender or religion, among other things, has been incorporated into the contents of the General Education Curriculum at all levels. The rules are often confronted with opposition from different sectors of society that try to create obstacles to effective implementation as a result of prejudices and religious beliefs. This is why the majority of schools continue to elude and censure discussion on discrimination.

In Argentina, treatment of PLWHA, including access to ARVs, is free of cost. Viral load and other associated studies are guaranteed in public health services and by Social Security by law. In spite of protective legislation, there are still difficulties to accessing treatment. Obtaining treatment often entails physical and emotional exertion owing principally to the extensive paperwork necessary to get medication. The paperwork is also difficult to complete correctly. There is also a lack of resources to cover other basic needs: there are complicated logistics involved in providing treatment, the management and organization of the health system is complex and the offices hours are restrictive. There is a lack of human resources and little training for health care teams, a lack of material resources, a complex infrastructure, fragmentation of services, a lack of care for young people and girls if they are unaccompanied by an adult, a concentration of services in capital cities and the presence of health care providers who are "unfriendly." *Most commonly, there is a lack of knowledge of the right to information for adolescents and Contraceptive Methods (CM) without the presence of an adult" (CRC, Córdoba). "Health care services are not entirely sensitized to caring for sex workers (doctors, nurses, administrators)"* (AMMAR Paraná).

GOAL 61 - Human Rights

"By 2005, to ensure the 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, and all forms of violence against women and girl. This includes harmful traditional customary practices, abuse, rape and other forms of sexual violence, battering and trafficking of women and girls."

Proposed Indicators:

• Adequacy, effectiveness and breadth of specific laws to prevent, punish, and repair the damage caused by violence against women.
• Adequate, effective and widespread actions specifically to prevent, punish and aid the recovery from abuse, rape and other forms of violence and trafficking.
• Adequacy, effectiveness and breadth of specific actions against the sexual exploitation of girls.
• Coverage, quality, and care of the attention services for women and girls who are victims of violence or sexual violence, with anti-HIV and anti-STD prophylaxis, emergency contraceptives, and abortion.
• Existence of a public system for collecting and publicizing the data about violence against women and girls.

Prevention programs often do not reach women, adolescents, girls and sex workers, with little distribution of what public resources are available. There has not been sufficient training for health educators and professionals in detecting situations of sexual abuse or violence, nor actions to follow up in cases of violence. There is no space to contend these abuses and there are no interdisciplinary teams for that purpose. The National Women's Council (NWC) has not developed public policies that prevent, sanction and eradicate violence against women. The Federal Council on Women, which has representatives from the provinces and Buenos Aires, does not specifically address violence against women either. Even if discrimination against women is included at the legislative level, it is necessary to keep updating legislation to comply with human rights treaties. In 1994, the National Constitution incorporated the international human rights treaties, like the Convention on the Rights of the Child and the Convention on the Elimination of All forms of Discrimination Against Women, which reaffirm and

guarantee the rights of all women to a life free of violence.

In 1994, the Protection Law Against Familial Violence was approved. In 1996, the obligations assumed under the Inter-American Convention for the Prevention, Sanction and Erradication of Violence Against Women (Belem do Pará) were incorporated into the law. Its reach is limited. It has not translated into laws, policies or concrete plans for service. Advances have been partial and insufficient. There have not been any actions taken at a national level to spread these rights. There is also widespread ignorance of the Convention, however, by justice personnel, police, health system personnel, public functionaries, teachers and others. The state has been significantly delayed in complying with the law in a comprehensive, effective and fundamental way at the national level.

The National Law for the Comprehensive Protection of the Rights of Children and Adolescents recognizes the right to dignity as inherent, as well as the right not to be subject to violent, discriminatory, humiliating and intimidating treatment, not to be subject to any form of economic exploitation, torture, abuse or negligence, sexual exploitation, kidnapping or trafficking for any purpose or under any cruel or degrading condition. Its implementation has been slow and disparate.

Child prostitution networks and sexual tourism of children and adolescents have recently been exposed. State organizations that are incumbent on addressing this issue have not developed policy activities to eliminate child sexual exploitation. The National Secretary on Childhood, Adolescents and Family (NSCAF) of the Ministry of Social Development established a Program for Training and Treatment for Family Violence, Child Abuse and Sexual Abuse in 2007. Its purpose is to provide care and assistance to child victims of "negligence, abandonment, physical and/or psychological mistreatment, sexual abuse and all forms of mistreatment exercised by parents or caretakers," but its development has been insufficient.

