

‘Unsafe’ and on the Margins

Canada’s Response to Mexico’s Mistreatment of Sexual Minorities
and People Living with HIV



UNIVERSITY OF TORONTO
FACULTY OF LAW

INTERNATIONAL
HUMAN RIGHTS
PROGRAM

This publication is the result of an investigation by the International Human Rights Program (IHRP) at the University of Toronto, Faculty of Law. The IHRP is a multiple-award winning program that enhances the legal protection of existing and emerging international human rights obligations through advocacy, knowledge-exchange, and capacity-building initiatives that provide experiential learning opportunities for students and legal expertise to civil society.

AUTHORS: Maia Rotman, Kristin Marshall

DESIGN: Shannon Linde

COVER ILLUSTRATION: Justin Renteria

This report was written in collaboration with Advisory Committee members:

Sandra Ka Hon Chu, Stéphanie Claivaz-Loranger and Richard Elliott, of the Canadian HIV/AIDS Legal Network; Dr. Meb Rashid and Dr. Philip Berger, of the former Canadian Doctors for Refugee Care; Meagan Johnston, of HALCO; and John Norquay and Andrew Brouwer of the Refugee Law Office at Legal Aid Ontario.

The IHRP would like to thank the Elton John Aids Foundation for its generosity in funding this project.



International Human Rights Program (IHRP)
University of Toronto Faculty of Law
39 Queen's Park, Suite 106
Toronto, Ontario
Canada M5S 2C3
<http://ihrp.law.utoronto.ca>

Copyright ©2016 International Human Rights Program, University of Toronto Faculty of Law
All rights reserved.
Printed in Toronto.

TABLE OF CONTENTS

2	I. EXECUTIVE SUMMARY
6	II. HUMAN RIGHTS IN MEXICO
6	A. Overview
6	1. Mexico as a Refugee-producing Country
8	2. Access to Health and HIV Treatment as a Human Right
12	B. Human Rights Abuses against Key Populations in Mexico
14	1. LGBTI
16	Transgender Women
17	Transgender women and access to healthcare
18	Gay Men and Men Who Have Sex with Men
18	Gay men and men who have sex with men and access to healthcare
18	2. Women and Girls
19	Women and girls and access to healthcare
21	3. Sex Workers
21	Sex workers and access to healthcare
23	4. People Who Inject Drugs
24	People who inject drugs and access to healthcare
28	III. CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN
28	A. Canada’s International Legal Obligations
28	B. Designated Countries of Origin
29	C. Impact of Designated Country of Origin
30	D. Mexico’s Designation
34	IV. RECOMMENDATIONS
38	V. APPENDIX A: TABLES
40	VI. APPENDIX B: METHODOLOGY
42	ACKNOWLEDGMENTS
43	ENDNOTES

EXECUTIVE SUMMARY

I. EXECUTIVE SUMMARY

On paper, Mexico's federal government professes to be a human rights protector. The country boasts an impressive array of human rights legislation and is a signatory to many international human rights conventions. In reality, vulnerable Mexicans, especially sexual minorities and people living with HIV, have little protection.

In June 2015, a few days before Mexico City hosted a massive Pride parade, unknown armed assailants savagely beat and shot in the head a transgender woman in Chihuahua. The victim's body was wrapped in a Mexican flag — apparently a protest against the Supreme Court's June ruling allowing gay marriage. According to the UN Special Rapporteur on extrajudicial, summary or arbitrary executions, between 2005 and 2013 in Mexico, 555 homicides targeting individuals because of their sexual orientation or gender identity were reported. The actual number is likely greater, as many crimes of violence in Mexico go unreported due to a lack of confidence in the justice system.

This report examines the right to health and HIV treatment in Mexico and is based on in-country interviews with 50 Mexicans, including human rights activists, journalists, members of the lesbian, gay, bisexual, transgender and intersex (LGBTI) community, people living with HIV, healthcare professionals and others involved in human rights advocacy. Julio, a gay asylum seeker from El Salvador, described how the discrimination he faced in Mexico prevented him from accessing healthcare and life-saving HIV treatment. Although Mexico has a national healthcare system that, by law, “guarantees” access to healthcare for all, including migrants, it failed Julio. He almost died from a cerebral infection after being denied HIV treatment for 18 months because of a lack of sufficient personal identification to access services. His experience is consistent with other cases from among Mexico's marginalized communities, as documented in this report by the International Human Rights Program (IHRP). Transgender women told the IHRP that they experience discrimination from healthcare administration and practitioners and are routinely denied HIV treatment. Many cannot even enter hospitals or other healthcare facilities because they lack identification and fear police officers stationed at entrances. People living with HIV in detention face similar discrimination and barriers to HIV-related healthcare services. Such mistreatment underscores the gap between a “paper right” to universal healthcare in Mexico and the on-the-ground reality of discrimination and exclusion facing vulnerable populations — a breach of Mexico's international human rights obligations.

According to the HIV Director of Mexico's National Commission for Human Rights (CNDH), HIV-prevalence is increasing in Mexico, especially among LGBTI individuals, heterosexual women, sex workers and people who inject drugs. The Mexican government's introduction of the *Programa Frontera Sur* (the “Plan”), a security control apparatus along Mexico's southern border, has had a chilling effect on HIV-prevention initiatives, including condom distribution, because of a fear of criminal charges under the new Plan. There is, in Mexico, a general insufficiency of access to information on sexual and reproductive health and to human rights-based health education. Even when sexual minorities do get access to HIV treatment, they continue to experience human rights violations. Health advocates report breaches of confidentiality, segregation within healthcare centres and other discriminatory practices that undermine the right to health of minorities and people living with HIV.

EXECUTIVE SUMMARY

This report criticizes Canada's ongoing designation of Mexico as a "safe" country, which arose as part of a massive overhaul of the refugee determination system by the former federal government in late 2012. The rationale for the designation was that Mexico, a significant trade partner with Canada, respects human rights and protects its citizens and thus, by extension, any refugee claim against Mexico must be "bogus" and unfounded. However, this report concludes that Mexico remains unsafe for many Mexicans, particularly for people living with HIV or at heightened risk of infection, as well as those belonging to communities disproportionately affected by the HIV epidemic. The country should be removed from Canada's Designated Country of Origin (DCO) list. The impact of designation is potentially harmful to refugee claimants because they are afforded fewer procedural rights, and coming from a country labeled "safe" can foster prejudgment among decision-makers at the Immigration and Refugee Board (IRB). Finally, the report concludes that greater investments in HIV prevention, care, treatment and support are critically needed in Mexico.

HUMAN RIGHTS IN MEXICO

II. HUMAN RIGHTS IN MEXICO

A. Overview

Mexico's government projects an inaccurate or, at the least, heavily curated image of itself as a progressive democracy, one where human rights instruments are adopted and institutionalized to protect and defend Mexicans from human rights abuses. Canada adopted this narrative when it labeled Mexico a "safe" country in early 2013. But the narrative is incomplete; in reality, the most marginalized people in Mexico, especially those living with or vulnerable to HIV, suffer as a result of this label.

The reforms undertaken by Mexico's federal government to combat discrimination and human rights violations are significant. Mexico amended its Constitution in 2011 to add a prohibition against discrimination on the basis of "sexual preference," in addition to the grounds of ethnic or national origin, social status, health condition, religious opinion, civil status or any other reason which violates human dignity.¹ In 2003, the *Federal Law to Prevent and Eliminate Discrimination* prohibited public and private sector discrimination, including discrimination based on sexual preference.²

However, on closer examination, the façade of a progressive, open and safe country reveals cracks. The president of the National Council for the Prevention of Discrimination (CONAPRED) has described the *Federal Law to Prevent and Eliminate Discrimination* in Mexico as "insufficient" because many Mexican states have failed to reform their laws in accordance with the federal law, leaving many Mexicans without access to this law's protection.³

Leading up to the Pride parade in Mexico City in June 2015, the historic El Ángel de la Independencia ("The Angel of Independence") monument in the centre of the city was illuminated in rainbow colours, an unprecedented symbolic act intended to convey Mexico's embrace of Pride celebrations and human rights. However, the IHRP later learned that the government only agreed to illuminate the monument after fierce debate in the moments before the parade and after significant pressure from the United States.⁴

Even with federal and state laws declaring protection for human rights, compliance is far from assured. Human Rights Watch reports that, because of corruption, collusion of government actors and public defenders and a general lack of resources, the criminal justice system in Mexico "routinely fails to provide justice" to victims of human rights violations and violent crimes.⁵ Mexico has the second highest number of hate crimes against sexual minorities in the Americas and these crimes, such as the murder of a transgender woman in Chihuahua in June 2015, are often perpetrated with impunity.⁶ The Catholic Church, entrenched in the Mexican political landscape, continues to advocate strenuously against progressive reforms.⁷ Indeed, CONAPRED has stated that homophobia is widely prevalent and deeply rooted throughout Mexico.⁸ Sexual minorities, targeted and vulnerable to enforced disappearances, report not feeling safe anywhere in the country.⁹

1. Mexico as a Refugee-producing Country

Mexico is a migration hub: It is a country of origin, destination and transit. The dominant narrative propagated by Mexico's government is that the country, a haven for human rights in the region, is a refugee-*receiving*, not

HUMAN RIGHTS IN MEXICO

a refugee-producing country.¹⁰ However, every year, tens of thousands of Mexican asylum seekers apply for refugee status abroad, and the numbers are rising. In 2014 alone, nearly 9,000 Mexicans applied for asylum in the United States.¹¹

Canada has recognized that Mexico is a refugee-producing country, despite its safe country labeling. As demonstrated by the chart below, a significant proportion of Mexico’s claimants who manage to get to Canada and make a refugee claim are accepted as Convention refugees, despite the visa requirement imposed on Mexican nationals in 2009 and the subsequent designation of Mexico as “safe.” Between 2010 and 2014, the Canadian refugee determination system found 2,539 refugee claimants met the international definition of “refugee” set out in the *1951 Convention Relating to the Status of Refugees* (“Refugee Convention”). In 2015, 41.7% of claimants from Mexico were found to be Convention refugees.¹² Furthermore, in apparent contradiction to the “safe” label, Global Affairs Canada (formerly the Department of Foreign Affairs, Trade and Development Canada [DFATD]) has issued near-continuous travel warnings for Canadians traveling to Mexico, advising them to “exercise a high degree of caution” in parts of Mexico due to violence, high levels of criminal activity and a deteriorating security situation.¹³

Table 1: Mexican Refugee Claims Made in Canada 2005–2014¹⁴

(see Appendix A, Table 1, for full statistics)

	Accepted	Rejected	Abandoned	Withdrawn & other
2014	94	188	10	34
2013	182	683	65	83
2012	568	2144	112	198
2011	1042	4184	284	600

Drug cartels and the culture of violence

To live in certain areas of Mexico is to be exposed to an epidemic of organized crime.¹⁵ As highlighted by the UN High Commissioner for Human Rights following his October 2015 visit to Mexico, 98% of all crimes in Mexico remain unsolved. The Commission found that Mexican society remains “wracked by high levels of insecurity, disappearances and killings, continuing harassment of human rights defenders and journalists, violence against women, and terrible abuses of migrants and refugees transiting the country on their way to the United States.”¹⁶ In November 2014, Mexican President Peña Nieto proposed a series of police reforms in order to combat years of insecurity — including centralizing control of each state’s local police — but implementation is seriously lacking.¹⁷ Violence has increased on the national level. Journalists attempting to report on drug cartel activity

and the enforcement of drug laws by military and police forces are assassinated or forcibly disappeared by perpetrators who are “frequently state authorities, state security forces, drug cartels and paramilitary groups many of whom have links to the Government and/or security services.”¹⁸ Because of collusion between police and drug cartels, a research director at the National Institute for Public Health in Cuernavaca, Mexico, told the IHRP that many human rights violations against marginalized populations in Mexico occur with impunity.¹⁹ National and international monitoring bodies, including the United Nations Human Rights Council in their most recent Universal Periodic Review, have echoed these concerns about impunity.²⁰

2. Access to Health and HIV Treatment as a Human Right

The protection of human rights is an essential pillar of a nation’s successful HIV prevention and reduction strategy. Studies show that people living with HIV or those at heightened risk of becoming infected with HIV will not seek testing, treatment or support if they believe they will face discrimination, a lack of confidentiality or other violations of their human rights and dignity.²¹ According to the UN’s *International Guidelines on HIV/AIDS and Human Rights*, there is international consensus that broad, inclusive and rights-based responses to HIV are crucial features of a successful HIV program.²²

HIV treatment is paramount to ensuring health: When HIV has severely weakened an individual’s immune system, a person is at high risk for certain life-threatening infections known as “opportunistic infections.”²³ There is currently no cure for HIV and no vaccine to prevent it, but early diagnosis and proper treatment enable people living with HIV to live healthy lives with a life-expectancy similar to uninfected individuals. There are dozens of anti-HIV drug treatment options, known as anti-retroviral therapies (ART) (consisting of combinations of anti-retroviral drugs [ARVs]). Treatment is also essential to maintaining healthy communities. A lower viral load in an individual living with HIV results in lower risk of transmission to sexual partners.²⁴ As HIV treatment becomes more readily available and immune system functions improve through ART, opportunistic infections and transmission of HIV become less common. However, late HIV diagnosis or lack of consistent HIV treatment can increase the risk of both life-threatening infections for the individual and onward transmission for those in the community.²⁵

HUMAN RIGHTS IN MEXICO

In September 2015, the World Health Organization (WHO) released a set of comprehensive guidelines for initiating ART.²⁶ According to the guidelines, *anyone* infected with HIV should begin ART as soon as possible following diagnosis, in order to reduce the effects of HIV on the health and well-being of the person. The recommendation applies to all populations and age groups living with HIV.²⁷

The guidelines also recommend daily pre-exposure prophylaxis (PrEP) — the use of ARVs by HIV-negative persons to reduce their risk of becoming infected with HIV — as a prevention measure for individuals at “substantial” risk.²⁸ This group includes gay men and other men who have sex with men (MSM), people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings.²⁹ According to WHO, these guidelines could help avert more than 21 million deaths and 28 million new infections by 2030.³⁰

Mexico

The HIV context in Mexico is one of deceiving numbers. Within the entire population, Mexico’s HIV-prevalence rate is relatively low, at 0.2% of the overall population.³¹ The government maintains the epidemic is receding, but Ricardo Hernandez, Director of Health, Sexuality and HIV at the Comisión Nacional de los Derechos Humanos (CNDH), or National Human Rights Commission, told the IHRP that the numbers tell a different story.³²

The virus disproportionately affects specific populations, such as LGBTI individuals, women and girls, sex workers, and people who inject drugs. For example, 15.5% of transgender women who engage in sex work are reported to be living with HIV, and prevalence is increasing among women, who represent more than 25% of new infections in certain regions of Mexico, such as Chiapas.³³

The epidemic also varies dramatically by region. In the state of Yucatán, for example, there were 427 reported new cases of HIV in 2014, while the state of Mexico (whose population is more than 13,000,000 greater than Yucatán’s), reported only 237 new cases.³⁴

According to the CNDH, Mexico ranks twenty-third among prevalence rates in the Americas.³⁵ However, by population size, Mexico has the third-highest number of individuals living with HIV in the Americas, behind only the United States and Brazil. In 2013, out of a population of just under 124 million people living in Mexico, approximately 190,000 were living with HIV.³⁶

Legal framework

Mexico has a clear obligation to provide effective healthcare and access to treatment for people living with HIV. International law recognizes that the right to health encompasses the right to effective and quality healthcare, without disparities in treatment.³⁷

The *Universal Declaration of Human Rights* (the “Declaration”) states that everyone has the right to life, liberty and security of the person, as well as the right to medical care to maintain a standard of living adequate for their health

HUMAN RIGHTS IN MEXICO

and well-being.³⁸ The Declaration also includes the right to equal protection of the law, the right to work and access education, the right to privacy and the right to an effective remedy for violations of human rights.³⁹ In adopting the Declaration, Mexico commits to ensuring these rights without “distinction of any kind,” including along lines of race, sex or other status, such as HIV status.⁴⁰

Mexico has an obligation to provide HIV prevention and education programs, as well as access to treatment, in order to achieve fulfillment of the right to health as set out in the *International Covenant on Economic, Social, and Cultural Rights* (ICESCR), ratified by Mexico in 1981.⁴¹ Access to healthcare as a basic right is set out in article 12 of the Covenant, ratified by Mexico in 1981. It explicitly recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁴² Article 12.2(c) specifies that the full realization of the right to health requires the government to take measures for the “prevention, treatment and control of epidemic, endemic, occupational and other diseases.”⁴³

Mexico also has an obligation to provide equal access, not just by making healthcare available, but by making it accessible to everyone. The ICESCR prohibits discrimination in access to health by virtue of article 2: “the rights enunciated in the present Covenant will be exercised without discrimination of any kind.”⁴⁴ Discrimination includes barriers to healthcare based on numerous grounds, such as HIV/AIDS status or sexual orientation, but also includes inaccessibility to healthcare as a result of inappropriate health-resource allocation.⁴⁵ Mexico ratified the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), which includes the obligation to take “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.”⁴⁶

In 2003, the Mexican government restructured its health system by legislating free access to healthcare for all citizens through a public insurance scheme, *Seguro Popular* (Peoples’ Insurance).⁴⁷ *Seguro Popular* was created as a public insurance program for universal and comprehensive healthcare coverage for those individuals who were not covered by employer-based insurance.⁴⁸ Lauded by many as a successful reform, *Seguro Popular* has provided healthcare to many Mexicans who had previously been unable to access services.⁴⁹ In 2000, the Supreme Court of Mexico ruled that access to health includes access to all treatment and medication.⁵⁰ As such, *Seguro Popular* is legislated to include all medication, including ART for HIV. In 2012, *Seguro Popular* covered 55.6 million people and the CNDH estimates that approximately 59.4% of Mexico’s population is now covered by the program.⁵¹

Healthcare

The IHRP found that, despite Mexico’s legislated provision of universal, free and quality access to healthcare, many people in Mexico living with HIV or at high risk of infection are unable to access *Seguro Popular*. For those who do have access to healthcare, many face discrimination and receive sub-par and inconsistent treatment that seriously jeopardizes their health.

