

COMPARATIVE REPORT  
2008



# UNGASS AIDS FORUM

MONITORING UNGASS-AIDS GOALS ON WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH



Wilza Vieira Villela | Alessandra Nilo

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## *Acknowledgements*

In order to contribute to the UNGASS-AIDS 2008 Review process, this report has collected strategic data on Sexual and Reproductive Health and Rights based on the UNGASS goals. Data was collected in sixteen countries— Argentina, Belize, Brazil, Chile, India, Indonesia, Kenya, Mexico, Nicaragua, Peru, South Africa, Thailand, Venezuela, Ukraine, Uganda, and Uruguay, aiming to use them as contents for governmental and non governmental political agendas and programs to fight AIDS.

This effort is part of the results of the project *Monitoring the UNGASS-AIDS Goals on Women's Sexual & Reproductive Health* of the National STD/AIDS Programmes. The project is sponsored by the Ford Foundation with support from CICT Brazil—International Centre of Technical Cooperation—and strategic partnerships that were established with UNAIDS and the Brazilian office of UNFPA. This project aims to foster and strengthen the participation of civil society in monitoring and evaluating the goals agreed to at UNGASS 2001, which were subsequently revised and expanded in 2006.

The results obtained were made possible by the efforts and dedication of the coordinating organisations of each country, that developed partnerships with Gestos based on the sense of collective construction, with local autonomy for determining priorities for research execution and advocacy strategies.

Perhaps the greatest result of this initiative, and one that we have not yet measured entirely has been that it has made it possible to find new partners—in civil society and some spheres of government—, each with their own particular way of seeing the world and of acting in it, but sharing the belief that it will only be possible to overcome AIDS through a culture of peace that is truly equitable and democratic.

Special thanks are due to Barbara Klugman for trusting Gestos' capability to develop the idea and execute the proposed plan.

Yours in solidarity,

*Alessandra Nilo*



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## *Foreword*

Ever since the so-called social cycle of United Nations Conferences<sup>1</sup>, it has been strongly recommended that civil society should carry out its own monitoring processes, aiming to make visible hidden gaps in policy implementation. This is particularly important in developing countries, where social inequality also means health inequality and disparities in the public health system.

During the UN General Special Assembly on HIV/AIDS—UNGASS—AIDS—in 2001, the heads of governments acknowledged the direct relationship between promoting Human Rights and reducing vulnerability to HIV. They also recognized that results could not be obtained through governmental action alone, demonstrating the need for the participation of Civil Society and HIV positive people in the construction and implementation of effective answers to the epidemic. This has stimulated civil society to use the UNGASS goals as an important instrument to follow the AIDS policies in their countries.

Gestos is a NGO founded in 1993 that has been accompanying UNGASS/AIDS ever since 2001, and has shared its experience with many organizations in Brazil and other countries. In 2007 it began a South-to-South cooperation that has mobilized over 500 NGOs,<sup>2</sup> from various social fields, to identify gaps and progresses made in the implementation of actions for the sexual and reproductive health of girls<sup>3</sup> and women in regard to confronting HIV/AIDS. The proposal integrates capacity building and community mobilization strategies for advocacy actions.

The present report sets out a synthesis of the results for each country and has been organized in six sections, namely:

1. Introduction
2. Theoretical-Methodological Approach
3. Syntheses of Results
4. Progresses and Challenges – Situations identified by the countries as progress and the challenges there are to their consolidation.
5. Gaps and Recommendations – Synthesis of situations identified as important gaps with their respective recommendations and final comments.
6. Attachments

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<sup>1</sup> Including Conferences on the Environment, Human Rights, Population and Development and Women, among others.

<sup>2</sup> Total number of NGOs and governmental bodies present in the 1st and 2nd UNGASS Forums up to the moment of completion of the present report.

<sup>3</sup> The UN Convention on the Rights of the Child defines a child as anyone under the age of 18; a young person is someone between the age of 10 and 24; an adolescent is between 10 and 19. For the purpose of this report, a girl is anyone up to the age of 18 and young women up to 24.

- a. Summary of the main findings for each country with the selected paragraph and the indicators defined on the basis of excerpts from the national reports followed by a brief commentary.
- b. Socio-economic Characteristics: a contextual overview of the countries that were studied to enable a better understanding of the specific scenarios in which the responses are elaborated. For that same purpose, data on women's health is presented as well as a characterization of each country's health system.

To highlight sexual and reproductive rights is crucial to tackling the HIV/AIDS pandemic. It must be at the centre of the global and national responses. We hope this collective effort of activists from different parts of the world will continue to contribute towards the perfecting of international responses to the HIV/AIDS epidemic.

## *List of Acronyms*

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic(s)
BSS	Behavioural Surveillance Survey
CBO	Community based Organization
CONISIDA	Nicaraguan AIDS Commission
OCDE	Cooperation and Economic Development Organization
CCM	Country Coordinator Mechanism from Global Fund
FBO	Faith Based Organization
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User(s)
IEC	Information Education and Counselling
MSM	Man who has Sex with Man
NA	Not Applicable or Not Available
NAC	National AIDS Commission
NAP	National AIDS Programme
NAS HIV/AIDS	National Spending Assessment
NGO	Nongovernmental Organization(s)
NSP	National Strategic Plan
ILO	International Labour Organization
OVC	Orphan and Vulnerable Children
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
SANAC	South African National AIDS Council
S&RH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease(s)
STI	Sexually Transmitted Infection(s)
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing

# SECTION I

## *Introduction*

Over the years, the participation of civil society in the monitoring of national and international policies on AIDS has increased. The process has been particularly visible in the accompaniment of commitments made by governments in 2001 at the United Nations. This process has raised awareness about the challenges to fulfil the commitments.

Civil society's contribution has occurred in two different ways. In addition to theoretically and politically mirroring the implemented policies, civil society has made great efforts to share the knowledge that it produces and, to that end, it faces the challenge of having the information and contents that it puts forward recognised as being valid. The creating and perfecting of public policies on AIDS has become a critical knot in most countries showing up the great disparity there is between the speed that is necessary to respond to the pandemic and the implementation of actions planned by governments.

In contrast with the first phase of the epidemic where the main action of the social movements was to denounce to the world the devastating potential of the HIV virus infection, in the second stage, where the epidemic is widely recognized and effective means of prevention and treatment are available, the struggle is to ensure universal access to those means.

This change has brought with it new responsibilities for civil society. Setting specific information on the ways of living, feeling and thinking of the different communities, before those governments and agencies that have committed themselves to addressing the epidemic, has become an undeniable contribution. It also represents a challenge; that of transforming individual experiences into rigorous and systematic knowledge so that it may be shared collectively and contribute towards the design of responses that are more appropriate to the needs of the affected populations.

The methodology that was adopted for this project, that of constructing a data gathering instrument based on the contributions of the leaderships of various civil society organisations involved in different countries and of promoting forums where the information could be shared and collectively analyzed, reiterates the conviction that *“we are no longer in a situation where some produce knowledge—universities, intellectuals—for others to make use of—social movements.”*<sup>4</sup>

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<sup>4</sup> Escobar, Arturo- *Actores, redes e novos produtores de conhecimento: os movimentos sociais e a transição paradigmática nas ciências*. In Santos, Boaventura Souza (org.) *Conhecimento Prudente para uma Vida Decente*. São Paulo, Cortez, 2004, p. 653.

## *Civil Society Articulation and Advocacy*

To put the project into effect, an initial data collection guide was elaborated which was then discussed and adapted during workshops referred to as UNGASS AIDS Forum, that were held in all sixteen countries and in which representative of different social movements linked to the fields of Human Rights, HIV/AIDS, Sexual and Reproductive Health participated.

After the UNGASS AIDS Forums, each country organised its own specific strategy for collecting information, seeking to involve the greatest possible numbers of people and organisations in the process. The results of those efforts were systematized in the form of a reference document and widely publicized through the holding of the 2<sup>nd</sup> UNGASS AIDS Forum in each country. The reports produced were incorporated in the National Reports by the governments of most of the countries involved in the project. Those whose reports were not included sent them on to UNAIDS as a *shadow report*. The table below synthesizes the results of the project in the various countries.

COUNTRIES	RESULTS
Argentina	→ Held the 1st UNGASS Forum from 02 – 03 August 2007 with the participation of 23 organizations in addition to the National AIDS Programme and UNAIDS. The government did not include the document produced by civil society in the country Report. Accordingly the data produced was sent as a shadow document on 31 January 2008. → To hold 2nd UNGASS Forum in March to publicize the results.
Belize	→ Held the 1st UNGASS Forum from 10 – 11 May 2007 with the participation of 11 organizations in addition to the National AIDS Programme and UNAIDS. Concluded the research and requested government to include it in the Country Report where it appeared as an attachment. → To hold 2nd UNGASS Forum in March to disclose the results.
Brazil	→ Held the 4th UNGASS Forum from 16 – 17 June 2007 with the participation of 39 civil society organizations in addition to the National AIDS Programme, UNFPA and UNAIDS. The research on Sexual and Reproductive Health was incorporated in the Country Report and civil society took part in the elaboration of the National informative document. → To hold 5th UNGASS Forum in May to disclose the results and prepare civil society for the UNGASS review meeting in June 2008.
Chile	→ Held the 1st UNGASS Forum from 02 – 03 April 2007 with the participation of 11 organizations and the 2 <sup>nd</sup> UNGASS Forum in January with the presence of civil society and the government, to validate the data collected. After concluding the research, requested government to include it in the Country Report where it appeared as an attachment.
India	→ Held the 1st UNGASS Forum from 06 – 07 July 2007 with the participation of 14 organizations and took part in meetings with government to discuss the collected information. The report was not incorporated by the government.

→ To hold 2nd UNGASS Forum in March to disclose the results and prepare civil society for the UNGASS review meeting in June 2008.

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Indonesia	<p>→ Held the 1st UNGASS Forum from 02 – 03 July 2007 with the participation of 15 NGOs;</p> <p>→ Concluded the research and held the 2nd UNGASS Forum to validate the collected data. Also defined a strategy of travelling to provinces far from Jakarta to mobilize more civil society organizations around the country.</p> <p>→ The civil society document was integrated in the official report in the form of an attachment.</p> <p>To hold the 3rd UNGASS Forum in April to disclose results and make civil society better prepared for the UNGASS 2008 in New York.</p> <p>→ Presently project coordinators in Indonesia are mobilizing together with Seven Sisters, to hold an ASIA regional Forum under the aegis of UNGASS in April 2008.</p>
Kenya	<p>→ Held the 1st UNGASS Forum from 13 – 14 July 2007 with the participation of 18 NGOs in addition to the Nations AIDS Council and University.</p> <p>→ The moment of concluding the research coincided with the presidential elections and the resulting serious political crisis in the country. They concluded the report and sent it as a shadow report to UN in 13 February.</p>
Mexico	<p>→ Held the 1st UNGASS Forum from 08 – 09 February 2007 with the participation of 24 organizations including UNFPA, the Ford Foundation, OPS and academic researchers;</p> <p>→ In December 2007, during the country's AIDS NGO conference, discussions on UNGASS were held seeking to increase the number of organisations involved in the process.</p> <p>→ Sent in a civil society shadow report on 31 January.</p> <p>→ To hold 2nd UNGASS Forum in March to disclose results.</p>
Nicaragua	<p>→ Held the 1st UNGASS Forum from 10 – 11 July 2007 with the participation of 17 organizations plus the Ministry of Labour, the Human Rights Department, the Municipal Authority of Masaya, the Commission for Women and the Communications Media.</p> <p>→ Held the 2<sup>nd</sup> UNGASS Forum in October 2007 with the participation of 29 organizations to validate the results with the participation of civil society and the government.</p> <p>→ In December civil society sent in its final report to the government and presented it for incorporation in the National Report to the Ministry of Health. Nicaragua's Country Report was prepared through a consultancy with the Public Health School, which has already been in contact with civil society.</p>
Peru	<p>→ Held the 1st UNGASS Forum from 12 – 13 June 2007 with 31 NGO as well as government bodies and United Nations Agencies;</p> <p>→ Concluded the research and in November 2007 held the 2nd UNGASS Forum to validate the collected data. Around 32 representatives of NGOs, networks and the government took part.</p> <p>→ Civil Society's report on S&amp;RH was included in the National Report sent to UNAIDS.</p>
South Africa	<p>→ Held the 1st UNGASS Forum from 30 – 31 July 2007 with the participation of 15 organizations and networks;</p> <p>→ Concluded research in December 2007. Requested inclusion of the document in the Country Report was denied.</p> <p>→ The 2nd UNGASS Forum will be in March.</p>

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Thailand → Held the 1st UNGASS Forum from 20 – 21 September 2007 with the participation of 17 organizations and networks;  
→ Concluded the research and in January 2008 held the 2nd UNGASS Forum to validate the collected data together with a national consultation with the Thai government. Over 300 representatives of NGOs, Networks, Government and UNAIDS took part in the event. The S&RH and AIDS report produced by civil society was included, by the Government, in the National Report sent to UNAIDS.

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Ukraine → Held the 1st UNGASS Forum from 30 May to 1 June 2007 with the participation of 08 organizations, networks and UNAIDS;  
→ Concluded the research and in January 2008 held the 2nd UNGASS Forum to validate the collected data together with a consultation with the government. Representatives of NGOs, Networks, Government and UNAIDS took part in the event.  
→ CS conducted a series of meetings with government and other NGO about incorporation of their S&RH report within the National UNGASS Report. Finally it was accepted to be included.

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Uganda → Held the 1st UNGASS Forum from 24 – 25 May 2007 with the participation of 15 organizations and 3 members of parliament;  
→ Concluded the research and from 29 – 30 January 2008 held the 2nd UNGASS Forum to validate the collected data. More than 40 representatives of NGOs, Networks, and Government (Ministry of Gender, Labour and Social Development and the Uganda AIDS Commission) took part in the event.  
→ Inclusion in the Country Report requested but not accepted. Shadow report sent in to UNAIDS on 15 February.

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Uruguay → Held the 1st UNGASS Forum from 12 – 13 March 2007 with the participation of 17 organizations;  
→ Concluded the research and had the informative document on Sexual and Reproductive Health and AIDS produced by civil society incorporated by the Government.  
→ To hold 2nd UNGASS Forum in March to publicize data and prepare civil society for the UNGASS review meeting in NY.

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Venezuela → Held the 1st UNGASS Forum from 28 – 29 March 2007 with the participation of 09 organizations;  
→ Concluded the research but the civil society report was not incorporated by the government;  
→ The collected data was sent in as a shadow report to UNAIDS on 30 January.  
→ To hold 2nd UNGASS Forum in March 2008 to publicize data and prepare civil society for the UNGASS review meeting in NY.

## SECTION 2

# *Theoretical-Methodological Approach*

## 1) CONCEPTUAL FRAMEWORK

Half of all people infected by HIV/AIDS in the world are women, mainly affected by HIV/ADS epidemic due to their lack of Sexual and Reproductive Rights. In fact, the growth of the epidemic among women and girls is helped by the explosive combination of poverty, migration, violence, lack of information and unsafe sex practices in a context of the expansion of fundamentalism and conservative morality.<sup>5</sup> HIV/AIDS has had a devastating impact on women and girls, whose vulnerability to the infection is exacerbated by economic and social inequality.

In our view, no process for debating and designing responses to HIV/AIDS can be productive, credible or successful without a comprehensive approach on Sexual and Reproductive Rights. However, despite the recognition that it is impossible to face women's HIV/AIDS vulnerability without an active process of empowering women themselves, and despite acknowledging that sexual and reproductive health and rights are key issues for that process, until 2006 government and civil society UNGASS reports have not provided sufficient information about the current situation of women's and girl's in order to improve the countries' responses to HIV/AIDS by strengthening sexual and reproductive policies and services.

This lack of information probably reflects the low priority of gender issues on the national and international HIV/AIDS agendas and in resource allocation.

## 2) DATA-GATHERING INSTRUMENT CONSTRUCTION

In elaborating the data-gathering instrument an effort was made to identify those paragraphs of each chapter of the *Declaration of Commitment* whose objectives required action in the field of sexual and reproductive health. After they had been identified, those points that were considered to be crucial for civil society were defined, that is, those actions which if they failed to be implemented with quality and wide outreach, would jeopardize the effective achievement of the goal.

That set of critical points was what guided the elaboration of the indicator matrix. The matrix was constructed on the basis of a search for qualitative data with relevance for the analysis of those policies, plans, or programmes necessary to make the

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<sup>5</sup> One World, One Fight report 2003-2005 - <http://www.umul.com.br>

satisfactory achievement of the goals in question feasible as well as operable.

In gathering information the following sources were used:

- Interviews with key informants – programme administrators, researchers and NGO leaderships;
- Interviews with service users;
- Analysis of official documents, literature produced by NGO and academic production in regard to each one of the themes addressed;
- Observation of service providing.

#### OPERATIONAL DEFINITIONS FOR POLICY ANALYSIS

This monitoring tool was developed on the basis of the importance of civil society's opinions on the policies regarding sexual and reproductive health and their concrete implementation, considering their adequateness, reach, coverage, effectiveness and civil society participation. The analysis of the respective services was done in the dimensions of access, quality, and care, as defined below:

##### ADEQUATENESS

*Does it provide the answers for the problems considered critical by civil society?*

##### REACH

*Does it include all different types of people affected by the problems the policy tries to solve?*

##### COVERAGE

*Does it reach people most affected by the problem?*

##### EFFECTIVENESS

*Does it happen in practice? Does it have a budget? Are there trained human resources for its implementation?*

*Does it have a communication strategy for reaching civil society?*

##### CIVIL SOCIETY PARTICIPATION

*Are there, indeed, representatives from civil society, especially the epidemic's most affected populations, involved in designing, monitoring, and evaluating the proposed actions?*

##### ACCESS

*Do people who need services get them easily, or are there challenges?*

#### CARE

*Do people feel well received, respected, and respected in their rights?*

#### QUALITY

*Do people get their needs met?*

#### MOST VULNERABLE WOMEN

*Women living with HIV; incarcerated; partners of MSM; drug users; married; affected; girls living with HIV; girls living on the streets; transsexual women; young women; women and girls who are sex workers; girls who are orphans due to AIDS; indigenous women; immigrants and indigenous women who migrate; women affected by migration; mobile populations (national and international); bisexual and lesbian women; women and girls victims of sexual exploitation; women and girls victims of violence and sexual violence; women and girls with special needs.*

Data analysis was oriented by the identification of the main strong points for promoting advances in the sexual health of women living with HIV/AIDS to prevent the epidemic amongst women, and the main gaps and deficiencies related to the articulation of sexual and reproductive health and HIV/AIDS, considering the socio-political and health environment that surrounds the implementation of actions of sexual and reproductive health and the national response to the epidemic. To enrich the data analysis and the final report elaboration, the analysis was collectively done through a debate between the distinct actors involved with the monitoring.