The Program for Victims Against Violence in the City of Buenos Aires has squads dedicated to emergency care, assistance and restraint for victims of sexual, family violence and for children against sexual exploitation, but it is not guaranteed that it will continue. "Women and girl victims of sexual violence in a relationship or not and sex workers are rarely provided the right kind of counseling about the risk of contracting HIV and STIs or getting pregnant. *They are also uninformed about access to PEP, diagnostic testing, STI treatment and the availability of emergency contraception"* (IGLHRC).

GOAL 62 – Vulnerability Reduction

"By 2003, in order to complement prevention programs that address activities which place individuals at risk of HIV infection, such as risky and unsafe sexual behavior and injecting drug use, all countries should have in place strategies, policies and programs 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 programs should address the gender dimension of the epidemic, specify the action that will be taken to address vulnerability and set targets for achievement."

Proposed Indicators:

- Adequacy, effectiveness and breadth of support programs for vulnerable women;
- Adequacy, effectiveness and breadth of productive programs or projects (small business) for vulnerable women;
- Adequate, effective and far reaching affirmative policies for the inclusion of vulnerable women.
- Adequate, effective and far reaching human rights defense policies and programs for vulnerable women;
- Adequate, effective and far reaching programs that attend the causes and structural problems of women and girls human traffic, without getting into individual criminalizing and discrimination.
- Adequate, effective and far reaching the international agreements, conventions, and treaties application in the country, as well as the effort of federal laws to punish women trafficking;
- Adequate, effective and far reaching government backed monitoring actions, with clear and available indicators and with the participation of civil society.

A recent study in Argentina done by the National Defender of the Population on the trade and trafficking of women with the objective of sexual exploitation showed that the trafficking and trade of people,

especially of women and girls with the purpose of sexual exploitation, is one of the biggest problems of our country. It underlines the strength of local trafficking networks as well as those with foreign contacts, at the expense of sociopolitical, cultural and economic conditions and existing exclusions. It predominates in some provinces more than others. There are few trustworthy statistics on the national level; there is newspaper data that alludes to the trafficking of women. The absence of policies oriented toward the inclusion of women from vulnerable groups translates into a lack of planning and evaluation committees in these initiatives. A special law on this issue was just approved.

GOAL 63 – Vulnerability Reduction

"By 2003, to establish and/or reinforce strategies, norms, and programs that recognize the importance of the family to reduce vulnerability, among other things, educating and orienting children, and that takes in consideration the cultural, religious, and ethical factors in order to reduce vulnerability of children and youth with the secured access to primary and secondary schools, with study programs for adolescents that include HIV/AIDS; protected and safe surroundings, specially for girls; broadening good quality services of information, sexual health education, and psychological support for youth; strengthening of sexual and reproductive health programs, and the inclusion, as much as possible, of the families in the planning, execution, and evaluation of HIV/AIDS attention programs;"

Proposed Indicators:

- Adequate, effective and wide reaching programs that consider cultures, religion and cultural contexts in the education strategies.
- Effectiveness and coverage of the implementation of safe and secure surroundings for vulnerable girls.
- Access to housing, education, and food for HIV infected girls.
- Adequate, effective and wide reaching integral health programs for adolescents.
- Adequate, effective and wide reaching sexual and reproductive health counseling at health service centers.
- Effective participation of youth in the design, monitoring, and evaluation of programs.
- Adequate, effective and wide reaching capacity building actions for teachers on the issue of sexual and reproductive health.

Diverse kinds of families are recognized, but they do not always coincide with the realities of the family situations of the most vulnerable groups: broken families, one adult – mother or father, grandparents or other family members in charge. *"The scholarly discourse assumes that the provision of sex education for children, adolescents and young people is the responsibility of families, without reflecting the realities in which these young people are living. When it comes to sex education for their children, the family maintains educational models based on myth, prejudice and taboos. This constitutes a giant obstacle to the formation of a healthy competency for children and young people on issues of sexual and reproductive health"* (Conciencia Joven). A multicultural perspective is absent in the creation of social projects. *"National programs do not always take these characteristics into consideration and often exclude indigenous populations, inhabitants of rural areas and foreigners"* (Jo.A.CyA Misiones).

The National Education law declares that the Ministry of Education will focus on and develop policies to promote educational equality aimed at confronting situations of injustice, marginalization, stigmatization and other forms of discrimination derived from socioeconomic, cultural, geographic, ethnic, gender or any other nature of factors which affect the free exercise of the right to education. **Actions to develop inclusive education as explicitly stipulated by the law have still not been carried out.** The contents of policies related to SRH are limited and expressed from a biological and unidirectional point of view. These issues are still addressed from within traditional disciplines (like biology) and there is still little precedent for work on prevention from a more comprehensive perspective.