HUMAN RIGHTS IN MEXICO

In order to access *Seguro Popular*, individuals must present valid Mexican identification.⁵² For many vulnerable populations, this requirement effectively disqualifies them from accessing services that the state is legislated to provide for free. This is particularly detrimental for transgender people, sex workers, migrants, people who inject drugs, Indigenous people and street-involved individuals, who, for many reasons explored below, may not have identification.⁵³

Under *Seguro Popular*, health supplies are limited, and what is available is discretionary, varying from state to state.⁵⁴ HIV treatment in Mexico is administered through various Ambulatory Centres for the Prevention of and Attention to HIV/AIDS and Other Sexually Transmitted Infections (CAPASITS) throughout the country.⁵⁵ CAPASITS, located in Mexican state capitals and funded by the government, are staffed with health practitioners trained in providing care for HIV and other sexually transmitted infections.⁵⁶ In a 2013 study, health providers in Tijuana reported an insufficient availability of ART medications in some CAPASITS in Mexico.⁵⁷ The IHRP was told that some health centres delay providing HIV treatment until a patient is showing visible signs of the illness in order to preserve their limited supplies.⁵⁸ Such delayed treatment can have a disastrous impact on the long-term health of the individual and HIV prevention efforts.⁵⁹ Moreover, the government does not cover any PrEP drugs, such as the combination product tenofovir/emtricitabine (marketed under the brand name Truvada).⁶⁰

An additional flaw with *Seguro Popular* is the non-availability of treatment for secondary health issues, such as tuberculosis, when one is already receiving treatment for HIV.⁶¹ Patients are forced to choose between interrupting their HIV treatment or neglecting opportunistic diseases, to which they are more vulnerable because of a weakened immune system. Either choice could have fatal repercussions.⁶² As the life expectancy of individuals living with HIV increases, such issues of singular treatment, not in keeping with good clinical practice, become increasingly problematic.⁶³

In addition to concerns about supply and quality of care, *Seguro Popular* remains inaccessible to many because of stigma.⁶⁴ Marginalized groups are not aware that they have the right to free healthcare or do not know how to access it. There are many segments of the population in Mexico — including LGBTI individuals, sex workers, women and girls, and people who inject drugs — that cannot access consistent HIV treatment.⁶⁵ More troubling, however, is the fact that some healthcare authorities seem unaware that *Seguro Popular* is available to all.⁶⁶

The Director of Clinica Condesa, the leading HIV/AIDS clinic and the only publicly funded free clinic with expertise in serving transgender clients, told the IHRP that individuals living with HIV seeking healthcare are routinely denied assistance at health centres.⁶⁷ In a 2013 report surveying healthcare providers' perspectives on access to HIV treatment, a Tijuana provider relayed that they encounter patients who have been sent away from hospitals because "the doctors or dentist refuse to see anyone who is HIV-positive."⁶⁸ Members of marginalized populations often rely on an advocate to accompany them in order to access care; without one, healthcare providers do not treat them in a professional manner. Even then, the IHRP learned that health authorities often behave as if they are providing charity, as opposed to acknowledging healthcare as a human right.⁶⁹

Programa Frontera Sur and its Impact on HIV Prevention⁷⁰

In July 2014, the Mexican government announced the launch of the *Programa Frontera Sur* (South Border Program) (hereinafter, the “Plan”). The Plan has the stated objective of providing care and protection to migrants and ensuring strict respect for human rights for a prosperous, secure and controlled border region.⁷¹ However, in reality, human rights advocates told the IHRP that the Plan has increased detention, criminalization and danger for migrants, sex workers and human rights defenders along the border and throughout the country.⁷²

Central to the Plan is a hard stance on human trafficking, allegedly to protect migrants and stem irregular movement across the border. HIV-prevention advocates, however, lament the Plan’s impact on HIV-prevention services throughout the country. By restricting HIV-prevention activities for sex workers under the guise of combating human trafficking, the Plan has put already-vulnerable populations at higher risk of HIV infection. The adverse effects are not isolated to non-citizens. The authorities are indiscriminately targeting all

individuals perceived to be connected to sex work: from third parties associated with sex workers to people possessing condoms.⁷³ Those providing condoms or implementing HIV-prevention programs now run the risk of being labeled “traffickers”⁷⁴ under the Plan. One migrant shelter director and HIV-prevention advocate used to give out condoms in bars in the southern city of Tapachula, but authorities are now criminally charging bar owners in the city for allowing condoms to be distributed.⁷⁵

In addition to dismantling interventions for the prevention of HIV, sex workers are more likely to be deterred from accessing health services for fear of being identified and arrested, undercutting years of advocacy work to recognize sex work as work.⁷⁶ The National Institute of Public Health in Mexico is currently trying to help highlight the differences between sex work and trafficking, so that there is not a complete deterioration of HIV-prevention efforts, but health experts told the IHRP that this is an uphill battle.⁷⁷

B. Human Rights Abuses against Key Populations in Mexico

A 2014 UNAIDS report identified populations who are more at risk of HIV. In Mexico, the populations disproportionately affected by HIV include LGBTI individuals, women and girls, sex workers and people who inject drugs.⁷⁸ Because of social, economic and legal exclusion, such populations generally do not have equal access to healthcare and live in more precarious situations, heightening their risks for HIV. These populations, marginalized by the state and unable to enjoy adequate human rights protections, are disempowered from seeking support to prevent and treat HIV.⁷⁹ As the *International Guidelines on HIV/AIDS and Human Rights* note, the violation of human rights, including discrimination against specific populations “creates and sustains conditions leading to societal vulnerability to infection by HIV, including lack of access to an enabling environment that will promote behavioural change and enable people to cope with HIV.”⁸⁰

HUMAN RIGHTS IN MEXICO

Discrimination against those with HIV

Despite positive legislation ensuring the right to health and the prohibition of discrimination based on health conditions, people in Mexico living with HIV remain vulnerable to human rights abuses, stigma and discrimination in all realms of life.⁸¹ In terms of education, employment, and access to healthcare, individuals living with HIV face substantial discrimination.⁸²

Stigma against individuals with HIV remains a reality in Mexico. The President of the Council for the Prevention and Elimination of Discrimination in Mexico City (COPRED) told the IHRP of individuals being refused service in restaurants, even in urban areas including Mexico City, simply because they were suspected of living with HIV.⁸³ In many places, individuals are scared to disclose their status, and fear accessing testing, treatment or support. The consequences of disclosure could be dire. According to an international health service organization, assailants in a small town in Chiapas marked homes with spray-paint to indicate that people living with HIV resided there, so that other residents could avoid and ostracize them.⁸⁴

In 2015, in Tijuana, in the Mexican state of Baja California, a judge refused to marry Rosario Padilla and her partner because Rosario was living with HIV. In many Mexican states, HIV tests are mandatory to obtain marriage licences, and the judge performing the marriage has access to the results.⁸⁵

Mexican labour law prohibits employers from demanding HIV tests for employment, but staff at an international health-service organization told the IHRP that individuals are commonly barred from employment because of their HIV status, or their employment is terminated when their status is disclosed or discovered.⁸⁶

Access to treatment, despite progressive legislation, remains difficult for many. A recurring problem is that many health professionals outside of CAPASITS refuse to treat individuals living with HIV, due to a misguided fear of exposure to the virus.⁸⁷ Because all HIV knowledge, training and protocols are centered on care providers at CAPASITS, staff doctors from the Clinica Condesa told the IHRP that other healthcare providers throughout Mexico are often ignorant when it comes to HIV treatment and prevention.⁸⁸

CAPASITS only operate in the capitals of Mexico's 31 states and in Mexico City and, as a result, many individuals living with HIV are unable to travel to the Centres for every health concern or monthly checkups.⁸⁹ When they attend other general medical clinics, they face stigma and discrimination, and are sometimes rejected outright from receiving care.⁹⁰ According to the Executive Director of the women's rights organization, Balance, persons living with HIV are often last to be seen, and forced to wait in a separate room, essentially quarantined from the other patients. In many cases, patients are required to come with their own medical supplies so as not to "contaminate" the clinics' instruments.⁹¹ Such discrimination jeopardizes lives because healthcare practitioners sometimes refuse to perform surgery or regular checkups, such as pap smears, on individuals living with HIV, because of ignorance on how HIV is transmitted.⁹²

In fact, according to staff doctors at Clinica Condesa, CAPASITS staff themselves often display ignorance and insensitivity toward patients living HIV, who rarely seek recourse because they consider they have no choice or rights.⁹³ According to submissions from stakeholders to the United Nations' most recent Universal Periodic Review of

HUMAN RIGHTS IN MEXICO

Mexico, there are no policies in place on comprehensive healthcare for LGBTI individuals and existing healthcare is particularly insufficient for LGBTI individuals living with HIV or other STIs.⁹⁴

Alejandro Brito, the Executive Director of Letra S, a non-profit organization dedicated to the dissemination of human rights information about sexuality, health and society in Mexico, told the IHRP about a young man he was assisting who was in prison in Mexico City. When prison authorities refused to provide the young man with HIV treatment, Alejandro Brito intervened and was able to arrange a visit to a CAPASITS. However, the doctor at the CAPASITS told the young man that “when he was sent to prison he lost his right to treatment.”⁹⁵ He now needs urgent medical attention because of an associated skin disease; it is only because his mother provided the necessary medication that he has survived.⁹⁶

This case is particularly worrisome because it demonstrates the existence of discrimination at both the prison and the CAPASITS in Mexico City, where access to healthcare and health rights are ostensibly more respected.⁹⁷ “How many of these cases are occurring without anyone’s knowledge?” Brito queried.⁹⁸ Only one prison in Mexico City provides HIV treatment to prisoners: Santa Martha. This fact represents a stunning denial of the right to health and essential treatment.⁹⁹

Stigma traumatizes many people living with HIV. As the Executive Director of Balance told the IHRP, “an HIV diagnosis is often seen as a death sentence because of insufficient or misinformed counselling and education.”¹⁰⁰

Medical Healthcare Exemption in Canadian Refugee Law

Subsection 97(1)(b)(iv) of Canada’s *Immigration and Refugee Protection Act* contains a medical exemption from refugee protection, which excludes consideration of the risk posed to a refugee claimant when caused by “the inability of that country [of origin] to provide adequate health or medical care.”

The Federal Court of Appeal has held that: “If it can be proved that there is an illegitimate reason for denying the care, however, such as persecutory reasons, that may suffice to avoid the operation of the exclusion.”¹⁰¹

Depending on the facts of a particular case, a refugee claimant could show they face a personalized risk to their life as a result of Mexico’s unwillingness to provide them with adequate medical care for persecutory reasons, i.e., a denial of HIV treatment based on their sexual minority status, or because they were in prison. Despite Mexico’s clear commitment to offer “universal healthcare” (*Seguro Popular*), the reality that some minority populations are denied healthcare could support a positive refugee determination.¹⁰²

1. LGBTI

The stigma and discrimination faced by the LGBTI community in Mexico renders them more vulnerable to HIV.¹⁰³ Despite the country's recently enacted laws and regulations to protect LGBTI rights, including a 2011 amendment to the Constitution to "prohibit discrimination on the basis of sexual preference," such legislation has not translated into meaningful protection of the LGBTI population in Mexico. There are more than 70 federal and state laws in Mexico that explicitly reference discrimination, human dignity and equal protection.¹⁰⁴ But, as one transgender activist told the IHRP, "the laws exist and everyone is waving the diversity flag but no one is implementing them, no one is practising anti-discrimination."¹⁰⁵

In April 2014, the Special Rapporteur on extrajudicial, summary or arbitrary executions reported an "alarming pattern of grotesque homicides of lesbian, gay, bisexual, and transgender (LGBT) individuals."¹⁰⁶ The Special Rapporteur highlighted the problem of broad impunity, coupled with "suspected complicity of investigative authorities" as a result of either a "total failure to investigate" or investigations misguided by "stereotypes and prejudice."¹⁰⁷ According to the Special Rapporteur, between 2005 and 2013, 555 homicides targeting individuals because of their sexual orientation or gender identity were reported. The CNDH learned of several cases in which police officers have been involved in homophobic attacks.¹⁰⁸ The Special Rapporteur reported that Mexican authorities will often choose not to prosecute hate crime cases, labeling them as "crimes of passion".¹⁰⁹ The Special Rapporteur concluded that homophobic and transphobic violence is not isolated, but is instead "emblematic of patterns of conduct of some members of society and recurrent actions of certain public servants, including prejudices, dislikes and rejections, reflecting the existence of a serious problem of intolerance."¹¹⁰ A 2010 national study compiled by Global Rights, International Human Rights Clinic at Harvard, the International Gay and Lesbian Human Rights Commission, and the Colectivo Binni Laanu indicated that 76.4% of LGBTI people in Mexico have experienced physical violence as a result of their sexual orientation or gender identity.¹¹¹ According to the same study, 53.3% of LGBTI people report being assaulted in public spaces.¹¹²

Discrimination against LGBTI youth is also of concern. According to the Director of an LGBTI community centre in Mexico City, school administrators and staff stigmatize LGBTI students, sometimes leading to the students dropping out of school.¹¹³ While school-dropout is a widespread problem across Mexico, it is especially detrimental to LGBTI youth, and transgender youth in particular, who are more likely to self-isolate, remain unaware of their rights or how to exercise them, and face severe discrimination in employment.¹¹⁴

Media Reflection of LGBTI Reality in Mexico

The Mexican media's portrayal of the reality for LGBTI people in Mexico is problematic and misleading, according to Alejandro Brito, the Executive Director of Letra S. Journalists refer to murders of LGBTI individuals as "crimes of passion," when in reality they are hate crimes.¹¹⁵ Murders of transgender women receive especially scant media coverage.¹¹⁶ The media publishes graphic images of victims' bodies, which some have suggested may desensitize the public to scenes of horrific violence against the gay community.¹¹⁷

Commercial media underplays homophobia and hate crimes and twists the discourse on human rights protection for LGBTI people.¹¹⁸ According to Human Rights Watch, journalists often self-censor their reporting of all violence because of attacks against them by government officials and organized criminal groups. Similarly, journalists are likely to underplay criticisms of the criminal justice system because of the government's continued financial influence over the media.¹¹⁹

Transgender Women¹²⁰

The majority of experts the IHRP interviewed identified transgender women as the population in Mexico most vulnerable to physical, emotional and health risks, including HIV. A staff member at an international health-service organization told the IHRP the life expectancy of transgender women in Mexico is significantly lower than the life expectancy for cisgender women in Mexico, which is 79 years.¹²¹ Transgender women are especially vulnerable if they are also migrants, sex workers, homeless or street-involved.