## SECTION 3

## *Synthesis of the Results*

The countries included in the project are very heterogeneous. In terms of population there are strong contrasts like India with one billion inhabitants and Belize with fewer than 300,000. The degree of urbanization is also very distinct and includes countries where the population lives predominantly in rural areas like Uganda, and Uruguay where almost the entire population lives in urban areas.

The countries all show roughly the same proportions of men and women or a slightly higher female except for India where the process of sex selection has produced an important unbalance on the side of more men<sup>6</sup>.

In terms of religion, there are many differences. Although Christian religions predominate it is known that there are many differences among them and in a similar way the degree of social adherence to religious precepts varies as does the political influence of the confessional groups and the respect for sexual and reproductive rights.

The percentage of the population in these countries living below the poverty line also varies. And there are some countries with a considerable percentage of people living in extreme poverty and others where there is practically no absolute poverty to be found. The illiteracy rates accompany the poverty levels: the countries with the highest numbers of people living below the poverty line have the highest illiteracy rates<sup>7</sup>. The levels of employment do not parallel the levels of poverty. What stands out is that in all the countries the unemployment rate is higher among women<sup>8</sup>.

In regard to the reproductive health of women there is great variation among the indicators of the countries included in the study. This does not merely mirror the socio-economic diversity among them but points to differences in the recognition of the sexual and reproductive rights of women given the strict close connection there is between health and exercising rights.

Those differences should be taken into account when planning and implementing actions in response to the HIV/AIDS epidemic in each country. Thus, as an example, the high maternal mortality rate in countries like Brazil and South Africa where almost all births take place in hospital environment is suggestive of the poor quality of such services; high maternal mortality allied to low coverage of condom use as in Uganda, Kenya and India suggest that there is little access to sexual and reproductive services in general. However, the countries with the lowest maternal mortality rates also have the highest rates of births attended by qualified personnel, the lowest illiteracy rates and the lowest proportions of people living below the poverty line.

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<sup>6</sup> See page 43.

<sup>7</sup> See page 45.

<sup>8</sup> See page 48.

It should be stressed that not all of the countries offer free universal health coverage which makes women's access to sexual and reproductive health care services difficult. Similarly, the practice of abortion, which is considered to be an indicator of the degree of respect for women's reproductive autonomy, is classified as a crime in most of the countries studied. In none of the countries studied, not even those that permit abortion in some situations where the mother or the child's life is at risk, does the status of serum-positive for HIV constitute a legal justification for voluntarily interrupting a pregnancy.

At the same time, in most of the countries studied, HIV transmission was predominantly sexual transmission<sup>9</sup>. It must be remembered that among the countries where the epidemic is expanding through the use of injected drugs as well, in the case of women, sexual transmission is still the most important means. The relative participation of women in each country and prevalence at national level are important factors that must be taken into account when organizing sexual and reproductive health actions capable of making an impact on the AIDS epidemic.

#### LEADERSHIP

[At the national level]

GOAL 37 –“ (...)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 marginalizing; 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 representatives of women and youth living with HIV in the HIV/AIDS Programmes, including the decision-making spaces and UNGASS monitoring actions.*
- *Participation of groups of women and youth in assisting the design, implementation, and evaluation of the programs directed at them.*

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<sup>9</sup> See page 51.

## SYNTHESIS AND REMARKS

The degree of involvement to which women and young people participate in the formulation of policies for confronting the epidemic, whether it is in the aspect of direct actions or that of empowerment, varies greatly among the countries. There are some where there is no participation whatsoever, others where women's participation occurs at the level of the National AIDS Commissions, and still others like Uganda, which has made efforts to guarantee the participation of women in many decision making entities such as in the Parliament and committees. In the case of Uganda, it is worthwhile pointing out that in spite of their participation's being formally guaranteed, in many of the interviews there were references to the fact that women's participation is not proportional to their real weight at the moment of making decisions.

It should be remembered that in the case of the National AIDS Commissions, they often do not enjoy legal backing or support in the form of a legally formalized public policy and their structure and composition is dependant on Government Administration, therefore not representing a State policy as such, and this may have an impact on the participation of women in such spaces.

Furthermore, in many countries, in the relations of civil society and the State, there is no clear understanding as to what should be the role of each one of them and as to how they could interact and integrate and synergise. *"(...) the role of civil society is not very well understood in terms of how to exercise social control and how to contribute to improving what is being done by the State"*. (Marcos Becerra, ACCIONGAY, Chile). There is also no consensus in regard to what the participation of civil society in modern societies is understood to be. *"Participation has to do with a more adult form of democracy, with a different, more deliberative form of participation. One that not only participates in the implementation of social programmes but also in their logic, in the reflections on them (...)"*

The importance of the actions of the Global Fund in some countries must also be stressed and therefore measures to ensure sustainability of the participation and representation of women even after that collaboration has been finalized. *"It is necessary that the CCM should include, in their statutes or internal regulations, specific items that make fair representation of the sexes obligatory and the representation of women"*<sup>10</sup>.

## PREVENTION

GOAL 52 – "By 2005, ensure a wide range of prevention programs which take into account circumstances, ethical and cultural values (...) including information, education and communication in languages most understood by communities (...) expanded access to essential

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<sup>10</sup> Idem.

commodities; expanded access to voluntary and confidential counselling and testing, (...) and early and effective treatment of sexually transmittable diseases.”

#### PROPOSED INDICATORS

- *Educational programs in Prevention for women and girls;*
- *Female and male condom availability in the health services, schools and associations, and a range of other places;*
- *Ease of condoms acquisition and proper orientation on their use, even by young women.*

#### SYNTHESIS AND REMARKS

Most countries mention that they do not have specific programmes for women or for young people. The specific actions, when they do occur, are in the form of campaigns and are considered insufficient because of their sporadic and isolated nature.

Three of the countries studied have adopted as a priority the inclusion of a perspective of fidelity and abstinence in the sexual education of youngsters. If on the one hand there is agreement that they do represent a possibility for prevention, on the other, in a similar manner the issue must be addressed in a more outreaching manner of prevention for those adolescents and young men and women that have an active sexual life and even more so for those who have sexual relations with persons of the same sex. Furthermore, ABC is not an effective approach or strategy for prevention among women and probably not for other populations in society at large either. Technical and political efforts must be made to incorporate other approaches and strategies that are less conservative.

It must be mentioned that several countries refer to HIV/AIDS prevention as having been mainly intramural and directed at prison populations which for one reason or another come before the public health services whether because of pregnancy or because of having some kind of STD. This fact has led to a kind of “*medicalisation of prevention*” which is carried out on the basis of controlling the “identified cases” which show up in the diagnoses that are made in the establishments themselves. Such a strategy has serious consequences, not only for the outside population which has no access to such services in spite of their vulnerability; adolescents in general, trans populations, MSM populations, adolescents that live and/or work in the streets, people deprived of their liberty among others, but also because it obscures the responsibilities of the State which has to direct its actions towards Public Health.

In regard to the male Condom there is repeated mention of the dependence of availability on the efficiency of the system as a whole with serious problems for

accessing the distribution in the interior of the countries. Access to the female condom appears as a considerable challenge to women and young women in all the countries. It is worth remembering that production of this material is on a limited scale and its cost is quite high in comparison to the male Condom and that does indeed make a more widespread availability very difficult.

There is consensus that Condom availability can increase considerably when there is integration between the AIDS Programmes and the Reproductive Health programmes and when the commitment to offering the Condom is embedded in a much wider policy. The reform in Indonesia clearly indicates the existence of that possibility: *“Indonesia is considered as having been successful in implementing a Family Planning program where condoms were offered as a mean of contraception. The Sentani commitment endorsed the implementation of ‘100% Condom Use’ in provinces in Indonesia. Bali and East Java have already advanced and provided District Regulation for their own provinces. These district regulations contain a comprehensive set of laws that regulates HIV prevention in their provinces, covering all aspects of HIV prevention from the basic principles such as considering humanity, gender, togetherness and justice as the foundations of regulation, regulations on VCT, and endorsing condom use.”*

#### PREVENTION

GOAL 53 – “By 2005 ensure that (...) young men and women have access to information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to the HIV infection in full partnership with young persons, parents, families, educators and health-care providers;”

#### PROPOSED INDICATORS

- *Sexual health programs for youth – content and quality, integration of services, access friendly.*
- *Access to unsafe sex post-exposure prophylaxis*

#### SYNTHESIS AND REMARKS

In almost all of the countries studied, there exists a proposal for sexual education. The exception is Thailand. The observation is repeatedly made that putting it into effect occurs very much as a function of the individual availability of a male or female teacher as there are no activities of continued education in the regular curricula or on the agendas of the teaching staff that guarantee that activities will be carried out with the prospect of effectively helping women and girls to protect themselves from HIV.

It is also worthwhile emphasizing a reflection put forward by Indonesia: Often, educational programs for young people (15 – 24years old) would mean NGOs coming to schools and giving 2-3 hours sessions on HIV, drugs and co-related issues. The commitment became real when the school allocated budget resources for regular training for their teachers, building school HIV policy and setting up a referral system & links with NGOs working with HIV & Drug Use.

With the exception of South Africa, the countries have no user-friendly healthcare services for young people and especially not for young women. As the Argentinean report remarks: *“there are no formal barriers but rather, informal ones. In regard to the barriers already mentioned that are characteristic of the institutional management of the system, the outstanding one is that attending to youngsters without the presence of a responsible adult continues to be very problematic for the health teams.”* The same observation is repeated in the Mexican report: *“Services provided for minors are not very accessible as they habitually require the presence of adults and the health personal question the various situations of the youngsters, both boys and girls”.*

Informal issues are also mentioned by Thailand *“Though there are many programmes for youths they cannot keep up with the situation of youths’ sexual problems. Currently Thai youths engage in sex earlier than before. The trend of HIV infection in youth is increasing continuously and the ratio of female youth is higher than male youth about two times. The other challenge is the Thai culture in regard to women’s virginity and precocious sex (sex at school age) which are taboo in Thai society.”*

## PREVENTION

GOAL 54 – *“By 2005, reduce the proportion of infants infected with HIV (...) by ensuring that (...) pregnant women accessing antenatal care have information, counselling 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 the mother to child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, access to treatment, especially anti-retroviral therapy and, where appropriate, breast-milk substitutes and the provision of a continuum of care;”*

## PROPOSED INDICATORS

- *Quality of counselling for HIV detection testing in pre-natal services*
- *Availability of appropriate detection testing*
- *Access and quality of services for HIV infected pregnant women*

- *Programs to guarantee breast milk substitutes*

#### SYNTHESIS AND REMARKS:

All the countries studied make ARV available and keep track of pregnant women with HIV although not all of them achieve the coverage they would wish to. In general there are problems with counselling, the continuity of the woman's treatment, the availability of formula milk substitutes, and furthermore, in many countries there were reports of attitudes of health teams whereby they force serum-positive women to undergo sterilization. The reflections set out below demonstrate the position of civil society in different countries in regard to the way in which practices to reduce vertical HIV transmission have been expanded:

According to Nicaragua's report, *"the prevention of vertical transmission has probably been one of the interventions with greatest effect, not only because it was an intervention in a captive population (pregnant women) who are increasingly making use of ante-natal care and institutional birth, but also as a consequence of the Law that obliges pregnant women to take the diagnostic tests. The obligatory nature of the test makes it somewhat difficult to improve the quality of care and counselling"*.

In Kenya, it was shown that *"there is need also for provision and sustainability of alternatives for those who can not afford exclusive breast feeding to avoid high rate of transmission of HIV from mother to child."*

However, many countries called attention to the need to avoid the infection of the foetus with HIV is a deeply engrained concept and in many cases an adequate evaluation of the consequences of the treatment for the mother is not made, nor is much interest taken in her. *"This reduces the attention of the women to the pregnancy and the labour which is soon concentrated on the new born child. The woman takes second place and forgetting that the mother-child dual is fundamental to the child's wellbeing"* (Argentina's Report.)

#### HIV AND HUMAN RIGHTS

GOAL 59 – "By 2005, bearing in mind (...) 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 women'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."

#### PROPOSED INDICATORS

- *Policies and programs directed at the promotion, security, and reparation of women's rights;*

- *Integrated policies directed towards women's rights within the HIV/AIDS National Programs;*
- *Policies and programs addressing men's responsibility in issues of sexual and reproductive health;*
- *Policies and programmes to protect the sexual and reproductive health of women in conditions of vulnerability to HIV/AIDS.*

#### SYNTHESIS AND REMARKS

The countries dispose of a significant body of Laws, regulations and plans regarding gender equity and aimed at fostering the protection of women's rights. Even countries like Nicaragua where it has been stated that *"there is no policy on gender and women's rights are not respected (...) the main obstacles are not of a regulatory nature because the State is signatory to international agreements and treaties."* As the Nicaraguan report continues *"the problem lies in the application of them"*. Indeed most of the reports refer to obstacles in translating the legal or programmatic framework into practical actions. There is a lack of political will, technical capability, and often there is no specific budget provision or integration among the policies developed by the various sectors of government. Returning to the Nicaraguan report *"However in practice, one can neither see nor feel such articulation in the provision of the said services associated to sexual and reproductive health, and HIV and AIDS because the orientations and focus all remain doggedly fixed in the written documents."*

Even in countries like South Africa where the political will exists, the problem of integrating the actions and programmes is still a considerable challenge. Also, in the terms of the Ukrainian report, *"the analysis of the implementation of UNGASS goals in relation to reproductive and sexual health found a lot of contradictions in the formulating and carrying out of national policy, namely: All governmental documents state comprehensive approach to the implementation of the policy that lies in uniting the efforts of many ministries and institutions, local authorities, NGOs in implementation of prevention programs and efforts but activities of and funding for particular institutions responsible for implementation of those programs are scattered, their coordination and cooperation remain merely formal. It is a regular occurrence that in regard to the implementation of certain programs by one ministry, representatives of other ministries and institutions only find out about them when they finalize their yearly reports on the execution of national and state programs or even later."*

Even work specifically directed at integrating policies and programmes does not guarantee an adequate focus on women living with HIV as the Mexican report highlights: *"Women's institutes and other similar entities readily link themselves to organizations that work with issues of gender, violence and sexual and reproductive rights but there has been no effective link to the theme of HIV/AIDS."*

The lack of integration of actions directed at women living with HIV is particularly important if we consider that in the community actions as well, they have to face great difficulties to obtain support or benefits.

According to the data in the report of the Bolivarian Republic of Venezuela for the period 2003–2005 on the Declaration of Commitment on HIV/AIDS—

UNGASS 2006—, since 2003 women have represented only 8% of the total users of HIV/AIDS services provided by NGOs nationwide.

It is not just women with HIV that are excluded from policies. In most of the countries, sex workers and transsexuals too are excluded from actions for fostering and protecting rights.

Furthermore, men have not been the main target for sexual and reproductive health actions except in the context of their sterilization. The Ukrainian report sums up the situation found in the countries: *“The issue of joint responsibility of men and women for safe sexual relations in the context of HIV/AIDS/STI has not been updated. The scope and quality of medical and social services aimed at the protection of reproductive health of men do not meet even minimal requirements.”*

## HUMAN RIGHTS

GOAL 60 – “By 2005, 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

- *Prevention Programs for young women.*
- *Non-formal sexual and reproductive health and rights education programs that promote gender equality.*

## SYNTHESIS AND REMARKS

Most of the countries remark that in spite of there being laws and regulations in place that provide for an education-based model in the proposals on gender equity they are not necessarily translated into actions specifically for young women, a group which, because of its particular social, economic and sexual and reproductive health vulnerability, ought to receive specific attention. On that topic it is worthwhile considering this reflection from the Chilean report: *“Concern has arisen in civil society with the government strategies of handling the themes within its administrative structure and in government policies and programmes in a crosscutting perspective. While it is true that such a manner of understanding the themes of gender and sexual and reproductive rights is very attractive theoretically, in practice it has not been possible to visualize the effectiveness of that strategy.”* To some extent this transversal approach—in the way it has been made—has meant that responsibilities in regard to them have not been clearly established and furthermore they have

not been mirrored by the concrete implementation of policies or programmes, especially in the case of women.

A similar reflection appears in the South African document as can be seen here: *“While there is substantive discussion noting key areas of Gender and Gender-based violence, Cultural attitudes and Practices, sexual concurrency and sex workers, there is no overall conceptual lens unpacking sexual and reproductive health and rights. The language of sexual and reproductive health and rights is used as part of prevention area, yet this is not continued into the Treatment and Monitoring and Surveillance areas. Currently reproductive health is not on the essential health priority list.”*

There are varied interpretations made of the lack of emphasis on addressing sexual and reproductive health from a gender perspective. In the Peruvian document it appears as being related to political-ideological pressures, while in Venezuela it is attributed to problems in the management and organization of services as illustrated by the following statement: *“In Peru there is very considerable influence exercised by organizations that deny the sexual and reproductive rights of adolescents, seriously affecting the achievement of their sexual and reproductive expectations as well their life plans. That situation has been consolidated in the most recent amendment to Article 173 of the Penal Code that declares that any intimate relations that take place with a minor (under 18) constitutes a sexual violation. That regulation, far from protecting adolescents from potential violators, constitutes a threat to the development of programmes related to sexual and reproductive health.”*

In Venezuela government policies and programmes that adhere to the line traced by international documents and agreements on human rights have not always been endowed with administrative instruments that guarantee that they be effectively complied within the care services. *“Differences appear between what has been announced by government programmes and what really takes place in the care services. On the one hand attitudes of respect for rights are displayed and encouraged, however they are not always to be found in the practice of the services which points to a failure in the implementation phase of the proposals.”*

## HIV/AIDS AND HUMAN RIGHTS

GOAL 6I – “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 customary practices, abuse, rape and other forms of sexual violence, battering and trafficking of women and girls.”

