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Human Rights and Multi-level Governance

Migration and the Right to Health:
HIV/AIDS prevention among undocumented Central American migrants in Nuevo León, México

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If prejudice is a disease, being informed is the cure.

To all the people who look around them for a hand to
hold and companions to keep on walking with,
even if it is through an unknown country.

To all the people who look around them for company
and confidence to face any illness or condition.

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ABSTRACT

Migratory dynamics continue to evolve, the routes change and the destination is no longer only the United States; many migrants seek to settle in Mexico, especially in the northern border states of the country. This paper offers a theoretical, conceptual, contextual framework as well as a practical study to demonstrate that ensuring the Right to Health as a Human Right and providing HIV/AIDS prevention strategies at all phases of the migration process helps decrease migrants' HIV/AIDS risk. A cross-sectional study on Central American migrants (N=55) in Nuevo León, Mexico was conducted in order to evaluate their KAPs on HIV/AIDS as wella s their overall experience with the Mexican Health System. The results indicate participants with limited exposure to prevention messages as well as a lack of information related to their human rights hence, having inadequate knowledge regarding HIV/AIDS and manifesting negative attitudes towards PLHIV. Findings underscore how mobile populations build new cultural configurations provoking new political, economic and cultural structures in a transnational sense, forcing the Mexican State to open its eyes to this new dynamic and leading it to elaborate public policies on migration and human rights and a need for culturally adapted HIV/AIDS prevention programs.

Keywords: Human Rights, KAP, Right to Health, Migrants, HIV/AIDS, Migration

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FOREWORD

Maybe someday, hopefully, we will stop talking about poverty, violence or corruption, but we will hardly ever stop talking about migration. If we briefly review Mexico's migration history, we can remember a group of immigrants who left the north in the distant and mythical Aztlan to settle in the Valley of Mexico. Then, came three centuries of colonial history, from military conquest and spiritual conquest, but also of immigration that indelibly marked our present. When describing our independent Mexico, it can be noted that for almost a century and a half, Mexicans have been coming and going from the north of its neighboring country and approximately 12 million Mexicans already live on the *other* side and more than 30 million are Americans of Mexican origin. Likewise, it can be seen the other way around, nowadays almost one million North American children and young people who were deported or returned with their parents live in Mexico and are now binational.

It was known as circular migration, Mexican migrants came and went. Unlike other migrants arriving in the U.S., Mexicans had no interest in naturalization. They got jobs easily and just as easily left. Because of this, many employers did not consider them as immigrants, they were temporary, circular workers. However, all this was transformed. Transformed by an American policy, which has gone from one extreme to the other throughout the 20th century and so far in the 21st century. From opening to closing their borders, massively deporting and then calling the *braceros* to go to work in the U.S.

In 1986 an immigration reform legalized two and a half million Mexicans. There was an amnesty, giving them papers and a chance to stay and live permanently in the U.S. The intention of the reform was to assume the obvious, that they were needed but at the same time pretending that this measure would prevent the arrival of new immigrants in an irregular situation, which did not happen. After a century of tolerating and encouraging surreptitious crossing, it was impossible to stop it with a law or decree. Rather, the opposite occurred, an intense process of family reunification through legal and informal channels took place. Legalized parents brought their spouses and children whilst others married and formed families. These two and a half million amnestied in 1986 eventually became five million.

Time passed and another immigration reform in order to tighten controls took place. The construction of the wall along more than a thousand kilometers began, making it more costly and risky to cross the border surreptitiously. A dissuasive policy was expressly designed and at the same time that this type of migration was prevented, visas that permitted a legal alternative were being granted.

This policy of closure and border control did not work either. On the contrary, since it was more expensive and risky to cross the border, those who managed to cross stayed there. What happened? The circularity was broken. Migrants who came and went, now went and stayed. Something failed in our integration policy and consular registration projection. Why did we let them go? Why do figures and hard data elaborated by social scientists have almost no impact among politicians, but demagogy does? In sociology it is said that there are unintended consequences in many of the public policies that are designed and carried out. However, in a way, many could have been prevented.

Mexico is not only a country of emigrants with 11 million people living abroad, a reality not often recognized, but it has also always been a country of transit (even since 1905 when documents were found of Chinese and Japanese coyotes passing Chinese and Japanese through Ciudad Juarez). Today, however, Mexico's reality is as a country of a *massive* and problematic amount of people transiting to other countries, mainly the United States of America.

Hence, once recognized then *what* are the main challenges migrants are facing on Mexican soil? How are their human rights violated? *How* are their human rights guaranteed? *Which* human rights are being placed on top priority and *why*? Mexico was proudly a place of refuge for Spanish Republicans in the 40s, South Americans in the 80s, Guatemalans in the 90s, but it somehow seems difficult now to give the same treatment to those seeking refuge today: Central Americans, Africans, Haitians, Venezuelans, Cubans. *Why?*

Mexican migration scenario's discussions should continue to take place because it is part of the past that we cannot renounce, part of a present that must be faced and of a future on which we must reflect. Migration in its various forms, is a real challenge. Emigration, immigration, both internal and external, return, displacement, refugees, international, etc. are processes that sow

and shape a country. Migration is a current that changes its shape day by day and although it has a predictable course, it can overflow, be confined or abruptly channeled. In times of chauvinism, xenophobia, racism and nationalist exaltation, migration as a transformative reality should not be neglected nor forgotten.

To a greater extent, the migrant population, already unprotected, is even more vulnerable when they are migrants in an irregular situation, making them more likely to become victims of human rights abuses due to their lack of knowledge of laws and economic, political and social rights (CIDH, 2013). In terms of health, according to information from Torres, the mobility that migrants go through, makes them even more vulnerable to health risks and exposes them to dangers related to the displacement itself, the insertion of new environments and reinvestment in previous environments. Poverty, marginalization and difficulty in accessing social and health services are some of the problems they face (Torres, 2016).

Exploring and analyzing the relationship between migration, the Right to Health and specifically access to HIV/AIDS services seems like a complex yet necessary task. Infinite questions of all sorts emerge. Some questions with a clear answer, others with a partial one and others with limited information to properly answer. Is Mexico still upholding discriminatory legislation and practices related to HIV/AIDS? What about discriminatory pratices related to irregular migrants? Are irregular migrants necessarily at higher risk of HIV infection? What would the appropriate approach to migration, health, and HIV/AIDS be? What knowleldge do we have in terms of specific sexual behaviors, characteristics of sexual partners, and sexual contexts at different migration stages? How aware are migrants, specially in irregular situations, of their human rights? How and from whom to demand human rights protection? Regarding HIV, are migrants part of the most affected populations in Mexico?

INTRODUCTION

According to the World Migration Report of 2022, the number of international migrants worldwide has continued to grow rapidly in recent years, reaching 281 million international migrants in 2020, or 3.6 per cent of the world's population, up from 272 million in 2019 (IOM, 2022). According to the latest UNAIDS fact sheet, in 2020 an estimated 27.5 million people were living with HIV globally at the end of 2020 (UNAIDS, 2021).

In Mexico, with an estimated 328,791 people living with HIV in the epidemiological surveillance registry, from which 201,439 people were alive (61.3%) and 111,229 were already dead (33.8%), (SS/DGE, 2021), the importance of this concentrated epidemic cannot be underestimated nor ignored. With an estimated 65% of people diagnosed and with only 60% receiving antiretroviral treatment (Censida, 2017), the importance of access to treatment and adherence cannot be underestimated nor ignored.

The Right to Health, specifically access to HIV services, and migration are major topics to be addressed at a global level. Moreover, when linking security, social and health issues, with mobility, elements of particular situations and membership of certain migrant populations may expose a person to become more vulnerable. In order to understand the difficulties for irregular migrants to access health services, it is important to remember that Mexico has an important and complex dynamic of population mobility, as it is a country of reception, transit and origin of migrants.

Likewise, as indicated in the work "International Migration and HIV/AIDS in Mexico" (n/d) by René Leyva Flores - Senior Researcher at the Health Systems Research Center of the National Institute of Public Health of Mexico - together with Frida Quintino, Marta Caballero and César Infante, the spread of HIV is strongly linked to the conditions of vulnerability of certain groups of migrants and their families. According to some scholars, the spread of HIV is strongly linked to the social vulnerability of migrants, both in their country of origin and at their destination and during the crossing (Leite & Giorguli, 2009).

The population of migrants in an irregular situation is often characterized by high levels of social and political vulnerability, and by a lack of knowledge of laws, policies, programas and

their economic, political and social rights (IACHR, 2013). Likewise, in the migratory trajectory of this population, they often face health risks and discrimination in accessing public services (Torres, 2016). Therefore, an analysis of the relationship between mobility in Mexico and the Right to Health, specifically access to HIV services, should be examined from a sociological perspective, with theoretical considerations and principles of interventions, through an analysis of migration in the international context taking into consideration the international and national instruments available to guarantee the Right to Health, whilst reviewing briefly the Mexican Health System history and finally how national human rights mechanisms should interact in order to avoid discrimination, stigma and a denial of health services and programs.

The situation faced by migrants in an irregular situation exposes them to events that threaten their physical and psychological health due to the loss of loved ones, fear, stress, accidents, torture, rape (ITAM, 2014) and they also face an increased risk of contracting infectious diseases such as HIV/AIDS (IOM, 2015). In order to propose public policies for HIV prevention, it is necessary to understand how the above concepts and variables interact and how the Right to Health should be guaranteed.

It might seemed clear that on the one hand, the consequences of poor health in migrants, can affect their ability to adapt and integrate into society, yet it may be forgotten that on the other hand, poor health can also lead to increased discrimination and xenophobia due to the perception of migrants as carriers of infectious diseases and as non-productive members of the community (*ibid.*).

In order to reduce the risk of contagion, it is of utmost importance to promote prevention. It is essential not only that mobile populations have a high level of knowledge about their rights as migrants and access to health care in the country of transit, but also that they are aware of how to carry on healthy sexual practices and about the healh risks during mobility (Médecins Sans Frontières, 2017). Promoting a culture and policies of respect, integration and inclusion allows people to show a more open attitude towards knowing their HIV status.

The relevance of the main axes of study of this research -migration, Right to Health, and HIV-

in Human Rights lies in the need to continue expanding the field of study in order to develop better programs and policies in favor of migrants, the same actors that are reconfiguring international relations (Rosales, 2009). Hence, reaching agreements to achieve a governance that aims to manage extreme vulnerability a person crossing national borders may endure (Rosales, 2009).

For the purposes of this research, vulnerability is concretized as an impediment to an adequate knowledge of their rights, among them the Right to Health and therefore to receive treatment for any condition that damages their quality of human life. On the other hand, the mere existence of international organizations (e.g. UNAIDS), international agreements and plans (i.e. UNICEF Medium Term Strategic Plan) and the fact that the issue of HIV is taken up again in the Millennium Development Goals (Goal number 6 which aims to end and begin to reverse the spread of HIV (UNAIDS, 2017)) demonstrates the relevance and importance of the issue in the field of International Relations and Human Rights protection.

Some achievements at the international level that reiterate the importance of HIV in International Relations:

> *"In 2001, the Commission on Human Rights adopted a resolution affirming that the right to the highest attainable standard of health includes access to antiretroviral therapy for HIV. In 2002, OHCHR and UNAIDS sponsored the Third International Consultation on HIV/AIDS and Human Rights for the purpose of revising the Sixth Guideline (consolidated in this reprint) to reflect the issue of human rights in access to HIV prevention, treatment, care and support" (UNAIDS, 2006).*

The constantly evolving epidemic of HIV crosses borders and may have an impact in the life of any person, migrant or not (UNAIDS, 2017). The simple fact that the first case of HIV in Mexico was caused by a Haitian person who had traveled to the U.S. and was now in Mexico, demonstrates a clear link between migratory trajectories and HIV (CENSIDA, 2017).

The aim is to re-discuss the nature of migrants and their migratory trajectory, in order to reflect on their access to health and specifically to HIV diagnosis and treatment, since a person should always be offered the possibility of knowing whether they are living with HIV or not, and thus

be given the corresponding treatment. Therefore, it is considered necessary to promote work in the area of migration and health in terms of both care and prevention and to opt for a vision that is not only more global but also more empathetic.

PRESENTATION OF STUDY

The study hereby described aims to provide a brief overview of the knowledge, attitudes and practices (KAP) related to HIV/AIDS prevention among undocumented Central American migrants in Nuevo León, México. The study also aims to offer complimentary practical information in order to understand through first-hand accounts what irregular migrants experience in a border Mexican state.

Migrants in an irregular situation, not having a legal or clear status that meet the requirements of the country of transit or destination, tend to be more reluctant when seeking for health services. This is mainly due to discrimination, hostile attitudes on behalf of health personnel and mainly fear of deportation. The impediment to free health access has been undermined by the criminalization of irregular migration through reforms and policies that focus on regulating the flow of migrants through detention and deportation.

In this sense, the relevance of this study lies in determining the impediments to effective and prompt access to treat HIV/AIDS and to analyze the particular role of discrimination and stigma. This will provide theoretical tools that may facilitate the intervention and implementation of preventive measures to foster empathy and the restructuring of policies that predispose hostile and discriminatory behaviors towards migrants that hinder their their human rights, such as access to health programs.

It is important to note that in this study, even though the more knowledge people had, the more likely they were to display positive attitudes towards PLHIV, having adequate knowledge did not imply engaging in safe practices and that misconceptions about HIV transmission and prevention also led to limited access to HIV treatment. The study hopes to lead to better adaptation and integration of migrants within communities, as well as to avoid high-risk health situations.

From the previous approach, the following general question arises: What is the knowledge, attitudes and practices related to HIV/AIDS prevention among undocumented Central American migrants in Nuevo León, México?

The specific questions of this research are the following: What are the misconceptions of HIV

transmission and prevention, as well as negative attitudes on behalf of Central American irregular migrants in Nuevo León? What knowledge do Central American irregular migrants in Nuevo León have about HIV prevention? What do Central American irregular migrants in Nuevo León think about HIV prevention in Nuevo León? What practices do Central American irregular migrants in Nuevo León carry out with respect to HIV prevention?

Based on the explanation and questions formulated above, the following hypothesis emerges: misconceptions about HIV transmission and prevention show a low level of knowledge, attitudes and practices concerning HIV/AIDS prevention among migrants in Nuevo León hence limiting access to HIV treatment for individuals whilst hindering their Right to Health and contributing to stigma. Evaluating their KAPs will help in the design of appropriate HIV prevention strategies.

METHODOLOGY

This study was conducted in the municipality of Guadalupe, in the State of Nuevo León. At the time of the study, the State of Nuevo León had approximately 5.2 million people (INEGI, 2017), where 20.59% were born in another entity; 0.38%, in the United States of America; 0.25% in another country; and 0.46% did not specify (INEGI, 2015). The first case of HIV/AIDS in Mexico was reported in 1983 in a Haitian male and in 1985 the presence of HIV in the country was officially recognized. In UNAIDS's annual report for the year 2020, in Nuevo León, from 1983 to 2021, there have been 10,847 cases of HIV, of which 9,248 are men and 1,599 are women (UNAIDS, 2021).

The migrants who participated in the surveys were at Casa del Migrante Casanicolás, located at the address Emiliano Zapata 4417, Guadalupe Victoria, 67180 Guadalupe, N.L. The fieldwork was conducted in the month of April 2018. This cross-sectional study was carried out on 55 migrants in an irregular situation who agreed to participate in the survey with informed consent. A total of 51 responses were successfully collected whilst four were removed due to methodological issues and lack of information in the questionnaires.

The participants completed a questionnaire where quantitative and qualitative data, information on socio-demographic, behavioral and contextual characteristics was obtained. The questionnaire was developed based on a previous study titled "Knowledge, attitudes and practices concerning HIV prevention among Burmese migrant workers in Thailand" (2012).

The model used for this work was accepted by the Social Studies of Health and had not been done in a border state of people in transit. One the one hand, the study is especially relevant since it represents a priority topic of the United States-Mexico Border Health Commission (USMBHC) and it was elaborated with a population that is difficult to access, socially invisible and in constant movement. To date of this study,, the only other with greater similarity carried out in Mexico is titled "Knowledge, attitudes and risk perception in reference to HIV/AIDS in the rural population of Yucatan, Mexico" by authors Norma Pavia-Ruz, Renan Gongora-Biachi, Ligia Vera-Gamboa, William Moguel-Rodriguez and Pedro Gonzalez-Martinez.

On the other hand, the relevance of this study lies in determining the impediments to an effective and prompt access to HIV/AIDS treatment in order to help reduce prejudices that surround the disease and migrant populations. This study hopes to provide theoretical tools that favor and facilitate the intervention and implementation of preventive measures to foster empathy and the restructuring of policies that predispose to hostile and discriminatory behaviors towards migrants that hinder their willingness to human rights, such as access to health programs. As mentioned before, this will lead to better adaptation and integration of migrants.

As mentioned in Elisabeth Nylander's research for the Department of Public Health and Care Sciences, "good knowledge, attitudes, and practices of HIV prevention are essential to avoid acquiring HIV infection and to prevent the disease from spreading" (2012). Thus, optimal HIV prevention requires research that provides relevant information and instructions to health care providers (Nylander, 2012).

This study presents an anonymous questionnaire where all responses to questions will be kept confidential, all information will be strictly used for research purposes and it will not be disclosed. Since it is desired to keep their identity private, participants were asked not to write their name anywhere in this questionnaire. The completed questionnaires were placed in an envelope containing other completed questionnaires, assuring participants that no one could identify their own questionnaire.

The objective of this questionnaire was to explore the knowledge, attitudes and practices related to HIV/AIDS prevention among migrants in Nuevo León. The questionnaire consisted of 50 questions and participants were instructed to answer the questions openly and according to their personal beliefs or behavior.

The dimensions to be evaluated were the following:

1. HIV/AIDS general knowledge
2. Knowledge of HIV transmission routes
3. Knowledge about prevention methods
4. Knowledge about risk behaviors

5. Knowledge about symptoms
6. Knowledge of causes of HIV
7. Stigma related to HIV
8. Work environment and social relationships
9. Perceived risk of infection through physical contact
10. Use of injectable drugs
11. HIV Testing
12. Sexual Behavior

The majority of the questions presented have been widely used or reported in the literature and in similar research and studies. The interviews were conducted face-to-face by the person in charge of the research, María Fernanda Zaragoza, trained by COESIDA/CAPASITS on the topic of Sexually Transmitted Infections (STIs), Sex Education and HIV/AIDS during the dates between February 2016 and October 2016. The present work was also advised and evaluated by researcher Philippe Stoesslé.