GOAL 64 – Vulnerability Reduction

"By 2003, to 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;"

Proposed Indicators:

• Effectiveness and breadth of government articulations with regional or international partners to strengthen the specific attention programs and activities of sexual and reproductive health to vulnerable women.
• Participation of vulnerable women in the regional or international articulation processes.

Within the NPFHRAS as well as provincial programs, there are no specific activities for WLWHA. With respect to the actions taken on behalf of populations in situations of incarceration, there is a dichotomy between the legal framework and the realities that exist. As a result of the unhealthy conditions of jails, the detriment of the physical conditions of detention and the activities and rights of the detained, women in situations of incarceration need concrete medical attention. Also, many of them were subjected to high levels of violence before their confinement. Prisons represent a focus point of high SRH risk. *"Women's prisons require a healthcare system specific to women, which emphasizes SRH, mental health, toxic substance abuse and counseling for victims of physical and sexual abuse"* (Argentine Women's Group). This does not exist. Also, in different studies, it has been indicated that women in situations of incarceration are at a higher risk of contracting some reproductive cancers and other similar illnesses. However, **the Argentine state has not oriented its public policies toward adequate health for women in situations of incarceration in Argentine jails.** In female penitentiary units, there is no periodic distribution of condoms to the detained women. This is a serious shortcoming in prevention since many inmates receive conjugal visits. Also, information on transmission and prevention mechanisms is not provided for inmates or personnel.

Incarcerated women *"declare that they do not have access to specialist medical care of any kind and that they NEVER have gynecological exams unless they have symptoms. They do not have any way of knowing what phase of illness they are in. If they are transferred, their Clinical Histories do not necessarily make the transition with them to the new penitentiary and in the majority of cases of WLWHA, treatment does not include Viral Load studies, CD4 counts, or any others. They feel stigmatized by health services and don't see them as 'friendly' or 'trustworthy'"* (MLCM+). Various reports have shown that the diagnostic test is not done with pre and post test counseling, in some cases it is done compulsively, without guarantee of the right to confidentiality.

Indigenous communities have alarming rates of infant and maternal mortality, malnutrition, infectious and contagious illnesses, among other traumas. **The health system does not generally address social medical care that takes into consideration the cultural practices of the communities involved. They do not develop educational strategies for health that consider the construction of the health-sickness cultural process, which makes it difficult for these communities access the healthcare system.** Within the framework of the Community Medical Program, community teams were created in 2006 that develop actions in communities all over the country (in 54 rural localities and two urban localities). However, these actions are continuously limited and the way they address the issues is not always respectful of the realities and practices of these women.

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 girls and boys infected and affected by HIV/AIDS, including the provision of 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;"

Proposed Indicators:

• Adequacy, effectiveness and breadth of specific support programs for orphans and children infected and affected by HIV.
• Adequacy, effectiveness and breadth of specific support programs for orphans and children infected and affected by HIV.
• Do models for the institutionalization of orphans exist?
• Quality of shelters, socio-affective contexts, family substitutes and/or support for extended family.

• Adequacy, effectiveness and breadth of educative programs for orphans and in vulnerable situation because of AIDS.

The government has implemented support strategies for children with HIV/AIDS, but there is fragmentation and no systematization of social medical care interventions. Resources distributed by different services and health care providers through different programs are carried out by a variety of NGOs. The law also provides for intervention of the judicial system with respect to underage children who are orphaned, with the purpose of defining their "guardianship" by finding a responsible adult to care for the child or adolescent and their wellbeing. The judicial system also intervenes in adoption procedures. HIV/AIDS has operated within the judicial system many times as a "risk" factor, sustained by discriminatory and stigmatizing positions and has given rise to judicial intervention as a result of complaints by schools and/or hospitals.

The judicial system has intervened for control over a group, for example, for lack of adherence to medical treatment or to house children in institutions (homes for minors), although they may have family members. There are no specific social support programs for women/families that take on care for an AIDS orphan. The general support for orphans is what is provided. *'There is no official support and the government is not reaching for strategies except for providing medication. None of the families that find themselves in this situation receive social support. Our experience in this field has been definitively hopeless. For example, a friend, Marisa, recently died and she was a widow with 4 children – 2 boys of 7 and 5 and 2 girls of 15 and 3 – the oldest took charge of caring for the other siblings. The two smallest are living with HIV. We have not found a single center that will take care of them and the young girl of 15 asked her biological father in desperation, whom she hadn't spoken to in years, if they could all go live with him. The father accepted even though three of the children were not his* (MLCM+).