## PROPOSED INDICATORS

- *Specific laws to prevent, prosecute, and repair the damage caused by violence against women.*
- *Specific actions against the sexual exploitation of girls;*

- *Emergency services for women and girls 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 disseminating data about violence against women and girls.*

#### SYNTHESIS AND REMARKS

Similarly to the previous paragraph analyzed, although the countries have regulatory instruments in place to counter gender-based violence in all its various forms, the implementation of actions is still highly deficient. The example from Kenya is clear: *“In Kenya the outcry through lobbying and advocacy led to the passing of the sexual offences bill into law on 31st May 2006, as sexual abuses are among the most cited constraints for girls education. The president has since signed it into law showing the government commitment in making a policy towards the achievement of Education for All—EFA—ensuring that girls will not be sexually harassed within or outside the school environment (FAWE 2006.)”*

A reflection made by Argentina on this indicates the main demands that need to be met: *“There remains much to be done especially in reinforcing and structuring these services and efforts in the form of a network. Other things are the creation of specialized care services for women victims of violence in most of the provinces; coordinating the various different services (in the fields of health, violence, women’s affairs, security, law); capacity building for teams in approaching the issue, the registration system and the importance of having reliable and comparable data; accessibility of the legal system with free legal advice and accompaniment and enhanced diffusion of protected rights through generalized and sustained awareness-raising campaigns. There also seems to be a need to develop sustained campaigns on a national scale countering Violence against Women and to set up shelters for adult women and their children nationwide, as well as for mechanisms to assist and reinsert the women victims of violence.”*

#### REDUCING VULNERABILITY

GOAL 62 – *“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 behaviour 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.”*

## PROPOSED INDICATORS

- *Support programs for women in situations of vulnerability, including income transfer and human rights defence programs;*
- *International agreements, conventions, and treaties application in the country*
- *Efforts to curb and punish trafficking in women;*
- *Monitoring activities.*

## SYNTHESIS AND REMARKS

As is well known, there are various situations that heighten the vulnerability of women to HIV such as being incarcerated, professional sex work, drug use and illiteracy. However to a greater or lesser extent all those situations have to do with the condition of poverty. Thus it becomes very important in facing up to the HIV/AIDS epidemic to develop actions directed at reducing poverty especially when taking into account the phenomenon of the feminizing of poverty which is taking place all over the world.<sup>11</sup>

Almost all the countries studied make reference to some kind of action specifically designed to try to improve the social condition of women. Nevertheless, not one of those that operate this type of programme undertakes any kind of monitoring activity that would enable society as a whole to discuss and form an opinion about a problem that afflicts us all. Furthermore there no programmes specifically for women living with HIV and many of the programmes operated for sex workers propose to deny this activity and do not create conditions for the professionals to work in a dignified manner.

The comment coming from Mexico gives us a good example of that type of situation: *“Even though capacity building events have been implanted as part of the fight against poverty, they are not directed at infected women who remain unaware of the existence of such capacity building. Very few productive projects are offered to such populations and in the case of sex workers, they are even fewer and there is a tendency to try to modify the way in which they gain entry by offering them training in handicraft work so that they may find alternative ways to sustain themselves, but they are insufficient and fail to ensure decent employment.”*

In the case of trafficking in women, Thailand registers that: *“While Thailand has committed itself to eliminating human trafficking, it remains an origin, source and transit state for human trafficking. One contributing factor, identified here, is the lack of citizenship for hundreds of thousands of hill tribe villagers. This prevents them from accessing state benefits like healthcare, education or travel permits to freely travel around Thailand. As a result, they become vulnerable to exploitation and human trafficking. If trafficked, victims without proof of citizenship receive limited protection, little assistance*

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<sup>11</sup> Women and girls represent 70% of the 1.2 billion people living on less than US\$1 a day - UNDP, Human Development Reports, 2002/2001.

*and may be denied re-entry into Thailand. Improving access to citizenship would eliminate a significant factor contributing to human trafficking in Thailand. Key elements of improving access to citizenship would include the: 1. Registering the birth of all children; 2. Improving the transparency of the citizenship application process; 3. Training local officials and people on the elements of the law.”*

#### REDUCING VULNERABILITY

GOAL 63 – “...develop and/or strengthen strategies, policies and programs which recognize the importance of the family in reducing vulnerability (...) and take account of the cultural, religious, and ethical factors; (...) ensuring access of both girls and boys to primary and secondary education, including HIV/AIDS in curricula; ensuring safe and secure environments, specially for young girls; expanding (...) sexual health education and counselling services; (...) strengthening reproductive and sexual and involving families and young people in planning, implementing and evaluating HIV prevention and care programs.”

#### PROPOSED INDICATORS

- *Social programs that consider the diversity of family arrangements*
- *Programs that consider cultures, religion and cultural contexts in the education strategies.*
- *Access to housing, education, social assistance, health care and food for girls and adolescents, in vulnerable situations including those infected with HIV.*
- *Actions of capacity building in sexual and reproductive health and rights for teachers.*

#### SYNTHESIS AND REMARKS

If the profusion of policies designed within the perspective of empowering women contrasts with the services and activities actually put into practice as previously shown, there is also a tremendous contrast with the scarcity of policies designed to capacitate the care personnel and improve their performances and that includes educators. In the same way, policies fail to recognise the diversity of family arrangements and of existing cultural, ethnic, and religious patrimonies that should be respected and to which educational messages need to be duly adapted. Schools (administrators and teaching staff) that carry out meaningful actions in a planned and articulated manner to foster a culture that encourages and guarantees the human rights of women, youths and girls are exceptions in the context of those countries where civil society conducted studies of the issue.

Furthermore, as the Argentinean report remarks, in spite of many countries' having introduced sexual education or subject matter on sexuality in the school curriculum, “*Generally speaking the line of discourse of the schools presumes that education on sexuality*

*for boys and girls and adolescents is the responsibility of the family and fails to take notice of the realities that the principal actors involved live in. In turn, the family preserves educational models that are charged with myths, prejudices and taboos when it comes to the sexual education of their children. The combination of all those aspects constitutes a formidable obstacle to imparting healthy skills to children and youngsters”.*

The scarcity of actions directed at young people in vulnerable situations, especially girls, should also be taken into account. The following account for example, registers a situation of extreme vulnerability, which although it refers to a single country, is probably not very different from what takes place in various others. “*A 2002-2003 baseline survey (International Programme on the Elimination of Child Labour—IPEC—and the University of Indonesia estimated that there were 2.6 million domestic workers in Indonesia, out of whom a minimum 688.132 (26%) were children; 93% of them were girls under the age of 18.*”

#### REDUCING VULNERABILITY

GOAL 64 – “By 2003, develop and/or strengthen 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 behaviour, livelihood, institutional location, disrupted social structures and population movements, forced or otherwise.”

#### PROPOSED INDICATORS

- *Outreach and effectiveness of Government articulation with regional and international partners to strengthen programmes and specific activities of sexual and reproductive health care for women in the most vulnerable situations;*
- *Participation of most vulnerable women in the articulation process.*

#### SYNTHESIS AND REMARKS

As can be seen there have been no great efforts made to guarantee technical, political or financial resources to support sexual and reproductive health actions for women in situations of great vulnerability. The work carried out with such groups has largely been left to the responsibility of civil society. In that regard, the participating countries consider that “*it is a blemish on the State to delegate that responsibility to the community, to civil society and to international cooperation.*” (Nicaragua)

On the other there is a notorious difference between the amounts spent on actions focussed on the epidemic and those invested in actions involving sexual and reproductive health of women as if the two were not intimately related.

As stated in the document from Belize *“while the HIV/AIDS sector has embraced the concern of general equity issues, women’s sexual and reproductive health and rights in relation to HIV/AIDS are not being explored and addressed with the same vigour and passion.”* The same reflection appears in the Uganda report when it declares: *“Reproductive Health and Rights is one of the critical components of the minimum package that was identified for implementation by Government. While reproductive health has remained a priority area in the Ministry in the last 4 or 5 years, inadequate resources have been allocated to support the main activities that are meant to encompass sexual and reproductive health.”*

#### CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS

GOAL 65 – “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 the provision of appropriate counselling 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

- *Existence of specific programmes to support orphans and children, especially girls infected and affected by HIV;*
- *Quality of shelter establishments;*
- *Existence of educative programmes for orphaned children, especially girls in situations of vulnerability because of HIV/AIDS.*

#### SYNTHESIS AND REMARKS

Just as there are very few actions directed at the most vulnerable children infected or affected by HIV there are also very few support initiatives for children orphaned by HIV and no specific reference can be found to children of the female sex. At the same time, there is visible fragmentation and in the systematization of the social-health interventions, the existence of resources distributed among distinct services and providers by means of different programmes and combined with actions that are finally executed by NGOs (on the one hand supplying medicines, on the other food allowances for the family, support for sporting activities, and

domestic support from the NGOs. The specific problems surrounding HIV/AIDS end up being diluted and integrated into the wider problem of vulnerable populations.

Nevertheless it is worthwhile underscoring the efforts that are being made in South Africa where *“a nationwide program for Early Infant Diagnosis has been embarked upon. Furthermore there is an effort to provide clinical mentorship and placements to health workers providing HIV care and treatment to children. The paediatric HIV training curriculum has been enriched with child counselling and communication skills.”*

#### ALLEVIATING SOCIAL AND ECONOMIC IMPACT

GOAL 68 – “By 2003, evaluate economic and social impact of the HIV/AIDS epidemic and develop multi-sector strategies to address the impact at individual, family, community, and national levels; develop and accelerate the implementation of national poverty eradication strategies to address the impact on the 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 impacts of HIV/AIDS on all levels of society, especially on women and the elderly, particularly in their role as caregivers, and on families affected by HIV/AIDS, and address their special needs; adjust and adapt the social and economic development policies, including social protection policies, to address the impacts of HIV/AIDS on economic growth, provision of essential economic services, labour productivity, government revenues, and deficit –creating pressures in public resources;”

#### PROPOSED INDICATORS

- *Availability of data or studies about the socio-economic impact of HIV on women.*

#### SYNTHESIS AND REMARKS

In Thailand was mentioned the existence of studies about the economic impacts of AIDS on families made up mostly of women and elderly people. In Uganda, the research in course may possibly contribute towards a greater reflection on this issue: *“The social economic impact of HIV/AIDS has been one of the critical areas of concern for government programming in the context that it is one among other major threats to human existence and economic development. The high number of orphans mainly due to the epidemic has made it difficult for extended families and orphanage centers cope with challenges. HIV/AIDS has increasingly caused poverty and discrimination and stigmatization of the victims. Women who lose their dear husbands are accused by in-laws and at times deprived of all resources”.*

All the other countries are unanimous in declaring that no study exists that identifies the socio-economic impacts of HIV on women. That is very serious because it is well known that the social impact of HIV on women is quite different from the one it has on

men due to her role as a care taker (which also has an important economic dimension), her reproductive role and also the type of discrimination that women with HIV suffer.

The absence of any studies mapping out in a quantitative and qualitative manner the impact of HIV on women is an important obstacle to designing mitigation policies and actions. As the Chilean report remarks on: *“The absence of studies conducted by the State on the socio-economic impacts of HIV/AIDS, the consequences of not having a multi-dimensional understanding of the issue of HIV; a vision that goes beyond the mere controlling of the pandemic and takes in the social, psychological, and labour dimensions and the citizenship of people living with HIV/AIDS as well as those affected by it. At the same time the lack of knowledge of the specific effects of HIV on those areas makes it more difficult to develop policies and programmes that are truly integral for their users and that have an impact on the quality of their lives”*.

#### RESEARCH AND DEVELOPMENT

GOAL 72 – “Develop and evaluate suitable approaches to monitoring treatment efficacy, toxicity, side effects, drug interactions and drug resistance and develop methodologies to monitor the impact of treatment on HIV transmission and risky behaviour;”

#### PROPOSED INDICATORS

- *Surveillance system for the side effects of antiretroviral medicines with data segregated by sex.*
- *Adaptation of health service providers' responses to the effects of resistance and secondary effects of antiretroviral medicines in women.*

#### SYNTHESIS AND REMARKS

Studies on the side effects of ARV in women that could provide better guidance for clinical procedures and counselling actions are not undertaken in any of the study countries. This leads to certain reflections like why is there such a preponderant focus on reducing vertical HIV transmission when specific actions for countering HIV among women are being considered and even then, in PMTCT+, more emphasis is placed on the child than the mother. Information about side effects of ARV intake and knowledge about other options of contraceptives, therefore, are rarely given (Thailand). There is clear evidence of gaps in regard to access to adequate treatment for women.

## SECTION 4

## *Progresses and Challenges*

In spite of the differences among the countries an analysis of the progress made and the gaps that still exist in facing the HIV epidemic have many points in common such as the fact that almost all the countries highlight the availability of treatment and the actions for prevention of vertical HIV transmission as being an important victory. As the Chilean report puts it *“access to ARV therapy is guaranteed by law to all persons living with HIV including women deprived of their liberty (...) access to voluntary ELISA testing and counselling for all pregnant women throughout the country, a treatment protocol for vertical transmission prevention that includes the provision of formula milk to substitute the mother’s milk, etc.”* While it is that there have been some problems in implementing those policies, nevertheless compared to those carried out in other environments it can be safely stated that there has been significant progress.

In a similar manner the Mexican document relates that there has been a considerable effort on the part of the government of the Federal District to foster better quality in the care offered and in the last administration the diagnostic test for pregnant women was widely promoted in the government care centres.

Some countries like Nicaragua are less emphatic. Although they admit that the existence of an AIDS programme and a Sexual and Reproductive Health programme constitutes an advance, they also recognise that the difficulties there are in their implantation as can be seen here: *“the strong point is the fact that an S&RH Programme and a National STD, HIV and AIDS programme exist even though they are not specifically for women and in spite of the deficiencies in their real application.”* In a similar direction, India’s report declares that *“sexual and reproductive health is largely translated as STI/RTI management and condom use; the health care system, including the public health care system, is not conceptualized on a rights and entitlements framework. Care and support are limited to treatment and access to ARVs, therefore, there is very little space to integrate issues of sexual and reproductive health. As the same report points out, difficulties in the health system end up limiting the access of the most excluded populations: “also, there are very few care and support services for women in prostitution, and other women in vulnerable situation.”*

Other countries however, whilst recognizing the existence of a specific structure to address the HIV/AIDS epidemics as an advance remark that the same political emphasis and social mobilization are not dedicated to Sexual and Reproductive Health. As the Belize report puts it: *“the policy in regard to HIV/AIDS medication is comprehensive and clear. In the National HIV/AIDS Policy the government has pledged to provide holistic treatment that is accessible and affordable. However, the National Health Policy and Sexual and Reproductive Health Policy both have gaps in regards to the provision of and access to services.”*

There are countries like Uganda and Thailand among others, where it is thought that very AIDS Programme itself can contribute towards the implementation of

Sexual and Reproductive Health actions. In the latter country for example, it is stated: *“The National Plan to Combat AIDS for the coming five years which was presented last October, is more sensitive to questions involving women than previous ones.”*

Even in South Africa where it is held that *“government supports women’s rights politically and in policy,”* and there is a good Sexual and Reproductive policy in existence, in the implementation of effective action it is often necessary to face the opposition of many professionals to carry out abortions when they are requested by women with HIV and at the same time they refuse to integrate care for pregnant women with HIV into the normal dynamics of childbirth and labour care as can be seen here: *“health workers have not easily accepted the provision of abortion service.(...) the South African Mother To Child Transmission Prevention Programme was introduced as a vertical programme to allow for central control and faster implementation; however the result is that it does not function integrally with broader maternal and child health services.”*

Countries like Argentina and Brazil with relatively well structured AIDS and Reproductive health programmes comment on the fact that they are federative republics whereby the states and municipalities have autonomy which means that many of the policies defined or recommended at the central level do not get carried out with the necessary quality and efficiency at the local level, a situation that should be examined carefully, not only by the government but by civil society so that the advances achieved in terms of legal frameworks may indeed be translated into concrete benefits for the women.

Another warning contained in the report from Chile should also be borne in mind: *“the greatest advances were seen in the sphere of Sexual and reproductive Health. However in the sphere of rights similar advances have not been obtained which has meant that in practice the approach has been health-based.”*

Indeed all the reports mention concrete actions in the field of reproductive health particularly in the prevention of vertical HIV transmission, as opposed to the proposals contained in documents plans and regulatory frameworks concerning guarantee for reproductive rights and sexual rights too, that never put into operation.

It must be stressed however, that the very same proposal for preventing vertical HIV transmission, which for many countries is the only thing that has been achieved, supposedly in a perspective of integrating HIV/AIDS and Sexual and Reproductive Health does not offer universal coverage in all the countries and neither is it orientate towards guaranteeing the rights of the women involved. As the South African report states, *“there has been considerable work done in the area of prevention of perinatal transmission, but only 51% of HIV positive pregnant women accessed PMTCT.”*

Thailand’s report points in the same direction when it declares that PMTCT+ places greater emphasis on the child than the mother. Information about side effects of ARV intake and knowledge about other options of contraceptives, therefore, is rarely given.

Furthermore, limiting Reproductive Health to the mother-infant sphere without including integral care for her sexuality or health has ended up stimulating

discriminatory behaviour towards mothers living with HIV/AIDS. Thus, HIV positive women's sexual and reproductive wishes are not provided for.

As the Brazilian report remarks, *"the idea 'Women's Health,' understood as being care in regard to conception and contraception is what guides the practices and services thereby restricting the approach to sexual health and sexuality to an inadequate perspective, unsuited to the proposals for addressing the epidemic."* That statement harmonizes with the observation that *"when we speak about 'women', we feel it is necessary to differentiate heterosexuals, lesbians, or bisexuals and different ethnic groups and cultures because the present campaigns are produced using a generalization for the category 'women' whereby all the printed material concerning relations and practices refers only to heterosexual bonds."* (Argentina)

Even within the narrower perspective of heterosexual women however, the attention given to conception and contraception is not guaranteed whether it be in regard to coverage, as the previous paragraph showed, or the quality of care and attention dispensed, the availability of free contraceptives, or counselling and guidance, especially in relation to women living with HIV. Indeed, as the Nicaraguan report sets out, *"however there is no quality, warmth or respect in the attention that is given to the population at large, particularly in the case of women living with HIV who are subjected to every kind of rudeness, rejection, discrimination and isolation above all at the moment of the birth and immediately after it. Confidentiality does not exist."*

One of the lines of the women's struggle is the defence of the right to control their own fertility which means making the decision not to have children but having the right to have them too. However in the case of serum-positive women that is questioned by health workers who thereby demonstrate how unprepared they are to handle the questions associated to the condition of serum-positive. The woman with HIV suffers all kind of pressures right from the beginning of pregnancy when she is induced to have an abortion and during pregnancy when she finds it difficult to access the service.

