



**Preventing the Further Spread of HIV/AIDS:  
The Essential Role of Human Rights  
By Joseph Amon**

“AIDS is no longer [just] a disease. It is a human rights issue.”

Nelson Mandela

After twenty-five years, the global AIDS pandemic is still expanding. More than forty million people are living with HIV/AIDS. In 2005, five million people were newly infected, and three million died of AIDS. Between 2003 and 2005, the number of people living with HIV in East Asia rose by more than 25 percent, and the number of people living with HIV in Eastern Europe and Central Asia rose by more than one-third. However, sub-Saharan Africa remains by far the worst-affected region.<sup>1</sup> Countries such as Lesotho and Swaziland, with nearly one in three adults infected, are openly presented as possibly being the first countries to “die” of AIDS.

Why has the epidemic spread so inexorably across the globe? Why have countries failed to act—or acted so ineffectually—to stop the epidemic from progressing? It has been acknowledged for almost as long as HIV has been recognized that HIV/AIDS is fundamentally tied to human rights abuses.<sup>2</sup> But such acknowledgment has had surprisingly little impact on the global response to the epidemic, and this failure explains, to a large extent, why we have made so little progress.

Worldwide, vulnerability to HIV/AIDS is linked to populations marginalized by society because of their gender, race/ethnicity, sexual orientation, or social or economic class. Human rights are central both to our understanding of the dynamics of the disease and to how we must combat it.

HIV/AIDS is commonly thought to be related to “economic, social, and cultural rights” (such as the right to health care), as opposed to “civil and political rights,” such as freedom of expression and association and due process of law. However, many of the human rights abuses that most increase HIV risk—violence and discrimination against

women and marginalized populations as well as people living with HIV/AIDS, harassment and imprisonment without due process of outreach workers and at-risk populations seeking HIV/AIDS information or services, and censorship of health information—are abuses of civil and political rights. The fact that these abuses have a concrete impact on the health of individuals underscores what has been called the “indivisibility” of human rights norms—the notion that civil and political rights and economic, social, and cultural rights are mutually reinforcing and derive from a single principle: the fundamental dignity of each human being.

While there is widespread, though by no means universal, recognition that social stigma can fuel the epidemic, and that the characteristics of HIV infection do not warrant intrusive restrictions on liberty, all too often these basic understandings are not reflected in law or in concrete policy terms. Equally important, there is uneven (at best) appreciation of the broader human rights issues that contribute to the continuing spread of the disease. Most perversely, some of the critical lessons about stopping HIV/AIDS, learned painfully and acted on with positive results in the 1980s and 1990s, are now being disregarded. Even while treatment options are expanding, responses to HIV/AIDS in many places are getting further from the kind of science-based, human-rights informed response that has been proven to stop the spread of the disease. Left unaddressed, human rights abuses will undermine both HIV/AIDS prevention and treatment.

### ***Mobilizing Communities, Increasing Awareness (1981-1999)***

Although the first AIDS case was diagnosed in 1981, little global recognition of the disease or response to the epidemic was seen before 1986 when, at the World Health Assembly, Uganda’s health minister declared that his country had an enormous problem with AIDS and needed help. The Minister and the Assembly called on the World Health Organization (WHO) to act. In September 1986, a WHO program for prevention and control of AIDS was formed, which, in February of 1987, became the Global Programme on AIDS (GPA).

By January 1990, the GPA was working in 123 countries to develop national AIDS prevention plans. The national programs that emerged from these plans emphasized public education and information on how HIV is and is not transmitted, and encouraged people to avoid unprotected sex. This was the main function of these first programs: urgent public education in the face of widespread denial—by governments as well as populations—that AIDS was a “local” problem.

Starting in the mid-1980s in the United States, Europe, and Australia, and throughout the 1990s in Uganda, Thailand and Brazil, a handful of pragmatic programs focused on equipping vulnerable populations with prevention information and services. Many of these programs implicitly incorporated human rights principles and produced impressive results.

In the United States, Europe, and Australia, outreach and education programs were initiated by new organizations created by men who have sex with men (MSM) and injecting drug users (IDU) who were concerned about the vulnerability of their peers. These programs emphasized reducing the number of sexual partners, condom distribution, and needle and syringe exchange, often in the face of great stigma and risk of criminal prosecution. As these programs became more established, some local government health departments extended cooperation and funding.

