

HIV/AIDS AND SEXUAL MINORITIES IN MEXICO

A Globalized Struggle for the Protection of Human Rights

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Abstract: The fight against HIV/AIDS is an example of a global struggle for the promotion of sexual health and the protection of human rights for all, including sexual minorities. It represents a challenge for the understanding of its impact on political, social, and economic processes. My central goal in this piece is twofold. First, I underline the importance of a political and human rights perspective to the analysis of the global response to the pandemic, and I introduce the concept of policy networks for a better understanding of these dynamics. Second, I argue that, in the case of Mexico, the constitution of HIV/AIDS policy networks, which incorporate civil society and state actors, such as sexual minority activists and public officials, and their actions—both domestic and international—have resulted in a more inclusive HIV/AIDS policy-making process. However, serious human rights violations of HIV/AIDS patients and sexual minorities still remain.

In the early days of the HIV/AIDS pandemic more than two decades ago, there was an outburst of discriminatory reactions against homosexual men and other minorities, who were among the illness's first known victims. Today, homophobic discrimination is still persistent worldwide, although it is more pervasive in regions such as Latin America, which makes the need to focus on sexual minorities even more urgent. Although the pandemic continues to disproportionately affect sexual minorities throughout the region, the spread of the virus among the general population has made evident the vulnerability of other population groups, such as women and children. As a result, there is broader consensus on the fact that HIV/AIDS must be regarded as a health issue determined by a complex set of social, economic, legal, political, and cultural factors.

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To contribute to the analysis of this ongoing global challenge, I have set a twofold goal for this article. First, in a more theoretical discussion, I underline some of the links among sexual health, HIV/AIDS, and human rights in the context of globalization, with a special focus on sexual minorities. I also argue in favor of a policy-network approach for analyzing HIV/AIDS public policies and in the context of the democratization process in Mexico. In the second part, I point to the concrete outcomes of a relatively more inclusive policy-making process: targeted prevention campaigns, improved access to treatment, and more generally increasing attention to the protection of human rights of sexual minorities and HIV patients. I argue that the tireless mobilization of various civil society activists—both at the local and the international level—and the formation of HIV/AIDS policy networks have contributed to the realization that success in the fight against the disease is inevitably associated with the recognition of sexual health for all, including and especially sexual minorities, as a universal human right.¹ After discussing some of the gains, in the final section, I focus on the persisting challenges related to law enforcement and human rights violations of sexual minorities and HIV/AIDS patients in Mexico.

THE HARD FACTS ABOUT HIV/AIDS

According to the UN AIDS Programme (UNAIDS), an estimated 33 million people were living with HIV in 2007, with approximately 2.7 million becoming infected and 2.1 million losing their lives to AIDS in that same year (UNAIDS 2008). The numbers are particularly staggering for sub-Saharan Africa, where an estimated 22.5 million people live with HIV, and around 1.6 million die every year as a result of HIV/AIDS and tuberculosis combined.

Although in most parts of Latin America the situation is still far from the catastrophic dimensions it has reached in Africa, there are increasing concerns regarding the need to look at the situation as an indicator of various sociopolitical and economic ills affecting the region. In 2005 alone, some 140,000 individuals were infected, bringing the total number of people living with the virus in the region to approximately 1.6 million (UNAIDS 2006). The region's biggest epidemics are in the most populated countries, such as Mexico and Brazil. Yet the most intense epidemics are under way in small countries such as Belize and Honduras, with

1. This piece draws from a broader research project based on my unpublished doctoral dissertation ("An Elusive Quest for Democracy and Development in a Globalized World: The Political Economy of HIV/AIDS in Mexico," University of Toronto), and from more recent work on Brazil and Cuba, all of which is part of the forthcoming book *A Tale of a Globalized Struggle: The Political Economy of HIV/AIDS and Human Rights in Latin America*.

more than 1.5 percent of those countries' respective adult populations living with HIV in 2005 (UNAIDS 2006). Similar to the Mexican case, in countries such as Guatemala, Honduras, Nicaragua, and Panama, there is high HIV/AIDS prevalence among men who have sex with men (MSM)—between 9 percent and 13 percent of that population is infected with the virus. In El Salvador, that figure reaches 18 percent (UNAIDS 2006). In most cases, this population group reported having female sexual partners as well. Although significant gains have been made in terms of access to treatment in countries such as Argentina, Brazil, Chile, Costa Rica, Mexico, Panama, Uruguay, and Venezuela, poorer countries in Central America and those in the Andean region have struggled to expand treatment access in the face of persistent barriers to affordability (UNAIDS 2006).

In Mexico, the estimated rate of people who live with HIV is less than 2 per 1,000 inhabitants (approximately 160,000 people), of whom 90,043 have been diagnosed with AIDS.² The rate is four times greater in men aged twenty to forty-four, for whom sexual transmission represents 91 percent of total infections, compared with 55.6 percent for women. The rate of infection has been growing in rural areas, with a significant increase also in the proportion of women (Cáceres 1999; Barclay 2008). This is closely related to the growing rate of infection among legal and illegal migrants and residents of Mexican origin in the United States, who often go back to their communities and infect their female partners (González-Block and Liguori 1992; Rangel et al. 2006). The rate of infection among drug users represents less than 0.7 percent of those infected.³

In the present analysis, I focus on the case of sexual minorities, and gay men and MSM more specifically, for the following reasons. First, greater attention to this historically discriminated sector of the population is well overdue, especially because political science analyses of Mexico have not shown much interest. Second, this population continues to be most affected by the pandemic, which has resulted in increasing activism and visibility of sexual minorities as a whole, both nationally and regionally. Finally, although I have a deep personal and professional interest in extending my analysis to other population sectors, women's HIV/AIDS activism, for example, is a relatively more recent phenomenon and has been the focus of other scholars' attention (Herrera and Campero 2002; Rico et al. 1997).⁴

2. The Ministry of Health regularly registers and updates the number of cases on its Web site (<http://www.ssa.gob.mx>).

3. See the Web site of the Secretaría de Salud, at <http://www.ssa.gob.mx>.

4. There is also a growing body of research on the factors affecting female sexual workers and their mobilization. See, e.g., Allen et al. 2003; Uribe et al. 1995.