Despite some legislative victories, such as laws implemented to remove administrative obstacles for transgender individuals changing their gender on identity documents, the transgender community faces a hostile and dangerous environment throughout Mexico. This is particularly true for transgender women.¹²² There are a significant number of unsolved murders of transgender women in Mexico, a phenomenon activist Ricardo Roman identified as the "maximum expression of the rejection of the transgender identity."¹²³ Access to justice is virtually non-existent for transgender women, and crimes against them are almost always committed with impunity.¹²⁴

Beyond hate crimes, transgender women face daily discrimination in Mexico. Stigma against transgender women, especially in the realm of employment, remains real.¹²⁵ Several activists and journalists told the IHRP that the only employment options for transgender women are: sex worker, hair stylist, or "night-time entertainer."¹²⁶ Mexico City offers no respite, as even in that so-called "progressive oasis," the private sector is opposed to hiring transgender women. The cycle of vulnerability continues in Mexico City because the only way transgender women can support themselves is on the fringes of society, where they are criminalized, incarcerated and vulnerable to abuse.¹²⁷ As staff at the Program for Human Rights in Mexico City stressed, there is still a likelihood that certain individuals are

HUMAN RIGHTS IN MEXICO

arbitrarily arrested because of how they look.¹²⁸ Such treatment is compounded by family and community rejection, commonplace in Mexico's largely traditional, Catholic society.¹²⁹

Transgender women and access to healthcare

The 2014 UNAIDS *Gap Report*—investigating people left behind by global HIV-prevention strategies—highlights the fact that due to a lack of identity documents, increased risk of violence, and exclusion from education, employment, and healthcare, transgender individuals face an increased vulnerability to HIV.¹³⁰ Transgender women have a much higher HIV-prevalence rate of between 16% and 17% compared with 0.2% for the general population.¹³¹ In a 2012 study of transgender women in Mexico City, public health researchers found a “very worrisome combination” of factors, including “very high HIV prevalence, low demand of HIV testing and low awareness of HIV status, as well as sexual risk behaviour with multiple partners.”¹³²

Access to healthcare is an ongoing difficulty for transgender populations in Mexico, particularly for transgender women. Because of profound discrimination in the healthcare system, transgender women are more likely not to receive treatment for their HIV until it has already developed into AIDS, which imperils their health.¹³³ *Seguro Popular* is inaccessible to most transgender women, largely because most do not have identification. In most cases, transgender women lack identification because they do not want to be associated with their past identities or they have lost their identification while incarcerated. In general, because of the vulnerabilities associated with being transgender in Mexico and the high likelihood of police involvement, the expectation that a transgender woman will retain identification is unrealistic.¹³⁴ According to the Executive Director of Clinica Condesa, Dr. Andrea Gonzalez, her clinic has never treated a transgender woman from Mexico or from elsewhere in Central America who has her identity documents.¹³⁵ While transgender women might carry one piece of identification, they almost never have sufficient records to meet requirements to access *Seguro Popular*.¹³⁶ Moreover, the IHRP learned that even when transgender women do have the requisite identification, health providers at health centres treat and refer to them as the gender indicated on their birth certificate or other identification, rather than their self-identified gender.¹³⁷

In 2012, Mexico City enacted the *Law for the Prevention and Comprehensive Care of HIV/AIDS of the Federal District*, guaranteeing the elimination of barriers to equal healthcare for individuals living with HIV and for populations at heightened risk of infection, including transgender people.¹³⁸ However, there are no protocols about how this law should be enforced or details concerning how transgender individuals might access HIV treatment.¹³⁹ Across the country, transgender women experience the greatest difficulties of any other group in accessing treatment and healthcare, and they continue to face discrimination from health authorities.¹⁴⁰

Crimes affecting the dignity and security of transgender people are rampant in health centres.¹⁴¹ Because of their often-fraught relationship with law enforcement, many transgender people in need of healthcare are reluctant to enter hospitals because of police officers posted at facility entrances.¹⁴² As two transgender activists told the IHRP, sexual minorities are harassed or abused by police and so avoid them, even to the detriment of their health, because of a fear they will be targeted and expelled from the hospital, or arrested.¹⁴³ Police have been known to send transgender women away from hospitals, but even if they manage to enter, they face discrimination from authorities and others at the hospital.¹⁴⁴

HUMAN RIGHTS IN MEXICO

Gay Men and Other Men Who Have Sex with Men

Despite improvements, gay men and other men who have sex with men (MSM) in Mexico are disproportionately affected by HIV and continue to encounter obstacles accessing consistent and quality healthcare.¹⁴⁵

Gay men and MSM are still victims of homophobia and violent hate crimes in Mexico. In September 2015, in what was attributed by some as retaliation for the Supreme Court's June 2015 decision to legalize gay marriage, emergency room doctors in Mexico City reported treating an increase of gay male patients suffering physical abuse.¹⁴⁶

Gay men and men who have sex with men and access to healthcare

Among LGBTI populations, gay men and MSM generally have the least difficulty accessing healthcare in Mexico.¹⁴⁷ Nonetheless, as seen below, there are also worrying trends within these communities.

MSM in Mexico have an HIV-prevalence rate of 17.3%,¹⁴⁸ but they have the lowest rate of testing.¹⁴⁹ This disparity has much to do with a lack of education targeting MSM who do not identify as gay. MSM can include a wide variety of individuals including men who are gay or bisexual, transgender men, and men who identify as heterosexual.¹⁵⁰ The Director of HIV programs of CNDH told the IHRP that most HIV campaigns are targeted at gay men, neglecting MSM.¹⁵¹ Stigma, social exclusion, violence and discrimination remain rampant in Mexico, and MSM are therefore more likely to engage in unsafe and illicit sex and are at higher risk of infection.¹⁵²

Several experts interviewed by the IHRP highlighted a worrying decrease in HIV testing and in the use of prevention methods among both young gay men and young MSM.¹⁵³ These statistics may reflect, in part, a belief among many members of the younger generation that the HIV epidemic only affects older men.¹⁵⁴ Many in Mexico have not seen anyone die of AIDS as more people living with HIV have longer and healthier lives.¹⁵⁵ However, the belief that HIV can be “fixed” through treatment neglects the fact that HIV — left untreated — can be a deadly disease, putting individuals at risk for a host of other health problems, including dementia, kidney disease and diabetes.¹⁵⁶

2. Women and Girls

Women and girls remain vulnerable to human rights abuses in Mexico despite the Mexican government's strides in improving laws to protect women's rights.¹⁵⁷ Implementation of these protections is lacking and, as a result, women experience poorer health, are more economically insecure and face higher rates of violence than men.¹⁵⁸ Women are less likely than men to be formally educated and they face greater inequality and discrimination in the workplace.¹⁵⁹ Women, for example, are still fired from their jobs for pregnancy.¹⁶⁰ In fact, this practice is the source of the highest number of human rights complaints in Mexico City.¹⁶¹

According to CNDH, violence against women is a persistent problem in Mexico.¹⁶² Human Rights Watch reports that Mexican laws do not provide adequate protection for women and girls who are vulnerable to domestic and sexual

HUMAN RIGHTS IN MEXICO

violence. As a result, victims will generally not report abuses or if they do, they will encounter “suspicion, apathy and disrespect.”¹⁶³ The UN Special Rapporteur on extrajudicial, summary and arbitrary executions reported in April 2014 on the persistence of often fatal violence against women and the impunity for perpetrators, despite progressive legislation concerning violence against women in Mexico.¹⁶⁴ There are few services, such as counselling and support groups, to address violence against women outside of Mexico City, and no specific services geared toward violence against lesbian, bisexual or transgender women victims of violence.¹⁶⁵

The Committee against Torture and the Committee on the Elimination of Discrimination against Women (CEDAW) have both highlighted concerns that women “continue to be the victims of gender-based murders and disappearances” despite the establishment of legal means of protection.¹⁶⁶ According to both Committees, impunity persists with respect to the “investigation, prosecution and punishment of perpetrators of acts of violence against women across the country.”¹⁶⁷

According to the 2012 CEDAW report, prepared for the UN's Universal Periodic Review of Mexico, violence against women, including rape, femicide and enforced disappearance, is prevalent in Mexico, especially in regions where the army or law enforcement are conducting operations against organized crime. These cases are rarely reported to authorities because of fear of retaliation and a lack of standardized procedures for responding to complaints, conditions which, according to CEDAW and the Inter-American Court of Human Rights, “hamper the right of victims to access to justice and leave a high proportion of cases unpunished.”¹⁶⁸ Between 2006 and 2012, six femicides occurred every day in Mexico, but between 2012 and 2013, only 24% of the murders were investigated by authorities and only 1.6% of those cases led to conviction and sentencing.¹⁶⁹

Women living with HIV are particularly susceptible to human rights abuses in Mexico. The IHRP heard reports that healthcare officials forcibly sterilize women living with HIV.¹⁷⁰ Among Nicaragua, El Salvador, Honduras, Guatemala and Mexico, a 2012–2013 study found that Mexico has the worst rate of forced sterilization for women living with HIV, with 28% of respondents reporting that health authorities had pressured them to get sterilized.¹⁷¹ The Ethical Committee of Puebla's State General Hospital has an unwritten rule that all women living with HIV who seek medical care must be sterilized to prevent vertical transmission (parent-to-child HIV transmission) in the event of pregnancy.¹⁷² In the state of Morelos, healthcare workers fabricated a fake consent for a caesarian section for a woman living with HIV, while she was under the effects of anesthesia, by taking an unauthorized imprint of the woman's fingerprint. She had not provided her consent and woke to find her thumb stained with ink.¹⁷³ As seen in countries like Canada, where vertical transmission is almost non-existent, proven scientific measures exist — for example, anti-retroviral treatment regimens — that do not involve such serious violation of a patient's human rights.¹⁷⁴

Women and girls and access to healthcare

Machismo culture is prevalent in Mexico and sexism permeates society, especially concerning access to healthcare.¹⁷⁵ There has been some progress in the sphere of maternal health, but stark differences persist throughout the country. According to a report on maternal health in Mexico, maternal mortality rates are high among “less educated, poor, rural, and Indigenous women,” reflecting “on-going inequalities in access to affordable, quality, and culturally appropriate maternal health services.”¹⁷⁶

HUMAN RIGHTS IN MEXICO

Discrimination in healthcare for women is exacerbated by stigma against people living with HIV for those more than 31,000 women living with HIV in Mexico. This number currently represents 18% of the epidemic, with 80% of women infected through heterosexual sex, most with a regular partner.¹⁷⁷

Women living with HIV in Mexico are a vulnerable population because they often have less formal education than men and are contending with high discrimination and stigma.¹⁷⁸ Forty-five percent of women living with HIV reported that healthcare personnel violated the confidentiality of their HIV diagnosis.¹⁷⁹ The Director of Balance told the IHRP of many women who indicated that health personnel disclosed their HIV status to their husbands or the men in their family before disclosing it to them. This type of breach, embedded deeply in a culture of gender discrimination, has far-reaching consequences for women's health, security and sense of self.¹⁸⁰

Almost 60% of women living with HIV in Mexico do not have any medical insurance and therefore must rely on *Seguro Popular*.¹⁸¹ As Dr. Jeremy Cruz, psychologist at Clinica Condesa in Mexico City told the IHRP, health services for women in Mexico are limited and providers are ill-equipped to provide women with the necessary mental health and gender-sensitive care, alongside their HIV treatment.¹⁸² The provision of HIV treatment for women must take into account stigma in communities and homes, and the risk of gender-based violence as a result of diagnosis. In fact, 44.1% of women in Mexico experience gender-based violence connected to their HIV status, which affects their adherence to treatment and their physical and mental well-being.¹⁸³

Government efforts to educate Mexicans about sexual and reproductive health are seriously lacking.¹⁸⁴ In particular, women's sexual health needs have largely gone unheeded because of sexism within the healthcare system.¹⁸⁵ The lack of education on sexual and reproductive health is significant; according to Eugenia Lopez, the Executive Director of Balance, a survey of female community leaders showed that a majority of respondents thought condom-use caused pregnancies.¹⁸⁶

Healthcare providers reportedly do not provide their patients living with HIV with necessary information about maintaining a healthy sexual life.¹⁸⁷ According to a 2015 report by UNAIDS, the Inter-American Commission of Women (CIM) and the Organization of American States (OAS), only 14.2% of surveyed women living with HIV reported receiving counselling on their reproductive choices (compared to, for example 54.9% in Honduras).¹⁸⁸ As a result, many women, in some cases traumatized by the way their healthcare provider has treated them, believe that their diagnosis is the end of their sexual and romantic lives.¹⁸⁹ Without appropriate counselling from a doctor, they self-isolate and sometimes leave their jobs and families.¹⁹⁰

Healthcare providers have denied birth control options to women living with HIV.¹⁹¹ Instead of informing their patients about how to avoid HIV transmission in child-bearing, healthcare professionals have instructed their patients to practise abstinence. As the Executive Director of Balance told the IHRP, "the worst thing a woman living with HIV can do in the eyes of healthcare practitioners in Mexico is have sex and reproduce."¹⁹²

Mexico is failing to link sexual and reproductive health with HIV, and hence contributing to increased transmission. Because women are perceived as low risk, HIV testing is not always offered during prenatal care, which means that

HUMAN RIGHTS IN MEXICO

many women are not diagnosed, remaining invisible to healthcare providers and policymakers.¹⁹³ As of 2015, only 58% of pregnant women were tested for HIV in Mexico — far below other countries in the region, such as El Salvador, Guatemala and Honduras, where the testing figures are 80% and higher.¹⁹⁴

Lesbian and bisexual women face the same obstacles in accessing rights-based comprehensive care as the larger population of cisgender women in Mexico; however, these obstacles are exacerbated by their sexual minority status. Human rights have improved for lesbians and bisexual women in Mexico over the last few decades, but they remain an outsider group, vulnerable to marginalization. This status in turn makes them less able to access HIV treatment and care.¹⁹⁵ Ongoing discrimination and a lack of training for healthcare professionals result in services that are blind to the particular needs of the lesbian and bisexual population. In research undertaken by the women's rights organization Balance, among 20 lesbian women, many reported being refused a pap smear because they identified as lesbians. This type of ignorance jeopardizes women's lives, overlooks medical issues that are crucial to lesbian and bisexual health, and also makes women from sexual minorities feel excluded from the healthcare system.¹⁹⁶

3. Sex workers

Sex workers are particularly vulnerable to abuse and violence from many segments of Mexican society, both state and non-state actors.¹⁹⁷ The hierarchy of power and control over sex workers globally means that human rights violations against sex workers are almost always perpetrated with impunity.¹⁹⁸

Sex workers and access to healthcare

As sex workers in Mexico face increasing criminalization as a result of the *Programa Frontera Sur* (the “Plan”), their ability to access quality healthcare has diminished.¹⁹⁹ Federal law has officially decriminalized the sex trade, but most local governments have not reformed their policies accordingly.²⁰⁰ Moreover, with the Plan, sex work nationwide has become associated with human trafficking, putting sex workers and those assisting them at risk of being criminalized.²⁰¹ Activists from Mexico City told the IHRP that the Plan goes directly against what civil society and aid groups have been striving to achieve for years, which is recognition of sex work as legitimate work.²⁰²

Rights advocates told the IHRP that sex workers have limited access to the healthcare system in Mexico; they are not provided with any reproductive or health education.²⁰³ Knowing they will receive inadequate care, and fearing identification and arrest, sex workers tend to avoid healthcare services.²⁰⁴

Etty, a leader in the sex worker community for over 30 years and the matron of Casa Xochiquezal, a home for elderly sex workers in Mexico City, told the IHRP how she recently enlisted help from priests to bring a young and very ill sex worker to the hospital. When Etty followed up hours later, she found the hospital had refused to admit the girl. It was only after hours of challenging the hospital administration and proving that she had connections to the police that the hospital finally agreed to let Etty into the emergency room, where she found the young girl unattended and nearly unconscious on the floor. Even then, Etty had to speak to several doctors before convincing one of them to care for the girl.²⁰⁵

HUMAN RIGHTS IN MEXICO

Cisgender female sex workers in Mexico have an HIV-prevalence rate of 0.67%, almost three times the national average for the general population.²⁰⁶ Male sex workers in Mexico have a prevalence rate of 24.1%.²⁰⁷ Because of discrimination and stigma, they may be conducting their work in precarious circumstances, leading to unsafe sexual encounters, diminished access to healthcare, STI prevention education and services, and increased vulnerability to HIV.²⁰⁸

Many sex workers are also homeless or street involved, which limits their access to healthcare and treatment, consequently increasing their risk of HIV transmission.²⁰⁹ Street-involved and homeless populations are largely invisible in Mexico. There are no public policies in place to support or assist these populations and no data about their numbers or their needs.²¹⁰ As far as the government is concerned, they do not exist because they do not have identification or a residence.²¹¹

The impact of the Plan on HIV-prevalence rates among sex workers has not yet been documented, but it is expected to be significant. The Plan has jeopardized all HIV-prevention services for sex workers, especially along the Guatemala–Mexico border.²¹² Those who attempt to implement HIV-prevention programs for sex workers face the danger of being labeled “traffickers” and facing criminal charges.²¹³ There is substantial evidence that the criminalization of sex work, whether official or perceived, increases vulnerability to HIV by impeding HIV prevention and response.²¹⁴

Migrants and Access to Healthcare²¹⁵

Migrants in Mexico are extremely vulnerable to forced disappearances, police brutality, “transactional sex, survival sex and non-consensual sex,” and destitution, making them vulnerable to HIV infection.²¹⁶ According to the Inter-American Commission on Human Rights (IACHR), “the extreme vulnerability to which migrants and other persons fall victim in the context of human mobility in Mexico is one of the worst human tragedies in the region today.”²¹⁷

According to estimates, about 300,000 people migrate to Mexico annually.²¹⁸ Of these migrants,

many tens of thousands are escaping violence and persecution in their countries of origin. Despite being a signatory to the Refugee Convention and the 1967 Additional Protocol on the Status of Refugees (1967 Protocol), Mexico fails to offer asylum to those in need of protection because of a broken asylum system, and Mexican policies such as the *Programa Frontera Sur* increase the vulnerability of these would-be refugees by forcing them to transit through Mexico along dangerous routes, in order to claim asylum elsewhere.²¹⁹

Migrants and Access to Healthcare (continued)

Migrants face abuse from the local population and authorities alike. According to the IACHR, the Mexican State's response to migrant abuse has been "patently inadequate" and detention has become the rule rather than the exception.²²⁰ In 2014, Mexican authorities detained 107,814 migrants, a 35% increase from the previous year.²²¹

Despite a national law that guarantees migrants access to healthcare regardless of their status, the reality is that migrants are unable to access healthcare in Mexico.²²²

Even Mexican migrants in the northern border region have poor access to healthcare. A 2015 study of HIV monitoring of Mexican migrant flows traveling across the Mexico–United States border indicated "unacceptably low" HIV-testing rates and an urgent need for "vigorous efforts to improve HIV diagnosis and engagement in HIV care among Mexican migrants."²²³

4. People who Inject Drugs

Intravenous (IV) drug use has become a significant problem in recent years in Mexico, and it is especially concentrated along the northern border.²²⁴ According to the Director of an NGO that provides harm reduction services in Tijuana, many drug users in the region were deportees from the United States who had decided to stay to make money before attempting to cross the border again. As a result of minimal work opportunities, however, many of these deportees end up living on the streets, and are susceptible to depression and heroin addiction.²²⁵ Without access to harm reduction services such as sterile needle and syringe distribution programs, IV drug use increases their risk of HIV infection. In many cases, access to healthcare remains elusive.²²⁶

Simultaneous vulnerabilities of sex work, homelessness or street-involvement, and migration combine to make people who inject drugs particularly susceptible to human rights violations, against which they have minimal recourse to justice.