I. THEORETICAL AND CONCEPTUAL FRAMEWORK

Due to its complexity and constant evolution, the study of migration requires a social analysis of multiple academic disciplines in order to acquire a complete knowledge as an object of study; therefore, complementarity and interdisciplinarity are necessary. According to Arango (2000, p. 45-46, cited by Gómez, 2010:83):

> *"Perhaps the greatest difficulty in the study of migration is its extreme diversity in terms of forms, types, processes, actors, motivations, socioeconomic and cultural contexts, etc. It is not surprising that theories have difficulty explaining such complexity. As Anthony Fielding says, "perhaps migration is another "chaotic concept", which needs to be "unpacked" so that each part can be seen in its own historical and social context so that its significance in each context can be understood separately". Such "unpacking" requires better integration of theory and empirical research".*

Based on Arango's (2000) explanation, it can be interpreted that an integration of classical and contemporary theoretical models is necessary to show the most relevant aspects of international migration. In this sense, it will be possible to provide an explanation of the patterns and trends of human mobility based on a more complete and accurate vision. The reasoning of the above is based on the fact that the causal factors of nature are varied and the empirical evidence is changing, which is why it is argued that no theory analyzed in isolation can offer a complete explanation of migration processes. However, prior to the explanation of the various theories of migration, it is necessary to clarify that a large number of these theories are mostly focused on causes and to a lesser extent on effects (Gómez, 2010:83).

Likewise, there is a tendency to resort to "extreme generalizations without checking concepts from other sciences, such as systems and network theory" (Gómez, 2010:83). Taking into account the above - in order to avoid misconceptions - it is recommended to extract the central elements and carry out a contextual analysis prior to incorporating it into a specific field of study. For the purpose of theoretically positioning the research, the most well-known theories used in the academic space will be pointed out. However, for reasons of length and in order to offer a

more precise approach, only neoclassical theory, the new economics of migration and the theory of networks and social capital will be addressed.

From the book titled "Theories of migration - Synthesis of individual decision making" written by Piguet (2013), the existing theories of migration are as follows:

1. "Classical" or traditional approach
    a. From rational choice to bounded rationality
    b. Life cycle
    c. Human capital
    d. Incomplete information
    e. The notion of "utility of place" and "residential stress"
    f. The New Economics of Migration (NEM)
    g. Migration as a risk management strategy
    h. Relative deprivation

2. Social psychology approaches
    a. Motivation theories
    b. Theories of expectations and values
    c. Reasoned action and planned behavior model

3. Sociological and geographic approaches
    a. Network theory and social capital
    b. Geographical imagination

It is relevant to comment that - as the author Piché (2013:19) argues - two main objectives must be achieved from a migration theory. One the one hand, it is necessary to explain the motives that lead a person to migrate (usually social or economic problems) and secondly, to demonstrate the effects of migration itself. As stated by Gómez (2010:85-86), although the causes of

international migration are varied and can be caused by all kinds of phenomena, the most outstanding ones are listed below:

A. Socio-economic, political, psychological, cultural, and of human nature
    a. Economic
    b. Political and legal
    c. Demographic
    d. Ethnological
    e. Geographic
    f. Historical
    g. Sociological
    h. Psychological and medical
    i. Cultural, educational, scientific and technological
    j. Missions
    k. Welfare state

B. Natural phenomena
    a. Physical-chemical origin
    b. Biological origin
    c. Inadequate practices in exploitation activities
    d. Adaptation and improvement of environmental conditions

On the other hand, the effects of migration must be distinguished in terms of the country of origin or the receiving country (Gómez, 2010:86) and careful evaluations of each particular situation are necessary to avoid generalizations (Gómez, 2010:87 citing Dustman, Frattini and Flitz, 2007), since it depends on various factors such as magnitude, regional demographic profile, characteristics of the people who make up the migratory flow.

The following is a broad outline of some of migration's effects/repercussions:

A. Demographic Effects
    a. Age and sex structure of the population
        i. Population growth
        ii. Structure imbalance
    b. Household composition and structure

B. Economic Effects
    a. Remittances
    b. Employment and wages
    c. Economic growth
    d. Productivity
    e. Fiscal costs

C. Social Effects
    a. Loss of labor force
    b. Acculturation
    c. Uprooting affecting stability
    d. Change of identity
    e. Stigma
    f. Rejection
    g. Loss of social networks

Undoubtedly, the neoclassical theory of migration continues being one of the most influential that has been produced, besides being the oldest (Franco, 2012:17). This theory originated with Ravenstein in his renowned work on the laws of migration, which emphasizes that the main reason for mobility is the desire of "the population to improve their living conditions" (Franco, 2012:17-18 citing Durand and Massey, 2003). This approach is based on the premise that "migration flows are caused by differences in wage rates between countries" (Franco, 2012: 17).

Therefore, it is necessary to consider applying policies aimed at labor markets since the emphasis of this theory is that, if wage differentials did not exist, labor migration flows would not occur.

In recent years, the neoclassical perspective has been questioned, leading to the emergence of a theory called "The New Economics of Migration" (Franco, 2012 citing Stark and Bloom, 1985 pp. 173-178). The premise of this theory is based on reducing the importance that neoclassical theory gives to wage differentials and not considering it as a determining factor in migration. Consequently, what the New Economics of Migration seeks to accomplish is: "An internal critique of some details of the micro version or as a variant of it (neoclassical), which refines and enriches it with a series of amendments and additions" (Franco, 2012:20 citing Arango, 2003:12). In short, the theory not only focuses on wages, but also considers other factors, giving greater importance to the group in which the individual with a desire to migrate is located.

> *"It analyzes conditions in various markets, not just labor markets. It conceives migration as a decision made by the family to minimize possible risks to income or to overcome the limitations of the capital generated by the family's productive activities. This theory helps to understand why the people most affected by supply and demand factors, the poorest in the community, are often the least inclined to leave, while those who do have some opportunities tend to consider relocation. Those with income to lose will be more inclined to try to minimize their risks, while having more capital to finance their relocation" (IOM, 2001).*

In other words, the determinant of migration is subject to the particularities of the group involved. The subject must consider what is convenient when moving and be guided by his or her "rational choice".

1.1 NETWORK THEORY AND SOCIAL CAPITAL

The next theory to be considered is the network theory that generates social capital. This theory has recently been used to explain various social science phenomena such as migration and health (Plascencia, 2005:22). It is necessary to clarify that "social capital is not social networks, but without social networks there is no social capital" (García-Valdecasas, 2011). In other words, an individual who is not part of any social network will not be able to make use of the social capital resources that can be generated (García Valdecasas, 2011).

The main exponents of this theory are Glenn Loury (1977), followed by Pierre Bourdieu and Loic Wacquant (1992) and Alarcón and González (1987) (Franco 2012:22). However, the contributions of the theorists Coleman and Putnam continue to be a key reference and offer the core ideas of the concept (Plascencia, 2005:22). It is clear that there are several definitions of the concept of social capital. Now, in the first instance, the theory elaborated by Bourdieu will be taken up again, followed by Coleman and finally Putnam as the most significant for the hereby research.

Bourdieu defines the concept of social capital as: "the accumulation of real or potential resources that are linked to the possession of a durable network of more or less institutionalized relations of mutual recognition" (Bourdieu, 1986:248). In order to complement and offer a concise view of Bourdieu's interpretation, author Jorge R. Plascencia (2005) synthesizes Bourdieu's definition as follows: "social capital as a mechanism of social differentiation and reproduction of classes" (2005: 22). From the above, it could be stated that, for the French sociologist, the concept of social capital is that which the members of a social network can acquire through their own connections. It is important to point out that, for Bourdieu, all the different types of capital (social capital, cultural capital, symbolic capital, etc.) are based on economic capital. This can be reflected in the words of the same author: For Bourdieu, to acquire social capital, it must be a requirement to belong to a group or network of relationships (Plascencia, 2005: 23).

The greater the number of people in the network of relationships, the greater the possibility of gaining social capital. This could be reflected in the "bourgeois life" since obtaining social

capital either materially or symbolically, ("words, women, gifts, etc.") also gives rise to exchanges and with them, mutual recognition, prestige, obligations that end up shaping certain social classes (Plascencia, 2005:24). Thus, Bourdieu defended a clear relationship between social capital and social classes. The concept of social capital he analyzes as a key factor in providing social classes with differentiation.

Although Bourdieu mentions the construct of social capital in the 1960s, the use given to his definition was unsystematic, occasional and with little precision in comparison with his other concepts presented (for example, cultural capital, habitus and linguistic capital) (Plascencia, 2005: 23). Likewise, Bourdieu defended that the different types of capital started from economic capital. The author states that: "Economic capital is the root of all other types of capital" and "all types of capital are ultimately reducible to economic capital" (Bourdieu, 1986: 252). In this sense, functioning economic capital becomes the root or the key concept from which to part. Offering, for certain theorists -such as Coleman- a reduced vision of the concept of social capital. In addition, together with Bourdieu, the authors Glenn Loury, Loic Wacquant and Alarcón y González defend that the establishment of interpersonal links is a direct consequence of population and is a determinant for other social consequences.

On the other hand, although James S. Coleman's contributions date back to before 1993 and were taken up by various authors such as Elinor Ostrom and Robert D. Putnam in the following years, Coleman was not the intellectual author of the concept since it had already been proposed previously by authors such as Pierre Bourdieu and Glenn Loury in the field of sociology (Plascencia, 2005:21). However, according to Plascencia (2005), Coleman should be considered as the progenitor of the phenomenon, since it was his contributions that gave rise to more rigorous discussions in the following years and continue to be applied in empirical research.

Plascencia (2005) reiterates that the belief of considering Coleman as the father of the theory is supported by Putnam himself, since he affirms that Coleman "is justifiably considered the intellectual father of the field" (of research on social capital) (Plascencia, 2005:22 citing Putnam, 2004: 668). Now, if we start from the idea that Coleman provided the general background of the

theory, it is first necessary to reconstruct his vision of social capital. In his book titled "Foundations of Social Theory" (1990: 302), Coleman defines the phenomenon as "an aspect of the social structure that facilitates certain actions of individuals who are situated within that structure". In short, Coleman analyzes "social capital as a link between the actor and the structure" (Plascencia, 2005:26). If some element of the structure serves for the individual to reach his or her certain end or objective, then this aspect would be called social capital. In this case, resources from social networks form a key part of social structures (García-Valdecasas, 2011).

Coleman distinguished six forms of social capital: "a) obligations and expectations; b) information potential; c) effective norms and sanctions; d) authority relations; e) social organizations appropriable for other purposes and f) intentional organizations" (Plascencia, 2005: 27 citing Coleman, 2000a and Coleman, 2000b). In the present project we will provide a definition of the first three since they were the main forms of social capital that the author distinguished in his first articles. It's to be noted that what is to be offered is a precise but not extensive analysis.

In the first place, the form of social capital related to obligations and expectations is based on the fact that, in an exchange context, when a subject performs a favor to another subject, the first can create an expectation of reciprocity while the second subject can create an obligation to repay the first subject. Each social structure may offer a different extension of obligations and expectations (Plascencia, 2005: 27). A rupture in social networks -and therefore a loss of social capital- may occur in the event that expectations are not fulfilled or obligations are not carried out, i.e., there is no retribution (García-Valdecasas, 2011).

The second form that the author Coleman distinguished is the "information potential inherent in social relations" (Plasencia, 2005: 28). This is based on how social relationships constitute a source of social capital that provides information "and facilitates action" (Coleman, 1990: 394-395). That is, a subject can obtain information based on his contacts without establishing some kind of relationship based on reciprocity.

For further clarity on this second form of analysis, author Coleman provides in his book Fundamentals of Social Theory the following example based on the 1955 studies of theorists Katz and Lazarsfeld: "A woman interested in being fashionable, but not to the point of wearing the latest fad, may turn to some friends, who do wear the latest fad, as a source of information" (Coleman, 1990: 395). Thus providing an example in which the woman can obtain information through another subject or through her network of relations, obtaining information that becomes social capital.

Finally, the third form of social capital according to Coleman is based on effective norms and sanctions. Coleman argues that a form of social capital of power or value are the effective norms. This is because norms can facilitate or inhibit actions. (Coleman, 1990: 395). According to Coleman, norms play an important role in a collectivity. For example, by introducing norms to act without selfishness, the development of social networks is facilitated.

On the contrary, Putnam's definition of social capital is based on certain characteristics of citizens (culturalist perspective) and on social networks (structuralist conception) (García-Valdecasas, 2011: 140). Thus, for Putnam, the concept of social capital is composed of trust, norms of reciprocity and networks of civic engagement (Plasencia, 2005: 30). Two important characteristics of Putnam's concept of social capital could be considered the following: they do not include authority and hierarchy relations (contrary to Coleman) and concepts of sociability should also be included -that is, casual encounters with friends could be considered objects of social capital according to Putnam (Plasencia, 2005: 30).

Likewise, Putnam distinguishes eight different types of social capital: formal/informal, dense/tenuous, turned inward/turned outward, binding/bridging (Plasencia, 2005: 30). As with Coleman's analysis, for reasons of length, Putnam's eight different types of social capital will be analyzed in broad strokes, offering a precise but not extensive analysis.

In the first place, formal social capital are those networks composed on bases with structure, authorities, operating rules, etc. while informal ones are based on social convivialities (such as family meals) that lack an established order or structure. On the other hand, dense versus tenuous social capital is based on the type of relationship the subjects have, i.e., the type of interaction they carry out. Certain interactions may be more dense while others may be limited by the context (Plasencia, 2005: 30).

Now, social capital turned inward consists of the purpose of networks. If social networks seek to support a particular interest they would be part of this concept. However, if social networks seek to promote public interests then it would consist of the counterpart: turned outward (Plasencia, 2005: 30). The last type of social capital to be analyzed is binding versus bridging. Binding social capital is based on reinforcing specific identities and stimulating solidarity. The author Plasencia (2005), indicates that an example of this can be the ethnic fraternal organizations or the parochial feminine reading groups. On the other hand, social capital builds bridges with subjects from different social classes. On the one hand, it is based on uniting its members among themselves and on the other on "building bridges with others" (Plasencia, 2005: 30).

Related to the concept of migration, interpersonal ties or networks can occur between migrants with a past trajectory, a recent trajectory, with non-migrants in areas of origin (social group, i.e. family, friends), networks of migrants belonging to the same community. In this way, the networks created increase the possibilities of international flow since the risks can be reduced by having an interpersonal network that can provide economic, emotional, social, labor, etc., support (Massey et al., 1993). (Massey et al., 1993).

These networks or connections constitute a form of social capital which, according to Durand and Massey (2003:30), can be defined as a "set of intangible (invisible) resources in families and communities that help promote social development among young people" or as Loury, Bourdieu and Wacquant define it as "the sum of real or virtual resources that correspond to an individual or group by virtue of their membership in a durable network of more or less institutionalized

relations of mutual knowledge and recognition" (Franco, 2012:22 citing Bourdieu and Wacquant, 1992: 119).

Getting a job, food, a place of arrival in the destination country, integration in the destination country or economic support for travel are some of the benefits that can be obtained from migration networks. Over time, and because the concept of migration is constantly changing, exponents have added elements to the theory and argue that a migration network is formed with each individual with whom the migrant relates and in turn, makes the migrant a candidate to start his or her own migration path and become a migrant (Franco, 2012:23). Social ties expand and consequently the costs for the new individual with a desire to migrate decrease.

1.2. SOCIAL VULNERABILITY

In this 21st century, the perception of uncertainty, insecurity and helplessness is becoming notorious in a large percentage of Latin American countries due to the consequences of the international economic situation (Ruíz, 2011). Some of these repercussions are: the withdrawal of the State in the provision of basic health services, unequal salaries, lack of employment, etc. - and causing, in turn, social disadvantages in some groups of the population (Busso, 2001). This has generated a vast literature on the definition and measurement of such social disadvantages, from which the notion of social vulnerability emerges.

The intrinsically complex nature of the theoretical concept of social vulnerability has caused it to be widely discussed by various fields of knowledge, such as sociology, politics, ecology, among others (Ruíz, 2011:64), so it can be said that the general lines of the concept are still in constant change and theoretical debates (Labrunée & Gallo, 2005:135). Despite having been defined from diverse fields and elements, it is possible to highlight common elements in most of the definitions, such as the relationship with some type of threat (whether origin events, diseases or anthropogenic threats) (Ruíz, 2011:64), the unit of analysis (individual or social group) (Ruíz, 2011:64 citing Alwang et al, 2001:3) that is vulnerable to a specific situation/threat or to being in a situation of deprivation.

The phenomenon of social vulnerability can be understood as a dialectical relationship between internal factors -individual, household, community- and the environment (Labrunée & Gallo, 2005:136). That is to say, the concept cannot be considered only as a consequence of the spatial field and external circumstances, but is also a product of the capacity of individuals/social groups to react (Labrunée & Gallo, 2005:136 citing Busso, 2001). It is for this reason that for the purposes of this study and the results of the interviews, the concept of social vulnerability should be analyzed based on the resilience capacity, personal support networks and the health and migration trajectory of migrants.

In understanding vulnerability from the above concept, three central aspects can be distinguished. Since the notion of vulnerability can be approached from "multiple theoretical and

epistemological perspectives" (Ruíz, 2011:64 citing Stallings, 1997:5-7; Cardona, 2004:44-45; Wisner et al, 2004:17-18); there are those that focus the weight of the concept on the naturalistic approach (whose central objective is physical hazards, such as droughts, earthquakes, floods, diseases, or anthropogenic hazards such as pollution, etc.) to those that focus the weight of the phenomenon on theoretical perspectives with a constructivist perspective, emphasizing "symbolic constructions, where the material conditions are subordinated to the cultural dimension and ideological dimension" (Ruíz, 2011:64 citing Douglas and Wildawsky, 1982; Oliver-Smith, 2004:18).