A POLITICAL AND HUMAN RIGHTS APPROACH TO HIV/AIDS

In general, the pandemic has accentuated the main problems associated with poverty, poor health-related infrastructure, marginalization, discrimination, human rights violations, and lack of democratization (Farmer 2003; Whiteside and FitzSimons 1992). Until recently, there had been little primary research on the links between HIV/AIDS and politics, particularly for Latin America. Yet there is increasing attention to those links, and widespread speculation about how democracy and related factors—such as good governance, social cohesion, and a strong civil society, as well as the absence of violent conflict—can help slow the HIV/AIDS epidemic and minimize its impact (Manning 2002; Ostergard 2007; Willan 2000). It has been argued that a fair legal system, transparent government institutions, and respect for human rights would help reduce stigma and increase policy responsiveness, thus aiding prevention and human security more generally (Ostergard 2007; UNAIDS 2008; Whiteside and FitzSimons 1992). At a more speculative level, it has also been argued that commitment by top political leaders to addressing the epidemic is more likely in a democracy with an active and free press (Patterson 2000), drawing some parallels between HIV/AIDS and famines, which, the development theorist Amartya Sen (1981) has argued, do not occur under such conditions.

Yet, with some more closely studied cases, conclusions regarding the links between the democratic character of a state and the actual governmental policies and results concerning HIV/AIDS prevention and treatment are not so clear (for analyses of sub-Saharan Africa, see Goyer 2001; for insights into Uganda and South Africa, see Morisky 2006; Thornton 2008). In the Americas, for example, Cuba is an often-cited case. Mandatory confinement of HIV carriers and compulsory HIV testing characterized the often-controversial beginnings of Cuba's approach. Although most regarded this as an authoritarian approach and source of human rights violations, the practices did help contain the pandemic. Today, Cuba serves as an example of a strong commitment by the state to the health and protection of all its citizens, including sexual minorities, with successful results (Leiner 1994; Lumsden 1996; Smallman 2007). In contrast, the cases of Brazil and Mexico serve as examples of the positive correlation between democracy—or democratization—and more effective and responsive HIV/AIDS policies. In both countries—and as I discuss herein in more detail for Mexico—the positive changes in the state's approach to the pandemic are part and parcel of the democratization process and the mobilization of civil society experienced over the past few decades (Frasca 2005; Smallman 2007).

For its part, a human rights approach to sexual health for all, including sexual minorities, has been at the center of the fight against the pandemic,

both globally and locally. Sexual health has been defined as a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity.⁵ The right to sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of pleasurable and safe sexual experiences, free of coercion, discrimination, and violence (Asher 2004; Chen, Leaning, and Narasimhan 2003). Thus, successful promotion of sexual health requires a comprehensive program of activities that encompasses the health and education sectors, as well as the broader political, economic, and legal domains.

The entitlements created by a human rights approach to health lead to governments' corresponding obligations and resetting of priorities. As a result, governments find it far more difficult to justify the withholding of basic provisions and services on account of alleged financial constraints or because of certain (often discriminatory) priorities. A central advocacy principle for civil society groups or nongovernmental organizations (NGOs) with a human rights approach to health is that governments are accountable for their obligations under international law and within the framework of national constitutions and legislation. This entails ensuring the incorporation of international treaty provisions into domestic legislation and the access of individuals and communities to effective judicial or other appropriate remedies in the face of violations of their rights.

In summary, the right to health has empowered civil society groups that are politically engaged in the fight against HIV/AIDS. Ultimately, under a human rights approach, becoming healthy and remaining so is regarded not merely as a medical, technical, or economic problem but also as a question of social justice and concrete government obligations.

HEALTH AND HIV/AIDS IN A GLOBALIZED CONTEXT

Scholars have defined HIV/AIDS as a prime example of a truly global concern, in terms of both its spread and the responses to it (Altman 2001; Fidler 2003; Whiteside and Barnett 2002). Thus, given my interest in underlining its global dimension, I distinguish *globalization*, defined as the process of universal, multifaceted interconnectivity, from *neoliberal globalism*, or the ideology of neoclassical economic prescriptions known as the Washington Consensus.

Defining neoliberal globalism as a political agenda helps us recognize the undercurrent of ideological commitment to market sovereignty that infuses the discourse generated by such leading international financial and economic institutions as the International Monetary Fund (IMF),

5. Definition drafted by the Technical Consultation Committee on Sexual Health of the World Health Organization, in January 2002.

the World Bank (WB), the U.S. Treasury, the World Trade Organization (WTO), and other powerful global actors, most particularly transnational corporations (TNCs) (see Howse and Nicolaidis 2003). Although I conceive of the international arena as a heterogeneous constellation of interwoven political, cultural, and economic interests, I take it as established that the globalist agenda has steered the phenomenon of globalization for the past quarter century.

By *globalization*, I refer to the ongoing and accelerating cultural, economic, political, social, and technological interconnectedness that characterizes the world today (see Giddens 1990; Held et al. 1997, 1999). What is characteristic of this set of circumstances, which Castells (1996) calls the age of the network, is that localization of polity has paralleled the globalization of some issues. In other words, we are witnessing the participation of civil society groups locally and increasing activism globally.