According to the NGO INSPIRA, a community organization with a decade's experience of working with LGBTI people, people living with HIV and people who inject drugs, "it's a fact that drug users are accosted by police."²²⁷ Typically, people who inject drugs are picked up by the police, thereby losing their money and possessions (including any identification they may have).²²⁸

In a rare public effort to bring police to account for their treatment of people who inject drugs, the harm reduction network, Redumex, filed a complaint with the National Commission against Discrimination concerning the Tijuana police in March 2015.²²⁹ The complaint included 37 pages of testimonials of human rights violations.²³⁰ By order of the Tijuana mayor, who was planning to run for governor, local authorities forcibly displaced a population of drug users from the banks of a canal to so-called "rehab" centres (where there was no guarantee of food or rehabilitation) or to their city of origin.²³¹ As of publication, there has been no official response to the complaint.²³²

HUMAN RIGHTS IN MEXICO

People who inject drugs and access to healthcare

As the number of people who inject drugs has risen, so has the HIV-prevalence rate among them. Recent statistics provided to the IHRP in June 2015 by the Director of HIV programs with CNDH indicate that the HIV-prevalence rate among people who inject drugs is 2.5% and rising.²³³ However, because people who inject drugs do not have consistent access to healthcare, it is likely this statistic is not representative.²³⁴

People who inject drugs face substantial barriers in accessing healthcare in Mexico. Most do not have identification, in many cases because the identification has been confiscated or lost, or intentionally discarded, to avoid association with their past identity or criminal record.²³⁵ In addition, police presence at hospitals tends to dissuade people who inject drugs who need healthcare from attempting to access it.

Often, as with other vulnerable groups, people who inject drugs need to be accompanied by an advocate in order to access healthcare.²³⁶ However, even if they get access, discrimination by hospital authorities results in people who inject drugs not remaining in care or failing to receive the comprehensive attention to which they have the right.²³⁷ There are numerous reports that hospitals lack respect and sensitivity toward, as well as protocols geared to, people who inject drugs. This includes failing to provide pregnant women or their newborn babies with methadone treatment during labour.²³⁸

In 2009, Mexico's federal government passed a law to divert individuals arrested for possession of small amounts of drugs from the penal system to addiction treatment. However, there has not been meaningful implementation of the intended scale-up of addiction treatment access. According to a 2011 National Household Survey, only 18% of drug-dependent individuals were in treatment.²³⁹

The Mexican government also does not provide sufficient harm reduction services, HIV/STI prevention or sexual and reproductive health education. Coverage is improving thanks to funders such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, which provides 77.6% of all syringes distributed to people who inject drugs in Mexico. Government syringe programs remain "under-resourced and insufficient" and access to these programs is hampered by drug laws that continue to criminalize individuals possessing small amounts of drugs.²⁴⁰ In particular, the paucity of harm reduction services, such as needle and syringe programs, increases the possibility of HIV and hepatitis C virus (HCV) transmission through needle sharing.²⁴¹ More broadly, the criminalization and vulnerability of people who use drugs makes adherence to HIV treatment (when accessible) very difficult. The IHRP was told of incidents where police have raided sleeping areas used by people who use drugs and discarded their HIV medication.²⁴²

Indigenous Populations and Access to Health

Indigenous populations are marginalized in Mexico and have difficulty accessing even basic medical care, not to mention reliable HIV treatment.²⁴³ According to the 2013 United Nations Universal Periodic Review on Mexico, 70.9% of Indigenous people live in poverty, affecting every aspect of daily life.²⁴⁴

There is widespread discrimination against Indigenous populations throughout Mexico. A 2013 poll concerning discrimination in Mexico City revealed that most people consider the Indigenous population as the most discriminated group in the city.²⁴⁵ The government tends to overlook Indigenous peoples and considers them important only when they live on profitable, resource-rich lands.²⁴⁶

Access to healthcare is a significant problem for Indigenous populations.²⁴⁷ According to the Program of Human Rights for Mexico City, which tracks compliance with government mandates, the government has failed to target or reach Indigenous populations for HIV-prevention efforts.²⁴⁸ In fact, Indigenous groups face substantial barriers in accessing any kind of healthcare.²⁴⁹ The health centres that purport to serve the Indigenous population are not geographically proximate to them.²⁵⁰ Moreover, health centres in these areas lack infrastructure and experienced staff.²⁵¹

CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN

III. CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN

A. Canada's International Legal Obligations

Canada is a signatory to the Refugee Convention, and the 1967 Protocol.²⁵² Under the Refugee Convention, Canada has a duty to recognize as a refugee any individual residing outside his or her country of nationality, who is unable or unwilling to return because of a “well-founded fear of persecution on account of race, religion, nationality, membership in a political social group, or political opinion.”²⁵³ Once recognized, refugees are entitled to legal status and protection in Canada.

A cornerstone of international refugee law and one of the most fundamental articles of the Refugee Convention is the principle of *non-refoulement*.²⁵⁴ *Non-refoulement* is the right to not be returned to experience persecution or danger based on one of the five Convention reasons, above.²⁵⁵

In addition to the obligation to recognize refugees and the prohibition against *non-refoulement*, as signatory to the Refugee Convention, Canada has a duty not to discriminate against refugee claimants by reason of “race, religion or country of origin.”²⁵⁶

B. Designated Countries of Origin

Canada's previous federal government circumvented its legal obligations to refugees. In December 2012, Bill C-31: *Protecting Canada's Immigration System Act* substantially changed Canada's refugee determination system.²⁵⁷

Bill C-31 gave the Minister of Citizenship and Immigration the power to identify certain countries he considered presumptively safe as “Designated Countries of Origin” (DCOs) for the purpose of deciding asylum claims.²⁵⁸ Canada added Mexico to the DCO “safe” list in February 2013.²⁵⁹ As of April 2016, there were 42 countries on the DCO list.²⁶⁰

Until July 2015, refugee claimants from DCO countries were barred from access to appeal a negative refugee determination to the newly created Refugee Appeal Division (RAD) of the Immigration and Refugee Board (IRB). It was also possible to deport failed DCO claimants from Canada immediately after a negative decision on their refugee claim; they did not have a right to an automatic suspension of deportation when they pursued review of a negative decision at the Federal Court.²⁶¹ The lack of access to the RAD had far-reaching consequences: an August 2015 Osgoode Legal Studies Research Paper reported that over 25% of failed refugees succeed on appeal at the RAD, indicating a high number of flawed decisions at the IRB.²⁶²

In *Y.Z.*, the Honourable Justice Boswell found that the RAD bar for claimants from DCO countries contravenes section 15 of the *Canadian Charter of Rights and Freedoms* (the right to equality and non-discrimination).²⁶³ The decision results in failed claimants from DCO countries being able to file an appeal to the RAD, which includes a suspension of

CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN

deportation from Canada while seeking this appeal.²⁶⁴ While the government launched an appeal of Justice Boswell's decision to the Federal Court of Appeal, following the fall 2015 election, the new Liberal government discontinued that appeal, leaving Justice Boswell's decision, and its positive implications for DCO claimants, intact.²⁶⁵

DCO refugee claimants were also denied access to publicly funded healthcare under the Interim Federal Health Program (IFHP), with the exception of care required to treat a medical condition deemed to pose a risk to public health. This "public health and public safety" coverage included anti-retroviral medications and other HIV-related care.²⁶⁶

As of April 1, 2016, the Liberal government has reinstated full IFHP coverage for all refugees. This means that claimants from DCO countries will have the same level of healthcare as all other refugee claimants.²⁶⁷

Finally, the Liberal government has promised to institute an "expert human rights panel" to determine DCO designations.²⁶⁸ As of April 2016, the specifics of such a panel's composition and the process for DCO designation (and de-designation) have not been announced. With or without input from such a panel, the government of Canada has the authority to remove Mexico from the DCO list.

C. Impact of Designated Country of Origin

In a 2012 report, the United Nations High Commissioner for Refugees (UNHCR) submitted that designating a country as "safe" for the purposes of expediting asylum applications is not *prima facie* problematic.²⁶⁹ However, such a designation would need to be used only in "carefully circumscribed situations" and be based on "reliable, objective and up-to-date information from a range of sources," including compliance with human rights instruments and openness to human rights monitoring.²⁷⁰ Importantly, UNHCR highlighted that a designation of a country as safe cannot establish a guarantee of safety for all residents of that country.²⁷¹

While the appointment of an expert human rights panel may reduce concerns about DCO designations being arbitrary or made without proper consideration, the DCO system remains problematic, particularly for its impact on claimants who are living with or vulnerable to HIV infection. Despite DCO claimants now having access to the RAD and healthcare through the IFHP, other obstacles to full access to justice and procedural fairness exist for claimants from designated "safe" countries.

A country that may be safe for the majority of the population may be unsafe for certain minority groups.²⁷² The success rate of sexual orientation claims for countries that do not otherwise produce a great number of Convention Refugees is illustrative of this fact (see Appendix A, Table II). A country that appears politically progressive — i.e., has legislated protection for human rights and has ratified international instruments — may not have protocols or resources to ensure enforcement and protection of these rights.

This is particularly true for populations that have traditionally been marginalized, such as populations living with HIV and those from groups at high risk of infection. This includes populations that, for reasons of their gender, sexuality,

CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN

citizenship status, or social class, are made all the more vulnerable by their HIV status and are not adequately protected by the government. Such populations tend to be stigmatized, criminalized and discriminated against, and are often rendered invisible in statistics purportedly representative of a larger population.²⁷³

Refugee claimants with fears based on their sexual orientation or gender identity face legal obstacles that can be compounded by coming from a DCO country and living with or being vulnerable to HIV.²⁷⁴ A claimant from a DCO country has half the time to prepare for their refugee hearing after filing their Basis of Claim form — that is, 30 days as opposed to 60 days for all other claimants.²⁷⁵ Because of the sensitive nature of claims based on sexual orientation, sexual minority status or gender-based violence, there are many factors that contribute to challenges in presenting these claims within the shortened time frame set out in the DCO regime. After what may be years of hiding their identity or being silent about gender-based or sexual abuse, many do not feel safe enough immediately upon arrival to share such information or acquire documentary evidence from their countries while seeking legal representation and navigating a new country.²⁷⁶ Many experts note that claimants may not make important disclosures to their lawyers in one meeting; often it takes months to establish trust.²⁷⁷ This is particularly true for claimants who have experienced trauma or who are not comfortable disclosing previous sexual violence, their sexual orientation or HIV status.

An additional factor is that some claimants may only discover their HIV status when they complete the required Immigration Medical Exam (IME).²⁷⁸ Claimants must then cope with their diagnosis and disclose this status to their counsel in an extremely short time frame. The shortened time frame for DCO claimants raises the risk that claimants living with HIV will not have the time to disclose their status to their lawyer, resulting in their health status not being pursued as a ground of risk at their refugee hearing.

Another impact of designation is that failed claimants from DCOs cannot apply for a Pre-Removal Risk Assessment (PRRA) for 36 months after their refugee claim is denied, compared with the 12-month bar on PRRAs for other claimants.²⁷⁹ The PRRA presents an opportunity for failed refugee claimants to show that they face a risk in their country based on new evidence arising after their refugee claim was refused. The risk assessment is of particular importance for claimants who may not have been able to disclose their HIV status, past sexual or gender-based violence, or sexual orientation in their initial refugee claim, and fear persecution if returned to their country.

D. Mexico's Designation

The designation of “safe” signals to the IRB member the Minister's opinion about refugee claims from Mexico, which could affect a claimant's chance of success at having their claim accepted in Canada.²⁸⁰ As Justice Boswell stated in the *Y.Z.* decision, the distinction between DCO and non-DCO claimants is “discriminatory on its face,” serves to “marginalize, prejudice, and stereotype” DCO claimants and perpetuates a stereotype that they are “somehow queue-jumpers” or “bogus,” that they only came here to take advantage of Canada's refugee system and its generosity.²⁸¹

CANADIAN ASYLUM POLICIES AND DESIGNATED COUNTRIES OF ORIGIN

Under the current designation scheme, “safe” countries are supposed to recognize “basic democratic rights and freedoms” and provide “mechanisms for redress if those rights or freedoms are infringed,” in order to be reviewed for possible designation.²⁸² As discussed throughout this report, the IHRP’s research has found that progressive and inclusive Mexican laws confirming basic democratic rights and freedoms do not translate into access to those rights or access to redress for violations of those rights for people living with HIV or those at heightened risk of infection.

RECOMMENDATIONS

IV. RECOMMENDATIONS

To the Canadian government and lawmakers:

Human Rights for Vulnerable Groups in Mexico

1. If the Canadian government retains a Designated Country of Origin list, it should immediately remove Mexico from the list.
2. Canada should urge Mexico to ensure full, prompt, effective, impartial and diligent investigation and prosecution of homicides perpetrated against women, migrants, journalists, human rights defenders, children, inmates and detainees, people who use drugs, and LGBTI people, to end the impunity for perpetrators.
3. Canada should offer support to Mexico to implement training for all police, prosecutors, border control and judicial authorities on HIV, gender identity, sexual orientation, gender-based violence, sex work, drug use and harm reduction. (Canada has some relevant experience and resources on *some* of these issues, but should also enhance such training domestically for its own police, prosecutors and other authorities on these issues, where it is absent or inadequate.)
4. Canada should actively participate in regional and global initiatives that work to amplify the voices of LGBTI activists in Mexico, just as it should support such initiatives around the world.
5. Canada should offer assistance to Mexico for LGBTI movement-building, including core and program support to organizations working in areas such as health, community development, and engagement of religious leaders and institutions, to assist in mobilizing key constituencies speaking out in support of human rights for LGBTI people.
6. Canada should ensure that LGBTI rights are systematically integrated into other international development and human rights funding programs in Mexico, such as those to alleviate poverty, protect against discrimination, promote civil liberties, address gender-based violence, and/or promote health (including HIV prevention, treatment and support, and sexual and reproductive health more broadly).

Access to HIV Health Services in Mexico

7. Canada should urge Mexico to stop criminalizing HIV-prevention work under the *Programa Frontera Sur*. Condom distribution can save lives; treating healthcare activists as traffickers undermines the health and human rights of all Mexicans.
8. Canada should urge Mexico to take steps to address discrimination in healthcare services, and to ensure access to ARVs for persons living with HIV. Canada should offer assistance to Mexico in

RECOMMENDATIONS

developing protocols for healthcare professionals to ensure equal and consistent access to *Seguro Popular*, with particular emphasis on the rights of sexual minorities, women and girls, sex workers, people who use drugs, migrant communities, Indigenous communities, people in prison and other forms of detention, and persons living with HIV.

9. Canada should urge Mexico to live up to its international obligations to ensure widespread availability of adequate HIV-prevention and care information, quality HIV-prevention measures and services, and safe and effective medication at an affordable price for all Mexicans, particularly marginalized populations.

10. Canada should encourage Mexico to provide access to HIV treatment for persons living with HIV in prisons throughout the country, pointing to Mexico's obligations under international law and international guidelines on prison health.

11. Canada should offer assistance to Mexico to create more harm reduction programs for people who use drugs.

12. Canada should offer assistance to Mexico to create specialized healthcare services for transgender people throughout Mexico.

13. Canada should urge Mexico to expand HIV testing during prenatal care, ensuring that any such testing is voluntary and carried out with women's informed consent as well as pre- and post-test counselling, consistent with international guidelines on HIV testing.

14. Canada should urge Mexico to prohibit the use of forced sterilization of women, including women living with HIV, as a profound human rights violation, denounced by numerous international human rights bodies and contrary to international human rights law.

15. Canada should work with the government of Mexico and international organizations to address the urgent need for information and educational resources concerning sexual and reproductive health for all Mexicans.

16. Canada should work with the government of Mexico and international organizations to address the urgent need for HIV-prevention education initiatives for populations living with HIV and at risk of infection, as well as education initiatives to promote awareness of human rights, including the right to medical treatment and the right to voluntary and confidential HIV testing with pre- and post-counselling.

17. Canada should urge Mexico to implement legal support services that will educate people living with and affected by HIV about their rights, and provide free or affordable legal services to enforce those rights.