However, for the purposes of this paper, the concept of social vulnerability will be analyzed from a realistic perspective that encompasses physical threats, as well as the social conditions that give rise to social inequalities and differentiated access to basic resources, such as access to health.
The choice of this perspective is due to the fact that migrants are usually exposed to physical threats (i.e. diseases, in this case HIV) either due to their migratory trajectory or due to their situation of departure and gives rise to a denial of basic access (in this case access to the health system) either due to lack of documentation, language barriers, scarce economic resources, stigma, etc.). This causes the migrant to increase his or her vulnerability. Likewise, the choice of this perspective is based on the fact that the situation of a migrant person is not caused by a single factor but by a set of factors.

The line of research to be followed consists of social vulnerability in health as a result of the different capacities of each unit of analysis (individual/group) to face the unequal conditions of availability and/or access to health services and risk management. It is important to clarify that "social vulnerability in health does not correspond to a natural condition"; groups in vulnerable situations or "vulnerable groups" are not vulnerable per se, but rather due to the conditions in which a given social group or individual finds themselves (INSP, 2010:1). This is particularly true in the case of migration, which in itself does not constitute a vulnerability factor, but rather the conditions in which it is exercised.

1.3. SOCIAL DETERMINANTS OF HEALTH

The social determinants of health shape the context of a person's daily life (NPHI, 2010:1) and -as the name suggests- are conclusive factors that shape the conditions in which a person develops. In short, the Social Determinants of Health are those conditions in which a person is born, grows, develops and ages. These greatly influence health and determine inequalities between different social groups and between individuals (Ponce González et al, 2016).

Their importance is such that in 2005 the World Health Organization (WHO) instituted the Commission on Social Determinants of Health (CDSS) for the proper development of inclusive and egalitarian policies on health issues. The SSHD refers to "structural determinants and living conditions as a whole, constitute the social determinants of health that are the cause of most of the health inequalities between countries and within each country" (INSP, 2010:1-2 citing SSHD-2008).

Thus, by taking into account the social determinants of health, a comprehensive approach based on respect for human rights is chosen. Recognizing inequalities and health determinants allows the development of effective strategies for the joint involvement of communities, patients and physicians (Ponce-González et al, 2016). Thus, prevention and treatment programs for certain diseases or health conditions would have a more appropriate approach. The National Bioethics Commission of the Secretariat of Health (2015) advocate that:

> *"In order to achieve the highest level of health of the population it is really necessary to rethink the vision of health care by governments. The planning and formulation of public policies, as recommended by the WHO, must incorporate the approach of these determinants and consider other indicators that are more significant than health coverage".*

It is important to mention that - as stated by the CDSS (2008) - the existing inequality of the phenomena that damage health is not something natural but the result of failed public policies of poverty, unequal economic agreements and incorrect management by the government. As long as there are elements in the social, cultural and physical environment that do not allow - or act as barriers to - behavioral change in people, this change will not happen, nor would it be

reasonable to expect it.

Within a population, health is influenced by the level of income, education and work. In the same way, health status is also changeable. Particularly in the case of migration, the type of diseases, behaviors and risk factors are different in migrants than in their countries of origin (WHO, 2007). But what are these determinants and what factors influence health?

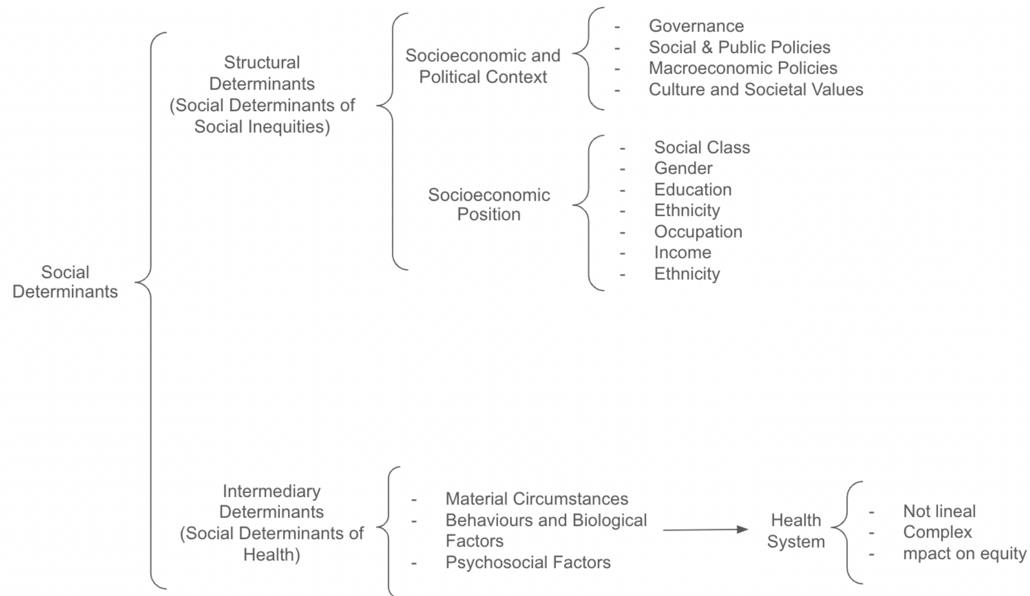
In the first instance, individual factors must be considered. This refers to who the person is and the factors within this individual level are age, gender and genetic/hereditary factors. The second level includes what are the behaviors or what the person does, factors such as the amount of physical activity performed, the diet followed and the consumption of narcotic substances (alcohol, drugs, cigarettes, etc.) should be considered.

On the other hand, at the third level it is necessary to evaluate the conditions where the person was born, grew up, lived, worked and aged. These include their social and community networks, work environment, water and sanitation, housing, the health systems/services, and socio-economic, cultural and environmental factors (Ponce-González et al, 2016). Together, the aforementioned factors make up the Social Determinants of Health.

In turn, these are influenced by the distribution -at international, national and local levels- of power, money and resources. The unequal distribution of the previously mentioned components, give rise to inequalities in terms of access to health services (among others) (Secretaría de Salud, 2015). The existence of various Social Determinants of Health, their considerable levels and their complex interactions tend to create confusion as to their impact. Therefore, the following will explain how these factors interact and how they influence people's health.

The World Health Organization (2005) - and hence its Commission on Social Determinants of Health - argues that the framework/model for a more accurate understanding of the Social Determinants of Health is as follows:

Diagram 1: Social Determinants of Health



Source: Own elaboration with information retrieved from the Commission on Social Determinants of Health.

According to the diagram above (based on the WHO Social Determinants of Health model), there are two broad types of determinants that influence health and can lead to inequalities in access to health. These are: structural determinants and intermediate determinants. In the first part, structural determinants refer to the socioeconomic and political context in which a person is born and in which he or she lives. This includes: governance (how society organizes itself to make and implement decisions), politics (social and public policy) and also the social and cultural values that communities place on health.

The above factors can determine and lead to an unequal distribution of material and monetary resources that determine the socioeconomic position of each person. Socioeconomic position describes a person's place in society, which may affect his or her exposure, vulnerability and outcomes, which could have some impact on his or her health. Moreover, socioeconomic

position is determined by a number of factors, such as education, occupation, income, gender, race or ethnicity, and social class.

Socioeconomic position interacts with the intermediate determinants of health. These include material circumstances, such as the quality of housing, financial means to buy good quality clothing or other requirements for a healthy life. On the other hand, the psychosocial circumstances include stressors, relationships and social support. Undoubtedly, in addition to the above, health systems also have an impact on the type and quality of medical care available to individuals. Health systems determine how easy it is for people to access health services and receive the medical care they need.

Social cohesion and social capital are factors that link structural and intermediary determinants as these describe the willingness of people living in a community to make sacrifices and cooperate with each other to obtain a broader benefit. It is important to mention that the links between these factors are not always linear, but rather, different, complex and can go in both directions. An example of this is the following; just as low income and education can have an impact on health, so poor health can limit opportunities for people to participate in the labor force or receive education.

Changing or influencing social determinants involves first identifying the structural and intermediate determinants of health so that appropriate measures can be taken to improve them. However, achieving this requires actions by all sectors of society and at all levels, including local, national and international. However, actions will depend on the existing socioeconomic and political context, available resources and commitment to action.

1.4. SOCIAL STIGMA

In this section, the main characteristics of the concept of social stigma, which acts as a major obstacle to effective inclusion and as a tool for the promotion of exclusion, will be discussed. Social stigma as a concept of the disqualification of an individual to obtain full social acceptance (Goffman, 2006). Although this construct is specific to social psychology, it is necessary that several disciplines choose to adopt it, since it can provide a more complete understanding of certain objects of study. Such is the case of its use within the perspective of Human Rights, a discipline in which the range of topics or approaches is so wide that in order to provide complete analyses it is necessary to analyze the psychology and behavior of the subjects themselves and/or their interactions in their social networks.

Likewise, within the discipline of International Relations and Human Rights, the understanding of this concept promotes in the field of social sciences, evidence that could serve to improve public policies and to be able to achieve -in this case- an improvement in the lives of migrants in order to achieve full development. Undoubtedly, it is of utmost importance and necessity to analyze the notion of social stigma in this research through its three main axes, i.e., migration, right to health and HIV/AIDS.

From the study of migration, the concept of social stigma is essential to understand the daily discrimination that migrants experience in transit or destination countries and ends up hindering their insertion in that space (Tijoux-Merino, 2013:84). Undoubtedly, the concept of migration can cause multiple scenarios in which the receiving society perceives migrants as "different" either because of physical features, language, traditions, values, etc. (Molero et al., 2001:12).

The differentiation that is given to migrants and that usually causes negative consequences (stigma, discrimination, prejudice, etc.) can occur because of the way of migrating (usually irregular, forced, spontaneous), the reason for migrating (refuge, improvement in economic conditions, interpersonal relations, resettlement, exile, etc.), the jobs for which the migrant is working, etc. (Molero et al., 2001:11).), by the jobs they opt for (usually poorly paid) and/or by the areas in which they live (usually marginalized neighborhoods) (Tijoux-Merino, 2013:84). As

mentioned by the author Lang (2015:1), the migrant becomes the "foreign stranger" who is socially excluded.

The problems of social stigma in terms of health can derive directly from their disease or disorder and those related to the stigma of the person him/herself (nationality, ethnicity or race, beliefs, etc.). As the authors Marcelino López, Margarita Laviana and other collaborators mention in their article entitled "The fight against stigma and discrimination in mental health. A complex strategy based on available information" (2008): "The consequence of both is a considerable decrease in the opportunities to enjoy an active civic life and the different aspects related to what, in more technical language, we call “quality of life”: social relations, couple, employment, housing, health, etc." (2008:43).

Based on the above, the notion of social stigma understood from the health approach is of constant concern, since it can interfere and act as a barrier in terms of access to traditional health care systems to improve the living conditions of those who wish to do so (López et al., 2008). The author Scambler (1993) clearly demonstrates in his 1993 publication the existence of a link between disease and social differentiation. The author analyzes how certain health conditions cause the same medical structures to favor social stigma and pejorative social labels, and also argues that the disease itself creates distinctions, an example of which is HIV/AIDS.

Likewise, stigma and discrimination (a consequence of stigma, i.e. practice) against people living with HIV/AIDS is an obstacle to adequate care and prevention management (UNESCO, 2003). Social stigma of people living with HIV/AIDS can lead them to miss out on testing and thus to deprive themselves of possible essential treatment. A serious danger of the HIV/AIDS issue and stigma is that such people are often excluded from public places such as hospitals, work, etc., as well as being deprived of some of their rights, such as the Right to Health (UNESCO, 2003).

Now, having explained the importance of the concept in the three main axes of this research, it is necessary to explain what social stigma per se consists of. The word stigma is of Greek origin and refers to the physical mark - or bodily signs - that used to be placed on individuals

considered strange or inferior, such a mark was made with fire or a razor to ensure permanence (Callejas and Piña, 2005:65). In this way, the mark helped to give notoriety to those who were slaves, criminals or traitors. Although this practice does not remain today, the concept of stigma is still present in certain societies due to the non-acceptance of a person to be part of a group (Callejas and Piña, 2005:65). It could be stated that nowadays it is a symbolic "mark" assigned to a person as a result of some kind of differential trait or a particular attribute that may be discrediting (López at al., 2008).

Based on Erving Goffman's formulations, the term "stigma" is nowadays used on a daily basis and consists of a theoretical approach. From Social Psychology, Goffman was the first author (1963) to define the concept and to understand the negative consequences for the person who carries it (Nieves, n/d). Likewise, it is necessary to emphasize that according to Goffman's approach:

> *"The stigmatized population incorporates the discourse that separates it from society to the point of accepting responsibility for its own situation; in addition, it adopts stigma as an identity category according to which it must learn to function in society" (Albicker, 2014).*

The above quote demonstrates that even the stigma-bearer often accepts and adopts the conceptions that are commonly held by society. Which demonstrates the possibility of a wide range of responses to stressors resulting from minimization and devaluation, including emotional, cognitive, biological, behavioral, damage in terms of identity, self-esteem and morality by accepting conceptions imposed by the counterpart (Albicker, 2014). Accepting his "defect" and that he is in a plane of inequality and/or uncertainty in front of the rest, turns shame into a possibility and the individual comes to denigrate himself (Goffman, 1963).

Returning to the basis of the concept formulated by Goffman, there is a classification of stigmas: physical deformities (i.e. blindness), character defects such as lack of will (i.e. homosexuality, addictions, unemployment) and trivial stigmas (i.e. nationality, race). In all three classifications, it is possible to analyze how the sociological traits are the same, i.e., it is necessary to distance

oneself from any subject who possesses a trait, an 'undesirable difference' that was not contemplated (Goffman, 1963).

In the above case, depending on the stigma attached to a person, various negative acts may occur. Such is the case of stereotypes, prejudice (emotional predispositions that tend to be negative) and/or discrimination. The three aspects mentioned are not opposed and can go together to reinforce each other (López et al. 2008:47). Likewise, annoying, tense and abusive relationships (labor, sexual, etc.) may occur (Goffman, 1963).

Likewise, the author Nieves (n/d) in her research entitled "Stigma and Social Marginalization of Youth Collectives" states that other authors (Jones, Farina, Hastorf, Markus, Miller, Scott (1984) and Crocker and Mayor (1989)) have defined the concept in a similar way to Goffman. The aforementioned authors consider that the fundamental criterion of stigma is discrimination, while other theorists consider that the conversion of a social category into a stigmatized category occurs when "information related to it is processed with a series of pejorative connotations" (Nieves, n/d:31).

In view of the above, the concept of social stigma is essential to understand the three key axes of the research: migration, health and HIV/AIDS. Three axes that are erroneously considered as carriers of social stigma.

1.5. TRANSNATIONALISM

In response to dissatisfaction with the excessive emphasis on economic aspects in the study of migration, the transnational theory emerged; its origin is usually attributed to Nina Glick Schiller in 1992 while she was researching Central American migrants in New York along with her colleagues (Castro, 2005:181). The anthropologist and researcher's dissatisfaction provoked a questioning of those traditional conceptions of migrants and led her to affirm that "our previous conceptions of immigrants and migrants are no longer sufficient" (Schiller et al., 1992:1).

Schiller's new proposal consisted of emphasizing the cultural aspects of migrants and how they continued to maintain ties with their places of origin and did not simply consist of an assimilation of the host culture (Castro, 2005:181). The new type of migrant population would give rise to networks, activities and life patterns that encompassed both their country of origin and the receiving country, giving rise to transnational communities (Castro, 2005:181).

Schiller (1992) argues that the lives of migrants crossed national borders and led to the emergence of two societies in a single social field. Thus, his definition encompasses the development of multiple cross-border relationships such as: familial, economic, social, organizational, religious and political (Schiller et al., 1992:1). However, the publication of the researcher and her colleagues was not the forerunner in linking the concept of culture with migration (Castro, 2005:182).

At the end of the 1980s, Roger Rause showed particular interest in the flows established by population mobility (Castro, 2005:182). The formation of flows -whether of people, symbolic exchanges or material goods- marked the center of his proposal of transnational migratory circuits, in which spatial aspects are highlighted (Castro, 2005:182). In this way, the work of Rause and Schiller helped lay the groundwork for future researchers to focus on the development of identities that arise from the concerns, actions and decisions of transmigrants (Castro, 2005:182).

Therefore, the assimilation paradigm -which assumed that migrants would end up detaching themselves from the culture of their country of origin once they had assimilated the cultures of the receiving or destination country- takes a back seat in the new reality of contemporary migrants in the 21st century who face difficulties that their predecessors did not experience (González-Vázquez et al., 2013).

As a result of the obstacles they face - problems of exclusion, labor informality, integration and social mobility - migrants tend to develop transnational links to counteract the difficulties presented and use their own cultural resources from their country of origin. Likewise, to decrease the cost and risks of migration, as well as to confront social vulnerability, migrants form social networks among individuals with similar backgrounds (González-Vázquez et al, 2013). However, despite the great relevance of the phenomenon of transnationalism, not all migrants are transnational. The scope of transnationalism ends when no links -whether political, social or economic- are established between the country of origin and the country of destination (Castro, 2005:185). It is the collateral effects of migration that form an evident relationship between space and culture. Therefore, the degree of transnationalism depends on the context of departure, country of origin and migratory trajectory (Gonzalez Vázquez et al, 2013).

On the other hand, along with the name of Nina Glick Schiller, it is essential to mention the scientist and sociologist Alejandro Portes for his pioneering work and contributions to the conceptualization of transnational theory. In theoretical terms, Portes' concept of transnationalism differs from Schiller's, since the latter reduces the unit of analysis to the individual and the family network, while Schiller gave a place to transnational communities - and took them as the unit of analysis - that developed in transnational spaces.

Based on Portes' contributions, it was possible to analyze the growth of the concept of transnationalism and its transcendence (Solé et al., 2008). He also points out the preconditions of this phenomenon and reiterates that it is not a general rule that migrants as a whole will engage in transnational practices (Solé et al., 2008).

