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Health and human rights in today's fight against HIV/AIDS

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Abstract

The development of the health and human rights framework coincided with the beginning of the rapid spread of HIV/AIDS. Since then, the international community has increasingly turned to human rights language and instruments to address the disease. Not only are human rights essential to addressing a disease that impacts marginalized groups most severely, but the spread of HIV/AIDS itself exacerbates inequality and impedes the realization of a range of human rights. Policy developments of the past decade include the United Nations (UN) Committee on Economic, Social and Cultural Rights' General Comment on the 'Right to Health', the UN Declaration of Commitment on HIV/AIDS, and the UN's International Guidelines on HIV/AIDS and Human Rights, among others. Rights-related setbacks include the failure of the Declaration and its 5-year follow-up specifically to address men who have sex with men, sex workers, and intravenous drug users, political restrictions placed on urgently needed US President's Emergency Plan for AIDS Relief (PEPFAR) funds, and the failure of many countries to decriminalize same-sex sex and outlaw discrimination against people living with HIV/AIDS. Male circumcision as an HIV prevention measure is a topic around which important debate, touching on gender, informed consent and children's rights, serves to illustrate the ongoing vitality of the health and human rights dialogue. Mechanisms to increase state accountability for addressing HIV/AIDS should be explored in greater depth. Such measures might include an increase in the use of treaty-based judicial mechanisms, the linking of human rights compliance with preferential trade agreements, and rights requirements tied to HIV/ AIDS funding.

Keywords

circumcision; human rights; male; social justice; women's rights; United Nations

Introduction

When history reflects on the devastation caused by AIDS in the early 21st century, to what will our failure to curtail the spread of this preventable disease be attributed? Unlike the stories told of plagues past, in which scientific ignorance about the spread of disease seems more unfortunate than unjust, the story of AIDS will surely be a story about rights. The story of AIDS is about haves and have nots, and about discrimination, denial and indifference. For many policymakers, advocates and health professionals who seek to abate the spread of HIV and care for those infected, the 'health and human rights' framework is a tool imbued with great hope for ameliorating these inequities [1].

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This article seeks to provide an update on the use of the health and human rights framework in the context of HIV/AIDS. It first provides a background on the development of the health and human rights framework, which coincided with the beginning of the rapid spread of HIV/AIDS. Next, it discusses the relevant policy developments of the past decade and highlights some recent setbacks. It then explores in greater depth the evolving discussion surrounding male circumcision as an HIV prevention measure, an issue around which important human rights-related debates are currently occurring. It concludes with observations about the need to explore new state accountability mechanisms as we move forward in the struggle against HIV/AIDS.

Background on health, human rights and HIV/AIDS

Early in the disease's history it became clear that HIV/ AIDS was not simply a medical issue, but an issue of social justice at its very core. Jonathan Mann, who directed the Zaire AIDS Research Program in the mid 1980s, followed by a stint leading the World Health Organization's (WHO) first AIDS project, emerged as an important leader in the fight against HIV/AIDS. A range of advocates and scholars working on HIV/AIDS, women's rights, and gay rights contributed to the health and human rights dialogue then emerging, and Mann is widely noted as an influential early framer of the health and human rights framework.

The major determinants of health are societal in nature, Mann [2] argued. A framework with values expressed in societal terms was therefore urgently needed. He asserted that 'the human rights framework offers public health a more coherent, comprehensive, and practical framework of analysis and action on the societal root causes of vulnerability to HIV/AIDS than any framework inherited from traditional health or biomedical science.' Until these root causes were addressed, the HIV/AIDS pandemic would continue.

Mann argued that the traditional public health approach, combining information, education and health services, although necessary, would prove to be far from sufficient. Measures were needed to address social problems such as inequality in its myriad forms. Despite the fact that HIV first affected different communities country by country, the disease, quite consistently, has eventually turned to disempowered, marginalized groups, impacting them severely. Where discrimination flourishes, HIV/AIDS has followed. Leaders in the field began to look to international human rights law as a field rich with potential for addressing these inequities.