APPENDIX A:

TABLES

V. APPENDIX A: TABLES

Table 1: Mexican Refugee Claims Made in Canada 2005–2014²⁸³

	Claims found eligible for a refugee hearing ²⁸⁴	Accepted	Rejected	Abandoned	Withdrawn & other	Claims finalized	Pending
2014	86	94	188	10	34	326	205
2013	110	182	683	65	83	1013	450
2012	382	568	2144	112	198	3022	1372
2011	763	1042	4184	284	600	6110	3997
2010	1299	653	3437	331	1406	5827	9322
2009	9296	516	3382	419	1748	6065	13873
2008	8069	606	3368	353	1327	5654	10681
2007 ²⁸⁵	7028	378	2132	262	842	3614	8243
2006	4948	931	1693	153	506	3283	4827
2005	3541	697	2286	225	471	3679	3174

Table II: Sexual Orientation versus All Claim Types, Selected Countries 2004–2007²⁸⁶

Country	Claim Type	Accepted	Rejected	Recognition Rate	Rejection Rate
India	Sexual Orientation	24	8	75.0	29.4
	All Claims	697	1,321	34.5	74.4
Jamaica	Sexual Orientation	38	18	67.9	34.5
	All Claims	134	481	21.8	80.9
St. Lucia	Sexual Orientation	21	10	67.7	36.4
	All Claims	122	389	23.9	79.0

APPENDIX B:

METHODOLOGY

VI: APPENDIX B: METHODOLOGY

For sixteen days in June/July 2015, the IHRP conducted field research in Mexico to assess whether Canada's 2013 declaration that Mexico is a "Designated Country of Origin" — a safe country — was valid for those living with or vulnerable to HIV. The IHRP conducted a total of 34 interviews with 50 doctors, academics, journalists, activists, and human rights defenders throughout Mexico to investigate possible human rights violations against individuals living with HIV and those who have experienced discrimination as a result of their marginalized or criminalized status, rendering them vulnerable to HIV infection.

In addition, the IHRP conducted four interviews in Canada with researchers and advocates to highlight the impact of Canada's policies on vulnerable groups.

All interviews adhered to strict confidentiality principles and were conducted using an open-ended questionnaire. The interviewees were fully informed about the nature and purpose of the report, and the manner in which their information would be used. They were also explicitly provided the option of not participating or remaining anonymous in the final report. The interviewees were not provided incentive in exchange for participation. The interviews were conducted in person with the exception of approximately six interviews, which were conducted either by Skype, phone or e-mail.

The IHRP provided for review an advance copy of the report and recommendations to our Advisory Committee:

Canadian HIV/AIDS Legal Network / Réseau juridique canadien VIH/sida

Canadian Doctors for Refugee Care (former)

HIV & AIDS Legal Clinic Ontario (HALCO)

Refugee Law Office, Legal Aid Ontario (LAO)

ACKNOWLEDGMENTS

ACKNOWLEDGMENTS

The IHRP would like to express our gratitude to the academics, journalists, human rights defenders, doctors and activists in Mexico who spoke to us for this report. We would also like to recognize the research contributions made by our interviewees in Canada, including Dr. Janet Cleveland, Maureen Silcoff, Professor Sean Rehaag, William Payne, Michael Battista, Adrienne Smith and Dr. Alexander Caudarella.

We would also like to recognize the exceptional work of our interpreters and guides, Enrique Torre Molina and Jaime Horatio Cinta Cruz.

We would like to thank our advisory committee for providing research guidance and feedback on drafts of the report: Sandra Ka Hon Chu, Stéphanie Claivaz-Loranger and Richard Elliott, of the Canadian HIV/AIDS Legal Network; Dr. Meb Rashid and Dr. Philip Berger, of the former Canadian Doctors for Refugee Care; Meagan Johnston, of HALCO; and John Norquay and Andrew Brouwer of the Refugee Law Office at Legal Aid Ontario.

This report was researched and written by Maia Rotman, IHRP Health and Human Rights Fellow, and Kristin Marshall, project supervising lawyer at the IHRP. Extensive research and writing support was provided by Petra Molnar, IHRP Health and Human Rights Fellow. Vajdon Sohaili copy edited the report. Michelle Hayman proofread and fact-checked the report, and Kaitlin Owens and Amy Tang conducted preliminary international research. Kara Norrington provided administrative support. The report was reviewed by Samer Muscati, IHRP Director; and Renu Mandhane, former IHRP Director.

The IHRP gratefully acknowledges the generous financial support of the Elton John AIDS Foundation.

We would like to extend special thanks to University of Ottawa Professor, Nicole LaViolette, who passed away in May 2015. She was a prolific writer on immigration and refugee law and a fierce defender of LGBTI rights. She advanced the Canadian conversation on sexual minorities in refugee determination and we are deeply grateful for her inspiration and significant contribution to the field.

ENDNOTES

¹ *Political Constitution of the United Mexican States*, 1917, as amended by decree published on 10 June 2011 art 1, online: Tribunal Electoral del Poder Judicial de la Federación <http://portal.te.gob.mx/sites/default/files/consultas/2012/04/cpeum_ingles_ref_26_feb_2013_pdf_81046.pdf> [Constitution].

² *Ley Federal Para Prevenir y Eliminar la Discriminación [Anti-discrimination Law]*, as amended, Diario Oficial de la Federación [DO] (Mex.), 3 March 2014, art 1, 2 and 4, online: <<http://www.diputados.gob.mx/LeyesBiblio/pdf/262.pdf>>. Through that same law, the National Council for the Prevention of Discrimination (CONAPRED) was established within the Mexican Secretariat of the Interior to combat discrimination. Letra S et al., *Human Rights Violations Against Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) People in Mexico: A Shadow Report* (July 2014) [Letra S Report], online: OHCHR <http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/MEX/INT_CCPR_ICM_MEX_17477_E.pdf>.

³ *Ibid* at 8.

⁴ International Human Rights Program in-person interview of Professor Gloria Careaga, UNAM, Mexico City (4 July 2015) [Interview of Gloria Careaga].

⁵ Human Rights Watch, *World Report 2015* (2015) at 380, online: Human Rights Watch <https://www.hrw.org/sites/default/files/world_report_download/wr2015_web.pdf> [Human Rights Watch 2015].

⁶ Interview of Gloria Careaga, *supra* note 4; "Mexico is No. 2 for homophobic crimes", *Mexico News Daily* (18 May 2015), online: Mexico News Daily <<http://mexiconewsdaily.com/news/mexico-no-2-for-homophobic-crimes/>>; Patricia Mayorga, "Asesinan a transexual y cubren su cuerpo con la banderanacional" (Transgender woman murdered and body covered with national flag), *Proceso*, (24 June 2015), online: Proceso <<http://www.proceso.com.mx/?p=408629>>; Eric Rosswood, "Trans person murdered, beaten and shot four times – 100 mourners attend vigil and protest", *The New Civil Rights Movement*, (26 June 2015), online: <http://www.thenewcivilrightsmovement.com/ericrosswood/trans_person_murdered_beaten_and_shot_4_times>.

⁷ Duncan Tucker, "Mexico's gay rights movement gaining ground", *Al Jazeera* (28 January 2014), online: Al Jazeera, <<http://www.aljazeera.com/indepth/features/2014/01/mexico-gay-rights-movement-gaining-ground-2014126125256612949.html>>.

⁸ Consejo Nacional para Prevenir la Discriminación (CONAPRED) [National Council for the Prevention of Discrimination], *El Combate a la Homofobia: Entre Avances y Desafíos* [Fighting Homophobia: From Advances to Challenges], (2012) at 2, online: CONAPRED <http://www.conapred.org.mx/documentos_cedoc/DocumentoHomofobia_ACCSS.pdf>.

⁹ Forced or enforced disappearance is defined as "the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons or groups of persons acting with the authorization, support or acquiescence of the State." *United Nation's International Convention for the Protection of All Persons from Enforced Disappearance*, 20 December 2006, UN Doc A/RES/61/177 art 2 (entry into force 23 December 2010), online: United Nations Office of the High Commissioner, <<http://www.ohchr.org/EN/HRBodies/CED/Pages/ConventionCED.aspx>>; International Human Rights Program in person interview of Antonio Medina, Journalist and Professor, Mexico City, 06.25.15; International Human Rights Program in person interview of Lupita Gonzalez, LGBT Community Centre Director, Mexico City (23 June 2015) [Interview of Lupita Gonzalez]; International Human Rights Program in person interview of Rocio Suarez, Coordinator, Center of Support for Trans Identity, Mexico City (3 July 2015) [Interview of Rocio Suarez]; International Human Rights Program in person interview of Eugenia Lopez, Executive Director, Balance, Mexico City (26 June 2015) [Interview of Eugenia Lopez]. See also, Amnesty International, *Report 2014/2015: The State of the World's Human Rights* (2015) at 249, online: Amnesty International <https://www.amnestyusa.org/pdfs/AIR15_English.PDF>.

¹⁰ "Migration is often analysed in terms of the "push-pull model", which looks at the push factors, which drive people to leave their country (such as economic, social, or political problems) and the pull factors attracting them to the country of destination." International Organization for Migration, *Key Migration Terms* (2011), online: International Organization for Migration <<https://www.iom.int/key-migration-terms>>.

¹¹ United States Department of Justice, *Asylum Statistics FY 2010-2014* (2014), online: U.S. Department of Justice <<https://www.justice.gov/sites/default/files/eoir/pages/attachments/2015/03/16/fy2010-fy2014-asylum-statistics-by-nationality.pdf>>.

¹² Sean Rehaag, "2015 Refugee Claim Data and IRB Member Recognition Rates" (30 March 2016), online: CCR <<http://ccrweb.ca/en/2015-refugee-claim-data>>.

¹³ Government of Canada, *Mexico Advisories*, online: Government of Canada <<http://travel.gc.ca/destinations/mexico>>.

¹⁴ Immigration and Refugee Board, "Country Reports" (Obtained through Access to Information and Privacy Requests made to Citizenship and Immigration Canada by IHRP, 5 May 2015, A-2015-00130 / JSJ; A-2015-00132 / JSJ; A-2015-00133 / JSJ) [ATIP Requests]; *YZ v Canada (Minister of Citizenship and Immigration)*, 2015 FC 892, [2015] FCJ No 880, Appeal Record, Affidavit of Sean Rehaag [*YZ v Canada*, Affidavit of Sean Rehaag].

¹⁵ International Human Rights Program in person interview of an International Health Service Organization staff person who wished to remain anonymous, Mexico City (1 July 2015) [Interview of International Health Service Organization].

¹⁶ United Nations Human Rights Office of the High Commissioner, *Statement of the UN High Commissioner for Human Rights, Zeid Ra'ad Al Hussein, on his visit to Mexico, October 7th, 2015* (7 October 2015), online: OHCHR <<http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16578&LangID=E>>.

¹⁷ William Neuman, "As Drug Kingpins Fall in Mexico, Cartels Fracture and Violence Surges", *The New York Times* (12 Aug 2015), online: NY Times <<http://www.nytimes.com/2015/08/13/world/americas/as-mexico-arrests-kingpins-cartels-splinter-and-violence-spikes.html?ribbon-ad-idx=4&rref=world/americas&module=Ribbon&version=context®ion=Header&action=click&contentCollection=Americas&pgtype=article&r=0>> [Neuman, "As Drug Kingpins Fall"]; *Human Rights Watch 2015*, *supra* note 5 at 377.

¹⁸ Human Rights Council Working Group on the Universal Periodic Review, *Summary prepared by the Office of the High Commissioner for Human Rights in accordance with paragraph 15 (b) of the annex to Human Rights Council resolution 5/1 and paragraph 5 of the annex to Council resolution 16/21 Mexico*, HRC, Seventeenth Session, A/HRC/WG.6/17/MEX/3 (2013) at para 67 [HRC Summary Mexico]; See also Cara Gibbons and Beth Spratt, *Corruption, Impunity, Silence: The War on Mexico's Journalists* (Toronto: PEN Canada and the International Human Rights Program, 2011), online: IHRP <[http://ihrp.law.utoronto.ca/utfl_file/count/documents/WorkingGroup_Clinic/CorruptionImpunitySilence_revised%20e-version%20\(English\)%20\(1\).pdf](http://ihrp.law.utoronto.ca/utfl_file/count/documents/WorkingGroup_Clinic/CorruptionImpunitySilence_revised%20e-version%20(English)%20(1).pdf)> [Gibbons and Spratt, *Corruption, Impunity Silence*]; Neuman, "As Drug Kingpins Fall", *supra* note 17; Freedom House,

ENDNOTES

"Mexico: Freedom of the Press 2015" (2015), online: Freedom House <<https://freedomhouse.org/report/freedom-press/2015/mexico>>; Nina Lakhani "Journalists are being slaughtered" – Mexico's problem with press freedom" *The Guardian* (4 August 2015), online: The Guardian <<http://www.theguardian.com/world/2015/aug/04/journalists-mexico-press-freedom-photographer-ruben-espinosa-murder>>; Interview of Gloria Careaga, *supra* note 4.

¹⁹ International Human Rights Program in person interview of Dr. Rene Levya, Director of Health Management and Research, National Institute of Public Health, Cuernavaca (24 June 2015) [Interview of Dr. Rene Levya].

²⁰ Human Rights Council Working Group on the Universal Periodic Review, *Compilation prepared by the Office of the High Commissioner for Human Rights in accordance with paragraph 15(b) of the annex to Human Rights Council resolution 5/1 and paragraph 5 of the annex to Council resolution 16/21*, HRC, Seventeenth Session, A/HRC/WG.6/17/MEX/2 (2013) [HRC Compilation Mexico].

²¹ Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, *International Guidelines on HIV/AIDS and Human Rights*, Second International Consultation on HIV/AIDS and Human Rights, (2006) [HIV/AIDS Guidelines] at para 96, online: OHCHR <<http://www.ohchr.org/Documents/Publications/HIVAIDSGuidelinesen.pdf>>.

²² *Ibid* at para 98.

²³ Some of the more common life-threatening infections include lung infections, eye infections, brain infection and generalized infections. In some cases of life-threatening infections, HIV has developed into AIDS. AIDS stands for acquired immunodeficiency syndrome. AIDS-defining illnesses are limited to serious life-threatening infections, fungal infections or cancers. See Derek Thaczuk, *Managing Your Health: a Guide for People Living with HIV* at ss 2, 12, online: CATIE, <<http://www.catie.ca/en/practical-guides/managing-your-health>>.

²⁴ UNAIDS, *The Gap Report* (16 July 2014) [UNAIDS Gap Report] at 126, online: UNAIDS <http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf>.

²⁵ Thaczuk, *supra* note 23.

²⁶ WHO, *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV* (September 2015), online: World Health Organization <<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/>> [WHO *Guideline*]; WHO is also planning to release a comprehensive update of its consolidated ARV guidelines, the current set of ARV guidelines from 2013 can be found here: WHO, *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infections* (30 June 2013), online: World Health Organization <http://www.who.int/hiv/pub/guidelines/arv2013/download/en/?utm_source=AVAC+Email+Updates&utm_campaign=d2a47894ee-PrEP_Guidelines_9_29_20159_29_2015&utm_medium=email&utm_term=0_6fd730be57-d2a47894ee-130140473>.

²⁷ WHO, Press Release, "Treat all people living with HIV, offer antiretrovirals as additional prevention choice for people at "substantial" risk" (30 September 2015) online: World Health Organization, <<http://www.who.int/mediacentre/news/releases/2015/hiv-treat-all-recommendation/en/>> [WHO, "Treat all people"].

²⁸ "Substantial risk of HIV infection is defined by an incidence of HIV infection in the absence of PrEP that is sufficiently high (>3% incidence) to make offering PrEP potentially cost-saving (or cost-effective). Offering PrEP to people at substantial risk of HIV infection maximizes the benefits relative to the risks and costs. People at substantial risk of HIV infection are present in most countries, including some (but not all) people identified with key and vulnerable populations and some people not so identified." WHO *Guideline*, *supra* note 26 at 8.

²⁹ WHO *Guideline*, *supra* note 26 at 42.

³⁰ WHO, "Treat all people", *supra* note 27.

³¹ International Human Rights Program in person interview of Ricardo Hernandez, Director of HIV Programs, CNDH, Mexico City (22 June 2015) [Interview of Ricardo Hernandez]; Powerpoint presentation, "*VIH y derechos humanos: Actualización de datos*", presented to the IHRP by Ricardo Hernandez, Director of HIV Programs, CNDH, Mexico City (22 June 2015) [CNDH Powerpoint Presentation]; "Mexico", UNAIDS, online: UNAIDS <<http://www.unaids.org/en/regionscountries/countries/mexico>> [UNAIDS, Mexico].

³² Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

³³ *Vigilancia Epidemiológica de casos de VIH/SIDA en México Registro Nacional de Casos de SIDA Actualización al cierre de 2014* (2014) [CENSIDA Update 2014], online: CENSIDA <http://www.censida.salud.gob.mx/descargas/epidemiologia/RN_CIERRE_2014.pdf>; Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; An HIV epidemic is defined by the prevalence in a given population. In a concentrated epidemic, "HIV has spread rapidly in one or more populations but is not well established in the general population. Typically, the prevalence is over 5% in subpopulations while remaining under 1% in the general population". In a generalized epidemic, HIV-prevalence is 1% or more in the general population. UNAIDS, *Terminology Guidelines* (October 2011) at 8, online: UNAIDS <http://www.unaids.org/sites/default/files/media_asset/JC2118_terminology-guidelines_en_0.pdf>.

³⁴ CENSIDA Update 2014, *supra* note 33; Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; See, for example, a video series about HIV in Tijuana: Jennifer Davies, "New Video Series Chronicles AIDS Epidemic in Tijuana", *US San Diego News Center* (5 October 2015), online: US San Diego News Center <http://ucsdnews.ucsd.edu/pressrelease/new_video_series_chronicles_aids_epidemic_in_tijuana>.