In Uganda, a national program was developed based upon a grassroots community dialogue explaining the new disease and emphasizing partner reduction (“zero grazing”). Community groups and religious institutions spoke out about the disease, and initiated programs of home-based care for those falling sick. In 1988, partly in response to a WHO review, Uganda made several key changes in its program including increasing the resources dedicated to HIV/AIDS prevention; decentralizing information, education, and communication activities; encouraging stronger community-based organizations and efforts; and increasing outreach programs to the illiterate and the poor.

In 1990 in Thailand, after the Ministry of Health revised the estimated number of HIV-infected persons from 1,700 to 150,000, a program emphasizing mass education and 100 percent condom use in brothels was established.

In Brazil, HIV/AIDS prevention programs made aggressive efforts to reach sex workers (including by organizing national sex worker conferences) and MSM with HIV information and instructions on how to use condoms and negotiate condom use with partners. Broader messages to the general population were conveyed through the mass media to “humanize” the disease and fight stigma and discrimination.

Although taking different approaches, these programs were all initiated by individuals from the most affected communities, supported by local or national governments (often

through financing as well as new legislation), and based on the dignity and autonomy of each individual. The programs quickly saw results. In New York, HIV prevalence among white MSM at STD clinics decreased from 47 percent to 17 percent between 1988 and 1993. In Uganda, adults reported increased condom use and decreased numbers of sexual partners, while youth reported delayed onset of sexual behaviors. Uganda saw the start of a downward trend in HIV prevalence, peaking in the early 1990s at over 15 percent and decreasing to 6-7 percent by 2003. In Thailand, decreases were seen in the number of men reporting commercial sex, while increases were reported in condom use. HIV prevalence declined to 1.5 percent in 2003. In Brazil, the percentage of young people who reported using condoms the first time they had sex increased from less than 10 percent in 1986 to more than 60 percent in 2003, and national HIV prevalence among pregnant women remained below 1 percent.

Despite these visible successes, in communities where outreach efforts were less focused—for example among drug users in Thailand, Hispanic MSM in New York City, or poor slum dwellers in Brazil—considerably less success was noted.

Nonetheless, these comprehensive programs, remarkable for their mobilization of resources, political will, engagement with the community, and respect for human rights, were seen as models for expanding the HIV/AIDS response worldwide.

Through the mid-1990s emphasis was also put on understanding the epidemic as a *multi-dimensional* problem, requiring a *multi-sectoral* response. This strategy emerged in part because HIV/AIDS was expanding unchecked with massive social and economic consequences and in part because of difficulties generating the resources required to fight the epidemic properly. Concerned officials and donors sought to leverage resources simultaneously from multiple sources including ministries of education, agriculture and industry.

Then, from the mid to the late-1990s, international efforts to fight HIV/AIDS foundered and splintered. The earlier focus and success in places like Thailand and Uganda were not replicated elsewhere, and the global leadership at WHO waned. Fast-growing epidemics were recognized virtually everywhere. Bilateral programs expanded, as did the prominence (and budget) of the World Bank, but these developments were unable to keep pace with the increasing demands of the pandemic. Increased attention was placed on the biomedical aspects of HIV/AIDS, including vaccine development and the use of anti-retroviral drugs to treat people living with HIV/AIDS and reduce the risk of mother-to-child HIV transmission.<sup>3</sup>

## ***Expanding Resources, Narrowing Approaches: Moralizing the Epidemic (2000-2005)***

In June 2001, a historic U.N. General Assembly Special Session (UNGASS) on HIV/AIDS for the first time generated global acknowledgement of the pandemic as not only a public health crisis but also a threat to societies and international security. The special session put virtually all of the world's leaders on record as endorsing a set of specific global targets in combating HIV/AIDS, while its formal declaration explicitly underscored the links between poverty, underdevelopment, and illiteracy to the spread and impact of HIV/AIDS. It also recognized that stigma, silence, discrimination, and lack of confidentiality undermined prevention and care efforts, and that gender equality and the empowerment of women and girls were fundamental to reducing vulnerability. The Declaration affirmed that access to medication in the context of pandemics such as HIV/AIDS was fundamental to the realization of the right to health.