International law took its own path before meeting at the nexus of public health and human rights. Because principles of sovereignty and non-intervention in the affairs of other states dominated world politics until World War II, human health was generally considered the province of states to address (or not address) within their own borders. To the extent that international governance touched upon health issues, it concerned only state-to-state interactions, not the interference of one state in the actions of another state towards its own citizens. The desire of powerful states to reduce their own citizens' vulnerability to disease spawned a limited degree of international lawmaking. Early treaties created a notification system that required states to alert one another of outbreaks and established the bases upon which states could restrict trade in order to prevent the spread of disease [3].

With the end of World War II came the establishment of the UN in 1945, WHO in 1948, and the passage of the Universal Declaration of Human Rights (UDHR) in 1948. The promotion of human rights is named as one of the four principal purposes of the UN. The WHO constitution asserts that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.' [4]. The UN's UDHR [5], the most revered international human rights instrument, articulates the right of the individual to 'a standard of

living adequate for the health and well-being of himself and of his family' including medical care and necessary social services.

Despite these groundbreaking developments of the 1940s, it would be decades before a human rights approach to health issues would gain real traction. Still, this new potential for the human rights paradigm to chip away at the sovereignty paradigm represented a seismic shift in international perspective on disease. It paved the way for a rights-based approach through which states might eventually be held accountable to the international community for respecting, protecting, and fulfilling human rights related to health.

In 1976 the International Covenant on Economic, Social and Cultural Rights (ICESCR) entered into force, allowing states to elect to sign and ratify it [6]. It addressed health-related obligations including reducing stillbirth and infant mortality and the creation of conditions to ensure medical services in the event of sickness. The ICESCR codified 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and required states to take steps necessary for 'the prevention, treatment and control of epidemic … diseases.' [6].

Generally speaking, the provisions of the ICESCR require those states that are signatories progressively to take affirmative steps towards ensuring humane social conditions. The rights enumerated include social security, education and the enjoyment of the benefits of scientific progress. In contrast, the 1976 International Covenant on Civil and Political Rights [7] generally sets out rights that state signatories must respect by refraining from harms such as torture and cruel, inhumane or degrading treatment. It also guarantees rights to life, liberty, security of person, assembly, association, and freedom from discrimination. These two UN treaties, together with the UDHR, are often considered to form an international bill of rights.

In 1978, the non-binding Declaration of Alma-Ata described health as a 'fundamental human right' and 'a most important world-wide social goal' requiring action by many actors other than just the health sector [8].

By the 1990s, human rights advocates were increasingly making health-centered arguments. In order to concretize rights violations, advocates, like those pressing for abortion rights, for example, made arguments that reached beyond familiar rights notions of liberty and autonomy, pointing to the increase in maternal mortality that is concomitant with restrictions on legal abortion [9]. In 1994 UNAIDS was established [10], and the 1994 Cairo and 1995 Beijing conferences on population and women, respectively, set out important (although non-binding) rights language related to health in international consensus documents.

During this period Mann co-taught the first-ever course on health and human rights, founded the Francois-Xavier Bagnoud Center for Health and Human Rights at Harvard, and launched *Health and Human Rights: An International Journal*. He and his colleagues used these new platforms to argue that, despite different histories, perspectives, and vocabularies, public health and human rights are synergistic – each being fundamentally concerned with advancing human wellbeing.

Although convinced of the interconnectivity of public health and human rights, the leaders in this emerging field recognized the potential for tension between the disciplines. Early in the fight against HIV, controversial public health measures such as the United States' practice of detaining HIV-positive Haitian refugees at Guanta-namo, and Cuba's forcible quarantine of its own HIV-positive citizens, loomed as issues ripe for critique by human rights advocates (although, despite their ostensible public health rationale, many health professionals opposed these practices). Mann himself worked to garner consensus among

world leaders against the exclusion of people living with AIDS from everyday life, including from employment and travel, and he was credited with important strides towards a human rights-based response to the disease [11].

Whereas the discourse of the 1980s focused on rights violations against HIV-positive people (and the reduced testing rates such violations would foster), a conceptual expansion in the 1990s embraced claims that human rights compliance across a wide range of issues was relevant to the broader fight against the disease. Linkages were made between a variety of health and rights issues: the subordination of women – tied to sexual violence, economic dependence, and the diminished ability to negotiate condom use – contributes to women's vulnerability to the disease. Collecting names during HIV testing drives down testing rates. Death caused by AIDS leaves children orphaned and communities decimated. People without money for food or schooling may engage in risky sex commerce. Housing discrimination against people living with AIDS jeopardizes wellbeing. Illiteracy hampers HIV/AIDS education. And so on.