³⁵ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

³⁶ UNAIDS, Mexico, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

³⁷ See also Alicia Ely Yamin, "The Right to Health Under International Law and Its Relevance to the United States" (2005) 95(7) *Am J Public Health* 1156; Committee on Economic, Social and Cultural Rights, *General Comment 14, The right to the highest attainable standard of health* (Twenty-second session, 2000), UN Doc E/C.12/2000/4 (2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc HRI/GEN/1/Rev 6 at 85 (2003) at para 16, <<https://www1.umn.edu/humanrts/gencomm/escgencom14.htm>> [General Comment 14].

³⁸ Universal Declaration of Human Rights, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71 arts 3, 25, online: UN <<http://www.un.org/en/universal-declaration-human-rights/>>.

³⁹ *Ibid* at arts 7, 8, 12, 23, 26.

⁴⁰ *Ibid* at art 2.

ENDNOTES

- ⁴¹ UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), online: UN <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-3&chapter=4&lang=en> [ICESCR]; General Comment 14, *supra* note 37.
- ⁴² ICESCR, *supra* note 41 at art 12.1.
- ⁴³ *Ibid* at art 12.2c.
- ⁴⁴ *Ibid* at art 2.
- ⁴⁵ Grounds include: "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health". General Comment 14, *supra* note 37 at paras 18-19.
- ⁴⁶ *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 13 art 12.1 (entered into force 3 September 1981).
- ⁴⁷ "Seguro Popular: Health Coverage For All in Mexico", *The World Bank* (26 February 2015) [World Bank], online: The World Bank <<http://www.worldbank.org/en/results/2015/02/26/health-coverage-for-all-in-mexico>> [World Bank].
- ⁴⁸ Julio Frenk, Octavio Gomez-Dantes, Felicia Maria Knaul, "The democratization of health in Mexico: financial innovations for universal coverage", *Bulletin of the World Health Organization* (May 2009), online: WHO <<http://www.who.int/bulletin/volumes/87/7/08-053199/en/>>.
- ⁴⁹ *World Bank*, *supra* note 47.
- ⁵⁰ Interview of Ricardo Hernandez, *supra* note 31; "Semana Judicial de la Federación", *Suprema Corte de Justicia de la Nación* (March 2002), online: SCJN <[Healthcare Quarterly 64, online: Longwoods <<http://www.longwoods.com/content/22365>>.](http://sjf.scjn.gob.mx/sjfsist/paginas/DetalleGeneralV2.aspx?Epoca=10080000000000&Apendice=1000000000&Expresion=&Dominio=Rubro&TA_TJ=2&Orden=4&Clase=DetalleTesisBL&NumTE=3556&Epp=20&Desde=-100&Hasta=-100&Index=121&ID=192160&HI%20=2424&IDs=192157,192158,192159,192160,192162,192164,192165,192166,192167,%20192168,192169,192183,192191,192192,192195,192196,192197,192286,192288,%20192289&tipoTesis=&Semana=0&tabla>>.</p><p>⁵¹ World Bank, <i>supra</i> note 47; Interview of Ricardo Hernandez, <i>supra</i> note 31; CNDH Powerpoint Presentation, <i>supra</i> note 31.</p><p>⁵² Interview of Ricardo Hernandez, <i>supra</i> note 31; CNDH Powerpoint Presentation, <i>supra</i> note 31; International Human Rights Program in person interview of Executive Director of Clinica Condesa, Dr. Andrea Gonzalez, Mexico City (25 June 2015) [Interview of Dr. Andrea Gonzalez].</p><p>⁵³ 'Street involved' refers to individuals who are precariously housed and/or have residential instability. For instance, see: Elizabeth McCay,)
- ⁵⁴ Interview of Eugenia Lopez, *supra* note 9.
- ⁵⁵ Alexandra McAnarney, "Efforts to Provide HIV-AIDS and Other Health Services to Migrants Face Major Obstacles" *CIP Americas Program* (9 February 2013), online: CIPamericas <<http://www.cipamericas.org/archives/8948>>.
- ⁵⁶ Interview of Eugenia Lopez, *supra* note 9.
- ⁵⁷ Argentina E. Servin, Fatima A. Munoz and Maria Luisa Zuniga, "Healthcare provider perspectives on barriers to HIV-care access and utilization among Latinos living of HIV in the US-Mexico border" 16: 5 *Culture, Health & Sexuality* 587 at 591 [Servin et al.].
- ⁵⁸ International Human Rights Program in person interview of Rosember Lopez, Director, Una Mano Amiga, Tapachula (30 June 2015) [Interview of Rosember Lopez]; Interview of Eugenia Lopez, *supra* note 9.
- ⁵⁹ Thaczuk, *supra* note 23 at s 2; Servin et al., *supra* note 57.
- ⁶⁰ Interview of Dr. Andrea Gonzalez, *supra* note 52; Jon Coen, "High Risk of HIV Infection Faced by Transgender Women in Tijuana" *The Pulitzer Center on Crisis Reporting* (July 22, 2015), online: The Pulitzer Center <<http://pulitzercenter.org/reporting/risk-of-hiv-infection-faced-by-transgender-women-in-tijuana>> [Coen, "High Risk"].
- ⁶¹ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.
- ⁶² Interview of International Health Service Organization, *supra* note 15; Interview of Eugenia Lopez, *supra* note 9.
- ⁶³ Diseases like cancer, for which individuals living with HIV are particularly susceptible, will become an increasing problem. According to Ricardo Hernandez of CNDH, in eight states in Mexico there is an outbreak of tuberculosis (TB), often associated with HIV because of its connection to the immune system. People living with HIV are more likely to get tuberculosis, and because they are unable to treat it without putting their health in danger by stopping their HIV medications, they are more likely to spread the outbreak. Globally, tuberculosis remains the principal cause of death for persons living with HIV, with 320,000 deaths as a result of infection in 2012. Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; Interview of International Health Service Organization, *supra* note 15.
- ⁶⁴ International Human Rights Program in person interview of staff at Clinica Condesa: Dr. Andrea Gonzalez Rodriguez, Executive Director; David Kelvin Santos, Coordinator Letra S; Dr. Steven Diaz, Deputy Director of Prevention; Dr. Jeremy Cruz, Psychologist; Luis Manuel Arellano Delgado, Subdirector of Integration and Communication; Dr. Florentino Badial Hernandez, Executive Director – associated Iztapalapa HIV Clinic, Mexico City (25 June 2015) [Interview of staff at Clinica Condesa]; Servin et al., *supra* note 57.
- ⁶⁵ Interview of staff at Clinica Condesa, *supra* note 64; International Human Rights Program in person interview of Etty, 'matron', Casa Xochiquetzal, home for elderly sex workers, Mexico City (2 July 2015) [Interview of Etty, Casa Xochiquetzal]; Interview of Rosember Lopez, *supra* note 58; International Human Rights Program in person interview of Julio Campos, Coordinator, Migrantes LGBT, Mexico City (25 June 2015) [Interview of Julio Campos].
- ⁶⁶ Interview of staff at Clinica Condesa, *supra* note 64; Interview of International Health Service Organization, *supra* note 15.
- ⁶⁷ Interview of staff at Clinica Condesa, *supra* note 64.
- ⁶⁸ Servin et al., *supra* note 57 at 592.
- ⁶⁹ Interview of Etty, Casa Xochiquetzal, *supra* note 65; International Human Rights Program in person interview of Karla Silvia Meza Soto, Coordinator, and Gilda Maribel Alvarez, social worker at Sin Fronteras, Mexico City (1 July 2015) [Interview of Sin Fronteras]; Interview of Rosember Lopez, *supra* note 58; Interview of Julio Campos, *supra* note 65.
- ⁷⁰ Despite its name, the Plan reaches far beyond the southern border region. There have been reports of increasing security measures and police

ENDNOTES

and military presence as far north as Puebla, Mexico. Enhanced checkpoints are so commonplace on highways that one advocate described the situation as if there were international borders inland, like an airport; Interview of Sin Fronteras, *supra* note 69; International Human Rights Program in person interview of Luis Eliud Tapia Olivares and Yeny Santiago Alcaraz of Centro Prodh, Mexico City (22 June 2015); International Human Rights Program interview of Salva Lacruz, Coordinator, Centro de Derechos Humanos Fray Matias de Cordova, Tapachula, (29 June 2015) [Interview of Salva Lacruz].

⁷¹ Mexico President of the Republic, "Pone en marcha el Presidente Enrique Peña Nieto el Programa Frontera Sur" ("President Enrique Peña Nieto starts the Southern Border Program") (7 July 2014), online: Presidencia <<http://www.presidencia.gob.mx/articulos-prensa/pone-en-marcha-el-presidente-enrique-pena-nieto-el-programa-frontera-sur/>>.

⁷² Interview of Rosember Lopez, *supra* note 58; Interview of Salva Lacruz, *supra* note 70; Interview of Sin Fronteras, *supra* note 69.

⁷³ Interview of Rocio Suarez, *supra* note 9.

⁷⁴ Interview of Dr. Rene Levya, *supra* note 19.

⁷⁵ Interview of Rosember Lopez, *supra* note 58. In 2014, Alejandra Gil, director of the organization APROASE that offers sliding-scale health services to street-based sex workers in Mexico City, was arrested for human trafficking because she was taking money from sex workers in exchange for healthcare. "Alejandra Gil" *NSWP: Global Network of Sex Work Projects* (2014), online: NSWP <<http://www.nswp.org/swleader/alejandra-gil/>>; International Human Rights Program telephone interview of Rosario Padilla, Director Centro SER health service centre Tijuana, (8 July 2015) [Interview of Rosario Padilla].

⁷⁶ Interview of Rocio Suarez, *supra* note 9.

⁷⁷ Interview of Dr. Rene Levya, *supra* note 19.

⁷⁸ UNAIDS *Gap Report*, *supra* note 24 at 118-119.

⁷⁹ HIV/AIDS Guidelines, *supra* note 21 at para 98.

⁸⁰ *Ibid.*

⁸¹ *Constitution*, *supra* note 1 at art 1; See also, Global Rights et al., *The Violations of the Rights of Lesbian, Gay, Bisexual and Transgender Persons in MEXICO* (March 2010) [Outright International Mexico], online: Outright International <<http://www.outrightinternational.org/sites/default/files/556-1.pdf>>.

⁸² Interview of Eugenia Lopez, *supra* note 9; Interview of Rosario Padilla, *supra* note 75.

⁸³ International Human Rights Program in person interview of Jacqueline L'Hoist, President – COPRED (Mexico City Council to Prevent Discrimination), Mexico City (22 June 2015) [Interview of Jacqueline L'Hoist].

⁸⁴ Interview of International Health Service Organization, *supra* note 15.

⁸⁵ Interview of Rosario Padilla, *supra* note 75; Regarding Canadians seeking to marry in Mexico states requirement: "A physician's certificate stating that according to the blood tests and x-rays taken in Mexico, neither applicant suffers from any contagious disease". Embajada de Mexico en Canada, *Marriage requirements in Mexico*, online: Mexico Gobierno de la Republica <http://embamex.sre.gob.mx/canada_eng/index.php/marriage-in-mexico>.

⁸⁶ Interview of International Health Service Organization, *supra* note 15; Outright International Mexico, *supra* note 81 at 4; Servin et al., *supra* note 57 at 594.

⁸⁷ Interview of staff at Clinica Condesa, *supra* note 64.

⁸⁸ *Ibid.*

⁸⁹ Interview of Eugenia Lopez, *supra* note 9.

⁹⁰ International Human Rights Program in person interview of Alejandro Brito, Letra S, Mexico City (1 July 2015) [Interview of Alejandro Brito].

⁹¹ Interview of Eugenia Lopez, *supra* note 9.

⁹² *Ibid.*

⁹³ Interview of Eugenia Lopez, *supra* note 9; Interview of staff at Clinica Condesa, *supra* note 64.

⁹⁴ HRC Summary Mexico, *supra* note 18 at para 79.

⁹⁵ Interview of Alejandro Brito, *supra* note 90.

⁹⁶ *Ibid.*

⁹⁷ Interview of International Health Service Organization, *supra* note 15.

⁹⁸ Interview of Alejandro Brito, *supra* note 90.

⁹⁹ M. Aranxta Colchero et al., "HIV prevalence, socio demographic characteristics, and sexual behaviors among transwomen in Mexico City" (2015) 57: Supp 2 Salud Pública Méx 99 at s102 <<http://bvs.insp.mx/rsp/articulos/articulo.php?id=003101>> [Colchero et al].

¹⁰⁰ Interview of Eugenia Lopez, *supra* note 9.

¹⁰¹ *Covarrubias v Canada* 2006 FCA 365, [2007] 3 FCR 169 at para 41.

¹⁰² *Ibid.*

¹⁰³ International Human Rights Program in person interview of Ricardo Roman, INSPIRA, Mexico City, (2 July 2015) [Interview of Ricardo Roman].

¹⁰⁴ Interview of Lupita Gonzalez, *supra* note 9; See e.g.: *Constitution*, *supra* note 1 at art 1; *Anti-Discrimination Law*, *supra* note 2 at art 1, 2, 4 (Federal Law to Prevent and Eliminate Discrimination - 2003: prohibits public and private sector discrimination based on various characteristics including "sexual preference," & includes homophobia as a form of discrimination); *Decreto por el que se declara 17 de mayo, Día Nacional de la Lucha contra la Homofobia*, Diario Oficial de la Federacion, 21 March 2014, online: Diario Oficial <http://www.dof.gob.mx/nota_detalle.php?codigo=5337843&fecha=21/03/2014> (National Day for the Fight Against Homophobia - May 17th. Signed by presidential decree (Peña Nieto administration) on March 21 2014); *Ley Para Prevenir y Eliminar La Discriminación del Distrito Federal*, [Federal District Anti-Discrimination Law], as amended, art 1, 5, Gaceta Oficial del Distrito Federal, 24 February 2011, (Mex.), online: Gaceta Oficial del Distrito Federal <<http://cgsservicios.df.gob.mx/prontuario/vigente/4119.pdf>>. (Mexico City antidiscrimination legislation prohibiting public and private sector discrimination on the basis of gender identity, as well as on the basis of sexual orientation); *Código Penal Para el Distrito Federal* [Federal District Criminal Code], as amended, art 206, Gaceta Oficial Del Distrito Federal. 24 February 2014, online: ALDF <<http://www.aldf.gob.mx/archivo-994197bf103f72d714726e94ce527125.pdf>> (Mexico City Criminal Code includes crimes committed on basis of sexual orientation/gender identity as hate crimes);

ENDNOTES

Acuerdo A/007/2012 del Procurador General de Justicia del Distrito Federal Mediante el Cual se Emite el Protocolo de Actuación Para la Atención a las Personas de la Comunidad LGBTTI [Federal District Attorney General Directive Establishing Protocol for LGBTTI Community Affairs], Diario Oficial de La Federación (1 June 2012), online: CDMX <<http://cgservicios.df.gob.mx/prontuario/vigente/4811.pdf>> (Mexico City 2012, the Federal District Attorney General issued a directive that provides instructions on effectively processing cases of crimes committed on the basis of the victim's sexual orientation and gender identity).

¹⁰⁵ Interview of Rocio Suarez, *supra* note 9.

¹⁰⁶ Human Rights Council, *Report of the Special Rapporteur on extrajudicial, summary or arbitrary executions, Christof Heyns, Mission to Mexico*, Twenty-sixth session, A/HRC/26/36/Add 1 (2014) at para 85, online: OHCHR <<http://www.ohchr.org/EN/Issues/Executions/Pages/CountryVisits.aspx>> [Special Rapporteur on extrajudicial, summary or arbitrary executions].

¹⁰⁷ *Ibid* at paras 85-86.

¹⁰⁸ *Ibid* at para 85.

¹⁰⁹ *Ibid* at para 86.

¹¹⁰ *Ibid*.

¹¹¹ Outright International Mexico, *supra* note 81 at 4.

¹¹² *Ibid*.

¹¹³ *Ibid* at 8.

¹¹⁴ *Ibid* at 6-8.

¹¹⁵ Interview of Rosember Lopez, *supra* note 58.

¹¹⁶ Interview of Alejandro Brito, *supra* note 90. Many factors contribute to the censorship and self-censorship of the media in Mexico generally, including corruption, cartel violence, fear and stigma, see Gibbons and Spratt, *Corruption, Impunity Silence*, *supra* note 18.

¹¹⁷ International Human Rights Program in person interview of Benjamin Alfaro, journalist, Tapachula (30 June 2015).

¹¹⁸ Interview of Gloria Careaga, *supra* note 4.

¹¹⁹ *Human Rights Watch 2015*, *supra* note 5 at 381.

¹²⁰ The term 'transgender women' refers to individuals who were assigned male at birth but identify and live as women. A transgender identity is not dependent on medical procedures, but some individuals may undergo surgery or take hormones. For the purposes of this report, transgender will include all whose gender identity or expression differs from what is traditionally associated with the sex they were assigned at birth. For more information, see: "GLAAD Media Reference Guide – Transgender Issues", online: GLAAD <<http://www.glaad.org/reference/transgender>>.

¹²¹ Interview of International Health Service Organization, *supra* note 15; The World Bank, "Life expectancy at birth, female (years)" (2015), online: Data World Bank <<http://data.worldbank.org/indicator/SP.DYN.LE00.FE.IN>>.

¹²² Gaceta Oficial Del Distrito Federal, *Código Civil Para el Distrito Federal* (Federal District Civil Code), as amended, art 135, 5 April 2014, online: <<http://www.aldf.gob.mx/archivo-e874716ab4a756cc528510ffeba2d84c.pdf>>.