Specifically, governments pledged: “by 2003, to enact, strengthen or enforce as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.”<sup>4</sup>

While this effort arguably increased the political will to address HIV/AIDS, the most important change in this era was perhaps the increased allocation of resources committed to fighting the epidemic. In 2001, the Global Fund to fight HIV/AIDS, TB and Malaria was created. Three years later, the United States Leadership against AIDS, Tuberculosis and Malaria Act of 2003 (the U.S. Global AIDS Act) and the U.S. President's Emergency Plan for AIDS Relief (commonly known as PEPFAR) were enacted. The same year, a revitalized WHO announced an ambitious plan to get three million people on anti-retroviral treatment by the end of 2005.

But these declarations and commitments of new resources, while seeming to recognize the central importance of combating the human rights violations underlying the epidemic, have addressed them in only limited ways. The integration of prevention and treatment programs has splintered. Science-based prevention programs increasingly are

being replaced by conservative, moralistic sexual abstinence campaigns that stigmatize those living with AIDS and deny people information about condoms. Treatment programs have made some headway but still do not reach many affected populations and still do not recognize critical obstacles that rights-based approaches would help overcome. In 2003, one-half of all governments in sub-Saharan Africa had yet to adopt legislation specifically outlawing discrimination against people living with HIV/AIDS and only one-third of countries worldwide had adopted legal measures specifically outlawing discrimination against populations especially vulnerable to HIV/AIDS.

Throughout the 1990s the dominant approach to HIV prevention among young people was comprehensive sex education, which teaches abstinence as a healthy choice for young people but also provides information about condoms and safer sex. As a part of the PEPFAR program, comprehensive sex education programs are being replaced by programs that emphasize “abstinence only” until marriage, which censor or distort information about condoms and safer sex. The U.S. Global AIDS Act requires that 33 percent of HIV prevention spending go to “abstinence-until-marriage” programs.<sup>5</sup> Abstinence-only proponents commonly rely on fear-based messages, making unsubstantiated claims about the psychological effects of pre-marital sex and exaggerating the failure rate of condoms. These programs often suggest that condoms are appropriate only for those who “fail” at abstinence or marital fidelity and “choose to engage in high-risk sex”—contributing to an environment of shame and stigma which discourages the use of condoms even for sexually active youth and among adults with multiple, concurrent partners.<sup>6</sup>

Another example of HIV/AIDS policies turning their back on proven, evidence-based approaches that respect human rights is the restriction in the U.S. Global AIDS Act requiring that organizations receiving U.S. anti-AIDS funding have a policy “explicitly opposing prostitution” and barring the use of funds to “promote or advocate the legalization or practice of prostitution.”<sup>7</sup> This approach recalls the efforts by Senator Jesse Helms in 1987 to block federal HIV/AIDS education funding to groups that “promote” homosexuality.

The U.S. requirements not only coerce organizations into adopting a particular ideology as a condition of receiving HIV/AIDS funding, but also negate the ability of outreach organizations to approach sex workers with the non-judgmental and non-moralistic attitude that has been shown to be effective with these communities. Empowering women marginalized in prostitution to participate in public life and to challenge the rights abuses that impede their struggle against HIV/AIDS has been a documented

success in the efforts against AIDS. Far from addressing the harms associated with sex work, the U.S. requirements are likely to alienate sex workers and to fuel public opprobrium against them, further driving sex workers underground and away from life-saving services. In addition, the lack of guidance from the U.S. government regarding just what it means to “oppose prostitution” casts a shadow of uncertainty over HIV prevention programs and places a chilling effect on organizations wishing to conduct outreach and HIV prevention with sex workers in a respectful, non-judgmental manner.<sup>8</sup>

U.S. restrictions on needle exchange and other “harm reduction” programs and U.S. law enforcement interference with grassroots HIV prevention work are additional examples of the disastrous effect of replacing science-based approaches with narrowly defined moralistic ones.<sup>9</sup> The sharing of hypodermic syringes accounts for the majority of new HIV infections in much of Eastern Europe, Central and Southeast Asia, and Latin America: needle exchange programs are a matter of life and death. Needle exchange programs, moreover, are perhaps the best studied HIV prevention intervention in the world. Rigorous evaluations consistently show that providing sterile syringes and information about sterile drug injection to people who use drugs reduces HIV risk without increasing rates of drug use.<sup>10</sup> Although the effectiveness of sterile syringe programs has been endorsed by the World Health Organization, the Joint United Nations Program on HIV/AIDS, the U.S. National Institutes of Health, the U.S. Institute of Medicine, and other leading public health bodies,<sup>11</sup> the United States remains the only country in the world to ban the use of federal funds for needle exchange. Recently, it has begun to aggressively export this standard internationally.