The scientist emphasizes three key requirements in order to correctly identify transnationalism activities and thus avoid the conception of the term transnational as synonymous with other phenomena such as international or cross-border, as this gives the term transnationalism a simplistic and not a theoretical meaning (Solé et al., 2008). Broadly speaking, the three requirements are the following: first, a transnational process must "promote non-institutional actors organized in groups across borders" (Morcillo, 2011 with reference to Portes, 2001).

Secondly, the practice or process must show stability and not be something changeable or volatile but resist over time, not a process of exceptional character. Finally, the concept of "transnationalism" should be applied to such practices; other concepts - as mentioned above - should not be applied to the term as they would make the creation of a new term unnecessary (Solé et al., 2008).

Research carried out by Portes together with other co-authors (for example, with Cristina Escobar) shows that the strength of transnational ties is not based on the different types of collectives. Rather, by way of conclusion, Portes argues that there should be "no contradiction between the pursuit of objectives in relation to the countries of origin and the ability to integrate satisfactorily into society" (Solé et al., 2008).

1.6. BEHAVIORAL ASPECTS OF HIV/AIDS

The purpose of the hereby section is to provide the theoretical basis for a better understanding and improvement in the development of educational programs designed to prevent, and thereby decrease, HIV transmission (Ostrow, 1990). The factors that determine health behavior will be analyzed and followed by a demonstration of how current AIDS education programs neglect numerous crucial issues if they focus solely on correcting knowledge deficiencies (Ostrow, 1990). For the present section we will return to David G. Ostrow's book, which, for this research, is the most appropriate and complete with respect to HIV/AIDS theory.

1.6.1. HEALTH BELIEF MODEL

In this section, the basic principles of the Health Belief Model (HBM) will be taken up and emphasized, since it provides research with a unifying vision of the different determinants of health behaviors and their consequences in behavioral decision making. Firstly, regarding the origin of the HBM, it emerged as a psychological model in the 1950s by the social psychologists Hochbaum, Rosenstock and Kegels. These three theorists worked for the U.S. Public Health Services and sought to develop the model in response "to the failure of a free tuberculosis screening program" (Glanz et al., 1997:50) and has since been successfully adapted "to explore a variety of short- and long-term health behaviors, including sexual risk behaviors and HIV/AIDS transmission" (*ibid.*).

The HBM, as its name indicates, is a model whose primary utility is to organize knowledge about health beliefs (Ostrow, 1990). It focuses on an individual's behaviors and assumes that "people act to maximize the net benefits of their actions" (*ibid.*). The model argues that when people make health decisions, they consider the consequences of their actions and relate them to both health and non-health external factors (e.g., social or economic conditions). In other words, it attempts to explain and predict people's health behaviors based on their attitudes and beliefs (*ibid.*).

Likewise, before an individual makes decisions about their health, they must consider the short-term benefits of certain behaviors they may engage in and ignore the long-term consequences of those same behaviors (*ibid.*). For example, in the case of HIV transmission, an individual's concern is clouded by short-term benefits such as sexual release, social approval from a partner, or the money he or she may receive from sex work (Ostrow, 1990). In the case of migrants, the short-term benefits could be, for the most part, receiving some type of remuneration for sex work performed, leaving their country of origin and avoiding responsibilities, etc.

Below is a table with the factors that operate to promote or delay the change of some behavior according to the HBM.

Table 1. Factors of the Health Belief Model

Concept	Definition	Potential Change Strategies
Perceived susceptibility	Beliefs about the chances of getting a condition	• Define what populations(s) are at risk and their levels of risk • Tailor risk information based on an individual's characteristics or behaviors • Help the individual develop an accurate perception of his or her own risk
Perceived severity	Beliefs about the seriousness of a condition and its consequences	• Specify the consequences of a condition and recommended action
Perceived benefits	Beliefs about the effectiveness of taking action to reduce risk or seriousness	• Explain how, where, and when to take action and what the potential positive results will be
Perceived barriers	Beliefs about the material and psychological costs of taking action	• Offer reassurance, incentives, and assistance; correct misinformation
Cues to action	Factors that activate "readiness to change"	• Provide "how to" information, promote awareness, and employ reminder systems
Self-efficacy	Confidence in one's ability to take action	• Provide training and guidance in performing action • Use progressive goal setting • Give verbal reinforcement • Demonstrate desired behaviors

Source: Table retrieved from: "Theory at a Glance: A Guide for Health Promotion Practice" (1997) de Glanz, K., Marcus Lewis, F. & Rimer, B.K.

The above table shows six constructs representing perceived threats and benefits: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, action signals and self-efficacy (Glanz, et al., 1997). Likewise, the previous table evaluates factors of knowledge of health risks, perceived an individual's perception of risk, the efficacy of changing his or her behaviors, and relying on perceptions of cure (e.g., that a vaccine to prevent HIV will soon be discovered) (Glanz et al., 1997).

The term "perceived susceptibility" refers to an individual's own assessment of his or her chances of contracting the disease and, as Joanna Hayden and Joanna Aboyoun Hayden indicate in their book entitled "Introduction to Health Behavior Theory" (2013), this is one of the most powerful perceptions to prompt people to choose to engage in healthier behaviors. The greater the perceived risk, the greater the likelihood of engaging in behaviors to decrease a given risk (Hayden and Aboyoun, 2013:64). For the purposes of this research, perceived susceptibility serves as the primary cause for individuals to use condoms in an effort to decrease susceptibility to HIV infection (Belcher et al., 2005).

On the other hand, the term "perceived severity, seriousness, or severity", consists of an individual's personal judgment as to how serious the illness is (Hayden and Aboyoun, 2013:64). Although the perception of severity is often based on medical knowledge, it can also be based on the beliefs an individual has regarding a particular disease and the difficulties it would have in his or her life (Hayden and Aboyoun, 2013 referencing McCormick-Brown, 1999). For example, a person with asthma may perceive a common flu more severe than a person without asthma.

As for the "perceived benefits" construct, it is based on an individual's conclusion as to whether there is a new behavior that is better than the one he or she is currently performing (Hayden and Aboyoun, 2013: 64). It is based on a person's opinion about the usefulness of a new behavior in order to decrease the risk of developing some disease (Hayden and Aboyoun, 2013). People will engage in healthier behaviors when they consider/believe that such action will help them reduce the chances of contracting or developing any disease.

Now, of all the constructs mentioned above, the concept of "perceived barriers" is one of the most significant in determining behavior change (Janz and Becker, 1984). Perceived barriers are based on an individual's assessment of the obstacles in the way he or she adopts a new behavior. Some of these barriers include difficulty in starting a new behavior because of fear, pain, embarrassment, embarrassment, unfamiliarity, etc. (Hayden & Aboyoun, 2013).

In addition to the four constructs mentioned above, the concept of "action cues" is also an influential factor. These are based on people, events or things that can succeed in motivating or moving individuals to change their behavior. Examples of action cues include the following: a family member having developed the disease, media reports, media campaigns (Hayden and Aboyoun, 2013 referencing Graham, 2002), advice from others, and postal reminders from a health care provider (Hayden and Aboyoun, 2013 referencing Ali, 2002).

Finally, the concept of "self-efficacy", which was added to the other constructs until 1988 (Rosenstock, Strecher and Becker, 1988) and refers to the belief or perception of one's abilities to do something (Bandura, 1977). People generally tend not to try to do something unless they think it is possible that they can do it. If the individual believes that the behavior is useful, but he or she does not consider him or herself capable of doing it, he or she is likely not to attempt it (Hayden & Aboyoun, 2013).

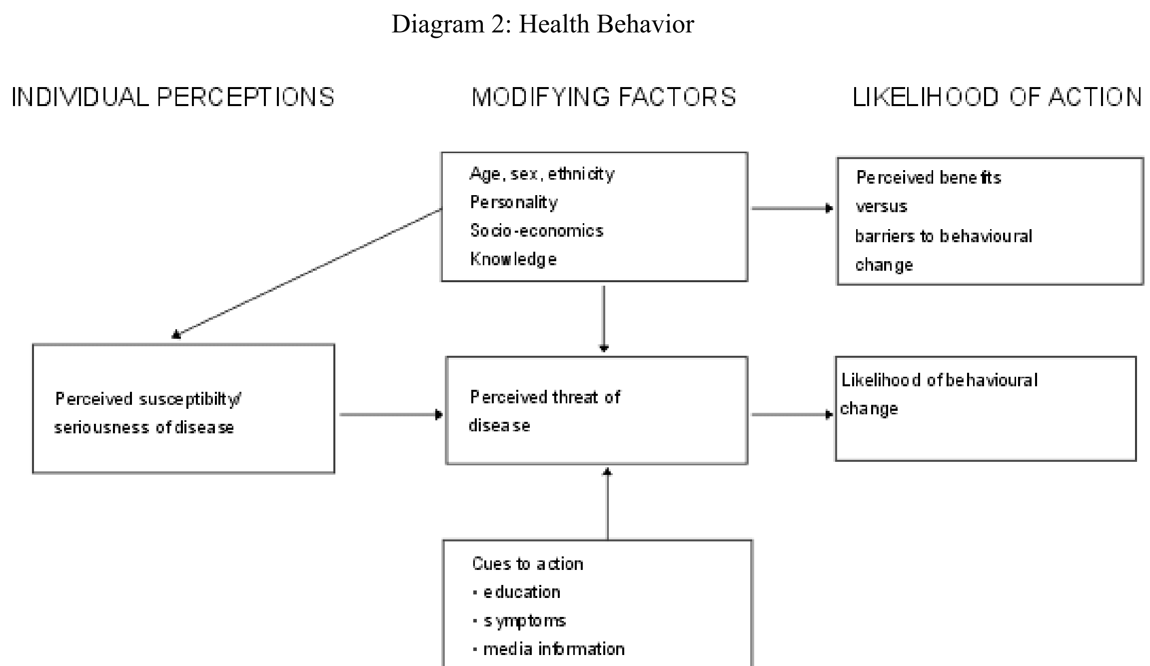
On the other hand, in the case of migrants, sociodemographic variables play an important role in their behavior (Ostrow, 1990). As an example of this, social network associations and group norms often influence people who are in different countries other than their own and thus rely solely on social networks (such as the network theory mentioned above) in the approval of people they know or trust in a new country (*ibid.*).

For the purposes of this research it is important to remember that we intend to analyze the knowledge, attitudes and practices of migrants, so it is important to differentiate whether their actions are mostly influenced by health factors (for example, the stigma of a condition in itself) or by external non-health factors, such as their vulnerability due to their migrant status, economic

deprivation, not knowing the location of hospitals or health centers, not sharing the same language for clear communication or lack of knowledge regarding mobility within a new country or lack of knowledge of their Right to Health (Glanz et al. , 1997).

In addition, the diagram below by the authors Glanz, K., Rimer, B.K. & Lewis, F.M. (2002) is useful for counting the number of people who are mobile in a new country. (2002) is useful to have a conceptual model based on individual perceptions, on the factors that modify these perceptions and the probability of action/behavior to be carried out.

Diagram 2: Health Behavior



Source: Diagram retrieved from: Glanz, K., Rimer, B.K. & Lewis, F.M. (2002). "Health Behavior and Health Education. Theory, Research and Practice". San Francisco: Wiley & Sons. p. 5253.

In the above diagram it can be seen that sociodemographic factors serve as a starting point. Based on a person's age, gender, ethnicity, socioeconomic status and knowledge, the severity of a condition or disease may be perceived differently (Glanz et al., 2002). Following this, depending on their perceptions, they assess whether or not a change in behavior is likely or whether they prefer to opt for short-term benefits (Glanz et al., 2002).

The diagram indicates that certain action signals (e.g., in the case of HIV, the use of a condom, risky sexual practices, needle use, adherence to treatment, etc.) can be seen to be based on education, information received in the media or the symptoms that a person may experience (*ibid*).

This model is of relevance for research and health policy making as it increases our understanding of health behavior and the reason for people's decisions (Conner & Norman, 1996:1). In terms of the application of this model, the primary method is surveys (as in the present research) and for the most part three general areas of its use can be identified: preventive health behaviors (referring to health promoting behaviors, e.g. diet or exercise) and health risk behaviors (e.g. smoking), behaviors that people with a disease condition should follow (adherence to recommended medical regimens), and clinic use, which includes visits to the doctor for various reasons (Conner & Norman, 1996:1).

II. CONTEXTUAL FRAMEWORK

On December 10, 1948, the document declaring the common ideal was proclaimed: the Universal Declaration of Human Rights. The document that marked the watershed in the history of respect for human dignity states in its Article 25 as follows:

> *"1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, widowerhood or other lack of livelihood in circumstances beyond his control.*
> *2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, are entitled to equal social protection" (United Nations Universal Declaration, 1948)*

Despite being a universally recognized right, the Right to Health is highly violated due to the greater difficulty in accessing medical services for the prevention, diagnosis and treatment of certain diseases (Leite, P. et al. 2009). Nowadays, there is a constant problem of the lack of comprehensive and periodic medical monitoring of a significant number of migrants in the world (Leite, P. et al. 2009).

In the case of Mexico, respect for human rights is the guiding principle of Mexican diplomacy. This implies not only deepening and guaranteeing the provisions of the various international human rights treaties, but also improving, coordinating and updating existing national policies with international policies.With regards to the Political Constitution of the United Mexican States, in the fourth paragraph of the fourth article of the Constitution, reference is made to the guarantee that all persons must have with respect to their Right to Health protection. Its text is as follows:

> *"Every person has the right to health protection. The Law will define the bases and modalities for access to health services and will establish the concurrence of the*

> *Federation and the federative entities in matters of general health, in accordance with the provisions of section XVI of article 73 of this Constitution" (DOF, 1983).*

Health, which serves as the object of protection of the right under discussion, can be understood, according to a definition of the World Health Organization, as "a state of physical, psychological and social well-being, both of the individual and of the community" (UNAM, 2013 with reference to Freire, 1999). Throughout this chapter, a contextual framework will be provided regarding the Right to Health, history of the Mexican Health System, the relationship between HIV and migration, HIV prevalence, risk factors, HIV prevention, the role of the National Human Rights Commission (Comisión Nacional de los Derechos Humanos, CNDH), and the methodological importance of the KAP.

2.1. THE RIGHT TO HEALTH

As mentioned before, although health is a universally recognized right, there are still conditions that encourage its violation, such as the limited access to medical services for prevention, diagnosis and treatment of certain diseases; as well as the persistent lack of comprehensive and periodic health monitoring programs, with a human rights approach and in accordance with the principles of equality, non-discrimination and gender perspective to ensure a coordinated and efficient planning for prevention and effective treatment for people living with HIV/AIDS.

This is relevant because the Right to Health is made up of "freedoms" and "rights". The "freedoms" refer to the fact that every individual has the freedom not to undergo any medical test (e.g. HIV test) without consent and without having received adequate information. Rights", on the other hand, are based on the obligation and responsibility of the State to provide quality and necessary health services.

From international human rights law, international organizations (i.e. UNAIDS), agreements and plans have been established (i.e. UNICEF Medium Term Strategic Plan, Resolution of the UN Commission on Human Rights, 2002/32). 2002/32); HIV/AIDS has been incorporated into the Millennium Development Goals and the resolution adopted in 2001 by the Commission on

Human Rights of the General Assembly and the Joint United Nations Human Rights Program on HIV/AIDS was issued, which states that "the right to the highest attainable standard of health includes access to antiretroviral therapy for HIV". Therefore, guaranteeing a dignified life to people living with HIV/AIDS involves the fulfillment of international commitments that the Mexican State is obliged to recognize, since these international instruments establish the humanitarian and human rights principles that should govern public policies that are developed in this area.

For Mexico, respect for human rights is the guiding principle of all its actions, as established in Article 1 of the Constitution. This implies guaranteeing the provisions of the various international human rights treaties, as well as improving, coordinating and updating existing national policies with said instruments, promoting regulatory harmonization. Similarly, as mentioned above, the Political Constitution of the United Mexican States (CPEUM), in its article 4º refers to the guarantee applicable to all persons in Mexican territory and the protection of their Right to Health.

Thus, in Mexico, the Right to Health is regulated by the General Health Law (LGS) and operated through the Health Sector Program (PROSESA). The General Health Law establishes the bases and modalities for the enjoyment and exercise of this right and determines that health protection must be guided towards improving the quality of life of all people, with special attention to the most vulnerable sectors. The groups most vulnerable to HIV/AIDS are: women, children and adolescents, persons in the context of migration, persons deprived of liberty, indigenous persons and the elderly.

2.1.1. MEXICO’S HEALTH SYSTEM

The following chapter provides background information regarding Mexico’s Health System. Initially, in Mexico, hospitals did not function as medical institutions and medicine was not considered a hospital profession; however, beginning in the early 20th century, the Mexican state began to participate in public health activities (Ruiz, 2011). This new interest was mainly due to the country's independence hence facing a strong instability where social, economic and political factors gained attention.

In his book titled "Políticas Públicas en Salud y su Impacto en el Seguro Popular en Culiacán, Sinaloa, Mexico", published in 2011, the author Manuel Ildefonso Ruiz Medina, states the following:

> *"In Mexico, the history of social rights is linked to inequality. Although the Constitution of 1917 succeeded in combining individual guarantees and social rights, the corporate model of distribution of wealth and social rights was not based on individual guarantees and social rights, the corporate model of distribution emanating from the Revolution necessarily led to a differentiated exercise of rights".*

The above statement reflects on the fact that, in Mexico, inequality and rights are directly linked to the moment of its inception. From the start, the Mexican legal system was based on inequality and differentiation in the application of such rights. Thus, ignoring the criterion of universal distribution, the foundation of human rights (Ruiz, 2011, referring to Pérez Argüelles, 2010:119). The Mexican Health System "was born divided by differentiating between those called *"derechohabiente"* (translated to right holder or beneficiary), who had their social rights perfectly defined, and those who were subject to the welfare action of the State, who were called the "open population" (Ruiz, 2011).

Who enjoys the benefits of the Mexican Health System? The beneficiaries first of all would be salaried workers, retirees and their families. This is followed by the self-employed, workers in the informal sector and the unemployed, and finally the population with the capacity to pay (Ruiz, 2011). Despite the fact that Article 4 of Mexico's Political Constitution addresses that the protection of health is a right of all citizens (Ruiz, 2011), not everyone can effectively exercise this right (Dantés et al., 2011).