The Indonesian report remarks that *"the main challenge in assisting HIV positive pregnant women is mainly with the stigma and discrimination they often face when accessing health care services in hospitals, clinics and other centres for health care. There are cases registered where health service providers refused to conduct caesarean section for HIV positive pregnant women, with allegations such as the hospital does not have sufficient medical equipment to proceed with caesarean section or that there is no formal permission from the head of the hospital."*

Another advance in regard to which there is a consensus among the countries concerns the policies for reducing violence against women. As the document from Peru points out, *"Violence represents one of the most serious violations of human rights that affect women and it has been largely ignored by society and by governments for many years. In recent years more and more legislation has been introduced concerning violence against women."* Once more, although the importance of a regulatory framework in place that endows the issue of violence against women with visibility must be admitted, the materialization of actions and especially the real extent of the impacts of policies and actions implemented as a response to violence against women are

highly unsatisfactory. As the Kenyan report remarks, *“there is a lack of an adequate system to gather data on gender violence and lack of adequate interventions to mitigate gender violence. Increased gender violence has also been noted.”*

Not only in Kenya but several other countries studied an increase in violence against women is referred to and the relative inability of the State to deal with the problem. The Peruvian report sets out in detail that *“(…) sexual violence in particular, is a source of great concern in the country. The increase in its occurrence is clearly visible (…) those most affected by it continue to be the women, especially girls and adolescents (…) the number of cases attended to does not reach the proportions of the numbers affected by it mainly due to the fact that the state is not seen as a reference for protection, justice or reparation. It is important that the inefficiency of the state be recognized in order prevent such occurrences and deal with the problem appropriately.”*

It is worthwhile remembering that violence is one of the components of the vulnerability of women to HIV and its magnitude has not been duly assessed and neither have the impacts of the actions implemented up till now to reduce it. However the report from Kenya below is very illustrative: *“19% of 324 HIV positive women declared that they had suffered violence at the hands of their partners, which seems to show that they are more liable to violence than men are when they reveal their serum-positive status. The situation is even more serious in the case of sex workers who are often accused by their clients of having transmitted HIV and therefore deserving physical punishment.”* (PAHO, 2005)

The last point that all the countries agree on when pointing to advances is that referring to the formulation of plans to guarantee equal opportunities between men and women. It is understood that this kind of plan makes it possible to implement actions that result in the empowerment of women which is a basic condition for them to be able to exercise their sexual and reproductive rights allowing the government and civil society to develop advocacy activities with a view to making them operational and monitoring them. The Venezuelan report underscores the following: *“The progress made in legislation on the rights of women and their protection based on principles of gender equity and justice does not only appear in the Constitution but in other bodies of legislation and they offer a legal framework that favours actions for empowering women. Becoming signatory to the various international treaties on Women, Sexual and Reproductive Health and HIV/AIDS obliges them to adjust their policies and programmes in accordance with the advances in the fundamental human rights of women.”*

In a more cautious tone, the Brazilian report comments that *“the prodigality of laws, proposals and documents aimed at gender equity does not always correspond to their effective implementation”*, and going a little beyond that the Uruguayan report comments that *“however, it is a law that needs to be made much more use of, that must be implemented in a much better manner.”*

Indeed, poverty, discrimination, migratory strategies in response to economic crises, unemployment that affects women to a greater degree, the infantilizing of poverty, children living on the streets, child labour and high levels of violence and sexual abuse of boys, girls and women, situations that occur to a greater or lesser extent in all the countries

studied, are a sign of their internal vulnerability and constitute a strong demand for public policies.

In that sense, the distance between the specific actions of the HIV/AIDS Programme and those of the Sexual and Reproductive Health Programmes and the recent volume of plans and proposals designed to address gender violence and empower women that have not been transformed into effective and extensive actions were identified in all the reports as one of the major challenges to fulfilling the agreements established in the UNGASS-AIDS Declaration of Commitment.

In the same way, the lack of integration of the different policies appears as one of the main challenges for the governments. As the Nicaraguan report remarks *“in practice (in reality) however, such articulation can be neither seen nor felt in the provision of the said services associated to S&RH, HIV and AIDS, because the orientation and approach do not leave the written documents”*, and the Venezuelan underscores that stating that: *“both the Sexual and Reproductive Health Programme and the HIV/AIDS Programme are independent programmes wherein there is no clear mechanism for their mutual articulation”*...

Associated to the lack of integration among the actions of Sexual and Reproductive Health and those of HIV/AIDS there is also a certain fragility in the implementation of inter-sector policies. As the Brazilian report puts it *“Insofar as many of the actions that are important for women are under the governance of other sectors and not the National DST/AIDS Programme and that of other ministries too, like Education, Social Action, Labour, and the Special Department for Policies for Women among others, it is necessary to intensify the construction of extensive inter-sector policies as proposed by the Declaration of Commitment.”*

In this context there is also consensus among the countries concerning the lack of a Sexual and Reproductive Health policy specifically for young people. With the exception of South Africa, the countries all refer to the lack of specific services, of integration with the education sector that could effectively guarantee that sexual education comes to be part of the school curriculum and furthermore, that youngsters that are not attending school have access to adequate social support and basic health care including sexual and reproductive health actions which are even more fundamental in the context of the AIDS epidemic.

In a wider approach to the problem, the Nicaraguan report points out that *“the main threats are: lack of sexual education beginning from a tender age in all levels of the education system to foster a change in behaviour, the lack of information on condoms and contraceptives in the primary health units, the weak diffusion of information on the benefits of responsible sexuality the inequalities in gender relations in the public, private and intimate spheres, women’s lack of autonomy and their subordination, the absence of any educational policies for the population at large and especially for women, young people and adolescents, and the growing level of poverty that affects women more than men because of the lack of specific capacity building and economic policies that benefit them.”*

That is to say, starting from the principle that a sexual education policy seeks to promote transformations that do not depend on individual conduct alone but fundamentally on collective behaviour in the family, institutional and community spheres.

There are many things pending or incipient that represent a challenge not only to the government but to society at large: sexual education in a perspective of gender and rights, and using suitable material; awakening sensitivity and awareness of health workers; capacity building on these subjects for teachers; availability of statistics on gender and violence; intensifying inter-sector work and working with civil society; sexual and reproductive health for female adolescents especially when they are highly vulnerable like those living on the streets; promotion and defence of the sexual and reproductive rights of women living with HIV and sex workers; an inter-cultural approach for women belonging to ethnic minorities; greater accessibility to condoms especially female condoms which are not presently included in prevention policies; improvements in pre- and post-test counselling; improvement in access to health services of incarcerated women especially in regard to sexual and reproductive health; actions regarding migrant women; elaboration and implementation of integral policies on sexual exploitation of children and trafficking in women; development of a wider outlook in regard to violence directed at women and not one that is limited to domestic violence; inclusion of transgender population in policies on health and sexual and reproductive rights.

## *Gaps and Recommendations*

Government and partners should play a critical role in ensuring that the policies are translated into actual service delivery for the communities especially those most affected which includes women, youth – especially young girls and the disabled, marginalised women and girls and those living in rural areas. Furthermore, considering the degree of autonomy of the municipalities in those countries undergoing decentralization processes it is necessary to make an extra effort in the sense of training and involving local administrators and managers. The rights of girls and women are not just linked to the existence of regulations, publications, documents and formal adherence to the principles that are established by them, but rather to the definition of public policies that foster capacity building of the staff in the health services.

Government and partners should strengthen their coordination, monitoring and supervision processes to ensure timely delivery of appropriate and adequate services to the infected and affected populations, specifically bearing in mind that a lot of HIV/AIDS funds are spent on administration costs and prevention campaigns and inadequate funding is left for treatment and psychosocial support to women living with HIV/AIDS, the most discriminated ones. The psychological services attached to voluntary counselling and testing services are also still a challenge.

Government in collaboration with development partners and other stakeholders should strength the capacity of civil society organisations to enable them to absorb resources that have been mobilised for the country. Furthermore the lack of updated data both on Sexual and Reproductive Health and on HIV/AIDS is a matter of concern. The urgent need for effective epidemiological surveillance mechanisms and data input that reflect the reality of the epidemic in the country represents a challenge. The access of civil society to opportune information of good quality is essential for the exercise of the social responsibility of sharing policy-monitoring actions with the government.

There is a shift from promotion of condom use to advocating for abstinence and fidelity and yet the gist of matter is that young people engage in sexual relationships and they need protection, and it is monogamy itself that makes women vulnerable in all the countries studied where the prevalence of HIV among married women is higher than that among sex workers.

The lack of effective national policies and international cooperation in regard to orphans—especially girls—is shocking. This population, which, in addition to having to bear the weight of being orphan also bears the stigma of the disease, continues to be completely invisible to policy makers.

The area of HIV/AIDS and the workplace doesn't generally deal with women as a category for labour rights. There has been little work in this area. Although there are laws that protect workers with HIV in general, they are not always enforced or activated for women with HIV who often work in informal situations. The higher unemployment rate among women is another factor that should be considered. There are frequent denunciations that women with HIV are discriminated and excluded from the labour market although there is no related documentation.

Access to information, publicizing, education, and S&RH services for adolescents as well without the need for authorization from anybody, protecting the right to privacy and confidentiality of adolescents, eliminating formal and informal barriers to education, information on sexual and reproductive health for adolescents, and especially, ensuring a lay educational system avoiding any interference from religious sectors.

There is a need of more solid actions and policies to combat STDs. *"There is a specified policy for the control and spread of HIV/AIDS, but not however, for the spread of other STIs,"* ensuring that the S&RH services guarantee the availability of condoms as well as prevention measures and treatment for STD and HIV infection.

It is urgent to increase the budgeted amounts for primary health care and the investments in health and social services for women dedicating special attention to the S&RH of poor women and girls.

## *Final Considerations*

Perhaps the greatest strongpoint lies in the existence of the CSO, NGO and women's community organizations and AIDS organizations, that is to say, the presence of organised sectors of civil society. They are the actors who with their daily efforts, in the networks and working with their peers, are most knowledgeable about the specific complex of problems and it is they who should promote a unified clamour for the effective implementation of actions aimed at guaranteeing the promotion and accessibility of sexual and reproductive health care for WLHA and for the prevention of the epidemic among women.

On the basis of this document we can conclude that no effort that is made to improve the responses to HIV/AIDS and to guarantee sexual and reproductive health can ever be successful unless it manages to incorporate a gender perspective into practice, whether that be in public policies or in the habitual activities of the civil society organizations.

# ATTACHMENTS

## *Countries Socio-economic Characteristics*

### A) SOCIO-DEMOGRAPHIC ASPECTS

#### POPULATION

COUNTRY	TOTAL POPULATION*	URBAN**	RURAL**	WOMEN*
South Africa	48,577,000	57.9%	42.1%	24,692,000
Argentina	39,531,000	90.6%	9.4%	20,200,000
Belize	294,385	48.6%	51.4%	143,000
Brazil	191,791,000	84.2%	15.8%	97,220,000
Chile	16,635,000	87.7%	12.3%	8,406,000
India	1,169,016,000	28.7%	71.3%	564,026,000
Indonesia	231,627,000	47.9%	52.1%	115,945,000
Kenya	37,538,000	41.6%	58.4%	18,827,000
Mexico	106,535,000	76%	24%	54,591,000
Nicaragua	5,603,000	58.1%	41.9%	2,813,000
Peru	27,903,000	74.6%	25.4%	13,928,000
Thailand	63,884,000	32.5%	67.5%	32,779,000
Ukraine	46,205,000	67.3%	32.7%	24,902,000
Uganda	30,884,000	12.4%	87.6%	15,431,000
Uruguay	3,340,000	93%	7%	1,728,000
Venezuela	27,657,000	88.1%	11.9%	13,764,000

\*Data for 2007; \*\*Data for 2005; Source: IBGE.

## RELIGION

COUNTRY	PREDOMINANT RELIGION
South Africa	79% Christian (the rest of the population is Muslim or Hindu)
Argentina	92% catholic
Belize	93% Christian
Brazil	89% Christian (74% catholic, 15% protestant)
Chile	89.5% Christian (Catholics 76,3%; protestant 13.2%)
India	81.5% Hindu, 12.2% Muslim
Indonesia	87% Muslim (9% Christian)
Kenya	73% Christian (19% tribal, the rest is Muslim)
Mexico	96% Christian (30% to 40% evangelist)
Nicaragua	91% Christian: 74% catholic; 17% protestant
Peru	Catholic
Thailand	90% Buddhist (4% Muslim)
Ukraine	Eastern Orthodox Christian
Uganda	Christian
Uruguay	75% catholic
Venezuela	96% catholic

POVERTY AND ILLITERACY

COUNTRY	POPULATION LIVING BELOW THE POVERTY LINE (%)			% OF ILLITERATE ADULTS (15 years old or over)
	1 Dollar/day*	2 Dollars/day*	National Poverty Line**	
South Africa	10,7	34,1	50%	17,6
Argentina	6,6	17,4	27%	2,8
Belize	...	...	33.5%	24,9
Brazil	7,5	21,2	21.5%	11,4
Chile	<2	5,6	17%	4,3
India	34,3	80,4	28.6%	39,0
Indonesia	7,5	52,4	27.1%	9,6
Kenya	22,8	58,3	52%	26,4
Mexico	3,0	11,6	17.6%	8,4
Nicaragua	45,1	79,9	47.9%	23,3
Peru	10,5	30,6	53.1%	12,1
Thailand	<2	25,2	13.6%	7,4
Ukraine	2	4.9	37.7%	0
Uganda	...	...	37,7%	33,2
Uruguay	<2	5,7	27.4%	3,2
Venezuela	18,5	40,1	*** 31.3%	7,0

\* Data for 1990-2005; \*\*Data for 1990-2004; the data refer to the most recent year for which they are available during the specified period. \*\*\* Data refer to a year or period other than that specified, or differ in the standard defined or only refer to a part of the country. Source: World Bank 2007b/ Source: calculated on the basis of adult literacy of the Statistics Institute—UNESCO 2007a.

## UNEMPLOYMENT RATE

COUNTRY	UNEMPLOYED PERSONS* (thousands)	UNEMPLOYMENT RATE*	
		TOTAL (% active population)	WOMEN (% male rate)
South Africa	4,385	26.6	100
Argentina	1,141	10.6	135
Belize	12	11.0	230
Brazil	8,264	8.9	172
Chile	440	6.9	139
India	16,634	4.3	100
Indonesia	10,854	9.1	155
Kenya	1,276	...	...
Mexico	1.367,3	3.2	118
Nicaragua	135	12.2	165
Peru	437	11.4	143
Thailand	496	1.4	80
Ukraine	1,601	7.2	91
Uganda	346	3.2	156
Uruguay	155	12.2	161
Venezuela	1,823	15.8	127

\* Data from 2005; Source: ILO 2007b. \*\* Data from 2006; Source: OCDE 2007;

Column 4: calculated on the basis of data on unemployment rates for men and women of the OCDE 2007.

B) WOMEN'S HEALTH

COUNTRY	MATERNAL MORTALITY* (per 100,000 live-born babies)	TFT** (birth per woman)	BIRTHS WITH QUALIFIED PROFESSIONAL ACCOMPANIMENT (%)***	% OF MODERN CONTRACEPTION USE****
South Africa	230	2.8	92	55
Argentina	82	2.4	99	
Belize	140	3.4	83	42
Brazil	260	2.3	97	70
Chile	31	2.0	100	
India	540	3.1	43	43
Indonesia	230	2.4	72	57
Kenya	1,000	5.0	42	32
Mexico	83	2.4	83	60
Nicaragua	230	3.0	67	66
Peru	410	2.7	73	50
Thailand	44	1.8	99	70
Ukraine	35	1.2	100	38
Uganda	880	6.7	39	18
Uruguay	27	2.2	100	
Venezuela	96	2.7	95	

\*Datos de 2000; Source: IBGE. \*\* Data for 2000-2005; The data refer to estimates for the period indicated; Source: ONU 2007e.

\*\*\* Source: UNICEF 2006. \*\*\*\* Source: UNFPA

GENERAL CHARACTERISTICS OF THE HEALTH SYSTEM AND SITUATION  
IN REGARD TO LEGALITY OF ABORTION

COUNTRY	PUBLIC HEALTH SYSTEM	SITUATION REGARDING ABORTION
South Africa	Primary Care Services.	Allowed in any circumstances.
Argentina	Primary Care Services + Pharmaceutical assistance.	Rape and risk to life of mother.
Belize	Health care and medication free access at public hospitals and clinics.	Risk to life of mother or foetal abnormality
Brazil	Universal and free of charge	Rape and risk to life of mother
Chile	Co-payment	Illegal in any circumstances
India	Mostly private	Rape, incest and risk to life of mother
Indonesia	Primary Care Services	Unclear.
Kenya	Mostly private. Poor access to health care services, drugs and referral systems	Illegal
Mexico	Co-payment	Risk to life of mother or rape-induced pregnancy (low accessibility)
Nicaragua	Primary Care Services	Illegal
Peru	Primary Care Services	Risk to life of mother
Thailand	Universal access free of charge	Only in cases of rape with legal authorization (low accessibility);
Ukraine	Universal and public	Illegal (widely used to regulate fertility.)
Uganda	Mostly private	Illegal
Uruguay	Mixed: public + Private	
Venezuela	Universal and free of charge	Risk to life of mother

## HIV PREVALENCE AND THE CHARACTERISTICS OF THE EPIDEMIC

COUNTRY	HIV PREVALENCE (% 15-49 years old) *	CHARACTERISTIC OF THE EPIDEMIC
South Africa	18.8 [16.8 – 20.7]	<i>55% of the cases among women.</i>
Argentina	0.6 [0.3 – 1.9]	<i>Sexual transmission. 29% of the cases among women.</i>
Belize	2.5 [1.4 – 4.0]	<i>Sexual transmission. 26% of the cases among women.</i>
Brazil	0.5 [0.3 – 1.6]	<i>Sexual transmission + IDU . 40% of the cases among women.</i>
Chile	0.3 [0.2 – 1.2]	<i>Sexual transmission. 15% of the cases among women.</i>
India	0.9 [0.5 – 1.5]	<i>Sexual transmission + IDU . 38% women</i>
Indonesia	0.1 [0.1 – 0.2]	<i>IDU + sexual 18% women</i>
Kenya	6.1 [5.2 – 7.0]	<i>Sexual transmission. 60% women.</i>
Mexico	0.3 [0.2 – 0.7]	<i>Sexual transmission. 25% women.</i>
Nicaragua	0.2 [0.1 – 0.6]	<i>Sexual transmission. 50% women.</i>
Peru	0.6 [0.3 – 1.7]	<i>Sexual transmission. 24% women.</i>
Thailand	1.4 [0.7 – 2.1]	<i>Sexual + IDU. 31% women.</i>
Ukraine	1.4 [0.8 – 4.3]	<i>IDU + sexual, 49% women</i>
Uganda	6.7 [5.7 – 7.6]	<i>Sexual. 60% women.</i>
Uruguay	0.5 [0.2 – 6.1]	<i>Sexual + IDU. 50% women.</i>
Venezuela	0.7 [0.3 – 8.9]	<i>Sexual. 29% women.</i>

\*Data for 2005; Source: UNAIDS 2006.