The U.S. has blocked resolutions at the United Nations that would recognize the human rights of injection drug users;<sup>12</sup> sought to obstruct the work of UNAIDS and the U.N. Office on Drugs and Crime in promoting harm reduction and needle exchange in countries hard-hit by HIV/AIDS;<sup>13</sup> and encouraged national governments to adopt criminal law approaches to drug use rather than recognizing that epidemics of drug addiction and HIV/AIDS are public health threats requiring humane, rights-based responses.<sup>14</sup>

With the expanded resources now available for HIV/AIDS, it is finally possible to imagine HIV treatment programs joining HIV prevention efforts in an integrated, rights-respecting continuum of services. Unfortunately, moralistic approaches to HIV prevention which place new obstacles in the way of reaching populations that most need information and services hinder such a comprehensive approach. Restrictive and



moralistic U.S. policies also endanger one of the most ardently promoted and potentially life-saving approaches to HIV prevention and treatment: expanded HIV testing.

Expanding access to HIV testing is a critically important step in improving responses to the epidemic. When accompanied by effective counseling and accessible post-test services—including comprehensive prevention (information and condoms) and treatment and care—expanded HIV testing can encourage more people to protect themselves and their partners, and to seek care which can prolong their lives.

Expanded HIV testing can take many forms, however. It is all too common for HIV testing to be mandatory for certain populations—prisoners and military recruits, for example. In many countries, moreover, even HIV testing outside such institutional settings is sometimes conducted without consent and test results sometimes are not given to the person who was tested.

In medical settings, two different approaches have recently been promoted: “routine offer” HIV testing—with an “opt-in” emphasis—proposes that every individual in the health care setting be offered an HIV test. By contrast, “opt-out” HIV testing attempts to increase the number of individuals consenting to an HIV test by requiring that individuals be tested unless they specifically decline the test. In some settings, protocols require individuals to decline the test three times before their refusal is accepted, and before they are entitled to receive medical care.

The newest approach to expanded HIV testing, however, goes beyond these approaches by seeking to bring HIV tests out of the medical setting and into communities. On December 1, 2005, the Ministry of Health of Lesotho and the WHO announced an unprecedented effort in the fight against HIV/AIDS: a village-to-village campaign to test every Mosotho (resident of Lesotho) aged twelve and older for HIV by the end of 2007.<sup>15</sup> This program was launched in Lesotho because it has one of the highest HIV prevalence rates in the world, with approximately one in three adults infected. With Lesotho facing a projected massive population loss from migration as well as mortality and a decrease in life expectancy from fifty-two to thirty-four years between 2000 and 2005, observers fear that Lesotho will collapse and fail—the first country to “die” of AIDS.

Village-to-village HIV testing recalls the great public health campaigns of thirty years ago, such as the worldwide eradication of smallpox through case detection, isolation, and



mass vaccination. Because of the inextricable link between HIV/AIDS and human rights abuse, however, this method of HIV testing also carries the potential for spreading stigma and, with it, discrimination and other human rights violations. HIV/AIDS, a disease with a long and silent incubation period, with transmission caused by intensely personal behaviors (sex, childbirth, drug use), and with disproportionate prevalence among the most marginalized populations in society, is strikingly different from smallpox, and must be treated as such.