Not only does the spread of HIV/AIDS impede the realization of a range of human rights, but human rights violations and state failure to fulfill human rights obligations negatively impact health and thwart the fight against HIV/AIDS. Despite any initial appearances to the contrary, the advancement of both public health and human rights were found to be inextricably linked and mutually reinforcing [12].

New developments in health and human rights

In the decade since Mann's untimely death, the field of health and human rights has continued to expand and evolve. Although the pandemic has not relented, new tools and ideas have emerged, and new points of intersection between health and rights have presented themselves, ripe for careful consideration.

In 2000, the UN committee that monitors the implementation of the ICESCR released its General Comment No. 14, 'The Right to Health'. This groundbreaking document, although not without criticism, was the first to lay out a detailed, substantive accounting of what states must do to realize the right to health. Created in collaboration with WHO and others, the General Comment offers a breadth and depth that helped propel the movement beyond simplistic rhetoric. Its oft-cited triad requires states to 'respect, protect, and fulfill' the right to health. In other words, not only must states refrain from rights violations, they must prevent abuses by non-state actors and take affirmative steps to create conditions conducive to achieving the highest attainable standard of health. General Comment 14 serves as the most definitive answer to the question of what, exactly, the human right to health entails [13].

Also in 2000, states aimed to reverse the spread of HIV/AIDS by 2015 in the UN Millennium Development Declaration [14]. In 2001 the UN General Assembly passed its historic Declaration of Commitment on HIV/AIDS, which outlined a response firmly grounded in human rights. The document set forth ambitious, measurable benchmarks aimed at containing and reversing the pandemic [15].

The early 2000s also saw the battle over the generic production of antiretroviral therapy (ART) pit international intellectual property law on the one hand against international human rights concerns on the other. The HIV/AIDS and human rights community, led by activists in South Africa, pressured multinational pharmaceutical companies to allow generic drug production to continue. The Commission on Human Rights passed a resolution in 2001 entitled 'Access to Medication in the Context of Pandemics such as HIV/AIDS', which

categorized access to these treatments as part of the progressive realization of the right to health [16].

UNAIDS established a Reference Group on HIV and Human Rights in 2002 to advise the joint UN programme on matters relating to human rights, and UNAIDS continues to maintain that curtailing the pandemic and realizing human rights are inextricably linked. Also in 2002, the Commission on Human Rights charged a new special rapporteur on the highest attainable standard of health with reporting and making recommendations about this issue [17]. In the same year, the Global Fund to Fight AIDS, Tuberculosis, and Malaria was launched [18].

Attention to HIV/AIDS as it affects specific populations is reflected in the 2003 General Comment dealing with HIV/AIDS and children's rights, issued by the Committee on the Rights of the Child [19,20]. Other populations to receive the attention of international agencies in the context of HIV/AIDS include peacekeepers as addressed by the Security Council [21], women and girls by the Commission on the Status of Women [22], and businesses and employees by the International Labor Organization [23].

WHO began its '3 by 5' initiative in 2003, setting a target of treating 3 million people with ART by the end of 2005. In 2005, members of the G8 and attendees of the United Nations World Summit committed to a massive scale-up in prevention and agreed to aim for universal access to treatment by 2010 [24]. The UN's International Guidelines on HIV/AIDS and Human Rights, first published in 1998, were revised, consolidated, and rereleased, most recently in 2006. Governments are urged to adopt these guidelines, which translate international human rights norms into recommendations for state-level action [25].

Human rights advocates around the globe began to use new tools in addition to 'shaming': the use of public education and protest to pressure governments to respect international obligations. Now international instruments are more likely to emphasize accountability through measurable assessments of whether states have met benchmarks set out in UN instruments. This new sophistication has coincided with a notable increase in involvement in health and human rights by civil society in low and middle-income countries [26].