Globalist policies, such as privatization and pressures to reduce the role of the state, have resulted in the underfunding of public services and the subsequent negative impact on health-care service delivery. In addition, the predominance of the global market economy, in which pharmaceutical companies operate, has meant relative neglect for the “unprofitable” developing-world diseases, such as malaria and several other mainly tropical diseases. For diseases that have long been treatable and for which there are effective remedies off-patent, governments have been able to meet many of their essential-medicines needs through the availability of generic products at competitive prices. However, the WTO recently moved to extend patent lifetimes, and recent years have also witnessed the emergence of new or more resistant diseases like AIDS, which requires new drugs such as antiretrovirals (ARVs). As a consequence, the expense of the new and patented products has made it more difficult for governments in relatively lower-resource countries to provide adequate supplies of essential medicines in accordance with human rights obligations.

As expected, the challenges the globalist agenda imposes have not gone unnoticed. The negative impact of international trade regimes on the right to health has been the subject of much international attention, debate, and NGO advocacy for a couple of decades now (Ostergard 2007; Tarabusi and Vickery 1993). As a consequence, exceptions have been introduced to certain trade rules in favor of human rights protection. For example, the Brazilian government led the way in the struggle for access to treatment. As early as November 1996, the same year in which new ARV drugs were launched at the International AIDS Conference in Vancouver, a law came into effect that gave HIV-positive people the right to free medications through the public health system. Brazil's government was then determined to produce generic versions of ARVs to meet its commitments (Smallman 2007). As expected, there was intense opposition to its efforts to break international patents to make generic medications more

affordable, which drew the country into confrontation with pharmaceutical companies and the U.S. government. The increasing international attention and support from various intergovernmental and international civil society actors—including the UN Human Rights Commission and Médecins sans Frontières (MSF), among others—for the efforts of a growing network of Brazilian NGOs (originally of the gay community) in concert with their government, resulted in the U.S. government's retraction of a complaint filed with the WTO in the summer of 2001 (Frasca 2005). As such, the Brazilian success story can be understood only in the global context; it represented a key policy lesson to be replicated by other countries in Latin America and beyond.

In fact, countries such as Thailand and South Africa in other regions followed suit. As a result of the sum of these countries' actions, the WTO's agreement Trade-Related Aspects of Intellectual Property Rights (TRIPS) protects international patents in favor of TNCs and contains provisions for bypassing patent restrictions in situations of public emergency. This aspect of TRIPS became a central point of focus between 1997 and 2001 in the highly publicized case between thirty-nine pharmaceutical TNCs and the South African government, which threatened to violate ARVs' patents. As a result of lobbying by international civil society organizations, there was the significant, formal clarification that public health emergencies could be invoked to bypass certain patent restrictions under TRIPS (personal interview with the former MSF president James Orbinsky, Toronto, April 28, 2004). This led to the adoption in 2001 of the Declaration on the TRIPS Agreement and Public Health at the Fourth Ministerial Conference in Doha (the Doha Declaration) (WTO 2001).⁶ The Doha Declaration recognizes that patents can impede access to affordable medicines and affirms that governments are free to take all necessary measures to protect public health in medical emergencies. As such, this major breakthrough in compulsory licensing represented a clear victory for countries like Thailand, South Africa, and Brazil, and it enabled others to implement similar policies. By 2002, other countries in Latin America, such as Argentina, Costa Rica, and Uruguay, had adopted national policies of providing free medication for all HIV/AIDS patients (Smallman 2007).

Overall, in international policy debates, universal access to health care and affordable drugs seems to be at odds with the globalist ideology, such that the orthodoxy of privatization exists alongside the growing recognition of the need to pay a closer look to the links among social justice, human rights, economics, human security, and health (Daniels, Ken-

6. This was facilitated by the fact that in the wake of the anthrax attacks in the United States, the Canadian and U.S. governments threatened to violate patents themselves on an anthrax antidote to get an affordable price.

ned, and Kawachi 1999; Kapstein, qtd. in Kaul, Grunber, and Stern 1999; Ostergard 2007).

A POLICY NETWORKS (PN) APPROACH TO HIV/AIDS POLITICS

As shown in the case regarding access to more affordable ARVs, globalization represents an opportunity for the strengthening of links among civil society actors across borders, which has resulted in increasing HIV/AIDS and human rights advocacy and closer monitoring of states' policies. In fact, taking advantage of these new opportunities, NGOs have formed national, regional, and international networks and have mobilized public opinion and activism on social and human rights issues to an unprecedented degree (Keck and Sikkink 1998; Eckstein and Wickham-Crowley 2003).

The types and nature of the linkages being established between domestic and international actors in the case of HIV/AIDS point to the emergence of a new dynamics, which goes beyond the more dichotomous division between the domestic and the international characteristic of the international relations literature (Evans, Jacobson, and Putnam 1993; on the concept of interdependence, see Keohane and Nye 1977; on the second image reversed, see Gourevitch 1978). This new environment is giving rise to complex processes of international lesson drawing, policy convergence, policy diffusion, and policy transfer. It is against this backdrop, which I also refer to as a new set of internationalized policy environments, that I adapt the concept of policy networks to the Latin American reality to facilitate the analysis of HIV/AIDS policies in Mexico.

I define policy networks (PN) as permeable clusters of interdependent organizations and individual actors (public and private), with frequent interactions and a common interest, connected to one another by resource dependencies, with a core and a periphery, whose members participate in the formulation and implementation of a set of policies. This definition draws from the works of various scholars (Coleman and Perl 1999; Hassenteufel 1995; Jordan 1990; Marsh and Rhodes 1992; Teichman 2001) and from previous efforts to understand the changing international environment, characterized by porous national-level health policy making and the presence of actors and forces that cross over state borders. For the health sector, Walt (qtd. in Merson, Black, and Mills 2001), for example, extended pluralist theory to the international level in her analysis of international health PNs. Thus, in the context of internationalized policy environments, the use of network analysis is a promising avenue for explaining policy changes induced by globalization. For the case of HIV/AIDS, the PN is a conceptual construction that helps describe a set of formal and informal relationships among various actors. It represents a

web, the core of which is defined by institutions and individuals situated in positions of decision-making power, most often, but not exclusively, represented by HIV/AIDS programs and public officials at the national and international levels, as well as some civil society organizations and individuals. For its part, the network's periphery represents those HIV/AIDS NGOs, other groups, and individuals that keep the core accountable and responsive to the concerns of the policy community at large.