# Comparative Country Information

## LEADERSHIP

[At the national level]

## GOAL 37 PROPOSED INDICATORS

- *Effective participation of representatives of women and youth living with HIV in the HIV/AIDS Programmes, including the decision-making spaces and in UNGASS monitoring actions.*
- *Participation of groups of women and youth in assisting the design, implementation, and evaluation of the programs directed at them.*

## COUNTRIES FINDINGS

Argentina	<p>The National Programme for the Fight against the Human Retroviruses AIDS and ITS (PNLRHS) does not contemplate the participation of women and youngsters in the decision making process.</p> <p>Although it is true that there are some forms of interaction between the PLHIV and government bodies, women's participation and in particular the gender approach and the incorporation of HIV as an SRH issue, is very limited.</p>
Belize	<p>Women and youth are represented on the board of the National AIDS Commission.</p>
Brazil	<p>The National Health Council, a body linked to the Ministry of Health has equal representation of users, administrators and service providers The National DST/AIDS Programme includes women in its consultative spaces.</p>
Chile	<p>There has been no representation in the country of civil society in the planning and evaluation of the National AIDS Plan much less any representation of women. Civil society participation is expressed in the form of its representation within the Country Committee (MCP) and the joint execution of projects within the framework of the Global Fund.</p>
India	<p>A robust consultative process was adopted to formulate the National AIDS Control Program III. However, this process did not have any specific focus on women. Mechanisms need to be developed for strengthening and sustaining the engagement of civil society—and women.</p>
Indonesia	<p>According to Presidential Regulation number 75/2006 regarding the National AIDS Commission, one of the members of National AIDS Commission is the Head/ Coordinator/ Chief of National PLHIV Organization. People living with HIV are also involved in several working groups established by the National AIDS Commission and Provincial/District AIDS Commissions.</p>
Kenya	<p>The priorities in the National Population Policy for Sustainable Development are: reproductive health and reproductive rights, adolescents' reproductive health, gender perspectives, and HIV/AIDS. However, there is no participation of civil society and reproductive health needs of youngsters have not been adequately addressed.</p>

Mexico	In both Federal and local spheres, the participation of women and young people is limited; the highest body for defining policy on HIV/AIDS is the National Council for AIDS Prevention and Control CONSIDA.
Nicaragua	There are no real effective spaces for the participation of women and they are only sought ought to legitimize processes. The policy of citizen participation and the Nicaraguan AIDS Commission itself (CONSIDA) give young people and women the right to participate in the public policy processes but in practice it does not work and their participation is non-existent.
Peru	The Multi-sector Health Coordinating Body CONAMUSA that brings together state and local civil society institutions is one of the main references in terms of the participation of people living with HIV. Starting with the implementation of projects financed by the World Fund, various organizations and leaderships have gradually been incorporated as community advisers and implementers directly influencing the design and implementation of actions directed at their own populations.  There is no representation of civil society specifically representing transsexuals or women. In spite of there being women living with AIDS in the Executive Bureau there is no legal device regulating gender equity in the composition of the MCP in Peru <sup>12</sup> .
South Africa	In March 2007 a women's consultative meeting was held funded by government as part of the process for revitalizing the South African National AIDS Council (SANAC). Three sector leaders were elected to lead the group, none of the sector leaders are HIV positive. There is a youth sector but not specifically a girls sector.
Thailand	Overall policy on AIDS does NOT consider any kind of gender approach and has NO actions specifically focused on women;
Ukraine	The problem of the lack of knowledge among decision makers on the practical use of gender approach in national policies is urgent. The measures for provision of equal possibilities for men and women approved by the government are mostly directed towards general educational, cultural or research activities, the rest of them are of a declaratory nature.
Uganda	The Uganda government through its Affirmative action of 1/3 representation of women/girls in every decision making body has helped them participate formally not only in the HIV/AIDS programs but also in other important interventions for the welfare and development of women in the country.
Uruguay	In the Country Coordinating Body, which is inter-institutional and functions as a kind of space for interaction and integration of governmental, non governmental and academic organisations in the discussions on HIV/AIDS, representatives of parliament and of persons living with AIDS, of sex workers, of sexual diversity, feminists and groups that have developed technical-professional capacity in this field, all participate.  Youngsters with HIV have not participated in the formulation of the HIV/AIDS programmes – with regard to the National Adolescence Programme there have been examples of participation and contribution of young people in elaborating the programme. That programme is an action directed at training youngsters in health promotion and it has

<sup>12</sup> Exploratory Analysis: Participation of Women (sex workers, HIV+ and from civil society organizations) and trans activists in the CCMs and in the processes of programmes financed by the Global Fund to Fight AIDS, TB and Malaria- Presentation made by the Latin Observatory at the 1<sup>st</sup> Regional LAC Forum of the World Fund, Bogota, October 2007.

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trained hundreds of them.

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Venezuela Young women do not take part in designing the programmes nor is there any formally established committee for them to interact with the National Programme.

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## PREVENTION

### GOAL 52 PROPOSED INDICATORS

- *Educational programs in Prevention for women and girls;*
- *Female and male condom availability in the health services, schools and associations- and a range of other places;*
- *Ease of acquisition of Condoms and proper orientation on their use, even by young people.*

### COUNTRIES FINDINGS

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Argentina In regard to Sexual and Reproductive Health it can be seen that there is a lack of an integral approach to HIV/AIDS. There are no specific campaigns and there are no prevention programmes for women (young or otherwise) and there is no place where the rights of women living with HIV are being promoted. There is free provision through the public system of male condoms and lubricants. Difficulties in obtaining them stem from the public health system itself. In turn, many care and assistance centres do not distribute them to women or youngsters. Neither is testing being stimulated among adolescents or young people.

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Belize It is not difficult for women and girls to obtain condoms in sufficient quantity and for free. Male condoms are more widely available. Lubricants are not as accessible because of the cost.

There is a specified policy for the controlling the spread of HIV/ AIDS, but not for the spread of other STDs

The Belize Family Life Association (BFLA) addresses HIV/AIDS issues specifically for ages 10-24 years. The content of the prevention information disseminated is age and culture appropriate.

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Brazil There are no specific prevention programmes for women and young people. The mass communication programmes are eventual and sporadic.

Implantation of Condom distribution in schools has not been totally completed. It depends on the administrator of the health services, there is no formalized flow. Male Condoms are distributed by the service but not always accompanied by orientation; female Condoms are available in very few services for specific populations that do not include young women.

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Chile In public policies there is a vacuum in regard to HIV/AIDS and STD prevention material directed at adolescents of either sex. There are initiatives that focus on HIV/AIDS and STD prevention but they have not included women in their diversity. The male Condom is the object of public policies albeit in an insufficient manner. Female Condoms have not been incorporated in public policies.

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India	Concentration on the epidemic may lead to an exclusive focus on Treatment, focusing high risk groups and leaving out prevention activities and a whole range of populations, e.g. women (widows), and youths.
Indonesia	Most of the educational programs on HIV for women and young women were done by the NGO/CBO/FBO. Although National Strategy for Sexual and Reproductive Health is already in place, the implementation of that strategy has not yet fulfilled young people's (girls or boys) needs.
Kenya	There is a big gap in gender-based education from the government. Most of the activities on sex and reproductive health are delivered by international NGO, without a specific focus on gender issues.
Mexico	<p>There are specific projects that have been implemented by the Government of the Federal District directly and in collusion with community organizations. Since 2006 there have been specific campaigns on HIV/AIDS implemented by civil society with resources that are competed for annually and financing that is scarce and usually of short duration. In 2006 some projects for women living with HIV received support.</p> <p>As for the government, there are no prevention programmes directed specifically at women, much less at young women. There are no secondary prevention or positive prevention programmes for women with HIV</p> <p>That situation is repeated in the case of young people. There are projects implemented by community organizations with resources stemming from various spheres of government, reproducing the situation of diminutive resources and short duration and furthermore such projects are not integrated among one another, or with other local government strategies. The reproductive health care services do not facilitate the presence of youngsters or adolescents and there exists pressure to ensure that they are indeed not attended to.</p>
Nicaragua	<p>The Ministry of Health has unfolded educative campaigns in the social communications media and has made efforts to include the theme on the education curriculum but they have not been very effective. The State itself does not run any prevention campaigns and does not have a wide education policy for HIV prevention.</p> <p>In Nicaragua there are insufficient facilities for free Condom and lubricant distribution and generally speaking, people that use them buy them in drugstores, which makes the access of women to them even more difficult. The female condom is unknown.</p>
Peru	The Global Fund, in collaboration with the Ministry of Women and Social Development, has carried out several different activities to provide the adolescent population with information on sexuality and the means of prevention against HIV and STDs; however public policies tend to favour abstinence and postponing sexual initiation among them.
South Africa	<p>Information, Education and Counselling (IEC) materials are widely available. The messages are articulated around abstinence, fidelity and Condoms (ABC), stigma-mitigation and human and legal rights.</p> <p>Government has been a signatory to the Maputo Plan of Action that highlights sexual and reproductive rights and integration leans on HIV/AIDS prevention, however this has not been matched by adequate services.</p> <p>There is wide availability of male Condoms. Female Condoms are not widely available and</p>

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	are generally limited to research sites and programmes. While sexual orientation is guaranteed constitutionally, good messaging and information on prevention materials for lesbians is limited.
Thailand	Condoms are available in public services but in insufficient quantities. Women do not feel comfortable about accessing them; Lately, there has been less preventive campaigning since the government sector places more emphasis on treatment and accessibility to ARV.
Ukraine	The mechanism of gender expertise of media products and their influence on non-government, especially electronic Mass Media, is not developed. Considerable numbers of commercial TV and radio channels, and Internet sites implements often very aggressive discriminatory media policy towards women, that leads to enforcement of gender stereotypes and increases vulnerability to HIV/AIDS/STI of representatives of both sexes. Female Condoms are not widely available.
Uganda	In the area of Information, Education, Communication (IEC) and Behaviour Change some printed messages were developed and others including HIV prevention were disseminated through the mass media, road maps, TV and Radio spots and programmes for condom promotion. Other practices include inveigling youths to promise to abstain from sex till marriage (District Level). In Uganda an increase in prevalence has now appeared after the initial success of the strategy of massive concentration on the ABC strategy stimulated by PEPFAR and the Global Fund.
Uruguay	Up till now sexual education has not been implanted in the formal education system. No specific educative prevention programmes directed at women and youngsters have been implanted by the State. The National Program for Adolescence together with INFAMILIA has installed adolescent health spaces with components of education in sexual and reproductive health. The Ministry of Public Health (MSP) does not distribute female Condoms to all the population and the population at large does not have easy access to male Condoms especially in the interior of the country,
Venezuela	HIV prevention programmes and the promotion of sexual and reproductive health among women are rare and restricted to the area of formal education. Prevention work is concentrated in sporadic projects rather than in permanent programmes. There are more projects directed at young people than at women. The projects have little coordination or integration among them and little evaluation of their effectiveness is done. There is free distribution of male Condoms throughout the country but it has been irregular, insufficient and inadequate and there has been no offer of lubricants. Very little information on the availability of Condoms in the Health Centres is disseminated to the public.

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## PREVENTION

### GOAL 53 PROPOSED INDICATORS

- *Sexual health programs for youth—content and quality, integration of services, access friendly.*
- *Access to unsafe sex post-exposure prophylaxis.*

COUNTRIES	FINDINGS
Argentina	<p>Sanctioned in October 2006, National Law N° 26.150 that makes it obligatory for all public and private schools throughout the country to implant an Integral Programme of Sexual Education. Nevertheless, there are provinces where it has not yet been regulated.</p> <p>The Public Health System does not have special services directed at care for young people. Those services in which they can obtain information and material for HIV prevention "Are available within the framework of the health services provided to the population at large". There are no youth-friendly services available to youngsters (boys or girls.)</p> <p>Emergency Contraception – EC has been incorporated among the methods recognised and provided for by the National Sexual and Reproductive Health and Responsible Parenthood Programme ever since the year 2006. Nevertheless, its provision is heterogeneous and EC availability depends on the Health policy of each province and municipality.</p>
Belize	<p>The National Health Policy and Sexual and Reproductive Health Policy both have gaps in regard to provision and access to services especially for the vulnerable group of adolescents between the ages of thirteen to seventeen. Young girls especially are not able to access these services related to sexual reproductive health and HIV/AIDS independently.</p> <p>Emergency contraceptives are not advertised and are administered at the discretion of physicians. Some emergency contraception is available at private pharmacies</p>
Brazil	<p>Sexual Education Programmes in schools depend on the local administration. No single programme of Adolescent Healthcare has been implanted nationwide although there are isolated instances in some municipalities;</p> <p>Anti-HIV prophylaxis is available and Emergency Contraception for cases of sexual violence but coverage outreach is poor and the services are not publicized.</p>
Chile	<p>Sexual Education depends on local wishes and private schools and is not part of the general curriculum subjects that are offered to all. There are no healthcare services specifically for adolescents;</p> <p>Emergency Contraception is administered on medical prescription in pharmacies (private) and is available free of charge in some public healthcare units although the service is not widely known to the population.</p>
India	NA

Indonesia	Sexual and Reproductive Health has already been integrated into the school curriculum, and we have National SRH Strategy that endorses training for youths in SRH matters. However, there is a law that forbids people from showing genital in any form (physically, through images, or visualizing an object as genitals (sex organ). This kind of contradiction contributes to a lack of effective sexual education for youth
Kenya	The Adolescent Reproductive Health Policy has been in place since 2001. Currently reproductive health education for youth focuses on promotion of responsible sexual behaviour. Peer education programmes are also being implemented in some districts
Mexico	The primary focus of government programmes is on family planning including those directed at young people, to avoid undesired adolescent pregnancies. However, information is insufficient and not based on evidence, depending largely on the personal positions of the teachers. There is post-exposure HIV prophylaxis in cases of unprotected sex; the emergency contraceptive pill is available in primary healthcare centres as a therapy to avoid pregnancy
Nicaragua	Educative programmes exist but they are discursive in nature and nominal. Gender inequalities are referred to cursorily in policies but in practice there are no specific programmes to address such realities.  In the national regulatory legislation the rights of young people to Sexual and Reproductive Education are clearly established. But the problem lies in their application and in the religious culture that creates difficulties for the effective materialization of what the legal system provides for. <sup>13</sup>  There are socio-cultural barriers to sexual education activities to counter the epidemic because HIV is viewed with great prejudice and discrimination. Emergency contraception is not available in any form.
Peru	The National Ministry of Education carries out sexual education in the regular School grades and regulates and monitors the actions. There are difficulties in identifying HIV and AIDS prevention as a part of an integral qualification in sexual education. Considering the small amount of time and the contents dedicated to dealing with it, it can hardly be expected to produce much effect in promoting responsible sexuality. There are no services providing care specifically for adolescents, much less for adolescent girls. Although the Ministry of Health recognizes that one of the strategies is the implementation of differentiated services, it can be seen that the number of such establishments is only a little over 3% of the total <sup>14</sup> .
South Africa	Government adopted a curriculum called 'Life orientation' in early 2002, where there is vast scope for prevention educational programs. However, it is up to the teacher to facilitate the educational program. The information regarding sexuality and gender may not all be adequate.  The public sector does have some specific clinical services for youths, aimed at providing services that are friendlier, more private and more welcoming to young people. Minors can access services without parental consent. Counselling is often not widely available. Post-exposure Prophylaxis is not consistently available in all public sector facilities. Many

<sup>13</sup> Dr. Carlos Emilio Lopez

<sup>14</sup> MINSA, Lineamientos de Política de Salud de los y las Adolescentes. 2005

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	<p>women do not know about this service.</p> <p>The National Youth Commission is aimed at involving youth in the reconstruction and development of our country. Services of young people are employed in order to educate other young people about dangers of unprotected sex.</p>
Thailand	<p>The sexual health program for youth is implemented by various sectors and organizations including government, non-government and youth groups through integrating the educational system (sexual education), health services (youth friendly service), and peer education. For sexual education on a large scale, PATH who is principal recipients (PR) from the Global Fund and partners develop a model called Master Trainer. They have trained teachers to be sexual educators. At the same time they have also emphasized life skills in activities on sexuality with youths (Please see more information on <a href="http://www.teenpath.net">www.teenpath.net</a>). They also develop a curriculum for youths and for teachers and integrate sexuality into the school curriculum.</p> <p>“The PEP service is available at government hospital mostly in rape cases. Its use is not common in other cases. That means that people do not come and ask for it (PEP). This may be because they do not know about this service or the PEP service has not been operated for the general public except in rape cases.”</p>
Ukraine	<p>Health Centres that report to the Ministry of Health and have to implement prevention activities do not have either relevant specialists or visual AIDS or the desire to do such work. Even in those educational institutions where informative and educational events are held, they are often formal and of little efficiency since they don't meet the demands of the age and target groups. Due to that lack of safer behaviour skills, there is a low level of sexual culture among youths concerning being responsible in regard to sexual and reproductive health.</p>
Uganda	<p>Medical services also depend on limited numbers of personnel trained to provide preventive counselling. The Prevention of Mother-to-Child Transmission (PMTCT), Voluntary Counselling and Testing (VCT), Orphan and Vulnerable Children (OVC) and ABC policies to provide contraceptives and the post-prophylaxis for unsafe sex have been implemented to some extent but not all are good in terms of coverage outreach and effectiveness.</p>
Uruguay	<p>The Ministry of Public Health's National Programme for Adolescence undertakes joint work with INFAMILIA. In regard to the Sexual Education Programme there has been no participation of young people living with HIV. Only youngsters in the general education system are called on to participate. In regard to the National Programme for Adolescence it is stated that the participation of youngsters is one of the goals especially in anything concerning heir local environment but without specifically mentioning the participation of young girls. There have been cases of participation and contributions from youngsters in elaborating the Programme. The line of action of the Programme seeks to qualify juvenile health promoters and in that direction hundreds of youngsters have been trained.</p>
Venezuela	<p>There are no Sexual and Reproductive Health guidance services exclusively catering for young people, neither in the schools nor in public health policies.</p>