By ignoring the primordial criterion of the universal distribution, only the salaried and organized population was the recipient of health services. This led to the birth of social security institutions such as IMSS and ISSTE, which focused on serving the "population of the formal sector of the economy" (Ruiz, 2011 referring to Pérez Argüelles, 2010: 119). With regards to the

contemporary history of the Mexican Health System, the author Ruiz (2011) provides the following dates based on Frenk and Gómez (2008:19-28).

Table 2. Contemporary History of the Mexican Health System

1905	Inauguration of the General Hospital of Mexico.
1917	Creation of the General Health Council and the Department of Public Health. In the new Constitution, Chapter IV of Article 123 highlights the responsibility of employers to secure rights.
1922	The School of Health was created, the first in Latin America. Today named: School of Public Health of Mexico.
1925	The scope of influence of the country's health services is extended from the territories, ports and borders to all federative entities.
1931	With the support of the Rockefeller Foundation and through the initiative of The Department of Public Health, the Rural Hygiene with vaccination services, school hygiene and maternal and child health services, were created in 1931.
1935	The social service is created to extend health care to the country's rural communities and to deepen the Department of Public Health's knowledge about local health conditions.
1937	Creation of the Public Assistance Secretariat.
1943	Merger of the Department of Public Health and the Secretary of Public Assistance, to create the Asistencia Pública, to create the Secretaría de Salubridad y Asistencia, today the Secretaria de Salud (Secretariat of Health), creation of the Mexican Institute of Social Security (Instituto Mexicano del Seguro Social, IMSS) and the first of the national health institutes, the IMSS and the first of the national health institutes, the Children's Hospital of Mexico.
1944	IMSS begins to provide services in Mexico City
1953	Creation of the Mexican Hospital Association
1960	Amendments to Article 123 of the Constitution - Creation of the Institute for the Social Security and Social Services for State Workers ISSSTE
Late 1970s	Services become more expensive with demand, system does not reach rural population, non-communicable diseases increase, resorting to private services.
1987	Creation of the National Institute of Public Health
2003	Creation of the Social Health Protection System, whose operative arm is the Seguro Popular.

Source: Own elaboration based on the table of Ruiz (2011), which provides the following dates based on Frenk and Gómez (2008:19-28).

The above table reflects Mexico's social response over the years to meet the great challenges in terms of the health of all people in Mexican territory. The instruments referred to in the table above should act as contributors to social welfare. Another table is provided below with the basic data on factors such as structure, coverage, stewardship, evaluation and surveillance of the Mexican Health System.

Table 3. Data factors Mexican Health System

Structure and Coverage	Public and private: - Private offices, clinics and hospitals - Mexican Institute of Social Security (IMSS), Institute of Social Security and Services for Workers (ISSSTE), Petróleos Mexicanos (PEMEX), Secretariat of Defense (SEDENA), Secretariat of the Navy (SEMAR) and the institutions and programs that attend to the population without social security, Secretariat of Health (SSa), State Health Services (SESA), IMSS Program (IMSS), and others such as IMSS-Oportunidades Program (IMSS-O), Popular Health Insurance (SPS).
Surveillance	Federal Commission for Protection against Sanitary Risks
Evaluation	General Directorate of Performance Evaluation
Stewardship	Through the Secretariat of Health

Source: Own elaboration based on data retrieved from Dantés, et al., 2011. "Sistema de Salud de México. Salud Pública de México, 53(Suppl. 2), s220-s232."

In Mexico, public institutions continue to be the main channel for the provision of health care services (Dantés et al., 2011). However, “despite the fact that during the last ten years, the number of human resources employed within the health system has increased, Mexico still faces a relative deficit of physicians and nurses" (Dantés et al., 2011). The rate of physicians per 1000 is 1.85, meaning there is a vast amount of Mexicans without access to health services (*ibid.*).

2.1.2. MIGRATION AND THE RIGHT TO HEALTH

The motivation of people to leave their countries of origin is not always the same. Among the many various reasons, it’s possible to identify conflicts, poverty, discrimination, lack of access to basic services, political persecution, search for new opportunities, etc. (IOM, 2013:7). There are undoubtedly several reasons, however, it can be said that ultimately people leave their countries of origin to improve their quality of life.

Among the various factors that shape a person's migratory trajectory, it is important to mention their effects on health. Although in most countries in the Latin American region they opt for "public discourse, plans, programs and political manifestations that express and project a good-natured and motivating image of migration issues" (Abreu and Batmanghlich, 2013:265). The truth is that acts of intolerance, discrimination and racism against migrants continue to exist in their own region, The truth is that acts of intolerance continue to exist in their own region, such as discrimination and racism against migrants, affecting their physical and/or mental health (IOM, 2013:7).

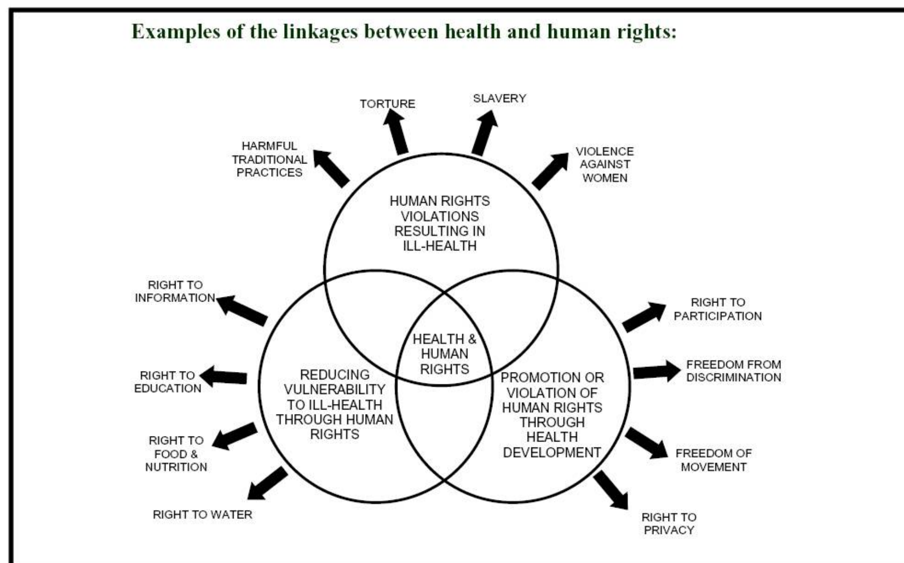
Medical services display a low usage on behalf of migrants in Mexico. This is not only linked to the migrant population's greater financial difficulties, but also due to the fear associated with the lack of documents, linguistic and cultural barriers (Leite et al, 2009). In addition, in the event that migrants have access to services, there is a possibility that these do not necessarily meet their needs, culture or language (IOM, 2013:7). Faced with this scenario, migrants tend to postpone or cancel hospital or medical consultation. The process of relocating to another country, with a culture, language, norms and customs different from one's own, often entails exposure to risks and behavioral changes that affect the quality of life and overall health of the individuals. Migrants' health is, therefore, an issue of vital importance, especially in countries such as Mexico - a country of origin, destination and transit of migrants - where transnational mobility is extremely intense and complex (Leite et al, 2009).

According to the National Development Plan (2007), "a new culture of migration in Mexico must be based on the congruence Mexico must be based on the principle of guaranteeing respect for and protection of the human rights of migrants from other countries on Mexican soil, just as it strives for the guarantees of Mexican migrants abroad," it is necessary to restate that the Right to Health is a primordial Human Right. Furthermore, the misconception that migrants constitute a heavy economic burden for countries of transit and destination, hinders migrants' enjoyment of better health (IOM, 2013:12). Likewise, there is empirical evidence that shows that what constitutes a greater risk of contracting diseases is the existence of constraints during the

migration process (IOM, 2013:12). Such misconceptions only lead to discrimination, stigma and xenophobic attitudes that interfere with access to health services for migrants.

Below is a diagram with examples of the relationship between health and human rights (IOM, 2013:15):

Diagram 3: Linkages Health and Human Rights



Source: Examples of the linkages between health and human rights, retrieved online from:https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health (WHO, 2013).

In the above diagram it can be perceived how the central axis Health and Human Rights encompasses Human Rights Violations Resulting in Ill-Health, Reducing Vulnerability to Ill-Health through Human Rights and the Promotion or Violation of Human Rights through Health Development. Regarding the consideration of the Right to Health as a Human Right, the World Health Organization (WHO, 2006) states that this is "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (Torres, 2016 citing WHO, 2006). Among the characteristics of the Right to Health as a human right that includes the principles of universality, indivisibility, imprescriptibility and inalienability (Torres, 2016). It is, therefore, a right to which all human beings, regardless of their conditions or circumstances,

should enjoy simply because of their human condition and because of the "essential equality of all" (Torres, 2016:8).

It is also important to mention that the right to health consists of "freedoms" as well as "rights" "freedoms" as well as "rights" (IOM, 2013:18). In terms of "freedoms", these refer refer to the fact that every individual has the freedom not to undergo any medical test (e.g. HIV test) without consent and without having received adequate information. On the other hand, such "rights" that emanate from it are based on the obligation and responsibility of the State to provide quality and necessary health services (IOM, 2013:18).

Population movements regularly, yet not always, cause migrants to be more vulnerable and exposed to health risks (WHO, 2007). At the beginning of a mobility movement, people often have to face situations of poverty and marginalization that may result in poor access to health services (*ibid.*). Likewise, during their stay or transit through Mexico, migrants often face rights violations or become victims of crime, thus becoming people at high risk of vulnerability (CNDH, 2016:5).

When the migratory process is carried out under inadequate and irregular conditions, it is likely that great risks are assumed that do not only affect the health of the individual but also of those related to the individual's migration process (IOM, 2013). With respect to the Social Determinants of Health of Health (mentioned previously in the Theoretical Framework), at each stage, transit, destination and return, these will be affected and modified, thus generating even more vulnerability for the health of those who migrate and and for the families and communities linked to the migration cycle (IOM, 2013).

Although all three stages are important, during the transit stage risks grow exponentially depending on the number of days and the means of transportation that individuals choose to use (IOM, 2013). A person starting a migratory trajectory may feel vulnerable to situations of violence, rape, transactional sex, robbery, etc.

Contrary to the existing myth that characterizes migrant populations as already sick or in poor health, there is abundant scientific evidence that indicates that most people who migrate do so because they feel physically healthy to face this challenge (IOM, 2013). The profile of migrants include mainly young people who start their migratory trajectory in good health, and it is the adverse conditions and inequities they face during the migration route that end up affecting their health, both physical and mental (Torres, 2016).

In this way, we insist on the assertion that migration is not a health risk in itself, but it is definitely a social determinant of health (IOM, 2013). The positive or negative effect on health depends to a large extent on the risks that the individual assumes, the adverse conditions in which he/she finds him/herself, and the conditions of vulnerability associated with the migration cycle (Torres, 2016) (IOM, 2013).

An important effort related to the creation of inclusive health services for migrants, is the World Health Assembly Resolution 61.17 (WHO, 2008) which is based on "improving information systems, research, follow-up and articulation of national and regional sources of information, to make this population and their health status visible" (WHO, 2008). It also addresses the need for the possibility of translation in certain cases that merit it, and the design of policies that invite any person -regardless of their migratory status- to be diagnosed and receive medical treatment (WHO, 2008).

The growing recognition of migrant communities' human rights of migrants has led governments in several countries to adopt and recognize in their policies the health needs and vulnerabilities of migrants, in order to put an end to inequalities and obstacles to access to health for the entire population (CNDH, 2016). Its importance is such that the Committee on Economic, Social and Cultural Rights, as a United Nations body, pointed out that using nationality as a barrier to any barrier to any health service (among others) was a ground for discrimination (Committee on Economic, Social and Cultural Rights: General Comment No. 20 on non-discrimination and Economic, Social and Cultural Rights, with respect to Article 2, paragraph 2 of the International Covenant on Economic, Social and Cultural Rights) (CNDH, 2016).

Accordingly, States should not use a legal status or nationality of a person to create a distinction between access to, or denial of a care service. International human rights law (taking into consideration what is enshrined in the International Bill of Human Rights) protects migrants Human Rights) protects migrants without taking into consideration their migratory status (CNDH, 2016).

2.1.3. IRREGULAR MIGRATION AND THE RIGHT TO HEALTH

One of the greatest challenges resulting from globalization is the management of irregular migration, including the management of individual and global public health. Current immigration laws and regulations, which are designed for orderly, regulated and accepted migratory movements, are less effective in addressing the challenges of new and emerging patterns of movement.

Although demands for health services for irregular migrants, such as trafficked and asylum-seeking populations, are increasing, the irregular nature of the migration process hinders access to health services and access to a healthy environment. “Irregular" migrants may be those individuals who are victims of human trafficking, those who have been moved from one country to another clandestinely, economic migrants, subgroups of migrant workers and even asylum seekers, and all by virtue of such status are more exposed to a number of important health risks.

One of the main effects on the health of migrants is decreased or poor mental health. This is because migrants, particularly irregular migrants, generally find themselves living in conditions of violence, threat and lack of control as if they were in detention. They are often deprived of food, the minimum necessary rest, personal space and security, as well as access to medical care, social services and support groups. The resulting psychological effects are complex, detrimental and often permanent for the health of migrants.

Continuing the human rights-based approach to the health of migrant populations, it is required that, to the extent possible, health care and public health entities provide access to physical and

mental health care, health education and advocacy to all migrants, including irregular migrants. Irregular migrants deserve medical care.

This requires striking a balance between the rights and responsibilities of migrants and the responsibilities and obligations of host states. A host state's obligation to provide protection against persecution increasingly contrasts with the state's right to sovereignty and its responsibility to protect its constituents from the consequences of insulting claims of protection. The issue involves the question of where a government's obligation to protect ends and the migrant's responsibilities begin.

The National Human Rights Commission (CNDH) in its "Special Report on Cases of Kidnapping of Migrants" adds that the vulnerability of migrants in an irregular situation who transit through Mexico is generated and aggravated because of their irregular status and the fear that being identified by the State generates.

> *"They travel in high-risk means of transportation, such as freight trains or double-bottom trucks; they use roads that lead them astray and in general solitary places; they spend the night in open places; they do not know the areas through which they pass; they avoid contact with the police or any State agent; they do not know their rights or prefer not to exercise them if it means being visible; they are far from their places of origin and do not know who to turn to if necessary or they do not know the laws of the country" (CNDH, 2019).*

Different forms of discrimination create obstacles to the exercise of the right to health and other rights of migrants. States often use nationality or legal status as a basis for making a distinction between persons who can and cannot enjoy access to health care facilities, goods and services. However, international human rights law establishes that all persons, without discrimination, should have access to all the fundamental human rights enshrined in the International Bill of Human Rights. Therefore, migrants, regardless of their status, are protected by international human rights law. The International Covenant on Economic, Social and Cultural Rights clearly states that the right to health obliges governments to ensure that "health facilities, goods and

services [are] accessible, in law and in fact, to the most vulnerable and marginalized sections of the population, without discrimination on any of the prohibited grounds."

2.1.4. LEGAL BARRIERS IN ACCESSING HEALTH SERVICES

Legal status is one of the most important factors determining the extent to which migrants have access to health services in a country. Laws and policies that prevent migrants from accessing social services, including health services, are often based on the assumption that it would be too expensive for the taxpayer to cover the health costs of the entire population, i.e., including those of irregular migrants. There is also the idea that excluding that particular group from social benefits will deter future flows of irregular migration. However, there is no empirical evidence to support this argument.

However, in recent years, a number of countries have continued to uphold this flawed reasoning and have prevented access to social services and health services, even for regular migrants. Under human rights law, governments are obliged to promote and guarantee the right to health for everyone on their territory. However, in practice, many countries continue to limit access to health services for irregular migrants. In these countries, irregular migrants may be entitled to emergency care, although some countries only provide health care for acute illness at the migrant's own expense, so many migrants are reluctant to see a doctor or delay treatment until they are seriously ill (PICUM, 2007).

As mentioned above, offering only emergency services to the migrant population lacks justification not only from a human rights point of view, but also from a public health perspective. Studies have shown that, in some cases, migrants, especially those in an irregular situation, try to solve their health problems either by self-medicating or by resorting to non-professional care provided by non-professionals in their own community.

An important factor that may deter irregular migrants - and their families, regardless of their legal status - from seeking health care and medical treatment is the fear that health care providers may maintain contact with immigration authorities (Wolf, 2008). Such links, if they exist, would

compromise the obligation to respect the right to privacy of persons seeking health care from any health professional. Moreover, such a relationship would run counter to the ethical duty and unwaivable obligation of professionals to provide their patients with the best possible care. To avoid situations such as these, some countries have enacted laws prohibiting whistleblowing. For example, Article 35.5 of the unified law on immigration and the legal status of foreigners in Italy.

2.1.5. POPULATION MOBILITY AND HIV/AIDS

In order to correctly address the relationship between population mobility and HIV, especially in Mexico, it is essential to retake the publications of Dr. René Leyva Flores, M.D., Surgeon with a Master's Degree in Social Medicine from the UAM, Specialty in International Health and Principal Researcher in Migration, HIV/AIDS and Medicines (INSP, 2014).

What is the relationship between population mobility and HIV? The interconnectivity between mobility and disease have long been recognized, and there is no a priori reason for HIV to be different (Callahan and Bond, 2001). According to some authors, the relationship is based on the type of conditions in which some people travel or face, such conditions increase their degree of vulnerability to contracting HIV (Leyva and Guerra, 2011). An example of exposure to risk factors is the lack of shelter, food and money or the possible use of intravenous drugs.

Being prone to contracting sexually transmitted diseases -including HIV- could happen because of the risks they face, not because they are migrants (Leyva and Guerra, 2011). Vulnerability of migrants with HIV is particularly alarming, since the virus itself entails discrimination. Moreover, because "the border between Mexico and the United States is the most heavily traveled in the world, the link between international migration and greater vulnerability to the acquisition and transmission of HIV" is greater (Leyva et al., 2005).