¹²³ Interview of Ricardo Roman, *supra* note 103.

¹²⁴ *Ibid*; Interview of Eugenia Lopez, *supra* note 9; Interview of Alejandro Brito, *supra* note 90; Letra S Report, *supra* note 2 at 5-6.

¹²⁵ Outright International Mexico, *supra* note 81 at 5-6.

¹²⁶ Interview of Ricardo Roman, *supra* note 103; Interview of Alejandro Brito, *supra* note 90; Interview of Rosember Lopez, *supra* note 58. See also: Coen, "High Risk," *supra* note 60.

¹²⁷ Interview of Ricardo Roman, *supra* note 103.

¹²⁸ International Human Rights Program in person interview of Itzel Checa, Claudia Ochoa and Armando Palacios Sommer, staff at the Program for Human Rights in Mexico City (2 July 2015) [Interview of staff at the Program for Human Rights in Mexico City].

¹²⁹ Juan Carlos Donoso, "On religion, Mexicans are more Catholic and often more traditional than Mexican Americans" *Fact Tank*, online: Pew Research Centre <<http://www.pewresearch.org/fact-tank/2014/12/08/on-religion-mexicans-are-more-catholic-and-often-more-traditional-than-mexican-americans/>>.

¹³⁰ UNAIDS Gap Report, *supra* note 24 at 217; Outright International Mexico, *supra* note 81 at 5-6.

¹³¹ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31. Some reports indicate this rate is even higher: a recent study of 585 transgender women in Mexico City found the prevalence rate to be 19.8 per cent among trans-women surveyed at common meeting places, Colchero et al, *supra* note 99 at s99.

¹³² *Ibid* at s105.

¹³³ According to activists, despite the high prevalence of HIV in the transgender community, the main physical challenge transgender women face is accessing safe hormonal therapy. Recent reports have indicated that once transgender women go through the often-grueling process of coming to terms with their identity, they feel like they need the physical change to happen quickly. But few clinics other than Clinica Condesa have the capacity or expertise to provide hormone therapy. As a result, transgender women outside of Mexico City and those who were not able to get into Clinica Condesa, are faced with extremely limited options for hormone therapy. Because Clinica Condesa is the only public hormone therapy provider in Mexico, there is not enough supply for the demand. Moreover, some transgender individuals are reticent about associating with Clinica Condesa because of the stigma it attaches to them as an HIV clinic. The IHRP was told of many reports of transgender girls and women fatally using homemade concoctions, like petroleum, as breast injections. According to transgender rights activist Rocio Suarez, if transgender individuals could be more visible, accepted into the system and guided through their transition with open and safe access to hormonal therapy, as opposed to being withdrawn to the margins of Mexican society, HIV cases would inevitably decrease. Interview of Rocio Suarez, *supra* note 9.

¹³⁴ Interview of Ricardo Roman, *supra* note 103.

¹³⁵ Interview of staff at Clinica Condesa, *supra* note 64.

¹³⁶ *Ibid*.

¹³⁷ Interview of Eugenia Lopez, *supra* note 9.

¹³⁸ Legislative Assembly of the Federal District, VI Legislature *Ley para la prevención y atención integral del vih/sida del distrito federal* (Law for the

ENDNOTES

Prevention and Comprehensive Care of HIV/AIDS of the Federal District, Mexico) art 17, online: ALDF <<http://www.aldf.gob.mx/archivo-12b28d9460f66f93a0268e3ed29bbe9d.pdf>>.

¹³⁹ Interview of Rocio Suarez, *supra* note 9.

¹⁴⁰ Interview of Eugenia Lopez, *supra* note 9.

¹⁴¹ Interview of International Health Service Organization, *supra* note 15.

¹⁴² Interview of staff at Clinica Condesa, *supra* note 64.

¹⁴³ Interview of Rocio Suarez, *supra* note 9; Interview of Eugenia Lopez, *supra* note 9.

¹⁴⁴ International Human Rights Program in person interview of Dr. Jeremy Cruz, psychologist at Clinica Condesa, Mexico City (25 June 2015) [Interview of Dr. Jeremy Cruz] who told IHRP that transgender women face harassment by other patients in the hospital, for example, being yelled at to leave the women's bathroom.

¹⁴⁵ International Human Rights Program in person Interview of Ricardo Baruch, National Institute of Public Health, Cuernavaca (24 June 2015) [Interview of Ricardo Baruch].

¹⁴⁶ Interview of Gloria Careaga, *supra* note 4; Claudia Solera, "Por homofobia llenan las salas de urgencias" ("Homophobia fills emergency rooms") *Excelsior* (08 September 2015), online: Excelsior <<http://www.excelsior.com.mx/nacional/2013/09/08/917644>>.

¹⁴⁷ Interview of Ricardo Baruch, *supra* note 145; Interview of Eugenia Lopez, *supra* note 9.

¹⁴⁸ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

¹⁴⁹ Interview of Ricardo Baruch, *supra* note 145.

¹⁵⁰ United Nations Population Fund, *Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men* (2015) at xvii, online: UNFPA <http://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf>.

¹⁵¹ Interview of Ricardo Hernandez, *supra* note 31.

¹⁵² Interview of staff at the Program for Human Rights in Mexico City, *supra* note 128. Prevalence rates available for men who have sex with men in Mexico are not available because respondents are less likely to be candid about their sexual orientation. Email correspondence with Ricardo Baruch, National Institute of Public Health, Cuernavaca (29 September 2015).

¹⁵³ Interview of International Health Service Organization, *supra* note 15; Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; Interview of Ricardo Baruch, *supra* note 145.

¹⁵⁴ Interview of Ricardo Hernandez, *supra* note 31.

¹⁵⁵ Interview of International Health Service Organization, *supra* note 15.

¹⁵⁶ Interview of Ricardo Hernandez, *supra* note 31; *Opportunistic Infections* (16 November 2010), online: AIDS.gov <<https://www.aids.gov/hiv-aids-basics/staying-healthy-with-hiv-aids/potential-related-health-problems/opportunistic-infections/index.html>>.

¹⁵⁷ *Human Rights Watch 2015*, *supra* note 5 at 381.

¹⁵⁸ See e.g. Amnesty International, Press Release, "State of Women's Rights in Mexico 'Alarming,' Authorities Urged to Stop Escalating Violence against Women" (12 July 2012), online: Amnesty USA <<http://www.amnestyusa.org/news/news-item/mexico-fails-to-tackle-increased-levels-of-violence-against-women>> [Amnesty, "Women's Rights in Mexico"]; See also HRC Summary Mexico, *supra* note 18 at para 47.

¹⁵⁹ 30% of HIV+ women in Mexico only have a primary school education. Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

¹⁶⁰ Interview of Jacqueline L'Hoist, *supra* note 83. In Mexico's 2013 UPR, the HR Committee expressed concern about discrimination against women in the maquiladora industry, where pregnancy tests are required. HRC Compilation Mexico, *supra* note 20 at 75.

¹⁶¹ Interview of Jacqueline L'Hoist, *supra* note 83.

¹⁶² HRC Summary Mexico, *supra* note 18 at para 12; Interview of Dr. Jeremy Cruz, *supra* note 144. See e.g. Amnesty, "Women's Rights in Mexico", *supra* note 158.

¹⁶³ *Human Rights Watch 2015*, *supra* note 5 at 381.

¹⁶⁴ Special Rapporteur on extrajudicial, summary or arbitrary executions, *supra* note 106 at 71-72.

¹⁶⁵ Interview of Eugenia Lopez, *supra* note 9; Interview of Lupita Gonzalez, *supra* note 9.

¹⁶⁶ Committee Against Torture, "Concluding observations on the combined fifth and sixth periodic reports of Mexico as adopted by the Committee at its forty-ninth session (29 October -23 November), *United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, CAT/C/MEX/CO-5-6 (11 December 2012) at para 3.

¹⁶⁷ Committee on the Elimination of Discrimination against Women, "Concluding observations of the Committee on the Elimination of Discrimination against Women" (9-27 July 2012), 52nd Session, CEDAW/C/MEX/CO/7-8, at 18(d).

¹⁶⁸ *Ibid* at 18(c). See also HRC Compilation Mexico, *supra* note 20 at 45.

¹⁶⁹ Judith Matloff, "Six women murdered each day as femicide in Mexico nears a pandemic" *Al Jazeera America* (4 January 2015), online: Al Jazeera America <<http://america.aljazeera.com/multimedia/2015/1/mexico-s-pandemicfemicides.html>>; "Femicidios alcanzan nivel de 'crisis' en Mexico: Informe de premios Nobel", *Observatorio Ciudadano Nacional del Femicidio* (13 March 2014), online: <<http://observatoriofemicidio.blogspot.ca/2014/03/femicidios-alcanzan-nivel-de-crisis.html>>.

¹⁷⁰ Interview of Eugenia Lopez, *supra* note 9. See also UNAIDS and CIM/OAS, *Human Rights of Women Living with HIV in the Americas* (2015) at 40-41, online: OAS <http://www.oas.org/es/cim/docs/VIH-DDHH-ENG.pdf?utm_source=Campaign+Created+2016%2F03%2F02%2C+12%3A49+PM&utm_campaign=+Human+Rights+of+Women+Living+with+HIV+in+the+Americas+CIM+and+UNAIDS&utm_medium=email> [*Human Rights of Women Living with HIV in the Americas*] (Forced sterilization or coercive sterilization violates several internationally protected rights, including: Article 5 of the American Convention on Human Rights; Article 7 of the International Covenant on Civil and Political Rights; Article 16(1) of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Article 6 of the Inter-American Convention to Prevent and Punish Torture).

¹⁷¹ Tamil Kendall and Claire Albert, "Experiences of coercion to sterilize and forced sterilization among women living with HIV in Latin America" (2015) *Journal of International AIDS Society*, online: <http://www.jiasociety.org/index.php/jias/article/view/19462/pdf_1> [Kendall & Alberta,

ENDNOTES

“Experiences of Coercion”].

¹⁷² Interview of Eugenia Lopez, *supra* note 9.

¹⁷³ Kendall & Alberta, “Experiences of Coercion”, *supra* note 171; Interview of Eugenia Lopez, *supra* note 9.

¹⁷⁴ Sheryl Ubelacker, “HIV transmission from mother to child nearly eliminated in Canada” *CBC News* (22 July 2015), online: CBC News <<http://www.cbc.ca/news/health/hiv-transmission-from-mother-to-child-nearly-eliminated-in-canada-1.3164274>>; World Health Organization, “Mother-to-child transmission of HIV”, online: WHO <<http://www.who.int/hiv/topics/mtct/about/en/>>; World Health Organization, “Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection” (2013), online: AVERT <<http://www.avert.org/sites/default/files/WHO-PMTCT-Guidelines.pdf>>.

¹⁷⁵ Interview of Gloria Careaga, *supra* note 4. See e.g. Nina Lakhani, “Mexico’s machismo culture has forced me to change the way I dress”, *The Guardian* (1 August 2014), online: <<http://www.theguardian.com/theobserver/she-said/2014/aug/01/mexicos-macho-male-attitudes-women-murders-rape-dress>>.

¹⁷⁶ Evidence and Lessons from Latin American (ELLA), *Observatory of Maternal Mortality in Mexico: A Civil Society-Led Initiative* (2013) at 2, online: ELLA <http://ella.practicalaction.org/wp-content/uploads/files/131011_GOV_GenEquPol_BRIEF4.pdf>.

¹⁷⁷ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

¹⁷⁸ 30% of HIV+ women in Mexico only have a primary school education. Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

¹⁷⁹ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; Estudio técnico-jurídico de las violaciones a los derechos reproductivos de mujeres con VIH en Mesoamérica [Technical-legal study of violations of the reproductive rights of women with HIV in four countries of Mesoamerica] reported that one-third of women respondents felt the confidentiality of their diagnosis had not been respected. Avalos Capín J, Balance, 2013 as quoted in: *Human Rights of Women Living with HIV in the Americas*, *supra* note 170 at 43.

¹⁸⁰ Interview of Eugenia Lopez, *supra* note 9.

¹⁸¹ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

¹⁸² Interview of Dr. Jeremy Cruz, *supra* note 144.

¹⁸³ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31; Interview of Dr. Jeremy Cruz, *supra* note 144.

¹⁸⁴ Interview of Eugenia Lopez, *supra* note 9.

¹⁸⁵ *Ibid.*

¹⁸⁶ Women’s reproductive rights are also not respected. According to Human Rights Watch, abortion rights in Mexico are inconsistent and confusing and women are forced to contend with information from officials that is inaccurate and intimidating. In 2009, the Supreme Court of Mexico made abortion legal and recommended every state enact its own legislation. While Mexico City has had legal abortion since 2007, it remains the only city where it is available despite the ruling. Women and girls face significant barriers to accessing safe abortions, including imprisonment even when they suffer miscarriages. *Human Rights Watch 2015*, *supra* note 5 at 383; Interview of Eugenia Lopez, *supra* note 9; Interview of Ricardo Baruch, *supra* note 145; Allyn Gaestel and Allison Shelley, “Mexican women pay high price for country’s rigid abortion laws: Mexico has some of the strictest abortion laws in the world, and women can find themselves criminalised even after miscarriage”, *The Guardian* (1 October 2014), online: <http://www.theguardian.com/global-development/2014/oct/01/mexican-women-high-price-abortion-laws>; Anayeli Garcia Martinez, “Porabortar, sentencian a 127 mujeres en los últimos cinco años” *Proceso* (22 April 2013), online: *Proceso* <http://www.proceso.com.mx/?p=339789&utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+revista_proceso+%28Revista+Proceso%29>; For an unofficial English translation, see “In Mexico, 127 Women Have Been Sent to Jail for Having an Abortion in the Last 5 Years” (26 April 2013), translated by Cecilia Ayala, online: Mexico Voices <<http://mexicovoices.blogspot.ca/2013/04/in-mexico-127-women-have-been-sent-to.html>> (Between 2007 and 2012, 127 women went to trial in Mexico for abortion).

¹⁸⁷ Interview of Eugenia Lopez, *supra* note 9.

¹⁸⁸ *Human Rights of Women Living with HIV in the Americas*, *supra* note 170 at 51.

¹⁸⁹ Interview of Eugenia Lopez, *supra* note 9.

¹⁹⁰ *Ibid.*

¹⁹¹ Interview of International Health Service Organization, *supra* note 15.

¹⁹² Ironically, in addition to being dissuaded or forcibly stopped from having a child, HIV positive women do not have access to abortion. They are disqualified by their HIV status. Interview of Eugenia Lopez, *supra* note 9.

¹⁹³ Tamil Kendall and Eugenia Lopez-Urbe, “Improving the HIV Response for Women in Latin America: Barriers to Integrated Advocacy for Sexual and Reproductive Health and Rights” (Fall 2010) VI: 1 Global Health Governance 1 at 5, online: http://ghgj.org/Kendall%20and%20Lopez_final.pdf

¹⁹⁴ In 2001, the United Nations committed to reaching 80% of pregnant women with interventions to avoid vertical transmission by encouraging countries to include reduction strategies in their national HIV and reproductive health plans. Interview of Eugenia Lopez, *supra* note 9.

¹⁹⁵ Many older lesbians told IHRP how their rights and protection have improved over the past years in Mexico. Lesbians and bisexual women report feeling comfortable holding hands and kissing in public in parts of Mexico City, for example, where once even that was unimaginable. Interview of Gloria Careaga, *supra* note 4.

¹⁹⁶ Lesbian and bisexual women are also reportedly excluded from assisted reproduction services. There are few public assisted reproduction services, but they are exclusively for heterosexuals. According to Eugenia Lopez, in terms of assisted reproduction for lesbian or bisexuals, you are only entitled to the rights you can afford to buy. Interview of Eugenia Lopez, *supra* note 9.

¹⁹⁷ The IHRP was informed of an incident in Tijuana in 2015 in which young female sex workers who had been deported back to Mexico from the United States were misled by the Casa del Migrantes (a migrant shelter), where they were staying. They were told by a staff member of the shelter that a friend from the United States had arranged for their transport back across the border. Instead of taking them across the border, however, they were put in vans that brought to a hotel where they were forced to perform sex work until they made sufficient money to pay for their escape. Interview of Rosario Padilla, *supra* note 75; See also June S. Biettel, “Mexico: Organized Crime and Drug Trafficking Organizations” (2015) Congressional Research Service at 29, online: <<https://www.fas.org/sgp/crs/row/R41576.pdf>>; Global Network of Sex work projects: Promoting

ENDNOTES

Health and Human rights, "Addressing Violence Against Sex Workers" (December 2012), online: <<http://www.nswp.org/sites/nswp.org/files/DGP%20Violence.pdf>>.

¹⁹⁸ Michele R Decker et al., "Human rights violations against sex workers: burden and effect on HIV", The Lancet HIV and sex workers series, (July 2014) online: <<http://www.hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/Human%20Rights%20Violations%20Against%20Sex%20Workers.pdf>>; Interview of Etty, Casa Xochiquetzal, *supra* note 65.

¹⁹⁹ Interview of Rosember Lopez, *supra* note 58.

²⁰⁰ Interview of Ricardo Roman, *supra* note 103.

²⁰¹ *Ibid.*

²⁰² Interview of Rocio Suarez, *supra* note 9.

²⁰³ Interview of Eugenia Lopez, *supra* note 9.

²⁰⁴ Interview of Rocio Suarez, *supra* note 9.

²⁰⁵ Interview of Etty, Casa Xochiquetzal, *supra* note 65.