In adopting a PN approach, although it does not represent an entirely new analytical framework, it does help soften the opposition between pluralism and corporatism, placing them at the two extremes of a spectrum (Hassenteufel 1995). In fact, Marsh and Rhodes (1992) argue that increasing interest in PNs is partly due to the limitations of the pluralist and corporatist models, or the state- and society-centered approaches, and the fact that it facilitates the study of varying relations between government and interest groups across different policy areas.

HIV/AIDS POLICY NETWORKS (PN) AND THE MEXICAN CASE

On the basis of the following discussion of both international and the Mexican response to the pandemic, it is clear that the convergence of a diverse set of actors, all working together against the pandemic, has been critical to the establishment of a more inclusive and responsive official national HIV/AIDS program.⁷

The International Dimension of the HIV/AIDS PNs

In Latin America, the emergence of HIV/AIDS in the 1980s coincided with the ending of military or authoritarian rule and civil society's challenging of old political structures. The increased engagement of Latin American civil society occurred in many areas, such as the environment, women's rights, and human rights more broadly defined (Friedman, Hochstetler, and Clark 2001), and reflected increasing civil society participation in public life in the 1980s and 1990s (Chalmers and Piester 1996; Oxhorn and Ducantzenzeiler 1998). In this context, beyond electoral participation, the politics of policy making, as in the area of HIV/AIDS, can reveal more about the nonelectoral dimensions of democratization.

The increasing engagement of civil society actors is also partly explained by the fact that, in the 1990s, major donors broadened their focus on NGOs and began funding a more diverse group of civil society groups.

7. In contrast, financing of health-care PNs is characterized as less inclusive, with a relatively small and tightly integrated group of policy makers, technical advisers, and scholars who define the content and process of policy reform (Lee and Goodman, qtd. in Merson et al. 2001).

As a consequence, an important number of HIV/AIDS NGOs were formed and received a steady stream of funding from international agencies. Yet this increasing interest in the promotion of NGO activities responded also to one of the central elements of the globalist agenda: the insistence on less government and reduced public budgets. In this regard, much has been said about the “NGOization” of social movements and the consequences this can have for the weakening of their autonomy and their causes (Alvarez, Dagnino, and Escobar 1998; Yúdice 2003).⁸ However, as I will discuss below, despite those risks, the close collaboration required between governmental and nongovernmental actors around the pandemic has had positive outcomes, with successful initiatives around human rights issues being brought forward, some of which go well beyond the more narrowly defined goals of HIV/AIDS policies.

It is under such circumstances of state and civil society engagement with international actors in the fight against HIV/AIDS and the protection of human rights, or the internationalized policy environment, that international and national HIV/AIDS PNs emerged. Intergovernmental institutions have played a key role in this process by working closely with both state programs and civil society organizations. It was in this context that, on July 26, 1994, UNAIDS—a joint and cosponsored UN program on HIV/AIDS—was established to provide an internationally coordinated response to the pandemic.⁹ As such, UNAIDS is guided by a program coordinating board (PCB) as its governing body. The PCB has representatives of twenty-two governments from all regions of the world; the seven UNAIDS cosponsors (UNICEF; UN Development Programme; UN Population Fund; UN International Drug Control Program; UN Educational, Scientific, and Cultural Organization; the World Health Organization; and the World Bank¹⁰); and five NGOs (which rotate yearly), including associations of people living with HIV/AIDS. It is important to note that UNAIDS was the first UN program to include NGOs in its governing body.

At its creation, Peter Piot, who had previously been president of the International AIDS Society (IAS), was appointed UNAIDS executive director and UN undersecretary-general. He came to the position as a distinguished academic and scientist, with a long career focusing on AIDS and women’s health in countries of the global South. As a scientist, manager, and activist, Piot has constantly challenged world leaders to view

8. “NGOization” refers to the process in which a new set of professionalized advocacy actors entered the public sphere with an emphasis on professional communication and planned action, transnational networking, and local agenda setting.

9. The first HIV/AIDS WHO program was the Special Program on AIDS (1986), which became the Global Program on AIDS (GPA) in 1987 and UNAIDS in 1994.

10. The World Bank has committed increasing resources for HIV/AIDS projects worldwide; however, its commitments in this area are often considered at odds with its global requests for systematic health care reforms such as privatization.

the pandemic in the context of social and economic development as well as human rights and human and national security. Under his leadership, UNAIDS has become the chief advocate for worldwide action against AIDS and very quickly moved to occupy a central position at the core of the international HIV/AIDS PN. Furthermore, in the opinion of most members of the policy community at large, Piot's personal support is behind the increased attention to combating discrimination and the implementation of prevention campaigns among MSM worldwide (interviews with several HIV/AIDS activists and public health officials at regional and World AIDS conferences, Rio de Janeiro 2000, Havana 2003, Toronto 2006, Mexico 2008).

For Latin America, international cooperation has represented a fundamental tool in the construction of national responses to HIV/AIDS. Throughout the region, international agencies, such as UNAIDS, the World Bank, and the Pan-American Health Organization (PAHO), have been developing collaborative efforts with national HIV/AIDS programs and establishing partnerships with local and national civil society groups (Child 1999; II Foro 2003; I Fórum 2000). Yet the increased economic resources from international institutions have also been a source of difficulties and, as discussed later here in Mexico's case, sometimes led to bitter divisions among civil society groups (Roberts 1995).