Recent setbacks in the fight against HIV/AIDS

In both international and national policymaking, marginalized populations remain dangerously neglected. For example, despite great urging by civil society groups, the 2001 Declaration of Commitment on HIV/AIDS did not specify that men who have sex with men, sex workers and injecting drug users are populations in particular need of protection. By instead using the vague and undefined term 'vulnerable groups', the declaration left room for states to avoid real commitments to these politically unpopular groups [27].

By 2006 it was clear that, despite significant strides, many of the goals set out in the 2001 declaration had not been met. When the UN developed its 5-year follow-up, the 2006 Political Declaration on HIV/AIDS [28], many saw an opportunity to redouble global efforts and concretize the steps that could lead to lasting change. Instead, advocates charged governments with thwarting the quest for inclusion and accuracy by refusing to mention vulnerable groups by name and with backing away from accountability by failing to set new benchmarks for measuring success [29].

Remarkably, funding for HIV/AIDS programmes worldwide has risen nearly 30-fold since 1996 [30]. Because external funding sources comprise the majority of HIV/AIDS budgets in a number of developing countries, donors have significant sway over programming. The United States, the largest international donor, conducts most of its granting through the US

President's Emergency Plan for AIDS Relief (PEPFAR). While providing vital funding for treatment and prevention services, PEPFAR priorities have been the subject of sustained critique by some lawmakers, scholars and advocates [31].

For example, the anti-prostitution pledge requirement forces agencies that receive PEPFAR money to adopt a written policy opposing prostitution. Groups risk losing vital support if their activities – even those paid for with their own, non-PEPFAR funds – may be interpreted as supporting the decriminalization of sex work. This is a problematical position for groups using a non-judgmental approach in their outreach to sex workers, and it fosters a climate that may discourage people from seeking needed services. Brazil recently refused US$40 million in US funding, explaining that they could not afford to endanger their HIV prevention partnership with the sex work community [32].

Unable to prove that abstinence-until-marriage messages work at home, the US administration nevertheless promotes this approach abroad. Despite the condom's confirmed effectiveness in HIV prevention, it has been de-emphasized by PEPFAR. Fully one-third of PEPFAR prevention funding must be directed to programmes that promote abstinence and faithfulness programmes [33,34]. PEPFAR guidelines do not require that abstinence-only programmes give any information about condoms, but programmes that do make condoms available are required to teach that abstinence is the only 'foolproof' strategy for preventing HIV and to highlight condom failure rates. PEPFAR funding recipients have claimed that homosexuality is a preventable disorder, that half of gay American teenagers are HIV positive, and that AIDS is God's punishment for being gay [35].

Moreover, the Bush administration frequently allies with fundamentalist states during UN conferences on matters related to sexuality, as it did at the UN General Assembly Special Session on Children in 2002. The United States worked with Sudan, Iran, Iraq, Libya and the Holy See (the political arm of the Catholic church, the only religion with non-voting member status at the UN) to challenge the right of adolescents to access appropriate and scientifically accurate reproductive and sexual health information and services [36]. Also troublingly, the United States has persistently pushed to drop the term 'human rights' from international consensus documents about HIV/AIDS [37].

At the national level around the world, the need for concrete legal changes persists. Only six in 10 countries in the world have laws and regulations that prohibit discrimination against those living with HIV [38]. For those states that have anti-discrimination laws, enforcement remains a major obstacle. Nearly half of all countries still have laws that may directly interfere with an effective response to the disease, including laws that prohibit condoms in prisons and disallow needle exchange [38]. More than half of all countries in Africa criminalize same-sex sexual conduct, and several new bans on same-sex marriage are emerging. In Zanzibar, a 25-year prison sentence is proscribed for sex between men [38].

Despite the increased prominence of health and human rights at the international policy level, and despite the fact that health and rights can strengthen and reinforce one another, many health professionals on the ground remain, to this day, unfamiliar with human rights. In most countries in the world, health professionals are still not taught about human rights [26]. Even those who have heard of human rights sometimes believe they are something that might cause them problems or get them into legal trouble [26].