Historically, the largest concerns around HIV testing were ensuring that testing was voluntary, that it was confidential, and that adequate counseling was provided. These concerns were of primary importance in a context where few resources existed for people who tested positive, and where people believed to be living with HIV/AIDS faced serious and often life-threatening violence and abuse (women facing domestic violence as well as MSM and marginalized populations generally). It was hoped that if individuals learned their HIV serostatus, they would adopt behaviors that would either reduce their risk of infection if they were HIV-negative, or reduce the risk that they would transmit the virus to others if they were HIV-positive. In some cases, where counseling was adequate, and decisions were truly voluntary, these programs were shown to work.<sup>16</sup>

In the past few years, as significant resources have been committed to expanding access to anti-retroviral drugs throughout the world, treatment that can alleviate suffering and postpone death has become a real possibility for hundreds of thousands of people living with AIDS. In this context, HIV testing has become increasingly critical to expanding access to treatment, and, in turn, is helping to transform HIV/AIDS from a death sentence to a manageable chronic disease. These changes have led to a justified re-evaluation of HIV testing principles, and have led many people in the public health community to push for a different approach.<sup>17</sup> Specifically, they emphasize the “right” to know one’s HIV serostatus and have called for dramatic increases in the numbers of people tested.

But much of the call for this type of expanded approach rests upon two assumptions: 1) that mass HIV testing will lead to positive changes as people change their behaviors and seek treatment; and 2) that few human rights abuses will result from this approach. There is little evidence to support these assumptions.

Studies in sub-Saharan Africa have found between 3.5 percent and 14.6 percent of women report abuse following the disclosure of their HIV test result. The highest rates

of negative outcomes have been reported by women tested in antenatal clinics, and the lowest rates by women tested at voluntary counseling and testing sites. Women who are tested at antenatal clinic sites do not have a chance to think about testing or prepare themselves or their partners for testing. Therefore they are both less likely to disclose results to their partners and also are more likely to be victims of violence when they do.

The Lesotho operational plan for universal access to HIV testing states that “every household will be offered an HIV test” and that “communities will choose how HIV testing and counseling will be carried out for [their] members.” Independent oversight “to guarantee the rights of community members” will be provided by a three-person committee in each health center catchment area, with each center providing “at least a biannual written report.” The government is also creating a national telephone hotline.<sup>18</sup>

Public health officials argue that it is unfair to criticize the lack of evidence in support of village-to-village testing in light of the public health crisis facing Lesotho. That argument would be justified if this were the only approach available. But it is not. The other available alternative—concerted, large-scale promotion of voluntary HIV counseling and testing—has not been tried.

The Lesotho plan will only be as successful as the government’s ability to get people to participate, as well as its ability to provide comprehensive HIV prevention information and necessary medicines. However, without better protections for human rights and without concerted efforts to reduce the stigma of HIV/AIDS within Lesotho, there is little hope for widespread, truly voluntary participation. Even if large numbers of people are tested, the Lesotho plan allocates only 3,000 Maloti (U.S.\$465) out of a total of 75,593,250 Maloti (U.S.\$11.7 million) to support post-test referrals and services.<sup>19</sup>

The Lesotho plan, like many calls for expanded HIV testing, focuses almost exclusively on individual behavior change and does not adequately take into account the structural barriers—violence, abuse, and interference with lifesaving information and services—that prevent individuals most vulnerable to infection from taking measures to reduce their HIV risk.

Efforts to expand HIV testing should not put public health experts on one side and human rights proponents on the other. Both recognize that people have a right of access to HIV testing as part of the broader right to health care enshrined in the International Covenant on Economic, Social, and Cultural Rights. Informed consent and

confidentiality requirements, protections against violence and discrimination, and measures to combat stigma need not be barriers to expanded HIV testing.

The 1984 Siracusa Principles on the Limitation and Derogation of Principles in the International Covenant on Civil and Political Rights, moreover, illustrate that, where there is a perceived conflict between critical public health needs and human rights imperatives, governments should proceed rationally and deliberately. Public health policies can infringe rights if they are sanctioned by law, serve a legitimate public health goal, are necessary to achieve that goal, are no more intrusive or restrictive than necessary, and are non-discriminatory in application. The International Guidelines on HIV/AIDS and Human Rights, issued as non-binding policy guidance to governments by the Office of the High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 1996, affirm that HIV testing of individuals “should only be performed with the specific informed consent of that individual” except where specific judicial authorization is granted to perform a mandatory test.