Among the NGOs at the international level, IAS is a key actor that, together with UNAIDS, is at the core of the international HIV/AIDS PN. It brings together the scientific community and most other actors involved in the fight against the pandemic, and it is in charge of the organization of the biannual world AIDS conferences. Other transnational civil society organizations, such as ACT UP (an activist group formed in New York in 1987 to advocate for access to HIV/AIDS treatments), AIDS Alliance, Global Network of Positive People, International Council of AIDS Service Organizations (ICASO) and its Latin American office LACCASO, International Lesbian and Gay Association, and regional and local groups (e.g., Latin American League of People Living with HIV/AIDS), have actively engaged in formulating responses to the disease. For instance, active pressure from some members of the Latin American League on the World Bank, the WHO, and UNAIDS officials, at the First Regional Conference in Rio de Janeiro in 2000, resulted in the firm commitment to fund prevention campaigns among MSM in Latin America, including Mexico (personal interviews with various HIV/AIDS activists in Rio de Janeiro, 2000). Overall, the creation of this international PN allowed HIV/AIDS policy making to become an issue that was not just left to the scientific and policy experts but also that includes most members of the broader policy community with multiple communication channels and cooperation mechanisms among them.

A telling example of the close links between the international and Mexican sides of the HIV/AIDS PN was the creation of ICASO, which has been a member of the UNAIDS PCB and has served as a coordinating body and permanent liaison for civil society groups (ICASO 1997). ICASO was founded in Paris in December 1989 by representatives of civil society groups from several countries, including the Mexican activist Arturo Díaz Betancourt (a member of the HIV/AIDS NGO and sexual-health news agency *Letra S*, which publishes a monthly supplement on sex, society, and AIDS in *La Jornada* national newspaper). Since the mid-1980s, Díaz Betancourt has been very active in the area of human rights and discrimination against sexual minorities in Mexico; in that same year, together with Francisco Galván (from the HIV/AIDS NGO *Ave de México*), he coorganized the first in a series of national meetings of NGOs working on HIV/AIDS (Galván Díaz, González-Villarreal, and Morales 1991). After the assassination of Galván in 1992, presumably motivated by homophobia (Del Collado 2007), Carlos García de León Moreno, recently appointed a member of the AIDS national program, was appointed president of *Ave de México* and became Mexico's liaison to ICASO.

In Mexico, as in Brazil, national meetings have been fundamental in building a national network; from the start, they received significant support from external aid. In fact, donor agencies pushed for broad-based coalitions, which in the case of Mexico eventually became Mexicans against AIDS, formed in July 1989 and headed by Díaz Betancourt. At the beginning, their work focused mainly on lobbying for the human rights of HIV/AIDS patients and sexual minorities and on supporting free testing and promotion of HIV education programs. Unfortunately, according to some critics, this coalition of fifteen NGOs worked fairly well as a political bloc to denounce government inaction, but it was too critical; by definition, anything coming from the government was useless (Frasca 2005). Eventually, competition for external funds and other disagreements resulted in internal divisions and resentment, which led to the coalition's collapse (Frasca 2005). This was, perhaps, also a result of forced union among disparate groups (personal interview with José Antonio Izazola, former head of the Regional AIDS initiative for Latin America and the Caribbean, the World Bank initiative for the control of AIDS and sexually transmitted diseases, hosted by the Mexican foundation FUNSALUD, and current head of Centro Nacional para la Prevención y el Control del VIH [CENSIDA], November 27, 2001; interview with Anuar Luna, of *Colectivo Sol*, December 12, 2001). As a consequence, as stated by *Ave de México's* Ninel Díaz (Frasca 2005), international funders blacklisted Mexico for some years, after it had been the poster child of NGO cooperation.

Eventually, as is discussed in the following section, hope for NGO-government collaboration and renewed external funding came from

abroad, in the form of policy learning and diffusion based on the Brazilian experience. In 1993, Brazil was the recipient of a major AIDS loan funded by the World Bank, which allowed the country to purchase the necessary health infrastructure to create a more effective national program, including the aforementioned universal treatment coverage. A receptive international climate and funding from abroad proved critical to the survival and growth of many civil society organizations, with some, such as the Associação Brasileira Interdisciplinar de AIDS (ABIA) excelling at being cosmopolitan, receiving financial and technical support from various external sources (Smallman 2007). The success of the Brazilian AIDS policy led to its integration into Brazil's foreign policy, with more than forty countries now having set up exchanges to learn from it (Smallman 2007).

The Domestic Dimension of the HIV/AIDS PN

Domestically, there has been a major improvement in the official response to a wider array of concerns and the incorporation of various groups into the elaboration of Mexico's national HIV/AIDS policies. I argue that the slow but steady constitution and strengthening of the international and domestic PN explains this transformation.

In February 1986, under Guillermo Soberón's supervision (President Miguel de la Madrid's Secretary of Health¹¹), the Mexican government created the National Committee for the Prevention of AIDS (Consejo Nacional para la Prevención y el Control del SIDA, or CONASIDA), which was the first official effort to respond to the pandemic at the national level (Sepúlveda et al. 1989). In 1988, before leaving office, de la Madrid decreed a new and higher status for the committee, transforming it into the National Board for the Prevention and Control of AIDS.¹² Under Carlos Salinas de Gortari's administration (1988–1994), despite the fact that CONASIDA received more federal resources because of its new status, most of its operations continued to be carried out with international financing from various organizations, including the WHO's Global Program on AIDS (Saavedra et al. 1999). In its early years, CONASIDA did not incorporate or consult any civil society actors and thus was not very responsive to the actual needs of those affected by the disease.