Migration implies changes at the emotional and behavioral level of individuals exposed to a new cultural context and, therefore, have different determinants related to lifestyle (Leyva et al., 2013). When an individual leaves his or her community of origin, he or she may begin to assume

new experiences, perhaps opting for behaviors with greater unperceived risk in the short term or or behaviors that make their health more vulnerable. This includes unemployment, living and working conditions, the work environment, drinking water, health services/housing, education, sexual behavior, etc. (IOM, 2013). The previous increases the risks of HIV and other Sexually Transmitted Infections (STIs). Moreover, adverse conditions can be found, with high levels of stigma and discrimination due to their migrant status, which affects their mental health, which has possibly already been udnermined due to the departure and separation from their loved ones (IOM, 2013).

Some scholars argue that there is a variety of research that serves as a tool for linking migration with the spread and prevalence of HIV (Dodson and Crush, 2003). They argue for the existence of at least four key ways in which mobility is linked to the spread of HIV:

1. "Mobility per se may encourage or make people vulnerable to high-risk sexual behavior;
2. Mobility makes individuals more difficult to locate, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care;
3. Migrants' multi-local social networks create opportunities for sexual networking; and
4. There is a high rate of HIV infection in "mobile communities," which often include socially, economically, and politically marginalized people."

(Dodson and Crush, 2003).

According to the joint article by IOM and the Southern Africa Migration Project (2005), Substantial movement of people is necessary for the epidemic of HIV infection to spread. In addition, they state that people who spread the infection tend to be sexually active and/or engage engage in high-risk sexual acts. "It would seem inevitable that mobility, but in particular migration in which men are separated from their wives, and vice versa, is one of the most important determinants of the spread of HIV infection" (IOM and the Southern Africa Migration Project, 2005:27).

2.2. MEXICO’S HIV/AIDS MONITORING BODIES

In Mexico, the National Center for the Prevention and Control of HIV and AIDS (CENSIDA) is the decentralized body of the Secretariat of Health, in charge of evaluating the impact of various programs, public policies and the dissemination of prevention information, etc. Likewise, Article 157 Bis of the LGS stipulates that: "the Secretariat of Health and the governments of the federative entities, within the scope of their respective competencies, will coordinate to promote the use of condoms, prioritizing the most vulnerable populations at risk of contracting HIV/AIDS infection and other sexually transmitted diseases" (Ley General de Salud, 1987, 2021 latest reform)[1].

To achieve the above, in our country the Federal States have State Councils for the Prevention and Control of AIDS (COESIDA). These seek to raise awareness about HIV/AIDS and various STIs through education and prevention programs at the state level, for which they work in conjunction with CENSIDA, as the "governing and coordinating body for the national response to HIV and STIs based on scientific evidence and in compliance with regulations, with respect for human rights, diversity and gender perspective" (CENSIDA, 2015).

Another important instance for the development of public policies in this area is the Ambulatory Center for the Prevention and Care of AIDS and Sexually Transmitted Infections (CAPASITS), which serves as:

> *"A health unit that provides services for the prevention and specialized care of patients with HIV and sexually transmitted infections, on an outpatient basis. This type of unit provides prevention and promotion services as a fundamental part of its functions, in addition to providing psychological and social work support to affected persons and their families. As part of these services is to provide access to antiretroviral treatment for all people with HIV who are not covered by social security schemes" (ibid.).*

[1] General Health Law. Mexico. Article amended DOF 27-05-1987. Last amendment published in the DOF 14-10-2021.

2.2.1. HIV HISTORY AND PREVALENCE

According to the Centers for Disease Control and Prevention (2006), the first reported case of HIV was in 1959 in the Democratic Republic of the Congo. However, the first formalized and official cases of acquired immunodeficiency syndrome (AIDS) were diagnosed in 1981 in the United States (INSP, 2009). "In the first 27 years since then, more than 65 million people worldwide have acquired human immunodeficiency virus (HIV) and more than 25 million people have died from it" (INSP, 2009).

Undoubtedly, there is an urgency to continue working towards the eradication of HIV. However, the lack of knowledge about the disease, the various types of risky sexual behaviors, poor or inadequate health care, infrastructure, poverty, and political and economic instability are today the main reasons for the continued existence of the disease pandemic (Nylander, 2012 with reference to Coovadia and Hadingham).

The most affected area is sub-Saharan Africa, which accounts for 68% of all people living with HIV/AIDS in the world. In the industrialized world, "the prevalence is much lower, but the vulnerable groups are racial and ethnic minorities, men who have sex with men, injecting drug users, and people who engage in sex work" (Nylander, 2012 referencing Cohen, Hellman, Levy, DeCock and Lange, 2008).

2.2.2. MEXICO AND NUEVO LEÓN

The first case of AIDS reported in Mexico was in 1983 and since that date through June 2017, the number of cases has been increasing to 191, 336 reported cases (CENSIDA, 2017). In the case of the State of Nuevo León, the issue of HIV/AIDS is marked by a very important factor: the gender gap in knowledge, attitudes and practices related toHIV/AIDS and population mobility (CENSIDA, 2017).

In terms of the gender gap, the number of AIDS cases reported in people residing in the State of Nuevo Leon, show an abysmal difference in terms of the gender gap. The total number of men residing in Nuevo Leon with HIV had a rate of 5,041 people while women had a rate of 739

(CENSIDA, 2017). According to UNAIDS typology, Mexico continues to have a concentrated epidemic.

In the State of Nuevo León, there is a State Council for the Prevention and Control of AIDS (COESIDA). As its name indicates, it seeks to raise awareness about HIV/AIDS and various STIs through education and prevention programs at the state level. COESIDA arose because Mexico was undergoing -or is still undergoing- a "marked population and epidemiological transition, which has had a major impact on the health profile of the population" and when the first cases of HIV/AIDS began to arrive in the State during 1986 (COESIDA, 2016).

According to COESIDA's official web page, its mission is "to be a guiding and coordination of the national response to HIV and STIs based on scientific evidence and in compliance with regulations, with respect for human rights, diversity and gender perspective" (COESIDA, 2016). Likewise, the values that distinguish COESIDA are those that are based on the code of conduct of the staff of the Secretariat of Health itself. These are: quality and humane care, vocation of service, respect and quality (COESIDA, 2016).

It is also necessary to mention the Ambulatory Center for the Prevention and Care of AIDS and Sexually Transmitted Infections Prevention and Care Center (CAPASITS), which acts as a as:

> *"A health unit that provides services for the prevention and specialized care of patients with HIV and sexually transmitted infections on an outpatient basis. This type of unit provides prevention and promotion as a fundamental part of its functions, in addition to providing psychological and social work support to affected persons and their families. As part of these services, it provides access to antiretroviral treatment for all people with HIV who are not covered by social security schemes" (CENSIDA, 2015).*

2.2.3. HIV/AIDS FUNDING

Another fundamental aspect to contextualize the importance of the evaluation of public policies aimed at the fulfillment of the human rights of people with HIV and AIDS is the designation of the budget for the prevention and control of diseases, which shows in 2020, a decrease to the federal budget program "Prevention and care of HIV / AIDS and other STIs" (PAVIH / AIDS / AIDS / STI or P016) compared to what is allocated in 2019. This is relevant, since this budget item (P016) is intended for the implementation of screening actions and linkage to antiretroviral treatment in a context where the effective and coordinated participation of national and state institutions and agencies is promoted.

Table 3. Spending on prevention: Secretariat of Health

Sector	Denomination	2015	2016	2017	2018	2019	2020
P016	"Prevención y atención de VIH/sida y otras ITS" Translated to: "Prevention and care of HIV/AIDS and other STIs."	460	489	414	387	451	416

Source: Own elaboration in reference to CIEP and with information from: SHCP (2019a) and SHCP (2019b). Note 1. Figures in millions of 2020 pesos.[23]

On the other hand, the "Proyecto de Presupuesto de Egresos de la Federación para el Ejercicio Fiscal 2021, Título Primero de las Asignaciones del Presupuesto de Egresos de la Federación" translated to "Federal Expenditure Budget Project for Fiscal Year 2021, First Title of the Federation Expenditure Budget Allocations", lists the Health Program No. 12 as one of the main programs, allocating the following:

[2] Original chart available at https://ciep.mx/presupuesto-para-prevencion-y-control-de-enfermedades/. Accessed October 14, 2021.
[3] Data obtained from: https://ciep.mx/presupuesto-para-prevencion-y-control-de-enfermedades/

Table 4. Expenditure Budget

Annex/Attached Document	Program	Page	Amount (Mexican Pesos)
ANEXO 13. EROGACIONES PARA LA IGUALDAD ENTRE MUJERES Y HOMBRES (pesos) *Translated to:* EFFORTS FOR EQUALITY BETWEEN WOMEN AND MEN (pesos)	12 Salud/Health Prevención y atención de VIH/SIDA y otras ITS *Translated to*: Prevention and care of HIV/AIDS and other STIs	70	404,229,242
ANEXO 14. RECURSOS PARA LA ATENCIÓN DE GRUPOS VULNERABLES (pesos) *Translated to:* RESOURCES FOR THE ATTENTION OF VULNERABLE GROUPS (pesos)	12 Salud/Health Prevención y atención de VIH/SIDA y otras ITS *Translated to*: Prevention and care of HIV/AIDS and other STIs	74	454,004,404
ANEXO 17. EROGACIONES PARA EL DESARROLLO DE LOS JÓVENES (pesos) *Translated to:* EROGATIONS FOR YOUTH DEVELOPMENT (pesos)	12 Salud/Health Prevención y atención de VIH/SIDA y otras ITS *Translated to*: Prevention and care of HIV/AIDS and other STIs	78	301,877,242

ANEXO 18. RECURSOS PARA LA ATENCIÓN DE NIÑAS, NIÑOS Y ADOLESCENTES (pesos) *Translated to:* RESOURCES FOR THE CARE OF CHILDREN AND ADOLESCENTS (pesos)	12 Salud/Health Prevención y atención de VIH/SIDA y otras ITS *Translated to*: Prevention and care of HIV/AIDS and other STIs	81	1,569,941

Source: Own elaboration in reference with data from SHCP (2019a) and SHCP (2019b).

The allocation of a specific budget is relevant in a context in which, according to the latest UNAIDS fact sheet, in the year 2020, approximately 37.7 million people were living with HIV worldwide. In Mexico, the estimated number of people living with HIV is 322,987 people, with an HIV mortality rate of 4.19 per 100,000 inhabitants and with only 60% of diagnosed people receiving antiretroviral treatment.

2.3. NATIONAL HUMAN RIGHTS COMMISSION

In Mexico, the National Human Rights Commission is the non-jurisdictional body in charge of the protection of human rights recognized by the Mexican State, for which it has the power to issue public, non-binding recommendations, complaints and denunciations before the respective authorities" which are mandatory for all public servants to respond. Therefore, the National Commission has the power and attribution to issue General Recommendations, Special Reports and Pronouncements, which are not binding, "nor directly motivated as a way of resolving complaints."

The National Human Rights Commission (CNDH), as the national institution for the promotion and protection of human rights in Mexico, in compliance with the attributions established in the Paris Principles, the main instrument that establishes the standards for the development and strengthening of National Human Rights Institutions (NHRI), has strengthened a series of actions aimed at issuing recommendations to the authorities of the Mexican State, linked to the fulfillment of their obligations to promote, respect, protect and guarantee human rights, as

stipulated in Article 1 of the Political Constitution of the United Mexican States (ACNUDH, 1993).

In this sense, as mandated by Article 2 of the Law of the National Human Rights Commission, the CNDH's mission is the protection, observance, promotion, study and dissemination of human rights, for which it formulates recommendations, through the development of General Recommendations, whose objective is to promote modifications of regulatory provisions and administrative practices that involve or may result in human rights violations, based on studies carried out by the National Commission. These recommendations do not require acceptance by the authorities to whom they are addressed, they are registered separately from the ordinary recommendations and compliance is monitored through the development of general studies.

Therefore, it is important to systematize and follow up on the recommendations addressed to federal authorities, which have been promoted by the CNDH through General Recommendations and Special Reports, since the defense, promotion and strengthening of human rights requires the establishment of legislative and regulatory frameworks, programmatic guidelines, strategies and practices that allow the federal authorities to generate concrete actions that contribute to broadening and integrating a culture of human rights in all public actions. This means that all actions must respond to the obligations to respect, protect, guarantee and promote human rights; consider the principles of progressiveness, universality, indivisibility and interdependence, as well as incorporate the criteria of availability, accessibility, quality and acceptability.

Furthermore, according to the National Human Rights Commission (2016), primary attention should be given to those persons who fall within the following characteristics or situations:

- "Unaccompanied children and adolescents (under 18 years of age)
- Pregnant women, persons with physical or mental disabilities,
- Chronically and seriously ill persons, including persons with HIV/AIDS
- Indigenous people and adults over 60 years of age
- Non-Spanish speaking persons
- Witnesses and victims of serious crimes

- Persons in need of international protection (political asylum, refugee status or complementary protection)."

(CNDH, 2016:10)

This indicates that among the vulnerable social groups that are often less likely to enjoy the right to health is HIV/AIDS. This indicates that irregular migrant populations with HIV suffer from a double discrimination due to their irregular status and their medical condition.

According to the National Commission on Human Rights (2016), any person -regardless of their migratory status- who is in Mexican territory, must be able to enjoy all the enjoyment of all human rights established in the Constitution and in the international treaties to which Mexico is a party. Among these rights are the following: the right to life, freedom of expression, conscience, and religion, access to justice and due process, and prohibition of discrimination, arbitrary detention, torture, slavery and human trafficking (CNDH, 2016). Likewise, the following public services must be available to any person, including migrants:

- “Any type of medical care, provided by the public and private sectors. All migrants have the right to receive, free of charge, any type of urgent medical care necessary to preserve their life" (CNDH, 2016 citing the Migration Law, LM, Art. 8).
- "Access to education both public, as well as private" (LM, Art. 8)
- "The authorization of the acts of civil status and the registration of births, marriages, divorces and deaths by judges and Civil Registry officials" (CNDH, 2016 citing LM, Art. 9).
- "The public servant who denies the provision of these services or exercise of other constitutional rights, is subject to sanction" (LM, Art. 148).

It is important to note that as of May 25, 2011, the aforementioned Migration Law replaced the General Population Law, which served as the main instrument for immigration regulation. Thus, only the National Institute of Migration (INM) has the capacity to review the status of foreigners and to withhold documents (CNDH, 2016, citing Articles 35 and 17 of the LM). In the event that

any other authority performs any activity that does not correspond, it will be subject to a sanction (LM, Art 17).

2.3.1. GENERAL RECOMMENDATION 42/2020

The General Recommendation 42/2020, titled "On the human rights situation of people with HIV and AIDS in Mexico" is the last General Recommendation issued by the National Human Rights Commission regarding HIV and AIDS. The aim of this section is to provide an overview of what the National Human Rights Commission considers to be the main issues regarding human rights and HIV/AIDS in Mexico.

General Recommendation No. 42/2020, issued on January 15, 2020, aims "to know and make visible the situation of the human rights of people with HIV and AIDS, through the quantitative and qualitative analysis of the information provided by the complaints received and processed in this National Agency from January 1, 2010 to July 31, 2019, as well as through a contextual study prepared by consulting various official documentary sources, academic and civil society organizations that regularly work on the subject."

Through this General Recommendation, prepared based on the obligations of the CNDH to protect and defend human rights in accordance with the principles of universality, interdependence, indivisibility and progressiveness, it aims to serve as a tool to promote the establishment of policies and programs with a human rights approach, by the authorities that make up the institutional system dedicated to the care of people with HIV.

From international human rights law, international organizations (i.e. UNAIDS), agreements and plans have been established (i.e. UNICEF Medium-Term Strategic Plan, Resolution of the UN Commission on Human Rights, 2002/32). 2002/32); HIV/AIDS has been incorporated into the Millennium Development Goals and the resolution adopted in 2001 by the Commission on Human Rights of the General Assembly and the Joint United Nations Human Rights Program on HIV/AIDS was issued, which states that "the right to the highest attainable standard of health includes access to antiretroviral therapy for HIV".

Therefore, guaranteeing a dignified life to people living with HIV/AIDS involves the fulfillment of international commitments that the Mexican State is obliged to recognize, since these international instruments establish the humanitarian and human rights principles that should govern public policies that are developed in this area.

For all of the above, the National Human Rights Commission recognizes the importance of following up on what has been done by the authorities at the federal level to comply with the points emanating from General Recommendation 42/2020, reiterating that it is of utmost importance to promote access to prevention, treatment, care and support related to HIV, through mechanisms, measures, regulatory harmonization and public policies with a human rights approach and that promote a culture of respect and inclusion of people living with HIV and AIDS.

The General Recommendation was addressed to the following federal authorities: *Secretaría de Gobernación, Secretaría de Salud, Secretaría de Relaciones Exteriores, Secretaría de Hacienda y Crédito Público, Instituto de Salud para el Bienestar, Centro Nacional para la Prevención y Control del VIH y el sida, Instituto Mexicano del Seguro Social, Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, Instituto de Seguridad Social de las Fuerzas Armadas Mexicanas, Petróleos Mexicanos, Comisión Federal para la Protección Contra Riesgos Sanitarios, Instituto Nacional de Migración, Instituto Nacional de Pueblos Indígenas and Congreso de la Unión*[4]. The human rights related to the General Recommendation are the following: Right to health, Right to dignified treatment, Right to legal certainty, Right to equality, Right to non-discrimination, Right to receive and disseminate information freely.

Moreover, the percentages of compliance, resulting from the analysis of the actions identified in the various sources used in this analytical document. Thus, it can be observed that 10% of the recommendation points established in GR 42/2020 have been fully complied with by the

[4] Translated to: Ministry of the Interior, Ministry of Health, Ministry of Foreign Affairs, Ministry of Finance and Public Credit, Instituto de Salud para el Bienestar, Centro Nacional para la Prevención y Control del VIH y el SIDA, Instituto Mexicano del Seguro Social, Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, Instituto de Seguridad Social de las Fuerzas Armadas Mexicanas, Petróleos Mexicanos, Comisión Federal para la Protección Contra Riesgos Sanitarios, Instituto Nacional de Migración, Instituto Nacional de Pueblos Indígenas and Congreso de la Unión.

corresponding federal authorities, in accordance with the specific and observable criteria established, and evidence of such compliance is identified. In addition, 34% of the recommendation points emanating from this GR, count one or more, policies, programs or legislative reforms carried out by the authorities, being congruent with the actions that have been recommended by the CNDH. Meanwhile, in 56% of the recommendation points, it was not possible to identify any action that complies with the criteria recommended by this instrument.