Too often, expanded HIV testing programs forget their goal is not simply to get a large number of people tested once. “Knowing your HIV status” is a dynamic issue with repeat testing required, as adolescents become adults, as an individual’s behavior (and risk) changes, or (as is especially true for women and girls in many parts of the world) as their own behavior stays the same but their partner’s behavior changes. Mass HIV testing programs may be able to test large numbers of people once, but only programs that protect individual rights will encourage people to seek follow-up treatment services and help people reduce their risk behaviors and their vulnerability to HIV infection over time.

### ***A Different Approach: Protecting Human Rights***

Over the course of the HIV/AIDS epidemic, too little has been done to change laws and practices that violate human rights, putting individuals at risk of infection and disease and impeding access to HIV information and services for those who need it most. Changing these laws is not only a moral imperative, but is also key to the sustained success of prevention, testing, and treatment programs.

In sub-Saharan Africa, for example, nearly 60 percent of individuals living with HIV infection are women. This disproportionate burden is due less to a specific biologic susceptibility to infection, and more to their lack of basic human rights. Women and

girls are put at risk by economic vulnerability resulting from discrimination and lack of legal protections; sexual violence, including in institutions such as schools, prisons, and workplaces; domestic violence, including marital rape; violations of property and inheritance rights; and, in some countries, harmful traditional practices such as exorbitant bride price, widow inheritance, and even ritual sexual “cleansing.” Governments, which have an obligation to stop such violations and abusive practices, too often tolerate them.

Responding to the HIV/AIDS epidemic requires addressing such vulnerabilities directly, not indirectly through general education campaigns or HIV testing. In Zimbabwe, an estimated 700,000 people lost their homes, livelihood, or both when, in May 2005, the government unleashed Operation Murambatsvina (Cleanse the Filth), a campaign of forcible evictions and demolitions in urban areas throughout the country. Six months into the crisis, hundreds of thousands of people remained displaced throughout the country. Among other things, the massive displacement disrupted access to life-saving therapies for individuals with HIV and TB, encouraging the emergence of multi-drug resistant strains, and it created the conditions—displacement, destitution, lack of legal protections—which are known to spur the epidemic. This was recognized by UNAIDS representatives when, in November 2005, they cautioned that recent declines in HIV prevalence in Zimbabwe “could start rising again if underlying vulnerabilities, which contribute to unsafe sexual behaviour and fuel the epidemic, are not sufficiently addressed. Such vulnerabilities include gender inequality, poverty and population mobility.”<sup>20</sup>

Stigmatizing attitudes and discrimination by health care providers continue to hinder access to HIV testing and treatment in many places. In other places, violence, or the fear of violence, prevents many people from obtaining HIV/AIDS testing and treatment. In Uganda, despite long-standing and well run programs, service providers have reported that women come to them secretly, fearing that their husbands will beat them if they seek HIV testing or medical attention. Jane Nabulya, a Ugandan woman, said that she secretly tested for HIV in 1999 when she found out her husband had AIDS. She explained: “I was scared to tell him that I had tested HIV-positive. He used to say [of] the woman who gives him AIDS, ‘I will chop off her feet.’ I have never told him.”<sup>21</sup>

## **Conclusion**

The response to the HIV/AIDS epidemic by governments and multilateral agencies must recognize and respect human rights. In parts of the world today, the lack of an adequate response to the epidemic—whether due to denial of the existence or extent of

the epidemic, misappropriation of resources, or hostility to those individuals infected or those populations most at-risk of infection—represents a basic violation of the right to health. In other countries, HIV education, prevention, and treatment programs are inaccurate or inequitable.

All individuals, including those most marginalized, must enjoy access to accurate information about HIV/AIDS and have equal access to HIV/AIDS programs. HIV testing in particular—as the entry point for access to anti-retroviral drugs and important services—must be accessible to all. But efforts to expand HIV testing, and to put in place “routine” testing, must not become coercive, must recognize the rights of the individuals being tested, and must provide linkages to both prevention and care.

Across the globe, people who test positive for HIV have been denied employment, fired from their jobs, kicked out of hospitals, denied both HIV specific and general medical treatment, harassed and assaulted by community members who find out their status, and sometimes even killed. Because human rights abuses fuel the HIV epidemic, HIV/AIDS programs must explicitly address, and find ways to mitigate, these abuses.