²⁰⁶ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

²⁰⁷ Interview of Ricardo Hernandez, *supra* note 31.

²⁰⁸ Interview of International Health Service Organization, *supra* note 15.

²⁰⁹ *Ibid.*; UNAIDS Gap Report, *supra* note 24 at 189.

²¹⁰ The Program of Human Rights Mexico City is currently spearheading a census project for this population but they are still processing the data. International Human Rights Program in person interview of Program of Human Rights Mexico City (2 July 2015).

²¹¹ Interview of International Health Service Organization, *supra* note 15.

²¹² International Human Rights Program in person interview of Darwyn Pereyra, Network for Same Rights for Same Names, in Chiapas (26 June 2015); Interview of Dr. Rene Levya, *supra* note 19.

²¹³ *Ibid.*

²¹⁴ UNAIDS Gap Report, *supra* note 24 at 193.

²¹⁵ While migrants in Mexico will not be affected by the DCO determination because they are not Mexican, and thus beyond the scope of this study, the extent of human rights abuses against migrants within Mexico disclosed to the IHRP is illuminating, when assessing the validity of the country's 'safe' designation. The poor treatment of migrants in Mexico illustrates another way that progressive legislation and rights-based rhetoric does not reflect on the ground reality. The illusion of safety comes at enormous cost to human lives. See Human Rights Watch, "Mexico: Asylum Elusive for Migrant Children" (31 March 2016), online: HRW <<https://www.hrw.org/news/2016/03/31/mexico-asylum-elusive-migrant-children>>; Sonia Nazario, "The Refugees at Our Door", New York Times (10 October 2015), online: <http://www.nytimes.com/2015/10/11/opinion/sunday/the-refugees-at-our-door.html?_r=0>.

²¹⁶ Mario Bronfman et al., "Mobile populations and HIV/AIDS in Central America and Mexico" (2002) 16:Suppl 3 AIDS s 42 at s45, online: BVS SIDA <<http://bvssida.insp.mx/articulos/4241.pdf>>.

²¹⁷ Inter-American Commission on Human Rights, *Human Rights of Migrants and Other Persons in the Context of Human Mobility in Mexico* (30 December 2013) OEA/Ser L/N/II/Doc 47/13 at para 5, online: Organization of American States <<http://www.oas.org/en/iachr/migrants/docs/pdf/Report-Migrants-Mexico-2013.pdf>> [*Human Mobility in Mexico*].

²¹⁸ International Human Rights Program Skype interview of Medecins Sans Frontieres (MSF) staff: Juan Antonio Vega, humanitarian affairs officer and Dora Nely Morales, psychologist, Mexico City (3 July 2015); International Organization of Migration, *Missions of the Region: Mexico*, online: IOM <http://costarica.iom.int/en/mexico/mission_more_information/>.

²¹⁹ Interview of Salva Lacruz, *supra* note 70; Axel Garcia, "International Refugee Law in Mexico" 31 Forced Migration Review 71, online: FMReview <<http://www.fmreview.org/FMRpdfs/FMR31/71.pdf>>.

²²⁰ *Human Mobility in Mexico*, *supra* note 217 at 307, 416.

²²¹ Clay Boggs, "Mexico's Southern Border Plan: More deportations and widespread human rights violations" (19 March 2015), online: WOLA <http://www.wola.org/commentary/update_on_mexico_s_southern_border_plan_new_routes_more_deportations_and_widespread_human>.

²²² Interview of Sin Fronteras, *supra* note 69; Mexico: *Ley de 2010 de Refugiados y Protección Complementaria* (Law on Refugees and Complementary Protection) (28 January 2011) (Mexico), Título sexto, capítulo I, artículo 44, II ("Recibir servicios de salud") at 8-9 online: Refworld <<http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=4d4293eb2>>; Interview of Dr. Rene Levya, *supra* note 19; Interview of staff at Clinica Condesa, *supra* note 64; Interview of Rosember Lopez, *supra* note 58; Interview of Julio Campos, *supra* note 65.

²²³ Ana P. Martinez-Donate et al., "Migrants in Transit: The Importance of Monitoring HIV Risk Among Migrant Flows at the Mexico-US Border" (2015) 105:3 American Journal of Public Health 497 at 505-506.

²²⁴ Interview of Ricardo Hernandez, *supra* note 31; Interview of Ricardo Roman, *supra* note 103.

²²⁵ Interview of Rosario Padilla, *supra* note 75.

²²⁶ Coen, "High Risk," *supra* note 60.

²²⁷ Interview of Ricardo Roman, *supra* note 103.

²²⁸ *Ibid.*

²²⁹ See: "Violentaron derechos de personas en 'El Bordo'" ("They violated rights of people in 'El Bordo'") AFN (5 May 2015), online: AFN <http://www.afntijuana.info/informacion_general/40299_violentaron_derechos_de_personas_en_el_bordo> ["Violentaron derechos de personas en 'El Bordo'"].

²³⁰ Interview of Rosario Padilla, *supra* note 75.

²³¹ Interview of Ricardo Roman, *supra* note 103.

²³² *Ibid.* See also: "Violentaron derechos de personas en 'El Bordo'", *supra* note 229.

²³³ Interview of Ricardo Hernandez, *supra* note 31; CNDH Powerpoint Presentation, *supra* note 31.

²³⁴ Interview of International Health Service Organization, *supra* note 15.

²³⁵ Interview of Ricardo Roman, *supra* note 103.

ENDNOTES

²³⁶ Interview of Rosario Padilla, *supra* note 75.

²³⁷ Interview of Ricardo Roman, *supra* note 103.

²³⁸ *Ibid.*

²³⁹ Dan Werb, "Mexico's drug policy reform: Cutting edge success or crisis in the making?" (2014) 25 *International Journal of Drug Policy* 823. See also: D. Werb et al, "Police Bribery and access to methadone maintenance therapy within the context of drug policy reform in Tijuana, Mexico" (2015) *Drug Alcohol Depend* 221, online: <<http://www.ncbi.nlm.nih.gov/pubmed/25655577>>. A recent Canadian study on drug users in British Columbia found individuals not prescribed methadone were nearly four times more likely to become infected with HIV. Keith Ahmad, "Effect of low-threshold methadone maintenance therapy for people who inject drugs on HIV incidence in Vancouver, BC, Canada: an observational cohort study" (2015) 2:10 *The Lancet HIV* e445.

²⁴⁰ Harm Reduction International, "The Global State of Harm Reduction 2014" (2014) at 80-81, online: <<http://www.ihra.net/files/2015/02/16/GSHR2014.pdf>>.

²⁴¹ Interview of staff at the Program for Human Rights in Mexico City, *supra* note 128.

²⁴² Interview of Rosario Padilla, *supra* note 75.

²⁴³ International Human Rights Program in person interview of Itzel Silva, FUNDAR, Mexico City (1 July 2015) [Interview of Itzel Silva].

²⁴⁴ HRC Compilation Mexico, *supra* note 20 at 79.

²⁴⁵ Interview of Jacqueline L'Hoist, *supra* note 83.

²⁴⁶ FUNDAR told the IHRP that the government's actions have shown that the government prioritizes profit over Indigenous rights. The IHRP was told of reports of Indigenous people with identification being stopped and detained in Mexico, along with irregular migrants. Interview of Itzel Silva, *supra* note 243.

²⁴⁷ Interview of Dr. Rene Levya, *supra* note 19.

²⁴⁸ Interview of staff at the Program for Human Rights in Mexico City, *supra* note 128.

²⁴⁹ HRC Compilation Mexico, *supra* note 20 at 82.

²⁵⁰ Interview of Itzel Silva, *supra* note 243.

²⁵¹ The case of Irene is representative of the problems Indigenous people face in accessing quality health care. Irene, an Indigenous woman, has been in a coma for 15 years due to medical malpractice. A complaint was made but there has been no justice. The case reflects racism and classism in the health system. People who can afford to pay can access quality health care, but there is severe stigma in the provision of health services in Mexico based on class, race, HIV status and gender. Interview of Itzel Silva, *supra* note 243; Interview of Eugenia Lopez, *supra* note 9.

²⁵² *Convention Relating to the Status of Refugees*, 28 July 1951, 189 UNTS 137, online: United Nations Treaty Collection <<http://treaties.un.org>> [*Refugee Convention*]; *Protocol Relating to the Status of Refugees*, 31 January 1967, 606 UNTS 267, online: United Nations Treaty Collection <<http://treaties.un.org>>.

²⁵³ *Refugee Convention*, *supra* note 252 at art 1.

²⁵⁴ UNHCR, *UNHCR Note on the Principle of Non-Refoulement* (November 1997), online: Refworld <<http://www.refworld.org/docid/438c6d972.html>>.

²⁵⁵ *Refugee Convention*, *supra* note 252 at art 33.

²⁵⁶ *Ibid* at Article 3.

²⁵⁷ Bill C-31, *Protecting Canada's Immigration System Act*, SC 2012, c 17, online: Parliament of Canada <<http://www.parl.gc.ca/LegisInfo/BillDetails.aspx?Language=E&Mode=1&billId=5383493>> [Bill C-31].

²⁵⁸ The category of DCOs was originally introduced by the Canadian government by the *Balanced Refugee Reform Act* [BRRRA] of 2010 as amendments to the *Immigration and Refugee Protection Act* [IRPA]. The original amendments, however, never came into force. Bill C-31 modified the BRRRA (s. 109.1). *Ibid.*

²⁵⁹ Immigration and Citizenship Canada, *Designated Countries of Origin*, online: Government of Canada <http://www.cic.gc.ca/english/refugees/reform-safe.asp>.

²⁶⁰ *Ibid.* (The countries are: Andorra; Australia; Austria; Belgium; Chile; Croatia; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Germany; Greece; Hungary; Iceland; Ireland; Israel (excludes Gaza and the West Bank); Italy; Japan; Latvia; Liechtenstein; Lithuania; Luxembourg; Malta; Mexico; Monaco; Netherlands; New Zealand; Norway; Poland; Portugal; Romania; San Marino; Slovak Republic; Slovenia; South Korea; Spain; Switzerland; United Kingdom; United States of America).

²⁶¹ *Immigration and Refugee Protection Act*, SC 2001, c27 at s 49(2)(c), online: Justice Laws < <http://laws.justice.gc.ca/eng/acts/i-2.5/page-10.html#h-28>> [IRPA]; *Immigration and Refugee Protection Regulations*, SOR/2002-227 at s 231, online: Justice Laws < <http://laws-lois.justice.gc.ca/eng/regulations/sor-2002-227/page-49.html#h-137>> [IRPR].

²⁶² Sean Rehaag & Angus Gavin Grant, "Unappealing: An Assessment of the Limits on Appeal Rights in Canada's New Refugee Determination System" (2015) 49:1 *UBC L Rev* 203.

²⁶³ *YZ v Canada (Minister of Citizenship and Immigration)*, 2015 FC 892, [2015] FCJ No 880 [*YZ v Canada*].

²⁶⁴ *IPRA*, *supra* note 261 at ss 49(1)(c), (2)(c).

²⁶⁵ Government of Canada, "The government discontinues its appeal in the Y.Z Litigation" (7 January 2016), online: Government of Canada <<http://news.gc.ca/web/article-en.do?nid=1027049>>.

²⁶⁶ See Order Respecting the Interim Federal Health Program, OC 2012/433, as amended by OC 2012/945, online: Justice Laws <<http://laws-lois.justice.gc.ca/eng/regulations/SI-2012-26/FullText.html>>; Canadian Doctors for Refugee Care, *The Issue*, online: Canadian Doctors for Refugee Care < <http://www.doctorsforrefugeecare.ca/the-issue.html>>.

²⁶⁷ Government of Canada, Press Release, "Restoring Fairness to the Interim Federal Health Program", (18 February 2016), online: Government of Canada <<http://news.gc.ca/web/article-en.do?nid=1034619&tp=1>>;

²⁶⁸ *Minister of Immigration, Refugees and Citizenship Mandate Letter* (November 2015), online: Prime Minister of Canada Justin Trudeau <<http://pm.gc.ca/eng/minister-immigration-refugees-and-citizenship-mandate-letter>>.

ENDNOTES

²⁶⁹ UNHCR, *UNHCR Submission on Bill C-31: Protecting Canada's Immigration System Act* (May 2012) at para 31, online: UNHCR <<http://www.unhcr.ca/wp-content/uploads/2014/10/RPT-2012-05-08-billc31-submission-e.pdf>> [*UNHCR Submissions on Bill C-31*]; Prima facie is a Latin expression that literally reads as "at first face" and is used in legal terms to refer to its first appearance, subject to further information. See Cornell University Law School, "Prima Facie", online: Legal Information Institute <https://www.law.cornell.edu/wex/prima_facie>.

²⁷⁰ *UNHCR Submission on Bill C-31*, *supra* note 269 at paras 31,32.

²⁷¹ *Ibid* at para 31.

²⁷² *Ibid*; Canadian Association Of Refugee Lawyers (CARL), Press Release, "Designated Country Of Origin Scheme Is Arbitrary, Unfair, And Unconstitutional" (14 December 2012), online: CARL <<http://www.carl-acaadr.ca/our-work/issues/DCO>>.

²⁷³ The quantitative criteria neglect entire subsets of claimants. A country that is safe for most claimants will have a low acceptance rate, but it may have a high recognition for subsets of the population. This is most often the case with gender and sexual orientation based claims. Statistics have shown that these claimants tend to come from countries with overall low recognition rates, for example, Jamaica, yet when their claims are isolated it is clear that they have generally higher recognition rates than other claimants. The result is that claims from subsets of the population are subject to DCO rules, even though their claims are likely well-founded. *YZ v Canada*, Affidavit of Sean Rehaag, *supra* note 14 at paras 31-42. See Appendix A, Table IV for example.

²⁷⁴ For a compilation of appellate decisions reviewing rejected refugee claims based on sexual orientation and gender identity, many of the appeals profiled involved claims made by Mexican nationals, see Nicole Laviolette, *Canadian Appellate Level Decisions Dealing with Refugee Claims Based on Sexual Orientation and Gender Identity - Listed According to the Definition of a Convention Refugee* (2015), online: SSRN <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2594937>.

²⁷⁵ *IRPA*, *supra* note 261 at s 111.1(2); *IRPR*, *supra* note 261, s 159.9; See Immigration and Refugee Board of Canada, *Claimant's Guide*, online: Immigration and Refugee Board of Canada <<http://www.irb-cisr.gc.ca/Eng/RefClaDem/Pages/ClaDemGuide.aspx>>.

²⁷⁶ International Human Rights Program Interview of Adrienne Smith (by email), (15 October 2015); *YZ v Canada*, *supra* note 263 at para 60; Sean Rehaag, "Patrolling the Borders of Sexual Orientation: Bisexual Refugee Claims in Canada" (2008) 53 McGill LJ 59; Envisioning Global LGBT Human Rights, *Envisioning LGBT Refugee Rights in Canada: Is Canada a Safe Haven?*, September 2015, online: York University <<http://yfile.news.yorku.ca/files/2015/09/Is-Canada-A-Safe-Haven-Report-2015.pdf>>; Nicholas Hersh, "Challenges to Assessing Same-Sex Relationships Under Refugee Law in Canada" (2015) 60:3 McGill LJ 527.

²⁷⁷ *YZ v Canada*, *supra* note 263 at paras 59,63,65.

²⁷⁸ Immigration and Citizenship Canada, *Who must submit to an immigration medical examination?*, online: Government of Canada <<http://www.cic.gc.ca/english/resources/tools/medic/exam/who.asp>>.

²⁷⁹ *IRPA*, *supra* note 261 at ss113(a), 112(2)(b.1).

²⁸⁰ Audrey Macklin, "A safe country to emulate? Canada and the European refugee" in Helene Lambert et al, eds, *The Global Reach of European Refugee Law* (Cambridge: Cambridge University Press, 2013) 99 at 103.

²⁸¹ *YZ v Canada*, *supra* note 263 at para 124. Refugee claims that fail the refugee determination process, moreover, should not be understood to be fraudulent. With a highly technical and restrictive refugee definition, many individuals who genuinely fear persecution are unable to meet the Refugee Convention criteria. Labeling these individuals with derogatory terms is harmful to the entire refugee system. Canadian Council for Refugees, *Concerns about changes to the refugee determination system* (December 2012), online: CCR <<http://ccrweb.ca/en/concerns-changes-refugee-determination-system>>.

²⁸² Government of Canada, "Backgrounder-Designated Countries of Origin" (1 Feb 2013), online: CIC <<http://www.cic.gc.ca/english/department/media/backgrounders/2012/2012-11-30.asp>>.

²⁸³ ATIP Requests, *supra* note 14.

²⁸⁴ The number of cases found eligible to be referred to the IRB in a given year may be fewer than the number accepted in a given year because under the previous system, refugee claims are often not heard in the same year that they were found eligible/referred to the IRB.

²⁸⁵ Because of a page missing from the Access to Information and Privacy (ATIP) Requests received from Citizenship and Immigration Canada, the statistics from 2007 included in this report are *YZ v Canada*, Affidavit of Sean Rehaag, *supra* note 14.

²⁸⁶ *YZ v Canada*, Affidavit of Sean Rehaag, *supra* note 14 at para 40.



UNIVERSITY OF TORONTO
FACULTY OF LAW

INTERNATIONAL
HUMAN RIGHTS
PROGRAM