Male circumcision: a closer look at a current public health and human rights intersection

Against this backdrop, it is useful to look at one issue around which public health and human rights concerns have recently intersected: male circumcision. Advocates and scholars are engaged in productive and important debate, illustrating the ongoing vitality of the health and human rights dialogue. Recent randomized controlled trials of male circumcision as an HIV prevention vehicle have inspired great hope among many engaged in the fight against the pandemic. Modelling studies project that universal male circumcision in sub-Saharan Africa could prevent 5.7 million new cases of HIV infection and 3 million deaths over 20 years [39]. Others have raised red flags about an enthusiastic embrace of male circumcision as a prevention tool, and the procedure has emerged as perhaps the new issue around which health issues and human rights concerns seem likely to collide.

News that male circumcision has significant prevention benefits called for a move that showed an immediate recognition of individual rights. With interim evidence that male circumcision provided a protective benefit of approximately 50% to male study participants in Uganda and Kenya, the National Institutes of Health terminated the trials early and offered circumcision to the men in the study who had not undergone the procedure [40]. When WHO and UNAIDS reviewed the results of the trials, alongside other evidence on HIV prevention and male circumcision, they concluded that ‘(t)he efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. This is an important landmark in the history of HIV prevention.’ [41].

In the face of this optimism, critics began to caution that the HIV/AIDS community, impatient for good news from vaccine and microbicide researchers, has rushed to embrace male circumcision at the risk of eliding important rights considerations. More than ‘just a snip’, the procedure is imbued with political and social meaning, with historic links to violence, colonialism, religion and moral codes [42]. Even those advocating for male circumcision’s availability have argued that the utilization of male circumcision should not come at the expense of social justice-related efforts to reduce other forms of vulnerability to HIV/AIDS [43]. Gender considerations include the concern that whereas women may eventually benefit from male circumcision if their male partners have lower incidence rates, male circumcision has not been shown to be directly protective for receptive partners whose partner is HIV positive. Concerns have also been raised that male circumcision may increase sexual disinhibition or reduce the ability of a receptive sexual partner to negotiate condom use [44]. Moreover, others have urged that messages about male circumcision should not contravene important advocacy efforts to eradicate female genital surgeries, which have no medical benefit and have been widely denounced as violative of girls’ human rights [46].

Another point of discussion concerns when to circumcise. Infant circumcision has been a hot-button issue in many countries around the world in its own right, outside of the HIV context [42]. As health practitioners have grappled with whether to oppose, recommend or remain neutral about the procedure, a range of rights-related arguments have been advanced against it. Some have compared male circumcision to female genital surgeries, arguing that both surgeries violate rights by harming an otherwise healthy body part of a person too young to give informed consent [47]. Because WHO and other international agencies devote resources to eradicating female genital surgeries but not male circumcision, and because international attention to ‘harmful traditional practices’ focuses predominantly on harms that befall girls, some have alleged a ‘double standard’ that violates equality rights by discriminating against boys [48].

Evidence that neonatal circumcision is safer and less expensive than adult or adolescent circumcision complicates the picture further. The stronger the evidence that male circumcision improves health outcomes, the weaker the 'insufficient justification' arguments become. Still, with other, non-surgical measures available to prevent HIV, the case for male circumcision on infants who cannot consent may remain a point of tension. The Convention on the Rights of the Child requires state signatories to employ a 'best interests of the child'standard [49], but reasonable minds may differ about which interests are most important.

Adult male circumcision, in contrast, may be somewhat less controversial, but it is not without health and rights intersections of its own. Informed consent requires much more than reaching adulthood. Because the procedure involves an element of pain, as well as a certain degree of risk, particularly in resource-poor settings, patients must be able to assess the costs and benefits accurately. The fact that the procedure by no means eliminates the risk of HIV exposure altogether requires intensive counselling that emphasizes simultaneous prevention methods such as condoms. Monitoring the ongoing use of prevention strategies in addition to male circumcision and assessing the long-term impact of the intervention on the rights and the health of all members of the community, not just circumcised men, will be essential to success.

In 2007 UNAIDS published a guidance for decision makers on human rights, ethical and legal considerations surrounding male circumcision. It describes male circumcision as 'an opportunity to reinforce HIV prevention efforts and thereby promote human rights'. It calls for safe, hygienic conditions, along with principles of informed consent, comprehensive counselling, confidentiality, and non-discrimination – conditions that should already be the hallmark of rights-respecting care. It also recommends that states planning to offer male circumcision develop a legal, regulatory and policy framework designed to ensure that these principles are implemented [50]. Rigorous attention to these concerns and to the dilemmas outlined above will help pave the way for a utilization of male circumcision that is respectful of rights.