On the one hand, efforts of some authorities were identified in the diagnosis and revision of NOM-010-SSA with the purpose of updating the regulatory framework; however, no reform was identified to Art. 42, paragraph 4 of the General Health Law Regulation on Social Protection, whose purpose would derive in not contravening Art. 8 and 27 of the General Migration Law and the provisions of Article 4°, paragraph 4° of the CPEUM. Neither was any reform to Art. 77, Bis 7, Section III, Bis 36 and 37, Article 157 Bis, of the General Health Law identified, nor any amendment proposals related to the development of a diagnosis or reform to NOM-010-SSA-2010 on the prevention and control of HIV infection, with the purpose of improving and updating the regulatory framework.

Similarly, no recent diagnoses of the Federal Law to Prevent and Eliminate Discrimination in the area of Human Rights for people living with HIV (in particular Article 9 for the creation of an enforcement mechanism to avoid stigma and denial of rights to people with HIV/AIDS, Migration Law and the Regulations of the General Health Law on Social Protection in Health (RLGSMPSS) were identified.

The objective of the expected legislative amendments is to have concordance with international commitments, in particular Sustainable Development Goal No. 16 of the 2030 Agenda, as well as with the 90-90-90 action of the Joint United Nations Program on HIV/AIDS. In addition, with respect to the level of compliance, a greater number of actions were identified related to guaranteeing the right to health to vulnerable populations such as pregnant women living with HIV (care during childbirth, puerperium and breastfeeding) and to the population in the context

of migration in transit or destination and repatriated persons, bringing the services of outpatient centers for the prevention and care of AIDS and sexually transmitted infections.

Also, several actions were identified, such as: campaigns and care services and promotion of a communication strategy coordinated with SEGOB and INM, the preliminary document of the PAEVIHITS 2020-2024, the Antiretroviral Management Guide for the Management of People with HIV (a tool that contributes to improving the quality of care, reducing the frequency of unnecessary, ineffective or harmful treatments) and the Sexual and Reproductive Health Guide for Women and HIV of the National Center for Gender Equity and Reproductive Health.

On the other hand, some actions were identified that were not fully complied with in relation to the recommendation points of Federal Social Reinsertion Centers, for the cases of people living with HIV and deprived of their liberty, as well as those related to correcting irregularities in the chain of acquisition and distribution of antiretroviral drugs.

Through General Recommendation 42/2020, it is possible to identify a clear call to federal authorities to continue watching over human rights and in particular, over the situation of the Human Rights of People with HIV and AIDS in Mexico and their Right to Health. As shown in multiple international treaties, agreements, conventions and laws; the Right to Health must be granted to any person without any discrimination. Thus, in order to achieve an effective prevention of HIV/AIDS, it is essential to have new strategies of information and participation of authorities from different institutions.

III. RESULTS AND DISCUSSION

3.1. SOCIODEMOGRAPHIC CHARACTERISTICS

The study's population was 51 people; 50 (98.04%) males and one (1.96%) female. The age of the participants was between 18 - 47 years old and the average age was 27.8 with a standard deviation of 7.1. Of all the participants, 44 (86%) were from Honduras, 5 (10%) were from Guatemala, 1 (2%) from San Salvador and 1 (2%) from Nicaragua. Regarding their marital status, 28 (56%) were single and 17 (34%) were in a free union. The average number of days participants have been in Mexico is 34.6 with a standard deviation of 43.8.

As for their education, most of them have completed elementary school (58%) while 20% have not completed any level of education at all. On the other hand, in the "occupation" section, 84% of the participants are without formal work in Mexico. It is important to note that these two factors - education and occupation - are considered to be two social determinants located in the structural determinants, which in turn are located in the socioeconomic position. Now, what is the importance of this? As mentioned in the theoretical framework, low income due to lack of work -or having a low-paid job- and education can have an impact on health by acting as barriers to accessing health services, and poor health can limit the opportunities for women to access health can limit opportunities for people to participate in the labor force or receive education.

The sociodemographic characteristics are presented below:

Table 5. Sociodemographic Characteristics

	Men	*Women*	*Total*	*Percentage*
Marital Status				
Married	4	1	5	8%
Long Distance Relationship	1		1	2%
Single	28		28	56%
Unmarried cohabitation/ Consensual Union	17		17	34%

Age				
18-23	18			
24-29	12			
30-35	12	1	13	24%
36-41	6			
42-47	2			
Occupation				
Agriculture	1		1	2%
Factory	3		3	6%
None	42		42	84%
Other	4	1	5	8%
Number of Days in Mexico				
1-15	15		15	30%
16-30	19		19	38%
More than 30 days	16	1	17	32%
Education				
None	10	1	11	20%
Primary	29		29	58%
Secondary	7		7	14%
High School	4		4	8%
Country of Origin				
El Salvador	1		1	2%
Guatemala	5		5	10%
Honduras	43	1	44	85%
Nicaragua	1		1	2%

3.2. HIV PREVENTION KNOWLEDGE

Regarding the knowledge of the migrants, study showed that the vast majority (90%) had heard of HIV, however, only 58% had received information on the subject. Moreover, 43% indicated that HIV was a bacterium, but since HIV is not a bacterium, it could be concluded that 43% had incorrect knowledge regarding the question.

However, in the next question: Is HIV a virus? 84% of participants answered yes. This indicates correct knowledge as HIV is indeed the human immunodeficiency virus. While a large proportion know that it is a virus, almost half of the same percentage answered that it was also a bacterium. This demonstrates an unclear distinction regarding the nature of exactly what HIV is. On the other hand, when it comes to distinguishing between HIV and AIDS, 58% consider that they are the same thing. This indicates incorrect knowledge since HIV and AIDS are not the same. HIV is responsible for causing acquired immunodeficiency syndrome (AIDS).

The reason why they lump the two terms into one may be due to the relationship of the two, since HIV can eventually lead to AIDS. However, in the present 21st century, a person can live with HIV all his or her life without it ever developing into AIDS. This is due to medical advances that allow a person to live with HIV treatment alone to avoid mutation of the virus. However, in the past this was not possible, so they may have been left with outdated knowledge.

Finally, another highly relevant fact is that 68% of the participants have correct knowledge of the fact that HIV can be found in pre-ejaculatory fluid. This indicates that it is likely that the same participants who indicated that it was possible to find HIV in pre-ejaculatory fluid, know that one of the routes of HIV transmission is through sexual intercourse.

The following are the synthesized results:

Table 6. HIV Prevention Knowledge/Awareness

	Men	***Women***	***Total***	***Percentage***
Have you ever heard of HIV and/or AIDS?				
Yes	45	1	46	90%
No	5		5	10%
Have you ever received information about HIV and/or AIDS?				
Yes	29		29	58%
No	21	1	22	42%
Is HIV a bacteria?				
Yes	21	1	22	42%
No	23		23	46%
Don’t know	6		6	12%
Is HIV a virus?				
Yes	42	1	43	84%
No	2		2	46%
Don’t know	6		6	12%
Is HIV and AIDS the same?				
Yes	29	1	30	58%
No	12		12	24%

Don't know	9		9	18%
Is HIV/AIDS a major problem in your country of origin?				
No	22		22	44%
Don't know	3		3	6%
Yes	25	1	26	50%
Is HIV/AIDS a major problem in Mexico?				
No	8		8	16%
Don't know	13		13	26%
Yes	29	1	30	58%
Is HIV found in pre-ejaculatory fluid?				
No	1		1	2%
Don't know	15	1	16	30%
Yes	34		34	68%
If a person has HIV, does it mean that he or she has only a short time to live?				
No	18		18	36%

Don't know	6		6	12%
Yes	26	1	27	52%
Can a job fire a person for having HIV?				
No	20	1	21%	40%
Don't know	8		8	16%
Yes	22		22	44%
Can a person who looks healthy have HIV?				
No	6		6	12%
Don't know	1		1	2%
Yes	43	1	44	86%

3.3. KNOWLEDGE OF HIV TRANSMISSION

Among the participants, the vast majority had the correct knowledge that HIV is not transmitted by hugging or shaking hands with someone (92%), drinking dirty water (86%) and sharing a meal with someone (78%). Moreover, 98% of the participants have the correct knowledge regarding the fact that HIV transmission is likely to occur without the use of a condom (92%) and through medical water containing infected blood (84%).

However, 54% of the participants have incorrect knowledge that a mosquito bite could be a way of transmission of HIV and 46% of participants have incorrect knowledge that kissing someone is a way of HIV transmission. Likewise, 78% of the participants are correct in indicating that oral sex is a form of HIV transmission. This could be related to the above mentioned 68% of

participants knowing that HIV can be found in the pre-ejaculatory fluid, as they know that one of the routes of HIV transmission of HIV is through sexual intercourse.

Table 7. Knowledge of HIV Transmission

	Men	***Women***	***Total***	***Percentage***
Is oral sex a form of HIV transmission?				
No	6			12%
Don't know		1		10%
Yes	39		39	78%
Hugging or shaking hands with a person with HIV/AIDS?				
No	46	1	47	92%
Don't know	2		2	4%
Yes	2		3	4%
Drinking dirty water?				
No	43	1	44	86%
Don't know	2		2	4%
Yes	5		5	10%
Having sex without a condom?				
No	3		3	6%
Don't know	1		1	2%
Yes	46	1	47	97%

Having sex with a condom?				
No	34	1	35	68%
Don’t know	3		3	6%
Yes	13		13	26%
Sharing a meal with a person living with HIV/AIDS?				
No	39	1	40	78%
Don’t know	2		2	4%
Yes	9		9	18%
Mosquito bite?				
No	19		19	38%
Don’t know	4		4	8%
Yes	27	1	28	54%
Kissing a person living with HIV/AIDS?				
No	24		24	48%
Don’t know	3		3	6%
Yes	23	1	24	46%
Use of medical needles containing infected blood?				

No	6		6	12%
Don't know	2		2	4%
Yes	42	1	43	84%
Using the same bathroom as a person with HIV/AIDS?	31			
No	31			62%
Don't know	4			8%
Yes	15	1	16	30%

3.4. ATTITUDES TOWARDS HIV PREVENTION

Regarding the attitudes toward HIV prevention held by the participants, the data indicates that if a participant found out that a friend had HIV/AIDS or had just contracted it, they would be
a friend has HIV/AIDS or has just contracted it, they would be more likely to support the person (72%) or would continue to be friends with the person, but would avoid physical contact (24%). The above data indicate that the vast majority would empathize with a person living with HIV and would seek ways to help. This may be either out of a feeling of pity or, as mentioned above, out of empathy.

On the other hand, 80% of the participants have the correct information regarding the fact that a condom can protect not only from pregnancy but from HIV as well. This demonstrates their knowledge of the efficacy of male condoms and its function as a barrier to STIs. This can be related to the Health Belief Model's term "perceived susceptibility" since the individual himself is aware of his own possibilities of contracting the disease and may choose to engage in healthier behaviors.

It is also relevant to mention that 72% of the participants do not know someone with HIV, however, it is the same percentage that would provide support to a person with HIV. Now, why, if

72% do not know someone with HIV, would they be willing to support them? This could be due to their perception of the seriousness or importance of HIV, which would be related to the Health Belief Model discussed above. The Health Belief Model's concept of "perceived severity, seriousness, or gravity," which is an individual as to how serious the illness is (Hayden and Aboyoun, 2013:64). Despite the fact that it is possible not to develop AIDS and that it is possible to receive treatment and live a lifetime with an undetectable load, there is still a perception of HIV as a "deadly disease," so it is likely that perception is likely to have inclined them to opt for support.

Table 8. Attitudes Towards HIV Prevention

	Men	***Women***	***Total***	***Percentage***
Do you know someone with HIV/AIDS?				
No	36	1	37	72%
Yes	14		14	28%
What would you do if you found out that a friend of yours had HIV/AIDS or has just contracted HIV?				
Continuing to be friends with the person, but avoiding physical contact	12		12	24%
Avoid the person	2		2	4%
Offer your support	36	1	37	72%
Would you use the same bathroom as a				

person with HIV/AIDS?				
No	27	1	28	54%
Don’t know	5		5	10%
Yes	18		18	36%
What can a condom do/provide?				
Spoil sexual relations	5		5	10%
To protect from pregnancy and HIV/AIDS infection	40	1	41	80%
Protect against pregnancy, but not against the transmission of HIV/AIDS	5		5	10%
Is it possible to reduce the risk of contracting HIV by only having sex with HIV-free people?				
No	4	1	5	6%
Don't know	3		3	6%
Yes	43		43	86%

3.5. HIV PREVENTION PRACTICES

Regarding HIV prevention practices that participants engage in, the data indicate that although 66% of the participants have used condoms in their lifetime, the last time they had sexual

intercourse, 82% of the participants indicated that they had not used a condom and 38% indicated having had sex with more than one person in the past year (2017). Moreover, 80% of participants would indeed use condoms if they could get them for free. It is important to reiterate that despite the fact that 80% of participants have the knowledge that condom use prevents STIs and pregnancy, 82% have not used one in the past year.

Despite the above data and the fact that 52% have not been tested for HIV, 78% do not consider themselves at risk of contracting HIV. This is somewhat paradoxical, since the vast majority of participants do not consider themselves at risk, despite engaging in high-risk practices. Linking HIV prevention practices to the Health Belief Model, it can be concluded that perceived susceptibility serves as a primary cause for people to use condoms in an effort to decrease susceptibility to HIV infection (Belcher et al., 2005). Likewise, in terms of one's belief in the efficacy of the recommended action to reduce risk or severity of impact, participants in this study the recommended action of using condoms would protect them from contracting HIV (Belcher et al., 2005).

Table 9. HIV Prevention Practices

	Men	***Women***	***Total***	***Percentage***
Have you ever used a condom?				
No	9	1	10	18%
Yes	41		41	82%
Did you use a condom the last time you had sex?				
No	33	1	34	66%
Yes	17		17	34%

Would you use condoms if you could get them for free?				
No	10	1	11	20%
Yes	40		40	80%
In the last year:				
I have had sexual intercourse with more than one person	19		19	38%
I have had sexual intercourse with just one person	27		27	54%
I haven't had sexual relations	4	1	5	8%
Did you know that it is possible to get HIV/AIDS through the use of injectable drugs/injections/needles?				
No	6		6	12%
Yes	44	1	45	88%
Do you know someone that uses injectable drugs?				
No	33	1	34	66%
Yes	17		17	34%

Do you consider yourself at risk for HIV/AIDS?				
No	39	1	40	78%
Yes	11		11	22%
Have you ever had an HIV test?				
No	26		26	52%
Yes	24	1	25	48%
Would you like to be tested for HIV?				
No	15		15	30%
Yes	35	1	36	70%
Do you know where to get tested for HIV in this city or country?				
No	44	1	45	88%
Yes	6		6	12%
Have you had any access to a health service in Mexico either through the formal health system or through an informal network (pharmacy, Casa del Migrante…)?				
No	31	1	32	62%
Yes	19		19	38%

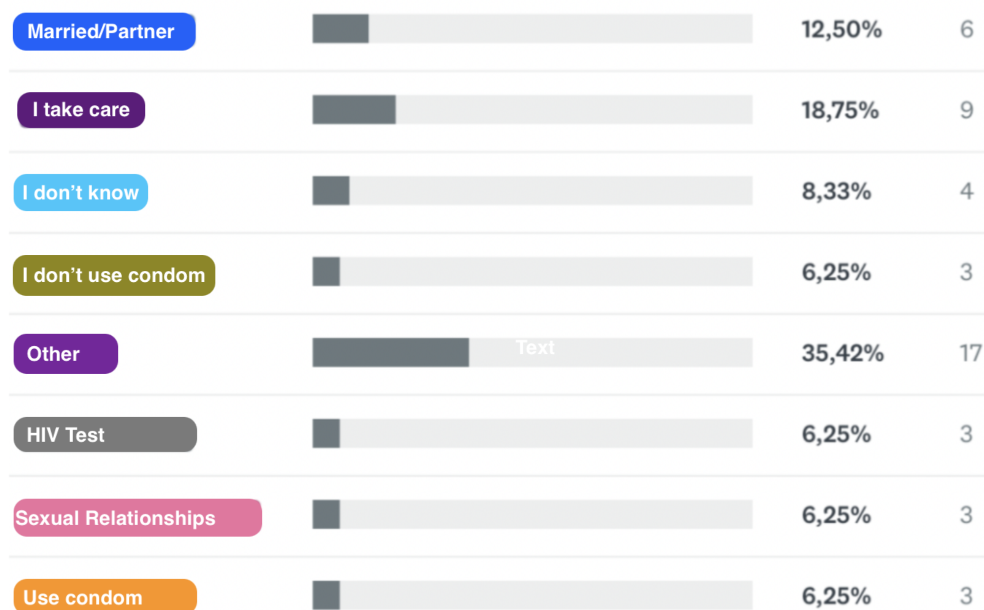
Do you want to learn more about HIV/AIDS?				
No	1		1	2%
Don't know	3		3	6%
Yes	46	1	47	92%

On the other hand, regarding the HBM's concept of "perceived barriers," it may be possible to interpret that the main barriers that the participants of this study experience in terms of their practices are likely to be based on the language barrier, fear of deportation that prevents them from going to medical centers to receive condoms or HIV testing, the lack of information regarding where or how to go to a medical center, lack of financial resources or lack of time.

3.6. QUALITATIVE DATA

Although the present study is primarily based on quantitative data, it is also complemented by a set of qualitative questions whose objectives were to assess the perceived risk of contracting HIV/AIDS, to identify the health trajectory of migrants during their stay in Mexico, to identify the support networks in their access to health care, to know the practices - and the reasons for them - that may expose them to HIV/AIDS, and further analyze attitudes towards HIV/TB and learn more about the means of information and the desire for greater knowledge of HIV/AIDS.