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## PREVENTION

### GOAL 54 PROPOSED INDICATORS

- *Quality of counselling for HIV detection testing in pre-natal services*
- *Availability of appropriate detection testing*
- *Access and quality of services for HIV infected pregnant women*
- *Programs to guarantee breast milk substitutes*

#### COUNTRIES FINDINGS

Argentina	Voluntary testing with prior counselling has been in place since the year 2001 but its implementation has been very heterogeneous and the quality of it varies a lot too. Access to an HIV test for every pregnant woman is a reality that has not yet been guaranteed and even less so, the results being informed before birth takes place. In regard to specific psychosocial care and nutritional guidance for serum-positive women, there is no help of any kind. The provision of breast milk substitutes is subject to obstacles and the vagaries of the internal administration of the health system.
Belize	A full-course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission is defined in Belize's PMTCT program, established in 2001. Almost every pregnant woman gets tested and the positives ones receive ARV.
Brazil	Voluntary testing and adequate ARV treatment are available in the public system. Counselling however, is not always done. The studies reveal a process conducted by health staff, of inducing serum-positive women to undergo sterilization and in the case of pregnancy to undergo an abortion.  The offering of substitutes for the mother's milk is officially provided for but the products are not always available especially in the country's smaller municipalities.
Chile	In Chile the offer of the ELISA and VDRL tests to all pregnant women has been guaranteed since 2005. For serum-positive pregnant women there is also a protocol that ensures ARV for the mother, ARV for the newborn child and milk product to substitute the mother's milk. In regard to the last item some difficulties are noted due to lack of coordination in the health services. There is no psychosocial support offered.
India	Although the focus of the Indian AIDS Programme is on the prevention of vertical HIV transmission, the coverage is poor and often counselling is not done. There have been bases of women being the victims of violence due to their serum-positive condition's having been revealed before their husbands.
Indonesia	There are significant improvements related to care, support and treatment for mothers living with HIV in Indonesia – however, the coverage of these improvements may still be limited to big cities such as Jakarta and other municipalities in Indonesia. First and second

	line ARV drugs are subsidized by the government, and some PMTCT programmes already include nutritional support and support for formula milk as substitute for breastfeeding.
Kenya	There are initiatives to increase women-targeted interventions such as PMCTC, pre-test and post-natal counselling, nutritional support especially for children born to HIV mothers and counselling and screening services during prenatal care
Mexico	Both the Social Welfare Services and the Government Health Service provide women living with HIV with health care, anti-retroviral medicines and products to substitute the maternal milk.  The process is accompanied by stigmatization and discrimination especially evinced by the health care staff.  Counselling is limited and in some health centres there are nobody on staff trained to do it. Sterilization is frequently offered to the infected women and they are asked to stop their sex lives. No access is offered to them either to information on safe protected sex or to the instruments that make it possible.
Nicaragua	There is a Programme for the Prevention of Mother-child transmission. The test is carried out albeit with no prior counselling and coverage only reaches half of the cases; there is discrimination and a notably negative treatment o the part of the services. There is no confidentiality. There is no guidance on contraception for the women with HIV. Formulas-substitutes for the mother's milk are only available in some of the hospitals.
Peru	The overall plan for reducing vertical STD/HIV transmission foresees early detection of the infection and determines the provision of antiretroviral prophylaxis for mother and future child. Pregnant women who have to talk the test obligatorily receive no counselling. Another problem is the carrying out of Caesarian sections because the health personnel and doctors always create obstacles.  Presently there is reported to be a lack of formula milk in the health establishments.
South Africa	Only 51% of HIV positive pregnant women accessed PMTCT. Children born to HIV positive mothers are provided with free formula to enable exclusive feeding up until three months. However there are problems with a sustainable supply. The focus of these programs is on the baby. The services that are integrated and able to provide services to the mother or pregnant women are limited. HAART treatment for pregnant women if indicated is not accessible to all women. There has not been adequate provision of contraceptives for HIV positive women. Health workers think that HIV positive women should not be sexually active and have children. This may lead to abuses of suggesting that they have sterilization procedure or an abortion.
Thailand	There is a well-established policy on PMTCT. However, health personnel have their own problems in performing effective counseling. They suggest that PLHA networks may assist in this specific context;  Provision of substitute milk is not enough.  Most nurses on duty do not believe in reproductive decision by HIV positive women. Many are disappointed with the repetition of pregnancy in women living with AIDS. In providing care during pregnancy and labour service, staff people try to persuade PLHAs to undergo sterilization.
Ukraine	The level of mother to child transmission was decreased from 27.5% in 2000 to 7.1% in

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	<p>2006. However there is still a lack of provision of stable state funding and satisfactory organization of main measures aimed at prevention of mother to child transmission; no continuous provision of test kits for testing for HIV of pregnant women, no continuous procurement and supply of ARV medications for prevention of mother to child transmission and baby formulas for children born to HIV positive mothers;</p> <p>There is also the use of outdated regimens of ARV prevention of mother to child transmission (mono therapy) and improper quality of ARV medications; low quality of VCT for HIV positive pregnant women, lack of adequate adherence to ARV prevention;</p> <p>Low level of training of medical staff providing services for HIV positive pregnant women, lack of specialist who have experience in performing “dry” Caesarean section that is advised for HIV positive pregnant women for prevention of transmission of HIV to a child.</p>
Uganda	<p>The PMTCT policy has been implemented to some extent but not all that well in terms of extent of coverage and effectiveness. The establishment of psychosocial support groups to support HIV positive mothers identified through PMTCT services is also considered a best practice</p>
Uruguay	<p>The National AIDS Programme sustains the offer of efficacious treatments to reduce HIV transmission from mother to child. In some maternity hospitals in the interior the fast test is not always available at the time needed. The formula products to substitute the maternal milk are available during the first six months of the child’s life.</p>
Venezuela	<p>The ELISA test is obligatory for all pregnant women. Pregnant women living with HIV attend regular antenatal examinations, there is no specific service. Serum-positive pregnant women receive antiretroviral treatment from the 21<sup>st</sup> week of pregnancy and after the Caesarean receive information on the theme of maternal lactation, substitutes for the maternal milk up till the fourth month and recommendations on how to proceed. They cannot count on any psychosocial support or any effective follow up on their cases.</p>

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## HIV AND HUMAN RIGHTS

### GOAL 59 PROPOSED INDICATORS

- *Policies and programs directed at the promotion, security, and reparation of women’s rights;*
- *Integrated policies directed towards women’s rights within the HIV/AIDS National Programs;*
- *Policies and programs addressing men’s responsibility in issues of sexual and reproductive health;*
- *Policies and programs to protect the sexual and reproductive health of women in conditions of vulnerability to HIV/AIDS.*

COUNTRIES FINDINGS

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Argentina	<p>The National Council for Women is the government body responsible for public policies on equality of opportunities and treatment between men and women. However its actions and the level of diffusion of its activities are limited. As regards the policies directed towards promoting the rights of girls, National Law Nº 26.061 for the Integral Protection of the Rights of Children and Adolescents (2005), its application has been slow and heterogeneous in legal circles.</p> <p>The Global Fund finances projects aimed at preventing HIV/AIDS in specific populations and at improving the quality of life of people living with HIV and AIDS and including groups in vulnerable conditions (IDU, TS, GLTTB), women living in poverty, and persons deprived of their freedom. In the last few years a Prisons Commission and a Sexual Diversity Commission have been formed within the sphere of the PNLRHS.</p> <p>Women living in prisons have very bad health conditions.</p> <p>The government does not develop programmes to promote the rights of female sex workers because it does not officially recognize that activity as being work;</p> <p>There are no working strategies to promote shared responsibility of men and women in regard to safe sex practices.</p>
Belize	<p>The Government has developed several policies to promote women's rights, such as the National Gender Policy, the National Gender-based Violence Action Plan and Sexual and Reproductive Health Policy, although with limited financial and human resources. There is also a need for adequate and sufficient monitoring and evaluation mechanisms to evaluate the actions and results.</p> <p>The Ministry of Health does not provide contraceptives, and family planning is limited to health education during pre- and postnatal services. Belize Family Life Association is the main provider of contraceptives.</p>
Brazil	<p>In the Federal Sphere there is a Policy for Women Department that has a National Plan of Policies for Women that defines actions directed towards women in the most vulnerable situations. Most of the actions that have been proposed are not being implemented and their coverage is low. Sex worker is classified as a profession<sup>15</sup> but there are frequent denunciations of sex workers being badly treated by the police. Pimping is illegal in the country.</p> <p>There are no specific proposals that involve the male population in questions of sexual and reproductive health.</p>
Chile	<p>The political will of the Government to advance in matters related to sexual and reproductive health is identifiable but obstacles can be seen in the form of pressure from conservative groups and from the Catholic Church.</p> <p>There are no specific policies for promoting the labour rights of women, only those directed at the population as a whole. The same is true of women living with HIV. The Equal Opportunities Plan has not managed to close the gap between men's salaries and women's.</p>
India	<p>Actions for empowering women depend on NGO and international cooperation. There is no integration of such actions with the AIDS programmes.</p> <p>The women's movement in India does not recognize HIV/AIDS as being an issue for them. However, there is no point of entry for women in the services delivery system other than the</p>

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<sup>15</sup> [www.mte.gov.br](http://www.mte.gov.br) Classificação Brasileira de Ocupações (CBO)- item 5.198

	PPTCT programme. Very little involvement of men.
Indonesia	The gender-mainstreaming program is already being done in 32 provinces of Indonesia and already covers 75% of the districts. However, the result of this gender-mainstreaming program remains unclear.
Kenya	There has been lack of adequate support to the empowerment of women and girls. There is a lack of appropriate gender perspective in the health policies
Mexico	In both the Federal and State spheres there are institutions handling questions of gender inequity. Many projects are implemented by civil society organizations and there have relevant alterations in the legislation to achieve women's rights and make them equal, among which a federal law for a Life without Violence and the Law for protecting the rights of children and adolescents. The legislation seeks to achieve shared responsibility in general with a focus on family planning, promoting vasectomy as well as educational components for prevention without jeopardizing the reduction of risk behaviour.
Nicaragua	The established rights of women are only formally in force, not in reality. Plans and projects do not take women's specificities into account. There is no effort on the part of Government to involve men in sexual and reproductive health actions.
Peru	In the last few years there have been significant changes in regard to the equality of women but they have not been put into practice. Legislation such as the Sexual Harassment and Equal Opportunities law contrast with the lack of definition to be found in the Sexual Violence Programme in which the state's priorities are increasingly difficult to discern. The Promoting the Family Programme of the National Integral Family Welfare Programme (INABIF) has held workshops aimed at fostering the creation of small businesses. There is a Law in force against Discriminatory Acts in employment offers and access to means of Educational Qualification that could be made use of to protect women. The General Education Law N° 28044, is aimed at guaranteeing the participation of women in the education system.
South Africa	A number of government policies have an excellent articulation of women's sexual and reproductive health and rights. However, these policies have not been matched by the allocation of resources and implementation of integrated services. There have been increased reports of attacks and specifically murders of Lesbian women and none of the reported crimes have had any people arrested.
Thailand	The work of sex professionals is prohibited in spite of its being public. Sex workers are highly discriminated. Working clandestinely has made it more difficult for the women to adhere to prevention actions and it is the local NGOs that are most efficient in getting to them. The situation of women drug users is more complicated There have been denouncements that in 2005, in one way or another, Thailand executed more than two thousand people that were drug users).
Ukraine	Existing legislation makes it difficult to discriminate based on sex, sexual orientation, or health condition (including people living with HIV/AIDS.) At the same time PLWH, especially HIV positive women, often face stigma and discrimination, particularly in medical institutions. There are known cases of violation of their reproductive and sexual rights, including the right to have a child. Stigmatization and discrimination of women in medical institutions leads to their reluctance to apply to those institutions when their child is born. No attention was paid to aspects such as men and boys' vulnerability to HIV/STI infection because of harmful gender norms.

Uganda	<p>We have Affirmative Action for Gender Balance, even in the private sector companies. It is being ensured through the Equal Opportunities Act (2007), though not respected as much and recognized by the general community though all these are general interventions for all issues concerning women and young women. The programs for people living with HIV/AIDS are still apart from the general population.</p> <p>Sex work is an illegal act in Uganda.</p>
Uruguay	<p>One of the fundamental actions of the National Women's Institute – INAMU, has been the coordination of other stakeholders. INAMU does not have a clearly defined policy in regard to women living with AIDS. There are three lines of action directed at women living in extreme poverty: one is care for women that are victims of domestic violence; another is the holding of workshops on ethic and gender identities. The third action is directed at women living in shelters. Promoting male responsibility is not a line that has been given priority.</p>
Venezuela	<p>In 2003, the National Women's Institute together with the Ministry of Health and Social Development elaborated the National Equal Opportunities for Women Plan (2003 – 2007). In July of 2006 the Venezuelan Women's Human Rights Observatory was created. Recently a Law has been approved on the Right of Women to a Violence-free Life.</p> <p>Policies, programmes and actions concerning sexual and reproductive health are directed much more at women than at promoting male responsibility.</p>

#### HUMAN RIGHTS:

#### GOAL 60 PROPOSED INDICATORS

- *Prevention Programs for young women.*
- *Non-formal sexual and reproductive health and rights education programs that promote gender equality.*

#### COUNTRIES FINDINGS

Argentina	<p>In Argentina there are public educational policies that tend to foster equality between the sexes in the context of the human rights, and there is also legislation based on sex and gender.</p> <p>Implemented prevention policies mostly focus on populations as a whole and there are no effective, specific policies directed towards women or young girls.</p>
Belize	<p>Government directives for education that promote gender equality include a Gender and Self Esteem Guidebook that has been developed by the Women's Department for Primary School teachers. The Gender Awareness Safe School Program aims to set the foundation for gender equality among students. In this program there is an HIV/AIDS component that addresses prevention.</p> <p>Belize Family Life Association implements strategies to reduce HIV prevalence among youth by addressing information on prevention through education, training and community</p>

	activities and peer educator programs in high schools, but without tailoring any specific activity for girls. BFLA has employed a targeted approach to ensure that women of the ages 15 to 18 and 18 to 24 years old have specific access to information and education about HIV and other sexually transmitted infections.
Brazil	There are no specific programs for young women or girls and activities with youngsters outside the school system are scattered and mainly carried out by NGOs. There are sporadic prevention campaigns aimed at youthful populations but not specifically at girls.
Chile	Based on the government policy of endowing gender themes with a transversal axis in public policies, the objective of promoting equality between the sexes has become integrated into education. However there is no specific focus on young women,
India	Lack of a gender rights perspective in programme designs. Absence of issues related to sexuality and gender in the national training curriculum for counselors.
Indonesia	Recently, the Ministry of Health launched a National Strategy for Sexual and Reproductive Health, focusing on educational aspects & empowering. However, there are no policies to protect Sexual and Reproductive Rights. The Health Law, never specifically aimed to protect women's sexual & reproductive rights.
Kenya	There is a lack of appropriate gender-based IEC materials
Mexico	In the Federal sphere there is no programme or policy promoting or guaranteeing sexual and reproductive rights of young people. The Reproductive Health care services do not facilitate the presence of young people or adolescents and indeed, there is a certain pressure not to provide care to them. There is a study subject in the secondary education curriculum that addresses the issue of gender equity. Unfortunately its effectiveness depends on the capability of the teachers and although there are capacity building processes in existence they do not have the necessary outreach. There are some interventions for young people with no schooling but its outreach is very limited. In addition to not being standardized and not necessarily addressing the HIV issue, the strategies are not articulated.
Nicaragua	The National Action Plan for Childhood and Adolescence 2002 – 2010 involves the main state bodies addressing aspects of sexual rights and reproductive rights issues. The National Education Plan sets out the proposal to create inter-cultural sexual education programmes as well as setting up the Municipal Body for the Defence of the Child and the Adolescent in each school programme that contemplates the protection of the rights of girls and adolescents.
Peru	In the National Education Plan, item N° 4.3 proposes overcoming gender discrimination in the education system.
South Africa	Goal 2 of the NSPI in referring to 'reduce sexual transmission of HIV' includes in its objectives 2.1 'strengthen behaviour change programmes (...)with a focus on those more vulnerable to and at higher risk of HIV infection' and objective 2.2 'implement interventions targeted at reducing HIV infection in young people, focusing on young women'
Thailand	There is no prevention program specifically for young women, the programmes are directed at both young women and young men. There are a few programs for non-formal

	sexual and reproductive health programs promoting gender equality but not enough. There is movement on sexual rights of gender diversity and reproductive rights for positive women through public education and forums.
Ukraine	Prevention and forming the values of healthy lifestyle are recognized as one of the main tasks of all programs for protection of reproductive and sexual health and counteracting HIV/AIDS. But for a long time funding of these activities was provided on the residual principle and was considered to be the responsibility of the Ministry of Family, Youth and Sport and to a certain degree of the Ministry of Health. Ministry of Health has in fact withdrawn itself from the organization of educational activities relating to health issues.
Uganda	There is a lot of Information, Education, Communication, and behavioural change activities. They include grassroots campaigns using drama and meetings, and condom distribution. Awareness is related to the Abstinence and Fidelity perspective in the IEC materials and media.  Information, education, and communication materials do not meet the language diversity of the country;
Uruguay	Prevention programmes specifically directed at young women have not been implemented.
Venezuela	There are no programmes specifically for young people.