Combating the rights abuses that put vulnerable populations at risk of HIV is essential to turning around the AIDS crisis. Concrete policy measures are urgently needed and can have immediate and long-term impact. New laws can be put in place, or enforced if they already exist, to protect women’s equal rights in the areas of inheritance, sexual violence, domestic violence and spousal rape, marriage, division of property upon divorce, land use and ownership, and access to housing and social services.

Programmatic reforms, designed to address human rights violations, should ensure that national HIV/AIDS programs include measures to combat discrimination and violence against people living with HIV/AIDS, with particular attention to marginalized populations. Efforts should also be made to provide human rights training for judges, police, and other officials; improve data collection relating to police abuse and domestic violence, women’s property rights, and sexual abuse of girls; ensure that anti-retroviral drug distribution systems recognize the challenges marginalized populations face in accessing treatment; and ensure that HIV test results and other patient information is kept confidential. Public education campaigns on the human rights of people living with HIV/AIDS in local languages and using appropriate media should be intensified.

It is sometimes suggested that paying attention to human rights is somehow so costly and time consuming that it should really be considered optional during a public health crisis. However, there is no reason that public health and human rights be considered in opposition to one another. In responding to the global HIV/AIDS epidemic, only programs that start with a basic respect for individuals, and their rights, will be successful. Those programs which adopt strategies in the name of efficiency or ideology and which fail to respect human rights will ultimately fail.

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<sup>1</sup> U.N. Joint Programme on HIV/AIDS (UNAIDS), *AIDS Epidemic Update: December 2005* (Geneva: United Nations, 2005), [http://www.unaids.org/epi2005/doc/EPIupdate2005\\_html\\_en/epi05\\_00\\_en.htm#TopOfPage](http://www.unaids.org/epi2005/doc/EPIupdate2005_html_en/epi05_00_en.htm#TopOfPage) (retrieved November 21, 2005).

<sup>2</sup> Jonathan Mann, who headed the first Global Programme on HIV/AIDS at the World Health Organization (WHO), recognized early in the epidemic the importance of linking HIV/AIDS and human rights, especially to ensure that those at risk would not be stigmatized in using services. See Jonathan M. Mann, "Human rights and AIDS: The future of the pandemic," in Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas, eds., *Health and Human Rights: A Reader* (New York and London: Routledge, 1999).

<sup>3</sup> HIV can be transmitted from an HIV-infected mother to her child during pregnancy, labor, and delivery, or through breastfeeding. The administration of antiretroviral drugs to HIV-infected pregnant women and to her infant shortly after birth greatly reduces the risk of mother-to-child HIV transmission.

<sup>4</sup> United Nations General Assembly, "Declaration of Commitment on HIV/AIDS," June 27, 2001.

<sup>5</sup> U.S. Global AIDS Act, 22 U.S.C. §§ 7672(b)(3), 7673(a); see also Office of the United States Global AIDS Coordinator, "The President's Emergency Plan for AIDS Relief. U.S. Five Year Global HIV/AIDS Strategy," February 2004.

<sup>6</sup> For further information about U.S.-funded abstinence-only-until-marriage programs, see Human Rights Watch, "The Less they Know, the Better: Abstinence-only HIV/AIDS Programs in Uganda," vol. 17, no. 4(A), March 2005; Human Rights Watch, "Ignorance Only: HIV/AIDS, Human Rights and Federally Funded Abstinence-Only Programs in the United States: Texas: A Case Study," vol. 14, no. 5(G), September 2002.

<sup>7</sup> U.S. Global AIDS Act, 22 U.S.C. § 7631(e, f) (2003); see also Letter from Human Rights Watch, et al., to President Bush opposing mandatory "anti-prostitution pledge," May 18, 2005, <http://hrw.org/campaigns/hivaids/hiv-aids-letter/>; Rebecca Schleifer, "United States: Funding Restrictions Threaten Sex Workers' Rights," *HIV/AIDS Policy and Law Review*, vol. 10, no. 2, August 2005.

<sup>8</sup> Two separate lawsuits have been filed in U.S. courts challenging the "anti-prostitution pledge" requirements as violating fundamental rights to health and to free expression. See Rebecca Schleifer, "Challenges filed to U.S. Anti-AIDS Law Anti-prostitution Pledge Requirement," *HIV/AIDS Policy and Law Review* (forthcoming) (describing cases); "Prostitution Loyalty Oath," <http://www.genderhealth.org/loyaltyoathsuit.php> (website links to court pleadings filed in cases).