Regarding each participant's consideration of being at risk of contracting HIV/AIDS, 78% do not consider themselves at risk of contracting HIV/AIDS, 78% do not consider themselves at risk and 22% do. The explanatory data for this first question were as follows:



The categories considered for not being at risk are: married or with a steady partner, condom use partner, care through the use of condoms, and HIV testing. On the other hand, the categories considered to be "at risk" are: do not know, do not use condoms, having a large number of sexual intercourse and/or practicing high-risk sex (e.g., with the combination of drugs or alcohol). When asked this question, several responses were received that were particularly related to social stigma: "I don't associate with that kind of people", "you know who you are getting involved with" and "I know who I have relationships with". Based on the above, the notion of social stigma understood from a health approach and the answers obtained in the question should be of great concern, as it can interfere and act as a barrier to access to traditional health care systems.

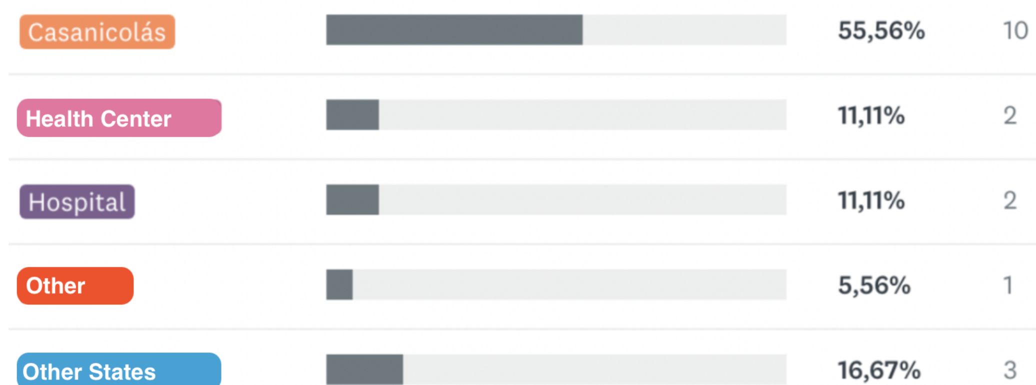
Likewise, we should take up what the author Scambler (1993) mentions in his publications, about the existence of a link between a disease and social differentiation. Scambler analyzes how certain health conditions cause medical structures and the beliefs of the individuals themselves favor social stigma and pejorative social labels. As can be seen in the responses obtained, it is possible to analyze how the disease itself can create distinctions and emotional predispositions that tend to be negative. An example of this is the fragments mentioned in the above paragraph.

Another interesting response was received from the only man from El Salvador, who indicated that: "In some accident (condom rupture) we are at risk or by having sexual relations without a condom with infected people". This 23 year old, received medical attention from the Tapachula Medical Brigade and has completed secondary school. The relationship between education and knowledge will be discussed later. In the "other" category, answers to particular questions were grouped together, such as: "because of my trip and leaving my country", "sometimes because of the food and saliva" and "there are many who appear not to have any (diseases), but you can't tell from the inside", among other answers.

The second highest percentage is made up of the "other" classification, followed by the "I take care of myself" classification. When asked to specify exactly how they took care of themselves, the vast majority chose not to answer. This may be due to differences in cultural issues in their countries of origin that may make them more traditional or reserved people, or because of stigma. However, noting a discomfort in questioning "how" they take care of themselves, it was decided not to insist any further.

Regarding the health trajectory of migrants in Mexico, we were told that in the shelters they feel confident and there is no fear of being deported. As mentioned in the section on the Social Determinants of Health, health systems determine how easy it is for people to access health services and receive the medical care they need. Therefore, we can reflect on how to strengthen the health care capacity of shelters, as they are the ones that are trusted by migrants. As mentioned in the theoretical framework, the Health Belief Model's "perceived barriers" could be reduced to achieve a greater number in good health.

For this reason, when asked about their access to health services in Mexico, either through the formal health system or through an informal network (pharmacy, Casa del Migrante...), of the 38% of participants who indicated that they have had access to medical services, 55.56% have had access to medical services, 55.56% have obtained them from the shelter "Casa del Migrante Casanicolas" shelter. The following are the summarized results of the other health services used:

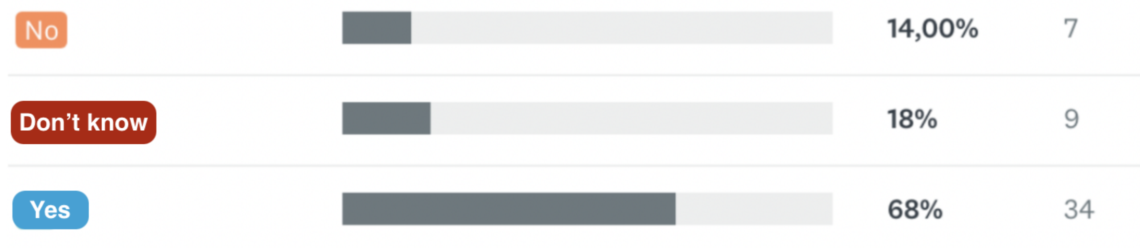


The following results are included in the "other states" classification: Irapuato Health Center, Tapachula Street Brigade and Casa del Migrante in Oaxaca (where they received medicines). Regarding the evaluation of the question concerning practices that could expose the individual to HIV/AIDS, 84.31% consider that they do not have any type of practices that could expose them, while only 17.65% (total of 9 people) stated that they do, they were asked which ones.

The most common practices of participants who said they were at risk were: having sex without condoms, the use of needles, and the non-use of condoms. Taking up the theory of transnationalism, because of the obstacles that they face (problems of exclusion, labor informality, and integration), migrants tend to develop social networks between individuals to counteract the difficulties presented, these social groups can modify their behavior, either positively or negatively. As an example of the above, if an individual is in a social network that uses needles, this may encourage non-injecting drug users to opt for what other people with similar backgrounds are resorting to. In this way, it is possible to analyze injecting drug use as a coping mechanism to avoid difficulties, to perform better at work, to obtain economic resources, etc., and the relationship between their social networks and their initiation, daily use and abandonment of drugs.

The study also aimed to analyze whether there should be concern about contracting tuberculosis (TB) when a person is already living with HIV/AIDS. The analysis was considered in order to

obtain data for future research to demonstrate the relationship and importance of HIV and being prone to tuberculosis (TB) due to having a weakened immune system. From this, the following data was obtained:



When participants were asked why they considered the relationship of HIV and TB, the text analysis shows that migrants opted for what they consider both as dangerous and "deadly" and, therefore, necessary to take care of both. Responses to this question had an important link to their level of education completed, since the most accurate response with respect to correct knowledge was the following: "Yes, because I believe that HIV/AIDS weakens the body and destroys the defenses". This response was provided by a 27-year-old Honduran man, single, with completed high school, with a factory job, who did not use a condom the last time he had sex and who has had sex with more than one person in the past year.

Of the 51 participants, he was one of only four with a high school diploma. As for the other participant with a completed high school education, he indicated that it was important to pay attention to the relationship between the two diseases and offered the following response: "Yes, because it is a disease that kills little by little (HIV) and you have to have treatment. Although his response does not show a clear relationship between HIV and TB, it can be deduced that the individual knows the importance of adherence to treatment and that the lack of treatment can lead to a greater likelihood of being prone to TB infection.

Also, the following response was obtained from the participant mentioning that he is from El Salvador: "because their defenses are very low and are exposed to any disease". On the other hand, the third man with a completed high school education - who is one of the five Guatemalans

who participated and also worked in a factory - is the only one who indicated that he is not at risk because he is tested for HIV every 6 months in the factory he works at. Thus, it can be seen that the participants with a higher level of education than the average of the other participants, offered more accurate responses to knowledge and correct practices. This can serve to reinforce the education offered not only by Mexico as a transit and destination country, but also of the countries of origin, since efficient educational programs can reduce HIV transmission and, therefore, reduce the prevalence of HIV.

Finally, they were asked if they would like to know more about HIV/AIDS and why. As a result, 92% indicated that they would like to know more about HIV/AIDS. The most common response was to indicate that it is "important" to know about it. It is curious to note that there were several meaningful and empathetic responses to this question. One of these was provided by a 25 year old man from Honduras with a completed primary education, who indicated that: "It is good to be informed, to be aware, if I come across a case, to know how to prevent it and move forward physically and morally". Also, other received responses were "yes, to understand it in case a friend has it, to support him", "yes, because this way one realizes and should be honest about it" and "yes, to take care of me and my partner too".

The above responses demonstrate the interest of migrants in preserving and caring about their social networks. It is interesting to note how these types of responses were given by relatively young people between 19 and 35 years of age. This may indicate that stigma may be decreasing and there may be greater acceptance. Likewise, we can see how the other valuable responses were "take care of myself" and "prevent it". The high statistic of 92% of migrants wishing to learn more about HIV, should serve as an element of motivation for workshops, courses, talks, etc. to provide information on the subject.

IV. PUBLIC POLICY PROPOSALS

Based on the results obtained, the identification of actions implemented and the rate of compliance with the General Recommendation on the Human Rights Situation of People with HIV and AIDS in Mexico, in addition to providing a situational analysis, it is essential to issue a series of proposals for improvement in order to comply with the points recommended and provide an improvement in the protection of human rights in the country. Although cooperative responses and partial compliance are identified, it is important to point out that the objective is to achieve total protection. Therefore, the following proposals are listed below:

- Based on the responses provided by the federal authorities, it was identified, for the most part, the failure to signal administrative provisions within the institution. For an optimal compliance evaluation, it is proposed to the federal authorities to mention protocols, guidelines, guides, specific programs.
- A periodic review by federal authorities of all General Recommendations and Special Reports issued by the CNDH is proposed in order to identify and follow up on them.
- It is suggested that the information that federal authorities choose to share be precise and concrete.
- In accordance with the Second Guideline of the International Guidelines on HIV/AIDS and Human Rights, the involvement and consultation of community organizations in the execution of programs becomes a key mechanism for optimal compliance.
- For an effective and efficient compliance, it is recommended the involvement and work in coordination with various organizations of the society, collectives, activist groups and the like in favor of the rights of those people living with HIV and/or AIDS. The involvement of these associations in response to the recommendation points could remedy deficiencies in the implementation of programs and improve weak relations with the government, since these groups are usually at the forefront and have a greater approach, experience and familiarity with the vicissitudes of people living with HIV/AIDS.

- It is recommended that the federal authorities establish minimum internal standards or systematizations in order to make it easier to communicate their actions and to have an optimal follow-up.
- In addition, public policies that seek to support the migrant population should seek to increase the dissemination and promotion of the human rights of migrants, in coordination with state and municipal governments, especially their right to health, in order to reduce racism and xenophobia towards migrants.
- State governments should establish public policies aimed at protecting the human rights of migrants, including campaigns to raise awareness among their inhabitants about the situation, the problems they face and the rights of the migrant population.
- Likewise, they should promote the training of clinic and hospital personnel on the urgency of protecting and comprehensively guaranteeing the human rights of migrants. In addition to guaranteeing, in coordination with the federal government, the security of migrant homes and organizations dedicated to the protection and defense of the human rights of this population.
- In order to promote the revision and updating of the Official Mexican Standard NOM-010-SSA2-2010, it is suggested to federal authorities to inform through the Transparency National Platform or via official communication, of efforts or technical meetings where significant progress is made.
- Finally, as a complement to the recommendations established in RG42/2020, federal authorities are advised to seek the opinion of people living with HIV and specialists in the subject, in diagnostic processes and development of programs and institutional protocols. The above in order to have a complete, sufficient and coordinated approach in such processes.

V. CONCLUSIONS

Health is a human right and the right to health is indispensable for the exercise of other human rights, i.e., it is closely related to and dependent on the exercise of rights such as the right to housing, food, social security, work and family. The right to health is also linked to the fundamental principle of non-discrimination, which recognizes the "inherent dignity" of every human being, migrant or non-migrant. This principle guarantees that human rights apply to all persons, without distinction as to nationality, race, color, sex or other status. Consequently, every state has the obligation to protect and promote the rights of migrants, without discrimination of any kind. In addition, States are also obliged to eliminate any type of discrimination exercised in their territory. The principles of non-discrimination and equal treatment of all individuals, including migrants, apply to different aspects of the right to health, so that countries must ensure that health facilities, goods and services are available, accessible, acceptable and of good quality. These obligations are the responsibility of all States parties to treaties that enshrine the right to health, whether they are countries of origin, transit or destination.

Effective public health includes all members within communities. Public health protects populations and communities from disease or illness and/or establishes policies and programs that promote healthy living conditions for all. In the context of migration, the promotion of healthy living conditions for all requires public health policies and practices that will include all members of communities, regardless of citizenship and migration status.

As mentioned above, attending to the health of migrants provides benefits not only to the migrants themselves, but also to the host States. This is because well-managed health services would benefit everyone living in the community. In addition, the inclusion of migrants in health programs will facilitate the integration of migrants within the communities. Together, timely diagnosis and treatment, prevention and health education can save economic, social and political costs in the future. In addition, healthy migrants are more receptive to education, are more likely to seek and obtain employment and integrate into the host society. Finally, healthy migrants contribute more to host societies.

The legal status of the migrant is the element that defines his or her ability to access health and social services. People who do not have legal status in a country, such as irregular migrants, may be reluctant to seek health, social and education services for fear of deportation.

Even though health is a human right recognized not only in the Mexican Constitution, but also in several International Conventions and Treaties that deal with the protection of human rights and to which the Mexican State is a party, and despite the existence of a broad legislation on health matters in the country, which indicates the obligations of the competent health institutions to guarantee an adequate and quality access to health, the truth is that this recognition has not been translated into adequate public policies, especially in public policies directed to the migrant population.

Another element that contributes to the violation of migrants' right to health is the lack of awareness of respect for human rights on the part of the personnel in charge of providing medical care. This is reflected in the discriminatory acts and mistreatment to which migrants who have come to be treated in Mexican health institutions are subjected. Added to this lack of sensitivity is the lack of knowledge that migrants have, especially those who are in an irregular situation, regarding their human rights and especially the right to access to health care. Since they do not consider themselves as subjects of rights within Mexican territory, they do not demand that their right of access to health be respected and in case of violation of such right, they prefer silence and non-reporting to mistreatment, discrimination, violence or medical negligence.
The focus of the State's public health policies should be on primary health care as the main point of access to the rest of the health services. In this way, together with the principle of non-discrimination, the State is obliged to create financing systems that integrate the entire population, including migrants. The commitment of healthcare professionals must be, above all, to patients and the defense of health as a human right. It is also essential that public policies and legislation promote access for everyone to basic preventive and curative health services, and clearly separate access to these services from the application of immigration laws.

This last section of the research aims to take up the hypothesis posed earlier: misconceptions about HIV transmission and prevention of HIV are evidence of a low level of knowledge, attitudes and practices concerning HIV/AIDS prevention among migrants in Nuevo León and limit people's access to HIV treatment, as well as stigma of the virus. In addition, this section presents the main findings, the limitations of the study, the main recommendations for public policies, as well as the opening and continuation of the research topic.

On the one hand, migration tends to bring benefits to society, with great contributions in the labor, economic, social and cultural spheres. Moreover, by having access to basic conditions, as well as comprehensive and friendly care, a migrant's health conditions may improve and with them, their contribution to their environment. However, in our region there are still great inequities and vulnerabilities associated with migration, and with it, serious repercussions on the health of migrants and the communities related to the migration process.

In relation to what has been presented in this research with respect to migration relationship with health, it is possible to arrive at the conclusion of three fundamental premises. Firstly, as stated in multiple international treaties, agreements, conventions and laws: health is a Human Right, thus acquiring the name Right to Health. Therefore, due to its nature as a Human Right, it must be granted to any person regardless of a person’s immigration status. The disease knows no borders. In the event that a person is in a health discomfort and, even more seriously, in possible contagion to others, the least important thing is their nationality or the nationality of those around him or her is of less importance. From a public health perspective, a key strategy should be to be able to secure a migrant person’s health from prevention to cure. As a basic principle of humanity, the fight should not be against the person who carries it, but in favor of the population in general.

As mentioned above, migrants bring great benefits to communities. In some countries - as is the case in Mexico - remittances are a fundamental part of the national economy. In the receiving countries, they generate work and cultural exchange, and the economy is streamlined. For this reason, we must recognize that health is an excellent investment, to the extent that people are

healthy, it means the possibility of working, consuming and contributing to their communities of origin and destination. It is now clear why we must analyze the issue of migrants' health. The need and importance of the creation of policies that provide comprehensive care for those who begin a migratory trajectory, or for those around them, in order to reduce vulnerabilities.

Because few studies have currently been conducted following the KAP methodology with respect to HIV prevention and knowledge, attitudes and practices among migrants in Mexico, it is difficult to compare this study with previous studies in Mexico. However, the importance of this study lies in the fact that the results can be used by health workers or state mechanisms can use the results of this study so that they may have a better understanding of migrants' knowledge, practices and attitudes of migrants about HIV prevention in Mexico and what needs to be improved. There is a need to acquire more information about the level of information available to migrants and prevention and transmission of HIV.

One of the main findings of the applied study was the relationship between people's educational levels and the answers they gave, as these were the most accurate. This indicates the need to reinforce the education offered, not only Mexico as a transit and destination country, but also the countries of origin, since efficient educational programs can reduce the transmission of HIV and, therefore, reduce its prevalence.

As for possible lines of research with respect to the social phenomenon addressed by the study, it would be interesting to investigate and compare what information and recommendations migrants have received from health care providers and what information and recommendations health personnel claim to have given to migrants. This could be useful to indicate the existence of any areas related to HIV KAP that need to be improved or lack of information on the part of prevention programs. Likewise, in order to broaden the results, it would be advisable to carry out the study in different migrant households and to have more women in order to make a distinction between the type of KAP that migrant women have and the type of KAP that male migrants have.

Effective HIV/AIDS prevention requires adequate and complete information. According to the results obtained in this study, HIV prevention campaigns in the most vulnerable migrant populations have not been effective. The context in which they are and from which they come from must be respected in order to create new information and education strategies for HIV/AIDS prevention. Fear of deportation, lack of knowledge, stigma and the vulnerable situations in which they find themselves are issues that need to be addressed.

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