## HIV/AIDS AND HUMAN RIGHTS

### GOAL 6I PROPOSED INDICATORS

- *Specific laws to prevent, prosecute, and repair the damage caused by violence against women;*
- *Specific actions against the sexual exploitation of girls;*
- *Emergency services for women and girls 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 disseminating data about violence against women and girls.*

### COUNTRIES FINDINGS

Argentina	There is a lack of a National Protocol to regulate the care offered to women who have been raped that specifies the provision of Emergency Hormonal Contraception and of Post-exposure Prophylaxis.  No National Campaign regarding the theme of Violence against Women has been undertaken and services are not adequately made known. There are presuppositions in public policies that affect their implementation.  State bodies have failed to execute active policies to eliminate the sexual exploitation of children.
Belize	Antiretroviral therapy, STD prophylaxis, emergency contraception, and counselling are not always readily available for sexually violated women at the hospitals;

Brazil	<p>The Maria da Penha Law has been in existence since 2006 and it penalizes men who commit domestic violence. There is also a National Plan to Combat Sexual Violence against Children and Adolescents since 2006 and a National Pact to Confront Violence against Women. Those instruments, even considering how recent they are, have not been sufficiently made known or made use of by the population. There are emergency contraception, counselling, HIV test and STD diagnosis. There are care services for victims of sexual violence available, but they are few, badly distributed, have low coverage outreach and are little known by the population at large.</p>
Chile	<p>The orientation of policies for the prevention of violence against women has favoured the legal sphere of action (denunciation, legal actions). Emphasis has been placed on violence inside the family reducing the visibility of violence against women in other contexts of their lives.</p> <p>In regard to sexual violence, according to the regulations women should have access emergency contraception, counselling to, HIV testing, and STD diagnosis. There would not be access to anti-HIV prophylaxis. There are no concrete governmental initiatives in course in regard to the sexual exploitation of girls or trafficking in women.</p>
India	<p>Although gender-based violence is largely disseminated and related to Feminization of the epidemic, there is a lack of clear gender articulation in the policy and a lack of effective policy against gender-based violence.</p> <p>One five-year study in four Indian states found that 23% of female Dalits interviewed had been raped, 43% had experienced domestic violence, 47% sexual harassment, 55% physical assault and 62% verbal abuse. Of all cases studied only 0.6% ever made it to court, due to obstruction by the police or by dominant castes.</p>
Indonesia	<p>In 2002, the government produced Bill number 23 – 2002, where all forms of violence against children would be considered illegal actions, including sexual exploitation and violation of human rights of children;</p> <p>In 2004, the government released Bill number 23 – 2004 regarding “The Elimination of Domestic Violence”.</p> <p>Currently in Indonesia, there is no use of Anti HIV Prophylaxis for HIV exposures</p>
Kenya	<p>In spite of the magnitude of violence against women in the country, especially sexual violence, there are no public actions originating from government to counter the problem.</p>
Mexico	<p>Legislation on the issue exists, the General Law on Access to a Life Free of Violence, the Federal Law for the Prevention and Elimination of Discrimination, the Statute of Youth of the Federal District, and the Federal Penal Code that establishes the sentences and specific penalties for those who practice violence against women.</p>
Nicaragua	<p>The National Plan to Combat Violence defines as one of its priorities, working for the empowerment of women, and fostering practices of respect and equity. However the government response remains firmly in the field of discourse alone. Antiretroviral drugs, STD prophylaxis, emergency contraception and counselling for women victims of sexual violence are all unavailable.</p> <p>There is nothing specific on the government’s part in regard to girls because sexual violence is seen as a health problem. The National Commission for the Eradication of Child</p>

	<p>Labour has promoted a lot of initiatives against the sexual exploitation of boys and girls but the program has no finance budgeted for it by Government.</p>
Peru	<p>The National Sexual and Reproductive Health Strategy establishes that cases of gender-based violence be detected and dealt with humanely;</p> <p>The Law for Prevention and Punishment of Sexual Harassment (2003) penalizes sexual harassment in the work environment;</p> <p>The Law directed at providing protection against violence inside the family establishes that municipal authorities should promote bodies for the protection and defence of women, children and adolescents, temporary refuge shelters, peer support groups, and rehabilitation services for the aggressors.</p> <p>According to the Care Protocol—About Violence Against Women—, they should receive integral care and attention but health service personnel are not aware of the Protocol's existence. Implementation of the AOE has faced great difficulties in achieving national distribution. The provision of antiretroviral medicines for the victims of sexual violence is also very faulty.</p>
South Africa	<p>The Domestic Violence Act (1998) was developed with the consultation of civil society stakeholders and addresses violence against women and articulates the mechanism for obtaining a protection order.<sup>16</sup> The Sexual Offences Bill has been drafted and has been the subject of intense negotiation for the past three years. Sexual Violence is not part of the syndrome-based management of STDs in South Africa.</p> <p>Emergency Contraception and Post Exposure Prophylaxis is a challenge within the public sector. Government has set up special courts to deal with sexual offences and in particular to assist young girls in not having to confront their offender. These are not wide spread and state financial support for these is erratic.</p>
Thailand	<p>There is the act for protecting domestic violence victims, sections 276 and 277 of rape legislation, and the reproductive health protection act.</p> <p>To fight the exploitation of girls, there are laws and governments bodies like the Bureau against Trafficking in Women and Children, the National Human Rights Commission and the care service for sexual violence including PEP, HIV test, and abortion in case of rape. In Thailand abortion is illegal except for rape cases or medical problems of the pregnant women - But it is not easy to guarantee access to abortion as the girls and women have to pass through many processes that take time and often the abortion is unfeasible.</p> <p>The data about violence is collected through many channels depending on how they get the service—One Stop Crisis Center (OSCC) in government hospitals, police station, SDS, emergency shelter, counselling services, hot line, government and non government entities such as Friend of Women Foundation, Foundation for Women, Women's Health Advocacy Foundation (WHAF), etc.</p>
Ukraine	<p>The problem of violence against women are addressed in the main laws such as the Criminal code, different regulations and decisions of Cabinet of Ministers of Ukraine and other executive and legislative authorities. There is a specific law "Prevention of violence in families", and "Declaration on extermination of violence against women". Actions are implemented by government and NGOs, but most of them are focussed on preventing</p>

<sup>16</sup> <http://www.info.gov.za/gazette/acts/1998/a116-98.pdf>

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	<p>violence against women.</p> <p>There are a limited number of emergency services. The most common is a Centre of work with women and shelter for women, who are victims of violence. But all of them are of the closed type and have strict criteria for women to be accommodated in them. Most of them attend to women victims of domestic violence. There are also some services for women who are victims of sexual violence.</p> <p>Most of the data is collected by social services that work with victims of violence and law enforcement agencies.</p>
Uganda	<p>The government with its development partners has initiated a number of programmes like the Gender-based Sexual Violence under the ministry of Gender, Labour and Social development. There is the current Domestic Relations Bill in the Uganda Parliament among others intended to curb violence against women and young girls</p>
Uruguay	<p>The National Women's Institute has elaborated the First Plan for Equal Rights and Opportunities (2007 – 2010). One of its primary axes is that of violence based on gender and above all domestic violence. Another line of action concerns trading and trafficking women. There is also the line of sexual and reproductive rights, political rights, citizenship and fostering leaderships and economic rights. The National Crime and Violence Observatory publicizes data on denunciations of domestic violence and sexual offences. However, the data on domestic violence offered by the Observatory is insufficient as the situations of domestic violence are overlaid by other types of offence. There is no system disclosing data specifically on violence against girls.</p>
Venezuela	<p>In March 2007 the New Organic Law on the Women's Right to a Life Free from Violence was sanctioned as was the Organic Law for the Protection of Children and Adolescents which penalizes the offences of sexual abuse and exploitation of boys, girls and adolescents; the National Council for the Rights of Children and Adolescents created an Inter-sector Commission against sexual abuse and exploitation (CICAES); INAMUJER made a toll-free call line available, 0800-mujeres to provide psychological and legal advice to women victims of violence. INAMUJER develops programmes for promoting the right to protection of women through its so-called Meeting Points (<i>Puntos de Encuentro</i>).</p>

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## REDUCING VULNERABILITY

### GOAL 62 PROPOSED INDICATORS

- *Support programs for women in situations of vulnerability, including income transfer and human rights defence programs;*
- *International agreements, conventions, and treaties application in the country*
- *Efforts to curb and punish trafficking in women;*
- *Monitoring activities.*

COUNTRIES FINDINGS

Argentina	<p>Both National and Provincial Programmes have registered specific programmes for women living with HIV/AIDS.</p> <p>There is no effective monitoring system that would allow for an evaluation of the impacts of actions related to the inclusion of women belonging to the most vulnerable groups. The application of the Belem do Pará Convention is obligatory throughout the country.<sup>17</sup> However, it has not been translated into regulations, policies, plans or concrete services and the advances have been insufficient and incomplete. Neither have any efforts been made at the national level to disseminate it. There are few reliable statistics available at country level that refers to trafficking in women. In turn, the lack of punitive legislation in place is one of the factors that facilitate the continued occurrence of this criminal practice.</p>
Belize	<p>In June 2006 Belize was one of six countries placed on a Tier Three list by the U.S. for "not meeting minimum standards to fight trafficking in persons, a criminal practice". Since 2006 the government has launched a number of public education campaigns and other initiatives on trafficking. The issue of trafficking was not addressed specifically to target the trafficking of women and young girls.</p>
Brazil	<p>There is a conditioned income transfer programme in place that, according to an independent assessment, has increased the autonomy of women beneficiaries.</p> <p>There is also a series of programmes for social inclusion and promoting equity but without a specific line directed at women. In 2006 a Policy to Combat Trafficking in Human Beings was launched but has not yet been implemented.</p>
Chile	<p>There are no government initiatives for the social inclusion of women in situations of high vulnerability except for one action carried out with sex workers that is contained within the sphere of sexual and reproductive health control. That control is to be monitored by the State through its Sentinel Centres.</p> <p>There is evident invisibility of boys and girls in sexual exploitation situations that have either acquired the virus through sexual transmission or are vulnerable to its acquisition. In that sense a crosscutting problem is the lack of any inter-sector work that makes it difficult to approach boys and girls that find themselves excluded from the formal health access ways.</p>
India	<p>Marginalized groups are grappling with issues of stigma and discrimination, major barriers to accessing services.</p>
Indonesia	<p>Government of Indonesia launched Bill number 7 – 1984 as a ratification of CEDAW (Convention on The Elimination of all Forms of Discrimination Against Women).</p>
Kenya	<p>There has been lack of adequate financial support to vulnerable women and girls and there are absolutely no structures or systems to protect women against trafficking.</p>
Mexico	<p>To the policies and programmes, women in high vulnerability situations are those living in rural environments, in extreme poverty or in difficult conditions and they do not necessarily contemplate serum-positive women or sex workers as such.</p> <p>There are specific programmes to stimulate education among adults but social exclusion</p>

<sup>17</sup> "Violence against women constitutes a violation of human rights and fundamental freedoms and partially or totally deprives the woman of the recognition, enjoyment and exercise of such rights and freedoms".

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	and discrimination are not articulated with the situation that HIV creates.
Nicaragua	<p>There are no specific State programmes of sexual and reproductive health for illiterate women due to the influence exercised by the Catholic Church.</p> <p>The same applies to specific actions for repressing trafficking in girls, adolescents, youngsters and women. The Office of the Public Prosecutor of the DD.HH is doing something about it but with insufficient resources. There are denunciations of trafficking in girls and women but there is no public policy on it.<sup>18</sup></p> <p>What shows up is “the existence of an inefficient programme, the absence of universal access to ARV therapy and a lack of orientation, education and care in Sexual and Reproductive Health for the population at large and especially the women including sex workers and incarcerated women.</p>
Peru	<p>Information generated and diffused by the State on the vulnerability of sex workers is very limited. In the populations there is a perception of the difficulties and lack of interest in recognizing the work as a profession and addressing it from a lay perspective. The projects financed by the Global Fund have carried out activities among these populations. There is no monitoring system as such and complaints are dealt with through individual actions undertaken by staff members.</p>
South Africa	<p>There have been a number of initiatives to enable women in poverty to obtain grants. There are disability grants, pension grants and child support grants for caregivers of children under the age of 18. While commendable, these are viewed as inadequate and there are campaigns in place for a basic income grant. The South African Law Reform Commission released an Issue Paper on Sexual Offences that call for the decriminalization of sex work in 2002.<sup>19</sup> No law exists currently dealing with trafficking.</p> <p>The “Developmental Programs for Unemployed Women with Children Under Five Years” has been launched with the aim of reducing poverty through providing income-generating activities to women.</p>
Thailand	<p>There is funding support for income generation run by GO, NGO, INGO such as the Asia Foundation but it may not be enough and does not give nationwide coverage. Similarly we also have GO, NGO and academics (universities) providing support and consultancy for rights protection and court that may not cover the whole country.</p> <p>The International agreements, conventions, and treaties about women applied in Thailand are as follows:</p> <ul style="list-style-type: none"> <li>• Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (1979)</li> <li>• The International Conference on Population and Development ICPD (1994)</li> <li>• Beijing Declaration and Platform for Action (1995)</li> <li>• The UN Millennium Development Goals (MDG) (2000)</li> </ul> <p>The government is committed to eliminate trafficking in women</p>
Ukraine	NA
Uganda	The government of Uganda carries out different initiatives through the Ministry of Gender,

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<sup>18</sup> Sonia Agurto –Investigator FIDEG.

<sup>19</sup> N Fick SWEAT. Personal Communication, November 2007.

	<p>Labour and Social Development and the Department of Labour and Industrial Relations under the Employment Act and the policy on Gender and Community Development under the National Women's Council Act and policy among other laws and policies that are crosscutting.</p>
Uruguay	<p>El INAMU has signed an agreement entitled "Sweet Measures for Homemade Food Production" which aims to foster economic ventures headed by women. There is also a national competition award for successful economic ventures headed by women from the poorer classes.</p> <p>Up to the moment no defined policy on trafficking in girls and women has been implanted by the Ministry of the Interior. There is no specific line of actions against sexual exploitation especially of young girls. A programme related to trade and trafficking in women has been implemented since 2005. It is called "Assisted Return for Irregular Migrants" and offers psychological assistance to women that the International Migrants Organization wishes to repatriate. This is a theme that came up very strongly at the Special Meeting of Women of the MERCOSUR. There is no system for monitoring trade in women and girls.</p>
Venezuela	<p>The work of empowering women has been carried out by a part of the government in two areas: the Meeting Points, grassroots organizations by means of which the participation of women in their communities is stimulated and the Women's Bank which grants micro-credit to women in the poorer classes thereby promoting self-management and the incorporation of productive and remunerative work. There is no information available that would allow for an evaluation of those programmes.</p> <p>The new Organic Law on the Rights of Women to a Life Free from Violence criminalizes trafficking in women and girls. In 2006, the Inter-sector Commission against Sexual Abuse and Exploitation of Girls and Adolescents elaborated the 5 years Plan of Action on this theme. The extent of execution of the said plan is still unknown.</p>

## REDUCING VULNERABILITY

### GOAL 63 PROPOSED INDICATORS

- *Social programs that consider the diversity of family arrangements;*
- *Programs that consider cultures, religion and cultural contexts in the education strategies;*
- *Access to housing, education, social assistance, health care and food for girls and adolescents, in vulnerable situations including those infected with HIV;*
- *Actions of capacity building in sexual and reproductive health and rights for teachers.*

COUNTRIES FINDINGS

Argentina	<p>To promote the rights of young girls, in 2005 National Law N° 26.061 for the Integral Protection of the Rights of Girls, Boys and Adolescents was sanctioned but its implantation is slow and heterogeneous within the legal sphere.</p> <p>The Health system encounters difficulties in attending to the realities of the families belonging to the most vulnerable groups—families that have broken up, or with only a single reference adult, or grandparents or other family members in charge. On the other hand the multi-cultural perspective is left out when formulating social projects. Education on HIV in schools does not have subject contents that have any relevance to those socio-cultural and gender aspects that are so intimately bound up with the AIDS epidemic. The subject matter related to Sexual and Reproductive Health is limited and impregnated with a unidirectional 'biological' point of view.</p>
Belize	<p>Gender expression plays a preponderant role in the dynamics associated with the reinforcement of gender stereotypes and human rights violations. There is no language to reflect its diversity in local culture in our laws.”<sup>20</sup> The Department of Human Services is responsible for the placement of the management of children that are placed in alternative care in Belize. There are currently six privately run children’s shelters and one government run children’s home that have some HIV positive children. .</p>
Brazil	<p>There are no specific policies for children or young people living with HIV especially not for young girls. Actions are limited to medical attention and financial support for the establishments that shelter such children. There are also no studies that quantify this population or qualify its needs. There is a law that prohibits schools to refuse to enrol children living with HIV but no work is being done with the teachers to enable them to handle the situations arising from the serum-positive condition such as how to avoid the child’s being discriminated and consequently abandoning its studies.</p>
Chile	<p>The concept of a family that orientates the government’s efforts in these matters is centred on a nuclear family and restricted to marital unions. Thus it fails to adapt to the more vulnerable populations and there is no protection of the interests of other types of family unit. The sexual education programmes planned by the government have not been applied because of various political pressures and the decentralization of the educational establishments.</p>
India	
Indonesia	<p>Most of the programs on this issue are done by community-based organizations.</p>
Kenya	
Mexico	<p>The traditional nuclear family with a standard format is the one with which the State works with even though a high percentage of Mexican families is headed by single or abandoned women.</p> <p>There is subject matter on human sexuality and AIDS in the schools. However, the information is reduced and the focus is merely informative. Capacity building is insufficient and does not cover all teaching staff.</p>
Nicaragua	<p>Public Policies consider that the nuclear family is predominant whereas in reality what</p>

<sup>20</sup> Acting Director of Women’s Department- Ms. Humes

	<p>predominate are single parent families and furthermore, there is no multi-cultural perspective in the policies.</p> <p>Because people living with HIV suffer intense discrimination they try to maintain anonymity and that does not facilitate support from family or the community. The government fails to back the communities and merely makes use of them, especially the women, when it has Programmes for eradicating some disease or other.</p> <p>The sexual education that is offered in public schools is deficient and centred on the biological aspects of reproduction and the sexual organs. It does not take note of cultural and historic influences or the social differentiation of men and women. Health workers and educators cannot free themselves of religious influences that lead to inadequate handling of the theme Sexual and Reproductive Health. Health services have been directed towards reproductive activities and essentially focussed on mother and child aspects.</p>
Peru	<p>There have been no State programmes as yet, directed at offering safe surroundings, shelters or other social conditions highly vulnerable girls whether infected or not. The spaces dedicated to reception like the INABIF are insufficient and are mainly located in the big cities and there are no specifications concerning them or the girls living with HIV.</p>
South Africa	<p>Given South Africa's internal History there is respect for difference and diversity.</p> <p>The Child Support Grant provided to caregivers of children under the age of 18 is an attempt by government to provide for vulnerable children.</p> <p>The Children's Bill currently being discussed makes provision for young girls from age 12 to obtain contraception.</p>
Thailand	<p>The Global Fund has some Sexual Education projects in schools but the quantity and quality of the teachers trained to do this kind of work are both very low.</p>
Ukraine	
Uganda	<p>There are government programmes that support orphans and other vulnerable children in Uganda under the aegis of the Ministry of Gender, Labour and Social Development and the Ministry of Health for the paediatric/medical programmes. The coverage of these programmes is quite high though they are not yet all that effective.</p>
Uruguay	<p>In formulating its Sexual Education programme, ANEP's Sexual Education Commission has tried to adopt a multi-cultural perspective and ethical point of view, based a laicism, acceptance of diversity, tolerance, the validity of cosmological visions, and the varying situations and conditions to be found.</p> <p>No line of action specifically directed at youngsters living with HIV has been defined within the programme.</p> <p>In regard to the Sexual Education Programme there has been no specific participation of youngsters living with HIV. Youngsters within the general education system as a whole are called on to participate.</p>
Venezuela	<p>Educative Missions, whose objective is to offer literacy training, and basic, diversified and university education to the vulnerable population that finds itself excluded from traditional, formal education.</p>