Under Salinas's administration, human rights became a major issue for both Mexico and its neighbors during the North American Free Trade Agreement (NAFTA) negotiations. Despite Mexico's 1981 ratification of main international and regional human rights treaties, Mexico had a rep-

11. As part of president de la Madrid's administration health reforms, the government launched a major decentralization process with long-lasting consequences (Torres-Ruiz 1996).

12. *Diario Oficial de la Federación*, August 24, 1988.

utation for a culture of impunity regarding human rights violations. Thus, increasing domestic and external pressures led the Mexican government to create the National Human Rights Commission (Comisión Nacional de Derechos Humanos, or CNDH) in 1990. The CNDH, however, has played a limited role in reducing the number of human rights violations, primarily because it is not vested with the power to prosecute violators, and most recommendations handed down by the CNDH have been only partially implemented. In this context, concerns about HIV/AIDS-related human rights violations became the point of increasing pressure from the HIV/AIDS PN. Together with international pressure, this led to the introduction of new HIV/AIDS legislation. Under President Ernesto Zedillo Ponce de León (1994–2000), the Official Mexican Regulation for the Prevention and Control of Infection by the Human Immunodeficiency Virus (Norma Oficial Mexicana para la Prevención y Control de la Infección por Virus de la Inmunodeficiencia Humana) went into effect on January 17, 1995. This law represented a concerted effort by Mexican authorities to address the HIV/AIDS epidemic within the parameters of the right-to-health guarantees enshrined in Mexico's constitution (González-Martin 1996). This forward-looking legislation was partly the result of cooperation among a wide array of societal actors, including seventeen governmental bodies and nineteen NGOs.

In 1997, Zedillo strengthened CONASIDA by giving it the status of a decentralized body of the Ministry of Health. Later, and as part of Zedillo's decentralization reforms in the health sector, state-level councils were also created (Consejos Estatales para la Prevención del SIDA, or COESIDAS). Since Zedillo's final year in office—and the last year of federal rule by the Partido Revolucionario Institucional (PRI)—that reforms to the HIV/AIDS program have increasingly reflected the emergence and strong positioning of the PN. In addition, as was the case for Brazilian NGOs, the introduction of ARVs at the 1996 AIDS Conference in Vancouver represented a turning point for the renewed collaboration among civil society groups in Mexico. Followed by a major protest in Mexico City, during a conference of epidemiologists in 1997, these events marked the beginning of an effective drug-access advocacy campaign, thus revitalizing the movement and creating a more cooperative spirit (Frasca 2005). A stronger human rights discourse, a less confrontational style of civic activism, and the relative decline of the PRI seem to have united forces (personal interview with Alejandro Brito, of Letra S, December 5, 2001). Drawing lessons from the Brazilian case, between 1999 and 2000, for instance, a major World Bank loan with a substantial HIV/AIDS component was negotiated with the direct involvement of civil society organizations. Silvia Panebianco (of the HIV/AIDS NGO called MEXSIDA), José Antonio Izazola (of SIDALAC), and Díaz Betancourt (of Letra S) worked together on the proposal for the HIV/AIDS content of the loan. This important step in the greater inclusion

of civil society actors in policy making was part of the democratization process and a sign of the increasing strength of the HIV/AIDS PN.

More recently, a significant restructuring of the national program further strengthened the PN's participation. In July 2003, under President Vicente Fox Quezada (2000–2006, of the Partido Acción Nacional), CONASIDA became the collegiate body of coordination (i.e., *órgano colegiado de coordinación*), formed by the Secretaries of Health and Education, the directors of the two main social security institutions (Instituto Mexicano del Seguro Social [IMSS] and Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado [ISSSTE]) and the National Institute for Nutrition and Medical Sciences (Instituto Nacional de la Nutrición). Its new mandate is to strengthen cooperation and coordination among public entities for the prevention and control of HIV/AIDS and other sexually transmitted diseases.¹³ According to these reforms, the functions previously assigned to CONASIDA are now the responsibility of CENSIDA. Thus, CENSIDA not only continues to perform the same functions assigned to CONASIDA before; its director general also functions as technical secretary of CONASIDA (as established in article 46 of the respective decree¹⁴).

The appointment of Dr. Jorge Saavedra as CENSIDA's new director in September 2003 was of major significance for strengthening of the HIV/AIDS PN. The appointment of Saavedra—an openly gay academic, activist, and public official living with HIV, with long experience in HIV/AIDS work and MSM issues and former manager of the previously mentioned World Bank loan—resulted from consultation with the broader policy community. In the eyes of most members of the PN, he had the expertise and legitimacy required for the position, which resulted in their full support for his designation. After the most recent federal election of August 2006, in which Felipe Calderón Hinojosa entered office, Saavedra was confirmed in his position and remained as head of the program until recently. In February 2009, he was replaced by José Antonio Izazola, who was involved in negotiating the WB loan and had joined the Secretary of Health in 1985. As an expert in public health and also openly gay, from the beginning, Izazola worked hard to convince decision makers to pay attention to the epidemic, in what he described as a macho government structure that made it hard to convince authorities to act against a disease that affected MSM (Frasca 2005).

Among some of these recent appointments, Carlos García de León, of Ave de México, took his new position as CENSIDA's director of prevention and social participation. García de León had worked with Díaz Batacort and CENSIDA authorities to create the Department for NGOs, putting together for the first time a national database of all civil society

13. *Diario Oficial de la Federación*, July 5, 2001.

14. *Diario Oficial de la Federación*, May 15, 2003.

organizations working on this issue. As such, Ave de México, MEXSIDA, Letra S, and others found themselves, together with CENSIDA, at the core of the domestic network. This has allowed them to play a central role in the strengthening and functioning of the network as a whole and in the definition and implementation of recent policies, such as prevention campaigns among MSM, campaigns for access to treatment, and campaigns against homophobia. For its part, Letra S, under the direction of Alejandro Brito, has also played a central role in consolidating a freer press that pushes for increased transparency and government responsiveness.