GOAL 68-69 - Mitigation of Social and Economic Effects

"By 2003, to evaluate the HIV/AIDS epidemic's social and economic effects and elaborate multi-sector strategies to face these effects in the individual, familial, community, and national levels; elaborate and accelerate the execution of national strategies to end poverty and face the epidemic in the places, the life styles, and access to basic social services, paying special attention to the people, the families, and the communities that are affected the most by the epidemic; study the social and economic impacts of HIV/AIDS in all social levels, especially women of age, particularly related to their function of support providers in the families affected by HIV/AIDS, and attend their special needs; adjust and adapt the social and economic development policies, including the policy of social protection, to face the effects of HIV/AIDS in the economic growth, in the essential economic services, labor productivity, fiscal income, and the prisons that produce a deficit in public resources;"

Proposed Indicators:

• Availability of data or studies about the social and economic impact of HIV on women;

The government does not do studies on the socio-economic impact of the HIV epidemic. *"As far as we know, there are no studies by the government on the impact of the HIV/AIDS epidemic in Argentina. The studies done by the state are reduced to the areas of behavior and epidemiology, and those in the area of epidemiology are broken down by sex. Nobody could say if there is trustworthy determination on the impact of the epidemic in women, young people or girls with respect to all aspects of the HIV/AIDS epidemic in Argentina. Those conducted by non governmental organizations or universities are not available as clear or transparent findings"* (IGLHRC).

GOAL 72 - Research and Development

"Establish and evaluate adequate methods to investigate the treatment efficacy, its toxicity, side effects, different medicines interaction, and the resistance to them; establish methodologies to survey the treatment effects in the HIV transmission and in risky behavior;"

Proposed Indicators:

• Breadth and quality of surveillance systems to detect side effects of ARV independent of sex and gender.

• Adequateness of the health care service providers' response to the resistance effects and side effects of ARV in women.

No specific research has been done on the natural history of HIV in the female body. The inclusion of women in clinical studies depends entirely on the objectives of the study, the number of volunteers depend on the objective and the variability of the drug among patients. These details figure in the protocol of an investigation, which must always be approved by the National Association of Medicine, Food and Medical Technology (ANMAT) and by an Ethics Committee. In these investigations, criteria of inclusion and exclusion are respected, i.e. age and sex, among others. There are no women representatives that participate in these committees.

Free consent and clarification in doing studies has been converted into a bureaucratic procedure in which women sign consent forms without receiving sufficient information about the reach and consequences of the clinical research. The rules of the study are always complied with, and when the research is being conducted at a laboratory that adapts its work to the applicable norms, it complies with international criteria and respects international and national auditing and monitoring of its research centers. In this way, it is the responsibility of competent government organizations to monitor these actions. **Women living with HIV/AIDS are not included in these bioethics committees as well as other women groups.**

The PNLRHS does not do research and or specific studies on the interaction between ARVs and contraception, not even to evaluate the impact of ARV therapy in women, particularly in relation to fertility and/or reproduction.

CONCLUSIONS

Principal ways of strengthening sexual health promotion for WLWHA and for preventing the epidemic in women:

• The existence of laws, rules and recommendations that guarantee a woman's right to health, sexual and reproductive rights, non discrimination and sexual education is and should be the framework for the effective implementation of actions. Aside from legislation, the provision of adequate care is not guaranteed in Argentina. There is ample difference between what government programs propose and what actually happens inside public health services.
• Respectful positions on the rights of PLWHA are taken at the legislative level but are not a reality in the provision of services. However, it is important to recognize that their existence provides concrete instruments to promote the full exercise of some rights, and creates the condition for public actions that demand prevention, control and treatment.
• CSOs and NGOs and community women's organizations, or rather, organized sectors of the Civil Society, especially WLWHA and organizations of women that promote respect for the human rights of PLWHA exist and are present. However, they do not always collaborate with each other to demand programs that address and respect human rights, especially those related to HIV/AIDS and SRH so that these rights are guaranteed.

Main gaps and deficiencies in collaboration between SRH/HIV/AIDS and recommendations to overcome them:

• Fragmented programmatic logic that translates into a lack of integration, collaboration and coordination of action from both programs. This disjointedness works against the application of effective and opportune measure of prevention, information and education for women and specifically violates sexual and reproductive health rights of WLWHA.
• Interventions with limited management capacity to crosscut programs and optimize results, which translates into poor use of material and human resources and a low impact in terms of health for those cared for.
• Segmented mechanisms in both programs to connect health actions with other sectors: education, social development, young people, women.
• Heterogeneity in implementation of programs at a jurisdictional level. Little or inexistent assistance outside of provincial capitals.
• Lack of data and cross epidemiological analysis related to young people and women.
• Lack of knowledge about legal Human Rights instruments, especially those related to HIV/AIDS and SRH on the part of teams from both programs.
• Insufficient collaboration between public services at the first and second levels of care. And, of

these with jurisdiction like NGOs, networks, women's groups working on HIV/AIDS and organisms of cooperation.
• SRH without personnel trained to counsel and care for WLWHA on issues like how to regulate their fertility, prevent unwanted pregnancy, and get pregnant without the risk of getting infected in the case of couples with discordant serostatus. They should recognize and guarantee sexual and reproductive rights.
• HIV/AIDS is not a priority in the political agenda; it does not have the political and economic support necessary to control and diminish the growth of the epidemic.
• Lack of prevention and assistance strategies for women with differential needs and with special attention to vulnerable sectors: women migrants, incarcerated women, sex workers, children and adolescents, the handicapped, drug users, rural people and ethnic minorities.
• Absence of programs and services that address the realities and specific needs of the LGTTTB population on national and provincial levels.
• Multiplicity of social health programs generated by different ministries and institutional environments in different jurisdictions that converge to be executed by health care providers and health teams. This heterogeneity makes demands of professionals and health care teams that are not accompanied conceptual frameworks and criteria that allow for the contemplation of the complexity of what would be appropriate support and intervention approaches and mechanisms to be developed.

Recommendations

• Prioritize HIV/AIDS and SRH programs in the health agenda and collaboration between the two.
• Encourage the coordination of joint activities between both programs, increase the efficiency and the impact of their actions and collaboration with other areas of the government for a more comprehensive approach.
• Establish collaborative action strategies with all social actors, especially organizations and community groups of PLWHA, women, young people and populations with increased vulnerability.
• Create committees and groups in response to the epidemic that guarantee the participation of all government and non governmental organizations including women's and youth organizations.
• Promote permanent sensitization and training on gender perspective for policy makers and health care providers, NGOs, networks and community organizations in order to promote access to services and primary and secondary prevention for WLWHA that is adequate for their needs, resources and interests.
• Promote and strengthen community groups that distribute information, train and sensitize all women, particularly WLWHA, about their rights, especially their sexual and reproductive rights. Improve/establish a network of services and create new spaces and strategies for prevention and care with an integral perspective on health/illness and a focus on the right to health.
• Create and train interdisciplinary teams with competent and adequate information to work with new approaches, especially with ample participation of the community. Increase the depth of systematic and sustained training for humanized care with a gender perspective.
• Guarantee free access to quality decentralized health services all over the country.
• Guarantee that laws will be followed all over the country that especially ensure open and free access to comprehensive or collaborative SRH and HIV/AIDS for the entire population, including adolescents.
• Promote epidemiological studies that are systematic and comparable on a national level and that incorporate a gender perspective. Promote the participation of women's organizations in their planning and execution.
• Guarantee the right to health with criteria for accessibility, universality, equality, integrity, participation, respect for diversity and respect for human rights in prevention activities as well as heath care and health promotion.
• Guarantee rights, especially those of young people and adolescents, promoting and motivating adequate responses.
• Program, implement and monitor sex education programs in schools for all grades with a gender perspective.
• Promote prevention programs that are not only oriented toward a change in individual behavior, but fundamentally in collective behavior within families as well as within institutions and communities and based on respect for peoples' human rights.
• Develop comprehensive care programs for LGTTTB from a gender and human rights perspective.
• Monitor programs collaboratively, with government and NGOs represented by real actors, and distribute the findings.

GLOSSARY

ARV – Antiretrovirals
CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women
CM – Contraceptive Methods
CSO – Civil Society Organization
EC – Emergency Contraception
HR– Human Rights
IDU – Intravenous Drug Users
ILO – International Labor Organization
LGTTTB – Lesbians, Gays, Transvestites, Transgendered, Transexuals, Bisexuals
NWC – National Women's Council
NGO – Non-Governmental Organization
NPFHRAS– National Program to Fight the Human Retrovirus AIDS and STIs
NPSRH– National Program on Sexual and Reproductive Health and Responsible Procreation
NSCAF – The National Secretary on Childhood, Adolescents and Family
PEP – Post Exposure Prophylaxis
PHC – Primary Health Care
PLWHA – People Living with HIV/AIDS
SINAVE – National System of Epidemiological Vigilance
SRH – Sexual and Reproductive Health
SRR – Sexual and Reproductive Rights
STI – Sexually Transmitted Infections
SW – Sex Workers
TTT – Transvestites, Transgendered, and Transexuals
VDRL – Lab study to detect syphilis
WLWHA – Women Living with HIV/AIDS

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