## REDUCING VULNERABILITY

### GOAL 64 PROPOSED INDICATORS

- *Outreach and effectiveness of Government articulation with regional and international partners to strengthen programmes and specific activities of sexual and reproductive health care for women in the most vulnerable situations;*
- *Participation of “women in most vulnerable situations” in the articulation process.*

#### COUNTRIES FINDINGS

Argentina	It has not been shown that the increase in some of the amounts allocated for public policies has been mirrored by an increase in plans and programmes directed at working with excluded populations including women in highly vulnerable situations.
Belize	Limitations continue to affect the most vulnerable populations such as commercial sex workers. Basic Human Rights legislation on sexual and reproductive health rights, health status and sexual orientation has not been addressed beyond a national HIV/AIDS policy that is limited and is often not enforced.
Brazil	By means of agreements with national and international agencies the government has been endeavouring to ensure an influx of finance for sexual and reproductive health actions. There are funds, albeit limited, for working with women in the most vulnerable situations like sex workers, HIV+ women, lesbians, Negro women, Afro-descendants, indigenous women and gypsy women. The orientation set out in the Policy on Integral Healthcare for Women <sup>21</sup> is that health actions must seek to include women. In practice this usually depends on the local administrator.
Chile	While it is true that international funds like the Global Fund have created structures that should remain in place even after the funding has ceased there is no guarantee that it will happen in practice. The National AIDS Commission states that political will exists to maintain the actions carried out in the sphere of the Global Fund. The permanence of each strategy will depend on the final evaluation and there have been some strategies that have not been successful.
India	The HIV/AIDS Programme is riding on a public health system that is weak where the government contribution is reducing and private players are taking over. At the same time the health system is not sensitive to marginalized communities nor is it equipped to deal with them.
Indonesia	
Kenya	
Mexico	Such articulations do not exist formally even though in concrete figures, government contributions to prevention through projects undertaken by civil society have increased,

<sup>21</sup> Brasil, Ministério da Saúde. Política Nacional de Atenção à Saúde Integral da Mulher. MS, SAS. Brasília, 2005

	<p>they are not directed at the overall population of women. While it is true that the classification 'women with HIV' exists it does not embrace incarcerated women, sex workers or other groups in highly vulnerable situations.</p> <p>The participation of affected women has mainly taken place through the community organizations. There is no support available for the regional or international articulations referred to.</p>
Nicaragua	<p>There are no government contributions to the work done with the most excluded populations because there has been a very limited vision of poverty. Those who are excluded carry on as excluded as ever.</p>
Peru	<p>National HIV-AIDS response actions directed at women consider only three categories of women:</p> <ol style="list-style-type: none"> <li>1. Female sex workers</li> <li>2. Pregnant women</li> <li>3. Women living with HIV-AIDS</li> </ol> <p>In regard to the first, the prevention activities revolve around controlling the epidemic in terms of their work situation and do not include their status as women in integral terms; as for the second group, pregnant women, the fundamental concern is with vertical transmission with giving attention to specific vulnerabilities or addressing them; the third group, women living with HIV and AIDS are handled in the dimension of care and treatment. The dimension of positive prevention is very limited and any consideration for their sex lives is often undetectable in the health services.</p>
South Africa	<p>Government played a key role in the development of the Maputo Protocol and the Maputo Plan of Action (Plan of Action on Sexual and Reproductive Health and Rights).</p>
Thailand	<p>With the arrival of the resources of the Global Fund and the decentralization process concerning AIDS actions that took place prior to it, the government has drastically reduced the amount of its own resources that it invests in AIDS. Nevertheless, here are expectations that the new AIDS plan will also mean more resources for working with women and AIDS.</p> <p>The Thai Positive Women Network gets funding support from the Ford Foundation, WHAF (Women's NGO) gets funding support from the Ford Foundation, and the Thai Health Promotion Foundation etc. Friend of Women works with trafficking issues and gets funding support from international NGO as well.</p>
Ukraine	<p>Most of the efforts in the capacity building of the civil society, advocating the rights of patients and vulnerable groups as well as revision of the legal base to bring it into compliance with international standards are being implemented only thanks to the technical and financial assistance of the international community.</p>
Uganda	<p>International donors finance approximately 90% of all investments in reproductive health, so their priorities are critical in shaping policies and programmes. It is also noted that the sector wide approach to development funding in the health sector has not necessarily resulted in increasing funding for sexual and reproductive health.</p>
Uruguay	<p>INAMU participates in some spheres of the MERCOSUR through the National Sexual and</p>

	Reproductive Health Commission. Joint preparation is being undertaken of a seminar on this issue.
Venezuela	There is no data on the participation of more vulnerable women in the processes of regional and international articulation.

## CHILDREN ORPHANED AND MADE VULNERABLE BY HIV/AIDS

### GOAL 65 PROPOSED INDICATORS

- *Existence of specific programmes to support orphans and children, especially girls infected and affected by HIV;*
- *Quality of shelter establishments;*
- *Existence of educative programmes for orphaned children especially girls in situations of vulnerability because of HIV/AIDS.*

### COUNTRIES FINDINGS

Argentina	The government has not implanted support strategies for boys/girls with HIV/AIDS; there are no social support programmes for the women/family members that take on the care of AIDS orphans. Nor are there any policies of psychological and emotional support for that population, not only the boys and girls living with HIV but also those children affected by it. Very few take any interest in how such children are living.
Belize	There is no orphanage in Belize. Three of the six homes run for children have children directly and indirectly affected by HIV/AIDS. The children who are HIV+ receive regular medical attention and adequate nutrition. There is not any specific psychological and social support mechanism in place. Two of the three shelters have personnel trained in basic HIV/AIDS education training. The children of school age in these shelters who are HIV+ have been enrolled in school.
Brazil	There are no actions distinctly targeting orphans and such work is still concentrated in the hands of civil society. The existing system for supporting orphans in Brazil is not very efficient in spite of the advances there have been in legal aspects of protection for children and adolescents (Childhood and Adolescence Statute); the homes and shelters are few and of a doubtful quality. Inter-sector initiatives are fragile; there are no initiatives to minimize the impacts of institutionalizing orphans and young adolescents who have to leave the shelters when they are 18 and become unsupported – there is no specification in regard to girls.  There is no mechanism to measure or to predict the number of children orphaned by AIDS at the moment
Chile	The Ministry of Health has managed to guarantee access to health care in the sphere of HIV to the great majority of boys and girls living with the virus. However, the care offered to the serum-positive children has a sanitary orientation that detracts from what

	should be an integral approach. Thus deficiencies can be seen in the environments for psychosocial, nutritional and educational support. There is certain abandonment in terms of programmes for the 14 to 18 year old age group.
India	
Indonesia	<p>Currently there is no official program launched by the government that specifically deals with children orphaned by or vulnerable to AIDS. Most of the programs on this issue are done by the community-based organizations.</p> <p>There is no mechanism to measure or to predict the number of children living with or affected by HIV at the moment</p>
Kenya	
Mexico	There are no specific programmes to address this situation, however, there is a government body that has a process for supporting situations of children orphaned by AIDS and it counts on the support of organizations that work with that question and that have hostels.
Nicaragua	There are no government strategies of this sort. This kind of action is carried out by NGOs. There is information concerning abuse and bad treatment of children with AIDS in schools and sexual abuse of boys in a shelter committed by an adult living with HIV.
Peru	<p>In October of last year a workshop was held in the Office of the Public Defence Attorney in which the priority was the issue of children living with HIV. The work done with adolescents is an effort that is still very little institutionalized in multi-sector terms. That of the Ministry of health bears little relation to other Programmes the work with young people, the actions of the Ministry of Education seem marginal and a far cry from the Sexual Education Programme that was begun in the nineties.</p> <p>In regard to children in highly vulnerable situations and those directly affected there are very few actions undertaken to attend to them and the violation of their rights.</p>
South Africa	The Child Support grant has been an effective provision to enable orphans and children to obtain support until the age of 18. There are bureaucratic barriers in obtaining the grant. In some rural areas, these barriers serve as a serious obstacle to obtaining the grant. Education is free to all children in the public system for the first ten years, however, other expenses with uniforms, books and equipment, contributions to the school activities do add an additional burden. Orphans are in some cases housed or attached to families where support can be offered
Thailand	<p>There is a program for orphans including HIV affected children which is run by GO, NGO, INGO, and Faith-based organizations. In addition, the health system and social welfare system provide care &amp; treatment and support for orphans and HIV affected children but they do not separate activities specific for girl or boy.</p> <p>The shelters in Thailand are quite good and run by GO, NGO, INGO, and Faith-based organization but they have some funding constrains. They have to raise funds to support their activities though they receive support from government but it is not enough. We have shelters for women and children who are the victims of violence or affected by HIV/AIDS. There are not enough shelters nationwide.</p>
Ukraine	HIV positive children apart from general rights and freedoms have also a number of privileges and the right to material support. Under the guardianship of the State social

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services for family, children and youth a system of municipal centres for provision of medical and social support for children affected by the epidemic of HIV/AIDS are gradually being created in the Ukraine. However support for HIV positive children is currently provided mostly by non-government organizations, primarily by the All-Ukrainian Network of PLWH with the funding from GF and other international organizations.

Provision of medical and social services for children affected by the HIV/AIDS epidemic is limited for the following reasons: Lack of state funding; specialized social institutions are located only in the regional centres and in the capital.

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Uganda Some CHAIs (Community-led HIV and AIDS Initiative) have engaged in innovative community strategies for sustaining productive activities the funds from which are used to support orphan children with school dues, buying essentials and for transport to receive treatment

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Uruguay There exists a joint project of the STD/AIDS Programme with UNICEF for HIV orphans that has already been elaborated but has not yet been put into effect because of lack of funds.

There are no specific programmes directed at orphaned children or adolescents in situations of vulnerability because of HIV AIDS. In the Polyclinic for HIV Follow up for children, work is carried out with infected children and young people offering them psychological accompaniment.

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Venezuela There are 448 children and adolescents registered and receiving antiretroviral therapy. However the juvenile population living with HIV is estimated to be much larger (2,500)... Specific care programmes for orphans and children infected or affected by HIV are unknown in Venezuela. There have been situations where their right of access to education has been violated. The Ministry of Education has established a regulation that prohibits the exclusion of people from the school system because of their health conditions and that includes people living with HIV but there is no specific policy as such on this issue. In practice, cases of discrimination and exclusion of children from the school system have occurred either because they were serum-positive for HIV or because it was known that their parents were serum-positive or had died from that cause.

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#### ALLEVIATING SOCIAL AND ECONOMIC IMPACT

#### GOAL 68 PROPOSED INDICATORS

- *Availability of data or studies about the socio-economic impact of HIV on women.*

COUNTRIES	FINDINGS
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Argentina	The government does not conduct studies on the socio-economic impact of the HIV epidemic
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Belize	The government has developed studies about the social and economic impact of the HIV epidemic. One such study was completed in 2000. The study on the social and economic impact of HIV is not specified by sex. There is limited information about the social and economic impact of HIV specifically on women in Belize.
Brazil	Non existent
Chile	Such studies do not exist
India	Not Available.
Indonesia	Not Available.
Kenya	No available data was found
México	Non existent
Nicaragua	Such information does not exist or is not available
Peru	The government has neither conducted nor disseminated studies on the socio-economic impacts of HIV in general or on women in particular.
South Africa	There has been limited work documenting the particular socio-economic impact of HIV on women and generally separation by sex is not done..
Thailand	There are studies about the social and economic impacts of AIDS on families made up mostly of women and elderly people.
Ukraine	Non existent
Uganda	The Government of Uganda in collaboration with UNDP has launched a major study determining the Macro economic effect of HIV/AIDS this will be a major source of information for the social economic impact of HIV/AIDS at a macro level.
Uruguay	No such data available.
Venezuela	No such data available.

## RESEARCH AND DEVELOPMENT

### GOAL 72 PROPOSED INDICATORS

- *Surveillance system for the side effects of antiretroviral medicines with data segregated by sex;*
- *Adaptation of health service providers' responses to the effects of resistance and secondary effects of antiretroviral medicines in women.*

### COUNTRIES FINDINGS

Argentina	The National Programme to Fight Human Retrovirus, AIDS and STD has no specific investigations into the Natural History of HIV in the female body. Women with HIV do not participate in the Bio-ethics committees.
Belize	There has not been specific research done in Belize about the Natural History of HIV in the female body. Women however have been included in the clinical analysis when it is distinguished by sex. Currently there is no national ethics committee. An <i>ad hoc</i>

	committee oversees the process of research. There are currently no behavior studies being conducted on women living with HIV.
Brazil	There is no data and no specific research regarding the impacts of anti-HIV therapy on women. Women living with HIV can participate in the research ethics committees as representatives of users but they have to fight for such spaces. There is no specific representation on those committees of women living with HIV.
Chile	There is an important lack of research dedicated to measuring the toxicity and the side effects of the medicines on the female body. There are some government initiatives like the clinical follow-up studies that include HIV programme users that may produce information specifically on women.  There are no behavioral studies on women living with HIV that could produce information on risk behaviour, managing sexuality and negotiating the use of prevention technology.
India	Did not report
Indonesia	Did not report
Kenya	Did not report
Mexico	No information on this matter was found
Nicaragua	However, there is no investigation being mde into the natural history of HIV in Nicaragua specifically in women. There are no incentives for men or for women to involve themselves in the research. There is a need to establish ethical positions or strengthen them. The TCLE is applied or not, depending on the Health Unit in question. There are no adequate governmental or institutional mechanisms to guarantee the rights of those that are the subjects of research.
Peru	The General Medicines, Materials and Drugs (DIGEMID) of the Ministry of Health has produced a report on adverse side effects of the HAART medicines which has not been made known to the public. It is necessary to publicize the report and to segregate the data by sex <sup>22</sup>
South Africa	South Africa has led and hosted a number of female controlled method studies – including microbicides, femidoms and diaphragms. A number of lessons have been learnt in this process, including better design and ethical issues. A Pregnancy register was to be set up to monitor the impact of ARV drugs in particular those contra-indicated in pregnancy and breast feeding (Tenofovir and Evavirenz) by the University of the Orange Free State but this has not taken place as yet. <sup>23</sup>
Thailand	Did not report
Ukraine	Did not report
Uganda	There are many interventions aimed at addressing side effects and toxicity of drugs. Women suffer intense side effects from these treatment.
Uruguay	The Polyclinic for HIV children of the CHPR has made a serious investigation of the natural History of HIV in the female body. It must be stated that there is nothing official about those kind of investigations but that the Polyclinic has investigated and

<sup>22</sup> Personal Communication – Prof. Gary Maartens. Pharmacology University of Cape Town. July 2007

<sup>23</sup> Personal Communication – Prof. Gary Maartens. Pharmacology University of Cape Town. July 2007

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published information on that theme.

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Venezuela Women do not take part in the bio-ethics committees and there was no answer respecting investigations into the impact of HIV on the behaviour of women and girls living with HIV.

There are no known government-run actions for evaluating the adverse side effects of antiretroviral therapy and there was no information found on the adaptation of such therapy for women.

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# Credits

## COUNTRY COORDINATORS

### *Latin America and the Caribbean*

<i>Argentina</i>	FEIM	Mabel Bianco (feim@ciudad.com.ar)
<i>Belize</i>	Alliance Against AIDS	Rodel Beltran (rodelbeltran@yahoo.com)
<i>Brazil</i>	GESTOS & GAPA/SP	(alessandra.nilo@gestospe.org.br, jcveloso@terra.com.br)
<i>Chile</i>	AciónGay & VivoPositivo	Francisco Vidal (fvidal@vivopositivo.org)
<i>Mexico</i>	Ave De Mexico	Carlos Garcia de León (carlos.nic@gmail.com)
<i>Nicaragua</i>	Nimehuatzin	Rita Arauz (rita.arauz@nimehuatzin.org)
<i>Peru</i>	Via Libre	Robinson Cabello (robincab@vialibre.org.pe)
<i>Uruguay</i>	ASEPO & MYSU	Lilian Abracinska (liliabra@adinet.com.uy, asepo@adinet.com.uy)
<i>Venezuela</i>	ACSSI & AVESA	Edgar Carrasco (carrascoedgar@cantv.net)

### *Asia*

<i>India</i>	ActionPlus & Naz Foundation	(naz@nazindia.org, tarshi@vsnl.com)
<i>Indonesia</i>	Yayasan Kita	Rico Gustav (rico.gustav@gmail.com)
<i>Thailand</i>	Raksthai Foundation	Sunee (stalawat@hotmail.com)

### *Africa*

<i>Kenya</i>	CHIACSOK	Joe Muriuki (nephak592003@yahoo.co.uk)
<i>South Africa</i>	MOSAIC	Marieta de Vos (mdevos@mosaic.org.za)
<i>Uganda</i>	UWONET	Carol Idembe (carolidibya@yahoo.com)

### *Eastern Europe*

<i>Ukraine</i>	All-Ukrainian Network of PLWH	Olga Sova (sova@network.org.ua)
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## GESTOS PROJECT TEAM

PROJECT COORDINATION	Alessandra Nilo (alessandra.nilo@gestospe.org.br)
TECHNICAL RESEARCH CONSULTANT	Dr. Wilza Villela (wilsa.vieira@terra.com.br)
FINANCIAL COORDINATOR	Ivete Albuquerque Xavier (ivete.xavier@gestospe.org.br)
RESEARCH ASSISTANT	Jose Carlos Veloso (jcveloso@terra.com.br)
PROJECT ASSISTANT	Manuella Donato (manuella.donato@gestospe.org.br)
FINANCIAL ASSISTANT	Luciana Carvalho (luciana.carvalho@gestospe.org.br)
COMMUNICATION & DESIGN	Claudio G. Fernandes (claudioguefer@gmail.com)
TRAINEES	Clarissa Carvalho and Sérgio Costa
TEXT PRODUCTION	Alessandra Nilo and Wilza Villela
TECHNICAL REVISION	Claudio G. Fernandes
TRANSLATION	Martin Charles Nicholl

## UNGASS AIDS FORUM FACILITATORS

Alessandra Nilo, Wilza Vieira Villela, José Carlos Veloso, Kariana Guerios, Manuella Donato, Claudio Guedes Fernandes, Carlos Garcia de León (Mexico), Edgar Carrasco (Venezuela).