Another positive and significant step has been the increase in the public budget devoted to treatment and prevention. In 2002, for example, the National Congress approved a budget of MEX\$9,914,456 for prevention and MEX\$39,098,047 for treatment, whereas the approved amounts for 2003 were MEX\$11,062,637 and MEX\$372,435,237, respectively (*Letra S*, in *La Jornada*, October 7, 2004). As late as 1994, the federal government had vowed “zero funding” for AIDS treatment. For Mexico, in contrast to Brazil, NAFTA meant that the generic solution was out of the question (Torres-Ruiz and Clarkson 2009). Yet because of persistent pressure from members of the HIV/AIDS PN, and a more receptive secretary of health (Dr. Julio Frenk), Fox’s government committed to universal treatment coverage for all HIV/AIDS patients by the year 2006, reaching the goal—in terms of resources available for the implementation of such program—three years earlier. This was possible through the creation of the Fund for Catastrophic Health Expenses (part of the corresponding reforms to the General Health Law).¹⁵ In addition, and as a result of global pressure on the pharmaceutical industry, there was a reduction in ARVs prices; Merck Sharp and Dohme, for example, lowered the price of one of its AIDS drugs by 82 percent. This contributed to a decrease in the cost of individual treatment per year from US\$9,000 in 2000 to about US\$5,000 in 2003 (*Notiese*, June 25, 2004). Yet there are still concerns regarding the persistently high prices of medications in Mexico, which in some cases are up to 30 times higher than in other countries with a similar level of per capita GDP (*La Jornada*, June 17, 2008).

Although the aim is to reach all those who need and want to be treated, to this day, not all patients have access to treatment. Because of lack of a proper health infrastructure and distribution problems, of the 90,043 registered cases of AIDS, only 28,600 have access to ARV treatment. Of those, IMSS treats 13,303 patients, the Secretary of Health treats around 8,304, and ISSSTE treats about 2,388 (the remainder are treated privately). Even in the case of IMSS and ISSSTE, which are committed to providing treatment to all their respective affiliates, there are reports of lack of availability of ARVs and other drugs needed for to treat HIV/AIDS patients

15. *Diario Oficial de la Federación*, May 15, 2003.

at some clinics (various confidential interviews with activists and people living with HIV/AIDS, Mexico City, 2001–2008).

Mexican public authorities have actively engaged with other governments in the struggle against the pandemic. For instance, Mexico joined other countries in Latin America as part of the Grupo de Cooperación Técnica Horizontal, which brings together all national HIV/AIDS programs to coordinate activities and share experiences.¹⁶ Furthermore, from 1998 to 2000, Mexico's government held the presidency of the governing council of UNAIDS (*Letra S*, in *La Jornada*, June 1, 2000). At a regional meeting in Panama, and as recognition of some of Mexico's recent efforts and policies about the pandemic, the country's health authorities were elected as representatives for Latin America in the Global Fund for Malaria, Tuberculosis, and HIV/AIDS by fourteen governments and six NGO networks (*Notiese* 2003). More recently, and with international support, Mexico City was designated host of the 2008 International HIV/AIDS Conference. This increased the attention of the world community on Mexico's performance in this area and raised expectations both domestically and internationally.

In summary, the formation of the HIV/AIDS PN has represented a very important shift in the policy-making process. Not only did civil society members of the PN participate between 1999 and 2000 in negotiating and drafting of a major World Bank loan; they also have worked intensely and with some success to reduce the price of ARVs and to extend treatment coverage. As discussed in the following section, they have also succeeded in their efforts to press the government to legislate against discrimination based on sexual orientation and health status.

Successes and Challenges Regarding Human Rights

A central element of an effective response to HIV/AIDS is the adoption of domestic legislative measures to guarantee individuals and communities access to effective judicial or other appropriate remedies in the face of human rights violations concerning their sexual health and/or sexuality. However, in Mexico, persistent problems in the administration of justice and the impunity of violators confirm the often-argued disconnect between the law and its observance (Panebianco 2000; Reding 1995). It must be acknowledged, however, that with increasing social pressure, some gains have been made in improving the country's legal framework for combating discrimination based on sexual orientation and HIV status, especially at the federal level and in the Federal District (Mexico City). These include the aforementioned creation of the CNDH and the National Council to Prevent Discrimination (Consejo Nacional para Prevenir la Discriminación, or CONAPRED), on July 11, 2003, with the appointment

16. See SIDALAC's website at <http://www.sidalac.org.mx>.

of long-time activist and respected political figure Gilberto Rincón Gallardo as president until his recent death.

The pressures from various human rights groups and the HIV/AIDS PN has also resulted in new legislation, such as the 2003 Federal Law to Prevent and Eliminate Discrimination (*Ley Federal para Prevenir y Eliminar la Discriminación*). For its part, Mexico City's government introduced sexual orientation among the issues addressed in the July 2006 Law to Prevent and Eliminate Discrimination in the Federal District (*Ley para Prevenir y Erradicar la Discriminación en el Distrito Federal*), as well as the creation of the Council for the Prevention and Elimination of Discrimination in the Federal District (*Consejo para Prevenir y Erradicar la Discriminación en el Distrito Federal*) in October 2006. This council has a mandate and objectives similar to those of CONAPRED but with jurisdiction limited to the Federal District.

Related to these positive changes, in November 2006, the Federal District adopted the Law on Domestic Partnerships (*Ley de Sociedades de Convivencia*), which, though limited in its scope, allows for legally recognized unions between same-sex partners (*Notiese* 2006). Under this law, same-sex couples can register their union with authorities and are granted inheritance and pension rights, which are central to the protection of partners in case of ill health and death. However, the law applies only in the Federal District, and does not include other rights, such as the right to adopt children.¹⁷ A similar and more ambitious law was approved three months later by the legislature in the state of Coahuila (Del Collado 2007).