<sup>9</sup> See Human Rights Watch, "Injecting Reason: Human Rights And HIV Prevention For Injection Drug Users; California: A Case Study," vol. 15, no. 2(G), September 2003.

<sup>10</sup> See studies cited in "Injecting Reason," pp. 10-17.

<sup>11</sup> See, e.g., World Health Organization, Joint United Nations Program on HIV/AIDS, and United Nations Office on Drugs and Crime, "Policy Brief: Provision of Sterile Injecting Equipment to Reduce HIV Transmission" (2004); Joint United Nations Program on

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HIV/AIDS, "Intensifying HIV prevention: UNAIDS policy position paper," August 2005, p. 23; U.S. National Institutes of Health, *Interventions to Prevent HIV Risk Behaviors: Consensus Development Statement*, February 11-13, 1997; Institute of Medicine of National Academy of Sciences, *No Time to Lose: Getting More from HIV Prevention* (2001).

<sup>12</sup> Transnational Institute, "The United Nations and Harm Reduction – Revisited: An unauthorized report on the outcomes of the 48<sup>th</sup> CND session," Drug Policy Briefing No. 13, April 2005.

<sup>13</sup> *Ibid.*; see also, Letter from Antonio Maria Costa, Executive Director, United Nations Office on Drugs and Crime, to Robert B. Charles, Assistant Secretary, International Narcotics and Law Enforcement Affairs, U.S. Department of State, November 11, 2004.

<sup>14</sup> See, e.g., Jole Baglolle, "Vancouver Drug Facilities Draw Ire of U.S. Officials," *Wall Street Journal*, April 1, 2003.

<sup>15</sup> "Lesotho launches groundbreaking HIV campaign on World AIDS Day," WHO website: <http://www.who.int/mediacentre/news/releases/2005/pr64/en/index.html> (retrieved December 1, 2005).

<sup>16</sup> See: The Voluntary HIV-1 Counseling and Testing Efficacy Study Group, "Efficacy of VCT in individuals and couples in Kenya, Tanzania, and Trinidad: A Randomised Trial," *The Lancet*, vol. 356, July 8, 2000, pp 103-112; M.H. Merson, J.M. Dayton, K. O'Reilly, "Effectiveness of HIV prevention interventions in developing countries," *AIDS*, September 2000, vol. 14, supp. 2, pp. S68-84; and C.A. Liechty, "The evolving role of HIV counseling and testing in resource-limited settings: HIV prevention and linkage to expanding HIV care access," *Current HIV/AIDS Report*, December 2004, vol. 1(4), pp. 181-5.

<sup>17</sup> See, e.g., Kevin De Cock et al., "A serostatus-based approach to HIV/AIDS prevention and care in Africa. *The Lancet*, vol., 367 (2003), pp. 1847-49; Kevin De Cock, et al., "Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century," *The Lancet*, vol. 360 (2002), pp. 67-72.

<sup>18</sup> Lesotho Ministry of Health and Social Welfare (STI, HIV & AIDS Directorate and Partners), "'Know Your Status' Campaign Operational Plan 2006-7; Gateway to comprehensive HIV prevention, treatment, care and support; Universal Access to HIV Testing and Counseling," December 1, 2005.

<sup>19</sup> This figure refers to the total budget for Strategic objective 7: "Strengthen post-test services for both HIV positive and HIV negative people" as specified in Lesotho Ministry of Health and Social Welfare (STI, HIV & AIDS Directorate and Partners), "'Know Your Status' Campaign Operational Plan 2006-7; Gateway to comprehensive HIV prevention, treatment, care and support; Universal Access to HIV Testing and Counseling," December 1, 2005.

<sup>20</sup> UNAIDS, "HIV rates decline in Zimbabwe," November 21, 2005, <http://www.unaids.org.zw/default.htm> (retrieved November 21, 2005).

<sup>21</sup> Human Rights Watch, "Just Die Quietly: Domestic Violence And Women's Vulnerability to HIV In Uganda," August 2003, vol. 15, no.15(A), p. 29.