Any human rights approach to male circumcision should acknowledge that meaningful rights claiming must always evolve and requires careful consideration of the best, most up-to-date medical knowledge. The debut of ART, for example, paved the way for new, realizable treatment demands. New developments in the field and the sheer numbers of those now infected must be taken into account in determining how any HIV/AIDS intervention is to proceed. Given a changing landscape, state efforts to explore new possibilities are an important component of fulfilling the right to health.

At this nexus of health and rights, it is important not to pit one set of rights against another artificially. The potential for rights violations in the rollout of male circumcision must inspire a call for vigilance in its implementation. To move unnecessarily incrementally as a result of violations concerns risks reinforcing too simplistic a conceptualization of rights – thwarting efforts to realize the highest attainable standard of health for populations in urgent need of HIV prevention strategies. A violations-only approach to human rights advocacy is unduly limiting; indeed it overlooks the duty of states affirmatively to create conditions necessary for the fulfillment of rights. In this case, research now indicates that the availability of male circumcision in some settings has the potential to serve as an important tool for realizing good health. Symbiotically, a non-violative, rights-respecting rollout is indispensable to encouraging men to elect the procedure.

Moving forward with meaningful accountability

Thomas Jefferson once declared that 'sick populations (are) the product of sick political systems' [51]. What systems, then, will help release the stranglehold that HIV/ AIDS has on so many populations? The health and human rights framework holds many promises, but it is not without limits, at least as it is currently actualized. When reading Mann's earlier writings about the progress that is needed on human rights and HIV/AIDS, one is struck by how tragically little things have changed in the ensuing years. He wrote 'In many places a variety of social factors have been identified as relevant to HIV/AIDS prevention. These can be grouped roughly into three categories: (1) political and governmental; (2) sociocultural; and (3) economic. Political factors include the inattention or lack of concern about HIV/ AIDS, as well as governmental interference with the free flow of complete information about HIV/AIDS. Sociocultural factors involve social norms regarding gender roles and taboos about sexuality. Economic issues include poverty, income disparity and the lack of resources for prevention programs… (T)he societal-level work carried out thus far, while courageous and creative, remains inherently limited in its scope, applicability, and impact. It has become clear that a deeper understanding of the societal nature of the pandemic and the societal preconditions for HIV vulnerability is now required.' [2].

Mann and his colleagues advocated the use of the health and human rights framework to provide that deeper understanding. Since then, the health and human rights rhetoric has been refined, and the components of relevant rights have been laid out in more detail. To make real progress, however, the human rights concerns that stand in the way of HIV/AIDS work must be addressed with patience, steadfastness and significant resource commitment – in other words, on a scale more typical of biomedical interventions. The development of a vaccine or microbicide is viewed in the long term, with numerous products in various stages of development, all unrelentingly moving towards a clear goal in the name of health. Likewise, advances in human rights must be undertaken with a seriousness of purpose that involves taking deliberate, measurable steps towards ultimately realizable goals.

Stating that discrimination must end is not enough; discriminatory laws on the books must be repealed, and laws that prohibit discrimination must be added. It is in this vein that law can lead, but law is not enough. Social and political will, with adequate funding for implementation and enforcement, must accompany rights-respecting policies if real change is to take hold.

That said, human rights practitioners need to do a much better job of evaluating their interventions using evidentiary standards common to social science. Although we know that the most socially and politically marginalized populations are often the populations most vulnerable to HIV/AIDS, we know far less about what kinds of interventions might change this. If it can be demonstrated that rights-based interventions result in positive health outcomes, such evidence would go a long way towards building the case for increased resource commitments for these strategies. Currently, such data are sorely lacking.