Despite the official commitment against homophobia-driven crimes by public authorities, there is a growing concern regarding impunity. Discriminatory attitudes against HIV/AIDS patients and homophobic crimes have been extensively documented (González-Ruiz 2002; Del Collado 2007; Panebianco 2000). For instance, according to statistics from the CNDH, more than 570 HIV/AIDS-related complaints were lodged with the commission between 1992 and 2006. The complaints centered on issues associated with homophobia and stigma, such as the alleged denial of adequate health services or medication for HIV/AIDS patients, acts of discrimination or negligence by medical personnel, and violations of confidentiality. Subsequently, the CNDH issued several recommendations to state and federal institutions, including hospitals, prisons, and educational facilities, requesting that they improve services for persons with HIV/AIDS. Most of the victims of human rights violations were MSM.

A civil society response to this reality was the creation of the Citizens' Commission against Homophobic Hate Crimes (*La Comisión Ciudadana*

17. More recently, the Federal District's local assembly voted 39–20 (on December 21, 2009) in favor of same-sex marriage, including the right to adopt, triggering a strong reaction from the Catholic Church and other conservative groups.

contra los Crímenes de Odio por Homofobia, or CCCCOH), on May 6, 1998 (Del Collado 2007). Unfortunately, there has been a lack of reliable statistical information on the level of discrimination against homosexuals in Mexico. However, in August 2005, CONAPRED presented a survey prepared jointly with the federal Secretary for Social Development (SEDESOL). The study was based on 1,482 interviews with members of the general public and 200 self-identified homosexuals.¹⁸ According to the study, 94.7 percent of Mexican homosexuals face some degree of discrimination. Díaz Betancourt, who at the time was coordinator of programs on discrimination based on sexual orientation at CONAPRED (also involved in the negotiations of the World Bank loan mentioned previously), noted that negative public attitudes against homosexuals and HIV/AIDS patients persist, particularly in smaller urban centers and in rural areas (personal interview with Arturo Díaz Betancourt, Mexico City, September 10, 2002).

As a response to CONAPRED's survey results and the coordinated efforts of the HIV/AIDS PN, the right-of-center federal government of Fox launched a national radio campaign against homophobia in 2005. The campaign, which was very explicit and challenged traditional conceptions, was organized by CONAPRED and CONASIDA, with full support from the national Ministry of Health and financial support from PAHO and UNAIDS (*La Jornada*, March 23, 2005; for a transcript of the actual campaign, see also Saavedra 2007a, 2007b, and Appendix 1 here). The very launch of the campaign points to the surprising effectiveness of the PN to work within a PAN administration, given that, in the case of Mexico, sexual minorities seem to have traditionally benefited from their alliance to and participation in a more progressive political front (De la Dehesa 2007). In a way, and paraphrasing Alejandro Brito, the construction of the PN and collaboration with the government might be considered a sign of maturity and tolerance on all counts (Frasca 2005).

CONCLUDING REMARKS

The links among the state, UN agencies, and NGOs described herein feature a new type of partnership, both global and local. The evidence presented here also reveals how various civil society members of the HIV/AIDS PN are firmly positioned at the core of the policy domain, which explains the relative continuity in policy formulation and implementation, which had not been possible under Mexico's one-party PRI regime and prevailing exclusionary policy-making process. Thus, the analysis of the PN shows how effective responses to the pandemic are rooted in the

18. The data here come from various reports dated August 2005 available at the Web site of CONAPRED (<http://www.conapred.org.mx>).

local context and critically engaged with national and international policies and practices. As in other countries, in the current global context, the confluence of grassroots organization and external funding, with expertise from the international community, enabled NGOs to build a human rights approach to the pandemic and to support an invigorated public health response.

In contrast, the professionalization of sexual minority movements, or so-called NGOization, raises an important question: does it represent the co-optation of voices or the extension of democratic participation? To an extent, this question remains open. After all, critics say, by working together with government programs, the tension that should exist between the government and civil society, to keep governments accountable, can be lost. Or, according to Yúdice (2003, 77), although "NGOization is not scandalous," it can weaken the public sphere. However, to end with an optimistic note, in the case of Mexico, some NGOs and individuals in the HIV/AIDS PN have been able to strategically mobilize resources, thus prioritizing their own agendas and retaining their character and their advocacy for the legal recognition and enforcement of more broadly defined sexual minorities' rights.

APPENDIX 1: CONAPRED AND CONASIDA CAMPAIGN TRANSCRIPTS

SPOT 1: LA CENA

MADRE: Te ves muy enamorado m'hijito.

HIJO: Ay, sí, Mamá.

MADRE: ¿Y cuánto llevan?

HIJO: Ya cinco meses.

MADRE: ¿Y le gustó la idea de venir a cenar con la familia?

HIJO: Sí, le encantó, es más, preparó un postre que te va a fascinar.

MADRE: Espero que le guste lo que yo cociné . . . Por cierto, ¿cómo me dijiste que se llama?

HIJO: Óscar, Mamá, ya te lo había dicho, se llama Óscar.

VOZ DE LOCUTOR: ¿Te parece algo raro? La homofobia es la intolerancia a la homosexualidad, la igualdad comienza cuando todos reconocemos el derecho a ser diferentes. Por un México incluyente, tolerante y plural.

SPOT 2: PREGUNTAS

VOZ DE LOCUTOR: Si ves a un homosexual o lesbiana en la calle, ¿ves para otro lado? ¿Sientes ganas de ofenderlo o que desaparezca? Si una persona cercana a ti es gay, ¿le dejas de hablar? ¿Sientes odio por los diferentes a ti? ¿Sabías que lo que tienes es homofobia? es decir, un odio irracional." La tolerancia a la diferencia sexual es más sana que el odio. Por un México incluyente, tolerante y plural.

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