Finally, securing progress requires meaningful state accountability. Whereas treatment needs have shone a spotlight on the multinational pharmaceutical companies of the industrialized world, prevention needs more often illuminate the responsibilities of governments at the national level. The early, determined undertakings by governments of countries such as Uganda and Thailand illustrate that resource-limited governments do not need a free pass regarding accountability for taking concrete prevention steps. Whereas Big Pharma is an easier target, advocates and citizens should not hesitate to expect responsible governance from developing nations. And although much is and should be expected from international

institutions and major philanthropists, it is, after all, the state that has the most explicit legal obligation to its citizens.

Accountability must also entail consequences. Despite the move from mere platitudes asserting that health is a human right to the use of measurable benchmarks and targets, the health and human rights movement is approaching a crossroads. What happens if and when the commitments made are not realized? When 2005 arrived and WHO had not reached the '3 by 5' initiative's target of having 3 million people on ART, little was said. Although not a legal instrument, the point remains: catchy concepts with future targets are only worth so much. The halls of the UN are currently bedecked with framed copies of the Millennium Development Goals, and the outcome remains to be seen. Repeatedly setting goals can create an illusion of progress, but results are what must count.

The clarity that measurable benchmarks provide is undermined by the lack of real consequences for states that do not live up to their pledges. In contrast to some other areas of international law, international human rights law largely lacks meaningful enforcement mechanisms. If no consequences stem from the failure to meet legal obligations, human rights instruments become exposed to charges that they represent nothing more than empty rhetoric. Shaming is an important tool, but it is hardly enough in the face of the overwhelming task of battling HIV/AIDS.

Tools such as the Optional Protocol to the International Covenant on Civil and Political Rights, which allows individuals to request opinions from a quasi-judicial body regarding state violations of the International Covenant on Civil and Political Rights, should be utilized to a greater extent. Similarly, the regional Inter-American Court of Human Rights and the European Court of Human Rights should be used to the maximum degree possible. The European Union has begun to include human rights demands in its preferential trade agreements, an approach that has been effective at promoting reform and deserves a closer look [52]. Sanctions, such as those used in trade and some other areas of international law are another option which, to date, have not seriously been considered.

As another possibility, state membership in (and compliance with) a health and human rights regime could be made prerequisite to the receipt of HIV/AIDS funds. Currently, Global Fund eligibility criteria require that grantees demonstrate 'political commitment' as measured by, among other things, 'supportive national policies' [53]. Proposals must also be 'consistent with international law and agreements' and 'contribute to the elimination of stigmatisation … and discrimination'. The intention is evident, but the requirements could easily be made more stringent and explicit by, for example, requiring states that apply to adopt anti-discrimination legislation in order to be eligible.

None of the above strategies is without pitfalls but, in the quest for meaningful accountability, each is worthy of further exploration.

The scale of the HIV/AIDS pandemic dwarfs the mortality rates of most of modern history's humanitarian crises, wars and periods of civil unrest. By holding steadfast to the framing of HIV/AIDS as a human rights issue, this massive pandemic is situated so as to leave no doubt about the responsibility of national leaders to address it. If there were ever a time for the international community to take concrete steps towards ensuring that states around the world are held accountable for responding to a crisis, the era of AIDS is that time.

Recommendations

1. A human rights approach to HIV/AIDS prevention and treatment is vital to the success of the struggle, and it should be continued and strengthened.

2. International agencies, national governments, and donors should prioritize the needs of marginalized and vulnerable populations including women, men who have sex with men, sex workers and injecting drug users. Law and policies that discriminate against women, criminalize same-sex sex, prohibit needle exchange, ban condoms in prisons, fail to address discrimination against people living with HIV/AIDS and require non-governmental organizations to promote abstinence-only and anti-prostitution messages should be re-examined.
3. Male circumcision is an important new HIV prevention tool. Its rollout should not be delayed unnecessarily and should be accompanied by rigorous attention to human rights concerns generally, and to informed consent, safety, comprehensive client education, and principles of non-discrimination specifically, all within a clearly defined legal and regulatory framework.
4. Increased resources should be committed to long-term rights-based interventions. These interventions should be evaluated using evidentiary standards common to social science.
5. The lack of state accountability remains a major obstacle to progress. New strategies to improve the enforcement of government commitments should be considered, including an increase in the use of treaty-based mechanisms, the implementation of sanctions, the linking of human rights compliance with preferential trade agreements and rights requirements tied to HIV/ AIDS funding.

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